Public Board Meeting

Thu 29 July 2021, 12:30 - 17:00

MS Teams

Agenda

1.
Welcome & Introductions

Charles Janczewski

2.
Apologies for Absence

Charles Janczewski

3.
Declarations of Interest

Charles Janczewski

4.
Minutes of the Board Meeting Held on:

Charles Janczewski

- Public Board 27th May 2021
- Special Board 10th June 2021
- Special Board 24th June 2021

4. Unconfirmed Board Minutes May 21 - v4 - AF.NF.pdf (17 pages)
4. Unconfirmed Special Board Minutes 10.06.21 - v3 NF.pdf (6 pages)
4. Unconfirmed Special Board Minutes 24.06.21 - v3 NF.pdf (8 pages)

5.
Action Log:

- Public Board 27th May 2021
- Special Board 10th June 2021
- Special Board 24th June 2021

05 - Action Log - 27.05.21 - v1.NF.pdf (2 pages)

6.
Items for Review & Assurance

6.1.

Patient Story

Ruth Walker

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

Charles Janczewski

6.2 - CAJ - Chair's Board Report July 21.pdf (8 pages)

6.3.
Chief Executive Report

Len Richards

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

6.4.
HIW Annual Report

Vanessa Davies 13:00 - 13:30

6.4 - HIW Annual Report.pdf (15 pages)

6.5.
Corona Virus Report including:

Len Richards

- Quality and Safety - Ruth Walker & Stuart Walker
- Workforce - Rachel Gidman
- Governance - Nicola Foreman
- Operations - Steve Curry

6.5 - Corona Virus COVID-19 Update Report.pdf (2 pages)
6.5.1 - COVID 19 Update Report - Appendix 1.pdf (6 pages)

6.6.
Board Assurance Framework

Nicola Foreman

6.6 - BAF Covering Report -July 2021.pdf (3 pages)
6.6.1 - BOARD ASSURANCE FRAMEWORK - July 2021.pdf (28 pages)

6.7.
Performance Report

Catherine Phillips & Steve Curry

6.7 - Performance report July 2021 (Final).pdf (10 pages)

6.8.
Mental Health Operational Update (Presentation)

Steve Curry & Dan Crossland

6.8 - MH operational update.pdf (16 pages)

6.9.
Patient Safety, Quality and Experience Report

Ruth Walker & Stuart Walker

6.9 - QSE Board Report - 29.07.21 - V8.pdf (26 pages)

7.
Items for Approval & Ratification

7.1.
Risk Management Strategy

Nicola Foreman

- 7.1 - Risk Management Strategy and Action Plan Cover Paper.NF2.pdf (3 pages)
- 7.1.1 - Risk Management and BAF Strategy_Draft.pdf (38 pages)
- 7.1.2 - UHB 024_Ver3-Risk Management Procedures_Final.pdf (21 pages)
- 7.1.2a - UHB 024_Ver3-Risk Assessment Template_Final.pdf (2 pages)
- 7.1.2b - UHB 024_Appendix 2_Risk Register Template.pdf (3 pages)
- 7.1.3 - Roll Out Plan.pdf (1 pages)

7.2.
Partnership and Recognition Agreement

Rachel Gidman

- 7.2 - Partnership and Recognition Agreement cover paper.pdf (3 pages)
- 7.2.1 - Partnership and Recognition Agreement_2021.pdf (21 pages)

7.3.
Committee Membership

Nicola Foreman

- 7.3 - Committee Membership - Covering report July 21.pdf (2 pages)
- 7.3.1 - Committee Membership - By Committee - wef 01.08.21.pdf (3 pages)

7.4.
Digital & Health Intelligence Committee:

Nicola Foreman

a) Terms of Reference
b) Workplan

- 7.4 (a) - Digital Health Intelligence Committee -Terms of Reference.pdf (2 pages)
- 7.4.1 (a) - DHIC Terms of Reference -final.pdf (8 pages)
- 7.4 (b) - Annual Workplan 2021-2022 - Digital and Health Intelligence Committee.pdf (2 pages)
- 7.4.1 (b) - DHIC Annual Work Plan 2021-2022.pdf (1 pages)

7.5.
PET Project Business Case - Letter of Support

Len Richards

NOTE - to access the additional appendices please use the link below which will direct you to the C&V board page for Appendices 7.5.2 & 7.5.3
https://cavuhb.nhs.wales/about-us/governance-and-assurance/board-meetings/2021-22/

- 7.5 - All Wales PET - SBAR cover paper 26.05.2021.pdf (2 pages)
- 7.5.1 - PBC for All Wales PET Executive Summary.pdf (3 pages)

7.6.
Committee / Governance Group Minutes:

Nicola Foreman

7.6.1.

Audit & Assurance Committee – 13th May & 10th June 2021

John Union

- 7.6.1a - Confirmed Audit Mins - 13 May 2021.pdf (6 pages)
- 7.6.1b - Confirmed Audit Mins - 10 June 2021 - Special.pdf (6 pages)

7.6.2.
Finance Committee – 28th April & 26th May 2021

Rhian Thomas

- 7.6.2a - Finance Committee Minutes - 28 April 2021.pdf (8 pages)
- 7.6.2b - Finance Committee Minutes - 26 May 2021.pdf (6 pages)

7.6.3.
Quality Safety & Experience – 13th April 2021

Susan Elsmore

- 7.6.3 - Confirmed QSE Minutes - 13 April 2021.pdf (15 pages)

7.6.4.
Strategy and Delivery Committee – 11th May 2021

Michael Imperato

- 7.6.4 - Confirmed S&D Minutes - 11 May 2021.pdf (17 pages)

7.6.5.
Digital Health & Intelligence Committee – 11th February 2021

David Edwards

- 7.6.5 - Confirmed DHIC Minutes - 11 Feb 2021.pdf (9 pages)

7.6.6.
Stakeholder Reference Group – 23rd March 2021

Sam Austin

- 7.6.6 - Minutes of SRG Meeting - 23 March 2021.pdf (8 pages)

7.6.7.
Emergency Ambulance Services Committee – 9th March 2021

Nicola Foreman

- 7.6.7 - Confirmed minutes EASC - 9 March 2021.pdf (13 pages)
- 7.6.7a - Cofnodion Pwyllgor EAS wedi eu Cadarnhau EAS Confirmed Mins Welsh 9March2021.pdf (14 pages)

7.6.8.
Local Partnership Forum - 16th April 2021

Rachel Gidman

- 7.6.8 - LPF minutes - 16 April 2021.pdf (7 pages)

7.6.9.
WHSSC Joint Committee Brief – 13th July 2021

Nicola Foreman

- 7.6.9 - WHSSC JC Brief - 13 July 2021.pdf (5 pages)

8.

Items for Noting and Information to Report

8.1.
Corporate Risk Register

Nicola Foreman

- 8.1 - Corporate Risk Register Covering Report - July 2021_draft.pdf (3 pages)
- 8.1a - Corporate Risk Register Board Summary.pdf (1 pages)

8.2.
Board Effectiveness Survey

Nicola Foreman

- 8.2 - Board Self Evaluation.pdf (9 pages)

8.3.
Chairs Reports:

Nicola Foreman

8.3.1.
Finance Committee – 26th May & 23rd June 2021

Rhian Thomas

- 8.3.1 - Finance Committee Chairs Report - 26 May 2021.pdf (4 pages)
- 8.3.1 - Finance Committee Chairs Report - 23 June 2021.pdf (5 pages)

8.3.2.
Audit & Assurance Committee – 13th May, 10th June, & 6th July 2021

John Union

- 8.3.2 - Audit Chair's Report - 13 May 2021 - v1 - JU.pdf (3 pages)
- 8.3.2. - Audit Chair's Report - 10 June 2021 - v1 - JU.pdf (5 pages)
- 8.3.2. -Audit Chair's Report - 6 July 2021 - v1 - JU.pdf (7 pages)

8.3.3.
Quality Safety & Experience – 15th June 2021

Susan Elsmore

- 8.3.3 - QSE Chairs Report - 15 June 2021.pdf (6 pages)

8.3.4.
Strategy & Delivery Committee – 13th July 2021

Michael Imperato

- 8.3.4 - S&D Chair's Report - 13 July 2021 - v1 - MI.pdf (7 pages)

8.3.5.
Digital Health & Intelligence Committee – 1st June 2021

David Edwards

- 8.3.5 - DHIC Chair's Report - 1 June 2021 - v1 - DE.pdf (6 pages)

8.3.6.
Stakeholder Reference Group – 25th May 2021

Sam Austin

- 8.3.6 - Chairs Report SRG - 25 May 2021.pdf (3 pages)

8.3.7.
Emergency Ambulance Services – 11th May 2021

Nicola Foreman

8.3.7 - EASC Chair summary - 11 May 2021.pdf (3 pages)

8.3.8.
Local Partnership Forum – 17th June 2021

Rachel Gidman

8.3.8 - LPF briefing - 17 June 2021.pdf (2 pages)

8.3.9.
NWSSPC Assurance Report – 20th May 2021

Nicola Foreman

8.3.9 - NWSSPC Assurance Report - 20 May 2021.pdf (4 pages)

8.3.10.
Future Hospitals Committee - 21st July 2021 (Verbal)

Rhian Thomas

9.
Agenda for Private Board Meeting:

Charles Janczewski

1. Integrated Performance Report
2. Private Committee Minutes
3. All Wales Robotics Report

10.
Any Other Business

Charles Janczewski

11.
Review of the Meeting

Charles Janczewski

12.
Date and time of next meeting:

Thursday, 30th September 2021

Unconfirmed Minutes of the Board Meeting
Held on Thursday, 27th May 2021 at 11:00am – 12:30pm
Via MS Teams Live Event

Present:		
Charles Janczewski	CJ	UHB Chair
Ceri Phillips	CP	UHB Vice Chair
Len Richards	LR	Chief Executive Officer
Abigail Harris	AH	Executive Director of Strategic Planning
Akmal Hanuk	AH	Independent Member - Community
Catherine Phillips	CP	Executive Director of Finance
David Edwards	DE	Independent Member - ICT
David Thomas	DT	Director of Digital & Health Intelligence
Fiona Jenkins	FJ	Executive Director of Therapies & Health Sciences
Fiona Kinghorn	FK	Executive Director of Public Health
Gary Baxter	GB	Independent Member - University
John Union	JU	Independent Member - Finance
Michael Imperato	MI	Independent Member - Legal
Mike Jones	MJ	Independent Member – Trade Union
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	Deputy Chief Executive Officer / Executive Medical Director
Susan Elsmore	SE	Independent Member – Local Authority
In Attendance:		
Nicola Foreman	NF	Director of Corporate Governance
Julie Cassley	JC	Deputy Director of People & Culture
Lance Carver	LC	Director of Social Services, Vale of Glamorgan Council
Sam Austin	SA	Chair of Stakeholder Reference Group
Malcolm Latham	ML	South Glamorgan Community Health Council
Stephen Allen	SA	Chief Executive Officer - South Glamorgan Community Health Council
Observers:		
Ian Virgil	IV	Head of Internal Audit
Jacqueline Evans	JE	Head of Corporate Governance
Joanne Brandon	JB	Director of Communications
Victoria Legrys	VL	Programme Lead, Shaping Our Future Clinical Services
Secretariat		
Raj Khan	RK	Corporate Governance Officer
Apologies:		
Allan Wardaugh	AW	Chief Clinical Information Officer
Rachel Gidman	RG	Executive Director of People & Culture

UHB	**Welcome & Introductions**	

21/05/001	The UHB Chair welcomed everyone to the Public Meeting in English and Welsh. The UHB Chair introduced the Chair of the Stakeholder Reference Group (CSRG) & the Deputy Director of People and Culture (DDPC) The UHB Chair highlighted to the Board that the Chief Clinical Information Officer (CCIO) had to stepped down as a board member to deal with other work related matters within the UHB and Welsh Government, he also thanked the CCIO for his outstanding contributions that he had made during his time on the Board. The UHB Chair added that the Director of Digital & Health Intelligence (DDHI) had been appointed as a Board level director.	
UHB 21/05/002	**Apologies for Absence** Apologies for absence were noted. **The Board resolved that:** a) Apologies for absences were noted.	
UHB 21/05/003	**Declarations of Interest** The Executive Director of Therapies & Health Sciences (EDTHS) declared an interest as a Board member of Cwm Taf Morgannwg UHB.	
UHB 21/05/004	**Minutes of the Board Meeting held on 29th April 2021** The UHB Chair reviewed the minutes with the Board with no further matters arising. **The Board resolved that:** a) The minutes of the meeting held on 29th April 2021were approved as a true and accurate record	
UHB 21/05/005	**Action Log – 29th April 2021** The Director of Corporate Governance (DCG) reviewed the action log and presented the updates to the Board. **The Board resolved that:** a) The action log updates were received and noted.	
UHB 21/05/006	**Patient Story** The Executive Nurse Director (END) introduced the Patient Story which focussed on patients who had been with the Health Board during the COVID period, the first patient spoke about his diffuculties and challenges whilst in hospital and the second patient spoke about the imoprtance of how the little things matter i.e. oxygen, trips around a lake, etc which highlighted the signnificance of these matters to patients in a new environement.	

	The END informed the Board that the patient experience team would develop a library of patient stories for sharing at Committees of the Board so that they are in line with the Institute of Healthcare Improvement principles and to remind Board and Committee Members of the importance of patient eperience. **The Board resolved that:** (a) The Patient Story was noted.	
UHB 21/05/007	**Chair's Report & Chair's Action taken since last meeting** The UHB Chair advised that his report focussed on the importance of staff well being and empashised the amazing work being undertaken across the Health Board to provide staff with access to support when needed. . The UHB Chair added that the report also contained a number of items that would require the approval of the Board, including the use of the Health Boards official seal and Chair's actions taken during the period. The Executive Director of Strategic Planning (EDSP) highlighted that the lease of the CRI Chapel, noted in the report, had been completed. The lease, which had been agreed with Cardiff Council was highlighted as a remarkable transformation of a site that would not otherwise have been an area of clinical priority. **The Board resolved that:** a) The Chair's report was noted. b) The Chair's actions and use of the seal was approved.	
UHB 21/05/008	**Chief Executive Report** The CEO provided his congratulations to the EDPC on her appointment as the Executive Director of People & Culture. The CEO informed the Board of the Green Health Wales launch and the Health Board's ISO accreditation. He stated that decarbonisation and the green agenda was significant for the organisation and health in general as they were large contributors to Carbon Dioxide and climate change. The CEO advised that the Launch would take place on the 29th June 2021 and encouraged people to join the event. The CEO informed the Board of his departure from his role at the Health Board in four months as he would leave to become CEO of the Mid Yorkshire Hospitals NHS Trust. He advised that the Executive Medical Director (EMD) would take up the role of Interim CEO during the transition phase.	

	The CEO assured the Board that they the transition was being taken very seriously and the Executive Team had discussed the process to plan what the transition would look like over the following four months. The EMD highlighted that a number of actions had been agreed in those discussions and included taking action to reassure staff so that they had the same level of trust in the Executive Team and also to develop the Executive Team to ready itself for a new CEO. introduce The Third action was around how they use their meetings and the change in the leadership programme to ensure they keep things progressing during that time. The Executive Team would also need to re-visit their 'risk appetite' as there was potential for risk within the system during the transition period. Coupled with this was a need to liaise with the Communications Team to ensure that appropriate engagement both internally and externally was maintained. The UHB Chair highlighted the very substantial contribution the CEO had made to the organisation and how he had moved the organisation forward in a very positive direction which had seen the Health Board's Strategy come to fruition as a result of the CEO's leadership. He added that the Health Board had appointed Frank McKenna of Harvey Nash Alumni to help in the search of a new CEO as he felt a global search was required instead. **The Board resolved that:** a) The Chief Executive's report be noted.	
UHB 21/05/009	**Corona Virus Update Report** **Quality & Safety:** The END advised that there weren't any active areas of hospital acquired COVID but the team continued to undertake investigations. **Workforce:** The DDPC highlighted that the UHB Chair had outlined the teams' focus on well-being which was further detailed within the report. There was sensitivity in the system managing overseas international nurses and doctors with individuals from India still wishing to join. This would be managed appropriately, safely, and within regulations with 5 staff members expected to come the following week. She added that the EDPC had held a group discussion with staff to support individuals with Indian heritage and families to help them in light of the prevailing concerns in India. **Governance** The DCG highighted that her report could be taken as read. **Operations:** the Cheif Executive Officer (COO) highlighted that the majority of remaining Covid patients were in recovery.	

	He informed the Board unscheduled care activity which was Non Covid related was returning at a higher rate than seen following the first wave. The COO stated that the planned care plans continued to develop and commitments within the plan were being met although 15% of activity was being lost due to COVID restricitions. He added that the acute phase secondary care areas that had been encountered in the second wave was now being experienced in primary care and Mental Health services which was being worked through. He highlighted that the the team maintained all esssential services and remained in a COVID ready position **Public Health** The Executive Director of Public Health (EDPH) highlighted that the current rates were low, including in many of areas of previous concern, such as clusters in care homes, workplaces and health care settings. She added that work remained underway in the community particularily around variants of concern. She appraised the Board of a Ministerial Statement regarding the challenges of variant and highlighted that there were challenges in many conurbations in parts of England around spread. The EDPH stated that the expectation was that the Delta variant would become the predominant strain as seen in the second wave with the Kent variant. It was still unclear what impact the variant would have on mass vaccination efforts but the teams would continue to press on with the vaccination effort and the public messaging of of hands, face, space The EPDH added that the team had been encouraged to push first dose vaccinations in groups 1-9 and where possible to bring forward second doses. The END added that a social media campaign, called “leave nobody behind”, had been pushed the previous weekend which, it was hoped, would encourage people to attend who had not previously chosen to be vaccinated or had been contactable. **The Board resolved that:** a) The attached COVID-19 Update Report be noted.	

UHB 21/05/010	**Board Assurance Framework** The DCG reminded the board that in March it was agreed that the risks for the end of the financial year, which feed into the annual report and annual governance statement, would be reviewed. Since March, the Exeutive team had agreed that the risks going forward for the financial year, would be updated to bring a more COVID focus particularly risks presented by the Covid-19 recovery. The DCG stated that 2 new risks had been added: • Impact of COVID-19 on Staff Wellbeing • Impact of COVID-19 on Reducing Health Inequalities The DCG informed the Board that work on the risk in relation to reducing health inequalities, had deteriorated over the COVID period and the EDPH and her team would be writing this risk up for consideration at the next Board Meeting. The DCG highlighted that her team were due to update the BAF and risk management strategy which would be brought to the Board in July. **The Board resolved that:** a) The 9 Strategic Risks to the delivery of Strategic Objectives detailed on the Board Assurance Framework (BAF) for May 2021, recognising that a further risk in relation to Reducing Health Inequalities would be presented to the next Board, be approved. b) The continuing progress which had been made in relation to the roll out and delivery of effective risk management systems and processes at Cardiff and Vale UHB be noted.	NF
UHB 21/05/011	**Performance Report** The COO advised that the overall trend was a shift of pressure from Secondary Care & Acute Services into Primary Care and Mental Health Services. He added that this had resulted in difficulties that teams hadn't seen in previous waves, including two applications for list closures in Primary Care. One of which was granted with the appropriate support put in place. Work was ongoing to ensure the right amount of support was given in those areas and the COO highlighted some of the actions in progress, including a session with Primary Care to ensure that the Health Board's reovery plan submission to Welsh Government had Primary Care and Mental Health Services at the forefront.	

	Elective Surgery continued to grow as a result of trying to reinstate services and committments that had been made in Q1 were being met in by returning to above 70% of pre COVID work. The COO highlighted that the CAHMS service was under significant pressure. Referrals into the service in the pre COVID periods were 150 per month where as in April 2021 they had risen 244 and in May 2021 to 194. He commented that it was predicted that the service would continue to see that pressure indefinitely. The CEO referred to the CAHMS service and highlighted the Health Board's relationship with Canterbury and their experience with the earthquake which although different, generated the same sort of demand particularily with children and mental health services. He identified that in Canterbury this pressure lasted for 5 years. The CEO highlighted that Canterbury had introduced a strong approach with schools in line with their health pathways system. The CEO queried whether the Health Board had explored that as an area to take learning from. The COO responded that he was part of a session with Canterbury where the approach was discussed and added that the data was shared with relevant teams who were very susceptible to the plans, particularly working with education and schools. The EDPH commented on the whole system approach and sought to provide assurance that there was a host of other work being undertaken outside of CAHMS. She acknowledged that the teams were coming out of an extremely difficult year which enhanced the challenges but she stressed that this would need to be veiwed as a system challenge. The EDPH felt it was important to highlight in a Public Board and Regional Partnership Board setting, how things sat in different areas and that work that would be undertaken on housing, vulnerability, poverty, parental and family support would also contribute to good emotional mental health in young people and children. **The Board resolved that:** a) The performance report be noted.	
Uhb 21/05/0012 	**Finance Update** The Director of Finance (DOF) updated the Board and advised that the report covered the period to 31st March 2021 where the Health Board: • Managed within their income allocation resources showing a small surplus of £90,000 • Managed within the capital resource of £95 Million with an underspend of £100,000 The DOF advised that this did not take away from the fact that there would be an underlying deficit which was supported last year as part of COVID resources.	

	She concluded that the Health Board was able to end the year as planned, managing within all resources. **The Board resolved that:** a) The current position against specific performnce indicators for 2020-2021 be noted.	
UHB 21/05/013	**Patient Safety, Quality and Experience Report** The END stated that this would be the last detailed Patient Safety, Quality and Experience Report outside of the Performance Report that would be brought to future meetings. She added that her team would be taking much of this detail to the QSE Committee moving forward. The END highlighted that the Health Board had seen a significant increase in concerns over the previous few months. The total for the year to date was 3549 which was double the amount compared to the same time the previous year. The focus of complaints had been in relation to visiting queries and the mass vaccination process. The team were focusing on this and were runnning a 7 day service and continue to respond to complaints at the same level as during Covid times. The END informed the board that her team continued with their implementation of plans to ensure that they have a function that was fit to deliver the framework that they had proposed. An update on this work would be taken to the QSE Committee in June 2021. The EMD highlighted that some sections within the report concerned the Clinical Effectiveness Committee, learning from deaths, NICE and HCW. He commented that the purpose of adding more detailed scrutiny processes was to help the team understand where it was in a number key of areas. Alongside the work being undertaken internally around the teams infrastructure to support the QSE Committee, the national landscape would also undrgo a period of change. This would mean that the team would be required to provide a different type of national reporting process into Welsh Government which would be more involved than current arrangements. Independent Member – Legal (IM-L) queried whether any particular issues were identified as a result of the serious incident entries relating to two patients who had died of the serious injuries. The END advised that the incidents concerned elderly patients who had taken warfarin, a form of medication that could exacerbate internal bleeding. This risk of internal bleeding was much higher for patients	

	from that patient group who suffer head injuries from falling, as was the case in the two incidents noted. She also added that fall rates had decreased during the COVID period. The Executive Director of Therapies & Health Sciences (EDTHS) stated that a falls update would be shared at the next QSE Committee meeting so a further discussion on the issue would be had at that meeting. In light of the new infrastructure being put in place to support the QSE Committee, the UHB Chair queried how information would be fed to the Board in regards to deaths across the organisation, their causes and the operational areas they occur in. The EMD advised that this was an area that could be strengthened in the report that the Board receives. Work was being undertaken to determine what the right metrics were and what should be reported at different levels, including the QSE Committee and the Board. In doing so the amount of information received by the Board would be less although the board would receive the minutes from the QSE Committee for additional detail. **The Board resolved that:** a) The contents of the report were considered. b) The areas of current concern were noted and it was agreed that the current actions being taken were sufficient.	
UHB 21/05/014	**Outcome Of Engagement On Shaping our Future Clinical Services** The EDSP stated that the report had been brought back for the Boards consideration following the outcome of a recent engagement exercise. A presentaion was then provided by the Programme Lead for Shaping our Future Clinical Services (PL-SOFCS) to highilight the key points from the engagement exercise. Both the EDSP and the PL-SOFCS expressed their gratitude to the Community Health Council (CHC) for providing their support and ecouragement and highlighted that the work was the result of a collaborative effort. The PL-SOFCS first highlighted the objectives of the engagement and stated the aim was to educate people on the case for change which was set as one of the key objectives. A 7 week engagement was undertaken which ran from 01/03/21 – 19/04/2021. The PL-SOFCS stated that before going out to engagement the team conducted a number of clinical strategy workshops to obtain feedback from clinicians, from which they gauged real support from the clinicians for a whole pathway approach with principles that were clinically led, with a relationship to COVID recovery and understanding of current challenges.The EDSP stated that despite nervousness on how effective	

	the engagement could be they realised at the time the willingness of people wanting to participate and had reached audiences that they may have never targeted before using traditional methods. The Independent Member-Community (IM-C) queried whether there were any plans to engage with the people who had not had access to this engagement / harder to reach communities i.e. elderly people who were not as digitally enabled or if it was considered to continue in further engagement as there was a clear section within the community that had not been targeted. He also referred back to primary and mental health issues as he was unsure if the survey clearly captured the demographics of people by ethnicity, faith, etc. The EDSP responded that as they had reflected on the terms of service delivery they realised that it wouldn't be an option for everyone as there would remain people who still required access face to face care. This remained an important feature of their care plan and needed to be individualised. She added that there was a lot of work going on with partners around digital inclusion by looking at how the Health Board could link with local authorities and the Wales Co-Operative Centre which was leading on national work around digital inclusion. The EDSP highlighted that in terms of this engagement the team also had the benefit of all the partners who sat on the Stakeholder Reference Group being represented and were able to cascade through those mechanisms. The CEO commented that as a standard part of these engagement events the makeup of the people providing their views should be recorded to prompt further engagement work if it was recognised that, for example, the seldom heard groups were not engaged with effectively, as this was not clearly demonstrated within the report. **The Board resolved that:** a) The content of the Shaping Our Future Clinical Services Public Engagement be noted. b) The views of the South Glamorgan Community Health Council submitted directly by the CHC were considered. c) The use of the engagement feedback to inform the implementation of the Shaping Our Future Clinical services programme be approved.	
UHB 21/05/015 Khan Raj 07/28/2021 11:01:43	**Outcome Of Engagement On Regional Model For Vascular Surgery** The EDSP stated that the team had been working in the South Wales region to develop a South East Wales regional model for establishing a network for vascular services based on a hub and spoke model. This would see C&V and UHW providing the hub for vascular surgery with spokes at Llandough for rehabilitiation and in Aneurin Bevan and Cwm Taf Morgannwg.	

	The EDSP added that as this was a change to the way current services were being delivered they had entered into an 8 week engagement period in February 2021 and were now bringing back the outcomes from the enagagement exercise. The EDSP informed the Board that the 3 community Health Councils worked well together and they had received good support from the CHC. She also gave her thanks to the clinicians who attended the evening sessions where they were able to set out the case for change in relation to this service. The EDSP highlighted that all the CHC's acknowleged that this was a good enagement exercise and the outcome supported the direction of travel and also that a further enaggement exercise would not be required The PL-SOFCS added that although the numbers were relatively low in terms of responses the reach was quite broad and the team were able to target a number of specialist interest groups to ensure they were able to get the message out though to those teams. She highlighted that the Health Board was one of the last Health Boards to develop a network for these types of services, commenting that the services would not be sustainable in the long term if a model of care was not developed for patients and for it to be equitable for patients wherever they live. The CEO-CHC commented that they had responded formally to the Health board with the caveat in place that the CHC did not feel further engagement or public consultation was required. **The Board resolved that:** a) The content of the Reorganisation of localised vascular services into a 'Hub and Spoke' model Vascular Network for the South East Wales Region: A Report on Engagement 2021 be noted. b) The views of the Community Health Councils submitted directly by the CHC were considered. c) The use of the engagement feedback to inform the Board be approved.	
UHB 21/05/016	**Endoscopy Expansion Business Justification Case** The EDSP stated that this was quite an important Business Justification Case for the expansion of the endoscopy unit at University Hospital Llandough (UHL). It was prioritised the previous year as part of the Capital Programme as one of the business cases to be progressed whilst recognising across the Health Board capacity had not been keeping up with demand. The EDSP advised that in terms of revenue implications expanding would influence workforce implications and she highlighted that whilst	

	there was an indication of what the cost implications would be the team were still working through the business case. The COO stated that the case in terms of the demand capacity gap was well made for the business case and that the recurrent demand made a good case for the need of additional capacity. The COO highlighted that even with all types of additionailty in place i.e. insourcing, there would still be a recurrent demand capacity gap of 4700 endoscopies needed to be done in the year 2022/23, reducing to 3500 in the following year and then 4100 in the year after that. The COO stated that this included the expected growth and demand from Bowel Screening Wales and from surveillance work expected to happen. The END expressed her suppport for the Business Case and confirmed that it was an example of positive forward planning that demonstrated learning within the organisation. The UHB Chair queried the 2 additional theatres and whether they would be able to to sufficiently staff the theatres. The EDSP stated that this was part of the wider business case that links to the service case. She added that part of the national programme was to ensure that training was in place to produce more endoscopists. **The Board resolved that:** a) the content of the attached BJC be noted. b) the submission of the Business Justification Case to seek approval from Welsh Government for the capital funding identified, be supported, whilst the UHB finalise the revenue costs required to operate the facility.	
UHB 21/05/017	**Board Development Programme for 2021/2022** The DGC advised that the Programme was shaped to support Board members in delivering the annual plan over the following 12 months and also included work to develop the Health Board's work on the 9 Protected Characteristics under the Equality Act 2010but has also incorporated the 9 protected characteristics. **The Board resolved that:** a) the attached Board Development Programme for 2021/2022 was reviewed and approved.	
UHB 21/05/018	**Standing Orders & SFIs** The DCG advised that the report and attachments detailed the annual updates that the Health Board recieve from Welsh Government for Model Standing Orders and Standard Financial Instructions which were	

	implemented on an all Wales basis. She highlighted that the last full review of these was in February 2019 with some changes made during the COVID period in May 2020. She highlighted that the changes made had been attached in the appendix. **The Board resolved that:** a) the updated Standing Orders, Reservation and Delegation of Powers and Standing Financial Intructions for CVUHB be noted and approved.	
UHB 21/05/019	**Nurse Staffing Act – Mental Health Nurse Staffing Levels** The END advised that her paper was the Annual Report for 2021 and deomstrated the complexity of some of the issues the Health Board had encountered whilst maintaining compliance with the Act and responding to the pandemic. The END highlighted that Board Members had the opportunity to discuss and scrutinse this in detail at the previous Board development session. **The Board resolved that:** a) the Annual Assurance Report on Compliance with the Nurse Staffing Act Levels (Wales) Act Report for 2020-2021 be approved.	
UHB 21/05/020	**Broad Street Clinic** The EDSP stated that this was a good opportunity for the Board. She reminded the Board that the Vale of Glamorgan Council (VoGC) had approached the UHB with a proposal for the regeneration of a gateway, designed to improve the entrance to the town centre, which included redevelopment of the Gladstone Bridge Compound site (currently in VoGC ownership) and the Broad Street Clinic site. The proposal was to develop two landmark buildings delivering new affordable residential apartments and replacement of Broad Street Clinic subject to statutory consents and funding. The EDSP stated that she had been invited to conversations regarding whether the UHB would be interested in being part of the development to enable the Local Authority to purchase the land where the clinic sits if declared surplus to requirements. Whilst the re-provision of Broad Street Clinic was not considered a priority for the UHB at this time, the opportunity to have a new facility within the development would be of significant benefit to the patients within the area The EDSP highlighted that Broad street clinic was currently not fit for purpose and she was bringing the matter to the Board to seek endorsement for the proposal. This would mean that the site would be	

	deemed surplus to requirements by the UHB which would allow the Health Board to enter into agreement with the local authority. Director of Social Services, Vale of Glamorgan Council (DSS-VOGC) commented that this would be a fantastic opportunity for both parties and highlighted that it was situated near the extra care unit which they could also expand upon when redeveloping the site. The CEO-CHC queried the timescales for the project as it was not detailed and if there was a hiatus in service during the transition period, how would this be communicated to the members of the public using the Broad Street clinic. The EDSP replied that plans were currently in early stages of devlopment and no definitive timescales would be available untik okans had formalised. She highlighted that the phasing of plans would mean there would be no delay in services and that along with the local authority the Health Board would fulfil its obligation to be fully engaged with the people who use the services so that they are kept assured that they are not losing the facilities and that they are instead being provided in a different way. **The Board resolved that:** a) The partnership working with the Vale of Glamorgan Council in relation to the Barry Town Centre Regeneration Project be supported. b) The declaration of Broad Street Clinic site as surplus, subject to formal agreements between both parties on the re-provision of the clinic in the Gladstone Bridge development be approved. c) The investment of the capital receipt associated with the disposal of the Broad Street Clinic site for the 'fit out' of the new clinic provided as part of the proposed development be approved.	
UHB 21/05/021	**Board Committee Minutes** The Committee / Governance Group Minutes were received as follows: 1. COVID-19 Board Governance Group Minutes – 11th February 2021 & 11th March 2021 2. Audit & Assurance Committee – 9th February 2021 3. Finance Committee – 24th February & 24th March 2021 4. Quality Safety & Experience – 16th February 2021 5. Strategy and Delivery Committee – 9th March 2021 6. Mental Health Committee – 19th January 2021 7. Stakeholder Reference Group – 26th January 2021 8. Health & Safety Committee – 5th January 2021 9. Emergency Ambulance Services Committee – 10th November 2020 10. Local Partnership Forum – 10th February 2021 11. WHSSC Joint Committee Briefing – 11th May 2021 Khan Raj 07/28/2021 11:01:43	

	The Board resolved that: a) The minutes outlined within the meeting be ratified.	
UHB 21/05/022	**Corporate Risk Register** The DCG stated that there are currently twenty four risks that were scored at15 and above on the risk register. She highlighted that work asongoing in this area and that more Clinical Boards were engaging and subsequently more risks were coming in. The team were continuing to review the process to ensure that risks that were presented to the Board had been appropriately reviewed and scored **The Board resolved that:** a) The Corporate Risk Register and the work which was now progressing be noted.	
UHB 21/05/023	**Chairs Report** The following Chair's reports were received: 1. Finance Committee – 24th March & 28th April 2021 Independent Member – Capital and Estates (IM-CE) informed the Board that the main focus of the Committee over the last few months had been on reviewing the financial performance and position at the end of the financial year and reflecting upon the additional COVID expenditure, adverse impact of COVID on costs savings programme and provisional year end revenue. She highlighted that within the Committee they had started to do deep dive into the data and assumptions that feed into the Committee when interpreting the information. The intention was, when appropriate, that any deep dives that are applicable for wider board awareness would be taken to a Board Development Session. 2. Audit & Assurance Committee – 6th April 2021 & 13th May 2021 Independent Member – Finance (IM-F) commented on the workshop that had been held in May and the huge amount of work undertaken to look at the End Of Year account requirements. He also reassured the Board that Audit Wales, Internal Audit, and Finance knew that there were no "red lines" and that they were in a good position for the Special Audit Meeting scheduled for 10/06/2021 to make appropriate recommendation's to the Board following that meeting. 3. Quality Safety & Experience – 13th April 2021 No further points were highlighted 4. Strategy & Delivery Committee – 11th May 2021 IM-L highlighted that the Pharmaceutical Needs Assessment was discussed at the last Strategy and Delivery Committee meeting which NHS Regulations now require Health Boards to undertake. He informed the Board that this was used to inform applications from pharmacies to	MI

	provide new services and he felt it was an important item for discussion and would need to come back to the S&D committee and Board in September. He also highlighted a presentation received from the COO on recovery planning and the strategic underpinning of how backlogs were being tackled 5. Mental Health Committee – 20th April 2021 Independent Member – Third Sector (IM-TS) highlighted that the Committee had discussed the issue of Children and Adolescence Mental Health and reinforced the need for compliance data on children and young people to come to the Committee and for clarity to be gained to avoid any confusion on reporting requirements. 6. Emergency Ambulance Services Committee – 9th March 2021 No further points were highlighted 7. Health & Safety Committee – 30th March 2021 IM-C highlighted the key area discussed was fire safety training as training targets were below expectations. 8. Stakeholder Reference Group – 23rd March 2021 The CSRG advised that the group had been receiving excellent presentations from members of the Health Board that had informed positive question and feedback sessions. 9. Local Partnership Forum – 22nd April 2021 No further points were highlighted 10. NWSSPC Assurance Report - 18 March 2021 No further points were highlighted **The Board resolved that:** **a)** The Committee Chair reports outlined within the meeting be noted.	
UHB 21/05/024	**Any Other Business** No other business was discussed	
UHB 21/05/025	**Review of the meeting** The UHB Chair asked if attendees were satisfied with the business discussions and the format of the meeting, and all members indicated that they were happy with the meeting, the updates provided and the meeting format. The CEO stated that the meeting held was a very good one with lots of points of discussion but highlighted the volume of papers that the Board received. They asked that for papers to be more succinct and to reduce the number of papers being recieved.	

UHB 21/05/026	**Date and time of next meeting:** **Special Meeting** Thursday, 10th June 2021 at 14:30 via MS Teams To discuss the sign off the Annual Accounts 2020-2021 **Special Meeting** Thursday, 24th June 2021 at 14:30 via MS Teams To Consider the Annual Operating Plan **Public Board** Thursday, 29th March 2021 at 1.00pm MS Teams	

Unconfirmed Minutes of the Board Meeting
Held on Thursday, 10th June 2021 at 14:30 – 15:00
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
Catherine Phillips	CP	Executive Director of Finance
Ceri Phillips	CP	UHB Vice Chair
Chris Lewis	CR	Deputy Director of Finance
David Edwards	DE	Independent Member - ICT
Fiona Jenkins	FJ	Executive Director of Therapies & Health Sciences
Fiona Kinghorn	FK	Executive Director of Public Health
Gary Baxter	GB	Independent Member - University
John Union	JU	Independent Member - Finance
Len Richards	LR	Chief Executive Officer
Mike Jones	MJ	Independent Member – Trade Union
Rachel Gidman	RG	Executive Director of People & Culture
Rhian Thomas	RT	Independent Member – Capital and Estates
Ruth Walker	RW	Executive Nurse Director
Steve Curry	SC	Chief Operating Officer
Stuart Walker	SW	Executive Medical Director
Susan Elsmore	SE	Independent Member – Local Authority
In Attendance:		
David Thomas	DT	Director of Digital Health & Intelligence
Nicola Foreman	NF	Director of Corporate Governance
Darren Griffith	DG	Audit Wales
Ian Virgil	IV	Head of Internal Audit
Mark Jones	MJ	Audit Wales
Sam Austin	SA	Chair of the Stakeholder Reference Group
Observing		
Aaron Fowler	AF	Head of Risk and Regulation
Joanne Brandon	JB	Director of Communications
Secretariat		
Raj Khan	RK	Corporate Governance Officer
Apologies:		
Sara Moseley	SM	Independent Member – Third Sector
Michael Imperato	MI	Independent Member - Legal

UHB 21/06/001	**Welcome & Introductions** The UHB Chair welcomed everyone to the Public Meeting in English and Welsh.	
UHB 21/06/002	**Apologies for Absence** Apologies for absence were noted.	
UHB 21/06/003	**Declarations of Interest** The Executive Director of Therapies & Health Sciences declared an interest as a Board member of Cwm Taf Morgannwg UHB	
UHB 21/06/004	**Introduction to the Annual Report and Accounts 2020-21** The Director of Corporate Governance (DCG) informed the Board that this was the first time it had received a full Annual Report and Accounts for sign off at this stage. Historically the Accounts and Accountability Report would be shared separately. She reminded members that the version shared was not the finalised version that would be presented at the Health Board AGM so that any errors that were identified could be rectified. She highlighted that the attendance table would be the final item to be checked before the final version was presented. The DCG stated that the annual Report was made up of 3 main sections: 1. Performance report; 2. Accountability Report; and 3. Accounts The DCG highlighted that the Performance report, Accountability report, Accountable Officer's responsibilities, Directors responsibilities, Annual Governance Statement and the Statement of Financial position would be signed off by the CEO as the Accountable Officer. In addition to the Directors Responsibilities which would also be signed off by the Executive Director of Finance (DOF) and the UHB Chair. The EDOF advised that the accounts were submitted on the basis of an unqualified opinion and would have a qualification for the 3 year rolling average for their break even duty which was supported by the ISA 260 and the Head of Internal Audit Opinion 2020/21. The EDOF stated that the Board were asked to approve the letter of representation and adoption of the accounts so that they could be submitted to Welsh Government having been approved by Audit Wales The EDOF informed the Board that the accounts had not changed in terms of value since the previous draft submission and that they did not have a qualification on their stock which they received the previous	

	year. She added that there was an issue around emphasis of matter on the Health Board's ability to value senior clinical pension tax liabilities as they come due which was also covered in the ISA 260 report. **The Board resolved that:** The introduction to the Annual Report and Accounts for 2021/22 be noted.	
UHB 21/06/005	**Audit Wales ISA 260 Report for 2020-21** Mark Jones – Audit Wales (MJ-AW) highlighted that an unqualified opinion had been provided for the Annual Accounts & Remuneration Report which had been properly prepared and he commented that it was a very positive outcome. He highlighted a qualification on the regularity opinion which was the fifth year this had occurred due to the 3-year resource limit being exceeded by £9.7 million. He added that this did not apply to the current financial year as there was a £9.8 million deficit in 2018/19. MJ-AW highlighted a lower materiality level had been set for the Dragons Heart Field Hospital where enhanced testing had been undertaken. He added that there were no uncorrected misstatements and all corrections that had been made were detailed within appendix 4 of the report. MJ-AW stated that the issue that featured most prominently within the report was the tax issue with Senior Clinician Pensions. He referred to the point made by the DOF in regards to stock with it being unqualified due to figures being marginally below materiality of £130,000. He advised that enhanced work was undertaken to satisfy themselves that the figure was not understated. MJ-AW added that the stock was qualified the previous year but due to the pandemic they were not able to attend the year end stock take. MJ-AW stated that the letter of representation would be subsequently signed by the UHB Chair and CEO pending Board approval, if there were any uncorrected misstatements they would be highlighted within the letter and that this year Audit Wales were accepting electronic signatures. MJ-AW thanked the Corporate Governance and Finance Teams along with everyone else at the Health Board for their cooperation.	

	The UHB Chair thanked Audit Wales for their work as it helped to ensure that the Board can obtain the best possible assurance that their financial affairs are in order. **The Board resolved that:** The Audit Wales ISA 260 Report for 2020-21 be noted.	
UHB 21/06/006	**The Head of Internal Audit Opinion and Annual Report for 2020-21** The HIA clarified that his annual opinion had been thoroughly reviewed by the Audit Committee via the Audit Workshop in May and in the Special Audit Meeting held prior to the meeting. The HIA highlighted the key messages from his opinion within section 1.2 which clarified the final Head of Internal Audit Opinion which stated that the Board could take reasonable assurance that arrangements to secure governance, risk management and internal control, within those areas under review, were suitably designed and applied effectively. The HIA highlighted section 1.3 of his report and advised that the team had to make significant changes to their Audit plan to progress throughout the year but, largely due to the ongoing engagement with executives, management, and staff within the Health board, the team were able to complete sufficient work to provide a full opinion for the year which was a very positive position. He added that the changes to the plan were communicated and approved regularly through the Audit and Assurance Committee as the year progressed. He highlighted figure 1 within the report which provided the final outcomes for all internal audit work completed throughout the year: - Completed 29 internal audits for the year - 7 received substantial assurance - 18 received reasonable assurance - 1 received limited assurance - 3 advisory pieces of work - Positive position considering the adjustments for the year The UHB Chair thanked the HIA and his team for their work this year as it was useful to the Board to have the assurance to improve on areas where there were limited assurance ratings. **The Board resolved that:** The Head of Internal Audit Opinion and Annual Report for 2020-21be noted.	
UHB 21/06/007	**The response to the audit enquiries of those charged with Governance and Management** The EDOF advised that the response was a mandatory document that needed to be prepared and provided to Audit colleagues in order to inform their work. She provided highlights from the document which included the response for 2020/21 and the previous year. She stated	

	that both responses were largely similar and that both years had been audited and prepared whilst dealing with the emerging issues of the pandemic. She added that the document along with the letter of representation were two of the documents that had to be submitted to Audit Wales to provide assurance that accounts were prepared in accordance with current guidance and best practice. **The Board resolved that:** The response to the audit enquiries of those charged with Governance and Management be noted and approved.	
UHB 21/06/008	**The CVUHB Annual Report 2020-21 including the Annual Accountability Report, Performance Report and the Financial Statements** The Independent Member – Finance (IM-F) advised that the Audit Committee had conducted a workshop where it reviewed, in detail, the draft papers and following that meeting had held a Special Audit Committee meeting where the final drafts were reviewed and approved prior to being presented to the Board. He advised that the outcome of the Special Audit meeting was that the Committee were happy to recommend the aforementioned reports to the Board with an assurance that the draft papers had been adequately scrutinised by the Audit Committee. The EDOF highlighted the increase of value in revenue received that year which was directly related to responding to the pandemic which amounted to £176 Million. The CEO commented that the Health Board was in a really good position for the year and had delivered on its duty for a three year rolling average which was a testament to the people within the organisation and also the leadership provided by the executive team. He added that the document was comprehensive, which is something that they had been working towards and he commended the DCG who had overseen the work. The CEO highlighted that two years previously there were five areas of limited assurance compared to the present time where they was only one area. This demonstrated the proactive management and good work undertaken to improve on these areas and was a significant move forward for the organisation. Independent Member – Local Authority (IM-LA) questioned whether a more simplified snapshot document would be made available to the public, despite the fact that receiving a comprehensive document was quite reassuring. The DCG stated that there would be a finalised formal version prepared for the upcoming AGM but proposed that an easy-to-read version with	

	key messaging for patients and employees would be produced alongside it. MJ-AW stated that the accounts would be sent to Welsh Government on 11/06/2021 as the AGW were certifying all Health Bodies on the same day, Tuesday, 15/06/2021. Following this the accounts would be formally laid before the Senedd alongside a press release from Welsh Government. **The Board resolved that:** a) The reported financial performance contained within the Annual Report and that the UHB has breached its statutory financial duties in respect of revenue expenditure be noted; b) The Audit Wales ISA 260 Report for 2020/21 which included the letter of representation be agreed and endorsed; c) The Head of Internal Audit Opinion and Annual Report for 2020/21 be agreed and endorsed; d) The response to the audit enquiries of those charged with governance and management be agreed and endorsed; e) The Annual Report and Accounts for 2020/21 be approved.	
UHB 21/06/009	**Date and time of next meeting:** Thursday, 24 June 2021 at 09:30am Via MS Team	

Unconfirmed Minutes of the Board Meeting
Held on Thursday, 24th June 2021 at 14:30 – 15:00
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
Catherine Phillips	CP	Executive Director of Finance
Ceri Phillips	CP	UHB Vice Chair
David Edwards	DE	Independent Member - ICT
Fiona Jenkins	FJ	Executive Director of Therapies & Health Sciences
Fiona Kinghorn	FK	Executive Director of Public Health
Gary Baxter	GB	Independent Member - University
John Union	JU	Independent Member - Finance
Len Richards	LR	Chief Executive Officer
Michael Imperato	MI	Independent Member - Legal
Mike Jones	MJ	Independent Member – Trade Union
Rachel Gidman	RG	Executive Director of People & Culture
Rhian Thomas	RT	Independent Member – Capital and Estates
Ruth Walker	RW	Executive Nurse Director
Steve Curry	SC	Chief Operating Officer
Stuart Walker	SW	Executive Medical Director
Susan Elsmore	SE	Independent Member – Local Authority
In Attendance:		
Sam Austin	SA	Chair of the Stakeholder Reference Group
David Thomas	DT	Director of Digital Health & Intelligence
Nicola Foreman	NF	Director of Corporate Governance
Malcolm Latham	ML	CHC
Observing:		
Aaron Fowler	AF	Head of Risk and Regulation
Ian Virgil	IV	Head of Internal Audit
Mark Jones	MJ	Audit Wales
Joanne Brandon	JB	Director of Communications
Wendy Wright	WW	Deputy Head of Internal Audit
Secretariat		
Raj Khan	RK	Corporate Governance Officer
Apologies:		
Sara Moseley	SM	Independent Member – Third Sector
Lance Carver	LC	Director of Social Services, Vale of Glamorgan Council

UHB 21/06/24/001	**Welcome & Introductions** The UHB Chair welcomed everyone to the Public Meeting in English and Welsh.	
UHB 21/06/24/002	**Apologies for Absence** Apologies for absence were noted. Independent Member – Legal (IM-L) notified the board that he would be late attending the meeting	
UHB 21/06/24/003	**Declarations of Interest** The Executive Director of Therapies & Health Sciences declared an interest as a Board Member of Cwm Taf Morgannwg UHB	
UHB 21/06/24/004	**Annual Plan 2021 / 2022** The UHB Chair informed the Board that the item would be presented in two parts. Firstly the Executive Director of Strategic Planning (EDSP) would position the Annual plan and the timetable for the 2022/23 planning process. The Second part would be presented by the Chief Operating Officer (COO) who would talk about the overall approach to recovery. The EDSP informed the Board that final plan was shared for approval and reminded Members that a draft was brought to the board in March 2021. The EDSP advised that the feedback on the draft received from Welsh Government had been addressed in the final plan which had a strong alignment between service planning, workforce, and finance. The EDSP informed the Board although the Plan shared was a final document there were some things that has not been finalised and were being worked on, including the format and style of the Plan which the Directors Of Planning and Assistant Directors Of Planning were working on. It was hoped that a consistent style would be adopted across all Health Boards that would appeal to Welsh Government. The EDSP advised that the Health Board was required to supplement the plan with a detailed minimal dataset which had been populated but Welsh Government had requested further information. She added that the data set would be submitted with the plan as a live document which would be updated regularly.	

The EDSP highlighted that much of the work the Health Board undertaken could not be done without their partners and the plan makes reference to the work undertaken through the Regional Partnership Board, Public Service Boards and others, particularly on the prevention agenda.

The EDSP advised that there was an expectation that a winter plan would be needed as indications suggested that the NHS could face a challenging winter period. She reminded the Board that a partnership winter plan had been prepared in 2020 under the leadership of the Regional Partnership Board and it was likely that this would be what was expected for 2021/22.

Independent Member – Finance (IM-F) queried what communications plan was in place to inform people within the organisation about the plan.

The EDSP responded that a number of mechanisms would be used

- A Plan on a page – to help people easily understand what would be focused on as the priorities for the year
- The Deputy Director of Strategic Planning Chaired a group which included all Corporate Department and Clinical Board leads so there was wide oversight of the plans delivery.
- The plan was and woould continue to be shared at Health Systems Management Board meetings to highlight what it contained and how it would be delivered.

She added that the Strategy and Delivery Committee also maintained oversight of the plan and its delivery to provide assurance to the board.

The Director of Communications (DOC) added that from a leadership perspective updates would also be shared through the CEO Connects Q&A sessions.

The Executive Director of Finance (EDF) added that the Finance Committee had also had the opportunity to review the plan in detail and that she had also reviewed the draft in previous Board Meetings.

The EDF highlighted that the Health Board had an underlying deficit of £21.3 Million and £25 Million had been requested from Welsh Government recurrently. Welsh Government had also been asked to confirm that Covid costs would be fully funded but were yet to agree the allocations. She stated that this moved the plan from a deficit in this year to a break-even position on the assumption that Covid costs would funded and added that the funding is only for that year and there would

	be a need to maintain a dialogue with Welsh Government on funding moving forward. The Executive Director of People & Culture (EDPC) commented that the report was explicit in what the Health Board was looking at in terms of numbers and also the culture and inclusion of the workforce. For the following year the plan would be about designing new curriculums for a new workforce as they would not be able to work in the same ways they had done in the past. The EDPC confirmed that the Health Board had strengthened its inclusive recruitment by going out into the community to diversify the workforce. She informed the board that there was a workforce hub which ensured that workforce plans were in-line with operational and financial plans. The UHB Chair commented that a huge amount of effort had been put into staff wellbeing as well as recruitment and to look after staff who have been through a tough 15 months **The Board Resolved that:** - The Annual Plan 2021/22 be approved for submission to Welsh Government subject to further minor amendments highlighted by the EDSP.	
UHB 21/06/24/005	**Annual Plan 2022 / 2023 Timetable** The EDSP stated that her team had begun planning for 2022/23 on the assumption that they would plan for a 3 year IMTP. The EDSP reminded the Board that the planning process was paused in light of the pandemic so they had moved into a quarterly, six monthly and an annual planning cycle but there was a desire from Welsh Government to move into a 3 year integrated planning framework, provided that circumstances allowed. The EDSP mentioned that her intention was to have the 2022/23 plan ready for Board approval in December to submit to Welsh Government. She emphasised that there was a need to reflect on feedback from Audit with any observations and comments on how they can further improve plans as part of their works. The EDSP highlighted the timetable at Annex 1 of her report which highlighted the following dates: • September – set out commissioning intentions via the	

	HSMB (02/09/2021) and Strategy and Delivery Committee (14/09/2021) • December – Special Board meeting to approve the final plan. The UHB Chair commented that if there was to be a return to a 3-year planning cycle then there would be a need to progress through milestones and to make those smarter and easier to monitor to enable the Board to understand progress made against the plan. The CEO welcomed the return to a 3-year planning cycle as it was a helpful reminder that the 2022-25 plan would be the last 3 years of the 10-year strategy and would be about consolidating the Health Board's drive on care in the community and population health. He added that there was a need to focus on GP cluster development plans and how they feed through into the IMTP to drive and connect Primary, Secondary, and Tertiary level services which would be in line with the Shaping our Future Wellbeing strategy. The EDSP advised her team were working with PCIC as the national lead on cluster plans and that she would bring an update to the next Strategy Review meeting. **The Board Resolved that:** The Annual Plan 2022/23 Timetable be noted.	AH
UHB 21/06/24/006	**Annual Plan 2021 / 2022 (Cont.) – Chief Operating Officer Presentation** The UHB Chair shared that he had recently met with the Health Minister who highlighted a number of priorities including: 1. Recovery 2. Transformation 3. Prevention The UHB Chair informed the Board that the Health Minister was very keen to move all Health & Care provision in those directions. The COO provided a presentation on the Recovery and Design aspects of the Annual Plan. He reminded the Board that the Health Board's approach to recovery & design would be: • Clinically led • Risk orientated	

- Data driven
- Progressed on the basis that the Health Board would remain Covid ready.

He advised that remaining Covid ready was one of the first principles considered in recovery plans. He highlighted the Covid ready operating model and the changes which adopted in relation to triggering events which were previously linked to community prevalence but had shifted to activity levels. He gave an example of the new Early Warning System which had three trigger levels:

- Level 1 – Community prevalence
- Level 2 – EU attendance
- Level 3 – Admissions

The COO informed the Board of the Programme approach adopted in 5 areas:

- Mental Health Strategy
- Planned Care Recovery
- Primary Care Strategy
- USC/Medicine Model
- Diagnostics

The COO also shared a timeline of how the 2021/22 annual plan had developed.

March 2021:

- Longlist Submission of Schemes by clinical boards which were Planned Care focused as per Welsh Government instruction.
- Plan submitted on 31st March 2021
- Due to clinical urgency with some schemes, plans were adopted at risk in anticipation of funding being provided with a value of up to £6M.

April 2021:

- Funding approval for £13.6M which covered the areas adopted at risk.

May 2021:

- Longlist submitted for broader programmes.

June 2021

- Finalisation of schemes and submission to Welsh Government.

The COO highlighted that:

- 140 Schemes had been submitted
- 50% were in planned care
- 60% represented cost in planned care
- Initial bids from the organisation had a cost of £60M+

	The COO advised that a framework was needed to ensure that the Schemes being put forward were congruent with the organisations intentions and Welsh Government requirements. The qualifying guidance that schemes needed to comply with for were: • Risk & Urgency • Sustainability • Transformation The COO shared detail of the spread of the bids that had been submitted to Welsh Government: • £13.3M planned care bids; • £23.5M in relation to new schemes; • The Cost for 2022-23 is estimated at £39.8M of which £13M would be recurrent with the remainder for fixed terms of 1-3 years The COO demonstrated that over the following year, if the plan was supported, 30% of the funds received in 2021-22 would go into Primary care and Mental health and that the following year this would rise to 36% to provide a more balance portfolio and progressive agenda. This would that operationally his team would be delivering transformational and process changes alongside their operational delivery. The COO highlighted that there were several moving parts which could significantly affect delivery of the plan and that a programmed approach would be taken to head off potential issues. He highlighted that the key issues his team had identified were: • Still working under IP&C covid safe conditions • A potential 3rd wave • Wellbeing of staff • Recruitment • Expediency of Welsh Government Decisions • Reconfiguring the Health Board's estate to make it fit for purpose The COO concluded that his team: • Would take a programme approach • Had appointed a Programmes Delivery Director • Would develop a formal programme with partners • Would progress Welsh Government approved schemes • Would undertake some new schemes at risk The UHB Vice Chair queried how the team could ensure the plan and the financial underpinning of it would move in a whole system direction with resource being allocated where it was needed to ensure transformation and prevention aims were achieved.	

	The COO responded that delivery would be a challenge and he and his team would work through contingencies. His team would also organise themselves to ensure that surprises were minimised. The COO added that funding would allocated as discussed once it became available. IM-University (IM-U) expressed his concern over the level of resourcing as the money detailed by the COO related to Covid recovery money that would needed to be supported by digital enablers. He added that aligning digital aspirations and associated resources should play a large part in re-design plans otherwise key aspects of the redesign ambitions could fail. The Director of Digital Health Intelligence (DDHI) advised that digital transformation was an enabler of all of the UHB's transformation work and a digital transformation strategy, which would be refreshed to reflect the short and long term plans of the UHB, had been prepared. The UHB Chair queried resourcing in the digital area and whether staffing would be an issue. The DDHI advised that this would be addressed and that the digital enablers mentioned by the COO were specifically for the programmes detailed and that a number of wider business cases, if approved, would be used to provide additional resource. The CEO commented that the funding detailed in the plan was to deliver on recovery and had to be focussed to highlight what was being requested and what could be delivered. **The Board resolved that:** **a)** the final Annual 2021 / 2022 was approved.	
UHB 21/06/24/007	**Date and time of next meeting:** Thursday, 29th July 2021 at 12:30pm Via MS Team	

ACTION LOG
Following Public Board Meeting
27th May 2021
(For the meeting 29th July 2021)

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
Actions Completed					
UHB 21/03/012	**Performance Report**	The CEO commented that for the June Board development sessions to have a focus on CAHMS to get an understanding of the breadth of the issues and where the Health board plays in and how they need to bring in other organisations	**24/06/2021**	Nicola Foreman	**Complete** On agenda for June Board Development Session
UHB 20/11/014 **UHB 21/02/005**	**Nurse Staffing Act – Mental Health Nurse Staffing Levels**	A further discussion to be had at an Executive level to consider Mental Health Nurse staffing levels for feedback to the Board The End stated that this work will now be picked up as part of the IMTP Process and brought to the May Board	**27/05/2021**	Ruth Walker	**Complete**
UHB 21/03/008	**Chief Executive Report**	The EDSP said that they are also getting the survey responses and questionnaires back with the intention to bring all that information together and share it with the CHC and Board on the Outcome Of Engagement On Shaping our Future Clinical Services.	**27/05/2021**	Abigail Harris	**Complete**

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
UHB 21/03/023	**Agenda for Private Board Meeting – Annual Plan 21/22**	EDSP said that they will be sharing with Welsh Government draft Annual plan 21/22 and will bring back to Board the final plans	**24/06/21**	Abigail Harris	**Complete** Presented at Special Board Meeting held on 24th June 2021.
Actions In Progress					
UHB 21/03/018	**Terms of Reference & Work Plan for all Committees of the Board**	The DCG confirmed to bring the DHIC TOR and work plan to a future Board meeting	**29/07/2021**	Nicola Foreman	To be brought to the July Board meeting – Agenda Item 7.5
UHB 21/05/010	**Board Assurance Framework**	The DCG highlighted that they are due to update the BAF and risk management strategy which will come to the Board in July.	**29/07/2021**	Nicola Foreman	To be brought to the July Board meeting – Agenda Item 6.6
UHB 21/05/022	**Chairs Reports: S&D Committee**	IM-L informed the Board that the PNA (Pharmaceutical Needs Assessment) would come to the Board in September following the September S&D meeting	**30/09/2021**	Fiona Kinghorn & Karen May	To be brought to the September Board meeting
Actions referred to Committees of the Board/Board Development					

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

Background and current situation

This report includes information on the key activities that have taken place since the last Board Meeting on the 27th May 2021 together with an outline of the work carried out by the District Nurses and the Community Resources Team.

District Nursing (DN) Teams

There are 14 District Nursing Teams operating across Cardiff and Vale. It is important to recognise the support that our community nursing services have provided to wrap around the clusters/ nursing homes/care agencies/residential homes/ hospices during the pandemic

- This includes the provision of PPE to nursing homes/care agencies/residential homes/ hospices and Prison health care and we continue to do so.
- Merging of Vale Community Resource Service (VCRS)/ Cardiff Community Resource Team (CRT)/Acute Response Team (ART) and DN and specialist teams to provide a stronger 7 day approach
- 50% increase in End of Life Care (EOLC) on the District nursing caseload (April 2019-September 2020)
- Hospital discharge risk assessment devised
- Proactive case management to support multiagency care home response following Covid outbreak in care homes
- DN's working and training up residential home staff to support individuals nursing care needs to reduce footfall into closed settings
- Roll out of verification of death across the DN service and encouraging the uptake of training and implementation of this into independent sector care homes

Vale Community Resource Service (VCRS)
This is an integrated multidisciplinary and multi-agency team consisting of health, local authority and third sector professionals.

- Over the pandemic 4,632 patients were referred into the service, 44% of these required homecare and 56% needed therapy only. Of those requiring homecare, 42% we rightsized their care tailoring it to focus around what matters to them , and a massive 42% we supported back to full independence.
- From a therapy and third sector perspective the service provided rehabilitation to aid recovery to those directly affected by COVID and also those who were indirectly impacted on and were struggling due to numerous factors during this pandemic.

- Collaborating with Cardiff CRT in the last year we launched virtual 'stay steady' clinics to support those at risk of falls.
- Specifically, within the Vale we have also continued to deliver a rapid response falls service to address those at a greater risk of falls or who have fallen. Later this month we plan to work in partnership with the Welsh Ambulance Service in managing falls in the community setting.

Cardiff Community Resource Team (CRT)

This is an integrated Health and Local Authority team that provides care and rehabilitation to people in their own homes within Cardiff. The team like the VCRS aims to prevent hospital admission where possible and to facilitate early discharge home for people who have been admitted but have recovered sufficiently to continue with care, rehabilitation and recovery at home.

- Referrals to CRT are received from a wide variety of sources from either the community or from hospitals. Over the last 18 months CRT has developed a Single Point of Access (SPA) for community services for all hospital discharges where the person requires a level of care or support to go home.

The service has also introduced a Trusted Assessor role to ensure we have maintained our ability to deliver care promptly and made many changes to process to allow timely flow of patients into and through our services.

The COVID-19 pandemic presented ever increasing challenges for district nursing. COVID-19 meant that we needed to adapt how the District Nurses worked to meet increasing demand for End of Life Care (EOLC) in the community setting. We pride ourselves in offering an excellent service to patients/relatives during their last days/weeks of life and we were uniquely placed to provide all health and social EOL care ranging from point of assessment following fast track approval, to death (verification and last offices). We wanted to maintain this high level of service during COVID-19 despite our capacity being stretched.

We realised that we had to maximise capacity across our system in order to meet the demand so we had to make significant changes in the way we managed our community nursing provision.

Nursing is the largest staff group within PCIC and 50% work within district nursing services (Fig 1 District Nursing workforce May 2021)

Fig 1 – District Nursing Workforce

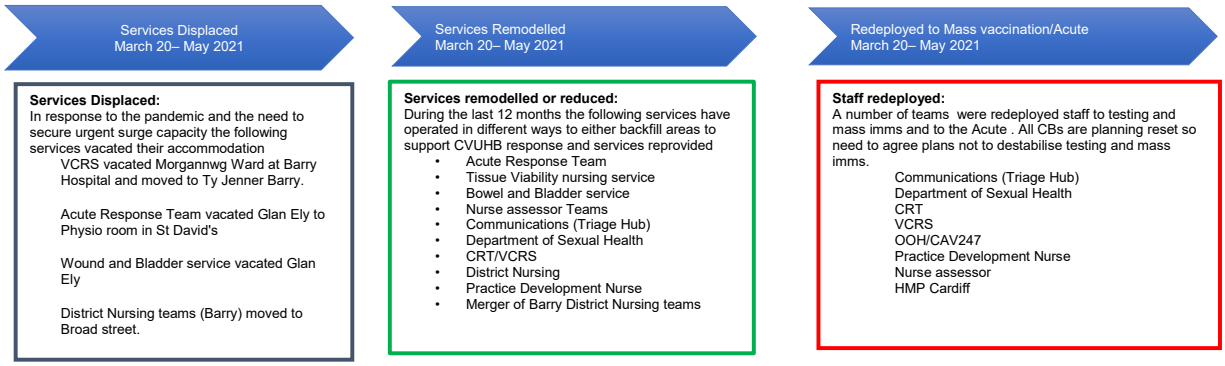
District Nursing Totals	
50%	**217 WTE**
185 RN	**32.7 HCSW**

The key aims for the district nursing service during the Covid 19 pandemic were:

- To support the predicted increase in number of patients wishing to die in their preferred place and have access to specialist services
- To provide 7-day resilient district (community) nursing service which was responsive to surge in demand
- To share skills, knowledge and processes between services to meet the needs of patients

- To support acute by avoiding admissions during the COVID-19 and MVC programme resulting in remodelling; displacement and redeployment of nursing teams to create greater resilience to the system. Figure 2 – provides an overview teams Displaced; Remodelled and Redeployed during the pandemic to support the wider system. At its peak 37 WTE staff were operating in areas outside of their normal employment and the current model continues which poses challenges for rest and recovery.

Figure 2 – Community Nursing Services redeployed March 2020- May 2021



Despite these challenges the Director of Nursing has used this as an opportunity for change. There has been a lot of flexibility and change in nursing teams throughout the PCIC. Some aspects of that are absolutely just for the pandemic, yet there are other areas where we've seen real innovation. We have used this as a start of looking and examining what changes we should take forward and so over the last 3 months we have triggered our PCIC Nursing Transformation Programme commencing March 2021.

We have produced a summary of activities within district nursing:

	Brief overview of the progress and highlights during last 3 months
Interim DN staffing principles	The March 2021 DN Staffing Principles submissions were cancelled in recognition of the challenges and operation pressures resulting from COVID 19. Feedback on the September 2020 submissions has been shared with the DN teams and progress is being made to suggest increasing compliance with the principles. This aligns to learning from the two-year Neighbourhood District Nursing scheme across Cwm Taf Morgannwg and Aneurin Bevan University Health Boards and Powys Teaching Health Board and the developing Cardiff and Vale @home programme.
Acuity tool	The All Wales District Nursing Group have recently revised its terms of reference. Cardiff and vale have refreshed the leadership at a strategic level and excellent progress is being with the DN (Draft) Welsh Levels of Care (WLOC) acuity dependency tool. A detailed implementation plan outlining the pilot has been developed. Phase 1 of the pilot has now commenced for June / July 2021 and training sessions on both the WLOC tool and the Microsoft (MS) Forms for data capture have commenced. Supplementary guidance and FAQ's are also being developed and shared during training sessions, these will be available fully before the start date of the pilot.

	Evaluation of this first phase of testing is planned for August / September with formal evaluation and recommendations available by November 2021.
Quality Indicators	Further changes in nurse leadership at a local and national level has triggered the refreshing and roll out of District Nursing quality so that we can evaluate the quality of the district nursing service within Cardiff and Vale. The Quality Audit exercise commenced 28 June 2021 and a revised plan has been agreed within the workstream. This revised plan will look to identify at least 5 District Nurse sensitive quality indicators, which will determine a baseline and provide assurance that good practice is being followed where appropriate identify any potential areas of concern, so that a pro-active approach can be taken to prevent any potential harm to patients and will support the measurement and evaluation of quality indicator measures in district nursing.
Digital Transformation (e-scheduling/ Malinko)	District nursing teams across Wales are now waving goodbye to time-consuming manual caseload scheduling following an all-Wales contract for the roll-out of intelligent e-scheduling software, Malinko. The Director of Nursing for PCIC Chairs this group at national level and which aligns to the work on the DN Quality Audit and WLOC. An Evaluation of the Neighbourhood District Nursing Pilots in Wales by the University of South Wales stated: Malinko has given Neighbourhood District Nursing teams an opportunity to work more safely and efficiently, "for example, reducing non-clinical contact time and duplicate visits. Staff using the system describe it as a new way of working from which they would not want to return." Cardiff and Vale received recurrent funding in March 2021 to implement Malinko. By transforming district nursing into a data-driven service, district nursing teams can integrate seamlessly into the broader health and social care network, and senior managers have the transparency and insight required to safely meet the needs of our communities. The Go Live for the Phase 1 implementation is July 2021
PCIC Nursing Academy	**What are we hoping to achieve with the Community Nurse Academy?** • A district nursing workforce with the skills and knowledge to meet the needs of a diverse population, adaptability to improve skills as the needs of the population change which aligns to the NMC Post Registration standards and "Future Nurse" proficiencies • Clearly defined developmental opportunities for all nurses – registered and unregistered • Leaders who are identified and supported to grow, aligned to talent and succession plans • Re-energising the Community Nurse role to a wider audience • Promoting opportunities to support career pathways to attract, recruit and retain the very best nursing workforce • Ensuring our workforce is more flexible and adaptable to current and future practice by introducing new and transformed roles, new ways of working with the skills to work at the top of their licence.

	• Building a more agile, healthy and resilient workforce by empowering and investing in them • Improving the staff and patient experience and deliver better outcomes that matter to people. • To extend the academy across multi-disciplinary teams to wrap around the patient. To become a leading edge area of best practice and excellence. **Where are we now?** What has been achieved: • We have agreed core competencies for district nurses, DOSH, CHAP, Nurse Assessors, homeless team, ART, wound team, bladder and bowel team and HMP. We have made the decision not to focus on core competencies for the OOH team as they do not have band 5 nurses. • The core competencies that are now available through e-learning will be accessible through ESR and the newly launched CONNECTS programme

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

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

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

Date Signed	Description of Document	Background Information
20.05.2021	Toys r Us – Mass Vaccination Centre Licence to Occupy, Lease and Licence for Alterations.	Agreements between (1) Cardiff County Council and (2) Cardiff and Vale University Health Board to regularise the Health Board's occupation of the Bayside Mass Vaccination Centre.
27.05.21	Deed of Surrender and Tenancy at will for the Lease of the UHW concourse.	Agreements between (1)Cardiff and Vale University Health Board and (2) Gentian Holdings Limited to end the current lease of the UHW concourse and put in place temporary rights of accommodation for the Tenant.
28.06.2021	Licence to Occupy land at Riverside Health Centre	An agreement between (1) Cardiff and Vale UHB and (2) Grow Cardiff for use of land as a community garden.

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 Action Details	Background Recommendation Approved	Date Approved	IM Approval	
			IM 1	IM 2
Contract for refurbishment of Rainbow Ward	Contract for refurbishment works totalling £1.4 million – Health Board contribution of £238k with the remaining balance to be funded by LATCH	24.05.21	Rhian Thomas 11.05.2021	John Union 12.05.2021
SNP Array Reagents	24 months with an option to extend for 12 months with Illumina Cambridge Limited for the supply of Single Nucleotide Polymorphism Array Reagents and Platform	12.05.21	Michael Imperato 12.05.21	John Union 08.05.21
Application of UHB Seal to lease of Chapel at CRI to Cardiff CC	Authority obtained for the application of the Health Board seal to complete a lease.	28.04.21	Rhian Thomas 28.04.21	Michael Imperato 27.04.21
Approval of Genomics FBC for submission to WG	Approval of FBC recommended at May 2021 Board meeting subject to minor changes. Chairs Action obtained for the final version prior to submission to Welsh Government.	20.05.21	Mike Jones 17.05.21	John Union 17.05.21
Approval of costs for the extension and increase in a current contract for additional Covid-19 capacity provision.	Approval given to extend an existing contract with St Joseph's Private Hospital for additional 'Green' covid capacity until March 2022.	25.05.21	Rhian Thomas 26.05.21	John Union 27.05.21

Approval of seal on Gentian lease deed of surrender	Approval granted for the application of the UHB Seal to complete legal documents.	27.05.21	Rhian Thomas 27.05.21	Michael Imperato 27.05.21
Marie Curie - Hospice Inpatient Palliative Care Extension	Approval of extension to current contract for a further 9 months.	03.06.21	Rhian Thomas 10.06.21	John Union 09.06.21
Cardiac Cath Lab Kit Replacement and Maintenance	Urgent approval given for the purchase of replacement equipment and maintenance support. Discounted price agreed as purchase was completed prior to 24.06.21. Total cost of £987,994.80.	21.06.21	Rhian Thomas 21.06.21	John Union 21.06.21
Approval of settlements over £1m	Approval given, following receipt of legal advice for one settlement of over £1m and for continued interim payments that cumulatively exceed £1m.	21.06.21	Michael Imperato 21.06.21	Gary Baxter 21.06.21
Mobile Theatres	Approval given for expenditure over £1M - Contract valued at £2,101,907.40	22.06.21	Rhian Thomas 22.06.21	Michael Imperato 22.06.21
Lease of Franking Machine	Approval given for expenditure over £500k for a new lease of equipment.	05.07.21	John Union 01.07.21	Gary Baxter 05.07.21
Aligned Medical Solutions	Approval provided for expenditure over £500k to secure a contract for additional locum medical staff.	05.07.21	Rhian Thomas 05.07.21	Mike Jones 05.07.21
Contract for the purchase of Dropper Bottles	Approval provided for a contract in excess of £500k for the purchase of Glucose/Ketone EQA vials (Dropper Bottles)	13.07.21	Ceri Phillips 13.07.21	David Edwards 13.07.21

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

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

Recommendation:

The Board is recommended to:

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

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

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

Equality and Health Impact Assessment Completed:	Not Applicable

Report Title:	**CHIEF EXECUTIVE'S REPORT**								
Meeting:	**CARDIFF AND VALE UHB BOARD MEETING**					**Meeting Date:**	**29.07.21**		
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**	✓	
Lead Executive:	**CHIEF EXECUTIVE**								
Report Author (Title):	**EXECUTIVE ASSISTANT TO THE CHIEF EXECUTIVE**								

Background and current situation:

This is the twenty third 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:

David Thomas joins the board as Director of Digital & Health Intelligence
I'd like to welcome David Thomas, Director of Digital & Health Intelligence, to the board.

David joined the UHB in January 2019 and created a new directorate bringing together IT and Information functions.

Previously, David worked as Director of ICT in various NHS commissioner and provider organisations in central London where he developed and led ICT strategy and implementation programmes across primary and secondary care services.

In addition to gaining broad ICT management experience over the past 20 years, David graduated from the NHS Leadership Academy in 2014 having successfully completed the Nye Bevan course in Executive Leadership in HealthCare.

A native Welsh speaker, David is committed to the values of the NHS and is keen to ensure that that digital solutions, as key enablers, can support the evolving services of the NHS. David is also the SRO for the Welsh Government led and funded All Wales IT Infrastructure Programme, developing robust IT infrastructure environment and the supporting management processes to underpin delivery of the NHS Wales digital strategy.

Spinal and Neurology Specialised Rehab Services move to UHL
As part of a programme of work to enhance our Spinal and Neurology Specialised Rehab services, a brand new facility has been established at the University Hospital Llandough (UHL).

It is an exciting time for the directorate as rehabilitation services are transferred from our Rookwood site to the new purpose built facility.

The new wards have state-of-the-art equipment which will further improve the outcomes of patients in our care. Designed around patient experience and modern healthcare requirements, the beds are more spaced out and there are more cubicles on the wards. The service will also benefit from out-of-hours medical support being co-located with Radiology services at the UHL site.

Our new rehabilitation facilities at UHL include a hydrotherapy pool, gymnasium and consultation rooms. These facilities will give patients the best possible chance of recovery and enhance their rehabilitation progress. The move is taking place in a phased approach over the coming weeks to ensure the transition is as smooth as possible.

Dragon's Heart Institute launch and publication of COVID-19 Discovery Report
I was thrilled to see the launch of the Dragon's Heart Institute website, (https://dragonsheart.org). The Dragon's Heart Institute has been formed as a result of our response to the COVID-19 pandemic to spearhead innovation in the UHB and act as a catalyst for improvement and change.

I have always advocated that staff on the front line have the permission to be bold in their practice and make the changes necessary to deliver the best outcomes for patients. However, we know that those with the big ideas do not always know where to turn to get the support they need to enact them effectively. The Dragon's Heart Institute will be the key to unlocking ideas, skills and specialist knowledge of our staff, helping us to achieve the goals in our ten-year strategy, *Shaping our Future Wellbeing*, and beyond.

The team have already begun working with Health Board partners such as the Innovation MDT to make is as easy as possible for staff to develop their leadership skills and make improvements in their areas of work. Do visit the website and get in touch with the team if you would like to discuss an idea.

Already, the Dragon's Heart Institute has published a COVID-19 Discovery Report, written by Cardiff and Vale UHB to capture what we learnt in the initial stages of the pandemic alongside a number of case studies of exceptional, innovative practice.

Introducing the 14,000 Voices Programme
I am delighted to announce the start of our 14,000 Voices programme, hosted by the Dragon's Heart Institute. It is an opportunity for staff to connect with the executive team, share their ideas, and drive meaningful change in a relaxed, informal setting.

We know that many of the best ideas about how to improve practice and processes across the health and care system are generated by those working on the front line but that they often face barriers to progressing them.

During the COVID-19 pandemic, staff across the health and care system worked in new, innovative ways to solve the challenges posed by the disease. Now, 14,000 Voices aims to capture that momentum and ensure that the staff are engaged, supported and empowered to make their ideas about improving care a reality.

The executive team at Cardiff and Vale UHB have committed to driving forward the best ideas and suggestions from the sessions and reporting back to those who suggested them with their progress regularly.

The first 14,000 Voices sessions will take place at the University Hospital Llandough in July and be chaired by the Executive Director for People and Culture. Further sessions planned for other Health Board sites will be announced in the near future.

Green Health Wales
Some of our Cardiff & Vale colleagues along with partners in other Welsh NHS organisations organised an online conference on 29th June called Green Health Wales (https://www.greenhealthwales.co.uk/). It's a network of clinical, non-clinical, administrative, support and managerial colleagues across Wales who recognise that the climate crisis is a health crisis. The Green Health Wales team organised an impressive range of speakers and also showcased the work that is going across Wales. I was pleased that conference was well attended.

Health Service Journal Partnership Award
I was delighted to hear that alongside our partners, Archus, Mott MacDonald, Q5, Hoare Lea, BDP, Welsh Rugby Union and countless others, Cardiff and Vale University Health Board was awarded the Health Service Journal (HSJ) Partnership Award in the regional COVID response category for the construction and operation of the Dragon's Heart Hospital (DHH).

The team representing the DHH partnership faced incredibly tough competition in their category from a range of other partnerships who have each delivered life-saving or life-changing interventions against the COVID-19 pandemic. To be simply shortlisted as a finalist for these awards, despite tough competition from a pool of brilliant applications, is a mark of real achievement for Archus, Mott Macdonald and partners working with Cardiff and Vale University Health Board.

However, the unprecedented scale of both the challenge and the strength of the partnership that rose to face it at the Dragon's Heart Hospital won the day at a socially-distanced ceremony in London on 29th June.

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

HEALTHCARE INSPECTORATE WALES
Annual Report 2020-2021

HIW Annual Findings 2020-2021
Cardiff and Vale University Health Board

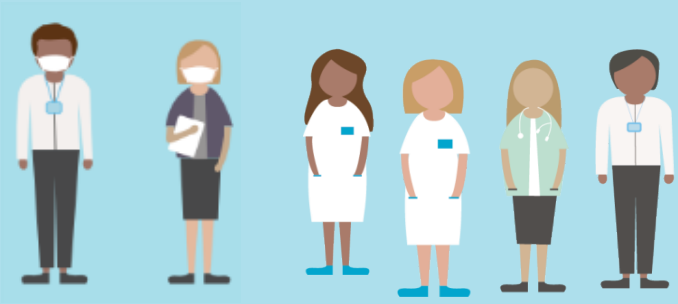
Vanessa Davies
Head of Reviews & Relationship Manager Cardiff and Vale

29 July 2021

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Agenda

- Introduction
- Our adapted approach
- All Wales Summary
- Cardiff and Vale University Health Board – Our Work
- Key findings



Healthcare Inspectorate Wales

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that people in Wales receive good quality healthcare.

Our values

We place patients at the heart of what we do.

We are:

- **Independent**
- **Objective**
- **Caring**
- **Collaborative**
- **Authoritative**

Goal

To encourage improvement in healthcare by doing the right work at the right time in the right place; ensuring what we do is communicated well and makes a difference.

Through our work we aim to:

Provide assurance: Provide an independent view on the quality of care.

Promote improvement: Encourage improvement through reporting and sharing of good practice.

Influence policy and standards: Use what we find to influence policy, standards and practice.

Healthcare Inspectorate Wales – Our adapted approach

We maintained oversight throughout the pandemic by:

- Working with partners and stakeholders
- Ongoing review of information and intelligence, which included Welsh Government COVID-19 reports and scenario modelling, and Public Health Wales COVID-19 surveillance information.

We introduced new ways of working to check on care by:

- Continuing to discharge our statutory function
- Introducing a flexible and an adaptable approach with assurance work
- Reducing the burden to a system under significant pressure
- Maintaining the safety of our staff and peer reviewers
- Rapid development of approaches to look at short and long term changes in healthcare provision.

Healthcare Inspectorate Wales – Our adapted approach

Our new approach, **HIW Quality Checks,** have been conducted entirely offsite, and their design aligns to key areas set out in the NHS Wales Planning Framework. The methodology focused on three areas:

- **Infection prevention and control**
- **Workforce Governance**
- **Environment of care.**

Each sector-specific methodology considers the above themes, plus other pertinent areas to that sector.

The work specifically explored the arrangements in place to protect staff and patients from COVID-19, and enabled us to provide **fast and supportive improvement advice** on the safe operation of services during the pandemic.

HIW assurance and inspection activity during 2021-21:

All Wales Summary

Remote work:

- 90 quality checks within the NHS and Independent Healthcare Settings
- 5 follow-up NHS hospitals and 5 IR(ME)R inspections
- Handled over 1000 calls through our First Point of Contact (FPOC) service
- Dealt with 439 concerns – 36 needing urgent action

Onsite inspections:

- 23 onsite inspections in NHS and Independent Healthcare Settings, which included:
  - 1 Field Hospital
  - 8 Mass Vaccination Centres

All Wales Themes 2020 - 2021

Overall, good standards of care delivered across Wales during a period of unprecedented challenge.

Rapid response from services by **adapting environments and introducing new ways of delivery** to enable essential services to continue. (e.g. redesign of fracture clinic services, increasing use of remote and telephone consultation options.

Services implemented **innovative approaches to support patients' physical and mental well-being** during the pandemic (e.g. a shop within a mental health hospital setting)

Wide range of changes were made to **Infection Prevention and Control (IPC)** arrangements to support the delivery of safe care. The COVID-19 outbreaks within hospitals during the second wave highlight the need for ongoing robust arrangements to maintain effective IPC, and follow latest national guidance.

Staff of all levels demonstrated **tireless commitment and flexibility**. However, working during this time will have impacted considerably on staff well-being and continued resilience. Measures should be in place to support staff and maintain their well-being.

Compliance with mandatory training should be a priority during recovery.

Cardiff and Vale - Our work in 2020-21

Remote Quality Checks:

- 5 Hospital
- 2 Mental Health
- 2 General Practice

Onsite Inspections:

- 1 Dental Practice
- 2 Mass Vaccination Centers (MVCs)

Key findings

Overall, our quality check findings were positive, with evidence that healthcare environments had been adapted to in response to the challenges of the pandemic. Throughout each check, staff interaction was good, and the ongoing engagement from senior leadership teams has been positive.

Our unannounced inspection within Birchgrove Dental Practice highlighted a number of issues with maintaining staff and patient safety. In particular, these were around compliance with Aerosol Generating Procedures (AGPs) and decontamination following AGPs, which increased the risk of cross-infection with COVID-19.

Within the two MVCs inspected, significant amount of work had been undertaken at pace to provide temporary environments with sufficient capacity to deliver the vaccination programme. We were assured that appropriate arrangements were in place to enable each site to function as intended, however some improvements were required to maintain staff and patient safety.

Where improvement was required through any of our assurance activities, all relevant departments responded in a productive manner and with good prompt engagement.

Assurance and Inspection Work- Hospitals

There were five hospital quality checks in Cardiff & Vale during 2020-2021- Morgannwg Ward in BCH, T4 and TCT in UHW, and East 3 and East 4 and the Medical Assessment Unit in UHL

Positive findings:

- Up-to-date policies, guidance and communication with staff for COVID-19, including access to and training for PPE
- Increased cleaning schedules and infection control audits
- Assistance and support for patients, with electronic communication with family and friends
- Strict management arrangements with visiting arrangements

Most significant areas requiring improvements:

- Compliance with mandatory training in some areas
- Timely action from Estates team to repair or replace environment issues
- Timely environment and IPC risk assessments in some wards

Assurance and Inspection Work - Mental Health

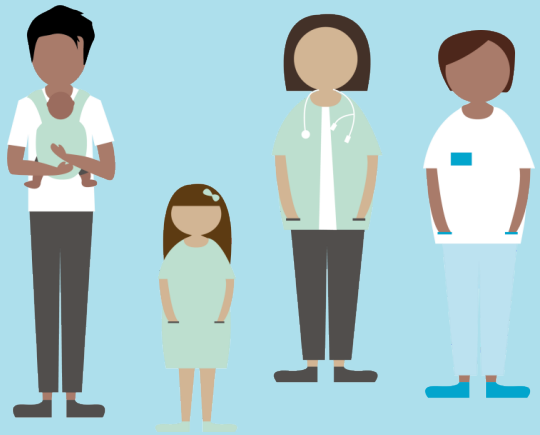
There were two mental health quality checks in Cardiff & Vale during 2020-2021 – East 12 in UHL and Hazel Ward in Hafan Y Coed

Good practice or positive findings:

- Up-to-date policies, guidance and communication with staff for COVID-19, including access to and training for PPE
- Increased cleaning schedules and daily patient checks for symptoms of COVID-19
- Appropriate staffing and attendance maintained
- Assistance and support for patients with electronic communication with family and friends

Most significant areas requiring improvements:

- Timely ligature risk assessments
- Timely compliance with mandatory training
- Negative impact on patient rehabilitation due to pandemic restrictions
- Timely environmental and IPC risk assessments



Assurance and Inspection Work – GP practices

There were two GP quality checks in Cardiff & Vale during 2020-2021 - Llandaff North Surgery and Ravenscourt Surgery (Vale Group Practice)

Positive findings:

- Clinician triage, telephone and e-consultations
- Robust measures for onsite appointments
- Staff guidance for COVID-19 and IPC
- Increased cleaning schedules and infection control audits

Most significant areas requiring improvement:

- Timely compliance with mandatory training in some areas
- Timely access to secondary care following referra
- Timely risk assessments for home visits

Assurance and Inspection Work - Dental

There was one unannounced onsite dental inspection in Cardiff & Vale during 2020-2021 - Birchgrove Dental Practice

Positive findings:

- Good hand hygiene arrangements
- Increased cleaning schedules and infection control audits
- Patient assessments prior to appointments
- Access and training with PPE
- Social distancing measures in place

Most significant areas requiring improvement:

- Compliance with AGP
- Inadequate cleaning products following AGP
- Inappropriate PPE when decontaminating post AGP
- Timely COVID-19 risk assessments for staff
- Timely implementation of standard operating procedures

Assurance and Inspection Work - MVCs

There were two onsite inspections of Mass Vaccination Centres in Cardiff & Vale during 2020-2021 - Splott and Holm View Centres

Positive findings:

- Safe social distancing and the flow of patients throughout the centres was efficient and timely
- Patients were assessed for symptoms of COVID-19 before entering the centres
- Non-registered vaccinators felt appropriately supported by their registered supervisors
- Volunteers and clinical staff spoke to patients in a friendly and respectful manner

Most significant areas requiring improvement:

- Appropriate and consistent clinical assessment prior to receiving their vaccination
- Reconstituted vaccine storage and traceability to maintain safe practice
- Staff awareness of evacuation procedures in the event of an emergency
- Audit activities to maintain patient safety

HEALTHCARE INSPECTORATE WALES
Annual Report 2020-2021

Thank you.
Any questions?

Vanessa Davies
Head of Reviews & Relationship Manager Cardiff and Vale

29 July 2021

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Report Title:	**Corona Virus Update Report**						**Agenda Item no.**	**6.5**	
Meeting:	**UHB Board Meeting**						**Meeting Date:**	**29.07.2021**	
Status:	**For Discussion**		**For Assurance**	**x**	**For Approval**		**For Information**		
Lead Executive:	**Chief Executive Officer**								
Report Author (Title):	**Director of Corporate Governance**								

Background and current situation:

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

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

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

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

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

Recommendation:

The Board is requested 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 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								

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

- **Covid outbreak position** – at the time of writing Cedar Ward is closed as one patient has tested positive to Covid -19. All the necessary precautions are in place and IP&C advice is being provided. The ward is currently closed to admissions, transfers (except for discharge home)

- **Investigation of hospital acquired Covid - 19 –** the UHB continues to work with colleagues across Wales, Welsh Government and the Delivery Unit to standardise the investigation of hospital acquired Covid – 19, and the application of the Putting Things Right regulations. An Executive Led Covid - 19 Investigation Oversight Group and Scrutiny Panel has been established and met for the first time on 6th July 201to oversee and monitor the process of investigation, review and Redress.

- **Concerns –** the department continues to receive high volumes of enquiries in relation to the Mass Vaccination programme.

Workforce	Executive Director of People & Culture

The Workforce Hub Steering Group set up to address workforce needs relating to Covid has changed its terms of reference and now focuses on providing the workforce required for three components:

1. Being Covid ready
2. The UHB recovery plan and
3. For business as usual

    - Being Covid ready is ensuring our we have the right staff who are flexible and rotas established at speed
    - For the recovery plan the initial additionality of 330 posts have been identified and it is recognised that this will be particularly challenging for those areas who already experience shortages in certain professions. It is essential, therefore, that a creative and flexible approach to filling these gaps is taken. A large number of schemes have been submitted to Welsh Government for funding (£37m), partly to recruit additional staff but also to increase Health Board activity and reduce waiting lists.
    - Business as usual – A plan to attract, recruit and retain staff is being proposed and planned to ensure our establishment is being fully recognised

As well as the additional staff required for the recovery plan, the Health Board will be using existing staff to work additional clinics and shifts. NHS employers are

currently reviewing the system for the All wales enhanced pay rates to increase attractiveness of overtime and local discussions about the principles on how to implement these are being discussed in partnership

The field hospital beds in the Lakeside Wing have been closed and have been replaced with winter pressure beds – this shows the unprecedented demand NHS services are currently facing Nationwide.
The Emergency Unit footprint is still extended due to social distancing which had had an impact on staffing requirements.

The Health and Wellbeing of our staff is a high priority with focus now shifting to recovery post-Covid. An Employee Wellbeing workshop was held on 7 July 2021 to identify those initiatives which have worked well during the Covid period as well as new initiatives for the future and an Employee Wellbeing plan for the next year will be developed in line with the People and Culture plan

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

Governance	Director of Corporate Governance

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

The Health Board has commenced preparations in readiness for an impending public inquiry into the Covid-19 pandemic. The Corporate Governance directorate are erring on the side of a Welsh Inquiry which would go into greater detail of the actions of the Health Board and a Covid-19 Response Archivist had been appointed to develop a database or relevant decisions, documentation and actions for this purpose.

A structure detailing the Health Board's response to an Inquiry was agreed by the Management Executive team in June 2021 and was developed from experienced garnered from participation in the Infected Blood Inquiry.

The Head of Risk and Regulation and the Archivist will meet with Clinical Boards, Corporate Directorates and external bodies to ensure that all relevant guidance, document and evidence is collected and recorded in preparation for an Inquiry. Monthly progress updates on this work will be shared at Management Executive meetings and where appropriate within sub-committees of the Board.

Operations including Operational Framework	Chief Operating Officer

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

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

Unscheduled care – Hospital Covid demand remained low as at May/ early June 2021. There is evidence however that primary care and mental health services are experiencing service pressures.

In terms of remaining ahead of a potential future 3rd wave, it is important that operational preparedness and early warning triggers are sensitive to the changing pandemic circumstances. In particular, the fact that the growing vaccine rate may have weakened the link between higher community prevalence and high admissions. The COO has asked services to refresh escalation procedures reflecting these changed circumstances.

The non-covid demand increase has continued and there are continuing challenges in remaining covid-ready while accommodating non-covid and planned care increases. Clinical teams are reporting some evidence of patients being admitted in a more 'deconditioned' state – potentially as a result of delaying seeking treatment. This would correlate with observed increases in hospital length of stay.

Critical care remains under some pressure due to the re-emergence of non-covid demand and an increase in elective operating.

The Health Board has received new bed modelling projections from Welsh Government and, as part of its Annual Plan return, has indicated it has access to sufficient beds to meet the demands described. The Lakeside Wing availability is a key component of this bed availability. The Health Board's Workforce Cell is active in planning to staff these beds in that eventuality.

Planned care –We have continued to focus on recommencing elective activity which ceased in January and February 2021. A number of service reconfigurations which were undertaken in response to the pandemic are being reinstated.

Cancer care – Cancer care continues to be provided as an essential service. As reported last month, the Health Board has been successful in maintaining treatment activity and referral rates. As a tertiary provider of services, we are now seeing referrals from outside the HB increasing - as other HB's reinstate access to their services. There is likely to be a period therefore where local and regional referrals will grow. The fact that this is still somewhat unpredictable means the trajectory for cancer improvement remains uncertain.

