Board Meeting - 28 January 2021

Thu 28 January 2021, 13:00 - 17:00

MS TEAMS

Agenda

1. Welcome & Introductions

Charles Janczewski

2. Apologies for Absence

3. Declarations of Interest

4. Minutes of the Board Meeting held on 17th December 2020

Charles Janczewski

4. Unconfirmed Board Minutes Dec 2020 (1) CAJ.pdf (8 pages)

5. Action Log – 17th December 2020

Charles Janczewski

5. Action Log - 17.12.20.pdf (1 pages)

6. Items for Review and Assurance

6.1. Patient Story

Ruth Walker

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

Charles Janczewski

6.2 - Chair's Board Report January 2021.pdf (5 pages)

6.3. Chief Executive Report

Len Richards

6.3 - Chief Executive Board Report - January 2021.pdf (4 pages)

6.4. Corona Virus Update Report

Len Richards

6.4 - Corona Virus Update Covering Report.pdf (2 pages)

6.4 - COVID 19 Update Report_BOARD JAN 21 - Appendix 1.pdf (7 pages)

6.5. Board Assurance Framework

Nicola Foreman

6.5 - BAF Covering Report -Jan 2021.pdf (4 pages)
6.5 - BOARD ASSURANCE FRAMEWORK - January 2021.pdf (23 pages)

6.6. Patient Safety, Quality and Experience Report

Ruth Walker - Stuart Walker

6.6 - Patient Safety - Q&E - Integrated Board Report.pdf (16 pages)

6.7. Performance Report

Steve Curry - Chris Lewis

6.7 - Performance report January 2021 (Final).pdf (11 pages)

7. Items for Approval / Ratification

7.1. Committee Minutes

Nicola Foreman

7.1.1. COVID-19 Board Governance Group Minutes – 4th November 2020

Charles Janczewski

7.1 - i. COVID 19 BGC Minutes 4 November 2020 Final.pdf (6 pages)

7.1.2. Finance Committee – 25th November 2020

Rhian Thomas

7.1 - ii. Confirmed Minutes - Finance Committee 25 November 2020.pdf (9 pages)

7.1.3. Strategy and Delivery Committee – 10th November 2020

Michael Imperato

7.1 - iii. Confirmed Minutes S&D 10 November 2020.pdf (13 pages)

7.1.4. Health & Safety Committee - 24th November 2020

Akmal Hanuk

7.1 - iv. Health & Safety Committee - Minutes of Meeting 24 November 2020.pdf (7 pages)

7.1.5. Stakeholder Reference Group – 23rd September 2020

Abigail Harris

7.1 - v. Minutes of SRG Meeting - 23 September 2020.pdf (6 pages)

7.1.6. Local Partnership Forum – 22nd October 2020

Martin Driscoll

7.1 - vi. LPF minutes 22 October 2020.pdf (7 pages)

7.1.7. Emergency Ambulance Services Committee – 8th September 2020

Nicola Foreman

7.1 - vii. EASC Confirmed Minutes - 8 September 2020.pdf (15 pages)

7.1.8. WHSSC Joint Committee – 15th December 2020

Nicola Foreman

7.1 - viii WHSSC Joint Commiittee Minutes - 15 December 2020.pdf (1 pages)

7.2. South East Wales Vascular Network Engagement and Consultation

Abigail Harris

7.2 - A - SE Wales Vascular Engagement Report Board Committee - January 2020.pdf (7 pages)
7.2 - B - Annex A - Draft for Board consideration 140120v2.pdf (43 pages)
7.2 - C - Annex B - Vascular Summary Documentv2.pdf (15 pages)
7.2 - D - Annex C Stakeholder handling plan.pdf (4 pages)
7.2 - E - Annex D EQIA SE Wales Vascular Network V4 2020.pdf (19 pages)

7.3. Urgent Service Changes to Support Oesophageal & Gastric cancer surgery for Swansea Bay UHB

Abigail Harris

7.3 - Urgent Service Changes to Support Oesophageal and Gastric cancer surgery for Swansea Bay UHB.pdf (4 pages)

7.4. UHL Engineering Infrastructure Business Justification Case

Abigail Harris

7.4 - Board Committee Report - UHL Electrical Engineering Infrastructure BJC.pdf (3 pages)
7.4 - UHL Engineering Infrastructure BJC Executive Summary 210113.pdf (11 pages)

8. Items for Noting and Information to Report

8.1. Chair’s Reports

Nicola Foreman

8.1.1. Finance Committee – 25th November 2020 & 6th January 2021

Rhian Thomas

8.1 - i Finance Committee Chairs Report November 2020 Public Meeting.pdf (5 pages)
8.1 - i Finance Committee Chairs Report January 2020 Public Meeting.pdf (5 pages)

8.1.2. Quality Safety & Experience – 15th December 2020

Susan Elsmore

8.1 - ii QSE Chairs Report - 15 December 2020.pdf (5 pages)

8.1.3. Strategy and Delivery Committee – 12th January 2020

Michael Imperato

8.1 - iii S&D Chair's Report - 12 January 2021.pdf (4 pages)

8.1.4. Health & Safety Committee – 5th January 2021

Akmal Hanuk

8.1 - iv H&S Chairs Report - 05 January 2021.pdf (3 pages)

8.1.5. Mental Health Committee – 19th January 2021 - Verbal

Sara Moseley

8.1.6. Stakeholder Reference Group – 24th November 2020

Abigail Harris

8.1 - vi. SRG Chairs Report - 24 November 2020.pdf (3 pages)

8.1.7. Local Partnership Forum – 10th & 16th December 2020

Martin Driscoll

8.1 vii. LPF briefing 10 + 16 December 2020.pdf (3 pages)

8.1.8. Emergency Ambulance Services Committee – 10th November 2020

Nicola Foreman

8.1 - viii. Chair's EASC Summary - 10 November 2020.pdf (3 pages)

8.2. Business of Other Committees and Review of Interrelationships

Nicola Foreman

8.2 - Committee Interrelationship Report.pdf (6 pages)

8.3. Corporate Risk Register

Nicola Foreman

8.3 - Corporate Risk Register Covering Report - January 2021.pdf (3 pages)
8.3 - Board Summary - Corporate Risk Register January 2021.pdf (3 pages)

9. Agenda for Private Meeting:

1. Private Committee Minutes

iii. Covid-19 Board Governance Group Minutes

10. Review of the meeting

Charles Janczewski

11. Date and time of next meeting: Thursday, 25th February 2021 Via MS Teams

Charles Janczewski

Unconfirmed Minutes of the Board Meeting
Held on Thursday, 17th December 2020 at 9.30 a.m. – 11.00 a.m.
Via MS Teams Live Event

Present:		
Charles Janczewski	CJ	UHB Chair
Abigail Harris	AH	Executive Director of Strategic Planning
Akmal Hanuk	AH	Independent Member - Community
Allan Wardhaugh	AW	Chief Clinical Information Officer
Chris Lewis	CR	Interim Director of Finance
Dawn Ward	DW	Independent Member – Trade Union
Eileen Brandreth	EB	Independent Member - ICT
Fiona Jenkins	FJ	Executive Director of Therapies & Health Sciences
Gary Baxter	GB	Independent Member - University
John Union	JU	Independent Member - Finance
Len Richards	LR	Chief Executive Officer
Martin Driscoll	MD	Deputy Chief Executive Officer / Executive Director of Workforce and Organisational Development
Michael Imperato	MI	Interim Vice Chair & Independent Member - Legal
Nicola Foreman	NF	Director of Corporate Governance
Professor Gary Baxter	GB	Independent Member - University
Rhian Thomas	RT	Independent Member – Capital and Estates
Ruth Walker	RW	Executive Nurse Director
Sara Moseley	SM	Independent Member – Third Sector
Steve Curry	SC	Chief Operating Officer
Stuart Walker	SW	Executive Medical Director
Susan Elsmore	SE	Independent Member – Local Authority
In Attendance:		
Sue Bailey	SB	Clinical Board Director - Quality, Safety and Patient Experience
Stephen Allen	SA	Chief Executive Officer - South Glamorgan Community Health Council
Secretariat		
Raj Khan	RK	Corporate Governance Officer
Observers:		
Bryn Harris	BH	IT Project Manager, IM&T
Apologies:		
Fiona Kinghorn	FK	Executive Director of Public Health
Malcolm Latham	ML	South Glamorgan Community Health Council

UHB 20/12/001	**Welcome & Introductions** The UHB Chair welcomed everyone to the Public Meeting in English and Welsh.	
UHB 20/12/002	**Apologies for Absence** Apologies for absence were noted.	
UHB 20/12/003	**Declarations of Interest** There were no Declarations of Interest.	
UHB 20/12/004	**Corona Virus Update Report** The CEO informed Board Members that a significant increase had been seen in infection rates across C&V: • 500 per 100k in Cardiff • 380 per 100k in The Vale The figures were based on a report dated 15/12/2020 and would therefore have increased further. The concerning factor was that the infection rate had increased in the over 60 population as this was used as a good predictor in terms of demand in Healthcare services. **Operational** The Chief Operating Officer (COO) stated that the most pressing operational update was around Covid and Unsheduled Care and was reflective of the all Wales position. The COO informed the Board that operational challenges were compounded by IP&C precautions resulting in bed reductions and staff shortages which restricted the pace at which roll out of the exisiting bed plan could take place. The current position was: • 181 active Covid positive patients across UHW, UHL and St David's • 108 beds occupied by patients suspected to have Covid or in the recovered phase (greater than 14 days since diagnosis) • Collectively in relation to Covid 289 beds were curently occupied • Further 90 beds closed by IP&C precautions – true bed burden around 379. Despite these figures, occupancy and admissions were lower in historic terms resulting in a demand capacity imbalance. Patient flow was highlighted which compromised the emergency unit and resulted in non acceptable delays in waiting i.e. ambulance delays, hospital waits. Although the position was not as extreme as other areas in South East Wales, it was still precarious. Unlike normal winter pressures, currently the UHB was operating by capactiy demand issues primarily driven by: • Beds being lost to IP&C precautions • Restriction in opening additional capacity due to staff shortages • Challenges in discharge in relation to policy. All of these were compounded operationally by an unprecedented	

complexitiy of challenges with multiple Covid pathways being put in place and IP&C restrictions affecting 15 areas in the hospitals.

In terms of plans going forward, the revised operating model introduced in the first wave was still intact, site based leadership had been reinforced and three local co-ordinating centres across primary care and the acute hospitals had been developed.

There was now a two stage plan as follows:
Plan 1 – Pre Christmas to New Year bridging plan which brought into play a number of actions from securing extra bed capacity, through to actions around discharge, working with local authority, also tactical options to keep people safe in relation to IP&C.
Plan 2 – 100 beds to be opened in the Lakeside Wing Field Hospital, this could become 250 beds if some of the actions around discharge and IP&C were achieved.

As we approach Christmas and New Year:

- The first 50 beds of the Lakeside Wing Field Hospital would be opened with 25 beds between Christmas and New Year
- Further 25 beds in the first week of 2021
- Further 50 later in January

This would be done by a Step Up and Down plan.

Essential services would be maintained throughout the period and emergency and cancer service patients would receive the priority they did throughout the first wave.

Primary Care were not immune to pressures and the example of one practice having to temporarily close due to the number of staff needing to quarantine was provided. The practice had pre developed contingency plans that were put in place and the patient population would be served throughout, the practice had now reopened. RAG ratings were in place for all practices and 9 were being actively supported.

In terms of planned care, there were plans to recover planned and unplanned care but going forward it remained to be seen due to current pressures.

- Primary Care referrals dropped to 27% during the first wave but were now back up to 75%
- Outpatient activity had risen from 21% to 78%
- Procedures including surgery were back to 70% of pre covid levels

Waiting lists continued to rise with:

- 90k people on the treatment waiting list
- 39k people waiting more than 6 weeks

It was highlighted that cancer services had been maintained throughout and cancer treatments had recently exceeded the level of treatment being provided pre Covid to try and reach as many patients as possible. The single cancer pathway had now come into use in Wales. However in recent weeks there were a small number of patients that

were more reluctant to recieve treatment.

The Mental Health position remained a challenge due to:

- Increase of PMHSS and Primary Care referrals after the first wave which continued
- Substantial staff losses many relating to Covid.

There were marginal changes to some elective servies in mental health in order to maintain the more urgent services, this mainly affected lower accuity elective work. Although a challenging position, the staff had been characteristic in their commitment and their efforts.

Independent Member – Community (IM-C) queried whether there was anything factored in for normal winter pressures. The COO responded that it was difficult to tease apart the Covid challenge from the general unscheduled care challenge.

Chief Executive Officer - South Glamorgan Community Health Council (CEO-CHC) queried what the public message would be for both elective and emergency care as it was key that people who needed to come in did so and felt safe in order to do that. In addition how would the new lockdown for 28th December affect services and what messages were planned should services need to be stepped down. The COO responded that these were not decisions taken lightly and given the fluidity of the situation, a judgment would have to be reached as to how much would have to be done and how much could be avoided; learning from the first wave, it was known that there was always harm no matter the approach taken.

The Chair thanked the COO for the update that illustrated the challenges currently faced and the operations team for their efforts to make things as smooth as possible for patients.

The CEO advised how the Executive team had responded to what was a very challenging situation. It was realised that this was a different phase of the pandemic, with a significant rise in infection rates which if continued, would take the UHB into territory beyond what was seen in the first wave, with a prediction that on the basis of the numbers presented in the report dated 15/12/2020, by Christmas Eve there would be 1300 positive cases per 100k.

The CEO confirmed that the Executive team were now on a 7 day working pattern and available over 7 days, working their normal 5 days over that time. In addition, communications woud be stepped up with staff, making the most of virtual meetings and putting in place virtual sessions where issues could be raised with him enabling the frontline to engage directly with queries and challenges.

The Chair reminded members that following discussions of the Covid-19 Governance Group, he had requested the streamlining of Committees to deal with essential business only, and defer non urgent items to take less time away from Executive colleagues during this emergency period.

Quality & Safety
The Executive Nurse Director (END) reminded members that a detailed briefing went to the QSE Committee earlier that week so members who attended would have foresight of the current position.

Update on outbreak position:

- 15 wards affected by outbreak or an incident – not including the prison
- 16/12/2020 – Day Hospital opened again for Mental Health Sevices for Older People
- 71 beds empty due to infection – 53 of these were admitting at risk patients
- Review of patients with Covid-19 on their death certificates

The END highlighted that a thematic review was being done on anything covid related to ensure appropriate action and aid learning. In the first wave, PPE issues were raised and in response the views of staff were obtained and 3 audit reviews conducted; the END assured the Board of significant progress ensuring all key areas were being addressed.

Staffing issues remained a challenge but training was taking place to ensure the correct individuals were in the correct areas with the necessary skills.

The END advised that throughout the pandemic, as would be done in normal cirumstances, the patient experience was continually monitored. More recently, complaints had been seen in relation to a busy environment where the quality of care may not be up to previous standards, there was close working with complainants to improve the situation.

In addition to key meetings with senior medical and nursing staff, the END and Executive Medical Director (EMD) were meeting staff in their clinical environments to avail any worries and confusion as staff were understandably anxious during these times.

Workforce
The Executive Director of Workforce and Organisational Development (EDWOD) stated that how staff had responded to the pandemic throughout 2020 was phenomenal but it was also recognised that they were very fatigued and overworked. The UHB was now in the second wave asking staff to go again into a challenging environment when their “batteries” were flat however staff were still responding.

Currently there was a 10% absence rate due to normal sickness and covid related issues, nevertheless staff rotas were required as staff were being asked to do something different from their normal jobs. This was being done in a way people were acknowledged and recognised, he highlighted that the END’s team were doing an exceptional job for those nurses who cross into these spaces so that they were made to feel protected with the suitable support behind them.

The EDWOD reminded members that earlier in 2020, 1200 people had been recruited in addition to 400 recruited during the winter period. He added that although there were certain areas of staff they could source and bring in, due to the required clinical skills there was a limited capacity within the UK as all health boards were chasing the same level of skills. The UHB was in a positive place regarding this compared to other health boards. Next year would see the UHB going overseas, as had been done earlier in the year, which had brought in circa 80 staff, it was expected that 60-70 would arrive in the first quarter of the next calandar year. He assured the Board that no stone would be left unturned to find staff to support activity.

The Health And Well Being Group met on a weekly basis and discussed how staff could be supported practically with transport to work, staff havens, access to food and water etc. He highlighted that we were not getting a similar public response to the first wave where 75k meals had been distributed and that now we as a health board had to support this, a click and collect service for staff had been introduced in Aroma and the opening hours of all cafes and restaurants extended to make them more accessible for staff.

In relation to redeployment, there was a limited ability to move people about within the organisation. He added that this was a moving feast as every time a rota was staffed there were occasions which stopped people from being available i.e. Covid. He added that it was not just frontline staff but support staff as well who were working unbelievably hard also, the partnership with trade union colleagues had been key in achieving this.

The IM-ICT queried whether more should be done in the media to encourage people to come out of retirement and volunteers as publicised in the first wave. The EDWOD responded that in terms of recruitment everything possible was being done, his teams were very active on social media and worked with the communications team. University recruitment was also being looked at to aquire undergrads for 3 month placements.

The END addressed the volunteering position saying that they had not seen huge numbers of people formally volunteering although they had seen returning volunteers. Some were doing a great job at the front door challenging people coming in, others were listening and talking to the bereaved or lonely via the chat line.

Governance
The Director of Corporate Governance stated that this section could be taken as read by Board members and there was nothing further to add

Public Health
The EDPH stated that the articulated detail was held within the report and highlighted that we were in a difficult position of exponential rise with an “R” rate above 1, also being one of the highest in Wales. A regional IMT was held on 15/12/2020 stated that we were currently in a

UHB 20/12/005	**Minutes of the Board Meeting held on 26th November 2020** The Board reviewed the Minutes of the meeting held on 26th November 2020. **The Board resolved that:** a) The minutes of the meeting held on 26th November 2020 be approved as a true and accurate record.	
UHB 20/12/006	**Board Action Log following the Meeting held on 26th November 2020** The Director of Corporate Governance (DCG) reviewed the action log from the Meeting held on the 26th November 2020. **UHB 20/11/010** – to be picked up in January **UHB 20/11/014** – the DCG would discuss with the END when this would need to be brought back **UHB 20/09/010** – went to S&D Committee - Complete **UHB 20/07/010** – Learning Committee - Complete **UHB 20/11/012** – DCG to agree a date with the COO **The Board Resolved that:** a) The Action Log and updates be received and noted.	
UHB 20/12/007	**Covid-19 Discovery Report** The EDWOD explained that this report originated from the unbelievable way the Health Board responded to Covid in the first wave and the fact that there were lessons to be learned from that. Open conversations, limited to 5 questions, had taken place with 100 senior members of staff. The future organisational direction pointed to conversations around culture and leadership engagement. Amplify was showcase and further engagement with the organisation. It was important to not lose sight of this feedback although we were seeing some behaviours reverting to pre covid. He emphasised that governance and management processes were needed but creativity, flair and initiative to make things happen for the benefit of the patients was also important and striking that balance going forward. The EDWOD expressed that this was a fantastic report which for the Health Board reflected the capability and capacity that it has as well as educating the next steps of Amplify and showcase. He also felt it was a document that the Board should reflect on from time to time. The Chair echoed that this was an impressive piece of work and that the team that pulled it together had done an excellent job as it captured the amazing work of our staff and the innovative, transformative ways they had worked. In addition the case studies highlighted not only the positive outcomes but also lessons learned and future plans which was a good combination of using the information available to us and taking it forward. **The Board resolved that:** a) The Corona Virus Update Report be noted.	
UHB	**Review of the meeting**	

20/12/008	All members were happy with the meeting and meeting format.	
UHB 20/12/009	**Date and time of next meeting:** Thursday, 28th January 2021 at 1:00pm Via MS Teams	

ACTION LOG
Following Board Meeting
17th December 2020

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
Actions Completed					
UHB 20/11/012	**Performance Report**	To provide a detailed position report to Strategy and Delivery on elective access/waiting.	TBC	Steve Curry	**Complete** Provided to S&D meeting on 12/01/21
Actions In Progress					
UHB 20/11/010	**Board Assurance Framework**	Revisit the risk score in regards to the workforce score	**28.01.20**	Nicola Foreman	On agenda for January Meeting 6.5
UHB 20/11/014	**Nurse Staffing Act – Mental Health Nurse Staffing Levels**	A further discussion to be had at an executive level to consider Mental Health Nurse staffing levels for feedback to the Board	**TBC**	R Walker	To be brought to a future Board meeting when concluded
Actions referred to Committees of the Board/Board Development					
20/07/010	**Patient Safety, Quality & Experience Report**	A 'Learning Committee' would be discussed and considered with operational colleagues.	17.12.2020	R Walker / S Walker	Workshop scheduled for 17/09/2020 Learning Committee will be considered, formal output of the workshops would be brought back to the Board Development & to Board in January

Report Title:	**Chair's Report to the Board**								
Meeting:	Public Board Meeting						**Meeting Date:**	28th January 2021	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**x**	**For Information**	**x**
Lead Executive:	Chair of the Board								
Report Author	Executive Assistant to Director of Corporate Governance								

Thank You

I would like to offer up my sincere gratitude to all of our staff working across our Health Board for your outstanding work and exemplary care that you continue to provide to our patients. It has been a very challenging 10 months or so since we first encountered the Covid-19 virus which has had such a major impact on all of our lives. You have all been amazing and so dedicated throughout this difficult period. Once again, thank you for your magnificent contributions to the welfare of our patients.

Background and current situation

This report provides an update of key activities that have taken place since the last Board Meeting on the 17th December 2020.

Vale of Glamorgan Public Services Board Climate Change Charter

Public sector partners in the Vale of Glamorgan have formally expressed their commitment to tackling climate change by agreeing a Vale Public Services Board Climate Change Charter https://www.valepsb.wales/en/Our-Progress/Tackling-Climate-Change-in-the-Vale-of-Glamorgan.aspx. The development of the Charter follows discussions over the last 14 months including a workshop held in November 2019 with young people where we were joined by members of the UHB's Youth Board alongside enthusiastic youngsters from local schools and the Vale Council's Youth Forum. Natural Resources Wales has taken a lead in this work, which fully aligns to the UHB's Sustainability Action Plan approved at the November 2020 Board. The Charter signs partners up to a set of principles including leading by example, taking positive action and reducing our impact, while recognising that approaches and plans for implementation within individual Organisations may differ. We wanted to bring this work to the attention of the Board and for the Board to support the Charter ahead of a formal launch by the PSB in February; the aim is for this to provide a catalyst for engagement with the wider community on the issues and how we can make a difference in line with the commitments in the charter.

Approach to Equality within Cardiff and Vale UHB

Following the killing of George Floyd in May, the subsequent Black Lives Matter protests that took place over the summer highlighted the systemic inequality that Black, Asian and/or Minority Ethnic (BAME) people face not only in the USA but also here in the UK. Also it has been found that Black, Asian and/or Minority Ethnic groups are disproportionately affected by COVID-19, with available statistics suggesting that these groups are up to two times more likely to die from the disease than

their white counterparts.

In light of this, in an edition of Chief Executive Officer Connects our Chief Executive asked members of staff from Black, Asian and/or Minority Ethnic backgrounds to share their experiences of working in the UHB and the issues of inequality they have faced. A report into their experiences will be shared with the Board in early 2021. This is only the start of the conversation. As an organisation, we know we need to do more, to keep learning and accept and act on the need for change.

Our organisation has a willingness and readiness to listen, reflect, learn and make changes in order to enhance our inclusivity, diversity and fairness. We really value the diversity within and across our workforce and the diverse population that we serve. We believe that the principles of inclusivity, equality and diversity are critical to us being an employer of choice. Inclusion, equality, diversity, human rights and fairness cut across all of our work.

We already have a Strategic Equality Plan - Caring about Inclusion 2020-2024 and an Equality Diversity and Inclusion (EDI) policy, and are making progress on the actions we have set ourselves. We intend to build on this during the coming year and beyond.

We know that many organisations struggle to talk about and address issues around equality or inclusion particularly as it inherently involves conversations about race, gender, sexual orientation, physical and mental ability, and more. Here, at the UHB, we recognise that it's a topic too important to ignore: we can't afford to be silent. It is critical to our workplace.

While we've seen the occasional inspiring story of grass-roots transformation initiated by employees looking to drive change, the truth is, diversity and inclusion has to come from all levels of an organisation. Therefore, 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), and I have chosen to lead on disability.

The Equality, Diversity and Inclusion agenda has been presented to the Board, the Health Service Management Board and our Stakeholders Reference Group to highlight and discuss the 'Improvement through Inclusion' approach that the organisation will be undertaking over the next couple of years. This approach will be about focussing on stepping up and stamping out prejudice and building a diverse and supportive culture of respect and fairness for all. We recently held a Board Development Day in which our leaders began to look at and reflect on the change that is required. Further some of our staff are members of both the Welsh Government Race Equality Action Plan Group and the Cardiff Race Equality Task Force.

Our ambition is to be a fair and inclusive employer go beyond complying with the requirements of equality and human rights legislation. We want to create an equal and diverse environment so people feel they can freely speak about diversity and inclusion about how we can make sustainable and meaningful change.

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

The common seal of the Health Board has been applied to 3 documents since the last meeting of the Board.

Seal No.	Description of documents sealed	Background Information
943	Extension of Licence period. Wedal Road Renewal of lease of land to Lakeside Home	Supplemental Agreement
944	Lease of Holm View Leisure Centre, Skomer Road, Barry	Between Vale of Glamorgan and Cardiff and the Vale council and the Local Health Board
945	NEC3 ECC - Option E (Costs reimbursable Contract) - Electrical Infrastructure installation at Lakeside wing	Between Cardiff and Vale UHB and F.P Hurley & Sons Limited

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

Date Signed	Description of Document	Background Information
30.12.20	Supplemental Agreement - Haulage Road, Whitchurch Hospital, extension of licence period	Cardiff and Vale UHB and Hugh James
17.12.20	Licence to Occupy on Short Term Basis relating to Ground Floor at Pentwyn Leisure Centre, Bryn Celyn, Road, Cardiff	NWSSP and Legal and Risk Input
22.12.20	Licence for Walk in testing centre	NWSSP and Legal and Risk Input
16.10.20	Construction contract for the 400 Bed Surge Hospital	Legal and Risk and Darwin Group

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	
07.12.20	Insourcing Endoscopy Procedures	The contract is urgently required to help support increased patient waiting lists due to Covid-19, therefore a Chair's Action has been requested.	16.12.20	Approved at Board Governance Group 16.12.20	Approved at Board Governance Group 16.12.20	Refer to minute stated for queries raised by IMs
10.12.20	Solid Tumor and Haemato Oncology	Contract increase inclusive of extension £7699.434.82	16.12.20	Approved at Board Governance Group 16.12.20	Approved at Board Governance Group 16.12.20	Refer to minute stated for queries raised by IMs
30.12.20	AHP Managed Service	Direct Award via Framework Agreement for the supply of Allied Health Professionals. Value £818.874.00	17.12.20	Rhian Thomas 30.12.20	Michael Imperato 30.12.20	No queries raised
23.12.20	Specialist Consultancy Framework	Value of proposed new contract inc VAT - £10.800.00.00 Previous approved contract value inc VAT £480.000.00	06.01.21	Rhian Thomas 06.01.21	Michael Imperato 06.01.21	No queries raised

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

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

Recommendation:

The Board is recommended to:

- **NOTE** the report
- **SUPPORT** the Vale of Glamorgan Public Services Board Climate Change Charter
- **APPROVE** the Chair's Actions undertaken.

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

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

Equality and Health Impact Assessment Completed:	Not Applicable

Report Title:	**CHIEF EXECUTIVE'S REPORT**								
Meeting:	CARDIFF AND VALE UHB BOARD MEETING					**Meeting Date:**	28.01.2021		
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**	✓	
Lead Executive:	**CHIEF EXECUTIVE**								
Report Author (Title):	**EXECUTIVE ASSISTANT TO THE CHIEF EXECUTIVE**								

Background and current situation:

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

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

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

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

Executive Team Changes

Following the news that Martin Driscoll will be leaving the UHB I am delighted to announce that I have appointed Dr Stuart Walker as Deputy Chief Executive and Rachel Gidman as Interim Executive Director of Workforce and Organisational Development. They will be starting their new roles in March after Martin leaves us for his new opportunity in Welsh Water. I am sure you will agree Martin has made a big difference in our Executive Team and he will be missed and we wish him well in his new role.

Stuart is a cardiologist by specialty and has over 30 years' experience working across a number of disciplines including medical leadership within an acute trust offering regional specialist services and also in a community and mental health trust. In the relatively short time he has been with us he has made a significant impression across the broad agenda that we have faced and I am particularly impressed by his leadership capability and the multi-disciplinary way in which he approaches his work. Stuart will now deputise for me when I am on leave and he will also develop a portfolio of work in that Deputy Position, his leadership will be very welcomed to this role.

Rachel has been working in Cardiff and Vale University Health Board for many years and her career has been diverse, having started in a clinical role and then progressing as Head of Nurse Education and LED. In 2017 she gained the role of Assistant Director of Organisational Development. Rachel is an enthusiastic and driven individual who invests in people to make a difference in Healthcare. Her drive to facilitate key initiatives such as Amplify and the Apprenticeship Academy, as well as her strategic experience in designing and delivering the Workforce and Organisational development plan for the Dragons Heart Hospital will give a great

foundation for her new interim role on the Exec Team.

Video Consultations

One of the major developments we've seen in 2020 has been the introduction of videos consultations, which have really been embraced by both patients and staff. The NHS Wales Video Consultation Service has not only provided a valuable, safe option for continuing to see our patients face-to-face throughout the COVID-19 pandemic, but it has also given patients greater flexibility in how they attend their appointment, reduced traffic in and around our sites, and delivered significant environmental benefits locally.

Since we launched the service in April, we have conducted around 15,000 consultations by video, which we estimate has prevented in excess of 150,000 miles of travel to hospital for our patients. It adds up to around 41 tonnes of CO_2 emissions having been avoided in and around local hospitals.

Joint statement from Velindre Cancer Centre and Cardiff and Vale UHB

Velindre University NHS (VUNHS) Trust and Cardiff and Vale University Health Board are committed to working together to deliver the best care and outcomes for patients with cancer within the population we serve. Both Organisations welcome the recent Nuffield Trust Report regarding the delivery of non-surgical cancer services in South East Wales and the development of the new Velindre Cancer Centre. The recommendations have been formally accepted by the VUNHS Trust Board.

The Nuffield advice provides a framework to expedite the planning of new models of care that will then determine the footprint of Velindre services in each of the local Health Boards. It also highlights the particular relationship and services that need to be strengthened and developed between Velindre Cancer Centre and Cardiff and Vale UHB. These include an enhanced Acute Oncology Facility, a Research Hub with links to Cardiff University through which complex early phase trials and complex advanced therapies for cancer can be delivered leading to an enhanced, integrated, multi-disciplinary Clinical Academic workforce. Services need to be aligned, where possible, so that pathways of care can be optimised for patients requiring complex, specialist inpatient care. This is also an opportunity further develop and align important aspects of service provision for both solid tumour and haematological malignancies.

Our two organisations are energised to meet this challenge which will require close partnership working. A new relationship board is being set up between the two organisations which will facilitate this process and ensure that we are able to jointly develop our services for patients.

Lakeside Wing

Our new Lakeside Wing on the grounds of UHW now has more than 50 patients, after receiving its first patient during the festive period.

The new surge facility currently has 166 beds which is on track to increase to 400 beds before the end of this month, enabling us to meet the capacity requirements for winter and COVID-19.

The facility is being used to support patients who are undergoing essential rehabilitation on their road to recovery after a period of acute illness, not necessarily COVID-19. These patients are benefiting from a multi-disciplinary model of care from staff including physiotherapists, occupational therapists, dieticians, pharmacists, healthcare support workers and registered

nurses. Find out more about Lakeside Wing here.

Mass Vaccination

The Mass Vaccination Programme is well underway and we have now passed 25,000 vaccinations. We continue to make good progress working through the JCVI priority groups one and two, with more than 13,000 frontline healthcare workers from Cardiff and Vale UHB and various partner organisations working on our patch, protecting our frontline from COVID-19 so that we can continue to care for our community. Numbers of over 80s receiving their vaccination are really starting to accelerate, with around 3,500 now vaccinated with the first dose. You can keep track of progress on our website.

This great progress is testament to the tireless work of our team delivering the vaccination programme across our sites, with all GP practices across the area now also on board and making an important contribution to our efforts. We have also been taken aback by the remarkable number of people showing an interest in supporting the roll out of the vaccination programme, whether to deliver vaccinations, help the booking centre, or support recipients of the vaccine.

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

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

Recommendation:

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

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

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

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant, click here for more information

Prevention	✓	Long term	✓	Integration	✓	Collaboration	✓	Involvement	✓
Equality and Health Impact Assessment Completed:	Not Applicable								

Report Title:	**Corona Virus Update Report**								
Meeting:	Board						**Meeting Date:**	28.01.21	
Status:	**For Discussion**		**For Assurance**	**x**	**For Approval**		**For Information**		**x**
Lead Executive:	**Director of Corporate Governance**								
Report Author (Title):	**Director of Corporate Governance**								

Background and current situation:

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

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

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

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

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

Recommendation:

The Board is asked to:

- Note the attached COVID-19 Update Report.

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

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

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

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

Equality and Health Impact Assessment Completed:	Not Applicable

COVID-19 – Update Report Covering Key Activities in Relation to: • **Quality and Safety** • **Workforce** • **Governance** • **Operations** • **Public Health**	**Month: January 2021**
Quality and Safety	Executive Nurse Director/Executive Medical Director
• **Covid outbreak position** – at time of writing there are 21 wards across the UHB managing covid outbreaks (10 at UHW, 10 at UHL and 1 at a community hospital). The Executive Nurse Director continues to chair daily Infection. Prevention and Control meetings with senior staff to monitor the overall situation. Lakeside Wing additional capacity was opened on the 27.12.20 to the first cohort of patients to support with Covid-19 pressures within the C&V UHB footprint. Further capacity remains available if deemed necessary to utilise. The UHB is complying with routine daily nosocomial reporting arrangements to Welsh Government. • **Healthcare Inspectorate Wales** – HIW have currently paused routine quality checks and inspections until the end of January 2021. • **Serious Incident (SI) reporting** – Welsh Government have re-introduced a more limited approach to SI reporting and have asked for proportionate investigations. The 60 day timeframe for investigations has been removed at present. • **Concerns** – There has been an increasing number of concerns raised by people not being able to contact the wards for updates. The Patient Experience Team continue to facilitate virtual visits and phone calls but the demand is increasing and if a clinical update is required then contact from the medical and nursing staff is required. The clinical areas are being encouraged to put Reception staff in wards to manage calls from relatives	
Workforce	Deputy CEO and Executive Director of Workforce and OD
• Workforce Hubs are established for Nursing, Medical, AHP, Facilities and Primary Care brought together through a Daily Workforce Steering Group chaired by Interim Director of Workforce & OD • **Lakeside Wing (LSW)** Workforce model developed to support phases – based on multiples of 28 beds. Phase 1 & 2 completed – now staffed to 66 beds. Plan in place to staff to 84 beds but no decision yet on opening these residual beds. o Progress remains on track for LSW with an improved nurse position o AHPs and pharmacy - flexing staff across the UHB where needed o Critical care in a better position due to internal deployment of staff volunteers, but pressure remains high o Staffing for Red wards has improved o HCSW position is improving due to rapid recruitment	

- Medical & Dental rotas have been changed but a more finessed approach this time to avoid disruption. 45-50 staff have now been moved to overall Mega Rota, with new compliant rotas in place. Feedback positive.
- The supply and demand of staff however is still changing due to a number of different factors including opening additional surge capacity, Covid outbreaks on ward areas where large numbers of staff have to self-isolate for 10 days and staff sickness
- Staff Haven being put in place at LSW

- **Mass Immunisation** & Vaccination Programme - Recruitment Plan & support in place (291 wte in plan, 145 recruited). Recruitment phases are on track. See Below for assurance.
  - **Call Handlers – Mass Immunisation**
  - Staff requirement increased due to service demand. 71 staff recruited
  - **COVID Immunisers**
  - Non-registered. Further 210 students have registered an interest. This equates to additional 67 whole time equivalents.
- **Registered Staffing**
  - Recruitment going through Nursing Hub, with Workforce Hub processing enrolments.
  - Further commission of 75 international nurses confirmed. 45 appointments made.
  - 6 Physician Associates appointed to support Medicine and Surgery CBs

- **Increasing temporary recruitment:–**
  There have been a total of 520 posts requested for urgent recruitment with the Workforce Hub, with 336 offered posts out of 520 requested.
  - Of the 336, 135 facilities staff recruited, with high interest in second advert. HR Team have interviewed total of 243 candidates.

Other:

- Staff-wellbeing being prioritised with a comprehensive full range of initiatives and support in place as well as a new initiative with Remploy to support staff with Long Covid and the Staff Haven
- Temporary enhanced overtime pay incentive scheme for Substantive Registered Nursing staff implemented which is now extended to HCSW
- A COVID-19 Learning Report has been produced
- Absence has been rising. Daily reporting through Clinical Board Absence is running at approx. 9-10%.
- This has been impacted due to the recent WG advice on Shielding which means shielding for Clinically Extremely Vulnerable staff resumed from 22 December – 7 February 2021. Our staff can work but they should work from home. Staff are being deployed into alternative roles and call handler roles wherever possible.

Mass Vaccination Workforce Plan @ 11.1.2021 (n.b. status improving daily)

Booking Centre			
Booking Centre	**Planned workforce (wte)**	**Current Position**	**Status**
Booking Centre Manager	1	1	
Deputy Booking Centre Manager	1	1	
Assistant Admin Manager	3	1	
Call Handler/Administrator*	44	40	
Digital Lead	1	1	
Digital Support	1	1	
Total	**51**	**47**	
*Total workforce need expected to increase			

11Jan-07Feb (4Weeks)				
Mode	**Current Capacity**	**Daily Staffing need (Headcount) - All roles**	**Position**	**Status**
Splott MVC	10 Immunisers	15	15	
UHL*	5 Immunisers	11	11	
UHW*	5 Immunisers	11	11	
Care Homes	5 Teams	20	12	
Mobile/Co-Morbidities	19 Teams	38	0	
Total		**95**	**49**	
*Satellite sites in temporary operation - workforce will move to other teams on completion				

01-Feb				
Mode	**Planned Capacity**	**Daily Staffing need (Headcount) - All roles**	**Position**	**Status**
Splott	20 Immunisers	35	15	
UHL*	5 Immunisers	11	11	
UHW*	5 Immunisers	11	11	
Care Homes	5 Teams	20	12	
Holme View	10 Immunisers	15	0	
Pentwyn	10 Immunisers	15	0	
Mobile/Co-Morbidities	19 Teams	38	0	
Total		**145**	**49**	
*Satellite sites in temporary operation - workforce will move to other teams on completion				

Governance	Director of Corporate Governance

The Chair of the Board has requested that the Committees of the Board continue to meet during the second wave of the pandemic. However, the Committee agendas are being reviewed with the Chairs of each Committee and the Director of Corporate Governance to ensure that they are reduced to only essential items to allow Executive time spent at the Committees to be minimised.

In line with the proposed amendments to Governance arrangements, which were agreed by the Board in November, the Board now meets on a monthly basis, the Board Governance Group meets on a monthly basis and the Committees of the Board are ensuring they are reporting appropriately on COVID-19 issues. e.g. Quality Safety and Experience Committee has an additional report at each meeting to outline the impact of COVID-19 on patient safety which identifies any areas of concern in relation to IPC, PPE or staffing levels impacting upon quality.

Management Executive continues to meet on a Monday each week and there is a twice weekly COVID-19 Operational Meeting which is Chaired by the Chief Operating Officer with 40+ Clinical Board staff attending in addition to the Executive Directors.

Operations including Operational Framework	Chief Operating Officer

The revised Covid-19 operating framework previously presented to Board and set out in the Health Board's IMTP remains in place. The key components of the revised operating framework continue to guide operations in the second wave of the Pandemic. The first principle of remaining 'covid ready' remains, along with a number of key operating principles which include using a 4-6 week planning horizon, a service 'gearing' approach in response to covid demand, Protected Elective Surgery Units (PESU) or 'green zones' and an increased emphasis on site-based management and leadership through Local Co-ordinating Centres (LCC's).

The update provided at last month's Board remains valid and all of the actions described within that report remain in place. Developments since the last Board include:

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

Unscheduled care – increased USC pressure due to winter and covid demand described in the last report continued and intensified throughout December and early January. In line with modelling, covid admissions continued to rise through Christmas and the New Year, with some indication of the increase moderating by the second week of January.

Critical care services were particularly challenged between Christmas and the New Year. This was mainly driven by staff shortages, as bed capacity was sufficient.

In line with the revised operating model Local Coordinating Centres deployed tactical capacity plans to accommodate the increased covid demand. This included re-purposing hospital capacity in line with the prevailing demands (covid, non covid etc).

The first beds in the new Lakeside Wing (LSW) surge facility were deployed on the 27 December. As at the 8 January two wards (56 beds) were in use, with a further 110 beds of the phase 1 capacity remaining available. Phase 2 is on track to be completed by the first week of February, taking the total capacity in LSW up to 400 beds.

Planned care – the Health Board remained on trajectory in terms of delivering its elective recovery plan in Q3. However, increased pressure from the second covid wave resulted in the Executive taking the decision to cease non-cancer and non-urgent elective activity for the month of January. The reduction in elective activity was particularly helpful in support of critical care staffing – through the redeployment of perioperative staff to ICU.

Cessation of elective activity is under constant review and the aim is to limit this to the month of January 2021. However, this is entirely dependent on the pandemic's progression and the resulting demand on health services.

Cancer care – As with the first cessation of elective services, cancer care continues to be provided as an essential service. Treatment volumes in November (the latest reportable period) were marginally above those for the same period last year. Referral levels have increased but are slightly below pre-COVID expected levels.

Mental Health services - Pressure on MH services has continued to grow. The increase in demand for PMHSS along with ongoing staff absence due to pressures in the system mean that 28 day access for primary mental health assessment has deteriorated. A significant majority of patients continue to be assessed within 30 days however. An increase in covid inpatients resulted in the need to establish separate inpatient areas. As a result some non-urgent work was suspended. It is anticipated this will resume in February.

Primary care services remain resilient despite significant pressures. High use of digital and virtual appointments continues. It was reported that one practice has had to cease operating for a short period due to staff needing to isolate, however pre-prepared contingency plans for mutual support were enacted and that practice has now reopened. No further practices have temporarily closed since the last Board report but there are a small number of practices being actively supported to avoid this.

Public Health	Executive Director of Public Health

Epidemiology update

During the first half of December confirmed cases of Covid-19 in Cardiff and the Vale of Glamorgan rose steadily, with 7 day rates peaking for samples taken on 19 December. The peak rate in Cardiff was 706.2 per 100k per week; and in the Vale 670.0 per 100k per week. Following Christmas, rates declined sharply but had stabilised at the time of compiling this report, at around 500 per 100k in Cardiff and Vale. While lower than the peak rate, this remains very high and of concern, ten times the level of the original threshold for introducing local lockdown measures at the end of September 2020 (50 per 100k per week).

Interpreting rates over the Christmas and New Year period is very difficult because we saw a steady increase in the volume of people tested in the run-up to Christmas (probably in anticipation of seeing vulnerable relatives), and a sharp drop-off after Christmas. This is likely to have increased the level of case-finding before Christmas, contributing to the rise, followed by a period of under-sampling (where reported rates are likely to understate the 'true' infection rate more than normal). In addition to this, both the introduction of hospitality restrictions across Wales on 4 December, and WG Alert Level 4 restrictions on 19 December, are likely to have had an impact on case rates. Finally, increased household mixing over the Christmas and New Year period will lead to additional - but hopefully short-lived - transmission of the virus.

Rates followed the patterns above across all age groups locally, with rates in people aged 60 and over (who are more at risk of severe morbidity, and mortality) slightly lower than the under 60s, but nevertheless very high. Covid-19 infections

are now embedded across our local communities and workplaces; there is no single pattern of transmission. Rates in the Vale are now marginally above those in Cardiff. There is ongoing engagement with the Black, Asian and Minority Ethnic community and faith leaders in the Butetown and Grangetown areas of Cardiff to help support testing for Covid-19 in these communities, which are more vulnerable to severe Covid-19 disease.

Hospital admissions for Covid-19 have risen considerably since the start of December and in the first week of January were around 50% higher than the peak of the first wave in April 2020. This has led to very high Covid-19 bed occupancy rates, two-thirds higher than the peak of the first wave.

Sadly as the rate of Covid cases in the community has risen during the autumn, we are now seeing a sustained increase in deaths in our area. The death rate is slightly above the five year average ('excess deaths'), though at a lower level than seen in the first wave. However, given patterns in deaths seen elsewhere in Wales and recent hospital admission rates locally (indicating severe Covid disease), excess mortality is likely to rise in the coming weeks.

The emergence of a new variant of Covid-19 with higher transmissibility reinforces the need for communities and workplaces to follow Covid precautions. Returning travellers from South Africa, where another new variant has emerged, are being quarantined and tested a week after leaving South Africa, to reduce the risk of spread of this variant in the UK. Other countries are being added to this list.

TTP update

The contact tracing service and multiagency regional team continue to work in a coordinated and collaborative manner, to identify and intervene in the management of clusters and outbreaks across the range of settings detailed above, with the aim of reduce Covid-19 risk within the population of Cardiff and the Vale of Glamorgan.

Vaccination update

The vaccination programme for Cardiff and the Vale has been in operation since 8 December 2020, and by 13 January over 15,000 people in Cardiff and Vale of Glamorgan had received their first vaccine dose. The number being vaccinated every week is growing, with the support of a growing workforce across the programme, from vaccinators to booking centre staff and administrative support. Invaluable support to deliver the programme is also being provided by the military and a large network of staff from many sources volunteering their time. Two vaccines are being used in Cardiff and the Vale, Pfizer and AstraZeneca, to enable vaccination of the eligible groups. Two doses of each vaccine are being provided, 11 weeks apart. The supply of the vaccines has significantly increased since the beginning of the roll out of the programme, and will grow further over the coming weeks. All appointments, vaccination reporting and data collection is managed through the Welsh Immunisation System (WIS).

The focus for the initial roll out is on the first four priority cohorts as defined by the Joint Committee on Vaccination and Immunisation: care home staff and residents; frontline health and social care workers; people aged 70 years and over; and people who are clinically extremely vulnerable.

A mobile team started operating on 6 January, and they are vaccinating residents and staff in care homes. The first week of operation saw 3 homes receiving vaccinations, and this number will grow weekly as more teams become operational, with 25 homes planned for the week of 11th January, and all care homes vaccinated by the end of January. Mobile teams will also be able to vaccinate people who are unable to leave their homes.

On 6 January, GP practices in Cardiff and the Vale began offering vaccinations to the population who are aged 80 and above. Three practices started delivering in the week of 6 January, with the remaining 57 practices all going live in the next few weeks, with a commitment to vaccinate the eligible cohorts of people aged 70 and above by mid-February, subject to vaccine supply being confirmed. GPs will be inviting eligible patients directly.

Two ‘satellite’ vaccination hubs for healthcare staff were opened in the week of 11 January, at UHW and UHL. 240 appointments per day are available at each of these sites. The first mass vaccination centre (MVC) opened in Splott in December and also offers appointment slots for health and social care staff. The MVC operates 7 days a week, from 8.30am to 7.30pm and currently offers 670 vaccination slots per day. Health and social care workers are invited to make bookings through a booking centre to attend the MVC. Two additional MVCs will be operational in the next few weeks.

Report Title:	**Board Assurance Framework (BAF)**								
Meeting:	Board						**Meeting Date:**	28th January 2021	
Status:	**For Discussion**		**For Assurance**	**x**	**For Approval**	**x**	**For Information**		
Lead Executive:	**Director of Corporate Governance**								
Report Author (Title):	**Director of Corporate Governance**								

Background and current situation:

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

The BAF for 2021 currently comprises the following 9 risks:

1. Workforce
2. Financial Sustainability
3. Sustainable Primary and Community Care
4. Patient Safety
5. Sustainable Culture
6. Capital Assets
7. Test, Trace and Protect
8. Risk of Delivery of IMTP
9. The risk of inadequate capacity to manage future COVID-19 peaks and introduce planned work safely.

The risk in relation to Brexit has not been added to the BAF due to the fact that there is a separate document already in place which details all the risks in relation to Brexit. It would also be very difficult to wrap 'Brexit' up into just one risk on the BAF. The Brexit Risk document is in the form of a Business Continuity Plan and is regularly reviewed by the Brexit Task and Finish Group. The plan details the risks, likely impact and mitigating actions. The last review of the Brexit Business Continuity Plan was undertaken on 5th January 2021. The Chair of the Group is the Executive Director for Strategic Planning. The Business Continuity Plan has also been reviewed by the Strategy and Delivery Committee on 10th November in order to provide assurance to the Board and appropriate scrutiny.

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

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

Since the last review in November 2020 there has been the following movement to risks on the BAF:

- Workforce has increased from 10 to 15
- Financial Sustainability has decreased from 15 to 10
- Patient Safety has increased from 15 - 20

Going forward all Committees of the Board will also be reviewing their risks on the BAF to provide further check and challenge and assurance to the Board when the BAF is presented in full.

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

The Strategic Objectives have now also been mapped to the risks on the BAF so there is clarity which risks impact on the objectives.

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

Risk Management continues to develop at Cardiff and Vale Health Board. Significant progress had been made but actions have been stalled for a number of months due to COVID-19. Work on now moving these actions forward has now restarted and includes the following:

Action	Update
Report the new BAF to the Audit Committee and the Board to ensure key risks to the achievement of objectives are identified.	**Complete –** Presented to Board on 24th September and will be reviewed by Audit Committee when it meets in November
Report individual risks on the BAF to the relevant Committees of the Board to allow the Committees to undertake a more detailed review and then provide assurance to the Board	**Complete and ongoing** – reported to S&D on 15th September. BAF risk reviews will also be added to the Committees of the Board going forward routinely.
Assess the organisation's 'Risk Appetite'	**Complete and ongoing** – A session was held at the Board Development on 29th October further work is now required to roll out the 'Risk Appetite' across the organization and ensure it is properly embedded in decision making
Review Risk Management and Board Assurance Framework Strategy.	This was approved by the Board initially in July 2019. There is a requirement within Standing Orders to review the Strategy on an annual basis. This will be presented to the Board, alongside the 'Risk Appetite' roll out plan in March 2021.
Development of Risk Management Procedure	**Complete –** A new procedure has been developed to support the Strategy approved by the Board on 25th July.
Ensure that the work on the Corporate and Clinical Board Risk Registers is	**Continuing** - There will be a phased approach to the development of risk registers within Corporate

completed within a timely manner and in line with the Risk Management Strategy and Procedure.	Directorates and Clinical Boards. This approach will be in line with the Risk Management and Board Assurance Framework Strategy presented to Board. The new Risk and Regulation Officer commenced on 12th October and will be developing and taking forward a programme of risk management training throughout the Health Board.
Corporate Risk Register to be presented to the Private Board July 2020	**Complete** – The last Corporate Risk Register was presented to the Board in private in March 2020. Again, due to COVID-19 work in this area was delayed however, a register is on the agenda for the July 2020 Private Board.
Ensure actions from Internal Audit Review are undertaken in line with timescales agreed	**On track** - The actions identified by Internal Audit were mainly around consistency of risk registers within the Clinical Board which included risk identification and scoring. Work in this area is on track to commence in September with the roll out of a Training Programme led by the Head of Risk and Regulation. The Internal Audit is planned to take place in the final quarter of 20/21.
Move to web based risk reporting	**On track**: Action due by April 2021.

Assurance is provided by:

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

Recommendation:

The Board is asked to:

- **Approve** the 9 risks to the delivery of Strategic Objectives detailed on the attached BAF.
- **Note** the progress which has been made in relation to the roll out and delivery of effective risk management systems and processes at Cardiff and Vale UHB.

Shaping our Future Wellbeing Strategic Objectives

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

1. Reduce health inequalities	x	6. Have a planned care system where demand and capacity are in balance	x
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x
3. All take responsibility for improving our health and wellbeing	x	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x

4.	Offer services that deliver the population health our citizens are entitled to expect	x	9.	Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5.	Have an unplanned (emergency) care system that provides the right care, in the right place, first time	x	10.	Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	x

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

Equality and Health Impact Assessment Completed:	Not Applicable

BOARD ASSURANCE FRAMEWORK 2020/21 – JANUARY 2021

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

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

Key Risks

Risk	Corp Risk Register Ref.	Gross Risk	Net Risk	Change from Nov 20	Target Risk	Context	Executive Lead	Committee
1. Workforce	5,11,16	**25**	**15**		**10**	Across Wales there have been increasing challenges in recruiting healthcare professionals. Meeting the requirements of a growing population which is older and with more complex health needs as well as increasing demand on health services has led for an increasing need in clinical staff. Staff costs represent the largest expense for the NHS in Wales. The pay bill has continued to increase year on year, with a significant increase over the last three years.	Deputy CEO & Executive Director of Workforce and OD	Strategy and Delivery Committee
2. Financial Sustainability	31,32,33	**25**	**10**		**8**	Across Wales, Health Boards and Trusts are seeking to manage their financial pressures by driving out inefficiencies, while at the same time looking to derive greater value from their resources through innovative ways of working and practicing prudent healthcare. As well as the NHS, public sector services, the third sector, and the public have significant roles to play to achieve a sustainable health and care system in the future. Covid 19 has had a significant impact on the finances of Healthcare in Wales and the UHB has significant financial pressures to now deal with.	Executive Director of Finance	Finance Committee
3. Sustainable Primary and	12,14	**20**	**15**		**10**	The strategy of "Care closer to home" is built on the	Chief Operating Officer	Strategy and Delivery Committee

	Community Care						assumption that there are a significant number of patients that are either referred to or turn up at a Hospital setting because there is no viable alternative at the time at which they become sick. They are then typically admitted because at that stage similarly there is no viable alternative to manage/support these patients in their local setting or their place of residence. Therefore it is important to create firstly the capacity of primary and Community Care, and then increase the capability of Primary and Community Care to be able to respond to the individual and varied needs of those patients in both crisis intervention but more commonly preventative and support arrangements.		
4.	Patient Safety	2,7,8,9,15,17,18, 19,20,21 ,25,26,29,40,41, 42	**25**	**20**		**10**	Patient safety should be above all else for the Cardiff and Vale University Health Board. Safer patient care includes the identification and management of patient-related risks, reporting and analysis of patient safety incidents, concerns, claims and learning from such then implementing solutions to minimise/mitigate the risk of them recurring.	Executive Nurse Director/ Executive Medical Director /Executive Director for Therapies and Health Science	Quality, Safety and Experience
5.	Sustainable Culture Change		**16**	**8**		**4**	In line with UHB's Strategy, Shaping Our Future Wellbeing and aligned to the Healthier Wales plan (2018), the case for change is pivotal to	Executive Director of Workforce and OD	Strategy and Delivery Committee

						transfer our services to ensure we can meet our future challenges and opportunities. Creating a belief which continues to build upon our values and behaviours framework will make a positive cultural change in our health system for our staff and the population of Cardiff and the Vale.		
6. Capital Assets	3,4,18,19,21	**25**	**20**		**10**	The UHB delivers services through a number of buildings across Cardiff and the Vale of Glamorgan, from health centres to the Tertiary Centre at UHW. All NHS organisations have statutory responsibilities to manage their assets effectively: an up to date estate strategy is evidence of the management of the estate. The IT SOP sets out priorities for the next five years and Medical Equipment is replaced in a timely manner.	Executive Director of Strategic Planning, Deputy Chief Executive, Executive Director of Therapies and Health Science	Finance Committee
7. Test, Trace and Protect	13	**20**	**15**		**10**	The Welsh Test, Trace, Protect strategy is to enhance health surveillance in the community, undertake effective and extensive contact tracing, and support people to self-isolate where required to do so. Test, Trace, Protect will mean asking people to report symptoms, testing anyone in the community who is showing symptoms of COVID-19, and tracing those they have come into close contact with. Contacts will be advised to self-isolate in order to stop further spread among	Executive Director of Public Health	Strategy and Delivery Committee

						family, friends and the community. Contact tracing is a long established public health approach to containing the spread of many infections and has proven effective in controlling coronavirus in other countries.		
8. Planned Care Capacity	9,11,15, 26,42	**20**	**16**		**12**	The impact of COVID 19 has had many consequences to Healthcare and in particular the continuation of the Health Board being able to undertake Planned Care both during the peak of the pandemic and any future peaks. This is due to the need to ensure that there is available capacity should there be a further peak in COVID 19 patients requiring hospital treatment.	Chief Operating Officer	Strategy and Delivery
9. Delivery of IMTP		**20**	**15**		**10**	The Integrated Medium Term Plan is the key planning document for the Health Board setting out the milestones and actions we are taking in the next 1 to 3 years in order to progress Shaping Our Future Wellbeing, our ten-year strategy. It is based on the health needs of our population, delivering quality services and ensuring equitable and timely access to services and sets out how we will deliver our mission Caring for People; Keeping People Well, and vision that a person's chance of leading a healthy life is the same wherever they live and whoever they are.	Executive Director of Strategic Planning	Strategy and Delivery Committee

1. **Workforce – Lead Executive Martin Driscoll**

Across Wales there are increasing challenges in recruiting healthcare professionals. Meeting the requirements of a growing population which is older and with more complex health needs as well as increasing demand on health services has led for an increasing need in clinical staff. This has been further exacerbated with COVID 19, winter and the Mass Immunisation Programme.

