Public Board Meeting

Thu 30 March 2023, 09:30 - 15:10

Barry Hospital, Mary Lennox Room

Agenda

09:30 - 09:40
10 min

1.
Welcome & Introductions

Charles Janczewski

09:40 - 09:40
0 min

2.
Apologies for Absence

Charles Janczewski

09:40 - 09:40
0 min

3.
Declarations of Interest

Charles Janczewski

09:40 - 09:40
0 min

4.
Minutes of the Board Meeting held on 26.01.23

Charles Janczewski

4 Public Board Minutes 26.01.23.pdf (22 pages)

09:40 - 09:40
0 min

5.
Action Log – 26.01.23

Charles Janczewski

5 Action Log.pdf (3 pages)

09:40 - 12:05
145 min

6.
Items for Review and Assurance

6.1.
Patient Story – A Patient and Relative's Experience of the Emergency Unit (EU)

15 minutes *Jason Roberts*

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

10 minutes *Charles Janczewski*

6.2 Chair's Report to Public Board - March 23.pdf (7 pages)

6.3.
Chief Executive Report

10 minutes *Suzanne Rankin*

6.3 CEO Report to Board - March 23.pdf (6 pages)

6.4.
Board Assurance Framework

10 minutes *James Quance*

6.4 Board Assurance Framework - March 2023 - Covering report.pdf (3 pages)
6.4a Board Assurance Framework - March 2023.pdf (59 pages)

6.5.
Chairs' reports from Committees of the Board:

10 minutes

6.5.1.
Mental Health Legislation and Mental Capacity Act Committee – 31 January 2023

Ceri Phillips

6.5.1 MHLMCA Chair's Report 31.03.23.pdf (4 pages)

6.5.2.
Quality, Safety and Experience Committee – 7 March 2023

Ceri Phillips

6.5.2 QSE Chairs Report 07.03.23.pdf (5 pages)

6.5.3.
Audit and Assurance Committee – 7 February 2023

John Union

6.5.3 Audit Chair's Report 07.02.23.pdf (3 pages)

6.5.4.
Digital and Health Intelligence Committee – 14 February 2023

David Edwards

6.5.4 DHIC Chair's Report 14.02.23.pdf (3 pages)

6.5.5.
Strategy and Delivery Committee – 14 March 2023 (Verbal)

Michael Imperato

6.5.6.
Finance Committee – February 15 (paper) & 22 March 2023 (verbal)

Rhian Thomas

6.5.6 Finance Chair's Report 15.02.23.pdf (3 pages)

6.5.7.
Senior Leadership Board – 5 January to 2 March 2023

Suzanne Rankin

6.5.7 SLB Chairs Report.pdf (5 pages)

6.6.
Integrated Performance Report:

45 minutes *Fiona Kinghorn / Angela Hughes / Rachel Gidman / Paul Bostock / Catherine Phillips*

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

6.6 Integrated Performance Report March 2023.pdf (35 pages)

6.7.
11:20am Break for Refreshment (10 minutes)

6.8.
Shaping our Future Wellbeing Strategy Refresh Update

15 minutes *Abigail Harris*

6.8 SOFW Strategy Refresh Update.pdf (4 pages)

6.9.
Strategic Planning Update

10 minutes *Abigail Harris*

6.9 Strategic Planning Update.pdf (4 pages)
6.9a Annex 1 - Regional Ophthalmology Strategy.pdf (14 pages)

6.10.
Maternity Services Update

10 minutes *Angela Hughes*

6.10 Maternity Services Update.pdf (3 pages)

12:05 - 14:45
160 min

7.
Items for Approval / Ratification

7.1.
Integrated Medium Term Plan including: -

20 minutes *Abigail Harris / Catherine Phillips*

Annual Plan & Medium Term Financial Plan

The Annual Plan & Appendices can be located in the Supporting Documents Folder

7.1 Integrated Annual Plan Board Cover Report.pdf (6 pages)
7.1b Appendices.pdf (2 pages)

7.2.
12:55pm Cardiff PSB Wellbeing Plan and Vale of Glamorgan PSB Wellbeing Plan

10 minutes *Abigail Harris*

The Cardiff and Vale Public Services Board (PSB) Wellbeing Plans can be located under the supporting documents folder

7.2 Wellbeing Plans - PSBs.pdf (3 pages)

7.3.
Decarbonisation Action Plan 2023/24

10 minutes *Abigail Harris*

7.3 Decarbonisation Action Plan.pdf (4 pages)
7.3a Decarbonisation Action Plan - Board.pdf (43 pages)

7.4.
12:45pm Break for Lunch (30 minutes)

7.5.
Velindre New Cancer Centre - Full Business Case

20 minutes *Abigail Harris*

7.5 nVCC FBC Board.pdf (9 pages)
7.5a Appendix 1 nVCC FBC Approval.pdf (21 pages)

7.5.1.
Strategic Case

Appendices can be found in the Supporting Documents Folder

7.5.1 Appendix 1 Strategic Case - Final.pdf (69 pages)

7.5.2.
Management Case

Appendices can be found in the Supporting Documents Folder

7.5.2 Appendix 2 Management Case - Final.pdf (39 pages)

7.6.
Business Cases:

20 minutes *Abigail Harris / Catherine Phillips*

7.6.1.
Mortuary Refurbishment Business Case

The Full Business Case can be located in the Supporting Documents Folder

7.6.1 UHW Mortuary Refurbishment BJC Cover Paper.pdf (4 pages)
7.6.1a Mortuary BJC Executive Summary.pdf (19 pages)

7.6.2.
Lift Refurbishment Business Case

The Full Business Case can be located in the Supporting Documents Folder

7.6.2 UHW Lift Refurbishment BJC Cover Paper.pdf (4 pages)
7.6.2a UHW Lift Upgrade Exec Summary.pdf (11 pages)

7.6.3.
Revenue Business Cases

The Full Business Cases can be located in the Supporting Documents Folder

7.5.3.1 - Ockenden Business Case

7.5.3.2 - Critical Care Expansion Business Case

7.5.3.2a - Critical Care P@RT Team 24/7 Business Case

7.5.3.3 - Regional Health Protection Service Business Case

- 7.6.3 Revenue Business Cases Cover Report.pdf (2 pages)
- 7.6.3.1 Ockenden Exec Summary.pdf (1 pages)
- 7.6.3.2 Critical Care Expansion Exec Summary.pdf (1 pages)
- 7.6.3.2a Critical Care Expansion PART 24-7 Exec Summary.pdf (1 pages)
- 7.6.3.3 Regional Health Protection Service Exec Summ.pdf (3 pages)

7.7.
Scheme of Delegation and Earned Autonomy

5 minutes *James Quance*

- 7.7 Scheme of Delegation and Earned Autonomy.pdf (3 pages)

7.8.
Armed Forces Covenant Duty Policy

5 minutes *James Quance*

- 7.8 Armed Forces Covenant Duty Policy Cover Report.pdf (2 pages)
- 7.8a Armed Forces Covenant Duty Policy.pdf (17 pages)
- 7.8b Armed Forces Covenant Duty Policy EHIA.pdf (16 pages)

7.9.
Assurance Strategy 2021-4 and Risk Management Strategy

5 minutes *James Quance*

- 7.9 Assurance Strategy 2021-4 and Risk Management Strategy Cover.pdf (3 pages)

7.10.
Board Committee arrangements for 2023/24

5 minutes *Charles Janczewski / James Quance*

- 7.10 Committee Arrangements for 2023.24.pdf (5 pages)

7.11.
Committee Terms of Reference & Work Plans 2023/24

James Quance

- 7.11 Committee ToR and Work Plans covering report.pdf (3 pages)
- 7.11a Committee ToR and Work Plans 2023.24v2.pdf (55 pages)