Mental Health services – With demands on Mental Health Services continuing, the Clinical Board is re-assessing pressures on the various points of access to get a whole system view. Clinical teams continue to report an increase in level of acuity in presentations, leading to an increase in hospital admissions. As a result, out of area placements have increased. The service is further supporting adolescent services as presentations increase in areas such as eating disorders. The Health Board is working closely with system partners in ensuring there is a holistic response at a system level.

Primary care services have seen significant pressures in the wake of the second covid wave. Feedback from clinical colleagues suggest the acuity of primary care presentations may be linked to delayed presentations as a result of lock down. Dental services are working to approximately 50% of pre-covid activity, with optometry being at 80%. The Health Board is supporting a small number of practices with merger and temporary list closure requests but remains in a position where no managed practices are necessary.

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

The Chief Operating Officer and Medical Director has held a number of engagement sessions with clinical staff as a 'check-in' following recent pressures. In addition, the COO has presented current thinking on recovery to a range of community stakeholders.

Public Health	Executive Director of Public Health

Epidemiology update

Cases of Covid-19 started to rise significantly in early June in both Cardiff and the Vale, with rates projected to exceed 100 per 100k per week in Cardiff at the end of June. Rates in the Vale exceeded 50 per 100k over the same time period. This is equivalent to around 50 cases per day in Cardiff, and over 10 per day in the Vale. Test positivity has increased in tandem with this, to over 5% in Cardiff (5.7%) and 3.9% in the Vale.

Notably, however, increases in cases in the community have been driven primarily in the 20-29 and 10-19 year old age groups, particularly young adults in Cardiff. This group includes but is not limited to, university students. In these age groups test positivity is over 10%, but below 5% in all other age groups, and very low (2% or below) in 60 year olds and over.

These rises are not unexpected in the context of relaxed social restrictions, the delta variant of Covid-19 becoming the predominant strain in the UK, and lower coverage of two vaccines among younger people.

Covid-19 hospital admissions and bed occupancy remain very low, though continues to be monitored carefully. This pattern, along with the lower case rates in older people, is reassuring as it suggests that vaccination is protecting these age groups, which are at highest risk of morbidity and mortality. As vaccination coverage with two vaccines continues to increase across younger adults this should extend protection to these age groups too.

Incidents in hospital settings remain very low, with no NHS incidents during May and June. There has been a small increase in positive tests in care homes, but few significant incidents. Workplace incidents remain small in number, and are usually only 2 cases in a given location, without evidence of further spread. However, we are seeing spread associated with hospitality venues. Positive cases are being

seen in our schools though in most cases these are related to spread within the individual’s household, with no further onward spread within the school.

Overall mortality rates remain below the 5 year average for Cardiff and Vale.

Test positivity among travellers from amber and green countries remains low, which is encouraging. However we continue to monitor carefully variants of concern (VOCs), as there remains a risk of importation of new VOCs which are more transmissible or for which our vaccines are less effective.

TTP update

Numbers accessing symptomatic (PCR) testing increased significantly during June and early July, but the majority of results continue to be received within 24 hours. Lateral Flow Tests (LFTs) continue to be used in healthcare, care home and school settings to screen asymptomatic staff and pupils, and are also available to people who volunteer or who cannot work from home. LFT kits can now be sourced from participating pharmacies via the ‘Pharmacy Collect’ scheme; 94% of pharmacies in Wales have registered to take part, thus increasing equity of access, particularly for those who are digitally excluded.

Contact tracing is one of the key measures in controlling COVID-19 risk, and will continue to be so for the foreseeable future although the nature of contract tracing and consequent public health action will be dependent on the public health approach for the summer and the autumn/winter. The increase in case numbers has caused pressure on contact tracing services. Staffing of contact tracing services is being increased in response to this demand, with the aim of ensuring that cases and contacts are traced as rapidly as possible. The regional partnership team continue to meet daily during the week to review incident cases and direct action to address any clusters or settings of concern, thereby managing risk within the population of Cardiff and the Vale of Glamorgan.

Our partnership communications teams work collaboratively across the region to share up to date information with local communities, particularly in relation to testing and vaccination.

It is now evident that we are experiencing a third wave and modelling indicates that the peak is likely to occur in coming weeks. Review of national measures may result in further relaxation of some, which could impact further on likely case numbers. We will be closely monitoring surveillance data to plan and manage the regional response.

Vaccination update

To date we have administered over 625,000 vaccinations in Cardiff and the Vale of Glamorgan. Of these 352,000 are first doses and 273,000 are second doses. Over 80% of the adult population (aged 18+) have now received at least one dose of vaccination. Over two thirds have received a full course (two doses) of vaccination. We have offered all people in Priority Groups 1- 10 (people aged 18+) a vaccination and we are implementing a variety of approaches (e.g. walk-in clinics and pop up vaccination) to ensure no-one is left behind. Planning for Phase 3 / Booster has been underway since April. Interim guidance on Covid-19 booster

vaccination was published on 30 June 2021 by the Joint Committee for Vaccination and Immunisation, followed by a Welsh Government written statement on the same day; both set out a steer for the next stage of the vaccination programme.

Mass vaccination centres: We have three Mass Vaccination Centres currently operating - Splott, Holm View and Bayside MVC. Delivery at Pentwyn Leisure Centre was paused in line with our vaccine supply and workforce capacity. Pentwyn LC will be utilised for community activities over the summer period. We are currently working through our estates requirements for the booster programme. We are continually reviewing our operational model in line with vaccine supply and workforce capacity.

Our Local Vaccination Centre (LVC) in the Western Vale has now provided first and second doses of Oxford Astra Zeneca vaccination to everyone aged 40 and over registered with the three GP practices in the Western Vale Cluster.

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

GP practices: Our GP Practices have completed delivery of second doses of AstraZeneca vaccine to people aged 75+ and 65-69.

Community Pharmacies
Six community pharmacies have been delivering vaccines to people aged 40-49. Appointments at Community Pharmacy can be accessed through our main booking line.

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

Communications:
As we are vaccinating our younger age cohorts, we are adapting and developing our communication strategy to meet differing needs as well as addressing key issues such as Do Not Attends (DNAs).

Report Title:	**Board Assurance Framework (BAF)**								
Meeting:	Board						**Meeting Date:**	29th July 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 upon the delivery of the Health Board's Strategy 'Shaping our Future Wellbeing'. It provides information on the controls and assurances in place to manage and/mitigate the risks identified and any further actions which are required.

Each year the Management Executive Team agree which significant risks will impact upon the delivery of the Cardiff and Vale UHBs Strategic Objectives. Below are those such risks:

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

These risks are all detailed within the attached BAF.

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 May 2021 all risks have remained at the same score with the exception of the risk in relation to Financial Sustainability. This risk has increased from a 10 (High) to 15 (Extreme). This is due to the uncertainty in relation to the funding of recovery.

The risk in relation to 'Exacerbation of Health Inequalities', which was flagged with the Board in May, has now been fully developed into a BAF risk.

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

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

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

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

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

A new Board Assurance Framework and Risk Management Strategy was presented to the Audit Committee on 6th July and is also on the Board agenda for today's meeting.

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 10 risks to the delivery of Strategic Objectives detailed on the attached BAF for July 2021.
- **Note** the continuing progress which has been made in relation to the roll out and delivery of effective risk management systems and processes at Cardiff and Vale UHB.

Shaping our Future Wellbeing Strategic Objectives

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

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

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

BOARD ASSURANCE FRAMEWORK 2021/22 – JULY 2021

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

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

Key Risks

Risk	Corp Risk Register Ref.	Gross Risk	Net Risk	Change from May 21	Target Risk	Context	Executive Lead	Committee
1. Workforce		**25**	**15**		**8**	Across Wales there have been increasing challenges in recruiting healthcare professionals. Meeting the requirements of a growing population which is older and with more complex health needs as well as increasing demand on health services has led for an increasing need in clinical staff. Staff costs represent the largest expense for the NHS in Wales. The pay bill has continued to increase year on year, with a significant increase over the last three years.	Executive Director of People and Culture	Strategy and Delivery Committee
2. Financial Sustainability		**25**	**15**		**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 Community Care	9	**20**	**15**		**10**	The strategy of "Care closer to home" is built on the assumption that there are a significant number of patients that are either referred to or turn up at a Hospital setting because there is no viable alternative at the time at which they become sick. They are then typically admitted because at that stage similarly there is no viable alternative to manage/support these patients in their local setting or their place of residence. Therefore it is important to create firstly the	Chief Operating Officer	Strategy and Delivery Committee

						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	1,2,4,6,7 ,8,10,11, 12.	**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 transfer our services to ensure we can meet our future challenges and opportunities. Creating a belief which continues to build upon our values and behaviours framework will make a positive cultural change in our health system for our staff and the population of Cardiff and the Vale.	Executive Director of People and Culture	Strategy and Delivery Committee
6. Capital Assets	12	**25**	**20**		**10**	The UHB delivers services through a number of buildings across Cardiff and the Vale of Glamorgan, from health centres to the Tertiary Centre at UHW. All NHS organisations have statutory responsibilities to manage their assets effectively: an up to date estate strategy is evidence of the management of the estate. The IT SOP sets out priorities for the next five years and Medical Equipment is replaced in a timely manner.	Executive Director of Strategic Planning, Executive Director of Therapies and Health Science, Executive Director of Finance	Finance Committee & Strategy and Delivery Committee

7. Planned Care Capacity	1,2,3,4,5 ,6,11,	**20**	**16**		**12**	The impact of COVID 19 has had many consequences to Healthcare and in particular the continuation of the Health Board being able to undertake Planned Care both during the peak of the pandemic and any future peaks. This is due to the need to ensure that there is available capacity should there be a further peak in COVID 19 patients requiring hospital treatment.	Chief Operating Officer	Strategy and Delivery
8. Delivery of Annual Plan		**20**	**15**		**10**	The Integrated Medium Term Plan is the key planning document for the Health Board setting out the milestones and actions we are taking in the next 1 to 3 years in order to progress Shaping Our Future Wellbeing, our ten-year strategy. It is based on the health needs of our population, delivering quality services and ensuring equitable and timely access to services and sets out how we will deliver our mission Caring for People; Keeping People Well, and vision that a person's chance of leading a healthy life is the same wherever they live and whoever they are.	Executive Director of Strategic Planning	Strategy and Delivery Committee
9. Staff Wellbeing		**20**	**15**		**6**	As a result of the global Covid19 pandemic, our employees have been exposed to unprecedented levels of psychological and physical distress both at home and in the workplace. Evidence indicates that, Healthcare workers are at greater risk of developing mental health problems as a result. The impact of this is unlikely to be experienced equally, with people with existing mental health difficulties and people from Black, Asian and minority ethnic communities among those who are likely to be affected disproportionately	Executive Director of People and Culture	Strategy and Delivery Committee

10. Exacerbation of Health Inequalities		**16**	**12**	**New Risk**	**8**	COVID-19 has compounded existing health inequalities in Wales, which have shown little improvement in the last ten years, based on the gap in life expectancy between the most and least deprived fifth of the population. Although the main disparities have been age, sex, deprivation and ethnicity, there is clear evidence of intersectionality, risk factors compounding each other to further disadvantage individuals with protected characteristics (based on the Equality Act 2010). As the granular level data emerges, there is no evidence to suggest that this pattern is not replicated fully at a Cardiff and Vale UHB level.	Executive Director of Public Health	Strategy and Delivery Committee

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

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

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

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

Current Controls	• Clinical Boards are actively reviewing workforce plans • Workforce plans are integrated with phased clinical recovery plans • Staff Turnover and retention plans are now being reviewed at CB. • International Nurse Recruitment Campaign is on-going – 185 have now been commissioned. • Re-launched nursing recruitment campaign through social media with strong branding. Events took place in May and further being planned after summer period • Strong clinical engagement with Student Streamlining – higher number this year • Values based recruitment. • Internal Career Development Scheme for band 5 nurses. • Nurse Adaptation and Returners Programmes are now business as usual. • Programme of talent management and succession planning. • Ward Accreditation Programme being implemented • Medical international recruitment strategies reinforced with BAPIO. • Medical Training Initiative (MTI) 2 year placement scheme. • Collaboration with Medics to fill hard to fill roles, search and selection methods, CV scanning by speciality. • On-going review of medical rotas to flex and increase medical cover capacity. • Appointment of Physician Associates to supplement MDT in a number of Clinical Boards • All Wales Single Lead Employer initiative for Junior Doctors to improve trainee experience and streamline hiring processes. • Link with Welsh Government Campaign *Train, Work, Live* to attract for Wales – GP, Doctors, Nursing and Therapies. • Enhanced overtime provisions for substantive nursing and HCSW staff to encourage take up of additional hours extended with a roadmap for phasing out by end May. • New All Wales Respect and Resolution Policy has been developed in partnership with trade union colleagues launched in June, with the aim to prevent bullying and harassment and improve workplace culture
Current Assurances	The Workforce Hub Steering Group has refocused and now meets weekly to co-ordinate proactive work around workforce plans to support Recovery. Deep dive monitoring at Clinical Board and operational level being undertaken monthly to ensure nursing capacity. The workforce position for Mass Immunisation programme remains amber as the Registrant workforce remains largely through Bank. Efforts continue to increase bank supply in addition to rolling permanent recruitment campaigns. Some workforce turnover being experienced, as expected. Team currently developing the Workforce Plan for the Booster programme. 11 international nurses joined in April, 23 joined in June and a further 21 joining in July and 8 in August, largely aimed at supporting Theatres extension and critical care. Nursing establishments are currently being reviewed now that covid has settled and this will provide for more accurate vacancy forecasting. Band 5 & 6 substantive nursing estimated to be at 91% in March. Estimate is due to nursing establishment changes not yet being verified. HCSW recruitment is going well, all permanent vacancies will be recruited to and some areas will be over recruited to where approved. Sickness absence has reduced but still variable by month – e.g., (5.14% March in month figure; 5.77% May in month figure). Workforce metrics will now focus on deep dive analysis - recent being reasons for staff turnover. Temporary recruitment remains active to support Mass Immunisation Programme. Student Streamlining engagement session recently held provided excellent feedback that students want to join C&V as an attractive place to work. Medical monitoring at Medical Workforce Advisory Group (MWAG).

	Medical rotas being monitored to ensure flexibility in place (RAG rated system)		
Impact Score: 5	Likelihood Score: 3	**Net Risk Score:**	**15(Extreme)**
Gap in Controls	Ability to on-board international nurses more quickly due to Visa, isolation and red country quarantine requirements and OSCE nurse facilitation capacity. National UK shortage of nurses remains which impacts on local campaigns.		
Gap in Assurances			

Actions	**Lead**	**By when**	**Update since May 21**
1. Recruitment Campaign in May with social media advertising	RG	From 30.9.2020	On-going permanent recruitment plan in place to underpin sustainable workforce
2. International Nurse Recruitment Campaign	RG	31.12.2021	Further commission recently confirmed for Peri-Operative and more being considered (185 total commissioned)
3. Implementation of a new Medical and Dental Bank through a Managed Service	SW/RG	From 8.8.2021	New initiative procured and being implemented imminently to create a Managed Medical and Dental Bank. This will increase supply and improve skills availability through a new bank system; dedicated central team; improved technology and a launched locum recruitment campaign.
4. Clinical Board Workforce Plans being reviewed during first quarter of 2021/22	SC/RG	30.6.2021	Specific plans being developed to support Recovery
5. Nursing establishments being reviewed	RW	31.7.2021	On-going compliance with Nurse Staffing Act and will also re-set establishments
6. New Nurse E-Rostering System being implemented during 2021/22, including Safe-Care Module and improved Bank App. functionality	RG	31.3.2022	All Wales contract has been procured. C&V will now align to all other HB's using Allocate Software. Local implementation team are recruited.

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

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

Across Wales, Health Boards and Trusts set out plans to manage their financial pressures by driving out inefficiencies, while at the same time looking to derive greater value from their resources through innovative ways of working and practicing Prudent and Value Based Healthcare. The three year planning process in NHS Wales has been paused but Annual Plans were submitted to Welsh Government at the end of June 21.

Risk **Date added:** 7.09.2020	There is a risk that the organisation will not be able to manage the impact of COVID 19 and other operational issues within the financial resources available.		
Cause	The UHB has incurred significant additional costs arising from managing the COVID 19 pandemic, this includes the non-delivery of savings plans. It also has to manage its operational budget. All additional costs need to be managed within the additional resources made available by Welsh Government to manage the pandemic.		
Impact	Unable to deliver a year-end financial position. Reputational loss. Improvement in the underlying financial position which is dependent upon recurrent funding provided		
Impact Score: 5	Likelihood Score: 5	**Gross Risk Score:**	**25 (Extreme)**
Current Controls	Additional expenditure in Managing COVID 19 is being authorised within the governance structure that has specifically been put in place which is reported to Management Executives on a weekly basis. This aligns with the UHB Scheme of Delegation. The financial position is reviewed by the Finance Committee which meets monthly and reports into the Board. Financial performance is a standing agenda item monthly on Management Executives Meeting.		
Current Assurances	The UHB is now assuming an additional funding to help manage the COVID 19 pandemic in line with Welsh Government Resource assumptions. Based upon this assumed additional funding, the financial forecast is now an in year break even position at year end. 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: 3	**Net Risk Score:**	**15 (Extreme)**
Gap in Controls	No gaps currently identified.		
Gap in Assurances	To confirm COVID 19 funding assumptions with Welsh Government for response and recovery. Certainty of COVID 19 expenditure and the management of non COVID 19 operational pressures		

Actions	**Lead**	**By when**	**Update since May 21**
1. Continue to work with Welsh Government to confirm additional funding to manage our recovery response to Covid 19.	CP	31/03/2022	Awaiting confirmation of response funding for the last six months of the financial year Recovery – awaiting feedback on recovery bids submitted with June Annual Plan.

2. To monitor and control additional expenditure and financial performance to ensure that the year-end forecast is within the resources available.		CP	31/03/2022	This will be reviewed once there is clarity in relation to 1. above
3. To understand the impact of responding to the Covid 19 pandemic has had on the organisations underlying position and that the costs and consequences are reflected within the 2021/22 plan.		CP	31/03/2022	Costs and consequences under constant review and will be reflected in 21/22 plans and beyond. To be completed on confirmation of funding
Impact Score: 5	Likelihood Score:1	**Target Risk Score:**		**5 (Moderate)**

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

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

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

	Annual Plan submitted to Welsh Government and presented to Board demonstrated a significant orientated strengthening of Primary Care Health and Population Management is tracked through Programme Management Investment decisions are prioritised.		
Impact Score: 5	Likelihood Score: 3	Net Risk Score:	**15 (Extreme)**
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 May 21**
1. Development of recruitment strategies for GP and non GP service solutions	RG	31/03/2022	GP Support Unit helps with recruitment and finding GP alternatives. The focus on a multi-disciplinary solution continues.
2. Develop Health and Social Care Strategies to allow seamless solutions for patients with health and or social needs	AH	31/03/2022	These are being developed through the Public Service Board and Transformation work and progressing well updates will continue to be provided.

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

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

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

Actions	**Lead**	**By when**	**Update since March 21**
1. Recovery plan in place and constantly being reviewed	Steve Curry	31.03.22	Plan in place which is continually been reviewed in relation to demand and capacity – see separate risk on BAF: the risk of inadequate planned care capacity
2. Waiting list position plan to be presented to Quality, Safety and Experience Committee to see if harm has occurred to those on the waiting list and what we are doing to prevent it going forward.	Steve Curry	30.06.21	Complete presented to QSE 15.06.21 To be presented to QSE Committee

3. CAHMS impact to be presented to Board Development in June due to demand and support for children increasing		Steve Curry	30.06.21	Complete presented to Board Development 24.06.21 To be presented to June Board Development session
4. Review of hospital acquired COVID 19 and COVID deaths being undertaken		Ruth Walker	30.09.21	Review has commenced early learning shared with operational colleagues and it is informing the development of the recovery plan
Impact Score: 5	**Likelihood Score: 2**	**Target Risk Score:**		**10 (High)**

5. Leading Sustainable Culture Change – Lead Executive Rachel Gidman

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

Risk	There is a risk that the cultural change required will not be implemented in a sustainable way		
Cause	There is a belief within the organisation that the current climate within the organisation is high in bureaucracy and low in trust. Staff reluctant to engage with the case for change as unaware of the UHB strategy and the future ambition. Staff not understanding the part their role plays for the case for change due to lack of communication filtering through all levels of the UHB.		
Impact	Staff morale may decrease Increase in absenteeism Difficulty in retaining and recruiting staff Potential decrease in staff engagement Increase in formal employee relations cases Transformation of services may not happen due to staff reluctance to drive the change through improvement work. Patient experience ultimately affected. UHB credibility as an employee of choice may decrease		
Impact Score: 4	**Likelihood Score: 4**	**Gross Risk Score:**	**16 (Extreme)**
Current Controls	Values and behaviours Framework in place Task and Finish Group weekly meeting Cardiff and Vale Transformation story and narrative Leadership Development Programme linked in with the launch of the Dragons Heart Institute (DHI) Management Programmes now including a virtual offering. The content will be management skills but will incorporate inclusive management skills. The additionality of data training will be offered by the Summer 2021 Talent management and succession planning cascaded through the UHB Values based recruitment / appraisal – Awareness campaign June 2021 Staff survey results and actions taken Increasing the diversity of the workforce through the Kickstart programme, Apprenticeship Academy, Project SEARCH Patient experience score cards CEO and Executive Director of People and Culture sponsors for culture and leadership Raising concerns procedure/Freedom to Speak Up relaunched in October 2018 and again in June 2021 "Neyber" launched to support staffs financial wellbeing with an emphasis on education – Awareness campaign and training to start in July 2021 Conducted interviews with senior leaders regarding learnings and feedback from Covid 19 Lessons learnt document to be completed by September 30th 2020 looking at the whole system. Discovery learning report completed in the Autumn 2020 Launch in 2021 to coincide with the DHI Proposal for Self-care leadership – Recovery for wellbeing and engagement of staff		
Current Assurances	Engagement of staff side through the Local partnership Forum (LPF) Matrix of measurement now in place which will be presented in the form of a highlight report		
Impact Score: 4	**Likelihood Score: 2**	**Net Risk Score:**	**8 (High)**

Gap in Controls	
Gap in Assurances	

Actions	Lead	By when	Update since May 21
1. Learning from Canterbury Model with a Model Experiential Leadership Programme- Three Programmes have been developed: (i) Acceler8 (ii) Integr8 (iii) Collabor8 (iv) Oper8 (for Directorate Managers or equivalent) Compassionate and inclusive leadership principles will be at the core of all the programmes	RG	01.04.2021	Currently all the leadership programmes are on hold due to the recovery phase of covid. Intensive learning academy bid was successful. Part of the bid incorporates a 10-month leadership programme. The current leadership programmes will be reviewed and will complement the DHI ILA Programmes to restart Sept 2021
2. Showcase	RG	~~31.03.21~~ From Sept 21	Virtual showcase now being considered and linking with the Clinical Service Redesign and exploring catering for bigger numbers Virtual showcase – Engagement for the case for change. The design of the showcase will be aligned with Shaping our clinical services. Approval agreed in ME in Feb 2021. Tender submitted March 2021 and completed May 2021 Launch of Virtual Showcase Sept 2021
3. Equality, Diversity and Inclusion Welsh Language Standard being implemented. Inclusion - Nine protected Characteristics	RG	From 14.12.20	Equality Strategy Welsh Language Group is taking place on a bi monthly basis with senior leaders across the organisation who can influence this agenda Two Welsh Language translators now recruited. – complete and fully operational All 9 protected characteristics including Welsh language are sponsored by an Executive and an independent member. An emphasis on engagement, leadership and recruitment with be prioritised in 2021 with an action plan / outcome to be achieved. The RACE network will be in place by July 2021, with further networks to be established- Met on the 5th July 2021 The development and dialogue is happening regarding individuals with learning disabilities gaining work experience in a structure approach pl. In collaboration with project Search Aim Sept 2021 classroom base / Jan 2022 placements The successful bid to be a direct employer for KICKSTART a WG initiative to assist 16 – 24 year olds to

			gain employed work for 6 months. Initiative starts April 2021. By April 2021 100 applications received. We now have 200 applicants
4. CAV Convention	RG	From 12.11.20	Proposing CAV convention conference in the Autumn in line with the virtual showcase. Illustrating the clinical groups progression and to formally launch the CAV convention into the health system.
Impact Score: 4	**Likelihood Score: 1**	**Target Risk Score:**	**4 (Moderate)**

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

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

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

	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 May 21**
1. The Estates Strategy requires review and refresh	AH/CP	30.09.21	It has been agreed that this document will be reviewed in 22/23.

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

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

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

Risk	There is a risk that there will be inadequate planned care capacity due to the impact of covid 19 resulting in longer and ageing waiting lists and the ability of the Health Board to manage planned care in a timely manner going forward.		
Date added:			
Cause	Covid pandemic resulting in a cessation of elective activity and result of longer and ageing waiting lists.		
Impact	A growing waiting list for planned care activity An ageing waiting list Potential clinical risk associated with delayed access – see risk in relation to patient safety.		
Impact Score: 4	**Likelihood Score: 5**	**Gross Risk Score:**	**20 (Extreme)**
Current Controls	Clinical risk assessments by specialty to prioritise access Following risk stratifications where available i.e. Royal College of Surgeons L1 to L4 classifications Development of 'green zones' to provide confidence for low risk operating environments Increase the use of virtual consultation to avoid person to person contact Securing additional capacity within the private sector Recovery Plans in place Programme Delivery Director appointed to lead Recovery Schemes		
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 May 21
8. Full assessment of risk to be undertaken	SC	May 2021	Assessment undertaken and presentations given in relation to timescales to achieve activity against various scenarios. Key measure are set out within the Annual Plan

				Initial bids for planned care which supported recovery schemes have been put into place as per the Annual Plan.
9. Bids for further schemes currently awaiting approval			SC	August 2021	Schemes from second rounds of bids awaiting approval
Impact Score: 4	**Likelihood Score: 3**	**Target Risk Score:**		**12 (High)**	

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

The requirement for a three year IMTP remains suspended by Welsh Government due to the Covid 19 pandemic. However, the Health Board are still required to produce an Annual Plan for 21/22 which will reference the last approved IMTP. From 22/23 there will be a requirement to develop a three Year IMTP.

Risk	There is a risk that the Health Board will not deliver the objectives set out in the Annual Plan out due to the challenge around recovering the backlog of planned activity (see separate risk), not taking the opportunity to do things differently and the potential risk associated with the Medium Term Financial position all of which could impact upon delivery of the Annual Plan or future IMTP.		
Date added:	April 20		
Cause	The focus of executive and operational efforts is on directing the organisational response creating the operational capacity to meet the immediate acute demand generated by the COVID-19 pandemic.		
Impact	The UHB may not be appropriately prepared to manage the consequences of a protracted and disruptive emergency response particularly in terms of: workforce (e.g. many will be exhausted and many will have built up leave) Infrastructure Planned care Unplanned care Financial delivery The benefits of emergency changes may not be adequately captured. There may be learning opportunities missed.		
Impact Score: 5	**Likelihood Score: 4**	**Gross Risk Score:**	**20 (Extreme)**
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. • Board approved Annual Plan 21/22 submitted to Welsh Government by end of June 21 with revised programme and project governance in place.		
Current Assurances	Outline draft Annual Plan presented to Board 25.02.21		
Impact Score: 5	**Likelihood Score: 3**	**Net Risk Score:**	**15 (Extreme)**
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 May 21**
Monitor implementation of Annual Plan and continue to report through Strategy and Delivery Committee	AH	31/03/22	The HB is still working in an uncertain environment but a winter plan is already being developed.
Impact Score: 5	**Likelihood Score: 2**	**Target Risk Score:**	**10 (High)**

9. Impact of Covid19 Pandemic on Staff Wellbeing

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

Evidence

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

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

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

10. Exacerbation of Health Inequalities in C&V – Lead Executive Fiona Kinghorn

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

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

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

Risk	There is a risk that the exacerbation of inequalities due to COVID-19 will reverse progress in our goal to reduce the 12 year life expectancy gap, and improvements to the healthy years lived gap of 22 years.
Date added:	29.07.21

Cause	• Deaths from COVID-19 have been almost double in the most deprived quintile when compared with the least deprived quintile of the population in Wales, and there has been a disproportionate rate of hospitalisation and death in ethnic minority communities
	• In Wales, socio-economic health inequalities in COVID-19 become more pronounced further along the hospital treatment pathway. Based on data from the first few months of the pandemic we can see that inequalities were not particularly pronounced for confirmed cases (unlike England) but the gradient became bigger for admissions, ICU and deaths. This may be related to the idea of staircase effects whereby health inequalities accumulate across the system and the 'inverse care law' whereby people from deprived areas may not seek help until later when their condition has deteriorated, which may be related to accessibility, health literacy and competing demands on their time. The role of the healthcare organisation in flexing to provide effective treatment according to individual need along that pathway is key
	• Health inequalities arise in three main ways, from
	  ○ structural issues, e.g. income, employment, education and housing
	  ○ unhealthy behaviours
	  ○ inequitable access to, or experience of, services, which can be a result of discrimination due to inaccessible services, public information or healthcare sites that may be relevant/pertinent to their particular needs
	• It follows, therefore, that services run by organisations which do not address their own structural issues (nor advocate others to do so), do not support staff and their population to take up healthier, or reduce health-harming, behaviours, and which are not tailored towards reducing inequalities will fail to address the causes of increasing health inequality

Impact	• The key population groups with multiple vulnerabilities, compounded or exposed by COVID-19, include:
	  ○ Children and young people
	  ○ Minority ethnic groups, especially Black and Asian populations
	  ○ People living in (or at risk of) deprivation and poverty
	  ○ People in insecure/low income/informal/low-qualification employment, especially women

	○ People who are marginalised and socially excluded, such as homeless persons • Risk factors interact and multiple aspects of disadvantage come together, increasing the disease burden and widening equity gaps. Underlying chronic conditions, as well as unequal living and working conditions, can in turn increase the transmission, rate and severity of COVID-19 infections • COVID-19 and its containment measures (lockdowns) can directly and indirectly increase inequity across living and working conditions; as well as inequity in health outcomes from chronic conditions. For example, working from home during and post lockdown may not be possible for many service sector employees. Marginalised communities are more vulnerable to infection, even when they have no underlying health conditions, due to chronic stress of material or psychological deprivation, associated with immunosuppression • The longer-term, and potentially largest, consequences for widening health inequalities can arise through political and economic pathways. Areas with higher unemployment have greater increase in suicides; and people living in the most deprived areas experience the largest increase in mental illness and self-harm • This is not simply a social injustice issue, health inequalities are also estimated to cost £3-4 billion annually in Wales through higher welfare payments, productivity losses, lost taxes, and additional illness		
Impact Score: 4	**Likelihood Score: 4**	**Gross Risk Score:**	**16 Extreme**
Current Controls	1. Statutory function The Socio-economic Duty places a legal responsibility on public bodies in Wales when they are taking strategic decisions to have due regard to the need to reduce the inequalities of outcome resulting from socio-economic disadvantage. Approaching implementation of the Socio-economic Duty effectively will help us maximise our contribution to addressing such inequalities, and also to meet our obligations under the Human Rights Act 1998 and international human rights law. Of note, but more of a reputational risk, if an individual or group whose interests are adversely affected by our strategic decision, in circumstances where that individual or group feels the Duty has not been properly complied with, they would have the right to instigate a judicial review claim against the UHB 2. Role as an Employer • In our Equality, Inclusivity and Human Rights Policy, we have an active programme, which sets out the organisational commitment to promoting equality, diversity and human rights in relation to employment, and ensuring staff recruitment is conducted in an equal manner • Our Strategic Equality Plan 'Caring about Inclusion 2020-2024' has a number of key delivery objectives and is premised on the basis of embedding equality, diversity and human rights, and Welsh language, into UHB business processes, for example: Recruitment and Selection Policy, Annual Equality Report, Equality reports to the Strategy and Delivery Committee, Reports/Updates to the Centre for Equality and Human Rights, Outcome Report to the Welsh Government Equalities Team regarding sensory loss, provision of evidence to the Health and Care Standards self-assessment, Equality and Health Impact Assessments • All our Executives have taken up a leadership role across the nine protected characteristics specified in the Equality Act 2010 - age, disability, gender identity, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation - our CEO is the lead for race 3. Refocused Joint strategic and operational planning and delivery • Each of our strategic programmes within Shaping our Future Well Being Strategy will need to consider how our work can further tackle inequalities in health. Our Shaping our Future Public Health strategic programme will include a focused arena of work aimed at tackling areas of inequalities where there are gaps, for example healthy weight, immunisation and screening. We will work closely with the 2 local authorities and other partners, through our PSBs and RPB partnerships to		

	accelerate action in our local communities. This will include building on local engagement to date with our ethnic minority communities during the Covid-19 pandemic. Such focused work will be articulated in 'Cardiff and Vale Local Public Health Plan 2021-24' within our UHB three-year plan • Through our PSB and RPB plans we already prioritise areas of work to tackle inequalities and the refreshed needs assessments for both PSBs and RPB will further identify collective actions • The Youth Justice Board is planning to implement the recommendations of our Public injecting & Youth Justice HNAs in Cardiff • Cardiff PSB and Cardiff and Vale Substance Misuse Area Planning Board will implement the recommendations of its Needle Exchange programme review to tackle health inequality as part of COVID-19 substance misuse recovery work • Our draft Suicide and Self-Harm Prevention Strategy is currently out for consultation • Action during the pandemic has included a multi-agency approach to Seldom Heard Voices, targeting initiatives towards areas of deprivation e.g. walk in vaccine clinics. This work will continue as we move toward delivery of a booster programme
Current Assurances	We are in the process of revising a bellwether set of indicators to measure inequalities in health in the Cardiff and Vale population through which we will measure impact of our actions. This will form part of the Annual Report of the Director of Public Health 2020, due to be published September 2021. Examples will potentially include: • The inequality gap in healthy life expectancy at birth in Cardiff and Vale UHB for males, increased from 20.4 years in 2005-2009 to 24.4 years in 2010-2014 • The gap in coverage of COVID-19 vaccination between those living in the least deprived and most deprived areas of Cardiff and Vale UHB, aged 80 years and above, reduced from 8.8% to 8.4% between May and June 2021
Impact Score: 4	**Likelihood Score: 3** | **Net Risk Score:** | **12 (High)**
Gap in Controls	• Uncertainty around progress of the pandemic due to variants and unpredictability of population behaviours • Unidentified and unmet healthcare needs in seldom heard groups • Capacity of partner organisations to deliver on plans and interdependency of work • Financial support to individuals following ending of the furlough scheme
Gap in Assurances	• Monitoring data (often managed via external agencies) and establishing trends difficult to determine over shorter timescales

Actions	**Lead**	**By when**	**Update since May**
11. Embed a 'Socio-economic Duty' way of thinking into strategic/operational planning, *beyond* complying with our statutory duty	FK/RG	March 2022	**New risk new action**
12. Take further actions, to improve COVID-19 vaccination rates (including delivering a booster vaccine) in minority ethnic communities and vulnerable groups	FK/RW	December 2021	**New risk new action**
13. Review and operationalise the recommendations of the Annual Report of the Director of Public Health 2020, including development of shorter term indicators using routine data	Executive Team	From September 21	**New risk new action**
14. Within the UHB and through our PSB and RPB partnerships, refresh a suite of focused preventative actions to tackling inequalities in health	FK	September 2021	**New risk new action**
Impact Score: 4 | **Likelihood Score: 2**	**Target Risk Score:**	**8 (High)**	

Key:

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

Report Title:	**PERFORMANCE REPORT**									
Meeting:	Board Meeting							**Meeting Date:**	29 July 2021	
Status:	**For Discussion**		**For Assurance**	**x**	**For Approval**		**For Information**			
Lead Executive:	Chief Operating Officer and Executive Finance Director									
Report Authors (Title):	Information Manager & AD Operations (Performance)									

Background and current situation:

The Health Board submitted an updated 2021/22 annual plan and 'Planning for Recovery and Redesign' addendum to Welsh Government on 30th June 2021, following submission of the first draft in March 2021. Recognising that our planning for recovery and redesign will continue to be agile and plans will develop and refine over time, the addendum sets out the Health Board's evolving position, overall approach to addressing the Recovery and Redesign challenge and details of schemes proposed to help the organisation meet the needs of our patients.

Our planning for recovery and redesign continues to be based on three key principles - clinically led, data driven and risk orientated. Specifically, in regard to the latter and relevant to operational performance, our recovery centres on patients being seen in order of clinical priority rather than time-based targets.

In considering this performance report, it is also important to recognise our prevailing operating conditions. We continue to operate within a context of significant uncertainty and with a requirement to remain 'covid ready'. Additionally, there are a further three factors impacting on the speed of our recovery – workforce, estates and ongoing Infection, Prevention and Control (IP&C) requirements.

There has been no change to national requirements since the last report to the Board. Performance and waiting list information continues to be reported with the published information used for management information and to provide assurance against the delivery of the Health Board's plan.

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

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

- 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 prioritisation rather than time-based targets.
- The re-emergence of non-covid unscheduled care demand and higher presentations arising from the indirect impact of covid e.g. in Mental Health is resulting in increased pressure across primary, community and secondary care.

- Operational performance needs to be considered in the context of our prevailing operating conditions. There is significant uncertainty alongside a requirement to remain 'covid ready'. Additionally, there are a further three factors impacting on the speed of our recovery – workforce, estates and ongoing IP&C requirements.

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

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 2021-22

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

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

Equality and Health Impact Assessment Completed:	Not Applicable

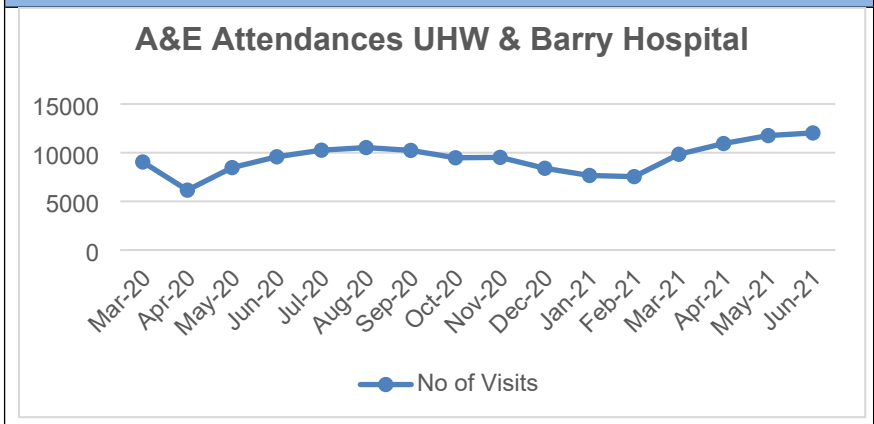
Unscheduled Care

Overview

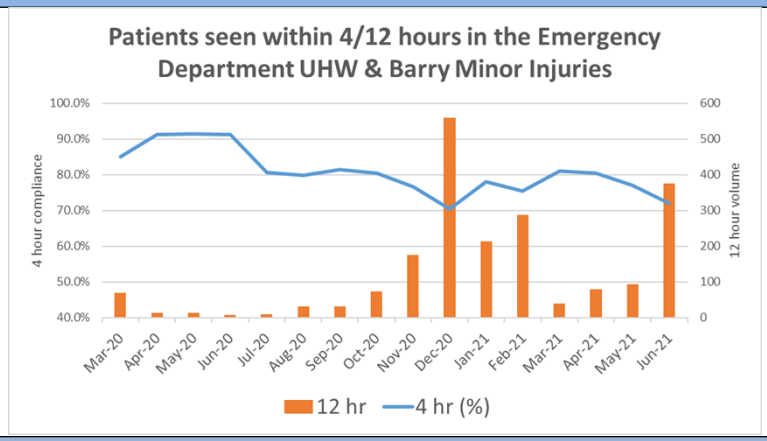
- Emergency Unit attendances have continued increasing from March 21 (9,839) to June 21 (12,029), an increase of 20%. Whilst this is 23% higher than 9,581 June 2020 (NB Covid Peak) it remains lower than 12,724 June 2019 (Pre Covid)
- 4-hour performance in EU has deteriorated since March (81.1%) to 72% in June. This compares to 91.2% in June 2020.
- Ambulance handover delays over 1 hour were stable between March and May, but increased in June to 287. 84% of Ambulance Handovers were completed in under 1 hour in June compared to 97% in June 2020.
- The percentage of red calls responded to within 8 minutes has improved in June (71%) since March (67.6%)

Performance

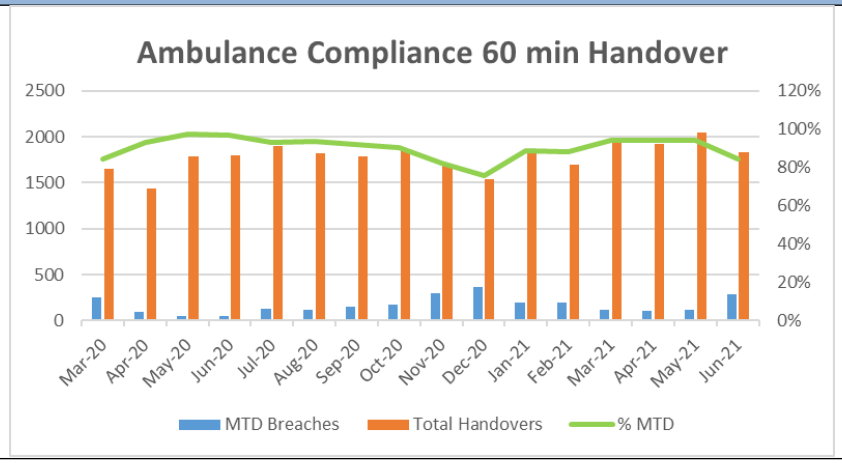
Graph 1: % A&E Attendances



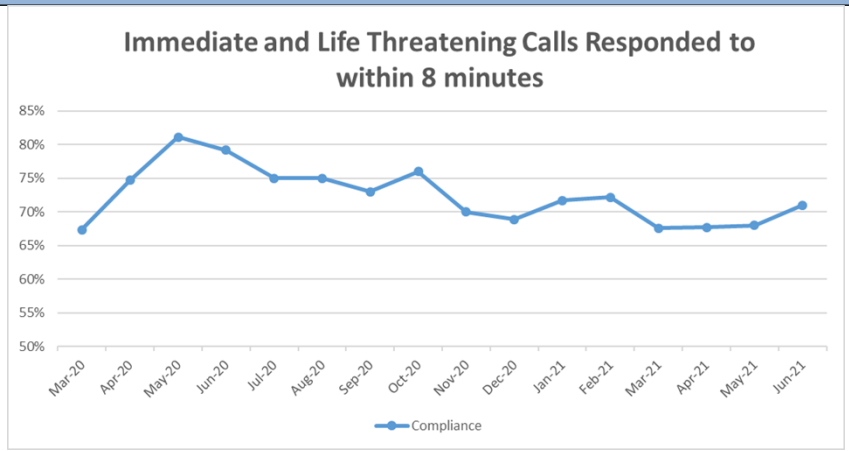
Graph 2: A&E waits – 4 & 12 hours



Graph 3: Ambulance handover > 1 hour



Graph 4: Red calls responded to within 8 minutes



Primary Care

Overview

In relation to General Medical Services (GMS):

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

In relation to GP Out of Hours (GPOOHs):

- In April & May 2021, 100% of patients prioritised as 'emergency' requiring a home visit were seen within one hour. This deteriorated in June to 50%. This was due to 1 of the 2 patients not being seen within 1 hour.
- In April, 100% of patients prioritised as 'emergency' requiring a primary care centre appointment were seen within one hour. This fell to 85% in May but has returned to 100% in June 2021.

Performance

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

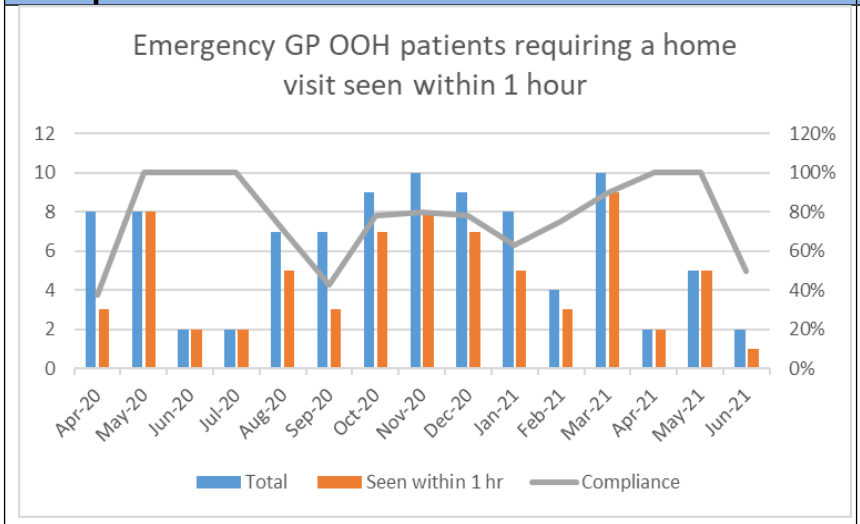
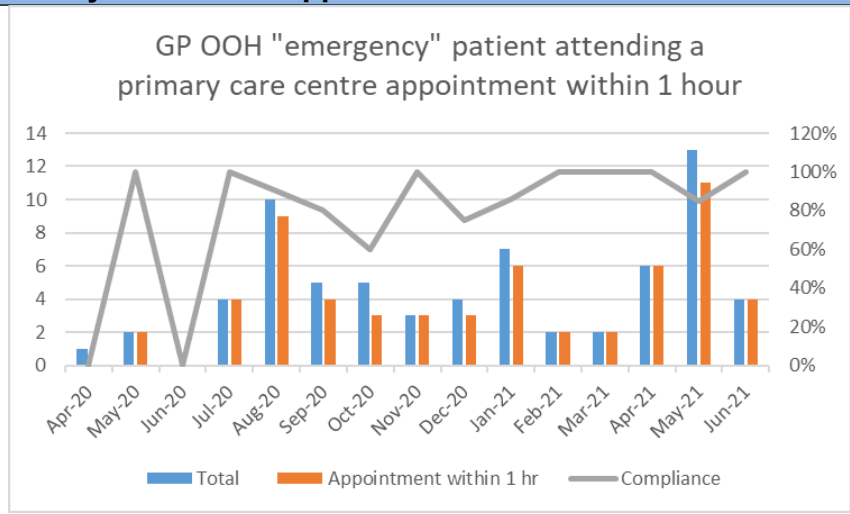


Chart 2: % of GP OOH "emergency" patients attending a primary care center appointment within 1 hour



Mental Health Measures

Overview

- Referrals have stabilised during April 2021 (968) and May 2021 (1006) following the sharp increase in March 2021 (1356), but remain higher than pre covid levels.
- Part 1a: The percentage of Mental Health assessments undertaken within 28 days is 16% overall and 28% for CAMHs in May 2021.
- Part 1b: 97% of therapeutic treatments started within 28 days following assessment at the end of May 2021.
- Part 2: 82% of health board residents in receipt of secondary mental health services have a valid care and treatment plan (CTP) at the end of May 2021.
- Part 3: 75% of health board residents were sent their outcome assessment report within 10 days of their assessment in March 2021.

Performance

Chart 1: Mental Health Referrals

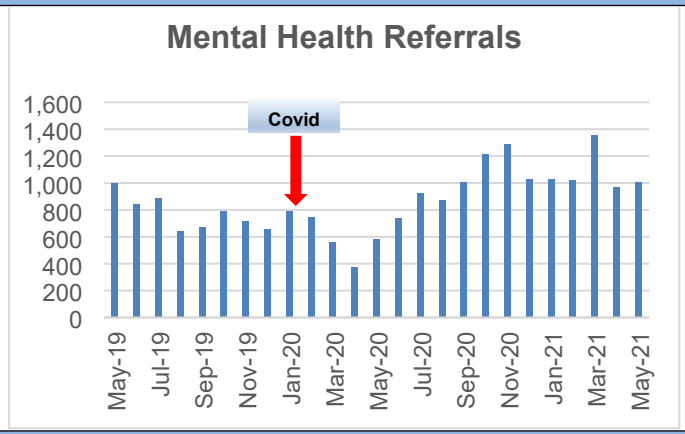


Chart 2: Performance against Mental Health Measures – Part 1a, 1b, 2 and 3

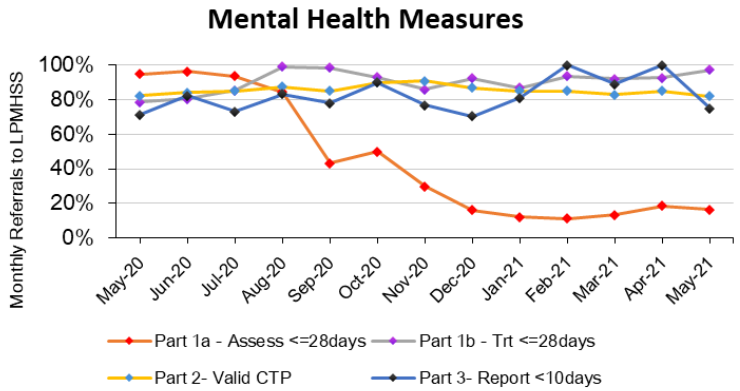
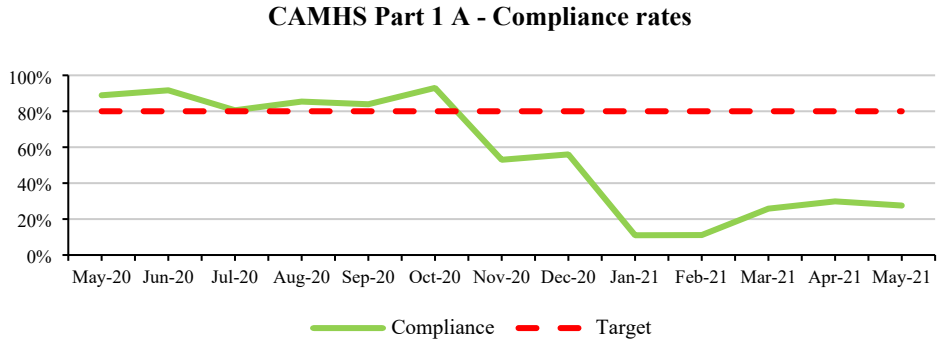


Chart 3: CAMHS Part 1a compliance



Cancer

Overview

- Referrals for patients with suspected Cancer have returned to pre covid levels. There were 1368 referrals from GPs in May. Incidental findings remain at higher levels than pre covid levels.
- SCP performance in May 2021 has decreased 66% in March 2021 to 58.7% in May 2021.

Performance

Chart 1: Cancer referrals

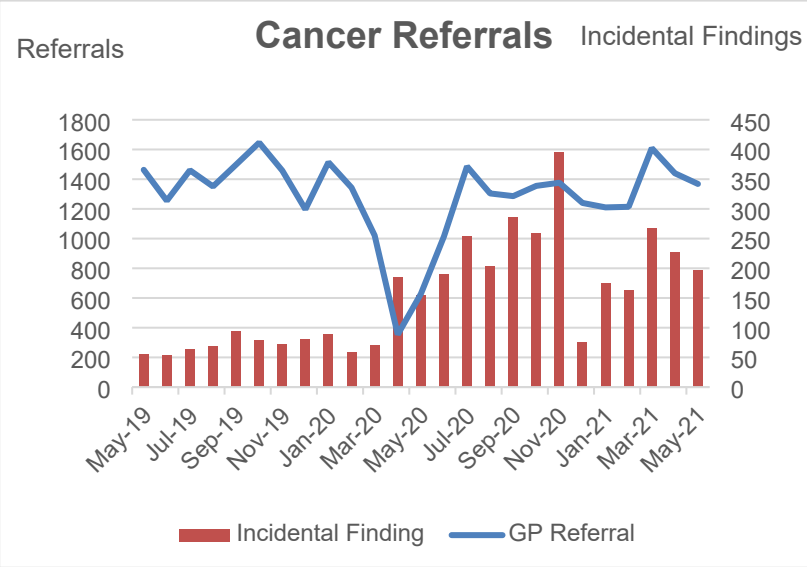
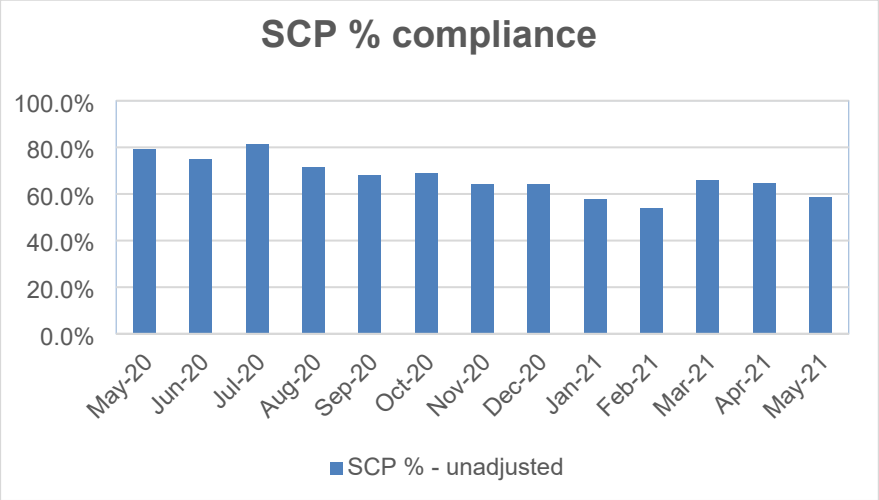


Chart 2: SCP performance



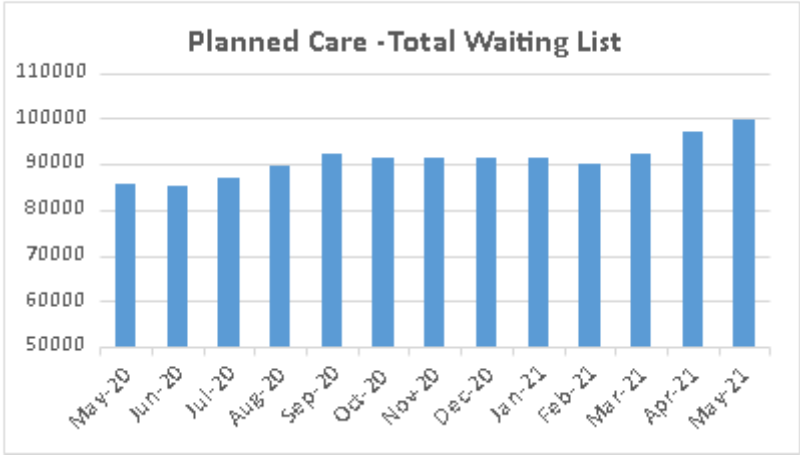
Elective access

Overview

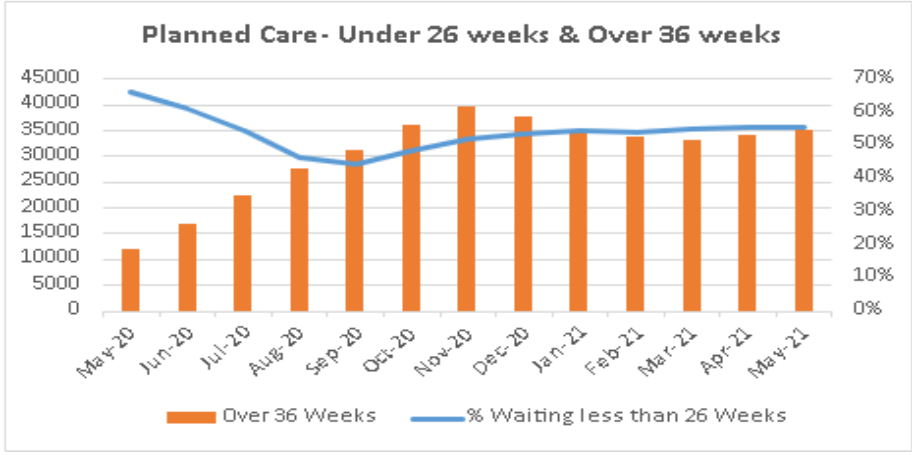
- The overall Referral to Treatment (RTT) waiting list has increased steadily to 99,664 at the end of May 2021, an increase of 7,378 from March 2021. There were 34,896 patients waiting over 36 weeks for treatment for planned care, 1,958 more than at the end of March 2021.
- Patients waiting greater than 8 weeks for a diagnostic test have increased since March (4,540) to 4,848 in May 2021.
- The total number of patients waiting for a follow-up appointment was 172,596 at the end of May 2021. The number of Follow Up patients waiting over 100% beyond their target date has decreased to 48,833 patients

Performance

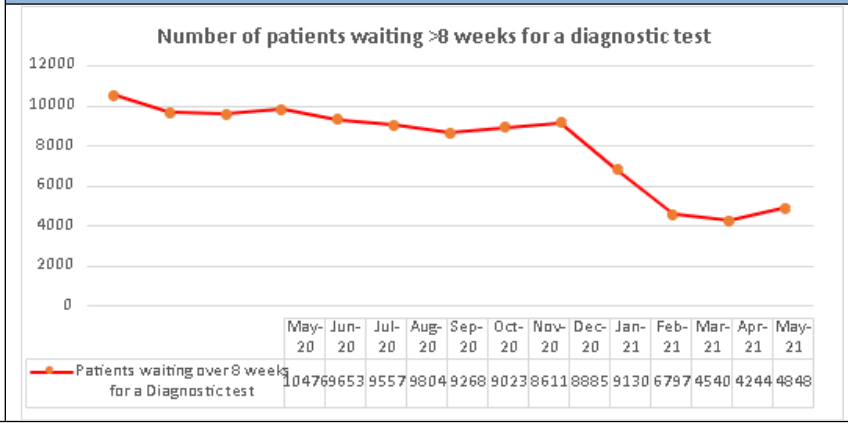
Graph 1: RTT total size of the waiting list



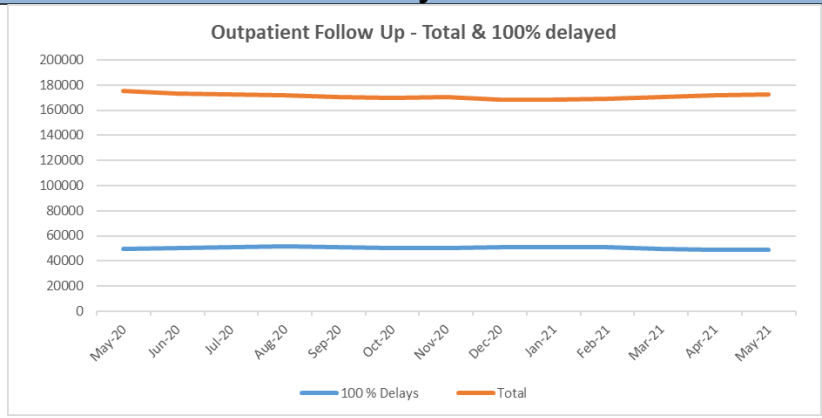
Graph 2: RTT % of patients 26 weeks and number of patients > 36 weeks



Graph 3: Diagnostics > 8 weeks



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



FINANCE

How are we doing?

After submitting a draft financial plan at the end of March 2021 the UHB submitted a final annual financial plan to Welsh Government the end of quarter 1 2021 following the receipt of further planning guidance. The final plan includes a breakeven year end position.

The Financial Plan sets out the UHB's financial strategy in three parts:

1. Core Financial Plan: Delivering in-year financial stability and maintain the current level of underlying deficit
2. Continuation of non-recurrent response to COVID within available funding
3. COVID recovery and reset (service) within available funding

The brought forward COVID deficit of £21.313m relating to non-delivery of savings in 2020/21 is assumed to funded non-recurrently as per the Welsh Government final annual plan financial principles issued on 26th May 2021.

The reported financial position for the 3 months to the end of June is an operational surplus of £0.124m.

Delivery of the core financial plan includes a 2% (£16.0m) savings requirement. At month 3 £12.873m Green and Amber savings have been identified against the target. Further progress will need to be made with a focus on recurrent schemes.

The full year gross COVID forecast has increased in month 3 from £111.149m to £117.083m largely relating to national programmes on TTP and PPE. The UHB has been told to assume that its COVID 19 response costs will be fully funded, but this will be subject to external review and is therefore not confirmed at this stage.

Reported month 3 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 3 is a surplus of £0.124m and this is summarised in Table 1 below:

Table 1 : Financial Performance for the period ended 30th June 2021

	Cumulative Month 3 £m	Forecast Year-End Position £m
COVID 19 Additional Expenditure	25.104	117.083
Welsh Government COVID funding received / assumed	(25.104)	(117.083)
Gross COVID 19 Forecast Position (Surplus) / Deficit £m	0.000	0.000
COVID FUNDING for Deficit due to non delivery of 2020/21 recurrent Savings	(5.325)	(21.313)
Operational position (Surplus) / Deficit	5.201	21.313
Financial Position £m (Surplus) / Deficit £m	**(0.124)**	**0.000**

The additional COVID 19 expenditure at month 3 was £25.104m with full year forecast costs totalling £117.083m

Further detailed work and review of COVID local response costs will continue ensuring that financials are aligned to workforce and activity. Workforce will continue to be a limiting factor throughout 2021/22 and this reality will continue to be reflected in financial assessments.

The UHB has an operational surplus of £0.124m at Month 3.

Underlying deficit position

The UHB's accumulated underlying deficit brought forward into 2021/22 is £25.3m which reflects the £21.3m shortfall against the recurrent savings 2020/21 target due to the pandemic.

Delivery of the UHB's draft financial plan will ensure that the underlying position does not deteriorate in 2021/22 and this will leave an underlying deficit of £25.3m to carry forward to 2022/23.

Creditor payment compliance

The UHB's public sector payment compliance performance was 94.0% at the end of June which is just below the statutory target of 95%. Performance is expected to improve as the year progresses.

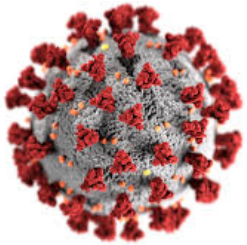
Remain within capital resource limit

The UHB had an approved annual capital resource limit of £33.922m at the end of June 2021. Capital expenditure for the first 3 months of the year was £2.663m against a plan of £3.207m. The UHB expects the final 2021/22 capital outturn to be broadly in line with its capital resource limit.

What are the UHB's key areas of risk?

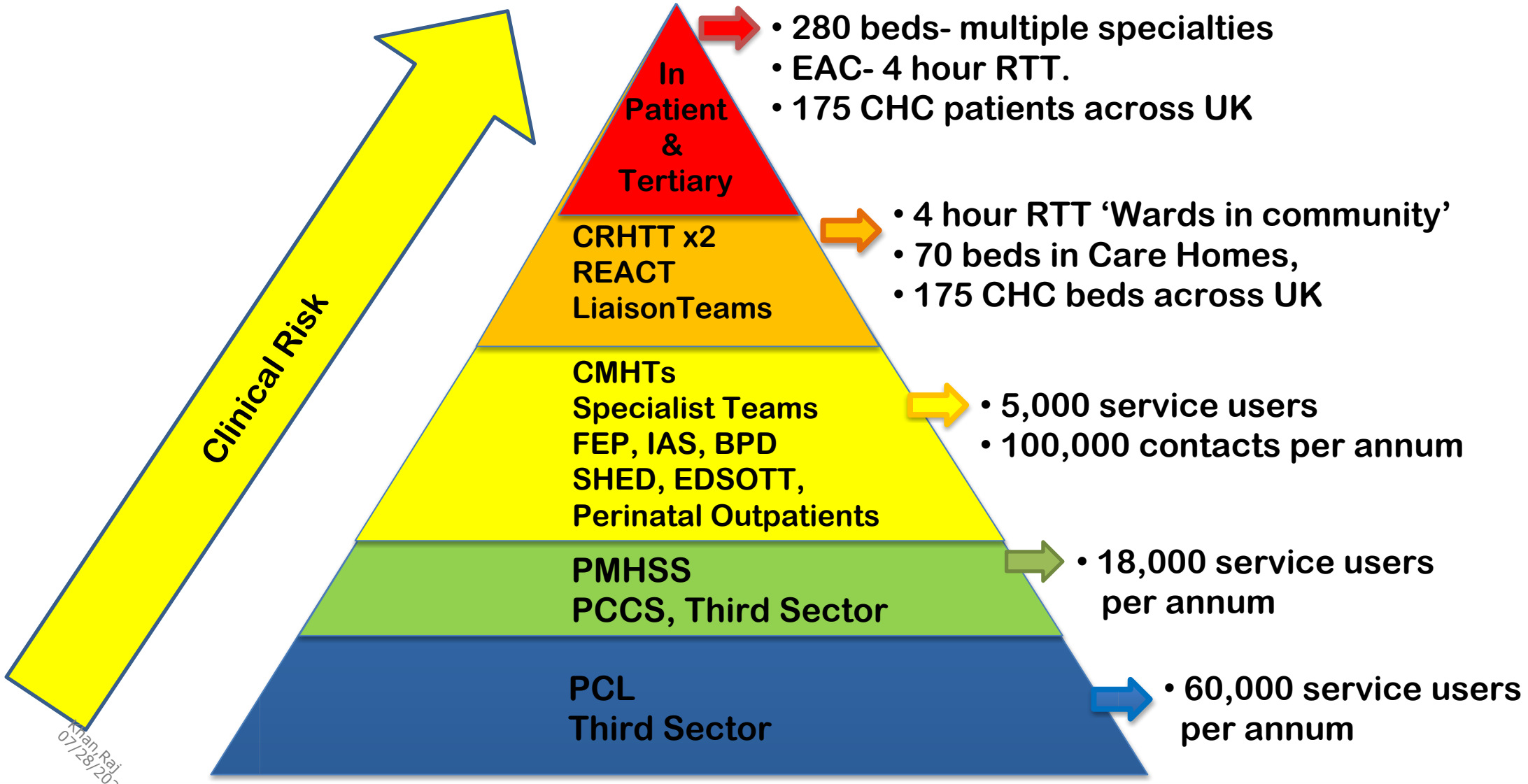
Delivery of the core financial plan includes a 2% (£16.0m) savings requirement. At month 3 £12.873m Green and Amber savings have been identified against the target. This shortfall of £3.127m will need to be addressed together with further progress on recurrent schemes in order to maintain the underlying position.

Whilst the UHB has been told by WG to assume that all COVID response costs will be funded, these will be subject to external review. This is therefore a risk until this funding is confirmed.



Covid-19:
Contexts
transformation
priorities

MENTAL HEALTH CLINICAL BOARD



Khan Raj
07/28/2021 11:01:43

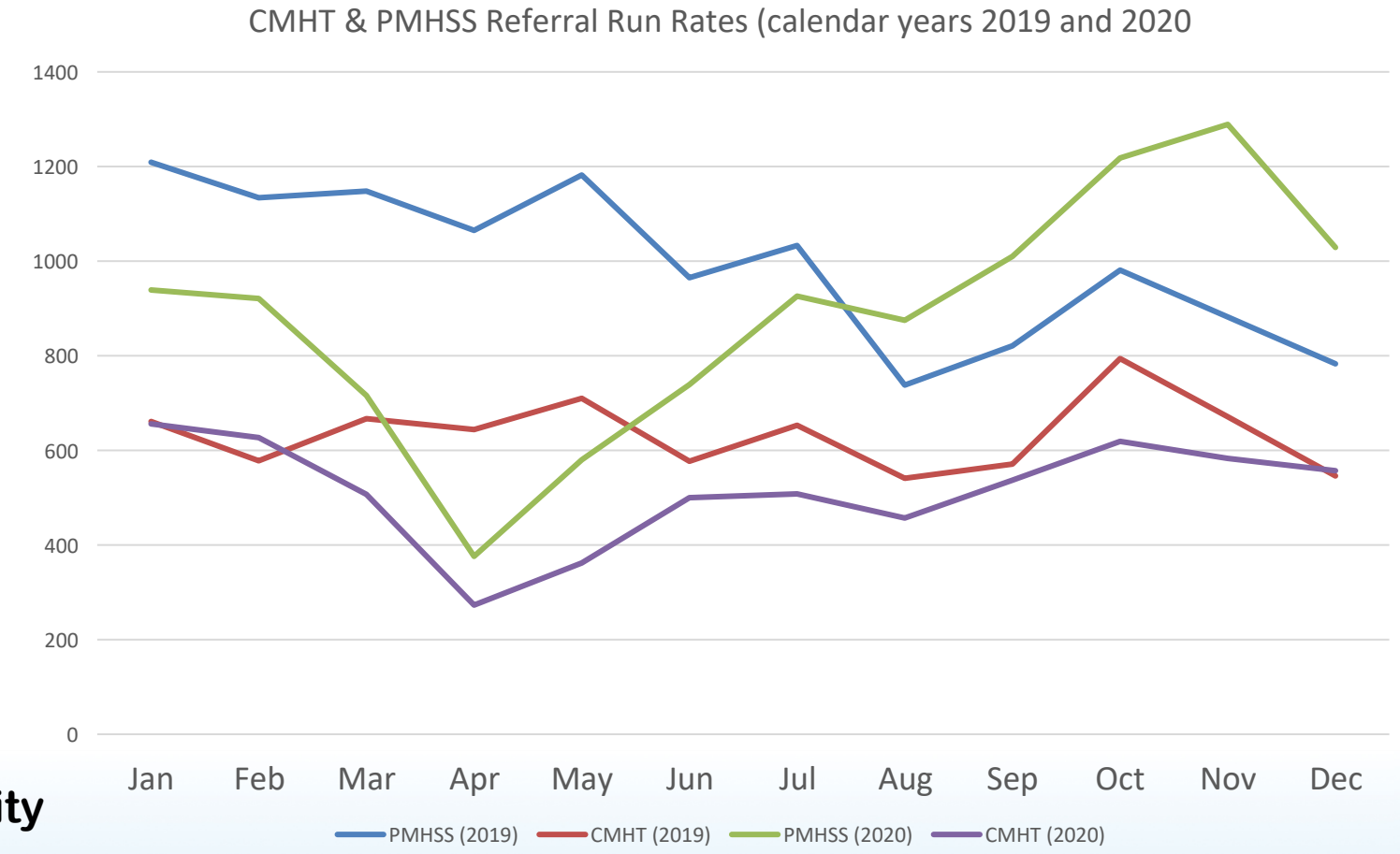
250,000 contacts per annum

Covid 19- Impact on services

Tier 0: Protecting frontline services
March 2020- 255 referrals
March 2021- 515 referrals

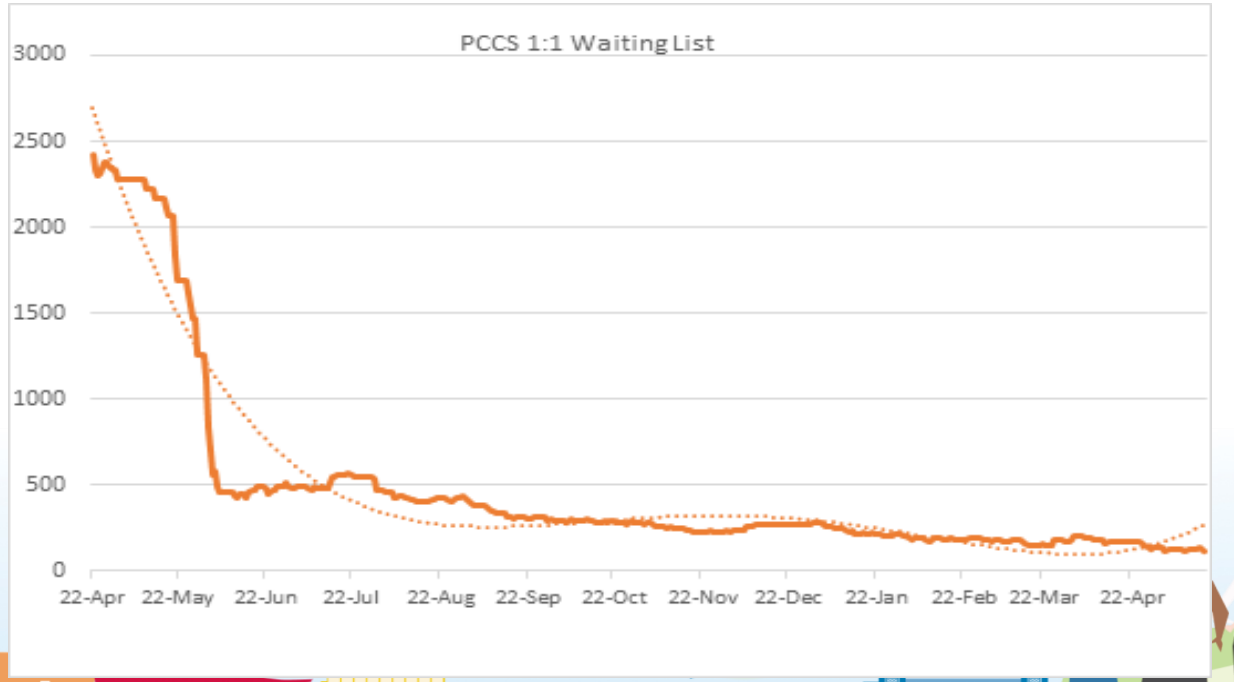
Tier 1: were decreasing, now rising
Tier 2: remaining consistent

Tier 3: increasing demands, acuity and risk
Tier 4: increasing demands, acuity and risk beyond usual capacity



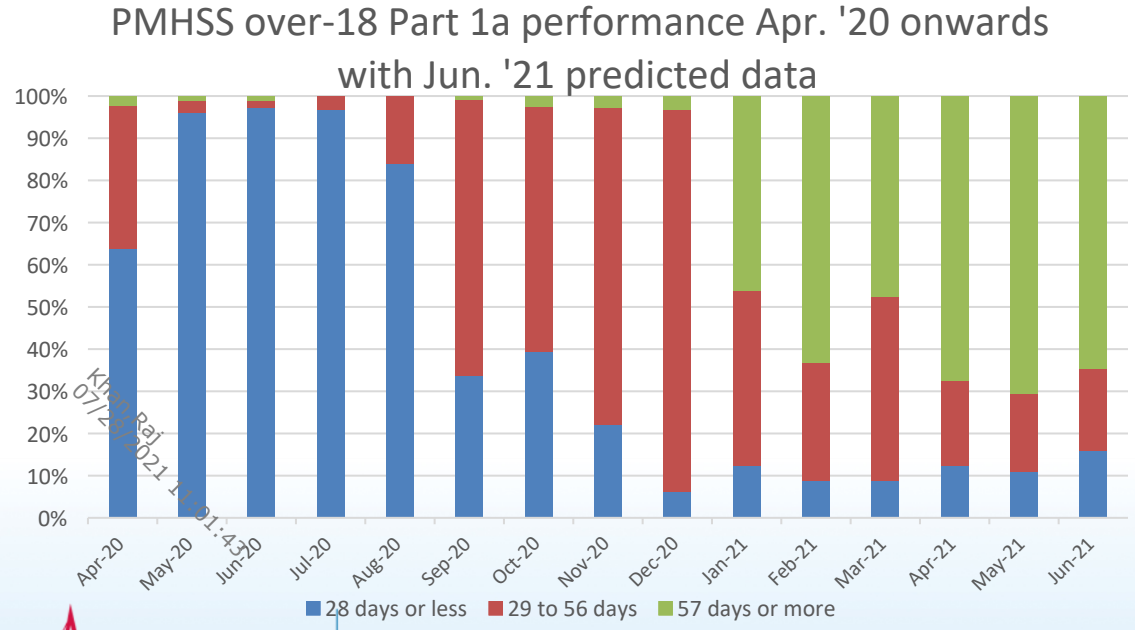
Tier 1: Targets and performance vs clinical impact

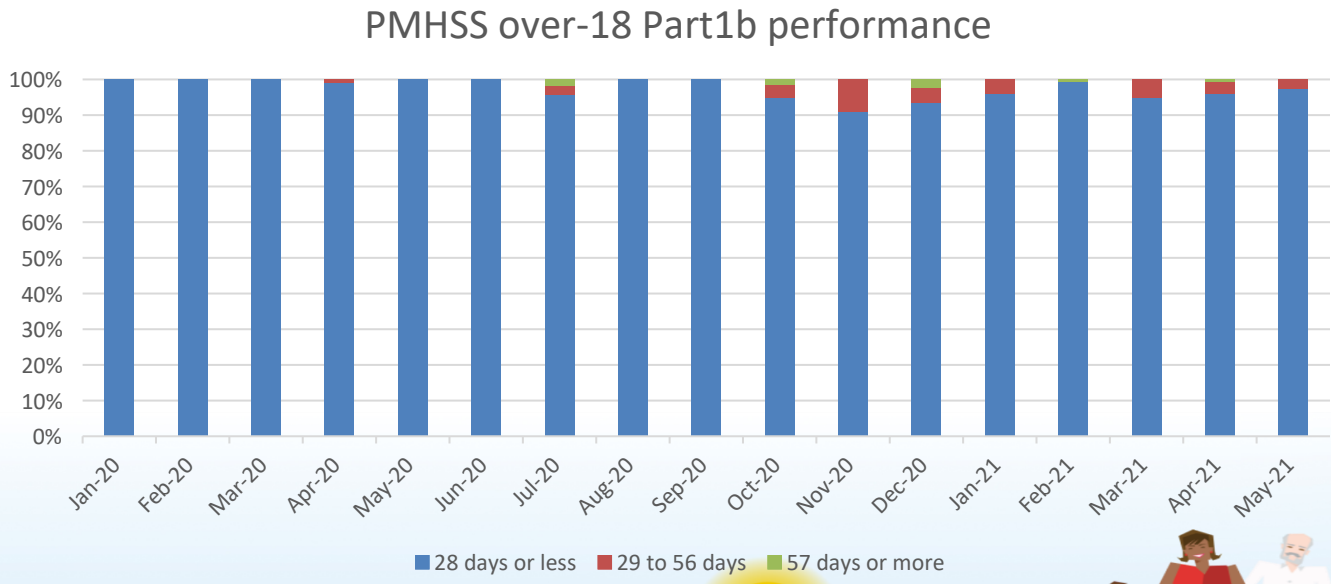
- Single point of access for PMHSS and counselling
- Has increased referrals by 300 per month
- Has cut counselling wait from 6 months to 4-6 weeks



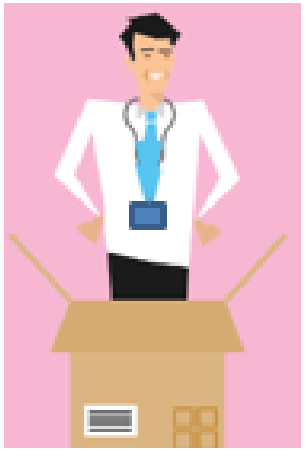
Meeting the Tier 1 targets

- **Two targets for Part 1 (PMHSS):**
  - **1a- 28 day referral to assessment- 80%**
  - **1b- 28 day assessment treatment- 80%**



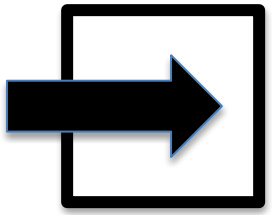


Recovering the Tier 1a target



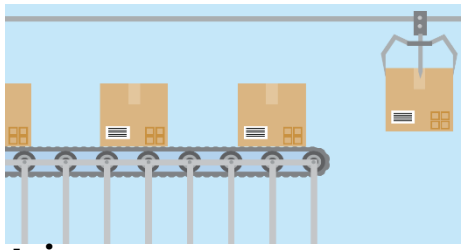
+ 4 extra bank staff
+ x3 extra staff
(but hard to find)
- Move Rx to Ax

Keeping the SPOE:

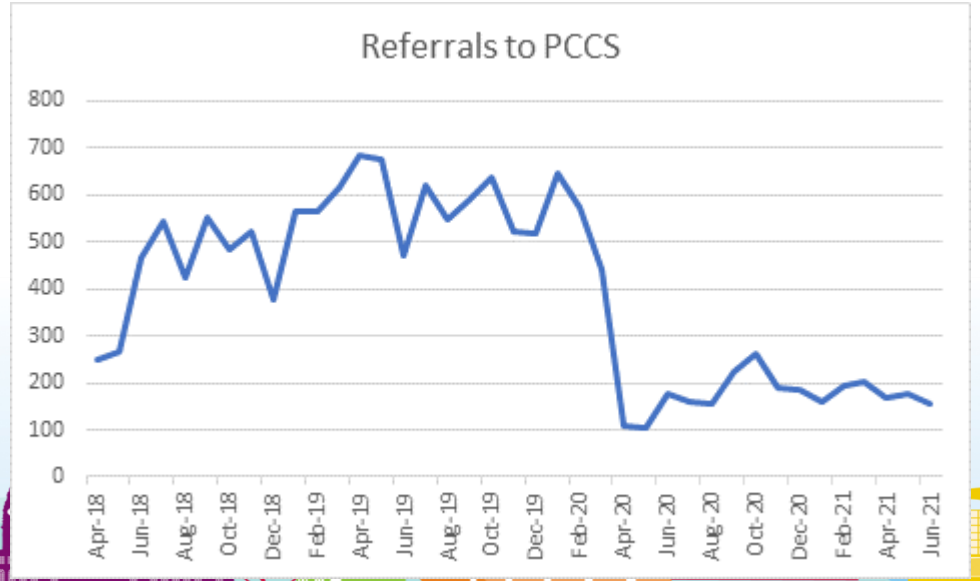


- more referrals
+ better for service-users
+ cuts waiting times

Change processes:



+ increase assessments
+ more efficient approach to DNAs
- beware of staff burnout



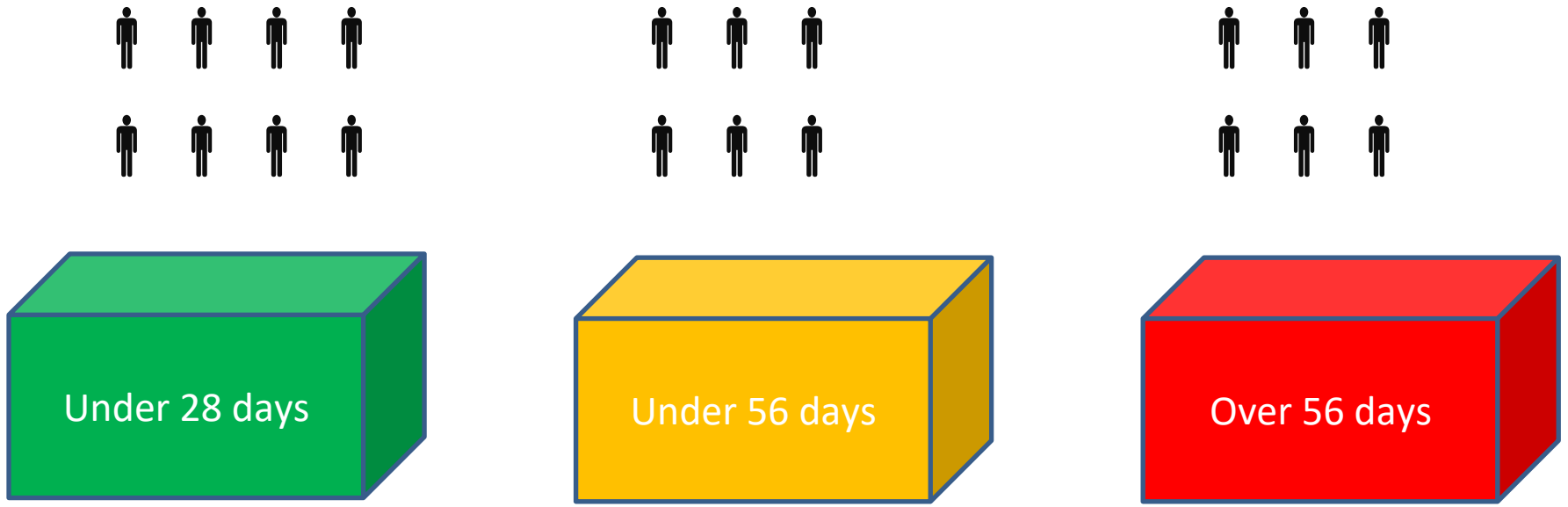
Khan Raj
07/28/2021 11:01:43

Trajectory

	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
A = Current wte + 2.0 Band 6	17%	17%	17%	17%	17%	19%	31%	47%	63%	79%
B = A + 12 slots/week Hub	24%	23%	23%	23%	23%	25%	35%	50%	65%	80%
C = B + 2.0 wte Band 6 starting Sept. '21	24%	23%	31%	31%	31%	33%	42%	55%	68%	82%
D = C + 1.0wte Band 6 currently on LT sick returning Oct. '21	24%	23%	31%	34%	34%	36%	44%	57%	69%	83%

- Worst case trajectory April 2022 (based on previous run rate activity- see above)
- Best case trajectory October 2021(based on a current peak and maintenance of DNA rates)
- Modelling suggests over 56 day wait will increase before sudden resolution

Trajectory modelling



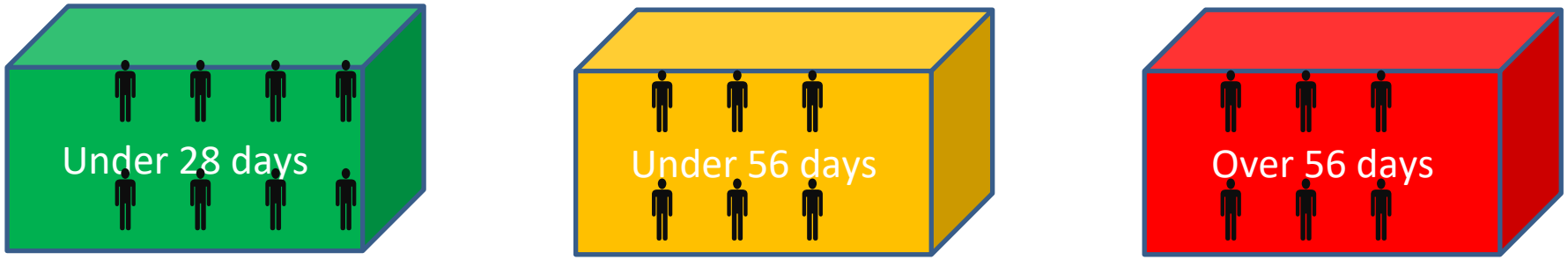
Khan Raj
07/28/2021 11:01:43

Trajectory modelling

- ✔ = number of assessment slots

✔ ✔ ✔ ✔

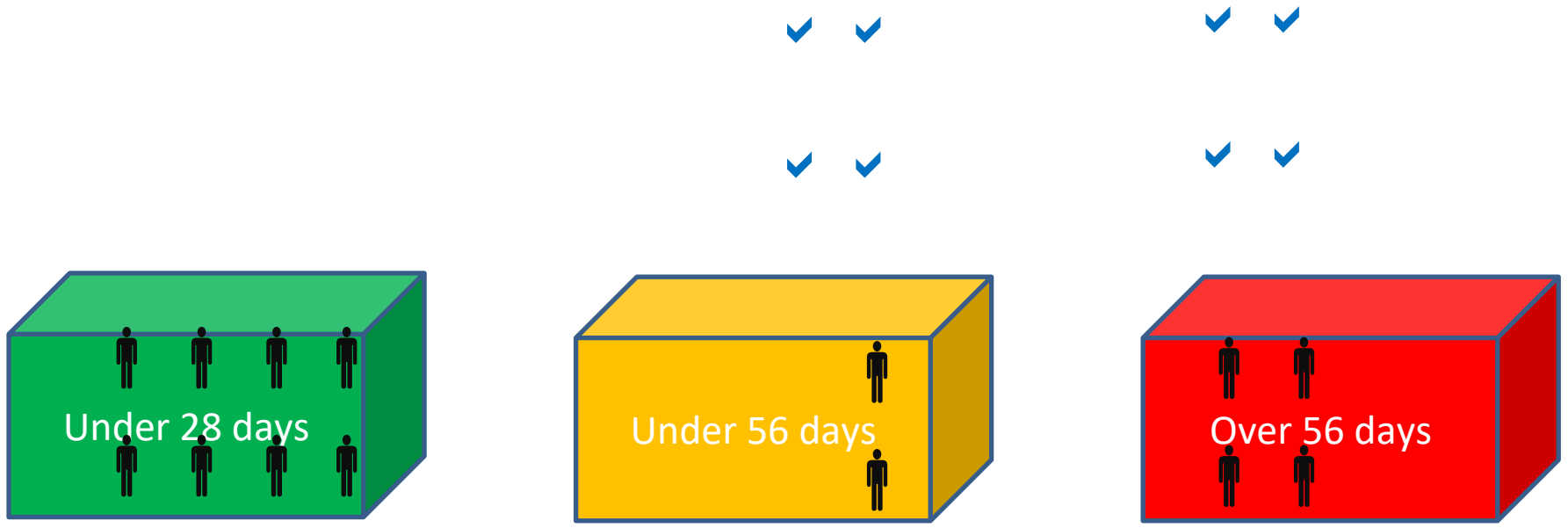
✔ ✔ ✔ ✔



Khan Raj
07/28/2021 11:01:43

Trajectory modelling

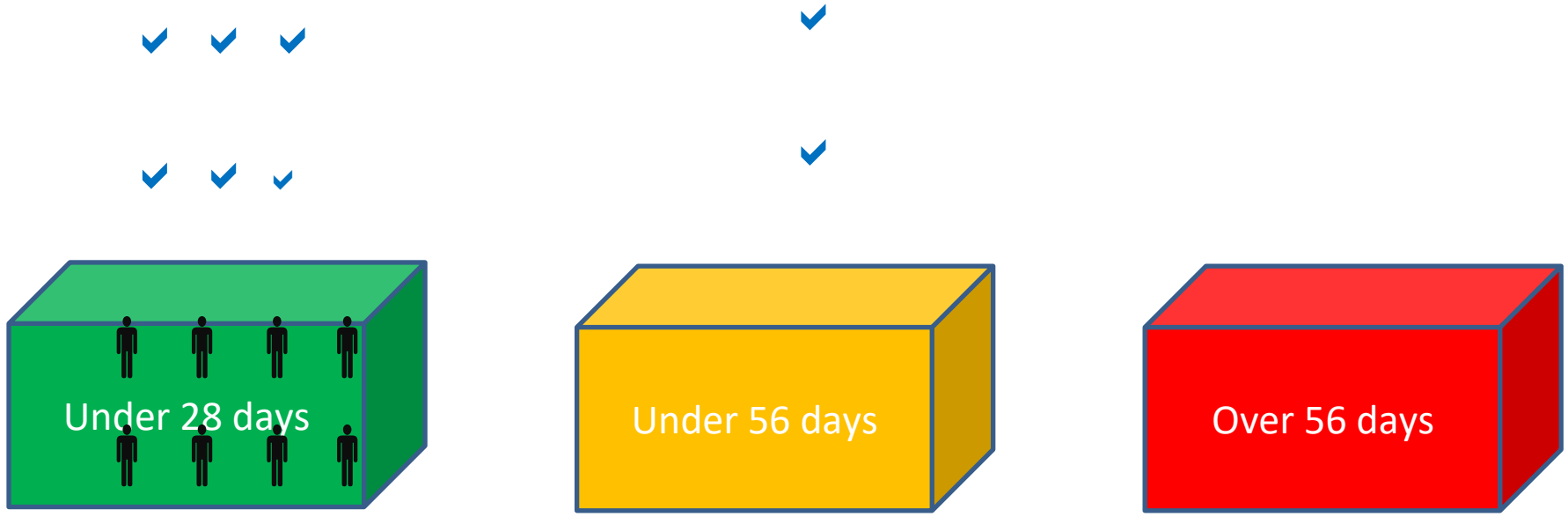
- ✔ = number of assessment slots



Khan Raj
07/28/2021 11:01:43

Trajectory modelling

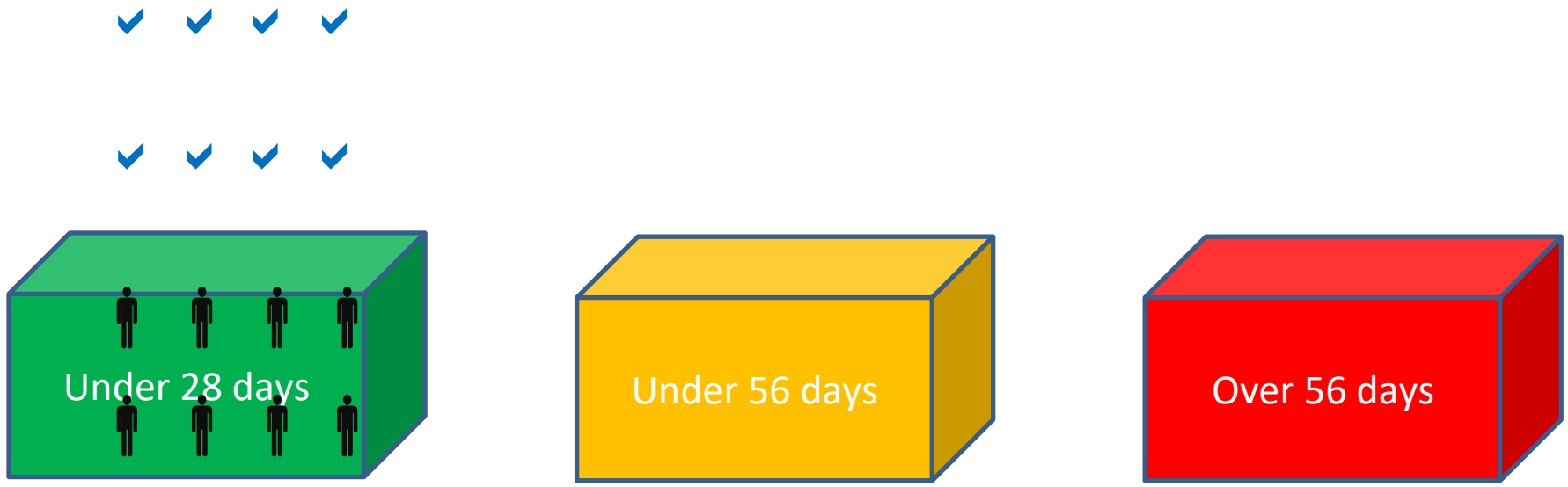
- ✔ = number of assessment slots



Khan Raj
07/28/2021 11:01:43

Trajectory modelling

- ✓ = number of assessment slots

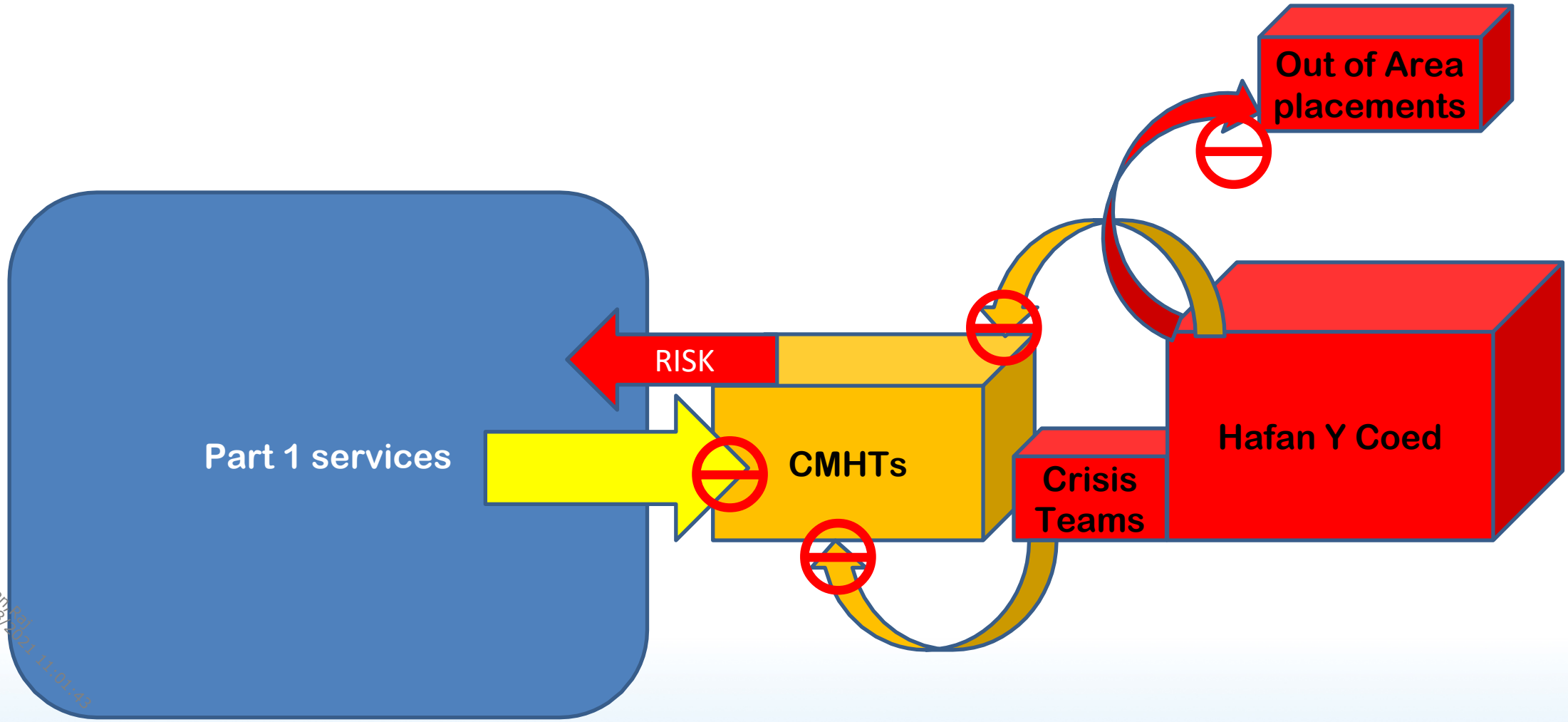


Khan Raj
07/28/2021 11:01:43

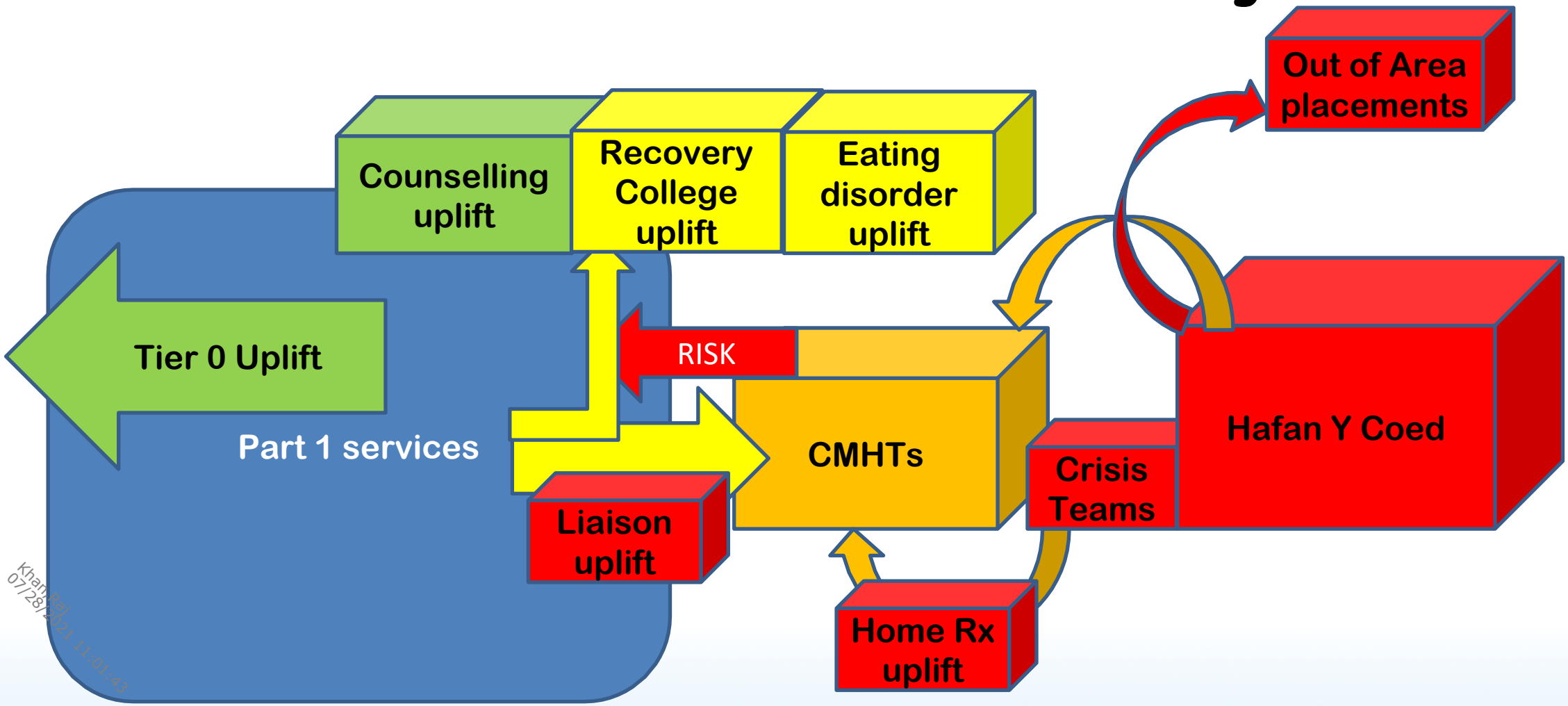
Prioritising safety

- The focus must be on preserving CMHTs
- These are the keystone to all MH services
- Currently in the middle of the biggest transformation in 20 years
- On the surface this is structural but behind this is a cultural change

Clinical Risks



Clinical Risks- Recovery



Q&A

Report Title:	**PATIENT SAFETY QUALITY AND EXPERIENCE REPORT**	**Agenda Item no.**	**6.9**
Meeting:	**Board Meeting**	**Meeting Date:**	29.07.21
Status:	**For Discussion** / **For Assurance** / **For Approval** / **For Information**		
Lead Executive:	Executive Nure Director Executive Medical Director		
Report Author (Title):	Assistant Director, Patient Safety and Quality Assistant Director, Patient Experience		

Background and current situation:

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

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

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

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

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

Serious Incidents

The 14th June 2021 marked the commencement of the new patient safety incident reporting framework from Welsh Government; as a result the restricted SI reporting process in place during the COVID-19 pandemic has now ceased.