Risk **Date added: 2.7.2020**	There is a risk that the organisation will not be able to recruit and retain a clinical workforce to deliver high quality care for the population of Cardiff and the Vale. This may be further exacerbated by the demand to simultaneously stretch our workforce capacity to cover Covid-19 pandemic, Mass Immunisation Programme as well as business as usual.		
Cause	Increased vacancies in substantive clinical workforce – to cover MTC specialist skill requirement and CAV 24/7. Winter Wards temporary bed expansion and COVID-19 – temporary bed expansion, community testing, mass vaccine immunisation, high staff absence due to covid-19 , increased demands on step up and step down demand for GP and CRT requirements of the Nurse Staffing Act and BAPM Standards. Ageing workforce Insufficient supply of registered Nurses at UK national level. High nurse turnover in Medicine, Surgery and Specialist Services Clinical Boards Insufficient supply of Doctors in certain specialties at UK national level (e.g., Adult Psychiatry, Anaesthetics, General Medicine, Histopathology, Neurosurgery, GP) Changes to Junior Doctor Training Rotations (Deanery). Brexit. Further extension of Government CMO shielding letters from 22 December – 7 February 2021. High prevalence of COVID-19 within community which is affecting our own staff absence levels.		
Impact	Impact on quality of care provided to the population. Inability to meet demands of both pandemic and business as usual. Potentially inadequate levels of staffing. Increase in agency and locum usage and increased workforce costs. Rates above Welsh Government Cap (Medical staff). Low Staff moral and higher sickness absence. Poor attendance at statutory and mandatory Training.		
Impact Score: 5	Likelihood Score: 5	Gross Risk Score:	**25 (Extreme)**
Current Controls	Recruitment campaign through social media with strong branding Job of the week, Skype Interviews. Social Media Campaign Open Days Nurse-led leadership embedded within recruitment drive. Values based recruitment. Comprehensive Retention Plan introduced from October 2018 – Internal Career. Development Scheme launched in September for band 5 nurses. Nurse Adaptation Programme commenced October 2018 (in house OSCE programme) – over 75 UK based nurses have qualified to date (100% pass rate). Returners Programme in conjunction with Cardiff University. Student Nurse clinical placement and on-going nurturing of talent. International Nurse Recruitment in place – international supply plentiful, local support mechanism to support new recruits in place – 67 international nurses have joined us to date. A further 75 have been commissioned and 11 of these join on 28 January; mainly in critical care. The Framework remains open to us going forward. Medical international recruitment strategies. Programme of talent management and succession planning. Medical Training Initiative (MTI) 2 year placement scheme. Collaboration with Medics to fill hard to fill roles, search and selection methods, CV scanning by speciality.		

	Link with Welsh Government Campaign *Train, Work, Live* to attract for Wales - GP, Doctors, Nursing and Therapies . Operationally, the development of Green Zones etc. which help stratify the workforce and maximise availability. Review of staff shielding to maximise home working, track and tracing etc. Central workforce hub meets daily to meet demand of recruiting temporary workforce. This has now been expanded to co-ordinate all Hubs, chaired by the Executive Director of Workforce & OD. CNS and nursing staff from elective, outpatient and corporate areas being deployed to support urgent need. Ceasing of non-urgent surgery and planned care during January will ensure clinical workforce capacity in place. On-going review of medical rotas to flex and increase medical cover capacity. Appointment of 9 Physician Associates to supplement MDT in a number of Clinical Boards – further commissioning being explored with CB's. Temporary recruitment of medical, nursing and therapy students. Retirement returners – noting positive change to the NMC register being expanded to support temporary workers. New initiatives on-going e.g., working with St Johns Ambulance. Enhanced overtime provisions for substantive nursing and HCSW staff to encourage take up of additional hours.		
Current Assurances	Daily COVID LCC Sitrep incorporates workforce status and escalation requirement – currently amber in most areas. Daily absence monitoring undertaken by Clinical Boards and compiled centrally. Workforce metrics reported to COVID-19 Operation Meetings, HSMB and Strategy and Delivery Committee High level temporary recruitment achieved at pace since March 2020. (454 currently being recruited to with 309 offered to date and further phasing in place). Mass Immunisation Workforce Plan in place to increase recruitment on a phased basis to meet demand. Ratio of registered to non-registered reviewed nationally to ensure HCSW role utilised fully. High conversion rates from media campaign and Open Day (some virtual ongoing). Again, this summer, student streamlining produced the biggest intake at C&V in Wales due to the way we engage, attract and support students. Nurse vacancy monitoring at meetings with CB's. Trajectory showing next vacancies in nursing. Majority of MTC posts filled successfully and high engagement. As at 31.102020 94% substantive posts filled at Bands 5 & 6 (combined).Predicted to be at 95% by December 2020 with some outliers in Surgery and Specialist CBs. Deep dive monitoring at Clinical Board and operational level being undertaken monthly to ensure nursing capacity to meet BAU, Covid-19 and winter pressures. Medical monitoring at Medical Workforce Advisory Group (MWAG) Paediatric Surgery now fully established A & E fully established since February 2019 Medical rotas being monitored by COVID-19 Operations team to ensure flexibility in place (RAG rated system) Medicine 2% gap (98% fully established) - on permanent nursing lowest it's been for 3 years		
Impact Score: 5	Likelihood Score: 3	Net Risk Score:	**15(High)**
Gap in Controls	Ability to retain flexible recruitment methods as level of permanent recruitment. resumes and further temporary requirement for COVID-19 and Mass Immunisation remains unpredictable. Further extension of Government CMO shielding letters from 22 December – 7 February 2021. High absence levels due to staff having COVid-19.		
Gap in Assurances			

Actions	Lead	By when	Update since November 20
1. Internal Nurse Career Development Scheme	RW	Relaunched in April 2020 and continuing	This scheme started in September 2019 but was re-launched in September 2020
2. Nurse recovery plan for Medicine and Surgery as part of financial recovery plan and business case for international recruitment	SC	31/03/21	**Complete** - Plan in place with 2nd part of International Nurse Recruitment approved. Financial Savings still being monitored and actions include Switch Off Sunday to help manage costs. Some international nurses delayed due to worldwide travel restrictions. Resumed
3. To consider how resources are used going forward in nursing	SC	31/03/2021	Resources being considered alongside bed occupancy plans – action ongoing
4. Local Social Media and Virtual Interview Campaigns to resume to support permanent nurse recruitment	MD	From 31/10/2020	Campaign took place July and October. New social media plan in place. Virtual recruitment on-going to support social distancing with some face to face happening at CB level.
5. Virtual Recruitment Panels established up to recruit to Consultant posts	SW/MD	From 30.9.2020	On-going permanent recruitment plan in place to ensure posts are not held up during COVID-19
6. Implementation of a new Medical and Dental Bank through a Managed Service	SW/MD	1.4.2021	New initiative currently being procured and implemented to create a Managed Medical and Dental Bank. This will increase supply and improve skills availability through a new bank system; dedicated central team; improved technology and a launched locum recruitment campaign.

2. **Financial Sustainability – Lead Executive Chris Lewis**

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

Risk **Date added:** 7.09.2020	There is a risk that the organisation will not be able to manage the impact of COVID 19 and other operational issues within the financial resources available.		
Cause	The UHB has incurred significant additional costs arising from managing the COVID 19 pandemic, this includes the non-delivery of savings plans. It also has to manage its operational budget. All additional costs need to be managed within the additional resources made available by Welsh Government to manage the pandemic.		
Impact	Unable to deliver a year end balanced financial position. Reputational loss. Increase in the underlying financial position which is dependent upon recurrent funding provided		
Impact Score: 5	Likelihood Score: 5	Gross Risk Score:	**25 (Extreme)**
Current Controls	Additional expenditure in Managing COVID 19 is being authorised within the governance structure that has specifically been put in place which is reported to Management Executives on a weekly basis. This aligns with the UHB Scheme of Delegation. The financial position is reviewed by the Finance Committee which meets monthly and reports into the Board. Financial performance is a standing agenda item monthly on Management Executives Meeting.		
Current Assurances	The UHB is now assuming an additional funding to help manage the COVID 19 pandemic in line with Welsh Government Resource assumptions. Based upon this assumed additional funding, the financial forecast is now an in year break even position at year end. The in year reported position at month 9 is an under spend of £0.3m. Financial performance is monitored by the Management Executive. Finance report presented to every Finance Committee Meeting highlighting progress against mitigating financial risks.		
Impact Score: 5	Likelihood Score: 2	Net Risk Score:	**10 (high)**
Gap in Controls	No gaps currently identified.		
Gap in Assurances	To confirm COVID 19 funding assumptions with Welsh Government in a couple of specific areas. Certainty of COVID 19 expenditure and the management of non COVID 19 operational pressures		

Actions	**Lead**	**By when**	**Update since November 20**
1. Continue to work with Welsh Government to confirm additional funding to manage our response to Covid 19.	CL	31/03/2021	No further updates current status remains
2. To monitor and control additional expenditure and financial performance to ensure that the year-end forecast is within the resources available.	CL	31/03/2021	No further updates current status remains

Impact Score: 4	Likelihood Score:2	Target Risk Score:	**8 (High)**

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

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

Risk **Date added:** 12.11.2018	The risk of losing resilience in the existing service and not building the capacity or the capability of service provision in the Primary or Community care setting to provide the necessary preventative and responsive services.		
Cause	Not enough GP capacity to respond to and provide support to complex patients with multiple co-morbidities and typically in the over 75 year age bracket. GP's being drawn into seeing patients that could otherwise be seen by other members of the Multi-disciplinary Team. Co-ordination of Health and Social Care across the communities so that a joined up response is provided and that the patient gets the right care. Poor consistency in referral pathways, and in care in the community leading to significant variation in practice. Practice closures and satellite practice closures reducing access for patients. Lack of development of a multidisciplinary response to Primary Care need. Significant increase in housing provision		
Impact	Long waiting times for patients to access a GP Referrals to hospital because there are no other options Patients turning up in ED because they cannot get the care they need in Primary or Community care. Poor morale of Primary and Community staff leading to poor uptake of innovative solutions Stand offs between Clinical Board and Primary care about what can be safely done in the community Impact reinforces cause by effecting ability to recruit		
Impact Score: 5	Likelihood Score:4	Gross Risk Score:	**20 (red)**
Current Controls	Me, My Home , My Community Signals from Noise to create a joined up system across Primary, Community, Secondary and Social Care. Development of Primary Care Support Team Contractual negotiations allowing GP Practices to close to new patients Care Pathways Roll out of MSK and MH First Point of Contact Services by Cluster Implement new urgent care Phone First helpline at Primary Care Level (CAV24/7) Implement nationally supported digital supported enablers (Consultant Connect and Attend Anywhere)		
Current Assurances Khan,Raj 01/21/2021 14:27:09	Improved access and response to GP out of hours service Sustainability and assurance summary developed to RAG rate practices and inform action Three workshops held to develop way forward with engagement of wider GP body in developing future models. Leading to the development of Mental Health and Risk Care Models at scale being implemented. Second peer review of PCOOH Services undertaken with commendations and exemplars referred to in WG reports		
Impact Score: 5	Likelihood Score: 3	Net Risk Score:	**15 (red)**
Gap in Controls	Actively scale up multidisciplinary teams to ensure capacity		

	Achieving scale in developing joint Primary/Secondary Care patient pathways Recruitment strategies to sustain and improve GP availability and develop multidisciplinary solutions			
Gap in Assurances	No gaps currently identified.			
Actions		**Lead**	**By when**	**Update since November 20**
1.	Health Pathways – to create a protocol driven of what should and can be done in Primary care/Community care.	~~SC~~ SW/JG	31/03/2021	Health pathways launched on 14/02/2019. As at 07/05/2019 32 pathways were live. Pathways will continue to be developed until the end of the financial year. 65 pathways are now active. Chief Operating Officer has met with partners in New Zealand who are rolling it out. This continues to be rolled out.
2.	Roll out of Mental Health and MSK MDT's to reduce the primary care burden on GP's	SC	From 28 August 2020	GMS Sustainability Implementation Board continues to see roll out of First Contact MDTs within all 9 clusters being covered for MSK and 7 out of 9 clusters being covered for MH services. However, all 9 clusters have access to an MH service as cross cover arrangements are in place CAV24/7 services implemented as at 5 August 2020 Attend Anywhere digital enabler in 56 of 61 practices as at July 2020 Consultant Connect available to all practices as at July 2020
3.	Roll out digital solutions for smart working	DT	31/03/2021	Platform procured- phased roll out plan to be implemented with completion due by end of the financial year
4.	Other digital platforms being considered e.g. Primary Care CAHMS Assessment platform being deployed	SC	31/03/2021	Digital Platform now been agreed for CAHMS. Contract has now been agreed and is currently being rolled out. Digital platform deployed and CAHMS assessment against Part 1 to be reached in Feb/Mar 2020 NB Digital platform successful in contributing to CAMHS access targets. Currently under review in terms of the FM

			New platforms being considered – Attend Anywhere and Consultant Connect
5. Development of recruitment strategies for GP and non GP service solutions	MD	Ongoing	GP Support Unit helps with recruitment and finding GP alternatives action also lined to No 2 above. As an indicator of in hour's resilience GP fill rates for PC out of hour's service have improved leading to a lower escalation status. The focus on a multi-disciplinary solution continues.
6. Develop Health and Social Care Strategies to allow seamless solutions for patients with health and or social needs	AH	Ongoing	These are being developed through the Public Service Board and Transformation work and progressing well

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

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

Risk	Patient safety may be compromised because of: Future national shortage of COVID treatment capacity (Beds, critical care, drugs, workforce, oxygen, other equipment – ventilators/renal replacement/CPAP) in the event of a second COVID surge Or because some elective services are not currently available for non-COVID patients Or because of sub-optimal workforce skill mix or staffing ratios, related to reduced availability of specific expert workforce groups, or related to the need to provide care to a larger number of patients in relation to a further COVID surge, alongside increasing demand for non-COVID unscheduled care and urgent scheduled care and winter pressures and activity. Or because patients are choosing not to ask for medical help, despite genuine illness, related to PH messaging and awareness of the COVID crisis Or because patients are contracting COVID 19 whilst in a hospital setting.		
Date added:	March 23.03.2020		
Cause	Patients not able to access the appropriate care because demand is outstripping supply, or patients fail to seek appropriate care in a timely way. Presentation of COVID 19 virus in inpatient settings due to patients presenting who are asymptomatic but are positive ~~Possible lack of PPE, poor IPC or inappropriate management~~		
Impact	Worsening of patient outcomes and experience, higher death rate.		
Impact Score: 5	**Likelihood Score: 5**	**Gross Risk Score:**	**25**
Current Controls	• Plans developed to continue with expanded critical care and COVID bed capacity within footprint of hospitals, taken alongside patient cohorting in 'non-COVID' areas. • Plans developed and deployed to optimise internal acute and critical care capacity with external options having been utilised for significant internal and external surge/field hospital capacity. • Internal estates and facilities team deployed to provide infrastructure enhancements to enable internal capacity plan • Principality stadium no longer available with further surge capacity available in Lakeside facility from late November • National/local procurement processes for under-supplied resources • Maintaining Training/Education of all staff groups in relation to delivery of care to COVID patients • Use of Spire Hospital as a dedicated facility for urgent cancer work - ongoing • Ongoing training and simulations for staff working in unfamiliar areas. • Recruitment of additional staff • Cancer patients treatment being reviewed and prioritised where appropriate • Restrictive visiting arrangements • Outbreak management plans and delivery		
Current Assurances	• Internal capacity expansion plans commissioned and reviewed regularly at Operational and Strategic Group to ensure right phasing • Operational Group meeting daily to ensure clinical staff remain engaged in managing phased expansion/area utilisation.		

	• Establishment of workforce hubs to ensure that staff are deployed on a competency basis • Review of clinical incidents and complaints continues as business as usual and has been aligned with core business and reviewed at Management Executives • Audit of IPC and Audit outcomes • Reporting of IPC Outbreak meetings into ME • IPC Daily Cell Meeting &Weekly PPE Cell Meeting • Expert and independent advice in outbreak meetings		
Impact Score: 5	**Likelihood Score: 4**	**Net Risk Score:**	**20**
Gap in Controls	Local Authority ability to provide packages of care and challenge around discharge to care homes		
Gap in Assurances	Discharging patients is out of the Health Boards control		

Actions	**Lead**	**By when**	**Update since November 20**
1. Reconfiguration of COVID/Non-COVID capacity delivery in light of new pandemic modelling projections – ongoing process.	Steve Curry	31.03.21	Ongoing discussion currently and gearing plans developed. Plan in place which is continually been reviewed in relation to demand and capacity – see separate risk on BAF: the risk of inadequate capacity to manage future COVID 19 peaks and planned work safety
2. Reconfiguration of COVID/Non-COVID workforce skill mix and staffing numbers in light of new pandemic modelling projections	Workforce groups	31.03.21	Discussions continuing staffing mix being reviewed in line with action 1 above.
3. Internal COVID 19 outbreaks being reported to Quality, Safety and Experience Committee with lessons learnt been fed back into the organisation.	Ruth Walker	24.09.20	Complete & ongoing
4. Learning from COVID 19 outbreaks at CTM and AB Health Boards and being utilised in management of outbreaks	Ruth Walker	From mid October	Complete and embedded in improvement plans for each outbreak
5. Genotype testing which shows whether outbreaks are linked and core case	Ruth Walker	From mid October	Requests now in place being delivered as capacity allows
Impact Score: 5 **Likelihood Score: 2**	**Target Risk Score:**		**10 (High)**

5. Leading Sustainable Culture Change – Lead Executive Martin Driscoll

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

Risk	There is a risk that the cultural change required will not be implemented in a sustainable way		
Cause	There is a belief within the organisation that the current climate within the organisation is high in bureaucracy and low in trust. Staff reluctant to engage with the case for change as unaware of the UHB strategy and the future ambition. Staff not understanding the part their role plays for the case for change due to lack of communication filtering through all levels of the UHB.		
Impact	Staff morale may decrease Increase in absenteeism Difficulty in retaining and recruiting staff Potential decrease in staff engagement Transformation of services may not happen due to staff reluctance to drive the change through improvement work. Patient experience ultimately affected. UHB credibility as an employee of choice may decrease		
Impact Score: 4	**Likelihood Score: 4**	**Gross Risk Score:**	**16 (Extreme)**
Current Controls	Values and behaviours Framework in place Task and Finish Group weekly meeting Cardiff and Vale Transformation story and narrative Leadership Development Programme Management Programmes Talent management and succession planning cascaded through the UHB Values based recruitment Staff survey results and actions taken – led by an Executive (WOD) Patient experience score cards CEO and Executive Director of WOD sponsors for culture and leadership Raising concerns relaunched in October 2018 "Neyber" launched to support staffs financial wellbeing with an emphasis on education Conducted interviews with senior leaders regarding learnings and feedback from Covid 19 Lessons learnt document to be completed by September 30th 2020 looking at the whole system		
Current Assurances	Engagement of staff side through the Local partnership Forum (LPF) Matrix of measurement now in place which will be presented in the form of a highlight report		
Impact Score: 4	**Likelihood Score: 2**	**Net Risk Score:**	**8 (High)**
Gap in Controls			
Gap in Assurances			

Actions	Lead	By when	Update since November 20
1. Learning from Canterbury Model with a Model Experiential Leadership Programme- Three Programmes have been developed: (i) Acceler8 (ii) Integr8 (iii) Collabor8 (iv) Oper8 (for Directorate Managers or equivalent)	MD	01.04.2021	Currently all the leadership programmes are on hold due to the recovery phase of covid. Awaiting Intensive learning academy bid if successful large leadership development. Programmes to restart 2021
2. Showcase	MD	31.03.21	Proposal for a virtual showcase now being considered and linking with the Clinical Service Redesign and exploring catering for bigger numbers
3. Welsh Language Standard being implemented.	MD	From 14.12.20	Equality Strategy Welsh Language Group commencing and will take place on a monthly basis with senior leaders across the organisation. Two Welsh Language translators now recruited. - complete
4. Proactive Wellbeing intervention	MD	Immediate	Wellbeing Group commencing and will be Chaired by Executive Director for Workforce and OD - happening and second bid in place so implementation now happening
5. CAV Convention	MD	From 12.11.20	The CAV Convention is clinically-led and is based on the values of the Health Board. It makes it easier for clinicians to do their jobs through rapid and agile change, flexible working, unlocking resources such as budgets and staff, and more productive relationships between staff members with the needs of the patient at the heart of everything. Proposal being presented to Management Executive 12.11.20 – Complete – proposing CAV convention conference in the Spring to showcase clinical group progression
Impact Score: 4	**Likelihood Score: 1**	**Target Risk Score:**	**4(Moderate)**

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

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

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

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

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

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

Actions	**Lead**	**By when**	**Update since November 20**
1. Progress implementation on the estates strategic plan	AH/CL	31.03.21	Priorities for Capital Programme included within 2020-2023 IMTP which were prioritised by Management Executive
2. Had to give up discretionary capital £1m allocation reduced to £500k	FJ	31.03.21	Prioritisation of capital managed through capital management group but overall capital position worse than last year. However, position rectified by WG as discretionary capital replenished.
3. The Estates Strategy requires review and refresh	AH	31.07.21	New action - This will be presented to S&D Committee prior to approval by the Board in September 2021

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

7. Risk that Test Trace and Protect Service and the Mass Vaccination Programme will fail to deliver effectively in Cardiff and the Vale of Glamorgan - Lead Executive – Fiona Kinghorn

Risk	The Cardiff and Vale Test, Trace and Protect (TTP) Service fails to deliver effective mass population contact tracing and vaccination		
Date added:	18.5.20		
Cause	Delivering TTP Services has been a complex and substantial partnership endeavour, delivered to a challenging timetable; Cardiff Council is hosting the TTP Service and the University Health Board is leading the delivery of mass vaccination. Risks to effective delivery include: 6. Upgrades to the national CRM (Customer Relationship Management) system are not sufficiently timely to support local delivery 7. Failure to maintain sufficient staff (either via redeployment or new appointment) at all levels to meet demand 8. Insufficient telephony/IT equipment to support home working model 9. Non coordinated working between partner organisations 10. Lack of engagement with the local population and settings in promote compliance with contact tracing, as well as maintain adherence to infection control and preventative advice (including physical distancing, wearing masks and frequent hand washing) 11. Increased demand created by influx of students to the City with reopening of universities 12. Increased demand due to co-circulation of flu during the winter months 13. Surveillance system unable to detect local disease activity 14. Insufficient funding to support longer term service delivery 15. Inability to maintain service for up to a year 16. Vaccine development and delivery: failure to develop an effective vaccine; delayed development of an effective vaccine; limited supply of vaccine; failure to vaccinate at sufficient scale and/or pace once a vaccine is available 17. Emergence of a new variant of Covid-19 with increased infectivity		
Impact	TTP Services would not run effectively with the result that there would be sub-optimal control of disease activity in Cardiff and the Vale of Glamorgan. This could result in avoidable cases of COVID-19 and an increased R value, meaning that community transmission could escalate, with the consequent risk to population health and demand on health and social care services. It may also necessitate reinstatement of restrictions and controls.		
Impact Score: 5	**Likelihood Score: 4**	**Gross Risk Score: 20**	**20 (Extreme)**
Current Controls	• Governance structures in place with partnership representation. Strategic and operational boards meet regularly. Work streams identified and leads named. Cardiff and Vale Prevention and Response Plan submitted to Welsh Government. • Cardiff and Vale representatives identified for all key national groups. Links established at a National level with Welsh Government, NWIS and PHW to optimise communication and influence service design and digital solution • Partnership communications plan in place, informed by both national and regional insight work, and taking in to account local population characteristics. • Regular, multidisciplinary and multi-agency regional team meetings to review cases and incidents. Regional SOP developed. Proactive engagement with settings e.g. schools, healthcare settings and universities • Links established at a National level with Welsh Government, NWIS and PHW to optimise communication and influence service design and digital solution • In response to local increase in cases a Regional Incident Management Team was established on 22nd September 2020, chaired by the Director of Public Health, which has met twice weekly and provided advice on the actions to be taken. These have been signed off by a Regional Leadership team and recommendations for national action escalated to Welsh Government		

	• Regional and local surveillance systems in place and providing timely information to inform the local response at all levels. • Partner organisations committed to offering staff for at least the first 6 months of contact tracing operational delivery, using a secondment arrangement. Service model based on home working, allowing shielded staff to contribute and increase the pool of available staff. Student workforce identified through links with HEIW and Environmental Health. Significant new recruitment by Cardiff Council has continued, on behalf of the partnership, and has ensured that tracing capacity is able to meet demand. • Welsh Government has agreed funding to support TTP delivery • Comprehensive Covid-19 immunisation plan and project team in place. One mass vaccination centre (MVC) is operational, offering immunisation to health and social care workers; two further MVCs are due to open within the next month. The licencing of the Oxford Astra Zenica vaccine, with its more routine storage and transportation requirements, allows vaccination to be offered in primary and community care venues; vaccination has begun to be offered in care home settings and to those aged 80+ (as per the JCVI prioritisation categories). Planning is progressing at pace to scale up delivery to meet national targets, subject to the availability of sufficient vaccine.			
Current Assurances	• Strengthened and functioning governance and operational arrangements in place			
Impact Score: 5	**Likelihood Score: 3**	**Net Risk Score: 15**		**15 (Extreme)**
Gap in Controls	• Timely availability of sufficient vaccine to meet national targets • Issues with compliance with Covid-19 prevention measures for a variety of reasons, including 'fatigue', confusion at complexity of messages, as well as some active resistance			
Gap in Assurances	• Longer term funding • Ability to recruit staff at sufficient scale and pace to meet demand			
Actions		**Lead**	**By when**	**Update since November 20**
1. Development and delivery of mass vaccination plan		Fiona Kinghorn	31/12/20	Complete
2. Deliver a mass vaccination programme to meet nationally agreed targets		Fiona Kinghorn	31/3/20	New action
Impact Score: 5	**Likelihood Score: 2**	**Target Risk Score: 10**		**10 (High)**

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

The impact of COVID 19 has had many consequences to Healthcare and in particular the continuation of the Health Board being able to undertake Planned Care both during the peak of the pandemic and any future peaks of the pandemic. There has been significant disruption to planned care and disruption to the progress which was being made after the first wave of Covid 19. There has now been a second cessation of elective activity and despite progress been made planned care has been significantly compounded by the second wave.

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

Actions	**Lead**	**By when**	**Update since November 20**
1. Roll out virtual consultation platforms	Information	July onwards	1/3 of outpatient activity now taking place virtually.
2. Establish private sector pathways for in-patients, outpatients and diagnostics	COO	April onwards	Private sector pathways in negotiation to continue beyond the end of the year. There has been a presentation to Management Executives and reflected in Board Reporting

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

10. Risk of Delivery of IMTP - Lead Executive – Abigail Harris

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

Risk	There is a risk that the Health Board will not deliver the objectives set out in the Annua Plan out due to the challenge around recovering the backlog of planned activity (see separate risk), not taking the opportunity to do things differently and the potential risk associated with the Medium Term Financial position all of which could impact upon delivery of the Annual Plan or future IMTP.		
Date added:	April 20		
Cause	The focus of executive and operational efforts is on directing the organisational response creating the operational capacity to meet the immediate acute demand generated by the COVID-19 pandemic.		
Impact	The UHB may not be appropriately prepared to manage the consequences of a protracted and disruptive emergency response particularly in terms of: workforce (e.g. many will be exhausted and many will have built up leave) Infrastructure Planned care Unplanned care Financial delivery The benefits of emergency changes may not be adequately captured. There may be learning opportunities missed.		
Impact Score: 5	**Likelihood Score: 4**	**Gross Risk Score:**	**20**
Current Controls	• Welsh Government has suspended the IMTP process and Health Boards are working to quarterly operational plans that reflect the current COVID29 situation and the need to re-establish as much of our non-COVID19 activity as possible, recognising the need to continue to provide services in different ways in light of the service transformation that took place in the emergency response phase and the ongoing requirement for social distancing and infection prevention and control measures. • Q2 plan developed and submitted to WG by the deadline required. • 'Recovery planning' with roadmap presented to Board for discussion on 29th June – planning underway with partners to reflect impact of COVID19 on communities and the need to accelerate delivery of Shaping Our Future Wellbeing and the Area Plan.		
Current Assurances	Recovery presentation to Board Development 30.04.20 Q2 plan received by the Board in July. WG review meeting on Q2 plan completed with regular meetings with key officials and planning and operations teams.		
Impact Score: 5	**Likelihood Score: 3**	**Net Risk Score:**	**15**
Gap in Controls	Timeliness of planning requirements for Q3/4 plan issued by WG. Risk of request for multiple overlapping plans – agreement with Local Authority Directors of Social Services – to pull this into one coherent plan with more detailed specific action plans where needed.		
Gap in Assurances	RPB required to sign off Winter Protection Plan – no clear guidance but work progressing in line with framework suggested by WG.		

Actions	**Lead**	**By when**	**Update since November 20**
Monitor implementation of Annual Plan and continue to report through Strategy and Delivery Committee	AH	31/03/22	New action
Impact Score: 5 / **Likelihood Score: 2**	**Target Risk Score:**		**10**

Key:

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

Report Title:	**PATIENT SAFETY QUALITY AND EXPERIENCE REPORT**						
Meeting:	Board Meeting				**Meeting Date:**	28.01.21	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**
Lead Executive:	Executive Nurse Director Executive Medical Director						
Report Author	Assistant Director, Patient Safety and Quality Assistant Director, Patient Experience				02921836331 02921836230		

Background and current situation:

The purpose of this paper is to present an integrated Quality, Safety and Experience report which covers the period from November to December 2020.

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

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

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

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

As discussed previously the UHB continues to see young people under the age of 18 being admitted to adult wards at Hafan Y Coed, in the absence of suitable tertiary Mental Health placements. The UHB continues to work with partners in Local Authority and with WHSSC to find effective solutions on a case by case basis as well as a long term solution to the issue.

The UHB continues to investigate and review any Covid 19 outbreaks through the daily operational infection, prevention and control meetings and outbreak procedures in place for each affected area.

The Concerns 7 day service has continued and the current complaints 30 working day response time is 82%

There have been two never events reported in Surgery Clinical Board during this time period – both are currently under investigation. There has been a total of 6 never events since May 2020.

Based on our usual annual numbers this is higher than normal. Two relate to wrong tooth extraction and two are in Trauma and Orthopaedic theatre settings. The remaining two relate to a retained instrument in an obstetric setting and a wrong route drug administration error. A detailed thematic review of Never events will be presented to the April 2021 Quality, Safety and Experience Committee.
Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc.):

PATIENT SAFETY QUALITY AND EXPERIENCE REPORT
November – December 2020

Serious Patient Safety Indicators (SIs reportable to Welsh Government)

How are we doing?

During November and December 2020, the following Serious Incidents and No Surprises have been reported to Welsh Government:

Serious Incidents		
Clinical Board	**Number**	**Description**
Children & Women	• 1	• An incorrect intravenous fluid was administered to a woman in labour. The error was noticed promptly and interventions were implemented to ensure the well-being of the woman and her baby.
Executive Nurse	• 2	• Two incidents were reported where the Procedural Response to Unexpected Death in Childhood (PRUDiC) has been initiated.
Medicine	• 4 • 1	• Four patients suffered injurious falls. The patients all sustained fractured neck of femurs. The incidents occurred on different wards. • A medical ward at UHL experienced an outbreak of COVID-19 which required reporting as a Serious Incident in line with requirements at the time. Reporting processes have since changed.
Mental Health	• 4 • 1 • 5	• Four incidents of young people under the age of 18 years being admitted to Adult Mental Health Services in Hafan Y Coed were reported. • A patient sustained an injurious fall in the community setting. It is not currently clear if the fall was deliberate or accidental. The Coroner is undertaking an investigation.

	• 6 • 1	• A number of patients who were known to Adult Mental Health services have died unexpectedly. The circumstances of the deaths are individually being investigated by the Coroner. • A number of patients who were known to Addictions services have died unexpectedly. The circumstances of the deaths are individually being investigated by the Coroner. • A patient known to Mental Health Services was arrested by police following a serious assault on a family member.
Primary Community & Intermediate Care	• 2 • 1 • 1	• Two patients under the care of community nurses sustained pressure damage to their sacrum which was deemed to be avoidable. • A patient with physical ill health problems was found collapsed in his prison cell and resuscitation was unsuccessful. The circumstances are being investigated by the Coroner. • Concern has been expressed regarding the management of a patient who required urinary catheterisation in his home.
Specialist	• 1	• A nephrology ward at UHW experienced an outbreak of COVID-19 which required reporting as a Serious Incident in line with requirements at the time.
Surgery	• 1 • 2 • 1 • 1 • 1	• A surgical ward at UHW experienced an outbreak of COVID-19 which required reporting as a Serious Incident in line with requirements at the time. • Two patients suffered injurious falls. The patients both sustained fractured neck of femurs. The incidents occurred on different wards. • A patient sustained pressure damage to their sacrum which was deemed to be avoidable. • A patient underwent surgery to repair a hip fracture. A retained swab was identified on a routine post-operative x-ray. This is being managed as a Never Event. • A patient required surgery for a complex fracture of her radius and ulna. An initial incision was made in line with site marking but it was promptly noted that this was the incorrect approach. Corrective action was taken. This is being managed as a Never Event.
TOTAL	36	

No Surprises		
Clinical Board	**Number**	**Description**
Mental Health	1	A BBC program was aired following the inquest of a former patient whose death had been subject to a Coroner's inquest in January 2020. A Regulation 28 report was issued to South Wales Police and the College of Policing and this was discussed in the program.
TOTAL	1	

How do we compare to our peers?

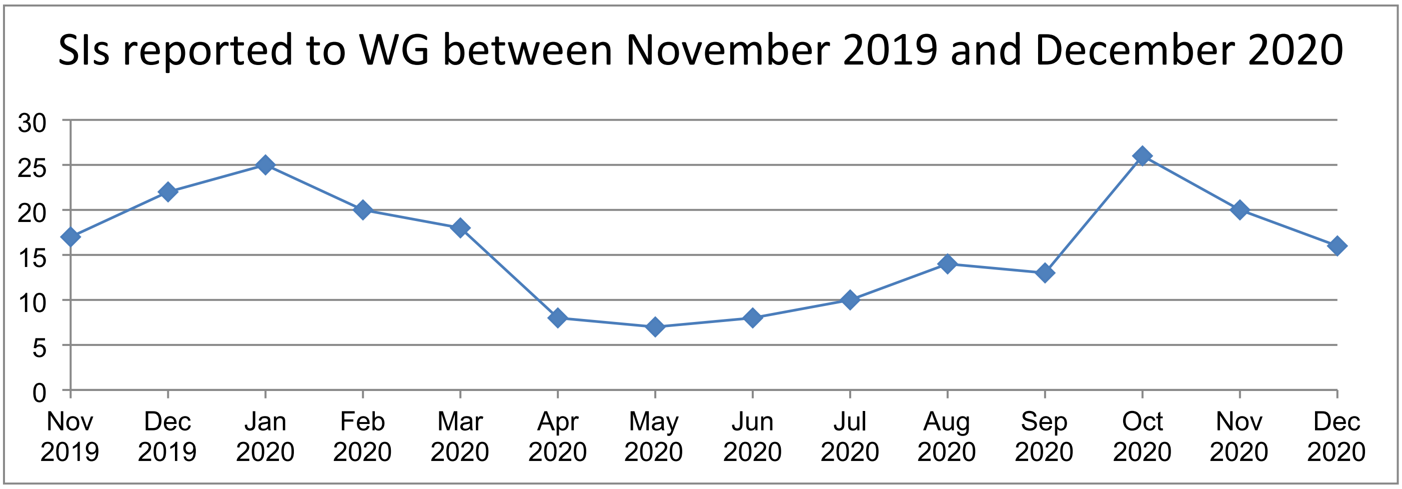
Welsh Government (WG) wrote to organisations in NHS Wales on 18th March 2020 to set out SI reporting requirements during the pandemic. They reinstated usual SI reporting requirements in August 2020 and SI reporting rates returned to pre-pandemic levels.

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

- All Never Events
- Inpatient suicides
- Maternal deaths
- Neonatal deaths
- Homicides
- Incidents of high impact / likely to happen again including child related deaths (for local decision)
- Covid-19 nosocomial transmission. The UHB is seeking clarity regarding this aspect in view of previous information setting out reporting arrangements for Covid-19 issues via a daily report to WG.

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

The following graph depicts the number of SIs reported to WG by month between November 2019 and December 2020.

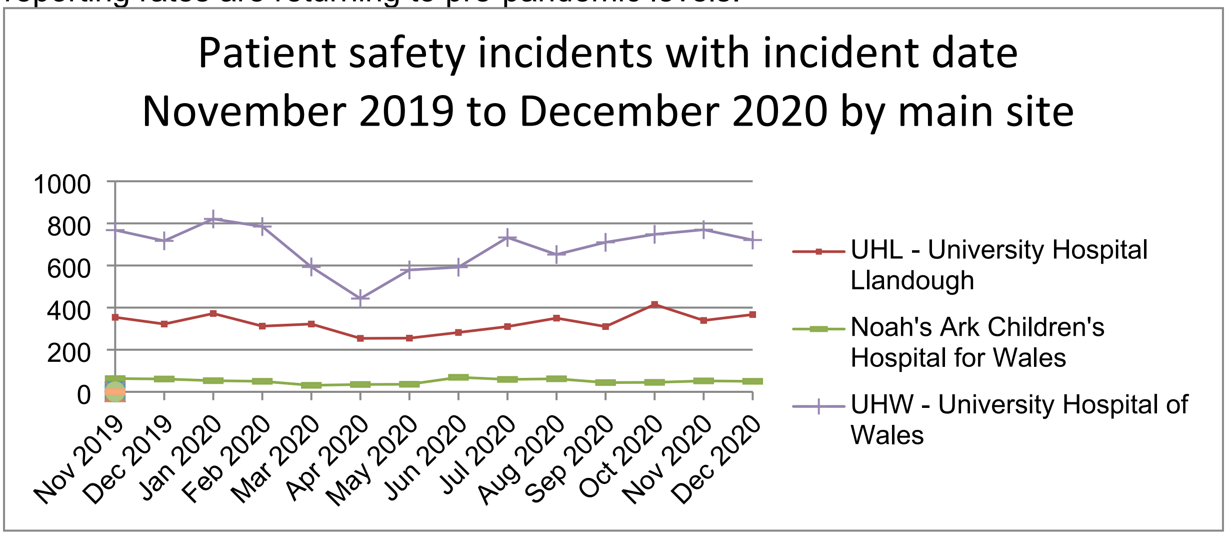


The top three reported categories of Serious Incidents reported overall during this timeframe include:

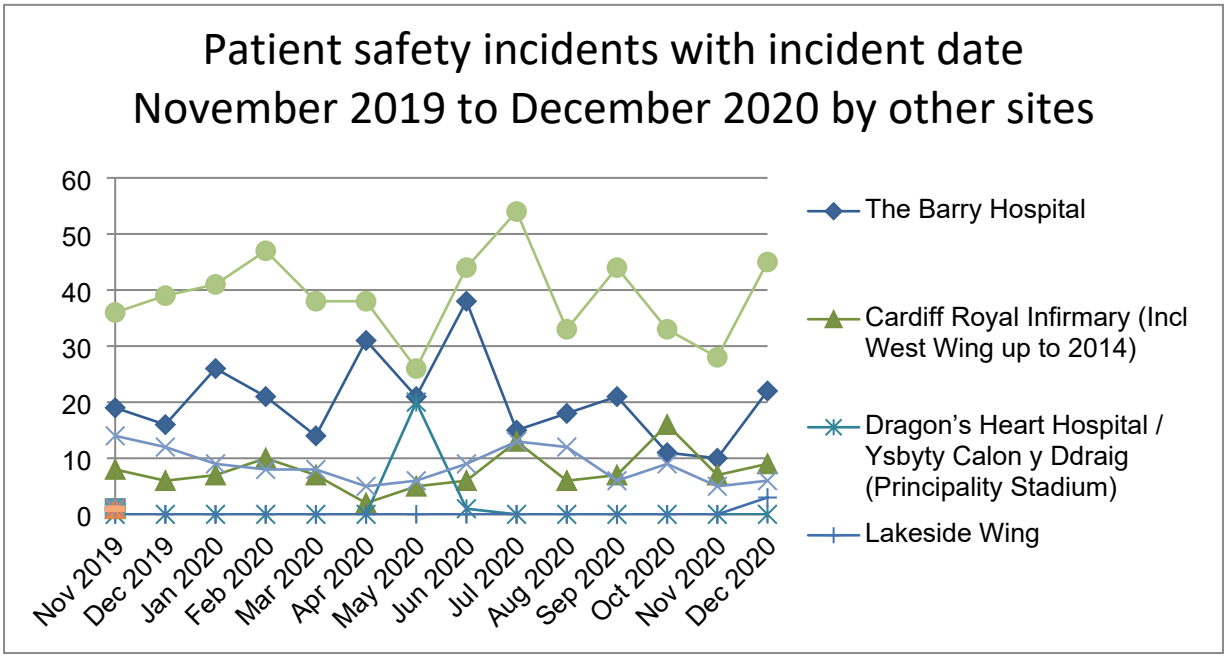
- Behaviour (including suicide, serious self-harm, absconsion)
- Patient accidents/falls
- Therapeutic processes/procedures (the Never Events reported in this timeframe were reported under this category)

These incidents are all reported to Board meetings and are subject to internal investigation by the Clinical Boards and Her Majesty's Coroner where appropriate.

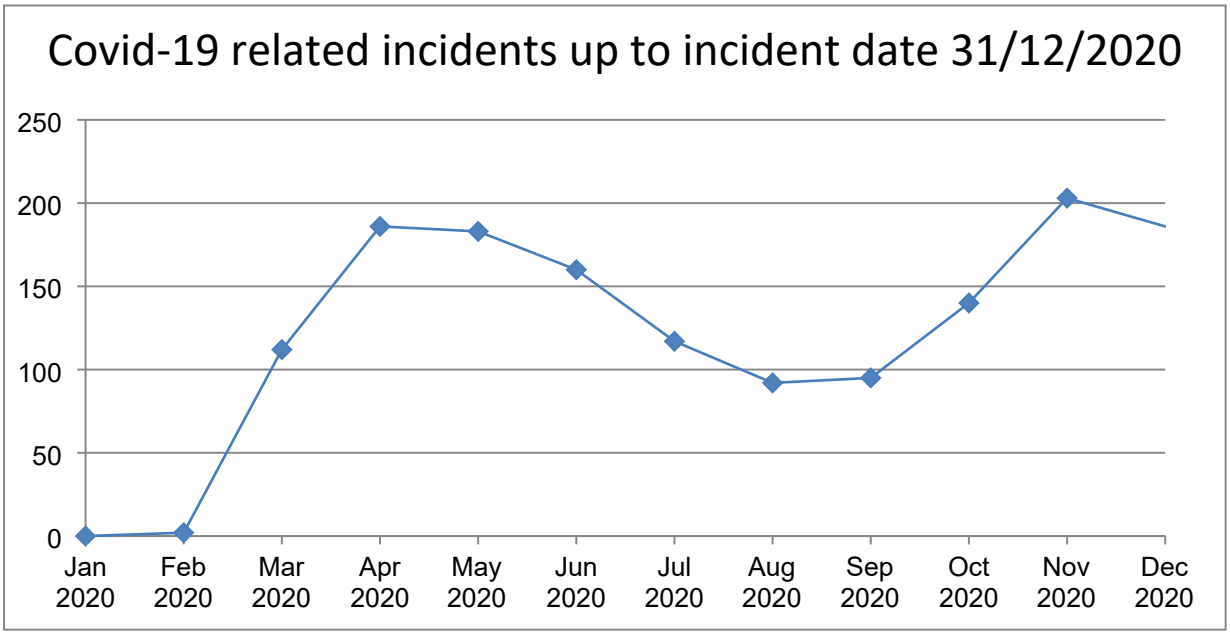
With regards to general incident reporting, it is evident that incident reporting rates fell initially during the pandemic, especially at UHW. However, the profile of incidents being reported and the reporting areas has been largely unchanged and it is believed that reduced clinical activity contributed to the situation. Review of current data suggests that reporting rates are returning to pre-pandemic levels.



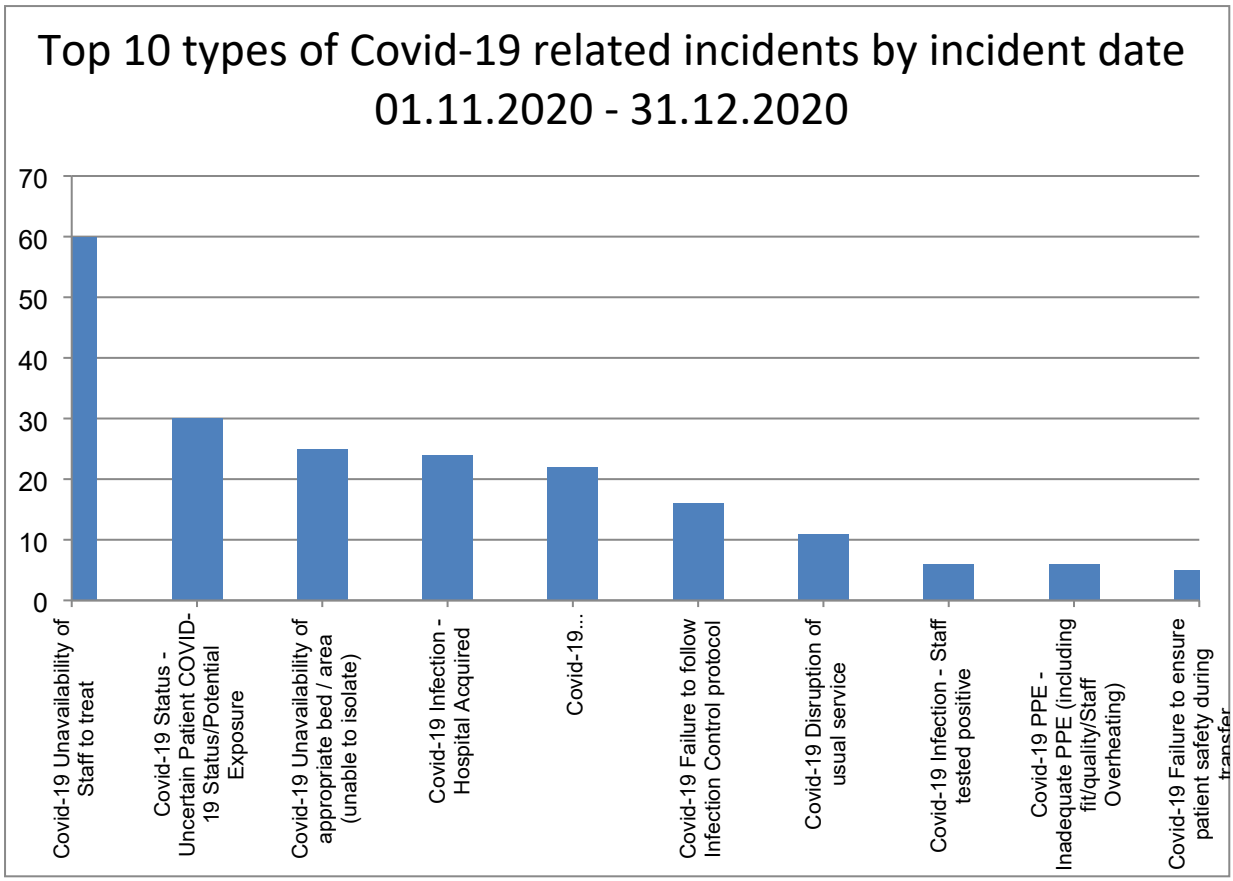
Review of patient safety incident reporting at other sites demonstrates fluctuating reporting rates at The Barry Hospital and St David's Hospital. There are low levels of reporting at the other sites for patient safety incidents. The incidents that are reported are largely patient accidents/falls (60% of the incidents). Greater than 90% of these incidents resulted in low harm to patients.



The UHB has been capturing incident forms where staff are raising issues in relation to Covid-19. It is evident that the volume of incidents began to steadily increase during the autumn months.



The following graph demonstrates the top 10 categories of Covid related incidents between November and December 2020.



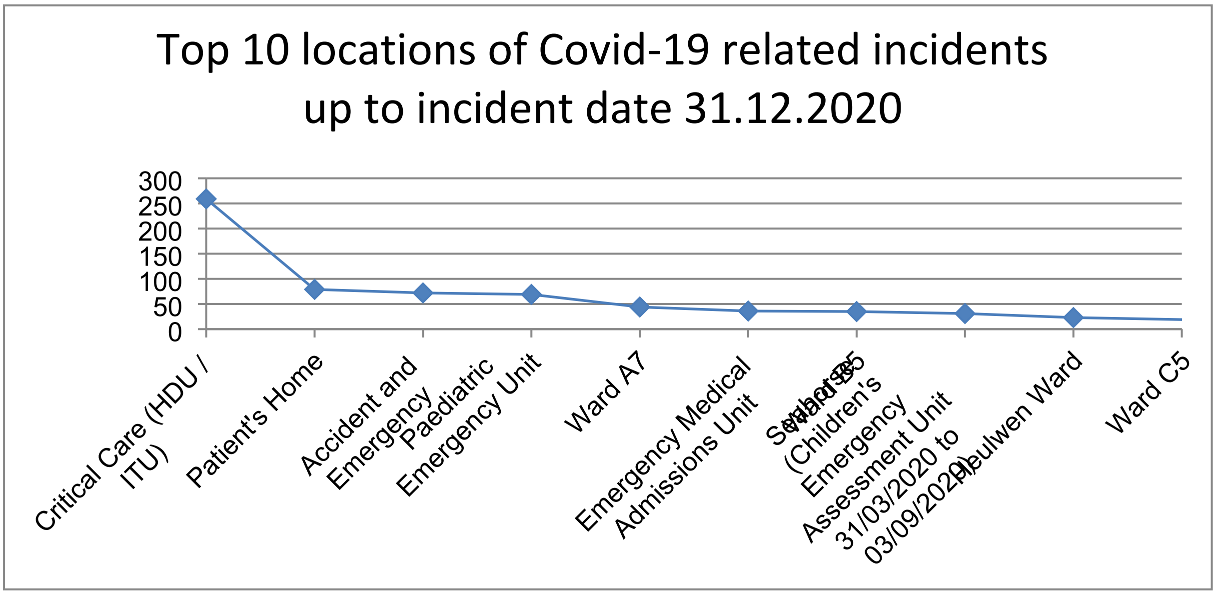
The highest volume of incidents continues to be in the 'Unavailability of staff to treat' category. The majority of the incidents are reported by staff in the Paediatric Emergency Department. They predominantly raise shortages in nursing staff. An establishment review is underway but staffing challenges are recorded across the UHB at the current time.

There are ongoing issues leading to 'Uncertain patient Covid-19 status / Potential exposure' incidents. These tend to include issues such as patients being transferred between clinical areas prior to results of Covid swabs being available. It is imperative that the advice of the Infection Prevention and Control Department is adhered to whilst managing the operational pressures that the UHB faces. Such operational plans are discussed at Covid Outbreak meetings to ensure appropriate measures are in place. The same considerations apply on review of the incidents in the 'Unavailability of appropriate beds' category.

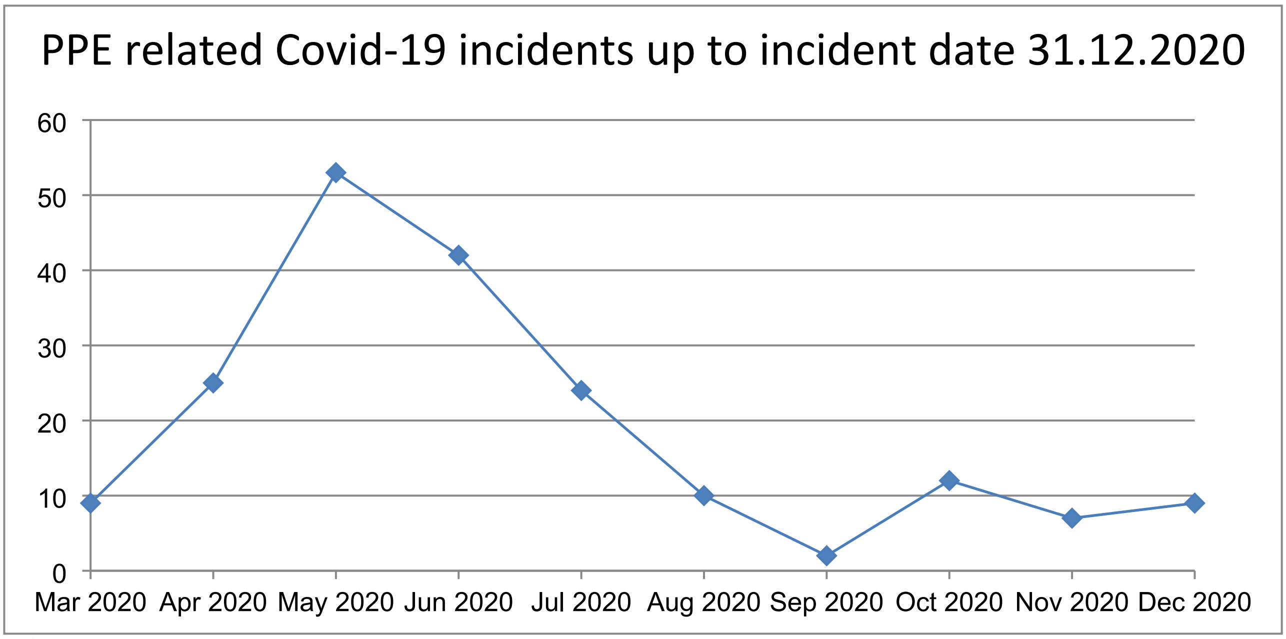
In terms of the 'hospital acquired Covid infection' category, it is being impressed upon clinical teams that it is crucial that they report outbreak incidents where there is evidence of patients and/or staff with healthcare acquired Covid. This facilitates monitoring of investigation requirements. Further consideration of next steps on conclusion of investigations is necessary to ensure compliance with Putting Things Right.

The Patient Safety Team continues to actively contribute to an all Wales working group that has been developing and revising investigation tools and supporting protocols for this process.

The overwhelming majority of Covid-related incidents up to 31.12.2020 were reported by the Critical Care Directorate. Approximately half of these incidents reported concerns in relation to PPE, with staffing concerns also expressed. The other clinical areas most frequently reporting Covid-related incidents are set out in the graph below.



In terms of PPE related incidents, the following graph demonstrates continued low volumes of incidents reported despite the current pandemic situation.



The Patient Safety Team is working in conjunction with Dr Andrew Carson-Stevens and colleagues from Cardiff University to undertake further analysis of the reported patient safety incidents relating to Covid-19. This builds on the foundations of a productive and valuable working relationship developed during a recent Health Foundation funded

research project. This saw the UHB collaborate with Cardiff University and the London School of Hygiene and Tropical Medicine for the Advancing Applied Analytics program.

Regulation 28 Reports

The UHB has not received any Regulation 28 Prevention of Future Deaths reports from Her Majesty's Coroner in this reporting timeframe.

Inquests continue to be significantly disrupted and postponed due to the pandemic. Cases are being rescheduled by the Coroner in order to bring them to a conclusion.

Patient Experience

Since March 2020, the PET (Patient Experience Team) has worked very differently having modified working practices to a 7-day working system and utilised a variety of methods to gain patient feedback.

The 3 main areas for feedback activity at this time are CAV 24/7 - survey of people who have used the service and feedback remains very positive, Prehab to rehab survey sent out after each nudge and this week some 1800 patients were nudged as they had intended to reduce their alcohol consumption. This is timely due to the information about dry January. Following the nudge a survey will be sent via text messaging.

The information provided to all people on the waiting lists (Prehab to Rehab) included contact details for the Concerns Team so than any queries could be addressed. The queries from many who called us was assurance that they remained on the waiting list and information regarding when their procedure was likely to take place.

Patient Experience Support Workers and Student Nurse Placement Support Workers

During the pandemic the paid Patient Experience Support Workers and placement students have provided over 10,000 hours supporting patients in UHW, UHL and St David's hospital. They facilitate virtual visits and phone calls at the patient's bedside, take toiletry and clothing requests and occasionally support with the clothing collection and drop off service when needed.