7.12.
Board Annual Plan

James Quance

- 7.12 Board Annual Plan 23.24 - Covering Report.pdf (2 pages)
- 7.12a Board Workplan 2023.24.pdf (3 pages)

7.13.
Committee & Advisory Groups Annual Reports

5 minutes *James Quance*

The Annual Reports can be located in the Supporting Documents Folder

1. Audit & Assurance Committee

2. Renumeration and Terms of Service Committee
3. Charitable Funds Committee
4. Mental Health Legislation & Mental Capacity Act Committee
5. Digital & Health Intelligence Committee
6. Quality, Safety & Experience Committee
7. Finance Committee
8. Strategy & Delivery Committee
9. Health & Safety Committee
10. Stakeholder Reference Group
11. Local Partnership Forum

7.13 Committee Annual Reports 2022-23.pdf (3 pages)

7.14.
Hosting Agreement Extension with National Imaging Academy Wales

5 minutes *Suzanne Rankin*

7.14 NIAW hosting agreement extention cover paper.pdf (2 pages)
7.14a NIAW hosting agreement March 2023 - Final Draft.pdf (14 pages)

7.15.
Procurement Contract Award - Vagal Nerve Stimulator

5 minutes *Catherine Phillips*

7.15 Vagal Nerve Procurement Request.pdf (2 pages)
7.15a Vagal Nerve Procurement Report.pdf (4 pages)

7.16.
Committee / Governance Group Minutes:

James Quance

7.16.1.
Charitable Funds Committee – 20 September 2022

7.16.1 CFC Minutes 20.09.22.pdf (8 pages)

7.16.2.
Audit Committee – 8 November 2022

7.16.2 Audit Minutes 8.11.22.pdf (16 pages)

7.16.3.
Digital Health and Intelligence Committee – 4 October 2022

7.16.3 DHIC Minutes 4.10.22.pdf (11 pages)

7.16.4.
Health and Safety Committee – 18 October 2022

7.16.4 HS Minutes 18.10.22.pdf (11 pages)

7.16.5.
Finance Committee – 14 December 2022 and 18 January 2023

7.16.5a Finance Minutes 14.12.22.pdf (8 pages)
7.16.5b Finance Minutes 18.01.23.pdf (6 pages)

7.16.6.
Mental Health Legislation and Mental Capacity Act Committee – 25 October 2022

7.16.6 MHLMCAC Minutes 25.10.22.pdf (13 pages)

7.16.7.
Strategy and Delivery Committee – 15 November 2022

7.16.7 SD Minutes 15.11.22.pdf (14 pages)

7.16.8.
Quality, Safety & Experience Committee – 10 January 2023

7.16.8 QSE Minutes 10.01.23.pdf (11 pages)

7.16.9.
EASC – 6 December 2022

7.16.9 EASC Minutes 06.12.22.pdf (10 pages)

7.17.
Break for Refreshments (10 minutes)

14:45 - 15:00
15 min

8.
Items for Noting and Information

8.1.
Audit Wales Annual Audit Report

5 minutes *James Quance*

8.1 Annual Audit Report 2022.pdf (24 pages)

8.2.
Corporate Risk Register

5 minutes *James Quance*

8.2 Corporate Risk Register Update - March 2023 (Final).pdf (4 pages)
8.2a Corporate Risk Register March 2023 - Board Summary.pdf (2 pages)

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

8.3.1.
1. Stakeholder Reference Group –

8.3.1 SRG Chairs Report January.pdf (3 pages)

8.3.2.
Local Partnership Forum – 8 February 2023

8.3.2 LPF Briefing (Feb 23) for March 2023.pdf (4 pages)

8.3.3.
EASC – 17 January 2023

8.3.3 EASC Summary 17.01.23.pdf (9 pages)

8.3.4.
WHSSC – 13 February 2023

8.3.4 WHSCC Joint Committee Briefing 13.02.23.pdf (3 pages)

8.3.5.
NWSSP – 19 January 2023

8.3.5 NWSSP Chairs Report 19.01.23.pdf (4 pages)

15:00 - 15:00
0 min

9.
Agenda for Private Board Meeting:

i) Approval of Private Board minutes

ii) Private Chairs Report (confidential - ongoing legal proceedings)

iii) Approval of Private Committee minutes:

1. *Audit Committee – 8 November 2022*
2. *Digital and Health Intelligence Committee – 4 October 2022*
3. *Finance Committee – 14 December 2022 and 18 January 2023*
4. *Strategy and Delivery – 15 November 2022*

iv) Cardiff Edge – Lessons Learned (Confidential Discussion)

v) Whitchurch Hospital Disposal Options (Confidential Discussion)

vi) Rookwood Hospital Disposal Strategy (Confidential Discussion)

vii) Mental Health Inquests (Confidential Discussion)

15:00 - 15:00
0 min

10.
Any Other Business

Charles Janczewski

15:00 - 15:00
0 min

11.
Review of the meeting

Charles Janczewski

15:00 - 15:00
0 min

12.
Date and time of next meeting:

Thursday 25 May 2023 – All Nations Centre – The Muller Hall 9.30am

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15:00 - 15:00
0 min

13.
Declaration:

Charles Janczewski

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

Unconfirmed Draft Minutes of the Public Board Meeting
Held On 26 January 2023
Barry Hospital
9.30am

Chair:		
Charles Janczewski	CJ	University Health Board Chair
Present:		
Ceri Phillips	CP	University Health Board Vice Chair
Paul Bostock	PB	Chief Operating Officer
Lance Carver	LC	Director of Social Services – Vale of Glamorgan Council
Emma Cooke	EC	Deputy Director of Therapies and Health Sciences
Nicola Foreman	NF	Director of Corporate Governance
Rachel Gidman	RG	Executive Director of People and Culture
Abigail Harris	AH	Executive Director of Strategic Planning
Michael Imperato	MI	Independent Member – Legal
Mike Jones	MJ	Independent Member – Trade Union
Fiona Kinghorn	FK	Executive Director of Public Health
Sara Moseley	SM	Independent Member – Third Sector
Catherine Phillips	CP	Executive Director of Finance
James Quance	JQ	Interim Director of Corporate Governance
Jason Roberts	JR	Executive Nurse Director
Richard Skone	RS	Deputy Medical Director
David Thomas	DT	Director of Digital Health & Intelligence
Rhian Thomas	RT	Independent Member – Capital and Estates
John Union	JU	Independent Member – Finance
In attendance:		
Stephen Allen	SA	Chief Officer South Glamorgan Community Health Council
Claire Beynon	CB	Deputy Director of Public Health
Stuart Davies	SD	Director of Finance - WHSSC
Nicola Johnson	NJ	Director of Planning - WHSSC
Malcolm Latham	ML	South Glamorgan Community Health Council Chair
Sian Lewis	SL	Managing Director - WHSSC
Observers:		
Joanne Brandon	JB	Director of Communications
Tim Davies	TD	Head of Corporate Business
Marcia Donovan	MD	Head of Corporate Governance
Secretariat		
Nathan Saunders	NS	Senior Corporate Governance Officer
Apologies:		
Susan Elsmore	SE	Independent Member – Local Authority
Meriel Jenney	MJ	Executive Medical Director
Suzanne Rankin	SR	Chief Executive Officer
David Edwards	DE	Independent Member – ICT
Akmal Hanuk	AH	Independent Member – Community
Sam Austin	SA	Stakeholder Reference Group Chair -Llamau
Fiona Jenkins	FJ	Executive Director of Therapies and Health Sciences