Concerns

In May and June, 2,368 concerns/contacts were received. This is a decrease when compared to 3,549 contacts received in March and April.

There has been a 4% decrease in the Health Boards 30-day performance (79%) in responding to concerns, however, despite the continuing demand on the Health Board, we are still exceeding the Welsh Government target of 75%.

Quality Safety and Experience Framework

A wide range of engagement has taken place to date, with 1000's of staff and external stakeholders. This has included open sessions with staff, an organisation wide Safety Culture Survey and a community wide Patient Experience Survey. Presentations and discussions have taken place with a wide range of key external stakeholders. The revised QSE Framework for 2021-2026 will be presented to the September 2021 QSE Committee for approval.

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

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

Serious Incidents		
Clinical Board	**Number**	**Description**
Surgery	4	1. Wrong-sided nerve block performed - Never Event 2. A patient admitted from a nursing home on 01/06/2021 has died unexpectedly 3. A patient who received surgery for bowel obstruction due to a possible malignant mass was 'lost to follow up' 4. A patient sustained a fractured neck of femur following an unwitnessed fall.
Mental Health	3	1. A patient detained under Section 2 MHA has died unexpectedly. No suspicious circumstances were found and it is believed the patient has died of natural causes. 2. A patient who had had an informal admission to Hafan-y-Coed, absconded whilst on escorted leave from the ward and was later witnessed falling from a bridge. Sadly they died from their injuries. 3. An in-patient suicide
Medicine	2	1. A delay in the care of 2 separate patients, referred for endoscopy by their GP.
CD&T	1	Concerns have been raised in relation to the performance of a Radiology trainee. The ultrasounds scans of 108 patients are being reviewed.
TOTAL	**9**	

No Surprises		
Clinical Board	**Number**	**Description**
Children and Women	1	Cardiff and Vale UHB reported potential failings with a Point of Care Testing (POCT) device used to test for pregnancy.
TOTAL	**1**	

How do we compare to our peers?

From 14th June, the way that Health Boards report incidents to NHS Wales Delivery Unit (DU) (Welsh Government) changed. The National Patient Safety Incident reporting policy supersedes the Serious Incident section (Section 9) of Putting Things Right guidance.

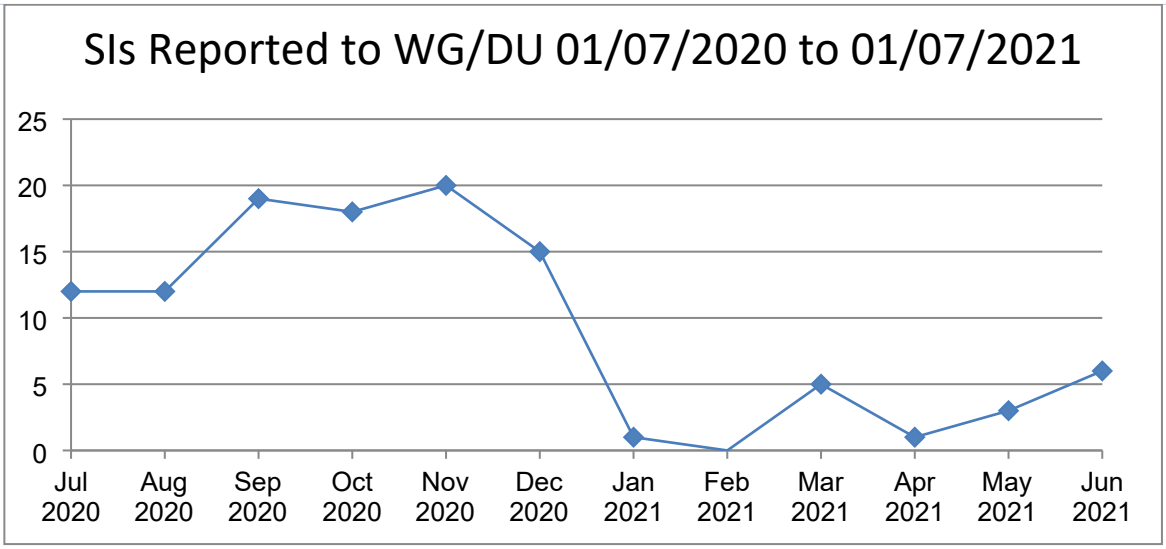
Never Events, in-patient suicides, maternal deaths, avoidable healthcare acquired pressure damage and incidents affecting a significant number of patients will continue to be reported to the Delivery Unit (DU) immediately.

In addition, the following changes will take place:

Phase 1 (immediate effect) requires incidents potentially causing major or catastrophic harm to be reviewed internally by Clinical Boards with onward reporting to the DU if any causative or contributory factors are established.

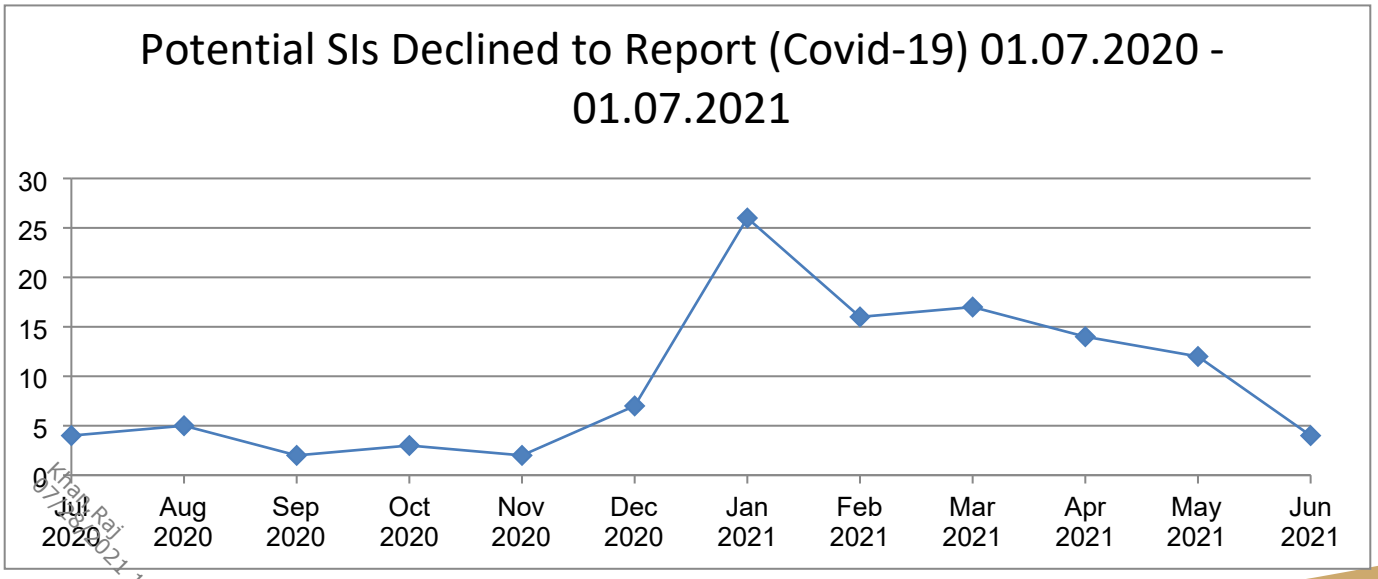
Phase 2 (implementation date to be confirmed) involves the thematic reporting of healthcare incidents based on common factors regardless of the harm outcome.

Health Boards now have seven days in which to review an incident and decide on whether it meets the requirements for external reporting. A significant change in the new reporting arrangements is that Health Boards will assign the investigation timeframe and level of investigation themselves, a role previously undertaken by WG/DU. This reflects a greater emphasis on ownership of the process by individual Health Boards. At the end of the investigation process, Health Boards will report back to WG/DU with one of three reports depending on the findings of the investigation report; a Learning from Event form, an Outcome report or a downgrade request form (the latter allows a Health Board to request that a previously reported incident no longer be considered as an externally reportable incident following further review of the incident).

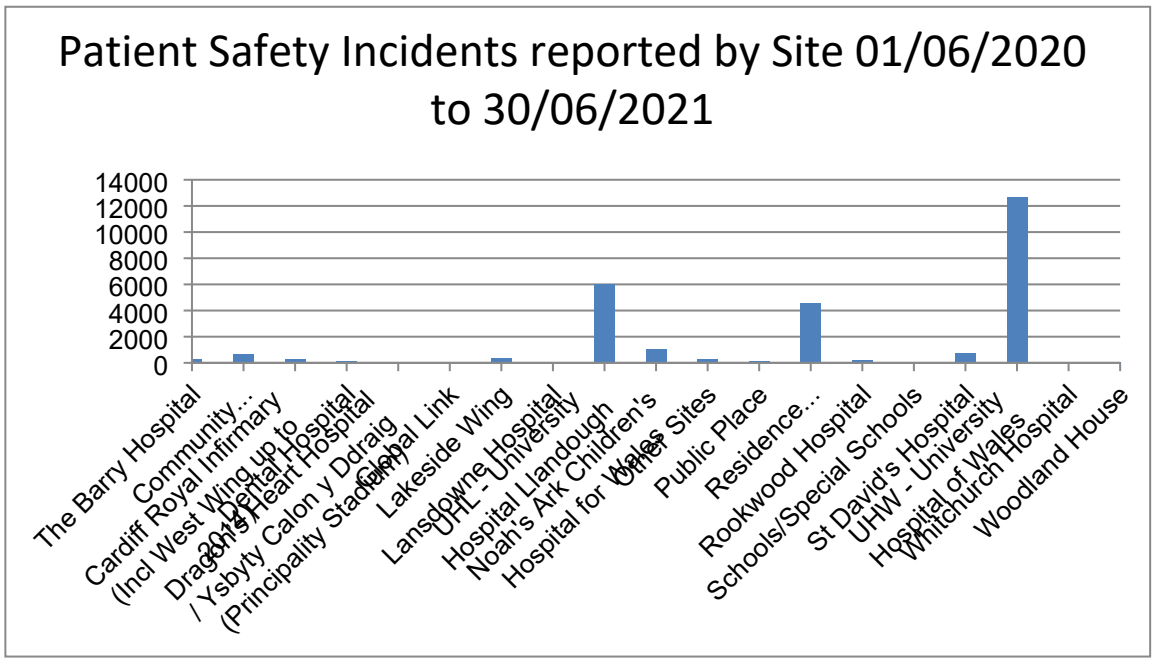


The above chart reflects the change in SI reporting criteria during the first and second waves of the pandemic. In August 2020, the restricted SI reporting criteria that had been in place during the first wave of COVID-19 was lifted and the usual reporting criteria resumed. This is associated with an increase in SI reporting as demonstrated in the chart above. In January 2021, during the second wave of COVID-19, the restricted reporting criteria resumed leading to significantly lower reporting rates. April 2021 to June 2021 did show a slight increase in SI reporting despite the restricted criteria being in place and from 14th June, all restrictions have been removed and the new incident reporting framework is in place. It is therefore anticipated that the graph will continue to increase to reflect pre-COVID-19 reporting levels.

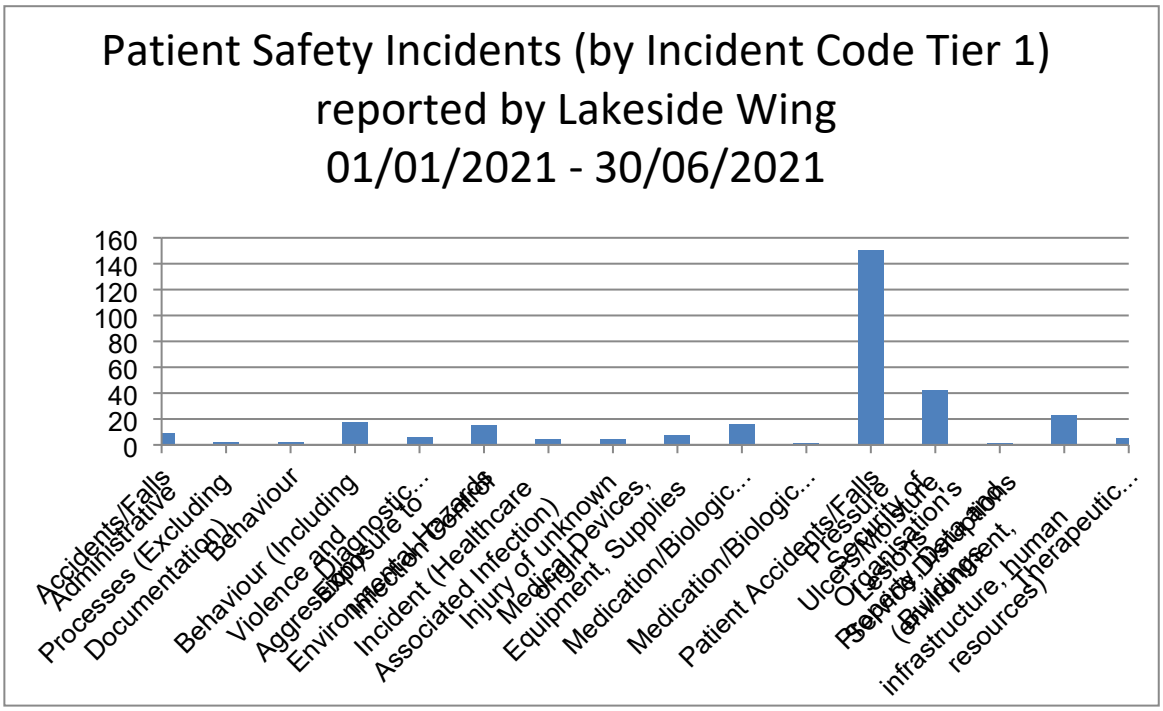
To ensure good governance of incidents that would have been externally reported if not for the restricted arrangements, Cardiff and Vale Patient Safety Team monitored incidents that would otherwise have been reported and ensured that these were still managed appropriately via a proportionate investigation, improvement actions and wider learning. From 14th June 2021, this process has concluded as all incidents that require external reporting will now follow this process.



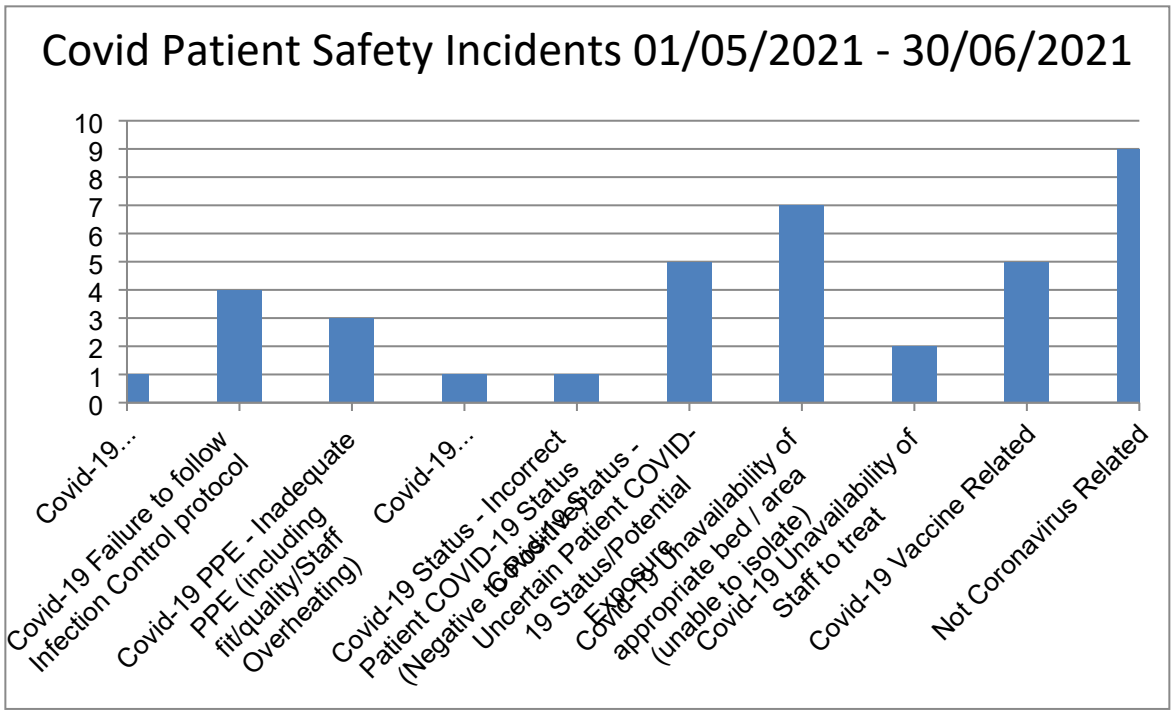
The above line chart demonstrates the increase in the SI type incidents that were not reported under the restricted reporting criteria during the second wave of COVID-19. This category has reduced with a corresponding increase in external reporting to DU/WG leading to the lifting of restricted reporting in June 2021.



The above chart reflects the higher incident reporting at the two main acute sites as would be expected between 1st June 2020 and 30th June 2021.



COVID-19 Related Incidents



There were 73 COVID-19 related incidents reported during May and June 2021, this is in contrast to the 463 reported between January and February 2021 during the height of wave 2. The top 10 COVID-19 related incidents are demonstrated in the chart above. The highest reported category in the top 10 are 'Not Coronavirus related' – these are incidents that are not directly related to COVID-19 but relate to a change of practice or procedure in place due to the pandemic.

The next highest reportable COVID-19 related incident is unavailability of appropriate bed/area followed by uncertain COVID-19 status. The number of incidents relating to inadequate PPE for staff were only three reported incidents for this period. These numbers are much lower than in previous months. All reported incidents related to PPE are reviewed by the PPE Cell and any necessary learning identified and implemented.

Critical Care had been the highest reporting area for COVID-19 related incidents, however for the period of May to June 2021, the Paediatric Emergency Unit was the highest reporter with incidents primarily relating to staffing numbers and available space for patients, either relating to bed availability or difficulty in maintaining social distancing measures due to the numbers of patients. Only two were reported by Critical Care for this period; one related to swab protocol and one related to nurse availability for plasma exchange.

A Nosocomial Review Oversight Group has been set up to review all cases of nosocomial Covid -19 to ensure that all have been proportionately reviewed/investigated and that all identified learning is being addressed. This is Chaired by the Executive Nurse Director.

Regulation 28 Reports

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

There are currently 134 open inquests and 11 Pre-Inquest reviews pending.

Patient Experience

Feedback

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

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

We undertake many bespoke surveys and the feedback is very positive NHS Welsh Health Collaborative.

Feedback

I want to express my sincere thanks for your support in preparing the survey for us. The response was overwhelming; we had in excess of 130 in less than 3 weeks. When it came to analysing the responses, particularly the free text questions, the comments were so emotional, I

did actually have to wipe a tear or two away. I am in the process of seeking assistance in analysing this wealth of qualitative data.

Volunteer Update

We continue to recruit to our Meet and Greet and Mass Vaccination Centre's at a great rate recruiting and starting 54 new Health Board volunteers between April and June.

Concourse (wayfinding and generally helping) - 11/11/20 to 28/05/21 – **2,126** interactions.

Volunteer Feedback received

"*Support from the Patient Experience team is very good and I feel valued".*

"Excellent support and very understanding, nothing is too much. I feel wanted and needed as a team member."

"Would just like to say a huge thank you for letting me be a part of this great team".

Patient Experience Support Staff

We continue to support with many of the initiatives that were developed during the pandemic, with the support of our nursing and medical students. They facilitate communication between families and their loved ones and will set up virtual visits or phone calls where appropriate. They spend time undertaking activities or talking with or being there to listen to patients.

Hours supporting our patients across sites are: Total hours since May 2020 are **13,794.**

Feedback from Cardiff University School of Medicine

We're contacting you to offer our sincere thanks for your contribution toward our students' continuing education during a year that has been challenging like no other in all areas.

We know from reading the students' reflections that their electives have been fulfilling, valuable and memorable. Their experiences have positively impacted upon their studies and how they will approach their forthcoming medical careers.

Patient Information Bags

During May, the Patient Experience Team, in partnership with the Surgery Clinical Board, launched our new Patient Bags on a number of green wards at UHW and UHL. Each bag contained useful items patients can use during their stay along with literature on COVID-19 awareness and how we as a Patient Experience Team can support them. A total of 550 bags will be issued to the wards during this pilot.

Patients Feedback

'Thank you so much for the gift bag you gave me on 20th May when I went into the Heath Hospital. You have no idea how it raised my spirits and set the tone for my whole hospital experience. I came home very happy.'

'The products in themselves are very useful but the giving of the gift is much more. It is a manifestation of the attitude of care and thoughtfulness which makes such a difference when patients are feeling so vulnerable'

Visiting Guidance

The Patient Experience Team have provided support with the development of Maternity Visiting Guidance Video in English and Welsh, which will be uploaded onto the Health Board's website offering support to partners, families etc. with visiting guidance for Maternity Services (A link to the video is provided here – Maternity video) The Welsh Video developed with audio is currently being added for the Welsh site.

From 2nd April 2021 we introduced a dedicated 7 day a week phone line for people to book a visit with their loved ones in line with the guidance and local conditions. We also developed a video and dedicated email address so that people could request a visit in a variety of ways. The visiting line receives approximately 700 calls per week and is especially busy on the weekend.

From 5th July the new guidance allows up to two parents, guardians, or carers at the bedside at a time for paediatric inpatients and neonates subject to local determination, and following a risk assessment including the ability to maintain social distancing. The previous guidance allowed one visitor at a time, unless there were exceptional circumstances.

We know this can be a distressing time for patients and loved ones so allowances are made as appropriate depending on the nature of the visit. These measures are in place to maintain a COVID-19 secure environment, reducing the risk to our patients, their families, and our staff. Wherever possible we try to enable visits, recognising the positive impact for both patients and families.

Living Well with a Long-Term Health Condition Focus Group

Members of the Patient Experience Team facilitated this on-line focus group, delivering within break out groups to provide essential feedback from service users on the development of the Living Well Programme for those living with long term health conditions.

Feedback from attendees

I have just participated in the teams meeting this morning regarding the patient focus group, which has been amazing.

Thank you for your time, and also thank you to your team, it was a great meeting and I have taken a lot away from it.

Smoking Cessation Support

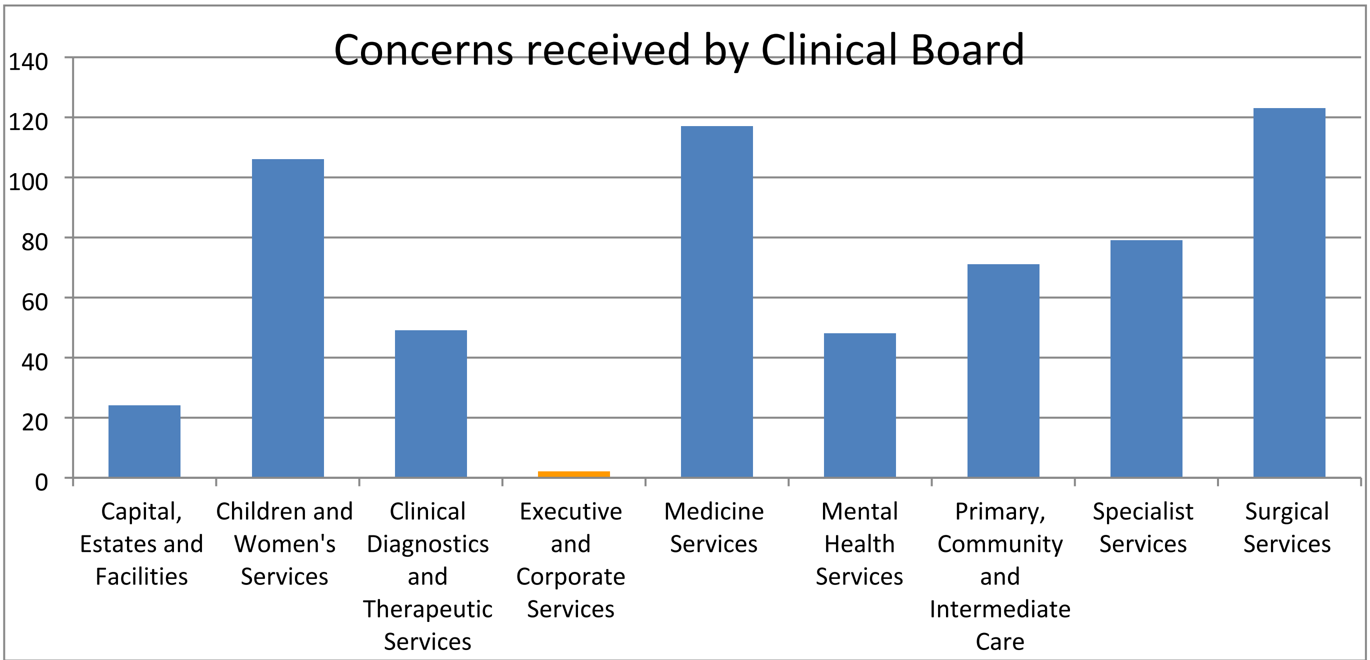
Patient Experience Team members have been supporting with observation visits, the design of a survey, video, poster and leaflet development specifically for Hafan y Coed to inform visitors, service users and public of the smoke free hospital policies and the aim to raise awareness about the support available for patients if they would like to stop smoking.

Complaints Management/Redress

In May and June, 2,368 concerns/contacts were received. This is a decrease when compared to 3,549 contacts received in March and April.

This decrease reflects the reduction in the number of enquiries the Concerns Team are having as more people are receiving their COVID-19 vaccinations. The Concerns Team also provide a 7-day booking line for relatives to arrange a visit which is extremely busy.

Concerns	Vaccination enquiries	Visiting Calls
619	1749	4,282

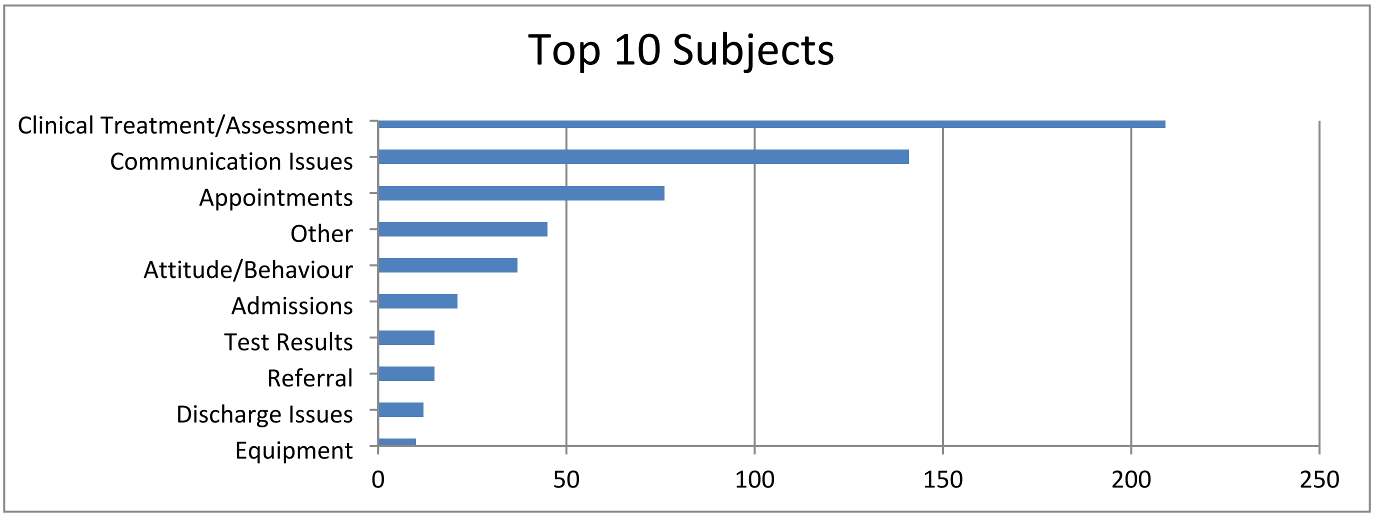


There is a significant increase in the number of concerns received during May and June 2021, 619, when compared to the same period last year (381). We currently have 339 active concerns. We continue to receive a high volume of patient's raising concerns relating to delays in follow-up appointments and planned procedures within the Surgical Clinical Board, and

enquiries regarding the Mass Vaccination roll out sitting within PCIC Clinical Board. It would be expected that the Medicine Clinical Board have a higher number of concerns based on the significantly higher number of patient contacts and level of activity they have had, in comparison to other Clinical Boards during the pandemic. Mental Health Services have also seen an increase in concerns following a number of significant cases.

There has been a 4% decrease in the Health Boards 30-day performance (79%) in responding to concerns, however, despite the continuing demand on the Health Board, we are still exceeding the Welsh Government target of 75%.

Communication continues to be a theme raised in concerns, however, there has been a significant increase in the number of concerns raised relating to clinical treatment and assessment. 165 raised during March and April and 209 during May and June. Therefore the key theme noted during May and June relates to clinical treatment assessment with concerns regarding communication now being the second highest reported theme. Many Patients on elective waiting lists have been contacted to advise of delays and they are provided with a contact number in the Patient Experience Team to speak with the team directly with any enquiries. In the letters people are reminded of the need to access care if there is a change in their symptoms.



It is pleasing to note that there has been a reduction in concerns raised relating to communication with 141 concerns raised during this period, in comparison to 187 raised during March and April. As reported previously, a reduction in these types of concerns was anticipated now that we are able to accommodate some visiting. Concerns regarding clinical treatment and assessment do not relate to any particular Clinical Board.

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

Training

We continue to offer training as and when required. During May and June, concerns training sessions have been provided to Medicine Clinical Board, with very positive feedback. Our plan

over the next two months is to develop on-line training on Breach Of Duty and Redress whilst also providing an opportunity for more bespoke training being available as and when requested.

What are we doing?

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

The Patient Experience Team have also supported Virtual Visiting which has helped to allay concerns regarding relatives not being able to visit during this very difficult time. In order to facilitate visiting when possible, the Concerns Team provide a 7-day booking line to support this – on average, we receive over 600 calls a week. To date we have received over 6,000 calls

Additional staff were required to support the Mass Vaccination enquiry line over seven days. During May and June we received 1,749 calls. This helpline provides an opportunity for members of the public to be reassured regarding when to expect the vaccine, to be signposted appropriately and facilitate arrangements for patients with more complex needs. As indicated the team have developed some videos regarding experience in the mass vaccination centres. We are pleased to be in a position to support staff who have been unable to continue work in their substantive roles due to the Covid Pandemic and the risks involved. We have had very positive feedback.

I was transferred temporarily 4 months ago to the Concerns Department following an occupational health review as I could not fulfil my nursing duties at the time. I was initially supporting Covid vaccination calls, but soon took an interest in the concerns process and I was encouraged and supported by the co-ordinators to start working with concerns more. I was gradually given more responsibilities and supported in this new role. This led to me applying for a co-ordinator position when it became available, something that has had a tremendous positive impact on my wellbeing. The support I received from my colleagues and senior staff in this was nothing short of amazing. I am extremely happy that this opportunity was presented to me when it did and for the support and guidance I received in pursuing it.

Quality, Safety and Experience Framework

A wide range of engagement has taken place to date, with 1000's of staff and external stakeholders. This has included open sessions with staff , an organisation wide Safety Culture Survey As part of this work we are engaging with patients, staff, volunteers and the wider community to help identify our priorities for the next five years. After holding a virtual town hall event to discuss the framework with volunteers we are now running a Patient Experience survey, which will be available until the end of July; to date 1,600 participants have completed the survey.

Presentations and discussions have taken place with a wide range of key external stakeholders. The revised QSE Framework for 2021-2026 will be presented to the September 2021 QSE Committee for approval.

Clinical Effectiveness Committee (CEC) Feedback

Since the last paper was written for the Board Meeting, two Clinical Effectiveness Committee meetings have taken place, on 11th May and 8th June, chaired by the Associate Medical Director.

The Committee is now well embedded and Clinicians are starting to attend to present their National Data and outline work that is being undertaken in relation to continuous improvement. A detailed account of current activity and Clinical Board monitoring and assurance is included in **Appendix 1.**

Learning from Deaths/Mortality

Summary

- The Mortality Review Group is functioning well. The ultimate purpose is to learn from deaths and act on that learning.
- Implementation of the Medical Examiner (ME) and Medical Examiner Office function is progressing according to plan. Good working relationships are being established to evolve structures and processes between Cardiff and Vale University Health Board and the ME Office. The UHB is being held as an exemplar for Wales.
- A business case is being developed to acquire resources that will enable the UHB to manage the additional workload.

Detail

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

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

Currently, one set of case notes is being scanned from University Llandough Hospital to the ME office per day. From 1st June one set will be scanned from University Hospital of Wales as well. By September 2021 it is expected that all hospital deaths will be reviewed by the ME. A business case is being developed to gain appropriate resources for this additional work.

The Chief Medical Examiner and the Chief Medical Examiner Officer (CMEO) for Wales have praised the partnership working between the operational group and the ME office. The UHB is being sighted as an exemplar.

A gap in understanding of the 2019 rules for referring deceased to HM Coroner has been exposed throughout Wales. The rules were implemented to standardise the approach and to

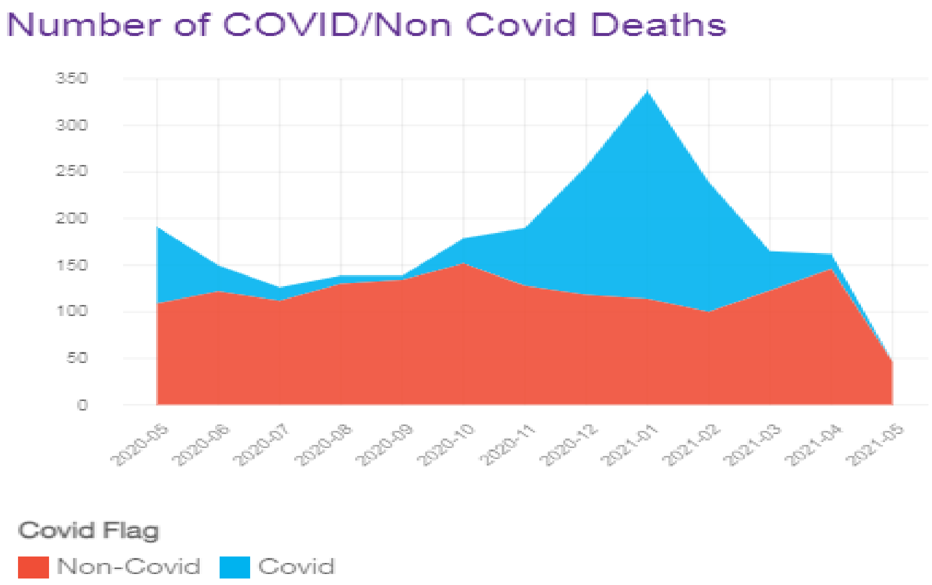
protect doctors, enabling them to fulfil their legal duties. Informal education via existing opportunities is being carried out by the CME.

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

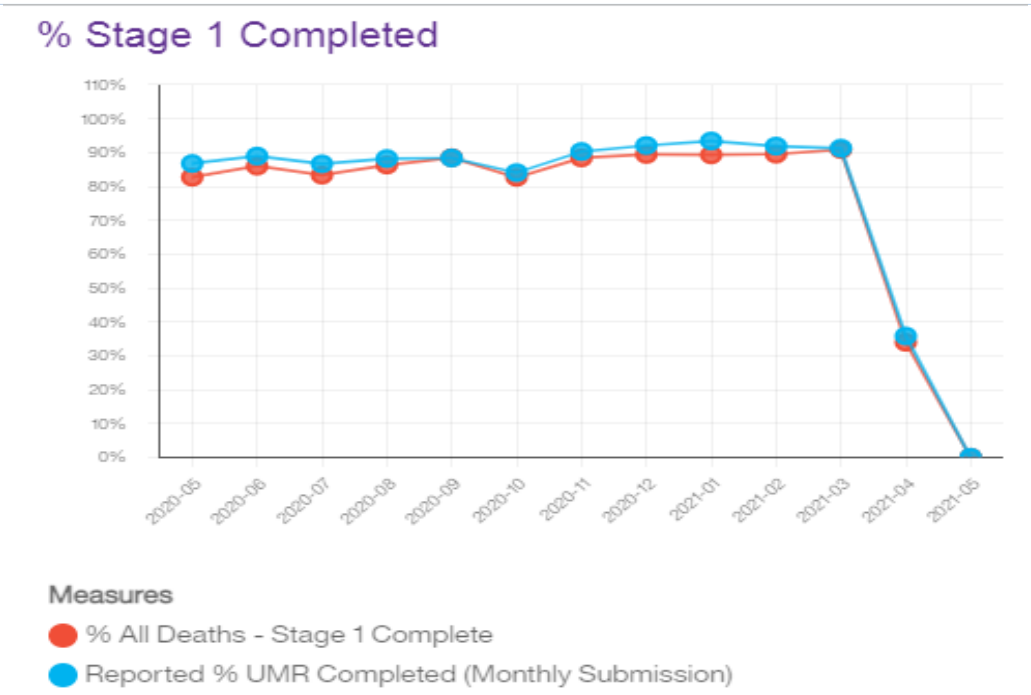
Stage 2 reviews are completed by MDTs, led by nominated Consultants. Findings should be discussed through the relevant Quality Safety and Experience Committee structures and a copy of the review sent to the Organisational Learning and Quality Improvement Team so that UHB-wide themes and trends can be determined.

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

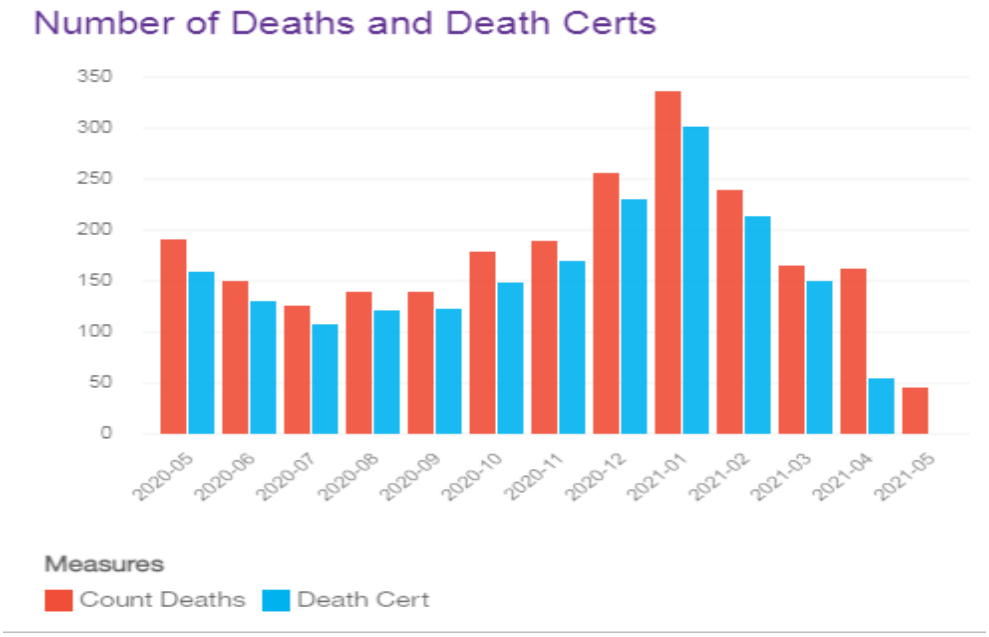
At the last MRG an update was provided on the learning from hospital acquired COVID-19 deaths and an update on the changes to the Do Not Attempt Cardiopulmonary Resuscitation Policy. DNACPR is a live policy that is adjusted to changes in clinical or legal circumstances as they emerge.
COVID-19 notwithstanding the number of deaths/the amount of joint work with the ME office is fairly predictable – as per the chart below.



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



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



Recommendation:

- The Board is asked to **NOTE** the contents of the Integrated Quality, Safety and Experience (QSE) 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:	Yes / No / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Appendix 1 – Clinical Effectiveness Committee activity and output.

Perinatal Mortality Review Tool (PMRT)

Following publication of the PMRT report two questions were posed to the Directorates:

1. Position on implementation of NICE guidance for diabetes in pregnancy.

2. How objectivity/impartiality is ensured when reviewing neonatal deaths and RCA investigations in the absence of an external member were highlighted. The Committee received responses from both the Neonatal Unit and Obstetrics that confirmed that NICE guidance NG3 had been fully implemented, and work is underway with the Welsh Neonatal and Maternity Network to establish external member to support Welsh Health Boards.

Paediatric Intensive Care Audit Network for the UK (PICAnet)

The Paediatric Intensive Care Audit Network Annual Report for 2020 was discussed. It was noted that the refusal rate following referral for urgent paediatric intensive care transport for CAVUHB was 12.8% during 2017-2019 – this was high in relation to peers. These were cases that had been referred by a PICU Consultant but refused. Following further discussion with the relevant teams to ensure the data was understood in context, the Clinical Lead together with the Audit Lead has been invited to present their data to the Clinical Effectiveness Committee meeting in August.

National Hip Fracture Database – May 2021

The National Hip Fracture Database Audit was presented by the Clinical Audit Lead, the Lead Nurse for Surgery was also in attendance. A demonstration was given on various aspects of the NHFD website, including an assessment benchmark summary that contains real time data. It was explained that using the website as a benchmarking tool with hospitals in England can be problematic due to the best practice tariff incentives in England. Below is the data and the expected standards developed by WG and presented to the Delivery Unit on a quarterly basis

Overview of Wales	AB		BCU			CTM			CV	HD			SB	Benchmarks				
	GWE	NEV	CLW	GWY	WRX	PCH	POW	RGH	UHW	BRG	WWG	WYB	MOR	NHFD	Wales	Eng	NI	Expectation
Prompt orthogeriatric review % (k1 annu	95%	93%	94%	39%	33%	0%	0%	8%	78%	95%	29%	64%	86%	87%	60%	89%	82%	75%
Prompt surgery % (k2 annual)	62%	79%	67%	81%	69%	65%	57%	75%	70%	44%	80%	74%	54%	69%	67%	69%	21%	75%
NICE compliant surgery % (k3 annual)	87%	79%	62%	64%	75%	46%	82%	83%	71%	95%	68%	76%	68%	71%	72%	71%	75%	75%
Prompt mobilisation % (k4 annual)	72%	71%	74%	85%	77%	76%	90%	61%	79%	78%	70%	61%	74%	80%	74%	81%	84%	75%
Not delirious post-op % (k5 annual)	58%	60%	78%	54%	18%	0%	73%	8%	51%	96%	63%	67%	74%	58%	54%	58%	36%	75%
Return to original residence % (k6 annual	75%	82%	77%	75%	67%	68%	64%	72%	77%	80%	76%	79%	76%	71%	75%	71%	79%	75%

*NEV data only up to April 2020

*NI data only up to Oct 2019. NHFD beyond Oct 2019 is only England and Wales.

For any questions regarding this spreadsheet, please contact James Davis, James.Davis2@wales.nhs.uk

Highlighted in red for CAV (KPI) , 'not- delirious post-operatively' is 51% and is an issue nationally, demonstrating the value of using real time data it was possible to see an improvement in this area, and audit data showing improvement on previous years. However, it was recognised that there is significant room for improvement. Current improvement plans are focused on the pre and perioperative period as well as the post-operative period. Inpatient falls as a result of post-operative delirium was also discussed and the need to develop a structured way of learning and sharing the learning across the Health Board. Learning from all inpatient falls is being picked up by the Falls Lead who was also present at the meeting.

Pressure area care was also identified as a concern, the Committee was informed of various work in process, including re-establishing the Pressure Damage Group, and working with bed suppliers to change Duo Two mattresses. Addressing post-delirium will also have an impact on safe post-operative mobilisation rates.

The National Early Laparotomy Audit (**NELA) – May 2021**

The National Early Laparotomy Audit was presented by the Clinical Audit Lead.

Positives from the presentation were: Improvement seen in mortality rates year on year, Cat 1 decision to theatre time, lactate and Surgical Consultant presence.

Areas for improvement were: In relation to timely administration of antibiotics in suspected sepsis, documentation of risk, clinical fragility score, Anaesthetics Consultant presence and access to ITU.

Work currently underway included a review of PTSD post emergency laparotomy, increase in frailty sessions, participation in UK-wide QI project, improving sepsis management and pathway documentation, working with Surgical Trainees and Nurse Practitioners.

NELA simulation is to commence when COVID-19 pressures ease. A national piece of work will be undertaken focusing on the patient's experience.

National Lung Cancer Audit

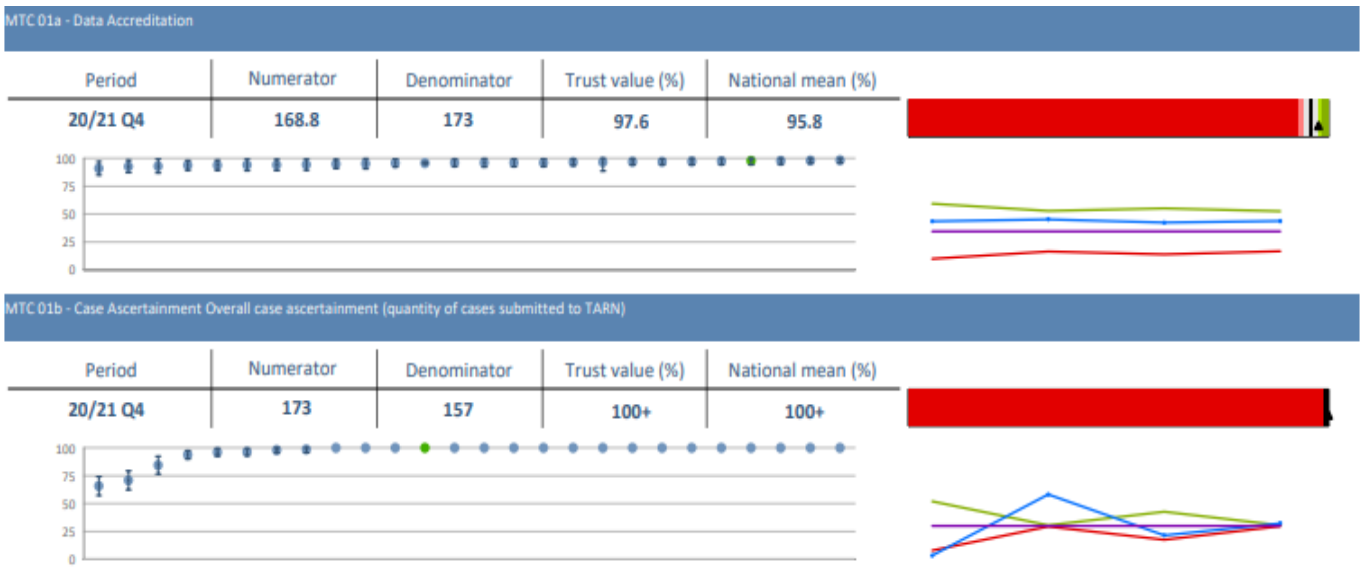
Crude Cardiff data was discussed and some questions were raised around the following:

- Reduction in the rate of surgical resections
- Reduction in the number of pathological diagnosis

Following further discussion with the Clinical Audit Lead, they have been invited to present the audit data at the August CEC meeting, following their internal MDT review and Quality Session.

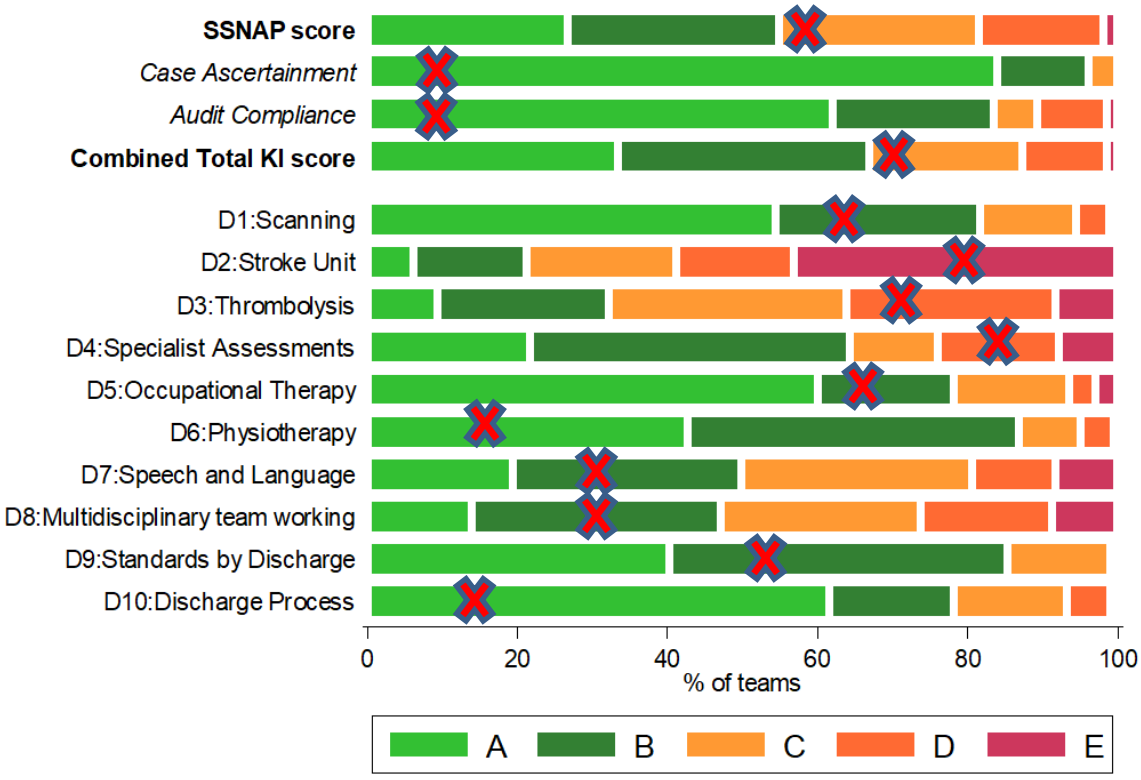
The Trauma Audit and Research Network (TARN) – May 2021 (Update)

A reduction was seen in the case ascertainment figures for March – December 2020. Issues were as a result of a member of staff shielding during COVID-19, training needs and retention due to banding issues and funding which, whilst during the last three months no TARN coordinators have been in post. The shortfall has been absorbed by the Clinical Audit Team through working overtime and allocated time from other commitments, which has had an impact on other national clinical audits. Case ascertainment is 100% and data accreditation is 97.6% which has been consistently the best in Wales. From 6th July 20231, two new TARN coordinators will commence their training. This will impact on case ascertainment during this period due to training requirements, and will be reflected in future reports. The complexity of the cases that are now seen in Cardiff and Vale UHB will also have an impact. Discussions have taken place with the MTC regarding the sustainability of the TARN audit and the need for additional funding to ensure future proofing. The Clinical Audit Lead for TARN will be invited to the CEC meeting in November to present the data and the work that has taken place during the first year of the MTC.



Sentinel Stroke National Audit Programme (SSNAP) – June 2021

Currently there is no Clinical Audit Lead appointed for this audit and plans for recruitment are underway. The SSNAP audit was presented by other lead members of the Stroke Team.



Source: SSNAP Jan to Mar 2021
Patient-centred results at national level

A system is in place to monitor the SSNAP data and initiatives such as 'door to ward' where the Stroke Team work closely and meet with the Emergency Department, Radiology and Patient Access. Over recent years SSNAP data has been used in several service developments and improvements, including time interval from admission to thrombolysis, HASU workforce gap analysis undertaken, thrombectomy pathway and referral procedures, and Stroke Response Nurse project.

The SSNAP data has consistently showed Cardiff and Vale UHB to be performing poorly in relation to:

- Admission to Stroke unit
- Time interval to thrombolysis
- Specialist assessments

An Introduction of a HASU Unit consistent with the rest of the UK would significantly improve outcomes for patient admitted with stroke. The issues have previously been recognised as a priority, and will be escalated to the next QSE Committee meeting.

Time Matters – National Confidential Enquiry into Patient Outcomes (NCEPOD)

The TIME matters NCEPOD was discussed in the RADAR meeting and discussed at CEC by Aled Roberts, Clinical Board Director, Medicine and Angela Jones, Head of Resuscitation Services.

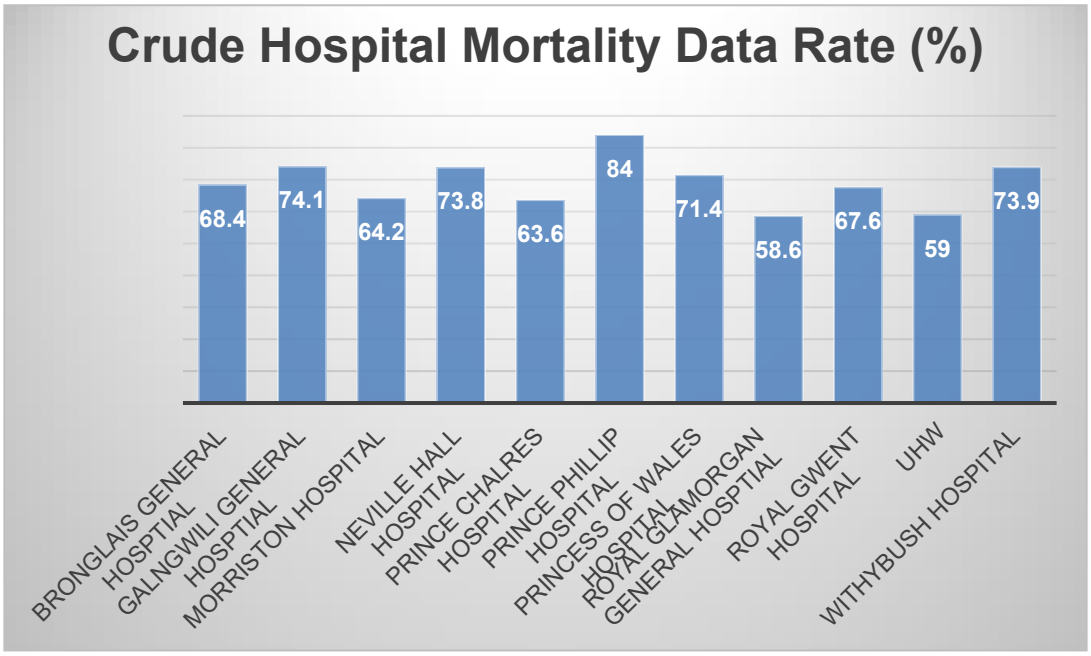
There were five key messages in the report:

1. Bystander cardiopulmonary resuscitation, including use of public access defibrillators improves outcomes.
2. Standardising advanced treatment plans helps patients receive realistic treatment based on their wishes, e.g. 'Do Not Attempt Cardiopulmonary Resuscitation'.
3. Delaying the assessment of neurological prognosis by at least 73 hours after the return of spontaneous circulation aids decision-making.
4. Ensure good temperature control is used following an OHCA as uncontrolled temperature is associated with a worse outcome.
5. Provide ongoing physical, neurological, cardiac and emotional support to ensure good quality of life for survivors on an OHCA.

From a resuscitation perspective, RADAR try to ensure that temperature control is discussed along with oxygen and DNR orders. However the RADAR Committee recognises that the process of sharing the learning from the meetings across the Health Board is difficult and needs to be strengthened.

The Resuscitation Service is currently under resourced. They currently have 2.8wte; the quality standard states it should be 14wte. The gap analysis will be presented at the QSE Committee.

ICU Admissions and Hospital Mortality Rates for Wales are over the page.



Conclusions from report

- Mortality rates are higher in Wales than in other parts of the UK.
- Approximately one third of OOHCAs are cared for DGH's that have poor access to the

neuro-prognostication tools required, with minimal local cardiology support 24/7 and struggle to engage tertiary services when they feel it is appropriate.

- There general trend is better survival rates in higher volume, well-resourced centres (although there is a selection bias with lower APACHE II scores).

NAIF (National Audit for Inpatient Falls)

The NAIF data was presented by the Falls Lead. The audit report found the Health Board to be compliant in the majority of the standards. It had been identified that there had been data collection issues due to long term sickness and capacity within the Clinical Audit Team which resulted in some cases not being submitted by the deadline. This is being addressed through submission of a business case to supplement the resource within the Clinical Audit Team.

The reporting of hip fractures should be as 'severe harm' in national reporting and learning systems, it was agreed at the CEC meeting that this would be graded as 'severe harm' going forward.

The Falls Review Panel meets monthly to review falls tools completed to ensure robustness and that correct actions are being taken and learning can be shared. The Falls Delivery Group meets on a bi-monthly occurrence. Part A and B Welsh Government National Clinical Audit proformas have been submitted in advance of the deadlines.

Fracture Liaison Service Database (FLS)

There appeared to be some data collection issues which may have resulted from redeployment of staff during COVID-19. The Head of Patient Safety will meet with audit leads and report finings back to the next CEC meeting.

National Clinical Audit of Psychosis (NCAP)

Issues with data collection are ongoing due to long term sickness within the Clinical Audit Team which has significantly affected case ascertainment. Meetings have been arranged with the Clinical Audit Leads to address the issues moving forward. Due to the current situation of staffing and capacity within the Clinical Audit Team, this will take some time to address, and is likely to impact on case ascertainment.

National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)

The suicide rate for Cardiff and Vale UHB area was 11%. The estimated number of patients who had been in contact with Mental Health Services across Wales in the twelve months before their death, in 2018, is estimated to be 73%. The number of patient suicides in Wales who died within three months of in-patient discharge was ten.

Rates of suicide per 100,000 population, by Health Board of residence (average rate 2016-2018)

Area	Rate
Aneurin Bevan	9.4
Cardiff and Vale University	11.0
Swansea Bay	12.4
Betsi Cadwaladr University	13.2
Powys Teaching	13.7
Hywel Dda	14.6
Cwm Taf Morgannwg	14.7

Service characteristics of patients who died by suicide in Wales (2008-2018)

Characteristic	Total=813	
	Number	%
In-patient†	53	6
Recent (<3 months) discharge†	122	16
Under crisis resolution/home treatment services†	89	12
Missed last contact in previous month	157	22
Non-adherence with medication in previous month	87	12
Contact with services		
Last contact within 7 days of death	354	46
Short-term risk: low or none	641	89 ▲
Long-term risk: low or none	445	64 ▲

Tier 2 patient safety Priority Audits

The following Tier 2 audits were noted:

- UTI audit (2 parts)
- Venous Thromboembolism Risk in Lower Limb Immobilisation.
- Audit of Major Trauma Patients with Spinal Injuries on PTU and Spinal ward (closing loop)
- Perioperative Management of patients with Diabetes mellitus (DM) in UHW
- Compliance with ED Clerking Proforma

- Eosinophilic Oesophagitis Audit

NICE & Health Technology Wales

Nice and HTW guidance response rate is shared on a quarterly basis and will be discussed in more detail at the next CEC meeting. The level of responses remains poor for April and May at 22%. Implementation was reported at 8.3%. Where clinical areas had responded, there was no evidence to support implementation with the current system. There are significant challenges associated with the current system and process in place for providing assurance against NICE and HTW implementation. It has been identified that investment in an audit management system such as AMaT software and the resource to manage and administer the system is required. With the required resource a more robust process will be implemented to ensure that evidence is provided of implementation of NICE and appropriate actions taken where NICE has not been implemented.

The Wales NICE Health Network met in May 2021, compliance around four specific guidelines was discussed and the following as found (unable to capture information from current system):

- Chronic Heart Failure in Adults: Diagnosis and Management NG106 (2018) – *Not implemented – Business plan has been submitted and discussions are ongoing.*
- Cerebral Palsy in Adults NG119 (2019) – *Partially implemented - Response on position provided to WG.*
- TWIN Triplet Pregnancy (NG137) – *Implemented.*
- Asthma: Diagnosis, Monitoring and chronic Asthma Management NG80 2017 updated March 2021 – *Not complaint - following AWMSG which slightly differs from NICE, further discussions taking place.*

The HTW Adoption Group has commenced and preliminary meetings have taken place with the Cardiff and Vale Associate Medical Director and Head of Patient Safety and Quality Assurance in attendance. Peter Groves has been invited to present implementation of NICE and HTW on the Grand Round to medical staff.

The Falls Lead has put forward the 'sensor devices in falls prevention' for appraisal to HTW and has been accepted by HTW Assessment Group and will be part of the appraisal group.

Peer Review and Accreditation

Following agreements that all peer reviews will be reported through the CEC and the last update for the Board report, three further peer reviews have been highlighted by Clinical Boards and noted at CEC which will be discussed at the next CEC meeting.

- CAHMS – *Review when report available.*
- Orthopaedic Joint replacement – *Invite to next CEC meeting.*
- Dermatology - *Action plan noted, discuss next CEC meeting and to review progress of Action plan in 6 months.*

Service Developments

- Patient Safety Notice – *MRI scanning, to be discussed further with CD&T Clinical Board.*
- Patient Safety Solution – *NG tube training for medical staff. A letter has been sent to Welsh Government and HEIW regarding the development of an All Wales approach.*

Patient Safety Solutions – *Non-adherence to inclusion of flushing of lines following anaesthesia on WHO checklist. Recent SI with investigation in progress, Investigating Officer to present findings at next CEC meeting.*

Report Title:	**Risk Management Strategy and Action Plan**								
Meeting:	**Board**							**Meeting Date:**	**29th July 2021**
Status:	**For Discussion**		**For Assurance**		**For Approval**	**x**	**For Information**		
Lead Executive:	**Director of Corporate Governance**								
Report Author (Title):	**Head of Risk and Regulation**								

Background and current situation:

It is a requirement of the Health Boards Standing Orders and Scheme of Reservation that the Risk Management Strategy is reviewed by the Board on an annual basis. An Internal Audit review has also been undertaken

The Risk and Regulation Team have now reviewed the Strategy and supporting procedures to produce a new suite of documents which include the agreed recommendations of the Internal Audit Review. The Internal Audit Report and recommendations were shared with the Audit Committee in April 2021.

The following revised documents are attached as appendices to this report:

- Appendix 1: Risk Management and Board assurance Framework Strategy; and
- Appendix 2: Risk Management Procedure (with supporting Risk Assessment and Risk Register)

Alongside this work an Action Plan has also been developed to ensure that the revised Strategy and Procedure are fully embedded into practice across the Health Board. A copy of that plan is attached as Appendix 3.

The revised Strategy has been through its consultation period, has been reviewed by the by the Audit and Assurance Committee at its July meeting where it recommended approval of the Strategy by the Board..

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

The revised Risk Management and Board Assurance Framework and Strategy and supporting Procedure have been produced in response to an Internal Audit review of the Health Board's Risk Management practices and update the existing policy and procedure that were implemented in July 2019.

The variations to the existing policy and procedure do not represent a substantial re-write of the documents. Instead the changes bolster the original documentation and to provide evidence of the Health Board's compliance with examples of best practice such as the ISO 31000 standards relating to risk management.

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc:)
The Internal Audit of the Health Board's Risk Management Strategy confirmed that the Board could take reasonable assurance that arrangements to secure governance, risk management and internal control, within those areas under review, were suitably designed and applied effectively. The report further confirmed that the areas requiring attention would have a low to moderate impact on residual risk until resolved.

It is suggested that the variations to the Risk Management and Board assurance Framework Strategy and Risk Management Procedure appropriately address the actions/recommendations detailed in the internal audit review.

Recommendation:

The Board is asked to:

- Approve the updated Risk Management and Board Assurance Framework Strategy and Risk Management Procedure; and
- Note the Action Plan for the implementation of the revised Strategy and Procedure.

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		Integration		Collaboration		Involvement	x

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

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Cardiff and Vale University Health Board
Risk Management and Board Assurance Framework Strategy

Document Reference No:	C&V UHB 470	**Version No:**	2	**Previous C&V UHB Ref No:**	N/A
Document Type:	Corporate Strategy			Non-Clinical	
Issue Date:	Xxxx 2021				
Implementation Date:	Xxxx 2021				
Review Date:	Xxxx 2022 (1 year post issue date).				
Documents to be read alongside this policy:	• Standing Orders • Scheme of Reservation and Delegation • Standing Financial Instructions • UHB 024 - Risk Management Procedure • UHB 435 - SOP Managing Concerns • UHB 043 – Raising Concerns (Whistleblowing Policy)				
Executive Summary:	This strategy sets out the UHB's approach to the Board Assurance Framework and Risk Management. For more information on the Board Assurance Framework or Risk Management please contact the Head of Risk and Regulation email: aaron.fowler@wales.nhs.uk.				

Disclaimer

The latest version of this document is located on the UHB's intranet. Please check the review date and if there are any doubts contact the author.

Proprietary Information

This document contains proprietary information belonging to Cardiff and Vale University Health Board. All or any part of this document should not be reproduced without the permission of the Document Owner.

Author/Reviewer:	Risk and Regulation Officer/Director of Corporate Governance
Document Owner:	Director of Corporate Governance
Accountable Executive:	Director of Corporate Governance
Consultation method/time period:	
Consultees:	
Approved by:	
Date approved:	
Scope:	UHB Wide

Engagement has taken place with:

Name	Title	Date Consulted

Version Control Table

Version	Issue Date	Summary of Amendment
1	27.09.2019	New Strategy approved by the Board in July 2019

2	**xxxxx**	1. References added. 2. 3 Lines of Defence added. 3. Revised risk scoring matrix. 4. Revised risk appetite..

Important Note:
The Intranet version of this document is the only version that is maintained.

Any printed copies should therefore be viewed as ‘uncontrolled’ and, as such, may not necessarily contain the latest updates and amendments.

Risk Management and Board Assurance Framework Strategy

TABLE OF CONTENTS

1. Introduction and aims

Risk is inherent in everything we do to deliver high-quality services. Effective and meaningful risk management… remains as important as ever in taking a balanced view to managing opportunity and risk (HM Government, Orange Book, 2020).

The purpose of risk management is the creation and protection of value. It improves performance, encourages innovation, and supports the achievement of objectives (ISO 31000, 2018). Risk management consists of defined steps which help us understand risks and their impact. Good risk management awareness and practice at all levels is a critical success factor for any organisation and needs to be seen as integral to effective management practice. Risk needs to be continuously managed in a systematic and consistent manner in all areas; patient, staff, health and safety, environmental, organisational, financial and commercial (NHS Wales Governance e-Manual, 2013)

Cardiff and Vale University Health Board (C&V UHB) is committed to developing and implementing a Risk Management and Board Assurance Framework Strategy that will identify, analyse, evaluate and control the risks that threaten the delivery of its strategic objectives. The Board Assurance Framework (BAF) is the key source of evidence that links strategic objectives to risk and assurance, and the main tool that the Board should use in discharging its overall responsibility for internal control (GGI, 2018). Therefore, the BAF will be used by the Board to identify, monitor and evaluate risks which impact upon Strategic Objectives. It will be considered alongside other key management tools, such as performance and quality dashboards and financial reports, to give the Board a comprehensive picture of the organisational risk profile.

Based on results, audit evidence and a wider understanding of the context, decisions will be made on how to improve the risk management policy, framework, processes and tools. These decisions will be aimed at improving the management of risk and risk culture throughout the organisation. The Risk Management Strategy will be reviewed annually.

The purpose of this document is to provide guidance to all staff on the management of strategic and operational risks and the BAF within the organisation.

It aims to:

- Set out respective responsibilities for strategic and operational risk management for the Board and staff throughout the organisation.
- Describe the procedures to be used in identifying, analysing, evaluating and controlling risks to the delivery of strategic objectives.

The objectives of C&V UHB's Risk Management and BAF strategy is to:

- Minimise impact of risks, adverse incidents, and complaints by effective risk identification, prioritisation, treatment and management.

- Maintain a risk management framework, which provides assurance to the Board that strategic and operational risks are being managed effectively.
- Maintain a cohesive approach to corporate governance and effectively manage risk management resources.
- Ensure that risk management is an integral part of C&V UHB's culture.
- Minimise avoidable financial loss, or the cost of risk transfer through a robust financial strategy.
- Ensure that C&V UHB meets its obligations in respect of Health and Safety.
- Describe the resources available for risk management in the organisation.

2. Scope

The Risk Management and BAF Strategy covers the management of strategic and operational risks and the process for the escalation of risks for inclusion on the BAF.

This Strategy applies to those members of staff that are directly employed by C&V UHB and for whom C&V UHB has legal responsibility.

The Risk Management and BAF Strategy is intended to cover all the potential risks that the organisation could be exposed to. A Risk Management Procedure (UHB 024) has been produced as a subordinate adjunct to this strategy.

3. Definitions

A full list of required definitions is provided in UHB 024 Risk Management Procedure but the following list of terms is provided to ensure understanding of this strategy.

- **Board Assurance Framework (BAF).** The key source of evidence that links strategic objectives to risk and assurance, and the main tool that the Board should use in discharging its overall responsibility for internal control Good Governance Institute, 2018).

- **Corporate Risk Register.** Clinical Boards/Corporate Directorates submit their candidate risks to the Risk and Regulation team. Candidate risks comprise of all risks with a current risk rating of 20 or above, or those risks with a lower score which in the opinion of the risk owner can no longer be managed at the local level due to a lack of authority/resource, or their complexity or the potential for a health board wide impact. Following review and, if required further consultation or clarification, these risks will then be placed onto the Corporate Risk Register to ensure the notification and the engagement of Executives, Committees or the Board.

- **Controls**. Any process, policy, device, practice or other conditions/actions which modify risk (ISO 31000, 2018). A risk treatment becomes a control once the effectiveness of the treatment has been confirmed through assurance processes.

- **Consequence.** The outcome of an event that has affected objectives. Can be certain or uncertain and can have positive, negative, direct or indirect effects on objectives. Can be expressed qualitatively or quantitatively (ISO 31000, 2018).

- **Current Risk Rating.** The risk score (consequence x likelihood) assessed at a specific period of time. The current risk rating will usually be lower than the initial rating but higher than the target risk rating.

- **Escalation** The act of advancing a risk to a higher management level for resolution, action or attention.

- **Event.** The occurrence or change of a particular set of circumstances. An event can have one or more occurrences and can have several causes and several consequences (ISO 31000, 2018).

- **Initial Risk Rating**. The risk score (consequence x likelihood) assessed before the application of risk treatments/controls.

- **Likelihood.** The chance of something happening, whether defined, measured or determined objectively or subjectively, qualitatively, or quantitatively, and described using general terms or mathematically (ISO 31000, 2018).

- **Operational risks**. These are key risks that affect individual Clinical Boards and Corporate Directorates. They are managed within the Clinical Boards and Corporate Directorates and if necessary, escalated through the risk reporting structure to the Corporate Risk Register and potentially the BAF.

- **Risk.** The effect of uncertainty on objectives. An effect is a deviation from the expected. It can be positive, negative or both, and can address, create or result in opportunities or threats. Risk is usually expressed in terms of risk sources, potential events, their consequences, and their likelihood (ISO 31000, 2018).

- **Risk Assessment.** The overall process of risk identification, risk analysis and risk evaluation. It should be conducted systematically, iteratively and collaboratively, drawing on the knowledge and views of stakeholders. It should use the best available information, supplemented by further enquiry as necessary (ISO 31000, 2018).

- **Risk Appetite** The amount and type of risk that the Trust Board is willing to take in order to meet its strategic objectives. (IRM, 2021). This reflects the Trust values, policies and objectives.

- **Risk Domains**. Risk domains help classify risks based on potential consequences for example risks impacting on safety or reputation.

- **Risk Management.** The systematic method of identifying, analysing, managing, monitoring and reviewing of risks (ISO 31000, 2018).

- **Risk Register.** A register of all identified risks within a team, department, speciality, board/directorate or the UHB as a whole.

- **Risk Treatment**. Any process, policy, device, practice or other conditions/actions with the potential to modify risk in a desired manner. Risk treatments become controls once their effectiveness in modifying the risk is assured.

- **Strategic risks**. These are significant risks that have the potential to impact upon the delivery of Strategic Objectives and therefore need to be raised and monitored by the Executive Team and the Board**.**

- **Target Risk Score** The estimated achievable risk score when all actions are completed.

4. Risk Management Organisational Structure

C&V UHB's risk management and reporting structure is attached at Appendix 1.

4.1 The Lines of Defence in Effective Risk Management and Control

This strategy describes risk and control functions across C&V UHB. The identification, management, coordination and assurance of risk in a broad and complex organisation such as ours involves an association of individuals and teams from diverse professional backgrounds such as internal auditors, risk specialists, compliance officers, health and safety and clinicians etc. Because these advising and controlling functions are increasingly split across multiple areas, the optimum coordination and control needed for effective risk management can become compromised and result in gaps in control or unnecessary duplication of coverage.

The Three Lines of Defence Model (see figure 1) has been designed to outline in principle the risk management roles, responsibilities and accountabilities to enhance communication and coordination of risk management and control across the organisation (The Institute of Internal Auditors, 2013).

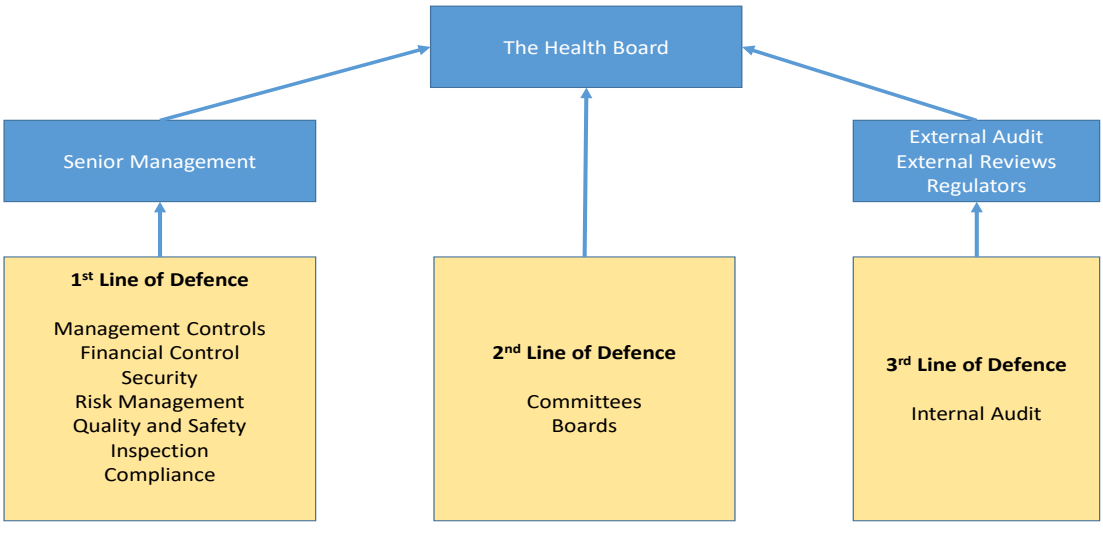


Figure 1: The Three Lines of Defence Model

Executives and the Board collectively have responsibility and accountability for identifying and attaining the organisation's objectives. Risk management is an essential part of governance and leadership and fundamental to how organisations are directed, managed and controlled at all levels (HM Government, The Orange Book, 2020). Therefore, Executives and Boards establish risk management structures and processes, including the lines of defence, to optimise their risk management framework to realise their strategic objectives.

The 1st Line of Defence is the level of operational management where managers own and manage risks. Operational management have responsibility for day to day risk management: identifying, assessing, recording, controlling and (where necessary) reporting risks to senior management. Operational management control of risk is ostensibly through the design, implementation and assurance of controls.

Also operating within the 1st Line of Defence are those risk management and compliance functions that have the specific authority, specialist tools, systems and advice to support those who own and manage risk. They work with risk owners and managers to ensure that the 1st Line of Defence is properly designed, and functioning as designed. Examples of these functions include Health and Safety, Risk and Regulation Teams, Patient Safety, Financial Control, and Corporate Governance. These functions have been established to ensure that the 1st line of defence is properly designed and functioning as designed.

The 2nd Line of Defence are the UHBs committees and management boards. These are ostensibly assurance functions independent of the first line of defence. The Institute of Internal Auditors (2013) identifies the responsibilities of the 2nd Line of Defence functions as follows:

- Supporting management policies, defining role and responsibilities, and setting goals for implementation.
- Providing risk management frameworks.
- Identifying known and emerging issues.
- Identifying shifts in the organisations implicit risk appetite.
- Assisting management in developing processes and controls to manage risks and issues.
- Providing guidance and training on risk management processes.
- Facilitating and monitoring implementation of effective risk management practices by operational management.
- Alerting operational management to emerging issues and changing regulatory and risk scenarios.
- Monitoring the adequacy and effectiveness of internal control, accuracy and completeness of reporting, compliance with laws and regulations, and timely remediation of deficiencies.

The 3rd Line of Defence are those functions providing independent internal assurance that the 1st and 2nd lines of defence are operating in a manner which ensures the overall effectiveness of the risk management framework, reporting the results of their assessment to Senior Management and the Board.

4.2 The Board

Executive Directors and Independent Members share responsibility for the success of C&V UHB, including the effective management of risk, and compliance with relevant legislation. In relation to risk management, the Board is responsible for:

- Articulating the Strategic Objectives for the organisation.
- Protecting the reputation of the organisation.
- Providing leadership on the management of risk.
- Approving the risk appetite for the organisation.
- Ensuring the approach to risk management is consistently applied.
- Ensuring that assurances demonstrate that risk has been identified, assessed and all reasonable steps taken to manage it effectively and appropriately.
- Reviewing the BAF (strategic risks) and the Corporate Risk Register (operational risks 20 and above) at each meeting.
- Endorsing risk related disclosure documents.
- Approving the Risk Management and BAF Strategy on at least an annual basis**.**

4.3 Audit and Assurance Committee

The Audit and Assurance Committee operates in the 2nd Line of Defence. It has a specific role to assess the effectiveness of the Risk Management and BAF strategy by reviewing the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the Annual Governance Statement), prior to endorsement by the Board.
- The underlying assurance processes that indicate the degree of achievement of strategic objectives, the effectiveness of the systems and processes for the management of risks, the BAF and the appropriateness of disclosure documents.

4.4 Other Committees of the Board

The Committees of the Board all have a role to play in ensuring effective risk management. In particular they will, following scrutiny in committee, provide onwards assurance to the Board in relation to their elements of the BAF.

4.5 Management Executive and Health Systems Management Board

A critical component of the 2nd Line of Defence, the Management Executive and Health Systems Management Board (HSMB) undertake the following duties:

- Promote a culture within the Health Board which encourages open and honest reporting of risk with local responsibility and accountability.
- Provide a forum for the discussion of key risk management issues within the Health Board.
- Ensure appropriate actions are applied to both clinical and non-clinical risks Health Board wide.
- Enable risks which cannot be dealt with locally to be escalated, discussed and prioritised.
- Ensure Clinical Board and Corporate Directorate Risk Registers are appropriately rated and agreeing action plans to control them.
- Review the risks on the Corporate Risk Register to determine whether any of them will impact on the Health Boards Strategic Objectives, and if so, adding the risk to the BAF.
- Review the BAF before presenting it to the Board.
- Advise the Board of exceptional risks to the Trust and any financial implications of these risks.
- Review and monitor the implementation of the Risk Management and BAF Strategy.

- Ensure that all appropriate and relevant requirements are met to enable the Chief Executive to sign the Annual Governance Statement.
- Approve documentation relevant to the implementation of the Risk Management and BAF Strategy.

These duties have the ultimate aim of providing assurance to the Board that there is an effective system of risk management across the organisation.

4.6 Clinical Boards and Corporate Directorates

The Clinical Boards and Corporate Directorates operate within the First Line of Defence. They are responsible for risks within their areas of operation and providing assurance to the Management Executive and HSMB on the operational management and any support required in relation to the management of risk.

The Clinical Boards and Corporate Directorates will review and update existing risks, consider new risks for inclusion and escalate any extreme risks, utilising, where required, specialist input from individuals/teams within the 1st Line of Defence. These are presented to the HSMB by the Clinical Boards or Corporate Directorates.

5. Duties

The following paragraphs set out the respective risk management duties and responsibilities for individual staff members.

5.1 All staff

All members of staff are accountable for maintaining risk awareness, identifying and reporting risks as appropriate to their line manager. More specifically they will:

- Accept personal responsibility for maintaining a safe environment, which includes being aware of their duty under legislation to take reasonable care of their own safety and all others that may be affected by the health board's business.
- Report all incidents/accidents and near misses and comply with the health board's incident and near miss reporting procedures;
- Be responsible for attending mandatory and relevant education and training events.
- Participate in the risk management system, including the risk assessments within their area of work and the notification to their line manager of any perceived risk which may not have been assessed.
- Be aware of and comply with the health board's Risk Management and BAF strategy, processes, and associated procedures.

5.2 Line Managers

The identification and management of risk requires the active engagement and involvement of staff at all levels. This First Line of Defence recognises that staff are best placed to understand the risks relevant to their areas of responsibility and that the identification and management of risk requires the active engagement and involvement of operational teams.

Therefore, staff must be supported and enabled to manage these risks, within a structured risk management framework, and Managers are expected to take an active lead to ensure that risk management is embedded into the way their service/team /ward operates. Managers must ensure that their staff understand and implement this Strategy and supporting processes, ensuring that staff are provided with the education and training to enable them to do so.

Managers must be fully conversant with the UHB's approach to risk management and governance. They will support the application of this Strategy and its related processes and participate in the monitoring and auditing process.

5.3 Clinical Board Directors

Clinical Board Directors are responsible for implementation of the Risk Management and BAF Strategy and any other policies which support the health board's risk management approach.

Specifically they will:

- Ensure a forum for discussing risk and risk management is maintained within their Clinical Board to encourage integration of risk management and the creation of a positive risk management culture.
- Co-ordinate the risk management processes to encompass risk assessments, incident reporting, the investigation of incidents/near misses and the management of the risk register.
- Ensure that there is a system for monitoring the application of risk management within their area, and that risks are treated in accordance with the risk grading action guidance contained in this document.
- Provide reports to the appropriate committees of the Board that will contribute to the UHB-wide monitoring and auditing of risk.
- Assess and communicate the risk management related training needs of their staff and ensure staff attend relevant mandatory and local training programmes.
- Ensure a system is maintained to facilitate feedback to staff on risk management issues and the outcome of incident reporting.

5.4 The Director of Corporate Governance

The Director of Corporate Governance will:

- Work closely with the Chair, Chief Executive, Chair of the Audit and Assurance Committee and Executive Directors to implement and maintain the Risk Management and Board Assurance Strategy and related processes, ensuring that effective governance systems are in place.
- Work with the Board to develop a shared understanding of the risks to the UHB's strategic objectives.
- Develop and communicate the Board's risk awareness, appetite and tolerance.
- Lead and participate in risk management oversight at the highest level, covering all risks across the organisation, on a UHB basis.
- Work closely with the Chief Executive and Directors to support the development and maintenance of Corporate and Directorate level risk registers.
- Develop and oversee the effective execution of the BAF and ensure effective processes are embedded to rigorously manage the risks therein.
- Monitoring the action plans and reporting to the Board and relevant Committees.
- Develop and implement the health board's Risk Management and Board Assurance Framework Strategy.

5.5 Executive Directors

Executive Directors are accountable and responsible for ensuring that their directorates are implementing this Strategy and related policies. Each Director is accountable for the delivery of their particular area of responsibility and will therefore ensure that the systems, policies and people are in place to manage, eliminate or transfer the key risks related to the health board's strategic objectives.

Specifically they will:

- Communicate to their directorate the Board's strategic objectives and ensure that directorate, service and individual objectives and risk reporting are aligned to these.
- Ensure that a forum for discussing risk and risk management is maintained within their area which will encourage integration of risk management.

- Co-ordinate the risk management processes to encompass risk assessments, incident reporting, the investigation of incidents/near misses and the management of the risk register.
- Ensure there is a system for monitoring the application of risk management within their area and that risks are treated in accordance with the risk grading action guidance contained in this document.
- Provide reports to the appropriate committee of the Board that will contribute to the monitoring and auditing of risk.
- Assess and communicate the risk related training needs of their staff and ensure staff attend relevant mandatory and local training programmes.
- Ensure a system is maintained to facilitate feedback to staff on risk management issues and the outcome of incident reporting.
- Ensure the specific responsibilities of managers and staff in relation to risk management are identified within the job description for the post and those key objectives are reflected in the individual performance review/staff appraisal process.

Executive Directors are also responsible for ensuring that the BAF and the risk management reporting timetable are delivered to the Board**.**

5.6 Chief Executive

The Chief Executive is the Accountable Officer of the UHB and has overall accountability and responsibility for ensuring it meets its statutory and legal requirements and adheres to guidance issued by the Welsh Government in respect of Governance. This responsibility encompasses risk management, health and safety, financial and organisational controls and governance.

The Chief Executive has overall accountability and responsibility for ensuring that the health board maintains an up to date Risk Management and Board Assurance Framework that is endorsed by the Board. In addition the Chief Executive will:

- Ensure that there is a framework in place which provides assurance to the Board in relation to the management of risk and internal control.
- Ensure that risk issues are considered at each level of business planning from the corporate process to the setting of staff objectives.
- Have in place an effective system of risk management and internal control;
- Set out the C&V UHBs commitment to the risk management principles, which is a legal requirement under the Health and Safety at Work Act 1974.

The Welsh Government requires the Chief Executive to sign a Governance Statement annually on behalf of the Board. This outlines how risks are identified, evaluated and controlled, together with confirmation that the effectiveness of the system of internal control has been reviewed.

5.7 Internal Auditors

Operating as the 3rd Line of Defence Internal Audit Services, provided by NHS Wales Shared Services Partnership will, through a risk based programme of work, provide the health board with independent assurance in respect of the adequacy of the systems of internal control across a range of financial and business areas in accordance with the standards and good practice contained within the NHS Internal Audit Manual. They will also review the effectiveness of risk management arrangements as part of their programme of audits and reviews, reporting findings to the Audit and Assurance Committee as appropriate.

5.8 Central Corporate Functions

Central Corporate Functions such as Corporate Governance, Patient Safety and Learning, Health and Safety Advisers, Capital Estates and Facilities, Finance Directorate, Workforce and Organisational Development Directorate, Occupational Health etc operate in the 1st Line of Defence. They will assist clinicians and managers by providing risk related advice and support specific to their area of responsibility.