Over the January and February we will be welcoming 14 new Student Nurses on placement as Support Workers for the Patient Experience Team to support patients on the wards. The feedback from Medical and Nursing Students, patients, families and staff has been extremely positive regarding this role particularly in the current times of no or restricted visiting. They try to support contact with families, activities with patients and link with the PE Team for undertaking focused feedback surveys.

Virtual House Visits

Wards have borrowed iPhone/tablets so that patients can watch a social services house visit take place in their house while staying in hospital. The feedback has been very positive. This model particularly benefitted one patient who was very anxious about someone accessing their home while they were not present.

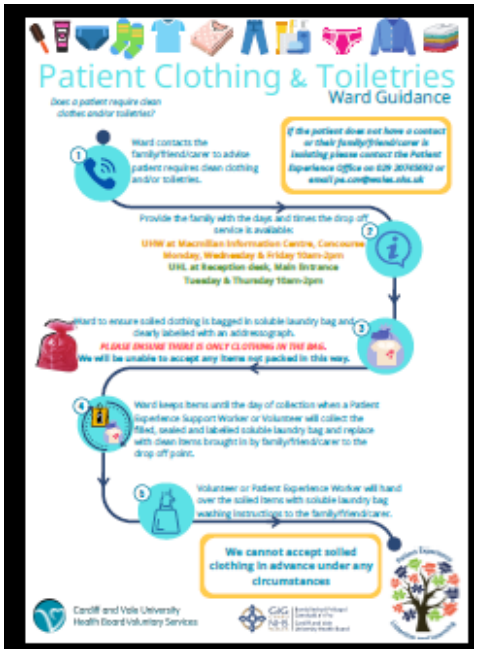
Tablets for ongoing care at home (Trial)

In November 2020 a Health Board tablet was loaned to a discharged patient from Hafen Y Coed who is using the tablet at home as part of their recovery. This is a trial and will be reviewed at the end of January with Speech and Language Therapists in Neuropsychiatry as it has enabled the patient to be safely discharged and continue with their therapy.

Patient Drop off and clothes collection

The PE Team and volunteers have supported a drop off and collection service for patient clothing and property on UHW and UHL sites.

1,625 drop off / collections have been made to date across both UHW and UHL Hospital sites.



The importance of this service is captured in the feedback from a relative

Thank you, *I am writing to you to ask you to pass on a very personal "thank you" to all the staff and volunteers of the Patient Experience Team from myself and my wife.*

Last week, my wife was taken ill with a suspected heart attack and was admitted to the UHW. She spent some time in the MAU, and was eventually transferred to Ward B7 North.

As you are aware, we have spent the past 2 weeks in the "firebreak" lockdown which meant that I was unable to visit my wife at a time which was very distressing for both of us.

Before we went to the hospital we gathered some basic essentials in a bag but due to the urgency of her condition, we didn't have time to put much thought into ensuring we had everything that might be needed for an extended stay and anyway, we were hoping that my wife might be home within 24 hours. Unfortunately, the treatment went on through the week.

As you can imagine, my wife was feeling pretty low and amongst the items that we had forgotten to pack was shampoo, (my fault, I put in conditioner instead). However, during the second day on the ward, your team of volunteers appeared and asked all the patients in the room if they needed anything. This was such a lift to my wife's spirits; she had borrowed some shampoo from a neighboring patient but it made such a difference to her dignity to have a full range of toiletries of her own. The team offered other items of course, but please let everyone at the Patient Experience Team know that an act of kindness like this made a huge difference to how my wife felt and although she is now home, we will think of them with gratitude.

Get There Together Project:

Please see the examples below of sharing a Patient's journey in this visual way which has had some lovely feedback from people who found it helpful to visualize the changes.

UHW Entrance and Journey

UHL entrance and Journey

Visiting Helpline

Prior to the no visiting decision except in particular circumstances, the Patient Experience Team worked with the clinical lead nurses to review the process.

We continued as previously established hosting the 7 day visiting helpline in the concerns team and we have a dedicated e mail.

We devised a video outlining the process which has been shared on social media and our website.

Visiting Video

All calls were directed to the concerns team on the numbers advertised on the website, posters and video.

We agreed that visiting slots were between 1-7 pm (allowing 45 minutes per visit and 15 minutes in between to allow for visitor's to vacate and any cleaning to occur). We identified wards where visiting would not be appropriate e.g. short stay elective surgery areas (Green zones). This was clearly communicated prior to admission.

We are offering an appointment to the caller if the patient had been in hospital for longer than a week. This was based on the assumption that these visits would be considered a wellbeing visit and restricted to one visitor per week, where possible. On a daily basis the ward verified the visiting requests and advised if the visit could not proceed due to any outbreaks or other concerns. The central concerns team collated the track and trace information and were a point of contact for the visitors advised if the visit needed to be cancelled.

Maternity adopted a risk based approach in line with the guidance and working with neighboring health boards to ensure an equitable approach.

This service will be recommenced when we reintroduce visiting and we are advising of the availability of virtual visiting, telephone calls and letters / messages to loved ones.

Mass Vaccination Centres (MVC)

We have been pleased to support the work in the MVC through communication with some co-horts, the development of a resource pack for care homes and support with Health Board Volunteers to meet and greet people attending the MVC. We have worked with partners in the British Red Cross and St John's Ambulances who will be providing 120 staff in varied roles, including; Vaccinators, Meet and Greet Volunteers and caring / observational roles, to support the program over the next 6 months.

This has included development of on-line induction sessions in the evenings and weekends. These sessions last around 1 hour 20 minutes and are facilitated via zoom. The chat function is used to allow participants to ask questions along the way. The

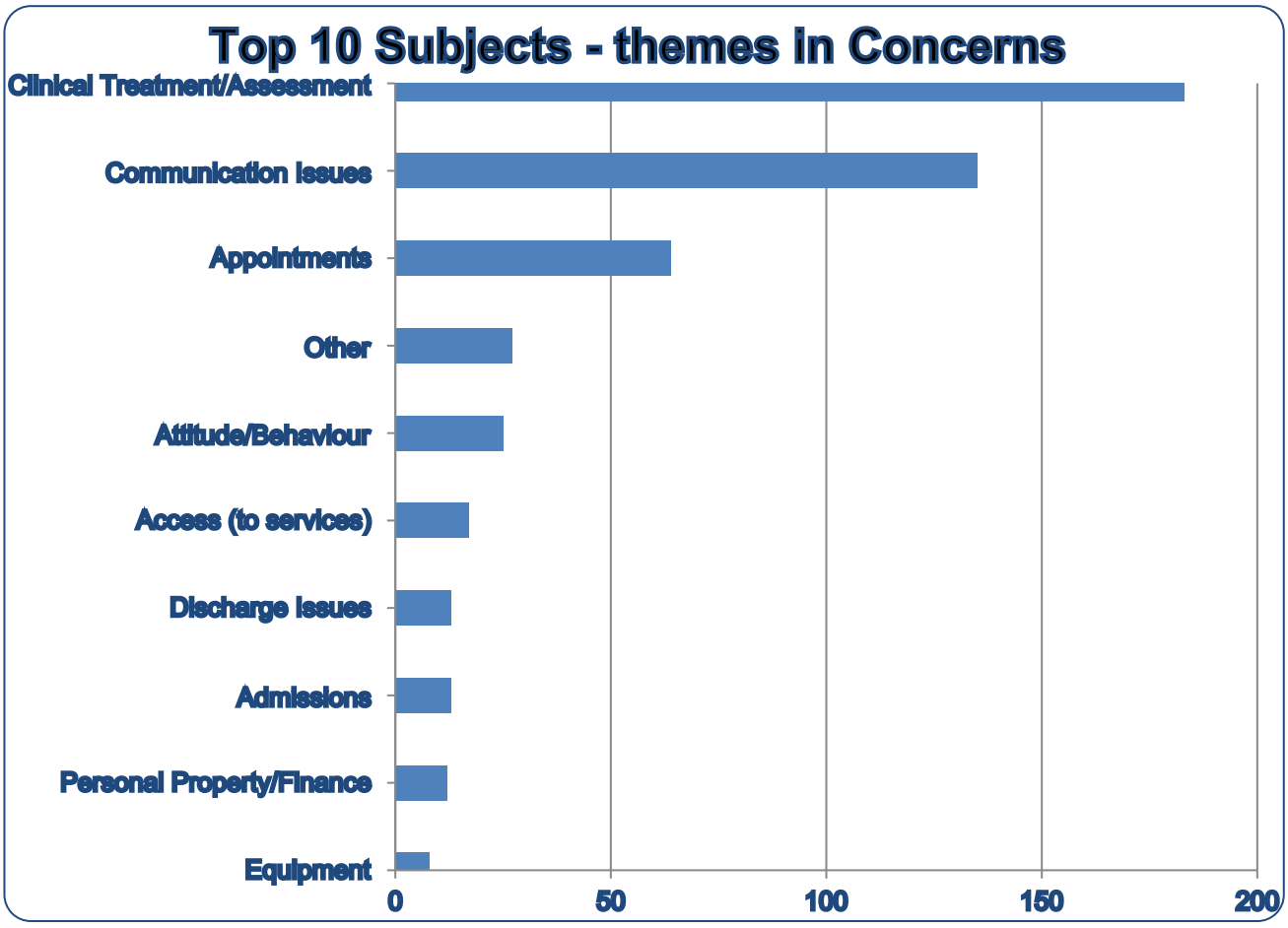
chat function allows questions to be seen by all participants or can be directed privately, which increases the opportunity for people to ask things.

Complaints Management/Redress

In November and December, 532 concerns were received, which is a slight increase when compared with 502 received in September and October. The numbers are slightly more than November and December 2019 when 503 concerns were received.

It is pleasing to note that the 30-working day performance for this period was 82%.

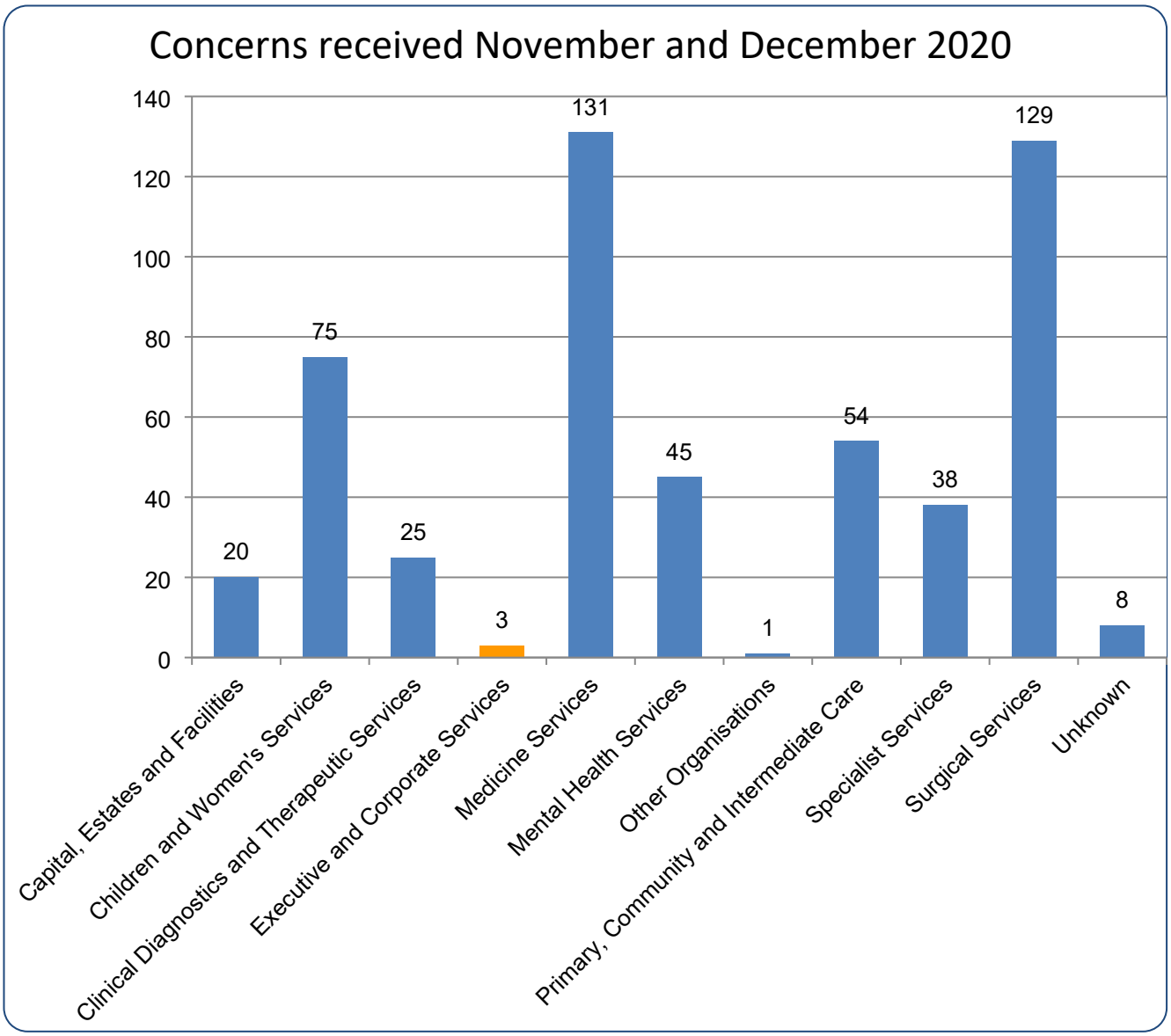
The Health Board continues to receive a high number of concerns regarding clinical treatment and assessment and communication as demonstrated in the diagram below:



Communication is a theme mentioned in the majority of concerns, on further analysis a key theme is in relation to lack of information when families are worried about their loved ones, inability to make contact directly to the wards via the telephone and lack of communication regarding discharge arrangements.

Some Patients, are raising concerns relating to delays in follow up appointments and planned procedures. Surgery Clinical Board and Medicine Clinical Board continue to receive the highest number of concerns. It should be noted that all Clinical Boards have seen a rise in concerns,

however, Medicine Clinical Board are seeing the greatest increase. This would be expected considering the high level of activity within Medicine Services.



Training:

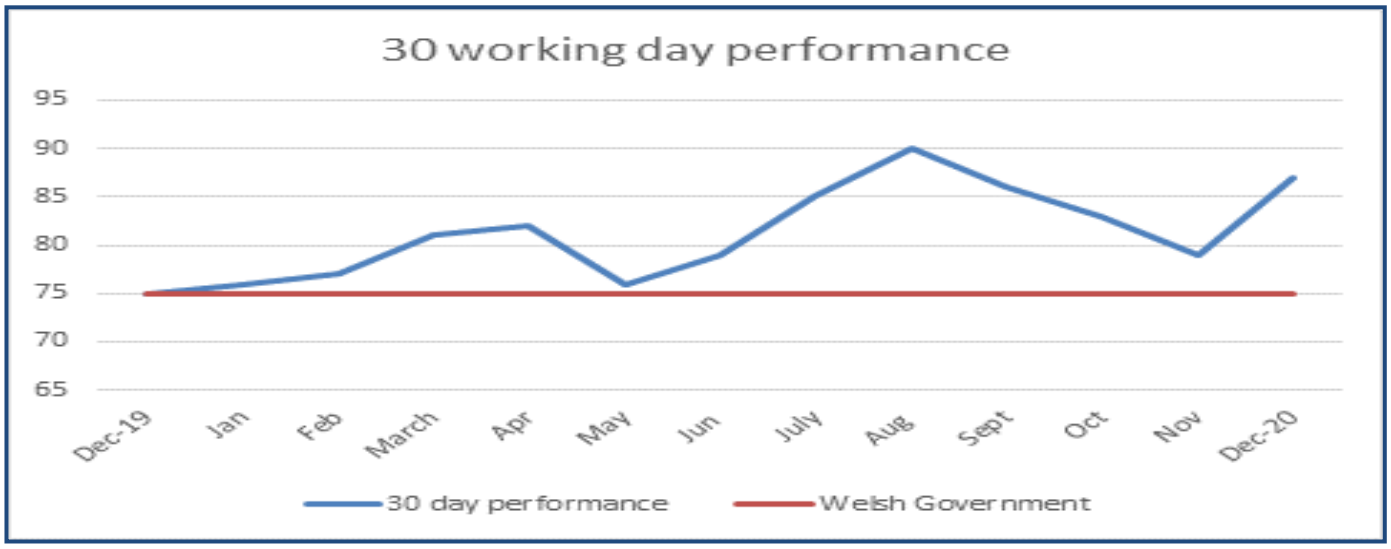
A live virtual interactive session took place on 6th November with a Clinical Negligence Barrister, the session was entitled Montgomery and Informed Consent - Where are we now. The session was open to all staff and was very well received with over 100 staff participating. The session was recorded and is being used in training sessions.

Our Redress lead, who is a solicitor, has undertaken virtual sessions to provide information about how we determine breach of duty and causation. The feedback has been very positive and we will continue to develop a training program.

Benchmarking

Whilst there is not any published benchmarking date for concerns performance across Wales we are consistently maintaining a 30 working day performance which exceeds the Welsh Government target.

One of the aims of the Once for Wales system for concerns management is that benchmarking dates will be available.



Recommendation:

The Board is asked to:

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

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

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

Equality and Health Impact Assessment Completed:	Yes / No / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Report Title:	**PERFORMANCE REPORT**								
Meeting:	Board Meeting						**Meeting Date:**	28/1/21	
Status:	**For Discussion**		**For Assurance**		**x**	**For Approval**		**For Information**	
Lead Executive:	Chief Operating Officer and Executive Finance Director								
Report Authors (Title):	Information Manager (029 20 745602) & AD Operations (Performance) (029 21 847549)								

Background and current situation:

The context for this performance report remains largely as that previously reported, with one exception regarding national publication of official statistics.

Welsh Government restarted publishing official statistics on NHS performance measures on 19 November. During the COVID-19 pandemic, the assurance and accountability requirements for local health boards have changed to reflect the immediate needs of safety. Welsh Government have confirmed that the data planned for publication in November and going forward will continue to be used for management information and to provide assurance against the delivery of health board quarterly plans.

The impact of Covid-19 continues to be seen across a range of key performance indicators. At the start of the pandemic, the focus of the Health Board switched to managing COVID-19 and maintaining essential services, in line with national guidance. Subsequently, comprehensive quarterly plans have been developed and received by the Board, with the focus of the service delivery element on managing COVID demand, minimising the risk of in-hospital COVID transmission, maintaining essential services and increasing activity through the re-introduction of other more routine services when it is safe to do so.

The format developed for the last report to the Board is used again for this current reporting period, with the focus on indicators deemed as essential services and / or those that continue to be routinely reported. Normal actions associated with the measures in this report will continue to be covered in the latest quarterly plan.

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

- The Health Board continues to operate within its local operating framework, with the first principle being to be COVID ready. This is congruent with the national framework.
- Whilst the Health Board continues to monitor the position for key performance indicators, prioritisation of need and service delivery continues to be based on clinical stratification rather than time-based targets.
- The continued uncertainty regarding future demand remains and is such that it will be some time before services are fully re-instated. Additionally, clinical re-design of services will continue and for some services this will result in a move away from traditional ways of delivery.
- Although the impact is not shown within the data in this report, the Health Board did at the end of December cancel some elective services in order to focus on meeting the increasing demands of Covid within our hospitals and in the community.

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

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

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

Throughout COVID-19, there has been a constant balance of risk made in relation to the extent to which services could continue to operate versus the potential harm from COVID-19. The continued uncertainty regarding future demand and increased level of complexity, particularly in light of the current second wave and the current winter period, is such that there remains risk in the system. The decisions and actions of the Health Board continue to be guided by clinical advice, local Executive-led support groups and national guidance.

Appendix 2 provides the Finance report for the Board.

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

Recommendation:

The Board is asked to **NOTE**:

- The current position against specific performance indicators for 2020-21

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

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

Unscheduled Care

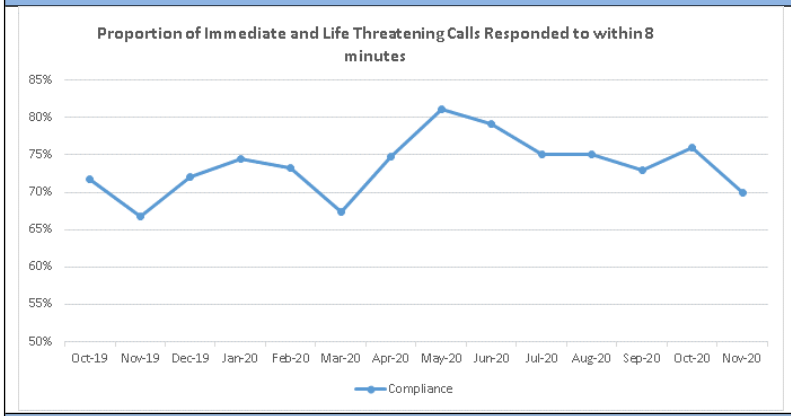
Overview

Emergency Unit attendances remain lower than previous levels due to Covid and were 68% and 72% of pre covid levels in October and November.

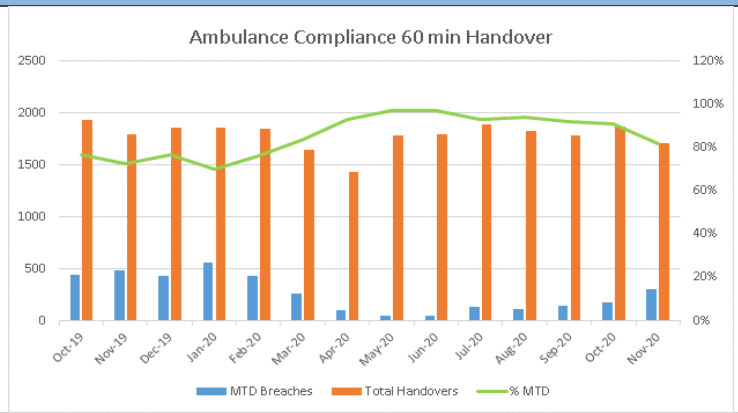
- 4 hour performance in EU was 80.3% in October (Oct 19 – 81.8%) and 76.6% in November (Nov 19 – 77.2%)
- There were 74 patients waiting greater than 12 hours in October 2020 and 176 in November 2020. This remains lower than previous years. (Oct 2019 – 173, Nov 2019 – 194)
- In October 2020 76% of red calls were responded to within 8 minutes. This reduced to 70% at the end of November. This compares with 71.7% in October 2019 and 66.7% in November 2019.
- Ambulance Handover within 1 hour was 91% in October and 82% in November.

Performance

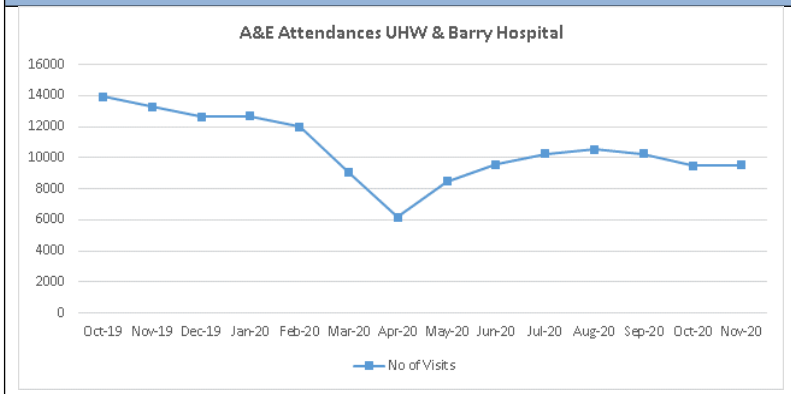
Graph 1: % Red calls responded to within 8 minutes



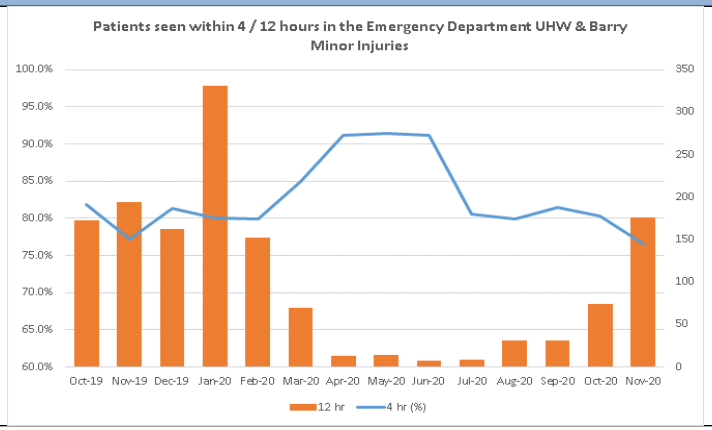
Graph 2: Ambulance handover > 1 hour



Graph 3: A&E Attendances



Graph 4: A&E waits – 4 & 12 hours



Primary Care

Overview

In relation to General Medical Services (GMS):

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

In relation to GP Out of Hours (GPOOHs):

- 78%, 80%, 78% of patients prioritised as ‘emergency’ requiring a home visit were seen within one hour in October, November and December.
- 60%, 100%, 75% of patients prioritised as ‘emergency’ requiring a primary care centre appointment were seen within one hour in October, November and December.

Performance

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

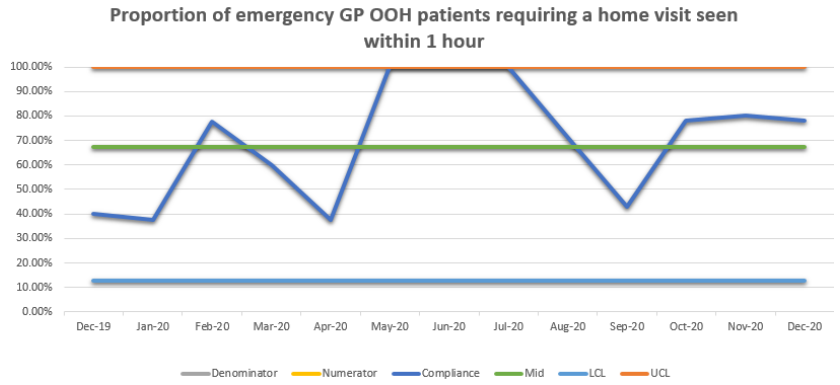
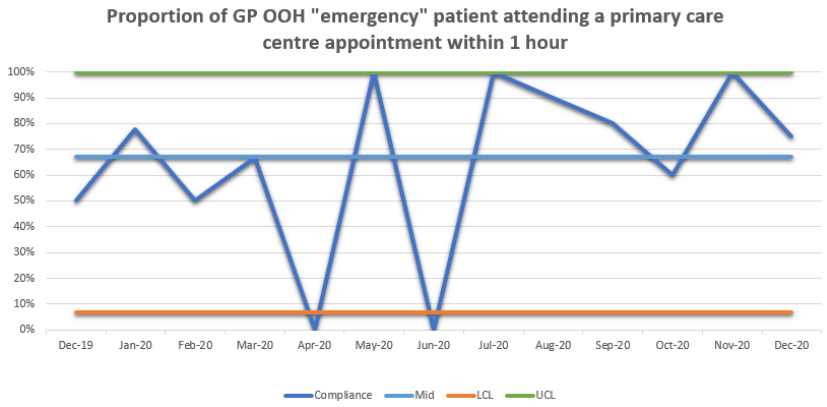


Chart 2: % of GP OOH “emergency” patients attending a primary care center appointment within 1 hour



Mental Health Measures

Overview

- Referrals for the Local Primary Mental Health Support Service (LPMHSS) have continued to rise and were again exceptionally high in November (1,289), showing a 50% increase from November 2019.
- Part 1a: The percentage of Mental Health assessments undertaken within 28 days is 30% overall and 53% for CAMHs in November 2020. Performance improved in October but deteriorated in November.
- Part 1b: 86% of therapeutic started within 28 days following assessment at the end of November.
- Part 2: 91% of health board residents in receipt of secondary mental health services have a valid care and treatment plan (CTP) as at November 2020
- Part 3: 77% of health board residents were sent their outcome assessment report within 10 days of their assessment in November 2020

Performance

Chart 1: Mental Health Referrals

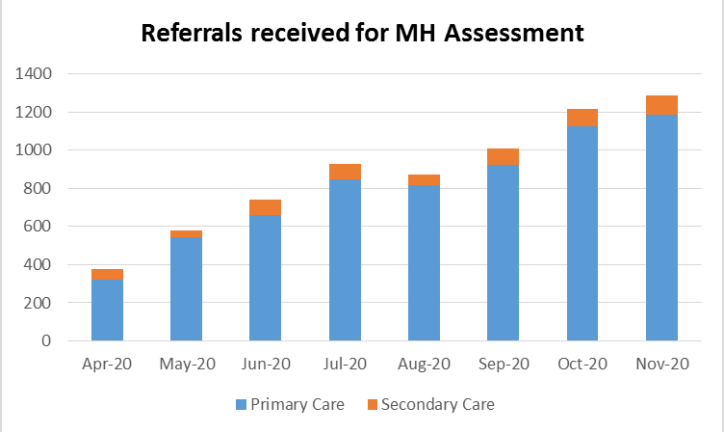


Chart 2: Performance against Mental Health Measures – Part 1a, 1b, 2 and 3

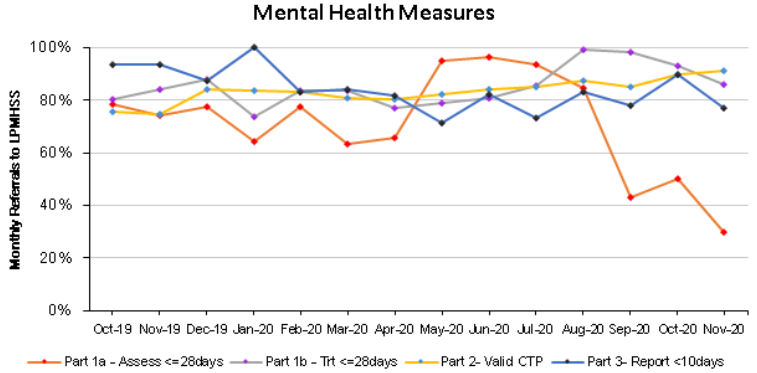
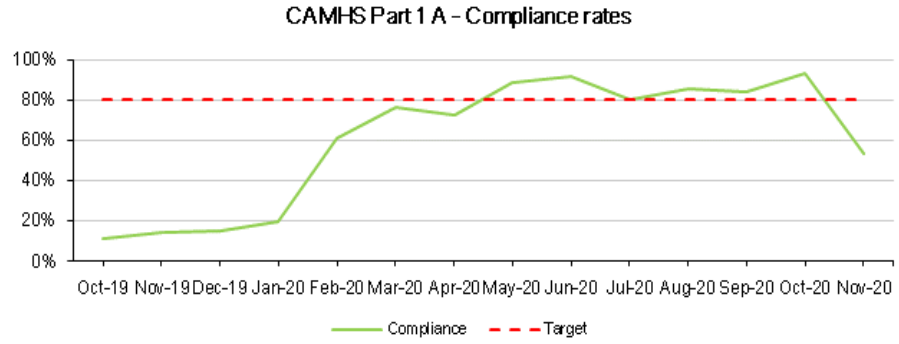


Chart 3: CAMHs Part 1a compliance



Cancer

Overview

- Referrals for patients with suspected Cancer have broadly returned to expected levels
- 148 patients started first definitive treatment in August, the same number as last August. The number of first definitive treatments commenced in September was 204, the highest in recent months.
- From December 2020, the Health Board in line with the rest of NHS Wales will switch to reporting the Single Cancer Pathway.
- 68% of patients on the Single Cancer Pathway, were seen and treated within 62 days of the point of suspicion in November.

Performance

Chart 1: Cancer referrals

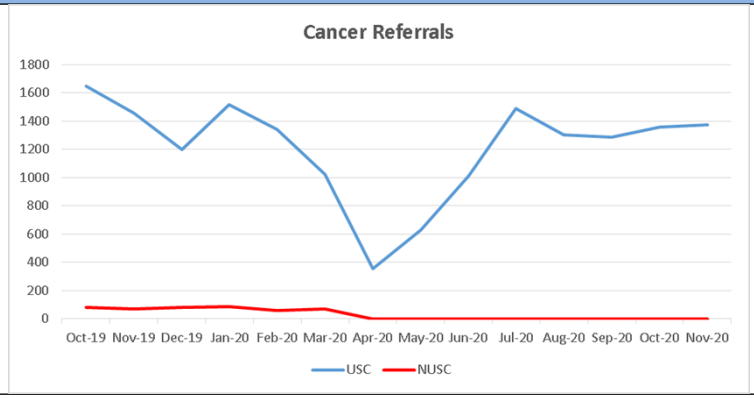
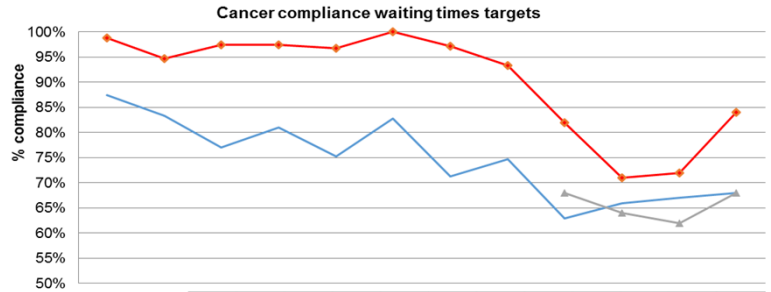


Chart 2: Performance against USC 62 day, NUSC 31 day and SCP performance



	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20
62 Day Actual	88%	83%	77%	81%	75%	83%	71%	75%	63%	66%	67%	68%
31 Day Actual	99%	95%	97%	97%	97%	100%	97%	93%	82%	71%	72%	84%
SCP % - unadjusted									68%	64%	62%	68%

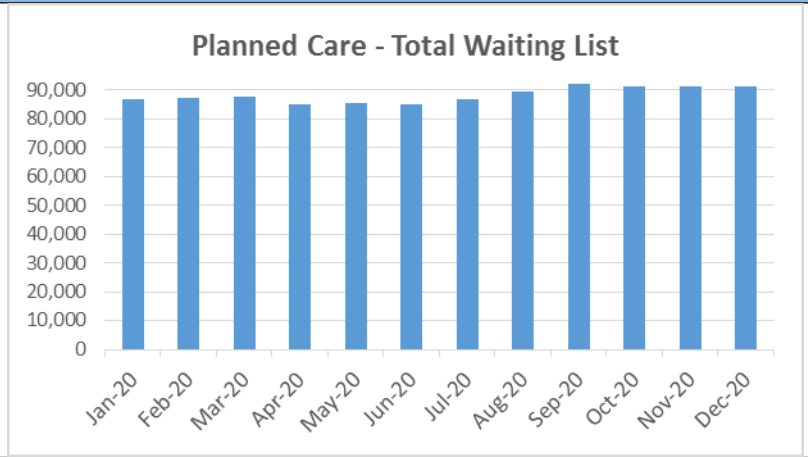
Elective access

Overview

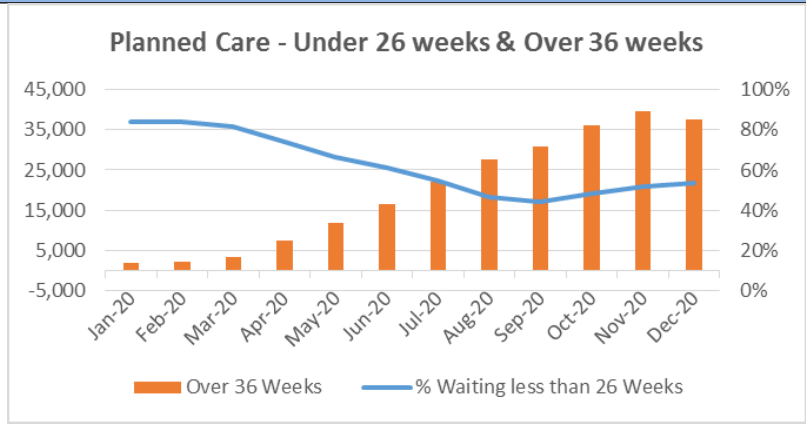
- The overall Referral to Treatment (RTT) waiting list was 91,408 at the end of December 2020, 184 greater than at the end of November. There were 37,434 patients waiting over 36 weeks for treatment for planned care, 2,121 fewer than at the end of November.
- Patients waiting greater than 8 weeks for a diagnostic test reduced to 8,885 in December, an increase of 274 from the end of November.
- The total number of patients waiting for a follow-up appointment was 168,642 at the end of December. The number of Follow Up patients waiting over 100% beyond their target date was 47,152 patients.

Performance

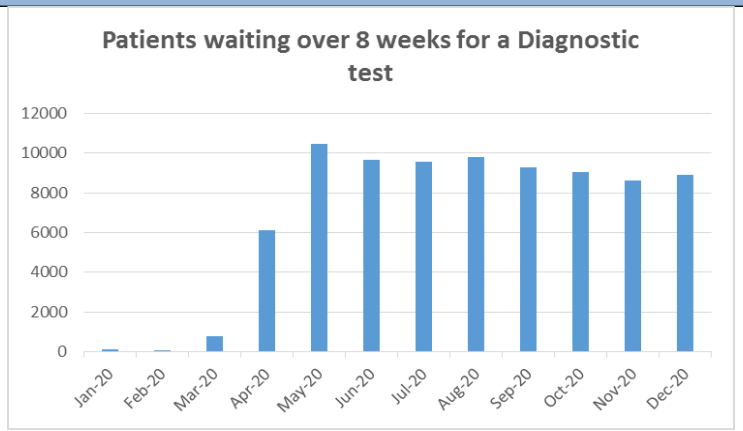
Graph 1: Total Waiting List – Planned Care



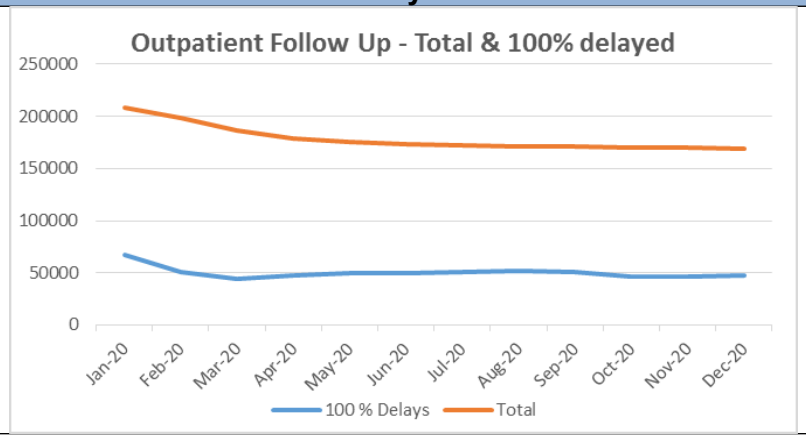
Graph 2: Waiting Times - % under 26 weeks and Volumes over 36 weeks



Graph 3: Diagnostics > 8 weeks



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



FINANCE

How are we doing?

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

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

At month 9, the UHB is reporting an underspend of £0.303m against this plan. During the 9 months to the end of December net expenditure of £111.315m arose from the management of COVID 19 which is offset by the same amount of Welsh Government COVID 19 funding leaving an operating surplus of £0.303m.

Reported month 9 position

The Welsh Government amended the monthly financial monitoring returns to capture and monitor net costs due to COVID 19 that are over and above LHB plans. The financial position reported to Welsh Government for month 9 is a surplus of £0.303m and this is summarised in the Table below:

Table 1: Financial Performance for the period ended 31st December 2020

	Cumulative Month 9 £m
COVID 19 Additional Expenditure	115.373
COVID 19 Non Delivery of Savings Plans	14.316
COVID 19 Reductions in Planned Expenditure	(16.923)
Total Release/Repurposing Of Planned Investments/Development Initiatives	(1.451)
Net Expenditure Due To COVID 19	**111.315**
Welsh Government COVID funding received / assumed	(111.315)
Net COVID 19 Forecast Position (Surplus) / Deficit £m	0.000
Operational position (Surplus) / Deficit	(0.303)
Finnacial Position £m (Surplus) / Deficit £M	**(0.303)**

The additional COVID 19 expenditure in the 9 months to the end of December was £115.373m. £53.357m of the additional costs related to the Dragon's Heart Hospital (DHH) and there was also £62.016m of other COVID 19 related additional expenditure.

COVID 19 is also adversley impacting on the UHB savings programme with underachievment of £14.316m against the month 9 target of £21.790m. Further material improvement is not anticipated until the COVID 19 pandemic passes.

Elective work has been curtailed during this period as part of the UHB response to COVID 19 and this has seen a £16.923m reduction in planned expenditure. The UHB has also seen slippage as a commissioner of £1.451m on its WHSSC commissioning plan due to impact of COVID 19.

The net expenditure due to COVID 19 is £111.315m and this is matched by an equal amount of additional Welsh Government COVID 19 funding. The UHB also has a small operating underspend of £0.303m leading to a net reported surplus at month 9.

Forecast Year End Position

Whilst the UHB expects the non COVID related operational position to remain broadly balanced as the year progresses, the additional costs arising from plans to manage COVID 19 are expected to continue. The forecast at month 9 of net expenditure due to COVID 19 in 2020/21 is £162.935m and this is offset by additional COVID 19 funding of £162.935m as summarised in table 2 below:

Table 2: Forecast Financial Performance at month 9

	Forecast Year-End Position £m
COVID 19 Additional Expenditure	166.328
COVID 19 Non Delivery of Savings Plans	19.799
COVID 19 Reductions in Planned Expenditure	(20.203)
COVID 19 Release of Planned Investments	(2.989)
Net Expenditure Due To COVID 19	**162.935**
Welsh Government COVID funding received / assumed	(162.935)
Net COVID 19 Forecast Position (Surplus) / Deficit £m	**0.000**

The UHB continues to forecast a break even position at year end based upon the resource assumptions set out in the NHS Wales Operating Framework 2020/21 for Q3 and Q4.

Underlying deficit position

The underlying deficit position brought forward from 2019/20 was £11.5m. Delivery of the 2020/21 plan would have reduced this to £4m by the year end. The achievement of this is largely dependent upon delivering the £25.0m 2020/21 recurrent savings schemes. The latest assessment is that this remains at circa £21.3m less than planned and this will increase the underlying deficit to £25.3m. What is unclear at the moment is whether Welsh Government will provide any recurrent funding to underwrite this. In addition, there is a risk that a small component of the COVID response will have a recurrent costs. These risks are being identified so that mitigating actions can be taken.

Creditor payment compliance

The reported Non-NHS Creditor payment compliance was 96.3% for the 9 months to the end of December and continues to meet the 95% performance target.

Remain within capital resource limit

The UHB had an approved annual capital resource limit of £85.594m at the end of December 2020. Capital expenditure for the first 9 months of the year was £67.100m against a plan of £69.934m. The UHB expects the final 2020/21 capital outturn to be broadly in line with its capital resource limit.

What are the UHB's key areas of risk?

At month 9, following confirmation of additional funding assumptions, the key revenue financial risk is managing the impact of COVID 19 within the additional resources provided and delivering a break even position.

What actions is the UHB taking to improve?

Continue to work with Welsh Government to identify and secure all additional costs of managing COVID 19.

CONFIRMED MINUTES OF THE COVID-19 BOARD GOVERNANCE GROUP HELD ON WEDNESDAY 4 NOVEMBER 2020 at 4pm VIA MS TEAMS/EXECUTIVE HEADQUARTERS, WOODLAND HOUSE MAES Y COED ROAD, HEATH, CARDIFF CF14 4HH

Present:

Charles Janczewski	CJ	Chair
Len Richards	LR	Chief Executive
Michael Imperato	MI	Interim Vice Chair
John Union	JU	Independent Member - Finance
Dr Rhian Thomas	RT	Independent Member - Capital and Estates
Sara Moseley	SM	Independent Member - Third Voluntary Sector
Dawn Ward	DW	Independent Member – Trade Union
Akmal Hanuk	AH	Independent Member – Local Community
Gary Baxter	GB	Independent Member University
Eileen Brandreth	EB	Independent Member – Information Communication &Technology

In attendance:

Nicola Foreman	NF	Director of Corporate Governance

Apologies:

Susan Elsmore	SE	Independent Member – Local Authority

CV19BGG: 20/11/04/001	**WELCOME AND INTRODUCTIONS** The Chair welcomed everyone to the meeting of the COVID 19 Board Governance Group. The Chair confirmed that the meeting was quorate to make decisions.	**ACTION**
CV19BGG: 20/11/04/002	**APOLOGIES FOR ABSENCE** Apologies for absence were noted from Cllr Susan Elsmore	
CV19BGG: 20/11/04/003 Khan Raj 01/21/2021 14:27:09	**MINUTES OF THE MEETING HELD ON** The minutes of the meeting held on 26th August 2020 were reviewed by the Covid 19 Board Governance Group (BGG) and were approved as a true and accurate record. There were no matters arising.	

CV19BGG: 20/11/04/004	**ACTION LOG FROM THE MEETING HELD ON** **Resolved that** The DCG confirmed that there were no actions carried forward from the meeting held on the 26th August 2020.	
CV19BGG: 20/11/04/005	**GENERAL UPDATE ON COVID 19** The CEO provided the Group with an update and confirmed that the Covid rate in Cardiff, per 100k of the population was stabilising and whilst there had been a reduction in the infection rate amongst the younger population, there had been a gradual rise in cases within the over 60 age group. There had also been a steep increase in cases within the Vale of Glamorgan across all age groups and hospital admissions had increased with 86 Covid patients currently in hospital and seven in ITU. He added that there had been a significant increase in cases within the last ten days and that nosocomial infections (hospital acquired infections) were driving the numbers up. He reported that there had been three outbreaks; two on the UHW site and one on the UHL site, that they were being managed and that IP&C were quarantining the wards and minimising footfall. He advised that some members of staff were travelling in from areas such as Cym Taf, where the Covid rates were much higher. He reported that he had joined the Chair at this morning's Leadership Group meeting, attended by representatives from Public Health, Environmental Health, the Community, South Wales Police and the CEOs from the Local Authorities and that they were happy with the Health Boards actions in responding to the outbreaks within the hospital. He advised that this was a very effective partnership which fed back in to Welsh Government. The CEO added that they would provide the group with any further updates and they would closely monitor the situation.	
CV19BGG: 20/11/04/006	**Governance Arrangements** The Chair presented a paper to the group, written by the DCG, seeking approval of the recommendation to approve the proposed amendments to the Governance arrangements, to approve the Covid-19 report template, to approve that the first 90 minutes of future Board Development Sessions be held in public and to approve the revised governance structure. He explained that three recent audits had taken place: • KPMG – Review of the Principality • Audit Wales – Structured Assessment	

	• Internal Audit – Governance Review That there was an additional Gateway Review audit in process relating to the Lakeside Surge Hospital. It was the intention of the Chair that the papers relating to the Board Governance arrangements be shared with the group prior to the meeting but due to a communication error, not all the group had received the papers in advance. It was agreed that they would be circulated. The Chair advised the group of the proposed changes and explained that a template report had been designed which outlined the key Covid impacted areas of quality of service and patient safety, workforce, Governance Arrangements, operational updates and Public Health updates. If approved, this report would be taken to Board and the public part of Board Development meetings to discuss those key areas in Public from the 1st December. It was proposed that the core membership of the group be expanded to include the CEO, the DCG, the Independent Member (IM) for Legal, IM for Finance and IM for Capital and Estates as most of the decisions involved either legal or financial documentation. All IMs would also be members with an open and standing invitation to all IM's. He added that similar papers would be taken into the other committees. The IM for Capital and Estates suggested that the data within the template be displayed in diagram or table format rather than multiple paragraphs as this would be more impactful and easier to review, especially as it would be under public scrutiny. The IM For Finance, queried the Gateway Review audit as other Health Boards had completed this prior to ours. The Chair confirmed that this was due to a timing event from their point of view and that the EDSP shared a draft report yesterday evening. It was agreed that once received, the final document would be shared with the Board but would not be a public document. The Vice Chair/IM for Legal referred to the proposal for the first 90 minutes of Board Development to be held in public. He asked if other Health Boards had done this, if notes of the meeting would be taken and if they would be published on the website. The Chair confirmed that this was the intention for the meeting to be on record and that although it may not run for the full 90 minutes, it allowed an opportunity for the Board to provide an update in public of the current situation and any issues relating to Covid. He added that the neighbouring Health Boards had gone into Gold Command, having held monthly public Board meetings.	

	Resolved that	
CV19BGG: 20/11/04/007	The Board Governance Group noted and approved the recommendations.	
	Terms of Reference Board Governance Group	
	The DCG presented a paper to the Board Governance Group seeking approval of the recommendation to note and approve the changes made to the Terms of Reference (TOR). She explained to the group that there had been a change to the membership of the committee following a recommendation from Wales Audit Office to expand it to ensure that it was open and transparent. However, the quorum remained the same as that required for a Chairs action which was three Independent Members plus the Chief Executive or his Deputy. The Independent Members would include the Chair or Vice Chair plus the Chair of Audit Committee and the Chair of Finance Committee. The Chair also asked that the Independent Member Legal also be added to the quorum. The Chair requested for any feedback on the Terms of Reference (TOR) to be submitted to the DCG by the 6th November 2020. He agreed to contact the group by email to confirm if they approved the report.	
CV19BGG: 20/11/04/008	**Resolved that** The Covid-19 Board Governance Group agreed to note and approve, once reviewed, the Terms of Reference (TOR).	
	Dragons heart hospital exit from Cardiff Blues Ground	
	The CEO referred to a paper, previously taken to ME for approval and relating to the costs incurred from exiting the Cardiff Blues Ground. He explained that when the Health Board moved into the DHH, they were granted permission to use the Cardiff Blues Ground to support the construction and decommissioning of the surge hospital. The CEO added that these were chargeable costs and that it was consequential loss in terms of income for the Blues. He informed the group of the reinstatement costs involved in returning the ground to its former state and that following an assessment and an independent review, an agreement was reached with WG for them to cover these costs of up to £1.250m. That there had been damage to the pitch itself and having entered into the agreement, the Health	

	Board were now liable for £250k overall costs to replace the pitch. He added that this fell within the CEO's threshold for sign off but due to the nature of the cost, it was important the group were sighted on this. The IM for Trade Union asked if this had been passed through a tender process. The CEO confirmed that a tender process was undertaken by the Blues and although they did not chose the cheapest quote, the Health Board's liability was limited to £250K. The CEO added that WG had agreed to cover this cost and therefore it did not compromise the health care budget. The IM for Capital and Estates requested clarification on the £289,699k consequential costs and what these were for as they didn't appear to be referenced in the body of the report. The CEO agreed to clarify this outside of the meeting. He added that C&V UHB do have the right of audit and that Mott McDonald have remained on the contract and carry out audits and have provided assurance that it was a reasonable liability. The DCG agreed to clarify this and feedback to the committee. The IM for Finance queried the cost of the replacement pitch and whether the fact that it had been in situ for some considerable time had been taken into account. The CEO confirmed that the pitch had been down for six years that Mott McDonald had taken this into consideration and it was beyond repair and in need of replacing. The IM for Finance also queried if there was liability with the contractors and if VAT was included in the cost. The CEO clarified that as part of the evaluation, it had been confirmed that there was no liability. He agreed to find out if VAT was included and to feedback to the IM for Finance. The IM for ICT queried the cost and the tender process. The CEO confirmed that it was not our tender. **Resolved that** The Board Governance Group noted the five bullet points.	LR LR
CV19BGG: 20/11/04/009	**CHAIRS ACTION** **Resolved that** The DCG confirmed that there were no Chairs Actions for this meeting.	
CV19BGG: 20/11/04/010	**DECISIONS LOG**	

	The DCG confirmed that the Decision log would be established from Monday 9th November 2020.	
CV19BGG: 20/11/04/011	**ANY OTHER BUSINESS**	
CV19BGG: 20/11/04/012	**DATE AND TIME OF NEXT MEETING** The date and time of the next meeting was confirmed as Wednesday 18th November 2020 10.00 a.m – 11.00 a.m Via MS TEAMS	

CONFIRMED MINUTES OF THE MEETING OF THE FINANCE COMMITTEE HELD ON 25th NOVEMBER 2020 VIRTUAL MEETING via TEAMS

Present:

Dr Rhian Thomas	RT	Chair, Independent Member – Capital and Estates
John Union	JU	Independent Member - Finance
Charles Janczewski	CJ	Board Chair
Abigail Harris	AH	Executive Director of Strategic Planning
Andrew Gough	AG	Assistant Director of Finance
Chris Lewis	CL	Interim Director of Finance
Len Richards	LR	Chief Executive
Nicola Foreman	NF	Director of Corporate Governance
Ruth Walker	RW	Executive Nurse Director

In Attendance:

Emily Kitt	IV	Ward Manager – East 16 (shadowing the Executive Nurse Director)

Secretariat:

Paul Emmerson	PE	Finance Manager

Apologies:

Martin Driscoll	MD	Executive Director of Workforce and Organisational Development
Steve Curry	SC	Chief Operating Officer

FC 20/106	**WELCOME AND INTRODUCTIONS** The Chair welcomed everyone to the meeting.	**ACTION**
FC 20/107	**APOLOGIES FOR ABSENCE** Apologies for absence were noted.	
FC 20/108	**DECLARATIONS OF INTEREST** The Chair invited members to declare any interests in proceedings on the Agenda. None were declared.	
FC 20/109	**MINUTES OF THE COMMITTEE MEETING HELD ON 28th OCTOBER 2020**	

	The minutes of the meeting held on 28th October 2020 were reviewed and confirmed to be an accurate record subject to an amendment to minute FC - 20/100 where the reference to the UHB Chair is to be amended to the Finance Committee Chair. **Resolved – that:** The minutes of the meeting held on 28th October 2020 were approved by the Committee as an accurate record.	
FC 20/110	**ACTION LOG FOLLOWING THE LAST MEETING** **FC 20/101- Forecast to Break-even.** A monthly forecasting graph is to be included in future finance performance reports. The graph should include any unfunded costs arising from the management of COVID 19. It was noted that this action had been **completed** and that a monthly forecasting graph was included in Month 7 Finance Report. The Finance Committee Chair (RT) observed that the scale required to cover the reported position in the first 5 months of the year meant that variation in performance was difficult to glean from the graph from month 6 onwards. The Director of Finance concurred and suggested that this could be overcome by amending the graph to report performance against forecast over the period from month 6 to year end. The Committee agreed with the suggested amendment. **Resolved – that**: The Finance Committee **received** the Action Log and agreed that the monthly forecasting graph would be amended to report performance against forecast from month 6 to year end for future reports.	Interim Director of Finance
FC 20/111	**CHAIRS ACTION SINCE THE LAST MEETING** There had been no Chairs action taken since the last meeting.	
FC 20/112	**FINANCIAL PERFORMANCE MONTH 7** The Assistant Director of Finance informed the Committee that at month 7, the UHB had reported an underspend of £0.362m and that the reported position included net expenditure of £88.478m arising from the management of COVID 19 which was offset by an equal amount of Welsh Government COVID 19 funding leaving an operating surplus of £0.362m. The Executive opinion noted that Welsh Government had now set out the resources available to support the COVID 19 response and there was an expectation that NHS bodies would manage within these resources to deliver their original planned position which in the case of the UHB was a break even position by year end. In addition the	

	UHB needed to avoid adding recurrent expenditure to the UHB's underlying position to support the recovery from this period. The Committee was informed that the UHB had discussed and agreed all key assumptions underlying the forecast year end breakeven position with the Welsh Government Finance Delivery Unit (FDU). Two of the eight measures on the Finance Dashboard remained RAG rated red namely: the reduction in the underlying deficit to £4m; the delivery of the recurrent £25m 3% devolved savings target. The delivery of the £4m non recurrent savings target had progressed to Green status in October. In addition, performance against the targets to remain within the revenue resource limit; to remain within the cash limit; to meet creditor compliance payments targets ; to maintain a positive cash balance; and to remain within the capital resource limit continued to be RAG rated green. The Assistant Director of Finance reported the cumulative financial performance and highlighted that the additional COVID 19 related expenditure was £94.720m at month 7. COVID 19 was also adversley impacting on the UHB savings programme where there was an underachievment of £10.426m against the month 7 target of £17.044m. The shortfall in savings was expected to continue until the COVID 19 pandemic passed. Elective work had been significantly curtailed during the first 7 months of the year as part of the UHB response to COVID 19 resulting in a fall in non pay costs and this was the main reason behind a £15.390m reduction in planned expenditure. In addition there had been slippage of £1.278m against planned investments including WHSCC. The net expenditure due to COVID 19 was £88.478m and this was matched by the same amount of additional Welsh Government COVID funding. In addition the UHB also had a small operating underspend of £0.362m leading to a net reported surplus at month 7. The UHB Chair (CJ) noted the reduction in costs of c £16.7m at month 7 arising from the reduction in elective work and slippage investments and asked if the UHB would need to re-apply for the associated funding. In reply the Assistant Director of Finance indicated that the reduction in elective costs and investments was primarily profiled in the first part of the year and was forecast to taper off in the later part of the year when elective activity was expected to increase. This was factored into the UHB's quarter 3/quarter 4 plan and the breakeven forecast and acknowledged by Welsh Government. Picking up on the resources required to catch up on the backlog of non Covid related heathcare, the UHB Chair (CJ) asked if the UHB had the staff and theatre capacity to catch up on the backlog of non Covid related heathcare that had built up during the pandemic. The Interim Director of Finance indicated that the additional funding provided in year was intended to stabilise the service in 2020/21. In	

	respect of the backlog, the UHB expected that the guidance from Welsh Government for 2021/22 would require a bold and ambitious plan which would address the additional capacity and resources required to recover access times for non Covid related heathcare services. The Committee was directed towards Table 4 of the written report which provided a breakdown of the £88.478m of additional Welsh Government COVID 19 funding supporting the month 7 position. A query was raised by the UHB Chair (CJ) in respect of the nil values ascribed to the additional Welsh Government Covid funding supporting independent sector provision and mental health services at month 7 and the Assistant Director of Finance confirmed that the UHB's plan assumed that the funding would be accessed in the later part of the year. In this context the UHB Chair indicated that continuing support to the UHB's mental health services was necessary in recognition of the demands on services during the pandemic. The Assistant Director of Finance moved onto performance against income, pay and non pay budgets. A surplus of £82.552m was reported against income targets at month 7 as a result of the additional Welsh Government funding of £88.478m for COVID 19 offset by net COVID 19 expenditure of £6.026m and an operational underspend of £0.100m. The key COVID 19 costs were largely unchanged and related to income reductions arising from reduced footfall and activity in retail and restaurant services; the Injury Cost Recovery Scheme; patient related English NHS non contracted income; dental patient charges income; laboratories; Radiopharmacy and private patients. It was noted that income from the Injury Cost Recovery Scheme had again held up and improved in month and that the level of other operating income being recovered was also improving. The Finance Committee Chair (RT) asked for confirmation that the loss of income arising from measures to manage Covid 19 was recognized by Welsh Government and the Assistant Director of Finance confirmed that the loss of income was reported to Welsh Government through the monthly monitoring returns and included in the table of additional costs arising as a result of Covid 19. The pay position at month 7 was a deficit of £14.671m made up of a net COVID 19 expenditure of £21.433m and an operational underspend of £6.762m. Additional COVID 19 pay costs had been incurred across all Clinical Boards and the main costs were for medical, nursing and ancillary staff in the Medicine Clinical Boards and in Facilities. The additional COVID pay costs were in part netted down by nursing staff savings in the specialist and surgical clinical boards.	