Item No	Agenda Item	Action
UHB 23/01/001	**Welcome & Introductions** The University Health Board Chair (UHB Chair) welcomed all to the Board meeting in English and in Welsh.	
UHB 23/01/002	**Apologies for Absence** Apologies for absences were noted.	
UHB 23/01/003	**Declarations of Interest** No Declarations of Interest were noted	
UHB 23/01/004	**Minutes of the Meeting Held on:** The minutes from the Board meeting held on 24 November 2022 were received. The Executive Director of People & Culture (EDPC) advised the Board that the percentage on the Values Based Appraisal should have read 60% by March 2023. **The Board resolved that:** a) The minutes from the Board meeting held on 24 November 2022 were approved as a true and accurate record of the meeting, pending the amendments outlined above.	
UHB 23/01/005	**Action Log** The Action Log was received. The Director of Corporate Governance (DCG) advised the Board that action UHB 22/07/013 could be marked as Complete as it was discussed at the Health & Safety Committee meeting in September 2022. She added that Tendable had replaced the old template. The UHB Chair noted that Tendable would be presented to the Board at its next Board Development session. The DCG advised the Board that action UHB 22/07/011 involved a discussion regarding communicating with patients on waiting lists and asked the Chief Operating Officer (COO) to update the Board. The COO responded that to keep patients safe and informed whilst on the waiting list, a steering group had been established which was chaired by the Deputy Director of Therapies & Health Sciences (DDTHS). He added that a number of people met on a monthly basis and discussed making sure patients who were on the waiting lists were kept informed. It was noted that the British Red Cross Waiting Well Programme was incorporated into the steering group and that so far 500 patients had been contacted. The COO added that a number of initiatives were in place to keep patients informed which included: • The Keeping Well website • The Recovery and Wellbeing College The Chair asked that the next update on patient waiting lists should form part of the future integrated performance reports.	PB

	The Board resolved that: a) The Action Log was reviewed and noted.	
UHB 23/01/006	**Patient Story** The Patient Story was received entitled: Jude's Story. This was in the form of a video which included the voice of Jude's Mum. The story outlined the experiences of five-year-old Jude who had been suffering stomach pains for months and was rushed into emergency surgery after an X-ray found 52 toy magnetic balls in his bowel. Jude's Mum explained in the video that Doctors at the Children's Hospital had to cut Jude's bowel in five places as the magnets were trapped. They also had to remove his appendix as one of the magnets had joined it to his bowel. Jude's Mum said the care her son had received at the Hospital was absolutely amazing. The story concluded that Jude had recovered well and Jude's Mum urged parents not to purchase toys with small magnets inside. **The Board resolved that:** a) The Patient Story was noted.	
UHB 23/01/007	**Chair's Report and Chair's Action taken since last meeting** The Chair's Report and Chair's Action taken since last meeting were received. The UHB Chair started by thanking the DCG for her work during her tenure as Director of Corporate Governance. It was noted that this would be her final Board meeting before moving onto a new role. The UHB Chair commented that the DCG had raised the bar in Corporate Governance at the Health Board and had managed to win over the confidence of the Board, the Committees of the Board, Welsh Government as well as the general public. He added that she had provided great Governance arrangements and that confidence could be shown in the governance arrangements left in place as the Board moved forward. The Chair of the Audit & Assurance Committee added that the work provided by the DCG on internal and external audit had been phenomenal and thanked her for that hard work. The UHB Chair advised the Board that his Chair's report was broken down into three sections, with the first being that the incredible work being undertaken by all staff across the Health Board during one of the most challenging periods in its history should be noted. He added that the second section of his report outlined an overview of HMP Cardiff which was a category B prison holding male adult prisoners on remand or those sentenced to less than two years, and that the challenges and improvements were outlined within the report. It was noted that the third section of the report outlined the fixing of the Common Seal/Chair's Actions and other signed documents. The Executive Director of Public Health (EDPH) highlighted a connection between prisoner services and the Health Inclusion Needs Assessment work being undertaken by the Health Board.	

	The Executive Director of Strategic Planning (EDSP) advised the Board that many of the seals outlined in the Chair's Report had referred to Whitchurch Surgery and she noted that the new Whitchurch Health Centre had been officially opened the night previously. The Chair of the Community Health Council (CCHC) added that he had also attended the opening of the Whitchurch Health Centre and noted that having such a good building and working environment would mean that there would be greater retention for staff and partners. **The Board resolved that:** a) The Chairs Report was noted b) The Chair's Actions undertaken were approved. c) The prospective use of the Health Board Seal detailed within the report was approved. d) The application of the Health Board Seal and completion of the Agreements detailed within the report were approved.	
UHB 23/01/008	**Chief Executive Report** The Chief Executive Report was received. The Executive Director of Finance (EDF) provided the Board with the report in the absence of the CEO. The EDF advised the Board that the report consisted of three areas for noting: • Reflections on Industrial Action • Maternity Services Update • Update on Health Inspectorate Wales (HIW) She added that she would take the report as read and noted that in each of the areas there was a wide range of issues which had been highlighted. It was noted that since the last Board meeting, the Health Board had entered the Winter months and had seen sustained levels of demand for care and treatment, especially within the Urgent and Emergency Care Pathway. It was noted that in addition to the impact of industrial actions the Health Board had seen the anticipated mix of seasonal pressures, a further COVID-19 wave, a peak in Strep A infections, and increased transmission of Flu and other respiratory and viral illnesses leading to an extraordinary patient demand alongside increased colleague absences. It was noted that the situation remained very challenging and whilst risk to quality and safety remained, it had to a large extent been mitigated and, in most domains, the operational performance compared well with other Health Boards. Reflections on Industrial Action: The EDF advised the Board that the Royal College of Nursing (RCN) Industrial Action took place on 15th December and 20th December 2022 and the GMB, affecting the Welsh Ambulance Service Trust (WAST), took industrial action on 21st December 2022 and 11th January 2023. She added that the Board should be highlighted on the robust planning, the debriefs and the lessons learnt which would be fed into the next process regarding Industrial Action. All of the staff involved in that work were commended. Maternity Services Update:	

	The EDF advised the Board that the Health Board had a Maternity Oversight Group which continued to meet fortnightly and was providing a well embedded and increasingly effective governance process across Maternity and Obstetrics. She added that the Executive Nurse Director (END) would provide more detail during the Maternity Services update item later on the agenda. The EDF concluded that a significant business case for recurrent funding to support the delivery of the post Ockenden report action plan had now been matured and would be presented to the next Investment Group meeting on 16th January 2023 and then to the Board in due course. Update on Health Inspectorate Wales (HIW): The EDF advised the Board that the reviews outlined in the paper had identified recommendations and action plans which were fed through the Quality, Safety & Experience Committee and that their progress was noted. The EDF concluded that she would commend the Board to read the appendices within the report which were a review of the Joint Executive Team (JET) meetings held with NHS Wales. The Independent Member – Third Sector (IMTS) asked if an operational picture could be seen following industrial action and how the Health Board was responding to that. The COO responded that the first two strikes had a minimal impact on the operation of the Health Board. He added that approximately 500 outpatient appointments and 80 planned operations had been cancelled and that had been managed well. It was noted that the upcoming strikes in February would cause more concern on the operational running of the Health Board because Nursing and the Welsh Ambulance Service (WAST) would be on strike. The COO advised the Board that potentially 5,000 outpatients were at risk. He added that in terms of Urgent Care, the Health Board had managed the ambulatory strikes well, but that there would be an impact. It was noted that the Health Board had a good relationship with the Trade Unions and that the Health Board had the least amount of derogations put in place compared to other Health Boards. The IMTS asked what was happening with Doctors, as she believed strike action was on the horizon. The Deputy Medical Director (DMD) responded that so far, the British Medical Association had balloted Junior Doctors and the result was awaited. He added that the Consultants had not been balloted yet. The IMTS noted that a lot of the issues raised in Maternity had been around the culture and asked how the Health Board was making sure the fundamental issues around culture and behaviours were being addressed. The UHB Chair responded that the answer could be provided during the END's update on Maternity later on in the meeting. **The Board resolved that:**	