5.8.1 Local Counter Fraud Services. The UHB's Local Counter Fraud Specialist (LCFS) provides assurance to the Board regarding risks relating to fraud and/or corruption. The UHB's Annual Counter Fraud Work Plan, as agreed by the Audit and Assurance Committee, identifies the arrangements for managing and mitigating risks as a result of fraud and/or corruption. Where such issues are identified they are investigated by the LCFS and then reported to the Audit and Assurance Committee as appropriate. The LCFS works with the Director of Corporate Governance to review any fraud or corruption risks. Such risks are referred to the relevant risk register for the Directorate concerned and are then escalated through the UHB's escalation process**.**

5.8.2 Health and Safety Team. The Health and Safety Department will be responsible for providing advice where a risk is related to Health and Safety (H&S). H&S issues are closely linked with risk management and specialist H&S advisers can assist with the conduct of specific and/or specialist assessments.

5.8.3 Risk and Regulation Team. The Risk and Regulation are responsible for co-ordinating the Health Board's operational and strategic risks, including the Corporate Risk register and the BAF. The team has a remit to work with Executives and Managers to co-ordinate, integrate, oversee and support the risk management agenda, ensuring that risk management principles are embedded across the Health

Board. The team will also coordinate the Risk Management Internal Audit process. On a quarterly basis they will receive from Clinical Boards and Corporate Directorates candidate risks for potential inclusion on the Corporate Risk Register, as well as updates on those risks already being managed on the Corporate Risk Register. The team also provides training and support for C&V UHB individuals and teams engaged in Risk Management.

6. Risk Management Process

The Risk Management Process involves the systematic application of policies, procedures and practices to the activities of communicating and consulting, establishing the context and assessing, treating, monitoring, reviewing, recording and reporting risk.

The risk management process can be applied at strategic and operational level, for risks of all types and it may be customised to achieve objectives within specific external or internal contexts (ISO 31000, 2018). Risk management must be collaborative and informed by the best available information and expertise (HM Government, The Orange Book, 2020).

6.1 Communication and Consultation

The purpose of communication and consultation is to assist relevant stakeholders in understanding risk, the basis on which decisions are made and the reasons why particular actions are required (ISO 31000, 2018). Communication and consultation aims to bring together expertise for each step of the risk management process, ensure that different views are considered when defining and evaluating risk, provide information to enable oversight of risk and to build or maintain a sense of risk ownership within the team.

This strategy recognises that communication and consultation is primarily the business of those individuals/teams operating in the 1st Line of Defence and therefore it does not prescribe specific mechanisms for risk communication and consultation. However, the specialist functions operating in the 2nd Line of Defence may be consulted as required.

6.2 Types of Risk

There are two categories of risk, **strategic** and **operational**. These include risks from all domains i.e. safety, financial, regulatory, clinical and non-clinical etc.

Strategic risks are risks that could significantly interfere with the Health Board achieving its strategic objectives as outlined in its IMTP. Operational risks are risks that, if they occur, will affect the quality, safety or delivery of services or continuity of

business. They are not mutually exclusive and a risk may escalate from an operational risk to a strategic risk or be both.

6.3 Risk Appetite

Organisations should specify the amount and type of risk that it may, or may not take, relative to objectives. They should define the amount of risk they are willing to take in pursuit of value, or that it is prepared to accept in the pursuit of its strategic objectives (ISO 31000, 2018). This is achieved through the publication of a risk appetite matrix that describes the organisation's willingness or tendency to take risk in specific circumstances, with the purpose of providing managers and stakeholders with guidance that enables a consistent approach to risk-based decision making at all levels of the organisation.

Decisions on accepting risks may be influenced by the following:

- The likely consequences are insignificant and/or the risk has a very low possibility of occurring.
- A higher risk consequence is outweighed by the chance of a much larger benefit if the risk is appropriately managed.
- The potential financial costs of minimising the risk outweigh the costs that would arise if the risk event occurred.
- Treating the risk may lead to further unacceptable risks in other ways.
- It is reasonable to accept a risk that under normal circumstances would be unacceptable if the risks or all other alternatives, including nothing, is even greater (NPSA, 2004).

The Board's assessment of Risk Appetite is based on the Good Governance Institute Matrix for NHS Organisations (GGI, 2019) and is published at Appendix 2. The Board will review its risk appetite on an annual basis.

The C&V UHB risk appetite matrix recognises the key elements described in the GGI matrix (financial, compliance, innovation/quality/outcomes and reputation) but it adds sub-elements to improve the precision of application to UHB activities and consequently greater risk sensitivity in decision making.

The C&V UHB risk appetite matrix retains the 5 risk levels described in the CGI Risk Appetite Maturity Matrix:

Avoid	Avoidance of risk and uncertainty is a Key Organisational objective
Minimal	Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential
Cautious	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward

Open	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward
Seek	Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk)
Mature	Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust.

Figure 2: CGI Risk Appetite Levels

6.4 Risk Assessment

Risk assessment is a collective term for an overall process of risk identification, risk analysis and risk evaluation that is conducted systematically, iteratively and collaboratively across stakeholders (ISO 31000, 2018).

Each Clinical Board or Corporate Directorate needs to identify operational and strategic risks through the completion of risk assessments and for ensuring that risk assessments are completed on an ongoing basis.

Detailed guidance on Risk Assessment is provided in UHB 024 Risk Management Procedure.

6.4.1 Risk Identification. Risk identification is the finding, recognition and description of risks that have the potential to assist or prevent an organisation from achieving it's objectives, or which might cause harm or loss. A range of techniques can be used to identify risk and this might include specific techniques advised or delivered by the risk management and compliance functions operating in the second line of defence. A variety of factors may be considered when identifying risk, either individually or in a co-relationship:

- Risk causes and risk events.
- Threats and opportunities.
- Vulnerabilities and capabilities.
- Changes to the internal or external context.
- The nature and value of assets and resources.
- Limitations of knowledge and the reliability of information.
- Time related factors
- The biases, assumptions and beliefs of those involved in decision making.

6.4.2 Risk Analysis. The purpose of risk analysis is to understand the nature of the risk including the level of risk it might present to the organisation. Risk analysis is an essential prelude to risk evaluation, where decisions are made on whether risks need to be treated, and if they are to be treated then how they are to be treated. Risk analysis requires a detailed consideration of context (including objectives),

uncertainties, risk sources, consequences, likelihood, events, scenarios and the effectiveness of any existing controls.

Risk analysis can involve varying degrees of detail and complexity according to the potential extent of the threat, the available decision-making time and the available resources. It should consider factors such as:

- The likelihood of a risk event and the consequences (impact) on objectives, or the harm/loss, if a risk event occurs.
- The complexity of a risk event and any connectivity with other risks.
- Time related factors (where feasible).
- The effectiveness of existing controls.
- The general level of confidence in the reliability of information and decision making related to the risk.

The approach to quantifying risk is described in Appendix 3. Each risk is assessed and scored on the likelihood of occurrence and the severity/impact in the initial (without controls), current (with controls) and target (after completion of actions) circumstances.

The score of a particular current risk rating will determine at what level decisions on acceptability of the risk should be made and where it should be reported to. The Board defines as “Extreme” any risk that has the potential to damage the organisation’s objectives. General guidelines are in Figure 3:

Risk Level	Risk Score	Action
Extreme Risk	15 -25	Immediately report the risk to the relevant Executive Director who will inform the Chief Executive. In the event that this might cause delay, the Clinical Board Director should report directly to the Chief Executive.
High Risk	8-12	Report to Clinical Board (or for Corporate Directorates to the Executive Director).
Moderate Risk	4-6	Report to Heads of Service with proposed treatment/action plans, for particular monitoring.
Low Risk	1-3	Report to local manager for local action to reduce risk
Figure 3: Risk Levels		

6.4.3 Risk Evaluation. Risk evaluation supports decisions. The evaluation takes account of the wider context and is a comparison of the results of the risk analysis

with the established risk criteria and risk appetite to determine what subsequent action is required. Potential decisions could be to:

- Do nothing further because the risk likelihood/impact, complexity or connectivity are within established risk criteria and the risk can therefore be tolerated. No active management of the risk is required.
- Decide that existing controls for this risk are effective. Therefore no new risk treatment is required but the risk will require continued active management.
- Decide that the risk is at an intolerable level and it therefore requires treatment.
- Reconsider objectives if the threat from the risk, even after treatment, remains significant.
- Undertake further analysis to better understand the risk.

6.5 Risk Treatment

Risk treatment is an iterative process in which options for the reduction of risks are identified, selected, implemented and monitored.

Identifying and selecting the most appropriate risk treatment option(s) requires the balancing of costs, efforts or disadvantages inherent in their implementation against the benefits derived in the achievement of objectives or minimisation of losses/harms.

ISO 31000 (2018) identifies that options for treating risk may involve one or more of the following:

- Remove the source of the risk i.e. eliminate the hazard(s) that create the risk potential.
- Avoid the risk by deciding not to undertake the activity that provokes the risk i.e. avoid exposure to the hazard(s).
- Accept the risk because it is unavoidable or because it might create opportunity.
- Reduce the likelihood.
- Reduce the impact (consequence).
- Share the risk (for example through contracts or insurance).

Risk treatments may not produce the desired outcomes, may produce unintended consequences, may not take effect within the desired timeframe or may even introduce new risks. Therefore, if there are no treatment options available or if they do not modify the risk in the required timeframe and/or to an acceptable level, then the risk should be recorded on a risk register and be regularly monitored and reviewed.

6.6 Monitoring and Review

Risk management should be continually improved through learning and experience (HM Government, The Orange Book, 2020). The purpose of monitoring and review is to assure and improve the quality and effectiveness of the (risk) process design, implementation and outcomes (ISO 31000, 2018).

Once a risk has been identified, analysed and evaluated a Risk Owner should be appointed. Risk owners should be the individuals best placed through their authority and influence to take responsibility for mitigation of the risk. The identified risk owner is responsible for:

- Ensuring that the risk is managed appropriately, controls are in place to mitigate the risk and an action plan is identified to address gaps in control measures.
- Reviewing the risk register at appropriate intervals to ensure the descriptor, controls and risk score accurately reflect the level of risk and that progress is being made at sufficient pace to reduce the risk score to the target risk level.
- Liaising with action owners to ensure they are aware of their responsibilities for delivering actions.
- Reporting on the overall status of the risk, escalating where appropriate in line with local risk procedure and the risk escalation process detailed in this policy.

Action owners have responsibility for the activities needed to address gaps in control measures and the assurance of the effectiveness of existing controls. Action owners are required to report progress to Risk Owners in a timeframe and manner identified by the Risk Owner. Action owners will normally be identified from within the same Clinical Board or Corporate Directorate as the Risk Owner but specialists from other areas of the organisation, such as HR or H&S may also be required to perform as specialist action owners.

Ongoing and continuous monitoring supports risk owners and the organisation in understanding if and how risks may be changing, and the extent to which risk treatments are operating as intended. The results of monitoring and review provide assurance that risks are managed to a level that is unlikely to threaten the attainment of objectives or create significant loss or harm. Risk owners are responsible for monitoring and reviewing their own elements of the risk management process; this will generally occur through the recording of assurance on risk registers but may also occur through the delivery of assurance reports to committees and boards. Functions within the second line of defence have specific responsibilities for the monitoring of the overall risk process through ongoing, regular, periodic and ad-hoc monitoring and review.

All C&V UHB risk management policies will be reviewed on an annual basis and as and when required in accordance with the following:

- Legislative changes.
- Good practice guidance including 1st and 2nd line audit.
- Case law.
- Significant incidents.
- New vulnerabilities.

- Changes to organisational structures.

Overall accountability for procedural documents across the Health Board lies with the Chief Executive who has overall responsibility for establishing and maintaining an effective document management system, for meeting all statutory requirements and adhering to guidance issued in respect of procedural documents.

Overall responsibility for the Risk Management and Board Assurance Framework Strategy lies with the Director of Corporate Governance who has delegated responsibility for managing the development and implementation of the strategy to the Head of Risk and Regulation.

6.7 Recording and Reporting

The purpose of risk recording and reporting is to communicate risk management activities and outcomes across the organisation, provide information for decision making, meet governance requirements and support the Board and oversight bodies in meeting their responsibilities.

6.7.1 Risk Registers. Risk registers will cover all risk types to create central references to inform the decision making of managers, executives, risk committees and the Board. Four levels of risk register will be maintained as follows:

- Ward/Department/Team Risk Register.
- Directorate Risk Register.
- Clinical Board/Corporate Directorate.
- Corporate Risk Register.

Risks registers will record the Initial Risk Rating, Current Risk Rating, and Target Risk rating. Current controls (and the assurance of their effectiveness) will be listed along with outstanding actions needed to create the control necessary to reach the target risk rating.

6.7.2 The Escalation of Risks. Action should be taken at each level of the organisation to lessen or remove the risk. As may be seen in Figure 4, risks will predominantly be escalated according to the current risk rating score. However, if the appointed Risk Owner feels that the risk can no longer be managed locally and requires more senior input and support, or that the risk event may impact across the wider UHB enterprise, then irrespective of its risk score it may be escalated, if necessary up to the Board. This should not be seen as failure but instead as prudent risk management that seeks to ensure an appropriate response at the most appropriate level within the organisation. The Risk and Regulation team are available for further advice on risks of this type.

Any risks identified and evaluated as having a low/moderate current risk rating (1-6) can be managed locally within the relevant area. These risks can typically be resolved quickly and relatively easily if the correct actions are identified, completed and become controls under business as usual. These risks are recorded locally in the local risk register within each ward / department; the Clinical Board/Corporate Directorate to which the ward/department belongs are responsible for the oversight and governance of the risk management process.

Risks identified and evaluated as having a high rating current risk rating (8-12) should be immediately escalated to the designated Clinical Board/Corporate Directorate Risk Lead who will place the risk onto the Clinical Board/Corporate Directorate risk register and monitor/report the progress of the risk thereafter.

Risks identified and evaluated as having an extreme current risk rating (15-25) should be immediately escalated to the designated Clinical Board/Corporate Directorate Risk Lead. The Risk Lead will immediately report risk greater than 20 to the relevant Executive Director who will inform the Chief Executive. In the event that this will cause delay the Clinical Board Director can report directly to the Chief Executive. Following this urgent notification process, risks greater than 20 should be notified to the Risk and Regulation Team for placement onto the Corporate Risk Register, using the proforma at Appendix 4.

The Corporate Risk Register will map extreme level risks, as well as risks that, whilst having a relatively low current risk rating, are sufficiently complex or wide in their potential impact, to require Executive Level/Board scrutiny. Risks appearing on this register have potential to impact on the achievement of strategic objectives. This information will be used by the Risk and Regulation Team to shape the agenda for Board and Committee meetings, and the BAF, to ensure that the Health Board is actively responding to and considering its key risks.

6.7.3 Review of Risks. Risk Owners should consider the frequency with which they want to review risks, and this decision will usually be influenced by the type of risk, or the strength of current controls. The decision may also be influenced by specific requirements imposed by statute or by regulators/auditors/inspectors. However, as a minimum standard Low risk (1-3) should be reviewed and updated at least biannually, Moderate risks (4-6) should be reviewed and updated at least quarterly, and High (8-12) and Extreme (15-25) risks should be reviewed and updated monthly.

Assurance	Current Risk Rating	Level	Actions
Board Bi-Monthly	20-25	Board Assurance Framework (BAF)	Strategic Risks identified by Committees, Clinical Boards or Corporate Directorates.
HMSB Quarterly		Corporate Risk Register	Extreme Operational Risks or Risks to Strategic Objectives

Board Bi-Monthly			
Clinical Board/QSE Quarterly	15-25	Clinical Board/Corporate Directorate	Risks scoring 20 or > require immediate escalation to Risk and Regulation team who will pass to appropriate Executive and/or committee and consider for placement on the Corporate Risk Register and, if strategic objectives are threatened, for ultimate placement on the BAF. Risks scoring less than 20 should be retained and managed at Clinical Board/Corporate Directorate level unless they require escalation to their complexity or cross health board impact.
Directorate Meeting Monthly	8-12	Directorate	Risk added to Directorate Risk Register. Risks to be reviewed monthly.
Ward Department Risk Review meetings – at least quarterly.	4-6	Ward/Department/Team	Inform Line Manager and risk may be added to the Risk Register. These risks will be managed by the Line Manager/Department Manager. These risks will form part of the departmental risk register that will be reviewed by the department at least every 6 months.
Risk Review meetings – at least 6 monthly	1-3	Ward/Department/Team	If unable to immediately mitigate the risk, add to local risk register. This risk should be managed locally with all staff having authority to manage the risk. These risks form part of the departmental risk register.
Figure 4: Risk Escalation Guide			

6.7.3 Board Assurance Framework (BAF)

The BAF identifies from the Corporate Risk Register the highest risks faced by the Health Board in achieving its strategic objectives, and the gaps in assurances on which the Board relies.

The BAF is developed through the following key steps:

a. The Board annually agree the Strategic objectives as part of the business planning cycle.

b. The Management Executive, with the support of the Director of Corporate Governance, will draft the principle risks that may threaten the achievement of the strategic objectives; these risks will then be discussed and approved by the Board of Directors.

c. For each principle risk the Executive Lead will:

(1) Give an initial (inherent) risk score, by determining the consequence and likelihood of the risk being realised.

(2) Link the risk to the strategic objectives.

d. Risks from the previous year's BAF will be reviewed and a decision made whether to:

(1) Transfer the risk on to the BAF for the current year.

(2) Move the risk to the Corporate Risk Register and nominate a Risk Owner or Management Group.

(3) Accept or Close the risk.

e. The Executive Lead will then:

(1) Identify the key controls in place to manage the risks and achieve delivery of the strategic objective(s).

(2) Identify the arrangements for obtaining assurance on the effectiveness of key controls across all the areas of principal risk.

(3) Evaluating the assurance across all areas of principal risk i.e. identifying sources of assurance the Health Board is managing the risks to an acceptable level of tolerance.

(4) Identify how / where / when those assurances will be reported.

(5) Identify areas where there are gaps in controls (where the Health Board is failing to implement controls or failing to make them effective).

(6) Identify areas where there are gaps in assurances (where the Health Board does not have the evidence to assure that the controls are effective).

(7) Develop an action plan to mitigate the risk.

(8) Agree a current (residual) risk rating for the first quarter of the financial year which is determined by the consequence and likelihood of the risks.

f. The BAF will be presented to the first meeting, in the financial year, of the HSMB. It will moderate the risk scores and ensure there are appropriate controls and assurances. Where gaps in control and assurances exist they will ensure that associated action plans are in place for each risk thus affected.

g. Bi-monthly the Executive lead, supported by the Director for Corporate Governance, will review and monitor the controls and reported assurances and update the risk score and action plans for each of the risks for which they are responsible.

h. The Executive will review and monitor all of the risks on the BAF each month prior to presentation to the Board. In particular the Management Executive will ensure that progress is being made to reduce or eliminate the impact of the risk.

i. Once agreed by Management Executive the completed BAF will be presented to the Board for scrutiny and approval on a monthly basis. At the first meeting of the financial year it will be reviewed in its entirety.

The Audit and Assurance Committee, as a sub-committee of the Board, has oversight of the processes through which the Board gains assurance in relation to the management of the BAF.

The BAF is an integral part of the system of internal control and defines those extreme risks with potential to impact upon the delivery of Strategic Objectives. It also summarises the controls and assurances that are in place, or the plans to mitigate them. The BAF aligns principal risks, key controls and assurances on controls alongside each of the Health Boards strategic objectives.

Gaps are identified where key controls and assurances are insufficient to reduce the risk of non-delivery of objectives. This enables the development of an action plan for closing the gaps and mitigating the risks, the implementation and progress against the action plan is then monitored by the Board for implementation.

Levels of assurance are applied to each of the controls as follows:

(1) Management Reviewed Assurance.

(2) Board or Committee Reviewed Assurance.

(3) External Reviewed Assurance.

This provides an overall assurance level on each of the strategic risks.

7. Risk Management Training

The following training is designed to complement the risk related elements of the Core Mandatory Training identified in C&V UHB Mandatory/Statutory Training Procedure (UHB 080). The aim of the tiered Risk Management training is to enable UHB personnel to meet their Risk Management responsibilities outlined in this strategy:

Level One – Risk Management Awareness. This will be provided to all staff on induction, as part of Core Mandatory Training, and will be repeated on ESR every 2 years. The intended learning outcomes are to understand what risk is, what risk management is, how a risk is reported and how the organisation's risk appetite and culture operates.

Level Two – Practical Risk Management. This level of training is targeted for any employee undertaking risk management as part of their primary or secondary roles, and for Team Leaders/Managers/Departmental Heads. Line Managers, Clinical Board Directors and Executive Directors have a specific role to play in identifying candidates for this training, ideally in prelude to assuming a risk facing role, but if not then as soon as practicable after assumption of role. Level Two training does not require repetition, though this does not mean that additional risk related training and education should not be identified through PDR. This training will be in two parts:

- **Part 1**. To understand the risk management framework including the risk management strategy, the BAF, the corporate risk register, risk appetite, risk culture, and roles and responsibilities.
- **Part 2**. To understand the risk management process including context, risk versus issue and incidents. Risk assessment, risk tolerance, risk scoring, risk treatments, escalation, communication, monitoring and review.

Level Three – Board Level Risk Management Awareness. This level of training is designed for Board Members and Board Directors. It will be provided on induction and to meet governance requirements it must be repeated every two years thereafter. Level Three training will be facilitated by the Director of Corporate Governance and scheduled within the rhythm of board meetings. The training aim is to provide the audience with an understanding of: the risk management framework, with specific emphasis on the operational risk management approach; the risk management strategy;

'setting the tone' and risk culture; risk appetite; the corporate risk register and the Board Assurance Framework.

Non-Specific Training and Support. It is recognised that, in addition to these three levels of specified training, there may emerge a need for non-specific risk management training and support. Where this is applicable the Risk and Regulation team can discuss the apparent training need and either signpost to external sources of training/education or provide a bespoke training event for individuals or small groups.

8. References

COSO (2017). Enterprise Risk Management – Integrating with Strategy and Performance. Available at: https://www.coso.org/Documents/2017-COSO-ERM-Integrating-with-Strategy-and-Performance-Executive-Summary.pdf

COSO (2020). Compliance Risk Management: Applying the COSO ERM Framework. Available at: https://www.coso.org/Documents/Compliance-Risk-Management-Applying-the-COSO-ERM-Framework.pdf

Good Governance Institute (2010). 'What every healthcare board needs to understand about patient safety. Available at: https://www.good-governance.org.uk/services/what-every-healthcare-director-needs-to-know-about-patient-safety/

Good Governance Institute (2019). Risk Appetite for NHS Organisations: A Matrix to support better risk sensitivity in decision taking. Available at: https://www.good-governance.org.uk/services/risk-appetite-for-nhs-organisations-a-matrix-to-support-better-risk-sensitivity-in-decision-taking/

Government Finance Function (2020). Risk Appetite: Guidance Note. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/929385/Risk_Appetite_Guidance_Note_v1.0_FINAL.pdf

Health and Safety Executive (2010). Leading Health and Safety at Work. Available at: https://www.hse.gov.uk/pubns/indg417.pdf

HM Government (2020). The Orange Book: Management of risk principles and concepts. Available at: https://www.gov.uk/government/publications/orange-book

HM Treasury (2014). Assurance frameworks. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/270485/assurance_frameworks_191212.pdf

Institute of Internal Auditors (2013). Position Paper: The three lines of defence in effective risk management and control. Available at: https://na.theiia.org/standards-guidance/Public%20Documents/PP%20The%20Three%20Lines%20of%20Defense%20in%20Effective%20Risk%20Management%20and%20Control.pdf

Institute of Risk Management (2011). Risk Appetite and Tolerance Guidance Paper. Available at: https://www.theirm.org/resources/find-a-resource/risk-appetite-and-tolerance-guidance-for-practitioners/

Institute of Risk Management (2018). Standard Deviations: A Risk Practitioners Guide to ISO 31000. Available at https://www.theirm.org/resources/find-a-resource/standard-deviations-a-risk-practitioners-guide-to-iso-31000-2018

National Patient Safety Agency (2004). Seven Steps to Patient Safety. Available at: https://www.publichealth.hscni.net/sites/default/files/directorates/files/Seven%20steps%20to%20safety.pdf

National Patient Safety Agency (2008). A Risk Matrix for Risk Managers. London: NPSA.

The Institute of Internal Auditors (2013). The Three Lines of Defence in Effective Risk Management and Control. Available at: https://na.theiia.org/standards-guidance/Public%20Documents/PP%20The%20Three%20Lines%20of%20Defense%20in%20Effective%20Risk%20Management%20and%20Control.pdf

The International Standards Organisation (2018). ISO 31000:2018 Risk Management-Guidelines. Available at: https://www.iso.org/standard/65694.html

Welsh NHS Confederation (2009). The Pocket Guide to Governance in NHS Wales. Available at: http://www.wales.nhs.uk/sitesplus/documents/1064/NHS%20Wales%20Confed%20-%20Governance%20Pocket%20Book%20FINAL%5B1%5D.pdf

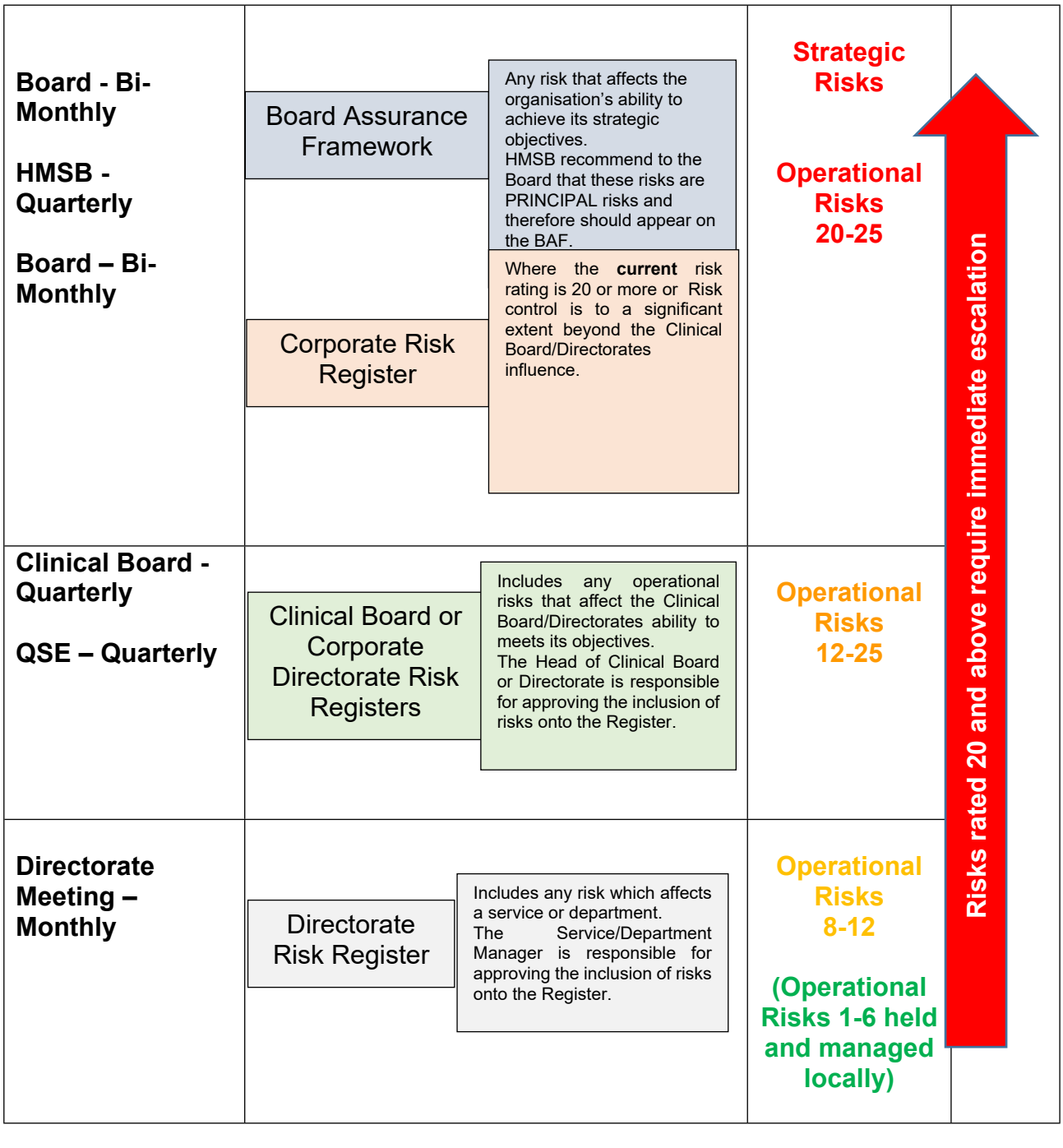
9. Equality impact assessment

C&V UHB aims to design and implement services and policies that are fair and equitable. As part of its development, this Strategy and its impact on staff, patients and the public have been reviewed in line with the Cardiff and Vale's Equality Impact Assessment. The purpose of the assessment is to improve service delivery by minimising and if possible removing any disproportionate adverse impact on employees, patients and the public on the grounds of race, socially excluded groups, gender, disability, age, sexual orientation or religion/belief.

The equality impact assessment has been completed and has identified impact or potential impact as "no impact".

Appendix 1

Risk Registers and Risk Reporting Hierarchy



Appendix 2

Cardiff and Vale UHB – Summary Risk Appetite Matrix

GGI Key Element/Lead	Sub Element	Current Risk Appetite	Target Risk Appetite
1. Financial/Value for Money (VfM) Executive Director of Finance	1a. The availability of Financial Resources and the value derived from their application.	**Cautious:** VfM remains our primary concern but we are prepared to accept limited financial loss or higher cost options where improvements to service delivery standards are possible.	Seek: We invest for the best possible return. We have controls in place but we still accept the possibility of financial loss.
2. Compliance and Regulatory Director of Corporate Governance	2a. The Regulation & Governance of our activity to ensure legal compliance and recognised best practice.	**Cautious**: Challenge of our decisions/actions/omissions *will* occur and we want to be reasonably sure that such challenge is defensible.	Open: Challenge will occur and *could* be problematic. However, the gain will outweigh the adverse impact
3. Quality and Outcomes Executive Nurse Director & Executive Medical Director	3a.The Safety, Quality and Accessibility of Care.	**Open**: Despite short term inherent risks we recognise potential for long term gain. We often challenge current clinical practices and often pursue innovative treatment and care solutions. Confident in our risk control we allow non-critical decisions to be devolved to a low operational level.	Seek: Despite short term inherent risks we seek potential for long term gain. We routinely challenge current clinical practices and routinely pursue innovative treatment and care solutions.
	3b. The Accessibility, Quality and Security of Information.	**Open**: Despite short term inherent risks we recognise potential for long term gain. We *usually* challenge current information management practices and pursue innovative technological solutions. We are confident that our risk management controls allow for non-critical decisions to be devolved to a low operational level.	Seek: Despite short term inherent risks we seek potential for long term gain. We *routinely* challenge current information management practices and pursue innovative technological solutions.
	3c. An effective, valued and well developed Workforce.	**Open**: Despite short term inherent risks we recognise potential for long term gain. We *usually* challenge current recruitment, retention, training and regulation practices and/or procedures. We are confident that our risk management controls allow for non-critical decisions to be devolved to a low operational level.	Seek: Despite short term inherent risks we recognise potential for long term gain. We *routinely* challenge current recruitment, retention, training and regulation practices and/or procedures.
	3d. The availability of the Materiel, Infrastructure and Sustainability required to meet our objectives, business needs or statutory obligations.	**Open**: There are short term inherent risks to the availability or sustainability of materiel/infrastructure. However, we are willing to manage these risks to a tolerable level because we recognise potential for long term gain.	Seek: Allocation and investment decisions related to sustainability, materiel and infrastructure will seek the best possible return. With rigid controls in place there is an acceptance of the possibility for financial loss, loss of resource availability or failure to meet statutory obligations.
4. Innovation Director of Transformation	4a.The application of Foresight & Innovation to our current and future activities	**Cautious**: Innovations in practice and/or risks arising from technological developments will only be considered if they have a strong potential to improve service quality, financial position or statutory compliance.	Seek: We consider the risks associated with innovation, creativity and research to be an essential component part of C&V UHB activity. We have devolved the authority for risk decisions to an operational level.
5. Reputation Chief Executive	5a.The positive Reputation of C&V UHB and the wider Wales NHS	**Open**: We are willing to take decisions that have potential to expose the organisation to additional scrutiny or interest. The means to manage the organisation's reputation are in place.	Seek: We recognise that the organisation will be subject to additional scrutiny/interest but we feel that the potential benefits outweigh the risks. New ideas are seen as potentially enhancing the reputation of the organisation.

Approach to assessing Risk

Consequence scores

Choose the most appropriate domain for the identified risk from the left-hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1–5 to determine the consequence score, which is the number given at the top of the column.

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment No time off work Physical injury to self/others that requires no treatment (including first aid) Minimum psychological impact requiring no support. Low vulnerability to abuse or exploitation – requiring no intervention.	Minor injury or illness, requiring minor intervention. Requiring time off work for <3 days Increase in length of hospital stay by 1–3 days Slight physical injury to self/others that may require first aid. Emotional distress requiring minimal intervention. Increased vulnerability to abuse or exploitation managed by local level intervention.	Moderate injury requiring professional intervention. Requiring time off work for 4–14 days Increase in length of hospital stay by 4–15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients Physical injury to self or others requiring medical treatment Psychological distress requiring formal intervention by mental health professionals. Vulnerability to abuse or exploitation requiring increased intervention	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects Significant physical harm to self or others Significant psychological distress requiring specialist mental health intervention. Vulnerability to abuse or exploitation requiring significant levels of intervention	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients

Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence

Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption **Environmental impact**	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Likelihood score (L)

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Risk scoring = consequence × likelihood (C × L)

	Likelihood

Consequence	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

1–3	Low risk
4–6	Moderate risk
8–12	High risk
15–25	Extreme risk

Instructions for use

Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.

Determine the consequence score(s) (C) for the potential adverse outcome(s) relevant to the risk being evaluated. Where a risk has multiple impacts score the impact with the highest consequence.

Determine the likelihood score(s) (L) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as the lifetime of a project or a patient care episode. If it is not possible to determine a numerical probability then use the probability descriptions to determine the most appropriate score.

Calculate the risk score the risk multiplying the consequence by the likelihood: C (consequence) × L (likelihood) = R (risk score).

Identify the level at which the risk will be managed in the organisation, assign priorities for remedial action, and determine whether risks are to be accepted on the basis of the colour bandings and risk ratings, and the organisation's risk management system. Include the risk in the organisation risk register at the appropriate level.

Appendix 4

Corporate Risk on a page Report as at Click or tap to enter a date.

Update: ☐		**New Risk for Corporate Risk Register:** ☐		
Risk Reference: Click or tap here to enter text.	**Director Lead:**	**Date of identification:** Click or tap to enter a date.		
	Assuring Committee Click or tap here to enter text.**:**	**Date Last Reviewed:** Click or tap to enter a date.		
	Risk: Click or tap here to enter text.	**Frequency of Review:** Click or tap here to enter text.		
	Impact: Click or tap here to enter text.			
	Links to Strategic Objectives: Click or tap here to enter text.			

Movement Since Last Update:			Consequence	Likelihood	Score (CxL)
↑	☐	Initial Risk Rating	Choose an item.	Choose an item.	Choose an item.
↓	☐	Current Risk Rating	Choose an item.	Choose an item.	Choose an item.
↔	☐	Target Risk Rating	Choose an item.	Choose an item.	Choose an item.

Controls	**Assurances of Control Effectiveness**
Click or tap here to enter text.	Click or tap here to enter text.
	Additional Risk Treatments Required
	Click or tap here to enter text.

Khan Raj 07/28/2021 11:01:43

GIG CYMRU NHS WALES — Bwrdd Iechyd Prifysgol Caerdydd a'r Fro / Cardiff and Vale University Health Board	**Reference Number:** UHB 024 **Version Number:** 3 **Next Review Date:** August 2022 **Previous Trust/LHB Reference:** N/A

Risk Management Procedure

Introduction and Aim

The University Health Board (the UHB) will face a number of risks which, if unmanaged, will threaten the achievement of its goals and objectives.

The Board describes its commitment to delivering effective risk management in the UHB 470 - Risk Management and Board Assurance Framework Strategy

This Guide is an adjunct to the strategy and has been written to provide risk leads at ward/departmental or clinical board level with detailed guidance on the risk management process, conduct of risk assessment and the purpose and use of risk registers.

Objectives

This procedure is intended to define the Risk Management process and:

- Guide users on Risk Assessment purpose and techniques.
- Guide users on Risk Treatment purpose and techniques.
- Provide considerations for monitoring and reviewing the Risk Management Process.

And to define the Risk Assessment and Risk Register procedures to:

- Provide guidance on risk description and risk scoring to enable consistency in the expression of risk by staff from a variety of roles and professions.
- Identify the purpose of initial, current and target risk ratings.
- Clarify who is responsible throughout the process from identification to resolution.
- Specify how risks will be considered, prioritised and managed within the UHB.
- Provide a mechanism to identify if a risk is tolerable taking into account the risk rating, risk appetite and the actions being taken to deal with the risk.

Scope

This procedure applies to all UHB staff in all locations, including those with Honorary Contracts.

Equality Impact Assessment	An Equality Impact Assessment has been written to support implementation of the Risk Management Strategy and Board Assurance Framework Strategy. The Equality Impact Assessment found no impact.
Documents to read alongside this Procedure	UHB 021 - Health and Safety Policy UHB 022- Fire Safety Policy UHB 034 - Lone Worker Policy

	UHB 060 - Maternity Risk Assessment Procedure UHB 088 - Display Screen Equipment Procedure UHB 089 - Control of Substances Hazardous to Health (COSHH) Procedure UHB 119 - Mental Health Clinical Risk Assessment and Management Policy UHB 287 - Information Risk Management Procedure UHB 344 - Ionising Radiation Risk Management Policy UHB 377 - Safety Notices and Important Documents Management Procedure UHB 433 - Incident, Hazard and Near Miss Reporting Procedure UHB 467 - Health and Safety Risk Assessment Procedure UHB 470 - Risk Management and Board Assurance Framework Strategy
Approved by	Director of Corporate Governance
Accountable Executive or Clinical Board Director	Director of Corporate Governance
Author(s)	Risk and Regulation Officer

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up date either by contacting the document author

Summary of reviews/amendments			
Version Number	**Date of Review Approved**	**Date Published**	**Summary of Amendments**

Introduction

Health services are inherently risky: their core activities involve a response to unpredictable events where the potential for harm or loss (both financial and non-financial) is high. Health services need to be aware of the risks they face and have procedures in place to manage these risks in the interests of both the organisation, their patients, staff, visitors and on occasion the wider public interest.

Risk management is the systematic identification, assessment and evaluation of risk. The UHB is committed to developing and implementing a Risk Management and Board Assurance Framework Strategy that identifies, analyses, evaluates and controls the risks that threaten the delivery of the UHB's strategic objectives and through pre-emption and reaction minimise the harm that clinical or resourcing errors can cause to patients, service users, staff or visitors.

The UHB's Risk Management and Board Assurance Framework Strategy is designed to provide guidance to all staff within the organisation on the management of strategic and operational risks through the completion and maintenance of Clinical Board and Corporate Directorate Risk Registers, the Corporate Risk Register and Board Assurance Framework. This document is subordinate to that strategy and is designed to provide amplifying guidance on the Risk Management Process (Part One) and a more detailed explanation of the Risk Assessment Process (Part Two).

PART 1: THE RISK MANAGEMENT PROCESS

1.1 Definition of Risk

There are many definitions of risk, with some implying that risk is something which should always be avoided. However, without any risk there would be very few opportunities or innovations. Modernising and improving our services requires the UHB to take opportunities whilst managing risk. For the purpose of its overall risk management activities the UHB defines risk as:

"The effect of uncertainty on the organisation's ability to achieve its objectives or successfully execute its strategies."

We operate in an uncertain world. Whenever we try to achieve an objective, there's always the chance that things will not go according to plan. Every undertaking has an element of uncertainty and some uncertainties have potential for risk. Risks may have more than one potential impact. Through analysis and targeted action the quantity of uncertainties or their potential impact can usually be reduced.

Risk deals with uncertainties. Once a risk has occurred it is no longer uncertain and therefore becomes an issue to be managed; the management of issues is beyond the remit of this guide.

1.1.1 Risk Types

The types of risk faced by the Health Board occur at two levels:

Strategic Risks: These are those risks that represent major threats to achieving the UHB's strategic objectives, or to its continued existence. Strategic risks can include key operational failures which would be very damaging to the achievement of strategic objectives if they materialised. Being clear about strategic risk enables the Board to be sure that the information it receives is relevant to the achievement of these objectives.

Operational Risks: These concern the day-to-day risks that the UHB faces, which if they occur could adversely impact on operational activity rather than strategic objectives. Operational risks arise from a variety of hazards and threats that may impact on patient safety, health and safety, service quality, financial governance etc. Operational risks have the potential to stop the Health Board achieving nationally or locally agreed targets or may have such an impact on service delivery that the Health Board is in breach of contract. Operational risks may also result in reputational harm. These risks are the responsibility of line management and should generally be identified and managed at the lowest possible level, with escalation to a higher level usually determined by the grading/scoring of the risk in accordance with the UHB's Risk Management and Board Assurance Framework Strategy.

The risks faced by the UHB can have a variety of causes and may exist across a variety of domains such as risks to patient safety, health and safety, financial governance, reputation etc. All risks, irrespective of cause/type, will be recorded and managed in a consistent way as described in the Risk Management and Board Assurance Framework Strategy.

Risk is the effect of uncertainty on the organisation's ability to achieve its objectives or successfully execute its strategies.

Once a risk has occurred it is no longer uncertain and it therefore becomes an issue.

The types of risk faced by the UHB fall into two categories; strategic and operational. The risks may occur in a variety of domains.

1.2 The Risk Management Process

The risk management process is depicted at figure 1. It is an iterative process that requires communication, consultation and regular monitoring and review to achieve optimal efficiency. The first 'step' in the process is establishing the context for the risk assessment. The risk assessment then involves the identification, analysis and evaluation of risk. Once a risk has been identified and understood through this process, decisions can be made with regard to how to treat the risk. At all stages of risk management there is a consistent need for monitoring and review of the process, with communication and consultation across all stakeholders.

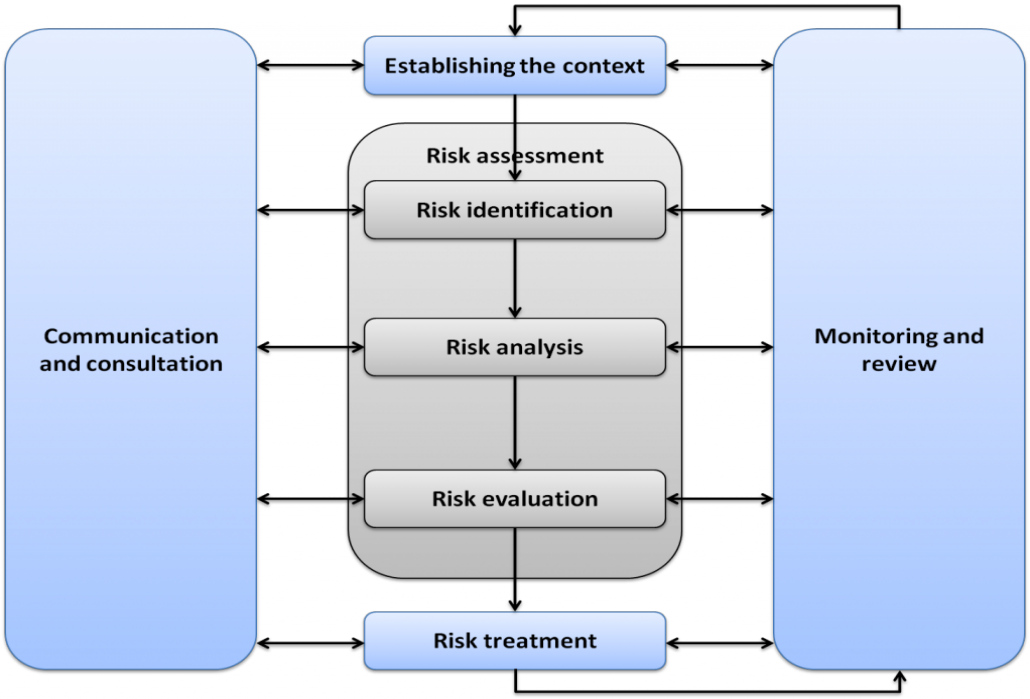


Figure1: ISO 31000 Risk Management Process.

1.2.1 Establishing the Context. To better enable risk assessment, communication and monitoring it is good practice to consider the overall context in which the other elements of the risk management process will occur. The context can be broken down into external and internal factors. Some examples of external factors are:

- National Health and Well-being initiatives.
- Service user expectations of high quality and safe services.
- Service user advocacy groups.
- Professional bodies.
- Legislation e.g. The Health and Safety Act 1974, The Mental Health Act 2007.

Some example of internal factors are:

- Results of internal audits and assurance processes.
- UHB policies and procedures.
- Project requirements or terms of reference.

It is useful to identify stakeholders at this stage. This is not just the people or groups potentially affected by the risk but also those who might be in a position to reduce or eliminate the risk and whose support might need to be sought. Since risks are linked to objectives it is also important, when appreciating context, to understand the UHB's strategic objectives as well as the objectives and issues relevant at a more local level within a department, speciality or clinical board.

Risk management is an iterative process.

Good risk management is about more than good risk assessment – communication and monitoring are essential.

It is important to understand the context for a potential risk event before assessing a risk.

Understanding context can be improved by focussing on external and internal factors.

1.2.2 Risk Identification

This is the process of identifying the type and nature of risk. Focus on this step is critical as without a sound understanding of the risk the remainder of the assessment process is flawed. A formal risk identification process is needed to identify:

- The extent and nature of risks.
- The circumstances under which risks may arise.
- The causes and potential contributing factors.

The aim is to identify the risks that patients, staff, volunteers or visitors may be exposed to, and/or, the risks that may prevent the UHB from achieving its objectives. Risks can generally be categorised as:

- Risks to the safety of patients, staff and the public.
- Risks to the quality of service provided by the UHB.
- Risks to the availability, competence or organisational development of human resources.
- Risks to compliance with statutory duties or standards.
- Risks to objectives and projects.
- Risks to business continuity.
- Risks to reputation.
- Risks to finances.

- Risks to the environment.

It is important to note that if a risk event occurs it may impact on more than one of these categories and this may need to be considered when assessing risk. For example a safety incident may result in injury to a patient but could also breach health and safety law resulting in a fine (financial) and result in press coverage which harms the UHB's reputation.

Proactive risk identification. Proactive risk assessment enables the UHB to identify actual or potential hazards and ensure that adequate control measures are in place to mitigate the risk. Proactive risk assessment is often a requirement to meet statutory duty e.g. Health and Safety risk assessments.

Reactive risk identification. The aim of effective risk management is to be proactive i.e. to identify risk early and either prevent its occurrence, reduce the likelihood of its occurrence or reduce the impact if it does occur. However, it is recognised that this is not always feasible and therefore reactive risk assessment has a role. Reactive risk assessments should take place after adverse events or near misses. This recognises the possibility that, with appropriate action, the likelihood of a similar incident occurring again can be reduced and/or the impact of any repeat event can be minimised. For example, post incident root-cause analysis, audit or a service review may identify new risks.

There are a variety of sources and methods for identifying risk. Quite often people focus on incident reporting, and although this is important, there are other, often equally important, sources of risk information, some of which are outlined in Figure 2.

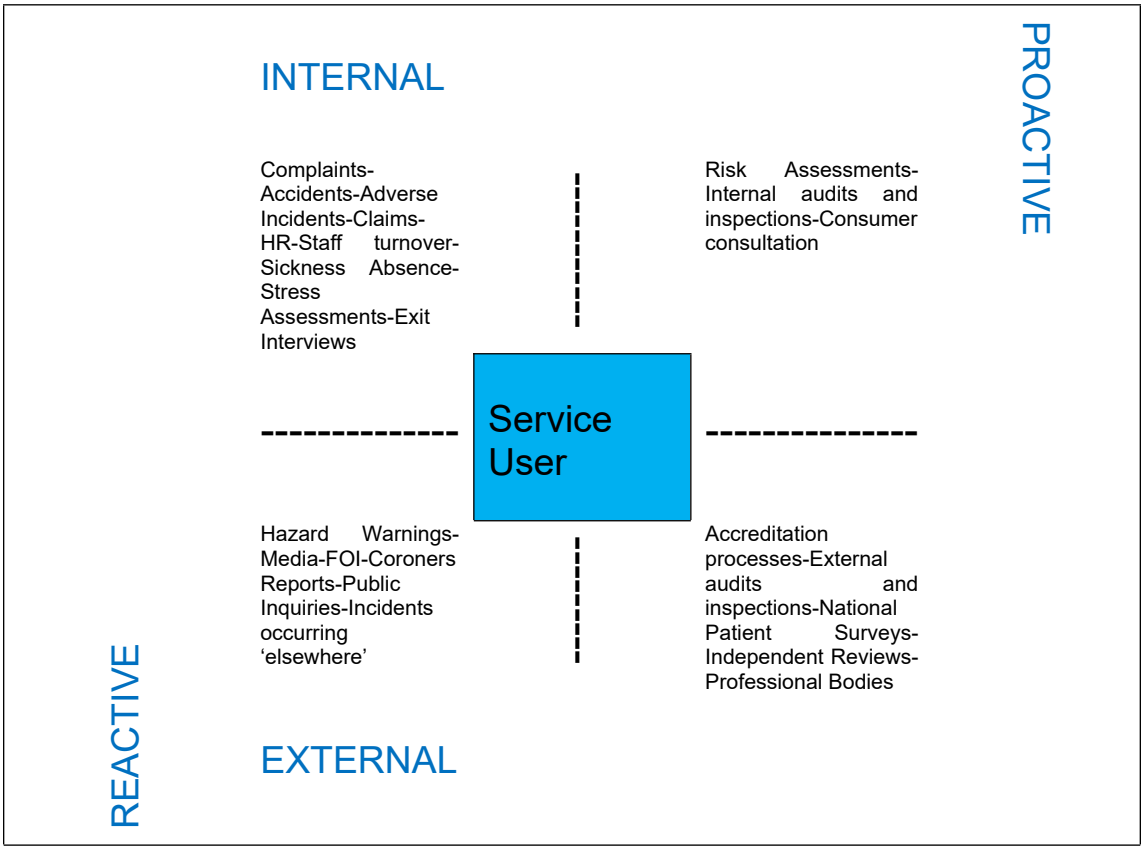


Figure 2: Potential Sources of Risk Information

Some areas of risk may be perceived as being 'entirely clinical' or 'entirely management'. While it is certainly useful for local clinical and management teams to conduct initial work in identifying risks specific to their area of expertise it is essential for an integrated system that at some point clinical and management teams work together to develop a comprehensive, organisational risk register.

Risk identification determines the nature of risks, the circumstances under which they may arise and the causes and potential contributing factors.

Risks can generally be categorised according to which aspects of operational activity may be impacted if the risk occurs.

Risk identification can be both proactive and reactive.

1.2.3 Risk Analysis

The purpose of risk analysis is to understand the nature of risk and where appropriate the level of threat that it poses. A risk event can have multiple causes and consequences, and can affect multiple objectives. Risk analysis involves a detailed consideration of uncertainties, risk sources, consequences, likelihood, events, scenarios, controls and their effectiveness.

Risk analysis should consider factors such as:

- The likelihood of risk events occurring.
- The magnitude (or consequences) that a risk will have on objectives if the risk event occurs.
- The complexity of the risk and any connectivity it may have to other risks or objectives.
- Any time-related factors that may influence likelihood or consequence.
- The confidence (i.e. assurance) held in the effectiveness of existing controls.

Risk analysis can be undertaken with varying degrees of detail and complexity, depending on the purpose of the analysis, the availability and reliability of information and the resources available. Analysis techniques can be qualitative, quantitative or a combination of these, depending on the circumstances and intended use. The risk analysis may be influenced by any divergence of opinions, biases, perceptions of risk and judgements. Additional influences are the quality of the information used, the assumptions and exclusions made, any limitations of the techniques and how they are executed. These influences should be considered, and where relevant documented and communicated.

Highly uncertain events can be difficult to quantify. This can be an issue when analysing events with severe consequences. In such cases, using a combination of techniques generally provides greater insight.

Risk analysis provides an input to risk evaluation, to decisions on whether risk needs to be treated and, if to be treated, the most appropriate risk treatment strategy and methods.

Risk analysis considers:

- The likelihood of risks occurring.
- The impact that a risk will have on objectives if the risk occurs.
- The complexity of the risk and any connection it may have to other objectives or known risks.
- Any time related factors that may influence likelihood, consequence or later risk treatment options.
- The level of confidence held in the effectiveness of existing controls.

1.2.4 Risk Evaluation

Risk evaluation involves comparing the results of the risk analysis with the established risk criteria and *Risk Appetite* to determine what action is required.

Cardiff and Vale University Health Board's Risk Appetite is published in the Risk Management and Board Assurance Framework Strategy. Risk Appetite describes the "Amount and type of risk that an organisation is prepared to pursue, retain or take" (ISO 31000). As such it helps us set an appropriate balance between uncontrolled innovation and excessive caution. It guides on

the level of risk permitted, encourages consistency of approach across the Health Board, and prevents the expenditure of time/resources on further reducing risks that are already at an acceptable level to the organisation.

Where possible risk evaluation might also include consideration of when a risk event might occur. This measure aims to identify *Risk Proximity*. Risk proximity is a consideration of the time period in which risk events may occur. It could be that risks will be more likely to manifest themselves at particular times, and awareness of these times will enable focused pre-emptive risk treatments. Awareness of 'risk time' can also enable a balanced focus on risks, allowing a greater emphasis on those risks that are likely to occur in the short term. Finally, risk proximity also allows identification of the potential for simultaneous risk events. This may be important because simultaneously occurring risk events might require similar (and scarce) risk treatments and thus pre-emptive planning may be required to mitigate the impact of these simultaneous events.

The output from risk evaluation is a decision to either:

- Undertake further analysis to better understand the risk before making a final decision.
- **Terminate** the risk i.e. avoiding the activity, process or practice that may give rise to the risk. Or adjusting the activity, process or practice to remove the risk.
- **Tolerate** the risk i.e. accept the risk as it is without taking any action to mitigate or reduce the risk. This would occur because the cost/effort of risk reduction or mitigation activity are not cost effective or the risk impact is acceptable (i.e. *within* the current risk appetite).
- **Treat** the risk. This will occur when the risk cannot be terminated, is intolerable (i.e. *beyond* the current risk appetite) and cannot be transferred. Options for reducing the likelihood of occurrence or minimising the impact are identified.
- **Transfer** the risk**.** This can be achieved through various forms of insurance or the payment to third parties who are prepared to take the risk on behalf of the organisation. This will usually only be an option for risks related to financial management or commercial activities.

1.2.5 Risk Treatment

The purpose of risk treatment is to select and implement options likely to reduce the negative effects of the risk or enable the opportunities that may result from a risk being realised. Risk treatment is a process that requires:

- The planning and implementing of risk treatment(s).
- Assessing the effectiveness of the treatment(s).
- Deciding whether the remaining risk (sometimes described as residual risk) is acceptable.
- And if not acceptable, deciding what further treatment is required.

Risk treatments even if carefully designed and implemented might not produce the expected outcomes and could produce unintended consequences. Therefore monitoring and review need to be an integral part of risk treatment implementation to give assurance that the different forms of treatment become and remain effective. If the risk cannot be avoided, if there are no treatment options available or if treatment options do not sufficiently modify the risk then the risk should be kept under ongoing review.

Controls. A control is any active measure or action that modifies (i.e. treats) risk in the intended manner. Controls may be policies, procedures, practices, processes, technologies, techniques, methods, or devices. They can also be modifications to existing controls e.g. modifying existing vaccination training packages to incorporate the specific requirements of a new vaccine.

It is sometimes helpful to consider Pre-Event Controls and Post-Event Controls; both may be relevant in reducing a risk. Pre-Event Controls seek to reduce the likelihood of a risk event occurring, and Post-Event Controls seek to reduce the consequence(s) of a risk event if it occurs. Differentiating controls in this way can help in the prioritisation of management focus and coordination of risk management actions.

Example: ABS braking systems are a pre-event control designed to reduce the likelihood of vehicle collision, whereas seatbelts are a post event control designed to reduce driver/passenger injuries (consequence) if collision occurs.

Once imposed, risk treatments may subsequently fail to modify the risk or fail to operate in the way that was originally intended. It is also worth noting that newly created and imposed treatments may not be immediately effective – they need time to 'bed in'. An essential aspect of risk management is the prior identification, implementation and ongoing monitoring of the risk assurance process. The effectiveness of controls is assessed by internal and/or external assurance processes. Any currently absent or ineffective risk treatments are described as *Gaps in Control*. Any identified gaps in control are recorded on risk registers and subsequent actions to regain control are identified and recorded.

Example: An increase in suitably qualified and experienced (SQEP) staff has been identified as a risk treatment for a patient safety risk. This will be achieved through recruiting new SQEP staff and 'up' training existing staff. However, these new staff will take time to recruit, and a training provider is not yet identified– so there is a current gap in control. Corresponding action is to ensure the minimum essential cover needed to reduce the risk as low as reasonably practicable. This could be achieved through an altered shift pattern for the existing SQEP staff, temporary re-deployment of SQEP staff from another ward, and temporary use of SQEP agency staff.

Controls are any active measure or action that modifies risk in the intended manner.

Controls may subsequently fail to achieve the intended effect. Therefore monitoring of their ongoing effectiveness is required. Gaps in Control are revealed through internal or external assurance processes.

Gaps in Control should be recorded and subject to specific rectifying action.

1.2.6 Monitoring and Reviewing Risks

Risk is not static – it is dynamic and evolutionary. Therefore, continuous monitoring and reviewing of the risk control system is essential.

The 'vehicle' for the monitoring and review of risk is the risk register. The risk register must contain details related to the risk such as the type of risk, its context, the risk ratings, the agreed corrective measures/action plan, persons responsible and review dates.

Departments, Specialities and Clinical Boards will establish their own routines and processes for risk monitoring and review, and the rhythm of these routines will often be dictated by the timings of higher level UHB activity. Beyond specific risk review meetings there are frequent opportunities to incorporate risk monitoring and review into routine activity. For example Clinical Board meetings or multidisciplinary team meetings may have risk monitoring and review as standing items on their agendas. It is notable that most organisations with mature and highly effective risk management processes have their risk control systems embedded into routine management activity.

Due to the dynamic nature of risk it is important to monitor whether the nature of risk has changed over time, resulting in altered consequence and/or likelihood. Where time (or risk proximity) is relevant it is also good practice to monitor changes to the anticipated timing of a risk event, to ensure that triggers and reactive mitigations remain relevant.

Risk is dynamic therefore continuous monitoring of the risk control system is essential.

To optimise monitoring and management actions, the risk register must contain details related to the risk such as the type of risk, its context, the risk ratings, the agreed corrective measures/action plan, persons responsible and review dates.

PART 2: GUIDANCE ON RISK ASSESSMENT AND RISK REGISTER PROCESS

2.1 Process for Completing Risk Assessments

2.1.1 Decide a Risk Title. The purpose of the risk title is primarily to enable tracking of the risk as it develops and, if necessary, as it progresses through escalation. Therefore, the risk title should provide a succinct description of the risk and ensure distinction from other risks of a similar nature.

2.1.2 Write a Risk Description. Early creation of an accurate, succinct and structured risk description significantly improves the risk management process.

Some risks may need to be escalated, for example from Directorate Risk Register to Clinical Board Risk Register. As risks 'percolate' up the risk reporting hierarchy there is likely to be increasing unfamiliarity with terminology and abbreviations used by local level subject matter experts. It should also be noted that risks escalated to the Corporate Risk Register will be placed in the public domain and all registers held below this level may be released for public scrutiny following appropriate access requests. Therefore, when writing risk descriptions, and especially context, it is a good discipline to write with a 'lay reader' in mind and avoid (or succinctly explain) specialist terminologies or abbreviations.

A well-written risk description contains three main elements:

a. **Context –** A summary of the relevant background facts. These may include prior decisions, assumptions, timelines, dependencies and relevant objectives.

b. **Source(s) of uncertainty / Cause Event -** The currently existing conditions that create the risk i.e. the factors that may cause the risk to occur and/or influence the extent of its effect.

c. **Consequence / Impact -** The impact to the Programme, Service and/or Organisation in the event of the risk occurring. Consequence could also result in opportunities that may surface in managing the risk.

The structure of a risk description can be compared to the telling of a story in which there is a beginning, a middle and an end:

A beginning (i.e. a setting)	*'Due to….'*	Context
A middle (something of interest)	'*The following might occur…'*	Risk Cause or Risk Event
An end (significance/importance)	*'Which could result in…'*	Consequence or Impact

The following example illustrates the relationship between context, cause, risk and impact:

Context. Nursing staff on an acute medical ward are required to use 'X' infusion pump. The 'X' pump is a new design that differs significantly from the infusion pumps previously used. The pump may be used on up to 30 patient interventions per day. No other type of infusion pump is available.
Cause. An internal audit has identified that this piece of equipment is often used incorrectly as staff are not trained appropriately. A recent DATIX trend identifies near misses from the incorrect use of this equipment and an internal audit has confirmed the causation between absent relevant training and potential harm.

Risk. There is a risk that this equipment may be used incorrectly if staff are untrained.

Impact. This could lead to medication errors resulting in; patient harm, patient complaints, notifiable incidents, statutory non-compliance.

2.1.3 Risk Scoring

Complete the Initial Risk Score. The initial risk score is calculated <u>without</u> consideration of any risk treatment (controls). As such it represents the organic, worst case scenario.

The Risk Management and Board Assurance Framework Strategy (Appendix 3) provides descriptors of severity levels and frequency that are essential when deriving risk scores. The descriptors are designed to ensure that they can apply equally to the impact on the safety of patients and staff, the risk of complaints, adverse media coverage, business objectives etc.

The *consequence* is given a numerical score by considering the severity of the risk on the scale of Negligible (1) through to Catastrophic (5). The *likelihood* is measured by considering how often an event will occur on a scale of Rare (1) through to Almost Certain (5).

The *Consequence* and *Likelihood* are then multiplied to give the *Initial Risk Rating.* The *Initial Risk Rating* is plotted on the Risk Matrix (see Figure 3). This identifies whether the risk is a *Low (1-3), Moderate (4-6), High (8-12) or Extreme Risk* (15-25) to the UHB.

	Likelihood				
Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

1-3	Low risk
4-6	Moderate risk
8-12	High risk
15-25	Extreme risk

Figure 3: Risk Matrix *from The Risk Management and Board Assurance Framework Strategy*

Complete the Current Risk Score. The Current Risk Score takes the Initial Risk Score and re-assesses it <u>with</u> consideration of the effect these controls

have on consequence, and/or likelihood. These control measures should be prioritised so that the actions likely to have the best effect are taken first.

The consequence if a risk occurs will seldom alter but, with effective controls in place the likelihood of the risk should reduce. Therefore it will usual for the current risk rating score to be lower than that provided for the initial risk rating.

Complete the Target Risk Score. The target risk rating is the level of risk that the organisation is happy to tolerate. The UHB Risk Appetite statement provides further guidance on the level of tolerable risk. The target risk score can also be seen as a projection of how the risk should look once it is has been reduced as low as reasonably practicable.

There is a relationship between the current risk score and the target risk score. If the current risk score is higher than the target risk score there is a remaining requirement for 'action' to further reduce either the likelihood or consequence of the risk. This remaining action is the action plan described in the actions element of the risk assessment table.

2.1.4 Gaps in Controls

Having calculated and recorded the current risk rating the next step is to record current gaps in control (a full description of Gaps in Control is provided in Part 1). Any gaps in control will need to be closed and therefore actions to reduce or eliminate gaps in controls should be planned, monitored and recorded.

2.1.5 Assurances

Assurances are evidence that the controls are working in the intended manner (as described in Risk Treatment at Part 1).

Gaps in Assurance. A gap in assurance demonstrates that insufficient evidence is available to demonstrate that a control is working effectively. Gaps in assurance need to be closed and therefore actions to reduce or eliminate gaps in assurance should be planned, monitored and recorded.

2.1.6 Actions

The actions area of the risk assessment should list all actions required to further mitigate or manage the risks. More specifically the actions table is a list of actions needed to close gaps in control or actions needed to close gaps in assurance. Actions should be SMART[1] and have an owner assigned in addition to a target date for completion.

[1] **S**pecific, **M**easurable, **A**ssignable, **R**ealistic, **T**ime-Related.

2.2 Monitoring and Review of the Risk Assessment

Risk assessments should be *suitable* and *sufficient* and where the form has been fully completed and the latest information/guidelines considered, it is likely to meet these requirements. The Risk Assessment should be signed off by the Assessor, Risk Owner and Directorate Manager and assigned to the most appropriate risk register, according to its risk level.

The score of a particular risk will determine at what level decisions on acceptability of the risk should be made and to whom it should be reported. General guidelines for risk escalation are as follows:

Risk Level	Score	Action
Extreme Risk	15 - 25	Risks greater than 20 to be reported immediately to the relevant Executive Director who will inform the Chief Executive. In the event that this may cause delay, the Clinical Board Director can report directly to the Chief Executive. **Risks of 20 or greater also reported to Risk and Regulation team for recording on the Corporate Risk Register.**
High Risk	8-12	Report to Clinical Board or for Corporate Directorates to the Executive Director. **Risk placed onto Clinical Board or Corporate Directorate Risk Register**.
Moderate Risk	4-6	Report to Heads of Service with proposed treatment/action plans, for specific monitoring. **Risk placed onto Ward/Departmental Risk Register**
Low Risk	1-3	Report to local manager for local action to reduce risk. **Risk placed onto Ward/Departmental Risk Register**

Figure 4: Actions according to Risk Level.

All recorded risk assessments must have a review date and all local risks should be reviewed and updated monthly as a minimum. The review date will initially be set by those recording the assessment but risk owning executives/managers may subsequently direct the review schedule according to how they are influenced by the risk rating.

As Risk Assessments are reviewed, the appropriate Risk Register should be updated to illustrate the date of review and any changes to controls, assurances or action plans.

Risk Assessments should be retained whilst they remain current, and for 12 months following the date of their acceptance or closure (as described in para 2.3.5).

2.3 Risk Registers

A risk register is a central collation of risks recorded in order to inform the decision making of managers, risk committees and potentially the UHB. The Risk Register records all identified risks; it then progressively describes their controls, their risk scores and any ongoing action necessary to reduce the risk as low as reasonably practicable.

Each risk should be assigned a Risk Owner (e.g. Ward Manager at Ward Level, Clinical Board Director at Clinical Board Level etc.). A UHB Board Committee should also be identified for all risks that are contained within the UHB's Corporate Risk Register for assurance purposes.

Each Directorate will maintain a central file of Risk Registers from their Wards/Departments. The Clinical Board Risk Lead will ensure that Directorate Registers are collated and amalgamated at a Clinical Board Level.

2.3.1 Low and Moderate Risks. These risks will be held on local level risk registers and will be managed by an appropriate risk lead at that departmental or speciality level. Risks at this level should be reviewed and updated at least quarterly.

However, following the implementation of all actions that are possible and practical at the local level there may be the need to report a risk by escalating it to the next level of management *irrespective of its risk rating score*. This may be necessary for the following reasons:

- Sufficient mitigation cannot be identified at the local level.
- Sufficient mitigation requires additional funding or authorisation not available at the local level.
- Where support is required from another area of the UHB to carry out risk mitigation.
- Where the risk consequences might adversely impact on another UHB area if the risk occurred.

2.3.2 High Risks. High risks should be escalated and recorded on the Directorate Risk Register. They should be managed by a senior and suitably empowered risk owner, and reviewed at least monthly.

2.3.3 Extreme Risks. Extreme Risks are those risk that score 15 or greater. Risks scoring 20 or greater require immediate escalation (see figure 4). Extreme risks will continue to be managed by the Clinical Board/Corporate Directorate but risks of 20 or greater should also be reported on the Corporate Risk Register and, if a threat to strategic objectives, further reported on the Board Assurance Framework.

2.3.4 The Corporate Risk Register. The Corporate Risk Register is a single document which brings together for Board oversight or decision the risks to the organisation in meeting its principal objectives, mapped against both the key controls in place and assurances of control effectiveness.

The Corporate Risk Register is reported at every Board Meeting and specific risks are also reported at appropriate Committees of the Board for further assurance, scrutiny and escalation where required. When risks are considered to have potential threat to the achievement of strategic objectives they will also be reported on the Board Assurance Framework.

2.3.5 Risk Acceptance or Closure. Risks are accepted when the risk score equals that of the target risk rating i.e. where all reasonable actions have been effectively carried out and the risk owner, cognisant of the risk appetite, is in all other respects confident that the risk has been reduced as low as reasonably practicable. A clear rationale for accepting the risk should be added to the risk register entry. Accepted risks should be held on a register and reviewed annually to see if anything changes.

Where risks have been agreed for removal from the Risk Register or are covered by an existing risk, the risk can be closed. The date of closure and the rationale for closure should be recorded on the risk register. Where closed risks have a potential for reoccurrence, an appropriate date for review should be recorded.

2.4 Glossary of Risk Terminology

Accepted Risk	Risks which are equal to or below the target score where all reasonable actions have been carried out, or there are no further actions possible, cannot be practically reduced any further. These risks may therefore be accepted by the risk owner. The rationale for acceptance must be recorded.
Adverse Event	Any event or circumstance leading to unintended harm and/or suffering which results in admission to hospital, or prolonged hospital stay, or significant disability at discharge or death
Assurance	The confidence gained, based on sufficient evidence, that internal controls are in place and are operating effectively so that objectives are being achieved. Sources of assurance include reviews, audits, and inspections (both internal and external).
Cause	An element which alone or in combination has the potential to give rise to risk
Closed Risk	A risk which is no longer relevant or is covered by another risk can be defined as closed on the Risk Register. The rationale for closure must be recorded.
Consequence	See **Impact**
Cost	Activities, both direct and indirect, which result in a negative outcome or impact for an individual or the organisation – cost includes money, time, labour, disruption, goodwill, political and intangible losses.
Control	Any measure or action that modifies risk in the desired manner. Controls may be policies, procedures, practices, processes, technologies, techniques, methods or devices.
Current Risk	The risk score with controls in place to manage the risk.

Escalation	The act of advancing a risk to a higher management level for resolution, action or attention.
Event	An occurrence or change in a set of circumstances. An incident or situation. Can be something that is expected which does not happen or something that is not expected which does happen. Events can have multiple causes and consequences and affect multiple objectives.
Frequency	A measure of the rate of occurrence of an event expressed as the number of occurrences of an event in a given time
Gaps (in controls or assurances).	Where an additional system or process is needed, or evidence of effective management of the risk is lacking.
Hazard	A source or situation of potential harm.
Inherent Risk	See **Initial Risk**
Initial Risk	The risk score where there are no controls in place to manage the risk. Precedes current risk.
Impact (or consequence)	The outcome of an event, being a loss, injury, disadvantage or gain in respect of the physical, emotional, financial, social or credibility status of the individual or organisation
Incident	Any unplanned event or circumstance resulting in, or having a potential to cause loss
Incident Reporting and Investigation	A formal structured process and approach to enable the occurrence of incidents to be reported, recorded and the root cause of reported incidents identified, in order to manage risk exposure and identify required corrective actions
Likelihood	A qualitative measure of the probability of a risk occurring.
Live Risk	An identified risk that has been approved and which is currently being managed.
Near Miss	A situation in which an event or omission (or a sequence of events or omissions), arising during clinical care fails to develop further, whether or not as the result of compensating action, thus preventing injury/harm to the patient.
Opportunity	An uncertain event that would have a favourable impact on objectives or benefits if it occurred
Patient Safety Incident	Any unintended or unexpected incident(s) that could have or did lead to harm of one or more persons receiving NHS funded healthcare
Pre-Event Controls	Risk controls intended to reduce the likelihood of a risk event occurring. Pre-event controls can be applied to a risk with or without post-event controls.
Post-Event Controls	Risk controls designed to reduce the impact of a risk event if it occurs. Post-event controls can be applied to a risk with or without pre-event controls.
Probability	The likelihood of a specific event or outcome occurring. Probability is usually expressed along a scale ranging from impossible to certain.
Residual Risk	See **Current Risk**.
Risk	The effect of uncertainty on the organisation's ability to achieve its objectives or successfully execute its strategies. Risk is usually expressed in terms of causes, potential events and their consequences (or impact).
Risk Analysis	A systematic use of available information to determine how often specified events might occur and the magnitude of their consequences if they were to occur.
Risk Appetite	The ISO 31000 risk management standard refers to risk

	appetite as the "Amount and type of risk that an organization is prepared to pursue, retain or take". This concept helps guide an organization's approach to risk and risk management. By defining its risk appetite, an organisation can arrive at an appropriate balance between uncontrolled innovation and excessive caution. It can guide people on the level of risk permitted and encourage consistency of approach across an organisation. Defined acceptable levels of risk also means that time/resources are not spent on further reducing risks that are already at an acceptable level.
Risk Avoidance	An informed decision not to become involved in a risk situation. For example termination of a risk generating activity.
Risk Escalation	A process that ensures identified risks deemed impossible or impractical to manage by a local team or function, and/or those risks with potential strategic impact are escalated to the appropriate level.
Risk Mitigation	Risk mitigation describes the compound effect of the *effective* actions and controls put in place to reduce or minimise the likelihood and/or impact should the risk occur.
Risk Owner	The senior person accountable for the risk; should have a decision making authority and be able to monitor the status of the risk.
Risk Treatment	Options likely to reduce the negative effects of the risk or enable the opportunities that may result from a risk being realised.
Target Risk	The risk level that the organisation is willing to accept in accordance with risk appetite.

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

RISK ASSESSMENT FORM

Clinical Board/Corporate Directorate:	Enter text	Directorate:	Enter text

Date Form Completed:	Enter a date
Main Risk Type:	Select One Item
	Other Risk Type (if applicable):

Risk Title	
Enter text.	
Risk Description	
Context	Enter text
Risk	Enter text
Causes/Sources/Events	Enter text
Impacts/Consequence	Enter text

Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

1-3	Low risk
4-6	Moderate risk
8-12	High risk
15-25	Extreme risk

Step 1 – INITIAL RISK SCORE - Score Risk without Current Controls							
Consequence	Choose a score	x	Likelihood	Choose a score	=	Initial Risk Score	

Step 2 – Determining the Current Risk Score							
2a: List Controls Currently in Place:							
Controls							
2b: List the Assurances for these Controls:							
Assurances							
2c: CURRENT RISK SCORE – Score Risk with Current Controls							
Consequence	Choose a score	x	Likelihood	Choose a score	=	Current Risk Score	Choose a score

Step 3 – Determining the Target Risk Score		
3a: What extra controls are required to reduce this risk as low as reasonably practicable (ALARP)?		
Enter text		
3b: What actions are required to provide these extra controls or increase the assurance of controls?		
Describe the action	Name the action lead	Target date for completion
Describe the action	Name the action lead	Target date for completion
Describe the action	Name the action lead	Target date for completion
Describe the action	Name the action lead	Target date for completion
Describe the action	Name the action lead	Target date for completion
Notepad:		

List here any other information that supports your risk assessment but which is not recorded elsewhere on this form							
3d: TARGET RISK SCORE – Considering all of the information you have on the controls and assurances how would you rate the risk when the actions are completed?							
Consequence	Choose a score	x	**Likelihood**	Choose a score	=	**Target Risk Score**	Choose a score

Name of Assessor:	Name of Assessor
Signature of Assessor:	
Date of Assessment:	Enter a date
Risk Owner:	Name of Risk Owner
Signature of Risk Owner:	
Date signed by Risk Owner:	Enter a date

Format of the Workbook

This workbook contains conditional formatting and protected areas. This will prevent you from deleting a row or column but you can delete the contents of a row.

Accepted or Closed Risks

Once risks are removed or accepted they should be cut and pasted onto the 'Accepted and Closed Risk' sheet.

Risk Acceptance. Risks are accepted when the risk score equals that of the target risk rating i.e. where all reasonable actions have been effectively carried out and the risk owner is in all other respects confident that the risk has been reduced as low as reasonably practicable (ALARP). A clear rationale for accepting the risk should be added to the risk register entry. Accepted risks should be held on the register and reviewed at least annually to see if they remerge.

Risk Closure. Where it is recognised that a risk no longer exists or is no longer relevant to the organisation the risk can be closed. Risks that are covered by another risk can also be closed. The date of closure and the rationale for closure should be recorded on the risk register. Where closed risks have a potential for recurrence an appropriate date for review should be recorded.

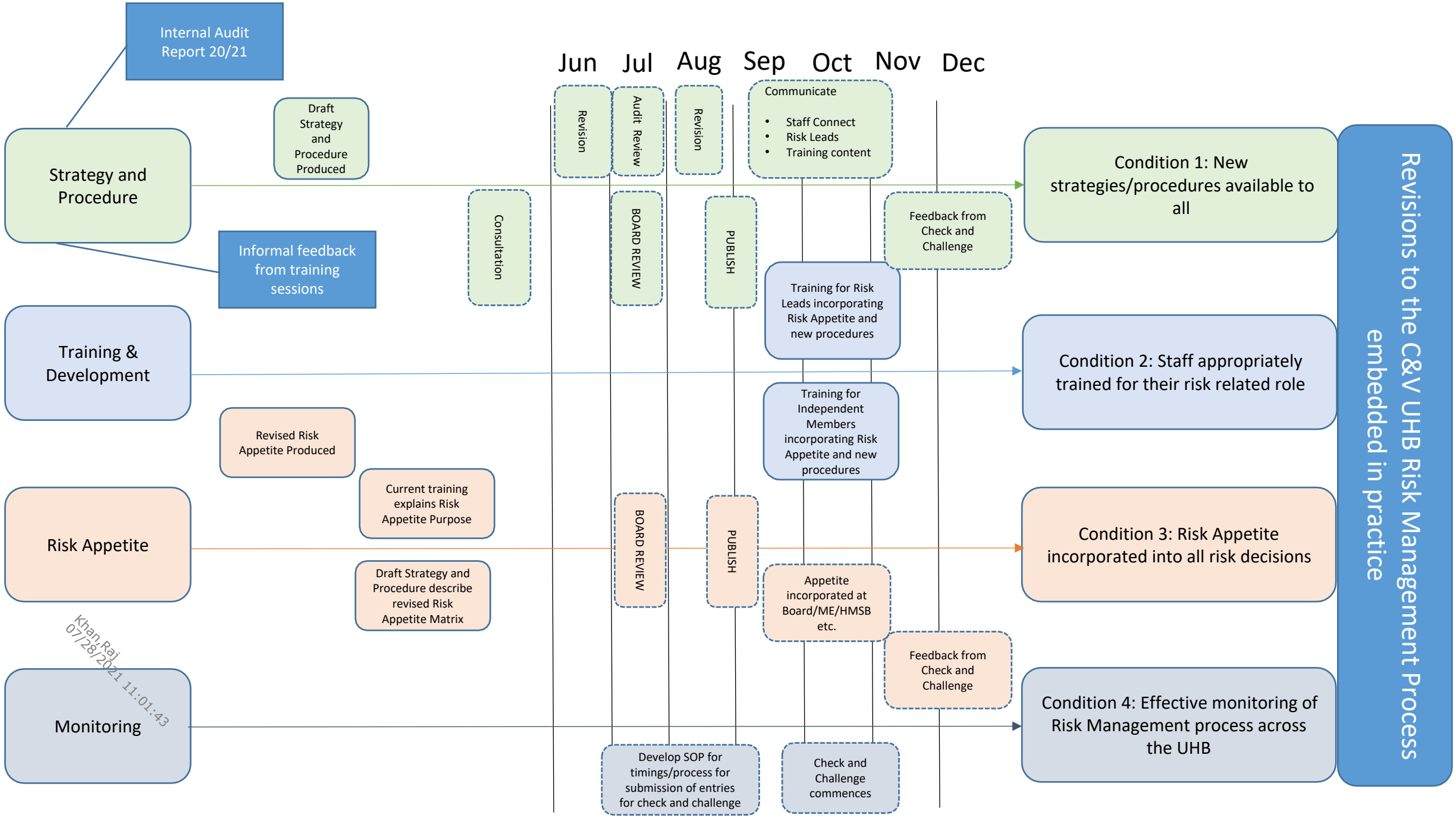
GUIDANCE FOR COMPLETING THE RISK REGISTER
Remember that all risks must have undergone a risk assessment prior to them being added to the Risk Register
Risk Reference Number: This should be sequential. In the event that a risk is accepted or closed and therefore archived to the accepted and closed sheet, there is no requirement to re-number the remaining open risks.
Strategic Objectives: The strategic objectives can be found in the comments box. Identify which objective(s) may be impacted if the risk event occurs, and record the corresponding number(s) in the box. For example the risk could adversely impact on the reduction of health inequalities and a planned care system where demand and capacity are in balance - therefore '1,6' are recorded.
Date Risk Added: Please enter in the format dd/mm/yyyy.
Risk Description: Introduce the topic, then state *there is a risk that if X happens then this could result in Y. The impact of this could be Z (or ZZ, ZZZ etc).* A well written risk description contains three main elements: 1. Context. A summary of the relevant background facts. 2. Source or Cause of Risk. The current conditions or factors that create the risk. 3. Impact. The impact on the programme/organisation objectives in the event of the risk occuring.
Executive Lead: This is the senior person, with decision making authority, best placed to monitor the risk. This person is accountable for the risk and should be aware of it's current status.
Initial Risk Rating: This is the risk score calculated without consideration of any risk treatment/controls i.e. what would the risk be if we did nothing to reduce it.
Controls: A control is any active measure or actrion that modifies (i.e. treats) risk in the intended manner. Controls may be policies, procedures, practices, processes, technologies, techniques, methods or devices. They can also be modifications to existing controls to increase their effectiveness. Controls should be listed in their priority order - bullet points are encouraged.
Assurances: List here evidence that existing controls are working in the intended manner. Examples of evidence include inspections, walk arounds, audits, training records, DATIX trends etc. There may be external as well as internal assurance processes.
Current Risk Rating: The Current Risk Score takes the Initial Risk Score and re-assesses it with consideration of the effect these controls have on consequence, and/or likelihood. These control measures should be prioritised so that the actions likely to have the best effect are taken first. The consequence if a risk occurs will seldom alter but, with effective controls in place the likelihood of the risk should reduce. Therefore it will usual for the current risk rating score to be lower than that provided for the initial risk rating.
Gaps In Control: These are controls which are required to reduce the risk but which are currently absent or only partially effective.
Actions: This is a bulleted list of the actions needed to provide/increase/improve controls or to provide assurance of control effectiveness.
Who is leading on these actions and **When** are they expected to be achieved?
Target Risk Rating: The target risk rating is the level of risk that the organisation is happy to tolerate. The UHB Risk Appetite statement provides further guidance on the level of tolerable risk. The target risk score can also be seen as a projection of how the risk should look once it is has been reduced as low as reasonably practicable.
Review Date: The Risk Management and Board Assurance Framework Strategy (UHB 470) described the required review periods.
Assurance Committee: For assurance purposes a UHB Board Committee should be assigned for any risks escalated to the Corporate Risk Register.

RISK REGISTER TEMPLATE	
CLINICAL BOARD/CORPORATE DIRECTORATE:	
SPECIALITY/DEPARTMENT:	

Risk Ref.	Strategic Objective	Date risk added dd/mm/yyyy	Risk	Exec Lead	Initial Risk Rating			Controls	Assurances	Current Risk rating			Gaps in Control	Gaps in assurance	Actions	Who	When	Target Risk rating			Date of next review	Assurance Co
					Consequence	Likelihood	Total			Consequence	Likelihood	Total						Consequence	Likelihood	Total		
							0					0								0		
							0					0								0		
							0					0								0		
							0					0								0		
							0					0								0		
							0					0								0		
							0					0								0		
							0					0								0		
							0					0								0		
							0					0								0		
							0					0								0		
							0					0								0		
							0					0								0		
							0					0								0		
							0					0								0		
							0					0								0		
							0					0								0		

Accepted or Closed Risks

Risk Ref.	Strategic Objective	Date risk added (to original risk register)	Risk	Exec Lead	Initial Risk Rating			Controls	Assurances	Current Risk rating			Gaps in Control	Gaps in assurance	Actions	Who	When	Target Risk rating			Accepted or Closed?	Date accepted/closed	Rationale	Review date (If applicable)
					Consequence	Likelihood	Total			Consequence	Likelihood	Total						Consequence	Likelihood	Total				


Internal Audit Report 20/21
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Strategy and Procedure
Draft Strategy and Procedure Produced
Revision
Audit Review
Revision
Communicate
Staff Connect
Risk Leads
Training content
Condition 1: New strategies/procedures available to all
Informal feedback from training sessions
Consultation
BOARD REVIEW
PUBLISH
Feedback from Check and Challenge
Training for Risk Leads incorporating Risk Appetite and new procedures
Training & Development
Condition 2: Staff appropriately trained for their risk related role
Training for Independent Members incorporating Risk Appetite and new procedures
Revised Risk Appetite Produced
Current training explains Risk Appetite Purpose
Risk Appetite
BOARD REVIEW
PUBLISH
Condition 3: Risk Appetite incorporated into all risk decisions
Draft Strategy and Procedure describe revised Risk Appetite Matrix
Appetite incorporated at Board/ME/HMSB etc.
Feedback from Check and Challenge
Khan Raj 07/28/2021 11:01:43
Monitoring
Condition 4: Effective monitoring of Risk Management process across the UHB
Develop SOP for timings/process for submission of entries for check and challenge
Check and Challenge commences
Revisions to the C&V UHB Risk Management Process embedded in practice

Report Title:	**Partnership and Recognition Agreement**	**Agenda Item no.**	**7.2**
Meeting:	**UHB Board**	**Meeting Date:**	**29.07.21**
Status:	**For Discussion**	**For Assurance**	**For Approval**	**x**	**For Information**
Lead Executive:	Executive Director of People and Culture		
Report Author (Title):	Workforce Governance Manager		

Background and current situation:

The Cardiff and Vale University Local Health Board (the UHB) is committed to working in partnership with recognised Trade Unions and Professional Staff Organisations. The Partnership and Recognition Agreement is intended to help further embed partnership working within the culture and practice of the organisation at all levels.

The document has been reviewed in partnership and has been considered by the Local Partnership Forum which has recommended that the Board approve it.

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

The Health Board is committed to the partnership agenda with its employees to ensure that they can be involved in the decisions that affect them and the services they provide for patients

The Health Board objective of delivering the highest quality services possible can only be achieved by a workforce that is sufficiently skilled, committed and feels valued.

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

The UHB has had a Partnership and Recognition Agreement signed off by the Chair, Chief Executive and Chair of Staff Representatives since its formation in 2010. The Agreement sets out:

- The principles of partnership working
- Definitions of key terms
- Duties, responsibiliites and commitments for the UHB, staff representatives and manager
- A list of Trade Unions and Professional Organisations recognised by the UHB and the scope of this recognition
- Arrangements for work place representatives
- The Local Partnership Forum Terms of Reference including the 6 TUC Principles of Partnership Working and the code of conduct for meetings

The Agreement has been reviewed in partnership and largely remain fit for purpose since it's last review in 2016 but the following changes have been made:

- Our UHB values have been updated

- The definitions of how the UHB and Unions will pursuit common objectives have been changed from negotiation, consultation and information to negotiation, consultation and communication to reflect that this is a two way process
- The Union of Construction and Allied Trade Technicans (UCATT) has been removed from the list of recognised Unions following its merger with UNITE
- A commitment to develop an annual staff involvement action plan has been removed as this has been superceded by other means of partnership working
- Reference to the Health and Safety Representatives has been incorporated

In addition, the style and layout of the Agreement has been changed with the aim of making it a more engaging and accessible document.

Recommendation:

That the revised UHB Partnership and Recognition Agreement is approved and given a new review date of July 2024.

The Board is requested to:

Approve the revised Partnership and Recognition Agreement

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		Involvement	

Equality and Health Impact Assessment Completed:	No

Reference Number: UHB 025
Version Number: 3
Approved By: UHB Board

Approval Date: dd mmm yyyy
Next Review Date: dd mmm yyyy
Date of Publication: dd mmm yyyy

Partnership & Recognition Agreement

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

Cardiff And Vale University Local Health Board

Partnership & Recognition Agreement

The Cardiff and Vale University Local Health Board (the UHB) is committed to working in partnership with recognised Trade Unions and Professional Staff Organisations.

The UHB will negotiate and discuss strategic issues with staff representatives and involve them in the decision making process to shape the Health Board's services.

Representatives and managers are required to work collaboratively for the benefit of staff, patients, visitors, relatives and the Health Board.

Charles Janczewski
Chair

Len Richards
Chief Executive

Dawn Ward
Chair of Staff Representatives

Contents

01 Introduction

The Health Board is committed to the partnership agenda with its employees to ensure that they can be involved in the decisions that affect them and the services they provide for patients.

The Health Board objective of delivering the highest quality services possible can only be achieved by a workforce that is sufficiently skilled, committed and feels valued. This agreement is intended to help further embed partnership working within the culture and practice of the organisation at all levels.

The Health Board will ensure that managers are committed to an open and participative working style by being honest, open and fair in their relationships with staff. Managers will demonstrate this through their own behaviour and the behaviour they expect from their staff.

02 Principles of Partnership Working

To deliver partnership working successfully, it is important to develop good formal and informal working relations that build trust and share responsibility, whilst respecting difference.

It is a principle of the UHB that all our staff and their representatives are involved at every level in matters affecting their jobs and working lives. This involvement should be at the earliest opportunity, prior to decisions being made.

To facilitate effective partnership working, all parties will commit to adopt the following principles in their dealings with one another:

- Building trust and mutual respect for each other's roles and responsibilities;
- Openness, honesty and transparency
- Top level commitment
- A positive and constructive approach
- Commitment to work and learn from each other
- Early discussion on emerging issues and maintaining dialogue on policy and priorities
- Commitment to ensuring high quality outcomes for service users
- Making the best of available resources
- Ensuring a 'no surprises' culture is maintained.

Working together on a basis of co-operation, openness and mutual trust is acknowledged by both the UHB and Trade Unions to be the best way to enhance the ability of the UHB to adapt to changing circumstances and financial constraints and to ensure the future success of the Health Board in the delivery of high quality patient services and our strategy Shaping Our Future Wellbeing.

The UHB's approach to partnership working is underpinned by our agreed values and behaviours:

We care about the people we serve and the people we work with	Treat people as you would like to be treated and always with compassion
We trust and respect one another	Look for feedback from others on how you are doing and strive for better ways of doing things
We take personal responsibility	Be enthusiastic and take responsibility for what you do.
We treat people with kindness	Thank people, celebrate success and when things go wrong ask 'what can I learn'?
We act with integrity	Never let structures get in the way of doing the right thing.

03 Definitions

3.1.

The UHB and Unions agree that the pursuit of the common objectives, aims and values outlined in the introduction to this agreement shall be by negotiation, consultation and the exchange of information which are defined as follows:

Negotiation
"conferring with another with a view to reaching a compromise or agreement." This is with the understanding that if this cannot be reached after a reasonable period of time, management will make a decision to move things forward.

Consultation
'a process of dialogue that leads to a decision' (Audit Commission). This will ensure the early involvement of Unions on key issues affecting the Health Board with a meaningful opportunity to influence decisions.

Communication
Ensuring that everyone is fully and promptly informed on all relevant matters.

3.2.

The issues to be relayed, consulted upon or negotiated under this agreement concern the Health Board's staff, and will therefore be between the Health Board's management and those accredited representatives of the staff belonging to the organisation listed in 5.1 who are themselves employed by the Health Board.

04 Duties, Responsibilities and Commitment

The following outlines the agreed responsibilities and commitment of the UHB, Staff Representatives and Managers in ensuring effective partnership working:

4.1.

The UHB will be responsible for:

- Developing and implementing an effective two-way communication process across the Health Board.
- Developing a culture where managers involve staff at all times, and as soon as possible, in decision making and where staff feel able to contribute and be confident that their contribution is valued
- Developing and implementing a structure and process which requires managers at all levels to involve staff in day to day service decisions and formulation of service plans
- Developing and implementing a structure that provides Staff Representatives and Managers to input into the formulation of UHB services plans and decisions.
- Appraise and discuss in partnership with Staff Representatives, the financial performance of the UHB on a regular basis
- Ensuring all levels of management are familiar with agreements and arrangements relating to partnership working / staff involvement including the facilities agreement
- Working in partnership to manage change more effectively and achieve long term goals
- Encouraging staff to join a recognised Trade Union, staff organisation or professional organisation. Unions have an important role in representing staff both individually and collectively. As members of a Trade Union participating in the Health Board's joint negotiation / consultation machinery, staff are able to influence plans and decisions relating to employment
- Recognising and acknowledging the Unions' right and responsibility to represent the interests of their members and to work for improved conditions of employment for the employees covered by this agreement.
- Ensure Staff Representatives are afforded reasonable paid time off to undertake their duties and activities

4.2.

Staff Representatives will be responsible for:

- Recognising and acknowledging that it is the responsibility of the Health Board's management to determine the most effective way of planning, organising and managing the activities of the Health Board according to the objectives set by the Health Board.
- Accepting that management has a responsibility to keep employees directly informed on matters concerning the activities of the Health Board, but this does not obviate the requirement under this agreement to negotiate or consult through the recognised machinery on matters covered by this agreement.

- Ensuring that their representatives are at all times committed to an open and participative working style. Staff and their representatives will demonstrate this through their own behaviour and the behaviour that they expect from colleagues.
- Ensuring their time and resources are used appropriately and cost effectively
- Ensuring that decisions reached in partnership will be supported through implementation
- Communicating effectively with their members to ensure that they fully represent their views
- Support the correct, appropriate and efficient application of Health Board Policies and Procedures
- Agree to maintain confidentiality regarding sensitive issues
- Demonstrating joint commitment to the success of the organisation with a positive and constructive approach
- Ensuring that representatives are elected and accredited in accordance with Trade Union constitutions
- Provision of appropriate training for representatives and members either separately or jointly in partnership

4.3.