	Picking up on pay pressures the UHB Chair (CJ) asked if the additional resources required to staff the 400 bed surge capacity would place pressure on pay budgets and in relation to this the Finance Committee Chair (RT) asked if existing budgets could absorb the cost of providing the surge capacity. The Director of Finance confirmed that the UHBs quarter 3 and quarter 4 plan did not assume that the full 400 beds would be used in 2020/21 and that the financial forecast included costs to support the partial usage of the surge capacity. The plan also recognised that the availability of qualified nursing was a constraining factor on the UHB's plans. The Executive Nurse Director indicated that the UHB had developed plans to safely staff the surge capacity and this included the consideration of processes in neighbouring health boards. The UHB had increased its workforce capacity using flexible options such as bank staff and costs could be reduced where necessary in line with service requirements. In respect of the Surge Hospital the Executive Nurse Director added that the UHB had managed to salvage a significant amount of the equipment and fittings from the Dragons Heart Hospital to use in the Lakeside Surge facility and the Committee recognised the additional value in this action. Non pay budgets reported a deficit of £67.520m at month 7 comprising of net COVID 19 expenditure of £61.020m and an operational overspend of £6.500m. The majority of additional non pay COVID 19 expenditure related to plant and premises costs at the Dragon's Heart Hospital with slippage against savings schemes and additional expenditure relating to PPE also adding to the total. It was noted that the net additional non pay costs of £61.020m arising as a consequence of COVID 19 had been netted down by £15.121m for reductions in non pay costs mainly arising from reduced levels consumables associated with elective activity. Turning to the financial forecast for 2020/21 the Assistant Director of Finance referred to table 9 of the written report which oulined that the additional costs of managing Covid 19 were expected to continue and that the net expenditure arising as a result of COVID 19 was expected to increase from the £88.478m reported at month 7 to a cumulative total of £151.726 at the year end and this was expected to be matched by the same amount of additional Welsh Government funding based upon the resource assumptions set out in the NHS Wales Operating Framework 2020/21 for Q3 and Q4. The UHB's non COVID operational position was expected to remain broadly balanced as the year progressed and the UHB expected to meet its break even duty in 2020/21. The month 7 forecast assumed the £151.726m of additional Welsh Government COVID 19 funding which was as outlined in Table 10 of the written Report as follows: • Dragons Heart Hospital - £60.284m • UHB's allocation share of Allocations to NHS Organisations - £50.100m	

- Funding reflecting COVID workforce costs month 1 to 3 - £11.016m
- Local Authority Test, Trace and Protect (TTP) - £6.654m
- PPE Funding - £6.884m
- UHB TTP costs - £3.147m
- NHS and Jointly commisioned packages of Care - £3.024m
- Indepedent Sector Provision- £2.700m
- Flu Vaccine Extension - £1.903m
- Transformation Discharge - £1.251m
- Mental Health Services - £0.503m
- GMS DES - £0.210m
- Urgent and Emergency Care Funding - £4.050m

The Finance Committee was informed that the key assumptions underpinning the forecast were still subject to variation in the remainder of the year and the following key issues were highlighted:

- Dragons Hearth Hospital (DHH) costs were estimated at circa £65.4m including £2.7m capital costs.
- The UHB had developed alternative plans which had been approved Welsh Government to establish a 400 bed facility for surge capacity on the UHW site and it was expected that 50 of the beds would be used to meet initial demand with the remainder being commissioned if there was further significant demand.
- Costs and assumed funding for additional capacity commissioned from the independent sector were included up until the end of the year.
- The cost of the enhanced flu vaccination programme was now estimated at £1.903m for 2020/21 and was included in the forecast and assumed to be funded.
  The forecast cost of a mass COVID vaccination programme was estimated to be £4.9m in 2020/21 and £11.8m in 2021/22 based on the current assumption of delivery of the vaccine within mass vaccination centres. The forecast assumed that Welsh Government would provide resource coverage for any additional costs arising from a COVID vaccination programme in 2020/21.
- Slippage against savings plans was estimated at £19.9m.
- The forecast cost of COVID 19 regional Test, Trace and Protect (TTP) was included in the forecast at c £9.8m. This excluded the cost of additional surge capacity which was expected to be included at month 8 together with the notified allocation.

The Assistant Director of Finance turned to performance within Clinical Boards and noted that the largest operational pressures were reported in Women & Children where there were pressures against medical staff and non pay and in Medicine where the main pressure was against nursing. The Committee was informed that the in month improvement in Medicine reflected the recognition of funding in support of NICE Drugs. The overall performance against delegated

	budgets was a reported operational surplus of £0.163m, however this would still need to be monitored to ensure that the position was maintained as there was variation across Clinical Boards. In this context the UHB Chair (CJ) asked what assurance could be provided to the Committee that Clinical Board positions continued to be performance managed. In reply the Interim Director of Finance indicated that whilst the primary focus in the financial year had been on managing the UHB bottom line, the Chief Operating Officer continued to monitor operational pressures with Clinical Boards and significant concerns were addressed at monthly OPG meetings. Moving on to the UHBs underlying deficit the Assistant Director Of Finance reported that as a result of the savings slippage the forecast year end underlying deficit was £25.3m which was £21.3m more than the planned £4m identified in the submitted IMTP. It was noted that the UHB has identified a number of areas where expenditure could impact upon the underlying position and these were outlined at appendix 6 of the written report. The list totalled £3.1m and further work was required to identify the recurrent impact. The Committee was informed that it was not clear at this stage whether Welsh Government would provide coverage for the underlying deficit arising from savings slippage in 2021/22. The Interim Director of Finance added that with the exception of the items outlined in appendix 6 the UHB was planning on the principle that all COVID costs were non recurrent. Referring to the savings slippage, the Finance Committee Chair (RT) noted that progress against the UHB's initial savings plan which was in part based on a reduction in beds had been abated by the change in plans required to manage the impact of Covid 19 and asked whether the UHB had scope to flex the savings plan to include savings realised in year which were not included in initial plans. The Assistant Director of Finance confirmed that the UHB did recognise and report opportunities as they arose in year. The Interim Director of Finance added that the UHB had not yet driven out all of the benefits around the changes in operational practice in response to the pandemic and that any costs which could be released would need to feature strongly in future plans. Turning back to the UHBs bed capacity the Chief Executive confirmed that the UHB's Shaping Our Future Well Being Strategy included the commitment to enable people to maintain and recover their health as close to home as possible and that the UHB's bed capacity would need to be continually reviewed in light of this objective. The Committee was informed that the balance sheet was outlined at Appendix 2 of the report. The UHB cash balance at the end of October was c £12.9m and the UHB was forecasting a positive year end cash balance in line with the financial forecast. PSPP performance continued to exceed the 95% target.	

	Capital expenditure was satisfactory with net expenditure to the end of October being 57% of the UHB's approved Capital Resource Limit (CRL). The Committee was informed that the UHB has requested a further 2.5m COVID 19 capital funding to support the provision of elective and routine services through the creation of green zones. £1.043m of the funding had been confirmed and the UHB has reprioritized its discretionary capital plan to mitigate the remaining risk. In conclusion, the Assistant Director of Finance highlighted that at month 7, the key revenue financial risk is managing the impact of COVID 19 within the additional resources provided. **Resolved – that:** The Finance Committee **noted** the month 7 financial impact of COVID 19 which is assessed at £88.478m; The Finance Committee **noted** the additional Welsh Government funding of £88.478m assumed within the month 7 position; The Finance Committee **noted** the month 7 reported financial position being a surplus of £0.362m; The Finance Committee **noted** the breakeven position which assumes additional Welsh Government funding of £151.726m to manage the impact of COVID 19 in line with quarter 3&4 planning assumptions; The Finance Committee **noted** the risks that are being managed on the capital programme; The Finance Committee **noted** the revised forecast 2020/21 carry forward Underlying Deficit is £25.3m and the risks identified that, if not managed, could increase this.	
FC 20/113	**FINANCE RISK REGISTER** The Assistant Director of Finance (AG) presented the Finance Risk register. The two remaining extreme risks were noted as being: **Fin01/20** – Reducing underlying deficit from £11.5m to £4.0m in line with IMTP submission. **Fin03/20** – Delivery of £29.0m (3.5%) CIP The Finance Committee noted that the COVID-19 financial plan risk (FIN10/20) including Surge capacity was shown in an appendix as a sub-set to the main risk register. The Finance Committee Chair (RT) referred to Risk Fin05/20 DHH which identified that in some instances a letter of intent was in place	

	with contractors in lieu of a formal contract and asked whether final contracts had been agreed. The Interim Director of Finance indicated that progress had been made through respective legal teams and that the UHB was ensuring that strong governance was maintained in closing down contractual discussions. **Resolved - that:** The Finance Committee **noted** the risks highlighted in the 2020/21 risk register. The Finance Committee **noted** the risks highlighted in the Surge Capacity sub set risk register.	
FC 20/114	**MONTH 7 FINANCIAL MONITORING RETURNS** These were noted for information.	
FC 20/115	**COMMITTEE EFFECTIVENESS REVIEW 2019-20 RESULTS AND ACTIONS** The Director of Corporate Governance highlighted the results for the Committee Effectiveness review undertaken by Finance Committee Members and the Executive Director Lead for the Committee. The Committee was directed to a proposed action plan attached at appendix 2 to improve the areas in which the results had either an 'adequate', 'needs improvement' or 'no' response to the questions asked. **Resolved – that:** The Finance Committee **noted** the results of the Committee's self-Assessment Effectiveness Review for 2019-20**.** The Finance Committee **approved** the action plan for improvement to be completed by March 2021 in preparation for the next annual self-assessment which will feed into the 2020-21 Annual Governance Statement.	
FC 20/116	**ITEMS TO BRING TO THE ATTENTION OF THE BOARD** There were no items to being to the attention of the Board.	
FC 20/117	**DATE OF THE NEXT MEETING OF THE COMMITTEE** **Wednesday 6th January 2.00pm; Virtual Meeting via Teams**	

Confirmed Minutes of the Strategy & Delivery Committee
Tuesday 10th November – 9:00am – 12:00pm
Via MS Teams

Chair:		
Michael Imperato	MI	Committee Chair
Members:		
Rhian Thomas	RT	Independent Member – Estates
Gary Baxter	GB	Independent Member – University *(Joined at 10am)*
In attendance:		
Martin Driscoll	MD	Executive Director of Workforce & Organisational Development
Nicola Foreman	NF	Director of Corporate Governance
Fiona Kinghorn	FK	Executive Director of Public Health *(for part of the meeting)*
Steve Curry	SC	Chief Operating Officer
Abigail Harris	AH	Executive Director of Strategic Planning
Stuart Walker	SW	Executive Medical Director (*for part of the meeting)*
David Thomas	DT	Director of Digital Health Intelligence
Lee Davies	LD	Operational Planning Director
Scott Mclean	SM	Director of Operations – Children & Women
Alex Young	AY	Service Improvement Manager
Jonathon Gray	JG	Director of Transformation
Sara Moseley	SM	Committee Vice Chair & Independent Member – Third Sector *(for part of the meeting)*
Secretariat		
Nathan Saunders	NS	Corporate Governance Officer
Apologies:		
Allan Wardhaugh	AW	Chief Clinical Information Officer

S&D 20/11/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the meeting.	**Action**
S&D 20/11/002	**Apologies for Absence** Apologies for absence were noted.	
S&D 20/11/003	**Declarations of Interest** There were no declarations of interest.	
S&D 20/11/004	**Minutes of the Committee Meeting held on 15th September 2020** The Committee reviewed the minutes of the meeting held on 15th September 2020.	

	The Executive Director of Strategic Planning (EDSP) raised that item 15/09/009 required an extension on the title to incorporate Avoiding waste, harm and variation. **Resolved that:** (a) The Committee approved the minutes of the meeting held on 15th September 2020 as a true and accurate record pending the update.	
S&D 20/11/005	**Action Log following the Meeting held on 15th September 2020** The Committee reviewed the action log and the following comment and update was made: The CC advised that most items had been completed on page 1 of the log and that items on page 2 were on today's agenda or scheduled to be discussed at a future meeting. The Independent Member – Estates (IME) asked the Committee if an end of Q1 update could be added to the log for future discussion. The Director of Corporate Governance (DCG) advised that the Director of Digital Health Intelligence (DDHI) and the Executive Medical Director (EMD) had met to discuss this and an integrated performance report looking at key indicators would be brought to the next Board meeting. **Resolved that:** (a) The Committee noted the Action Log.	
S&D 20/11/006	**Chair's Action taken following the meeting held on 15th September 2020** There had been no Chair's Actions taken following the meeting held on 15th September 2020.	
S&D 20/11/007	**Performance Framework Dashboard Update** The DDHI advised that a dashboard would be brought to January's meeting. The Committee were advised that incorporation of the strategic measures was one of the challenges. At present, it showed one measure with the Executive Director of Strategic Planning (EDSP) as the lead. As there were now 15 measures, it was about how these were included. **Resolved that:** (a) The Committee noted the update.	**DT**
S&D 20/11/008	**CAMHS Update - Neurodevelopmental Situation**	

	The Director of Operations – Children & Women (DOCW) presented an update on Neurodevelopmental Assessment services for children. The Committee were advised that the figures mainly represented children with ADHD and Autism spectrum disorder and that the service seeks to work with these patients with the target set at 80% of patients to be seen and assessed within 26 weeks of referral. A local decision was made in May 2019 to stop seeing new patient referrals due to a backlog of high risk review patients and this had created growing waiting lists in both volume and the length of the wait. In terms of referral demand, before March 2020, 83 referrals per month were being received as far back as January 2017, however since COVID-19 this had decreased to 19 referrals per month. There were currently 741 patients waiting to be seen. Based on the figures, and taking an average of around 59 referrals per month, the waiting list volumes would increase by 30% by December 2021. There had been a significant transformation across Wales, however this area had been slower than others and the team had reviewed waiting lists and analysed the data to enable them to stratify based on age and risk. Lockdown had perpetuated the waiting list problem and the Committee was advised to challenge anyone who stated that they were back on track with waiting lists because a children's assessment involved an 18 hour assessment which had not been accomplished during COVID-19. The Committee were informed that the teams had managed to review all cases on the current waiting list during lockdown and the DOCW demonstrated the benefit of moving away from a doctor only model. The DOCW advised the Committee that he was not in a position to give assurance that neurodevelopment would be fixed because a piece of work lasting between 12 to 18 months was needed. The DOCW advised that performance management at a Clinical Board level was required. The Independent Member – Estates (IME) asked why referrals had reduced down to 19 a month and whether it was because schools tended to be at the front end of everything and had been closed. The DOCW responded that one reason was that schools had not been open and also that people had not been going to the GP. IME asked if the team were ready to implement this. The DOCW provided assurance that the design was clinically led and that Catherine Norton (Neuropsychologist) delivered sessions with the team and Welsh Government (WG) about what neurodevelopment should look like across Wales.	

	The CC asked when the Committee would revisit this to see what progress had been made. The DOCW responded that due to increased scrutiny, the Committee would need at least a monitoring report in 3 or 4 months' time. **Resolved that:** (a) The Committee noted the report. (b) The Committee endorsed the transformation and performance management arrangements outlined.	**SM**
S&D 20/11/009	**CAMHS Update - Early Intervention Position** The DOCW advised the Committee that he was not able to provide an update at this time.	

S&D 20/11/010	**CAMHS Update - Appointment of Clinical Posts** The DOCW advised the Committee that the clinical posts had been recruited to. **Resolved that:** a) The Committee noted the update.	
S&D 20/11/011	**Strategy - Shaping Our Future Wellbeing** a) Existing Strategy, commitments & forward look The Executive Director of Strategic Planning (EDSP) presented to the Committee. In 2015 the Shaping our Future Wellbeing Ten Year Strategy Delivery Programme was published and the UHB was now at the midway point. Since 2015, a lot had happened and a midpoint review was performed in March 2020 which would be sent to Committee Members. The EDSP presented what had been learnt over the last 6 months whilst responding to COVID-19 and how to set about an accelerated programme. The Director of Transformation's (DOT) team with the help of Q5 provided the project management at the Dragon's Heart Hospital. The EDSP commented that the UHB was good at starting things but not quite so good at being explicit at what change was going to take place and Q5 had done a piece of work around this and the 8 stage principles. The EDSP presented to the Committee – Establishing 'what 2025 means'. The EDSP noted that there was an extensive performance dashboard available but a series of bellwether measures for the 10 to 15 key indicators was absent. The EDSP advised that feedback around virtual consultations had been very positive. Canterbury District Health Board had been able to reduce their average bed days by doing more in the community. The EDSP advised the Committee that there could be some push back with some saying, "that's a hospital measure" in relation to reducing average length of stay in hospitals. The EDSP provided the example of how the Mental Health service had increased resources in the community which in turn had reduced bed stays and posed the question of what the picture could look like if 50% of our resources were spent in the community.	**AH**

	The EDSP outlined the strategic priority programmes that sat above the line and needed to be driven executively, and advised the Committee that this could not be done without significant partners, the two Local Authorities and the University. The EDSP also advised that there needed to be engagement of wider RPB partners such as care homes and the third sector and noted that the UHB could not deliver the strategy without these partnerships. It was highlighted that there had to be learning from COVID-19 and that the giving of responsibility and accountability to individuals was essential. The EDSP presented the projects that sat below the line which were equally important. The EDSP advised that the current task was to continue working with the DDHI, his team and use Q5 support to populate the baseline and enable the knowledge of how this could be used as a strategic measure. The Chief Operating Officer (COO) advised that over the last couple of years, the term "system shift" had been used quite a few times and the UHB had invested two million pounds in primary care. In addition, a sophisticated piece of work was being done on the outcomes framework to track back to what outcomes matter to people. The COO continued that the direction of travel was to empower frontline clinical teams to design and own these outcomes and design solutions. Project management support, transformation expertise and science around these was needed but the focus should be around the clinical team. There was also a strong voice for service user involvement. The CC queried the next step for the Committee. The COO responded that the next step would be a twin track approach and that the framework would be brought to the clinicians to build upon it and lead the work in a very practical sense. The EDSP commented that a high level progress summary of the programmes could be brought back every quarter. The CC commented that the discussion had been really useful and that it would be helpful to revisit the framework to see progress made.	**AH**
S&D 20/11/012	**Strategy - Shaping Our Future Wellbeing** **b) Primary Care Development Strategy** The Operational Planning Director (OPD) advised the Committee that many of the objectives set out emphasised a rebalancing of the system from hospital to community and primary care and that there had been a shift towards prevention and healthier populations.	

	The OPD advised that in the context of the primary care strategy, knowing how to connect the immediate challenges to move forward on that broader strategic direction was needed. The OPD advised that the role of the MDT was to broaden which in turn brought sustainability within Primary Care so that they could devote more cause to other areas. The COO advised that to move it forward practically as a roadmap, consideration needed to be focused on the rebalancing out of hospital services. The COO presented how the plan could look and data that showed it would not start from a standstill. The COO advised that Clinical leads had been very forthcoming and that there had been no disagreement to the plans. Pathway leads needed to be identified, public engagement arranged and alignment with year to come plans and beyond. The COO advised that contract reform would need to be considered. The COO queried whether in regards to cluster structure, there was a need to rebalance and include local authority input. The COO commented that the organization wanted to move forward in a scale and pace way and thought was required as to how it could deliver this service yet keep everything joined up. The COO advised that these were the things that would be worked though over the coming months.	
S&D 20/11/013	**Planning** **a) Q3-4 Plan** The EDSP advised that the Plan was going to the next Board meeting for formal ratification. The financial aspect of the Plan was in a positive position and feedback was good. The EDSP advised that the Plan has had no formal sign off by the WG in the new planning regime but a letter of endorsement had been received from WG. **Resolved that:** a) The Committee noted the ongoing work in relation to planning over the next six months.	
S&D 20/11/014	**Planning** **b) Winter Protection Plan**	

	The EDSP advised that the Plan was going to the next Board for formal ratification. **Resolved that:** a) The Committee noted the ongoing work in relation to planning over the next six months.	
S&D 20/11/015	**Board Assurance Framework (BAF)** a) **Sustainable Culture change** The DCG advised that the information had been updated for the next Board meeting at end of November. The EDWOD was invited to comment and advised the Committee that work was still progressing behind the scenes but due to COVID not as fast as he had wished. The DCG advised that the overall score was 8 which was still high on the BAF. The IME asked how aware the typical staff member would be of these activities. The EDWOD responded that this was difficult to answer but that in his experience, the UHB communicated clearly and consistently from a Board level however conversations were needed between ward managers and staff which was not happening at present. The CC commented that this was a very important issue and was pleased that it was on today's agenda. **Resolved that:** a) The Committee reviewed and noted the report.	
S&D 20/11/016	**Social Care and Well Being Act – Partnership with Local Authorities & RPB Update** The EDSP advised the Committee that WG were not expecting to return to a "pre-covid world" and recognized that there were challenges the UHB would have to face, especially the economic impact on the more deprived communities. The EDSP advised that this included how we treated the planet and take serious action to reduce our carbon footprint and become a carbon neutral organisation. The EDSP acknowledged that from a Strategic point of view, there was a lot to consider. The EDSP advised that there were too many uncertainties and that we were not yet clear if there would be continuation of the quarterly planning process or if it would be an annual plan. At present, the working function	

	was an annual plan and that would be very difficult to develop without knowing the financial situation we were operating in. The EDSP advised the Committee that high level priorities were being developed with Clinical Boards. The Independent Member – University (IMU) queried the financial shortfall for the winter protection plan and when we would know that shortfall would be made good and whether it would be in time. The EDSP responded that we did not know the answer but advised that it was reassuring that we were not the only RPB that had submitted a winter protection plan that needed more funding, however at present, no formal feedback had been given on the content of the plan or the financial plan. The EDSP advised that we should press ahead with all of the items in the plan, however it would prove challenging in January/February and difficult decisions would have to be made if we did not secure the funding. **Resolved that:** a) The Committee noted the update.	
S&D 20/11/017	**Performance Reports:** Key Organisation Performance Indicators The COO highlighted 2 areas of the report: • Mental Health Performance The COO advised that Mental Health performance had significantly deteriorated with 43% of assessments being undertaken within 28 days down from 84% previously. This was a product of 2 things: 1) An increase in volume of referrals which was expected (to some extent) – There had been almost 1000 referrals this month. 2) A redesign which took place during COVID as a needs must task. This provided counselling services through Primary Care and there was little distinction between the need of counselling services – two thirds of the referrals did not warrant a full counselling intervention. The COO advised that nobody was waiting for more than 30 days with patients gaining access within 48 hours. • Cancer Performance The COO advised that the UHB was moving to a single cancer measure pathway which would be formalized on 1st December. A rationale for the deterioration was provided, in that cancer breaching occurred at the point of treatment and the following actions had been taken:	

1) Through GP colleagues referrals were back to where they were before.

2) Treatment levels were back to pre-covid levels by August.

Over the next few months, varying performance would be seen as a result of treating the buildup over COVID and that it would take a few months for the headline performance to recover.

In comparison to other Health Boards across Wales, the UHB had remained relatively low in its cancer backlog. The extra activity being done was reducing the back line.

The COO advised that there was an issue with streaming patients into the system and the losses from IP&C - there were currently 40 beds closed because of IP&C.

IME asked how CAV247 influenced the figures. The COO responded that it did not and that the 4 hour transit time for the Emergency Department (ED) was not part of it.

The COO advised that up to a third of the ED had been transferred from an unplanned event to a planned event.

The IMU asked about the data for Diagnostics & Therapies (D&T) presented in appendix 1 that showed a rise and remained sustained without any decline or recovery. The COO clarified that the Diagnostics figures were patients that had waited more than 8 weeks and the Therapies figures, patients who had waited more than 14 weeks. The COO advised that during COVID there was a point in D&T where zero waits were being delivered and wanted to pay tribute to those teams.

The COO advised that there had been a marked impact in Therapies during September primarily due to virtual appointments.

The CC asked when the October figures would be available which would give a more up to date picture. The COO responded that as a public meeting, a validated reported position was taken to ensure what came to the Committee meeting was correct but advised that there was intelligence on what had been happening since the presented data such as the RTT position being closer to 35K patients in early November which was an increase on today's presented figures.

The COO advised that the October position for the second wave of covid was starting to become apparent. Until now we had managed to maintain essential and some other services and had not had to stop these yet but due to staffing issues that could change over the next few months.

Resolved that:

a) The Committee noted and discussed the contents of the report.

S&D 20/11/018	**Performance Reports: Workforce Key Performance Indicators** The EDWOD advised the Committee that 2020 told a story of COVID-19. In relation to staff absence a peak was seen then it started to reduce. Interestingly, the recruitment peaked and there were now around 550 more people working for the UHB in medical, nursing and general areas compared to last year. The work done around retaining people to the UHB was really now baring fruit. There were still challenges to face around meeting winter and covid pressures, and a weekly taskforce was in place to discuss issues. An alternative solution for training was needed otherwise there would be a difficult situation in 12 months' time with compliance. The EDWOD advised that training could be done remotely. The Executive Director of Public Health (EDPH) asked that flu data be added back on and commented that the staff flu campaign was going really well. There was a slight delay in getting statistics out due to sheer demand and it was still a hard copy and so more time consuming. 56.1% of frontline staff have had their flu vaccination, this time last year it was 15.7% and the aim was for 75% uptake. The intention was to conclude the flu vaccination before the mass covid vaccination plan starts. **Resolved that:** a) The Committee noted and discussed the contents of the report.	
S&D 20/11/019	**Leadership Engagement** The EDWOD advised that an interactive review of the UHB had been scheduled following on from an Amplify event supported by the UHB in 2019 but that this had not been done due to COVID. A remote option was now being explored, however the finances were challenging. A training and leadership programme had been launched for staff which provided the potential to move onto greater opportunities in not just our health board but others. The Talent Management and Succession Planning work at Executive level supported the UHB in being able to provide HEIW with considered and timely nominations for 'Talentbury'. 18 people were identified who had the capability of fitting into that space. This was not something the NHS had broadly done before but by identifying talent it formally helped to see the gaps that needed filling. He added that this was a range of work that came together over time and allowed development of individuals in the UHB in the right way so for	

	example, when a new senior manager was needed, the capability for that was in place. IMU asked what the philosophical approach to mentorship/coaching staff was, not just going into senior roles but all roles across the UHB. The EDWOD responded that it was not something that we insisted on and that staff had to be willing, there were formal coaching processes in place. IME advised that talent pools could work very well but advised challenges that could arise such as: 1) Easy to build resentment. Were there clear guidelines for membership? 2) Disillusionment if nobody in it advances onto the Executive team. The EDWOD acknowledged that these were fair points and that there was nothing without risk. The EDWOD advised that guidelines for membership would be stressed when nominating talent. There would be constant review and honest and important conversations with staff at annual reviews with clear feedback as to what was needed from them to achieve. As this was a new process it was hoped that there would not be any disillusionment. The EDWOD referred to the values based appraisal which enabled managers to hold a good discussion around staff development. The CC commented that the report asked for a number of points to be noted by Committee and that it would useful for Committee to receive an update in a few meetings' time. The EDWOD suggested that Rachel Gidman provide a more detailed insight for the Committee. **Resolved that:** a) The Committee noted the report and agreed to continue to support and cascade the Talent Management and Succession Planning approach across the UHB. b) Encourage all staff attendance at the Values Based Appraisal training to support the UHW wide understanding of the new process. c) Support the development of an experiential leadership programme aimed at a small group of Senior Leaders across the UHB. d) Consider the exploration of an internal and external Mentoring Scheme to support CPD activity identified by staff at all levels. e) Support a young leader's network which will assist the design of a leadership career pathway for the next generation.	**RG**
S&D 20/11/020	**Review of the Meeting** The CC noted that apart from a couple of technical difficulties, the meeting had run smoothly and that a lot of content was covered.	

S&D 20/11/021	**Date & Time of next Meeting** Tuesday 12th January 2021 9:00am via MS Teams	

CONFIRMED MINUTES OF THE HEALTH AND SAFETY COMMITTEE HELD ON 24 NOVEMBER 2020
VIA TEAMS

Present:		
Akmal Hanuk	AK	Independent Member – Local Community (Committee Chair)
Michael Imperato	MI	Independent Member – Legal
Rhian Thomas	RT	Independent Member – Capital and Estates (Vice Chair)
Dawn Ward	DW	Independent Member – Trade Union

In Attendance:		
Janice Aspinall	JA	Staff Safety Representative
Julie Cassley	JC	Deputy Director of Workforce and OD
Rachael Daniel	RD	Interim Head of Health and Safety
Stuart Egan	SE	Staff Safety Representative
Nicola Foreman	NF	Director of Corporate Governance
Geoff Walsh	GW	Director of Estates, Capital and Facilities

Secretariat:		
Rachael Daniel	RD	Interim Head of Health and Safety

Apologies:		
Martin Driscoll	MD	Director of Workforce and OD
Carol Evans	CE	Assistant Director of Patient Safety and Quality
Fiona Jenkins	FJ	Director of Therapies and Health Sciences
Fiona Kinghorn	FK	Director of Public Health

HSC: 20/11/001	**WELCOME AND INTRODUCTIONS** The Committee Chair (CC) welcomed everyone to the meeting. The CC thanked Independent Member – Legal (IML) for previously chairing the Committee and welcomed Independent Member – Capital and Estates who was undertaking the role of Vice Chair (VC) to the Committee. The CC also noted Mr Charles Dalton's contribution to the Committee over many years and wished him well for his retirement. He also noted that the Director of Workforce and OD (DWOD) who has executive responsibility for health and safety would be leaving the Health Board in February 2021.	**ACTION**
HSC: 20/11/002	**APOLOGIES FOR ABSENCE** Apologies for absence were noted.	
HSC: 20/11/003	**DECLARATIONS OF INTEREST**	

	The Chair invited Committee Members to declare any interest in the proceedings included in the agenda. None were declared.	
HSC: 20/11/004	**MINUTES OF PREVIOUS MEETING** The minutes of the Health and Safety Committee held on the 21st January 2020 and 30th April 2020 were reviewed. **The Committee resolved – that:** The Committee approved the minutes of the meetings held on 21st January 2020 and 30th April 2020.	
HSC: 20/11/005	**COMMITTEE ACTION LOG** The Committee reviewed the action log from the meeting held on the 21st January 2020. HSC: 20/01/008 – The IML advised at the meeting in January it was discussed that the terms of reference were to be reviewed to reflect the strategic intentions of the Committee. The terms of reference would then also determine the work programme of the committee. The Director of Corporate Governance (DCG) advised she would circulate the Terms of Reference to the committee. **The Committee resolved – that:** (a) The action log and updates in it were received and noted.	**NF**
HSC: 20/11/006	**CHAIRS ACTION TAKEN SINCE LAST MEETING** The CC informed the Committee he did not have anything to report.	
HSC: 20/11/007	**ANNUAL REPORT OF THE HEALTH AND SAFETY COMMITTEE** The DCG explained the annual report was in relation to year ending 2019/20 but due to the Health and Safety Committee being stood down during Covid this was the 1st opportunity to bring to the Committee. The DCG added the secretariat of the Committee would now be overseen by the governance team so that it could be treated the same as all other Committees. The Independent Member – Trade Union (IMTU) stated attendance by Executive Directors was key and the membership should be looked at as part of the terms of reference review. The IML stated the Executive Director was not always the best placed person to give updates on statutory issues. The VC queried whether incident data was considered by the Committee on a regular basis. The IML advised that the Committee	

	considers incident data, statutory reports, and training and when setting the agenda for the meeting, themes within the statutory framework were considered. The IMTU observed that during the last 12 months the Committee were lacking sight of strategic high risks, and whilst the role of the Committee was that of assurance an open mind was also required in respect of key operational risks. The Director of Capital, Estates and Facilities (DCEF) added it was refreshing for members of his team to present their services and associated risks to the committee. The DCG advised she would ensure the right input was received in relation to the terms of reference and work plan. **The Committee resolved that:** (a) The terms of reference would be circulated for discussion at the January meeting.	**NF**
HSC: 20/11/008	**RISK REGISTER FOR HEALTH AND SAFETY** The DCG advised the risk register would be reviewed with the DWOD. **The Committee resolved that:** (a) The update was noted.	**NF/MD**
HSC: 20/11/009	**HEALTH AND SAFETY TRAINING UPDATE** The Interim Head of Health and Safety (IHS) informed the Committee that health and safety classroom training had been re-introduced, however the number of courses offered were limited due to the pandemic and the demands that it was placing on the health and safety team. In addition, course numbers had been reduced to allow for social distancing. As a result compliance for classroom based (practical skills) remains low. The IHS added on a risk priority basis resources were being diverted to foundation courses (new starters) as opposed to update/refresher training. The IMTU agreed with this approach as the risks to new staff would potentially be greater than those to existing staff. The IMTU acknowledged the health and safety training team had excelled during these extraordinary times with regards to the amount of training that had been delivered in a short period of time particularly at the height of the pandemic. The IMTU also raised her concern that Link Worker training had been suspended, The IHS explained this was due to the process being	

reviewed to ensure it was fit for purpose for the needs of the Health Board and assured her it was not covid related.

The IML reflected on the discussions at the January 2020 meeting where it was imparted that more bespoke training to reflect individuals roles was being pursued, so that staff would then only undertaken relevant training and considered this was key to improving compliance.

The Committee resolved that:

(a) The report was noted.
(b) An update be presented to the January meeting in respect of the progress of bespoke training. **MD**

HSC: 20/11/010

ENFORCEMENT AGENCIES REPORT

The IHS informed the Committee there were 4 new issues since the last meeting, these being;

(i) Covid safe workplace – Woodlands House
(ii) Death of a member of staff as a result of covid.
(iii) Self-isolating concerns – Radiology Department, University Hospital Llandough
(iv) Fit testing within a Nursing Home

The IHS informed the Committee the Health and Safety Executive had received a complaint from a member of staff in relation to Woodland House being a covid safe workplace. The HSE requested information in relation to cleaning regimes, information provided to staff and monitoring arrangements. The HSE were informed of the measures being undertaken to keep the workplace safe and were satisfied no further action was to be taken.

In relation to the death of a member of staff the HSE were investigating as to whether the member of staff acquired covid-19 through work related exposure. A group of relevant personnel was formed to pull together the requested information which was provided to the HSE. The outcome of the investigation is awaited.

The HSE contacted the Health Board in relation to a concern that had been raised with them by a member of staff in the Radiology Department, UHL, where it was alleged that there had been 3 – 4 confirmed positive cases of covid-19 amongst staff, and the manager had told them to still come to work and not to speak to the test and trace service as he did not want anyone self-isolating.

This concern was fully investigated by the Clinical Board and a number of documents were provided to the HSE, following receipt of the documentation the HSE confirmed no further action would be taken.

The PCIC Clinical Board received communication from the HSE in relation to face fit testing practices in a Nursing Home, following a response to this communication, the HSE had subsequently followed

up with the Health and Safety Department and this was currently being investigated.

The VC queried how reporting was normally made to the HSE. The IHS clarified that the majority of reporting was through RIDDOR reporting, however members of staff can contact the HSE directly with any health and safety concerns they may have.

The Committee resolved that:

(a) The report was noted.
(b) Agreed that appropriate actions were being pursued to address the issues raised.

HSC: 20/11/011

FIRE ENFORCEMENT AND MANAGEMENT COMPLIANCE REPORT

The DCEF informed the Committee Covid-19 was having an impact on a number of areas.

Unwanted fire signals had reduced as a direct result of decreased footfall on the sites, to date there had been 69 calls whereas 12 months ago it had been 260.

There were also a small number of fire risk assessments that were unable to be completed as they were in Covid-19 red areas and therefore access restricted.

The DCEF added whilst electronic training had seen an improvement, face to face training had reduced significantly. He added the Fire Advisers were still doing face to face training however the numbers attending were very low.

The IMTU commended to the DCEF and his team in relation to the risk assessment position, however she was concerned at the low training compliance. The CC queried whether an external arrangement could be utilised to improve the compliance. The DCEF stated he did not have a concern in relation to resources to deliver training, the issue was that specific arrangements were made with clinical areas and then staff would fail to attend.

The VC was curious as to why staff would not turn up as there was no cost implication to the Clinical Boards. The DCEF advised that pre covid Clinical Boards would be held accountable by the Executives as part of the Executives' challenge.

The IHS informed the Committee charges were introduced for manual handling and violence and aggression DNAs, this was due to the number of complaints received that courses were full and then approximately 50% of course participants would fail to attend, she added the charges had been suspended during the pandemic.

The IMTU stated that the clinical boards need to be held to account and whether internal enforcement notices should be explored.

The Committee resolved that:

(a) The report was noted.

HSC: 20/11/012

DISCRETIONERY CAPITAL COMPLIANCE

The DCEF informed the Committee that estates compliance was initially reviewed in 2013 where there had been 41 areas of compliance in the red at the time and the Board had supported a programme a works to address these. The DCEF reported there had been a significant improvement and there were now only 6 areas of non-compliance. He also added there was annual spend of 3.5 million on inspections and testing.

The IMTU stated there had been a vast improvement since 2013 however was however concerned at the non-compliance in relation to the helipad. The DCEF assured the Committee that the helipad underwent daily checks as per the operational procedures and the non-compliance was in relation to documentation as opposed to an operational nature.

T**he Committee resolved that:**

(a) The report was noted.
(b) Agreed that appropriate actions are being taken to address the issues raised.

HSC: 20/11/013

UPDATED HEALTH AND SAFETY RELATED POLICIES SCHEDULE

The IHS informed the Committee that a number of Health and Safety Policies were out of compliance. This had been discussed at the Operational Health and Safety Group where it was agreed to seek approval from the Committee to extend the review period by a maximum of 18 months. The IHS assured the Committee that there were no immediate concerns in relation to any of the policy content.

The DCG agreed this was a sensible approach and requested that an extra column be added to the schedule detailing when the policies would now be reviewed. **RD**

The Committee resolved that:

(a) The updated schedule be noted.
(b) The out of compliance policies be extended for a maximum of 18 months.

OPERATIONAL HEALTH AND SAFETY GROUP

HSC: 20/11/014

The Committee resolved that:

(a) The minutes of the Operational Health and Safety Group held in March 2020 be ratified.

ENVIRONMENTAL HEALTH INSPECTION REPORTS

HSC: 20/11/015

The DCEF informed the Committee that no inspections had taken place since March 2020, although these were due to be recommenced in the near future.

The Committee resolved that:

(a) The update was noted.

HSC: 20/11/016

ITEMS TO BRING TO THE ATTENTION OF THE BOARD/OTHER COMMITTES

There were no items to being to the attention of the Board or other Committees.

REVIEW OF MEETING

The CC welcomed comments from the Committee. The Committee considered the review of the terms of reference to be critical to the working of the Committee going forward.

HSC: 20/11/017

DATE OF THE NEXT MEETING OF THE COMMITTEE

Tuesday 5th January 2020 at 9.00am via TEAMS

MINUTES OF CARDIFF AND VALE STAKEHOLDER REFERENCE GROUP MEETING HELD ON WEDNESDAY 23 SEPTEMBER 2020 CONDUCTED VIA MICROSOFT TEAMS

Present:	
Geoffrey Simpson	One Voice Wales (Chair)
Sam Austin	Llamau
Frank Beamish	Volunteer
Mark Cadman	WAST
Sarah Capstick	Cardiff Third Sector Council
Iona Gordon	Cardiff Council
Shayne Hembrow	Wales and West Housing Association
Zoe King	Diverse Cymru
Dean Loader	South Wales Fire and Rescue
Tim Morgan	South Wales Police
Linda Pritchard	Glamorgan Voluntary Services
Lani Tucker	Glamorgan Voluntary Services
In Attendance:	
Marie Davies	Deputy Director of Strategic Planning, UHB
Katja Empson	Consultant in Emergency Medicine, UHB
Abigail Harris	Executive Director of Strategic Planning, UHB
Angela Hughes	Assistant Director of Patient Experience, UHB
Keithley Wilkinson	Equality Manager, UHB
Apologies:	
Duncan Azzopardi	Cardiff University
Jason Evans	South Wales Fire and Rescue
Paula Martyn	Independent Care Sector
Secretariat:	Gareth Lloyd, UHB

SRG 20/22 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting.

The SRG was informed that the Vale of Glamorgan Council had nominated Cllr Janice Charles to replace Cllr Rachel Nugent-Finn as its member on the SRG.

The SRG was also informed that Tricia Griffiths had resigned from the SRG due to health issues and family commitments. Anne Wei and Gareth Lloyd would be seeking a replacement carer member for the Group. On behalf of the SRG the Chair thanked Tricia Griffiths for her contribution to the Group and wished her all the best for the future.

SRG 20/23 APOLOGIES FOR ABSENCE

The SRG **NOTED** the apologies.

It was **NOTED** that although not members of the SRG, apologies had been received from Nikki Foreman, Wendy Orrey and Anne Wei.

SRG 20/24 DECLARATIONS OF INTEREST

There were no declarations of interest.

SRG 20/25 UPDATE ON CAV24/7

The SRG received an update on the CAV24/7 service from Katja Empson.

The SRG was reminded that the service is a phone first service for all but true emergencies. It had been introduced to ensure that patients receive the right care at the right place at the right time. It also reduced overcrowding in the Emergency Unit which is particularly important during the C-19 pandemic. Since it commenced on 5 August, the service had generally been successful. Significant numbers are using the service and there is no evidence of any patient being harmed as a result of the new model. Some people had self-presented to the Emergency Unit a number of whom had been redirected to other services but they had all been treated with compassion. Staff have been mindful that some individuals might be unable to phone first for a number of reasons including difficulties in communicating, no access to a phone etc. Staff have also been cognisant of safeguarding issues. There have been a few examples of patients being 'ping-ponged' between different elements of the health service and discussions are being held to address this issue.

90-95% of minor injuries are now managed via an appointment. Additional resources have been provided at Barry Minor Injuries Unit and this will continue to be developed. Some Cardiff residents are being referred there and there is an expectation that they make their own travel arrangements.

Mark Cadman reported that Welsh Ambulance Services NHS Trust welcomed CAV24/7. They had received over 300 calls but had only needed to convey 14 patients to the Emergency Department. The only slight area of concern was that where ambulance crews have been called and assessed patients as not needing emergency transport it can sometimes take over 45 minutes to secure an appointment.

In response to an enquiry Katja Empson explained that if individuals turn up at the Emergency Department without an appointment and it is assessed that they do need to be treated there, priority would still be given to those with appointments unless clinical priority dictated otherwise.

Abigail Harris reminded the SRG that CAV24/7 was the pathfinder for Wales and would continue to be developed as lessons are learnt. The Minister for Health and Social Services had published a Winter Protection Plan of which CAV24/7 was an important part. It was interesting to note that in England the national policy was to move towards a similar emergency care model.

The SRG enquired how patient feedback was being obtained. Katja Empson reported that those using the service had received a text message requesting feedback. Although only 12% had responded the replies had been generally very positive with no significant area of concern identified. The Community Health Council had also conducted its own survey outside the Emergency Department and had interviewed staff. .Angela Hughes explained that the 12% of respondents equated to circa 750 patients. There was also a robust patient experience programme in place that would include patient stories and work with 'seldom heard' groups.

In response to an enquiry, Katja Empson explained that the UHB was cognisant of the needs of all vulnerable groups including the homeless. The majority of the homeless who attend the Emergency Department arrive via ambulance. Staff are acutely aware of the need to be cautious in redirecting the homeless to alternative service provision.

The SRG enquired whether learning was emerging about the people attending the emergency Department who should have gone elsewhere. Katja Empson explained that information was being collated and the UHB now had more than just anecdotal information on the patients attending.

On behalf of the SRG the Chair congratulated the UHB on the successful introduction of CAV24/7.

SRG 20/26 MINUTES AND MATTERS ARISING FROM

- **STAKEHOLDER REFERENCE GROUP MEETING HELD ON 22 JULY 2020**

The SRG **RECEIVED** and **APPROVED** the minutes of the SRG meeting held on 22 July 2020.

Major Trauma Centre

Marie Davies confirmed that the Major Trauma Network and Major Trauma Centre (MTC) at UHW had gone live on 14 September. The first week had been extremely busy and although there had been a number of 'teething' issues the service was generally working well.

SRG 20/27 FEEDBACK FROM BOARD

The draft minutes of the UHB Board meeting held on 30 July 2020 had been circulated to the SRG for information.

It was agreed that SRG should address any questions relating to them to Anne Wei or Gareth Lloyd.

SRG 20/28 CLINICAL SERVICES PLAN

Marie Davies explained that work was being undertaken with clinical colleagues and stakeholders to develop a Clinical Service Plan (CSP) that articulated the key components that will be necessary to deliver the UHB's Shaping Our Future Wellbeing (SOFW) Strategy. The intention was to produce a document and engagement materials for an engagement programme during the autumn. The UHB was currently reviewing its approach to engagement on the CSP in the context of C-19 which had already stretched the UHB's limited communications and engagement staff resource. There was also the issue of whether it was appropriate to conduct an engagement exercise on strategic change in the midst of a pandemic when the context was continually evolving.

Marie Davies explained that over the next 1-2 years a number of acute services are likely to be regionalised which will ensure that they are sustainable and improve patient outcomes. In addition, a key principle of the CSP will be the provision of non-complex surgery and rehabilitation on a separate site from specialist and complex surgery. It is likely that UHL will become principally an elective site and UHW will become the site for all emergency admissions and specialist and complex work. Formal engagement and public consultation exercises will be required for specific service change proposals. Dr Navroz Masani had been appointed as clinical lead for the programme of clinical change.

The UHB would be seeking people's views on a small number of questions on key components of the Strategic Clinical Services Plan including:

- whether there are any other drivers for change we need to consider in designing future service models;

- the rationale we have put forward for changing the way we deliver acute medicine and planned surgery;
- the emerging models for providing more care closer to home;
- what else should be taken into account as when developing these plans; and
- how would people like to be involved in this work going forward

The SRG suggested that it would be important to ensure that the most deprived communities had a voice in shaping future service provision. It enquired whether the UHB was engaging with Public Health Wales (PHW) to identify need in specific communities. Marie Davies explained that the CSP was not just about reconfiguring acute services, indeed the starting point is what is required within local communities to enable people to remain at home or receive care as close to home as possible.. PHW colleagues undertook comprehensive population needs assessments and this data was used in the planning of future service provision. The UHB was also a member of the Regional Partnership Board which is a collaboration of all public and third sector partners. Cath Doman Programme Director for Integrated Health and Social Care ensures that the UHB's operational and strategic planning is joined up with that of its partners.

The SRG made a number of suggestions about the engagement process:

- Engagement should be a continuous and iterative process and should not be delayed due to C-19.
- A mixture of on- line and off-line engagement methodologies should be adopted e.g. social media, traditional paper leaflets, posters etc.
- ProMo Cymru, EYST and Age Concern might be able to provide advice/assistance.
- Consideration should be given to how to capture the views of the 'seldom heard'
- Clear language must be used. Patient Experience will be able to assist with this.

SRG 20/29 IMPROVING EQUALITY AND INCLUSION

The SRG received a presentation from Keithley Wilkinson on the UHB's initiatives to improve equality and inclusion.

The SRG was reminded of the nine protected characteristics set out in the Equality Act 2010 and informed that each Board member sponsored an individual characteristic including the Welsh language. There was also discussion about the new Socio-Economic Duty the overall aim of which is to deliver better outcomes for those who experience socio-economic

disadvantage. The Socio-Economic Duty will support this by ensuring that those taking strategic decisions understand the views and needs of those impacted by the decisions, as well as driving change in the way that decisions are made and the way that decision makers operate.

The importance of the Welsh Language Standards have also been identified in the UHB's Strategic Equality Plan 2020/24 which the UHB is obliged to publish. The Plan would be published in October and would be circulated to the SRG for information.

Action: Gareth Lloyd

The Plan has been reviewed to identify the key inequalities exacerbated by the C-19 pandemic and the UHB is developing a clear action plan with equality outcomes.

The SRG was informed of the good practices being adopted within the UHB, the principles that will inform the UHB's inclusion work strategy and further recommendations aimed at improving equality and inclusion.

The SRG welcomed the progress being made on equality and inclusion but reminded the UHB not to forget other specific groups not directly referenced including women, the gender fluid, and those with learning disabilities.

It was agreed that in a few meetings' time Keithley Wilkinson would provide the SRG with an update on how the UHB had moved from principles to practice.

SRG 20/30 ANY OTHER BUSINESS

SRG Eligibility
Gareth Lloyd requested that those yet to return their forms could please do so as soon as possible.

Action: All

SRG 20/31 NEXT MEETING OF SRG

Microsoft Teams meeting, 9.30am-12pm, Tuesday 24 November 2020.

LOCAL PARTNERSHIP FORUM MEETING

Thursday 22 October 2020 at 10.00am, via Zoom

Present	
Mike Jones	Chair of Staff Representatives/UNISON (co-Chair)
Martin Driscoll	Exec Director of Workforce and OD (co-Chair)
Len Richards	CEO
Lorna McCourt	UNISON
Jonathan Strachan-Taylor	GMB
Julie Cassley	Deputy Director of WOD
Peter Hewin	BAOT/UNISON
Jo Brandon	Director of Communication and Engagement
Ruth Walker	Exec Director of Nursing
Julia Davies	UNISON
Ceri Dolan	RCN
Abigail Harris	Exec Director of Strategy and Planning (part of meeting)
Stuart Egan	UNISON
Fiona Salter	RCN
Rhian Wright	RCN
Rachel Gidman	Assistant Director of OD
Dawn Ward	Independent Member – Trade Union
Chris Lewis	Interim Director of Finance
Rebecca Christy	BDA
Caroline Bird	Deputy COO
Fiona Jenkins	Exec Director of Therapies and Health Science
Mat Thomas	UNISON
Peter Welsh	General Manager UHL and Barry
Pauline Williams	RCN
In Attendance:	
Cheryl Williams	Public Health Wales
Apologies	
Fiona Salter	RCN
Joe Monks	UNISON
Bill Salter	UNISON
Andrew Crook	Head of Workforce Governance
Nicola Foreman	Director of Corporate Governance
Stuart Walker	Medical Director
Janice Aspinall	RCN
Fiona Kinghorn	Executive Director of Public Health
Steve Gaucci	UNISON
Secretariat	
Rachel Pressley	Workforce Governance Manager

LPF 20/053 WELCOME AND INTRODUCTIONS

Mr Jones welcomed everyone to the meeting

LPF 20/054 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

LPF 20/055 DECLARATIONS OF INTEREST

There were no declarations of interest in respect of agenda items.

LPF 20/056 MINUTES OF PREVIOUS MEETING

The minutes from 3 August 2020 were confirmed as an accurate record of the meeting.

LPF 20/057 ACTION LOG

The action log was noted

LPF 20/058 DPH ANNUAL REPORT

Cheryl Williams, Principal Health Promotion Specialist from Public Health Wales, was in attendance to present the Director of Public Health's annual report 'Re-imagining Aging into the Future'. This report had been based on a literature review, focus groups and a staff survey around retirement. Aging well was the focus due to the demographic changes of an aging population, especially in the 85+ age group

The report looked at the following three areas and how they interacted:

- Purpose and fulfilment in life
- Active and healthy places
- Social connections in life

It included key messages for the public and actions the UHB can lead on.

Mrs Gidman advised that a film about Wyn aging well was being produced and might be useful. She would link in Ms Williams outside the meeting.

Mr Hewin was very positive about the report and said that it resonates well with Occupational Therapy. However, he felt that the UHB had a lot of work to do especially around attitudes to flexible working as it was often not seen as good management.

(Ms Williams left the meeting)

LPF 20/059 LEARNING FROM COVID-19

The Forum received a presentation on the initial learning from Covid-19. Mrs Gidman advised that this had been undertaken on a whole system basis and included discussions with small groups of clinical and non-clinical staff.

(Ms Bird joined the meeting)

Key points from the presentation included:

- One of the aims of Amplify had been in increase trust. This had happened almost overnight, with a 'can do' attitude toward decision making
- There had been significant transformational work especially in relation to digital capability (e.g. remote working, teams, virtual patient experience)

(Mr Richards joined the meeting)

- People advised that they felt reassured by hearing the senior team had a strategy for dealing with Covid
- Staff wellbeing was an important priority and a Health and Wellbeing group had been established immediately
- The UHB had played an important part in researching treatment
- PPE had improved and a presentation from the Executive Director of Nursing had led to increased confidence
- Within Primary Care the GPs had restructured themselves and there had been improvements around the care homes
- 12 case studies in the report showed the transformational work during the pandemic
- When asked how they felt, people described a real mix of emotions. They were scared but energised.

Mrs Gidman advised that this presentation only provided a snapshot and that there was also a 50 page report which she would share with the Forum

Action: Mrs Gidman

Mr Hewin suggested that while the presentation included a lot of elements which were good and which he could corroborate, he felt that it was not very realistic to suggest that it was all positive. He stated that there were negative and traumatic experiences and that it would be right to acknowledge them too. He also suggested that this could be useful evidence for the pay review body and asked for the UHBs support in the joint TU campaign for an early and significant pay rise. Mr Driscoll advised that participants had been asked 6 questions, one of which was 'if we have to do it again how can we do it differently or better'. He advised that the presentation was very much an abridged version and that there was a lot about this in the report.

Ms Ward stated that if we are presenting lessons learnt they need to be balanced and open. She believed that we had learned during Covid that we are more resilient that we expected, but had also seen and learnt from changed behaviour by the public, especially at the front door. Mrs Gidman advised that they had started by having discussions with senior leaders then the wider organisation. She suggested that this was still growing and had not finished, and acknowledged the need to include the Local Authorities and 3rd sector as well.

Mr Hewin raised concerns about managers accessing individual's results without their consent and asked if it was appropriate to invite Information Governance for a discussion about this. Ms Ward suggested that there were wider issues around consent which should be discussed including advice for staff on consent for treatment. Mr Richards suggested that a discussion with the Caldicott Guardian would be more appropriate than Information Governance because these issues are about clinical information rather than GDPR.