	a) The Strategic Overview and Key Executive Activity described in the report were noted.	
UHB 23/01/009	**Board Assurance Framework** The Board Assurance Framework (BAF) was received. The Director of Corporate Governance (DCG) advised the Board that she would take the paper as read and noted that there were 15 risks on the BAF because a further 6 had been added. She added that as per usual, any changes to the BAF had been discussed with the relevant Executive and highlighted on the BAF. It was noted that no significant change had occurred to the BAF and that the scores remained the same as per the previous Board meeting in November 2022. The COO added that to provide further assurance to the Board, whilst the scores had not changed since November 2022, actions were being taken forward and the risks were being reviewed often. **The Board resolved that:** a) The 15 risks to the delivery of Strategic Objectives detailed on the BAF for January 2023 were reviewed and noted.	
UHB 23/01/010	**Chairs reports from Committees of the Board:** The Chairs Reports from the Committees of the Board detailed on the agenda were received and the following specific comments were highlighted by Chairs: **Quality, Safety & Experience (QSE) Committee Chairs Report** – The Vice Chair of the QSE Committee emphasised the need to approve the policy documented within the report. He added that he would take the report as read and noted that reflecting upon earlier discussion around operational pressures, the Medicine Clinical Board had provided its assurance report to the Committee in November. It was noted that that in the January QSE meeting, a demonstration of robotic surgery had been provided by the Surgical Clinical Board and that it was good to note the areas that enhanced the care received by Patients. **Finance Committee Chairs Report** – The Chair of the Finance Committee advised the Board that there was nothing specific to add and that she would take the report as read. She added that the Finance Committee had looked at the overspend and the financial pressures. **Health & Safety (H&S) Committee Chairs Report** – The Chair of the H&S Committee advised the Board that a member of staff had sustained injuries following an accident which involved a large waste container being unloaded from a Stericycle lorry. He added that, fortunately, the member of staff had recovered from their injuries and had returned to work and that following a risk assessment, measures had been taken to guard against that type of accident happening again, which included the tightening up of processes relating to the area of activity. **Strategy & Delivery (S&D) Committee Chairs Report –** The Chair of the S&D Committee advised the Board that the Committee had only met the previous Tuesday and so a verbal update would be provided.	

	It was noted that the Committee had looked at Workforce and comparative figures on sickness and absence against other Health Boards. It was noted that the Committee had received "deep dives" into Cancer Services, delayed transfers out of hospital, and the cost of living crisis and the impact that had on staff. The Chair of the S&D Committee concluded that the Committee had received a report on the Kings Fund from the EDPH which had looked at headline issues. The Committee had also considered a Decarbonisation report. The Independent Member – Capital & Estates (IMCE) noted that "sustainability" was discussed a lot at the Board meetings, but that very few practical steps were observed. She asked if it was worth elevating Decarbonisation to a Board Champion level. The UHB Chair asked for an action for Decarbonisation to be looked at as a Board Champion level offline. The Vice Chair of the University Health Board (UHB Vice Chair) advised the Board that reports had impact assessments at the bottom and that one of the areas outlined was Decarbonisation. The DCG added that work would be done to ensure that the Decarbonisation aspect of the Impact Assessments were completed. The EDPH added that the Health Board had declared a climate emergency and so noted her support for the Decarbonisation work. The EDSP noted that Decarbonisation could be looked at in a Board Development session in the future. She added that the Decarbonisation Final Plan would be received by the Board in March 2023. The UHB Chair thanked the Chairs of the Committees for their continued support. **The Board resolved that:** a) The Chairs' reports were noted. b) The Concerns, (Complaints) and Claims (Clinical Negligence, Personal Injury and Redress) Policy (UHB 332) was approved.	NF/JQ NF/JQ
UHB 23/01/011	**Integrated Performance Report:** The Integrated Performance Report was received. The UHB Chair invited each Executive to comment on the relevant section of the report and noted that the report should be taken as read. **Population Health:** The EDPH advised the Board of three areas for noting: • Epidemiology – It was noted that all indicators across Respiratory Health were declining. • Immunisation – It was noted that the Health Board had performed very well in the overarching Covid data with 84% uptake across all eligible groups.	

The EDPH noted that the Health Board had done quite well on the update of the Flu vaccine, but not as well as the Covid uptake. She added that the Mass Vaccination Centres were open for Flu vaccine walk-ins until the end of March 2023.

It was noted that Public Health were waiting for a JCVI policy statement on vaccination for the future.

The IMCE asked if any guidance had been received on how Test, Trace and Protect (TTP) would look like in the future.

The EDPH responded that there was an ongoing live discussion and further clarity from WG would be required.

She added that the testing offer would need to change from blanket testing over set periods to periods with no testing, (for example, Spring/Summer time) but noted that it was a live discussion being held with WG.

It was noted that the testing ask was that the Health Board should move towards meeting other health protection requirements.

Quality and Safety:

The END advised the Board that the report was very mixed and he would highlight the following areas.

- Patient Concerns - It was noted that during October and November 2022, the Health Board had maintained an overall 30 working day response time for all Patient Concerns, of 80%.

  The END added that in October and November, the Health Board processed 60% of concerns in line with Early Resolution which aimed to ensure a response was received within 2 working days.

  It was noted that due to the current demands on the service the volume of concerns was increasingly challenging and it was appreciated that failure to answer concerns in a timely way was not acceptable. There continued to be a focus upon improving the response times whenever possible and addressing the underlying themes.

- Incident Reporting - It was noted that there had been higher incident reporting identified within the Health Board due to difficult and challenging operational pressures and that the highest incident reported was still pressure damage.

- Nationally Reportable Incidents (NRIs) – It was noted that the position had improved over the last month and that the open NRIs had increased. However, the number of overdue NRIs had reduced.

  The END added that reducing overdue NRIs each month had been a trend over the last few months and had reflected the focus and hard work of the Clinical Boards and Patient Safety Team.

- Civica ‘Once for Wales’ platform – It was noted that the Civica ‘Once for Wales’ software platform enabled Health Boards to collect and report on feedback. That could be feedback from patients, staff or the wider public. The initiative was currently being implemented across all Welsh Health Boards.

  The END advised the Board that the Health Board’s system went live on Friday 28th October 2022 and 600 patients were currently being surveyed daily via SMS.

  He added that it was anticipated that a QR code would be available at each bed space in the Health Board by February 2023 and would link Patients/Visitors to the

	Civica platform to leave feedback. A report on that feedback would be provided to the Board later in the year. • Infection, Prevention & Control (IPC) - The END advised the Board that the grouped total Cdiff, Ecoli, MRSA and MSSA infections was showing no in-year improvement against the 2018/2019 baseline. However, Ecoli, MRSA and MSS were demonstrating an in-year improvement, whereas Cdiff in-year had increased, compared to baseline of December 2018. He added that Cdiff rates were observed to be high across the UK after the first and subsequent waves of Covid and that all community cases were now subject to investigation to understand the cause of the infection. The Deputy Medical Director (DMD) advised the Board with regards to the Mortality data within the report. • Mortality – The DMD noted that all Mortality data fed back to a learning and death framework of which there were 3 tiers; - Health Board level - Clinical Board level - Speciality level It was noted that in Tier 1, the Health Board used crude mortality which was benchmarked against Health Boards of a similar size to the Health Board. It was noted that in Tier 2, the identification of Clinical Board mortality indicators would further support the proposed approach to mortality oversight and that learning from death could be achieved by identifying trends in mortality data that supported additional actions and scrutiny. The DMD added that for the purpose of the report, mortality was reported as funnel charts for September 2021 to September 2022 and compared performance against the 2021 Acute Trust Peer Group. It was noted that in Tier 3, local services drove their own services using their own local data. The IMTS noted that the report stated that the completion of clinical coding was vital to support the generation of accurate mortality data but noted that the percentage of uncoded primary diagnosis had increased to 32.89% in September 2022. She asked for more information on that. The DMD responded that improvements were being sought across coding in the Health Board and triangulating the information to provide greater clarity in terms of the causes of death. The IMTS asked if it was a workforce issue. The UHB Chair responded that there was a staffing issue around the digital element and noted that it was quite staggering the amount of papers clinical coders were working through. The Director of Digital and Health Intelligence (DDHI) responded that the issues were recognised with regards to coding and that prioritisation was in place to ensure work was ongoing. He added that one of the main issues regarding clinical coding staff was that other sectors could offer higher pay and more home working, and that one of the main solutions would be for the Health Board to fully digitalise Patient records to compete with other Organisations.	**JR**