Managers will be responsible for:

- Communicating and engaging with staff on a regular basis and keep them informed of developments across the organisation
- Encourage staff and their representatives to be involved at the earliest stages of any new developments
- Ensure that staff representatives are released to support the engagement and partnership work of the Health Board
- Ensure that the views of the staff are passed up the organisation, as well as communicating the views of the Executives and the Health Board
- Encourage and support staff to challenge and question systems of work
- Staff involvement taking place throughout the organisation, irrespective of boundaries of profession, service and functional structure
- Staff have the opportunity to express their opinions and be actively involved in issues affecting them
- Ensure that Trade Union representatives have access to all relevant information, other than confidential information about patients or staff, to support involvement in decisions that affect working lives and the delivery of healthcare
- Recognising that staff, and their representatives, must have a degree of protected time away from their place of work to enable them to attend and contribute to the staff involvement process. To achieve this, managers will ensure employees are treated fairly for their Trade Union involvement and careers are not prejudiced

05 Recognition

5.1.
The Health Board agrees to recognise for negotiation, meaningful discussion and debate on key issues and individual representation all Unions nationally recognised and who have members within the Health Board.

British Association of Occupational Therapists	BAOT
British Dental Association	BDA
British Dietetic Association	BDA
British Medical Association	BMA
British Orthoptic Society	BOS
Chartered Society of Physiotherapy	CSP
Federation of Clinical Scientists	FCS
GMB	GMB
Hospital Consultants and Specialists Association	CSA
Royal College of Midwives	RCM
Royal College of Nursing	RCN
Society of Chiropodists and Podiatrists	SOCP
Society of Radiographers	SOR
UNISON	UNISON
UNITE	UNITE

5.2.
Any Union listed which ceases to have any members employed by the Health Board will cease to be recognised under this Agreement.

If this Union subsequently gains members and wishes to become recognised again they should follow the process set out in the Trade Union and Labour Relations (Consolidation) Act 1992.

06 Scope of Recognition

6.1.
This agreement will cover major issues of Health Board policy including:

- Organisational culture
- Organisational change
- Employment security
- Employment practices (e.g. family friendly, best practice, equal opportunities, health and safety at work, etc)
- Lifelong learning
- Employee Health and Wellbeing

6.2.
In addition this agreement will cover such other matters agreed as being of common interest, for example:

- Terms and Conditions of employment
- Allocation of work and duties of employment
- Matters of Discipline / Grievance
- Facilities and time off for Union Officials
- Machinery for consultation and negotiation and any procedures relating to the above and other relevant matters.
- Union membership or non-membership

07 Work Place Representatives

7.1.
In order to ensure appropriate representation of Union members and their interests, the Unions will make arrangements from among their members, who are employees of the Health Board, for such numbers of representatives as are appropriate to provide adequate representation. The election of representatives and officials shall be determined by the individual Unions in accordance with their Rules. The names of representatives, the constituencies they represent or function they carry out, and their term of office, will be notified in writing to the Executive Director of People and Culture, who will be notified of any changes in the Union representatives or officials.

7.2.
On receipt of details or amendments, the Executive Director of People and Culture will formally accredit the nomination, ensure the provision of facilities to accredited representatives and inform the appropriate manager(s).

7.3
The Health Board will provide time off and facilities in accordance with current legislation, and the relevant Code of Practice. Details of time off and facilities are outlined in the Time Off and Facilities for Accredited Representatives document which forms part of this Agreement.

7.4.
The Health Board recognises the value of work place representatives and will ensure that representatives suffer no detriment in relation to career progression as a result of their role.

7.5.
It is acknowledged that there will be circumstances where it is beneficial for Full Time Officers to be involved. Full Time Officers may therefore be involved at the request of the local representatives, following prior notification to management and in accordance with any constitutional arrangements agreed for any joint forum.

7.6.
The Health Board also recognises the role and contribution of Union Learning Representatives in accordance with the provisions of the Employment Act 2002, and the role of Health and Safety Representatives

08 Communication

8.1.
The Health Board will provide timely information required for collective bargaining purposes, in accordance with current legislation and Code of Practice.

8.2.
The Health Board will also seek to ensure that its' Communication Policy and practices ensure that all staff are able to be informed of the Health Board's plans, objectives and progress.

8.3.
The Unions will supply to the Health Board, upon request, a copy of their rules, either free or at a reasonable charge.

09 Negotiation / Consultation Machinery

9.1.
The NHS Terms and Conditions handbook requires that Joint Consultation arrangements should be set up in agreement with employee representatives. Agreement should be reached on a number of issues, including:

- Size and composition of the committee
- Organisation of committee meetings
- Subjects to discuss
- Facilities for committee members; and
- Arrangements for reporting back

9.2.
Detailed arrangements for the working of the Health Board's Local Partnership Forum are outlined in the Terms of Reference for that committee and form part of this agreement, and are attached as Appendix 1.

10 Review

10.1.
This agreement may be amended at any time following agreement by both parties.

10.2.
The operation of the agreement will be reviewed after a period of 3 years from its commencement.

Appendix 1

Local Partnership Forum

Terms of Reference and Operating Arrangements

01 Introduction

1.1.
The Cardiff and Vale University Health Board Local Partnership Forum (LPF) is the formal mechanism where the Health Board and trade unions* work together to improve health services for the people of Cardiff and the Vale of Glamorgan and for others accessing services provided by the Health Board. It is the forum where key stakeholders will engage with each other to inform, debate and seek to agree local priorities on workforce and health service issues.

1.2
Cardiff and Vale University Health Board (the UHB) will engage staff organisations in the key discussions at the UHB Board, UHB Partnership Forum and Locality/Clinical Board level.

1.3
The UHB LPF will provide the formal mechanism for consultation, negotiation and communication between the Unions and management. The TUC principles of partnership will apply the principles are attached at Annex 1.

** all references to Trade unions include Trade Unions, Professional Staff Organisations and Staff Associations*

General Principles

1.4.
The Partnership Forum accepts that partnerships help the workforce and management work through challenges and to grow and strengthen their organisations. Relationships are built on trust and confidence and demonstrate a real commitment to work together.

The principles of true partnership working between Trades Union and Management are as follows:

- TU's and management show joint commitment to the success of the organisation with a positive and constructive approach
- they recognise the legitimacy of other partners and their interests and treat all parties with trust and mutual respect
- they demonstrate commitment to security for workers and flexible ways of working
- they share success – rewards must be felt to be fair
- they practice open and transparent communication – sharing information widely with openness, honesty and transparency
- they must bring effective representation of the views and interests of the workforce
- they must demonstrate a commitment to work with and learn from each other.

All members must:

- be prepared to engage with and contribute fully to the Forum's activities and in a manner that upholds the standards of good governance set for the NHS in Wales
- comply with their terms and conditions of appointment

- equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes, and
- promote the work of the LPF within the professional discipline he/she represents.

A Code of Conduct is attached as Annex 2.

02 Purpose

2.1.

The purpose of the UHB Local Partnership Forum is to:

- establish a regular and formal dialogue between the UHB Executive and the Trade Unions on matters relating to workforce and health service issues
- enable Employers and Trade Unions to put forward issues affecting the workforce
- provide opportunities for Trade Unions and Managers to input into UHB service development plans at an early stage
- consider the implications on staff of service reviews and identify and seek to agree new ways of working
- consider the implications for staff of NHS reorganisation at a national or local level and to work in partnership to achieve the mutually successful implementation
- appraise and discuss in partnership the financial performance of the organisation on a regular basis
- appraise and discuss in partnership the UHB service and activity and its implications
- provide opportunities to identify and seek to agree quality issues, including clinical governance, particularly where such issues have implications for staff
- communicate to the partners the key decisions taken by the Health Board and senior management
- consider national developments in NHS Wales Workforce Strategy and the implications for the UHB including matters of service re-profiling
- negotiate on matters subject to local determination
- ensure Trade Union representatives are afforded reasonable paid time off to undertake trade union duties
- develop in partnership appropriate facilities arrangements using Agenda for Change Facilities Agreement as a minimum standard.

In addition the Health Board will establish Clinical Board Partnership Forums to establish ongoing dialogue, communication and consultation on service and operational management issues specific to Clinical Board areas. Each Clinical Board will have a 'Lead' Staff Representative who will jointly chair the Clinical Board Partnership Forum. Each Clinical Board Partnership Forum will report to the Health Board Local Partnership Forum.

03 Delegated Powers and Authority

3.1.

The Partnership Forum may establish sub committees or task and finish groups to carry out on its behalf specific aspects of Forum.

Three sub-groups have been established, namely the Employment Policies sub-group (EPSG), the Workforce Partnership Group (WPG) and the Staff Benefit's Group.

3.1.1.

Employment Policies Sub Group

Local Employment Policies will continue to be developed in partnership. For each policy a nominated Management and Staff representative will jointly develop the policies, seeking views/comments from management and staff colleagues. Each Policy will be subject to an Equalities Impact Assessment.

The proposed policies will be submitted to the Health Board Partnership Forum for consideration with final approval being made by the Health Board's Strategy and Delivery Committee.

The EPSG will approve all employment and other related Human Resources (HR), Workforce and Organisational Development (OD) procedures and other written control documents

3.1.2.

Workforce Partnership Group

The Workforce Partnership Group (WPG) has been created to provide a forum for the Health Board and Trade Unions to work together on issues of service development, engagement and communication specifically as they affect the workforce

The purpose of the WPG is to provide a focused opportunity to establish a regular and formal dialogue between the Director of Workforce and OD and the Trade Unions on matters relating specifically to workforce issues.

3.1.3

Staff Benefits Group

Cardiff and Vale University Health Board is one of the major employers in Wales with over 15,000 staff.

Given the size of the organisation this provides a great opportunity to ensure all staff has exclusive access to a comprehensive range of specially selected products and services. As an employee of the Health Board this will provide money saving discounts and extra value for money on special and everyday purchases.

The Health Board has established a "Staff Benefits Group" to explore and maximise benefits for staff, and advising the Local Partnership Forum (LPF).

04 Membership

Members

4.1

All members of the LPF are full and equal members and share responsibility for the decisions of the LPF. The Health Board shall agree the overall size and composition of the LPF in consultation with those Trades Unions it recognises. The UHB's Trade Union Independent Member will be expected to attend the LPF in an ex-officio capacity. As a minimum, the membership of the LPF shall comprise:

Chair
Joint chairmanship by the Executive Director of People and Culture and Chair of Staff Representatives

Members
Management Representatives
Chief Executive
Executive Director of Finance
Medical Director
Executive Director of Nursing
Executive Director of Planning
Executive Director of Therapies and Health Sciences
Chief Operating Officer
Executive Director of People and Culture (Chair)
Director of Corporate Governance
Director of Communications and Engagement
Assistant Director of Organisation Development
Assistant Director of Workforce
Head of Workforce Governance
Peter Welsh, Hospital General Manager, UHL and Barry

Staff Representatives
The Health Board recognises those Trade Unions listed in Annex 3 for the representation of members who are employed by the organisation.

It will be the prerogative of the staff representatives to decide on the formula to achieve the maximum number of representatives. This can be reviewed locally as required.

Standing Invitation Independent Member (Trades Unions)

4.2.

Staff representatives must be employed by the organisation and accredited by their respective organisations. If a representative ceases to be employed by the Health Board or ceases to be a member of a nominating organisation then he/she will automatically cease to be a member of the LPF. Full Time Officers of the Trade Unions may attend meetings subject to prior notification and agreement.

4.3

Members of the Forum who are unable to attend a meeting may send a suitable deputy who will contribute to the meeting being quorate.

4.4.

Consistent attendance and commitment to participate in discussions is essential. Where a member of the Forum does not attend within a year (except for reasons of sickness, pre-planned annual leave, maternity leave, etc.), the Joint Chairs will write to the member and bring the response to the next meeting for further consideration and possible removal from the Forum.

In attendance

4.5.

By invitation
The LPF Joint Chairs may invite:
any others from within or outside the organisation to attend all or part of a meeting to assist it with its discussions on any particular matter

Chairs

4.5

The Executive Director of People and Culture and Staff Representatives' Chair will co-chair the LPF. The Chairs shall work in partnership with each other and, as appropriate, with the Chairs of the Health Board's other advisory groups. Supported by the Workforce Governance Manager, Chairs shall ensure that key and appropriate issues are discussed by the Forum in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions. Vice Chairs will be identified.

Secretariat

4.8

The Workforce Governance Manager will act as Secretary and will be responsible for the maintenance of the constitution of the membership, the circulation of agenda and minutes and notification of meetings.

4.9

Consistent attendance and commitment to participate in discussions is essential. Where a member of the Forum does not attend within a year (except for reasons of sickness, pre-planned annual leave, maternity leave, etc.), the joint Chairs will write to the member and bring the response to the next meeting for further consideration and possible removal from the Forum.

05 Committee Meetings

Quorum

5.1

There should be 6 management representatives and 6 staff representatives for the meeting to be quorate.

5.2

If the meeting is not quorate no decisions can be made but information may be exchanged and recommendations can be endorsed at the next meeting (when quorate).

Frequency of Meetings

5.3

Meetings will be held bi monthly but this may be changed to reflect the need of either staff or management representatives.

5.4

Where joint chairs agree extraordinary meetings may be scheduled with 7 calendar days notice.

Management of Meetings

5.6

The business of the meeting shall be restricted to matters pertaining to Health Board Wide strategic issues. Local operational issues should be raised at the Clinical Board Partnership Forums and will not be considered unless it is agreed that such issues have Health Board wide implications.

The agenda and papers shall be sent out no later than 7 days prior to the following meeting. Items for the agenda and supporting papers should be notified to the LPF Secretary as early as possible, and in the event at least three weeks in advance of the meeting.

06 Reporting and Assurance Arrangements

6.1

The LPF shall:

- report each of its meetings formally to the Board via submission of its minutes;
- bring to the Board's specific attention any significant matter under consideration by the Forum;

07 Review

7.1

These terms of reference and operating arrangements shall be reviewed as directed by Welsh Government following recommendation by the NHS Wales Partnership Forum or as and when required by the Health Board.

Annex 1

Six TUC Principles of Partnership Working

- a shared commitment to the success of the organisation
- a focus on the quality of working life
- recognition of the legitimate roles of the employer and the trade union
- a commitment by the employer to employment security
- openness on both sides and a willingness by the employer to share information and discuss the future plans for the organisation
- adding value – a shared understanding that the partnership is delivering measurable improvements for the employer, the union and employees

Annex 2

Code of Conduct

A code of conduct for meetings sets ground rules for all participants: -

- Respect the meeting start time and arrive punctually
- Attend the meeting well-prepared, willing to contribute and with a positive attitude
- Listen actively. Allow others to explain or clarify when necessary
- Observe the requirement that only one person speaks at a time
- Avoid 'put downs' of views or points made by colleagues
- Respect a colleague's point of view
- Avoid using negative behaviours e.g. sarcasm, point-scoring, personalisation

- Try not to react negatively to criticism or take as a personal slight
- Put forward criticism in a positive way
- Be mindful that decisions have to be made and it is not possible to accommodate all individual views
- No 'side-meetings' to take place
- Respect the Chair
- Failure to adhere to the Code of Conduct may result in the suspension or removal of the member
- Be mindful of other agenda items when delivering to ensure that the meeting runs on time.

Annex 3

List of Recognised Trade Unions

British Association of Occupational Therapists
British Dental Association
British Dietetic Association
British Medical Association
British Orthoptic Society
Chartered Society of Physiotherapy
Federation of Clinical Scientists
GMB
Hospital Consultants and Specialists Association
Royal College of Midwives
Royal College of Nursing
Society of Chiropodists and Podiatrists
Society of Radiographers
UNISON
UNITE

Appendix 2

Welsh Partnership Forum Time Off And Facilities For Trade Union Representatives

Key Principles Framework November 2011

Introduction

1. The Welsh Partnership Forum is committed to the principles of partnership working and staff involvement. Partnership underpins and facilitates the development of sound and effective employee relations throughout the NHS. It also recognises that the participation of trade union representatives in the partnership process can contribute to delivering improved services to patients and users.
2. The Welsh Partnership Forum recognises the importance of ensuring that the representatives of trade unions recognised for purposes of collective bargaining at local level are released appropriately to participate in local partnership arrangements. The principles of partnership working are set out in the annex to this document.
3. It is for employers and representatives of locally recognised trade unions to agree in partnership local arrangements and procedures on time off and facilities that are appropriate to meet local circumstances. Local arrangements are expected to be consistent with the principles set out below.

Time Off for Accredited Trade Union Representatives

Accredited Representatives

4. Local arrangements should apply to accredited representatives of trade unions recognised by local NHS organisations. Accreditation will only be given to employees of the organisation who have been duly elected or appointed in accordance with the rules of the respective trade unions.
5. Accredited representatives of trade unions will:
   Abide by the rules of their trade union and the policies and procedures of the employing organisation. Represent their members on matters that are of concern to the employing organisation and/or its employees.
6. It will be for the relevant trade unions to discuss and agree with the local employer an appropriate number of representatives. Local discussions should have regard to the size and location of the unions' membership and the expected workload associated with the role. The unions would be required to issue written credentials and notify the human resources department of the number and location of work groups for which each representative will be responsible.
7. Subject to the needs of the service and adequate notification, accredited representatives should be permitted paid time off, including time to prepare for meetings and disseminate information and outcomes to members, during working hours to carry out duties that are concerned with any aspect of:-

- Negotiation and/or consultation on matters relating to terms and conditions of employment or agreed partnership processes – examples include:
  - terms and conditions of employment;
  - engagement or termination of employment;
  - allocation of work;

- matters of discipline;
- grievances and disputes;
- union membership or non-membership;
- facilities for trade union representatives;
- machinery for negotiation or consultation or other procedures.

- Meetings with members;
- Meetings with other lay officials or full time officers;
- Appearing on behalf of members before internal or external bodies;
- All joint policy implementation and partnership working;
- Environmental issues linked to the Green workplaces projects;
- Other matters relating to employee relations and partnership working

8. The expectation is that it is good practice that staff representatives should indicate the general nature of the business for which time off is required, where they can be contacted if required. Requests should be made as far in advance as possible as is reasonable in the circumstances. Wherever possible, the representatives should indicate the anticipated period of absence. The expectation is that requests for paid time off for trade union representatives will not be unreasonably refused.

Training

9. Accredited trade union representatives should be given adequate time off to allow them to attend trade union approved training courses or events. Time off should not be regarded as automatic, as employers have responsibilities to take account of the needs of service delivery. However, the expectation is that requests for paid time off to attend training courses should not be unreasonably refused as long as locally agreed processes are followed.
10. The expectation is that requests for release for training should be made with reasonable notice to the appropriate manager. Any training course should be relevant to their duties approved by their trade union. Local representatives should provide details of the course to local management.

Payment Arrangements

11. Where time with pay has been approved, the payment due will equate to the earnings the employee would otherwise have received had/she been at work.
12. Where meetings called by management are held on matters covered by paragraphs 7 where staff representatives have to attend outside their normal working hours, equivalent time off will be granted or appropriate payment should be made by local agreement.
13. There should be local agreement on when travelling and subsistence expenses will be reimbursed to accredited representatives who are undertaking approved work in relation to the partnership process and/or joint policy implementations (as listed in paragraph7).

Trades Union Activities

14. It is the responsibility of the recognised local trade unions to ensure that the time and resources provided in this context are used appropriately.
15. NHS organisations are encouraged to support partnership

working, by giving reasonable time off, during working hours to enable trade union members or representatives for:-

- executive committee meetings or annual conference or regional union meetings;
- voting in properly conducted ballots on industrial relations;
- voting in union elections;
- meetings to discuss urgent matters relating to the workplace;
- recruitment and organisation of members.

16. Local arrangements should specify the circumstances when time off may be refused for either representatives or members. These may include:-

- unreasonable notice periods on behalf of the representatives
- activities which do not fall within the any of the categories in paragraphs 7, 10 and 15;
- activities are not authorised by the union
- service needs;

17. Locally, it may be agreed that it is appropriate in the interests of partnership working and good industrial relations for trade union representatives to be released from work for regular defined periods each week.

Trade Union Learning Representatives

18. Trade Union Learning representatives are accredited by their unions to support organisations in identifying training needs and ensuring staff access to training. Learning representatives also have the right to reasonable paid time off for undertaking these duties and for relevant training.

Health and Safety Representatives

19. The Safety Representatives and Safety Committee Regulations 1977 provides a legal entitlement for trade union appointed safety representatives to have paid time from their normal work to carry out their functions and undergo training

Facilities For Trades Union Representatives

20. The local partnership should agree the facilities that are provided to representatives of recognised trade unions. It is recommended that local employers provide the following facilities:-

- Access to appropriate private accommodation, with storage facilities for documentation, appropriate administrative facilities and access to meeting rooms.
- Access to internal and external telephones with due regard given for the need for privacy and confidentiality.
- Access to appropriate internal & external mail systems.
- Appropriate access to the employer's intranet and email systems.
- Access to appropriate computer facilities
- Access to sufficient notice boards at all major locations for the display of trade union literature and information.

- Access for staff representatives to all joint documents relating to the local partnership process.
- Based on the geographical nature of the organisation consideration may need to be given to access to suitable transport facilities.
- Backfilling of posts where practical. The extent to which practical would inevitably be dependent on such factors as the numbers of representatives needing time off and the work areas that would need to be covered and the needs of the service.

Annex

Principles and Best Practice of Partnership Working

[Taken from: Partnership Agreement. An agreement between Department of Health, NHS Employers and NHS Trade Unions.]

To deliver partnership working successfully it is important to develop good formal and informal working relations that build trust and share responsibility, whilst respecting difference. To facilitate this, all parties commit to adopt the following principles in their dealings with each other:

- Building trust and a mutual respect for each other's roles and responsibilities;
- Openness, honesty and transparency in communications;
- Top level commitment;
- A positive and constructive approach;
- Commitment to work with and learn from each other;
- Early discussion of emerging issues and maintaining dialogue on policy and priorities;
- Commitment to ensuring high quality outcomes;
- Where appropriate, confidentiality and agreed external positions;
- Making the best use of resources;
- Ensuring a no surprise culture.

Report Title:	**Committees of the Board - Membership**	**Agenda Item no.**	**7.8**
Meeting:	**Board**	**Meeting Date:**	**29th July 21**
Status:	**For Discussion** / **For Assurance** / **For Approval** / **For Information**		
Lead Executive:	**Chair of the Board**		
Report Author (Title):	**Director of Corporate Governance**		

Background and current situation:

The Membership of the Committees of the Board was last reviewed in November 2019 and since that time there has been a number of changes in both Independent Members and Executive Directors. Most recently we have appointed the following three new Independent Members:

- Vice Chair
- Independent Member ICT
- Independent Member Trade Unions

It is important that the Committees of the Board are properly constituted to ensure the right number of Members are appointed to the Committee, that meetings are quorate and that Members with the right specialisms/ experience/interests are also on the right Committee.

Under Standing Orders 3.4.5 Membership of Committees including the designation of Chair will be determined by the Board on the recommendation of the Chair of the Board and subject to specific requirements, directions and regulations made by the Welsh Ministers.

The Chair of the Board has considered the Membership of each Committee and has discussed this with each Independent Member.

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

Attached at Appendix 1 is the recommended Membership for the Committees of the Board. The Chair has agreed with individual Independent Members the changes which are detailed.

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

There are no risks associated with the approval of Committee Membership.

Recommendation:

The Board is asked to:

- Approve the Membership of the Committees of the Board and specifically approve the changes detailed within the last column of appendix 1 with effect from 1st August 2021.

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
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		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:	~~Yes / No /~~ Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

COMMITTEE MEMBERSHIP **With effect From 1st August 2021**

	Committee	Members	Chair	Vice Chair	Exec Lead	Quorum	Actions to approve at Board
1.	Audit & Assurance (3 Independent Members)	John Union Ceri Phillips Mike Jones David Edwards	John Union	David Edwards	Catherine Phillips	2 members (one must be Chair or Vice Chair)	1. Approve Ceri Phillips, Mike Jones and David Edward as Members of the Audit Committee 2. Approve David Edwards as Vice Chair of the Audit Committee 3. Approve Catherine Phillips as Executive Lead
2.	Quality, Safety and Experience (4 Independent Members)	Susan Elsmore Gary Baxter Mike Jones Akmal Hanuk Ceri Phillips	Susan Elsmore	Ceri Phillips	Ruth Walker Stuart Walker	3 Members (one must be Chair or Vice Chair)	1. Approve Mike Jones, Akmal Hanuk and Ceri Phillips as Members of the Committee 2. Approve Ceri Phillips as Vice Chair of the Committee
3.	Strategy and Delivery (3 Independent Members)	Michael Imperato Sara Mosely Gary Baxter Rhian Thomas Ceri Phillips	Michael Imperato	Sara Mosely	Abigail Harris	2 Members (one must be Chair or Vice Chair)	1. Approve Ceri Phillips as a Member of the Committee
4.	Finance (3 Independent Members)	Rhian Thomas John Union David Edwards	Rhian Thomas	John Union	Catherine Phillips	2 Members (one must be Chair or Vice Chair)	1. Approve David Edwards as a Member of the Committee 2. Approve Catherine Phillips as Executive Lead
5.	Mental Health and Capacity Legislation (4 Independent Members)	Ceri Phillips Sara Mosely Akmal Hanuk	Ceri Phillips	Sara Moseley	Steve Curry	2 Members (one must be Chair of Vice Chair)	1. Approve Ceri Phillips as Member and Chair of the Committee 2. Approve Sara Moseley as Vice Chair
6.	Digital Health Intelligence (3 Independent Members)	David Edwards Michael Imperato Gary Baxter Sara Moseley	David Edwards	Michael Imperato	Len Richards	2 Members (one must be Chair or Vice Chair)	1. Approve David Edwards and Sara Mosely as Members of the Committee

							2. Approve David Edwards as Chair of the Committee
7.	Charitable Funds (6, 3 Independent Members and 3 Executive Director Members)	Akmal Hanuk Sara Mosely Fiona Jenkins Ruth Walker Rachel Gidman Susan Elsmore Mike Jones	Akmal Hanuk	Mike Jones	Ruth Walker	3 members (one must be Chair of Vice Chair)	1. Appoint Rachel Gidman and Mike Jones as Members of the Committee 2. Appoint Mike Jones as Vice Chair of the Committee
8.	Health and Safety (3 Independent Members)	Mike Jones Michael Imperato Akmal Hanuk Ceri Phillips	Mike Jones	Akmal Hanuk	Rachel Gidman	2 Members (one must be Chair or Vice Chair)	1. Appoint Mike Jones and Ceri Phillips as Members of the Committee 2. Appoint Mike Jones as Chair of the Committee 3. Appoint Akmal Hanuk as Vice Chair of the Committee 4. Appoint Rachel Gidman as Executive Lead of the Committee
9.	Future Hospitals (UHW2)	Rhian Thomas John Union David Edwards Gary Baxter	Rhian Thomas	John Union	Abi Harries	3 Members (one must be Chair or Vice Chair)	1. Appoint Rhian Thomas, John Union, Gary Baxter and David Edwards as Members of the Committee 2. Appoint Rhian Thomas as Chair of the Committee 3. Appoint John Union as Vice Chair of the Committee
10.	Remuneration and Terms of Service (4 Independent Members)	Jan Janczewski Ceri Phillips Susan Elsmore John Union Michael Imperato Rhian Thomas (Co-opt as necessary)	Jan Janczewski	Ceri Phillips	Len Richards	3 members (one must be Chair of Vice Chair)	1. Appoint Ceri Phillips and Rhian Thomas to the Committee 2. Appoint Ceri Phillips as Vice Chair to the Committee

Report Title:	**Digital and Health Intelligence Committee – Terms of Reference**								
Meeting:	Board						**Meeting Date:**	29th July 2021	
Status:	**For Discussion**		**For Assurance**		**For Approval**	**x**	**For Information**		
Lead Executive:	**Director of Corporate Governance**								
Report Author (Title):	**Director of Corporate Governance**								

Background and current situation:

In line with the UHB's Standing Orders, Terms of Reference for Committees of the Board, should be reviewed and approved by the Board on an annual basis.

This Committee was established as a Committee of the Board in 2019 prior to that it was a sub Committee of the Strategy and Delivery Committee. This was rectified due to the fact that within the Health Boards Standing Orders its states that a Committee for the Board should be established which deals with Information Technology.

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

The Terms of Reference for the Digital and Health Intelligence Committee were last reviewed in March 2020 and approved by the Board in March 2020. Only a few changes have been recommended to the Terms of Reference and these are shown as tracked changes.

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

The Terms of Reference for the Digital and Health Intelligence Committee have been reviewed by the Director of Corporate Governance, Chair of the Committee and the Director of Digital and Health Intelligence. They were reviewed by the Digital Health Intelligence Committee on 1st June and recommended for approval to the Board.

Recommendation:

The Board is asked to:

(a) Approve the changes to the Terms of Reference for the Digital and Health Intelligence Committee

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	
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x

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

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, 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.*

Digital and Health Intelligence Committee (DHIC)

Terms of Reference

Approved by the Board: ~~26th March 2020~~29th July 2021

Next Review Due: ~~March~~ February ~~2021~~2022

DIGITAL AND HEALTH INTELLIGENCE COMMITTEE

TERMS OF REFERENCE AND OPERATING ARRANGEMENTS

1. INTRODUCTION

1.1 The UHB Standing Orders provide that "*The Board may and, where directed by the Welsh Government must, appoint Committees of the LHB Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*".

1.2 In line with Standing Orders (3.4.1) and the UHB Scheme of Delegation, the Board shall nominate annually a committee to be known as the **Digital and Health Intelligence Committee**. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set out below.

1.3 Digital & Health Intelligence Committee comprises Information Technology, Business Intelligence/Analytics, Information Management, Information Governance, Clinical Coding. It includes some specific IT project teams including those managing the PARIS system, use for mental health/Community services and local management of the Welsh Clinical Portal. Its function is to provide enabling services across the UHB to support the effective use of technology and the use of data/intelligence in the delivery of services.

2. PURPOSE

The purpose of the DHIC is to:

2.1 Provide **assurance** to the Board that;

- Appropriate processes and systems are in place for data, information management and governance to allow the UHB to meet its stated objectives, legislative responsibilities and any relevant requirements and standards determined for the NHS in Wales.
- There is continuous improvement in relation to information governance within the UHB and that risks arising from this are being managed appropriately.
- Effective communication, engagement and training is in place across the UHB for Information Governance

2.2 Seek assurance on the development and delivery of a Digital Strategy (which encompasses the areas detailed in paragraph 1.3 above) for the UHB ensuring that:

- It supports Shaping our Future Wellbeing and detail articulated within the IMTP
- Good partnership working is in place
- Attention is paid to the articulation of benefits and an implementation programme of delivery
- Benefits are derived from the Digital Strategy

3. DELEGATED POWERS AND AUTHORITY

~~In order to~~To achieve its ~~purpose~~purpose, the DHIC must receive assurance that:

- The UHB has an appropriate framework of policies, procedures and controls in place to support consistent ~~standards based~~standards-based processing of data and information to meet legislative responsibilities.
- Accepted r~~R~~ecommendations made by internal and external reviewers are considered and acted upon on a timely basis.
- A risk register is in place and that risks are being appropriately identified, assessed and mitigated at all levels in relation to information governance, management and technology.
- Statutory and mandatory requirements are being met such as Caldicott Guardian, FOI, GDPR etc.

~~In order to~~To do this the Committee will take the following actions:

3.1 Approve policies and procedures in relation to the Strategy

3.2 Receive assurance that all statutory and mandatory requirements are being met such as Caldicott Guardian, FOI, GDPR etc.

3.3 Receive assurance on the delivery and implementation of the strategy and associated work plan.

3.4 Receive assurance on clinical and staff engagement of the digital agenda.

3.5 Receive, by exception, data breach reports on the following areas:

- Serious reportable data breaches to the Information Commissioner (ICO) and the Welsh Government and any near misses that may be informative for the Committee.
- Sensitive information (break glass system)
- E-mail
- National and local auditing such as NIIAS
- freedom of information,
- subject access requests
- Data Quality
- IG risk assessments
- Incidents – lessons learned from all recorded / reported incidents.

3.6 Receive periodic reports on development, procurement and implementation of national and local IM&T systems

3.7 Review risks:

- Periodically consider risks escalated to the Committee from Clinical Boards / Corporate Departments in relation to:
  - Information Governance
  - Information Management

- Information Technology

- Review risks escalated to the Committee that have a risk rating of 12 and above.

4. AUTHORITY

4.1 The Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the UHB relevant to the Committee's remit, and ensuring patient/client and staff confidentiality, as appropriate. It may seek relevant information from any:

- employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and
- any other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

4.2 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

5.0 ACCESS

5.1 The Chair of Digital & Health Intelligence Committee shall have reasonable access to Executive Directors and other relevant senior staff.

6.0 SUB COMMITTEES

6.1 The Committee may, subject to the approval of the UHB Board, establish sub committees or task and finish groups to carry out on its behalf specific aspects of Committee business.

7. MEMBERSHIP

Members

7.1 A minimum of four (4) members, comprising:

Chair	Independent member of the Board
Vice Chair	Chosen from amongst the Independent members on the Committee
Members	At least one other independent members of the Board

The committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

Attendees

7.2 In attendance:

		Director of Digital Transformation ~~and Informatics~~
		Director of Digital and Health Intelligence
		~~Assistant Medical Director IT~~Chief Clinical Information Officer
		Director of Corporate Governance
		Data Protection Officer
		Workforce Representative
		Other Executive Directors will attend as required by the Committee Chair
7.3	By invitation	The Committee Chair may invite: - any other UHB officials; and/or - any others from within or outside the organisation - to attend all or part of a meeting to assist it with its discussions on any particular matter.

Secretariat

7.4	Secretary	- As determined by the Director of Corporate Governance

Member Appointments

7.5 The membership of the Committee shall be determined by the Board, based on the recommendation of the UHB Chair - taking account of the balance of skills and expertise necessary to deliver the committee's remit and subject to any specific requirements or directions made by the Welsh Government.

7.6 Committee members' terms and conditions of appointment, (including any remuneration and reimbursement) are determined by the Board, based upon the recommendation of the UHB Chair {and on the basis of advice from the UHB's Remuneration and Terms of Service Committee}.

Support to Committee Members

7.7 The Director of Corporate Governance, on behalf of the Committee Chair, shall:

- arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and
- ensure the provision of a programme of organisational development for committee members as part of the UHB's overall OD programme developed by the Director of Workforce and Organisational Development.

8. COMMITTEE MEETINGS

Quorum

8.1 At least two members of the Committee must be present in addition to the Director of Digital and Health Intelligence and/or an Executive Director to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice Chair.

Frequency of Meetings

8.2 Meetings shall be held no less than three time per year, and otherwise as the Chair of the Committee deems necessary – consistent with the UHB annual plan of Board Business.

Withdrawal of Individuals in Attendance

8.3 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

9. RELATIONSHIP AND ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

9.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

9.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

9.3 The Committee, through its Chair and members, shall work closely with the Board's other committees, including joint (sub) committees and groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business; and
- sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

9.4 The Committee will consider the assurance provided through the work of the Board's other committees and sub groups to meet its responsibilities for advising the Board on the adequacy of the UHB overall framework of assurance.

9.5 The Committee shall embed the UHB's corporate standards, priorities and requirements, e.g., equality and human rights through the conduct of its business.

10. REPORTING AND ASSURANCE ARRANGEMENTS

10.1 The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board and the Accountable Officer on the Committee's activities. This includes verbal updates on activity and the submission of committee minutes and written reports throughout the year;
- bring to the Board and the Accountable Officer's specific attention any significant matters under consideration by the Committee;
- ensure appropriate escalation arrangements are in place to alert the UHB Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the UHB.

10.2 The Committee shall provide a written, annual report to the board and the Accountable Officer on its work in support of the Annual Governance ~~Statement..~~Statement.

10.3 The Board may also require the Committee Chair to report upon the committee's activities at public meetings or to community partners and other stakeholders, where this is considered appropriate, e.g., where the committee's assurance role relates to a joint or shared responsibility.

10.4 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any sub committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Audit Committee Handbook.

11. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

11.1 The requirements for the conduct of business as set out in the UHB Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- quorum (set within individual Terms of Reference)

12. REVIEW

12.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee with reference to the Board.

Report Title:	**Annual Workplan 21-22 - Digital and Health Intelligence Committee**								
Meeting:	**Board**						**Meeting Date:**	29th July 2021	
Status:	**For Discussion**		**For Assurance**		**For Approval**	**x**	**For Information**		
Lead Executive:	**Director of Corporate Governance**								
Report Author (Title):	**Director of Corporate Governance**								

Background and current situation:

The purpose of the report is for Members of the Board to approve the work plan for the Digital Health Intelligence Committee.

The work plan for the Committee should be reviewed on an annual basis to ensure that all areas within its Terms of Reference are being delivered. This work plan was not submitted as the same time as the other Committees due to the appointment of a new Chair to the Digital Health Intelligence Committee and the need to have their input into the work plan prior to Board approval.

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

The work plan for Digital and Health Intelligence Committee 2021/22 has been based on the requirements set out within the Terms of Reference.

The Work Plan should be kept under review to ensure appropriate reporting requirements are met.

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

The Work Plan provides a structure for reporting to ensure that the requirements set out within the Terms of Reference are met.

Recommendation:

For Members of the Board to approve the Digital Health Intelligence Committee Work Plan for 2021/22 on the recommendation of the Digital Health Intelligence Committee who reviewed the work plan at their meeting on 1st June 2021.

Shaping our Future Wellbeing Strategic Objectives

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

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

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		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:	~~Yes / No /~~ Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Digital Health Intelligence Committee Work Plan 2021-22				
A -Approval D- discussion I - Information	**Exec Lead**	**01-Jun**	**05-Oct**	**01-Feb**
Agenda Item				
Assurance				
Assurance Review on processes and sysems for Data, Information management	DT	D		
Assurance on Information Governance Training, Communications and Engagement Plans	DT		D	
Assurance on the development and the delivery of the Digital Strategy	DT		D	
Review of the framework of policies , procedures and controls	DT	D	D	D
Internal Audit Reviews	DT/NF	D	D	D
WAO Reviews	DT/NF	D	D	D
Other external reviews	DT	D	D	D
Risk Register	DT/NF	D	D	D
Development, procurement and implementation of national and Local IMT systems	DT			D
Statutory and Mandatory Requirements				
Assurance that Caldicott Guardian requirements are met	SW	D	D	D
Assurance that Freedom of Information requirements are met	DT	D	D	D
Assurance that GDPR Compliance is met	DT	D	D	D
Data Breach Reports: Serious Reportable Data Breaches to the ICO Sensitive Information Email National and Local Auditing FOI Subject Access Requests Data Quality Incidents	DT	D	D	D
Policies and Procedures	DT	D	D	D
Digital and Health Intelligence Committee Governance				
Annual Work Plan	NF			A
Self assessment of effectiveness	NF	D		
Induction Support for Committee Members	NF			
Review Terms of Reference	NF			A
Produce Digital and Health Intelligent Committee Annual Report	NF			A
Minutes of Digital and Health IntelligentCommittee Meeting	NF	A	A	A
Action log of Digital and Health Intelligent Committee Meeting	NF	D	D	D

Cover paper for Health Board and Velindre NHS Trust Colleagues on the All Wales Positron Emission Tomography Programme

May 2021

Situation:

On review of the full business case, the Chief Executive Group (CEG) of the NHS Wales Health Collaborative confirmed their support for the All Wales Positron Emission Tomography (PET) Programme Business Case (PBC) on 18 May 2021. At the meeting, the Chief Executives agreed to a request for letters of support from their organisations (being the seven health boards and Velindre NHS Trust) to accompany submission of the PBC to Welsh Government (WG).

The Capital, Estates and Facilities team at WG indicated that they were willing to accept the PBC immediately following this endorsement by CEG. As such, the PBC has been submitted.

Background:

The mandate for this Programme was issued by Andrew Goodall in March 2019, following publication of key strategic reports on both PET and the wider imaging provision in Wales. WHSSC host the Programme Board for this strategic Programme and have used HM Treasury Green Book methodology and extensive engagement to develop the All Wales PET PBC.

The preferred way forward for the programme seeks to have four Projects that will, over the course of five years, update the existing fixed facility at Cardiff, replace mobile scanners with fixed scanners at the Swansea and North Wales sites and at a fourth location (to be defined).

The PBC is primarily a capital funding request business case (£24.881 million) and has focused on the supporting infrastructure for PET-CT service delivery over the next ten years, thus ensuring deliverability and sustainability is at the heart of the overall strategic approach.

Assessment:

There has been wide engagement on the Programme and there is representation from each Health Board and Velindre NHS Trust on the PET Programme Board, in addition to regular updates at the NIPSB. There will be no fundamental change to any referral pathways and the revenue costs required to fund the increase in PET scanning capacity in the future, set out in the business case, will be funded by the commissioning health boards through the usual Integrated Commissioning Plan process.

Recommendation:

We kindly request that Boards issue a letter of support to accompany the PBC submission to WG, addressed to Sian Lewis (Programme SRO). We understand from discussions at the CEG meeting (18 May) that some Health Boards may be able to expedite this. To facilitate the process, we ask that a letter of support is issued as soon as possible, but no later than the week following your July Board meeting.

Programme Business Case
for an All Wales Positron Emission Tomography (PET) Service

May 2021

GIG CYMRU NHS WALES

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)

Welsh Health Specialised Services Committee (WHSSC)

Executive Summary

Introduction

PET-CT has become a central diagnostic tool in the management of cancer, and increasingly in many non-cancer conditions. Its role and the evidence base continue to evolve. Although it is a relatively expensive investigation, when used appropriately, PET-CT can significantly improve clinical decision making, particularly with respect to the appropriate use of complex and expensive specialist treatments.

This is supported by an increasing body of high-quality evidence outlining the contribution of PET to improved patient outcomes. There are many studies that demonstrate the role PET-CT has in accurately determining the staging of certain cancers and subsequent treatment plans, which enables reduction of inappropriate patient management and allows for best prognosis and patient care.

Demand for PET-CT is growing with England realising an approximate 18% rise in demand per annum. However, in Wales, scanning activity levels are low compared with the rest of the UK. It is estimated that in 2020 Wales was performing approximately 33% of the PET scans per head of population compared to England. In addition, NHS Wales has a list of funded indications for PET-CT which is limited compared to England and Scotland. The picture becomes bleaker when comparing performance with the rest of Europe and beyond.

Continuing to meet growing demand by relying on external providers is likely to cost an additional £25.6 million p.a. revenue by 2031/32. This approach would not only prove expensive but would deliver no improvements to the existing service structure. Indeed, without investment, the PET service in Wales would likely be served by expensive external providers, using mobile scanners, and the Welsh NHS would miss the opportunity to build a future-proofed network of centres of excellence.

Shortly after the Welsh Government published the Imaging Statement of Intent (March 2018), the All Wales PET Advisory Group (AWPET) and the Welsh Scientific Advisory Committee (WSAC) produced a report “Positron Emission Tomography (PET) in Wales – Overview and Strategic Recommendations” (November 2018). One of its five key recommendations was that WHSSC should be commissioned to produce a Programme Business Case for PET-CT capacity in Wales that considers increased demand projections, estates, staffing requirements and research.

These reports clearly demonstrates that much like other imaging modalities in Wales, there is an obvious and clear need to address the multifactorial issues facing the PET service including staffing, equipment age, facilities and research, development and innovation (RD&I).

In March 2019, the Director General, Health and Social Service/NHS Wales Chief Executive, Welsh Government endorsed the 2018 AWPET/WSAC report recommendations and outlined the expectations for NHS Wales to collaborate on their implementation. As there was recognition that additional capital investment would be required to develop the service, the Director General requested that WHSSC develop the PBC, with support from the National Imaging Strategic Programme Board (NIPSB), to guide the development of future service provision for the whole of Wales.

WHSSC has led the All Wales PET Programme development and produced this Programme Business Case (PBC) which justifies the rationale to invest in the All Wales PET service.

The resulting PBC assesses future Welsh PET scanning demand needs and focuses on the surrounding infrastructure of PET scanning delivery. As such, it provides a ten-year strategic view of service delivery, in addition to describing the business change and technical aspects of implementation.

Following a robust assessment of options, the PBC identifies the preferred way forward which involves investing in four fixed PET-CT scanners which will reduce the cost pressure by £6.8 million p.a. by providing sufficient capacity for NHS Wales and PETIC to meet demand. WHSSC therefore seeks capital funding of £24.881 million from Welsh Government over five years to invest in equipment and building works required to deliver the preferred way forward.

Confirmed Minutes of the Public Audit and Assurance Committee
Held on Thursday 13 May 2021 9am – 10.30am
Via MS Teams

Chair		
John Union	JU	Independent Member – Finance
Present:		
Ceri Phillips	CP	Vice Chair
Mike Jones	MJ	Independent Member – Trade Union
In Attendance:		
Catherine Phillips	CP	Executive Director of Finance
Ian Virgil	IV	Head of Internal Audit
Jacqueline Evans	JE	Interim Head of Corporate Governance
Mark Jones	MJ	Audit Wales Financial Manager
Nicola Foreman	NF	Director of Corporate Governance
Nigel Price	NP	Local Counter Fraud Specialist
Rachel Gidman	RG	Executive Director of People and Culture
Secretariat		
Nathan Saunders	NS	Corporate Governance Officer
Apologies:		
Anthony Veale	AV	Audit Wales
Darren Griffiths	DG	Audit Wales Manager
David Edwards	DE	Independent Member – ICT

AAC 21/05/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the public meeting.	**ACTION**
AAC 21/05/002	**Apologies for Absence** Members noted that apologies for absence had been received from David Edwards, the Independent Member – ICT, Darren Griffiths, the Audit Wales Manager and Anthony Veale from Audit Wales.	
AAC 21/05/003	**Declarations of Interest** No declarations of interest were noted.	
AAC 21/05/004	**Minutes of the Committee meeting held on 6 April 2021** The minutes of the Committee meeting held on 6 April 2021 were received. **The Committee resolved that:** (a) The minutes of the meeting held on 6 April 2021 be approved as a true and accurate record of the meeting.	

AAC 21/05/005	**Action log following meeting held on 6 April 2021** The action log was received and the CC advised the Committee that all of the actions were in hand, had been completed, were on the agenda for today's meeting or scheduled for a future meeting.	
AAC 21/05/006	**Any other urgent business: To agree any additional items of urgent business that may need to be considered during the meeting** No additional urgent items of business were raised.	

AAC 21/05/007	**Internal Audit Progress Reports**
	
	The Internal Audit Progress Reports were received and the Head of Internal Audit (HIA) provided the Committee with the current position regarding the work to be undertaken by the Audit & Assurance Service as part of the delivery of the approved 2020/2021 Internal Audit plan. The HIA advised that the report was brought to each meeting for assurance and noted:
	
	• 8 audits had not been completed in time to submit to the Committee, however they were anticipated to be finalised to feed into the final annual report and Head of Internal Audit Opinion for 2021,
	• The 8 unfinished audits were:
	  ○ Engagement Around Service Planning,
	  ○ C&W CB – Rostering in Community Children's Nursing,
	  ○ Recruitment & Retention of Staff,
	  ○ Annual Planning Process 2021/2022,
	  ○ Data Quality Performance Reporting,
	  ○ Infrastructure / Network Management,
	  ○ Cyber Security System Follow-up,
	  ○ Shaping Future Wellbeing in the Community Scheme,
	• at the time of producing the report, 3 of the outstanding audits had been issued in draft format with a positive audit assessment rating of "reasonable assurance",
	• a further piece of work had been issued in draft on quality data performance reporting which had also received a positive audit assessment rating of "reasonable assurance",
	
	The Vice Chair (VC) advised that when he had read the information provided on the Consultant Job Planning follow up, he had been surprised to see that it had been given a reasonable assurance given the information contained in the report.
	
	The HIA responded that the Consultant Job Planning Audit had started in May 2018 and it had been given a limited assurance rating. A follow up audit was undertaken in January 2020 and the current "reasonable assurance" assessment rating reflected the latest follow up and the scope focused on the agreed actions that had been implemented and progressed.
	
	The CC noted that a further update would be given in 6 months.	

	The Executive Director of People and Culture (EDPC) advised that the medical workforce work was progressing at pace, they had a CD in place and had increased compliance to 22% and there was confidence this would increase rapidly over the next 6 months. The HIA concluded that there was one remaining outstanding action concerning the Consultant Job Planning Follow Up report which would feed into the CVUHB recommendation tracker to monitor progress in managing the outstanding action. The Committee noted that: • the Health and Care Standards assessment report had been finalised which was a high level review to look at the plans and processes in place, • the internal audit team had also undertaken work on the IM&T control risk assessment, which had been a detailed advisory piece of work that had looked at the overall assurance actions in place concerning IT and Information Governance. Whilst no formal audit assessment rating had been given, information had been provided to managers for them to consider, • there had been one additional report within the CD&T Clinical Board which was being deferred to the 2021/2022 plan and had been agreed with the Clinical Board. The CC queried if the items that did not have a formal assurance rating would be recorded as actions and tracked in the usual way, and the HIA confirmed they would still be included in the formal tracking process. **The Committee resolved that:** a) The Audit & Assurance Committee internal Audit Progress Report, including the findings and conclusions from the finalised individual audit reports be noted. b) The proposed amendment to the Internal Audit Plan for 2020/2021 be approved.	
AAC 21/05/008	**Standing Orders, SFI's, Reservation and Delegation of Powers** The Standing Orders, SFI's, Reservation and Delegation of Powers report was received, and the Director of Corporate Governance (DCG) set out the changes that had been made to the Welsh Government model Standing Orders, Standing Financial Instructions (SFI's), and Reservation and Delegation of Powers. The Committee noted: • The Minister of Health and Social Services wrote to the Chair of the Board on the 7 April 2021 advising that the Board was required to incorporate and adopt the latest review of the NHS Wales model Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions into the Health Board's own standing orders, • Cardiff and Vale University Health Board's (UHB's) Standing Orders were last reviewed in February 2019,	

	• Cardiff and Vale University Health Board's (UHB's) Standing Orders were last reviewed in full in February 2019, • temporary amendments were made to the Standing Orders in July 2020 following the publication of a Welsh Health Circular 2020/11 relating to public appointments in Wales due to COVID-19, **The Committee resolved that:** a) The updated Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions for CVUHB be noted and endorsed for submission to the Board on the 27 May 2021 for final approval.	
AAC 21/05/009	**Compliance with the Corporate Governance Code** The Compliance with the Corporate Governance Code information was received, and the DCG advised that the required annual assessment against the "Corporate Governance Code for Central Government Departments" had been undertaken and that there was a requirement to include the information on CVUHB's accountability report. The Committee noted: • An assessment had been undertaken against the applicable elements of the Corporate Governance Code for Central Government Departments" (the Code) • There were no reported/identified departures from the Code during the reporting period, • The assessment had been informed by the Audit Wales "Doing it Differently, Doing it Right? Governance in the NHS during the COVID-19 crisis – Key themes, lessons and opportunities" report published in January 2021 which focused on how NHS bodies had governed during the COVID-19 crisis, with a particular focus on putting citizens first, decision making and accountability, and gaining assurance. The CC asked if any of the Executive Team had seen the assessment and the DCG responded that they had not but she would take it to the Management Executives (ME) meeting if appropriate. **The Committee resolved that:** a) The assessment of compliance against the UK Code of Corporate Governance for April 2020-March 2021 be noted.	
AAC 21/05/010	**Board effectiveness survey 2020-2021** The Board effectiveness survey 2020-2021 report was received, and the Committee noted: • Section 10.2.2 of CVUHB's Standing Orders stipulates that the Board shall introduce a process of regular and rigorous self-assessment evaluation of its own operations and performance of its Committees, and this is undertaken through an annual Board effectiveness survey,	

- CVUHB had undertaken a review of the Board and its sub-committees, using survey questions derived from best practice guidance, including the NHS Audit Handbook,
- Due to COVID-19 the findings of the 2019-2020 Board and Committee self-assessment for 2019-2020 were provided to the Audit and Assurance Committee on the 17 November 2020,
- The actions completed on the Board Effectiveness Action Plan 2019-2020 following the survey undertaken in 2019-2020,
- The survey questionnaire for the annual Board/Committee effectiveness survey 2020- 2021 was issued in early April 2021 and attained a positive response rate overall,
- For the 2020-2021 self-assessment, the survey was disseminated via Survey Monkey to all Board members enabling an efficient yet effective reflection on Board effectiveness and mirroring the method used for the Committees,
- The overall findings were positive which provided an assurance that the governance arrangements and Committee structure in place were effective,
- Out of the questions posed, room for improvement was identified in 5 areas and a Board Effectiveness Action Plan 2020-2021 had been developed to strengthen and develop the areas identified, the action plan would be progressed via Board Development sessions,
- The individual Board/Committee survey findings would be presented to each relevant Committee for assurance,
- For the 2020-2021 self-assessment, a survey was disseminated via Survey Monkey to all Board members enabling an efficient yet effective reflection on Board effectiveness and mirroring the method used for the Committees.

The DCG advised that there were 5 questions that had suggested a need for Further Improvement, specifically:

- **Board – Question 8** - We Identify and Share Best Practice and benchmark,
- **Charitable Funds Committee Question – 4 -** Committee meetings packages are complete, received with enough lead time for members to give them due consideration and include the right information. Minutes are received as soon as possible after the meeting,
- **Health & Safety Committee – Question 2 -** The Board is active in its consideration of the Committee's composition,
- **Health & Safety Committee – Question 4** - Committee meetings packages are complete, received with enough lead time for members to give them due consideration and include the right information. Minutes are received as soon as possible after the meeting,
- **Quality, Safety, Experience Committee – Question 11 -** The Committee agenda setting process is thorough and led by the Committee Chair.

The DCG advised that there was a requirement to include the information in CVUHB's accountability report.

	The VC asked if the response rate numbers could be misinterpreted as the survey tool used to collect survey responses used bar charts which only took the responses given into consideration, irrespective of the response rate. He also noted the low response rate and if there was asked if work could be undertaken to attempt to increase the responses received. The DCG responded that in future surveys could be sent out earlier which would allow the Corporate Governance team to chase up the members that had not submitted a response. The VC requested that the use of tables to present the information could be presented instead of the bar charts in future, and the DCG responded that the survey process would be revisited and the whole approach would be refreshed and the suggestions made would be included. **The Committee resolved that:** a) The results of the Annual Board Effectiveness Survey 2020-2021, and the action plan for 2020-2021 were noted and will be progressed via Board Development sessions, b) The completed actions within the Board Committee Effectiveness Action plan 2019- 2020 were noted.	
AAC 21/05/11	**Items for Approval & Ratification** There were no items for approval and ratification.	
AAC 21/05/012	**Internal Audit reports for information:** The following Internal audit reports were received: 1. Consultant Job Planning Follow-up: Limited Assurance Report, 2. Health and Care Standards, 3. IM&T Control and Risk Assessment **The Committee resolved that:** (a) The internal audit reports be noted.	
AAC 21/05/013	**Review of the Meeting** The CC asked if attendees were satisfied with the business discussions and format of the meeting, and attendees indicated they were satisfied.	
AAC 21/05/014	**Items to be deferred to Board / Committee** There were no items to be brought to the attention of the Board / Committees.	
AAC 21/05/015	**Date and Time of Next Meeting** The CC thanked everyone for their attendance and contribution to the meeting and confirmed that the next meeting would be held on **Thursday 10 June 2021 (Special Meeting) at 9am.**	

Confirmed Minutes of the Public Audit and Assurance Committee
Held on Thursday 10th June 2021 09:00am – 12:30am
Via MS Teams

Chair		
John Union	JU	Independent Member – Finance
Present:		
Ceri Phillips	CP	UHB Vice Chair
Mike Jones	MJ	Independent Member – Trade Union
In Attendance:		
Aaron Fowler	AF	Head of Legal & Risk
Anthony Veale	AV	Audit Wales
Catherine Phillips	CP	Director of Finance
Chris Lewis	CL	Deputy Director of Finance
Helen Lawrence	HL	Head of Financial Accounts and Services
Ian Virgil	IV	Head of Internal Audit
Mark Jones	MJ	Audit Wales
Nicola Foreman	NF	Director of Corporate Governance
Nigel Price	NP	Local Counter Fraud Specialist
Rachel Gidman	RG	Interim Executive Director of Workforce & OD
Rhodri Davies	RD	Audit Wales
Wendy Wright	WW	Deputy Head of Internal Audit
Secretariat		
Raj Khan	RK	Corporate Governance Officer
Apologies:		
Nigel Price	NP	Local Counter Fraud Specialist

AAC 21/06/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the public meeting and confirmed that the meeting was quorate. The CC advised that the majority of the content was reviewed at the Audit Workshop and the aim of the meeting was to approve all documentation in readiness for the Special Board meeting which would follow later that day.	**ACTION**
AAC 21/06/002	**Apologies for Absence** Apologies for absence were noted.	
AAC 21/06/003	**Declarations of Interest** No Interests were declared.	
AAC 21/06/004	**Report from the Losses and Special Payments Panel** The Deputy Finance Director (DFD) stated that this was the only item of non-accounts business on the agenda and concerned a timing issue regarding losses and special payments approval.	

	The report had been presented because the losses were included within the accounts and would need to be approved before being formally approved in the Annual Report. The report confirmed that the losses and special payments panel met on 18th May 2021 which considered the accounts of the last 6 months of the year. The DFD informed Members that the papers set out recommendations for losses and write offs regarding criminal negligence, personal injury, bad debt, permanent injury, small claims, employment tribunals and stock. The CC queried the net impact loss of the clinical negligence claims of £12.522 million and asked how much was outside the amount that was reclaimed as each claim required the UHB to pay £25,000. The DFD responded that the net costs for clinical negligence and personal injury was £1.2 million. A budget was provided for this at the beginning of the year and was included within financial plans. **The Committee Resolved that:** a) The write offs outlined in the Assessment Section of this report be approved.	
AAC 21/06/005	**Introduction to the Annual Report and Accounts 2020-21** The DFD informed the Committee that the paper introduced the Annual Report which included the Performance Report, Accountability Report, and the Annual Accounts. The DFD added that it supported the key changes made to the draft statements and outlined and confirmed the financial performance of the UHB. The DFD highlighted that the Audit & Assurance Committee had a key role in reviewing the Annual accounts and the ISA 260 report from Audit Wales and that the Annual Report contained the Annual Accounts & Remuneration Report. The DFD stated in reviewing the financial statements and associated documentation the committee needed to consider the work carried out throughout the year by Internal Audit & Counter Fraud with specific reference to the opinion provided by the Head of Internal Audit (HIA). In regards to the Annual Report and Accounts assurance, the accuracy on the statements could be provided by the programme of work undertaken by the Audit & Assurance Committee throughout the year and the process that it had followed to sign off the Annual Report and accounts. This included an Audit Workshop and the Special Audit meeting. Assurance was also provided by the work completed by Audit Wales, which was detailed in the ISA 260 report, the response to the audit enquiries to those charged with governance and management, and the letter of representation that would be sent to Audit Wales.	

The DFD highlighted the changes made in the draft Annual Report and Accounts and how Audit Wales had reviewed the drafts and provided feedback with a number of narrative modifications being included in the final report. He added that:

- The Remuneration Report had been corrected where Audit Wales had detected a number of disclosures which required amendment.
- Where reasonable assurance was required, the HIA Opinion was included in the Accountability Report

The financial position recorded in the draft accounts was still the financial position reflected in the final accounts. The DFD highlighted that there had been a number of changes primarily within the notes regarding the values and disclosures. These changes were set out in appendix 4 of the ISA 260 report.

The DFD highlighted that Audit Wales had queried the accounting treatment of ICF Capital monies which would be worked through and agreed as part of the 2021/22 Audit Plan.

In terms of the financial performance of the UHB the DFD advised that:

- There were no changes to the draft accounts.
- In regards to Revenue Resource Limits, although a plan had been approved it did not achieve a 3 year break even position and there was an aggregated deficit of £9.724 million. Therefore the UHB failed against the financial duty within the Revenue Resource Limit.
- The financial duty related to the Capital Resource limit had been met with an aggregated surplus of £257,000 over a 3 year period.

The DFD highlighted that the key item of assurance was provided by the work from Audit Wales as set out in the ISA 260 report where they had worked through and verified the draft accounts into the final accounts over a period of 5 weeks.

The Committee Resolved to:

a) Note the reported financial performance contained within the Annual Report and Accounts and that the UHB has breached its statutory financial duties in respect of revenue expenditure.
b) Note the changes made to the Draft Annual Report and Accounts;
c) Review the ISA 260 Report, the Head of Internal Audit Annual Report, the Letter of Representation, the response to the audit enquiries to those charged with governance and management and the Annual Report and Accounts;
d) Recommend to the Board that it agreed and endorses the ISA 260 Report, the Head of Internal Audit Annual Report, the Letter of Representation and the response to the audit enquiries to those charged with governance and management;
e) Recommend to the Board approval of the Annual Report and Accounts for 2020/21.

AAC 21/06/006	**Audit Wales ISA 260 Report** Anthony Veale – Audit Wales (AV-AW) gave his thanks to the Director of Finance (DOF), DFD, and the finance teams in the production of the accounts. Mark Jones – Audit Wales (MJ-AW) highlighted that the report discharged their responsibility to report their findings to the Audit & Assurance Committee and to the Board before the Annual Report & Accounts were considered for approval. He stated that Audit Wales intended to issue an unqualified opinion on the accounts and the remuneration report in terms of them being properly prepared, materially true and fair and he added that he intended to qualify the regularity opinion as highlighted by the DFD. He highlighted that this was the fifth year that this had happened and that the following year the qualified regularity opinion may not be required. MJ-AW highlighted the matters that needed to be brought to the attention of the Audit Committee: - There were no uncorrected misstatements - Tax issues around senior clinicians pensions He informed the Committee that the one area not highlighted within the report was the inventory which had been queried at the Audit Workshop. He advised that it was not mentioned within the report as Audit Wales were not qualifying the opinion on the inventory as they did last year. The inventory was marginally below materiality and had been subject to enhanced audit work on the inventory to provide assurance that it was not understated and Audit Wales were satisfied with the figure within the balance sheet. MJ-AW made the Committee aware of deadlines stating that Audit Wales had to submit Audited documents to Welsh Government by the 11/06/2021 and were on schedule, subject to Board approval, to do so. All Health Bodies accounts were scheduled to be certified on 15/06/2021and soon after the certification would be laid before the Senedd publicly and Welsh Government would issue a press release alongside it. The DFD commented that the final letter of representation had been slightly modified but was in the standard recommended format as set by Audit Wales. The draft had been reviewed at the Audit Workshop and stated that it was not contentious so it was presented for agreement and recommendation. The DOF agreed with the points made. The DFD highlighted that on the last page under appendix 1 the date was incorrect and read 09/06/2021 but should say 10/06/2021. This had been corrected in the actual letter of representation to be signed. **The Committee Resolved to:** - Note the Audit Wales ISA 260 Report	

AAC 21/06/007	**The Head of Internal Audit Opinion & Annual Report for 2020-21** The HIA advised that the majority of the content within the report remained the same as per the draft reviewed at the Audit Workshop. The HIA highlighted the key messages from his opinion within section 1.2 which clarified the final Head of Internal Audit Opinion which confirmed that the Board could take reasonable assurance that arrangements to secure governance, risk management and internal control, within those areas under review, were suitably designed and applied effectively. The HIA thanked the Corporate Governance team, Executives, Management within the HB and others for their ongoing engagement throughout the pandemic which had enabled his team to complete enough internal audit work to provide his opinion for the year. He highlighted figure 1 within the report which provided the final outcome for all internal audit work completed throughout the year: The HIA added that there were 2 audits within the reasonable assurance area on Infrastructure Network Management and another on the Maelfa Well-Being Hub. He stated these items were in draft at the time of the HIA producing his final opinion for the year and those outputs had been included within his opinion for the year. The HIA reminded members that since producing the draft report at the Audit workshop,5 pieces of work were still ongoing and had not progressed to a stage where they could provide an assurance rating but wanted to clarify that all 5 had been progressed to either a final or draft stage. **The Committee Resolved to:** - Note the Head of Internal Audit Opinion.	
AAC 21/06/008	**To receive and consider the following for 2020-21:** **a. The Letter of Representation included within the ISA 260 report (see item 4.3)** The DDF stated that this was reviewed earlier in the meeting as part of the ISA 260 report. **b. The response to the audit enquiries to those charged with governance and management** The DDF stated that this was previously endorsed by the CEO, UHB Chair, DCG, DOF, & Chair of the Audit & Assurance committee. This had been reviewed at the Audit workshop and there had been no changes since and was shared at the meeting to be recorded.	

	c. The CVUHB Annual Report 2020-2021 including the Annual Accountability Report, Performance report and the Financial Statements The DCG commented that this was the first time that the Health Board had received the full Annual report and Accounts as one document as previously it had received the Accountability report and accounts separately. The DCG stated that the final published document would have minor changes in terms of corrected typographical errors and title changes of Executives. **The Committee Resolved that:** The following documents were noted and approved: a. The Letter of Representation included within the ISA 260 report (see item 4.3) b. The response to the audit enquiries to those charged with governance and management c. The CVUHB Annual Report 2020-2021 including the Annual Accountability Report, Performance report and the Financial Statements	
AAC 21/06/009	**Date and Time of Next Meeting** To note the date, time and venue of the next Committee meeting: **Tuesday 6th July 2021 at 9.00am**	

CONFIRMED MINUTES OF THE MEETING OF THE FINANCE COMMITTEE
HELD ON 28th APRIL 2021
VIRTUAL MEETING via TEAMS

Present:

Dr Rhian Thomas	RT	Chair, Independent Member – Capital and Estates
Charles Janczewski	CJ	Board Chair
John Union	JU	Independent Member - Finance
Ceri Phillips	CP	Board Vice Chair
Abigail Harris	AH	Executive Director of Strategic Planning
Andrew Gough	AG	Assistant Director of Finance
Catherine Phillips	CP	Executive Director of Finance
Chris Lewis	CL	Deputy Director of Finance
Nicola Foreman	NF	Director of Corporate Governance
Rachel Gidman	RG	Executive Director of People and Culture
Steve Curry	SC	Chief Operating Officer

In Attendance:

Secretariat:

Paul Emmerson	PE	Finance Manager

Apologies:

Len Richards	LR	Chief Executive
Ruth Walker	RW	Executive Nurse Director

FC 21/04/001	**WELCOME AND INTRODUCTIONS** The Chair welcomed everyone to the meeting.	**ACTION**
FC 21/04/002	**APOLOGIES FOR ABSENCE** Apologies for absence were noted.	
FC 21/04/003	**DECLARATIONS OF INTEREST** The Chair invited members to declare any interests in proceedings on the Agenda. None were declared.	

FC 21/04/004	**MINUTES OF THE COMMITTEE MEETING HELD ON 24th MARCH 2021** The minutes of the meeting held on 24th March 2021 were reviewed and confirmed to be an accurate record. **Resolved – that:** The minutes of the meeting held on 24thMarch 2021 were approved by the Committee as an accurate record.	
FC 21/04/005	**ACTION LOG FOLLOWING THE LAST MEETING** There were no outstanding actions. **Resolved – that**: The Finance Committee **noted** that there were no outstanding actions.	
FC 21/04/006	**CHAIRS ACTION SINCE THE LAST MEETING** There had been no Chairs action taken since the last meeting.	
FC 21/04/007	**FINANCIAL PERFORMANCE MONTH 12** The Deputy Director of Finance summarised the key points within the Month 12 Finance Report. The UHB's provisional year end revenue outturn was a surplus of £0.090m which was broadly in line with the break-even position previously forecast. The UHB is also reporting that it stayed within its Capital Resource limit and achieved its creditor payment compliance target. The Finance Committee was asked to note that these are all provisional at this stage as the accounts would be subject to external audit scrutiny, though the reported year end position was not expected to materially change. Referring to table 2 of the written report, it was highlighted that despite achieving a surplus in 2020/21 and 2019/20 that the UHB had still breached its statutory break even duty by £9.724m over the three year period from 2018/19 to 2020/21 as a consequence of the deficit recorded in 2018/19. The UHB Chair (CJ) reflected that the relatively small operating surpluses reported by the UHB in both 2019/20 and 2020/21 represented a satisfactory financial outcome and acknowledged the support of the Finance Team in delivering this position. Looking forwards, the UHB Chair (CJ) observed that the financial result that the UHB could expect to achieve in 2021/22 was compromised by the £21.3m increase to the UHBs underlying deficit which had arisen in 2020/21 as a result of the shortfall in the delivery of recurrent savings schemes during the pandemic. Referring to this, the UHB Chair (CJ) noted that the financial position that the UHB could reasonably deliver in 2021/22 would in part be determined by the level of funding that Welsh Government provided to cover the increase in the underlying deficit.	

	Six of the eight measures on the Finance Dashboard were RAG rated green. Two measures remained RAG rated red namely: the reduction in the underlying deficit to £4m and the delivery of the recurrent £25m 3% devolved savings target. Progress against the 2 measures had been impeded by the COVID pandemic in 2020/21 Moving onto financial performance in month 12 it was noted that the operational position had moved from a year to date surplus of £0.502m in month 11 to a surplus of £0.090m at year end. This was broadly in line with the forecast. The UHB had received additional revenue funding of £176.120m in 2020/21 to manage the impact of COVID. Referring to the line by line analysis of Welsh Government COVID Funding received 2020/21, the Executive Director of Strategic Planning asked how the £4.141m of funding labelled Support for Adult Care Providers was applied and in response the Deputy Director of Finance indicated that the funding was passed onto care providers to cover the additional costs and the financial impact of voids during the pandemic. In this context, the Executive Director of Strategic Planning indicated that the UHB would need to consider the impact that the pandemic may have had on the level of care provider capacity moving into 2021/22. The UHB Chair (CJ) noted the costs at the Dragons Heart Hospital (DHH) were highlighted in the reported position but queried why the costs of the Lakeside Wing were not shown in the same way. The Deputy Director of Finance stated that this was because the majority of the costs incurred in the construction of the DHH were revenue costs as they could not be capitalised because of the interim nature of the Field Hospital and were therefore reported in the revenue position. The Committee was informed that the costs incurred in the construction of the Lakeside Wing Surge Hospital which would provide additional capacity in the longer term were capitalised and supported by an additional capital allocation provided by Welsh Government. These were therefore not included in the revenue position but shown in the Appendix on capital expenditure. The year end outturn analysed by income, pay and non pay was largely in line with forecast and it was noted that additional pay spend was reported in month 12 due to the inclusion of COVID related liabilities for the additional annual leave accrual; the additional study leave accrual for training grade doctors and the NHS bonus payment. Picking up on the additional annual leave accrual the Independent Member – Finance (JU) asked if the accrual was in line with the forecast. In response, the Deputy Director of Finance indicated that the accrual was less than the original forecast, however the shortfall had provided cover for the training grade study leave accrual which was required in respect the UHBs liability for untaken study leave. The Finance Committee Chair (RT) asked how the additional accruals would be managed in 2021/22 and the Deputy Director indicated that the accruals were expected to be released in 2021/22 as the uptake of annual leave and study leave increased as the pandemic eased. Turning to Clinical Board performance it was highlighted that the in month operational underspend in the PCIC Clinical Board was expected and that the	

	in month overspend in the Surgery Clinical Board reflected the shift in year end stock levels. The UHB had maintained a positive cash balance throughout 2020/21. The public sector payment compliance performance was 96.2% at the end of March and therefore the UHB achieved its statutory target in 2020/21. The Finance Committee Chair (RT) asked whether the increase in trade and other debtors since the start of the year which related to amounts due from the Welsh Risk Pool (WRPs) was a risk to the UHB and the Deputy Director of Finance confirmed that the debtor was the WRPs contribution to cover liabilities and that this was not a significant risk to the UHB's balance sheet. In conclusion, the Deputy Director of Finance reiterated that the reported position was a very satisfactory conclusion to the financial year, with the UHB having remained within its revenue and capital resource limits in year and met its creditor payment compliance target. **Resolved – that:** The Finance Committee **noted** the provisional draft year end revenue surplus of £0.090m against the planned breakeven position; The Finance Committee **noted** that the year end capital underspend of £0.104m against a CRL of £95.447m; The Finance Committee **noted** that the UHB achieved its creditor payment compliance target of 95%. The Finance Committee **noted** the month 12 financial impact of COVID 19 which assessed at £176.120m; The Finance Committee **noted** the additional Welsh Government COVID 19 confirmed funding of £176.120m included within the month 12 position: The Finance Committee **noted** the revised forecast 2020/21 carry forward Underlying Deficit of £25.3m.	
FC 21/04/008	**DEEP DIVE – RESOURCE ALLOCATIONS AND FUNDING** The Deputy Director of Finance introduced a presentation on Resource Allocations and Funding and highlighted that the presentation would cover the following areas: • How the Welsh Government is funded • Funding from Welsh Government (including the new allocation formula & the UHBs assessed share of NHS Funding) • Cross Border flows and LTAs • How the UHB spends its resources	

The Deputy Director of Finance moved through the presentation and highlighted:

Welsh Government Funding

- the majority of Welsh Government is determined by the Chancellor of the Exchequer, and is approved by the UK Parliament in Westminster.
- More than 80% of Welsh Government funding is provided via Parliament with the rest coming from taxes collected in Wales. Welsh Government has the power to apply different rates of income tax in Wales compared to other parts of the UK. To date the rates applied have been consistent with England and Northern Island.
- The share for Wales of the extra funding given to each Whitehall Department in the Spending Review is determined by the Barnett formula. The current Barnett share is circa 5.8% of the additional funding announced for each Whitehall Department where powers have been devolved to Wales.
- The shares are referred to as consequentials however Welsh Government can determine how the consequentials are allocated over each Welsh Government Expenditure group.
- The Welsh Government undertakes an Annual Budget Round and normally publishes a draft budget in October which details its spending plans for the next three years for Main Expenditure Groups (MEGs) e.g. Health and Social Services; Housing and Local Govt.; Economy and Transport; Education; Mental Health, Wellbeing and Welsh Language; Environment, Energy and Rural Affairs; and Central Services and Administration.

NHS Funding

- Welsh Government normally issues annual NHS revenue allocations in December for the following financial year
- Revenue allocations are based on previous years funding uplifted for growth, and new development funding. A new allocation formula was introduced in 2020/21 and this is used to allocate annual growth funding.
- Funding is allocated to the 7 Health Boards to fund healthcare services for their resident population based on previous years funding uplifted for growth, and new development funding. The funding flows from each Health Board to: neighbouring Health Boards; Independent Contractors (GPs, Opticians, Dentists, Pharmacists); WAST & Velindre Trusts; WHSCC; Local Government; and Voluntary/Independent sector.
- The UHB's Initial Resource Limit for 2021-22 is £981.786m.
- Further allocations are made during year – some are non recurrent and some are recurrent. In part due to the Covid pandemic, 2020/21 was exceptional with a starting allocation of circa £0.950bn and a closing allocation of circa £1.2bn.
- Some health funding is held in Welsh Government central budgets and issued direct to Trusts, LHBs or other bodies

New Allocation Formula; Principles & Aims

- Intended to be transparent, simple to maintain and based on readily available robust population needs and financial data.
- The formula results are expected to be mapped and robust at the following levels: 7 Local Health Boards; 22 Public Services Boards; 64 Locality Networks / Primary Care Clusters. This will enable Health Boards to match resources to needs within their boundaries.
- The formula used in Wales has been influenced by the Scottish approach which has 4 main measures of health need being: population; age sex adjustment; morbidity and Life circumstances adjustment (MLC); Unavoidable Excess Costs of Supply adjustment - remoteness and rurality
- The Welsh Formula has 4 components as follows: Acute (72.2%); Maternity (3.40%); Community (13.40%) and Prescribing (11.0%)
- New funding is allocated to LHBs based on: Population share; age sex cost index; additional Needs index for each component. In addition the Community component is weighted for an additional cost index.
- Graphical data was presented that indicated that the annual cost of Acute Care was far greater in the early (years 1-4) and later (years 60 onwards) part of life.
- Data collected to inform the latest allocation applied the following weights to Cardiff and Vale in comparison to the average for Wales:

	Acute	Maternity	Community	Prescribing		Overall
Vale of Glamorgan	0.946	0.917	0.872	0.892		0.929
Cardiff	0.792	0.906	0.829	0.807		0.802
Cardiff & Vale of Glam.	0.833	0.909	0.841	0.830		0.836
All Wales	1.000	1.000	1.000	1.000		1.000

- The formula on average allocated 92.9% and 80.2% of the overall national funding per head of population to a typical resident in the Vale of Glamorgan and Cardiff respectively.
- The application of the formula meant that the UHB received 13.3% of the £105m core cost and demand uplift for Wales in 2021-22 as against a crude (unweighted) population share of 15.9% or the current "Townsend" share of 14.4%. The latest assessment indicated that the UHB currently received 13.53% of total funding allocated across Wales.

Allocations – Resource Limits

- The UHB's funding from Welsh Government is split between the Revenue Resource Limit – funding for day-to-day services (e.g. salaries, consumables and services), and the Capital Resource Limit – funding for significant capital investment – tangibles assets costing £5,000 or more with an expected life in excess of 1 year (e.g. buildings, equipment or groups functionally inter-dependant assets (e.g. all networked IT equipment >£250)).
- Capital and Revenue are treated as two different funding streams and are accounted for separately. They have separate statutory targets and resource limits can only be swapped upon agreement by Welsh Government

LTA Financial Frameworks

- LHB/ Trust LTAS are based on historic costs, inflated year on year however some are being remodelled. LTAs are supplemented for clinical developments (e.g. Robot, blood products) and delivery is measured at a specialty and patient category level
- The WHSSC LTA was established through Resource Mapping in 2010 and the UHB's provider contract was rebased in 2015-16 to better align the income to service costs individual services
- LTAs are a mixture of; Block Contracts – where there no adjustment for variation; Traditional 'Cost & Volume' Contracts – variation adjusted for at marginal rates; Cost per Case Contracts – full cost price variation; and 'Pass Through' Contracts – actual expenditure e.g. NICE and High Cost Drugs

The presentation concluded by noting that the UHBs budget in 2020/21 was circa £1.7bn and whilst the majority of the income is provided through allocations from Welsh Government, a significant level of income (circa 1 quarter) was recovered from the Welsh Health Specialist Services Committee (WHSSC), Other Local Health Boards and Commissioners of Training and Education . Against a comparison of the UHB's expenditure it was evident that in financial terms the UHB collected more income for services provided to external commissioners that it spent on services provided to Cardiff & Vale residents by external providers.

Comments and queries were received as follows:

The Executive Director of Strategic Planning asked whether Welsh Government had discretion over the way that consequential funding was allocated between Expenditure Groups and the Deputy Director of Finance confirmed that Welsh Government had discretion to prioritise between different MEG budgets e.g. Housing and Local Government could be prioritised before Health and Social Services and vice versa.

The UHB Vice Chair (CP) noted that the UHB delivered a significant proportion of the tertiary services provided to all Welsh residents and asked what assurance could be given that the cost of providing tertiary services to patients residing outside of Cardiff and Vale was recovered through LTA agreements from external commissioners. In reply the Deputy Director of Finance indicated that Welsh Health Specialist Services (WHSSC) were responsible for commissioning specialist and tertiary services on behalf of Welsh residents and that the UHBs provider contract with WHSCC was rebased in 2015-16 to better align the income to service costs for individual services. The Deputy Director of Finance added that the UHB was presently working with Aneurin Bevan to rebase the LTA agreed by both organisations and intended to review the LTA with Cwm Taf once the Covid pandemic passed.

Referring to the measurement of population for the new revenue allocation formula the UHB Vice Chair (CP) observed that the population count for each Health Board was based on residency and noted that the absence of a large part of Cardiff's significant student population as a result of the lockdown in place during the COVID pandemic at the time of the 2021 Census may impact on the population data informing the formula. The Committee agreed that this

	was a fair concern and that the UHB would need to assure itself that future population projections were adjusted for issues at the time of the 2021 census. The Finance Committee Chair (RT) queried whether GP registrations could provide a better basis for a measuring populations. In response, the UHB Vice Chair (CP) indicated that there could be a reluctance to use GP lists as these could be unrepresentative unless patient registrations were regularly reviewed for patients who had re-registered with other GPs. This was a particular concern in areas where there were large numbers of students who may have moved on following the completion of studies without de-registering from a GP practice. **Resolved - that:** The Finance Committee **noted** the presentation.	
FC 21/04/009	**MONTH 12 FINANCIAL MONITORING RETURNS** These were noted for information.	
FC 21/04/010	**ITEMS TO BRING TO THE ATTENTION OF THE BOARD** There were no items to being to the attention of the Board.	
FC 21/04/011	**DATE OF THE NEXT MEETING OF THE COMMITTEE** **Wednesday 26th May 2.00pm; Virtual Meeting via Teams**	

CONFIRMED MINUTES OF THE MEETING OF THE PUBLIC FINANCE COMMITTEE HELD ON 26th MAY 2021 VIRTUAL MEETING via TEAMS

Present:

Dr Rhian Thomas	RT	Chair, Independent Member – Capital and Estates
Charles Janczewski	CJ	Board Chair
John Union	JU	Independent Member - Finance
Abigail Harris	AH	Executive Director of Strategic Planning
Catherine Phillips	CP	Executive Director of Finance
Chris Lewis	CL	Deputy Director of Finance
Julie Cassley	JC	Deputy Director of People and Culture
Nicola Foreman	NF	Director of Corporate Governance
Steve Curry	SC	Chief Operating Officer

In Attendance:

Secretariat:

Paul Emmerson	PE	Finance Manager

Apologies:

Andrew Gough	AG	Assistant Director of Finance
Len Richards	LR	Chief Executive
Rachel Gidman	RG	Executive Director of People and Culture
Ruth Walker	RW	Executive Nurse Director

FC 21/05/001	**WELCOME AND INTRODUCTIONS** The Chair welcomed everyone to the meeting.	**ACTION**
FC 21/05/002	**APOLOGIES FOR ABSENCE** Apologies for absence were noted.	
FC 21/05/003	**DECLARATIONS OF INTEREST**	

	The Chair invited members to declare any interests in proceedings on the Agenda. None were declared.	
FC 21/05/004	**MINUTES OF THE COMMITTEE MEETING HELD ON 28th APRIL 2021** The minutes of the meeting held on 28th April 2021 were reviewed and confirmed to be an accurate record. **Resolved – that:** The minutes of the meeting held on 28th April 2021 were approved by the Committee as an accurate record.	
FC 21/05/005	**ACTION LOG FOLLOWING THE LAST MEETING** There were no outstanding actions. **Resolved – that**: The Finance Committee **noted** that there were no outstanding actions.	
FC 21/05/006	**CHAIRS ACTION SINCE THE LAST MEETING** There had been no Chairs action taken since the last meeting.	
FC 21/05/007	**FINANCIAL PERFORMANCE MONTH 1** The Deputy Director of Finance summarised the key points within the Month 1 Finance Report. It was signposted that the UHB was monitoring it performance against its draft financial plan which included a planned £21.3m deficit. The refinement of plans for Covid response and recovery was moving at pace and a review process was in place to drive down Covid response costs. The UHB reported a deficit of £1.929m in month 1 which was made up of a planned deficit of £1.775m (being one twelfth of the planned £21.3m deficit for 2021/22) and a small operational overspend of £0.154m. The UHB Chair (CJ) signalled some unease around the £0.154m operational overspend which had emerged at month 1 and asked whether this was linked to the £6m of Covid Response plans where the UHB had progressed schemes at risk in lieu of confirmation of funding. In response, the Deputy Director of Finance agreed that the operational overspend was unwelcome at this stage and confirmed that this was not linked to the UHBs decisions to progess Covid response plans at risk. The Committee was informed that the operational overspend was driven by a small number of hotspots some of which were also causing concern last year and that these would need to be addressed as part of the UHB's performance review. The Chief Operating Officer concurred with this view and confirmed that work had already commenced to resolve and improve the position through the established performance review process and added that there was still a relatively high	

level of uncertainty over what level of response and recovery was required to manage the continuing impact of Covid.

Moving onto the Finance Dashboard the Deputy Director of Finance noted that 4 of the key indicators were RAG rated as red. Two of the measures were linked the draft planning deficit. In addition it was noted that there was a shortfall against the £12m recurrent savings target had been identified at month 1 and that the creditor payments compliance was reported at 93% against the 95% target. Both measures were rated red accordingly and the Committee was informed that the scores were expected to improve over the first quarter of the year.

Referring to table 3 of the written report the Committee was informed that month 1 net expenditure of £8.145m 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 and that the individual cost elements incurred in managing the impact of Covid 19 were outlined in table 4.

Referring to the forecast COVID response costs for the first 6 months which were estimated to be £4.056m higher than the confirmed allocation, the Finance Committee Chair (RT) asked when the UHB expected to have firm confirmation of the costs which would be funded. In reply, the Chief Operating Officer indicated that the UHB was focusing efforts to manage the impact of operational pressures; CIP development and COVID response and recovery in the light of considerable uncertainty and as a result the UHBs operational plans would need to evolve as the year progressed. In this context the UHB Chair (CJ) indicated the Committee would need to continue to monitor planned spend against confirmed additional Covid allocations and the Executive Director of Finance confirmed that the UHB needed to ensure that Covid response and recovery plans worked within the additional resouces provided by Welsh Government.

Operational pressures against income and non pay budgets were broadly offset by an underspend against pay budgets in month 1. The Finance Committee Chair (RT) noted that there was a significant overspend against drugs and prescribing at month 1 and observed that this appeared to be a recurring theme. The Deputy Director Of Finance confirmed that additional budget had been allocated to drugs through the 2021/22 planning process and that there was an expection that Clinical Boards would manage within the total budget provided. Any further increase to drug budgets would require an increase in the UHB savings target.

The Committee was informed that the UHB was required to categorise and report actual and forecast COVID expendiure for 2021/22 in line with the programmes defined by Welsh Government. The programmes were outlined within table 11 of the written report and the Deputy Director of Finance indicated that some of the programmes e.g. Vaccination would be funded by Welsh Governent based on actual costs. Actual and reported reductions in planned expenditure as a consequence of COVID 19 were relatively low which in part reflected the progress of work to restore levels of planned care.

Turning to COVID 19 recovery Schemes it was reported that the UHB had been succesful in obtaining funding of £13.660m against the £15.360m of bids

	submitted to Welsh Government on the 26th April. The funding provided coverage for the £5.3m of schemes which the UHB had advanced at risk in lieu of confirmed funding. It was noted that the UHB would need to plan to manage any recurrent costs arising out of the schemes if additional funding was not provided in 2022/23 and that this would be achieved through the inherent flexibility that was available to an organisation of the UHB's size and the management of premium staff costs. The Independent Member – Finance (JU) asked whether there were any implications arising from the bids of circa £1.7m for which the UHB had not received confirmed funding and the Chief Operating Officer confirmed that the associated schemes would be supported by slippage against other schemes. It was also stated that the UHB is expected make a further submission for recovery funding in 2021/22. Reporting on Clinical Board performance it was highlighted that the largest operational overspend was in the Medicine Clinical Board (£0.410m deficit) where the main pressure areas are nursing and medical staffing. Financial performance in other Clinical Boards was broadly balanced. Savings of circa £8.5m had been identified against the £16m 2021/22 savings target leaving a further £7.5m of savings to be developed to meet the target. The Finance Committee Chair (RT) noted that the gap in the savings plan was just under 50% and indicated that the Finance Committee would require further assurance around the progress to bridge the gap and delivery before approving the revised financial plan. The UHB Chair (CJ) noted that the delivery of the savings target was an integral part of the plan and that the UHB would normally have identified a higher proportion of the savings target by this stage of the year and in this context further assurance was required that the UHB would not be adding to its planned deficit. The Chief Operating Officer stated that the UHB had an established process to maintain a pipeline of savings schemes which would be developed into actual schemes and that the focus of schemes coming out of the pandemic would be on reviewing high cost variable pay and the new working processes developed to manage the pandemic. The Deputy Director of Finance confirmed that there were detailed savings plans underpinning the analysis of saving schemes by Clinical Board presented at Appendix 1 and added that a more detailed review of the Savings Programme could be provided to the Committee at its next meeting, prior to submission of the Final Plan to Welsh Government. **ACTION** A more detailed update on savings plans to be provided at the next meeting of the Finance Committee to allow a more thorough review. Turning to the Revised Annual Financial Plan the Finance Committee agreed that it would need to determine whether the plan could be recommended to the Board before the Board meeting on the 24th June. It was agreed that it would be helpful to allow as much time as possible so that the plan could refined before being brought back to the Finance Committee. In this context it	CL

	was agreed that the next Finance Committee should be scheduled for June 23rd in order to consider the revised annual plan. **ACTION** Next Meeting of the Finance Committee to be brought forward to 2.00pm June 23rd from June 30th 2021. **Resolved – that:** The Finance Committee **noted** the month 1 financial impact of COVID 19 which is assessed at £8.145m; The Finance Committee **noted** the additional Welsh Government COVID 19 funding of £8.145m assumed within the month 1 position.; The Finance Committee **noted** the reported overspend of £1.929m at month 1 due to £0.154m of operational pressures and a planning deficit of £1.775m; The Finance Committee **noted the** forecast deficit of £21.3m which is consistent with the draft financial plan and assumed additional Welsh Government funding of £118.741m to manage the impact of COVID 19 in 2021/22 in line with response and recovery assumptions; The Finance Committee **noted that** the UHB has a risk in its current and forecast level of COVID response costs which are in £4.056m in excess of funding received for the first 6 months: The Finance Committee **noted** the 2021/22 brought forward Underlying Deficit of £25.3m and the forecast carry forward of £25.3m to 2022/23.	PE
FC 21/05/008	**FINANCE RISK REGISTER** The Deputy Director of Finance presented the 2021/22 Finance Risk Register to the Committee and highlighted that the scoring in part reflected the level of uncertainty in the early part of the year. The following 3 risks identified on the 2021/22 Risk Register were categorized as extreme risks (Red): • Maintaining the underlying deficit of £25.3m on line with the draft annual plan. • Management of budget pressures. • Delivery of the 2% CIP (£16.0m) The Finance Committee Chair (RT) noted that the red risks were normally considered in some detail within the monthly finance reports and indicated that some of the other risks would be considered in more detail in the later part of the year if further scrutiny was required. **Resolved – that:**	

	The Finance Committee **noted** the risks highlighted within the 2021/22 risk register.	
FC 21/05/009	**MONTH 1 FINANCIAL MONITORING RETURNS** These were noted for information.	
FC 21/05/010	**ITEMS TO BRING TO THE ATTENTION OF THE BOARD** There were no items to being to the attention of the Board.	
FC 21/05/011	**DATE OF THE NEXT MEETING OF THE COMMITTEE** **Wednesday 23rd June 2.00pm; Virtual Meeting via Teams**	

Confirmed Minutes of the Quality, Safety & Experience Committee
Held on 13 April 2021 at 09.00am
Via MS Teams

Chair:		
Susan Elsmore	SE	Independent Member – Local Authority
Present:		
Gary Baxter	GB	Independent Member – University
Mike Jones	MJ	Independent Member – Trade Union
Michael Imperato	MI	Independent Member – Legal
In Attendance		
Ruth Walker	RW	Executive Nurse Director (END)
Stuart Walker	SW	Executive Medical Director (EMD)
Abigail Harris	AH	Executive Director of Strategy and Planning (EDSP)
Fiona Jenkins	FJ	Executive Director of Therapies & Health Science (EDTHS)
Steve Curry	SC	Chief Operating Officer (COO)
Nicola Foreman	NF	Director of Corporate Governance (DCG)
Scott Mclean	SM	Director of Operations – Children & Women's (DOCW)
Cath Heath	CH	Director of Nursing – Children & Women's Clinical Board (DNCW)
Hywel Pullen	HP	Assistant Director of Finance (ADF)
Jason Roberts	JR	Deputy Executive Nursing Director (DEND)
Clare Rowntree	CR	Clinical Board Director for Children & Women's Clinical Board (CBDCW)
Carol Evans	CE	Assistant Director of Patient Safety and Quality (ADPSQ)
Kirsty Hook	KH	Secretary Children & Women's Clinical Board (SCWCB)
Angela Hughes	AH	Assistant Director of Patient Experience (ADPE)
Rajesh Krishnan	RK	Assistant Medical Director (Patient Safety and Clinical Governance) (AMD)
Suzanne Hardacre		Directorate Lead Nurse – Maternity (DLNM)
Stephen Allen	SA	Chief Officer – Community Health Council (CHC) (COCHC)
Amy English	AE	Deputy Chief Officer, Community Health Council (CHC) DCOHC
Annie Burrin	AB	Patient Safety Team
David Poland	DP	Audit Wales
Ian Virgil	IV	Audit Wales
Jacqueline Evans	JE	Interim Head of Corporate Governance (IHCG)
Secretariat		
Nathan Saunders	NS	Corporate Governance Officer (CGO)
Apologies		
Fiona Kinghorn	FK	Executive Director of Public Health (EDPH)
Catherine Phillips	CP	Executive Director of Finance (EDF)
Charles Janczewski	CJ	Chair

QSE 21/04/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the meeting.	**Action**
QSE 21/04/002	**Apologies for Absence** Members noted that apologies for absence had been received from Fiona Kinghorn, Executive Director of Public Health, Catherine Phillips,	

	Executive Director of Finance and Charles Janczewski, Chair to Cardiff and Vale University Health Board (CVUHB).	
QSE 21/04/003	**Declarations of Interest** No declarations of interest were noted.	
QSE 21/04/004	**Minutes of the Committee Meeting held on 16 February 2021** The minutes of the meeting held on 16 February 2021 were received and confirmed as a true and accurate record of the meeting, pending some minor typographical amendments which the CC advised she would send to the Corporate Governance Officer (CGO) for amendment. **The Committee resolved that:** a) The minutes of the meeting held on 16 February 2021 were approved as a true and accurate record of the meeting, pending minor amendments.	
QSE 21/04/005	**Action Log following the Meeting held on 16 February 2021** The action log was received and the Committee noted that the majority of the actions had been completed or were on the agenda for discussion during the meeting, or were due for discussion at a future meeting.	
QSE 21/04/006	**Chair's Action taken since last meeting** No Chairs Actions were noted.	
QSE 21/04/007	**Children & Women's Clinical Board QSE Assurance Report** The Children & Women's Clinical Board (CWCB) QSE Assurance Report was received and the Director of Operations – Children & Women's (DOCW) gave an informative presentation and provided an overview of the patient safety and quality agenda over the preceding 18 months and highlighted achievements, innovation and transformational work undertaken to date, and gave an update on residual risks and mitigating actions being carried forward into 2021-2022. The Committee noted that: • During 2020/2021 the CWCB comprised of five clinical directorates with associated clinical services and specialties. The CWCB delivers a number of highly specialised services to both the South East region and wider all Wales population and has responsibility for universal services which support the health, well-being, education, development and Public Health amongst the population of children, young people, parents, families, women and their partners. This includes partnership and safeguarding priorities. The services also provide primary and secondary care services to the local Cardiff and Vale population, • The CWCB has a budget of £102.646m and a current workforce establishment of 1,906 WTE,	**Centre**

	• Some services are commissioned from the Welsh Health Specialised Services Committee (WHSCC) through the relevant directorates, including Obstetrics, Gynaecology and Sexual Assault Resource Centre (SARC) and Cancer Services, • The CWCB has a well-established Quality, Safety and Patient Experience Committee chaired by the Director of Nursing for the CWCB with strong representation from midwifery, medical, nursing and Allied health professionals staff, • The annual self-assessment against the Welsh Government's Health and Care standards framework was not undertaken last year due to COVID-19, and are not required this year. The quality and safety patient experience group led on the self-assessment and identified improvement against each element of the standard, • In December 2020 the CWCB held a risk assessment and governance workshop to analyse and review all risk assessment processes. Each Directorate has a risk register which aligns to Clinical Board Risk Register. The DOCW informed the Committee that the Clinical Board leadership team had framed conversations around quality, performance and cost and were confident in providing these conversations to services. The Director of Nursing for the C&W clinical board (DNCW) gave an update on the Clinical Boards performance over the last 12-18 months and the Committee noted: • Child immunisations had worsened which was thought to be due to parent's reluctance to take their child for the vaccination, and due to school closures, • The Staff influenza vaccine uptake had increased by 11% compared to the previous year, • Safeguarding training compliance was at 75%, which was an improvement compared to the health board average of 63%, • Healthcare Acquired Infection rates had improved and there was a 50% reduction in C-Diff infections and E-Coli bacteraemias, • Vaginal/Non-interventional childbirth had worsened. Caesarean section, instrumental delivery and induction of labour rates had all increased, • Research & Development (R&D) had improved. A new C&W R&D group had been established, • Timely Access to care pre-COVID-19 had improved with significant improvements in Referral to Treatment (RTT) time, Cancer services and Tier-1 Primary Mental Health, • Timely Access to care peri/post COVID-19 had worsened with a significant deterioration in RTT, Tier-1 Primary Mental Health and others, • There were concerns response times had worsened with increasing volume and complexity as well as decreased capacity, • Staff absence had improved with a decrease to 4.3% from 5.2%, • Staff appraisal had worsened and reduced to 38% from 50%.	