LPF 20/060 CEO REPORT

Mr Richards updated the Forum on the current position in relation to Covid and 3 other matters:

- There had been an increased incidence of positive cases in Cardiff, but this was mainly among young people and students. The age 60+ group was reporting at 75 per 100k and had remained quite stable for 3 or 4 weeks. At a Major Incident Management meeting the previous day the view was that we were starting to see the impact of the local lockdown, though the risks of young people infecting those from older age brackets was recognised

There were 43 covid positive cases in UHB hospitals. Mr Richards noted that in neighbouring Health Boards at that time there were lower infection rates but higher rates of admissions as the positive cases tended to be in older groups.

- Mr Richards felt that overall the TTP process was working well for us, with over 90% of contacts being traced and the view that most were self isolating. Turnaround times for testing were not as good as we would want and we were working with Lighthouse Laboratories around this, though this is a UK Government contract rather than a UHB or WG one.
- We are starting to prepare for a mass vaccination programme. There is no timetable at present but the planning has started to ensure that we are ready when the time comes
- The Surge Hospital is progressing on target and there should be 160 beds available by the end of November. Work is taking place around the environmental impact and replacement of trees etc., but part of the learning from the Dragons Heart Hospital was around the complications of having staffing and other services off site.
- Welsh Government have released additional funding to cover our costs for TTP, the Surge Hospitals and the impact of the infection on shifts and staffing, and we think that is enough to cover our costs, which puts us in a good position for the end of the year though there may be a need for further additional funding depending on the impact of the second wave . Our previous management of finances has put us in a good position for these discussions with WG.
- Mr Richards stated that while he recognises the difficulties we cannot have unsafe car parking on site and he will be writing to staff. The Parking Eye contract had been deferred but if they are needed to ensure a safe site they would be brought back. Mr Richards asked for a joint position on this as a way of getting the message out to staff.
- With regards to working from home, people should only be on site if that is the only place they can do their job. There have been outbreaks in the workplace and we need to minimise the risk of infection between colleagues.

Mr Hewin reminded the Forum that a set of principles from the group looking at working remotely had been circulated at the June LPF Meeting. This referred to infection, but also the benefits in terms of efficiencies and acknowledged the problems. He suggested that this could be re-circulated if it was helpful

Ms Ward asked what the issue was around Lighthouse Labs? Mr Richards advised that it was mainly due to poor turnaround where there had been a policy requirements (e.g. increased demand in care homes) or the time it takes to establish efficiency when a new lab was set up. He advised that the lab in Newport was new and that there were ironing out staffing and procedural issues now.

Ms Ward stated that she had been impressed with the leadership from PCIC as staff had been asked to show extreme efforts to support the fire break. She suggested that the re-establishment of Clinical Board Local Partnership Forums on a regular basis would help drive these messages.

Mr Driscoll advised that he had asked for a piece of work to capture formally how far we can go in the future in relation to working from home. He wanted this to include our office footprint and green credentials, and stated that he hoped any IT costs could be offset by reducing our office space.

LPF 20/061 OPERATIONAL UPDATE

Ms Bird advised that there had been an increase in admissions but they were still relatively low numbers. We continue to operate with the first principle being covid ready, but there are complexities such as the footprint changing and adapting to meet patient needs. Ms Bird acknowledged the work by staff who are dealing with this.

A Covid operational meeting was held virtually twice a week and was open to all – if any LPF members wanted to join the meeting they should let her know.

Ms Bird wanted to acknowledge the staff support for Cwm Taf and the wider system while we had a formal agreement in place for 999 diverts.

We continue to see an increase in demand and activity though still lower than pre-covid levels with OPD at 74% and day cases at 60%. We are putting measures in place to increase activity in cataracts, orthopaedics and cardiac theatre. More information is available about this in the Quarter 3-4 Plan. Following feedback from staff about how to make it easier to hold virtual out patients clinics, a 'virtual village' is being tested in UHL – this enables staff to work in a designated space rather than from home and will be rolled out further once tested.

Mrs Walker advised the Forum that there had been covid outbreaks in E6 and SRC. She reminded members that an outbreak is 2 or more people within a defined area who are positive. This includes non-clinical areas, and they need to be treated the same way. Mrs Walker thanked staff who were managing the outbreaks very well.

LPF 20/062 QUARTER 3-4 PLAN

Mrs Harris reminded the Forum that normal planning processes were suspended due to Covid and WG had asked us to move to quarterly planning to reflect how quickly things were changing. This has now moved to 6 monthly and the plan for Quarters 3 and 4 had been submitted that week.

It focuses on 4 harms:

- Direct harm of covid-19 - Bed Capacity (including the Surge Hospital), TTP, mass vaccination preparations, workforce response (ie roles and skills mix, wellbeing of staff)
- Indirect harm of covid-19 –planned care, essential services, Primary care
- Preventing our system becoming overwhelmed – our approach to winter planning, surge and workforce plans
- The wider harm of covid-19 - Mental Health, Long Covid, recognising that all of the above require collaboration

Mrs Harris advised that this is an ambitious plan due to our attempts to continue with the delivery of Shaping Our Future Wellbeing at the same time, though much of it is in the same direction.

Mr Hewin stated that he was very pleased to see mental health included and agreed that it needed to be. However from a therapies perspective he had heard that there was a recruitment freeze pending a service review and he felt that this timing of this was questionable. He also asked what staff side involvement there had been in the workforce plan. Mrs Harris advised that while she knew that a move to the locality model had started pre-covid, she was not aware of a recruitment freeze. Ms Bird agreed to pick this up with the Clinical Board

Action Ms Bird

Mrs Cassley advised that the workforce plan is not a full IMTP, but illustrates what is taking place in in terms of wellbeing, working from home etc. Work was still taking place around staffing numbers for e.g. Lakeside. She advised that the plan covers three scenarios and while the financials are

pitched in the middle, it is tricky to predict which we will be in and some of those elements have not been pinned down yet. Ms Bird added that while we need to plan for the worst case scenario we need to understand the impact each of these scenarios will have on an already stressed workforce.

Ms Ward said that there needed to be a formal mechanism for discussion, as well as the sub groups. She said that from a TU perspective a worst case scenario would be increased staff sickness due to tiredness etc. Mrs Cassley reminded the Forum that temporary recruitment continued, that bank workers had been moved into fixed term posts and that the Physicians Associate role was being advertised, but welcomed further discussion and offered to attend the staff side meeting or include this in a future Workforce Partnership Group agenda
Action: Mrs Cassley

LPF 20/063 FINANCE REPORT

Mr Lewis presented the Finance Report for the period up to the end of August 2020 to the Forum. He referred to the comments made by Mr Richards in his update and noted that the forecast was aligned to the Quarter 3-4 Plans.

LPF 20/064 WORKFORCE KPI REPORT

Mr Driscoll suggested that the KPIs showed the Covid story with additional recruitment in the spring, absence rises (though not at the levels which had been predicted) and anticipated reductions in mandatory training compliance.

Miss Salter noted that ER cases which are undergoing police investigations cannot be progressed internally and asked if we liaised with the police to ensure none of them are missed. Mrs Walker advised that Jason Roberts and Lianne Morse meet monthly and do chase the police for an update. Miss Salter indicated that she had a specific case in mind and she would follow it up outside the meeting.

LPF 20/065 PATIENT QUALITY, SAFETY AND EXPERIENCE REPORT

The LPF received the Patient Quality, Safety and Experience Report. Mrs Walker pointed out that the WG reporting requirements had changed recently but that the emphasis was still on learning rather than performance.

Miss Salter asked for clarity with regards to the position on wearing masks. Mrs Walker advised staff are currently encouraged to wear masks or face coverings in corridors etc. but there are discussions taking place about whether the water repellent masks used in clinical settings give more protections than face coverings. We are currently waiting for guidance from the experts and once it has been received it will be shared via CEO Connects.

LPF 20/066 Part 2 - ITEMS FOR INFORMATION

The Local Partnership Forum received and noted:

- Employment Policy Sub Group minutes from 30 September 2020
- Staff Benefits update report and revised Terms of Reference

LPF 20/067 ITEMS FOR BOARD

There were no specific items which the LPF wanted to be brought to the attention of the Board.

LPF 20/068 ANY OTHER BUSINESS

Mr Driscoll advised that a shortened version of the Staff Survey was due to be launched in early November. Unfortunately there had not been time to engage beforehand in the way that he wanted to but he asked everyone to participate and to encourage others to do so. There were only 20 questions so it was hoped that we could have a high level of returns. Mr Thomas is the lead staff representative for this work.

LPF 20/069 FUTURE MEETING ARRANGEMENTS

The next meeting will be held on Wednesday 16 December at 10 am with a staff representatives pre-meeting at 9am. The meeting will be held remotely.

Pwyllgor Gwasanaethau Ambiwlans Brys
Emergency Ambulance Services Committee

EMERGENCY AMBULANCE SERVICES JOINT COMMITTEE MEETING

'CONFIRMED' MINUTES OF THE MEETING HELD ON 8 SEPTEMBER 2020 AT 13:30 VIRTUALLY BY MICROSOFT TEAMS

PRESENT

Members:	
Chris Turner	Independent Chair
Stephen Harrhy	Chief Ambulance Services Commissioner
Judith Paget	Chief Executive, Aneurin Bevan ABUHB
Gill Harris	Interim Chief Executive, Betsi Cadwaladr BCUHB
Steve Curry	Chief Operating Officer, Cardiff and Vale CVUHB
Nick Lyons	Interim Chief Executive, Cwm Taf Morgannwg CTMUHB
Carol Shillabeer	Chief Executive, Powys PTHB
In Attendance:	
Cath O'Brien	Chief Operating Officer, Velindre NHS Trust
Hannah Evans	Director of Transformation, Swansea Bay SBUHB
Jason Killens	Chief Executive, Welsh Ambulance Services NHS Trust (WAST)
Stuart Davies	Director of Finance, Welsh Health Specialised Services Committee (WHSSC) and EASC Joint Committees
Ross Whitehead	Assistant Director of Quality and Patient Experience
James Rodaway	Head of Commissioning & Performance Management
Rachel Marsh	Director of Planning, Strategy and Performance, Welsh Ambulance Services NHS Trust
Mark Harris	Patient Care Services Manager, Welsh Ambulance Services NHS Trust (For Focus On – NEPTS agenda item only)
Gwenan Roberts	Assistant Director Corporate, National Collaborative Commissioning Unit (NCCU) (Committee Secretary)

Part 1. PRELIMINARY MATTERS		**ACTION**
EASC 20/66	**WELCOME AND INTRODUCTIONS** Chris Turner (Chair), welcomed Members to the virtual meeting (using the Microsoft Teams platform) of the Emergency Ambulance Services Committee. Hannah Evans, Director of Transformation for Swansea Bay UHB and Cath O'Brien, Chief Operating Officer for Velindre NHS Trust were welcomed to their first meeting.	
EASC 20/67	**APOLOGIES FOR ABSENCE** Apologies for absence were received from Tracy Myhill, Sian Harrop-Griffiths; Steve Moore, Karen Miles, Len Richards and Glyn Jones.	

EASC 20/68	**DECLARATIONS OF INTERESTS** There were no additional interests to those already declared.	Chair
EASC 20/69	**MINUTES OF THE MEETING HELD ON 14 JULY 2020** The minutes were **confirmed** as an accurate record of the Joint Committee meeting held on 14 July 2020 subject to one amendment to the bottom of page 4 which now reads: 'Some concerns had been raised by staff at ABUHB and Judith Paget agreed to share the Datix reports from the UHB in order that the WAST team could understand the issues involved.' The action log was also amended to reflect the change. Members **RESOLVED** to: • **APPROVE** the Minutes of the meeting held on 14 July subject to the one amendment noted above.	Chair
EASC 20/70	**ACTION LOG** Members **RECEIVED** the action log and **NOTED** specific progress as follows: **EASC 20/36 Coronavirus action** Members agreed that there were no further items to add at present although the issues would need to be reviewed on an ongoing basis. **EASC 20/56 DATIX report** The action log was amended to reflect the change that ABUHB would share the Datix reports with WAST. Jason Killens explained that the team at WAST were planning to respond directly to the concerns raised shortly (added to the Action Log). **EASC 20/57 Different usage of personal protective equipment** Members noted that this was now more consistent across Wales and the matter was closed. **EASC 20/57 Unscheduled Care Dashboard** Stephen Harrhy updated Members by explaining the link to the Unscheduled Care Board's work and the need for live data to support the development and provision of agile timely services. A procurement exercise was underway the outcome of which would be reported back to the NHS Executive Board.	All CEO WAST Chair CASC

	EASC 20/57 Healthcare Inspectorate Wales (HIW) Report Members noted that WAST had received the draft report from HIW and had provided comments on matters of factual accuracy. It was likely the final version of the report would be published by HIW at the end of September. The report would be circulated to Members as soon as received. **EASC 20/58 Emergency Medical Retrieval and Transfer Service (EMRTS)** Members noted that work was underway to try and secure capital funding for the EMRTS service. A further update would be provided at the next meeting. **EASC 20/60 Governance Update** Members were aware that the effectiveness survey information was outstanding and would be shared once all surveys had been received from the sub groups. **EASC 20/29 CASC as Co-Chair Task and Finish Group** Members noted the ongoing work with the Fire and Rescue Services in relation to their work as first responders. A service level agreement was being developed in partnership by WAST. Stephen Harrhy explained that a briefing session had been planned with the Minister for Local Government and Jason Killens agreed to provide information for the briefing by 14 September 2020 (added to the Action Log). Members **RESOLVED** to: • **NOTE** the Action Log.	Ctte Sec CASC Ctte Sec CEO WAST
EASC 20/71	**MATTERS ARISING** There were no matters arising.	
EASC 20/72	**CHAIR'S REPORT** The Chair's report was received. Members **RESOLVED** to: • **NOTE** the Chair's report.	
Part 2. ITEMS FOR DISCUSSION		**ACTION**
EASC 20/73	**CHIEF AMBULANCE SERVICES COMMISSIONER'S REPORT** The Chief Ambulance Services Commissioner's (CASC) report was received. In presenting the report, Stephen Harrhy highlighted the following key items:	

	• Ministerial Ambulance Availability Taskforce Members noted that arrangements were continuing to start the work related to the Taskforce. The proposed framework was being developed including the key output products identified. Stephen Harrhy agreed to share the draft work and asked for comments to shape the work as it develops. The aim was to use existing mechanisms where possible and an interim report was planned to be developed by the end of November (Added to the Action Log).	CASC
	• Refreshing the Emergency Medical Services (EMS) Framework Members were aware of the plans to refresh the EMS Framework and it was suggested that this take place by April 2021. Detailed discussions would take place at the EASC Management Group and a report would be developed for the next EAS Committee meeting (added to the Forward Look). The aim of the refresh would be to ensure that the Framework was streamlined and more reflective of the current position for EMS services. Members noted that some issues would need Health Board and WAST support in order that the Framework could operate from the beginning of the next financial year.	CASC
	• Quality and Delivery (Q&D) Meeting with the Welsh Government (WG) Members noted a recent Q&D meeting had taken place and the areas discussed where the biggest concern, and the majority of the meeting's focus, was on the current performance. The WG officials were also updated on the plans for the Ministerial Ambulance Availability Taskforce.	
	• EASC allocation letters for Major Trauma Services and Critical Care Transfer Services Members noted that the allocation letters had been received by the CASC and were pleased to note that they were in line with the expectations of the financial plan within the Integrated Medium Term Plan (IMTP). Members noted that a full year allocation had been provided and the CASC agreed to develop options for the use of this funding (added to the Action Log).	CASC
	• Progress on the Emergency Medical Services Demand and Capacity Implementation Plan Members were aware of the agreement at EASC to fund up to 90wte additional staff within the plan. The WAST team had previously discussed that a further 46wte staff could be recruited and trained within the financial year.	

	Members noted that a discussion had taken place at the EASC Management Group regarding the recruitment of the additional front line staff which had been supported, although the source of the funding was unclear. Stephen Harrhy suggested that this additional cost of £1.4m could be included as part of the process to bid for resources under the winter protection fund to ensure maximising front line staff. This suggestion was supported by Members. The Chair thanked Stephen Harrhy for his report and Members discussed the following matters: • Concerns were raised regarding the capacity of the system to meet all of the ongoing plans during the potential resurgence of the pandemic. In terms of the revision of the EMS Framework, Members felt that clinical outcomes would be important but there may be a wider requirement to filter the work of the Committee to business critical areas only. • Members noted that the review of the IMTP would provide an opportunity to redefine the key areas of work and this would be discussed at the EASC Management Group and would be reported to the next EAS Committee meeting (added to the Forward Look). It was suggested that further information may be circulated outside of the formal meeting arrangements as the current system may not have sufficient capacity to deliver all of the previously agreed plans. • Members noted the opportunity to align with the work already underway on seasonal planning and the potential opportunity to be more coordinated with the option of needing to work outside of the formal Committee arrangements if required. • Members noted that good collective progress had been made on the arrangements to open the Grange University Hospital and a helpful recent meeting had taken place which had resolved some key outstanding issues. The Chair summarised the discussion and Members **RESOLVED** to: • **NOTE** the Chief Ambulance Services Commissioner's report • **NOTE** the need to identify a set of specific priorities • **NOTE** the aim to link to seasonal priorities • **APPROVE** the intention to seek £1.4m from the winter protection funding for the additional staff within the EMS Demand and Capacity Implementation plan.	CASC

EASC 20/74	**WELSH AMBULANCE SERVICES NHS TRUST (WAST) PROVIDER REPORT** The update report from the Welsh Ambulance Services NHS Trust (WAST) was received. To provide more clarity in relation to activity and performance Jason Killens asked the Chair if he could share a presentation and it would be shared with Members after the meeting. The Chair reminded Members that he would prefer to avoid having tabled information at the Committee meetings in order for opportunity to scrutinise the information in advance. However, he agreed to the use of the presentation to assist Members, particularly as performance had deteriorated. Members noted: • Serious Adverse Incidents (SAIs) – a marked reduction in numbers over the recent months although now monitored weekly by the WAST Directors, reported to a WAST sub-committee and onto the WAST Board. A report would be compiled monthly and more examples would be shared with the EASC Team (added to the Action Log). The Chair asked if it would be possible to compare the levels of SAIs with other comparable areas as it was difficult to set in context the data presented. Jason Killens agree to try and benchmark with other areas and present the information in the next report (added to the Action Log). • Long waits – the reasons were provided as was more evidence of the shift back to normal working • Health and Safety Executive (HSE) – two improvement notices had been received (sharps injury (disputed) and extended time spent in personal protective equipment). A full response had been provided to the HSE and the policy position on personal protective equipment (PPE) had been updated. The importance of the turnaround of ambulances at emergency departments was discussed and that WAST staff wearing PPE were reliant on health board staff to comply with the guidance (added to the Action Log). Members noted that it was likely that the HSE would escalate this issue if further situations arose • Performance position - RED position – for August was below 65%, however the number of calls responded to in 8 minutes was more than the previous August - 999 handling and 999 calls – good performance - Incidents – volumes increased from August 2019	CEO WAST CEO WAST All

	- Production comparison August – more this year compared to previous years - EMS Abstractions – increase due to annual leave as staff were encouraged to take leave before winter - Overtime reductions – no incentivised overtime - Covid 19 abstractions now at 3% - More activity August 2020 compared with 2018 and 2019 - Emergency Ambulance Utilisation (3% tolerance) - Staffing – focus is on additionality and recruitment Forecast - Production stronger in September – on or over 100% for emergency ambulances, more work required on rapid response vehicles - Amber performance and patients experiencing long waiting times - Anticipating further Covid19 surge - Modelling forecast for September - 66%. Members were concerned about the deterioration in performance; it was noted that Powys had not met the target over the last 5 or 6 months although ongoing discussions were taking place. The performance was worse during 2020 and it was suggested that this could be attributed to the switch away from the deployment of rapid response vehicles (RRVs); it was hoped that the recommencement of RRVs would improve the performance in Powys and other health board areas. Members asked regarding the impact of 'consultant connect' in terms of managing conveyance and whether any learning could be shared across the system. Members noted that the numbers to date were small and that there was a large variation in the uptake. The CASC responded to the content of the presentation and highlighted: - Helpful to note that more front line staff available in August than previous year despite reduction in overtime and an increase in annual leave allocated; therefore, additional investment in demand and capacity plan is starting to become effective - Support the rebalancing of emergency vehicles and RRV as this will have a positive impact on red performance; however, WAST need to keep in mind any potential negative impact on amber performance	CASC

	- Keen to work with health board colleagues re handover delays and what do their plans look like – it was agreed that the CASC to contact everyone for their plans (added to the Action Log) - Confirmed that a detailed analysis of the ambulance performance in August was being undertaken to supplement WAST improvement plan including variation in mobilisation times in South East Wales compared with other regions - Opportunities for learning across Wales including Cardiff and Vale UHBs CAV 24/7. The Chair asked regarding the information on current and forecasted future performance and suggested that it would be helpful to have a coordinated plan from WAST to tackle the issues identified. It was felt this overview list would also be helpful for the work of the Ministerial Ambulance Availability Taskforce to coordinate the actions to be taken. Members agreed that the EASC Management Group receive and discuss the overview list (Added to the Action Log). Members also noted the importance of the impact of cultural issues in terms of the ownership and professional responsibilities in working together and this would be key during the winter months. Other matters highlighted from the WAST provider report included: • the recruitment of the additional staff for the front line which was at 119.28wte to date which subject to additional resources could be increased although the additional work by the finance teams would provide clarity. • Where health board service changes had been planned, Jason Killens thanked colleagues for including the WAST Team as early as possible to support service changes across NHS Wales. Members **RESOLVED** to: • **NOTE** the provider report and the actions agreed.	CEO WAST
EASC 20/75 	**FOCUS ON – NON EMERGENCY PATIENT TRANSPORT SERVICE (NEPTS)** The report and presentation on the Non-Emergency Patient Transport Service (NEPTS) was received. In presenting the report, James Rodaway and Mark Harris explained that the report had been received at the NEPTS Delivery Assurance Group and also at the EASC Management Group.	

	Members noted: • NEPTS Headline statistics • The Collaborative approach undertaken at the NEPTS Delivery Assurance Group – this work included the team at WAST but also health board teams with a focus on continuous improvement • Commissioning and Quality Assurance undertaken – the Framework was in place and robust processes were in operation. Step 1 and 2 were considered key in ensuring the transport solution is as good as possible • NEPTS Service Development • Enhanced Service Provision – renal, oncology and end of life service; renal patients account for 30% of all NEPTS journeys which was steadily increasing and more work ongoing to develop oncology services. It was noted that the End of Life Care Service had won a Health Service Journal Award and the team were warmly congratulated on this achievement • Performance/ Service Delivery Improvements • Governance and Planning – this included a more joined up approach and particularly the tiered staff structure in health boards to support the local commissioning • NEPTS Demand and Capacity Review now underway • The Impact and Learning from Covid19 • The NEPTS Delivery Assurance Group at the end of September would be discussing winter planning and discharge capacity matters and the impact of Covid19 on NEPTS activity. Mark Harris provided detailed operational information regarding the different ways of working within the NEPT service during the pandemic which included support providers, people driving themselves to appointments, student paramedics and also the voluntary sector. The team were working to manage through the agreed script and were finding alternative ways of transporting patients. Members noted that the NEPT Service were also working with Optima using the modelling tool to analyse how the service could be used in the winter. Other complementary work included how volunteer drivers could be protected including consideration for early vaccination (when available). The importance of the whole system approach to developing winter plans was discussed and particularly for this service. The longer term issues would also need to be considered including the resetting of plans for outpatients and other work.	

	The CASC emphasised the importance of the joined up approach and informed Members of the ongoing work with the procurement team to look at all spend on private providers as there may be an opportunity to realise savings and the further development of the NEPT service in line with the 'Once for Wales' ethos. Members were very supportive of the All Wales approach and the improvements being made within the NEPT service to date. Members suggested that the NEPTS Demand and Capacity Review would need to understand the learning from the Covid19 experience in terms of how the service could be rebalanced and provided in different ways. Members discussed the outstanding transfers to complete the 'Once for Wales' approach as agreed and asked about the timescales. Members noted that prior to the pandemic and lockdown all of the work required pre transfer had been completed for the ABUHB area. The aim was now to revisit the data and WAST had appointed a lead manager to oversee the work – ABUHB would be the next area to transfer. The Powys area had also provided data and would follow ABUHB before the end of the financial year. The CASC explained that the detail would be developed and reported via the NEPTS DAG to the next Committee meeting. In terms of the timescales, it was expected that CTMUHB would transfer in the first half of 2021 and BCUHB by the end of the financial year 2021-22 (added to the Action Log). The Chair, in summary, confirmed that effectively phase 1 had been achieved and further work was now required to transfer the other services as soon as possible. The WAST team were also congratulated by the Chair on their achievement of the Health Service Journal Award for their End of Life service. Members **RESOLVED** to: **NOTE** the presentation and report.	
EASC 20/76	**OUTLINE COMMISSIONING INTENTIONS** The report outlining the commissioning intentions was received. In presenting the report, Ross Whitehead highlighted the initial aim to facilitate further discussion at the EASC Management Group to analyse the commissioning intentions for previous years and undertake and option appraisal for each intention. This would then allow for the development of additional intentions or amend the intentions for the next financial year.	

	Members noted that the aim is to issue draft commissioning intentions towards the end of October with the suggestion that a report would be provided to the next EAS Committee on 10 November. Jason Killens supported the work and confirmed that the WAST would want to be fully involved as early as possible (added to the Forward Look). Members **RESOLVED** to: **NOTE** the report.	Assistant Director of Quality and Patient Experience
EASC 20/77	**FINANCE REPORT** The EASC Finance Report was received. Members noted the stable position. Stuart Davies explained that the finance team were working closely with the WAST finance team to verify the net increase in staff related to the 90wte previously agreed by the Committee. Members were pleased to note the report from the WAST CEO regarding the net additionality and the aim of the finance team was to give assurance to the Committee that the net position of staff in post at WAST was increasing. Members **RESOLVED** to: • **NOTE** the report.	Director of Finance
EASC 20/78	**UNSCHEDULED CARE PRESENTATION** Stephen Harrhy gave the presentation on Unscheduled Care. Members noted that the presentation had been previously received by the NHS Executive Board. The following areas were highlighted in terms of the connection to ambulance services and the plans for the future: • Aim to maximise the use of phone first / contact first - likely this would be best done nationally but without cutting across work already in place (e.g. Cardiff and Vale - CAV 24/7); this presents an opportunity for WAST and the 111 service to provide the service • Health board hubs organised and run locally, 'flow hubs'. Likely to include minor injury or illness units/ lower acuity respiratory services / people who have fallen and mental health; other services which would be decided locally on the 80/20 rule (local/national) • Scheduling and how this may look, allowing ready access toservices already available • Phase 1: what can be developed in preparation for winter? For WAST • 111 and call taking	

	• Access to the distribution hubs – what might this mean? • Link to consultant connect and how to maximise the opportunity and measure through whole system – the development of an unscheduled care dashboard will become helpful • Important for separate streams 999 and 111 (design principle) • Need to be careful not to 'double-count' staff and need to be practical how to use staff • Measurement – some information shared for the whole system approach including primary care measures and working with the primary care programme and emergency departments where is there an alternative to 4 hour target – potential to create an aggregated measure? • Consulting and engaging regarding ambulance quality indicators with the measures a one system approach is exciting and it is being supported nationally • Specific ambulance service opportunities • Helpful for winter and future. Members noted the update and asked if the information would be presented for the whole system to better understand the co-dependencies. Outlining the real priorities was felt to be important to include the outputs which could be achieved. The CASC suggested that all of the information would need to be coalesced into a presentation to inform the seasonal planning work too (added to the Action Log). Members noted the processes which could be adopted and also considered the requirements for the public in accessing services appropriately. Members felt there was an opportunity to measure patient safety, experiences and outcomes in different ways. It was felt that patients would want clarity regarding accessing the right service available and the actions to assist when services not accessed appropriately. Members felt that the fall-back position for patients trying to access services would be very important and the right communications would be essential for success. Members **RESOLVED** to: • **NOTE** the report. Khan Raj 01/21/2021 14:27:09	

EASC 20/79	**EASC INTEGRATED MEDIUM TERM PLAN (IMTP) REVISED DELIVERY PLAN** Stephen Harrhy gave an oral overview of the plans to revisit the delivery plan in light of the latest requirements for the Welsh Government to include the latest learning, direction and to concentrate on key priority areas in view of current pressures within the system. Members noted that the EASC Management Group would discuss the plan in more detail before resubmission to the Committee in due course. Members **RESOLVED** to: **NOTE** the report.	
Part 3. ITEMS FOR APPROVAL OR ENDORSEMENT		**ACTION**
EASC 20/80	**EMERGENCY MEDICAL RETRIEVAL AND TRANSFER SERVICE (EMRTS CYMRU) FRAMEWORK AGREEMENT FINAL DRAFT** The final draft of the Emergency Medical Retrieval And Transfer Service (EMRTS Cymru) Framework Agreement was received. James Rodaway presented the report. Members noted the development of the suite of collaborative commissioning frameworks in place and EMRTS was the final version. Members noted that sections of the report needed to be completed and importantly the need to amend the financial information section as confirmation had not been received for the Major Trauma and Critical Care transfer services at the time of writing. EMRTS Delivery Advisory Group had received the document and would finalise all sections. The CASC asked for support in making amendments outside of the formal meetings arrangements and whether the Chair could sign off the final version on behalf of the Committee (Chair's Action). The final version would be received and ratified by the Committee at the next meeting. Members noted that in the meantime the interim framework was in place and the service was operating within the governance required. Members **RESOLVED** to: • **NOTE** the report. • **APPROVE** the final draft • **APPROVE** that the CASC and Chair finalise the framework for submission for ratification of Chair's Action at the next meeting.	

EASC 20/81	**EMERGENCY MEDICAL RETRIEVAL AND TRANSFER SERVICE (EMRTS CYMRU) FRAMEWORK AGREEMENT FINAL DRAFT** Members received the confirmed minutes of the EASC Sub Groups as follows: • EASC Management Group - 26 June • EASC Management Group - 27 July 2020 • NEPTS Delivery Assurance Group – 7 July 2020 Members **RESOLVED** to: • **APPROVE** the confirmed minutes as above.	
EASC 20/82	**EASC RISK REGISTER** The new EASC Risk Register report was received. In presenting the report, Stephen Harrhy explained that the register had been developed in line with the CTMUHB Risk Management Strategy (as the host body). Members noted that the EASC Management Group had received the EASC Risk Register and had provided useful comments which had been used to amend the register. The scope of the risks had been widened to cover the responsibilities of the Committee and no red risks had been identified. Members noted that the commissioning risks had been clarified and the importance of capturing the risks for which the Committee was responsible. Further discussion took place regarding the risk appetite of the Committee and the tolerance for the risk target which were felt to be quite low. Members felt it would be important to ensure that these were set correctly to be able to manage or mitigate the risks identified. The Chair suggested and it was agreed that the risk appetite would need to be fully discussed by the Committee at a future date and it would be added to the 'Focus On' list of topics (added to the Forward Look). Members **RESOLVED** to: • **APPROVE** the risk register • **NOTE** the risk register would be received at every Committee meeting. Khan Raj 01/21/2021 14:27:09	

EASC 20/83	**FORWARD PLAN OF BUSINESS** The forward plan of business was received. Members discussed the arrangements for the Committee and agreed that the next 'Focus On' topic was Commissioning Intentions. Following discussion, Members **RESOLVED** to: • **APPROVE** the Forward Plan.	Chair
Part 4. OTHER MATTERS		**ACTION**
EASC 20/84	**ANY OTHER BUSINESS** No other business matters were raised at the meeting.	

DATE AND TIME OF NEXT MEETING		
EASC 20/65	A meeting of the Joint Committee would be held at 09:30 hrs, on Tuesday 10 November 2020 at the Welsh Health Specialised Services Committee (WHSSC), Unit G1, The Willowford, Main Ave, Treforest Industrial Estate, Pontypridd CF37 5YL but likely to be held virtually on the Microsoft Teams platform.	Committee Secretary

Signed ……
Christopher Turner (Chair)

Date ……

Khan Raj
01/21/2021 14:27:09

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)
Welsh Health Specialised Services Committee (WHSSC)

WELSH HEALTH SPECIALISED SERVICES COMMITTEE JOINT COMMITTEE MEETING – DECEMBER 2020

The Welsh Health Specialised Services Committee held its latest public meeting (which was an extra-ordinary meeting) on 15 December 2020. This briefing sets out the key areas of consideration and aims to ensure everyone is kept up to date with what is happening in Welsh Health Specialised Services.

The papers for the meeting are available at: https://whssc.nhs.wales/joint-committee/committee-meetings-and-papers/2020-2021-meeting-papers/

Managing Director's Report

The Managing Director's report included a report from the Operational Delivery Network and the Major Trauma Centre on the key highlights from the first six weeks of operation of the south Wales major trauma network, which was based on the report presented to the first South Wales Major Trauma Network Commissioning Delivery Assurance Group meeting that was held on 25 November 2020.

Resource Utilisation for Value - Options 2020-21

Members received a paper that provided an update on the improving financial position of WHSSC for 2020-21 and the options to deploy a proportion of the forecast surplus to mitigate the impact of the worsening waiting list position on specialised services patients, deliver service improvement and innovation.

Members approved authorisation of the WHSS Team to deploy additional surpluses over and above the month 7 level of £13.2m towards mitigation of waiting lists, service improvement, innovation and risk reduction. It was also agreed that in the interests of time these plans will be undertaken by Chair's Action and reported to the next available Management Group and Joint Committee meetings.

Tîm Gwasanaethau Iechyd Arbenigol Cymru
Welsh Health Specialised Services Team

PARCH - RESPECT
PARTNERIAETH - PARTNERSHIP
GWELLA AC ARLOESI - IMPROVEMENT & INNOVATION

Report Title:	**South East Wales Vascular Network Engagement & Consultation report**								
Meeting:	**Cardiff and Vale UHB Board**						**Meeting Date:**	28.01.21	
Status:	**For Discussion**		**For Assurance**		**For Approval**	**x**	**For Information**		
Lead Executive:	**Len Richards, Chief Executive Officer**								
Report Author (Title):	**Claire Harding, Engagement Lead SE Wales Vascular Programme** **Victoria Le Grys, Programme Director**								

Background and current situation:

Work has been underway for many years regarding the sustainability of vascular services in South East Wales. It remains the only region in the UK without a formal network in situ, although clinicians have worked well together over time to enable joint arrangements to be put in place, particularly during out of hours provision.

There is a range of guidance and reference points that propose that a networked arrangement is the most appropriate configuration for vascular services which is a view supported by clinicians across the 3 provider Health Boards. A lot of work has been undertaken through clinical teams in exploring potential future options for the delivery of the service in the area, and these were first articulated in a clinical option appraisal undertaken in 2014.

With a strong rationale, clinicians, through their work over many years have arrived at a consensus opinion for a hub and spoke model, with the hub being at University Hospital of Wales and spokes remaining within Health Board footprints. The spoke arrangements are proposed as follows:

	Step up spoke (acute phase)	**Step down spoke (rehabilitation phase)**
Aneurin Bevan University Health Board	Grange University Hospital, Cwmbran	Royal Gwent Hospital Newport
Cardiff & Vale University Health Board	University Hospital of Wales, Cardiff	University Hospital Llandough, Vale of Glamorgan
Cwm Taf Teaching Health Board	Royal Glamorgan Hospital, Llantrisant	Ysbyty Cwm Cynon, Mountain Ash Ysbyty Cwm Rhondda, Rhondda

Of late, clinicians have revisited the option appraisal undertaken in 2014 to confirm its validity as the basis for engagement/consultation. A letter confirming that position is awaited however there is anecdotal evidence to suggest there is consensus that this remains valid for the purposes of engagement.

Requirements on managing change in NHS Wales

The guidance on changes to NHS services in Wales proposes a two stage process to the management of change that requires consultation and engagement. It should be noted that there is also provision in the guidance for the management of urgent temporary change which is a situation that applies to Cwm Taf Morgannwg who had to make this arrangement for Vascular services during Covid19 as the service became unsustainable. The proposals set out below seek to enable good governance and management of the change as well as enabling the temporary arrangements in place for Cwm Taf to be formally engaged and consulted upon.

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

The development of the proposed model and changes are much needed to ensure that we can all provide a safe and sustainable service for our patients.

This is a great example of collaboration between Health Board providers and work has continued at pace and with good engagement from all providers during the pandemic.

There is a robust and detailed programme of work that needs to be delivered over the next six months which will be challenging for the teams during the current environment however I am confident that the overarching programme is delivering on time, with good support and leadership.

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

Proposal for the management of engagement and potential consultation

Over the past two years programme arrangements have been developed around vascular surgery and most recently, an engagement and consultation work-stream has been formed as part of the overall governance structure.

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

Organisations that need to be part of the consultation and engagement are Aneurin Bevan University Health Board, Cardiff and Vale University Health Board, Cwm Taf Morgannwg Teaching Health Board and Powys Teaching Health Board, as commissioners of these services for their local population. It will also be the responsibility of these organisations to lead the programme of engagement and consultation in their respective areas, however overall co-ordination will be held within the programme structure.

Focus of consultation and engagement

Further to the decision made by Joint Executive Board for a two stage process, a workshop was held on 17 November 2020 to agree the scope of the engagement and consultation and also to have discussions that would inform the gaps in a skeletal draft consultation document.

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

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

It was however noted that given the extensive work that had been undertaken on a clinical option appraisal and formulation of ideas regarding a hub and spoke model of delivery, that this information should also be shared at the engagement phase, so as to offer as much information as possible, in order to explore with members of the public, and interested stakeholders views on the process that has been followed and whether there is any other information that should be considered. To confirm this as the basis of the exercise, clinical colleagues were asked to revisit the clinical option appraisal, and confirm that the conclusion remained valid for the current time. Confirmation was given that the option appraisal remained relevant, and in fact that the preferred option had now been strengthened since the location of the Major Trauma Centre was identified at University Hospital Wales.

As this approach goes beyond the normal parameters of an engagement process, questions that are posed to support the discussion on the *future configuration of vascular services in South East Wales* are proposed as:

- From reading this discussion document, do you have a good understanding of what vascular services are?
- From reading this document, do you understand how services are currently organised
- From reading this document, do you have an understanding of the challenges that are currently facing vascular services?
- Is there any other information you think we should consider in order to decide whether we should move towards a networked arrangement for Vascular services in South East Wales?
- Do you agree/disagree with the national evidence and recommendation from the clinical option appraisal that a hub and spoke model would improve vascular services and patient outcomes in South East Wales?
- What are your thoughts on the hub being identified as the University Hospital of Wales Cardiff given the dependencies on other services that are located there?

- Would you agree/disagree that spoke arrangements need to have a consultant led ED and an emergency surgery response on site?
- Subject to your view on the above, would you agree/disagree with the suggested spoke arrangements?
- Do you have a view on the options that have been considered as part of this, are there others we should consider?
- Do you have any thoughts on the process that has been followed to date to consider the future configuration of vascular services in South East Wales?
- Do you have an alternate view on the proposals put forward within this document for the configuration of services?

A draft discussion document for purposes of engagement is attached at Annex A. (Note the inclusion of a jargon buster, a questionnaire and an equalities impact assessment as part of the pack). A summary document is attached at Annex B.

Potential Timeline

The consultation needs to be signed off by all individual Health Boards and be discussed with the Board of CHCs/local CHCs. This means a complex governance arrangement to navigate with Board dates being key dependencies. The following sets out the next available dates:

ORG	DEADLINE	ACTUAL
Board of CHCs	By COP Friday 8th January	13th January 2021
Aneurin Bevan University Health Board	Approx 2 weeks prior	27th January 2021
Cardiff & Vale University Health Board	Approx 2 weeks prior	28th January 2021
Cwm Taf Morgannwg Teaching Health Board	Approx 2 weeks prior	28th January 2021
Powys Teaching Health Board	Approx 2 weeks prior	27th January 2021

Based on these dates the following timeline is possible, subject to appropriate resourcing:

Preparation of engagement materials	Mid December 2020
Draft shared and signed off at vascular steering group	23rd December 2020
Informal testing of approach with local CHCs and members of vascular governance structure	End of December
Vascular joint Exec Board (for decision and approval)	06 January 2021
Agreement of final process at Board of CHCs	13th January
Board considerations	27th and 28th January 2021
Translation (approx. 2 weeks)	Mid Feb

Commence engagement	15th February 2020 - 29th March (6/8 weeks)
Outcome of engagement to Boards & CHCs and approval to move to consultation	Board of CHCs 14thApril 2021 ABUHB 26th May 2021 CTMTHB 27th May 2021 CVUHB 27th May PTHB 26th May 2021
Subject to approval from Boards to proceed – translation (approx. 2 weeks)	Mid June
Commence consultation	June 18th 2021 (period of 8 weeks)
Consultation ends	August 13th 2021
Analysis and mitigations	End of August
Back to CHCs	Date to be received
Back to Boards	September Boards

It will be important to keep an open dialogue between Health Boards and CHCs throughout.

Stakeholder profiling and release

All Health Boards have well established mechanisms through which they enable cascade and delivery of engagement and consultation materials and these will be used for this programme too. There are also national groups and professional bodies that would need opportunity to engage and consult and these are being profiled within the programme. Given that the engagement and consultation will be happening within a Covid19 context, different ways of engaging the population will need to be established and ***could*** include, virtual drop-ins, facebook lives, videos etc.

One of the biggest challenges to ***all*** organisations at the current time, is the ability to engage people who are not connected electronically (digitally excluded). It is suggested that in this regard, that a letter and hard copy of the discussion document is shared with existing patients and a telephone number offered for contact and discussion. As people are still attending super markets, there is also potential to put a flier in the community board section offering a telephone number contact too (this is likely to mean 'call back' from a member of the project team, rather than immediate discussion).

A stakeholder management plan is attached at Annex C

Products required

The following products will be required to support the engagement:

- Stakeholder profile and plan
- Core engagement document (Welsh and English)
- Summary engagement document (Welsh and English)
- Presentation

- EQIA
- Frequently Asked Questions list
- Questionnaire
- Videos
- Opportunities for virtual and telephone engagement (as outlined above)

CHC Considerations

The affected Community Health Councils considered together, the proposals at their meeting of 13th January 2021. There was explicit support expressed by both Cwm Taf Community Health Council and Aneurin Bevan Community Health Council, with further discussions to take place within both Powys and South Glamorgan CHCs. A verbal update on these positions should be available at the Board meeting.

Resourcing considerations

The development of a vascular network delivered through a hub and spoke model is the preferred option for clinicians across the South East Wales region. All Health Boards are committed to considering this and will as appropriate reflect that commitment within their IMTP and annual financial planning processes.

Engagement costs will be split between Health Boards. There is an element of risk to the availability of resource, both within the programme and at Health Board level to implement the arrangements at pace, however this is being worked through with new posts due to come on line shortly.

Conclusion

Clinical discussion has been underway for many years regarding the future configuration of vascular services. A proposal has been developed and is subject to appropriate engagement and consultation in line with the guidance on NHS service changes in Wales. A cross Health Board process has been designed, the content of which has been set out in this paper and supporting documentation attached.

Recommendation:

Members of the Board are recommended to:

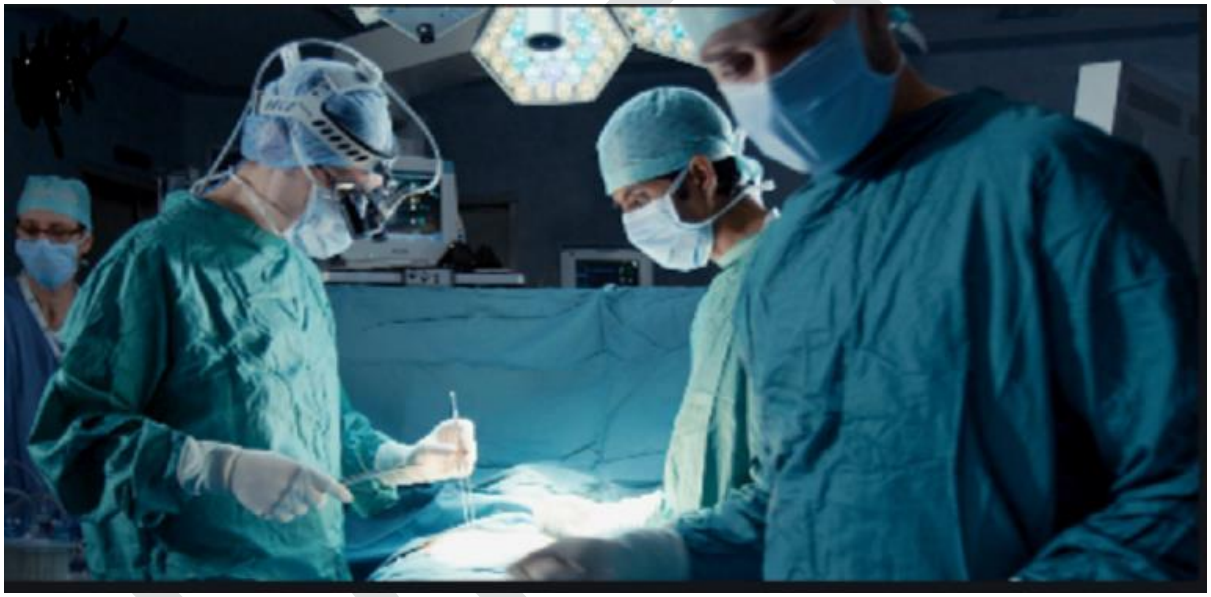
- Note the background, history and longevity of clinical discussions in respect of vascular surgery in South East Wales
- Consider the proposed focus of engagement and the process designed to enable it
- Consider the documentation prepared to support a discussion on the future configuration of vascular services in South East Wales
- Support the proposed timeline
- Agree to receive the outcome of the engagement back to the May meeting of the Board (or alternate should any programme slippage arise)

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

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

Equality and Health Impact Assessment Completed:	Yes *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

THE FUTURE PROVISION OF VASCULAR SERVICES FOR THE POPULATION OF SOUTH EAST WALES : A DISCUSSION DOCUMENT



Aneurin Bevan University Health Board

Cardiff & Vale University Health Board

Cwm Taf Morgannwg University Health Board

Powys Teaching Health Board

CONTENT

APPENDICES

FOREWARD FROM CHAIR OF THE VASCULAR JOINT EXECUTIVE BOARD AND CHIEF EXECUTIVES OF THE 4 HEALTH BOARDS IN SOUTH EAST WALES.

To be scripted following agreement of document

1. INTRODUCTION

This document is being shared with people across South East Wales, to start a conversation about how Vascular services are organised in the future. It aims to share information and gain your views about :

- What vascular services are
- Which people may be in need of vascular care
- How vascular services are currently provided
- The challenges facing vascular services
- The options we have started to consider about how we could respond to these challenges
- A preferred way for organising services
- What may be the advantages and disadvantages of any future changes

After considering the issues contained within the paper, we hope you will share your views, thoughts and ideas with us. We have offered a questionnaire at the end of this document, but should you wish to tell us about issues that are broader than this, please do not hesitate to do so.

Your responses should be with the team co-ordinating this by xxx/xxx/xxx.

You can respond by:

E-mail	*Need to set up a dedicated e-mail address (who will manage)*
Post	*South East Wales Vascular Programme* *Woodland House* *Maesycoed Road* *Cardiff* *CF14 4HH*

Following this period of engagement, we may need to enter a more formal period of consultation about the services. If you would be interested in continuing the conversation with us, please let us have the best contact details to keep you engaged with the conversation.

We recognise that this document will have some medical terms associated with Vascular surgery within it. We have added a 'Glossary of Terms' to the end of the document to help with this.

We have also completed an equality impact assessment which you can view at appendix C. We will use the information gained through the engagement process to increase our understanding here.

2. WHAT ARE VASCULAR SERVICES?

Vascular disease is any condition that affects the network of your blood vessels. This network is known as your **vascular** or circulatory system. The main aim of vascular services is to reconstruct, unblock or bypass arteries to restore blood flow to organs. These are often one off procedures, to reduce the risk of sudden death, prevent stroke, reduce the risk of amputation and improve function. Vascular services are also provided to support patients with other problems such as kidney disease

Vascular disorders can reduce the amount of blood reaching the limbs, brain or other organs, causing for example severe pain on walking or strokes. Additionally vascular abnormalities can cause sudden, life threatening, blood loss if abnormally enlarged arteries burst. Vascular specialists also support other specialties, such as major trauma, cardiology, diabetic medicine, stroke medicine, kidney dialysis and chemotherapy.

The core activities of vascular specialists are:

- Preventing death from abdominal aortic aneurysm (AAA);
- Preventing stroke due to carotid artery disease;
- Preventing leg amputation due to peripheral arterial disease;
- Symptom relief from peripheral arterial and venous disease;
- Healing venous leg ulceration;
- Promoting cardiovascular health;
- Improving quality of life in patients with vascular disease;
- Assisting colleagues from other specialties with the control of vascular bleeding;
- Providing a renal access service for patients requiring haemodialysis.

Aneurin Bevan University Health Board; Cardiff and the Vale University Health Board; Cwm Taf Morgannwg University Health Board and Powys Teaching Health Board have worked together for a number of years to discuss the best way of delivering vascular services, and already have a number of shared arrangements already in place (eg out of hours rota) We are therefore collectively talking to you about the future of vascular services, following which we may enter a period of more formal consultation on the services.

3. WHO NEEDS THESE SERVICES?

The prevalence of vascular disease increases with age. Average life expectancy continues to rise especially in males. This suggests that demand for vascular services is likely to increase over time. There are currently an estimated 200,000 people with diabetes mellitus in Wales, and prevalence is increasing.[1] Vascular disease is the major cause of morbidity in diabetes and the risks of disease progression are higher, with an epidemic of diabetic foot disease expected in the next decade.

Risk factors for vascular disease include:

- Being over the age of 50
- Smoking
- Being overweight
- Having abnormal cholesterol
- Having a history of cerebrovascular disease or stroke
- Having heart disease
- Having diabetes
- Having a family history of high cholesterol or high blood pressure
- Having high blood pressure
- Having kidney disease or haemodialysis

Early diagnosis is key to successfully treating vascular related disease. Patients will be admitted with a variety of both emergency and planned vascular conditions and not all patients will go on to require a complex surgical or interventional radiology procedure. Emergency care is immediate treatment to save a life or limb, urgent care is planned treatment within a limited number of days.

Patients who receive vascular services may have:

- Had a stroke and are at risk of having further strokes
- Blocked arteries in the legs causing pain which may deteriorate further and threaten the leg
- A bulge in the wall of the body's main artery which needs repair to prevent it rupturing
- Untreated or untreatable arterial blockages which mean they need a limb amputation

Not all patients admitted to a specialist service will need a complex surgical or interventional radiology intervention, however due to the nature of their condition, these patients need specialist assessment and care provided in a specialised vascular unit.

Vascular services are provided to the populations of South East Wales with the exception of Bridgend who receive care from the South West Wales vascular network. This is a population of approximately 1.6 million people.

To give a sense of demand for services, the following shows activity across the Health Boards for the 2019 year:

Matric	Period	Aneurin Bevan University Health Board	Cardiff & Vale University Health Board	Cwm Taf Morgannwg University Health Board	Powys Teaching Health Board	South East Wales Total
Population		600,000	472,000	450,000	132,500	1,654,500
Total Outpatient Appointments	**2019**	**830**	**2391**	**2340**	**N/A**	**5561**
New Patients	2019	462	867	1181	N/A	**2510**
Follow ups	2019	368	1524	1159	N/A	**3051**
Total number of Cases/ Procedures	2019	456	437	355	N/A	**1248**

- Powys has a population of 132,500 people of which around 40,000 people in South Powys are served by vascular services in South East Wales. Other parts of Powys will be served by vascular services in other parts of Wales and in England.
- Activity data is collected on the basis of provider Health Board rather than place of residence. Activity for South Powys residents is therefore included within the provider activity for other health boards."

4. HOW ARE SERVICES CURRENTLY PROVIDED?

National Context

Across the UK Vascular services have been reconfigured into a 'hub and spoke' integrated regional networks as a result of a number of recommendations and published evidence of the Department of Health (DH) in England, the Vascular Society of Great Britain and Ireland (VSGBI), the Royal College of Radiologists (RCR). Evidence shows implementation has led to improved clinical outcomes following these changes, with reduced waiting times for patients and an improved ability to attract and retain staff ensuring these services are more sustainable in the long term. Most recently North Wales implemented an integrated network model with Ysbty Glan Clywd as a single for major arterial surgery in 2019 which means that South East Wales are now one of the last regions to form a hub and spoke network model.

The last few years have seen great changes in vascular services in the UK, partly stimulated by challenges such as poor surgical outcomes and the introduction of national screening for Abdominal Aortic Aneurysm (AAA), but also endorsed by a specialist group trying to improve its quality and performance. This has meant a contraction of the service into a smaller number of higher volume centres to improve outcomes. Whilst complex in-patient work is concentrated in a single network centre, outpatient and outreach services for the entire network are provided locally so that patients attending smaller network hospitals are not disadvantaged.

Since 2001, the Vascular Society of Great Britain and Ireland (VSGBI) has funded and maintained a registry of index arterial procedures (National Vascular Registry – NVR). In 2008, data from the previous five years in the UK were included in a European report (Vascunet), that suggested the UK had the worst elective abdominal aortic aneurysm (AAA) mortality rates in Europe (7.5% versus 3.5% European average). These data were supported by similar results from the Vascular Anaesthesia Society audit and the Intensive Care Database. The main conclusion was that many patients were being treated in small UK centres undertaking a limited number of AAA repairs, with poorer outcomes. Studies have consistently shown that higher volume centres produce better outcomes for many surgical procedures, and this is well recognised for aortic aneurysm surgery. The conclusion was that concentrating aortic surgery in higher volume centres should improve surgical outcomes. Subsequently similar conclusions

regarding improved outcome for patients have been drawn with regard carotid surgery and lower limb revascularisation.

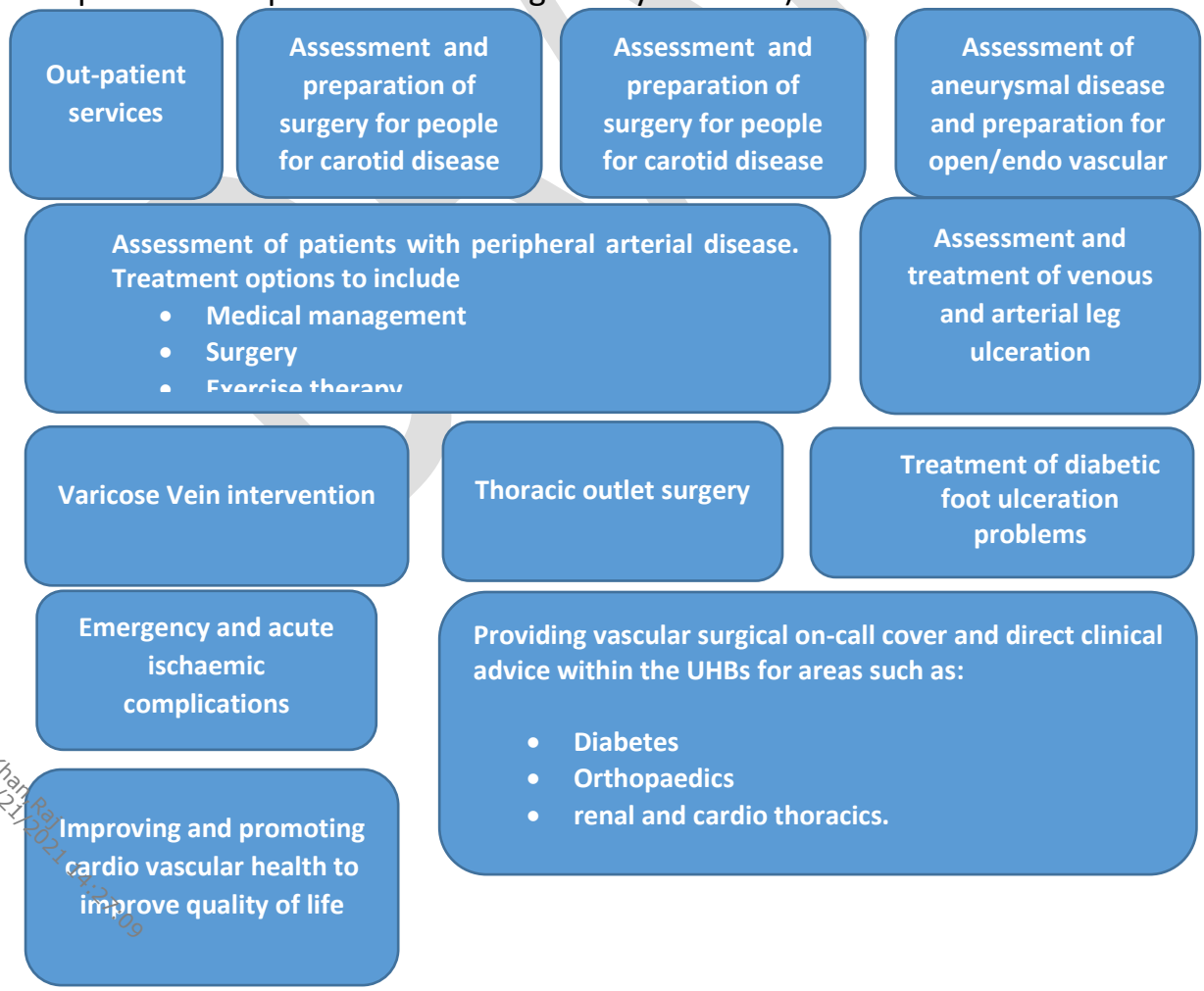
Local Context

Collectively, Aneurin Bevan University Health Board, Cardiff and the Vale University Health Board and Cwm Taf Morgannwg University Health Board provide Vascular services to the following populations:

ANEURIN BEVAN	CWM TAF MORGANNWG	CARDIFF & THE VALE OF GLAMORGAN	POWYS
Blaenau Gwent	Rhondda	Cardiff	S. Powys
Caerphilly	Cynon	Vale of Glamorgan	
Monmouthshire	Taff Ely		
Newport	Merthyr Tydfil		
Torfaen			

- *Note that the population of Bridgend is served by the South West Vascular network*

A summary of the services that are provided is offered here (you can find a simplified description of all in the glossary of terms):



To deliver these, each Health Board has full access to:

- A vascular team that comprises vascular surgeons, vascular anaesthetists, vascular interventional radiologists, clinical nurse specialists, podiatrists, tissue viability nurses, physiotherapists, occupational therapists, social workers, pharmacists and members of the prosthetics team. The teams are used to working across Health Board boundaries.