	The UHB Vice Chair noted that the complaints were calculated per 1000 residents and noted that the denominator was incorrect because the Health Board often treated patients who were "non-residents". The END noted he would pick that up with the team. The Director of Social Services – Vale of Glamorgan Council (DSSVGC) noted that Patient falls had seen a positive improvement in the Mental Health Clinical Board and asked if the same level of scrutiny was being seen in other Clinical Boards. The Deputy Director of Therapies and Health Sciences (DDTHS) responded that the learning from the Mental Health Clinical Board would be shared across the Organisation. She noted that the lead nurse for older people in Mental Health would be attending the Falls Committee and a standardised packet of training would be discussed which could then be rolled out across the Organisation. **Workforce:** The EDPC advised the Board that workforce issues were still very challenging and highlighted the balanced score card within the paper which showed a lot of the data was still within the red range of a red, amber and green (RAG) rating. She added that the November 2022 data showed that the sickness absence rate was 6.9%, which was an increasing trend. It was noted that the People and Culture Team was looking at targeting specific areas to discuss solutions for reducing absence and that over the Winter months the People and Culture Team would focus on the 'Main Effort' with the team being aligned to the following UHB priorities and the People and Culture Plan: • Wellbeing (including cost of living support) • Recruitment • Retention • Workforce Planning The Independent Member – Trade Union (IMTU) asked if people understood that they could retire and then return. The EDPC responded that conversations had been held with the COO around the retire and return policy and whether it was equitable around the whole of the workforce. The COO added that the observation around the retire and return policy was that it did not necessarily benefit the whole Organisation and that it was not implemented consistently across the Health Board. He added that it would be reviewed to ensure that it met the needs or the Organisation as well as the staff. The Independent Member – Legal (IML) noted that a discussion had been held at the Strategy & Delivery Committee regarding the activities taken to try and improve absence and asked how the activities could be tracked. The UHB Chair agreed that the Board needed to be assured that the data was moving in the right direction and that trajectories were being delivered. The UHB Vice Chair noted that improvement had been noted in "workplace conflict" and asked the EDPC to provide further information. The EDPC responded that values-based conversations were being held before escalation of conflict and that the improvement had been noted.	**PB/RG**

She added that values-based training had been positive with regards to early intervention and noted that the number of tribunals had decreased because those conversations were happening earlier on in the process.

The Independent Member – Finance (IMF) asked if data from exit questionnaires was valuable.

The EDPC responded that it was, but noted that uptake was poor and that further work was required on the exit questionnaires.

The END added that he had a group of Nurses working with the People and Culture team, and they had started to interview staff members to ask them what would keep them within the Organisation.

Operational:

The COO advised the Board that system wide operational pressures had continued and that the Health Board was still seeing access or response delays at a number of points across the Health and Social Care system.

- Emergency & Urgent Care – It was noted that despite the Winter, improvements had been made against 4-hour ambulance wait times.

- Medically fit for discharge – It was noted that there were 285 patients in December who were medically fit for discharge.

  It was noted that actions being taken had stabilised the position and progress was being made with further progress to be made during the Easter period.

- Cancer – It was noted that Cancer performance remained significantly below the Single Cancer Pathway (SCP) standard and that October 2022 had seen a significant 12% improvement compared with September, with 54.8% of patients receiving treatment within 62 days.

- It was noted that there had been a number of actions taken to improve the oversight and operational grip of the process for overseeing patients. A Cancer summit had taken place with the tumour group leads and operational teams to understand the demand, the causes for delay in the 62-day pathway and what actions were required to reduce the delays experienced by patients.

- Primary Care - It was noted that the Health Board was 83% compliant in November 2022 against the standard of 100% for 'Emergency' GP OOH patients who required a home visit within one hour, with 5 of 6 patients receiving their visit within one hour.

  The COO added that the opening of the Whitchurch Health Centre as mentioned previously had created around 1100 appointments a week which was really pleasing to observe.

- Stroke and Fractured Neck of Femur – It was noted that the metrics were obtained and that the percentages were not quite right and so further work was required on those before presenting to the Board.

  The COO added that a Stroke summit had taken place and that data had been looked at nationally and a follow up conversation would be held around actions required to improve.
  Planned Care – It was noted that Dental was being delivered upon as well as all of the other areas the Health Board had said it would deliver on and noted that no elective surgeries had been cancelled during the Winter pressures.

	Mental health – It was noted that the Clinical Board had done very well considering the increase in referrals received and the COO advised the Board that assurance could be provided that CAMHS performance had increased and that the operational team had been pleased with the progress made. **Finance:** The EDF advised the Board that the month 8 position had been received by the Board in the papers and that the Finance Committee had received month 9 the day prior to the meeting. She added that the Health Board was at a £20.5m deficit against a reluctantly revised forecast deficit of £26.9m It was noted that a Board Development session had been held on the Monday prior to the Public Board meeting where details had been received on the financial plan. The EDF advised the Board that in terms of the 2022/23 finance, the capital resource limit was being managed very well and that the Health Board anticipated spending all of the funds in the way it was planned. She concluded that the Public Sector Pay Policy had been received and reviewed by the Finance Committee and that the performance remained below the target of 95%. It was noted that performance for the 9 months to the end of December was 94.6% which represented an improvement of 0.1% in month. **The Board resolved that:** a) The contents of the report were noted.	
UHB 23/01/012	**Welsh Government Addendum to SFIs – Framework Contracts** The Welsh Government Addendum to SFIs – Framework Contracts were received. The DCG advised the Board that it was not an addendum to SFIs even though the letter received had said it was. She added that it was a reminder from WG of when the Health Board would need to go to WG to note contracts and when to go to WG for approval of contracts. It was noted that the letter was checked by the Head of Procurement for the Health Board to provide extra assurance to the Board. **The Board resolved that:** a) The reissued guidance from Welsh Government and the assurance provided by the Assistant Director of Procurement Services was noted.	
UHB 23/01/013	**Maternity Services Update** The Maternity Services Update was received. The END advised the Board that he would take the paper as read. It was noted that the Health Care Inspectorate (HIW) Wales commenced an unannounced inspection of Maternity services on 8 November 2022 and that the HIW had convened an Executive Immediate Assurance Briefing on 9 November to advise the Executive Team of initial findings. The END advised the Board that a number of immediate assurance recommendations were discussed and those included:	

- Compliance with mandatory training
- Equipment maintenance
- Environment
- Staffing levels
- Antenatal, birth and post-natal pathways
- Clinical risk and governance

It was noted that a comprehensive improvement plan was developed to address all immediate assurance recommendations and a programme of work commenced immediately to progress the improvements.

The END advised the Board that since the paper had been published for the Board, the formal correspondence from HIW had been received, HIW had approved the Health Board's action plan and that the service remained under normal monitoring.