	The DOCW advised the Committee that the C&W clinical board were proud of the spirit, commitment, resilience and performance of the teams prior to, during and coming out of the COVID-19 pandemic. The Committee noted the challenges facing the CWCB teams and that a number of plans were being developed to improve services, including: • A Community Children's Services COVID-19 response plan, • Attempting to maintain the Youth Board, • Securing infrastructure for, and exploring the redesign of Benign Gynaecology services, • Development of Clinical effectiveness strategy for the clinical board in line with the Cardiff and Vale University Health Board (CVUHB) strategy, • Transforming inpatient care for Children and Young People with mental illness, • Contributing to the WHSS National Strategy for Specialist Children's Services. To progress the plans, it was suggested that the Board would need to support the Clinical Board in influencing external stakeholders and partners and that urgent short-term and other medium-term Estates work would be required in the Obstetrics and Gynaecology block at the University Hospital Wales (UHW). It was also suggested that parity of access would be required in relation to Theatres and Anaesthetic resources and that resourcing would be needed, at scale, for a Community Children's Services COID-19 response plan. The Executive Nurse Director (END) asked the Directorate Lead Nurse for Maternity (DLNM) what the greatest learning had been from the maternity services review and what changes had been made to strengthen and develop existing practice. The DLNM responded that the maternity services had been overwhelmed over the past 18 to 24 months and advised the Committee that the findings of the Royal College of Obstetricians and Gynaecologists (RCOG) report into maternity services at Cwm Taf Morgannwg University Health Board (CTMUHB) had provided an opportunity to review our own maternity services and assess existing service delivery. The report had highlighted vulnerable areas and areas for improvement within CTMUHB, which CVUHB could benchmark against. Two areas had already been improved as a consequence of the report concerning consultant cover and ante-natal and ward rounds. The END asked the DNCW to share with the Committee the work that the Neonatal department had undertaken on the recurrent infection position, and the DNCW responded that a local Infection, Prevention & Control (IP&C) team had been established, was led by a consultant and met on a monthly basis to review practice. In addition, a new MRSA working party had been developed to look at increased incidents on neonatal screening.	

	The Executive Director of Therapies & Health Science (EDTHS) advised the Committee of three areas in which she wished to thank the C&W clinical board: • The Additional Learning Needs and Education Tribunal (Wales) Act (ALN). The C&WCB are hosting the Designated Education Clinical Lead Officer (DECLO) role and an update on progress will be given to the Health System Management Board (HSMB) in May 2021, • The Women's health implementation group had an impact on the expectations around CVUHBs Women's services at national level, • Children's Services – The therapists had been using digital methods to communicate and provide help and support. It was recognised that there would be some children who have been profoundly affected by the COVID-19 pandemic. The Independent Member – Trade Union (IMTU) asked how staff morale had been. The DNCW responded that some nurses who had been supporting adult services had found it difficult but had stepped up when required. She added that had supported staff and that opportunities had been given to support and manage them in the workplace as they return to their main posts. The DLNM advised that it had been challenging for community colleagues as the number of home births had increased due to the pandemic. She added that clinical psychology sessions had been offered to staff and it was noted that the Royal College of Nursing (RCN) had undertaken a census, the findings of which were was currently being analysed. The Independent Member – University (IMU) asked how many more Caesarean sections (C-Section) were being seen and what the reasons were. The DLNM responded that there were several factors contributing to the increase in C-sections and noted that it was not unique to CVUHB. She added that it showed that the service were detecting vulnerable babies more frequently and through early intervention, they were seeing a decrease in still-birth and perinatal morbidity. The IMU asked what the issues were concerning infrastructure at UHW and the DLNM responded that the main concern was ageing lifts which frequently broke down and reflected the ageing estate in the Delivery unit and Theatres. The issues was captured on the Clinical Board's risk register. The COCHC advised the Committee that a link to the Children and Adolescent Mental Health Services (CAMHS) high level service could not be seen, and the DOCW responded that it was a long standing issue and a number of conversations had been undertaken with CTMUHB concerning Tier-4 specialised services. He added that a significant approach was needed. The COCHC noted that the birth rate was decreasing, however the acuity of care was increasing and that home births were less than 1% of total births and asked how that could be explained. The DLNM responded that	

there was a national drop in birth rates and that more women with underlying comorbidities were getting pregnant.

She added that when the University Hospital Llandough (UHL) closed and the birth centre opened at UHW, all eligible women who could receive midwifery led care could go to the maternity led unit (MLU) or have a home birth. Home birth was promoted but women tended to choose MLU.

The COCHC advised the Committee that there had been no mention of the child incontinence service and that concerns had been raised concerning children waiting 2 years to be assessed, and support was required to improve access to the service. The DOCW responded that the child incontinence service was under increased pressure and fell into the bundle of Community Children's Services. Improving the service would be included as part of the bigger plan for a response to COVID-19.

The Executive Medical Director advised:

- C-Section rate was described as "worsened" and he asked if that was the correct phrase as the World Health Organisation (WHO) stated that C-sections should be 10-15% and that CVUHB were running at around 25% on par with the rest of the UK. It was recommended that trend data and national benchmarking data could interpret that number,

- Having nationally mandated audits, outcome data and NICE (National Institute for Healthcare Excellence) guidance included in the quality and safety reports for Clinical Boards was informative and he welcomed the use of the information at future meetings. He thanked colleagues for the informative report.

The CC asked for a comment from the C&W Clinical Board in relation to the number of concerns received and the interventions to deal with those concerns in real time. The DNCW responded that the response times the C&W clinical board had experienced were around 80%, however during the pandemic there had been other competing pressures. Despite this, the Clinical Board had managed to hit above 75% and the last rating was above 83%.

She added that the Clinical Board had tried to resolve the majority of concerns informally, and had started some clinics within the crisis team in which children and their parents could talk through concerns.

The CC noted the open clinical negligence claims and asked how the figures compared to 2018/2019. The DNCW responded that the figures had not increased dramatically.

The CC asked if the Clinical Board were confident that everything was being done in terms of mitigating risk and ensuring good outcomes. The EMD responded that medical appraisals had a slightly different remit and different format for non-medics and noted that for the year 2020/2021 they had been effectively on hold which meant that the appraisal rate would be very low.

	The Clinical Board Director for Children & Women's (CBDCW) advised the Committee that the medical engagement in quality and safety processes through the maternity department were probably the highest across the Clinical Board, to address this they had a risk lead, with protected time to undertake assessments of concerns and complaints, which proved an assurance that issues were being reviewed. The CC requested that the estates issues to be escalated as a matter of urgency. The Executive Director of Strategy and Planning (EDSP) advised that she had discussed the issue with the Director of Capital Estates and Facilities and requested a briefing on the situation. **The Committee resolved that:** a) The progress made by the Clinical Board to date be noted, b) The approach and strategies for improvement be noted, c) The content of the report and the assurances provided by the Children and Women's Clinical Board were approved.	
QSE 21/04/008	**Quality Indicators Report** The Quality Indicators Report was received and END gave an update on the report. The Committee noted that: • The Committee had previously agreed a set of key indicators at the June 2020 meeting and had agreed to introduce a QSE dashboard. This was the first update since that meeting, and the dashboard was still under development, • The number of Serious Incidents (SI's) reported had reduced significantly over the last 2 years and this was a continuing trend. This was mainly due to the change in the requirement to report pressure damage within the SI reporting framework for Wales, • a detailed thematic review of Never Events was presented to the QSE Committee in April 2021 and work was ongoing to support staff in reducing the number of Never Events, including an awareness campaign, staff survey and the development of a Human Factors Training Strategy, • The number of complaints had increased during February and March 2021, mainly due to concerns in relation to the vaccination waiting times. Despite the current challenges, compliance with the Welsh Government 30 day response time target remained consistently well above 75%, • the number of reported pressure ulcers had again increased in the last two months, and the Director of Nursing for the Surgery Clinical Board, who was the national lead for pressure damage prevention was working with the Wound Healing Team to develop an improvement plan and this will be presented to the QSE Committee in June 2021, • the Patient Safety Team had developed a detailed falls dashboard which would be monitored by the Falls Delivery Group, • A pilot of the Royal College of Physicians (RCP) National Audit of In-patient Falls (NAIF) debrief tool was currently being undertaken on a medical ward at the UHW to help inform a review of the current risk assessment and injurious falls investigation template,	CE

	• The latest Stroke performance data was 40% compliance and demonstrated 100% compliance for patients seen by a Stroke Consultant within 24 hours. This issue would be discussed at the Clinical Board and Acute Stroke Team at the next Clinical Effectiveness Committee, • There was an increase in mortality within 30 days of an emergency admission in December 2020, linked to an increase in patients with COVID-19 during the second wave. Data for March 2021 was incomplete due to time lag data input. The CC asked the END if there were any early indication on the falls dashboard use, the END responded that all of the data was available right from the frontline and that every charge nurse and Multi-Disciplinary Team (MDT) had access to the data at ward level and that the data would be extended to the community. Discussion had also been held with Lightfoot concerning how to integrate some of their data into the pathway and to produce real time data. The CC noted that the Stroke indicators had deteriorated to 17% but had since increased to 40% and asked if that was compliant against the 4 hour target. The END responded that it was against the 4 hour target. The EDTHS advised the Committee that the COVID-19 pandemic had been a challenge for NHS Wales concerning Stroke performance. She added that there had been outbreaks of COVID-19 within the stroke unit which had required non-admittance of patients. It was suggested that the data needed to be looked at and monitored. All Health Boards were having a "restart" of stroke services and CVUHB were working with a strong stroke group. The EDTHS provided assurance to the Committee that plans were in place to move forward. In relation to falls, the EDTHS advised that patients not admitted into hospital did not fall as much. Sometimes there was a correlation with falls and length of stay. The Committee noted that the National falls group was being re-established and a new appointment had been to CVUHBs quality team who would monitor falls within CVUHB. The Independent Member – Legal (IML) asked if context could be provided on the number of falls, the EDTHS responded that she would ask the falls group to provide an update and provide assurance around the work. The Assistant Director of Patient Safety and Quality responded that Annie Burren, from the Patient Safety Team had undertaken some positive work on building a dashboard around falls and noted that it would be presented to the next fall's group. **The Committee resolved that:** a) The contents of the Quality Indicators report and the actions being taken forward to address areas for improvement be noted.	FJ

QSE 21/04/009	**Exception Reports – IP&C Position (Presentation)** The Exception Reports – Infection Prevention & Control (IP&C) Position presentation was received. The Deputy Executive Nursing Director (DEND) gave an informative presention and the Committee noted that CVUHB had encountered unprecendented challenges over the last 12 months including: • 60 ward closures from 17 April 2020 to 23 February 2021, • Approximately: - 8,000 bed days lost to date, - 740 patients with laboratory confirmed COVID-19 associated with incidents or outbreaks, - 370 staff with laboratory confirmed COVID-19 and possible links to incidents or outbreaks. The DEND advsied that the figures were from patients who had been admitted to hospital COVID-19 symptom free and had acquired COVID-19 whilst in hospital. It was noted that the A1N-MDU at UHW had the highest number of deaths and that CVUHB was average in comparison with other Welsh Health Boards, however in January and February 2021, CVUHB saw a significant spike in cases. The DEND advised the Commitee of the mortality rates from November 2020 to January 2021: • 25% Mortality rate from hospital acquired COVID-19, • 44% of inpatient COVID-19 deaths were hospital acquired, • 89% of those deaths were linked to an outbreak, • November to December 2020 there were 45 HCA COVID-19 deaths, • January to April 2021 there were 176 HCA COVID-19 deaths. Themes were identified that drove the data to the levels presented. Some of the themes included: • Patients testing negative and becoming positive up to 5 days into admission, • Patients having multiple moves during their hospital stay, • Staff behaviours, • Issues with documentation. The Committee noted that a significant number of lessons had been learnt during the pandemic and noted that two of the biggest lessons had been the ability to provide cessation of services, and waiting for the laboratory result before transferring patients on amber wards. The DEND advsied that the following actions had been taken to improve: • Continuation of regular communications to staff regarding social distancing, Personal Protective Equiment (PPE) and not coming into work when exhibiting symptoms,	

	• Retesting patients in amber areas 72 hours after admission and then every 5 days, • A daily IP&C Cell and fortnightly PPE Cell, • early discussions had commenced with the laboratory in planning for a third wave, • Next steps included work with Public Health Wales (PHW) to ensure a cohesive approach. The DEND finalised that it had been 36 days since the last HCA infection at the UHW and 31 days in University Hospital Llandough (UHL). **The Committee resolved that:** a) The Exception Reports – Infection Prevention & Control (IP&C) Position presentation be noted.	
QSE 21/04/010	**Impact of COVID-19 on Patient Safety (Verbal)** The verbal update on the Impact of COVID-19 on Patient Safety was received, and the END advised the Committee that hospital visiting had been restarted and was being done very carefully to ensure that all risks were balanced. The Committee noted that over 300,000 people had been vaccinated and that CVUHB were now inviting priority group 10 and over for vaccinations. 80% of groups 1 to 7 have been vaccinated which is 2 weeks ahead of the original plan. The END advised that the biggest challenge was the Did Not Attend (DNA) rate which had been significantly high last week due to the issues concerning the AstraZeneca vaccine. However, since opening up to allow more people to book themselves an appointment, DNA rates had slightly decreased over a 24 hour period. **The Committee resolved that:** a) The verbal update on the Impact of COVID-19 on Patient Safety be noted.	
QSE 21/04/011	**HIW – Activity Update and Primary Care Update** The Health Inspectorate Wales (HIW)-Activity Update and Primary Care Update was received, and the Assistant Director of Patient Safety and Quality (ADPSQ) gave an update on the reviews/inspections undertaken by HIW since the last report to the Committee in February 2021. The Committee noted that: • HIW had scaled down their inspection work during the pandemic and in October 2020, HIW informed CVUHB of a planned programme of quality checks from November 2020 to January 2021, • HIW undertook a focused inspection at the Splott Mass Vaccination Centre (MVC) in March 2021 for which HIW issued an	

	immediate action, an improvement plan was devised and accepted by HIW,
	• Two Tier 1 Quality checks have been undertaken:
	  ○ Tier 1 Quality Check for Mental Health Services for Older People (MHSOP) E12 – HIW undertook a remote quality check of ward East 12 UHL, which had been positive overall with one ongoing issue concerning environmental risk assessments which the patient safety team were reinstating,
	  ○ The Hazel Ward at Hafan y Coed for which feedback has not yet been received,
	• a Tier 1 Quality check was planned to take place on the Teenage Cancer Trust on the 31 of March 2021,
	• on the 13 January 2021 HIW informed the health board that the second phase of the maternity review will be delayed by around six months due to the effects of the COVID-19 pandemic,
	• HIW have announced their intention to undertake a national review of Mental Health Crisis prevention in the Community, which will be completed by autumn 2021.
	
	The Committee resolved that:
	
	a) The level of Health Inspectorate Wales (HIW) activity across a broad range of services be noted,
	b) The appropriate processes in place to address and monitor the recommendations were agreed,
	c) The HIW Primary Care Contractor report be noted.	

QSE 21/04/012	**Themes and Trends in Never Events** The Themes and Trends in the Never Events report was received and the ADPSQ gave an update of the Never Events reported by CBUHB. The Committee noted: • That since April 2015 34 Never Events had been reported by CVUHB. The highest number per year was 7 and the lowest was 3, • 16 Never Events had been reported since April 2018, the most common type reported related to wrong site surgery with 8 incidents being reported, the second most common was retained object post-surgery with 4 incidents occurring, • half of the Never Events had occurred at UHW, all of the 8 wrong site surgery Never Events were reported by the Surgery Clinical Board and half of them had occurred in the Dental Hospital, • a number of themes and trends had been identified including staff factors, patient factors, distractions and non-adherence with established policies and processes, • There were also some patient factors involved with Never Events concerning dental treatment whereby the patients were anxious and in distress so communication between the patients and clinical staff had decreased. The ADPSQ advised the Committee that development of a Human Factors Framework and Training Strategy would be an important element of the revised Quality, Safety Experience (QSE) Framework for the next 5	

	years. Embedding a Human Factors and Systems based approach to safety would support the reduction of Serious incidents (SI's) and Never Events. The EMD responded that focusing on the human factors was a positive step and that it could be key to the reduction of Never Events. He added that wrong site tooth extraction had been removed from NHS England's list of Never Events and Welsh Government had not yet confirmed its position on whether it would be removed from the list for Wales. **The Committee resolved that:** a) The Themes and Trends in Never Events report be noted.	
QSE 21/04/013	**Gosport Review - Verbal** The verbal update on the Gosport Review was received and the ADPSQ advised the Committee that she and the END had reviewed the original report that had been presented to the Committee in 2019 informing the Committee of the Gosport report concerning deaths caused by excessive opiate usage at the Gosport War Memorial Hospital. The Committee noted that there was an outstanding action related to building a clinical audit of anticipatory prescribing into the national audit of end of life care, and that an update on all outstanding issues would be brought to the Committee meeting in June 2021. **The Committee resolved that:** a) The verbal update on the Gosport Review be noted.	
QSE 21/04/014	**Draft Quality, Safety and Experience Framework (Presentation)** The Draft Quality, Safety and Experience (QSE) Framework presentation was received, and the ADPSQ advised the Commitee that the purpose of the presentation was to provide the Committee with an update on the plans for the QSE framework over the next 5 years. The Committee noted that for strategic context, key documents would be needed to shape the thinking to support the QSE framework which included: • Welsh Government's "A Healthier Wales: Our Plan for Health & Social Care, June 2018, • NHS Patient Safety Strategy 2019 (2021), • WHO Global Patient Safety Action Plan 2021-2030. Seven themes had been identified for CVUHB to base the QSE framework on: 1. Safety Culture, 2. Leadership and Prioritisation, 3. Pateint experience and involvement ,	

	4. Patient safety, learning and communication, 5. Staff engagement and involvbement, 6. Data and insight, 7. Professionalism, 8. Quality governance. The ADPSQ added that the Welsh Ergonomics and Safer Patient Alliance (WESPA) would be established The Committee noted that a revised QSE Committee and Group infrastructure with revised monitoring, reporting and scrutiny would be implemented with demonstrable and consistent learning. An update would be provided to the next meeting. The IMU asked how and when it would be rolled out, and the ADPSQ responded that the framework would be presented to the Committee in June accompanied by an implementation plan setting out what was achievable each year. The Committee noted that some of the work was already underway and that cultural change would take time. The COCHC advised that it was pleasing to see the themes identified, however queried if patients had played a part in influencing those themes. The END responded that co-production was very important and would form how the framework would be taken forward. **The Committee resolved that:** a) The Draft Quality, Safety and Experience Framework presentation be noted.	CE
QSE 21/04/015	**Board Assurance Framework (BAF) – Patient Safety** The Board Assurance Framework (BAF) was received. The Director of Corporate Governance (DCG) advised the Committee that the BAF had been presented to the Board in full and this risk had been brought to the QSE Committee to provide assurance to the Board that the issues were being discussed at Committee level. The Committee noted the patient safety risk which had increased from 15 to 20 at the Board meeting in January 2021 due to an increased risk to patients associated with COVID-19, and that the risk remained at 20 and was managed through the Corporate Risk Register. The DCG advised that a conversation would be undertaken with the CC and the EMD to move the risk forward and focus the need to manage patient safety effectively as we move into the recovery phase post COVID-19. The BAF would be reported to the Board meeting in May 2021. **The Committee resolved that:**	NF

	a) The risk in relation to Patient Safety be noted, to enable the Committee to provide further assurance to the Board when the Board Assurance Framework is reviewed in its entirety.	
QSE 21/04/016	**Thromboprophylaxis Policy** The Thromboprophylaxis Policy was received. **The Committee resolved that:** a) The policy for the prevention of venous thromboembolism (VTE) in adult and teenage inpatients be approved, b) The full publication of the venous thromboembolism (VTE) in adult and teenage inpatients in accordance with the UHB Publication Scheme be approved.	
QSE 21/04/017	**Swab, Instrument and Sharps Count Policy and Procedure** The Swab, Instrument and Sharps Count Policy and Procedure was received. **The Committee resolved that:** a) The Swab, Instrument and Sharps Count Policy and Procedure be approved, b) The full publication of the Swab, Instrument and Sharps Count Policy and Procedure in accordance with the UHB Publication Scheme be approved.	
QSE 21/04/018	**Minutes from Clinical Board QSE Sub Committees: Exceptional Items to be raised by Assistant Director Patient Safety & Quality:** The Minutes from the Clinical Board QSE Sub-Committees were received: a) Children & Women's Clinical Board Minutes – 26.01.21 b) Specialist Clinical Board Minutes – 20.11.20 c) CD&T Clinical Board Minutes – 9.12.20 / 10.2.21 d) Surgery Clinical Board Minutes – 19.01.21 e) Mental Health Clinical Board Minutes f) Medicine Clinical Board Minutes – 22.10.20 g) PCIC Minutes The CC noted that there were no minutes from the Mental Health Clinical Board. The ADPSQ provided assurance that the Mental Health Clinical Board undertook weekly meetings advised that that minutes would be brought to future meetings. **The Committee resolved that:**	

	The Minutes from the Clinical Board QSE Sub-Committees be noted.	
QSE 21/02/019	**Corporate Risk Register** The Corporate Risk Register was received and the DCG advised the Committee that there were 14 risks that related to patient safety within the Clinical Boards that had been given a risk assessment rating of 15 and above. The Committee noted that work was ongoing to manage the risks. **The Committee resolved that:** a) The Corporate Risk Register be noted.	
QSE 21/02/020	**Induction Support for New Committee Members (Verbal)** The verbal update on induction support for new Committee members was received and the DCG gave an update on training opportunities for members. **The Committee resolved that:** a) The verbal update on induction support for new Committee members be noted.	
QSE 21/02/021	**Items to bring to the attention of the Board / Committee** There were no items to be brought to the attention of the Board / Committees.	
QSE 21/02/022	**Any Other Business** No other business was noted	
QSE 21/02/023	**Review of the Meeting** The CC asked if attendees were satisfied with the business discussions and format of the meeting, and CC commented that she had allowed ample time for the presenters as this provided the Committee with good quality presentations. The Committee discussed the length of the meeting and it was suggested that 2 hours was not long enough to fully discuss the items on the full agenda, and it was agreed that the length of time required for future meetings would be discussed at the next agenda setting meeting.	
QSE 21/02/024	**Date & Time of Next Meeting:** The CC thanked everyone for their attendance and contribution to the meeting, and confirmed that the next meeting would be held on **Tuesday 15 June 2021 at 9am** Via MS Teams	

Confirmed Minutes of the Strategy & Delivery Committee
Tuesday 11 May 2021 – 9:00am – 12:00pm
Via MS Teams

Chair:		
Michael Imperato	MI	Committee Chair
Members:		
Rhian Thomas	RT	Independent Member – Estates
Sara Moseley	SM	Committee Vice Chair & Independent Member – Third Sector
In attendance:		
Paul Burns	PB	Primary Care Commissioning
Emma Cooke	EC	Head Of Physiotherapy Services
Steve Curry	SC	Chief Operating Officer
Nicola Foreman	NF	Director of Corporate Governance
Rachel Gidman	MD	Director of People and Culture
Abigail Harris	AH	Executive Director of Strategic Planning
Fiona Jenkins	FJ	Executive Director of Therapies and Health Science
Fiona Kinghorn	FK	Executive Director of Public Health
Karen May	KM	Head of Medicines Management - PCIC
Catherine Philips	CP	Director of Finance
Ceri Phillips	CP	UHB Vice Chair
Jason Roberts	JR	Deputy Executive Nurse Director
David Thomas	DT	Director of Digital Health Intelligence
Keithley Wilkinson	KW	Equalities Manager
Secretariat		
Raj Khan	RK	Corporate Governance Officer
Apologies:		

Min Ref	Agenda Item	Action
S&D 21/05/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the meeting.	
S&D 21/05/002	**Apologies for Absence** No Apologies for absence were received.	
S&D 21/05/003	**Declarations of Interest** The Independent Member – Third Sector (IM-TS) declared an interest as being part of the General Medical Council (GMC) in Wales The Executive Director of Therapies and Health Science (EDTHS) declared an interest as a Joint Executive Director of Cwm Taf Morgannwg UHB (CTMUHB).	

S&D 21/05/004	**Minutes of the Committee Meeting held on 9 March 2021** The minutes of the meeting held on 9 March 2021 were received and confirmed as a true and accurate record of the meeting. **The Committee Resolved that:** a) The Committee **APPROVED** the minutes of the meeting held on 9 March 2021 as a true and accurate record of the meeting.	
S&D 21/05/005	**Action Log following the Meeting held on 9 March 2021** The action log was received and the Committee noted that the majority of the actions had been completed or were on the agenda for discussion during the meeting, or were due for discussion at a future meeting. The CC confirmed the action relating to the Integrated Performance Report would be presented to the Public Board meeting in May 2021.	
S&D 21/05/006	**Chair's Action taken following the meeting held on 9th March 2021** The CC advised that he met with the Director of Digital Health Intelligence (DDHI) regarding the Strategy & Delivery Dashboard and had received a demonstration of the most updated iteration.	
S&D 21/05/007	**Draft Pharmaceutical Needs Assessment (PNA) report** The Draft Pharmaceutical Needs Assessment (PNA) report was received and the Executive Director of Public Health (EDPH) introduced the Head of Medicines Management – PCIC (HMM) & Paul Burns, Primary Care Commissioning (PB-PCC) who gave an update on the PNA process. The Committee noted: • The Welsh Government had changed the way in which applications from pharmacies, dispensing appliance contractors and dispensing doctors to provide pharmaceutical services are made and determined, by introducing pharmaceutical needs assessments (PNAs), • The NHS (Pharmaceutical Services) (Wales) Regulations 2020, which introduce the PNA in Wales, came into force on the 1 October 2020 and placed a statutory duty on each Health Board to publish its first PNA by the 1 October 2021. As a result, Cardiff & Vale UHB (CVUHB) had begun the process of developing its first PNA, • From the 1 October 2021, Health Boards would need to use the published PNA when determining applications from pharmacies, dispensing appliance contractors and dispensing doctors to provide pharmaceutical services under these regulations. She added that it was a significant change in the way applications to open new pharmacies were considered having a shift from a contractor driven, dispensing focused process to a system that could respond to the wider pharmaceutical needs of a population.	

	She highlighted that the assessment would be used to determine: • Additional contractor premises were required – pharmacies and appliance contractors, • Additional dispensing by doctors was required, • Existing contractors were adequately addressing pharmaceutical needs, • Where additional services were required from existing contractors The HMM advised that the following processes were followed: • CVUHB had set up a PNA Steering Group which would oversee the drafting of the PNA which was being supported by PCC CIC who were contracted in December 2020 to author the report, • The Chair of the Steering Group was the Head of Medicines Management Primary Care (HMMPC) and the members included representatives from Primary Care, Pharmacy, Public Health, the Local Medical Committee (LMC), Communications team, Finance, Planning, the Community Health Council (CHC), and Community Pharmacy Wales also had Pharmacy project management support, • Conducted a patient/public engagement survey, • Issued Community pharmacy questionnaires to 106 pharmacies, • Data collation and consideration at cluster level, which was draft edited and approved by the steering group, • Data examined to identify evidence regarding: o Current gaps that must be immediately met , o Future needs – gaps that would arise within the 5 year timescale of the PNA. The Committee noted that the following information was considered for each cluster: • Population demographics, • General health needs of the population, • Current provision of pharmaceutical services, • Access to pharmaceutical services, • Identification of other services that affect the need for pharmaceutical services, • Health needs that can be met by pharmaceutical services, • Developments planned in the cluster & progress, • Capacity of existing pharmacies to meet demand from planned developments. The Committee noted: • the findings of the PNA, • based on the information available at the time of developing the PNA no current or future gaps were identified in the provision of essential, advanced or enhanced services • the next steps which were to undergo a 60 day consultation from 12 May – 20 July 2021 and then review the responses and update the PNA. There are regulations as to who the PNA must be consulted with which will be published on their website, • The PNA would be reviewed by the steering group on the 23 August 2021, and be brought back to the S&D committee for sign	KM

	off on the 14 September 2021, before being published by the 21 October 2021. The Independent Member – Third Sector (IM-TS) queried what the potential was for the pharmacies to be used in terms of prevention and maintenance of health as part of CVUHB's strategic ambition. The HMM responded that the community pharmacy contract included a health promotion stream within it, and whilst this year had been more focused on dispensing predominantly due to COVID-19, there was a requirement within the core contract to undertake health promotion and offer health promotion advice including healthy eating, smoking cessation, alcohol, etc. She added that there could be up to 6 health promotions per year including National stop smoking day and Antibiotic awareness. The Independent Member – Estates (IM-E) queried what influence the Health Board had on the quality of the service provided. The HMM responded that as a Health Board they had the ability to monitor the pharmaceutical services over a 3 yearly monitoring cycle and that they also reviewed enhanced service data to identify and monitor delivery. She added that there were significant comments received in the patient questionnaires that were influenced by COVID-19 and advised that this needed to be taken into account, for example when people have to queue outside to maintain social distancing. The Executive Director of Strategic Planning (EDSP) queried the reference within the report which stated that Cardiff had the sixth largest percentage increase, she advised that Cardiff was the largest growing core city outside of London, and had the largest growing Local Authority area in terms of size, and queried if the reference was correct. She added that consideration should be given on how the population would be changing over time and how we could ensure that they are on the front foot to ensure that service provision was effective and that patients were still able to access them. The HMM stated that she would double check the information concerning the population figure. She added that the trajectory going forward was to improve and increase services and that Welsh Government had structured pharmacy contracts in Wales to support that, unlike in England. The Director of Corporate Governance (DCG) stated that due to the significance of this that it should be ratified by the Board in September 2021, following sign off by the Strategy & Delivery (S&D) Committee in September due to the statutory requirements. **The Committee Resolved that:** a) The Pharmaceutical Needs Assessment (PNA) Update report be noted, b) the proposed approach for Cardiff & Vale UHB (C&VUHB) to develop a process for developing its first PNA be endorsed, c) the need to take chair's action to include, and or act on, information contained within the report be considered.	KM

S&D 21/05/008	**Strategic Equality Plan – Action Plan** The Strategic Equality Plan – Action Plan report was received and the Equalities Manager (EM) stated that this was the first year of their action plan, and that the original plan was received and approved in September 2020 and it had been agreed that a more action orientated plan be developed for the future. The Committee noted: • Since the last report to the Committee the Equality Strategy & Welsh Language Standards Group (ESWLSG) had been established and had met on three occasions. The purpose of the ESWLSG was to advise, embed and assure the Strategy and Delivery Committee on the development and implementation of the UHB's Strategy Equality Plan - Caring about Inclusion 2020-2024 (SEP) and compliance with the Welsh Language Standards, and key enabling plans, • The agreed EDWLSG Terms of Reference of the group would be brought to the next S&D Committee for noting, • The first year action plan was developed to ensure the delivery of the SEP in the new healthcare landscape as a result of the COVID-19 pandemic and the disproportionate impact on those with protected characteristics and those who come from socio-economically deprived communities. The objectives had been reviewed and commitment reaffirmed that equality and human rights must take centre stage to the thinking and planning of the Health Board and inform our response to COVID-19, • The forthcoming year would be about sustainability and enhancement with its continuation of some actions as well as the identification of new actions as we move into a more inclusive and partnership approach for our SEP which initially began in April 2020 and would be ending in March 2024, • the new Socio-economic Duty came into force on the 31 March 2021 and some of the aspects of the legislation had been adopted within the first year plan, in particular how the Health Boardmust take into consideration all of their decisions to help reduce inequalities associated with Socio-disadvantage which was around poverty in regards to financially, accessibility, education, health, etc, • the original plan had been accepted and noted by the Equality & Human Rights Commission who were public sector enforcers who ensured the Health Board were adhering to legislation and to ensure that the plan was up to standard. The EDPH expressed her support for the equalities work and advised that she was pleased to see the range of actions within the plan and the work undertaken over the past year. She advised that the work undertaken for the Socio-Economic Duty had involved a lot of work on inequalities in health across the Health Board and within the partnership arena, and felt there was an opportunity to expand how they describe and take the inequalities work further as it was a key component of their strategy. The EDPH queried if the three actions from the "Black Lives Matter" task group were included in the action plan, and the EM confirmed that they were included in the plan and that he and Catherine Floyd – Public Health,	KW

	were members of Cardiff Council's Race Equality Task Force and were leading on the Health Work streams concerning the three actions. The UHB Vice Chair highlighted work undertaken by the Kings Fund concerning "The Road to Renewal" and "5 Priorities for Health & Social Care" which was a step change in inequalities and population in health. He advised that it suggested a movement away from recognising something needed to be done, to actually transforming the way things were done to secure reductions in inequalities. He stated that part of the agenda was to measure things appropriately to monitor the trajectory. He queried if a piece of work needed to be undertaken to get measures and metrics in place. The EM responded and advised that work was progressing to get measures and metrics in place. The EDPH added that that there were many areas of inequalities statements that require action to change the statistics, and that there was more work to be undertaken and there was much wide reaching and consideration needed to be given to how this work was reported. The Committee noted that work was being undertaken to consider additional reporting requirements and the findings would be brought back to a future meeting. **The Committee Resolved that:** a) the Strategic Equality Objectives - Delivery Plan Framework 2020-2022 report be noted, **b)** the first year Strategic Equality Plan (SEP) delivery framework Plan be approved.	KW
S&D 21/05/009	**Employment Policies for Approval** The employment policies report was received and the Director of People & Culture (DPC) advised that there were three policies for approval, two of which had been changed and one had been amended: **(a) Respect and Resolution Policy** The DPC advised that the Respect and Resolution Policy would come into force from the 1 June 2021 and would replace the existing the dignity at work policy. She advised that a lot of collaboration had gone into this piece of work on an all Wales basis in conjunction with the Trade Unions. The CC queried how staff would know about the new Respect and Resolution policy being implemented and the changes that had been made, and the DPC responded that numerous staff workshops had been held to create awareness of the new policy, and that hundreds of staff attended. She added that they were also issuing further communications through the HR Governance Team via emails and on the Electronic Staff Record (ESR). The Chief Operating Officer (COO) highlighted the difficulty of communicating out to a large organisation like CVUHB and wanted to point out the challenge for the DPC's team in doing this and that it was	

not just the policy itself but also how ourselves as leaders and managers build that into daily practice.

(b) Special Leave Policy

The DPC advised that the Special Leave Policy had been reviewed and a number of changes introduced including:

- The introduction of an underlying principle that managers should 'know their staff' and be familiar with any issues or particular needs they may have. The manager, in knowing their staff, had the ability to apply discretion to the application of the policy,
- Individual, social, cultural, religious and geographical circumstances should be considered when granting special leave for bereavement purposes,
- A section on staff experiencing domestic abuse had been added – managers should be flexible and treat each instance sensitively and individually,
- Definitions, including that of a dependant and a carer, had been updated,
- The section on Public Duties had been strengthened to make it clear that individuals who had been allowed paid time off for public duties must refrain from claiming or accepting a fee or allowance for undertaking that duty,
- The section on time off and pay during jury service had been widened to include attending court as a witness,
- Support and reasonable time off would be provided to an employee who was the partner of someone receiving fertility treatment,
- The provisions in respect of the death of a child, which previously applied to staff employed on AFC terms and conditions only, had now been widened to include medical and dental staff.

(c) Recruitment and Retention Protocol

The Recruitment and Retention Protocol had been reviewed by the Welsh Partnership Forum (WPF) and a small number of amendments were made as follows:

- Further information was provided on what makes the payment robust enough to resist an equal pay challenge,
- If an extension was sought the review process needed to be initiated 12 months before the expiry date of the RRP,
- Reference was included to the public sector equality duty.

The Committee Resolved that:

a) the Respect and Resolution Policy be approved and adopted by CVUHB with effect from 1 June 2021,
b) the Dignity at Work Process and NHS Wales Grievance Policy be rescinded with effect from 1 June 2021,
c) the revised Special Leave Policy be approved for adoption by the CVUHB,
d) the revised Recruitment and Retention Payment (RRP) Protocol be approved for adoption by the CVUHB.

S&D 21/05/010	**No Smoking and Smoke Free Environment Policy** The No Smoking and Smoke Free Environment Policy was received and the DCG and CC confirmed that as the policy document had been brought to the committee the EDPH would send the policy out to the CC so that a chairs action could be taken to approve. The EDPH advised that the Public Board meeting in March 2021 had received a report on the smoking regulations and that the policy had since been updated and an Equality Health Impact Assessment had been completed and articulated the requirements under the regulations. The Committee noted that the following amendments had been made to the Policy: • Reference to the legislative requirements relating to the Smoke-Free (Wales) Regulations 2021, • Reference to the use of e-cigarettes inside specific, risk assessed areas for in-patients with mental health conditions, • Smoking Cessation Service provider name changes and updated information (including the implementation of the Level 2 Enhanced Smoking Cessation Service for Community Pharmacies, introduced June 2020), • Data updates where available, • Evidence updates where available. The EDPH highlighted that CVUHB had a comprehensive smoking cessation policy in place since 2011 and that they had a track record on having an approach to tackling smoking on hospital premises. She added there had been a revision of the original policy and not a complete re-write. The Committee noted that: • the policy included a Policy Statement including aims which were to protect Employees, Contractors, Visitors, Patients, and Service users to UHB sites from exposure from second hand smoke in line with legislation and to actively promote Health & Well-being, • smoking and tackling smoking played into being an inequality gap and that one of their tasks was to reduce smoking prevalence in their most disadvantaged communities and with populations that were more vulnerable and at risk. • The Management Executive Team had already considered the updated policy and an emphasis was placed on the importance of showing leadership right across all other leadership responsibilities to encourage and push the requirements within the policy. • the Equality Impact Assessment had not identified any negative impacts, however there were a few areas where they had compiled an action plan that they would take action on, to enable people with learning disabilities to have appropriate access and additional work to ensure they have the right materials and communication tools for people with visual impairments.	

	The EDPH added that when the regulations had been discussed with the Board it was suggested that this formed a component part alongside support and highlighted that Welsh Government expected the public to be widely compliant with the new legislation. As such, local arrangements for enforcement would depend on adherence by both the public, patients and staff. She added that there were enforcement arrangements in place with Local Authorities as they had a duty to support Health Boards with enforcement. **The Committee Resolved that:** a) the No Smoking and Smoke Free Environment Policy was noted and endorsed, b) the No Smoking and Smoke Free Environment Policy be published in full in accordance with the UHB Publication Scheme, c) That Chairs action be taken to formally approve No Smoking and Smoke Free Environment Policy, as the revised policy document had not been included in the papers for the Committee.	
S&D 21/05/011	**Recovery Planning Update – Presentation** The Recovery Planning Update – Presentation was received and the COO gave an update on the planned care recovery. The COO advised that it had been a difficult year and that there were a number of recovery challenges with the continued uncertainty both in terms of the impact of the mass vaccination programme, the potential of a third wave, the significant supressed demand, and a fatigued team from facing COVID-19 challenges. The COO gave an overview on the recovery planning approach and the Committee noted the Recovery Planning Cycle and Scenario modelling which was informed by: 1. Infection, Prevention & Control (IP&C) conditions, 2. A requirement to put capacity into the system, and 3. Access to skilled personnel All of these were assumed under the context of the uncertainty of a third wave. The COO explained the scale of the challenge they faced and presented modelling to demonstrate the peak of the waiting list backlogs that were likely to be seen, where they might peak, where they levelled off, and what would happen to them. He advised they would apply assumptions to the modelling process to forecast where the backlogs may appear. The Committee noted the level of activity lost from March 2020 to February 2021, in which more than 22,000 procedures had not been undertaken. He stated this was expressed in different ways showing the top 10 volume specialties on how capacity was lost. The COO stated that when planning at a modelling level they had needed to put some assumptions in related to the scenarios and had included a best, central, and worst case scenario. He added it will be dependent on	

	the IP&C restrictions being removed and the degree to which lost activity will return:
	• **Best Case** – 30 weeks to return to normal levels,
	• **Central** – 60 weeks to return to normal levels,
	• **Worst Case** – 90 weeks to return to normal levels
	
	The COO stated that their assessment would be:
	1. A full 'recovery' from the pandemic was likely to take 5-10 years and would require sustained and significant additional capacity,
	2. Additional capacity alone would not be enough and the NHS would need to fundamentally review the services it provided and the way in which they were provided,
	3. Both additional capacity and pathway redesign would take time and therefore there would be a need to support patients, manage expectations and enhance the services which were alternatives to treatment.
	
	The COO added that he was providing a level of modelling that was informing their planning to date and would continue to do so culturally and sustainably as they wanted to get into specialty level planning. This would help them orientate themselves into the 'Clinically Validate, Prioritise, & Design' element of the Recovery Planning Cycle which would give them different levels of planning.
	
	The COO advised that they needed to ensure that there was proper capacity and capability to make this work and that each of the cells (i.e. Workforce, IP&C, Capacity & Estates, etc.) would have Programme Management Support, Improvement Support, and Data Support. From that they would have learned from the COVID-19 response in terms of corporate cells that function to support Clinical Boards.
	
	The Committee noted the current position:
	• Maintenance of essential services through the first and second COVID-19 peaks,
	• The development of Protected Elective Surgical Units (PESU),
	• Independent Sector capacity,
	• An ambition to return to elective activity to:
	  ○ 70% of pre-COVID-19 levels in Q1,
	  ○ 80% of pre-COVID-19 levels in Q2,
	• An Outpatient transformation programme
	
	The COO presented graphs which demonstrated re-establishing activity in 3 areas:
	• Outpatients – returned to 81% of activity in February 2021
	  ○ Outpatient activity was slightly different as not all activity recovered was good activity as they wanted to do things differently and not just recover.
	• Inpatient / Day Case – Achieved 70% in November 2020 before having to suspend in January 2021 but was now up to 66% in February which was on target for the 70% that they aimed for by Q1,	

- Radiology – was now at 100% of pre-COVID-19 activity and had remained at a strong and improving position since September being at 96%.

The Committee noted that:

- that there had not been a significant waiting list increase since January 2020 – March 2021, however assurance should not be taken from this as it was part of the cycle of recovery activity coming back which hadn't grown significantly, and would change as other activity started to pick up,
- the 26-week position was starting to rise and had been since September 2020 – March 2021, however this was anticipated, and there was an assumption that as people got referred back into the system the under 26 week group would increase and in proportion the over 36 weeks group should reduce,
- they were starting to make some progress in Diagnostics showing the number of 8-week waits highlighting that they had made some significant gains in this area and that sustaining this would be an issue however there were signs that they could make rapid progress in some areas.

The COO advised that next steps would be a huge challenge, and that a start had been made on some major schemes including:

- Endoscopy was being worked through,
- Green Zones were being expanded and had been a success in terms of outcomes and volumes,
- Continuing to use the Independent Sector,
- Continuing to use Mobile MRI Scanners – which affected the 8 week diagnostic position,
- Using Mobile Day Surgery Units – the rate limiter would be staff,
- Using traditional methods of waiting list initiatives which were not sustainable.

He added their long term plans would be Risk Orientated, Data Driven, Clinically Led, through a programme delivered approach, looking through a number of lenses.

The CC queried what the difference of the new approach would be in comparison with the old approach used 3 years ago, the COO responded that the differences were the scale and the priority as they used to manage people by wait time whereas now they needed to shift to risk.

The Independent Member Capital & Estates (IM-CE) queried the viability of a long term dependency on the independent sector and that as the workforce was identified as a rate limiting factor, assuming there was an injection of cash into the system which would create public perception on how quickly recovery could happen, she also queried how they would deal with that.

The COO responded that long term dependence on the independent sector was not what they should be planning for and that one of the things they were doing through their annual plan bids was to be clear that short

	term planning would not get them out of this and that strong bids for recurrent funding should be made to be able to invest and grow their own core services to ensure they could recover in a sustainable way. The COO advised that in relation to workforce CVUHB were planning ahead and were actively recruiting staff as it was anticipated there would be a need to grow capacity staff, and that there will be significant competition for skills and a lag to growing those skills locally. The CC queried what advice was being sought from Welsh Government on what should be done to manage the workforce, and the COO stated that there was active discussion and a keenness to get a scale of planning at granular level from the clinicians on the front line as the Clinicians were informing this and the risk would be appropriate in terms of that need. He added that the Clinicians were also involved on national committees and were keeping Welsh Government sighted on the discussions to provide an informed view. **The Committee Resolved that:** a) the Recovery Planning Presentation be noted.	
S&D 21/05/012	**Shaping Our Future Wellbeing Strategy (SOFW) Update** **a) Flash Update** The flash update presentation on "Accelerating delivery of our strategy - our road to recovery and renewal" was received and the EDSP shared a presentation to illustrate how they had regrouped some of their work concerning the strategic programmes. The EDSP reminded the Committee that the overarching vision was about the health inequalities in the population and that they were striving to equalise the inequalities seen which would have likely deteriorated throughout the pandemic. The Committee noted that the strategy was delivering joined up care based on home first; avoiding harm, waste and variation; empowering people; and delivering the outcomes that matter to them. The strategic objectives set out in their strategy were: • Reduce health inequalities – reduce the 12 year life expectancy gap, and improve the healthy years lived gap of 22 years, • Deliver outcomes that matter to people, • All take responsibility for improving our health and wellbeing. The Committee noted the 4 design principles: • Empower The Person, • Home First, • Outcomes That Matter To People, • Avoid Harm, Waste And Variation. The EDSP advised that they were keen to ensure they were able to shift the power balance and show they had greater equity in relation to people who use the services.	

	The EDSP reminded the committee in November 2020 there was a mid-year review of the strategy which was informed by all of the learning from the response to the pandemic. The Committee noted: • the emerging strategic programmes of the UHB were Strategic Programmes, Operational Programmes, and Enabling Programmes, • work was being undertaken on the measures, metrics, and indicators of how they would know they are delivering on the principles and outcomes that they wanted to achieve for the population, • they were developing a live interactive outcomes framework by applying the learning taken from Canterbury Hospital, • the Annual plan focussed on the four COVID-19 harms, remaining COVID-19 ready, COVID-19 recovery (staff wellbeing, planned care, MH demand, long COVID-19 rehabilitation, emergency care and planning for the winter), moving beyond COVID to transforming services in line with Shaping our future wellbeing (SOFWB) strategy, Zero carbon, Dragon's Heart Institute, Spread and scale intensive learning academy and Working in collaboration, • a strategic programme meeting was held each fortnight where the individual programmes were discussed. The purpose of this was to make sure as a collective group of directors they had responsibility across all programmes, also to hold Senior Responsible Officers (SRO's) to account that they are on course to deliver. **b) Deep Dive – (Rehabilitation Model Implementation)** The deep dive presentation on the Rehabilitation Model Implementation was received and the Head Of Physiotherapy Services (HPS) advised that the rehabilitation model was launched in 2020 and was being used to try and map where and when they should be implementing rehabilitation services and that they were aligned to the model. The Committee noted that there are 5 tiers within the model: **<u>Specialised Rehab</u>** • Critical Care / Rookwood facility, • MDT rehabilitation, **<u>Non Specialised rehab</u>** • Supported rehabilitation – non specialised rehabilitation, • Primary Care support – delivered in a primary care setting in peoples home or GP's, • My Health and Well Being – centred on enabling and empowering the population to use their community assets to support their health and wellbeing. The Committee noted: • a programme was being developed that would look at how they would deliver rehabilitation against their model,	

	• as it was 8 weeks of support they decided to focus on areas that were least developed within their tier one and two areas and felt that they needed to be developing more co-produced behavioural changed programmes focusing on prevention, self-management, for people with chronic conditions living within the community, • the 8 week programme will include fortnightly 60-minute catch-ups with the programme lead, workshops with more than 60 individuals attending, 60-minute meetings with stakeholders from across the organisation and Kick-Off meetings with the key stakeholders, • key topics identified for discussion include Stakeholder engagement, Communication and IT & Digital Capabilities, • the short term aim which was to start developing a Living Well Programme for long-term conditions in partnership with the Recovery College and their long term aspiration which was a long-term condition rehabilitation service in the community to support people to live well, • an initial 90-day implementation plan has been designed and CVUHB are developing an 18 month implementation plan The HPS outlined the Governance and reporting structures and felt the work would be better aligned in the Shaping Our Future Clinical Services (SOFCS) strategy. The CC asked that a brief update on this item be brought back to the committee later in the year. **The Committee Resolved that:** a) The Flash update Presentation be noted. b) The Deep Dive presentation on the Rehabilitation Model Implementation be noted.	
S&D 21/05/013	**Strategy & Delivery Dashboard Demonstration Update – Verbal** The verbal update on the Strategy & Delivery Dashboard Demonstration was received and the CC advised that he had met with the Director of Director of Digital Health Intelligence (DDHI) and received an update / demonstration on the Dashboard. He stated that he was impressed with the proposal, and that it provided a simpler easy to use dashboard, which highlights key targets and performance. The CC stated that he had discussed having the dashboard presented at a Board development session with the UHB Chair to ensure that IM's were sighted on this. Once this had been done the CC could sign it off for completion. The DDHI advised that the dashboard was published and validated data and that were looking to expand the number of indicators, as it currently only focussed on the 38 indicators mapped to the S&D Committee. He added the plan is to have a "Biz Dashboard" set up for each IM to show them the data in a useful way. **The Committee Resolved that:**	DT

	a) The verbal update on the Strategy & Delivery Dashboard Demonstration was noted.	
S&D 21/05/014	**People and Culture** The People and Culture update was received and the DPC advised that her title has now changed to People and Culture and wanted to encapsulate that in a People and Culture plan going forward. The Committee noted that the team were working on: • developing a wellbeing plan for the next 12 months, • A VBA Campaign – which would be very important when referring to statistics and was a foundation that they needed to drive forward on. The DPC advised that a presentation will be brought a future meeting providing an update, • Project Search – in relation to diversifying the workforce and were working in collaboration with the Local Authority and Project Search concerning individuals coming into the Health Board with learning disabilities, • a procurement tender for a virtual showcase to help spear a social movement and to encourage staff to be on board with the strategy. This will link in with SOFCS and engage with the population in a creative way, • Discussion with the CEO of Health Education improvement Wales (HEIW) regarding higher level apprenticeships. **The Committee Resolved that:** a) The verbal People and Culture update be noted.	RG
S&D 21/05/015	**Performance Reports** **(a)Organisation Key Performance Indicators** The **Organisation Key Performance Indicators** update was received and the COO advised that he wanted to recognise the good work being undertaken in the Diagnostics & Therapies department as they had reached almost zero 8-week waits for diagnostics last year. He stated that it then increased to 10,000 as a result of COVID-19 but they had reduced to 4,500 in March 2021. The COO highlighted two areas of concern: • **Stroke** – 4 hour access was very poor and this was directly related to COVID-19 as the stroke reception unit is very small where patients go to receive optimal care. The front door pathways state that if any of the patients are suspected to have COVID-19 symptoms they had to go to a different place, • **Mental Health 28 Day Assessment** – this continued to be a concern and they were seeing some real improvements for the trajectory for Children and Adolescent Mental Health Services (CAHMS). There is a slight improvement in Mental Health highlighting that the previous months referrals were 1,400 but that were not at 900. The COO stated that he and the mental health	

team had gone through a recovery plan and were seeing some recovery up to 20% for May 2021, but it was dependent on recruitment which had a lag to benefit. They were working on what could be done in the short term whilst the recruitment was ongoing.

The IM-TS queried what was being offered in lieu of an assessment and if there was a watchful waiting support for individuals rather, than them having to wait in distress. The COO advised he would happy to arrange a meeting with the CC, IM-TS and the UHB Vice Chair to provide greater detail. He added that with other services Mental Health protected the higher acuity essential services and therefore they had taken a risk based approach to this, however this is not acceptable but is understandable, as the figures demonstrated that their staff have been affected in the same way as Physical Health staff.

The CC queried the impact of CAV 24/7 and how it was being assessed. The COO advised that it was being measured in the same way as before and was still constituting one third of activity in the emergency department (ED). He added that a new scheme was proposed which extended access to surgical direct referrals which rather than book people into ED would also book them into a direct urgent surgery slot going forward. The Committee noted that if the surgical teams were keen on this there was potential to replicate this. They would be going from an unplanned event to a semi-planned event so at the end point of the event it will not default to the ED anymore but instead to cardiology, surgery, psychiatry, etc.

(b)Workforce Key Performance Indicators (KPI's)

The Workforce Key Performance Indicators (KPI's) report was received and the DPC gave a summary of performance against the KPI's presented within the report.

The Committee noted that the total monthly pay bill had doubled and that the DPC she was working with the finance teams to discuss the central monies received from Welsh Government for this purpose.

The DPC advised that there was an additional £17 Million bonus for NHS staff plus the accrual of £10 Million and that they had to give the estimation for annual leave carryover and study leave for junior doctors.

The Committee noted that of the 1,600 voluntary resignation monitored from the period 2019-2020 there had been only an 8% return of exit questionnaire feedback, and the DPC felt that more work was required in this area through discussion with managers and managers training. She advised that people were generally leaving to transfer to other NHS organisations in the same profession.

The DPC advised that they had analysed the number of staff leaving and that 11% of the 130 staff had retired, and some comments of concern were identified stating staff were not feeling valued or managers were not behaving in the correct way.

	The DPC advised that the sickness absence rates correlated with the first wave in April 2020, which saw the biggest spike of over 8% sickness which was similar to December 2020 when the second wave occurred. The Committee noted that the sickness rates were decreasing, however they were not yet below the target set for NHS Wales. **The Committee Resolved that:** a) The year to date position against key Organisational Performance Indicators for 2020-21 but in the context of current operating framework principles be noted, b) the Workforce & OD Key Performance Indicators Dashboard report be noted.	
S&D 21/05/016	**Board Assurance Framework** The Board Assurance Framework (BAF) report was received and the DCG outlined the risks that would be presented to the Public Board meeting in May 2021 for discussion. The DCG also detailed which risks were aligned to the S&D Committee and proposed to bring two risks to each committee going forward, rather than one in an effort to maintain the momentum and risk discussions going. The Committee noted that in addition to the nine risks detailed, the DCG would work with the EDPH to integrate the risk concerning inequalities into the BAF, and that this will be taken to the Board meeting on the 29 July 2021. **The Committee Resolved that:** a) the Board Assurance Framework (BAF) and the risks which will be presented to the Strategy & Delivery Committee once the full BAF has been agreed at the Board meeting on the 27 May 2021.	NF
S&D 21/05/017	**Induction Support For New Committee Members – Verbal** The verbal update on the Induction Support for New Committee Members was not received as there was no need for the matter to be discussed further.	
S&D 21/05/018	**Review of the Meeting** The CC asked if attendees were satisfied with the business discussions and format of the meeting, and all Committee members confirmed it was a positive meeting with an appropriate level of Independent Member challenge and scrutiny.	
S&D 21/05/019	**Date & Time of next Meeting** The CC thanked everyone for their attendance and contribution to the meeting, and confirmed that the next meeting would be held on Tuesday 13 July 2021 at 09:00am Via MS Teams	

Confirmed Minutes of the Public Digital Health & Intelligence Committee
Thursday 11th February 2021 9:00am – 10:00am
Via MS Teams

Chair:		
Eileen Brandreth	EB	Committee Chair / Independent Member - ICT
Members:		
Michael Imperato	MI	Committee Vice Chair / UHB Interim Vice Chair
In Attendance:		
Allan Wardaugh	AW	Chief Clinical Information Officer
Angela Parratt	AP	Director of Digital Transformation – IM&T
Christopher Lewis	CL	Interim Finance Director
David Edwards	DE	Independent Member - ICT
David Thomas	DT	Director of Digital & Health Intelligence
James Webb	JW	Information Governance Manager
Nicola Foreman	NF	Director of Corporate Governance
Secretariat:		
Raj Khan	RK	Corporate Governance Officer
Apologies:		
Gary Baxter	GB	Independent Member

DHIC 21/02/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the public meeting. She also welcomed David Edwards who will be the new Independent Member responsible for IMT and will be the new chair of the Digital Health & Intelligence Committee from 1st April 2021. CC confirmed that the meeting was quorate	**Action**
DHIC 21/02/002	**Apologies for Absence** Apologies for absence were noted.	
DHIC 21/02/003	**Declarations of Interest** There were no declarations of interest.	
DHIC 21/02/004	**Minutes of the Committee Meeting held on 8th October 2020** The Committee reviewed the minutes of the meeting held on 8th October 2020 **The Committee resolved that:** (a) The Committee approved the minutes of the meeting held 8th October 2020 as a true and accurate record.	

DHIC 21/02/005	**Action Log following the Committee Meeting held on 8th October 2020** The CC reviewed the action log and confirmed that the actions were either completed or on the agenda for today. **The Committee resolved that:** **a)** The action log updates were received and noted	
DHIC 21/02/006	**Chair's Action taken since the Committee Meeting held on 8th October 2020** None	
DHIC 21/02/007	**Information Governance Policy EHIA** The CC reviewed the policy and stated that the policy applies equally to everybody irrespective of their protected characteristics and asked members of the committee if they were content to approve. The UHB Vice Chair queried that within the policy it states throughout that it "applies to all staff so no problems" and asked if that was correct and whether that was enough analysis. Information Governance Manager (IGM) responded that it was completed in line with other NHS organisations which they used as a bench march, he added that there were no issues identified in any assessment so it seems that those considerations haven't been made or that they have and there haven't been any issues with any groups of people. The UHB Vice Chair felt that there may be staff with characteristics which may result digital access problems and felt the policy skates over that. The IGM stated that if requested by staff with i.e. physical, visual impurities, needed in Welsh, etc. They would make the policy available to them. The UHB Vice Chair queried if this was the correct method as it puts an onus on the staff to raise the issue as the point of the policy is for the Health Board to take responsibility to identify there could be problems for staff and mitigate problems. The CC asked the UHB Vice Chair to pick up the concerns of the committee outside of the meeting to which the IGM could bring back an update EHIA to the next meeting.	**JW**
DHIC 21/02/008	**Digital Transformation Progress Report - (Digital Dashboard)** Director of Digital Health Intelligence (DDHI) stated that they have produced a brief progress report which they have been working through the last few months, with the aim to produce this into a dashboard format but has proven slightly difficult as moving from a reporting to dashboard format requires a bit of time. He said that the focus of the report is based on what they have been doing around Covid highlighting the first 2 pages of the report which details some of the activities they are continuing to do. He mentioned that the Mass Immunisation piece has diverted a number of	

	resources away from other activity to provide digital support to this programme across C&V. he highlighted that the other progress is to demonstrate that although the focus has been on focus but other activities have been carried on in the background so that things have not been halted The Interim Finance Director (IDF) commented that the amount of activity taken on within the digital teams have been amazing and that the breadth of things not only with the pandemic but in order to drive forward the strategy has been a tremendous effort. The CC commended the DDHI and his team on the huge amount of work being done to support the Covid period with little warning. She added that from this report it can be seen the amount of work that is happening and understands in its own way is transformative and feels they need to get to a point in time where its clearer exactly what needs to be done to support transformation i.e. what are the actual initiatives that are planned and be able to deliver against. The DDHI agreed with the comments made by the CC. **The Committee resolved that:** (a) **NOTE** the progress across the broader Digital Work Programme	
DHIC 21/02/009	**Digital Strategy - Plan on a Page** Director of Digital Transformation – IM&T (DDT-IMT) stated that this is still considered as a draft as they continue to iterate on it but said that this is the outline of transformation activity that they are looking to undertake to enhance and increase their digital maturity over the next 5 years. She mentioned that it is not set out as a priority order and highlighted EPMA saying that it may not be done until 2025 but they are mobilising it now but requires 37 months to implement. She said in terms of which initiatives they are working on now she highlighted a roadmap of activities which have been given RAG ratings. She mentioned the additional funding in Q4 and stated the need for resource investment in digital, she said that they had benefitted in Q4 from some additional funding which is being invested in the Roadmap as well as supporting the Covid response and Windows 10 Programme. She highlighted the following achievements: • Work involved with Digital in regards to the Mass Vaccinations which is ongoing • O365 Broadcast – able to broadcast CEO Connect and also the public meetings which is a really good capability of O365 Suite • Telephone Advice & Guidance (TAG) – they use a national supplier Consultant Connect and highlighted that has resulted in 46% of elective referrals avoided, Virtual consultation, 5.67K hours travel time saved for patients • Electronic Test Requesting mandated In terms of opportunities she highlighted:	

- Cardiff City Region Bid – stated that this is a big opportunity for the region and are re-procuring for the Patient held records to figure out how they can make that work better for them through this process.
- They are nearing conclusions for a number of business cases that are captured within the roadmap Digital comms, FollowMe print, Community scheduling, ePMA, Scan4Safety, Cash release of real estate

She highlighted the strategic questions that need to be considered:

- Covid-19 – how do they sustain what has worked really well, what is going well, how to support those new ways of working people aspire to but are not yet fully enabled
- Gillick Competence – in the context of a patient held record which is what age a child is considered competence that will be part of a clinical assessment.

She highlighted the Risks and issues:

- Equipment, Resources
- Sustainable funding
- Activity levels & Capacity
- Duration of pandemic

The DDT-IMT then went onto discuss the ENT new model of delivering Planned care which is currently a work in progress but is making huge strides. She referred to how the world changed in response to Covid-19 and how a slew of digital solutions were brought in but not in a planned way. She said this piece of work now is focusing on how they can optimize and leverage those solutions in redesigned Health Care Pathways, which is led by Alan Tomkinson who is the Clinical Board Director for surgical services.
She demonstrated via the presentation how the digital enablers are enabling Patients & Carer's, Primary & Community Care Physicians, and Secondary Care in terms of time, place, space etc. for consultations and patient and clinician interactions.

The CC queried in terms of the strategic questions, she feels that it has been incredibly helpful is introducing flexibility in the workplace to the workforce. She queried if the Health Board are working on how to leverage that further.
The DDT- IMT confirmed this and that this is in scope for one of their programs highlighting it is a theme and that in the road map it is described as staff mobilization including use your own device, it is also part of making things easier for staff piece.

The UHB Vice Chair stated that there are some things that maybe out of control such as contractors, GP's, dentist, etc. and asked how easy it maybe to get the interfaces with those kind of people into the plan and strategy when they are not directly managed by us.
Chief Clinical Information Officer (CCIO) stated that this is a key issue and is subject to ongoing conversation.

The Committee resolved that:

	(a) RECEIVE and **NOTE** the progress being made in developing the underpinning roadmap plans in support of the Digital Strategy	
DHIC 21/02/010	**Digital Strategy – Case for Investment** The DDT – IMT stated that the purpose is to properly enable &CV to achieve its ambitions and is making the case it is not possible to achieve this if we do not become digitally enhanced or mature and that it requires additional funding. She said that the paper also offers options on how these funding requirements can be met, she added that the paper has been socialized with the Management Executives. The DDHI stated that this was sent to the Management Exec team in December for consideration with a further discussion in February where it was recognised in order for them to achieve the ambitions of the Health Board there needs to be a sustainable investment programme within digital. He stated that he does not underestimate the ask although they are requesting a large sum of money it reflects the legacy and lack of investment over a long period of time. The IDF commented that there is a degree of tension in the system with regards to having a finite amount of capital, an ask for digital, ask for medical equipment, an ask from the estate, and trying to hit an equitable distribution of the limited resources available will be a struggle. He recommended that there should be a tempered expectation about the level of resource that will be made available from the discretionary programme. He stated that he is aware of some of the business cases and if they are above a certain amount they can be taken to Welsh Government for specific funding. The other observation he made was in regards to agreeing £250k for each of the Clinical Boards, he said he would be supportive of this if they can demonstrate where this £250k is coming out of their current cost base as he would like to avoid having a £1.5 Million cost pressure which falls to a bottom line. The IDF wanted to inform the committee that next year nationally there will be £75 Million to be made available specifically for digital and asked the DDHI how we can get access to that and how much of it as possible to take forward the local strategy as opposed to a national one. The DDHI responded that there will be £75 Million of digital funding available from Welsh Government from the 1st April and that there will be conditions attached to most of that therefore with deliverables out of it. He informed the committee that Welsh Government have stated that this should not been seen as subsidizing what individual Boards should be investing in. He referred back to the point about clinical boards investing money, he said that this has been socialized with some and are in agreement as they can see the rationale for that particularly as a number of clinical boards are facing problems with IT due to lack of investment and there being no central pot to allocate. The CC was encouraged to see the different approaches being tried and supports the need to find ways to create a sustainable flow of money to roll and replace the underpinning infrastructure. She added that more so than	

	ever the services are reliant on having adequate IT services and as this digital transformation agenda rolls forward, if you are not sitting on a firm base it will fail. She emphasized the need for the Health Board to consider the provision of funding to the underlying infrastructure to be equally important to the provision of oxygen to ICU, although no one may die but there won't be any access to the services if the IT fails and said that there has been a consistent lack of investment in the underpinning infrastructure of the Health Board. **The Committee resolved that:** (a) **RECEIVE** and **APPROVE** the approach and content within the investment case for consideration by the UHB's management executive group.	
DHIC 21/02/011	**Wales Audit Reports** The CC said that this was asked to be included on the agenda from the Audit Committee receive and approve the findings of the reports. **Management of Clinical Coding Across Wales** The DDHI stated that having benchmarked against others despite having a lower number of accredited coders is very positive. The CC stated that the report makes it clear that C&V performance is very strong and commended the IGM and his team. She said that before this was not the case and felt it is an excellent turnaround and position it has maintained. She added that why this was recommended to come to today's meeting was for the committee to encourage consideration of how we can use technology to drive an improvement agenda in this area. The IGM commented that the technology utilizes SNOMED and is part of the digital transformation plan, it is about how it is utilized within the coding department and the wider UHB will be about how this report ties into that digital strategy. The CC stated that these comments can be fed back into the Audit committee that the committee received and approved the findings of the report and be assured that the consideration of how technology could assist the digital agenda in this area is part of the planning already. **Welsh Community Care Information System** The CC requested to note this report and reserve a wider discussion as part of the Private session **The Committee resolved that:** **(a) RECEIVE** and **APPROVE** the findings including the WCCIS recommendations contained within the SBAR above	

DHIC 21/02/012	**IG Data & Compliance (SIs, Data Protection, GDPR, FOI, SARs, Staffing & Mandatory Training)** • **Update on NIIAS Position** The CC wanted to commend the information governance team for maintaining some standard when the pressures have been on them to support the Covid effort in the way that they are, she said the failure to meet targets is understandable given the current situation and is confident that this will return to a normalized situation in due course **The Committee resolved that:** **(a) RECEIVE and NOTE** the updates relating to significant Information Governance issues	
DHIC 21/02/013	**Clinical Coding Performance Data** The CC noted the consistent achievements of the Welsh Government targets despite the Covid pressures. **The Committee resolved that:** (a) **Note** the performance of the UHB's Clinical Coding Department.	
DHIC 21/02/014	**Joint IMT & IG Corporate Risk Register** The CC queried that the WCCIS risk had reduced on this report and given the conversation to be had in the private session and was surprised by this. The DDHI responded that this relates to some of the pressure being removed in terms of the uptake of the WCCIS, he said there is annual funding allocated through the integrated care fund for preparation work and is being used to date. He informed the committee that they will not be accepting funding for the new financial year as there is no further prep work required which will be further discussed in the private session. **The Committee resolved that:** **(a) NOTE** progress and updates to the Risk Register report.	
DHIC 21/02/015	**IMT Audit Assurance Tracker** The CC wanted to congratulate all involved as there is all but one outstanding action are closed and stated fantastic work had been done **The Committee resolved that:** **(a) NOTE** progress and updates to the IMT Audit Assurance report.	

DHIC 21/02/016	**IG Audit Assurance Tracker and Work Plan** The CC stated that very good progress has been made The IGM stated that the ICO will be re-auditing them in October and will be expected to disclose to them in advance of that meeting on all work undertaken on high/urgent recommendations. **The Committee resolved that:** (a) **NOTE** progress and updates of the Information Governance Audit Tracker.	
DHIC 21/02/017	**IMTP Work Plan Exception Report** **The Committee resolved that:** **(a) NOTE** the areas of exception which require further attention and consideration.	
DHIC 21/02/018	**Schedule of Control Documents (Policies & Procedures)** The CC stated that this forms the basis for renewal review of policy and procedures. She highlighted that there is a policy that is due in February and if it has been completed as suggested this needs to come to the committee to be approved as all policy relating to IG and IMT is approved by committee procedures. She asked that this policy be brought to the next committee meeting to be formally approved by the committee **The Committee resolved that:** **(a)** The Committee is asked to **NOTE** progress to date and plans to address the review of remaining documents.	**NF/JW**
DHIC 21/02/019	**IG Training, Communications & Engagement Plan** **The Committee resolved that:** **(a) NOTE** the proposed engagement plan	
DHIC 21/02/020	**Minutes:** i. IMT Capital Management Group Report ii. Capital Management Group 16/11/2020 **The Committee resolved that:** **(a)** The Digital Health & Intelligence Committee is asked to **Note** the IT Infrastructure priority spend programme outlined at appendix 1	

DHIC 21/02/021	**Items to bring to the attention of the Board / Committee** The DDHI referred back to the investment case and that the investment case and the need for the Board to be aware that without adequate investment the Digital Strategy will not succeed.	
DHIC 21/02/022	**Review of the Meeting** The CC conducted a review of the meeting. All present confirmed the meeting had run very smoothly and good, positive discussions had been held.	
DHIC 21/02/023	**Date & Time of next Meeting:** Tuesday 1st June 2021 09:00am – 12:00pm	

MINUTES OF CARDIFF AND VALE STAKEHOLDER REFERENCE GROUP MEETING HELD ON TUESDAY 23 MARCH 2021 CONDUCTED VIA MICROSOFT TEAMS

Present:	
Sam Austin	Llamau (Chair)
Frank Beamish	Volunteer
Janice Charles	Vale of Glamorgan Council
Iona Gordon	Cardiff Council
Zoe King	Diverse Cymru
Paula Martyn	Independent Care Sector
Linda Pritchard	Glamorgan Voluntary Services
Anna Ros-Wodstra	Cardiff Third Sector Council
Geoffrey Simpson	One Voice Wales
Siva Sivapalan	Third Sector, Older Persons
Lani Tucker	Glamorgan Voluntary Services
In Attendance:	
Cath Doman	Director for Health and Social Care Integration. UHB
Nikki Foreman	Director of Corporate Governance, UHB
Abigail Harris	Executive Director of Strategic Planning, UHB
Angela Hughes	Assistant Director of Patient Experience, UHB
Vicky Le Grys	Programme Director, Strategic Clinical Redesign, UHB
Navroz Masani	Associate Medical Director, Clinical Redesign, UHB
Apologies:	
Mark Cadman	WAST
Jason Evans	South Wales Fire and Rescue
Shayne Hembrow	Wales and West Housing Association
Tom Hurlock-Norton	Carers Trust
Duncan Innes	Cardiff Third Sector Council
Tim Morgan	South Wales Police
Secretariat:	Gareth Lloyd, UHB

SRG 21/11 WELCOME AND INTRODUCTIONS

Anna Ros-Woudstra was welcomed and introduced to the Group.

SRG 21/12 APOLOGIES FOR ABSENCE

The SRG **NOTED** the apologies.

It was **NOTED** that although not members of the SRG, apologies had been received from the Community Health Council, Anne Wei and Keithley Wilkinson.

SRG 21/13 DECLARATIONS OF INTEREST

There were no declarations of interest.

SRG 21/14 MINUTES AND MATTERS ARISING FROM STAKEHOLDER REFERENCE GROUP MEETING HELD ON 26 JANUARY 2021

The SRG **RECEIVED** and **APPROVED** the minutes of the SRG meeting held on.26 January 2021.

SRG 21/15 FEEDBACK FROM BOARD

Nikki Foreman drew the SRG's attention to some specific items discussed at the UHB Board meetings held on 28 January and 25 February 2021.

January

- Patient Story - Concerned a member of staff who had been moved around during the C-19 pandemic. It had demonstrated the flexibility of staff.
- Condolences were passed to the family of Andrew Woodhouse a porter who had sadly passed away after contracting C-19.
- The Vale of Glamorgan Public Services Board Climate Change Charter
- The approach to equality and diversity within the UHB.
- Executive Team changes – Martin Driscoll would be leaving the UHB. Dr Stuart Walker would replace him as Deputy Chief Executive and Rachel Gidman as Interim Executive Director of Workforce and Organisational Development. They would be starting their new roles in March.
- Joint statement from Cardiff and Vale UHB and Velindre University NHS Trust welcoming 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.
- Update on the mass vaccination programme
- Regular C-19 Report

- Board Assurance Framework – there had been 6 'never events' which would be reported to the UHB's Health and Safety Committee.
- Urgent Service changes to support oesophageal and gastric cancer surgery for Swansea Bay UHB
- Business Justification Case for improving the Engineering Infrastructure at UHL

February

- The focus of the meeting was on C-19
- Two new Independent Board members had been recruited: Mike Jones, Independent Member, Trade Union and David Edwards, Independent Member Information and Communications Technology. They would commence on 1 April.
- The UHB had signed a Memorandum of understanding with British Association of Physicians of Indian Origin

A link to the papers for these meetings would be sent to the SRG

Action: Gareth Lloyd

The SRG enquired whether the UHB provided the Health Minister with regular reports. The SRG was informed that the Minister does not attend Board meetings but keeps a close eye on the Board papers which are all posted on the UHB's website. The UHB Chair has regular meetings with the Minister and the UHB also has regular Quality Planning and Delivery meetings with Welsh Government officials.

SRG 21/16 SHAPING OUR FUTURE CLINICAL SERVICES ENGAGEMENT

The SRG was informed that the Shaping Our Future Clinical Services engagement process had commenced on 1 March and would conclude on 19 April 2021. The UHB wanted to start a conversation about the need to transform clinical services in Cardiff and the Vale of Glamorgan, and explore what is most important to people about the way services are delivered in the future.

The SRG received a presentation from Nav Masani and Vicky Le Grys on the UHB's proposed changes to make the healthcare it provides sustainable and efficient for better patient outcomes.

The SRG was then asked to consider:

- The challenges and opportunities we have described
- The case we have made for the need to transform some of our clinical services

- The principles we have set out to transform:
    - Emergency and Urgent Care
    - Elective Care
    - Specialised Care
- The most important things we need to consider in making any changes, to limit any negative impacts.
- How we can enable more services to be delivered at home
- What to consider in the design of our hospitals for the future

The SRG raised a number of questions and made several observations.

- The direction of travel is welcome and exciting.
- The pandemic has resulted in a backlog of activity and created a tired workforce which might make it difficult to move forward with transformational changes to the way services are provided. Abigail Harris acknowledged this challenge but indicated that it was clear that the UHB could not simply revert to providing services in the same way that they had been provided prior to the pandemic. If it did it could take up to ten years to clear the backlog. There must instead be greater emphasis on prevention and early intervention and improved clinical pathways. The proposals that the UHB was developing were very much in line with the National Clinical Framework that had been published that week. Staff were certainly exhausted but it had been encouraging that they had come forward in large number to engage in clinical workshops on the future of clinical services.
- If the volume of patients/visitors to UHL is to increase, car parking facilities and access to UHL will have to be improved. The SRG was informed that there would always be a constraint on the amount of parking that could be provided on hospital sites which was why the UHB was committed to active travel. The UHB was hoping to recommence the UHL/Toys R Us park and ride and was also looking into the feasibility of a park and ride facility in the western Vale of Glamorgan. Abigail Harris explained that a significant amount of footfall on hospital sites was accounted for by outpatients. Many outpatient consultations can now be conducted virtually. The UHB has made increasing use of this capability during the pandemic and feedback from both patients and staff has generally been very positive. The UHB has an Outpatient Modernisation Programme and it is anticipated that within the next few years 50% of outpatient consultations will be virtual and that this will increase to 75% once UHW2 opens.
- Concern was expressed that some people, frequently with serious conditions, are presenting too late to primary care. Access to a wide range of different practitioners, not just GPs, must be improved. Abigail Harris acknowledged that access to primary care had been a problem for some time and primary care would be a key component of the service redesign work. Many GP practices had introduced new arrangements for consultations in response to the pandemic but there

remains a need to ensure people can easily access the most appropriate support whether this be provided by the NHS or third sector.

- Do the other Health Boards have a similar clinical service redesign programme? The SRG was informed that all Welsh Health Boards had developed clinical service strategies but they were all at different stages. Cardiff and Vale were talking with the other Health Boards and sharing learning.
- Concern was raised that the elderly have less access to technology and could therefore be disadvantaged by some of the proposed changes. Abigail Harris explained that face to face consultations would remain available for those who preferred it or who could not access or use the technology. Generally people would prefer to avoid having to attend hospital wherever possible. One option might be to provide access to technology at Wellbeing Hubs, Health and Wellbeing Centres and local authority Hybs where there would be people who could assist with using the technology.
- Health inequality is an issue and the UHB must be mindful of the recently published Race Equality Action Plan. Vicky Le Grys explained that an Equality Health Impact Assessment had been undertaken and would continue to be updated throughout the programme. It was vitally important to engage with all communities and a comprehensive engagement programme had been devised. She had presented to third sector partners the previous day and equity of access to services had been raised. Third sector partners had agreed to be involved in the process of developing new patient pathways.
- The development of Wellbeing Hubs, Health and Wellbeing Centres was welcomed. It is pleasing to note that Cardiff Royal Infirmary is being developed as a Health and Wellbeing Centre and the success of the local campaign to keep it open should be recognised. Abigail Harris explained that it was extraordinarily expensive to redevelop the CRI site as much of it was Listed. The Chapel had however recently been renovated into a fantastic facility.
- Active travel must be encouraged and cycle parking needs to be improved at CRI, Riverside Health Centre and Canna Surgery. Abigail Harris explained that there was £100k in the UHB's Discretionary Capital Programme to improve cycle parking.
- Where were the population growth figures obtained? Abigail Harris confirmed that the figures had been obtained from official statistics.

The SRG was informed that the feedback obtained during the engagement process would be shared with the Community Health Council (CHC). This feedback and the views of the CHC would then be used to make a recommendation to the UHB Board in May on the way forward. As plans develop the UHB would continue to engage to obtain stakeholder views on

more detailed proposals. Some of these proposals would potentially also require formal public consultation.

It was agreed that members of the SRG would help publicise the engagement process within their organisations and networks and encourage people to participate.

Action: All

SRG 21/17 SOUTH EAST WALES VASCULAR SERVICES ENGAGEMENT

The SRG received a presentation from Vicky Le Grys.

The SRG was informed that the purpose of the engagement was to begin a conversation with citizens across South East Wales about how Vascular services are organised in the future. It is jointly led by all of the Health Boards that secure Vascular services for their populations i.e. Aneurin Bevan UHB, Cardiff and Vale UHB, Cwm Taf Morgannwg UHB and Powys Teaching Health Board. Vascular disease is any condition that affects the network of an individual's blood vessels. 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 in South East Wales are provided from UHW, Grange University Hospital and Royal Glamorgan Hospital. At present, however, there is an urgent temporary arrangement in place for Cwm Taf residents. The service in Cwm Taf UHB became undeliverable at the end of 2020 and these patients are currently being seen in either Aneurin Bevan UHB or Cardiff and Vale UHB.

There are lots of challenges facing Vascular services which make it difficult to provide them from all the hospitals that currently provide them. The challenges .include a growing need for the services as the population grows and ages, an inability to meet all the quality standards required and difficulty in recruiting and retaining the workforce required. Clinicians have been discussing how Vascular services could be reconfigured. They have reached a collective agreement that the best way to provide Vascular services would be via a hub and spoke model. This would mean all major Vascular operations would be done in one hospital but patients would still attend their local hospital for work/advice prior to their operation and for rehabilitation after their operation. This model would make the best use of skill and staff and would result in better outcomes for patients. A number of things were considered when identifying where the 'hub' should be including the need for a range of other services to be on the same site such as Major Trauma

services. Taking these requirements into account, UHW is considered the 'best fit' for the 'hub'. 'Spoke' hospitals will be retained at Royal Gwent Hospital, Grange University Hospital, Royal Glamorgan Hospital and UHL.

The SRG was then asked to consider:

- The recommendation that a hub and spoke model will improve patient outcomes
- The proposal for UHW in Cardiff to be the Hub
- The suggested Spoke arrangements
- Any other information we should consider in deciding the future of vascular services
- The process undertaken to reconfigure services
- Any alternative view on the proposals put forward

The SRG raised a number of questions and made several observations.

- Is population the main reason for selecting UHW as the Hub and if there were more people in South East Wales would there be more than one Hub? Vicky Le Grys explained that one hub was required as this would then provide the critical mass of operations required to enable clinicians to develop and maintain their skills. UHW was selected due to the other specialties on the site.
- Is recruitment an issue? Vicky Le Grys explained that there are insufficient Vascular surgeons which has driven the development of Hub and Spoke models for Vascular services across the UK including the other parts of Wales.

The SRG was informed that the engagement would end on 16 April. Members of the SRG would help publicise the engagement process within their organisations and networks and encourage people to participate.

Action: All

SRG 21/18 @ HOME LOCALITY BASED INTEGRATED CARE MODEL

The SRG received a brief presentation from Cath Doman on the development of an @ hpme locality-based integrated care model.

The SRG was informed that the development of the model is based on keeping people well, healthy, independent and at home. This will require an extensive range of support and expertise. Specialist care and support e.g. hospital care and specialist children's services must be there when required

but the default position must be to provide care in peoples' homes or as close to it as possible.

The SRG raised a number of questions and made several observations

- The @ home concept was welcomed.
- Education/information and early intervention will be key to the success of the model
- The SRG enquired how health and social care budgets would be integrated. Cath Doman explained that although there were a lot of pots of funding available to the Regional Partnership Board this was separate funding and did not challenge the traditional 'siloing' of budgets. There was a need to consider where resources should be brought together to enable improved quality of care and better outcomes for people.
- The SRG enquired what the UHB was doing with regards to falls prevention. Cath Doman explained that falls were a huge factor in long term disability and dependency. Primary care, community health and social care colleagues were often aware of the signals that could indicate that individuals might be at increased risk of falls. Earlier intervention is key. If someone does fall admission to hospital might not necessarily be the best course of action and instead there needs to be support to allow then to remain at home safely.

It was agreed that Cath Doman would return to a future meeting of the SRG to provide more detail of the development of the model.

SRG 21/19 NEXT MEETING OF SRG

Microsoft Teams meeting, 1.30pm-4pm Tuesday 25 May 2021.

GIG CYMRU NHS WALES
Pwyllgor Gwasanaethau Ambiwlans Brys
Emergency Ambulance Services Committee

EMERGENCY AMBULANCE SERVICES JOINT COMMITTEE MEETING

'CONFIRMED' MINUTES OF THE MEETING HELD ON 9 MARCH 2021 AT 13:30HOURS VIRTUALLY BY MICROSOFT TEAMS

PRESENT

Members:	
Chris Turner	Independent Chair
Stephen Harrhy	Chief Ambulance Services Commissioner
Glyn Jones	Deputy Chief Executive, Aneurin Bevan University Health Board ABUHB
Jamie Marchant	Director of Primary, Community and Mental Health, Powys PTHB
Jo Whitehead	Chief Executive, Betsi Cadwaladr BCUHB
Paul Mears	Chief Executive, Cwm Taf Morgannwg CTMUHB
Sian Harrop-Griffiths	Director of Planning, Swansea Bay SBUHB
Len Richards	Chief Executive, Cardiff and Vale CVUHB
In Attendance:	
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, National Collaborative Commissioning Unit (NCCU)
Ricky Thomas	Head of Informatics, National Collaborative Commissioning Unit
Rachel Marsh	Director of Planning, Strategy and Performance, Welsh Ambulance Services NHS Trust (WAST)
Gwenan Roberts	Committee Secretary, National Collaborative Commissioning Unit

Part 1. PRELIMINARY MATTERS		**ACTION**
EASC 21/01	**WELCOME AND INTRODUCTIONS** Chris Turner (Chair), welcomed Members to the virtual meeting (using the Microsoft Teams platform) of the Emergency Ambulance Services Committee. Jo Whitehead was welcomed to the meeting. The meeting in January 2021 had been cancelled due to the operational pressures related to the coronavirus pandemic.	Chair

EASC 21/02	**APOLOGIES FOR ABSENCE** Apologies for absence were received from Judith Paget, Carol Shillabeer, Steve Moore, Andrew Carruthers and Mark Hackett.	Chair
EASC 21/03	**DECLARATIONS OF INTERESTS** There were no additional interests to those already declared.	Chair
EASC 21/04	**MINUTES OF THE MEETING HELD ON 10 NOVEMBER 2020** The minutes were **confirmed** as an accurate record of the Joint Committee meeting held on 10 November 2020. Members **RESOLVED** to: • **APPROVE** the Minutes of the meeting held on 10 November 2020.	Chair
EASC 21/05	**ACTION LOG** Members **RECEIVED** the action log and **NOTED** specific progress as follows: **EASC 20/45 & 20/57 Learning Lessons of working during a pandemic** Jason Killens confirmed that information had been received at the Welsh Ambulance Services NHS Trust (WAST) Board meeting and would be circulated with the minutes of the meeting. **EASC 20/70 CASC as Co-Chair Task and Finish Group** Members noted the ongoing work with the Fire and Rescue Services in relation to their work as first responders. Stephen Harrhy explained that the work was of joint Ministerial interest. Members noted three areas of interest; response to non-injury fallers aligned with local schemes; falls prevention and checks on homes (similar to fire prevention) and working with WAST to provide direct support in a first responder role where time matters most. Members noted that there was general support for this and the latest update report would be circulated with the minutes of the meeting. **EASC 20/74 Serious Adverse Incidents (SAIs)** Jason Killens gave an update on the position related to SAIs and benchmarking the WAST position and some issues in bringing information together. A further report would be brought to the next meeting. Other SAI information was also being shared via the Directors of Nursing Group across Wales.	CEO WAST CASC CEO WAST

	EASC 20/74 Health and Safety Executive Improvement notices re personal protective equipment Jason Killens explained that a letter had been sent to Chief Executives during the summer of 2020 to explain the position. Members noted that the amount of time WAST staff were in PPE was still an issue for the HSE although the concern was being mitigated. This action was closed. **EASC 20/74 Overview list to tackle performance** Members noted that the EASC Management Group would discuss this issue at its next meeting and report back. **EASC 20/93 Beyond the Call** Members noted that the Beyond the Call document - the National Review of Access to Emergency Services for those experiencing mental health and /or welfare concerns was now available on the EASC website: https://nccu.nhs.wales/qais/btc/ **EASC 20/95 NEPTS Winter Capacity** Members noted the central winter funding monies provided and it was agreed this was a positive report. This action point was closed. **EASC 20/95 Safe Cohorting of Patients** Members noted the variety of work to reduce handover delays. Providing additional capacity was key across NHS Wales and a number of initiatives were ongoing which would be monitored via the EASC Management Group and would be reported back at a future meeting. **EASC 20/95 Operational Delivery Unit (ODU)** Members were aware that the ODU was up and running and was linking with the Chief Operating Officers meeting and that the work on escalation would also be important to its function. A report would be provided to the next Chief Operating Officer's meeting and a further update would be provided at a future meeting. (Len Richards joined the meeting) **EASC 20/95 Information** Members noted that this work was linked with the development of a dashboard. This work would also allow health board to better plan services by working in partnership with WAST in managing the demand in real time. The aim was to work with health boards and Welsh Government to integrate ongoing work. A further update would be provided at a future meeting.	CASC CASC CEO WAST CASC

	EASC 20/95 Post production lost hours Jason Killens explained that active conversations had been taking place with trade union and staff side colleagues on the modernisation agenda. A further report would be provided in the WAST report at the next meeting. The Chair suggested reordering the Action Log to have the most recent issues first which was agreed. Members **RESOLVED** to: • **NOTE** the Action Log.	CEO WAST Ctte Sec
EASC 21/06	**MATTERS ARISING** There were no matters arising.	
EASC 21/07	**CHAIR'S REPORT** The Chair's report was received. Members noted the meetings being attended by the Chair and that the work of the groups were all overlapping and crossing boundaries. The Urgent and Emergency Care Programme was changing and this would have an impact on the work of the Committee. The complex landscape had been referred to in 'A Healthier Wales' and Members felt that more work was needed to simplify the system in Wales. Members also noted the Chair's objectives set by the Minister. Members **RESOLVED** to: • **NOTE** the Chair's report.	
Part 2. ITEMS FOR DISCUSSION		**ACTION**
EASC 21/08	**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 the Interim Report had been unanimously supported by the Taskforce Members and submitted to the Minister. The report would be shared with Members following its clearance through Welsh Government processes. The aim of the Taskforce was to work in a complementary way with the EAS Joint Committee. One of the main aims would be to develop a vision of what a modern ambulance service needs to look like and Members welcomed an opportunity to have a detailed discussion at a future meeting.	CASC

	Members were notified of a secure website which had been developed to share information with the Taskforce and the EASC members would also be invited to access the information provided. • Emergency Medical Retrieval and Transfer Service (EMRTS) Members were notified that accessing capital funding had been an issue for the service in terms of their expansion plans and this had now been resolved. Stephen Harrhy agreed to discuss the capital funding with Sian Harrop-Griffiths (Swansea Bay UHB) outside of the meeting. • Non-Emergency Patient Transport Service (NEPTS) Members noted that the roll out was almost complete; the final two health boards would soon complete the transfer and the CASC thanked the Members for their support in progressing this matter. • Emergency Medical Services Framework Members noted that the EMS Framework had been refreshed. The version produced was less technical than previous iterations but continued to link to the care standards and core requirements but was more focused on outcome and outputs, a change which was welcomed by the Members. There were no specific issues to raise and the framework had been discussed at the EASC Management Group. Members noted a small number of small amendments would be required (although not likely to be material) and the Members agreed that the Chair take Chair's action to sign off. The Chair thanked Stephen Harrhy for the report and Members **RESOLVED** to: • **NOTE** the Chief Ambulance Services Commissioner's report • **APPROVE** the Chair and CASC to finalise the EMS Framework (subject to no material issues being identified) for 2021-22.	CASC / Director of Finance CASC/Chair
EASC 21/09	**WELSH AMBULANCE SERVICES NHS TRUST (WAST) PROVIDER REPORT** The update report from the Welsh Ambulance Services NHS Trust (WAST) was received. Members noted: • Covid Pandemic WAST had been able to de-escalate from REAP3 (Resource Escalatory Action Policy) to REAP2 and additional support which had been received, for example from the military, would be stepped down by the end of March.	

Work had commenced on reconfiguring the crews to the previous position and work also was underway to capture any lessons learned from the second wave.

- Red Performance

Members noted red performance had increased since December (which had been very challenging); the previous month (February) had closed at 64%.

- Delays

Patient waiting times and the pressures in the system due to the second wave had led to unacceptable ambulance waiting times. Members noted that an increase in serious adverse incidents relating to patient waiting times had been experienced. This was also the experience of other ambulance services across the UK in terms of the impact on communities. In terms of community based incidents Members noted that they were being investigated jointly between WAST and health boards.

- Non-emergency patient transport services (NEPTS)

Two further health boards were just about to cross over to the national model with only one health board yet to transfer.

- Changes at Health Boards

Members noted the impact of health board service changes on WAST and it was important to learn lessons. Recruitment had taken place, which was additional to the WTE136, for the changes in the ABUHB services.