- A dedicated vascular ward. There is a provision for inpatient facilities along with day case access for various veins and minor day case surgery. Outpatient clinics are held in each Health Board area.

- Access to Doppler ultrasound, Computer Tomography (CT) and Magnetic Resonance (MR) Angiography..

- Vascular clinics within their area and has weekly interventional radiology clinics in which patients are consented for interventional radiology procedures.

- An interventional radiology suite with high quality rotational fluoroscopic imaging, in a room which is equipped for a full range of anaesthetics. The rooms can be used for endovascular aneurysm repair, combined vascular surgery and interventional radiography techniques.

- Day Case and Short Stay Facilities for minimally invasive varicose veins procedures are performed under local anaesthetic.

- Operating Theatres

- Vascular team access to a critical care unit

- Pathways in place for those patients presenting with critical limb ischaemia (CLI)

- Out of hours arrangements (which are already managed across Health Board sites). Normally, vascular patients are referred to the admitting general surgical on call team and depending on the urgency, the patient is either assessed by the emergency surgeon or referred directly to the vascular surgeon.

- In hours interventional radiology.

- Out of hours interventional radiology which is managed via an on call rota, meaning that outside of normal working hours, the patients are admitted by the on call surgical team at UHW and assessed. If emergency interventional radiology input is required, the case is discussed with the vascular surgeon on for the region, who will in turn contact the on call interventional radiologist.

It should be noted however that at the time of writing, temporary arrangements have had to be put in place to support Cwm Taf Morgannwg whose vascular service has recently become unsustainable. There are therefore temporary arrangements in place with services being provided to patients from Rhondda, Cynon, Taff Ely and Merthyr Tydfil by vascular services in Aneurin Bevan University Health Board and Cardiff and the Vale University Health Board.

5. HOW DO WE PERFORM?

The National Vascular Registry (NVR).is a national clinical audit commissioned by the Health Quality Improvement Partnership (HQIP) to measure the quality of care for patients who undergo vascular surgery in NHS hospitals. It was formed in January 2013. The NVR forms part of The Vascular Society and partner organisations quality improvement programmes. Their aim is to drive up the quality of care for patients with vascular disease in the UK.

Each Health Board sends information to the NVR who then analyse this to provide information on their standard of clinical care and patient outcomes. This allows hospitals to know where they are doing well, as well as highlighting areas that they can improve.

The NVR measures currently collects information on five vascular surgical procedures:

- Repair of abdominal aortic aneurysm (AAA)
- Carotid endarterectomy
- Lower limb angioplasty
- Lower limb bypass
- Lower limb amputation

Below is the analysis of each surgical procedure for the South East Wales health boards.

- **Abdominal Aortic Aneurysm**

An **abdominal aortic aneurysm** (AAA) is a bulge or swelling in the **aorta**, the main blood vessel that runs from the heart down through the chest and tummy. An AAA can be dangerous if it is not spotted early on. It can get bigger over time and could burst (rupture), causing life-threatening bleeding

In the UK in 2019, 3445 people underwent surgery for abdominal aortic aneurysm. Of these, 80 people were from the South East Wales region. 44 were from the Aneurin Bevan University Health Board area, 21 from the Cardiff and Vale University Health Board area and 15 from within Cwm Taf Morgannwg Teaching Health Board.

The National AAA screening programme recommends that patients have treatment within 8 weeks of referral (56 days). The actual wait nationally is on average 69 days. Performance in the South East Wales region is set out below:

Metric	Period	Aneurin Bevan UHB Figures	Cardiff & Vale UHB Figures	Cwm Taf Morgannwg UHB	National
Elective Infra-renal Cases	**2019**	**44**	**21**	**15**	
Type of elective infra-renal AAA repairs	2019	64% EVAR	62% EVAR	60% EVAR	61% EVAR
Average time from assessment to procedure	2019	67	68	111	69
Average length of stay for open repair	2019	9	9	9	7
Average length of stay for EVAR	2019	1	3	2	2
Risk adjusted survival	2017-2019	98.40%	94.40%	98.20%	98.60%

The average length of stay for patients in the South East Wales region is in line with the national range.

The Vascular Services Quality Improvement rated all three health boards in South East Wales 'Green' on a green, amber, red scale for elective abdominal aortic aneurysm outcomes.

- **Lower Limb bypass for peripheral arterial disease**

Peripheral artery bypass is surgery to reroute the blood supply around a blocked **artery** in one of your legs. Fatty deposits can build up inside the **arteries** and block them. A graft is used to replace or **bypass** the blocked part of the **artery**. In the UK between 2017 and 2019, 18'090 people had a bypass of this kind. 6'807 of these were undertaken as an emergency and 11'283 as a planned procedure. Of these, 497 were in the South East Wales region.

Nationally, the average length of stay for a patient who has had a planned surgery is 5 days and average length of stay for a patient admitted as an emergency is 14. How Health Boards in the South East Wales region compare is outlined below

Metric	Period	Aneurin Bevan UHB Figures	Cardiff & Vale UHB Figures	Cwm Taf Morgannwg UHB	National
No. of Cases	**2017-2019**	**206**	**209**	**82**	
Average Length of stay	2017-2019	7	9	9	7
Risk adjusted survival	2017-2019	97.8%	96.8%	99.0%	97.6%

The Vascular Services Quality Improvement rated one of the Health Boards in the South East Wales area as green, and two of the health boards as'Amber' due to a slightly higher than expected length of stay in hospital.

- **Lower limb bypass angioplasty and stenting**

Angioplasty is a **procedure** to open narrowed or blocked blood vessels that supply blood to your legs. Fatty deposits can build up inside the arteries and block blood flow. A **stent** is a small, metal mesh tube that keeps the artery open. **Angioplasty and stent** placement are two ways to open blocked peripheral arteries. Between 2017 and 2019, 23'881 procedures of this kind were carried out across the UK. Of these 6'605 patients were admitted as an emergency, and 17'276 as planned procedures.

The number of patients across the South East Wales region during this period is recorded as 265, however there are some challenges with validation of the data in both Aneurin Bevan and Cardiff and Vale University Health Boards, .so the actual figure is likely to be much higher.

Metric	Period	Aneurin Bevan UHB Figures	Cardiff & Vale UHB Figures	Cwm Taf Morgannwg UHB	National
No. of Cases	**2017-2019**	**25**	**90**	**150**	
Average Length of stay	2017-2019	0	2	0	100%
Risk adjusted survival	2017-2019	92.50%	97%	99.30%	98.40%

The Vascular Services Quality Improvement rated One Health Board in the region as 'Green' on a green, amber, red scale for lower limb angioplasty and stenting, and two red based on incomplete data sets.

- **Major lower limb amputation**

There are occasions when the blood flow in the legs cannot be increased and an operation is not possible. In these cases, and amputation of the leg may be required. During 2017 – 2019, there were 10'022 procedures of this kind undertaken across the UK. The average length of stay for patients nationally is 23 days. All 3 Health Boards in the South East Wales region have higher lengths of stay than the national average.

Metric	Period	Aneurin Bevan UHB Figures	Cardiff & Vale UHB Figures	Cwm Taf Morgannwg UHB	National
No. of Cases	**2017-2019**	**132**	**113**	**86**	
Average time from assessment to procedure	2017-2019	8	10	37	7
Average length of stay	2017-2019	29	40	27	23
Risk adjusted survival	2017-2019	98.4%	96.2%	96.0%	95.4%

The Vascular Services Quality Improvement rated all three health boards in South East Wales 'Green' on a green, amber, red scale for lower limb amputation outcomes.

- **Carotid endarterectomy**

A **carotid endarterectomy** is a surgical procedure to unblock a carotid artery. The carotid arteries are the main blood vessels that supply the head and neck. During 2017 and 2019, there were 4'141 of these procedures carried out in the UK. The recommended time from symptom to treatment is 14 days.

75 of these patients were from the South East Wales region and were all treated underneath the minimum timescale of 14 days. The average national length of stay for patients who undergo this procedure is 2 days. 2 of the 3 Health Boards are within this range, with one reporting a higher length of stay than the national average.

Metric	Period	Aneurin Bevan UHB Figures	Cardiff & Vale UHB Figures	Cwm Taf Morgannwg UHB	National
No. of Cases	**2019**	**49**	**4**	**22**	
Median time from symptom to procedure	2019	12	8	8	12
Median Length of stay	2019	1	7	2	2
Risk adjusted stroke free survival	2017-2019	96.60%	100%	98.60%	98.10%

The Vascular Services Quality Improvement rated two of three health boards in South East Wales 'Green' on a green, amber, red scale for carotid endarterectomy outcomes. Cardiff and Vale University Health Board were rated 'Red' due to a low ascertainment rate i.e. an incomplete data set.

6. WHAT ARE THE CHALLENGES FACING THESE SERVICES?

Vascular services need to be provided in a safe and sustainable way that is consistent with National guidelines and best practice. The key challenges facing the service at this time are summarised below:

- **A growing need for the service –** There is an increasing demand on vascular services across the South East Wales region due an increasing population and worsening rates of diabetes. There are a number of issues that contribute to this:

    - **Age** - Vascular disease and its consequences increase with age. Our 65 to 84 and 85+ age groups are projected to have the largest increase by 2036, when an estimated one in four people in Wales will be aged 65 and over. These projections will have significant implications for the way in which we design and provide health (and increasingly integrated health and social care) services. With an increasing population and especially an increasing older population it is even more important that we support the people living in our communities to live long and healthy lives, free from the limiting effects of multiple chronic conditions.

    - **Diabetes –** There is a diabetes epidemic in Wales. There are more than 194,000 people over the age of 17 diagnosed with diabetes and, we estimate, a further 61,000 people living with undiagnosed Type 2. This takes the total number of people living with diabetes in Wales now to over 250,000. It is not just the raw figures that are concerning. Wales' prevalence as a proportion of its population is 7.4% - the highest in the UK and Western Europe. The number of people with diabetes has been steadily increasing and has doubled in the last 20 years. NHS Wales estimates 11% of our adult population will have the condition by 2030. This is mainly a result of the drastic increase in Type 2 diabetes. This is unsustainable, both for our health service and wider society. Vascular disease is the major cause of morbidity in diabetes and the risks of disease

progression are higher. Prevalence of peripheral arterial disease was 4.5% in the general population but increased to 9.5% in people with diabetes. It is likely that the great increase in the number of patients with diabetes over the next decade will have the biggest impact on vascular services. Many of these patients present as an emergency, and are at high risk of amputation. Prompt treatment of the infected diabetic foot can minimise the risk of subsequent amputation. Lower limb amputation is carried out more than 20 times as often in people with diabetes than it is in people without diabetes. Only around half of people who have lost a leg because of diabetes survive for two years.

Smoking - Smoking is a major cause of vascular disease and over 80% of vascular patients are current or ex-smokers. Smokers are at greater risk of complications from vascular interventions because of cardiac and respiratory co-morbidity and the longer-term success of vascular intervention is reduced in patients who continue to smoke. (HSE 2007)

- **Obesity –** Obesity and being overweight are linked to several factors that increase risk for cardiovascular disease. Almost 60% of adults in Wales are currently overweight or obese, of which 24% are obese. There is evidence of an upward trend in recent years. It is estimated that the percentage of adults who are overweight or obese will increase to around 64% by 2030 if the current pattern continues.

- **Minimum population requirements -** A minimum population of 800,000 is considered necessary for an Abdominal Aortic Aneurysm screening programme and is often considered the minimum population required for a centralised vascular service. This is based on the number of patients needed to provide a comprehensive emergency service; maintain competence among vascular specialists and nursing staff; ensure the most efficient use of specialist equipment, staff and facilities; and the improvement in patient outcome that is associated with increasing caseload. A minimum population of 800,000 would be appropriate but for a world class service a larger catchment area will be required. The population of SE Wales (the resident population of the Health Boards taking forward this proposal is approximately 1.6 million (StatsWales 2016). The current configuration of services across separate hospital sites

across South East Wales are too small to meet the quality and safety standards set out by the Vascular Society and the Royal College of Surgeons. None of the current individual units meet this requirement.

- **Meeting quality standards -** Not all units are able to currently achieve the quality indicators individually as units. These are:

    - The Vascular society recommends a vascular unit should be performing 60 elective aneurysm repairs per year. Collectively in SE Wales 99 aneurysm repairs were performed in 2019. No units individually reached the required number.
    - The Vascular society recommends a vascular unit should be performing 40 carotid endarterectomies per year. Collectively in SE Wales 75 were performed in 2019.
    - Between 2017-19 497 bypass procedures and 331 major limb amputations were performed in SE Wales

- **Workforce –** A workforce survey undertaken by the Vascular Society for Great Britain and Ireland in 2019 concluded that both the number and complexity of vascular surgery procedures per capita population is increasing year-on-year. Worldwide there is a shortage of vascular surgeons to meet increasing demand and this shortfall is significant in the UK. There are a few workforce challenges to note:

    - Vascular services need to be organised to allow reasonable volumes of elective activity to exist alongside an acceptable consultant emergency on call rota thus ensuring appropriate critical mass of infrastructure and patient volumes.

    - The vascular society recommend 1 surgeon per 100,000 of population. (it was previously 1 per 130,000 population). This would mean that South East wales should have 14 consultants supporting vascular services in the area. It actually has 9 surgeons across the 3 provider Health Boards. Seven of these cover on-call arrangements too which means there is very little opportunity to foster learning and growth in the workforce.

    - There is challenge in recruiting to vascular posts in Wales and even where appointments happen, retention proves very difficult.

- The age profile of current consultants and vascular nurse specialists makes it very difficult to succession plan.

- Disparate teams mean that there is little opportunity for people to specialise however this is something that we know would attract more consultants and specialist therapists.

- **Services spread across South East Wales –** The National Vascular Registry has shown a constant improvement in vascular surgical outcomes over the last 10 years. However, as shown above this could be improved further by concentration of services into a single arterial hub. The Getting It Right First Time (GIRFT) report showed co-location of vascular services with other specialist services such as nephrology, major trauma and interventional radiology improve outcomes. This is not currently the case within the South East Wales region.

- **Patient outcomes -** There is strong evidence that case volume influences outcomes. The 31 highest volume hospitals (which perform 57% of all elective Abdominal Aortic Aneurysm procedures in the UK) have mortality rates that are under half those seen in the 32 hospitals with the lowest volume of procedures. These data lend support to the current move towards performing major arterial surgery in larger volume units in order to further optimise outcomes. The Royal College/national professional view, is that it is no longer acceptable to provide elective or emergency vascular cover outside a fully centralised service or a formalised modern clinical network with a designated single site for all arterial interventions providing a 24/7 on-site service.

All of the issues outlined above mean that services are becoming increasingly unsustainable and could become unsafe unless changes to the way services are organised and delivered are made.

The service models emerging nationally across the UK all enable sustainable delivery of the required infrastructure, patient volumes, and improved clinical outcomes and are based on the concept of a network of providers working together to deliver comprehensive patient care pathways, centralising where necessary and continuing to provide some services in local settings. There are a number of reviews and reports that support this which include:

1. Vascular Society of Great Britain and Ireland Provision of service for patients with vascular disease (2012) http://www.vascularsociety.org.uk/library/quality-improvement.html
2. https://gettingitrightfirsttime.co.uk/wp-content/uploads/2018/02/GIRFT_Vascular_Surgery_Report-March_2018.pdf

7. WHAT OPTIONS HAVE WE CONSIDERED TO RESPOND TO THE CHALLENGES?

Our focus has to be on long term resilience and sustainability of vascular services, therefore, changes to how the services are currently being delivered will be required to ensure that everyone in need of vascular care receives it without unnecessary delay.

Our aim is to create vascular services that:

- Achieve best practice agreed by experts, to get the best outcomes for patients and the best chance of survival
- Ensure we have more doctors with the right specialist skills
- Meet national standards

The issues outlined in the previous chapter that are facing the service have been emerging over recent years. Unsurprisingly therefore, our clinicians and senior leaders have already been giving some thought to how they may respond to the challenges.

During 2014, senior clinicians across the Health Boards undertook a clinical option appraisal about the best way that services may be organised in the future. They tested the following options for future delivery which would help reduce the risks of future delivery:

Option 1	**Do nothing** – Continue to deliver all services as they are with a thin layer of regional co-ordination to share best practice
Option 2	**Centralise delivery** - All services are delivered to the three Local Health Boards by a central team, located in one of the provider Health Boards. A single site for all vascular surgery services in South East Wales.
Option 3	**Single hub and spoke model**-Some functions, services and procedures (or elements of such) are delivered at scale by a central team, within one provider Health Board – the hub. These would only be provided at this central site location for SE Wales. Other functions and services are delivered on a more local basis, through spokes.

Option 4	**Multiple hubs** - Each LHB leads on a specific function or functions within the overall service, on behalf of all LHBs across SE Wales, e.g. arterial surgery.
Option 5	**Outsourcing -** All services are provided for Health Boards in South East Wales by another provider, which is not one of the constituent Health Boards of the network, but for which the network acts as the commissioner of the service.
Option 6	**A whole of South Wales option.** Widening the scope to include that which is currently provided by the South West Wales Vascular Network, to establish a joined up network across all of South Wales. If this was a viable option at this stage of the development of both networks, this would again then open up a range of future options to be considered, including many of the above, but on a wider South Wales basis. The initial option of considering this approach in this way at this stage was worth considering however, if only to discount it at this stage.

A range of clinical and managerial staff appraised the options against the following criteria:

- Quality & Safety (highest priority)
- Acceptability
- Strategic Fit
- Sustainability (ability for the services to be fit for now and the future)
- Access
- Achievability

They also considered the growing evidence base and used this to inform the proposed future service model for vascular surgery services in SE Wales. This includes a number of recommendations and published evidence of the Department of Health (DH) in England, the Vascular Society of Great Britain and Ireland (VSGBI), the Royal College of Radiologists (RCR), the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) and all relevant NICE Guidance.

Based on considering the evidence, and a full range of issues, the outcome from the clinical option appraisal was that the most feasible option for the future

delivery of vascular services in South East Wales is considered to be a hub and spoke model, managed through a clinical network as outlined in option 3.

There are a number of areas across the UK that are already configured in this way, and a number of reports and recommendations that support a networked arrangement for the organisation and delivery of vascular services with strong evidence that improvement to outcomes for patients undergoing vascular surgical procedures are seen as a result of centralising vascular surgery to a Major Arterial Centre. A more detailed description on the way we may organise delivery against a hub and spoke model is outlined in the following chapter.

8. PROPOSED SERVICE MODEL

There is strong National and International evidence that patients who need vascular interventions will receive a better quality of care and have a better chance of survival when they are treated and cared for by specialists (including vascular surgeons, interventional radiologists, nurses and therapists) who see a large number of these patients, which helps specialists to develop and maintain expertise in their field of work.

Based on considerations over recent years, there is good clinical consensus to proposed that if supported, the new vascular service will be based on a hub and spoke model and will have:

- Diagnosis and assessment of vascular disease (including the input of the vascular laboratory and diagnostic imaging);
- Outpatient management of patients with peripheral arterial disease;
- Inpatient spells, emergency and elective activity;
- Day case activity;
- Multidisciplinary outpatient follow up of patients receiving vascular surgery/endovascular interventions;
- Seamless repatriation of patients following rehabilitation care pathways particularly for post amputation care;
- Limb Fitting Service – the vascular service must ensure its patients have access to a local limb fitting service, which meets the standards set by The British Society of Rehabilitation Medicine.
- A dedicated vascular day case facility in both hub & spoke to allow day case surgical & interventional radiology procedure.

It is proposed that the hub and spokes have the following components:

HUB	SPOKE
➢ Emergency Vascular Service: • Amputations and "*nibbling*" • Aneurysm surgery;	➢ Emergency Vascular Service:- • Angioplasty; • Angiogram;

• Patients requiring CEA within 48 hrs of index event; • Peripheral arterial reconstructions.	• As noted above, the "front door" will remain the patient's local hospital, defined as a Local Hospital with an Emergency Department and an Emergency General Surgery Service; • Rehabilitation.
➢ **Elective Vascular Service:** • Abdominal Aortic Aneurysm • Endovascular aneurysm repair • Carotid endarterectomy	➢ **Elective Vascular Service:-** • Venous surgery angiography and angioplasty; • Outpatient clinics

Based on this, the main procedures that are expected to transfer from each of the current sites to any future hub are the following:

- ➢ Iliac and femoral artery procedures
- ➢ Carotid
- ➢ Open Abdominal Aortic Aneurysm
- ➢ Endovascular Abdominal Aortic Aneurysm
- ➢ Open Thoracic Aortic Aneurysm
- ➢ Thoracic endovascular aortic repair (TEVAR)
- ➢ Operations on vena cava
- ➢ Other artery.

To achieve delivery, there will be a number of infrastructure requirements for both the hub and the spoke:

HUB	**SPOKE**

➢ Dedicated vascular surgery ward(s). Beds will need to be staffed by an appropriate skill mix of nurses who have been trained in the care of vascular patients. Doppler investigation will need to be available on the ward; ➢ Hybrid theatre, with experienced vascular theatre staff; ➢ Scheduled elective lists (IP / DC); ➢ Anaesthesia – elective vascular services will have dedicated vascular anaesthetic input, from anaesthetists experienced in dealing with vascular patients and with a special interest in this area. This may include anaesthetists from Spoke sites given the opportunity to support elective lists in the hub; ➢ Intensive Treatment Unit (ITU) and High Dependency Unit (HDU) – Facilities with full renal support must be available on-site to support the vascular service. Bookable HDU/ITU with sufficient beds will need to be available for elective patients ➢ Interventional radiology suite with access to nursing staff trained in vascular procedures.	➢ Mixed surgical wards but with ring fenced vascular beds; ➢ CEPOD theatre model; ➢ Interventional radiology; ➢ Scheduled elective DC lists; ➢ Outpatient Clinics – including access to nurses/therapists experienced in ulcer and wound dressing. Doppler ultrasound machines should be available. To support this, it is also assumed that each of the spoke sites will have the following: ➢ A consultant led Emergency Department (A&E); ➢ An Emergency General Surgery service.

➢ Out-patients clinics	

Given the range of services already in situ on the University Hospital Wales site, its position as a specialist and tertiary provider, and the co-dependencies between them and the vascular service, particularly major trauma, interventional cardiology and cardio-thoracic surgery, the preferred option for the hub is identified as the University Hospital Wales, Cardiff. Given the need for consultant led A&E and a general surgery emergency service, the spokes for each of the areas are proposed as:

- **Aneurin Bevan University Health Board** – Grange University Hospital and Royal Gwent Hospital
- **Cwm Taf Morgannwg Teaching Health Board** – Royal Glamorgan Hospital, Llantrisant
- **Cardiff and Vale University Health Board** – Llandough Hospital Vale of Glamorgan

It is important to note that the majority of pre and post operative care will continue to be provided locally. There are a few patient stories outlined below that help illustrate this.

Patient 1 : Mrs Edmunds

Mrs Edmunds is an 81 year old lady who has lived in Crickhowell all her life. Ten days ago, while getting ready for bed, her husband noticed that she was slurring her words and her right arm seemed clumsy and weak. Worried that his wife was having a stroke Mr Edmunds dialled 999 and Mrs Edmunds was taken to Grange University Hospital by ambulance.

On admission to hospital she was assessed by the Acute Stroke Team and underwent a CT scan of her brain and the next day underwent an ultrasound scan (duplex scan) of her carotid arteries (these are the arteries in the neck that supply the brain). The duplex ultrasound scan showed that Mrs Edmunds had a 90% narrowing in her left carotid artery. The Acute Stroke Team told Mr Edmund's that he had done exactly the right thing.

The Stroke Physican telephoned the Vascular Surgical Regional Coordinator on the same day that the duplex scan was performed. After discussion with the duty Vascular Surgeon Mrs Edmunds was offered the choice between an operation at University Hospital of Wales (UHW) to "clear out" the blockage in her carotid artery (carotid endarterectomy) or

continuing with medication. The Vascular Surgeon at UHW felt that, on balance, the operation would reduce her risk of stroke more than medication alone.

After discussion with her husband Mrs Edmunds decided that she would like to go ahead with surgery. She was transferred to Cardiff as a "day of surgery admission" and underwent left carotid endarterectomy under local anaesthetic. As is usually the case, she made an uncomplicated post-operative recovery and was allowed to go home to Crickhowell the next day. She was offered the choice of a telephone follow up consultation or a clinic appointment with a vascular surgeon at Nevill Hall Hospital in Abergavenny 6 weeks after the operation. At follow up she had fully recovered from her stroke and had made a good recovery from her operation.

Patient 2 : Mr Evans

Mr Evans is a 71 year old retired postman from Newport. He saw his GP because of sudden onset, 2 days previously, of pain in his right calf on walking. He could walk about 30 meters but then had to stop and rest because of the pain. The pain was relieved by rest. He described the pain to his GP as being "like severe cramp".

Because of the sudden onset of this pain the GP called the Vascular Surgical Regional Coordinator. Mr Evans was previously well, he had given up smoking 30 years ago and was not diabetic. The Coordinator arranged for Mr Evans to be seen in the Vascular Surgical "Hot Clinic" at Gwent Vascular Institute in Royal Gwent Hospital in Newport the following day. The coordinator also arranged for a CT scan of the arteries in Mr Evan's leg to be performed an hour before his clinic appointment.

Mr Evans was seen, with the result of his CT scan by a Consultant Vascular Surgeon. On further questioning the Vascular Surgeon discovered that Mr Evans had some numbness in the toes of his right foot. This numbness had been present and constant since the onset of the calf pain 3 days ago. The CT scan showed that there was an abnormally dilated artery behind Mr Evan's right knee (a popliteal artery aneurysm) and that there was a lot of thrombus (blood clot) in the abnormally dilated artery.

The Vascular Surgeon showed the CT images to Mr Evans to help explain what the problem was. He then informed Mr Evans of the choices with regard to management of his symptomatic popliteal artery aneurysm. Since there was a 1 in 4 risk of lower limb amputation if the aneurysm was not operated on, Mr Evans agreed that surgery was the best option. The Vascular Surgical Regional Coordinator arranged for Mr Evans to be admitted to University Hospital of Wales (UHW) in Cardiff under the Vascular Surgical Service from clinic. The next day an operation was performed to fix the popliteal artery aneurysm through an incision behind his knee.

Mr Evans made a good recovery after his operation. After input from the physiotherapists Mr Evans was allowed to go home 3 days after his operation. He was followed up 6 weeks

later by a Vascular Nurse Specialist at Royal Gwent Hospital who noted that his surgical wounds had healed well and his symptoms had all resolved.

Patient 3 Mrs Richards

Mrs Richards is a 45 year old teacher from Pontypool. During the summer she thinks that she suffered a nasty insect bite just above her left ankle on the inside of her leg, while having a BBQ. This was approximately 4 months ago. Over this time the "insect bite" became badly inflamed on 2 or 3 occasions. The GP treated her with antibiotics but, despite this, she developed an ulcer at the same site as the suspected insect bite.

The GP referred her to the South East Wales Vascular Network because of the lower limb ulcer. Mrs Richards was given a telephone appointment with a Consultant Vascular Surgeon 2 weeks later. Over the telephone the Vascular Surgeon found out that Mrs Richards left leg had been "a bit swollen" for 2 or 3 years. She also told the surgeon that she had had varicose veins affecting her left leg since the birth of her 2 children. The varicose veins had never really bothered her and she had never mentioned them to her GP.

The Consultant Vascular Surgeon explained, over the telephone, that the varicose veins were probably contributing to the leg swelling and the ulcer. Between them Mrs Richards and the Consultant Vascular Surgeon arranged for an ultrasound scan of the leg to be performed at Royal Gwent Hospital to investigate her veins. On the same day as the scan she was reviewed by a Vascular Nurse Specialist at Royal Gwent Hospital. The scan showed that Mrs Richards had a fairly typical pattern of varicose veins. The Nurse explained that by treating the varicose veins, the ulcer would heal more quickly and would be less likely to recur. The Vascular Nurse Specialist also gave Mrs Richards a prescription for moisturising cream and support stockings to help improve the condition of the skin on her left leg.

Following discussion and explanation of the different treatment options available for varicose veins Mrs Richards and the Vascular Nurse Specialist agreed that a minimally invasive procedure (Radiofrequency Ablation/Endothermal Ablation) would be the most appropriate way to treat the varicose veins in Mrs Richard's case. Radiofrequency ablation of the left varicose veins was performed for Mrs Richards 8 weeks later. This procedure was performed at Royal Gwent Hospital as a "walk in – walk out" procedure under local anaesthetic. By the time she attended for the treatment the ulcer was well on the way to healing thanks to the moisturiser and support stockings.

Mrs Richards was not given a routine follow up appointment but was given a card with the contact details for the vascular nurse specialists at Royal Gwent Hospital in case she needed them. She made a good recovery and was delighted with the result of her treatment. She did not need to contact the Vascular Surgical Unit again.

Patient 4 : Mr Williams

Mr Williams is a 78 year old retired builder from Treorchy. He was generally fit and well but needed admitting to Royal Glamorgan Hospital after becoming increasingly short of breath. After investigation by the Care of the Elderly Medical Team he was found to have pneumonia and dehydration. He was started on a drip to give him fluid as well as intravenous antibiotics.

At 11 o'clock at night he complained to his nurse that his right hand had suddenly become painful and cold and he had noticed that his arm and hand were weak. The ward doctor examined him and found that as well as the coldness and weakness the hand was pale and the doctor couldn't feel any pulses in Mr Williams's right arm. The ward doctor did some blood test and arranged for an electrocardiogram (ECG) to be performed. The ECG showed that Mr Williams had developed an irregular heartbeat, probably as a result of the pneumonia and dehydration. The ward doctor wondered if Mr Williams had "thrown a clot" (an embolus) down the arteries to his right arm. With this in mind he telephoned the on call Vascular Surgical Registrar for advice.

The Vascular Surgical Registrar arranged emergency ambulance transfer for Mr Williams from Royal Glamorgan Hospital to the Vascular Surgical Unit at University Hospital of Wales (UHW) in Cardiff. Before the journey Mr Williams was given an injection of blood thinning drugs. When he arrived at UHW Mr Williams was taken straight to the CT scanner where a scan of the arteries in his right arm was performed. This scan confirmed an arterial embolus.

Because his arm was profoundly ischaemic Mr Williams was taken to theatre that night to remove the blood clot from the arteries in his right arm. The operation was performed under local anaesthetic by the on call Consultant Vascular Surgeon and the On Call Vascular Surgical Registrar. The operation was successful. Apart from some bruising around the surgical incision the arm and had were pink, ward and working normally. Mr Williams was relieved and delighted.

Because he was still recovering from pneumonia Mr Williams was transferred back to Ysbyty Cwm Rhondda Hospital on the following day by ambulance. This made it a lot easier for his son and daughter to visit him as he recovered from his pneumonia in his local general hospital.

Patient 5 : Mr Roberts

Mr Roberts is a 70 year old gentleman from Penarth who had a small Abdominal Aortic Aneurysm (AAA) diagnosed 5 years ago, when he was invited to attend the Welsh Abdominal Aortic Aneurysm Screening Programme at the age of 65. At his last, scan earlier in the week, he was told that his aneurysm now measured 56mm in diameter. He understood from the patient information sheets given to him and the conversations that he had had with the staff at the screening programme that this was the size at which interventions began to be considered to reduce the risk of aneurysm rupture.

Mr Roberts was referred to the South East Wales Vascular Network Coordinator. He was given an outpatient appointment for two weeks later. He was booked to have a CT scan of his aneurysm at 09:00 in the morning and a clinic appointment with a Consultant Vascular Surgeon at 11:00; both at University Hospital of Wales. The Consultant Vascular Surgeon showed Mr Roberts the images from his CT scan along with some diagrams to help explain what the problem was and what options were possible regarding treatment of the AAA. The anatomy of Mr Roberts's AAA meant that the "keyhole" technique of Endovascular Aneurysm Repair (EVAR) was not likely to be successful. Mr Roberts and the Vascular Surgeon agreed that Open Surgical Repair (OSR) of his AAA was preferable to continuing with conservative management. Mr Roberts understood that Open Surgical Repair of an Abdominal Aortic Aneurysm was major surgery. He understood the risk of surgery had read that the results of this operation were better when it was done in centres that performed a lot of these operations. He was therefore relieved and pleased to find out that the operation would be performed at The Major Arterial Centre at UHW in Cardiff. He understood that he would probably need to be in the Intensive Care Unit in Cardiff for a day or two after his operation. All being well he was told to expect to be in hospital for between 7 and 10 days.

The Vascular Network Coordinator arranged for Mr Roberts to have an Echocardiogram and a bicycle test (Cardio Pulmonary Exercise Test CPET) to assess his fitness for surgery. Four weeks after his referral both these tests were performed at University Hospital of Wales. Mr Roberts was then seen by a Consultant Anaesthetist to further explain the risks of surgery and what was involved regarding an anaesthetic for major surgery.

Seven weeks after his initial referral to the Vascular Surgical Service Mr Roberts was admitted to UHW through the "Day of Surgery Admission" unit. His operation was performed by two Consultant Vascular Surgeons and a Vascular Surgical Registrar. After his operation Mr Roberts only needed to spend one night on Intensive Care. By the third post-operative day he was recovering well. His pain was well controlled, he was eating and drinking and was walking around the ward with some help from the Physiotherapists or Ward Nurses.

After discussion with Mr Roberts it was agreed to transfer him to University Hospital Llandough, closer to home for a few more days of hospital care while he recovered from his operation. He no longer needed any specialist vascular surgical input. This transfer to Mr Roberts local hospital made it easier for his family to visit him while providing him with the medical, nursing and physiotherapy input that he needed.

Mr Roberts was discharged from University Llandough Hospital 9 days after his operation. He was followed up 6 weeks later in University Hospital Llandough by a Specialist Vascular Nurse who documented that Mr Roberts had made a good post-operative recovery.

9. ADVANTAGES/DISADVANTAGES & IMPACT

WHAT ARE THE ADVANTAGES OF THE PROPOSED CHANGES?

There are significant benefits to the model proposed:

- A sustainable delivery model that will provide the best outcomes to all patients within the region as advised by the Vascular Society. The vascular surgeons will work as a team to provide a resilient vascular surgical workforce model for the region's patients.

- Patients admitted to the 'Hub' will be nursed on a specialist vascular ward and receive daily review, including weekends, by a consultant vascular surgeon ('Consultant of the Week') working within a specialist multi-disciplinary team.

- Patients admitted to the 'Hub' will have on site access 24/7 to both vascular surgery and vascular interventional radiology.

- Aside of surgery, all other parts of a patient's treatment and rehabilitation will happen in their own area (with the exception of Powys residents who may access services from Cwm Taf Morgannwg Teaching Health Board or Aneurin Bevan University Health Board).

- Rapid access to diagnostics and interventions forms part of a high quality service. The need for this has been an important driver for centralisation, as it requires around the clock working, which larger units are better placed to provide. The units would be staffed by vascular specialists and would operate 24 hours a day, seven days a week.

- Performing all complex procedures at central units would ensure all patients have their surgery at a high volume hospital by an experienced vascular specialist, using the latest technology and techniques

- Centralisation should ensure improved facilities for patient care (dedicated vascular wards), investigation (larger radiology units with 24/7 interventional radiology) and treatment (vascular operating theatres and staff, vascular anaesthetists, improved facilities for endovascular management, better critical care).

WHAT WOULD THE IMPACT BE?

The proposals could mean:

- Patients would potentially need to travel further for their operation, as would their visitors
- Patients would be treated at a centre carrying out higher volumes of complex work, which is linked to improved outcomes
- Patients would be treated by a surgeon or interventional radiologist carrying out large volumes of complex work
- Patients would be able to access the full range of procedures 24/7

ARE THERE ANY DISADVANTAGES TO THE PROPOSALS ?

Some patients from the Aneurin Bevan and Cwm Taf Morgannwg areas will need to travel to University Hospital of Wales - rather than the Royal Gwent or Royal Glamorgan Hospitals - to receive surgery, (as they do now out of hours). Powys residents will need to go to University Hospital of Wales for their surgery rather than to the Grange University Hospital in Cwmbran.

10. HOW YOU CAN CONTRIBUTE : ENGAGEMENT AND CONSULTATION.

This is the beginning of our conversation with you about Vascular services in South East Wales. We would like to hear your thoughts about what you have read. Specifically:

- Whether you have an understanding of what vascular services are
- How services are currently provided
- The challenges facing the services and some of the options that have been considered for the future organisation and delivery of the services.

A questionnaire is attached at Annex xx to aid your response. It should be returned to

South East Wales Vascular Programme
Woodland House
Maesycoed Road
Cardiff
CF14 4HH

The date by which we would welcome your response is xx/xx/xx.

WHAT NEXT?

When this engagement exercise has ended, the 4 Health Boards will consider all of the feedback and share this with the individual Health Boards and the relevant Community Health Councils. We will also publicly make available a report that outlines a summary of what has been received. We will consider all of the issues and whether there are any mitigating actions that need to be taken. We will also use the information received to update the Equalities Impact Assessment.

Subject to further discussions with the Community Health Councils, we may wish to enter a period of formal consultation and should we do that we will once again invite your views.

APPENDIX A - GLOSSARY OF TERMS

Abdominal Aortic Aneurysm (AAA)	An **abdominal aortic aneurysm** (AAA) is a bulge or swelling in the **aorta**, the main blood vessel that runs from the heart down through the chest and tummy. An AAA can be dangerous if it is not spotted early on. It can get bigger over time and could burst (rupture), causing life-threatening bleeding
Aneurysmal Disease	An **aneurysm** occurs when part of an artery wall weakens, allowing it to balloon out or widen abnormally. The causes of **aneurysms** are sometimes unknown. Some may be congenital, meaning a person is born with them. Aortic **disease** or an injury may also cause an **aneurysm**.
Arterial Disease	A common circulatory problem in which narrowed arteries reduce blood flow to your limbs
Arterial Duplex scan	Arterial **duplex scan** is a painless exam that uses high-frequency sound waves (ultrasound) to capture internal images of the major arteries in the arms, legs and neck. A special jelly is placed on the area being examined while a wand-like device called a transducer is passed lightly over the skin above the artery.
Arterial Ulcer	**Arterial Ulcer**. An **ulcer** is simply a break in the skin of the **leg**, which allows air and bacteria to get into the underlying tissue. This is usually caused by an injury, often a minor one that breaks the skin. ... **Arterial ulcers** are often very painful, they are often on the foot, around the ankle, sometimes the lower **leg**.
Carotid Disease	**Carotid** artery **disease** occurs when fatty deposits (plaques) clog the blood vessels that deliver blood to your brain and head (**carotid** arteries). The blockage increases your risk of stroke, a medical emergency that occurs when the blood supply to the brain is interrupted or seriously reduced
Critical limb ischaemia	A severe blockage in the arteries of the lower extremities, which markedly reduces blood-flow. It is a serious form of peripheral arterial disease, or PAD, but less common than claudication. ... Left untreated, the

	complications of CLI will result in amputation of the affected **limb**.
Doppler Ultrasound scan	A **Doppler ultrasound** is a **test** that uses high-frequency sound waves to measure the amount of blood flow through your arteries and veins, usually those that supply blood to your arms and legs. Vascular flow studies, also known as blood flow studies, can detect abnormal flow within an artery or blood vessel
Endovascular aneurysm repair (EVAR)	A minimally invasive procedure in which an interventional radiologist places a covered stent (a metal mesh tube covered with fabric) into the area with the aneurysm so that blood can flow through the vessel.
Endovascular Surgery	**Endovascular surgery** is an innovative, less invasive procedure used to treat problems affecting the blood vessels, such as an aneurysm, which is a swelling or "ballooning" of the blood vessel. The **surgery** involves making a small incision near each hip to access the blood vessels.
Fluroscopic imaging	**Fluoroscopy** is a type of medical **imaging** that shows a continuous X-ray image on a monitor, much like an X-ray movie. During a **fluoroscopy** procedure, an X-ray beam is passed through the body
Interventional Radiology	A medical specialisation that involves performing a range of imaging procedures to obtain images of the inside of the body. The **interventional radiologist** carefully interprets these images to diagnose injury and disease, and to perform a range of **interventional** medical procedures
Ischaemic Complications	A restriction in blood supply to tissues, causing a shortage of oxygen that is needed for cellular metabolism (to keep tissue alive). Ischemia is generally caused by problems with blood vessels, with resultant damage to or dysfunction of tissue
MR angiography	**MR angiography** (MRA) uses a powerful magnetic field, radio waves and a computer to evaluate blood vessels and help identify abnormalities
Thoracic outlet surgery	**Surgery** for **thoracic outlet syndrome** involves decompression of the **thoracic outlet** – removal of the

	first rib or an anomalous rib, partial removal of the anterior and middle scalene muscles, and decompression of the brachial plexus. ... This operation is performed through a two-inch incision in the axilla.
Varicose Veins	**Varicose veins** are swollen and enlarged **veins** that usually occur on the legs and feet. They may be blue or dark purple, and are often lumpy, bulging or twisted in appearance. Other symptoms include: aching, heavy and uncomfortable legs. swollen feet and ankles
Vascular	**Vascular**: Relating to blood vessels. For example, the **vascular** system in the body includes all of the veins and arteries. And, a **vascular** surgeon is an expert at evaluating and treating problems of the veins and arteries.
Vascular Team	The **vascular** department is a multidisciplinary **team** who provide out-patient and in-patient care for people with diseases of the circulation
Venous Disease	When the venous wall and/or the valves in the leg veins are not working effectively

APPENDIX B - QUESTIONNAIRE

ABOUT YOU
Lead needs to design into here demographics and questions for those with protected characteristics
From reading this discussion document, do you have a good understanding of what vascular services are?
Yes ☐ No ☐ Don't Know ☐
Please comment:
From reading this document, do you understand how services are currently organised?
Yes ☐ No ☐ Don't Know ☐
Please comment:
From reading this document, do you have an understanding of the challenges that are currently facing vascular services?
Yes ☐ No ☐ Don't Know ☐
Please comment:
Is there any other information you think we should consider in order to decide whether we should move towards a networked arrangement for Vascular services in South East Wales?
Yes ☐ No ☐ Don't Know ☐
What other information would be useful for you?

Do you agree/disagree with the national evidence and recommendation from the clinical option appraisal that a hub and spoke model would improve vascular services and patient outcomes in South East Wales?
Agree ☐ Disagree ☐ Don't Know ☐
What other information would be useful for you here?
What are your thoughts on the hub being identified as the University Hospital of Wales Cardiff given the dependencies on other services that are located there?
Please share your views
Would you agree/disagree that spoke arrangements need to have a consultant led ED and an emergency surgery response on site?
Agree ☐ Disagree ☐ Don't Know ☐
Please comment or let us know what additional information would be useful here
Subject to your view on the above, would you agree/disagree with the suggested spoke arrangements
Agree ☐ Disagree ☐ Don't Know ☐

Please comment or let us know what other information would be useful here
Do you have any thoughts on the process that has been followed to date to consider the future configuration of vascular services in South East Wales?
Please comment:
Is there any other information you think we should consider in order to decide whether we should move towards a networked arrangement in South East Wales?
Yes ☐ No ☐ Don't Know ☐
Is there other information we could supply that would help here? Please comment.
Do you have a view on the options that have been considered as part of this, are there others we should consider?
Yes ☐ No ☐ Don't Know ☐
Please comment
Do you have any comments on the process that is being undertaken to consider the best configuration of vascular services in South East Wales?
Please comment

Do you have an alternate view on the proposals put forward within this document for the configuration of services ?
Yes ☐ No ☐ Don't Know ☐
Please share your thoughts

EQIA – separate attachment.

THE FUTURE OF VASCULAR SERVICES IN SOUTH EAST WALES

ANEURIN BEVAN UNIVERSITY HEALTH BOARD; CARDIFF & VALE UNIVERSITY HEALTH BOARD; CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD; POWYS TEACHING HEALTH BOARD

NHS WALES GIG CYMRU

WHAT ARE VASCULAR SERVICES?

- **Vascular** disease is any condition that affects the network of your blood vessels. This network is known as your **vascular** or circulatory system. The main aim of vascular services is to reconstruct, unblock or bypass arteries to restore blood flow to organs. These are often one off procedures, in the main, to reduce the risk of sudden death, prevent stroke, reduce the risk of amputation and improve function. Vascular services also provide support to patients with other problems such as kidney disease

WHAT ARE VASCULAR SERVICES?

- Vascular disorders can reduce the amount of blood reaching the limbs, brain or other organs, causing for example severe pain on walking or strokes. Additionally vascular abnormalities can cause sudden, life threatening, blood loss if abnormally enlarged arteries burst. Vascular specialists also support other specialties, such as major trauma, cardiology, diabetic medicine, stroke medicine, kidney dialysis and chemotherapy.

WHY ARE WE TALKING ABOUT THEM?

- There are lots of challenges facing the services which are making them difficult to run from all of the hospitals that they currently do.

- The challenges the services are facing are
  - A growing need for the service
  - Standards that say there is a need for a larger population to be served that is currently the case across our hospitals
  - Unable to meet all of the quality standards required
  - Difficulty in getting and keeping the workforce needed
  - Services are spread too thinly across South East Wales
  - Patient outcomes could be better

- We would like to join these up in a better way

- By doing so, we would have similar arrangements to those already in place in South West Wales and North Wales

WHO IS INVOLVED?

- This engagement opportunity is being jointly led by all of the health organisations that secure vascular services for their populations:
  - Aneurin Bevan University Health Board
  - Cardiff & Vale University Health Board
  - Cwm Taf Morgannwg Teaching Health Board
  - Powys Teaching Health Board
- The populations affected are:
  - Blaenau Gwent, Caerphilly, Monmouthshire, Newport. Torfaen
  - Cardiff & Vale of Glamorgan
  - Rhondda, Cynon Taff & Merthyr (Bridgend part of South West Wales Network)
  - South Powys (other parts of Powys served by South West/North Wales Networks as well as networks in England)

FOCUS OF ENGAGEMENT/CONSULTATION

The future configuration of vascular services in South East Wales

Specifically: To start a discussion with citizens across South East Wales about how Vascular services are organised in the future. It aims to share information about :

- What vascular services are
- Which people may be in need of vascular care
- How vascular services are provided now
- The challenges facing vascular services at the current time
- The options we have started to consider about how we could respond to these challenges
- Is there a preference for how we organise services?
- What may be the advantages and disadvantages of any future changes

WHO NEEDS VASCULAR SERVICES?

Patients who receive vascular services may have:

- Had a stroke and are at risk of having further strokes
- Blocked arteries in the legs causing pain which may deteriorate further and threaten the leg
- A bulge in the wall of the bodys main artery which needs repair to prevent it rupturing
- Untreated or untreatable arterial blockages which mean they need an amputation
- There are approximately 1300 appointments/operations undertaken every year in the South East Wales area

HOW ARE SERVICES PROVIDED NOW?

- Services are provided from

  - University Hospital Wales, Cardiff
  - Royal Glamorgan Hospital Llantrisant (see note below)
  - Grange University Hospital Cwmbran

At the time of writing there is an urgent temporary arrangement in place for Cwm Taf Morgannwg residents. Patients are currently being seen in either Aneurin Bevan University Health Board or Cwm Taf Morgannwg Teaching Health Board as the service became undeliverable at the end of 2020.

HOW DO WE DO?

- A measure of how well organisations do is kept and reported by the National Vascular Registry. They report against 5 key areas:

  - An **abdominal aortic aneurysm** (AAA) is a bulge or swelling in the **aorta**, the main blood vessel that runs from the heart down through the chest and tummy
  - A **carotid endarterectomy** is a surgical procedure to unblock a carotid artery.
  - **Peripheral artery bypass** is surgery to reroute the blood supply around a blocked **artery** in one of your legs
  - **Angioplasty** is a **procedure** to open narrowed or blocked blood vessels that supply blood to your legs
  - **Major lower limb amputation**

- If you are interested in learning more about this, the information is publically available at XXXXXXXX

OUR DOCTORS HAVE BEEN TALKING ABOUT THESE SERVICES FOR SOME TIME

We do ok on the outcomes but think we could do better by changing the way our services are organised

We don't have the right number of people to treat to keep the skills we need by working separately

Developing a networked arrangement for vascular services would bring South East Wales into line with other parts of Wales

It would be better if we could do all of the operations in one place to make best use of workforce and keep the right level of skill

IN FACT THEIR DISCUSSIONS GO BACK TO 2014

- Taking account National guidance and best practice, they looked at the best way to organise services

- They assessed all of the options possible against the following:

  - Quality & Safety (highest priority)
  - Acceptability
  - Strategic Fit
  - Sustainability (ability for the services to be fit for now and the future)
  - Access
  - Achievability

THEY REACHED COLLECTIVE AGREEMENT

- That the best way to provide vascular services in the future would be via a hub and spoke model.
- This would mean that all major vascular operations are done in one hospital
- It would not change people going to their local hospitals for any work/advice before an operation or after the operation for recovery and rehabilitation
- It would mean best use of skill and staff
- It would mean better outcomes for patients

HAVE WE GIVEN THOUGHT TO WHERE THE HUB MAY BE?

- Yes – there are lots of things to consider which include the need for a range of other services to be on the same site (eg Major trauma services)

- Having considered these and the location of those other services, the only viable option for a hub is University Hospital Wales, Cardiff

WHAT ABOUT THE SPOKES?

- Spoke hospitals will be maintained at:
  - Royal Gwent Hospital and Grange University Hospital
  - Royal Glamorgan Hospital
  - Llandough University Hospital Wales
- Rehabilitation will continue to take place through all communities and local hospitals across the region

TELL US WHAT YOU THINK …..

- The document you have just read is a summary of a much larger piece of work. If you are interested in more detail you can access it via xxxxx
- We'd like to hear your thoughts on the information we have shared.
- If you would like to have your thoughts know, please send them to (insert details) by xxxx
- There are some questions that follow which we would really like a view on, but please don't let that prevent you from telling us anything more

VASCULAR ENGAGEMENT HANDLING PLAN

STAKEHOLDER GROUP	SPECIFICALLY	PRODUCT	RESPONSIBLE	HANDLING PLAN/RELEASE DATE
Comms leads	All affected HBs	All core documentation for posting on HB websites	Programme Manager	Ensure ready to run and cascade with: Launch of documents Cascade through established networks and mechanisms
General Public	Population of Aneurin Bevan University Health Board • Blaenau Gwent • Caerphilly • Monmouthshire • Newport • Torfaen	Core document Summary document EQIA Invite to online events/presentations Access to websites and on-line resources ie videos	ABUHB Planning/engagement lead	Day of launch through existing public cascade mechanisms
	Population of Cardiff & Vale University Health Board • Cardiff • Vale of Glamorgan	Core document Summary document EQIA Invite to online events/presentations Access to websites and on-line resources ie videos	C&V Planning/engagement lead	Day of launch through existing public cascade mechanisms
	Affected population of Cwm Taf Morgannwg Teaching Health Board • Rhondda • Cynon	Core document Summary document EQIA Invite to online events/presentations Access to websites and on-line resources ie videos	CTM Planning/engagement lead	Day of launch through existing public cascade mechanisms

	• Taff Ely • Merthyr Tydfil			
	Affected population of Powys Teaching Health Board • South Powys	Core document Summary document EQIA Invite to online events/presentations Access to websites and on-line resources ie videos	PTHB Planning/engagement lead	Day of launch through existing public cascade mechanisms
Welsh Government	Director General Health and Social Care	Letter from chair of Vascular Joint Programme Board (Ann Lloyd) signposting towards resources website etc	Chair of Vascular Board – engagement lead (CH) to draft	Following approval at Boards and just before launch
Patients, their families and carers	Patients who have received services since 2019 (linked to timescales outcomes reported in NVR report) with reference to inviting views from families and carers too	Letter from relevant consultant/MDT Core document Summary document Invite to online events/presentations Access to websites and on-line resources ie videos Access to a telephone line for discussion	Planning leads with MDT teams - ***need to check info governance***	Week of launch
NHS Wales	All CEOs of HBs and Trusts in Wales: Aneurin Bevan University Health Board Betsi Cadwaladr University Health Board Cardiff and Vale University Health Board Cwm Taf Morgannwg Teaching Health Board	Letter from Chair of Joint Vascular Board Ann Lloyd identifying launch and signposting towards all products	Chair of Vascular Board – engagement lead (CH) to draft	Following approval at Boards and just before launch

	Hywel Dda Health Board Powys Teaching Health Board Swansea Bay Health Board Velindre NHS Trust Welsh Ambulance Services Trust			
Community Health Councils	AB CHC C&V CHC CTMCHC PCHC	Report to joint Board CHCs 13 Jan 21 Receipt of all documentation	Programme Manager	Launch day
Third Sector Organisations	GAVO TVA PAVO CAVOC	Core document, summary document and signpost to online resources and opportunities	Health Board leads	Launch day
National bodies/organisations including Professional Societies and Royal Colleges concerned with the delivery of Vascular Surgery	To be plotted by programme	Core document, summary document and signpost to online resources and opportunities	Programme Manager	Launch day
National Voluntary Organisations	To be plotted by programme	Core document, summary document and signpost to online resources and opportunities	Programme Manager	Launch day
Local authorities and elected representatives	CEOs & Leaders of the councils	Core document, summary document and signpost to online resources and opportunities	Health Board leads	Via local cascade mechanisms requesting sharing with staff and members

National Politicians	Members of the Senedd and Members of Parliament	Core document, summary document and signpost to online resources and opportunities	Programme Manager	via a letter from Chair of vascular group
Stakeholder Reference Groups	ABUHB SRG C&V SRG CTM SRG PTHB SRG	Core document, summary document and signpost to online resources and opportunities	ABUHB lead C&V lead CTM lead Powys lead	Via local cascade mechanisms on day of launch
Trade Union Partnership Fora	ABUHB TUPF C&V TUPF CTM TUPF PTHB TUPF	Core document, summary document and signpost to online resources and opportunities	ABUHB lead C&V lead CTM lead Powys lead	Via local cascade mechanisms on day of launch
EQIA Targeted groups	Local Diabetic groups National Stroke Association and any local stroke groups	Core document, summary document and signpost to online resources and opportunities	Programme Manager as links to programme EQIA	Group contacts to be sourced by programme manager
Town and Community Councils	All town and community councils in Gwent, Cardiff, Vale of Glamorgan, Rhondda, Cynon, Taf Early and Merthyr and South Powys	Core document, summary document and signpost to online resources and opportunities	ABUHB lead C&V lead CTM lead Powys lead	Via local cascade mechanisms on day of launch
Local Medical Committees	Aneurin Bevan LMC Cardiff and Vale LMC Cwm Taff Morgannwg LMC Dyfed-Powys LMC	Core document, summary document and signpost to online resources and opportunities	ABUHB lead C&V lead CTM lead Powys lead	Via local cascade mechanisms on day of launch
Public Service Board and Regional Partnership Boards	Powys Regional Partnership Board Powys Public Service Board	Core document, summary document and signpost to online resources and opportunities	ABUHB lead C&V lead CTM lead Powys lead	Via local cascade mechanisms on day of launch

VASCULAR HUB AND SPOKE NETWORK FOR SOUTH EAST WALES

EQUALITY IMPACT ASSESSMENT EVIDENCE DOCUMENT

Introduction

This document presents the evidence collected to date in support of the equality impact assessment (EIA) process for the development of a Hub and Spoke Vascular Network service to serve South East Wales.