It was noted that the April 2023 Clinical Effectiveness Committee would be dedicated to oversight of all Maternity and Neonatal national audits, Neonatal Peer review and the Neonatal annual report as well as the associated improvements.

The Chief Officer South Glamorgan Community Health Council (COCHC) advised the Board that a percentage of patients had informed the Community Health Council that they had not received enough emotional support from the Maternity service.

He added that 83% of patients had noted that they had been spoken to in a way in which they could understand, which was positive, although 80% of those patients the Community Health Council (CHC) had spoken with had not been given the choice of where their antenatal appointment would take place.

The COO responded that in response to the Ockenden Review of Maternity Services at Shrewsbury and Telford a RAG rated assurance report had been produced benchmarking against the 89 report recommendations.

He added that a business case was being presented to the Health Board's Investment Group in January 2023 to set out proposed investments to address the requirement which included some of the concerns identified by the CHC.

The END advised the Board that a Maternity Oversight Group chaired by himself and attended by the EMD and Clinical Board representatives convened every two weeks and that the purpose of the group was to oversee progress with the HIW improvement plan, Ockenden improvement plan and wider quality and patient safety themes so that the Board could be assured.

He added that the pressures seen in the Maternity service were not unique to the Health Board and that it was a wider health system issue which was why the 'MatNeo' function had been developed.

It was noted that phase one was for fact finding and that phase 2 would be developed following a report on the fact finding.

The UHB Chair asked who was receiving the assurance from the Maternity Oversight Group.

The END responded that the group had been convened quickly to oversee the immediate assurances that the Health Board was working to and that dashboards had been created to show key performance indicators (KPIs).

He added that the data would be reported into the Quality, Safety & Experience Committee.

The Board resolved that:

	a) The recent HIW inspection and outcomes to date and the assurance provided in relation to the response were noted.	
UHB 23/01/014	**IMTP/Annual Plan** The IMTP/Annual Plan was received i) Q3 Current Position The EDSP advised the Board that the report presented the Health Board's quarter 3 position in regards to delivery of the plan's commitments. She added that the Strategy & Delivery Committee had received the report for scrutiny on the 24th January. It was noted that the report followed feedback received from Audit Wales about making sure that, in addition to the detailed performance report received by the Board, a more rounded overview was required for Board assurance purposes. The EDSP advised the Board that the report was split into 2 parts: 1) The narrative and what the Health Board expected to pick up in the next quarter moving forward. 2) What the baseline target was and what the original plan stated would be achieved. She added that she was cautiously optimistic that the Health Board was on track to deliver what it had outlined in the plan. It was noted that the report received by the Board at its March meeting would maintain the same format and template, and that the report in the new financial year would look different pending reflection of the past year. The IMTS asked for more information on major capital schemes and how the Board could get assurance from the risk elements associated with different capital needs. The EDSP responded that in terms of planning progress, the risk register should be used to identify where the highest organisational risks were and that those risks should they be provided to Clinical Boards to manage in terms of risk to service delivery. She added that every year, Clinical Boards were asked to identity their risks and submit priorities as part of their process and noted that there was an agreed ten-year plan. It was noted that the capital funding in WG accessed through discretionary allocation was wholly inadequate to cover gaps. The EDSP concluded that it was a big challenge because the Health Board's infrastructure was deteriorating faster than it could be improved and that an annual assessment was received on the state of the Health Board estate which outlined the major risks to the Health Board in terms of business continuity. The EDF added that the risk was very high in terms of Health Board infrastructure and that up until this point a lot of faith had been put into the building of UHW2 but that no planning had been done beyond the agreed ten-year plan. She added that with the exception of the Mortuary, all of the major capital projects had been new items coming through and that the backlog maintenance had grown to £15m over the past 5 years and was going up. It was noted that the risk had started to be reported to the Health & Safety Committee where compliance and assurance versus risk was discussed.	

	The EDF advised the Board that the Health &Safety Committee should continue to hold that discussion. The IMF noted that the risk register was sent to all Clinical Boards and asked to what extent themes were seen from those risks. The EDF responded that they were common and were not risks but realities. She added that a Corporate piece of work needed to be undertaken to own the overall picture rather than wait for Clinical Boards to identify their risks. **The Board resolved that:** a) The progress achieved in delivery of the 22-23 plan as at quarter three was noted.	
UHB 23/01/015	**Planning Update** The Planning Update was received. The EDSP advised the Board that the 2023/24 position would be included in the overarching planning update being provided. She added that the report showed the current positions in terms of the IMTP, with five key areas of strategic planning progressed. It was noted that the purpose was to provide the Board with assurance that actions agreed in the annual work programme or Annual Plan were being progressed and risks around delivery were being managed. The Planning Update included: - • The development of the 2023 – 2026 Integrated Medium-Term Plan (IMTP). • Progress with the strategy refresh. • Progress with the regional planning work programme. • Progress with our strategic programmes. The EDSP advised the Board that in terms of the Health Board's Strategy refresh, the Health Board was engaging with various groups and also running internal sessions. She added that feedback from those groups should be encouraged. The EDSP also highlighted that in relation to the regional work and that there had been an expectation from the Minister that the Health Board needed to work differently in relation to solutions to some of the operational challenges. She added that one of the risks identified was to make sure that the Health Board was engaged with its population. It was noted that the WG had signed off the scope for the business Strategic outline case for Shaping Our Future Hospitals and the request for resource to enable the Health Board to complete the work. The ESDP concluded that the sooner a sense of timelines could be achieved, the sooner the Health Board would know how long it had to manage the work in relation to the poor environments identified. **The Board resolved that:** a) The progress with the development of the IMTP and verbal update on the Board development session held on 23rd January was noted.	

	b) The next phase of the development of the refreshed strategy and the participating as appropriate in the engagement co-production events taking place was supported. c) The progress in relation to partnership and regional strategic service planning was noted. d) The progress in relation to the Health Board's strategic programmes was noted.	
UHB 23/01/016	**Director of Public Health Annual Report** The Director of Public Health Annual Report was received. The EDPH advised the Board that the report was a statutory part of her role. She added that she had taken a different stance on the report for 2021 and outlined it as an approach which would fit well with the Health Board's refresh of its Strategy. It was noted that the report focused on "what does value mean" and what the component parts of that were. The EDPH thanked the Deputy Director of Public Health (DDPH) and her many team members from different departments who had contributed to the report. The DDPH presented slides in relation to Delivering Better Outcomes for People Through a Value-based Approach. She noted that the presentation consisted of 4 chapters which included: • Introduction to value and the Value-based approach • The tools and techniques to deliver a Value-based approach • The relationship between a Value-based approach and equity • Towards the consistent application of a Value-based approach The DDPH advised the Board that the Health Board was facing difficult economic circumstances and that a Value-based approach helped to make sure that everything the Health Board was investing in would have a positive impact on outcomes for the local people served. She added that the definition of value was the equitable, sustainable and transparent use of the available resources to achieve better outcomes and experiences for every person. It was noted that there were 5 elements to a Value-based approach which included: • Equitable – Not everybody required the same service, it was circumstances based. • Sustainability - Not just the present, but thought about the future. It was noted that included designing realistic services and thought about the environmental impact and carbon footprint; and stopping services that were providing little or no value • Transparency – It was noted that the Health Board could not meet everybody's needs all of the time and that the Health Board needed to be clear to its population on that, whilst focusing on what was/was not possible and why. • Outcome focussed – It was noted that all public services should be focussed on finding out what outcomes were important for local people and then working towards those with the local people as partners. • High quality – It was noted that the services provided should be of high quality, meaning that the journey through services was a positive experience and that services were safe. The DDPH advised the Board that chapter 2 of the presentation spoke about the tools and techniques required. She added that for all public sector organisations there were 5 tools and techniques required which included:	

- Prevention – a refocus upstream
- Improving outcomes for the population through partnership working
- Shared decision making
- Describing desired outcomes and monitoring actual outcomes
- Providing feedback on quality of the services and the experience.