The Chair thanked Members in relation to the work undertaken to transfer NEPT services into WAST.

The Chief Ambulance Services Commissioner also highlighted that WAST had undertaken escalation procedures which had not previously been taken. At the Demand Management Plan (DMP) levels 5 and 6 this had led to people in communities who would have normally received an ambulance response being left to make their own arrangements. These decisions had been reviewed and at the time no other actions were available. However, Members noted the opportunities for learning and creating a system where escalation processes across the system, working with the operational delivery unit, might assist in avoiding such drastic action needing to be taken.

Members **RESOLVED** to:

- **NOTE** the WAST provider report.

Part 3. ITEMS FOR APPROVAL OR ENDORSEMENT		ACTION
EASC 21/10	**EASC ANNUAL PLAN & COMMISSIONING INTENTIONS** The EASC Annual Plan and Commissioning Intentions was received. In presenting the report, Ross Whitehead explained that the Annual Plan was shorter than usual to meet the expectations of the Welsh Government and focussed on EASC activities only. Members noted the intention to focus on three areas in alignment with health boards' resetting: 1. Focus on commissioned services 2. Transformational work programmes 3. Develop the commissioning cycle more fully Members noted that the Annual Plan and Commissioning Intentions had been discussed at the EASC Management Group and the guiding principles agreed included: • Intentions will be at the strategic level and will be extant for a minimum of 3 years • Collaborative priorities ie WAST, HBs and EASC Team will be agreed annually for each intention • They will focus on delivery and outcomes • Each intention will have annually agreed aims, product or indicator or a combination of these. • They will recognise the challenges of resetting in post-Covid environment and the opportunities to fast track service transformation • They will not replace or override extant requirements within the commissioning framework or statutory targets or requirements. Ross Whitehead explained that for emergency medical services the commissioning intentions included: • seizing the opportunities afforded by the Welsh Clinical Response Model and the 5 Step EMS Ambulance Pathway. • optimising the availability and flexibility of front line resources to meet demand. • maximising productivity from resources and demonstrate continuous improvement. • developing a value-based approach to service commissioning and delivery which enables an equitable, sustainable and transparent use of resources to achieve better outcomes for patients. • collaborating to reduce and prevent harm, and improve quality of service and outcomes for patients. • collaboratively developing and delivering services that allow the ambulance service to contribute to the wider health system.	

	For NEPTS and Emergency Medical Retrieval and Transfer Service (EMRTS), a slightly different approach was taken as both services were in a transition period and would need time to consolidate the major service changes. The EMRTS expansion work would also include the development of the Critical Care Transfer Service for Wales. A Task and Finish group had been developed working towards the service going live later in the year. Members asked about the 111 Service Programme and Contact First which were more specifically mentioned within the WAST plan. Members discussed that the Committee was not currently responsible for commissioning these services under the Statutory Establishment Order for the EAS Joint Committee. Members were aware of the increasing symbiosis of the 999 service and the 111 Service Programme. The 111 Service Programme Board was also considering the right governance arrangements to avoid duplication. Stephen Harrhy explained that plans were in place to meet with the Programme Director of the 111 Service and WAST to discuss how progress could take place and would advise EASC and the 111 Programme Board in due course. Jo Whitehead shared some reflections on being new in NHS Wales; recent induction meetings and the potential of developing a modern ambulance service and increasing the roles of staff groups such as paramedics and diversifying health care control rooms to support patients before they fail. Jo Whitehead also raised the opportunity for real change to blur primary, community, secondary, tertiary and ambulance service care lines and whether more opportunity for additional transformational service development could be included in the plan and intentions. Members noted the work of the Ministerial Ambulance Availability Taskforce and the need to consolidate ambition which would be a helpful discussion at a future meeting as a 'Focus on' session. The finance section of the Annual Plan was discussed including the requirement of the recurrent funding commitment from last year to support WAST in recruiting the additional 136wte staff to close the relief gap. Other provisions for non-recurrent funding was discussed as well as recognising the commitment from ABUHB to fund the service changes associated with the new Grange University Hospital. There were no additional resource expectations for the NEPT service within the plan.	CASC Chair

	The EMRT service had been allocated funding to establish the Critical Care Service (£1.7m) as well as funding to support the Major Trauma Network. Members noted that the expectations of WAST regarding the requirement in the demand and capacity review for efficiency changes, roster reviews, reduction of post-production hours lost has been clarified. In summary, the non-recurrent finance element approved last year for both WAST and EMRTS would be recurrent if the plan was approved. Any funding in year would need to demonstrate the additional numbers of staff recruited in line with the demand and capacity plans. Members noted that the financial schedules (at beginning of February) had been shared with the deputy directors of finance as well as at the EASC Management Group. The Ministerial Ambulance Availability Taskforce had been tasked by the Minister to describe a modern ambulance service and it was likely that further work groups would be established to contribute to the ongoing work with opportunities for support from all parts of the system. The work to deliver the plans for the major trauma network were also continuing with specific elements related to training. Jason Killens offered to present personal views and the views of WAST in relation to what a modern ambulance service could offer and Members felt it would be helpful as there were significant opportunities to ensuring the best possible service for Wales; it would also be important to share that understanding at the Joint Committee. It was agreed that Jason Killens would present at the next Committee meeting in the Focus on session (Added to the Forward Look). The new Critical Care Transfer Service was also discussed as this would be the first time that Wales would have a dedicated service available. Members noted that it was a slightly different model across Wales but it would provide equity of access. The work to progress the national transfer and discharge service would also be undertaken in the financial year which would also capture inter hospital service transfers and service transformation in health boards. The EASC Management Group had suggested that a 3-year commissioning cycle would be beneficial to the system and therefore the work to develop next year's plans would start during the summer for discussion and collaborative working. Members discussed where plans for the 111 Service and Contact First would be approved (as outside the EASC responsibilities).	Chair CEO WAST

	Members noted the current position that the 111 Service reported through its Programme Board and the Contact First reported through to the National Programme for Urgent and Emergency Care. Members felt it would be helpful that the processes could be simplified and noted that the EASC Joint Committee could provide strong governance for these services. Members **RESOLVED** to: • **APPROVE** the EASC Annual Plan and • **APPROVE** the Commissioning Intentions.	
EASC 21/11	**WELSH AMBULANCE SERVICES NHS TRUST (WAST) DRAFT INTEGRATED MEDIUM TERM PLAN (IMTP)** The draft WAST IMTP was received. In presenting the plan, Jason Killens highlighted the overarching (current draft) summary position including: • The plan built on previous plans • Recognises the EMS 999 service and also the front end of the 111 service (through the programme board) • Recognised that this was a 3 year plan although Welsh Government only asked for an annual plan • Demand and Capacity review investment and efficiencies to be made; increasing hear and treat rate Next 12 months • Call handling (111 roll out – BCUHB in June and CVUHB will be the last health board to come on line) • Implement new SALUS system – national system for 111 in the summer (Plans for CVUHB could be brought forward after the new system is implemented if required) • More call handlers and clinicians and investing in senior clinicians in 111 to develop options for patients • Digital options and offers to be developed – including video assessments with clinical staff (begin to defray as much activity with a digital offer) • WAST expect 111 and 999 services to come together as a clinical service and work through how this may look in the future • Demand and capacity – appointing a further 127 staff to close relief gap and concurrently the efficiency work – will involve changing rosters • Electronic patient clinical record; will improve data collection and accessibility and connection of data sets which will inform decision making • Respiratory and other pathways • NEPTS – national footprint for the first time	

	Additional offers could include (if commissioned) • Recruit a further 50 paramedics • More staff through advanced practice (20 in September) • Implement 'Beyond the Call,' responding with specialist clinicians and a level 2 full service nationally. Members noted that additional information would be developed to provide a sense of what might be achieved on performance into the final version of the IMTP. The model for rural areas was also of interest to Members and further work would take place to discuss improving services. Members suggested that further conversations regarding the additional offers could take place at the Chief Operating Officers meeting or with separate health boards although economies of scale was an important consideration. Other options could also be considered although taking a national 'Once for Wales' approach would be helpful. Members noted that additional staff could be recruited and understood the capacity for next year would be sensible and helpful for plans for next year. The extended training course for paramedics in the year after next would lead to a reduced number of new paramedics available at that point. The training capacity was finite and it would be helpful to clarify how this could work across Wales particularly for urgent and emergency care settings. The Chair raised the issue of red and amber performance and the expectation of the public to receive a timely service as well as understanding how the service needed to change going forward and communicating and engaging the changes with the public. Ensuring the core service delivers would be key to providing other options for a modern ambulance service. Members **RESOLVED** to: • **SUPPORT** the draft WAST IMTP. • **NOTE** the IMTP was consistent with the EASC Annual Plan and financial assumptions are similar • **NOTE** issues relating to the 111 service and the governance routes • **APPROVE** the Chair and CASC sign off the plan at the appropriate time before submission to the Welsh Government.	Chair and CASC

EASC 21/12	**FINANCE REPORT** The EASC Finance Report was received. Members noted the stable position, 100% balanced plan. There were no anticipated difficulties to complete the finance report at year end. Members **RESOLVED** to: • **APPROVE** and **NOTE** the report.	Director of Finance
EASC 21/13	**EASC SUB GROUP MINUTES** Members received the confirmed minutes of the EASC Sub Groups as follows: • EASC Management Group - 22 October and 18 December 2020 • EMRTS Delivery Assurance Group – 10 Dec 2020 • NEPTS Delivery Assurance Group – 27 Oct 2020 Members **RESOLVED** to: • **APPROVE** the confirmed minutes as above.	CASC
EASC 21/14	**EASC GOVERNANCE INCLUDING THE RISK REGISTER** The EASC Governance report was received. In presenting the report Gwenan Roberts explained that the Annual Report would be presented at the next meeting and this would include the effectiveness survey. Members noted: • The temporary changes to the model Standing Orders in line with the Welsh Health Circular 2020/11 would revert to the original Standing Orders on 31 March 2021. • The EASC Directions and Regulations • The Risk Register which had been received at the EASC Management Group • The EASC Sub Group membership had been clarified for all health boards • Plans to improve public access to Committee meetings in line with health boards. Members **RESOLVED** to: • **NOTE** the plans to complete the Effectiveness Survey at the next meeting • **APPROVE** the Model Standing Orders for EASC noting the changes following the completion of the Welsh Health Circular 2020/011 on 31 March 2021 • **NOTE** that all health boards need to review the representatives at the Sub Groups	CASC

	• **NOTE** the governance arrangements for the EASC • **APPROVE** the risk register.	
EASC 21/15	**FORWARD PLAN OF BUSINESS** The forward plan of business was received. The next Focus On session would be the 'modern ambulance service'. Following discussion, Members **RESOLVED** to: • **APPROVE** the Forward Plan.	Chair
Part 4. OTHER MATTERS		**ACTION**
EASC 21/16	**ANY OTHER BUSINESS** There was none.	

DATE AND TIME OF NEXT MEETING		
EASC 21/17	A meeting of the Joint Committee would be held at 09:30 hrs, on Tuesday 11 May 2021 at the Welsh Health Specialised Services Committee (WHSSC), Unit G1, The Willowford, Main Ave, Treforest Industrial Estate, Pontypridd CF37 5YL but likely to be held virtually on the Microsoft Teams platform.	Committee Secretary

Signed ……
Christopher Turner (Chair)

Date ……

Pwyllgor Gwasanaethau Ambiwlans Brys
Emergency Ambulance Services Committee

CYFARFOD Y PWYLLGOR GWASANAETHAU AMBIWLANS BRYS

COFNODION 'WEDI EU CADARNHAU' O'R CYFARFOD A GYNHALIWYD AR 9 MAWRTH 2021 AM 13:30 AR LEIN TRWY MICROSOFT TEAMS

YN BRESENNOL

Aelodau:	
Chris Turner	Cadeirydd Annibynnol
Stephen Harrhy	Prif Gomisiynydd Gwasanaethau Ambiwlans (CASC)
Glyn Jones	Dirprwy Brif Weithredwr, Bwrdd Iechyd Prifysgol Aneurin Bevan
Jamie Marchant	Cyfarwyddwr Gofal Sylfaenol, Cymunedol ac Iechyd Meddwl, Bwrdd Iechyd Addysgu Powys
Jo Whitehead	Prif Weithredwr, BIP Betsi Cadwaladr
Paul Mears	Prif Weithredwr, BIP Cwm Taf Morgannwg
Sian Harrop-Griffiths	Cyfarwyddwr Cynllunio, BIP Bae Abertawe
Len Richards	Prif Weithredwr, BIP Caerdydd a'r Fro
Eraill yn Bresennol:	
Jason Killens	Prif Weithredwr, Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru
Stuart Davies	Cyfarwyddwr Cyllid, Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru a Chydbwyllgor EAS
Ross Whitehead	Cyfarwyddwr Cynorthwyol Ansawdd a Phrofiad Cleifion, yr Uned Gomisiynu Cydweithredol Genedlaethol (NCCU)
Ricky Thomas	Pennaeth Gwybodeg, yr Uned Comisiynu Cydweithredol Genedlaethol (NCCU)
Rachel Marsh	Cyfarwyddwr Cynllunio, Strategaeth a Pherfformiad, Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru
Gwenan Roberts	Ysgrifennydd y Pwyllgor, yr Uned Gomisiynu Cydweithredol Genedlaethol

Rhan 1. MATERION RHAGARWEINIOL		**CAM GWEITHREDU**
EASC 21/01	**CROESO A CHYFLWYNIADAU** Croesawodd Chris Turner (Cadeirydd) Aelodau i gyfarfod ar lein (gan ddefnyddio Microsoft Teams) o'r Pwyllgor Gwasanaethau Ambiwlans Brys. Croesawyd Jo Whitehead i'r cyfarfod. Roedd y cyfarfod ym mis Ionawr 2021 wedi'i ganslo oherwydd y pwysau gweithredol yn gysylltiedig â phandemig y Coronafeirws.	Cadeirydd

EASC 21/02	**YMDDIHEURIADAU ABSENOLDEB** Derbyniwyd ymddiheuriadau am absenoldeb gan Judith Paget, Carol Shillabeer, Steve Moore, Andrew Carruthers a Mark Hackett.	Cadeirydd
EASC 21/03	**DATGANIADAU O FUDDIANNAU** 1.3 Ni ddatganwyd unrhyw fuddiannau ychwanegol ar wahân i'r rhai a ddatganwyd eisoes	Cadeirydd
EASC 21/04	**COFNODION Y CYFARFOD A GYNHALIWYD AR 10 TACHWEDD 2020** **Cadarnhawyd** bod y cofnodion yn gofnod cywir o gyfarfod y Pwyllgor Gwasanaethau Brys (Pwyllgor EAS) a gynhaliwyd ar 10 Medi 2020. **PENDERFYNODD** aelodau: • **GYMERADWYO** cofnodion y cyfarfod a gynhaliwyd ar 10 Tachwedd 2020.	Cadeirydd
EASC 21/05	**COFNODION GWEITHREDU** **DERBYNIODD** yr Aelodau y cofnodion gweithredu **a NODWYD** cynnydd penodol fel a ganlyn: **EASC 20/45 a 20/57 Dysgu gwersi o weithio mewn pandemig** Cadarnhaodd Jason Killens fod gwybodaeth wedi dod i law yng nghyfarfod Bwrdd Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru (WAST) ac y byddai'n cael ei chylchredeg gyda chofnodion y cyfarfod. **EASC 20/70 CASC fel Cyd-gadeirydd Grŵp Gorchwyl a Gorffen** Nododd yr Aelodau y gwaith sy'n mynd rhagddo gyda'r Gwasanaethau Tân ac Achub mewn perthynas â'u gwaith fel ymatebwyr cyntaf. Esboniodd Stephen Harrhy fod y gwaith o ddiddordeb Gweinidogol hefyd. Nododd yr aelodau dri maes oedd o ddiddordeb; ymateb i gympwiadau lle na chafwyd anaf yn unol â chynlluniau lleol; atal cwympiadau a gwirio cartrefi (tebyg i gamau i atal tanau) a gweithio gyda WAST i roi cefnogaeth uniongyrchol mewn rôl ymatebydd cyntaf lle mai amser oedd bwysicaf. Nododd yr aelodau fod cefnogaeth gyffredinol i hyn ac y byddai'r adroddiad diweddaru diweddaraf yn cael ei gylchredeg gyda chofnodion y cyfarfod. Khan Raj 07/28/2021 11:01:43	PRIF WEITHREDWR WAST CASC

	EASC 20/74 Digwyddiadau Niweidiol Difrifol Rhoddodd Jason Killens y wybodaeth ddiweddaraf am y sefyllfa o ran Digwyddiadau Niweidiol Difrifol a meincnodi sefyllfa WAST, ac am rai materion wrth gasglu gwybodaeth. Byddai adroddiad pellach yn cael ei roi gerbron y cyfarfod nesaf. Roedd gwybodaeth bellach am Ddigwyddiadau Niweidiol Difrifol yn cael ei rhannu trwy'r Grŵp Cyfarwyddwyr Nyrsio ledled Cymru hefyd.	PRIF WEITHREDWR WAST
	EASC 20/74 Hysbysiadau Gwella gan y Weithrediaeth Iechyd a Diogelwch ynghylch offer amddiffyn personol Esboniodd Jason Killens fod llythyr wedi'i anfon at Brif Weithredwyr yn ystod haf 2020 i egluro'r sefyllfa. Nododd yr aelodau fod faint o amser yr oedd staff WAST yn ei dreulio mewn PPE yn dal i fod yn broblem i'r Weithrediaeth Iechyd a Diogelwch, er bod y pryder hwnnw wrthi'n cael ei liniaru. Caewyd y cam gweithredu hwn.	
	EASC 20/74 Rhestr drosolwg i fynd i'r afael â pherfformiad Nododd yr aelodau y byddai Grŵp Rheoli Pwyllgor EAS yn trafod y mater hwn yn ei gyfarfod nesaf ac yn adrodd yn ôl.	
	EASC 20/93 Tu Hwnt i'r Alwad Nododd aelodau fod y ddogfen Tu Hwnt i'r Alwad - yr Adolygiad Cenedlaethol o Fynediad at Wasanaethau Brys i'r Rheiny Sy'n Profi Pryderon Iechyd Meddwl a/neu Lesiant bellach ar gael wefan Pwyllgor EAS: https://nccu.nhs.wales/qais/btc/	CASC
	Capasiti Gaeaf y Gwasanaeth Cludo Cleifion Mewn Achosion Nad Ydynt yn Rhai Brys (NEPTS) Nododd yr aelodau y cyllid canolog a ddarparwyd ar gyfer y gaeaf, a chytunwyd bod hwn yn adroddiad cadarnhaol. Caewyd y pwynt gweithredu hwn.	
	EASC 20/95 Carfannu cleifion yn ddiogel Nododd yr aelodau amrywiaeth y gwaith ar y gweill i leihau oedi wrth drosglwyddo cleifion. Roedd darparu capasiti ychwanegol yn allweddol ledled GIG Cymru, ac roedd nifer o fentrau'n mynd rhagddynt a fyddai'n cael eu monitro trwy Grŵp Rheoli Pwyllgor EAS ac a fyddai'n cael eu hadrodd yn ôl mewn cyfarfod yn y dyfodol.	CASC
	Uned Cyflenwi Gweithredol Pwyllgor EAS 20/95 Roedd yr aelodau'n ymwybodol bod yr Uned Cyflenwi Gweithredol ar waith a'i bod yn rhan o Gyfarfod y Prif Swyddogion Gweithredol lle byddai'r gwaith ar uwchgyfeirio hefyd yn bwysig i'w swyddogaeth.	PRIF WEITHREDWR WAST

	Byddai adroddiad yn cael ei ddarparu yng nghyfarfod nesaf y Prif Swyddogion Gweithredol, a byddai diweddariad pellach yn cael ei ddarparu mewn cyfarfod yn y dyfodol. (Ymunodd Len Richards â'r cyfarfod) **EASC 20/95 Gwybodaeth** Nododd yr aelodau fod y gwaith hwn yn gysylltiedig â datblygu dangosfwrdd. Byddai'r gwaith hwn hefyd yn caniatáu i'r Byrddau Iechyd gynllunio gwasanaethau yn well trwy weithio mewn partneriaeth â WAST i reoli'r galw mewn amser real. Y nod oedd gweithio gyda Byrddau Iechyd a Llywodraeth Cymru i integreiddio gwaith sydd ar y gweill. Byddai diweddariad pellach yn cael ei ddarparu mewn cyfarfod yn y dyfodol. **EASC 20/95 Colli oriau ar ôl dechrau sifft** Esboniodd Jason Killens fod sgyrsiau wedi eu cynnal â chydweithwyr yn yr undebau llafur a staff am yr agenda foderneiddio. Byddai adroddiad pellach yn cael ei ddarparu yn adroddiad WAST yn y cyfarfod nesaf. Argymhellodd y Cadeirydd y dylid aildrefnu'r Cofnodion Gweithredu fel bod y materion mwyaf diweddar yn dod yn gyntaf, a chytunwyd i wneud hynny. **PENDERFYNODD** aelodau: • **NODI'R** Cofnodion Gweithredu.	CASC PRIF WEITHREDWR WAST Ysg. y Pwyll.
EASC 21/06	**MATERION SY'N CODI** Ni chodwyd unrhyw faterion eraill.	
EASC 21/07	**ADRODDIAD Y CADEIRYDD** Derbyniwyd adroddiad y Cadeirydd. Nododd yr aelodau y cyfarfodydd yr oedd y Cadeirydd yn eu mynychu a bod gwaith y grwpiau i gyd yn gorgyffwrdd ac yn croesi ffiniau. Roedd y Rhaglen Gofal Brys ac Argyfwng yn newid a byddai hyn yn effeithio ar waith y Pwyllgor. Cyfeiriwyd at y sefyllfa gymhleth yn 'Cymru Iachach' ac roedd yr Aelodau'n teimlo bod angen mwy o waith i symleiddio'r system yng Nghymru. Nododd yr aelodau hefyd amcanion y Cadeirydd a osodwyd gan y Gweinidog. **PENDERFYNODD** Aelodau: • **NODI** adroddiad y Cadeirydd. Khan Raj 07/28/2021 11:01:43	

Rhan 2. EITEMAU I'W TRAFOD		**CAM GWEITHREDU**
EASC 21/08	**ADRODDIAD PRIF GOMISIYNYDD GWASANAETHAU AMBIWLANS** Derbyniwyd adroddiad Prif Gomisiynydd Gwasanaethau Ambiwlans (CASC). Wrth gyflwyno'r adroddiad, tynnodd Stephen Harrhy sylw at yr eitemau allweddol canlynol: • Tasglu Argaeledd Ambiwlansys y Gweinidog Nododd yr aelodau fod yr Adroddiad Dros Dro wedi cael cefnogaeth unfrydol gan Aelodau'r Tasglu a'i fod wedi ei gyflwyno i'r Gweinidog. Byddai'r adroddiad yn cael ei rannu â'r Aelodau ar ôl iddo gael ei glirio trwy brosesau Llywodraeth Cymru. Nod y Tasglu oedd gweithio mewn ffordd gydweithredol gyda Pwyllgor EAS. Un o'r prif nodau fyddai datblygu gweledigaeth am sut mae gwasanaeth ambiwlans modern yn edrych, a chroesawodd yr Aelodau gyfle i gael trafodaeth fanwl mewn cyfarfod yn y dyfodol. Hysbyswyd yr aelodau am wefan ddiogel a ddatblygwyd i rannu gwybodaeth â'r Tasglu, a byddai aelodau Pwyllgor EAS hefyd yn cael eu gwahodd i weld y wybodaeth a ddarperir. • Y Gwasanaeth Casglu a Throsglwyddo Meddygol Brys (EMRTS) Hysbyswyd yr aelodau bod cyrchu cyllid cyfalaf wedi bod yn broblem i'r gwasanaeth o ran eu cynlluniau ehangu, ond bod hyn bellach wedi'i ddatrys. Cytunodd Stephen Harrhy i drafod yr arian cyfalaf â Sian Harrop-Griffiths (BIP Bae Abertawe) y tu allan i'r cyfarfod. • Gwasanaeth Cludo Cleifion Mewn Achosion Nad Ydynt yn Rhai Brys (NEPTS) Nododd yr aelodau fod y gwaith o gyflwyno'r gwasanaeth bron wedi ei gwblhau; byddai'r ddau Fwrdd Iechyd olaf yn cwblhau'r trosglwyddiad yn fuan, a diolchodd y CASC i'r Aelodau am eu cefnogaeth wrth fwrw ymlaen â'r mater hwn. • Y Fframwaith Gwasanaethau Meddygol Brys Nododd yr aelodau fod y Fframwaith hwn wedi'i adnewyddu. Roedd y fersiwn a gynhyrchwyd yn llai technegol na fersiynau blaenorol, ond roedd cysylltiad o hyd â'r safonau gofal a'r gofynion craidd. Roedd ffocws cryfach fodd bynnag ar ganlyniadau ac allbynnau, sef newid a groesawyd gan yr Aelodau. Nid oedd unrhyw faterion penodol i'w codi ac roedd y fframwaith wedi'i drafod yng Ngrŵp Rheoli Pwyllgor EAS. Nododd yr aelodau y byddai angen nifer fach o welliannau (er nad oeddent yn debygol o fod yn rhai sylweddol), a chytunodd yr Aelodau fod y Cadeirydd yn eu cymeradwyo.	CASC CASC / Cyfarwyddwr Cyllid

	Diolchodd y Cadeirydd i Stephen Harrhy am ei adroddiad a **PHENDERFYNODD** yr Aelodau: • **NODI** adroddiad Prif Gomisiynydd Gwasanaethau Ambiwlans (CASC) • **CYTUNO** bod y Cadeirydd a'r CASC yn cwblhau'r Fframwaith EMS (ar yr amod na nodir unrhyw faterion o bwys) ar gyfer 2021-22.	CASC / Cadeirydd
EASC 21/09	**ADRODDIAD DARPARWR YMDDIRIEDOLAETH GIG GWASANAETHAU AMBIWLANS CYMRU (WAST)** Derbyniwyd yr adroddiad diweddaru gan Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru (WAST). Nododd yr Aelodau y canlynol: • Pandemig Covid Roedd WAST wedi gallu mynd i lawr o REAP3 (Polisi Gweithredu ar gyfer Uwchgyfeirio Adnoddau) i REAP2, a byddai cymorth ychwanegol a gafwyd, er enghraifft gan y fyddin, yn dod i ben erbyn diwedd mis Mawrth. Roedd gwaith wedi cychwyn i ailosod y criwiau fel y gallant ddychwelyd i'w ffurf cyn y pandemig, ac roedd gwaith hefyd ar y gweill i nodi unrhyw wersi a ddysgwyd o'r ail don. • Perfformiad Coch Nododd yr aelodau fod perfformiad coch wedi gwaethygu ers mis Rhagfyr (a oedd wedi bod yn heriol iawn); 64% oedd y ganran ar ddiwedd y mis blaenorol (Chwefror). • Oedi Roedd amseroedd aros cleifion a'r pwysau yn y system oherwydd yr ail don wedi arwain at amseroedd aros am ambiwlans oedd yn annerbyniol. Nododd yr aelodau i gynnydd gael ei weld mewn digwyddiadau niweidiol difrifol yn ymwneud ag amseroedd aros. Dyma hefyd brofiad gwasanaethau ambiwlans eraill ledled y DU o ran yr effaith ar gymunedau. O ran digwyddiadau yn y gymuned, nododd yr Aelodau fod ymchwiliadau i hyn ar y cyd rhwng WAST a'r Byrddau Iechyd. • Y Gwasanaeth Cludo Cleifion Mewn Achosion Nad Ydynt yn Rhai Brys (NEPTS) Roedd dau Fwrdd Iechyd arall ar fin mewid i'r model cenedlaethol gyda dim ond un Bwrdd Iechyd arall eto i drosglwyddo.	

	• Newidiadau mewn Byrddau Iechyd Nododd yr Aelodau effaith newidiadau yng ngwasanaethau'r Byrddau Iechyd ar WAST, a nodwyd ei bod yn bwysig dysgu gwersi. Roedd recriwtio wedi mynd rhagddo, sef swyddi oedd yn ychwanegol at y 136 staff CALl, ar gyfer y newidiadau yng ngwasanaethau BIP Aneurin Bevan. Diolchodd y Cadeirydd i'r Aelodau mewn perthynas â'r gwaith a wnaed i drosglwyddo gwasanaethau NEPT i WAST. Amlygodd y Prif Gomisiynydd Gwasanaethau Ambiwlans (CASC) hefyd fod WAST wedi dilyn gweithdrefnau uwchgyfeirio na chawsant eu dilyn o'r blaen. Ar lefelau 5 a 6 y Cynllun Rheoli Galw (DMP), roedd hyn wedi golygu bod pobl mewn cymunedau, a fyddai fel arfer wedi derbyn ymateb ar ffurf ambiwlans, wedi gorfod gwneud eu trefniadau eu hunain. Roedd y penderfyniadau hyn wedi'u hadolygu ac ar y pryd nid oedd yn bosibl cymryd unrhyw gamau eraill. Fodd bynnag, nododd yr Aelodau y cyfleoedd i ddysgu ac i greu system lle gallai prosesau uwchgyfeirio ar draws y system, gan weithio gyda'r uned gyflawni weithredol, helpu i osgoi'r angen i gymryd camau mor ddifrifol. **PENDERFYNODD** yr Aelodau: • **NODI** adroddiad darparwr WAST.	
Rhan 3. EITEMAU I'W CYMERADWYO NEU EU CEFNOGI		**CAM GWEITHREDU**
EASC 21/10	**CYNLLUN BLYNYDDOL A BWRIADAU COMISIYNU PWYLLGOR EAS** Derbyniwyd Cynllun Blynyddol a Bwriadau Comisiynu Pwyllgor EAS. Wrth gyflwyno'r adroddiad, eglurodd Ross Whitehead fod y Cynllun Blynyddol yn fyrrach na'r arfer er mwyn bodloni disgwyliadau Llywodraeth Cymru, a'i fod yn canolbwyntio ar weithgareddau Pwyllgor EAS yn unig. Nododd yr aelodau y bwriad i ganolbwyntio ar dri maes i gyd-fynd â gwaith y Byrddau Iechyd wrth ailgychwyn gwasanaethau. 1. Canolbwyntio ar wasanaethau a gomisiynwyd 2. Rhaglenni gwaith trawsnewidiol 3. Datblygu'r cylch comisiynu yn helaethach Nododd yr aelodau fod y Cynllun Blynyddol a'r Bwriadau Comisiynu wedi'u trafod yng Ngrŵp Rheoli Pwyllgor EAS ac ymhlith yr egwyddorion arweiniol y cytunwyd arnynt yr oedd: • Bydd bwriadau ar lefel strategol a byddant yn bodoli am o leiaf 3 blynedd	

	• Bydd blaenoriaethau cydweithredol yn cael eu cytuno bob blwyddyn ar gyfer pob bwriad h.y. WAST, Byrddau Iechyd a Thîm Pwyllgor EAS • Byddant yn canolbwyntio ar gyflawni a chanlyniadau • Bydd gan bob bwriad nodau, allbwn neu ddangosydd y cytunwyd arnynt yn flynyddol, neu gyfuniad o'r rhain. • Byddant yn cydnabod yr heriau wrth ailgychwyn gwasanaethau yn dilyn Covid a'r cyfleoedd i drawsnewid gwasanaethau yn gyflym • Ni fyddant yn disodli nac yn diystyru gofynion sy'n bodoli eisoes o fewn y fframwaith comisiynu, na thargedau neu ofynion statudol. Esboniodd Ross Whitehead fod y bwriadau comisiynu yn cynnwys: • bachu ar y cyfleoedd ar gynnig gan fodel Ymateb Clinigol Cymru a Llwybr Ambiwlans 5 Cam EMS. • gwneud y gorau o argaeledd a hyblygrwydd adnoddau rheng flaen i ateb y galw • sicrhau'r cynhyrchedd uchaf posibl gan adnoddau a gwella'n barhaus • datblygu dull o gomisiynu a darparu gwasanaethau seiliedig ar werth sy'n hwyluso defnydd teg, cynaliadwy a thryloyw o adnoddau, er mwyn sicrhau canlyniadau gwell i gleifion. • cydweithredu i leihau ac atal niwed, a gwella ansawdd gwasanaethau a chanlyniadau i gleifion. • datblygu a darparu gwasanaethau ar y cyd sy'n caniatáu i'r gwasanaeth ambiwlans gyfrannu at y system iechyd ehangach. Ar gyfer NEPTS a'r Gwasanaeth Adalw a Throsglwyddo Meddygol Brys (EMRTS), cymerwyd dull ychydig yn wahanol gan fod y ddau wasanaeth mewn cyfnod trosglwyddo a byddai angen amser arnynt i wreiddio newidiadau mawr i wasanaethau. Byddai gwaith ehangu EMRTS hefyd yn cynnwys datblygu Gwasanaeth Trosglwyddo Gofal Critigol i Gymru. Datblygwyd grŵp Tasg a Gorffen i weithio tuag at greu'r gwasanaeth a fyddai'n cael ei lansio yn ddiweddarach yn y flwyddyn. Gofynnodd yr aelodau am y Rhaglen Gwasanaeth 111 a Cysylltu'n Gyntaf a grybwyllwyd yn fwy penodol yng nghynllun WAST. Trafododd yr aelodau y ffaith nad oedd y Pwyllgor ar hyn o bryd yn gyfrifol am gomisiynu'r gwasanaethau hyn o dan y Gorchymyn Sefydlu Statudol ar gyfer Pwyllgor EAS. Roedd yr aelodau'n ymwybodol o'r symbiosis oedd yn mynd yn gryfach rhwng gwasanaeth 999 a Rhaglen Gwasanaeth 111.	CASC

	Roedd Bwrdd Rhaglen Gwasanaeth 111 hefyd yn ystyried y trefniadau llywodraethu cywir i osgoi dyblygu. Esboniodd Stephen Harrhy fod cynlluniau ar waith i gwrdd â Chyfarwyddwr Rhaglen Gwasanaeth 111 a WAST i drafod sut y gellid gwneud cynnydd, ac y byddai'n cynghori Cyd-bwllgor EAS a Bwrdd Rhaglen 111 maes o law. Rhannodd Jo Whitehead ei meddyliau am fod yn newydd i GIG Cymru, am gyfarfodydd ymsefydlu diweddar a'r potensial i ddatblygu gwasanaeth ambiwlans modern, ynghyd ag ehangu rolau grwpiau staff fel parafeddygon ac ehangu rolau ystafelloedd rheoli gofal iechyd i gefnogi cleifion cyn iddynt fethu. Cododd Jo Whitehead y cyfle hefyd ar gyfer newid go iawn yn y berthynas rhwng gofal sylfaenol, cymunedol, eilaidd, trydyddol a'r gwasanaeth ambiwlans, ac a oedd yna gyfle i ddatblygu gwasanaeth trawsnewidiol ychwanegol yn y cynllun a'r bwriadau. Nododd yr aelodau waith y Tasglu Argaeledd Ambiwlans Gweinidogol a'r angen i gryfhau uchelgais, a fyddai hefyd yn drafodaeth ddefnyddiol mewn cyfarfod yn y dyfodol yn rhan o sesiwn 'Ffocws'. Trafodwyd adran gyllid y Cynllun Blynyddol, gan gynnwys gofyniad yr ymrwymiad cyllid rheolaidd o'r llynedd i gefnogi WAST i recriwtio 136 aelod o staff CALl ychwanegol i ateb y galw am y gwasanaeth. Trafodwyd darpariaethau eraill ar gyfer cyllid anghylchol yn ogystal â chydnabod ymrwymiad BIP Aneurin Bevan i ariannu'r newidiadau gwasanaeth sy'n gysylltiedig ag Ysbyty Prifysgol y Faenor. Nid oedd unrhyw ddisgwyliadau o ran adnoddau ychwanegol i wasanaeth NEPT yn y cynllun. Dyrannwyd cyllid i'r gwasanaeth EMRT i sefydlu'r Gwasanaeth Gofal Critigol (£ 1.7m) yn ogystal â chyllid i gefnogi'r Rhwydwaith Trawma Mawr. Nododd yr aelodau fod disgwyliadau WAST o ran yr adolygiad galw a chapasiti ar gyfer newidiadau effeithlonrwydd, adolygiadau o amserlenni sifftiau, a lleihau oriau a gollir ar ôl i sifftiau ddechrau ,wedi cael eu hegluro. I grynhoi, byddai'r elfen o gyllid anghylchol a gymeradwywyd y llynedd ar gyfer WAST ac EMRTS yn troi'n gyllid cylchol pe bai'r cynllun yn cael ei gymeradwyo. Byddai angen i unrhyw gyllid yn ystod y flwyddyn adlewyrchu'r niferoedd ychwanegol o staff sy'n cael eu recriwtio yn unol â'r cynlluniau galw a chapasiti. Nododd yr aelodau fod yr atodlenni ariannol (ar ddechrau mis Chwefror) wedi'u rhannu â'r dirprwy gyfarwyddwyr cyllid yn ogystal â Grŵp Rheoli Pwyllgor EAS.	Cadeirydd

	Roedd y Gweinidog wedi gofyn i'r Tasglu Argaeledd Ambiwlans Gweinidogol ddisgrifio gwasanaeth ambiwlans modern ac roedd yn debygol y byddai gweithgorau pellach yn cael eu sefydlu i gyfrannu at y gwaith parhaus gyda chyfleoedd i gael cefnogaeth gan bob rhan o'r system. Roedd y gwaith i gyflawni'r cynlluniau ar gyfer y rhwydwaith trawma mawr hefyd yn parhau gydag elfennau penodol yn ymwneud â hyfforddiant.	Cadeirydd
	Cynigiodd Jason Killens rannu ei farn bersonol a barn WAST mewn perthynas â'r hyn y gallai gwasanaeth ambiwlans modern ei gynnig, ac roedd yr Aelodau'n teimlo y byddai hyn yn ddefnyddiol gan fod cyfleoedd mawr i sicrhau'r gwasanaeth gorau posibl i Gymru; byddai hefyd yn bwysig rhannu'r ddealltwriaeth honno yn y Pwyllgor. Cytunwyd y byddai Jason Killens yn bresennol yng nghyfarfod nesaf y Pwyllgor yn y sesiwn Ffocws (Wedi'i Ychwanegu at y Rhagolwg).	PRIF WEITHREDWR WAST
	Trafodwyd y Gwasanaeth Trosglwyddo Gofal Critigol newydd hefyd gan mai hwn fyddai'r tro cyntaf i Gymru gael gwasanaeth pwrpasol o'r fath. Nododd yr aelodau ei fod yn fodel ychydig yn wahanol ledled Cymru ond y byddai'r un model ar gael i bawb yr un fath. Byddai'r gwaith i fwrw ymlaen â'r gwasanaeth trosglwyddo a rhyddhau cenedlaethol yn mynd rhagddo hefyd yn y flwyddyn ariannol, a fyddai hefyd yn cynnwys trosglwyddiadau rhwng ysbytai a'r gwaith i drawsnewid gwasanaethau mewn Byrddau Iechyd. Roedd Grŵp Rheoli Pwyllgor EAS wedi argymell y byddai cylch comisiynu 3 blynedd yn fuddiol i'r system ac felly byddai'r gwaith i ddatblygu cynlluniau'r flwyddyn nesaf yn dechrau yn ystod yr haf ar gyfer trafodaeth a chydweithio.	
	Trafododd yr aelodau lle byddai cynlluniau ar gyfer y Gwasanaeth 111 a Cysylltu'n Gyntaf yn cael eu cymeradwyo (am nad ydynt yn gyfrifoldeb i Gyd-bwyllgor EAS). Nododd yr aelodau y sefyllfa bresennol sef bod y Gwasanaeth 111 yn adrodd trwy ei Fwrdd Rhaglen a bod Cysylltu'n Gyntaf yn adrodd trwy'r Rhaglen Genedlaethol ar gyfer Gofal Brys ac Argyfwng. Teimlai'r aelodau y byddai'n ddefnyddiol symleiddio'r prosesau, a nodasant y gallai'r Pwyllgor gynnig proses llywodraethu gryf i'r gwasanaethau hyn.	
	PENDERFYNODD yr Aelodau: • **GYMERADWYO** Cynllun Blynyddol Pwyllgor EAS a • **CHYMERADWYO'R** Bwriadau Comisiynu.	

EASC 21/11	**CYNLLUN TYMOR CANOLIG DRAFFT (IMTP) YMDDIRIEDOLAETH GWASANAETHAU AMBIWLANS GIG CYMRU (WAST)** Derbyniwyd IMTP drafft WAST. Wrth gyflwyno'r cynllun, amlygodd Jason Killens y sefyllfa gyffredinol yn gryno (o ran y drafft presennol) gan gynnwys: • Roedd y cynllun yn adeiladu ar gynlluniau blaenorol • Roedd yn cydnabod gwasanaeth EMS 999 a hefyd y gwasanaeth 111 (trwy'r Bwrdd Rhaglen) • Roedd yn cydnabod mai cynllun 3 blynedd oedd hwn er bod Llywodraeth Cymru wedi gofyn am gynllun blynyddol yn unig • Adolygiad galw a chapasiti, buddsoddi a gwneud arbedion effeithlonrwydd; cynyddu'r gyfradd clywed a thrin 12 mis nesaf • Trin galwadau (cyflwyno gwasanaeth 111 - BIP Betsi Cadwaladr ym mis Mehefin a BIP Caerdydd a'r Fro fydd y ddau Fwrdd Iechyd olaf i ymuno â'r gwasanaeth). • Gweithredu system SALUS newydd yn yr haf- system genedlaethol ar gyfer 111 (Gellid dod â chynlluniau ar gyfer BIP Caerdydd a'r Fro yn eu blaen ar ôl i'r system newydd gael ei rhoi ar waith os oes angen) • Mwy o drinwyr galwadau a chlinigwyr, a buddsoddi mewn uwch-glinigwyr yn y gwasanaeth 111 i ddatblygu opsiynau i gleifion • Opsiynau a chynigion digidol i'w datblygu - gan gynnwys asesiadau fideo gyda staff clinigol (cynnig gwasanaethau digidol gymaint â phosibl) • Mae WAST yn disgwyl i wasanaethau 111 a 999 ddod at ei gilydd fel gwasanaeth clinigol a gweithio ar sut y gallai hyn edrych yn y dyfodol • Bydd gwaith galw a chapasiti - penodi 127 aelod arall o staff i ateb y galw, a'r gwaith effeithlonrwydd ar yr un pryd- yn golygu newid amserlenni • Cofnod clinigol cleifion electronig; bydd hyn yn gwella'r gwaith o gasglu data ac yn gwella hygyrchedd, a bydd yn gwella'r cysylltiad hefyd rhwng setiau data, a fydd yn llywio'r broses o wneud penderfyniadau • Llwybrau anadlol a llwybrau eraill • NEPTS - gwasanaeth cenedlaethol am y tro cyntaf Gallai cynigion ychwanegol gynnwys (os cânt eu comisiynu) • Recriwtio 50 o barafeddygon eraill • Mwy o staff yn gwneud ymarfer uwch (20 ym mis Medi) • Gweithredu 'Tu Hwnt i'r Alwad,' gan ymateb gyda chlinigwyr arbenigol a gwasanaeth llawn lefel 2 ledled y wlad.	

	Nododd yr aelodau y byddai rhagor o wybodaeth yn cael ei chasglu er mwyn dod i ddeall yr hyn y gellid ei gyflawni o ran perfformiad, ac y byddai'r wybodaeth hon yn cael ei chynnwys yn fersiwn derfynol yr IMTP. Roedd y model ar gyfer ardaloedd gwledig hefyd o ddiddordeb i'r Aelodau a byddai gwaith pellach yn cael ei wneud i drafod gwella gwasanaethau. Argymhellod yr aelodau y gallai sgyrsiau pellach ynghylch y cynigion ychwanegol ddigwydd yng nghyfarfod y Prif Swyddogion Gweithredol neu gyda Byrddau Iechyd ar wahân, er bod arbedion maint yn ystyriaeth bwysig. Gellid ystyried opsiynau eraill hefyd er y byddai ymagwedd 'Unwaith i Gymru' yn ddefnyddiol. Nododd yr aelodau y gallai staff ychwanegol gael eu recriwtio, ac roeddent yn deall y byddai'r capasiti ar gyfer y flwyddyn nesaf yn synhwyrol ac yn ddefnyddiol o ran cynlluniau ar gyfer y flwyddyn nesaf. Byddai'r cwrs hyfforddi estynedig ar gyfer parafeddygon yn y flwyddyn ar ôl yr un nesaf yn arwain at nifer is o barafeddygon newydd ar gael bryd hynny. Roedd y capasiti o ran hyfforddiant yn gyfyngedig a byddai'n ddefnyddiol egluro sut y gallai hyn weithio ledled Cymru yn enwedig yn achos lleoliadau gofal brys ac argyfwng. Cododd y Cadeirydd fater perfformiad coch ac oren a disgwyliad y cyhoedd i dderbyn gwasanaeth amserol, a chododd hefyd yr angen i ddeall sut roedd angen i'r gwasanaeth newid wrth symud ymlaen a chyfathrebu ac ymgysylltu â'r cyhoedd am y newidiadau. Byddai sicrhau bod y gwasanaeth craidd yn cyflawni yn allweddol i'r gwaith o ddarparu opsiynau eraill ar gyfer gwasanaeth ambiwlans modern. **PENDERFYNODD** yr Aelodau: • **GEFNOGI** IMTP drafft WAST • **NODI** bod yr IMTP yn cyd-fynd â Chynllun Blynyddol Pwyllgor EAS a bod y rhagdybiaethau ariannol yn debyg • **NODI** materion yn ymwneud â gwasanaeth 111 a'r llwybrau llywodraethu • **CYMERADWYO** bod y Cadeirydd a'r CASC yn llofnodi'r cynllun ar yr adeg briodol cyn ei gyflwyno i Lywodraeth Cymru.	Cadeirydd a CASC
EASC 21/12	**ADRODDIAD CYLLID** Derbyniwyd Adroddiad Cyllid Pwyllgor EAS.	

	Nododd yr aelodau y sefyllfa sefydlog, a bod cydbwysedd o 100% i'r cynllun. Ni ragwelwyd unrhyw anawsterau o ran cwblhau'r adroddiad cyllid ar ddiwedd y flwyddyn. **PENDERFYNODD** yr Aelodau: • **GYMERADWYO** a **NODI'R** adroddiad.	Cyfarwyddwr Cyllid
EASC 21/13	**COFNODION IS-GRWP PWYLLGOR EAS** Derbyniodd yr Aelodau gofnodion a gadarnhawyd o gyfarfodydd Is-grwpiau Pwyllgor EAS fel a ganlyn: • Grŵp Rheoli Pwyllgor EAS - 22 Hydref a 18 Rhagfyr 2020 • Grŵp Sicrhau Cyflawni EMRTS – 10 Mehefin 2020. • Grŵp Sicrwydd Cyflenwi NEPTS - 27 Hydref 2020 **PENDERFYNODD** yr Aelodau: • **GYMERADWYO'R** cofnodion a gadarnhawyd fel uchod.	CASC
EASC 21/14	**LLYWODRAETHU PWYLLGOR EAS GAN GYNNWYS Y GOFRESTR RISG** Derbyniwyd adroddiad llywodraethiant Pwyllgor EAS. Wrth gyflwyno'r adroddiad, eglurodd Gwenan Roberts y byddai'r Adroddiad Blynyddol yn cael ei gyflwyno yn y cyfarfod nesaf ac y byddai hyn yn cynnwys yr arolwg effeithiolrwydd. Nododd yr Aelodau y canlynol: • Y byddai'r Rheolau Sefydlog model dros dro yn unol â Chylchlythyr Iechyd Cymru 2020/11 yn cael eu disodli gan y Rheolau Sefydlog gwreiddiol ar 31 Mawrth 2021. • Cyfarwyddiadau a Rheoliadau Pwyllgor EAS • Y Gofrestr Risg a ddaeth i law yng Ngrŵp Rheoli Pwyllgor EAS • Roedd aelodaeth Is-grŵp Pwyllgor EAS wedi'i chadarnhau ar gyfer pob Bwrdd Iechyd • Cynlluniau i wella mynediad y cyhoedd at gyfarfodydd Pwyllgor fel y Byrddau Iechyd. **PENDERFYNODD** yr Aelodau: • **NODI'R** cynlluniau i gwblhau'r Arolwg Effeithiolrwydd yn y cyfarfod nesaf • **CYMERADWYO** Rheolau Sefydlog Model ar gyfer Pwyllgor EAS gan nodi'r newidiadau yn dilyn Cylchlythyr Iechyd Cymru 2020/011 ar 31 Mawrth 2021 • **NODI** bod angen i bob Bwrdd Iechyd adolygu'r cynrychiolwyr yn yr Is-grwpiau • **NODI'R** trefniadau llywodraethu ar gyfer y Pwyllgor EAS • **CYMERADWYO'R** Gofrestr Risg.	CASC

EASC 21/15	**BLAENGYNLLUN BUSNES** Derbyniwyd y blaengynllun busnes. Pwnc y sesiwn 'Ffocws' nesaf fyddai'r 'gwasanaeth ambiwlans modern'. Yn dilyn trafodaeth, **PENDERFYNODD** yr Aelodau: • **GYMERADWYO'R** Blaengynllun.	Cadeirydd
Rhan 4. MATERION ERAILL		**CAM GWEITHREDU**
EASC 21/16	**UNRHYW FATERION ERAILL** Dim.	

DYDDIAD AC AMSER Y CYFARFOD NESAF		
EASC 21/17	Bydd cyfarfod o Gyd-bwyllgor EAS yn cael ei gynnal am 09:30 o'r gloch, ddydd Mawrth 11 Mai ym Mhwyllgor Gwasanaethau Iechyd Arbenigol Cymru (WHSSC), Uned G1,The Willowford, Main Ave, Ystâd Ddiwydiannol Trefforest, Pontypridd CF37 5YL ond mae'n debygol o gael ei gynnal ar lein ar lwyfan Microsoft Teams.	Ysgrifennydd y Pwyllgor

Llofnod .....
Christopher Turner (Cadeirydd)

Dyddiad .....

LOCAL PARTNERSHIP FORUM MEETING

Thursday 16 April 2021at 10am, via Teams

Present

Rachel Gidman	Interim Director of Workforce and OD (co-Chair)
Dawn Ward	Chair of Staff Representatives – BAOT/UNISON (co-Chair)
Julie Cassley	Deputy Director of WOD
Jo Brandon	Director of Communications
Peter Hewin	BAOT/UNISON
Zoe Morgan	CSP
Stuart Egan	UNISON
Mike Jones	Independent Member – Trade Union
Peter Welsh	General Manager UHL and Barry
Mat Thomas	UNISON
Joe Monks	UNISON
Rebecca Christy	BDA
Jonathan Strachan-Taylor	GMB
Caroline Bird	Deputy COO
Ruth Walker	Executive Nurse Director (part of meeting)
Rhian Wright	RCN
Stuart Walker	Deputy Chief Executive / Medical Director
Andrew Crook	Head of Workforce Governance
Fiona Kinghorn	Exec Director of Public Health
Steve Gauci	UNISON
Catherine Phillips	Executive Director of Finance
Caroline Bird	Deputy COO
Fiona Salter	RCN
Ceri Dolan	RCN

In attendance:

Victoria Legrys	Programme Director
Dan Crossland	Deputy Director of Operations, MHCB

Apologies:

Abigail Harris	Exec Director of Strategic Planning
Julia Davies	UNISON
Len Richards	Chief Executive
Lianne Morse	Head of HR Operations
Lorna McCourt	UNISON
Pauline Williams	RCN
Fiona Jenkins	Exec Director of Therapies and Health Sciences

Secretariat

Rachel Pressley	Workforce Governance Manager

LPF 21/017 WELCOME AND APOLOGIES

Mrs Gidman welcomed everyone to the meeting and apologies for absence were noted.

It was noted that Dawn Ward was the new Chair of Staff Representatives. Mrs Gidman welcomed her to the meeting in her new capacity and said that she looked forward to them working together.

LPF 21/018 Declarations of Interest

There were no declarations of interest in respect of agenda items

LPF 21/019 MINUTES OF THE PREVIOUS MEETINGS

The minutes of the meetings held on 10 February 2021 were agreed to be an accurate record of the meeting.

LPF 21/020 ACTION LOG

The Action Log was noted. Ms Bird noted that there would be a presentation from PCIC Clinical Board at a future meeting

Action: Ms Bird

LPF 21/021 Shaping Our Future Clinical Services

The Forum received a presentation from Victoria Legrys, Programme Director, on Shaping Our Future Clinical Services. Ms Legrys had previously met with the Forum prior to the formal launch of the engagement process. This was now complete and an analysis of the feedback had begun. Ms Legrys asked for support and feedback from the Forum.

Key points noted included:

- The scope of the engagement – testing the thinking and principles, setting the scene for where and how clinical services could be delivered
- The approach to engagement – an alternative was needed due to covid-19
- The response – 351 survey responses but also social media etc. 20% of responses were from staff. There was strong support for the need for change and the challenges/opportunities set out. The best outcomes was considered the most important factor for most people. More than 70% of people were happy to have digital appointments and had the means to do so, but the team were aware that due to covid restrictions there had not been the usual face to face roadshows – this was not a one size fits all solution.
- A number of key themes had been generated through open questions including the role of clinicians and what would happen next.
- It was noted that change was dependant on having sufficient staff with the rights skills and training for their role

The next steps would be further discussion with the CHC and at Management Exec / Board.

Mr Hewin stated that he was pleased to see new ways of working and skills mix included as he believed this needed to be part of the solution. He was also pleased to see the role of Trade Unions recognised in the presentation. However, he asked about staff wellbeing and how the need for

staff to 'reset' or 'take a breather' would be taken into consideration and built into the plan, especially given the talk about a 3rd wave.

Ms Bird advised that she would be talking in more detail about the recovery plan at the next meeting and stated that the impact on staff was a key consideration. She indicated that the plan was system wide and was not just business as usual, but it was being led by clinicians using a risk based approach that was informed by data. New ways of working were being explored and Welsh Government had been asked for additional resources to enable more staff to be recruited.

Mrs Kinghorn noted that it was good to see prevention and equality highlighted as important elements and stated that we need to continue our preventative approach

Miss Ward noted that we are now half way through the SOFW timeframe and that it is important to get into a position where we have sufficient staff with the right training and skills to support care closer to home. She asked if this was deliverable and in what timeframe? Ms Legrys advised that the Clinical Services plan is high level and that over the next 12 months some of the detail on how this will be delivered will be mapped out. This would include what the workforce might start to look like, and prioritising clinical pathways. Staff, clinical leads and the third sector would all need to be involved in this. Data would be applied to the model to see that the changes would mean and that would inform the programme of work. She advised that this work had already begun in Vascular Services.

Mrs Gidman thanked Ms Legrys for attending the Forum and suggested that alongside this could be some work on 'Shaping Our Future Workforce'.

LPF 21/022 Deputy Chief Execs Update

Dr Walker updated the Forum on the following points:

- A Programme Business Case had been submitted to Welsh Government (WG) for UHW2 asking for endorsement. If approved, this would allow us to proceed to the Strategic Outline Case stage. It was hoped that if WG were able to respond reasonably quickly that the Strategic Outline Case would be submitted in March 2022
- The Annual Plan had been submitted to WG. This set out the approach to be taken over the next year in three areas:
    - Response to the ongoing covid pandemic (bearing in mind that the range of possibilities was very wide)
    - A reconstructive plan setting out the short and medium term recovery for a range of services including dementia, cancer and mental health as well as scheduled care and primary care
    - Links with our long term strategic plan
- The recruitment process for the permanent appointment for the Executive Director of People and Culture was due to take place the following week. Dr Walker was asked why the title had changed from Exec Director of Workforce and OD and explained that it was related to how we viewed the organisation in the future and a recognition that people are our priority, not a resource.

LPF 21/023 Covid-19 Response and recovery in Mental Health

Dan Crossland, Deputy Director of Operations for Mental Health Clinical Board, was in attendance to provide a joint presentation on the Covid-19 Response and recovery in Mental Health with Peter Hewin (lead rep for MHCB). He described a strong history of partnership working with staff, but also with service users and the other Clinical Boards.

Highlights from the presentation included:

- It was predicted in March 2020 that there would be an increased need for Mental Health Services as a result of the pandemic. As a Clinical Board they tried to prepare for this to ensure readiness while also keeping momentum around their transformation agenda and keeping safe. They also needed to be prepared for positive covid cases.
- An 'at a glance' guide was prepared in June 2020 setting out their intentions and how they would be delivered.
- 4 priority areas were identified as staff and team resilience, outpatient models and locality working, effective home working and co-production
- Mr Hewin noted that many Trade Unions and Professional bodies have well developed networks and champions for wellbeing and suggested that links should be made with the Recovery College which had been set up to support staff and service users. He suggested that a network to share resources and work together with initiatives like the recovery college could be a good way of supporting staff.
- There were some exciting developments around co-production, especially around the engagement of new roles with experience of mental health conditions and services built into the job description (peers). There had also been discussions with Physiotherapy about the possibility of employing someone with long covid for the Recovery College
- A number of challenges were also identified including activity and demand, but also new ways of working and positive risk taking.

Mrs Gidman described this work and the joint delivery of the presentation as great partnership working. She said she was curious about the new roles and the role of the Workforce team in supporting this, and suggested that the principle of spread and scale could be used.

Mr Hewin advised that the UHB Peer Lead had been in touch with the ImROC Recovery College and they had given some time in June to help us think about our Peer Strategy. Involvement from Workforce, Occupational health and Staff Representatives was welcomed, and Exec support was sought.

LPF 21/024 Patient Quality, Safety and Experience Report

Mrs Walker noted several highlights from the Patient Quality, Safety and Experience Report covering January and February 2021:

- There are less serious incidents reported but this is predominantly due to changes in WG reporting requirements. The way incidents are managed has not changed
- The number of concerns logged has increased but this is because the team are also dealing with concerns relating to the mass vaccination programme
- A new Clinical Effectiveness Committee has been set up and a Learning Committee will also be introduced. Both of these will sit under the QSE Committee

- There are no covid outbreaks in clinical areas at the current time but Mrs Walker reinforced the need to wash hands, maintain a distance and wear a mask. The number of outbreaks may increase as restrictions are relaxed

In terms of hospital acquired cases of covid, it was noted that clarity had been received from WG and Mrs Walker agreed to share this with the Forum.

Action: Mrs Walker

Cardiff and Vale had seen an increasing trend but every outbreak was being investigated and actions taken. The environment did not help as there are only a small number of single rooms and the placement of each patient has to be risk assessed. There have not been many cases of people being admitted who are asymptomatic and lateral flow tests are being carried out every 3 days. Mrs Kingorn reminded the Forum and prevalence is currently low and lateral flow tests are not as effective when it is low. She said that the biggest risk currently is returning travellers. Miss Ward asked for information about the test reliability and how many false -/+ we are seeing from the labs. Mrs Kinghorn advised that she did not have this information to hand but would request it

Action: Mrs Kinghorn

Mrs Walker advised that a report on the Nurse Staffing Act was going to the Board Development Session later this month and would be shared at a future LPF meeting.

Action: Mrs Walker

LPF 21/025 Respect and Resolution Policy

Mr Hewin noted that throughout the meeting they had touched on staff wellbeing and culture and that these 2 things have a strong connection. The UHB has had Values and Behaviours for a number of years, but the 2018 staff survey showed a concerning level of bullying, harassment and dignity at work cases throughout Wales. As a result the Welsh Partnership Forum was tasked by the Minister to find a new approach to dealing with these issues and to change the culture of NHS Wales.

A new Respect and Resolution Policy has now been developed which supersedes both the Dignity at Work Process and Grievance Policy. It has been approved at an All-Wales level and is going through local ratification processes ahead of the official launch date of 1 June 2021.

Mr Hewin explained that the new Policy builds upon an approach started with the Maximising Attendance at Work Policy which recognises that treating people fairly doesn't mean treating everyone the same. It requires us all to make sure we approach difficult workplace issues with the aim of resolving them at an early stage and without formal policy and processes being invoked.

The Policy is ACAS approved and includes tools and flowcharts to support staff and managers find solutions earlier. There will also be an All-Wales mediation network.

There is a requirement for joint training to be rolled out and a number of awareness sessions are scheduled for the beginning of May, including one especially for organisational leads and trade unions.

LPF 21/026 FINANCE REPORT

Mrs Gidman welcomed Mrs Phillips to her first LPF meeting since joining the UHB as Executive Director of Finance.

Mrs Phillips provided an update on the financial position up to the end of month 11 (February 2021), noting that there was a slight underspend of £500k and a small amount of capital.

The year-end position was being finalised but there was an underspend of around £90k and a similar amount of capital.

The plan for this year had been submitted but there were so many uncertainties due to covid and backlogs etc that we had been asked to resubmit it at the end of June when we can triangulate finance, workforce and activity more clearly.

As we had been unable to deliver the £25m recurrent savings last year there is still an underlying deficit to address. LPF will be updated as and when plans to address this are developed.

LPF 21/027 WOD PERFORMANCE KPI REPORT

Mrs Gidman noted that as an organisation we are trying to be more data driven but there is still more to do in terms of our workforce data. Areas to note from the report include:

- Sickness has been seasonally high but is starting to come down again
- Lianne Morse is overseeing education on an interim basis has been tasked with implementing a campaign to increase mandatory training and VBA rates
- Rob Warren, Head of Health and Safety will be invited to a future meeting to talk about his ambitions for H&S and fire training
- Future reports will include a deep dive, with a focus on turnover/voluntary resignations at the next meeting

Mr Hewin asked a couple of questions which were perhaps rhetorical or could be picked up through the Workforce Partnership Group: he noted that the ER Caseload was at 'reasonable tolerance levels' and asked how that was determined; how had VBA training gone up but VBA rates gone down; and what was being done as a Health Board to collectively recognise the efforts that everyone had made without raising some individuals above others. With regards to his last point, Ms Brandon agreed that this was a challenge. She noted that a huge amount had been done for the anniversary but it was difficult to capture everything achieved. She indicated that she would be happy to work with anyone who had an idea about how we could celebrate holistically.

Mrs Kinghorn noted that 66% of front line staff and 62.9% of all staff had received a flu vaccination which was higher than ever before.

LPF 21/028 ANY OTHER BUSINESS

Miss Ward advised that a letter had been written by the UHB Staff Representatives to Welsh Government, thanking them for the bonus payment to staff and asking that it doesn't detract from an early and significant pay rise. She would share this letter with Mrs Gidman and asked the Board to encourage WG in the same way.

LPF 21/029 FUTURE MEETING ARRANGEMENTS

The next meeting will be held on Thursday 17 June 2021 at 10 am with a staff representatives pre-meeting at 9am. The meeting will be held remotely.

WELSH HEALTH SPECIALISED SERVICES COMMITTEE (WHSSC)
JOINT COMMITTEE MEETING BRIEFING – JULY 2021

The Welsh Health Specialised Services Committee held its latest public meeting on 13 July 2021. This briefing sets out the key areas of consideration and aims to ensure everyone is kept up to date with what is happening within Welsh Health Specialised Services.

The papers for the meeting can be accessed at:
https://whssc.nhs.wales/joint-committee/committee-meetings-and-papers/2021-2022-meeting-papers/

1. Minutes of Previous Meetings
The minutes of the meeting held on the 11 May 2021 were **approved** as a true and accurate record of the meeting.

2. Action log & matters arising
Members **noted** the progress on the actions outlined on the action log.

3. Chair's Report
Members received the Chair's Report and **noted**:

- Chairs actions taken in relation to:
  - the appointment of Professor Ceri Phillips, Vice Chair of Cardiff and Vale UHB (CVUHB), as an Independent Member of the Joint Committee, with effect from 1 June 2021 for an initial term of two years, in accordance with the Welsh Health Specialised Services Committee (Wales) Regulations 2009 and the WHSSC Standing Orders (SO's),
  - variation of the Governance and Accountability Framework and that the amended WHSSC SOs and Standing Financial Instructions (SFIs) be taken forward for approval by the seven Health Boards (HBs),
- an update regarding Dr Chris Jones, Vice Chair of the All Wales Independent Patient Funding Panel (IPFR) stepping down,
- an update on attendance at the Welsh Renal Clinical Network (WRCN) meeting 9 June 2021,
- an update on the Integrated Governance Committee (IGC) meeting 8 June 2021,
- Attendance at the Cwm Taf Morgannwg UHB (CTMUHB) Board meeting 9 June 2021 during which the WHSCC Annual Governance

Statement 2020-2021 and financial statements were formally approved.

4. Managing Director's Report

Members received the Managing Director's Report and **noted** updates on:

- Children and Adolescent Mental Health Services (CAMHS),
- All Wales Positron Emission Tomography (PET) Programme Business Case,
- Ty Llidiard Escalation Review,
- Status Report on Annual Audit of Accounts 2020-2021

5. Appointment of Vice Chair

Members received a report proposing that a Vice Chair be appointed to WHSSC. Members noted that Ian Phillips, Independent Member, WHSSC, had been an Independent Member with WHSSC for 2 years, and was reappointed for a further two years from 1 April 2021 and has extensive knowledge and experience of the breadth of the work undertaken by WHSSC and the Joint Committee.

Members **approved** the appointment of Ian Phillips as Vice Chair of WHSSC.

6. Appointment of Interim Chair to the Welsh Renal Clinical Network (WRCN)

Members received a report proposing that an Interim Chair is appointed to the Welsh Renal Clinical Network (WRCN) for a 6 month period to support business continuity and to allow sufficient time to prepare for and undertake an open and transparent recruitment process to appoint a substantive Chair.

Members **noted** the important work of the WRCN and that traditionally, the WRCN Chair role had been undertaken by a senior renal clinician, however given the remit of the WRCN working closely with the charitable sector, third party providers and Welsh Government, consideration had been given to developing a person specification to incorporate experience of working with a variety of diverse stakeholders as an essential/desirable requirement and recognising that the role should no longer be reserved to a senior renal clinician.

Members **approved** the appointment of Ian Phillips as the Interim Chair of the Welsh Renal Clinical Network (WRCN) for a period of 6 months.

7. Commissioning of Mesothelioma MDT

Members received a report outlining the case for establishing an all Wales specialist mesothelioma Multi-Disciplinary Team (MDT) commissioned by WHSSC; and proposing that a scheme for an all Wales mesothelioma MDT is included within the Clinical Impact Assessment Group (CIAG) process for the Integrated Commissioning Plan (ICP) for 2022-2023.

Members **noted** the information provided in the report regarding mesothelioma incidence and outcomes for people in Wales, and the potential benefits of an all Wales specialist mesothelioma MDT; **approved** the proposal to transfer the commissioning of specialised mesothelioma services from Health Boards (HBs) to WHSSC; and **supported** the inclusion of a scheme for an all Wales mesothelioma MDT within the CIAG process for the ICP 2022-2023.

8. Audit Wales Report – Committee Governance Arrangements at WHSSC

Members received the Audit Wales report concerning the review into Committee Governance arrangements at WHSSC undertaken between March and June 2020. Members **noted** that as a result of the COVID-19 pandemic, aspects of the review had been paused, and re-commenced in July 2020. Members **noted** that:

- A survey was issued to all HBs and the fieldwork was concluded in October 2020,
- the scope of the work included interviews with officers and independent members at WHSSC, observations from attending Joint Committee and sub-committee meetings, feedback from questionnaires issued to HB Chief Executive and Chairs and a review of corporate documents.
- The findings were published in May 2021 in the Audit Wales Committee Governance Arrangements at WHSSC report,
- The report outlined 4 recommendations for WHSSC and the 3 recommendations for Welsh Government

Members **noted** the report and the Lead Auditor thanked the Joint Committee and the Executive team for their involvement in the production of the report.

9. Audit Wales WHSCC Governance Arrangements – Management Response

Members received the Management Response to the Audit Wales report concerning the review into Committee Governance arrangements at WHSSC.

Members **noted** that the report outlined 4 recommendations for WHSSC and the draft management response has been circulated to HB CEO's, Welsh Government and Audit Wales for comment and feedback. Progress against the actions outlined within the management response will be monitored through the Integrated Governance Committee (IGC) on a quarterly basis, and a full progress report will be presented to the Joint Committee 18 January 2022, once the actions related to the Integrated Commissioning Plan (ICP) process and engagement events have been completed.

Members **noted** that the report outlined 3 recommendations for Welsh Government (WG) and the WG management response had been outlined

in a letter from Dr Andrew Goodall, Director General Health & Social Services/ NHS Wales Chief executive to Mr Adrian Crompton, Auditor General for Wales. Progress against the WG management response will be monitored through discussions between the Chair, the WHSSC Managing Director and the Director General Health & Social Services/ NHS Wales Chief Executive.

Members **noted** the report and the proposed WHSSC management response to the Audit Wales recommendations outlined in the WHSSC Committee Governance Arrangements report, **noted** the Welsh Government response to the Audit Wales recommendations, and noted the proposed arrangements for monitoring progress against the actions outlined in the management responses.

10. Governance & Accountability Framework

Members received a report which provided an update on the WHSSC Governance and Accountability Framework and **noted**:

- the Minister for Health & Social Services had issued updated model standing orders for NHS Bodies in Wales in April 2021, including WHSSC,
- at the last Joint Committee meeting on the 11 May, it was proposed that the revised Governance and Accountability Framework documents, including the Standing Orders (SOs) and Standing Financial Instructions (SFIs), would be approved via Chair's Action outside of the meeting to facilitate expediency,
- on the 21 June, the Chair acting in conjunction with Dr Sian Lewis and Professor Ceri Phillips, Independent Member, took Chair's Action to update the documents and to recommend that the amended SOs and SFIs be taken forward for approval by the seven LHBs for inclusion within their own respective HB SOs,
- Once the updated documents have been approved Chief Executives are required to sign the Memorandum of Agreement (MOA) and the Hosting agreement,
- A report on the updated Governance and Accountability Framework for WHSSC will be presented to the CTMUHB Audit and Risk Committee on the 17 August 2021 to provide assurance in accordance with the hosting agreement.

Members **noted** the report, **noted** the Chair's Action taken on 21 June 2021 to recommend variation to elements of the Governance and Accountability Framework for onward approval by the seven HBs; and **approved** the updated versions of the MOA and Hosting Agreement.

11. Annual Governance Statement 2020-2021

Members received the WHSSC Annual Governance Statement (AGS) 2020-2021 for assurance.

Members **noted** the report.

12. Activity Reports for Months 1 and 2 2021-2022 COVID-19 Period

Members received a report that highlighted the scale of decrease in specialised services activity delivered for the Welsh population by providers in England, together with the two major supra-regional providers in South Wales. The report illustrated the decrease during the peak COVID-19 periods, the level of potential harms to specialised services patients and the loss of financial value from the necessary national block contracting arrangements introduced to provide overall system stability.

Members **noted** the information presented in the reports.

13. Financial Performance Report – Month 2 2021-2022

Members received a paper the purpose of which was to provide the final outturn for the financial year. The financial position reported at Month 2 for WHSSC was a year-end outturn under spend of £3,364k.

The majority of this under spend relates to the English SLA forecast underspend which reflects the difference between the plan baseline and the agreed blocks for Q1 & Q2, 2020-2021 reserve releases and development slippage. There is a partial offset with the over spend in Mental Health at month 1 that includes high Children and Adolescent Mental Health Services (CAMHS) CAMHS out of area (OOA) activity and an exceptional high cost medium secure patient with the forecast to plan.

Members **noted** the report.

14. Other reports

Members also **noted** update reports from the following joint Sub-committees and Advisory Groups:

- Management Group;
- Quality & Patient Safety Committee; and
- Integrated Governance Committee
- All Wales Individual Patient Funding Request Panel

Report Title:	**Corporate Risk Register**								
Meeting:	Public Board Meeting						**Meeting Date:**	29th July 2021	
Status:	**For Discussion**	✓	**For Assurance**	✓	**For Approval**		**For Information**		
Lead Executive:	**Director of Corporate Governance**								
Report Author (Title):	**Risk and Regulation Officer**								

Background and current situation:

The Corporate Risk Register has been developed to provide the Board with an overview of the key operational risks from the Clinical Boards and Corporate Directorates.

The Corporate Risk Register includes those extreme risks which are rated 20 (out of 25) and above.

The Board now has oversight of strategic risks via the Board Assurance Framework and extreme Operational Risks (Corporate Risk Register) for the Health Board.

The Corporate Risk Register Summary is attached at Appendix A. The detail of each risk listed is also discussed and reviewed at the appropriate committees of the Board.

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

The Board are asked to note that the Corporate Risk Register now contains those operational risks graded 20 or above. This differs to Corporate Risk Registers previously presented to the Board which contained risks graded 15 or above. This change is due to increasing confidence in the appropriateness of Clinical Board and Corporate Directorate risk scoring.

The Risk and Regulation Team ("the Team") continue to work alongside Clinical Boards and Corporate Directorates to ensure that risks are clearly defined and appropriately scored in line with the Health Board's Risk Management Strategy and Procedure. To achieve this the Team now provide a risk register 'check and challenge' feedback report to Clinical Boards/Corporate Directorates detailing recommendations for the improvement of their risk registers and, where relevant, the rationale for not placing candidate risks onto the Corporate Risk Register (e.g. due to significantly aberrant scoring).

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

There are currently 12 Extreme Risks (risks rated 20 and above) on the Corporate Risk Register; these have been provided by the following Clinical Boards; Medicine, Children and Women's, Mental Health, Specialist Services, and PCIC. Following recent re-engagement with the Corporate Risk Register, Capital Estates and Facilities Directorate now have a number of risks

accepted for inclusion on the Corporate Risk Register, with potential for others to be included in future subject to amendment recommended by the Team.

Human Resources/Workforce, CD&T and Finance currently have no candidate risks for inclusion on the Corporate Risk Register.

The Risk and Regulation Team are now in discussion with Digital Health to support the migration of their Directorate Risk Register into the correct format, and until this occurs none of their candidate risks can be considered for placement onto the Corporate Risk Register. As previously reported, the Health and Safety Directorate have historically managed risk internally and an audit of their risk system continues prior to their adoption of the C&V UHB risk management system.

Given that candidate risks for placement on the Corporate Risk Register must now score 20 or greater it is not possible to make meaningful comparison between the May 2021 and July 2021 position. However, the July 21 Corporate Risk Register has carried forward 4 risks unaltered from May 21 and includes 8 new risks.

The present position is as follows:

May 2021	July 2021
6 risks rated 15 (extreme risk) 10 risks rated 16 (extreme risk) 8 risks rated 20 (extreme risk)	12 Risks rated 20 (extreme risk)

COVID-19 continues to have a causal or exacerbating effect on a significant quantity of the presented risks. It is anticipated that the normalising COVID-19 situation currently being experienced across the UHB will enable a future reduction in the quantity of extreme risks presented to the Board. Each risk on the register can be linked to the Strategic Risks detailed upon the BAF.

ASSURANCE is provided by:

- Ongoing discussions with Clinical Boards and the Corporate Directorates regarding the scoring of risk.
- The Risk and Regulation Team's 'check and challenge' of Clinical Board/Corporate Directorate candidate risks.
- The programme of education and training that is being implemented by the Risk and Regulation team to ensure that the Health Board's Risk Management policy is engrained and followed within Clinical Boards and Corporate Directorates.

RECOMMENDATION

The Board is asked to:

NOTE the Corporate Risk Register and the work which is now progressing.

Shaping our Future Wellbeing Strategic Objectives

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

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

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

Equality and Health Impact Assessment Completed:	Not Applicable

CORPORATE RISK REGISTER SUMMARY JUL 2021

Risk Ref	Risk (for more detail see individual risk entries)	Clinical Board / Corporate Directorate	Link to BAF	Initial Risk Score	Risk Score May 21	Risk Score Jul 21	Trend	Target Risk Score
1	Risk of patient and staff harm due to potential failure of anaesthetic gas scavenging system in UHW theatre GF	Estates	Patient Safety/Planned Care Capacity	5x4=20		5x4=20	→	5x1=5
2	Risk of patient harm due to interruption of oxygen supply to the whole of UHL resulting from a corroded oxygen pipeline.	Estates	Patient Safety/Planned Care Capacity	5x4=20		5x4=20	→	5x1=5
3	Risk of loss of heating throughout UHL due to serious corrosion of Main Boiler F&E Tanks	Estates	Planned Care Capacity	5x4=20		5x4=20	→	5x1=5
4	Lack of gastroenterology bed base (UHL) leads to risk of patient harm due to inability to admit patients with suspected/confirmed cancer for treatment.	Medicine	Patient Safety/Planned Care Capacity	5x5=25	5x4=20	5x4=20	→	5x3=15
5	Risk that Medicine CB will be unable to provide meaningful evidence of the harm sustained by patients and staff as a result of Healthcare acquired Covid-19 outbreaks for the purpose of impending investigations and a public inquiry that could result in regulatory sanction.	Medicine	Planned Care Capacity	4x5=20		4x5=20	→	4x3=12
6	Risk of patient harm or patient experience due to delay in assessment of medical patients resulting from a paucity of medical cover across all specilaities and disciplines.	Medicine	Patient Safety/Planned Care Capacity	5x5=20		5x4=20	→	4x4=16
7	Risk of harm to women in labour and babies from potential delays in treatment due to lifts in the Women's Unit breaking down.	Children & Womens	Patient Safety	4x5=20	4x5=20	4x5=20	→	1x1=2
8	Risk to the health and wellbeing of a minor inpatient following admission to adult mental health services	Mental Health	Patient Safety	5x5=25	5x4=20	5x4=20	→	5x2=10
9	Risk to safety and quality due to insufficient staffing capacity and resilience	PCIC	Sustainable Primary and Community Care	4x5=20	4x5=20	4x5=20	→	4x3=12
10	Risks to harm to haematology patienst (including bone marrow transplant) due to cross infection hazards created by an inadequate clinical environment.	Specialist Services	Patient Services	5x5=25	5x4=20	5x4=20	→	5x1=5
11	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
12	Risk that patients will not receive care in a suitable environment due to a number of shortcomings in Critical Care facilities.	Specialist Services	Patient Safety/Capital Assets	5x5=25	5x4=20	5x4=20	→	5x2=10

Report Title:	**Board Effectiveness 2020-21 Self-assessment**								
Meeting:	Board					**Meeting Date:**	29th July 21		
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**		**x**
Lead Executive:	Director of Corporate Governance								
Report Author (Title):	Corporate Governance Officer								

Background and current situation:

It is good practice and good governance for the Board and its Committees to undertake a self-assessment of their effectiveness on an annual basis, in line with the requirement of Standing Orders.

For the 2020-21 self-assessment, a survey was disseminated via Survey Monkey to all Board members enabling an efficient yet effective refection on Board effectiveness and mirroring the method used for the Committees.

The next self-assessment will be done at the end of the financial year to feed into the 2021-22 Annual Governance Statement.

The outcomes of the self-assessments of the Board and the Committees were reported to the Audit Committee on 13th May 2021 so the results could be included within the Annual Governance Statement.

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

Each Committee Effectiveness Review undertaken 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. An overview of the Committee self-assessment process was provided to the Audit Committee on 17 November 2020.

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

Attached are the results for the Board effectiveness review. Out of the 14 questions posed, room for improvement was identified in 1 area around:

- Benchmarking and identifying / sharing best practice.

Recommendation:

The Board is asked to:

- Note the results of the Self-assessment Effectiveness Review for 2020-21;

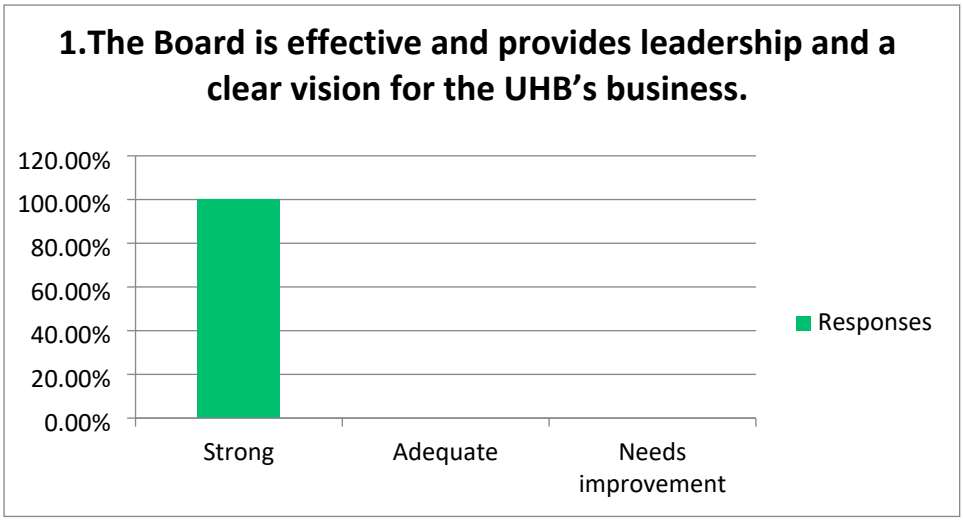
Shaping our Future Wellbeing Strategic Objectives

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

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

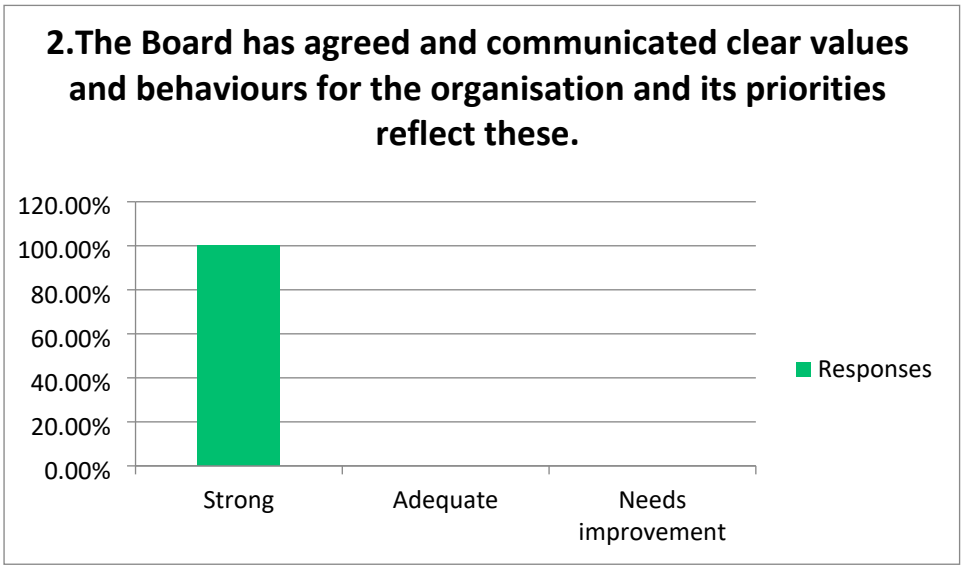
Board Self-Evaluation 2020-2021

- 8 responses received.