The Equality Act 2010 places a positive duty on public authorities to promote equality for the nine protected characteristics [1] and requires Welsh public bodies to demonstrate how they pay 'due regard' when carrying out their functions and activities. Equality is about making sure people are treated fairly. It is not about treating 'everyone the same', but recognising that everyone's needs are met in different ways. In the context of this work we are required to assess the impact of policies and services on equality. The purpose of this is to ensure that, as far as is practicably possible, the opportunities for promoting equality and human rights for people with protected characteristics are maximised and any actual or potential negative impact is eliminated or minimised.

The Human Rights Act 1998 also places a positive duty to promote and protect rights. We clearly recognise the importance of putting human rights at the heart of the way our services are designed and delivered. We believe this makes better services for everyone, with patient and staff experiences reflecting the core values of fairness, respect, equality, dignity and autonomy.

In addition we recognise that Wales is a country with two official languages: Welsh and English. We have a responsibility to comply with the new Welsh Language (Wales) Measure (2011). This will create standards regarding Welsh which will result in rights being established that will ensure Welsh speakers can receive services in Welsh. The importance of bilingual healthcare for all patients in Wales is

[1] Race; Sex; Gender Reassignment; Disability; Religion; belief/non belief; Sexual orientation; Age; Pregnancy and Maternity; and Marriage and Civil Partnerships: Equality Act 2010

fundamental and is particularly important for four key groups - people with mental health problems; those with learning disabilities; older people and young children. Research has shown these groups cannot be treated safely and effectively except in their first language (Welsh Language Services in Health, Social Services and Social Care, 2012)[2]. Our consideration of equality takes account of this.

EIA requires us to consider how the development of a centralised Vascular service, including an arterial centre (Hub), supporting non arterial units (spokes) and a comprehensive rehabilitation pathway, operating within a network structure for South East Wales, may affect a range of people in different ways. The EIA will help us answer the following questions:

- Do different groups have different needs, experiences, issues and priorities in relation to the proposed service changes?
- Is there potential, or evidence that the proposed changes will promote equality?
- Is there potential for, or evidence that the proposed changes will affect different groups differently? Is there evidence of negative impact on any groups of people?
- If there is evidence of negative impact, what alternatives are available? What changes are possible?
- How will we monitor impact in the future?

This document is not intended to be a definitive statement on the potential impact of the vascular centralisation on protected characteristic groups. The document's purpose is to describe our understanding at this point in the EIA process of the likely impact.

Background

A collaboration between Cardiff and Vale, Cwm Taf Morgannwg and Aneurin Bevin University Health Boards, has been coordinating the development of proposals for a centralised vascular service for South

[2] More than just words: Strategic Framework for Welsh Language Services in Health, Social Services and Social care (2012)

East Wales. Emergency Vascular services have already been centralised at the University Hospital of Wales (UHW).

The project is being led through the SE Wales Vascular steering committee, which is overseeing the work, and is supported by a clinical advisory group, operational group and a number of workstreams. The work will lead on the development of a clinical model and pathways including a comprehensive rehabilitation pathway, operating within a network structure for the region.

Through the steering committee, clinical reference group, clinicians and stakeholders have been working together to examine national guidance and to develop service models to improve care, treatment, rehabilitation and outcomes for vascular patients.

Rationale

Vascular disease accounts for 40% of deaths in the UK, many of which are preventable.

The report 'The provision of services for patients with Vascular Disease (Vascular Society, 2014)[3] compiles key recommendations to deliver standards for the care of vascular patients. The evidence is consistent that the best outcomes following elective and emergency interventions are achieved by concentrating inpatient care into arterial centres, this ensures the most efficient use of staff, specialist equipment and facilities.

A minimum population of 800,000 is often considered the minimum population required for a centralised vascular service. This is based on the number of patients needed to provide a comprehensive emergency service; maintain competence among vascular specialists and nursing staff; ensure the most efficient use of specialist equipment, staff and facilities; and the improvement in patient outcome that is associated with increasing caseload. A minimum population of 800,000 would be appropriate but for a world class service a larger catchment area will be

[3] The Provision of Services For Patients with Vascular Disease, The Vascular Society (2014)

required. The population of SE Wales (the resident population of the Health Boards taking forward this proposal is approximately 1.6 million (StatsWales 2016). The current configuration of services across separate hospital sites across South East Wales are too small to meet the quality and safety standards set out by the Vascular Society and the Royal College of Surgeons. None of the current individual units in SE Wales meet this requirement.

Benefits to the whole population will derive from an Inclusive Vascular System that provides for the needs of patients in its region by moving patients to the hospital best able to provide suitable care, freeing resources at other units.

At present, there is no vascular network or designated arterial centre operating across or within South East & Wales. Evidence demonstrates that the introduction of an arterial centre (hub) supported by non arterial units (spokes) and a comprehensive rehabilitation pathway, working in an integrated and mutually supportive way, is expected to raise the quality of services, reduce deaths, and reduce regional limitations and variations in services.

Expected outcome

The SE Wales Vascular service aims to ensure patients have appropriate, timely access to reliable, safe, high quality and sustainable services at all points along their care pathway, in line with best practice standard requirements, and evidenced through key performance indicators.

The proposal is to establish an arterial centre operating within an integrated Vascular network for South East Wales. This will provide patients with the right level of service 24 hours a day, 365 days a year. The arterial centre or ‘hub’ will be supported by a network of non-arterial units or ‘spokes’, and rehabilitation provided through specialist and local rehabilitation services.

Rehabilitation is a process of assessment, treatment and management with ongoing evaluation by which the individual, and their family and carers, are supported to achieve their maximum potential. It is a key part of the patient pathway, commencing before admission to an arterial centre, continuing through the inpatient phase to discharge from the hub or spoke into the community and is a true enabler to achieving the best outcomes for individuals.

How it will be delivered

Based on considerations over recent years, there is good clinical consensus to proposed that if supported, the new vascular service will be based on a hub and spoke model and will have:

- Diagnosis and assessment of vascular disease (including the input of the vascular laboratory and diagnostic imaging);
- Outpatient management of patients with peripheral arterial disease;
- Inpatient spells, emergency and elective activity;
- Day case activity;
- Multidisciplinary outpatient follow up of patients receiving vascular surgery/endovascular interventions;
- Seamless repatriation of patients following rehabilitation care pathways particularly for post amputation care;
- Limb Fitting Service – the vascular service must ensure its patients have access to a local limb fitting service, which meets the standards set by The British Society of Rehabilitation Medicine.
- A dedicated vascular day case facility in both hub & spoke to allow day case surgical & interventional radiology procedure.

It is proposed that the hub and spokes have the following components:

HUB	**SPOKE**
➢ Emergency Vascular Service:	➢ Emergency Vascular Service:-

• Amputations and "*nibbling"* • Aneurysm surgery; • Patients requiring CEA within 48 hrs of index event; • Peripheral arterial reconstructions.	• Angioplasty • Angiogram; • As noted above, the "front door" will remain the patient's local hospital, defined as a Local Hospital with an Emergency Department and an Emergency General Surgery Service; • Rehabilitation.
➢ **Elective Vascular Service:** • Abdominal Aortic Aneurysm • Endovascular aneurysm repair • Carotid endarterectomy	➢ **Elective Vascular Service:-** • Venous surgery angiography and angioplasty; • Outpatient clinics

Based on this, the main procedures that are expected to transfer from each of the current sites to any future hub are the following:

- Iliac and femoral artery procedures
- Carotid
- Open Abdominal Aortic Aneurysm
- Endovascular Abdominal Aortic Aneurysm
- Open Thoracic Aortic Aneurysm
- Thoracic endovascular aortic repair (TEVAR)
- Operations on vena cava
- Other artery.

To achieve delivery, there will be a number of infrastructure requirements for both the hub and the spoke:

HUB	**SPOKE**
➢ Dedicated vascular surgery ward(s). Beds will need to be staffed by an appropriate skill mix of nurses who have been trained in the care of vascular patients. Doppler investigation will need to be available on the ward; ➢ Hybrid theatre, with experienced vascular theatre staff; ➢ Scheduled elective lists (IP / DC); ➢ Anaesthesia – elective vascular services will have dedicated vascular anaesthetic input, from anaesthetists experienced in dealing with vascular patients and with a special interest in this area. This may include anaesthetists from Spoke sites given the opportunity to support elective lists in the hub; ➢ Intensive Treatment Unit (ITU) and High Dependency Unit (HDU) – Facilities with full renal support must be available on-site to support the vascular	➢ Mixed surgical wards but with ring fenced vascular beds; ➢ CEPOD theatre model; ➢ Interventional radiology; ➢ Scheduled elective DC lists; ➢ Outpatient Clinics – including access to nurses/therapists experienced in ulcer and wound dressing. Doppler ultrasound machines should be available. To support this, it is also assumed that each of the spoke sites will have the following: ➢ A consultant led Emergency Department (A&E); ➢ An Emergency General Surgery service.

service. Bookable HDU/ITU with sufficient beds will need to be available for elective patients ➢ Interventional radiology suite with access to nursing staff trained in vascular procedures. ➢ Out-patients clinics	

Given the range of services already in situ on the University Hospital Wales site, its position as a specialist and tertiary provider, and the co-dependencies between them and the vascular service, particularly major trauma, interventional cardiology and cardio-thoracic surgery, the preferred option for the hub is identified as the University Hospital of Wales, Cardiff. Given the need for consultant led A&E and a general surgery emergency service, the spokes for each of the areas are proposed as:

- **Aneurin Bevan University Health Board** – Grange University Hospital and Royal Gwent Hospital
- **Cwm Taf Morgannwg Teaching Health Board** – Royal Glamorgan Hospital, Llantrisant
- **Cardiff and Vale University Health Board** – Llandough Hospital Vale of Glamorgan

It is important to note that as patients begin their recovery and rehabilitation journey, that this too will be provided from a hospital/community setting which is much more local to them.

Who needs these services?

The prevalence of vascular disease increases with age. Average life expectancy continues to rise especially in males. This suggests that demand for vascular services is likely to increase over time. There are currently an estimated 200,000 people with diabetes mellitus in Wales, and prevalence is increasing.[1] Vascular disease is the major cause of

morbidity in diabetes and the risks of disease progression are higher, with an epidemic of diabetic foot disease expected in the next decade.

1. Diabetes UK

Risk factors for vascular disease include:

- Being over the age of 50
- Smoking
- Being overweight
- Having abnormal cholesterol
- Having a history of cerebrovascular disease or stroke
- Having heart disease
- Having diabetes
- Having a family history of high cholesterol or high blood pressure
- Having high blood pressure
- Having kidney disease or haemodialysis

Early diagnosis is key to successfully treating vascular related disease. Patients will be admitted with a variety of both emergency and planned vascular conditions and not all patients will go on to require a complex surgical or interventional radiology procedure. Emergency care is immediate treatment to save a life or limb, urgent care is planned treatment within a limited number of days.

Patients who receive vascular services may have:

- Had a stroke and are at risk of having further strokes
- Blocked arteries in the legs causing pain which may deteriorate further and threaten the leg
- A bulge in the wall of the body's main artery which needs repair to prevent it rupturing
- Untreated or untreatable arterial blockages which mean they need a limb amputation

Not all patients admitted to a specialist service will need a complex surgical or interventional radiology intervention, however due to the nature of their condition, these patients need specialist assessment and care provided in a specialised vascular unit.

Vascular services are provided to the populations of South East Wales with the exception of Bridgend who receive care from the South West Wales vascular network. This is a population of approximately 1.6 million people.

Where are we now?

Equality impact assessment is an ongoing process that runs throughout the course of the decision making process, and through implementation and review.

This paper defines the proposal for change and the rationale, sets out the expected outcomes and who will be affected by the proposal, and considers potential impacts on different groups and any possible actions for reducing or eliminating disadvantage.

Stakeholder engagement is an important part of the development of the proposals. Stakeholders have been involved in reviewing the EIA and further opportunities will be taken to assess the impacts as the work progresses.

What the evidence tells us on the need for change

The case for change is founded on firm clinical evidence and guided by national and international good practice.

There is strong evidence that case volume influences outcomes. The 31 highest volume hospitals (which perform 57% of all elective Abdominal Aortic Aneurysm procedures in the UK) have mortality rates that are under half those seen in the 32 hospitals with the lowest volume of procedures. These data lend support to the current move towards performing major arterial surgery in larger volume units in order to further optimise outcomes. The Royal College/national professional view, is that it is no longer acceptable to provide elective or emergency vascular cover outside a fully centralised service or a formalised modern clinical network with a designated single site for all arterial interventions providing a 24/7 on-site service.

There are a number of reviews and reports that support this which include:

1. Vascular Society of Great Britain and Ireland Provision of service for patients with vascular disease (2012) http://www.vascularsociety.org.uk/library/quality-improvement.html

2. https://gettingitrightfirsttime.co.uk/wp-content/uploads/2018/02/GIRFT_Vascular_Surgery_Report-March_2018.pdf

What are the potential impacts on protected characteristic groups?

EIAs require analysing impacts on the basis of protected characteristics: sex; disability; race; religion or belief/non belief; age (younger people and older people); sexual orientation (lesbian; gay and bi-sexual people); gender reassignment; pregnancy and maternity; and marriage and civil partnerships. We have been gathering evidence to inform our assessment of the potential impact of the proposed establishment of a vascular hub and spoke model network on patients, families and carers, staff, and other stakeholders.

Looking at a range of national research evidence has helped us to consider the potential impact. In particular, we are aware that many people who share certain protected characteristics such as disability, older age, younger people and some minority ethnic groups also face social and or economic disadvantage. Looking at socio-economic disadvantage goes some way to showing due regard to equality considerations. There will also be other distinct areas that are not driven by socio-economic factors but which relate directly to people with different protected characteristics. The proposals under consideration for the establishment of a vascular network will result in the concentration of life-saving treatment for a relatively very small number of patients but with the most serious disease. Non arterial units and a comprehensive rehabilitation service will ensure that as a patient's condition improves responsibility for ongoing care will transfer to healthcare facilities closer to home. The key issue for the protected characteristic groups would seem to be one of access as evidence tells us that some traditionally underrepresented groups' access to health facilities is disproportionately low when compared to the general population. The same can be said with regard to good health outcomes.

Below, from review of national evidence and research, discussion concentrates on the 'at risk groups' and the sections of the population which are likely to be most affected by the Vascular proposals (those

groups that are expected to experience impacts which are disproportionate to those experienced by the general population). There is also reference to health care needs in general.

The first observation to make is that Vascular disease tends not to be closely associated with particular equality groups; are not simple to predict on the basis of socio-economic characteristics. Of the protected characteristics, none are particularly susceptible to Vascular disease. However, a few groups are certainly key to consider in this assessment.

A literature review was carried out as a first stage of gathering evidence to inform the EIA. The results are provided below against each of the protected characteristics. There has also been engagement with stakeholders through work to develop the rehabilitation pathway.

Age

Engagement with stakeholders on the rehabilitation element of the patient pathway identified that the involvement of carers and family in rehabilitation is more difficult the further away rehabilitation is from local support mechanisms. It should be recognised that patients are not always able to return ‘home’, or to the setting they came from. Older patients will have different co-morbidities such as dementia or medical requirements, and it will be necessary to ensure that staff in the vascular network has all the skills required to care for these patients.

Race

There will be a need to consider requirements of those patients who may require translation or interpretation services, and access to volunteers or staff who can converse in a chosen language.

Disability

Rehabilitation services should give choice to patients with pre-existing mobility issues. Specific patient needs, such as bariatric needs should be considered to ensure the ability to provide equipment across boundaries and within social care sector.

As well as physical disability, there is a need to consider learning disabilities and mental health. It is recognised that the involvement of carers/family in any programme is more difficult the further away rehabilitation is from local support mechanisms, and patients are not always able to return to the 'home/setting' they came from. Communication needs in these client groups may be more challenging and care should be adapted accordingly.

There are specific standards under the All Wales Standards for Communication and Information for People with Sensory Loss[4] that apply directly to emergency and unscheduled care and these outline the staff training requirements, communication systems and patient needs information which should be provided by health boards.

Improved service will reduce the rates of disability and increase socio-economic functioning.

Marriage and civil partnership

No impacts upon this protected characteristic are anticipated.

Pregnancy and maternity

No impacts upon this protected characteristic are anticipated.

Religion or belief (including lack of belief)

It will be important to note that staff consider and recognise that patients' personal beliefs may lead them to ask for a procedure for mainly religious, cultural or social reasons or refuse treatment that you judge to be of overall benefit to them[5]. There are also many issues in relation to prayer, diet, death and dying rituals that would have to be considered.

Sexual orientation

Despite an appreciation that awareness of sexual orientation and gender identity issues in the health and social care sector has improved, Lesbian , Gay, Bisexual and Trans (LGBT) patients in Wales report

[5] http://www.gmc-uk.org/guidance/ethical_guidance/21179.asp

significant barriers to health and social care services[6] . Feedback provided at a Stonewall event indicated that service providers often use inappropriate language when dealing with LGBT patients, and make assumptions about patients' sexual orientation or gender identity. This makes LGBT people feel anxious about accessing health or social care and creates barriers to honest discussions about their health needs. Moreover, it can lead to serious health risks. There is a need to ensure that patients' needs and personal circumstances are taken into consideration when providing care along the patient pathway, including any implications for rehabilitation services.

Stonewall has commended work by healthcare employers around setting up LGBT staff networks, putting zero tolerance policies in place towards discrimination, and taking a more active approach to LGBT community engagement as having improved the experiences of staff and their patients. Health boards should continue to seek to make progress in this area.

Transgender

Trans* is an umbrella term used to describe the whole range of people whose gender identity/or gender expression differs from the gender assumptions made at birth. In 'It's just Good Care: A guide for health staff caring for people who are Trans' 2015[19] Trans* people must be accommodated in line with their full-time gender expression. This applies to toilet facilities, wards, outpatient departments, accident and emergency or other health and social care facilities, including where these are single sex environments. Different genital or chest appearance is not a bar to this. Privacy is essential to meet the needs of the trans* person and other service users. If there are no cubicles, privacy can usually be achieved with curtaining or screens. For people who are still in transition, any compromise must be temporary. The wishes of the trans* person must be taken into account rather than the convenience of nursing staff. An unconscious patient should be treated according to their gender presentation. Absolute dignity must be maintained at all times. It also states that breaching privacy about a person's GRC or gender history without their consent could amount to a criminal offence. A medical emergency where consent is not possible may provide an exception to the privacy requirements. All these issues, as well as others, could be mitigated through training.

[6] http://www.stonewallcymru.org.uk/our-work/research/have-your-say

Welsh Language

Public services have a responsibility to comply with the Welsh Language (Wales) Measure. This has created standards which establish the right for Welsh language speakers to receive services in Welsh. There is a risk that the location of the arterial centre within the Vascular network may impact negatively on Welsh language users. Service users who prefer to communicate in the medium of Welsh may be required to access services at sites which do not have sufficient Welsh speaking staff. This could affect the service user's ability to communicate with service providers in their preferred language. Meeting the information and communication needs of patients who speak Welsh will need to be taken into account. 'Language is the core of establishing and expressing identity. Responding sensitively to language, whilst focusing on the individual is an essential principle of maintaining dignity and respect in care within a bi-lingual setting (Welsh Language Services in Health, Social Services and Social Care, 2012)[7].

Socio-economic status

While socio-economic status is not a protected characteristic under the Equality Act 2010, there are new legal socio-economic duties for public bodies that will come into force in March 2021 and will apply to any decision made from this date. The overall aim of the duty is to deliver better outcomes for those who experience socio-economic disadvantage.

The report Transport and Social Exclusion: Making the Connections (Social Exclusion Unit, 2003) highlighted the current challenges faced by socially excluded groups in accessing health and other services. They found people who are socially excluded are more likely to experience a number of factors that in themselves have a negative impact on gaining access to health services. These may include low income, disability and age, coupled with poor transport provision or services sited in inaccessible locations. It also found that the location of health services and the provision of transport to health services can reinforce social exclusion and disproportionately affect already excluded groups.

[7] More than just words: Strategic Framework for welsh language services in Health, Social Services and Social Care (2012)

What are the potential impacts on NHS staff?

Proposals to establish a Vascular network may affect NHS staff as the final configuration may require staff to have to travel to new workplaces and work more flexibly across health board boundaries.

There is anecdotal evidence that the establishment of a Vascular network and arterial centre within South Wales would improve recruitment and retention for those clinicians who wish to practise in such a structure. It would also ensure the arrangements for the delivery of Vascular services in South East Wales are on a par with the structures in the rest of the UK.

Staff will be engaged and consulted on the proposals and any staff affected by the final outcome will be supported by the NHS Wales Organisational Change Policy (2009). A partnership approach with trade union colleagues will be ensured to achieve an effective transition to any new arrangements.

What are the human rights implications of the Vascular development?

The EIA needs to be cognisant of the European Convention on Human Rights incorporated into domestic law through the Human Rights Act 1998 as well as international treaties.

Everyone has the right to participate in decisions which affect their human rights. The convention on the rights of people with disabilities contains protection of the right to participate in decisions and access to support for participation and access to information.

The assessment so far has indicated *Article two: the right to life*, and *Article eight: the right to respect for private and family life, home and correspondence,* are of particular relevance and potential impact to the development of the Vascular network.

Right to life (taking reasonable steps to protect life): It is anticipated that having a regionalised service, with the most complex care provided from an arterial centre, will improve clinical outcomes which will have a positive impact on individuals' right to have their life protected.

Right to respect for private and family life, home and correspondence: the improved quality of care possible through a

vascular network structure should result in patients spending less time in hospital. However, increased travel distances could have a negative impact on the right to maintain family life. This would apply to the patient and individual members of the family.

This is not an absolute right and any interference should be justified, lawful, necessary and proportionate.

Initial summary conclusion

We believe that the introduction of a vascular network, including rehabilitation and the development of both an arterial centre and non-arterial units, is intended to improve patient care and outcomes for Vascular disease including timeliness of access, quality of outcome and improved equality of access and reduce inequalities.

We believe that the proposed service redesign does not introduce any additional obstacles; improving standardisation for access and specialist treatment should improve outcomes across all social groups. At this stage, this assessment indicates that there are a relatively small number of cases not currently treated at a centralised site (UHW) and, from national evidence and research, the majority of cases are male and over aged 65.

For those visiting patients whilst being cared for at an arterial centre, longer and more complex journeys are likely to be necessary for some. Being required to travel to an unfamiliar hospital and longer distances could be particularly difficult and disorientating for people. Journey times will be increased for users of public transport, which is highly relevant in terms of equality groups. Car ownership amongst most equality groups and, particularly, socially deprived communities tends to be lower than average, requiring a high reliance on public modes. Early transfer of the patient back to a 'local' hospital would help to mitigate long periods in unfamiliar surroundings.

What happens next?

The work of the South East Wales Steering Committee, Clinical Advisory Group, Operational Group and a number of workstreams, is continuing to plan for a Vascular service, and enter a period of engagement with the arterial centre being located at UHW and a number of supporting non arterial units and a comprehensive rehabilitation pathway, operating within a network structure for South East Wales. The EIA will continue to

be reviewed to further develop and refine this assessment and to ensure.

Report Title:	**Urgent Service Changes to Support Oesophageal and Gastric cancer surgery for Swansea Bay UHB**								
Meeting:	UHB Board					**Meeting Date:**	28/01/2021		
Status:	**For Discussion**		**For Assurance**		**For Approval**	**x**	**For Information**	**x**	
Lead Executive:	**Executive Director of Strategic Planning**								
Report Author (Title):	**Associate Programme Director for Tertiary and Specialist Services Planning Partnership**								

Background and current situation:
Oesophageal and gastric cancer surgery services are currently provided at two sites in South Wales:

- University Hospital of Wales – serving the population of Aneurin Bevan, Cardiff and Vale, Cwm Taf Morgannwg (excluding Bridgend), Hywel Dda. This service employs four consultant surgeons, with additional in reach support provided by two consultant surgeons who are employed by Cwm Taf Morgannwg UHB. The service undertakes approximately 60-70 surgical procedures for OG cancer per annum.
- Morriston Hospital – serving the population of Swansea Bay and up until recently Bridgend. This service employs one consultant surgeon, for the Swansea Bay population. The service undertakes approximately 20-30 surgical procedures for OG cancer per annum. A temporary arrangement has been in place with Cwm Taf Morgannwg UHB, to allow the OG cancer surgery consultant based in Princess of Wales Hospital, to undertake surgery for patients from Bridgend at Morriston Hospital.

Over the last eighteen months, a work programme has been established to respond to the recommendations from the review of services undertaken by the Wales Cancer Network in 2017. This includes the development of a service specification, which was approved by the NHS Wales Health Collaborative Executive Group in January 2020.

Following the approval of the service specification, the two Health Boards established a working group through their partnership arrangements, to develop a service model that will comply with the service specification, and provide a safe, sustainable and effective service for South and West Wales.

The working group has proposed an option appraisal methodology to inform the selection of the future service model. Care has been taken to engage with key stakeholders throughout the process, and the working group has agreed that it is important to maintain this engagement over the next stages, to ensure compliance with legislation and public law. Discussions are currently ongoing with CHC's to develop a detailed plan, which will inform an engagement exercise in advance of the option appraisal process.

However, over the course of the last few weeks, it has been necessary to suspend the surgical service provided by Swansea Bay, as neither consultant is currently available for work. At this stage it is not clear when the service will be able to resume, and as a consequence the Cardiff OG surgical service has been asked to provide support to manage the existing cohort of

patients, and new referrals into the Swansea Bay service.

In response the service is currently being supported by a surgical team from the South East Wales (SEW) Network. The surgical team is travelling to Swansea on a weekly basis to attend the MDT meeting, and support the outpatient clinic.

The Bridgend patients are currently being seen by the two consultant surgeons from CTM, who also form part of the SEW Network, on a weekly basis at a local clinic, following the MDT meeting. This falls under the commissioning responsibility of CTM UHB.

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

As a consequence of sudden unforeseen staff shortages, Swansea Bay UHB is currently unable to provide the oesophageal and gastric cancer surgery surgical service.

Cardiff and Vale UHB service has been asked to establish interim arrangements to manage the existing cohort of patients and new referrals into the Swansea service.

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

Safety
In view of the current situation, it is clear that a temporary urgent service change will be necessary in order to ensure that patients in Swansea Bay UHB are able to receive timely, safe and effective care. As a result, it is proposed that the timelines for the engagement exercise are revised to reflect the current position, whilst arrangements are put in place to manage patients in the interim.

The interim arrangements include the provision of temporary surgical support to the Swansea Bay OG outpatients and MDT from the Cardiff and Vale service, and will involve patients from Swansea Bay receiving their surgical procedures at UHW.

Financial
There are currently no commissioning arrangements in place to support the transfer to patients from Morriston to UHW for OG cancer surgery. It will be necessary to put in place appropriate funding arrangements with Swansea Bay to support:

- the transfer of patients for surgery;
- consultant input into the weekly MDT;
- outpatient clinics in Morriston Hospital

The intention is to develop an arrangement, similar to that between Hywel Dda UHB and the service, to ensure that the activity is funded at an appropriate rate.

It will also be necessary to ensure that there are similar arrangements in place with Cwm Taf Morgannwg UHB for the Bridgend patients.

Reputational
It will now be necessary to review the timelines for the engagement exercise and option appraisal exercise, and to notify all stakeholders engaged in the service model workstream of the current situation.

Operational Impact

The temporary service change is intended as a short term measure, with the level of additional OG cancer surgical activity estimated to be circa 2 cases per month. This is unlikely to impact directly on the provision of OG cancer surgery for the population of Cardiff and Vale and South East Wales. However, there is likely to be an indirect impact on other elements of surgical activity, although all decisions will continue to be informed by clinical priority.

A formal review will be undertaken at the end of January, to assess whether the period of temporary support needs to be extended, whilst work continues to determine the service model for South and West Wales . This will include an assessment of the operational impact on:

- Theatre capacity
- Beds – Ward and PACU capacity
- Consultant time

This will be necessary in order to identify the support required from commissioners to ensure that there are effective patient pathways in place, and that the service is appropriately resourced to deliver the additional activity.

Recommendation:

It is recommended that:

- A joint letter from the Regional and Specialised Services Provider Planning Partnership is issued to all Health Boards in South and West Wales to notify them of the temporary changes, and seek their support to establish the appropriate temporary commissioning arrangements for OG cancer surgery.
- The timelines for the engagement exercise and service model workstream are reviewed and adjusted to reflect the current circumstances.

Shaping our Future Wellbeing Strategic Objectives

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

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

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant, click here for more information

Prevention		Long term		Integration		Collaboration	x	Involvement	
Equality and Health Impact Assessment Completed:	No								

Report Title:	**University Hospital Llandough Electrical and Medical Gas Infrastructure upgrade.**								
Meeting:	UHB Board						**Meeting Date:**	28th January 2021	
Status:	**For Discussion**		**For Assurance**		**For Approval**	√	**For Information**		
Lead Executive:	**Executive Director of Strategic and Service Planning**								
Report Author (Title):	**Director of Capital Estates and Facilities**								

Background and current situation:

This paper sets out a summary of proposals and associated capital and revenue implications for the upgrade of the electrical and medical gas infrastructure at University Hospital Llandough. It is provided to the Board to approve the submission of the Business Justification Case (BJC) to Welsh Government (WG) for £5.522m capital funding. The Executive Summary is attached (and the full BJC is available on request).

The capital cost figures included within the document have been prepared following a comprehensive procurement process as required as part of the WG process for BJC development.

The Board is asked to approve the submission of the infrastructure upgrade at University Hospital Llandough – Business Justification Case to Welsh Government as part of the process to access capital funding.

This business case seeks approval to enable the upgrade of the electrical infrastructure on the West side of the Llandough Hospital site and medical gas services for the whole Llandough Hospital site to ensure the continued provision of safe services for patients and staff.

The existing electrical system consists of a single high voltage electrical substation with an automatic changeover system on failure to a single low voltage backup generator. The current system is liable to faults and failures that can result in loss of supply. With the current system there is potential for multiple single-points of failure arising from a complex changeover system and distribution network arrangements of the primary electrical and secondary source which does not meet the requirements of HTM 06-01 and has no resilience on the current system.

The existing medical oxygen system for the hospital is supplied via a primary and secondary vacuum insulated evaporator storage facility located on the east side of the hospital site. The oxygen supply from this VIE is via a single pipe system buried directly in the ground that serves the whole of the Hospital site. The system is not currently HTM compliant and gives no resilience for the Hospital site.

The existing medical air and surgical air systems within the Hospital are provided via a compressor plant located within the main theatres plant room. The plant produces seven bar surgical air and four bar medical air via a pressure reducing system. The plant room also houses the emergency reserve manifold for the medical air and vacuum plant. The current system is not

compliant with HTM02-01 and does not fully meet the current capacity demand placed on the system. The existing vacuum system for Theatres does not comply with HTM 02-01 and is undersized for the current demand.

Due to the critical nature of services now being provided at Landough Hospital the proposed infrastructure upgrade is vital and failure to the existing infrastructure will have a substantial impact on clinical services at the site.

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

The UHB have recognised the potential issues with the existing site infrastructure and are committed to providing a new fit for purpose engineering system to meet the changing clinical needs of the site.

The upgrade will ensure that the electrical infrastructure on the West side of the Llandough Hospital site is fully HTM compliant and future-proofed to meet the changing needs of the clinical services being undertaken on the site.

The proposed system will eliminate the single point of failure risk on the electrical and medical gas supply at the Llandough Hospital site that have been identified as significant risks.

The upgrades will ensure that the electrical and all medical gas systems are fully HTM Compliant.

A summary of the projected capital costs is shown below:

	£000
Works costs	3,989
Fees	617
Non-works costs	546
Equipment	0
Risk provision	478
Total Net	5,630
VAT Reclaim	108
Total Gross	**5,522**

The following hyperlink will provide access to the full version of the Business Justification Case:

210113 UHL Engineering Infrastructure BJC v3.pdf

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

The current electrical system feeds all of the accommodation on the west side of the UHL site which in addition to wards includes Operating Theatres, CAVOC and HDU / ITU.

The existing medical gases serves all operating theatres at the site and all wards throughout the

whole of the UHL site.

A failure of either service would have potential implications on patient safety and could result in financial and legal claims against the Health Board.

Recommendation:

The Board is asked to:-

APPROVE the Business Justification Case for the Engineering Infrastructure upgrade at UHL.

APPROVE submission of the Business Justification Case to the Welsh Government for capital funding to proceed with the works.

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

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

Equality and Health Impact Assessment Completed:	~~Yes~~ / ~~No~~ / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Development of a New Substation & Medical Gas Upgrade at University Hospital Llandough (UHL)

Business Justification Case –

Executive Summary

January 2021 – Final Draft

1.0 EXECUTIVE SUMMARY

1.1 Overview and Introduction

This business case seeks the approval for a capital investment of £5.522m to enable the installation of a new sub-station which includes the complete replacement of existing distribution sub-station DSS4 and the installation of an additional vacuum insulated evaporator (VIE) tank and line to enable further resilience and back up to the University Hospital Llandough (UHL) site.

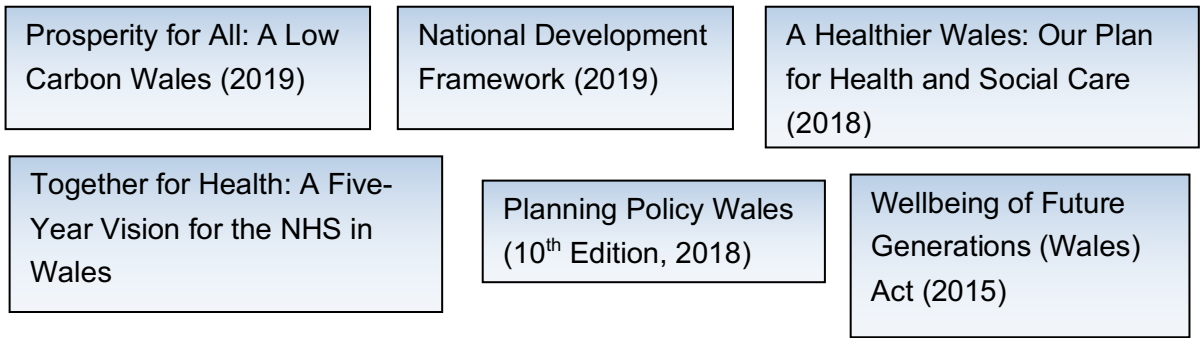
1.2 Strategic Context

Cardiff and Vale University Health Board (UHB) is responsible for planning and delivering health services for its local population of around 485,000, which represents 15.5% of the country's residents. This includes health promotion and public health functions as well as the provision of local primary care services (GP practices, dentists, optometrists and community pharmacists) and the running of hospitals, health centres, community health teams and mental health services. The Health Board employs approximately 14,500 staff and has an annual budget of £1.4 billion. The Health Board provides approximate 75 distinct tertiary services i.e. those that meet the Welsh Health Specialised Services Committee (WHSSC) definition of 'services provided' in a relatively small number of centres and requiring planning at a population of more than 1 million.

As a teaching Health Board, there are very close links to Cardiff University, which boasts a high-profile teaching, research and development role within the UK and abroad. This is alongside other academic links with Cardiff Metropolitan University and the University of South Wales. Training the next generation of clinical and non-clinical professionals, in order to develop expertise and improve clinical outcomes is a key priority for the Health Board.

The population served by the Health Board is growing rapidly in size, projected to increase by 10% between 2017-27, higher than the average growth across Wales and the rest of the UK. An extra 36,000 people will live in Cardiff over the next five years who require access to health and wellbeing services.

The Health Board is confident that the strategic drivers for this investment and associated strategies, programmes and plans are consistent with national, regional and local strategy and policy documents. Some of the key Welsh Government policies that have shaped this Business Justification Case (BJC) are:



Executive Summary Figure 1: Key strategies and policies

This BJC also takes cognisance of the relevant local strategies, these are:

- Shaping Our Future Wellbeing: In Our Community Strategy 2015 – 2025
- Integrated Medium Term Plan 2019 – 2022
- Cardiff and Vale UHB Estates Strategy

1.3 The Case for Change

The specific investment objectives for this business case are:

Investment Objective 1: Quality and Safety of Electrical and Medical Gas Services	
Specific	Services that deliver to appropriate quality and safety standards
Measurable	Evidenced by: ▪ The services meeting all applicable regulatory requirements
Achievable	Providing functionally suitable equipment appropriately sized to appropriate quality and safety standards
Relevant	This objective ensures the service will: ▪ Provide compliance with legislation, regulations and accreditation standards / performance; ▪ Support rapid adoption of best practice.
Time-bound	Service remains open throughout the development of the new facility and meets regulatory requirements upon commissioning of the new department
Investment Objective 2: Provide Sufficient Capacity to Meet Demand	
Specific	To ensure that the changing needs at UHL are met and that the solution does not destabilise other mechanical or electrical services
Measurable	Evidenced by: ▪ Facility meeting current demand; ▪ Providing increased capacity to ensure growth in demand is met; ▪ Providing resilience to provide short term capacity when required
Achievable	Providing functionally suitable equipment with sufficient capacity to meet the demands both now and in the future.
Relevant	This objectives will ensure access to services is optimised with: ▪ Service capacity that will meet demand in a timely way; ▪ Services delivered in an appropriate manner.

Time-bound	Upon commissioning of the new equipment
Investment Objective 3: Effective Use of Resources	
Specific	To maximise the use of available resource and provide equipment that delivers improved service efficiency Onsite infrastructure that can be drawn upon during contingency and business continuity management
Measurable	Evidenced by: ▪ Meeting capacity; ▪ Minimal emissions
Achievable	By providing additional capacity through the installation of modern equipment
Relevant	This objective will promote improved service efficiency through improved productivity and improved medical gas flow capacity
Time-bound	Upon commissioning of the new equipment
Investment Objective 4: Sustainability	
Specific	To provide a solution that will ensure the reputation of the Health Board and will support the delivery of safe and sustainable services both in the short and medium term
Measurable	Evidenced by: ▪ Utilising new / modern transformers - less energy will be lost in the form of wasted thermal energy generated from the existing ohmic resistance of the transformer's nonferrous windings
Achievable	By providing new equipment specified to modern standards and in line with best practice in regard to the green agenda and move towards zero carbonisation
Relevant	This objective will ensure built-in resilience to adapt to changing needs
Time-bound	One year after commissioning the new equipment

Executive Summary Table 1: Investment Objectives

1.3.1 Existing Arrangements and Business Need

1.3.1.1 Electrical Service

The existing sub-station DSS4 is located to the West side of the Llandough Hospital site and consists of a free standing out-building that is remote from the main hospital site. The building consists of three distinct areas with separate access to each. That being a high voltage transformer room, a low voltage electrical switch room and a generator room. The existing low voltage changeover is a complex system that is liable to faults and failures resulting in loss of supply. This is compounded with the inclusion of an extension panel within the supply distribution network adding further complications to the automatic transfer system. With the current system there is potential for multiple single-points of failure at DSS4 arising from the complex changeover system and distribution network arrangements of the primary electrical and secondary source which does not meet the requirements of HTM 06-01, particularly due to the lack of resilience of the current system.

1.3.1.2 Mechanical Service

The existing medical oxygen system for the hospital is supplied via a primary and secondary vacuum insulated evaporator storage facility located on the east side of the hospital site. The oxygen supply from this VIE is via a single pipe system buried directly in the ground. This single pipe system serves the whole of the Llandough Hospital site. The system is not currently HTM compliant and gives no resilience for the Llandough Hospital site.

The existing medical air and surgical air systems within the Llandough Hospital are provided via a compressor plant located within the main theatres plant room. The plant produces seven bar surgical air and four bar medical air via a pressure reducing system. The plant room also houses the emergency reserve manifold for the medical air and vacuum plant. The current system is not compliant with HTM02-01 and does not fully meet the current capacity demand placed on the system. The existing vacuum system for Theatres does not comply with HTM 02-01 and is undersized for the current demand.

1.3.1.3 Business Need

As outlined above, the current systems are not HTM compliant and are not suitable for either the current or proposed developments at the Llandough Hospital site. The electrical services upgrade will ensure that the infrastructure is fully HTM compliant and provide the resilience required for all current and future critical services being developed on the site. The mechanical services are all critical for the changing needs of main operating theatre services being performed at Llandough Hospital and the overall site need for additional oxygen services required for current demand and future development demand on the site.

There are current substantial risks that have been identified throughout the business case and without the proposed infrastructure works all future developments will be at risk from failures of these critical services.

1.3.2 Proposed Scope

The usual process is to comply with Welsh Government guidance is to assess the scope against a continuum of need ranging from:

- A minimum – essential or core requirements/outcomes;
- An intermediate – essential and desirable requirements/outcomes;
- A maximum – essential, desirable and optional requirements/outcomes.

However, with regards to this business case there is only one scope that is possible and that is a proposed new sub-station and additional VIE tank to provide further resilience to the UHL site. There is no other scope that can be considered as part of the development of this BJC in order to deliver the required project outcome and investment objectives.

1.3.3 Main Benefits

A summary of the main benefits is provided below:

Benefits are expressed by investment objective, recipient and benefit classification:

- CRB – cash releasing benefits (e.g. avoided costs);
- Non CRB – non cash releasing benefits (e.g. staff time saved);
- QB – quantifiable benefits (e.g. achievement of targets);
- Non QB – non-quantifiable or qualitative benefits (e.g. improvement in staff morale).

Investment Objective	Beneficiary	Main Benefits
Investment Objective 1: Quality and Safety of Electrical and Medical Gas Services	Service Users and wider Health Board	Non QB - High quality, safe and timely services to patients QB - Services that meet all applicable regulatory requirements
Investment Objective 2: Provide Sufficient Capacity to Meet Demand	Service Users and wider Health Board	QB - Provision of sufficient capacity to meet the demands both now and in the future at UHL QB – Reducing pressures on other facilities and provide resilience in the short term
Investment Objective 3: Effective Use of Resources	Service Users and wider Health Board	QB – Improved service efficiency
Investment Objective 4: Sustainability	Service Users, Health Board and wider societal economy	QB – Provides a reduction in emissions, promotes best practice in regard to the green agenda and move towards zero carbonisation

Executive Summary Table 2: Main Benefits

1.3.4 Main Risks

The table below provides a summary of the key risks that might affect the delivery of the project along with the counter measures:

Risk Description	Counter Measure
Availability of diverse cable routes and approval of the same	Limited access to all internal areas due to COVID-19 could mean that services need to be redirected during construction.
Accuracy of information received (Existing Services)	Med Gasses requirements awaited from UHB specialist supplier.
Location of the secondary VIE Plant	Awaiting planning approval and feedback from the BOC.
Risk of interruption to hospital operational services during construction stage	Daily liaison with Estates and Hospital staff.
Insolvency of the main contractor	Due diligence undertaken during tender process.

Executive Summary Table 3: Main Risks

1.4 Available Options

Due to the specific nature of this business case, there is only one viable option for the development on the UHL site. That is to provide:

- A complete replacement of existing distribution sub-station DSS4, with a new highly resilient sub-station and installation of a new low voltage sub-distribution network from the new substation to the feed existing downstream switchgear and plant.
- A secondary VIE line and plant with base and delivery are along with refurbishment of the existing VIE plant concrete base.

Whilst there were some minor options with regards to the exact location these were all in very close proximity as to make no material difference to either qualitative or economic values, therefore no option appraisal has been undertaken.

1.5 Preferred Option

The scope of works include the complete replacement of existing distribution sub-station DSS4, with a new highly resilient sub-station in accordance with the latest Health Technical Memoranda. This will include the construction of a new multi-room sub-station structure to house the capital plant including all ancillary services, interconnections onto the existing private high voltage ring network, and installation of a new low voltage sub-distribution network from the new substation to the feed existing downstream switchgear and plant.

A secondary VIE line and plant with base and delivery are along with refurbishment of the existing VIE plant concrete base.

Further information is within the Estates Annex that accompanies this business justification case.

1.6 Procurement Route

After careful consideration of the appropriate and available procurement routes, and due to the specialist nature of the scheme, the preferred procurement routes for the various project stages will be as follows:

- Scape Built Environment Consultancy Services ("BECS") Framework for design - RIBA Stage 2 – 4;
- NHS SBS Construction Consultancy Service (NHS Shared Business Services) for RIBA Stage 5 – 7;
- The Health Board's internal tender process (Contractor).

It is anticipated that the construction programme will run for approximately 42 weeks although the start date for this is dependent on the approvals process and securing support for the investment.

1.7 Funding and Affordability

The financial implications of the scheme on the financial position of the Health Board has been considered.

1.7.1 Capital Costs

This Business Case seeks approval to invest £5.522m from the All Wales Capital Programme, a breakdown of the capital costs is summarised in the table below:

	£000
Works costs	3,989
Fees	617
Non-works costs	546
Equipment	0
Risk provision	478
Total Net	5,630
VAT Reclaim	108
Total Gross	**5,522**

Executive Summary Table 4: Capital Costs for the Preferred Option

Year	£000
2020/21	4,141
2021/22	1,381
Total	**5,522**

Executive Summary Table 5: Phasing of Planned Capital Costs for the Preferred Option

1.7.2 Capital Charges and Depreciation

A summary of the capital and depreciation for the project is as follows:

	£000
Building / Engineering	5,522
Equipment	0
Total capital cost per cost forms	5,522
Impairment	4,950
Reversal of Impairment	0
Building / Engineering Depreciation	14
Engineering Depreciation	0

Executive Summary Table 6: Capital Charges and Depreciation

1.7.3 Revenue Costs

It has been estimated that the revenue costs will be minimal and circa £1,800 per year.

1.7.4 Impact On The Income And Expenditure Account

The anticipated capital spend, capital charges and depreciation profile for the extent of the project is as follows:

	2020/21 £000	2021/22 £000	2022/23 £000	2023/24 £000	2024/25 £000
Capital (Ex VAT)	0	4,692	0	0	0
Accelerated Depreciation	0	0	0	0	0
Depreciation	0	0	14	14	14

Executive Summary Table 7: Impact on Income and Expenditure Account

1.7.5 Overall Affordability

This BJC assumes the impairment and recurrent charges for depreciation will be funded by Welsh Government for the years stated. The funding and net additional revenue costs are summarised in the table below:

	£000
WG impairment funding	4,950
WG depreciation funding	14
Revenue Costs to be managed by the Health Board	018

Executive Summary Table 8: Overall Affordability

1.7.6 Assumptions That Underpin Affordability

- Funding is anticipated from WG for additional recurrent capital charges and non-recurrent impairment based on actuals;
- It is assumed that there will not be any transition or decant costs.
- This business case and associated additional revenue costs will be considered by the UHB Business Case Approval Group (BCAG). This will determine how the additional revenue costs will be funded.

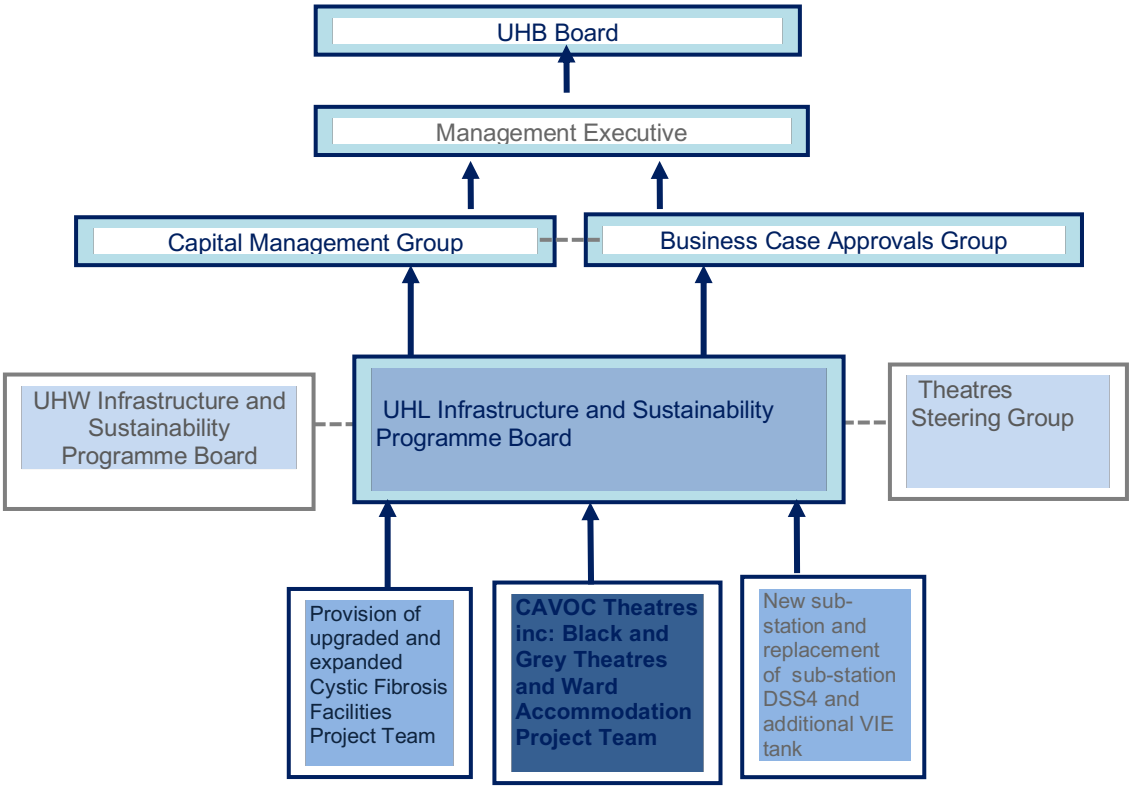
1.7.7 Project Bank Account

The Health Board can confirm that a Project Bank Account will be prepared at the appropriate stage as the project exceeds the Welsh Government value threshold for the mandatory use of Project Bank Accounts.

1.8 Management Arrangements

Robust project management arrangements are vital to ensure the implementation of the overall project and that effective control is maintained over the capital scheme.

The reporting organisation and the reporting structure for the whole of the project is shown as follows:



Executive Summary Figure 2: Project Reporting Structure

The dates detailed below highlight the proposed key milestones of the project:

Milestone Activity	Date
BJC submission to WG	January 2021
Design completion and commence construction	April 2021
Construction completion	December 2021
Operational (complete with change over)	March 2022

Executive Summary Table 9: Project Plan

1.8.1 Risk Management

The risk management strategy has been integrated into the project management procedures, with responsibility for implementation of the strategy resting with the Project Director. A project risk register has been established and is subject to review and update on a regular basis during the lifecycle of the project.

1.9 Recommendation

If this project does not go ahead, the risk is extremely high on lack of, or complete loss of oxygen across the Llandough Hospital site. There would also be a reduction in capacity for the current and future related projects taking place on the site therefore it is recommended that approval be given for the Cardiff and Vale University Health Board to develop the preferred option to secure the infrastructure required.

Report Title:	**FINANCE COMMITTEE CHAIRS REPORT**								
Meeting:	Board Meeting						**Meeting Date:**	28th January 2020	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**	**X**	
Lead Executive:	**Chris Lewis, Interim Director of Finance**								
Report Author (Title):	**Dr Rhian Thomas, Chair of Finance Committee**								

Background and current situation:

To provide the Board with a summary of key issues discussed at the Finance Committee held on the 25th November 2020.

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

With the operation imperative being managing the impact of COVID 19, the initial financial focus was on justifying additional expenditure incurred in dealing with the pandemic. Welsh Government has now set out the resources available to support the COVID 19 response and there is an expectation that NHS bodies will manage within these resources to deliver their original planned position, which for the UHB is a break even position by year end.

How the UHB recovers from the pandemic is also key and in this context the UHB needs to avoid adding recurrent expenditure to its underlying position and to embed the many transformation changes that have been delivered at pace.

Assessment and Risk Implications

Financial Performance Month 7

The report updated the Committee on the UHB's financial plan.

The UHB developed plans at pace for managing COVID 19 including the deferral of elective work and an increase to available bed capacity to manage surges in activity.

The Welsh Government amended the monthly financial monitoring returns to capture and monitor net costs due to COVID 19 that were over and above LHB plans. The financial position reported to Welsh Government for month 7 was an underspend of £0.362m as summarised in table 1 below:

Table 1: Month 7 Financial Position 2020/21

	Month 1 £m	Month 2 £m	Month 3 £m	Month 4 £m	Month 5 £m	Month 6 £m	Month 7 £m	Total £m
COVID 19 Additional Expenditure	38.438	17.290	5.330	6.565	10.597	7.939	8.561	94.720
COVID 19 Non Delivery of Savings Plans	2.118	2.150	2.056	2.094	1.752	(1.704)	1.960	10.426
COVID 19 Reductions in Planned Expenditure	(2.522)	(4.241)	(2.921)	(1.626)	(1.885)	(0.965)	(1.230)	(15.390)
COVID 19 Release of Planned Investments	0.000	(0.168)	(0.679)	(0.089)	(0.244)	(0.142)	0.044	(1.278)
Net Expenditure Due To COVID 19	38.034	15.030	3.786	6.944	10.220	5.129	9.335	88.478
Operational position (Surplus) / Deficit	0.191	(0.048)	(0.204)	0.244	(0.361)	(0.094)	(0.091)	(0.362)
Welsh Government COVID 19 funding received			(11.016)	(0.306)	(34.950)	(32.871)	(9.335)	(88.478)
Financial Position (Surplus) / Deficit	38.225	14.982	(7.434)	6.882	(25.091)	(27.836)	(0.091)	(0.362)

The table shows that in October, the in month net expenditure of £9.335m due to COVID 19 was matched by an equal amount of additional Welsh Government funding to cover the costs arising from the impact of COVID 19.

The additional COVID 19 expenditure in the 7 months to the end of October was £94.720m. Within this, the costs of the Dragon's Heart Hospital were significant, especially the set up costs which allow for significant expansion. At month 7 costs of £47.925m related to the Dragon's Heart Hospital (DHH). There was also £46.795m of other COVID 19 related additional expenditure.

COVID 19 was also adversley impacting on the UHB savings programme with underachievment of £10.426m against the month 7 target of £17.044m. Further improvement was not anticipated until the COVID 19 pandemic passed.

Elective work had been significantly curtailed during the first 7 months of the year as part of the UHB response to COVID 19 and this had led to a £15.390m reduction in planned expenditure.

The UHB had also seen slippage as a commissioner of £1.278m on the WHSSC commissioning plan due to the impact of COVID 19.

The net expenditure due to COVID 19 was £88.478m and this was matched by an equal amount of additional Welsh Government COVID 19 funding. The UHB also had a small operating underspend of £0.362m leading to a net reported surplus at month 7.

Whilst the UHB expected the non COVID related operational position to remain broadly balanced as the year progressed, the additional costs arising from plans to manage COVID 19 were expected to continue. The month 7 forecast of net expenditure due to COVID 19 in 2020/21 was £151.726m and this was offset by additional COVID 19 funding of £151.726m as summarised in table 2 below:

Table 2 : Summary of Forecast COVID 19 Net Expenditure

	Cumulative Month 7 £m	Forecast Year-End Position £m
COVID 19 Additional Expenditure	94.720	154.949
COVID 19 Non Delivery of Savings Plans	10.426	19.908
COVID 19 Reductions in Planned Expenditure	(15.390)	(20.893)
COVID 19 Release of Planned Investments	(1.278)	(2.238)
Net Expenditure Due To COVID 19	**88.478**	**151.726**
Operational position (Surplus) / Deficit	(0.362)	0.000
Welsh Government COVID funding received / assumed	(88.478)	(151.726)
Net COVID 19 Forecast Position (Surplus) / Deficit £m	**0.000**	**0.000**

The forecast additional Welsh Government funding was based upon the resource assumptions set out in the NHS Wales Operating Framework 2020/21 for Q3 and Q4

Within the forecast the Dragon's Heart Hospital costs were assessed at £62.7m with a further £2.7m capital costs.

It was noted that the forecast was based on a number of variable assumptions and assumed Welsh Government funding to help meet the additional costs arising from COVID 19.

The forecast year end underlying deficit was £25.3m which was £21.3m more than the planned £4m identified in the submitted IMTP as a result of the slippage against savings schemes.

Risk Register

The 2020/21 Finance Risk register was presented to the Committee.

It was highlighted that 2 of the risks identified on the 2020/21 Risk Register were categorised as extreme risks (Red) namely:

- Reduction in the £11.5m underlying deficit c/f to 2020/21 to the IMTP planned £4m c/f underlying deficit in 2021/22.
- Delivery of the 3.5% CIP (£29m)

Finance Committee Effectiveness Review – Results And Actions

The results for the annual Committee Effectiveness review undertaken by Finance Committee Members and the Executive Director Lead for the Committee were discussed and the action plan for improvement which had been developed was agreed for completion by the end of

March 2021.

Recommendation:

The Board is asked to:

- **NOTE** this report.

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

5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

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

Equality and Health Impact Assessment Completed:	Yes / No / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Report Title:	**FINANCE COMMITTEE CHAIR'S REPORT**								
Meeting:	Board Meeting						**Meeting Date:**	28th January 2020	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**		**X**
Lead Executive:	**Chris Lewis, Interim Director of Finance**								
Report Author (Title):	**Dr Rhian Thomas, Chair of Finance Committee**								

Background and current situation:

To provide the Board with a summary of key issues discussed at the Finance Committee held on the 6th January 2020.