It was noted that for Health specifically, there were a further 3 tools and techniques:

- Improvement of Health literacy
- Understanding and addressing unwarranted variation
- Programme budgeting and marginal analysis

The DPPH advised the Board that chapter 3 of the presentation outlined the relationship between a Value-based approach and equity and noted that:

- Health inequities were avoidable, unfair, and there were widespread differences in Health between different groups of people.

- Some groups of people could need more support than usual, whether that be welfare support, housing support, or healthcare.

- By using a Value-based approach the Health Board could move resources upstream to make services more accessible, of higher quality and in so doing would reduce costs.

The DPPH advised the Board that chapter 4 of the presentation outlined the consistent application of a Value-based approach and the six steps to success:

- Step 1 – To establish the right policy framework to work collaboratively with people.
- Step 2 – To establish Organisational readiness
- Step 3 – To normalise the culture of discussing outcomes with people
- Step 4 – To provide adequate funding to support change and shift funds to high value interventions
- Step 5 – To record outcomes routinely in systems that were available to staff in a timely way
- Step 6 – To report success routinely by using outcome measures that mattered to people.

The DDPH concluded the presentation with the six recommendations from the Director of Public Health Annual Report.

The EDPH added that the report had many examples within it which could be read by Board members.

The UHB Chair thanked the EDPH and their team for the report and noted that it was very timely in terms of what the Health Board was trying to achieve.

The COCHC noted that it would be key to get the public to help devise future reports and that because the report outlined a number of community areas, there were a number of opportunities for the public to provide their thoughts and to help understand the logic of what was trying to be achieved.

The EDPH responded that it was a point well-made and that because it was a framework, the Health Board should be working with the public on the report.

The UHB Vice Chair noted that they welcomed the approach but noted that it should be approached with a degree of caution because shifting towards prevention did not mean that demand was going to be immediately reduced.

	The EDPH responded that the Health Board needed excellent acute services as well as excellent community services and that more skills and analytics were required about the different it could make. **The Board resolved that:** a) The Annual Report of the Director of Public Health 2021 was approved. b) The enablement of progressing a Value-based approach in the Health Board, including through developing value capability, and through partnership opportunities was endorsed.	
UHB 23/01/017	**Audit and Assurance Arrangements** The Audit and Assurance Arrangements were received. The DCG advised the Board that pursuant to the Health Board's Standing Orders and Scheme of Reservation, the Board was required to approve the Health Board's Audit and Assurance arrangements on an annual basis. The UHB Chair asked the Chair of the Audit Committee to comment. The Chair of the Audit Committee responded that the Audit Committee was happy with the report and that it could be taken as read. **The Board resolved that:** a) The arrangements in place for Audit and Assurance as set out in the report were approved.	
UHB 23/01/018	**Board Champions** The Board Champions information was received. The DCG advised the Board that in accordance with Standing Order 1.4.12 the Chair would ensure that individual Board Members were designated as lead roles or 'champions' as required by Welsh Ministers or as set out in any statutory or other guidance. The IMF asked if the activities undertaken by Board Champions were tracked. The DCG responded that a piece of work could be undertaken that showed how the roles worked and then a report could be provided at the end of each year. The IMCE asked if there was scope to focus on protected characteristics and revisit some of the actions and activities that had been planned around those. The UHB Chair responded that the People and Culture equality team could explore that work and noted it as an action. **The Board resolved that:** a) The proposed Board Leads and Champions set out in Appendix 1 of the report were approved. b) The Board Champion Role Description set out at Appendix 2 within the report were confirmed. c) It was agreed that where the Champion Role was allocated to an Independent Member that they would work with the relevant Executive Director to form a plan to fulfil the role. d) It was agreed that the schedule (Additional Areas of Responsibility Delegated to the Chair, Vice Chair and Independent Members) as set out in the Health Board's Standing Orders was updated to reflect the allocated roles.	**JQ** **RG**

UHB 23/01/019	**Committee / Governance Group Minutes:** The Committee / Governance Group Minutes were received. **The Board resolved that:** a) The Committee / Governance Group Minutes were noted	
UHB 23/01/020	**MMEW/Healthy Weight in Children** The MMEW/Healthy Weight in Children information was received. The EDPH advised the Board that the paper had been received for information. She added that assurance had been sought by Board, in the context of the waiting list for certain levels of the healthy weight support service and noted that the Health Board had a strong approach to support the healthy weight of children and young people in Cardiff and Vale. It was noted that the report outlined the huge amount of work undertaken around Healthy Weight in Children and provided the assurance required whilst acknowledging the caveats outlined within the report. **The Board resolved that:** a) The ambition of delivery, and implementation to date was noted. b) The direction of travel was supported.	
UHB 23/01/021	**Corporate Risk Register** The Corporate Risk Register (CRR) was received. The DCG advised the Board that she would take the paper as read and that it was for noting. She added that there were currently 22 Risks on the Corporate Risk Register, 21 of which recorded a score of 20/25 and 1 risk (CRR 6), in relation to Nurse Staffing levels which had a recorded score of 25/25. It was noted that Risk CRR6 was continuing to be monitored by the Executive Team with conversations ongoing in relation to recruitment strategies and how best to mitigate the risk in light of ongoing industrial action. It was noted that the CRR was cross referenced to and reflected the BAF in line with discussions that had already taken place earlier in the Board meeting. The DCG concluded that some of the risks identified were issues and not risks and she noted that they would be properly aligned. **The Board resolved that:** a) The Corporate Risk Register and the work in the area which was now progressing was noted.	
UHB 23/01/022	**Annual Consultations Summary** The Annual Consultations Summary was received.	

	The DCG advised the Board that it had been received for noting and added that the Health Board had been criticised for not responding to various consultations. She added that a Consultation tracker was established in June 2020 to record the detail of known and relevant Consultations that the Health Board should, or would like to respond to, and that the tracker was created and continued to be maintained by the Risk and Regulation Team within the Corporate Governance Directorate. **The Board resolved that:** a) The Annual Consultations Summary was noted.	
UHB 23/01/023	**Chair's Reports from Advisory Groups and Joint Committees:** The Chair's Reports from Advisory Groups and Joint Committees were received. The EDSP advised the Board that the Health Board had received notification that the Minister had commissioned a review of National Commissioning Bodies. **The Board resolved that:** a) The Chair's Reports from Advisory Groups and Joint Committees were noted.	
UHB 23/01/024	**WHSSC Annual Report** The WHSSC Annual Report was received. The Managing Director – WHSSC advised the Board that WHSSC would be providing information to the Board on future developments. The Managing Director – WHSSC gave a presentation to the Board and reminded Board Members of WHSSC's role. The Director of Planning – WHSSC advised the Board that the aim in 2023/24 for WHSSC was take a more strategic commissioning approach, which included: • Specialised Services Strategy (in development) - Sustainable services - Clinical and cost effectiveness - Increasing value • Specialist Mental Health Strategy (under agreement) - Sustainable services; adding value - Total Spend £80M • Specialist Paediatric Strategy (implementation phase) - Sustainable services; adding value - Total Spend £124M • Specialist Rehab. Strategy (in development) • Haematology Review (under agreement) The Director of Planning – WHSSC noted that because WHSSC was involved in highly specialist services, it was often the bridge between policy and delivery for the highly innovative techniques. • Policy agenda – ATMPS (Advanced Therapeutic Medicinal Products), Genomics, Cystic Fibrosis (CF) drugs - NHSE commitment and investment already made - NHS Wales Statements of Intent - NICE mandated medicines	

- NHS Wales commitment for CF

- Integrated Commissioning Plan (ICP)
  - Developments prioritised according to evidence-base/clinical and cost effectiveness/patient benefit/burden of disease
  - Integrated planning and choices to be made by the Joint Committee

The Director of Planning – WHSSC advised the Board that the ICP had a number of key elements to provide the required development which included:

- Identification of key strategic priorities
- Horizon scanning and adoption of new NICE guidance
- Clinically-led service prioritisation
- Contracting, assessment of growth and commitments
- Requests for new services and services at risk
- Assessment of performance and commissioning risks
- Value and re-commissioning opportunities

The Director of Finance – WHSSC presented the financial requirements to the Board.