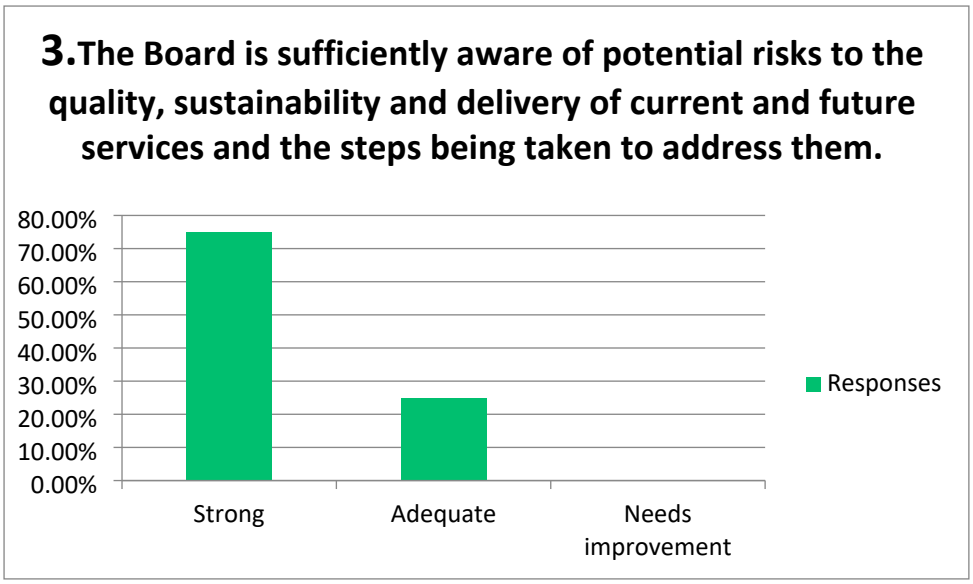
Comments received:

- *A competent Board which has matured well over the last 12 months.*
- *Clear strategy and Board agenda arranged to ensure we deliver it.*



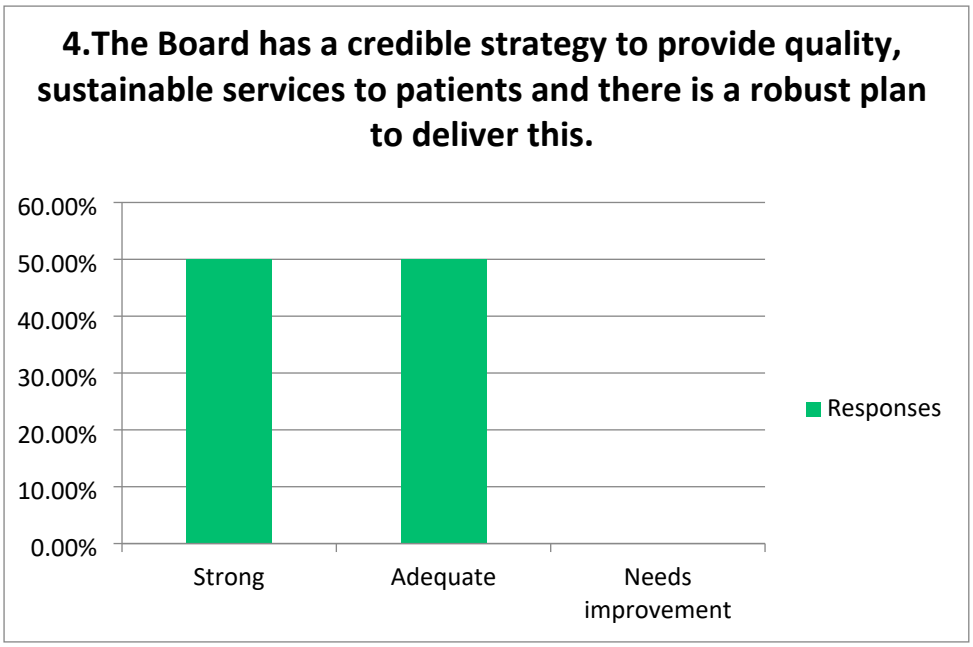
Comments received:

- *The values agreed by the Board have been well communicated over recent years and have never been more important than during the course of the current pandemic. Our values have been extended into our recruitment and staff appraisal and development processes.*
- *All Board members assigned a protected characteristic to promote, values underpin all our work.*



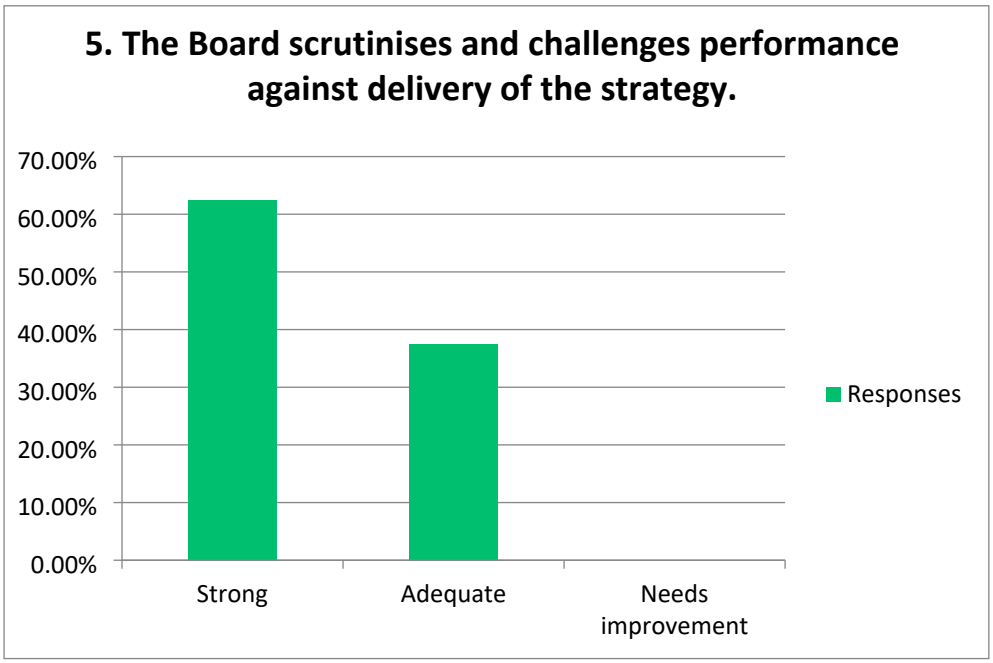
Comments received:

- *There is a robust Board Assurance Framework in place which identifies risks to strategic objectives. This is presented to each meeting of the Board.*
- *A very sound Board Assurance Framework (BAF) has been developed by the Director of Corporate Governance which provides a clear picture of the main risks faced by the organisation. The BAF also has clear links into the strategic objectives of the UHB providing a positive overview for Board members and the public.*
- *Have reviewed risk appetite. Risk register much improved.*



***Comments received**:*

- *The strategy of the organisation is well developed with work currently underway to ensure effective delivery of the strategy in terms of outcomes achieved. Moving towards a "strong" rating.*
- *Current uncertainty and scale of post-covid challenge makes this challenging.*
- *An area of strength, this has been given much focus and good progress made.*

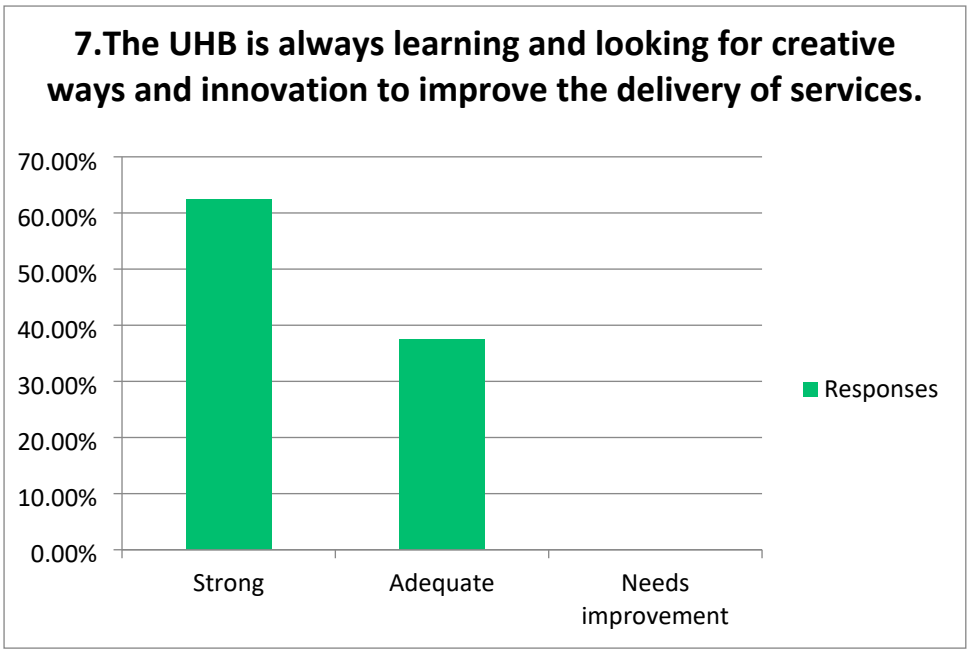


Comments received:

- *Has improved during the last period*
- *Yes and this has seen the execs respond with key priorities to drive delivery.*

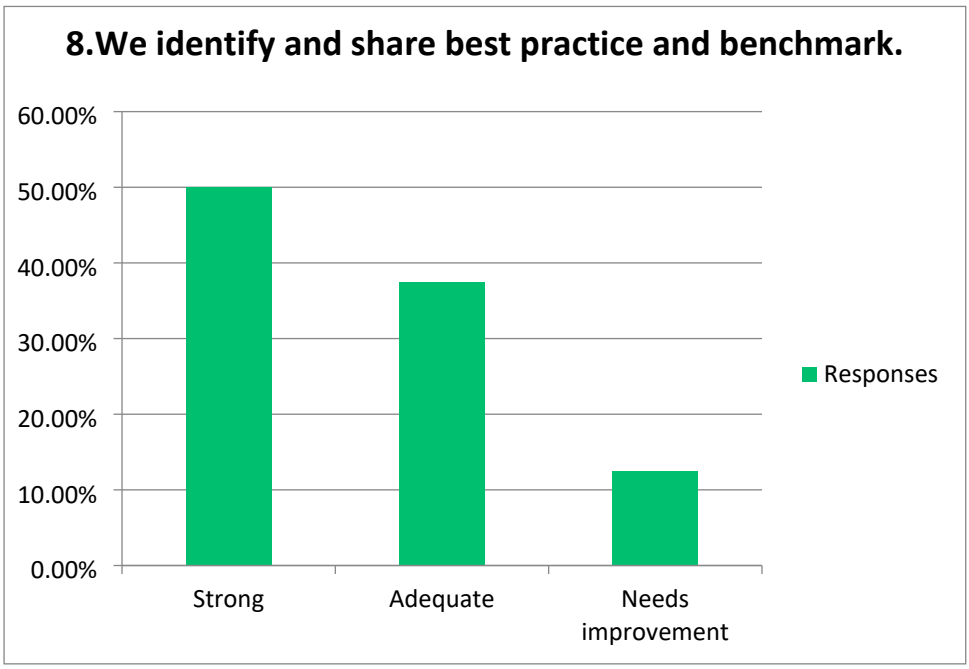
Comments received:

- *This has been a particular strength during the current pandemic with very strong partnership working being particularly evident*
- *I am not aware that the Board has a formally process in place to capture feedback from all stakeholders but this is a function which is generally overseen by the Strategic Planning Team and the Comms and Engagement Team.*
- *Yes ongoing but always an area for improvement.*



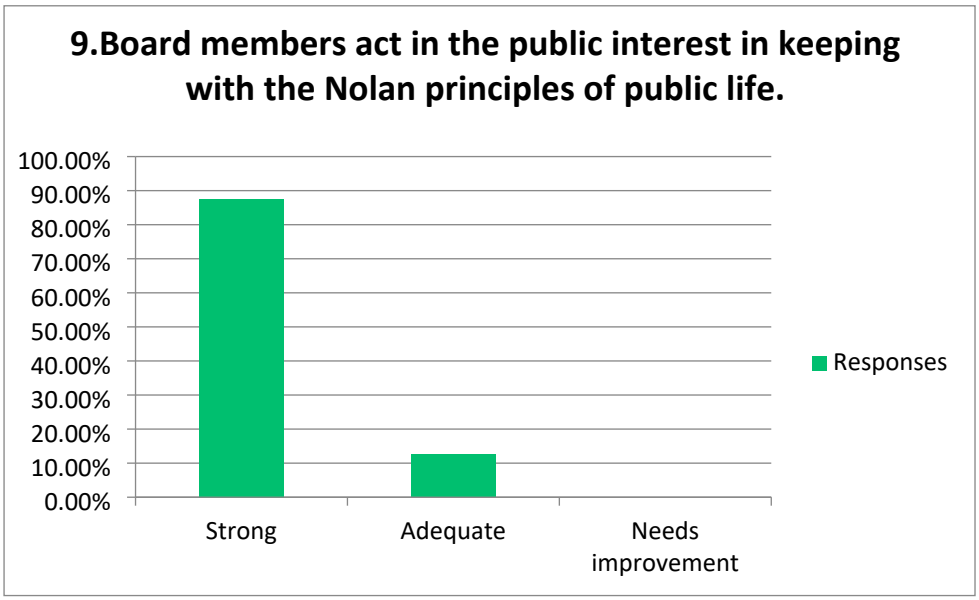
Comments received:

- *Aided by the challenges presented by the pandemic, the Board (in particular executive Board members) has facilitated new and creative ways to provide our services during a very challenging period.*
- *Keen to lead innovation but also adopt and adapt.*



Comments received:

- *Benchmarking is weak across the performance areas considered at Board*
- *Best practice sharing could always be improved further even though the last 12 months has witnessed significant cooperative working throughout the organisation. The "strong" rating reflects the amazing team working that has been undertaken during the year. There will be a need for us to sustain this level of sharing best practice as we move out of the pandemic.*
- *Yes embedded in teams and services*

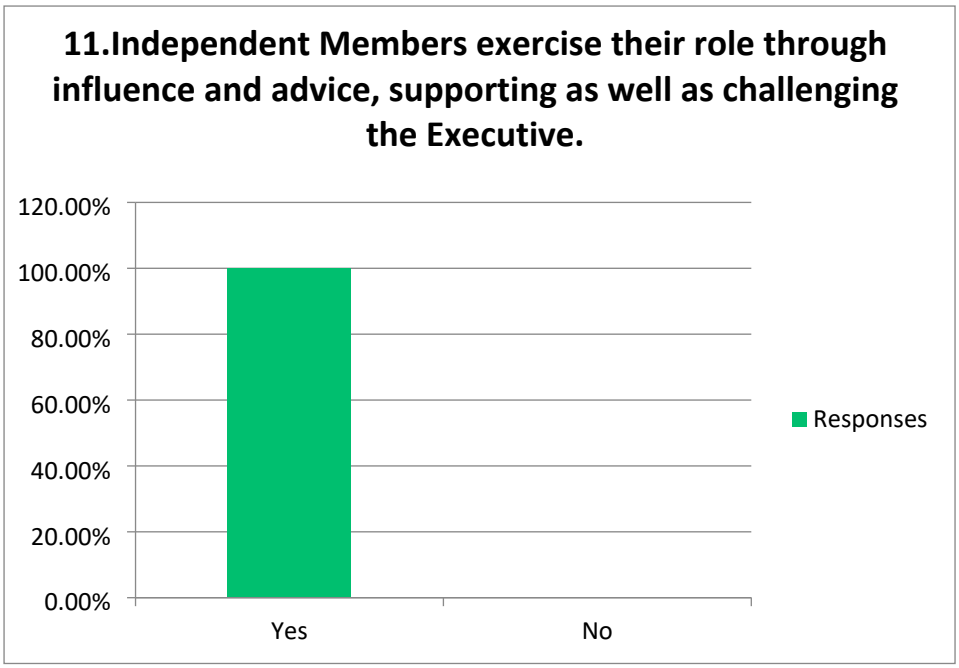


Comments received:

- *Not aware of any concerns, all act in line with the principles in my observation*

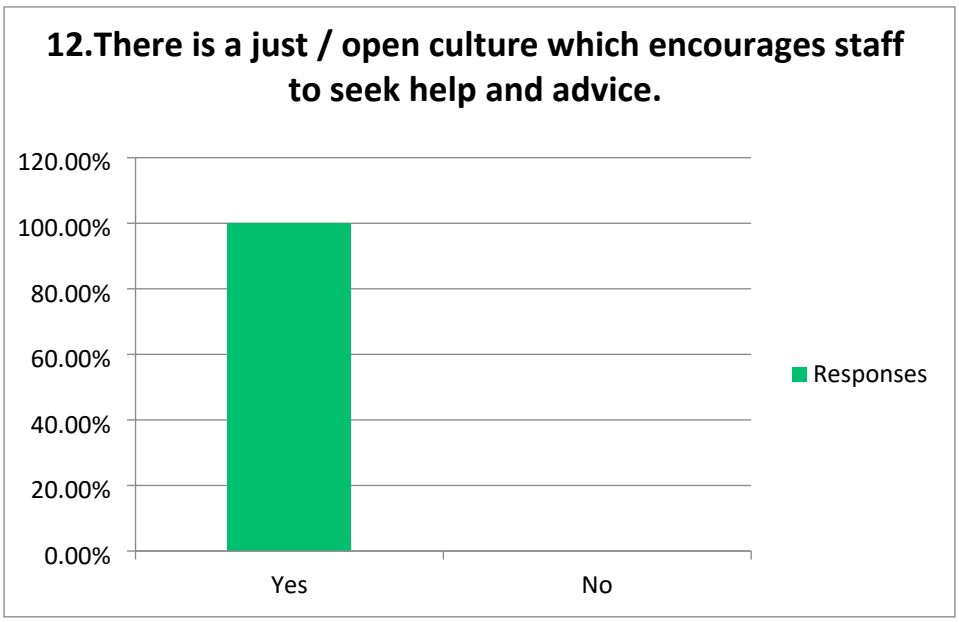
Comments received:

- *Open transparent culture seem by the breadth of issues discussed in public Board*



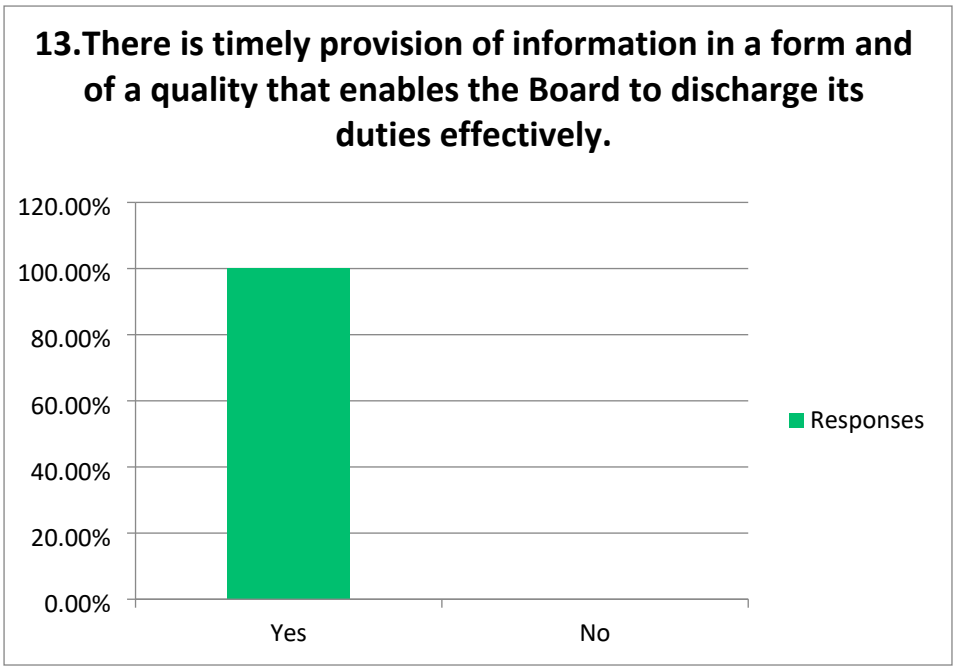
Comments received:

- *Scrutiny, challenge and support are consistently demonstrated by Independent Members who all make a very valuable contribution to the effectiveness of the Board.*
- *Regularly demonstrated.*



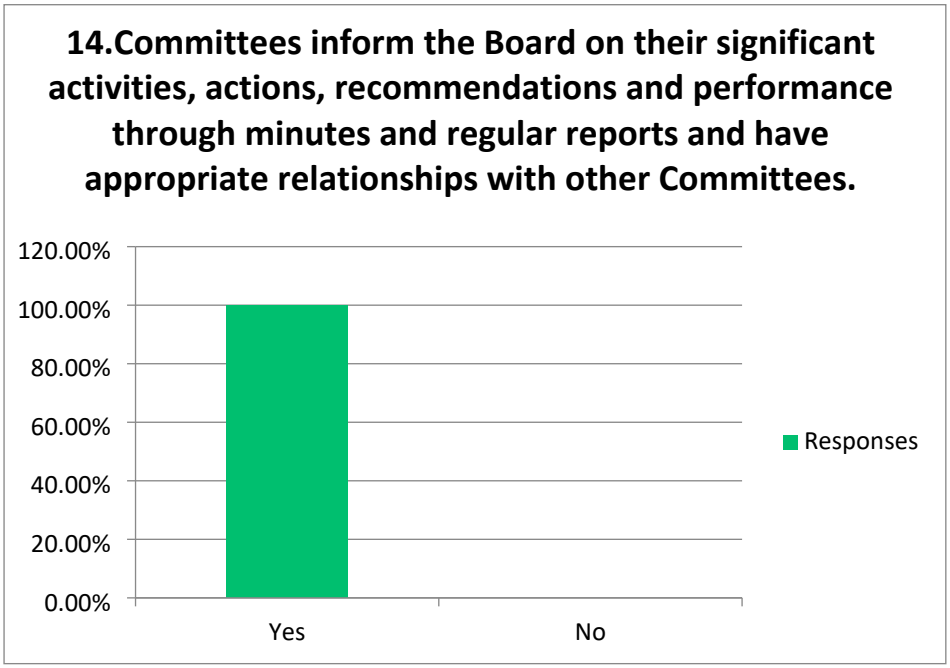
Comments received:

- *In place but we will need to refresh the Freedom to Speak Up process to ensure that all staff are fully aware.*
- *Yes and have revised this, but needs ongoing review and publicizing.*



Comments received:

- *Papers are produced in a timely way. Admincontrol is a useful library function too*



Comments received:

- *Minutes are received by the Board after each Committee meeting in addition to a Chairs report from each Committee Chair to the Board.*
- *Written reports and chance for lead IM to raise items for Board attention.*

Report Title:	**FINANCE COMMITTEE KEY ISSUES REPORT**								
Meeting:	Board Meeting						**Meeting Date:**	29th July 2021	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**		**X**
Lead Executive:	**Catherine Phillips, Executive Director of Finance**								
Report Author (Title):	**Dr Rhian Thomas, Chair of Finance Committee**								

Background and current situation:

To provide the Board with a summary of key issues discussed at the Finance Committee held on the **26th May 2021**.

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

The draft Financial Plan sets out the UHB financial strategy in three parts:

1. Core Financial Plan: Delivering in-year financial stability and maintain the current level of underlying deficit
2. Continuation of non-recurrent response to COVID within available funding
3. COVID recovery and reset (service) within available funding

Delivery of the core financial plan includes a 2% (£16.0m) savings requirement. At month 1 £8.486m Green and Amber savings have been identified against the target. Further progress will need to be made before the final plan is submitted at the end of quarter 1.

The UHB also has a risk in its current and forecast level of COVID response costs which are in excess of funding received. The estimated costs for the first 6 months are £4.056m higher than confirmed allocations.

Assessment and Risk Implications

Financial Performance Month 1

The report updated the Committee on the UHB's draft financial plan.

The UHB's draft plan included a planned deficit of £21.3m in 2021/22 and if delivered would ensure that the underlying position does not deteriorate. The draft plan was subject to further review during quarter 1 of 2021/22 in the light of additional planning guidance and the UHB expected to submit a final financial plan for 2021/22 at the end of quarter 1.

The provisional financial position reported to Welsh Government for month 1 was an overspend of £1.929m as summarised in table 1 below:

Table 1: Month 1 Financial Position 2021/22

	Cumulative Month 1 £m
COVID 19 Additional Expenditure	8.806
COVID 19 Reductions in Planned Expenditure	(0.661)
Net Expenditure Due To COVID 19	**8.145**
Welsh Government COVID funding received / assumed	(8.145)
Net COVID 19 Forecast Position (Surplus) / Deficit £m	0.000
Planned Deficit per Draft Plan	1.775
Operational position (Surplus) / Deficit	0.154
Financial Position £m (Surplus) / Deficit £m	**1.929**

The table shows that in April, the in month net expenditure of £8.145m as a consequence of COVID 19 was matched by an equal amount of additional Welsh Government funding.

The additional COVID 19 expenditure in month 1 was £8.806m and this was offset by an expenditure reduction £0.661m as a consequence of the curtailment of services arising from measures to manage COVID 19 leaving net expenditure due to COVID 19 of £8.145m.

The UHB had a small operational overspend of £0.154m at Month 1 which was over and above 1/12th of the planned £21.3m deficit (£1.775m) giving a month 1 reported overspend of £1.929m.

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 1 forecast of net expenditure due to COVID 19 in 2021/22 was £118.741m and this was offset by additional COVID 19 funding of £118.741m as summarised in table 2 below:

Table 2 : Summary of Forecast COVID 19 Net Expenditure

	Month 1 £m	Forecast Year-End Position £m
COVID 19 Testing	0.243	2.914
COVID 19 Tracing	1.016	15.767
COVID 19 Vaccination	1.580	18.903
Extended Flu vaccination	0.000	1.536
Cleaning Standards	0.155	3.978
PPE	0.379	4.601
Continuing Care and Funded Nursing Care	0.249	0.747
Urgent and Emergency Care	0.157	2.057
COVID 19 Local Response	4.891	58.364
COVID 19 Recovery	0.136	13.660
COVID 19 Non Delivery of Savings Plans	0.000	0.000
COVID 19 Reductions in Planned Expenditure	(0.661)	(3.786)
COVID 19 Release of Planned Investments	0.000	0.000
Net Expenditure Due To COVID 19	**8.145**	**118.741**
Welsh Government COVID funding confirmed / assumed	(8.145)	(118.741)
Net COVID 19 Forecast Position (Surplus) / Deficit £m	**0.000**	**0.000**

The UHB forecast included funding assumed from Welsh Government totaling £118.741m to match the forecast costs. Additional further COVID response funding was assumed in line with the forecast costs which included a forecast over commitment of £4m against the first 6 months Local Response allocation. Whilst additional income had been assumed at month 1 for the forecast over commitment for the first six months against the £22.6m allocation, action was also being taken to review the assessed level of spend to bring it back in line with the allocated funds.

On this basis, the UHB was reporting a forecast deficit of £21.3m which was consistent with the draft financial plan and assumed additional Welsh Government funding of £118.741m to manage the impact of COVID 19 in 2021/22 in line with response and recovery assumptions.

The assessed year end underlying deficit was £25.3m in line with the draft financial plan.

Finance Risk Register

The 2020/21 Finance Risk register was presented to the Committee.

It was highlighted that 3 of the risks identified on the 2021/22 Risk Register were categorised as extreme risks (Red) namely:

- Maintaining the underlying deficit of £25.3m on line with the draft annual plan.
- Management of budget pressures.
- Delivery of the 2% CIP (£16.0m)

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 KEY ISSUES REPORT**								
Meeting:	Board Meeting						**Meeting Date:**	29th July 2021	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**		**X**
Lead Executive:	**Catherine Phillips, Executive Director of Finance**								
Report Author (Title):	**Dr Rhian Thomas, Chair of Finance Committee**								

Background and current situation:

To provide the Board with a summary of key issues discussed at the Finance Committee held on the **23rd June 2021**.

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

The draft Financial Plan sets out the UHB financial strategy in three parts:

1. Core Financial Plan: Delivering in-year financial stability and maintain the current level of underlying deficit
2. Continuation of non-recurrent response to COVID within available funding
3. COVID recovery and reset (service) within available funding

The brought forward COVID deficit of £21.313m relating to non-delivery of savings in 2020/21 is assumed to funded non-recurrently as per the Welsh Government final annual plan financial principals.

The reported financial position for the 2 months to the end of May is an operational deficit of £0.436m. Mitigating actions will need to be taken to ensure this position is recovered.

Delivery of the core financial plan includes a 2% (£16.0m) savings requirement. At month 2 £10.431m Green and Amber savings have been identified against the target. Further progress will need to be made before the final plan is submitted at the end of quarter 1.

The UHB also has a risk in its current and forecast level of COVID response costs which are in excess of funding received. The estimated costs for the first 6 months are £0.495m higher than confirmed allocations which is a significant improvement on the position reported at month 1.

Since reporting the month 2 financial position, the UHB has been informed that it can retain any reductions in planned expenditure due to the impact of the pandemic to offset financial pressures, with COVID costs being funded gross of this. This is a departure from the treatment in 2020/21 when COVID costs were funded net of reductions in planned expenditure.

Assessment and Risk Implications

Financial Plan 2021/22

The Finance Committee was provided with an update on the financial plan which built upon previous presentations made to the Finance Committee and the February 2021 Board Development session. The financial narrative which would be inserted into the overall annual plan was included in the papers.

The following points were emphasized:

- The key change in the plan since it was considered by the Finance Committee at its previous meeting was that the plan now assumed non recurrent COVID funding of £21.3m to cover slippage in the 2020/21 savings programme due to the impact of the pandemic. As a result, the UHB plan now included a breakeven in year position.
- The other main change to the plan was that it now assumed that the gross costs of managing the impact of COVID 19 would be fully funded and that reductions in planned expenditure arising from the curtailment of elective services due to the pandemic were available to the UHB to manage in year operational pressures, including the delivery of savings.
- The key risks to the plan which would need to be managed and mitigated were noted as follows:
  - Finalisation of planning assumptions and financial allocations.
  - Achievement of the 2 % efficiency plan target.
  - Management of Operational Pressures
  - Working within the COVID Response funding.

Review of 2021/22 Savings Plans

The Finance Committee received a presentation which provided detail on the following:

- (Cost Improvement Programme) CIP monitoring and reporting
- Cardiff and Vale CIP tracker
- CIP tracker governance
- Cost reduction and Efficiency savings definitions
- Current savings position and detailed schemes

Financial Performance Month 2

The report updated the Committee on the performance against the UHB's draft financial plan.

The UHB's draft plan had been updated to a break even plan to reflect assumed additional COVID income to cover slippage in the 20/21 savings programme due to the impact of the pandemic. The draft plan which would ensure that the underlying position does not deteriorate was subject to further review during quarter 1 of 2021/22 in the light of additional planning guidance. The UHB expected to submit a final financial plan for 2021/22 at the end of quarter 1.

The financial position reported to Welsh Government for month 2 was an overspend of £0.436m as summarised in table 1 below:

Table 1: Month 2 Financial Position 2021/22

	Cumulative Month 2 £m	Forecast Year-End Position £m
COVID 19 Additional Expenditure	16.635	111.149
COVID 19 Reductions in Planned Expenditure	(1.177)	(3.543)
Net COVID 19 Expenditure	**15.458**	**107.606**
COVID 19 Funding assumed	(19.008)	(128.919)
Deficit due to non delivery of 2020/21 recurrent Savings	3.550	21.313
Operational position (Surplus) / Deficit	0.436	0.000
Financial Position £m (Surplus) / Deficit £m	**0.436**	**0.000**

The month 2 deficit of £0.436m reflected the operational performance of the UHB with all COVID costs and the shortfall on the 2020/21 savings plan assumed to be funded. The UHB was forecasting a break even position by year end and all risks needed to be managed to deliver this.

The additional COVID 19 expenditure in the year to month 2 was £16.635m and this was offset by expenditure reduction £1.177m as a consequence of the curtailment of services arising from measures to manage COVID 19, leaving net expenditure due to COVID 19 of £15.458m.

It was assumed that Welsh Government COVID funding including additional further COVID response funding will be provided to cover the COVID costs arising to month 2 and for the remainder of the year.

Whilst the UHB expected the non COVID related operational position to move to a broadly balanced position as the year progressed, the additional costs arising from plans to manage COVID 19 were expected to continue. The month 2 forecast of net expenditure due to COVID 19 in 2021/22 was £107.606m and this was offset by additional COVID 19 funding of £107.606m as summarised in table 2 below:

Table 2 : Summary of Forecast COVID 19 Net Expenditure & Funding

Welsh Government COVID Funding	Month 2 £m	Forecast Year-End Position £m
COVID 19 Testing assumed	(0.426)	(2.557)
COVID 19 Tracing assumed	(1.972)	(11.532)
COVID 19 Vaccination assumed	(2.924)	(18.291)
Extended Flu vaccination assumed	0.000	(1.536)
Cleaning Standards assumed	(0.108)	(3.707)
PPE assumed	(0.752)	(4.545)
Continuing Care and Funded Nursing Care assumed	(0.498)	(2.988)
Urgent and Emergency Care assumed	(0.318)	(1.997)
COVID 19 Response - confirmed	(9.227)	(22.618)
COVID 19 Response - assumed	0.000	(27.533)
COVID 19 Recovery - Confirmed	(0.406)	(13.660)
COVID 19: Vaccine Allergy SLA	(0.004)	(0.090)
COVID 19: Long Covid Recovery Pathway	0.000	(0.096)
COVID 19 Reductions in Planned Expenditure	1.177	3.543
Sub Total COVID funding confirmed / assumed £m	**(15.458)**	**(107.606)**
NR Funding for Non Delivery of 2020/21 Recurrent Savings	**(3.550)**	**(21.313)**
Total COVID funding confirmed / assumed £m	**(19.008)**	**(128.919)**

The UHB had a risk in its current and forecast level of COVID response costs which were in excess of funding received. The estimated costs for the first 6 months were £0.495m higher than confirmed allocations. The surplus non recurrent COVID funding is to be applied to the brought forward COVID deficit of £21.313m relating to a shortfall in recurrent savings delivery in 2020/21.

On this basis, the UHB was reporting a breakeven year end position which was consistent with the draft financial plan and assumed additional Welsh Government funding of £128.919m to manage the impact of COVID 19 in 2021/22 in line with response and recovery assumptions.

The assessed year end underlying deficit was £25.3m which was in line with the draft financial plan.

Finance Risk Register

The 2020/21 Finance Risk register was presented to the Committee.

It was highlighted that 3 of the risks identified on the 2021/22 Risk Register remained categorised as extreme risks (Red) namely:

- Maintaining the underlying deficit of £25.3m on line with the draft annual plan.
- Management of budget pressures.
- Delivery of the 2% CIP (£16.0m)

In addition, COVID response and recovery funding risks were rated as **High** pending WG funding confirmation

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:	**Audit & Assurance Committee – Chair's Report**	**Agenda Item no.**	**8.3.2**
Meeting:	**UHB Board Meeting**	**Meeting Date:**	29.07.2021
Status:	**For Discussion**	**For Assurance**	**For Approval**	**For Information**	**x**
Lead Executive:	**Chair, Audit & Assurance Committee**		
Report Author (Title):	**Corporate Governance Officer**		

Background and current situation:

To provide the Board with a summary of key issues discussed at the Audit & Assurance Committee held on **13 May 2021**.

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

Internal Audit Progress and Tracking Reports

The Internal Audit Progress and Tracking Reports were received and the Head of Internal Audit (HIA) provided the Committee with the current position regarding the work to be undertaken by the Audit & Assurance Service as part of the delivery of the approved 2020/21 Internal Audit plan.

The Committee was advised of 8 audits that had not been completed in time to submit to this Committee but it was noted that they were anticipated to be finalised to feed into the final annual report and opinion for 2021.

The 8 unfinished audits were:

- Engagement Around Service Planning
- C&W CB – Rostering in Community Children's Nursing
- Recruitment & Retention of Staff
- Annual Planning Process 21/22
- Data Quality Performance Reporting
- Infrastructure / Network Management
- Cyber Security System Follow-up
- Shaping Future Wellbeing in the Community Scheme

It was noted that at the time of producing the report, 3 of the outstanding audits had been issued in draft with a positive reasonable assurance rating and a further piece of work had been issued in draft on quality data performance reporting which had also received a positive reasonable assurance rating.

It was noted that there had been one additional report within the CD&T clinical board which was being deferred to the 2021/22 plan and had been agreed with the clinical board.

Standing Orders, SFI's, Reservation and Delegation of Powers

The Standing Orders, SFI's, Reservation and Delegation of Powers was received, noted and endorsed by the Committee.

It was noted that the report set out the changes that had been made to the model standing orders from Welsh Government (WG).

It was noted that the changes had been made in February 2019 and that there had been further changes made in relation to Covid-19 which were taken to the Board in May 2020.

Compliance with the Corporate Governance Code

The Committee was advised that the assessment against the Compliance with the Corporate Governance Code had been done so that it could be included in the CVUHB accountability report.

It was noted that CVUHB were compliant with the Corporate Governance Code.

Board effectiveness survey 2020-2021

Areas that had suggested a need for Further Improvement were identified:

- Board
  8. We Identify and Share Best Practice and benchmark

- Charitable Funds Committee
  4. Committee meetings packages are complete, received with enough lead time for members to give them due consideration and include the right information. Minutes are received as soon as possible after the meeting.

- Health & Safety Committee
  2. The Board is active in its consideration of the Committee's composition
- Health & Safety Committee
- 4. Committee meetings packages are complete, received with enough lead time for members to give them due consideration and include the right information. Minutes are received as soon as possible after the meeting.

- Quality, Safety, Experience Committee
  The Committee agenda setting process is thorough and led by the Committee Chair.

The Committee was advised that the areas would be fed into the accountability report.

Internal Audit reports for information:

The following Internal audit reports were received:

1. Consultant Job Planning Follow-up: Limited Assurance Report
2. Health and Care Standards
3. IM&T Control and Risk Assessment

Recommendation:

The Board is asked to:

- **NOTE** the report.

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

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

Equality and Health Impact Assessment Completed:	Not Applicable

Report Title:	**Audit & Assurance Committee – Chair's Report**	**Agenda Item no.**	**8.3.2**
Meeting:	**UHB Board Meeting**	**Meeting Date:**	29.07.2021
Status:	**For Discussion**	**For Assurance**	**For Approval**	**For Information**	**x**
Lead Executive:	**Chair, Audit & Assurance Committee**		
Report Author (Title):	**Corporate Governance Officer**		

Background and current situation:

To provide the Board with a summary of key issues discussed at the Special Audit & Assurance Committee held on **10th June 2021**.

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

Report from the Losses and Special Payments Panel

The Deputy Finance Director (DFD) stated that this was the only item of non-accounts business on the agenda and concerned a timing issue regarding losses and special payments approval.

The report had been presented because the losses were included within the accounts and would need to be approved before being formally approved in the Annual Report.

The report confirmed that the losses and special payments panel met on 18th May 2021 which considered the accounts of the last 6 months of the year.

The DFD informed Members that the papers set out recommendations for losses and write offs regarding criminal negligence, personal injury, bad debt, permanent injury, small claims, employment tribunals and stock.

The write offs outlined in the Assessment Section of this report were **APPROVED**.

Introduction to the Annual Report and Accounts 2020-21

The DFD informed the Committee that the paper introduced the Annual Report which included the Performance Report, Accountability Report, and the Annual Accounts. The DFD added that it supported the key changes made to the draft statements and outlined and confirmed the financial performance of the UHB.

The DFD highlighted that the Audit & Assurance Committee had a key role in reviewing the Annual accounts and the ISA 260 report from Audit Wales and that the Annual Report contained the Annual Accounts & Remuneration Report.

The DFD stated in reviewing the financial statements and associated documentation the committee needed to consider the work carried out throughout the year by Internal Audit &

Counter Fraud with specific reference to the opinion provided by the Head of Internal Audit (HIA).

In regards to the Annual Report and Accounts assurance, the accuracy on the statements could be provided by the programme of work undertaken by the Audit & Assurance Committee throughout the year and the process that it had followed to sign off the Annual Report and accounts.

The DFD highlighted the changes made in the draft Annual Report and Accounts and how Audit Wales had reviewed the drafts and provided feedback with a number of narrative modifications being included in the final report.

In terms of the financial performance of the UHB the DFD advised that:

- There were no changes to the draft accounts.
- In regards to Revenue Resource Limits, although a plan had been approved it did not achieve a 3 year break even position and there was an aggregated deficit of £9.724 million. Therefore the UHB failed against the financial duty within the Revenue Resource Limit.
- The financial duty related to the Capital Resource limit had been met with an aggregated surplus of £257,000 over a 3 year period.

The DFD highlighted that the key item of assurance was provided by the work from Audit Wales as set out in the ISA 260 report where they had worked through and verified the draft accounts into the final accounts over a period of 5 weeks.

The Committee had **NOTED** the reported financial performance contained within the Annual Report and Accounts and that the UHB has breached its statutory financial duties in respect of revenue expenditure.

NOTED the changes made to the Draft Annual Report and Accounts;

REVIEWED the ISA 260 Report, the Head of Internal Audit Annual Report, the Letter of Representation, the response to the audit enquiries to those charged with governance and management and the Annual Report and Accounts;

RECOMMENDED to the Board that it agreed and endorses the ISA 260 Report, the Head of Internal Audit Annual Report, the Letter of Representation and the response to the audit enquiries to those charged with governance and management;

RECOMMENDED to the Board approval of the Annual Report and Accounts for 2020/21.

Audit Wales ISA 260 Report

Mark Jones – Audit Wales (MJ-AW) highlighted that the report discharged their responsibility to report their findings to the Audit & Assurance Committee and to the Board before the Annual Report & Accounts were considered for approval.

He stated that Audit Wales intended to issue an unqualified opinion on the accounts and the remuneration report in terms of them being properly prepared, materially true and fair and he added that he intended to qualify the regularity opinion as highlighted by the DFD. He

highlighted that this was the fifth year that this had happened and that the following year the qualified regularity opinion may not be required.

MJ-AW highlighted the matters that needed to be brought to the attention of the Audit Committee:

- There were no uncorrected misstatements
- Tax issues around senior clinicians pensions

He informed the Committee that the one area not highlighted within the report was the inventory which had been queried at the Audit Workshop.

The DFD highlighted that on the last page under appendix 1 the date was incorrect and read 09/06/2021 but should say 10/06/2021. This had been corrected in the actual letter of representation to be signed.

The Audit Committee received and **NOTED** the Audit Wales ISA 260 Report

The Head of Internal Audit Opinion & Annual Report for 2020-21

The HIA advised that the majority of the content within the report remained the same as per the draft reviewed at the Audit Workshop.

The HIA highlighted the key messages from his opinion within section 1.2 which clarified the final Head of Internal Audit Opinion which confirmed that the Board could take reasonable assurance that arrangements to secure governance, risk management and internal control, within those areas under review, were suitably designed and applied effectively.

He highlighted figure 1 within the report which provided the final outcome for all internal audit work completed throughout the year:

The HIA added that there were 2 audits within the reasonable assurance area on Infrastructure Network Management and another on the Maelfa Well-Being Hub.

The HIA reminded members that since producing the draft report at the Audit workshop, 5 pieces of work were still ongoing and had not progressed to a stage where they could provide an assurance rating but wanted to clarify that all 5 had been progressed to either a final or draft stage.

The Audit Committee had received and **NOTED** the Head of Internal Audit Opinion.

To receive and consider the following for 2020-21:

a. **The Letter of Representation included within the ISA 260 report (see item 4.3)**

The DDF stated that this was reviewed earlier in the meeting as part of the ISA 260 report.

b. **The response to the audit enquiries to those charged with governance and management**

The DDF stated that this was previously endorsed by the CEO, UHB Chair, DCG, DOF, & Chair of the Audit & Assurance committee.

c. The CVUHB Annual Report 2020-2021 including the Annual Accountability Report, Performance report and the Financial Statements

The DCG commented that this was the first time that the Health Board had received the full Annual report and Accounts as one document as previously it had received the Accountability report and accounts separately.

The DCG stated that the final published document would have minor changes in terms of corrected typographical errors and title changes of Executives.

The following documents were **NOTED** and **APPROVED**:

a. The Letter of Representation included within the ISA 260 report

b. The response to the audit enquiries to those charged with governance and management

c. The CVUHB Annual Report 2020-2021 including the Annual Accountability Report, Performance report and the Financial Statements

Recommendation:

The Board is asked to:

- **NOTE** the report.

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

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

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

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

Report Title:	**Audit & Assurance Committee – Chair's Report**	**Agenda Item no.**	**8.3.2**
Meeting:	**UHB Board Meeting**	**Meeting Date:**	29.07.2021
Status:	**For Discussion**	**For Assurance**	**For Approval**	**For Information**	**x**
Lead Executive:	**Chair, Audit & Assurance Committee**		
Report Author (Title):	**Corporate Governance Officer**		

Background and current situation:

To provide the Board with a summary of key issues discussed at the Audit & Assurance Committee held on **6th July 2021**.

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

Internal Audit Progress and Tracking Reports

The Head of Internal Audit (HIA) informed the committee that this is the first report from the 2021/22 Plan and provides the committee with a brief update against the Audit plan that was agreed in April 2021.

He highlighted section 2 of the report and stated that there are no final reports from the 2021/22 plan to be brought to the committee on this occasion however highlighted the completion of 7 reports from the 2020/21 plan that were not finalised in time for the committee meeting in May 2021.

The Deputy HIA (DHIA) stated in regards to the Engagement Around Service Planning report they gave reasonable assurance on this with a range of medium and low priority recommendations.

The DHIA stated that the pandemic affected the sample they selected due to a change in focus through 2021 which meant their teams were looking into the communications of temporary changes and adaptations to the pandemic.

The DHIA highlighted the Data Quality Performance Report, the report was given reasonable assurance with a range of medium and low priority recommendations with a focus on policy and procedures.

The DHIA highlighted the Children's & Women's Clinical Board - Rostering in Community Children's Nursing report stating that the Audit was requested by the Clinical Board with an appetite to improve their efficiency and effectiveness of their processes. She stated that it received reasonable assurance with a range of medium and low priority recommendations.

The HIA highlighted the Staff Recruitment Report which received a reasonable assurance rating and that they focused on the processes in place for nurse recruitment which were very robust and had good controls in place.

The HIA highlighted the Wellbeing hub at Maelfa which was a capital project where some issues were raised around completion of contract documentation and timeliness of payments of the schemes. He stated that it received reasonable assurance rating.

The HIA highlighted section 4 of the report which provides an update of proposed changes to the plan since agreed in April 2021 which were:

- **The ALNET Act**
- **Consultant Job Planning Follow Up**

The committee received the report and considered the Internal Audit Progress Report, including the findings and conclusions from the finalised individual audit reports and approved the proposed amendments to the Internal Audit Plan for 2021/22.

Audit Wales Update

Darren Griffiths, Audit Wales (DG-AW) highlighted 2 matters:

The Phase two structured assessment work where they decided to undertake their structured assessment work into stages. He stated that phase one has been completed and phase two will focus on the Health Boards corporate governance financial management arrangements and how the arrangements have changed since last year and how learning from the pandemic is shaping future arrangements for ensuring good governance.

DG-AW highlighted the follow up of radiology services which will focus on progress made to date against implementing the recommendations of the 2016 review and that this field work is underway.

The Committee received and noted the Audit Wales update

Structured Assessment 2021 (Phase One) – Operational Planning Arrangements

DG-AW highlighted how Internal Audit focused on the 2021/22 planning arrangements and described how the work Audit Wales are doing focusses on Q3 & 4 planning arrangements.

He stated that it was a positive report and found the health boards planning arrangements were robust and effective but still felt there was a need to strengthen the health boards overall arrangements for monitoring and reporting on operational delivery particularly to the Strategy & Delivery (S&D) Committee and to the Board.

He stated that they did not make any recommendations at this point however they will be as part of the phase 2 work on whether there has been any improvement in reporting progress as part of the 2021/22 plan to the S&D Committee and Board.

The Committee received and noted the Audit Wales update

Rollout of the COVID-19 vaccination programme in Wales

DG-AW stated that this was a facts based review and haven't provided any judgements as they normally do with national reports. In terms of key findings the programme was delivered at significant pace with the milestones in Welsh Governments (WG) vaccination strategy providing a strong impetus to drive the programme. He highlighted that vaccine uptake is high with lower uptake in some ethnic groups and the more deprived communities.

He stated that some sites have been more effective than others and that some sites may become unavailable as they return to normal use. He added retaining workforce reliance would be vital especially to support the autumn booster programme if introduced and that there are many positive learning examples on how this was rolled out and the NHS and WG should look to apply this learning to wider immunisation strategies and delivery of other programmes across the NHS.

The Committee received and noted the Audit Wales update

Procuring and Supplying PPE for the COVID-19 Pandemic

DG-AW stated that the report specifically focusses on the national efforts to supply the Health and Social Care sectors in Wales. He added that they did not review the arrangements for local procurement for PPE or the logistical arrangements in place to locally distribute PPE directly to frontline staff.

In terms of their overall conclusion they found that NWSSP overcame some of the early challenges to provide PPE required by guidance without having to run stock at a national level but did find through staff surveys undertaken by the BMA and RCN in Wales that some staff had reported they experienced some shortages in PPE and felt that they should have received a high level of PPE than required by guidance.
DG-AW highlighted that they found that good arrangements were put in place by most governments and NWSSP to procure PPE however contract award notices were not published in all cases within 30 days.

He stated that they have made 8 recommendations to address weaknesses and areas for improvements

He stated it was demonstrated that the system as a whole is very effective at working at pace and transforming at pace to meet some of the current challenges. He added going forward there will be a need to ensure minimum standards are being adhered to.

The Committee received and noted the Audit Wales update

Welsh Health Specialised Services Committee (WHSSC) Governance Arrangements

DG-AW informed the committee that this is a joint committee of each local health board in Wales with responsibility for making collective decisions on the review, planning, procurement and that performance management have agreed specialised and tertiary services.

He stated that it is organised by Cwm Taf Morgannwg UHB and has an annual budget of £680 Million. They found that the governance arrangements, management operations, and planning

arrangements have improved since the previous reviews were undertaken in 2015 but the impact of the pandemic means that WHSSC will require a clear strategy to recover services.

He highlighted that they have made a number of recommendations for WHSSC and Welsh Government. There no specific recommendations were made for individual Health boards but drew attention to the fact that the committee may want to reflect on findings in relation to the flows of assurance between the joint committee and individual boards.

The Committee received and noted the Audit Wales update

Declarations of Interest and Gifts and Hospitality Tracking Report

The DCG reminded the committee that they chase up declarations of interest on an annual basis and at the last meeting in May they had done a significant amount of work over a period of 12 months on bringing the number of declarations up.
She stated that they start the process again in the new financial year as people are meant to declare their interests on an annual basis, if changes are required in any interests and also target staff graded 8A and above as they are considered the ones who have responsibility for budgets, purchasing, etc. and are more likely to be in a position of conflict.

The DCG stated that currently they have 18 declarations for this year and none have presented any conflicts of interests but 6 of those have secondary employment forms alongside them. She added there are a few declarations of gifts and hospitality with no cause for concerns.

The committee received Declarations of Interest and Gifts and Hospitality Tracking Report and noted the ongoing work being undertaken within Standards of Behaviour and noted the update in relation to the Declarations of Interest, Gifts, Hospitality & Sponsorship Register

Regulatory Compliance Tracking Report

The DCG highlighted that there is an ongoing audit in this area at the moment. She stated that the system has been in place for two years and can look at improving areas and moving forward with it.

The DCG highlighted two entries have gone onto the tracker since it was last presented, one in relation to the British Standards institute and another in relation to food hygiene inspection. She also highlighted inspections that are due to take place between now and September, one inspections is in relation to Pharmacy, Radiology and The Welsh Scientific Advisory Committee.

The DCG stated that all these inspections have not taken place routinely due to Covid but are seeing inspection visits increase slightly.

The committee noted the inspections which have taken place since the last meeting of the Audit Committee in April 2020 and their respective outcomes and noted the continuing development of the Legislative and Regulatory Compliance Tracker.

Internal Audit Tracking Report

The DCG informed the committee that they have been trying to track the most recent audits but have also tracked recommendations back for up to 3 years as agreed with Internal Audit so that they do not lose sight of the recommendations.

She stated that in their current position there are 126 recommendations that have been made which has increased from 106 for April and June. She stated that this is due to the end of year internal audits that were pushed through at the end of the financial year.

The DCG highlighted that out of the 126 recommendations:
60 recorded as complete
33 partially complete
33 have no action

The committee received and noted the tracking report which is now in place for tracking audit recommendations made by Internal Audit and noted that progress will be seen over coming months in the number of recommendations which are completed/closed.

Audit Wales Tracking Report

The DCG highlighted that there were some ITC recommendations that came to the committee in May 2021 that were not included in the current tracker and will ensure they get added and tracked in the usual way.

the DCG highlighted that of the 21 recommendations:
7 recorded as complete
12 partially complete
2 have no action

The committee noted the progress which has been made in relation to the completion of Audit Wales recommendations and noted the continuing development of the Audit Wales Recommendation Tracker.

Risk Management Strategy & Action Plan

The DCG highlighted that within their standing orders there is a requirement for the Board to sign off the Risk Management Board Assurance Framework arrangements on an annual basis. In addition to that they have had an internal audit and have encompassed the recommendations within this strategy and procedure.

She informed the committee that it has been presented to the Management Executive and that board members would be aware that they have done sessions in regards to risk appetite to take stock of where they are in that area.

The DCG highlighted the plan on a page, she reminded the committee that this is an ongoing piece of work as they have to continually remind and train people. She informed the committee that she has a member of staff in her team who goes out to the clinical boards and are training them on their risk management processes, systems and scoring to gain some consistency.

The committee approved the updated Risk Management and Board Assurance Framework Strategy and Risk Management Procedure and noted the Action Plan for the implementation of the revised Strategy and Procedure

Self-assessment of effectiveness

The DCG reminded the committee that all the results had come to the committee previously and they also brought the Board and individual committee results.

She stated this time they are only brining the Audit committee self-assessment which received 6 responses, she added that there was also a commitment made by herself to increase the response rates of the surveys as before they only opened it up to members of the committee and will look at a broader attendance from the committee to get a more complete result.

She highlighted there were four actions that they felt needed to be taken forward and highlighted an action plan to show an update where they are against those actions.

The committee noted the results of the Committee's self-assessment Effectiveness Review for 2020-21 and approved the action plan.

Outstanding Audit Recommendations Update:

I. **2018/19**
II. **2019/20**

The DCG stated that these are the outstanding recommendations from the internal audit tracker as they are only trying to recommendations from the current and previous year to avoid constantly adding to the tracker.

She highlighted for 2018/19:
9 of the 12 entries are complete
3 outstanding recommendations – one in regards to the ToR for the Strategic Commissioning meeting has been revised and now includes two Clinical Board representatives. The document will be reviewed again following the appointment of the new EDF and an updated copy subsequently shared to reflect that they have a new EDF following this and an updated copy will be provided. Given the work undertaken on the Terms of Reference It is proposed that this recommendation is closed as complete.
The other 2 recommendations were in relation to the Legislative/Regulatory Compliance tracker. She stated that there was already an internal audit ongoing in this area. She highlighted those recommendations relate to Health & Safety and Fire Safety. she added an independent review was done on Health & Safety and feels that these recommendations can also be closed down

She highlighted for 2019/20:
There were 33 entries left on the tracker
8 recommendations were complete
25 recommendations left incomplete – the DCG highlighted the detail in the report recommending that they be closed as complete

The committee noted the Outstanding Audit Recommendations Update – 2018/19 and 2019/20 and approved the proposals for the future recording and removal of historic recommendations Health Board's Internal Audit Tracker.

Internal Audit reports for information:

Assignment	**Assurance Rating**

1. Annual Planning Process 21/22 Report
2. Engagement Around Service Planning Report
3. Data Quality Performance Reporting (Single Cancer Pathway) Report
4. Infrastructure / Network Management Report
5. C&W CB – Rostering in Community Children's Nursing Report
6. Staff Recruitment Report
7. Wellbeing Hub at Maelfa Report

The committee received and noted the Internal Audit reports

NHS Counter Fraud Services in Wales - Q4 Report

The committee noted the NHS Counter Fraud Services in Wales - Q4 Report.

Recommendation:

The Board is asked to:

- **NOTE** the report.

Shaping our Future Wellbeing Strategic Objectives

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

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

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant, click here for more information

Prevention		Long term	x	Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Not Applicable

Report Title:	**Quality, Safety & Experience Committee – Chair's Report**	**Agenda Item no.**	**8.3.3**
Meeting:	**UHB Board Meeting**	**Meeting Date:**	**29.07.2021**
Status:	**For Discussion**	**For Assurance**	**For Approval**	**For Information**	**x**
Lead Executive:	**Chair, Quality, Safety & Experience Committee**		
Report Author (Title):	**Corporate Governance Officer**		

Background and current situation:

To provide the Board with a summary of key issues discussed at the Quality, Safety & Experience Committee held on **15 June 2021**.

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

CHILDREN & WOMEN'S CLINICAL BOARD (CWCB) ASSURANCE REPORT

The Clinical Board report gave an update on the continued progress made regarding the Quality, Safety and Patient Experience Agenda despite the significant challenges of the past year.

A Staff story was received which told the story of a staff member who had been redeployed to a Covid-19 area during the pandemic and their feelings and experiences towards that, both positive and negative.

The Committee was advised that a number of changes had occurred within CD&T teams during the pandemic and the impact they had on patient experience. An example of the Physiotherapy department was provided which during the first wave had circa. 2000 patients waiting which had been reduced to zero. It was noted that this was due to a combination of efforts including virtual working and management of face to face appointments.

It was noted that the Clinical Board recognised the need to progress Electronic Test Requesting (ETR) for Laboratory Medicine and noted that good progress had been made especially within the laboratories.

It was noted that good progress was being made with electronic prescribing and medicine management (EPMA) and that it was something that had been needed since 2007. It was noted that a decision was made at Board level to take a leadership role in Wales in delivering EPMA.

QUALITY, SAFETY AND EXPERIENCE FRAMEWORK UPDATE

The committee was advised that it had previously been agreed that an update would be provided to the committee with a view to bringing the final Quality, Safety and Experience Framework (QSE Framework) to the September committee meeting.

It was noted that a workshop had taken place in 2020 and had provided discussion around QSE priorities for the next 5 years. This included:

- A Healthier Wales 2018
- National Clinical Framework: a Learning Health and Care System 2021
- NHS Patient Safety Strategy 2019 (2021)
- WHO Global Patient Safety Action Plan 2021-2030
- The Patient Safe Future: A Blueprint for action 2019
- Patient Experience Improvement Framework 2018

It was noted that a Safety Culture Survey had been sent out to staff and that 988 members of staff had started the questionnaire but, due to the length of the questionnaire, a number had not completed it upon starting.

Themes identified from the survey included:

- The need to improve feedback following incidents, more work would be needed on 'Just culture', workload, time for training, and near-miss reporting and information exchange between departments.

The Committee was advised of the 8 areas within the framework:

- Safety Culture,
- Leadership and Prioritisation,
- Patient experience and involvement,
- Patient safety learning and communication ,
- Staff engagement and involvement,
- Data and Insight,
- Professionalism,
- Quality Governance

QUALITY INDICATORS REPORT

The Committee was advised of areas to note:

- In May 2021, Welsh Government (WG) in partnership with the Delivery Unit have issued a new All Wales Patient Safety Incident Reporting Policy.
- Phase 2 would commence in July 2021 and would focus on developing new thematic ways of reporting certain incident types across a number of specialities, including commonly reported incidents such as pressure damage, falls, and hospital acquired infections (including nosocomial Covid-19).
- The number of reported pressure ulcers continued to increase and it was noted that the trend would be kept under review by the UHB Pressure Ulcer Collaborative. It was noted that considerable work had been undertaken in the organisation to improve the rate and quality of reported pressure damage; nevertheless this was a trend which would require continued monitoring.
- The stroke position. There were a number of indicators in the report which show how challenging performance had been.

- The IP&C Team were working with relevant Clinical Boards to identify possible areas for improvement.
- Nutritional assessments had increased since the last committee meeting.

EXCEPTION REPORTS

It was noted that Covid-19 transmission had been building over the previous weeks and was being closely monitored as at the time of the meeting there were 3 patients with Covid-19 in a hospital setting.

It was noted that there were 61 cases in Cardiff and the Vale and that all 61 cases were being treated as a variant of concern despite further clarity being needed.

WAITING LISTS AND CANCER SERVICES UPDATE

The Committee was advised that there were 4 harms in the Welsh Government annual framework:

- Harm from COVID
- Harm from an overwhelmed NHS and social care system
- Harm from wider societal actions/lockdown
- Harm from reduction in non-covid activity.

The amount of activity lost over the pandemic between March 2020 and February 2021 was noted. It was noted that over 22K inpatient day case surgeries were not undertaken during that period.

In the Health Board's plans being submitted to WG, some assumptions had been made and Health Board Level Scenario Modelling had been undertaken which identified the following:

- Substantial uncertainty in forward projections due to lack of predictability of;
  - Further wave(s)
  - The point at which additional IP&C measures could be removed
  - The proportion of lost activity that would need to be re-provided

- Three case scenarios had been developed to better understand the range of possible scenarios;
  - Best-case
  - Central-case
  - Worst-case.

It was noted that when the scenarios were applied to the modelling, it showed that in the best case scenario, waiting lists would go back to pre-Covid levels by 2024.

The Committee was advised that a full recovery from the pandemic would likely take at least 5 years and would require sustained and significant additional capacity.

The Committee was advised that all patients on the inpatient waiting list who were on the Patient Management System (PMS) had been categorised against the Royal College of Surgeons categories.

It was noted that the ambition was to return to elective activity of 70% pre-Covid levels in Q1 of 2021 which had been achieved and for that to be increased to 80% in Q2.

PRESSURE DAMAGE REPORT

The pressure Damage Report was received and it was noted that the activity of the pressure group had decreased during the Covid-19 pandemic but was increasing again and a collaborative had been formed that encompassed both Primary and Secondary Care. It was noted that the aim of the Collaborative was:

- To reduce the incidence of healthcare acquired pressure damage within the Health Board.
- To speed up adoption of innovation into practice to improve clinical outcomes and patient experience.

It was noted that a project plan had been put together for some of the key themes of work that needed to be taken forward to tackle pressure damage within CVUHB.

The contents of the report and the actions being taken forward to address areas for improvement were noted and a further update was deemed necessary at a future QSE Committee meeting.

FALLS GROUP UPDATE

The Committee was advised that falls had been a big issue for CVUHB and assurance was needed about where the organisation was in relation to falls.

It was noted that a dashboard had been created to provide further information to members of the committee.

It was recommended that mandatory training should be provided for staff around falls as recommended by the Royal College of Physicians.

It was noted that the head injury figures were not huge but assurance could be given that the organisation had looked at each of the cases in detail and WG were also looking at how to develop further supporting guidance.

GOSPORT REVIEW UPDATE

It was noted that the Assistant Director of Patient Safety & Quality had met with relevant key stakeholders and had provided a high level of assurance that there were processes and systems in place to monitor prescribing habits across CVUHB.

Health Inspectorate Wales (HIW) – Activity Update

The Committee was advised that Health Inspectorate Wales (HIW) had scaled down their inspection work during the pandemic.

Since the last HIW activity report in April 2021, there had been checks on Owl Ward on 12th May 2021 and a positive check to the teenage cancer trust and Hazel Ward.

It was noted that as part of the HIW annual review programme for 2020-21, a local review of the Welsh Ambulance Service Trust (WAST) was being undertaken and that the focus of the review was to consider the impact of ambulance waits outside Emergency Departments (ED) on patient safety, privacy, dignity and overall patient experience.

It was advised that HIW had announced their intention to carry out a National Review Of Mental Health Crisis Prevention in the Community and it was anticipated that the review would be completed and published by Autumn 2021.

It was noted that a review of diagnostic imaging would be carried out in August 2021.

BOARD ASSURANCE FRAMEWORK – PATIENT SAFETY

The committee was advised that the Board Assurance Framework (BAF) recorded the Strategic Risks faced by the Health Board and the paper presented highlighted the patient safety risks within the BAF that were reviewed and approved by the Board in May 2021.

HEALTH CARE STANDARDS STRATEGY AND ACTION PLAN

The Committee was advised that there had been an internal decision to review the 16 standards internally and that they had been taken to Board and Independent members.

COMMITTEE EFFECTIVENESS SURVEY RESULTS 2020-2021

The results of the Annual Board Effectiveness Survey 2020-2021, relating to the Quality Safety & Experience Committee were noted.

PREVENTION AND MANAGEMENT OF IN-PATIENT FALLS POLICY

The Prevention and Management of In-Patient Falls Policy was received and approved.

MINUTES FROM CLINICAL BOARD QSE SUB COMMITTEES

The Committee was advised that the Clinical Boards (CB) had managed to keep their Quality and Safety meetings wholly in place throughout the COVID-19 pandemic, and that items of importance could be found in the QSE Committee meeting minutes.

Recommendation:

The Board is asked to:

- **NOTE** the report.

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

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

Equality and Health Impact Assessment Completed:	Not Applicable

Report Title:	**Strategy & Delivery Committee – Chair's Report**	**Agenda Item no.**	**8.3.4**
Meeting:	**UHB Board Meeting**	**Meeting Date:**	**29.07.2021**
Status:	**For Discussion**	**For Assurance**	**For Approval**	**For Information**	**x**
Lead Executive:	**Chair, Audit & Assurance Committee**		
Report Author (Title):	**Corporate Governance Officer**		

Background and current situation:

To provide the Board with a summary of key issues discussed at the Strategy & Delivery Committee held on **13th July 2021**.

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

Annual Capital Plan Report

The Deputy Executive Director of Strategic Planning (DEDSP) highlighted the capital programme plan for this financial year is subject to change due to its continually rolling programme where schemes are being developed and approved.

For this financial year there is a significant number of recovery schemes where they will be seeking support, some through revenue which they have already done and others through capital. She stated that this year this would present a challenge for them as demonstrated in the programme plan they have already an over commitment on their capital programme.

She informed the committee that the programme is overseen by the Capital Management Group which is chaired by the Executive Director of Finance (EDF)

The DEDSP stated that they do not have a fixed point at which the plan is signed off is due to the fact that this year they have a number of plans which they needed to pull together at pace and the detail that underpins those plans still requires working through with facilities and planning colleagues which is being done currently.

The DEDSP added that when schemes are undertaken at risk they are done with the knowledge of Welsh Government but are undertaken at risk in the sense that they will fund the planning costs associated to the outline business case / full business case development. She stated that the costs are normally paid back once the scheme is approved by Welsh Government. Prior to approval costs are funded via their discretionary capital programme, schemes that are undertaken at risk and not funded by Welsh Government are then funded through their revenue stream.

The Committee Noted the content of the paper including the level of funding which will be challenging to manage in year

Approved the Capital Plan as presented with any ‘in year’ changes to the Plan being dealt with in line with the UHB Standing Financial Instructions (SFI’s) and scheme of delegation.

Noted that all Business Cases will follow the appropriate approvals process with consideration by the respective Project Team/Board, CMG, the Business Case Advisory Group (BCAG), ME and Board.

Noted the schemes that the UHB are developing through the Business Case process pending WG approval

Shaping Our Future Wellbeing Strategy (SOFW) Update :

a) **Flash Update**

The DEDSP stated that they are well through the programme of delivering SOFW Strategy and are in Year 6 of the strategy, the vehicle that has been established to drive forward the implementation of this has now been established through 4 clinical programmes:

- Shaping our Future Clinical Services (SOFCS)
- Shaping our Future Hospitals (SOFH)
- Shaping Our Future Community Hospitals (At Home Programme)
- Shaping Our Future Population Health (SOFPH)

The DEDSP stated with the programme approach in addition to being a key vehicle for implementation of the strategy also aligns in terms of governance and approach with the recovery programmes set up in the operational arena, so they are trying to take an integrated approach to the delivery of their strategic, operational, and recovery activities.

The DEDSP highlighted Appendix B which is a flash report of the programmes

The committee received the flash update, approved the proposed governance framework and noted the progress and risks described in the Programme Portfolio Flash Reports.

People & Culture:
Welsh Language Strategy Update

The Executive Director of People & Culture (EDPC) informed the committee that there is now legislation around the Welsh Language Strategy which came in place in 2019 which took over from the Welsh Language Measure from 2011.

The Equalities Manager (EM) highlighted that they have received numerous complaints which mainly focus on the Cardiff & Vale website so are now working with the comms teams and commissioner on this issue. He highlighted work they have done with the Improvement & Innovations team where they use software called Virto to assess their compliance.

The EM highlighted a few of the challenges that they have faced in areas such as Primary Care, Financial Cost, and timescales on meeting demands. He assured the committee that these challenges and risks are being worked on and are monitored on a bi-monthly basis by the Equality Strategy Welsh Language Standards Group (ESWLSG).
The EM stated although there have been challenges in this area they have also had some major achievements

He highlighted appendix 1 of the report so the committee was aware that 70 / 120 standards have been met leaving 50 standards, he stated that they are in an amber state although they are not closed off with ongoing work on this area. He also informed committee of the amount of work that the 2 senior Welsh language translators have undertaken i.e. 500,000 words translated over the last 6 months.

The Committee received the Welsh Language Strategy Update, noted & approved the contents of this paper with an update to come to the S&D committee in 6 months' time. The committee also approved & supported the ongoing Welsh Language compliance with the Welsh Language Standards across the UHB.

Performance Reports:

(a) Organisation Key Performance Indicators

The Chief Operating Officer (COO) stated that the paper sets out the current operating context which remains a challenging one in the circumstances.

He highlighted:

- Un-scheduled Care
  - Now experiencing significant increases in activity from non Covid activity
  - Starting to see smaller amounts of Covid activity coming into the bed base of the hospital
  - Significant pressures at the front door services, primary care services, and Mental Health services
  - They are beginning to configure themselves in a Covid ready position but also starting to see a small number of Covid patients coming through
- Planned Care
  - Are now at the end of their first quarter and the challenges of staying Covid ready remain with them
  - Recovery plan has been submitted to Welsh Government
  - Their trajectory for recovering planned care in the first quarter which was to reach 70% of pre Covid activity has been met and exceeded. They now aim for 80% for the end of the second and third quarter and 90% for the fourth quarter
- Mental Health services
  - Focus on this area placed in other forums such as a deep dive on CAHMS in Board development and the adult Mental Health Teams will deliver a presentation to the Public Board at the end of July

The committee received the Organisation Key Performance Indicators and noted the year to date position against key organisational performance indicators for 2021-22 but in the context of prevailing operating conditions.

(b) Workforce Key Performance Indicators

The EDPC highlighted to the committee that the wellbeing side of the workforce is really paramount and that wellbeing is now a potential risk within the Board Assurance Framework (BAF) as if this is neglected it could become a significant risk to the workforce. She added that she chairs a wellbeing strategy group where they recently met and drafted a 12 month

programme of work which demonstrates ambition but also tangible changes for staff and would bring this plan back to a future meeting for the committee to review.

The EDPC stated with the KPI's and the matrix for workforce there is a lot of work on an all Wales basis that needs to be done but as an organisation they are doing a deep dive to find out what is happening around that data and today will be looking into employee relations.

The EDPC highlighted that they are managing and focusing on:

- The workforce being Covid ready – workforce hubs are ready to support
- Focusing on recovery elements
- Current establishment and the attraction, recruitment, and retention elements

The Head Of Operational Human Resources (HOHR) gave a presentation to the committee on a deep dive of Employee Relations

The committee received the Workforce Key Performance Indicators & presentation on Employee relations. The committee also noted and discussed the contents of the report.

Shaping Our Future Wellbeing Strategy (SOFW) Update :

b) Deep Dive - Shaping our Future Population Health (SOFPH)

The Executive Director of Public Health (EDPH) shared a presentation which will give an overview of the framing of their strategic approach to moving their population health approach forward in the medium term which will sit alongside other strategic programmes.
The EDPH highlighted the 3 approaches of the strategy:

- People and places
- Home First
- Prevention and Early Intervention

She stated this is how the Regional Partnership Board focusses its business, understands the context of wider population health, and frames the work in a wider context of wider health & wellbeing to help support people at whatever stage of the life course they are at. She stated the infrastructure and governance around it is based on:

- Starting well
- Living Well
- Ageing well

She highlighted that health outcomes in the wider sense have a great influence in these areas as Health care is not the single factor which will affect Health outcomes:

- Fair economic development
- Housing and homelessness
- Environment
- Education
- Community safety

The EDPH provided a diagram which is an articulation of what does Population Health thinking really mean in each of the areas.

- Shaping Our Future Clinical Services
- UHW 2
- @Home

The EPDH highlighted a table which demonstrates how they embed population health across various arenas of work within their strategic programme portfolio, operational recovery portfolio, and enabling programmes:

- Shaping our Future hospitals
- Unscheduled Care
- Workforce
- Digital & Data

The EDPH informed the committee on specific system programmes in relation to SOFPH:

- Vaccination and immunisation
- Healthy weight: Move More Eat Well
- Systematically tackle inequalities
- Sustainable and healthy environment
- King's Fund recommended programmes

The EDPH discussed the areas where they are addressing health behaviours and risks across care pathways and life stages, in relation to the aforementioned Starting well, Living well, and Ageing well. She highlighted the areas of work that goes on in the background in relation to those such as:

- Immunisation
- Tobacco
- Physical Activity
- Diet
- Falls preventions

The committee received a Deep Dive update on Shaping our Future Population Health and supported this strategic programme and direction of travel, Noting that further work will be taking place to define deliverables for our supporting projects, and resource requirements.

Wellbeing of Future Generations Act Annual Update

The EDPH stated that this reminds the Health Board of its statutory duties under the Future Generations Act and also the contribution they make to public service boards both in Cardiff and the Vale.

The EDPH informed the committee there is a steering group for this however has been paused for a year due to the pandemic. She highlighted that the steering group is not to control all the work surrounding the act but more to keep the processes right and act as a governance mechanism to monitor progress in this area.

The EDPH reminded the committee that their wellbeing objectives under the act are also their strategic objectives and is about delivery of their strategy but also taking on board the sustainability principles and the 5 ways of working.

The committee received the Wellbeing of Future Generations Act Annual Update and noted the attached Flash Report, which provides regular assurance of progress against the Steering Group's action plan, to undertake actions required for the UHB to meet its statutory duties under the Act

Board Assurance Framework (BAF)

The DCG reminded members that previously she had informed the committee that 7 of the risks on the BAF are allocated to the S&D Committee which is expected as the committee deals with the risks in the strategy.

The DCG highlighted the risks coming to the committee today are Workforce and Sustainable Primary & Community Care.

The committee received the Board Assurance Framework and reviewed the attached risks in relation to Workforce and Sustainable Primary and Community Care to enable the Committee to provide further assurance to the Board when the Board Assurance Framework is reviewed in its entirety.

Annual Board Effectiveness Survey 2020-2021 - Strategy and Delivery Committee

The DCG stated that this is the results for this committee and is based on the results that went to the Audit Committee in May to allow all of the results to be fed into the Annual Governance Statement and Annual Report.

The DCG highlighted the response rate for this committee as they only received 2 responses. She informed the committee that next year they will broaden the survey out to ensure they receive a fuller response.

The DCG stated that the actions pulled out here are the same for all committees of the board and they will also be monitored by the board.

The committee received and noted the results of the Annual Board Effectiveness Survey 2020-2021, relating to the Strategy and Delivery Committee. They also noted the action plan developed for 2020-2021, which will be progressed via Board Development sessions.

Equality Strategy & Welsh Language Standards Group ToR's

The Committee received & noted the Equality Strategy & Welsh Language Standards Group ToR's and Approved & Supported the ongoing work of the ESWLSG

Q4 reports for all RPB short term funding streams

The committee received & noted the Q4 reports for all RPB short term funding streams

10 Opportunities for Planned Care

The DCG highlighted the report was developed by Audit Wales and looks at the all Wales context and that it was produced before the winter after the first cessation of planned care and reminded the committee that there has also been a second cessation of planned care.

The committee received and noted the contents of the 10 Opportunities for Planned Care report

Recommendation:

The Board is asked to:

- **NOTE** the report.

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	x
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x
3. All take responsibility for improving our health and wellbeing	x	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
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:	**Digital & Health Committee – Chair's Report**	**Agenda Item no.**	**8.3.5**
Meeting:	**UHB Board Meeting**	**Meeting Date:**	29.07.2021
Status:	**For Discussion**	**For Assurance**	**For Approval**	**For Information**	**x**
Lead Executive:	**Chair, Digital & Health Intelligence Committee**		
Report Author (Title):	**Corporate Governance Officer**		

Background and current situation:

To provide the Board with a summary of key issues discussed at the Audit & Assurance Committee held on **1st June 2021**

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

Information Governance Policy EHIA

The committee received the report and the Information Governance Manager (IGM) advised that he was satisfied that the Information Governance Policy EHIA was in line with the Health Boards Corporate documents and limited impact had been identified. The IGM sought approval of the EHIA as the final step prior to implementation of the Information Governance Policy.

The Information Governance Policy Equality and Health Impact Assessment (EHIA) was **APPROVED**

Committee Terms of Reference

The Director of Corporate Governance (DCG) highlighted that the terms of reference had taken longer to be shared at the committee than usual as the previous CC, who departed the Health Board at the end of the previous financial year, felt that the new chair should have the opportunity to consider the Terms of Reference.

The DCG highlighted that the changes for the year were minor and that the tracked changes had been left in the document to clearly show what changes had been made.

The changes to the Terms of Reference for the Digital and Health Intelligence Committee were **APPROVED** and the changes to the Terms of Reference were **RECOMMENDED** to the Board for approval

Annual Work Plan

The DCG advised that the Annual Work Plan was updated with the terms of reference. The work plan would be used at each meeting to formulate the agenda along with any actions that come out from previous meetings.

The Committee Work Plan for 2021/22 was **REVIEWED** and **APPROVED** and the Committee Work Plan for 2021/22 was **RECOMMENDED** to the Board for **APPROVAL**.

Induction Support for Committee Members

The DCG highlighted that there were a number of new independent members and that the UHB Chair intended to undertake a re-structure of committee memberships.

The Induction Support for Committee Members update was **NOTED**

Digital Transformation Progress Report (Digital Dashboard)

The DDHI advised that the report provided an overview of the progress made on the Digital Dashboard and highlighted that COVID continued to have an impact on the Health Board and the digital and information support that continued to be needed.

The DDHI added that his team were building a library of positive feedback to capture good news stories of user experiences with IT and digital.

The Director of Digital Transformation (DDT) commented that they had an aged estate which had an impact of what could be achieved in some areas. She added that the Health Board was unlikely to achieve a fully pervasive wireless connection within the current hospital sites but that this had been incorporated into plans for UHW 2.

The progress across the IT Delivery Programme was **NOTED**

Digital Strategy and Roadmap Update

The DDHI advised that the digital strategy was approved by the DHIC Committee and Board in July 2020 and his team were putting in place a roadmap to help bring the contents of that strategy to fruition.

The DDT informed the committee that 5 business cases had been produced (3 of which had been signed off and were moving forward to implementatio):

1. Scan 4 Safety
2. Electronic Prescribing & Medicines Administration
3. Digital communications
4. Flexible working business case
5. Rationalising Printer Estate

The DDT also informed the committee of a Small Business Research Initiative (SBRI) bid that had been submitted. The Health Board's bid had not been successful but it had set out a pathway model which would be built upon so that an E-triage, see on symptom pathway, could be developed.

The DDT shared a presentation which provided an update on the digital strategy. The DDT also provided a refresher of the governance structure that surrounded the digital strategy delivery which included the roadmap and the Digital Services Management Board which:

- Reports the the Management Executive and HSMB

- Feeds into DHIC for assurance
- Is supported by 2 specialist advisory groups
- Incorpoated 4 Channel Programme Boards

The DDT presented the 5 year development highlights of the 4 Channel Programme Boards which included developments since 2020 and the things they wish to achieve by 2025. This included:

- Patient Channel Programme Board
- Clinicians Channel Programme Board
- Capabilities Channel Board

The following areas of ongoing work were also highlighted:

- Electronic Test Requesting – Blood requesting uptake had increased from 28.7% to 53% in 2021
- Consultant Connect - 2,060 calls since 1 Jan 2021 (exc EU) & 36% outcomes reported
- PCIC – Circa 400 smart handsets provided to community & primary care staff with a Pilot for 'agile' workforce model.

The progress being made in developing a roadmap to support implementation of the digital strategy was **NOTED**

Digital Strategy – Case for Investment

The DDHI shared a further update for the new committee chair and advised that things had not progressed since the previous meeting. He took the opportunity to reaffirm what the team were asking for.

The DDHI advised that the amount of capital investment that came in routinely as an annual reccuring sum was circa £500k from discretionary capital. He compared the sum of money to the size of the organisations turnover of £1.4 Billion and staff of 14.5k and commented that it wasn't a significant amount. He had compared that figure against other health boards and discovered that the UHB was an outlier in terms of what was being received as a recurring sum.

He emphasised that many other transformational type programmes underway within the organisation were asking for circa £1.75 Million per annum to help addequately resource the projects.

The DDF referred to the resources and highlighted that there were 2 issues coming out of the discussion. Firstly the finite amount of resource within the capital programme allocated to IT (£0.5m) which he commented would not be sustainable. He added that there had also always been additional resource from Welsh Government which equated to around £3M over the previous few years.

The DDF referred to section 10.4 of the report where the ask of each clinical board was an investment of £250K revenue per annum to fund staff and software managed by D&HI. He informed the committee that currently the clinical boards were £7 Billion off delivering the their own cost improvement programme and they would not be able to find another £250K unless they had schemes which would underpin this.

The DCG commented that what had become more apparent in the Strategy & Delivery committee was that they it was not seeing the financial elements that support the strategy in terms of digital. The DCG advised that they would need to bring this piece of work to the Strategy & Delivery

Committee and subsequently to the Board to highlight the impact of how not investing in Digital would impact on the delivery of the Health Board's overarching strategy.

The Digital Strategy – Case for Investment was **NOTED** and **DISCUSSED.**

GP Pilot Action Plan

The DDHI advised that the plan would provide GP practices with access to the Cardiff & Vale Portal. Previously GP's could only access their own registered patients on the system. As a result of Covid it was decided that this rollout could be made to every single practice so they could access the entire Cardiff & Vale population irrespective of where the individual patient was registered. The DDHI stated that this work was completed over a year ago but was brought to the meeting to be formally recorded at the request of the previous chair.

The actions taken to achieve closure on the GP action plan were **NOTED** and the plan was **RATIFIED**

Business Case Development Summary

The DDHI advised that majority of this item had been covered under the previous agenda item "Digital Strategy and Roadmap Update".

The DDT highlighted the section about Business Case progress and the outcomes & benefits which showed an £8Million release to care across 3 business cases.

The progress across the Digital Strategy Delivery Programme was **NOTED**

IG Data & Compliance (SIs, Data Protection, GDPR, FOI, SARs, Staffing & Mandatory Training)

The IGM shared his report and advised that there was still work to be done to get back to a pre Covid position however whilst pressures had shifted to recovery they were being mindful to not to overburden services with requests. He did however provide assurance to the committee that the team acknowledge their responsibilities as a public facing authority and their statutory requirements to comply with SARS and FOI's.

He informed the committee that the IG mandatory training continues to drop as well as most other mandatory training and other E-learning modules. He stated that the team had been asked to address this via a communication programme that had been put aside due to Covid but he was confident that this would be rolled out within the coming meetings

The IGM stated that the team continue to review a large number of IG related incidents but only a small number of them were reported to the ICO as the majority did not meet the reporting threshold. The detail of these incidents would be reported to the private DHIC committee meeting.

The Information Governance Data and Compliance report, which outlined a series of updates relating to significant Information Governance issues was **NOTED**

Clinical Coding Performance Data

The IGM shared a Clinical Coding Performance Data update.

The CC advised that he was concerned about the loss of staff within the department and how this was not reflected in the risk register.

The IGM advised that was a change they had seen over the previous 12 months as English Health boards were able to pay staff a band higher for the same role and allow staff to work from home. Within the UHB they were unable to provide home working access as they do not have an electronic record to allow staff to have all the access they need as they were still working from paper records. He added that English trusts had a higher priority on coding and therefore were able to pay more for staff. He suggested that the correct solution would not be to pay staff more but acknowledged that there was a need to look at how they could support staff in other ways.

The performance of the UHB's Clinical Coding Department was **NOTED**

Joint IMT & IG Corporate Risk Register

The DDHI proposed that the departmental resource and financial challenges which were not listed as red would be considered their top risk.

The progress and updates to the Risk Register report were **NOTED**

IMT Audit Assurance Tracker

The IMT Audit Assurance Tracker was shared for noting and information.

The progress and updates to the IMT audit assurance tracker were **NOTED**

IG Audit Assurance Tracker and Work Plan

The IG Audit Assurance Tracker and Work Plan was shared for noting and information.

The Progress and updates to the Information Governance Audit Tracker were **NOTED**

IMTP Work Plan Exception Report

The DDHI highlighted that the report was shared for information and picked up on the issues covered previously but provided further detail of departmental expenditure which would be of interest to the committee as it detailed what allocations were made and where funds were spent.

The Digital Delivery Programme – Exception & Issues Report, and the progress against the roadmap and the areas of exception which require further attention and consideration were **NOTED.**

Schedule of Control Documents (Policies & Procedures)

The DDHI shared his report and advised the committee that it highlighted the status of various policies, procedures, and guidance applicable to the D&HI team. He informed the committee that

this team had a work programme to work through out of date documents and they would continue to work with the corporate team to progress this.

The Schedule of Control Documents (Policies & Procedures), the progress to date and plans to address the review of remaining documents was **NOTED**

Minutes:

The minutes of the IMT Capital Management Group Report and the Capital Management Group 19/04/2021 were **NOTED**

Recommendation:

The Board is asked to:

- **NOTE** the report.

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

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

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

Report Title:	**Stakeholder Reference Group Report**								
Meeting:	**UHB Board**						**Meeting Date:**	**29th July 2021**	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**		**X**
Lead Executive:	**Abigail Harris**								
Report Author	**Sam Austin, Chair of Stakeholder Reference Group**								

SITUATION:

The following report provides Board with a summary of the key issues discussed at the Stakeholder Reference Group (SRG) meeting held on **25 May 2021.**

REPORT

BACKGROUND
This is a report provided to the Board by the Chair of the UHB SRG.

ASSESSMENT
The SRG considered the following.

Shaping Our Future Clinical Services
The SRG was informed that the formal engagement had concluded. It had been extremely successful. More than 350 completed questionnaires had been returned and there had been good attendance at the virtual engagement sessions. The responses had been overwhelmingly helpful and positive. For the majority of respondents, receiving the right treatment at the right time was more important than where they received their treatment. A detailed analysis of the responses will be presented in a report to the UHB Board on 27 May and would be circulated to the SRG.

South East Wales Vascular Services Engagement
The SRG was informed that the formal engagement had concluded. The feedback received had been positive and people understand the reason for the proposed service changes. All the Community Health Councils were satisfied that the engagement had been sufficiently comprehensive and that a formal public consultation would therefore not be required. A report would be considered by the UHB Board on 27 May and it was envisaged that the direction of travel would be endorsed.

Recovery Planning
The SRG received a presentation from Steve Curry on the UHB's current thinking on its COVID-19 recovery planning and was asked to consider these specific questions

- How, as a wider system do we support patients who will inevitably wait longer to access non urgent care? Is there a role beyond health and care?
- How do we embrace new ways of working in order to re-set service provision as part of the recovery?

The SRG enquired whether there would be a shortage of theatre and intensive care capacity. They were informed that capacity and therefore activity would be severely compromised due to the imperative of working in a C-19 safe way. Intensive Care facilities had been expanded during the pandemic but some of these would have to be mothballed in order to be able to respond quickly to further waves of the pandemic. The SRG was informed that the UHB had been the highest user of private facilities during the pandemic. Initially this capacity had been commissioned on an all-Wales basis but was now being commissioned by the UHB itself. The SRG was informed that there would be shortages of staff in some

areas and the UHB had commenced recruitment of additional theatres staff and had increased its overseas recruitment.

In response to an enquiry, the SRG was informed that Dr Stuart Walker had commissioned a piece of work looking at the composition of the UHB's waiting lists and details would be provided to the SRG.

The SRG asked how patient expectations would be managed and whether they would be informed that they are likely to have to wait much longer for treatment. The SRG was informed that it would be imperative to be honest with the public about the implications for their care. It would also be important to explain what other support/services they are able to access while they await treatment.

Steve Curry will provide the SRG with an update on the UHB's recovery planning at a future meeting.

Development of Acute Cancer Services in South East Wales and Implications for Cardiff and Vale
The SRG received a presentation from Meriel Jenney on proposals to improve Acute Oncology Services (AOS) in South East Wales and the implications for Cardiff and the Vale of Glamorgan.

The current service provision and its limitations were described and the SRG was informed that in order to address these limitations, the regional Collaborative Cancer Leadership Group (CCLG) had drafted and endorsed a business case aimed at improving Acute Oncology Services in South East Wales. The business case was now being discussed in each of the organisations represented on the CCLG including Cardiff and Vale UHB. The aim of the cancer service developments is to improve the pathway for those patients with cancer who require acute/emergency care for the management of their cancer or complications of the cancer treatment. The SRG was asked whether there is a role for organisations beyond Health and Social care in this work or indeed is there anything we have yet to consider that would further improve outcomes for the people of Cardiff and the Vale of Glamorgan with cancer who require urgent care?

The SRG asked about the timescale for implementing the proposals and was informed that Welsh Government was keen for the implementation of acute cancer services to be progressed. The implementation of the first phase of the proposals were included in the UHB's Annual Plan. The SRG was informed that there was little doubt that the proposed service changes would improve the time to treatment and patient experience, reduce length of stay and reduce the risk of sepsis. They might not have a significant effect on mortality rates as many of these patients present with late stage disease or complications of highly complex care. The SRG enquired whether patients diagnosed with cancer have a 'hot line' for advice and support. The SRG was informed that patients receiving treatment at Velindre certainly do but individuals who present with undiagnosed cancer and not yet on a cancer pathway might not have immediate access to such advice. Under the new proposals these patients would be placed on the correct pathway and have access to a key worker.

The SRG observed that despite the understandable focus on recovery planning, it was pleasing to learn of potential service improvements.

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

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	11 May 2021

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

An electronic link to the papers considered by the EAS Joint Committee is provided via the following link: https://easc.nhs.wales/the-committee/meetings-and-papers/may-2021/

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 (CASC) REPORT

Stephen Harrhy (CASC) presented an update on the following areas:

- Ministerial Ambulance Availability Task Force – an evidence gathering session had been planned to capture the latest information on 'handover delays' which would be shared with Committee Members at a future meeting.
- Ambulance performance remained under the target of 65%; Members noted the re-setting and more normal expectations in terms of what was required and the WAST transition plan; this would be discussed in more detail, including plans for improvements to meet the target at the EASC Management Group and reported to the Joint Committee.
- Non-Emergency Patient Transport Services (NEPTS) Stephen Harrhy thanked the team at Betsi Cadwaladr (BCUHB) for their work in transferring into the service and also recognised the work of the NEPTS Team at WAST in ensuring the progress made to date. Members noted that conversations were taking place with the team at Cwm Taf Morgannwg (CTMUHB) to finalise the date for the transfer as the last health board area.
- Emergency Medical Retrieval and Transfer Service (EMRTS) Members noted that last year no specific capital allocation has been made for the EMRT Service including equipment replacement. This had now been agreed with Welsh Government officials and would be administered through the hosting arrangements at Swansea Bay (SBUHB).

PROVIDER ISSUES

Jason Killens, Chief Executive at the Welsh Ambulance Services NHS Trust (WAST) gave an overview of key matters including:

- Performance at 60-62% remained below target despite good solid production against the unit hours of production and rosters

- the performance team had been tasked to undertake a deep dive to begin to correct position, but activity had increased significantly
- PPE issues continue to have an impact but aiming to return to normal activity in the next couple of weeks
- Routine activity increasing e.g. last week busier than Christmas week
- 111 Service progressing well – live with BCUHB next month
- Challenges for new call handling and supply meeting and discussing with 111 Programme Board

FOCUS ON – A MODERN AMBULANCE SERVICE

The presentation 'A modernised ambulance service for the future' was received. Jason Killens, Chief Executive of the Welsh Ambulance Services NHS Trust introduced the session and explained the intention was to build on the conversation at the last EASC meeting in terms of modernisation and transformation of ambulance services. In particular, the aim is to change the ambulance service to move from the traditional transport organisation to provide more direct clinical care as a system partner in Wales. The ambition of the offer to the commissioners was in line with the intentions of 'A Healthier Wales' and similar to other high performing ambulance services.

The Chair thanked Jason Killens and Rachel Marsh for the interesting and thought-provoking presentation. Members agreed on the importance of the work and having some time to reflect on the discussions and held with a view to further refinement to take matters forward and provide a clear vision for the future.

FINANCE REPORT

The EASC Finance Report was received. In presenting the report Stuart Davies, the Director of Finance highlighted the following:
- Underspend of £395,000
- Challenges to show in year spend on new initiatives.

Members **RESOLVED** to: **APPROVE** and **NOTE** the report.

EASC GOVERNANCE INCLUDING THE RISK REGISTER

The EASC Governance report was received. Members received the second EASC Annual Report which captured the work undertaken by the Committee in 2020-2021. The EASC Risk Register had one additional risk added namely 'Failure by the whole system, policy makers, commissioners and providers to utilise EASC in matters which related to its areas of responsibility'. There remained two red risks which related to the failure to achieve the performance targets for red and amber calls.

The EASC Management Group Annual Report and Terms of Reference was received which had been endorsed by the EASC Management Group. Members noted that attendance and more regular membership had been achieved this year.

The discussion on the effectiveness survey had identified further issues for discussion by the EASC Management Group members particularly in relation to how the information and knowledge was shared within individual organisations.

Members also noted that an updated Model Standing Orders had been received following the last EAS Committee meeting. The Members agreed that the Chair and the Committee Secretary review the Standing Orders and take Chair's action to ensure that all health boards receive the EASC Standing Orders as they are included as part of every health board's governance arrangements. The Standing Orders would be submitted for ratification at the next EASC meeting.

Members **RESOLVED** to:

- **APPROVE** the EASC Annual Report and Effectiveness Survey
- **ENDORSE** the EASC Annual Governance Statement for submission to the host body (Cwm Taf Morgannwg University Health Board)
- **APPROVE** the risk register
- **APPROVE** the EASC Management Group Annual Report and Terms of Reference
- **APPROVE** the Chair take Chair's action and work with the Committee Secretary to review and finalise the EASC Model Standing Orders for distribution to health boards.

Key risks and issues/matters of concern and any mitigating actions

- Increasing handover delays
- Red performance not meeting the target - risk register reflected the deterioration in performance
- Decreasing Amber performance - risk register reflected the deterioration in performance

Matters requiring Board level consideration and/or approval

- EASC Model Standing Orders would be shared for inclusion with health board Standing Orders

Forward Work Programme

Considered and agreed by the Committee.

Committee minutes submitted	Yes	✓	No	
Date of next meeting	**13 July 2021**			

Report Title:	**Local Partnership Forum Report**	**Agenda Item no.**	**8.3.8**
Meeting:	**UHB Board**	**Meeting Date:**	**29 July 2021**
Status:	**For Discussion**	**For Assurance**	**For Approval**	**For Information**	**x**
Lead Executive:	**Executive Director of People and Culture**		
Report Author (Title):	**Workforce Governance Manager**		

Background and current situation:

The UHB has statutory duty to "take account of representations made by persons who represent the interests of the community it serves". This is achieved in part by three Advisory Groups to the Board and the Local Partnership Forum (LPF) is one of these.

LPF is co-chaired by the Chair of Staff Representatives and the Executive Director of People and Culture. Members include Staff Representatives (including the Independent Member for Trade Unions) and the Executive Team and Chief Executive. The Forum usually meets 6 times a year.

LPF is the formal mechanism for the Health Board and Trade Union/Professional Organisation Representatives to work together to improve health services. Its purpose, as set out in the Terms of Reference, fall into four overarching themes: communicate, consider, consult and negotiate, and appraise.

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

This report provides Board with a summary of the key issues discussed at the meeting held on 17 June 2021

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

- The Forum received a presentation from the Health Improvement Team looking at the purpose of the team, work completed since the team started in April 2021 and the approach adopted, and the 5 ways to wellbeing concept which is being utilised (give, take notice, connect, be active, keeping planning). During the presentation the HIT team asked the following three questions as part of their wider consultation exercise:
  - What does wellbeing mean to you?
  - What would an organisation with excellent standards of wellbeing look like?
  - What change would you make to enhance staff wellbeing in the organisation?

- The Deputy COO delivered a presentation on the UHB Reset and Recovery Plan. It was noted that while this was the latest position, it was an iterative process and the plan will change as we go forward and learn more. She talked about the impact of covid, the context of the plan, the principles of the response and the approach adopted.

- In the absence of the Chief Executive, the Chief Operating Officer attended to update LPF on the following topics: current pressures in the system; reset and recovery; the Annual Plan; a Joint Executive Team (JET) meeting; the vaccination position; and the appointment of a new CEO.

- The Partnership Recognition Agreement was considered and LPF recommended that it should be approved by the Board

- The revised Terms of Reference for the Employment Policy Sub Group were considered and approved

- LPF received the Finance Report, Workforce KPI Report (including a deep dive into voluntary turnover) and Patient Safety, Quality and Experience Report for March 2021.

Recommendation:

The Board is requested 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	
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

ASSURANCE REPORT

NHS WALES SHARED SERVICES PARTNERSHIP COMMITTEE

Reporting Committee	**Shared Service Partnership Committee**
Chaired by	Mrs Margaret Foster, Chair
Lead Executive	Mr Neil Frow, Managing Director, NWSSP
Author and contact details.	Peter Stephenson, Head of Finance and Business Development
Date of meeting	20 May 2021

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

Presentation on IP5

The Programme Director provided an update on the facility at Imperial Park, Newport (IP5). The building was originally purchased to provide contingency for a no-deal BREXIT but has proved to be invaluable in responding to the challenges provided by COVID and in developing additional services. The site was formally acquired by NWSSP in March 2019 and the original business case (prior to COVID) envisaged a number of services moving into the facility. Many of these have been achieved (Relocation of the Cwmbran Store and the HCS South East Regional Hub; Temporary Medicines Unit and the development of office space which is now being used by the Medical Examiner Service). Some planned developments have been either delayed or abandoned due to the impact of COVID (Theatre Kitting; WEQAs; Health Incubators and Baby Bundles). A number of services that were never envisaged prior to COVID have now been established in IP5 (Production of PPE Packs for Primary Care; Storage of Lateral Flow Test Kits; Storage of Renal Fluids and Pulse Oximeters; Medical Records Storage; establishment of the Temporary Medicines Unit; Picking of PPE and Diluent Packs for the Vaccination Programme and more recently the collation of support for India). Members were very appreciative of the presentation, and of the efforts of staff at the site, in supporting NHS Wales and the wider public sector over the last 12 months.

Presentation on Primary Care Services

The Director of Primary Care Services provided a presentation on how NWSSP could better support the objectives of the Strategic Programme for Primary Care. Traditionally, NWSSP Primary Care Services has been largely a transaction-based service but recent months and years have seen the development of a number of expert services. Focusing on Cluster development, the Director highlighted a number of recognised issues including governance and IT issues, evaluation of performance, and support for development. He saw a number of opportunities where NWSSP could assist further with Clusters, including governance and

workforce support, data management and Shared Care Interface. NWSSP would be acting on behalf of Health Boards in helping to drive this agenda, rather than looking to replace them, and could utilise standard systems and processes to tailor solutions to local circumstances. SSPC members were appreciative of the presentation and were particularly focused in ensuring that NWSSP made use of the data at its disposal to benefit the wider NHS community.

Managing Director's Report – the main issues noted were:

- **Engagement with the Foundational Economy** One of the key priorities in this year is to build opportunities for strengthening our engagement with the foundational economy in supply chain and procurement. Our Procurement Strategy embraces the Wales First principles nurturing local supply chains and provides opportunities via competitive tendering to promote economic regeneration, by ensuring equal opportunities via local, regional, and national strategies on all contracts for goods and services. By adopting these principles this improves the Welsh economic operators' abilities to access and realise opportunities, which in turn also provides significant environmental benefits by sourcing locally. We are continuing to engage with stakeholders and the market to enable foundational economy outcomes from our procurement processes.
- **HCS – Electrification of Fleet -** Our Health Courier Services recently took delivery of six fully electric vans that are the first in a number that have been ordered and which will be a key component in the implementation of our Decarbonisation Strategy.
- **Annual Plan -** Positive feedback has been received following the submission of the Annual Plan to Welsh Government and we are currently awaiting official feedback.
- **Quality and Safety Committee -** Arrangements have now been finalised with Velindre regarding the establishment of the Quality and Safety Committee which enables us to discharge the (Partnership) Committee's resolution on this matter from last September.
- **TRAMS -** We are in the process of appointing a Director of Pharmacy Technical Services to help manage the Transforming Access to Medicine Service. A revised Programme Board will also be established to drive forward both the OBC and FBC. The role of the SRO is likely to be held jointly between the NWSSP Managing Director and the Chief Pharmacy Officer, Welsh Government.

Items Requiring SSPC Approval

Scheme of Delegation

The Director, Legal & Risk Services presented a paper to request changes to the Scheme of Delegation in respect of the Existing Liabilities Scheme. The paper also covered a request to further extend the COVID expenditure limits to the end of September and to increase the ESR recharge limit from £750k to £1m. The SSPC **ENDORSED** these requests.

Legal & Risk Case Management System

The Director, Legal & Risk Services, presented a paper on the award of a Case Management System. Implementation of this system will deliver a host of benefits for NHS Wales, including enabling more administrative tasks to be undertaken by junior staff, and thereby freeing up the time of senior lawyers, and also providing an easier route for Health Boards to access information on cases relevant to them. The SSPC **NOTED** and **ENDORSED** the contract award.

PPE Strategy

The Director of Finance & Corporate Services introduced this item which included the recent Audit Wales review into the procurement and delivery of PPE which concluded positively, and particularly when compared to the NAO report into the arrangements in England. The task now is to deliver a longer-term strategy for PPE provision. The aim is to have the plan in place with effect from September 2021.

Oracle Finance and Procurement System Upgrade

The Director of Finance & Corporate Services provided a verbal update on progress with the new Oracle upgrade. It was noted that an update on the results of the User testing would be presented at a STRAD meeting later that day and a decision to progress with the update would be made once the results from the user testing had been reviewed.

Annual Governance Statement

The Head of Finance & Business Development presented the final draft Annual Governance Statement which will be formally approved at the end of June Audit Committee. The statement is largely positive, reflecting the challenging year of working in a pandemic, and for which external and internal audit reports have demonstrated that systems and controls have largely been maintained, whilst measures implemented in direct response to the pandemic (e.g. PPE provision and site safety) have been successful. There were no limited or no assurance reports and only a very small number of control weaknesses identified, which had previously been reported to the Committee. There are still a few aspects of the statement which are still in draft. The Committee **ENDORSED** the statement for formal approval at the June Audit Committee.

Service Level Agreements

The Head of Finance & Business Development presented a paper on changes to the SLAs in place between NWSSP and health organisations across Wales for provision of services. The SLAs require formal annual review and approval by the SSPC. It was noted that both Digital Health and Care Wales and Health Education and Improvement Wales became full members of the Partnership Committee with effect from 1 April. The SSPC **APPROVED** the updated SLAs.

Audit Committee Terms of Reference The Head of Finance & Business Development presented an updated Terms of Reference for the Shared Services Audit Committee which the Committee **APPROVED**.
Finance, Workforce, Programme and Governance Updates
Laundry Services - Three of the current five NHS laundries in Wales transferred over to NWSSP on 1 April 2021 as planned. Work is now on-going to improve the facilities and arrangements for each of these laundries, and to implement the operational SLAs that have previously been agreed at Committee. Further work is being undertaken with Cwm Taf Morgannwg UHB and Hywel Dda UHB to enable the two remaining laundries to be transferred later in the year. **Project Management Office Update –** The Committee reviewed and noted the programme and projects monthly summary report, which highlighted the team's current progress and position on the schemes being managed. **Finance and Workforce Report –** The final position for 2020/21 was that all financial targets had been met and NWSSP achieved planned surplus of £21K (after a £2m distribution to Health Boards and Trusts), subject to external audit. The total expenditure for Welsh Risk Pool for 2020/21 was £123.8m and the Risk Share agreement was invoked at the IMTP value of £13.8m. **Corporate Risk Register –** there remain one red risk on the register, relating to the replacement of the NHAIS system. A new risk has been added following a number of attempted bank account mandate frauds in March, but procedures have been further strengthened to protect against this. **Issues and Complaints 2020/21 Annual Report** – The report highlighted a slight drop in the number of complaints and an improvement in response times. **Finance Monitoring Reports –** the Committee were provided with the monitoring returns for Months 12 and 1 for information. **Audit Committee Assurance Report –** the report relating to the Audit Committee held on 20 April was provided for information.
Matters requiring Board/Committee level consideration and/or approval
• The Board is asked to **NOTE** the work of the SSPC and ensure where appropriate that Officers support the related work streams.
Matters referred to other Committees
N/A

Date of next meeting	22 July 2021