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

With the operation imperative being managing the impact of COVID 19, the initial financial focus was on justifying additional expenditure incurred in dealing with the pandemic. Welsh Government has now set out the resources available to support the COVID 19 response and there is an expectation that NHS bodies will manage within these resources to deliver their original planned position, which for the UHB is a break even position by year end.

How the UHB recovers from the pandemic is also key and in this context the UHB needs to avoid adding recurrent expenditure to its underlying position and to embed the many transformation changes that have been delivered at pace.

Assessment and Risk Implications

Financial Performance Month 8

The report updated the Committee on the UHB's financial plan.

The UHB developed plans at pace for managing COVID 19 including the deferral of elective work and an increase to available bed capacity to manage surges in activity.

The Welsh Government amended the monthly financial monitoring returns to capture and monitor net costs due to COVID 19 that were over and above LHB plans. The financial position reported to Welsh Government for month 8 was an underspend of £0.461m as summarised in table 1 below:

Table 1: Month 8 Financial Position 2020/21

	Month 1 £m	Month 2 £m	Month 3 £m	Month 4 £m	Month 5 £m	Month 6 £m	Month 7 £m	Month 8 £m	Total £m
COVID 19 Additional Expenditure	38.438	17.290	5.330	6.565	10.597	7.939	8.561	8.776	103.496
COVID 19 Non Delivery of Savings Plans	2.118	2.150	2.056	2.094	1.752	(1.704)	1.960	1.946	12.372
COVID 19 Reductions in Planned Expenditure	(2.522)	(4.241)	(2.921)	(1.626)	(1.885)	(0.965)	(1.230)	(0.299)	(15.689)
COVID 19 Release of Planned Investments	0.000	(0.168)	(0.679)	(0.089)	(0.244)	(0.142)	0.044	(0.142)	(1.420)
Net Expenditure Due To COVID 19	38.034	15.030	3.786	6.944	10.220	5.129	9.335	10.281	98.759
Operational position (Surplus) / Deficit	0.191	(0.048)	(0.204)	0.244	(0.361)	(0.094)	(0.091)	(0.099)	(0.461)
Welsh Government COVID 19 funding received			(11.016)	(0.306)	(34.950)	(32.871)	(9.335)	(10.281)	(98.759)
Financial Position (Surplus) / Deficit	38.225	14.982	(7.434)	6.882	(25.091)	(27.836)	(0.091)	(0.099)	(0.461)

The table shows that in November, the in month net expenditure of £10.281m as a consequence of COVID 19 was matched by an equal amount of additional Welsh Government funding.

The additional COVID 19 expenditure in the 8 months to the end of November was £103.496m. Within this, the costs of the Dragon's Heart Hospital were significant, especially the set up costs which allow for significant expansion. At month 8 costs of £50.178m related to the Dragon's Heart Hospital (DHH). There were also £53.318m of other COVID 19 related additional expenditure.

COVID 19 was also adversley impacting on the UHB savings programme with underachievment of £12.372m against the month 8 target of £19.417m. Further improvement was not anticipated until the COVID 19 pandemic passed.

Elective work had been significantly curtailed during the first 8 months of the year as part of the UHB response to COVID 19 and this had led to a £15.689m reduction in planned expenditure.

The UHB had also seen slippage as a commissioner of £1.420m on the WHSSC commissioning plan due to the impact of COVID 19.

The net expenditure due to COVID 19 was £98.579m and this was matched by an equal amount of additional Welsh Government COVID 19 funding. The UHB also had a small operating underspend of £0.461m leading to a net reported surplus at month 8.

Whilst the UHB expected the non COVID related operational position to remain broadly balanced

as the year progressed, the additional costs arising from plans to manage COVID 19 were expected to continue. The month 8 forecast of net expenditure due to COVID 19 in 2020/21 was £155.493m and this was offset by additional COVID 19 funding of £155.493m as summarised in table 2 below:

Table 2 : Summary of Forecast COVID 19 Net Expenditure

	Cumulative Month 8 £m	Forecast Year-End Position £m
COVID 19 Additional Expenditure	103.496	158.211
COVID 19 Non Delivery of Savings Plans	12.372	19.860
COVID 19 Reductions in Planned Expenditure	(15.689)	(19.463)
Total Release/Repurposing Of Planned Investments/Development Initiatives	(1.420)	(3.114)
Net Expenditure Due To COVID 19	**98.759**	**155.493**
Operational position (Surplus) / Deficit	(0.461)	0.000
Welsh Government COVID funding received / assumed	(98.759)	(155.493)
Net COVID 19 Forecast Position (Surplus) / Deficit £m	**0.000**	**0.000**

The forecast additional Welsh Government funding was based upon the resource assumptions set out in the NHS Wales Operating Framework 2020/21 for Q3 and Q4

Within the forecast the Dragon's Heart Hospital costs were assessed at £61.2m with a further £2.7m capital costs.

It was noted that the forecast was based on a number of variable assumptions and assumed Welsh Government funding to help meet the additional costs arising from COVID 19.

The forecast year end underlying deficit was £25.3m which was £21.3m more than the planned £4m identified in the submitted IMTP as a result of the slippage against savings schemes.

Risk Register

The 2020/21 Finance Risk register was presented to the Committee.

It was highlighted that 2 of the risks identified on the 2020/21 Risk Register were still categorised as extreme risks (Red) namely:

- Reduction in the £11.5m underlying deficit c/f to 2020/21 to the IMTP planned £4m c/f underlying deficit in 2021/22.
- Delivery of the 3.5% CIP (£29m)

Financial Plan 2021/22 - Update on 2021/22 Revenue Allocations

A presentation on the 2021/22 Revenue allocation and the process to establish the 2021/22 Financial Plan highlighted the following points:

- The draft 2021/22 allocation letter was issued in December 2021. Funding to cover the ongoing response to Covid-19 was not included in the draft letter and resource planning assumptions for Covid-19 were expected to be issued separately.

- Subject to further Covid-19 funding, there is an expectation that the UHB will operate within the funds set out in the allocation.
- Additional funding for key priorities will be allocated as appropriate when costs are identified.
- The core uplift was 2% and this was expected to cover the first 1% of the 2021/22 wage award with an expectation that Welsh Government would provide further funding to cover any award above 1%.
- Further funding was being held centrally by Welsh Government to cover national priorities and the continuing response to COVID 19.
- In lieu of further clarification the UHB expects to develop a baseline financial plan to secure financial sustainability with Covid-19 response costs and recovery plans layered on top of the baseline plan. The developing plan would be brought back to future Finance Committee meetings. It was expected that an additional Finance Committee meeting to consider the final plan would be scheduled for March and that a wider invitation to attend the meeting would be sent to Board members.

Recommendation:

The Board is asked to:

- **NOTE** this report.

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

5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

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

Equality and Health Impact Assessment Completed:	Yes / No / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Report Title:	**Quality, Safety & Experience Committee – Chair's Report**								
Meeting:	**Board Meeting**						**Meeting Date:**	**28/01/2021**	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**	**X**	
Lead Executive:	**Chair - Quality, Safety & Experience Committee**								
Report Author (Title):	**Corporate Governance Officer**								

SITUATION

To provide the Board with a summary of key issues discussed at the Quality, Safety & Experience Committee held on 15th December 2020.

Hot Topics

The Committee was advised of the Advancing Applied Analytics Health Foundation Project. The Committee was supplied with data from incident reporting and the value of data taken from the reports. It was noted that on one end of the scale there was Incident Reporting and on the other there was In-Depth investigations and that somewhere in between there were other various data sources such as Patient stories, Coroner's reports, Audit of clinical care and Culture surveys.

The Committee was advised that the data sources offer a window on the healthcare system and could give insight on how to maximise the opportunities available using that data to identify the Patient Safety priorities.

The Committee was advised that due to lack of demonstrable progress, staff are deterred from reporting incidents.

The Committee was advised that the patient safety team had been working with the World Health Organisation (WHO) and had been exploring what slows down the data driven patient safety improvement agenda and culture and that from observations from multiple countries it can be realised that the range and utility of the patient safety data we already have is key.

The Committee was advised that, this would become the premise for the health foundation advancing analytics award that had progressed over the previous 15 months and that the health foundation had funded;

1. The exploration of how to build the capability of the administrative informatics team members to generate learning from patient safety data.
2. How to support patient safety risk managers to regularly learn from patient safety data to

inform their work

3. Build will amongst the staff reporting patient safety incidents.

The Committee was advised that UHB staff from a range of professions wanted to undertake Quality Improvement (QI) projects however the selection of topics that could be used for the projects was not targeted and that they needed to test how clinical staff could be supported to use and analyse patient safety data to inform their QI projects.

The Committee was advised that staff from the acute child health directorate had joined to undertake a pilot project which was named Quality Improvement using Data in Child Health (QIDICH) and that 2 years' worth of acute child health patient safety incident reports had been collected.

The Committee was advised that registration of QI projects was not consistent and so the patient safety team removed paper forms and had developed an electronic form.

The Committee was advised that that the patient safety team were moving into the next phase of the project which would be to roll it out across the health board and that this will be known as CAVQi.

Quality Indicators Report

The Committee was advised that work had been undertaken to work on what could be reported into each Committee.

The Committee was advised that the number of serious incidents (SI) being reported had reduced significantly over the last two years and that the number of SI closure forms submitted to Welsh Government (WG) had dropped during Q1 and Q2 of 2020/2021.

The Committee was advised that the compliance for patients admitted to the stroke ward was worrying because patients were not getting to the places where they should be and that was being looked at by the effectiveness committee.

The Committee was advised that due to the ongoing agenda item of pressure ulcer issues, a report would be brought to Committee to get a better understanding of the functionality and aims of the Pressure Ulcer Group

The IMTU asked about the stroke patient figures and asked if it was because the numbers presenting had gone up or whether it was because there were less staff?

Exception Reports

The Committee was advised that the reporting of staff testing positive for COVID-19 was not done via DATIX and Riddor and that recording was undertaken if 2 or more staff members were positive because that would be classed as an outbreak.

Impact of COVID-19 on Patient Safety

The Committee was advised that at the front door, the team had been working closely with WAST colleagues due to major incidents being called in relation to handover and there had been some patients waiting in ambulances for long periods of time.

The Committee was advised that this was the most concerning point subsequent to the original peak earlier in the COVID-19 pandemic and that it was well recognised that in the community instance the number of COVID-19 positive cases were going up and there was a significant increase in patients on critical care.

The Committee was advised that there was sufficient bed capacity but not a sufficient amount of nurses to staff all beds.

The Committee was advised by the Executive Medical Director that the commencement of level 3 or above surgery should not go ahead post-Christmas.

Public Services Ombudsman for Wales Annual Letter

The Committee was advised that there were no real concerns raised by the Public Services Ombudsman.

Clinical Board Assurance Reports:

1) Surgery Clinical Board

The Committee was advised that that a number of principles, aims and objectives were used to ensure that their patients were made as safe as they could be.

The Committee was advised of the the risks involved:

- Fearful staff and patients.
- Lack of understanding around what the clinical board had tried to do, internally and externally.
- "Old habits die hard" – Working around people or trying to work with them.
- Anecdotes not evidence
- Mental Fatigue – Staff have worked tirelessly.
- Responsive, agile change in crisis wears thin.

The Committee was advised of what had been achieved from April 2020 until November 2020.

- The clinical board had managed to undertake 7308 elective operations.
- 5946 emergency operations.
- Total redesign of surgical footprint to support the UHB and patients.
- Flexible and responsive workforce.

- Clinically lead models of care
- One eye on the future
- Clinical publication of the CB audit
- “Stars are born” – Staff who have shown their true methods.

Health Care Standards Self-Assessment Plan and Progress Update

The Committee was advised that work had been undertaken with specialist leads in the UHB to ensure that improvement plans had been implemented.

Board Assurance Framework – Patient Safety

The Committee was updated on the work being undertaken with the Board Assurance Framework (BAF) to ensure that each of the risks were allocated to appropriate Committee to provide an extra level of assurance and to open up risks for check and challenge before going back to the board.

Quality, Safety & Experience Workshop – Feedback & Action Plan

The Committee was advised that a workshop had taken place with contributions from staff across the whole of the UHB. There had been a further feedback session on 13th November with staff across the UHB to ensure that all of the learning had been taken from the event.

Minutes from Clinical Board QSE Sub Committees

The Committee was advised that the Clinical Boards (CB) had managed to keep their Quality and Safety meetings wholly in place throughout COVID-19 and that items of importance could be found in the QSE Committee meeting minutes.

HIW Activity Overview

The Committee was advised that HIW stepped down their normal approach to inspections during the first wave of the COVID-19 pandemic and that they had introduced some quality checks via offsite virtual inspections.

The Committee was advised that the published reports had been very positive and that the focus was on COVID-19 preparedness.

HIW Primary Care Contractor Report

The Committee was advised that the amount of activity seen by HIW in Primary Care had significantly reduced to what was normally expected due to COVID-19.

The Committee was advised of an onsite inspection at the Birchgrove Dental Surgery around COVID-19 precautions due to an anonymous concern being raised. The Committee was advised that necessary mitigations had been put in place.

Blood Inquiry Update

The Committee was advised that the outcomes from the Blood Inquiry would be brought to the Committee as and when and if any significant issues were raised these would put into the private domain.

Recommendation:

The Board is asked to:
• **NOTE** this report.

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

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

Equality and Health Impact Assessment Completed:	Not Applicable

Report Title:	**Strategy & Delivery Committee – Chair's Report**								
Meeting:	**Board Meeting**						**Meeting Date:**	**28/01/2021**	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**	**X**	
Lead Executive:	**Chair – Strategy & Delivery Committee**								
Report Author (Title):	**Corporate Governance Officer**								

SITUATION

To provide the Board with a summary of key issues discussed at the Strategy & Delivery Committee held on 12th January 2021.

Hot Topics

1. **Tertiary Services Planning Update**
   The Executive Director Strategic Planning updated Committee that in relation to Upper GI, Esophageal and Gastric Cancer, the UHB had been working with Swansea Bay UHB on developing a permanent solution to the sovereignty of the service across C&V and Swansea Bay UHB. The Royal College had observed that the sustainability of the service needed strengthening and this was being worked through, a paper would be going to the January Board regarding this.

2. **Strategy & Delivery Dashboard**
   Director of Digital Health Intelligence highlighted the initial work regarding the dashboard indicators for this Committee and the correlation with work being done by the Director of Corporate Governance with executive directors in terms of high level performance.
   An overview was provided on how the portal homepage will navigate to grouped measures based on performance indicators that are mapped to Committees. The Strategy & Delivery Committee had 38 indicators to consider. A live demonstration would be brought to the March meeting.

3. **Capital Plan Update**
   The Committee heard how significant investment had been received for capital allocation to manage all Covid related schemes/work. It was highlighted that the following business cases were due for approval:
   - Business Case for Electrical Engineering infrastructure in Llandough
   - Genomics outline business case being finalized for February Board.

4. **Performance Reports**
   (A) Organization Key Performance Indicators
   The Committee noted a number of challenges in performance, the most dominating factor being the current Covid challenge. Some respite in unscheduled care had now been seen partly due to some reconfigurations made by the Health Board and partly due to a slightly

slower admission rate across the region.

Surge capacity in lakeside wing at UHW had been opened.

The Committee was informed of the impact on planned care and in particular the:
•Rising 36 week breach position
•Fall in 26 week compliance
•Overall waiting list – waiting list growth had decreased slightly in the last month by 1000 against a 92,000 figure.

The Committee was assured that Cancer services and emergency and urgent operating would continue as in the first wave. Mental Health was regarded as an essential service and the approach had not changed much during the second wave. An overview of the service's formal targets was provided:
• Targets attached to the Crisis team – all intact
• Targets attached to High intensity psychological interventions – currently compliant
• Mental Measure – 2, 3, 4 all compliant – part 1a of the measure were non-compliant for the last few months due to demand in addition to staff shortages adding further pressures

Primary care and community services had been under various levels of pressure throughout the pandemic. Direction regarding services had been given at a national level to primary care contractors, they were still expected to deliver enhanced services to Care homes to help deliver the vaccination. The GMS status was currently Amber and there was a formal escalation with 5 practices reporting either level 3 or 4 with staff absences due to Covid impacting on delivery of services and two reporting due to patient demand.

(B) Workforce Key Performance Indicators
The Committee heard how a tired workforce is responding to new Covid pressures, winter pressures, and the vaccination work. Some services had to close down near the Christmas and New Year period due to workforce issues.

5. **Staff Well Being Plans**
The paper reinforced that the UHB was pro-actively putting in place interventions at different stages for its staff. The Staff haven was ready and available for staff to use from next week.

6. **Service Change Update**
The Committee was advised that a number of service changes had been made in response to Covid, some of which the UHB would want to maintain post Covid. The Committee was assured that a process was being formulated around this, in discussion with the CHC.

7. **Employment Policies for Approval - Equality, Inclusion and Human Rights Policy**
The updated policy was approved and took into account Socio-Economic Duties and Welsh Language standards. The new strategic equality plan enforced our ongoing commitment to inclusion, which also took into account recent events i.e. BLM, Covid-19, etc.

8. **Update of Healthy Eating Standards for Hospital Restaurant and Retail Outlets**

The Committee was advised that the Health Board was an outlier in Wales with minimum standards in restaurant and retail where 75% of food and drink could be healthier options. The following steps were being taken:

- Reintroduction of the audit schedule, applicable to in-house catering outlets at this time;
- Continued development of this work to include an assessment of the market and potential impact of the standards on external providers;
- New UHB retail space EOI process and procedure to be re-commenced in January 2021, to fully inform a realization and impact assessment of UHB Retail market positioning, in order to accurately inform our Strategic Plan going forward and to mitigate identified risks.

9. Mass vaccination paper

13,596 vaccines had been delivered to date with the UHB currently third in Wales behind Aneurin Bevan and Betsi.

A Booking Centre was established on 1 December 2020 and Splott Mass Vaccination centre opened on 8 December (capacity increased from 225 – 1000 vaccines per day). Three sentinel GP practices started vaccination of 80s and over on 6 January 2021. Care Home Mobile Vaccination team started on 6 January 2021 (3 homes vaccinated). Two satellite Vaccination Hubs were established in UHW on 8 January and UHL on 11 January.

Recommendation:

The Board is asked to **NOTE** this report.

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

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

Equality and Health Impact Assessment Completed:	Not Applicable

Report Title:	**Health & Safety Committee – Chair's Report**								
Meeting:	**Board Meeting**						**Meeting Date:**	**28/01/2021**	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**	**X**	
Lead Executive:	**Chair Health & Safety Committee**								
Report Author (Title):	**Corporate Governance Officer**								

SITUATION

To provide the Board with a summary of key issues discussed at the Health & Safety Committee held on 5th January 2021.

Health and Safety Policies Schedule

The Committee was advised that a number of policies were out of date however a 12 to 18 month extension to review theses had been agreed due to the ongoing COVID-19 pandemic. The Committee was also advised that polices that needed to be reviewed, required no major changes and remained valid.

The Committee was advised that a new policy around Protective Personal Equipment (PPE) had been looked at and work on that remained ongoing.

Priority Improvement Plan – Verbal Update.

The Committee was advised that the Priority Improvement Plan (PIP) needed a complete overhaul and that this work would be undertaken conjunction with the appointment of the new Head of Health and Safety (who is due to commence employment in February). It was hoped that the PIP would be fully reviewed to look at where the organisation would be when coming out of the COVID-19 pandemic.

Fire Enforcement Report

The Committee was advised that there had been no activity in terms of audits from the enforcing authority as they had been preoccupied during the COVID-19 pandemic.

The Committee was advised that there had been a decrease in unwanted fire signals and there had been a reduction in fire activity across all sites.

The Committee was advised that there was a statutory obligation for clinical teams to have face to face training on an annual basis which had not been met and that this remained a significant issue, particularly so given the difficulties presented by COVID-19.

The Committee was advised that offline training was being looked at and how to engage with

the Health and Safety Executive (HSE) around this.

Enforcement Agencies Report

The Committee was advised of 2 HSE updates since the last H&S meeting.

1) HSE had investigated the death of a member of staff who had tested positive for COVID-19. A formal update had been provided from HSE who noted that it was not RIDDOR reportable so was not considered a work related death. This item is now closed.

2) Communication from the HSE on the 11th November 2020 in relation to face fit testing practices in a Nursing Home. A meeting took place with the IPC Department on 20th November 2020 to address the concerns raised by the HSE.

The Committee was advised of a prioritisation regarding a staff wellbeing location at the Lakeside Wing. It was agreed that this could be opened by the end of January 2021.

The Committee was advised that the Health and Safety Committee should clearly set the priority items in relation to COVID-19 and winter pressures.

Committee Terms of Reference & Work Plan for 2021-22

The Committee was advised of the changes made to the Terms of Reference for the next financial year.

The Committee was advised that it was currently under review as to whether it should remain a Committee of the Board and it was noted that, if it did not remain so, it would likely report into the Quality, Safety and Experience Committee or the Strategy and Delivery Committee. The Terms of Reference would require amendment to take that into account.

Environmental Health Inspection Report – Verbal Update

The Committee was advised that Environmental Health were not prioritising inspections and that there had not been any in 2020. The committee was reassured that everything was still being done as it should be had the inspections taken place.

The Board is asked to:
• **NOTE** this report.

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	X
2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	X
3. All take responsibility for improving our health and wellbeing	X	8. Work better together with partners to deliver care and support across care	X

			sectors, making best use of our people and technology	
4.	Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	X
5.	Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	X

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

Equality and Health Impact Assessment Completed:	Not Applicable

Report Title:	**Stakeholder Reference Group Report**								
Meeting:	**UHB Board**						**Meeting Date:**	**28th January 2021**	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**		**X**
Lead Executive:	**Executive Director of Strategic Planning**								
Report Author	**Sam Austin, Chair of Stakeholder Reference Group**								

SITUATION

The following report provides Board with a summary of the key issues discussed at the Stakeholder Reference Group (SRG) meeting held on 24 November 2020.

REPORT

BACKGROUND

This is a report provided to the Board by the Chair of the UHB SRG.

ASSESSMENT

The SRG considered the following.

Membership

New members Cllr Janice Charles (Vale of Glamorgan Council), Amy Faulkner (Carers Trust) and Siva Sivapalan (Third Sector, Older Persons) were welcomed to the SRG.

Clinical Services Plan

The SRG was informed that the UHB's Clinical Services Plan had been branded 'Shaping Our Clinical Services'. The engagement process would commence during early 2021 and SRG members would be asked for their support in publicising via their networks and encouraging people to get involved. The aim would be to bring it to SRG in January as part of the engagement.

Quarters 3 and 4 Service Delivery Plan

The SRG received an update from Abigail Harris on the UHB's Quarters 3 and 4 Delivery Plan. The SRG was reminded that Health Boards were normally required to submit a three year Integrated Medium Term Plan (IMTP) to Welsh Government (WG) before the start of each fiscal year for approval by the Minister for Health and Social Services. The Minister had approved the UHBs IMTP but due to the pandemic WG had quickly introduced a quarterly planning cycle. WG had informed the UHB that it would not require a three year IMTP in 2021 but that UHBs would be asked to produce a one year annual plan. The plan would set the UHB's proposals in the context of its overall strategy. It had not been possible to set out a fixed plan for the quarter 3 and 4 period due to the unpredictable nature of the pandemic. Three broad scenarios had therefore been developed: C-19 'worst case'; C-19 'best case'; and C-19 'central'. For the purpose of the Plan, the UHB has adopted the C-19 'central' as its triangulation point. The UHB has used these scenarios to shape the description of its response around the 'four harms' association with C-19 i.e. harm from C-19 itself, the indirect harm of C-19, harm from an overwhelmed NHS and social care system and harm from wider societal actions.

At the beginning of the pandemic the UHB had suspended all elective activity except life-saving interventions. During quarter 2 the UHB began to recommence elective activity. The UHB has now created 'green' (C-19 free) and 'red' (C-19) zones within its hospitals to enable it undertake more elective activity. Elective activity was currently approximately 65% of its pre-pandemic levels. This figure was higher for outpatients but only around 50% efficiency is being achieved in theatres due to the need to introduce far more rigorous cleaning regimes. The UHB is using theatre capacity in Spire Hospital and looking to see if it could utilise further additional capacity in other independent hospitals. The UHB's bed capacity has been increased and it is not currently utilising all of its C-19 capacity. In addition, a

temporary modular build known as the Lakeside Wing is being constructed on the UHW site. The first phase of 166 beds would become available later that week and a further circa 230 beds would become available at the end of January 2021 when the second phase is due for completion. Staffing levels rather than infrastructure is the biggest constraint on activity and the UHB is undertaking a large recruitment drive.

The UHB is working with WG to identify potential options to address the activity backlog including regional solutions and further outsourcing and in-sourcing. Cases will have to be prioritised according to clinical need and it could take 2-3 years to clear the backlog. It was likely to be several months before plans are confirmed. Additional WG funding would be required but it was encouraging that WG had hitherto made quick decisions on the release of funding to address the pandemic.

Plans for a mass C-19 vaccination programme are being refined. It is anticipated that the vaccination of priority groups will commence prior to Christmas and it could be as soon as week commencing 30 November. The vaccination programme would, however, be another draw on staffing resources.

The UHB is providing the Test Trace Protect service for Cardiff and the Vale of Glamorgan in partnership with Cardiff and Vale of Glamorgan local authorities. The service has a very good trace rate and provides extremely good data on which to make decisions.

UHB staff have adapted incredibly well to the changing practices but they were now understandably tired. The challenges facing the NHS during December and January are likely to be more severe than during the first wave of the pandemic due to a combination of all the other usual winter pressures and the need to maintain elective services. The Health Board's Management Executives has received a presentation on staff wellbeing and are keen to ensure staff are given appropriate support, adequate breaks and refreshments and receive mental health support.

The SRG noted the imperative for anyone worried about their health to seek appropriate medical advice and do not put off contacting their GP due to concerns about C-19. SRG members agreed to use their networks to help get this message out to the public. They would also use their networks to encourage people to have the flu vaccination.

On 1 December the UHB and Community Health Council would be discussing engagement for three or four service changes introduced in response to the pandemic that the UHB would like to make permanent. Engagement and Equality Health Impact Assessments would be required for any permanent service changes.

Regional Partnership Board Winter Protection Plan
The SRG received a presentation from Cath Doman on the Regional Partnership Board's Winter Protection Plan. The Plan reflects the increased demand during the winter months and the continued circulation of C-19 which make the winter period even more challenging than usual. The focus of the Plan is on increasing capacity to ensure effective and timely discharge from hospital when individuals are ready to the most appropriate location and with proactive support to reduce the chance of readmission. All partners should contribute and support delivery of the Plan and ensure alignment of their own organisational plans and resources. The cost of the proposals contained in the Plan is £2.77m against approved funding of £1.35m. The funding received will only take the region through to January therefore a further £1.42 m has been requested from WG. The SRG noted that the number of carers had increased during the pandemic and it was increasingly difficult for them to fulfil their carers' roles. They were assured that the crucial role of carers is acknowledged in the Plan indeed the timely discharge of people from hospital necessitates very close liaison with carers.

RECOMMENDATION
The Board is asked to:

- **NOTE** this report.

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

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

Report Title:	**Local Partnership Forum Report**								
Meeting:	UHB Board						**Meeting Date:**	28 January 2021	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**		**x**
Lead Executive:	Executive Director of Workforce and OD								
Report Author (Title):	Workforce Governance Manager								

Background and current situation:

The UHB has statutory duty to "take account of representations made by persons who represent the interests of the community it serves". This is achieved in part by three Advisory Groups to the Board and the Local Partnership Forum (LPF) is one of these.

LPF is co-chaired by the Chair of Staff Representatives and the Executive Director of Workforce and OD. Members include Staff Representatives (including the Independent Member for Trade Unions) and the Executive Team and Chief Executive. The Forum usually meets 6 times a year.

LPF is the formal mechanism for the Health Board and Trade Union/Professional Organisation Representatives to work together to improve health services. Its purpose, as set out in the Terms of Reference, fall into four overarching themes: communicate, consider, consult and negotiate, and appraise.

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

This report provides Board with a summary of the key issues discussed at an extraordinary LPF meeting held on 10 December 2020 and the scheduled meeting held on 16 December 2020

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

1. An extraordinary meeting was held on the 10 December to provide LPF members with the opportunity for discuss the mass vaccination programme, especially in relation to the workforce. Mrs Fiona Kinghorn (Executive Director of Public Health) and Mrs Lorna Bennett (Consultant in Public Health) attended the meeting.

2. A scheduled meeting of the Forum also took place on 16 December 2020

- Tracy Meredith, Vale Integrated Locality Manager , was in attendance to provide information and assurances around the covid testing pathway for staff, particulalry in relation to consent and access to results
- The Deputy COO provided an operational update. Ms Bird advised that it was very challenging operationally and there was sustained pressure both within Primary Care and the hospitals. She said that it felt different to the first wave, partly because of increased non-covid demand but also because staff resilience has changed. A number of actions

being taken to mitigate against this were described.

- The Head of LED provided the Forum with a high level summary of the 2020 NHS Wales Staff Survey process and initial results. She outlined the timescales and responsibilities and reminded the Forum of the questions asked. The response rate was 22%, which while lower than hoped for was not too bad given that there were no hard copies and the survey was only open for 3 weeks. In 2018 the response rate was 23%. The results will be considered in more detail at the next meeting of the Workforce Partnership Group
- The Chief Executive provided an update report – this included information about the number of cases, the Surge Hospital, the maintenance of non-covid services and the financial position. Mr Richards also emphasised that staff should be working from home wherever possible
- The Forum received a presentation of the Shaping Our Clinical Services Transformation Programme and UHW2. This was part of the engagement plan and regular updates will be received as the programme progresses.
- Mrs Walker took the opportunity to talk to the Forum about some of the issues facing the nursing workforce at the current time including concerns about returning to clinical practice, being asked to move to a different area, and covid outbreaks. Mrs Walker also confirmed the current guidance around surgical masks vs face coverings and offered to write an open letter to the nursing workforce.

Recommendation:

The Board is asked to:

- **NOTE** the contents of this report

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

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

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant, click here for more information

Prevention		Long term		Integration		Collaboration	X	Involvement	
Equality and Health Impact Assessment Completed:	Not applicable								

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	10 November 2020

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/meeting-papers-archive/nov20/

Chris Turner (Chair), welcomed Members to the virtual meeting (using the Microsoft Teams platform) of the Emergency Ambulance Services Committee.

CHIEF AMBULANCE SERVICES COMMISSIONER'S REPORT

Stephen Harrhy presented an update on the following areas:

- Ministerial Ambulance Availability Taskforce – interim report planned at the end of the year
- Ambulance Quality Indicators - now published following a pause during the pandemic interactive view available here: https://easc.nhs.wales/ambulance-quality-indicators/
- Emergency Medical Retrieval and Transfer Service (EMRTS) – capital funding being sought to support the 24/7 service
- Non-Emergency Patient Transport Service (NEPTS) – plans progressing to transfer services to WAST by Aneurin Bevan, Betsi Cadwaladr, Powys and Cwm Taf Morgannwg health boards
- Revising the EASC Integrated Medium Term Plan – revised priorities have been agreed and the detail is being developed by the EASC Team and the Welsh Ambulance Services NHS Trust (WAST)
- Beyond the Call – A short presentation was received by Members of the work commissioned by the Welsh Government to the Mental Health Crisis Care Concordat in relation to the National Review of Access to Emergency Services for those experiencing mental health or welfare concerns. The document was published and would be shared with health boards in due course.
- Commissioning Intentions (CI) – a more streamlined approach would be taken to the Cis and further work was being progressed through the EASC Management Group.

PROVIDER ISSUES

Jason Killens, Chief Executive at WAST gave an overview of key matters including:

- Covid pandemic – abstractions had risen almost to the level of the peak in the first wave and support was being provided from the Fire and Rescue service
- Health and Safety Executive – policies relating to staff using personal protective equipment had been amended and progress was being made in relation to the notification of contravention notice received
- Clinical indicators / clinical outcomes – progress had been made in relation to the electronic case card, a supplier had been identified and capital funding secured. This would be implemented before the end of 2021.
- Non-Emergency Patient Transport Services (NEPTS) - In keeping with the requirement for social distancing this was having an impact on the service where vehicles were more used for individuals.
- Emergency Medical Services Demand and Capacity Review - Members were reminded that the staff growth had been planned for a further 136WTE this year and good progress had been made with the expectation to meet the target..

FOCUS ON - SYSTEM PRESSURES

A short presentation was received on system pressures with an aim to stimulate debate on the following areas:

- Ensure ambulance availability - actions to take over handover delays and WAST actions to maximise resources available
- Understand the impact of escalation across the system as a whole – health boards and WAST.
- How health boards and WAST work together and the regional solution
- Align escalation plans with covid learning
- Capacity for alternatives for demand management
- Find the tolerances
- Identify actions to take.

A helpful and open discussion was held and the following actions were agreed:

- Ambulance resource – to be maximised
- Resource efficiency – to match additional resource where a mismatch was identified
- Safe cohorting of patients and operating model – to enable the timely release of ambulances
- Operational Delivery Unit – supporting the system level information flow
- Information – to ensure sharing appropriate information to assist with patient flow
- Handover levels – important not to have levels over 150 lost hours per day and no tolerance approach to delays to patients of over 1 hour
- Escalation – develop a standardised approach across Wales with a focus to be proactive and only escalate regionally in extremis
- Post production lost hours – ensure the availability of the WAST workforce

Members supported the requirements to maximise the availability of ambulances this winter, the need to have a focus on reducing harm and improving quality and patient outcomes and the need to act in a proactive way starting from a Health Board footprint but to engage collectively on a regional basis where this was **needed by exception.**
Key risks and issues/matters of concern and any mitigating actions
• Increasing handover delays • Red performance not meeting the target - risk register amended to demonstrate deterioration in performance • Decreasing Amber performance - risk register amended to demonstrate deterioration in performance • WAST Demand Management plan at level 6
Matters requiring Board level consideration and/or approval
• None
Forward Work Programme
Considered and agreed by the Committee.

Committee minutes submitted	Yes	✓	No	
Date of next meeting	**26 January 2021**			

Khan Raj
01/21/2021 14:27:09

Report Title:	**Business of Other Committees and Review of Interrelationships**									
Meeting:	Board							**Meeting Date:**	28.01.21	
Status:	**For Discussion**		**For Assurance**	**x**	**For Approval**		**For Information**			**x**
Lead Executive:	**Director of Corporate Governance**									
Report Author (Title):	**Director of Corporate Governance**									

Background and current situation:

It is good governance and good practice for the Audit and Assurance Committee to receive a report on the performance and interrelationships of each of the Committees of the Board. This in turn provides independent assurance to the Board through the Audit and Assurance Committee. The Audit Committee received this report on 17th November 2020.

Cardiff and Vale UHB Standing Orders states that 'the Board shall establish a Committee structure that it determines best meets its own needs, taking account of any regulatory or Welsh government requirements'. As a minimum the Board must establish Committees which cover the following aspects of Board business:

- Quality and Safety – (Quality, Safety and Effectiveness Committee)
- Audit – (Audit and Assurance Committee)
- Information Governance – (Digital Health Intelligence Committee)
- Charitable Funds – (Charitable Funds Committee)
- Remuneration and Terms of Service – (Remuneration and Terms of Service Committee)
- Mental Health Act requirements – (Mental Health Capacity Legislation Committee)

In addition to the above the Board has also established the following Committees of the Board:

- Finance Committee
- Health and Safety Committee
- Strategy and Delivery Committee

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

The Board can receive assurance from the Audit Committee, based upon this review that the Committees of the Board operated effectively during the year and they were aligned with the Board's assurance requirements. This can be demonstrated by:

- Committee and Board reviewed and approved Terms of Reference
- Committee and Board reviewed and approved Annual Work Plans
- Committee and Board reviewed and approved End of Year Annual Reports which feed into the overall Accountability Report
- Committee Effectiveness Reviews each reported to the Committees of the Board with actions plans for improvement moving forward.

Some of the end of year reviews did not happen due to circumstances explained within the body

of the report and also the impact of COVID-19 which disrupted some reviews due to timings of Committees and Committees being stood down in line with Welsh Government Guidance. Where this was the case the previous year's Terms of Reference remained in place as did the work plans which were reviewed 12 months earlier.

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

(a) Committee Terms of Reference and Workplans:

Committee	Terms of Reference in place and approved by the Board		Workplan in place and approved by the Board		Annual Committee Report completed and signed off by Committee Chair and reported to Board	
	2019	2020	2019	2020	2019	2020
Audit and Assurance Committee	Yes	Yes	Yes	Yes	Yes	Yes
Quality, Safety and Experience	Yes	No	Yes	No	Yes	Yes
Digital Health Intelligence Committee	Yes	Yes	Yes	Yes	Not a Board Committee at that time	Yes
Charitable Funds Committee	Yes	Yes	Yes	Yes	Yes	Yes
Remuneration and Terms of Service Committee	Yes	No	Yes	No	No	30.11.20
Mental Health Capacity Legislation Committee	Yes	No	Yes	No	Yes	Yes
Finance Committee	Yes	Yes	Yes	Yes	Yes	Yes
Health and Safety	Yes	No	Yes	No	No	Yes
Strategy and Delivery Committee	Yes	Yes	Yes	Yes	Yes	Yes

The Quality, Safety and Experience Committee agreed that they would wait to review their Terms of Reference until later on in the year this was due to the following:

(i) The publication of the Health and Social Care Bill in summer 2020
(ii) The outputs of the Quality Governance Self-Assessment
(iii) WAO piece of work on Quality Governance – delayed due to COVID-19
(iv) Executive Nurse Director and Medical Director reviewing the processes and structures associated with Quality Governance – delayed due to COVID-19
(v) Learning from Cwm Taf Maternity Services Review.

These areas could all impact upon the Terms of Reference therefore it was agreed that they

would be reviewed in light of these areas and at a more appropriate time and then a new Work Plan would also be developed aligned to the new Terms of Reference. The current Terms of Reference and Work Plan would remain in place until the review could be undertaken and at the time it was agreed this would take place by the September Quality, Safety and Experience Committee. This work has been delayed due to COVID-19 but is still ongoing with a new timeframe for the end of the financial year.

The Mental Health and Capacity Legislation Committee currently has an Interim Chair. The Interim Chair is undertaking, with the support of relevant professionals, a programme of training and is keen to ensure appropriate participation of service users within the Committee. Once the training is complete a review of the Terms of Reference will be undertaken. The time frame for this is now the end of the financial year. The current Terms of Reference and work plan have remained in place from the previous year.

The Health and Safety Committee Terms of Reference were due to be reviewed at the April 2020 Health and Safety Committee and reported to the May 2020 Board. However, due to COVID-19 the Health and Safety Committee was stood down and the May Board was reduced to an 'essential items' only agenda. This review has now taken place and was reported to the Health and Safety Committee held on 5th January 2021. The Health and Safety Committee is now also administered by the Corporate Governance Team rather than the Health and Safety department this is to ensure independence in reporting of Health and Safety and to align it more effectively to the other Committees of the Board.

The Remuneration and Terms of Service Committee Terms of Reference were due to be reviewed at the May Committee and reported to the May Board. However, due to COVID-19 the Remuneration and Terms of Service Committee was stood down and the May Board was reduced to an 'essential items' only agenda. This will review will now take place by the end of the financial year. The current Terms of Reference and work plan have remained in place from the previous year.

Annual Reports from the Committees were presented to each Committee of the Board prior to sign off by the Board. These reviews fed into the Accountability Report at the end of the Financial Year.

(b) Committee Effectiveness Reviews

Committee	Effectiveness Review reported to Committee		No of areas where improvements required
	Yes/No	Date	
Audit and Assurance Committee	Yes	17.11.20	7
Quality, Safety and Experience	Yes	15.12.20	10
Digital Health Intelligence Committee	Yes	08.10.20	11 (first annual self-assessment)
Charitable Funds Committee	Yes	01.09.20	8

Remuneration and Terms of Service Committee	No		To be completed by end of financial year
Mental Health Capacity Legislation Committee	Yes	20.10.20	5
Finance Committee	Yes	25.11.20	10
Health and Safety	Yes	05.01.21	14
Strategy and Delivery Committee	Yes	15.09.20	1

Each Committee Effectiveness Review undertaken this year has been or will be reported to their respective Committees. In addition to this an action plan for improvement is produced which is also compared to the previous years reviews where these took place. There is one outstanding reviews which will be completed before the end of the year and reported to the respective Committee with an action plan for improvement.

(c) Inter relationships

Risk

Within the Effectiveness Review of the Audit Committtee there is a question which asks

'Has the Committee formally considered how it integrates with other Comittees that are reviewing risk?'

80% of respondents to the review stated 'yes' and 20% stated 'no'.

Risk Management arrangements within the Health Board are now moving forward and developing. It will be important to report back to the Audit Committee at its Febuary meeting our plans in relation to Risk Management. This will include (but not limited to) the following:

Each risk on the BAF being reported to the relevant Committee of the Board to provide further challenge around the risk and further assurance to the Board. This is happening within the Strategy and Delivery Committee but also needs to happen in relation to other Committees which are aligned to BAF risks including:

- Finance Committee
- Quality, Safety and Experience Committee

In addition to this, risks on the Corporate Risk Register which are currently only reported to the Board also need to be reported to their respective Committees of the Board. This would provide further challenge around the Corporate Risks the organisation is managing in additon to further assurance to the Board.

In effect there will be a robust hierachy of risk reporting through the Committees to the Board.

Key Performance Indicators

The way we monitor and manage performance is developing and the ultimate aim it to provide an integrated performance report to the Board focussing upon key indicators in the areas of Quality, Workforce, Finance and Operations. These areas will be reported through the respective Committees of the Board such as Quality, Strategy and Delivery and Finance.

Clinical Audit

The Audit Committee is responsible to ensuring the effectiveness of the Clinical Audit and Quality Improvement function and that it meets the standards set for the NHS in Wales. The Audit Committee achieves this by reviewing the Clincal Audit Plan on an annual basis. This review is next taking place at the February Audit Committee.

Regulatory Compliance

Regulatory Compliance is now tracked through the Audit Committee but includes regulatory requirements from across the Health Board and those areas where other Committees of the Board have a responsibility for ensuring delivery for example HIW Inspections through the Quality and Safety Committee and Fire Safety Inspections through the Health and Safety Committee and Information Commission Office (ICO) Inspections through the Digital Intelligence Committee.

The Audit Committee reviews the Regulatory Tracker and can provide assurance to the Board on the oversight of these inspections.

Internal Audit Recommendations and Auidt Wales Recommendations

Internal Audit Recommendations and Audit Wales recommendaions are now also tracked by the Audit Committee and this has been happening routinely since September 2019.

Recommendations from Auditors will be reviewed, where relevant by the respective Commitees of the Board such as Finance, Strategy and Delivery and Digital Health Intelligence Committee thereby providing assurance to the Audit Committee and the Board. This will commence in the next cycle of business.

Recommendation:

That the Board:

(a) Note the outcome of this review to provide 'independent' assurance to the Board that the Board assurance requirements are appropriately aligned.
(b) Note the areas of development within the report to provide further assurance to the board on the Inter relationships between the Committees particularly in the areas of Risk, Regulatory Tracking, Performance Monitoring and Audit recommendations.
(c) Note the outputs of the Committee self-assessment and the action plans in place to improve effectiveness of the Committees and that where the self-assessments were not undertaken that they will be undertaken before the end of the year.

Shaping our Future Wellbeing Strategic Objectives

This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	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	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	x

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

Report Title:	**Corporate Risk Register**								
Meeting:	Public Board Meeting						**Meeting Date:**	28/01/2021	
Status:	**For Discussion**	✓	**For Assurance**	✓	**For Approval**	✓	**For Information**		
Lead Executive:	**Director of Corporate Governance**								
Report Author (Title):	**Head of Risk and Regulation**								

Background and current situation:

The Corporate Risk Register has been developed to enable the Board to have an overview of the key operational risks from the Clinical Boards and Corporate Directorates. Since the onset of Covid-19 key operational Covid-19 related risks, including those related to the Dragon's Heart Hospital and Lakeside Wing Surge Hospitals have also been recorded. The Corporate Risk Register includes those risks which are rated 15 (out of 25) and above.

The Board will now have oversight of strategic risks via the Board Assurance Framework and extreme Operational Risks (Corporate Risk Register) for Cardiff and Vale University Health Board.

The Corporate Risk Register Summary is attached at Appendix A. The detail of each risk listed is discussed and reviewed at the appropriate committees of the Board. This month, risk entries 37 to 41 were discussed at the Mental Health Capacity Legislation Committee on the 19th January.

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

Since the Health Board introduced the Corporate Risk Register the Corporate Governance Team and the newly established Risk and Regulation Team have worked alongside Clinical Boards and Corporate Directorates to ensure that risks are clearly defined and appropriately scored in line with the Health Board's Risk Management Strategy and Procedure.

Following the employment of a new Risk and Regulation officer in October 2020, the Risk and Regulation Team have begun to deliver a programme of education and training to risk leads within Clinical Boards and Corporate Directorates. That training focuses on the Health Board's Risk Management Strategy and will, over time, be tailored to meet the individual needs of Clinical Boards/Corporate Directorates via periodic meetings and training sessions, to ensure that a consistent approach to the recording of risk and risk appetite is adopted across the Health Board.

From February 2021 the Risk and Regulation team will also deliver a monthly webinar on the Health Board's Risk Management Strategy which will be available to all members of staff. It is hoped that this system of training will further embed the Health Board's Risk Management Strategy across all areas.

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

There are currently 27 Extreme Risks (risks rated 15 and above) on the Corporate Risk Register as the table below shows. This represents a decrease of 11 Extreme Risk entries since

November's Board meeting and the reduction in score of all risks previously rated 25. Of those 27 risks, 10 entries, whilst still recorded as extreme risks, have shown a reduced score since November. One risk, relating to complex packages of care in the community (entry 12) has shown and increased risk score. In the current climate this shows a positive trend and is reflective of the ongoing work in the risk management arena across the Health Board.

The Board will note that Risk Entries 1, 5, 12, 21 to 24, 27 and 28 highlight two 'Initial Risk' scores. The score in brackets is the score reported at November's Board meeting but subsequently revised following review by risk leads and the Risk and Regulation Team. The revised Initial Score will be used moving forward.

On this occasion no extreme risks have been returned by the Children and Women Clinical Board nor the Emergency Planning or Human Resources/Workforce Corporate Directorates.

Assuming that scores do not increase prior to the next board meeting a total of 15 entries (those shaded grey) will be removed from the Corporate Risk Register prior to March's Board meeting.

The present position is as follows:

November 2020	January 2021
5 risks rated 15 (extreme risk) 7 risks rated 16 (extreme risk) 23 risks rated 20 (extreme risk) 3 risks rated 25 (extreme risk)	7 risks rated 15 (extreme risk) 9 risks rated 16 (extreme risk) 11 risks rated 20 (extreme risk)

Over the course of time, as the impact of Covid-19 reduces and with further scrutiny and review of risks, it is hoped that these risks should reduce either in number or rating. It should also be noted that the register, despite being over scored in some areas, does provide the Board with an indication of the risks that the organisation is dealing with operationally. Each risk can also be linked back to the Strategic Risks detailed upon the BAF.

It should be noted that the Command Centre risk registers for UHW and UHL have not been received. It has therefore been assumed that their entries have remained stagnant for the purpose of this report and that no extreme risks are reportable.

The PCIC Command Centre Risk Register has returned five extreme risks (an increase of two) that relate to staff availability (Rated 20), the flow of patients from secondary care (Rated 16), staff testing (Rated 16), the management of the Clinical Board's Budget within forecasted projections (20) and GP sustainability (Rated 15).

Risk Registers for the Surge Hospitals (Dragon's Heart Hospital (DHH) and the Lakeside Wing (LSW)) have returned 2 extreme risks (1 each) which are summarised below.

1) DHH – The risk that reinstatement costs will exceed projections due to damage to the Principality Stadium Pitch (Risk Score 20);
2) Lakeside Surge Hospital (LSH) – Risk of quality, safety or staff wellbeing detriment due to a potential shortfall in the number of available staff (Risk Score 20).

ASSURANCE is provided by:

- Ongoing discussions with Clinical Boards and the Corporate Directorates regarding the scoring of risk.
- The programme of education and training that is being implemented by the Risk and Regulation team to ensure that the Health Board's Risk Management policy is engrained and followed within Clinical Boards and Corporate Directorates.

RECOMMENDATION

The Board is asked to:

NOTE the Corporate Risk Register and the work which is now progressing.

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

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

Equality and Health Impact Assessment Completed:	Yes / No / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

CORPORATE RISK REGISTER SUMMARY January 2021

Risk Ref	Risk (for more detail see individual risk entries)	Clinical Board / Corporate Directorate	Link to BAF	Initial Risk Score	Risk Score Nov 20	Risk Score Jan 21	Trend	Target Risk Score
1	Non compliance with regulatory and accreditation requirements	CD&T	Patient Safety	(5x4=20) 4x4=16	5x3=15	4x3=12	↓	4x2=10
2	Backlog of Diagnostics and Therapies	CD&T	Patient Safety	4x5=20	4x4=16	4x4=16	→	4x3=12
3	Suboptimal estate in some areas making delivery of safe and sustainable healthcare difficult	CD&T	Capital Assets	4x5=20	4x4=16	4x4=16	→	4x3=12
4	Suboptimal IT provision	CD&T	Capital Assets	4x5=20	4x4=16	4x4=16	→	4x3=12
5	Non compliance with All Wales Staffing Act	Medicine	Workforce	(5x5=25) 4x5=20	5x4=20	4x4=16	↓	5x2=10
6	Risk of loss of service provided by Macmillan due to funding ceasing in April 2018 creating a cost pressure	Medicine	Financial Sustainability	5x5=25	5x4=20	-	↓	5x2=10
7	Risk of patient and staff harm due to inadequate social distancing.	Medicine	Patient Safety	5x5=25	-	5x4=20	↓	5x2=10
8	Risk of patien harm due to patients remaining on ambulances longer than agreed time frames	Medicine	Patient Safety	5x5=25	-	5x4=20	↓	5x2=10
9	Risk of serious incidents due to delayed cancer diagnosis	Medicine	Patient Safety/Planned Care Capacity	4x5=20	4x5=20	4x5=20	→	4x3=12
10	Non achievement of the Financial plan resulting in the Clnical Board not contributing to the Health Boards ability to break even	PCIC	Financial Sustainability	5x4=20	5x3=15	-	↓	5x2=10
11	Lack of sufficient capacity and resilience to deliver consistent and high quality service delivery at times of high demand	PCIC	Workforce/Planned Care Capacity	4x5=20	4x5=20	4x5=20	→	4x2=10
12	Risk of breakdown of complex care packages leading to hospital admission , patient flow issues and impact upon patients and their families	PCIC	Sustainable Primary and Community Care	(5x4=20) 4x5=20	5x3=15	4x5=20	↑	4x3=12
13	Covid-19	PCIC	Test Trace and Protect	4x5=20	4x4=16	4x4=16	→	4x3=12
14	Risk that GP Practicies are becoming unsuitable in the current climate.	PCIC	Sustainable Primary and Community Care	5x4=20	5x3=15	5x3=15	→	5x2=10
15	Risk to patient safety causing serious incidents due to patients not being admitted to Critical Care Department in a timely manner due to insufficient nursing workforce	Specialist Services	Patient Safety/Planned Care Capacity	5x5=25	5x4=20	5x4=20	→	5x2=10
16	Risk to patient safety causing serious incidents due to patients not being reviewed within the Critical Care Department in a timely manner due to insufficient medical workforce	Specialist Services	Workforce	5x5=25	5x4=20	5x3=15	↓	5x2=10
17	Risk to patient safety causing serious incidents due to patients not being admitted to Critical Care Department in a timely manner due to lack of bed capacity	Specialist Services	Patient Safety	5x5=25	5x4=20	5x3=15	↓	5x2=10
18	Risk that patients will not receive care in a suitable environment due to a number of facility shortcomings.	Specialist Services	Patient Safety/Capital Assets	5x5=25	5x5=25	5x4=20	↓	5x2=10

19	Risk of increased rates of cross infection and compromised delivery of medical and nursing care due to facility issues	Specialist Services	Patient Safety/Capital Assets	5x5=25	5x4=20	5x4=20	→	5x2=10
20	Risk to patient safety due to different approaches to Chemotherapy prescription for TYA Cancer patients between sites.	Specialist Services	Patient Safety	5x4=20	5x4=20	5x3=15	↓	5x1=5
21	Risk that patients will not receive access to emergency caredue to reduced theatre capacity for Major Trauma	Specialist Services	Patient Safety/Capital Assets	(5x4=20) 4x4=16	5x4=20	4x4=16	↓	4x2=8
22	Unsustainable Services at Rookwood Hospital	Specialist Services	Capital Assets	(5x4=20) 4x4=16	5x4=20	4x3=12	↓	4x2=8
23	Information governance and patient safety risks in relation to Cwm Taf Morgannwg Neurology Service	Specialist Services	Patient Safety	(5x4=20) 3x4=12	5x4=20	3x3=9	↓	3x2=6
24	Lack of appropriate referral system in place to appropriately manage high volume of emergency Neurosurgical referrals.	Specialist Services	Patient Safety	(5x4=20) 3x4=12	5x4=20	3x3=9	↓	3x2=6
25	Cardiothoracic - Risk to patient harm due to clinical area relocations and reduced footprints	Specialist Services	Patient Safety	5x5=25		5x4=20	→	5x2=10
26	Risk of safety to patients on the cardiac waiting list due to failure to meet the RTT 36 week wait	Specialist Services	Patient Safety/Planned Care Capacity	5x4=20	5x5=25	5x3=15	↓	5x2=10
27	Risk of cyber security threats to service continuity	Digital Health Intelligence	Financial Sustainability	(5x4=20) 4x4=16	5x4=20	4x3=12	↓	4x2=8
28	Risk of compatibility with systems and applications both nationally and locally as PCs require upgrading to Windows 10	Digital Health Intelligence	Financial Sustainability	(4x5=20) 4x4=16	4x5=20	4x3=12	↓	4x2=8
29	Compliance with Data Protection Legislation	Digital Health Intelligence	Patient Safety	4x4=16	4x4=16	4x4=16	→	5x2=10
30	Server Infrastructure fragility	Digital Health Intelligence	Capital Assets	4x5=20	4x5=20	4x3=12	↓	4x3=12
31	The opening underlying deficit in 20/21 is planned to be £11.5m. The IMTP planned c/f underlying deficit in 2021/22 is £4m.	Finance Committee	Financial Sustainability	5x5=25	5x4=20	5x4=20	→	5x2=10
32	Deliver 3.5% cip (£29m)	Finance Committee	Financial Sustainability	5x4=20	5x4=20	5x4=20	→	5x2=10
33	There is a risk that reinstatement costs at the DHH will exceed project provision	Finance Committee	Financial Sustainability	4x4=16		4x4=16	→	4x3=12
34	Risk adverse project cost variance that for reinstatement at the DHH	Strategy and Delivery Committee	Financial Sustainability	4x5=20	4x5=20	-	→	5x1=5
35	There is a risk that there will be insuffcient Covid Bed capacity between the period of Egress from the DHH and access to the new surge hospital.	Strategy and Delivery Committee	Patient Safety/Capital Assets	5x4=20	5x4=20	-	→	5x1=5
36	Risk of adverse cost variance following a potential delay vacating the DHH and Cardiff Arms Park.	Strategy and Delivery Committee	Financial Sustainability	5x4=20	5x3=15	-	→	
37	Nursing establishments and staffing levels - below the 60:40 registered to unregistered ratios for in-patient areas.	Mental Health and Capacity Legislation Committee	Workforce	4x4=16	4x4=16	4x3=12	↓	4x2=8
38	Poor quality of accommodation for community services bases at Park Road, Pendine CMHT, Gabalfa CMHT, Datt dispensingservice and CAU on the CRI site.	Mental Health and Capacity Legislation Committee	Capital Assets	4x5=20	4x5=20	4x3=12	↓	4x2=8

39	Staff are exposed to persistently high levels of violence and aggression, particularly in in-patient care.	Mental Health and Capacity Legislation Committee	Patient Safety	4x4=16	4x4=16	4x3=12	↓	4x2=8
40	Poor WAST response to MH services with conveyancing of 1) detained patients to hospital from community and 2) transferring medically unwell patients on the UHL site from MH to Physical health facilities	Mental Health and Capacity Legislation Committee	Patient Safety	5x4=20	5x4=20	5x3=15	↓	5x2=10
41	Risk to the health and wellbeing of a minor inpatient following admission to adult mental health services	Mental Health and Capacity Legislation Committee	Patient Safety	5x5=25	5x5=25	5x3=15	↓	5x1=5
42	Failure to provide timely access to surgery.	Surgery	Patient Safety/Planned Care Capacity	4X5=20	4x4=16	4x4=16	→	4x3=12