He noted that the net financial requirements had reduced to 3.11% from 3.89% which had been provisionally agreed by the Board and that the main components of WHSSC's plan were to start with the rollover position of the previous year and build upon it.

It was noted that in 2022/23 WHSSC had substantially underspent their budget because significant reserves had been brought forward which was returned to Health Boards.

The Director of Finance – WHSSC added that significant underspends were observed due to underperformance.

He added that from the financial planning aspect for 2023/24, WHSSC presumed that activity would be restored to pre-Covid levels and then all of the underspends associated with that would come back into the system as cost.

The Board were presented with the draft ICP Requirements 2023/24 which included financial figures from:

- 2022/23 closing income
- 2023/24 opening income
- 2022/23 underlying deficit
- Disinvestments and Re-Commissioning
- Strategic Specialist Priorities
- Deficit, Growth, Savings and Developments
- Investment 2023/24

The Director of Planning – WHSSC advised the Board of how WHSSC would be refreshing its Interfaces which included:

- Refreshing interfaces with WHSSC's main Welsh providers following the pandemic.
- Ensuring the right conversations were being held in the right places with the right people.
- Being clear in strategic; planning; assurance; performance mode
- Trying to reduce duplication
- Ongoing discussions with Cardiff and Vale Health Board Operational & Planning colleagues

The Director of Planning – WHSSC presented to the Board the Performance and Commissioning Risks associated with the Health Board as a provider which included:

	• Apart from neurosurgery the Health Board was not planning to restore WHSSC capacity to contract in 22/23 • Paediatric surgery outsourcing would proceed in-year • Contract activity may consequentially be reduced in the ICP 23/24 • Cardiac rebasing • Neonatal cot reconfiguration to report in March 2023 • Other services on WHSSC's risk register to be addressed. She concluded that WHSSC and the Health Board needed to work together to enable delivery by having a more constructive relationship. The UHB Chair noted that a number of risks had been identified in the presentation and noted that there were real challenges to be addressed. He added that it was pleasing to hear that WHSSC had strong working relationships with the Health Board's Executive team. The Chief Operating Officer noted that there was some tension between WHSSC and the Health Board mainly around the Paediatric waiting lists. The Managing Director – WHSSC responded that it was recognised and that it was healthy to have a degree of tension between WHSSC and a provider as long as it was managed correctly which she believed it was. The DCG added that some of the risks sat within WHSSC services and noted that they were reported to every Joint Committee. **The Board resolved that:** a) The WHSSC Annual Report was noted.	
	Agenda for Private Board Meeting: ***i.*** *Approval of Private Board minutes* ***ii.*** *Approval of Private Committee minutes* ***iii.*** *Inpatient Suicides (exempt from publication on the grounds of patient confidentiality)* ***iv.*** *New Velindre Cancer Centre Update (commercially in confidence discussion)* ***v.*** *Covid-19 Public Inquiry Update (confidential discussion).*	
UHB 23/01/025	**Any Other Business** No other business was raised.	
UHB 23/01/026	**Review of meeting**	
	Date & time of next Meeting: 30th March 2023 – Barry Hospital – Mary Lennox Room	

ACTION LOG

Following Public Board Meeting

24 November 2022

(Updated for the meeting 26 January 2023)

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
Actions Completed					
UHB 22/07/013	**Health & Safety Annual Report**	Discussion required around actions arising from Patient Walk rounds	**26.01.2022**	Rachel Gidman / Jason Roberts	**COMPLETED**
UHB 22/07/011 **UHB 22/11/012**	**Integrated Performance Report**	**Performance Section**: Improvements required in communication around waiting times Stroke data update	**26.01.2022** **26.01.2022**	Paul Bostock / Jo Brandon	**COMPLETED** **Discussed at Board on 26 January 2023** Discussed at Board on 29 September 2022 - Further update to be provided at the January Board meeting. Discussed at Board on 26 November 2022 - Further update to be provided at the January Board meeting. Agenda item 6.6
Actions in Progress					
UHB 23/01/010	**S&D Committee – Chair's Report - Decarbonisation**	To consider having a Board Champion role for Decarbonsiation. To carry out further work to ensure the impact assessment for Decarbonisation in the covering report template was	**30.03.2023**	James Quance	**Update on 30 March 2023** Agenda item 7.4 Board champion role considered and discussed with UHB Chair – likely to

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
		properly considered/addressed by report authors.			continue to be included within the remit of the existing role of Wellbeing of Future Generations champion. Work is in progress to improve the completion of cover papers in general. Decarbonisation impact identified as an area that requires further guidance which is being developed.
UHB 23/01/011	**Integrated Performance Report: Quality and Safety**	Civica 'Once for Wales' – A report on Civica Patient feedback would be provided to the Board later in the year.	**27.07.2023**	Jason Roberts	**Update on 27 July 2023**
UHB 23/01/005	**Action Log re Integrated Performance Report – Operational Performance**	Update on patient waiting lists should form part of the future integrated performance reports	**30.03.2023**	Paul Bostock	**Update on 30 March 2023** Agenda item 6.6
UHB 23/0-1/011	**Integrated Performance Report 0**	To undertake a review of the Retire and Return Policy	**25.05.2023**	Rachel Gidman/Paul Bostock	**Update in May 2023**
Uhb 23/01/018	**Board Champions**	Report to be provided at the end of each year to detail the work undertaken by Board Champions.	**25.05.2023**	Rachel Gidman/James Quance	**Update in May 2023.**
Actions referred TO Committees of the Board/Board Development					
UHB 22/09/011	**Integrated Performance Report**	Pressure damage – the management approach to mitigating pressure damage issues to be explored further at the	**09.05.2023**	Jason Roberts	**Update on in May 2023**

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
		Quality, Safety and Experience Committee			Due to be considered at the QSE Committee meeting on 9 May 2023.
Actions referred <u>FROM</u> Committees of the Board/Board Development					

Report Title:	**Chair's Report to Board**				Agenda Item no.	6.2
Meeting:	**Board**	Public	x		Meeting Date:	30th March 2023
		Private				
Status *(please tick one only):*	Assurance		Approval	x	Information	x
Lead Executive:	**Chair of the Board**					
Report Author (Title):	**Head of Corporate Business**					

Main Report
Background and current situation:

Mental Health Services for Older People

The Mental Health Services for Older People (MHSOP) directorate provides person centred, inter-disciplinary care to meet individual needs, support choice and enhance wellbeing for people with a dementia or functional severe mental health illness after the age of 65.
Services span community and inpatient settings.

Inpatients University Hospital Llandough (UHL)

There are 5 inpatient wards based in UHL. There are currently 4 wards providing care for patients requiring assessment and treatment associated with a dementia, and one ward providing care for patients with a functional mental health need.

Inpatient stays tend to be longer than in general hospital settings, due to a large proportion of our patients requiring move on to alternative appropriate placements e.g. residential or nursing care, or requiring packages of care in their own home; both of which are dependent on availability within the care setting. Average MHSOP bed occupancy is currently 92 days
UHL wards have been designed in line with dementia standards and tend to feel less clinical. There are large communal lounge and dining areas, as well as smaller cosy lounge areas. Half of the patient bedrooms are ensuite.

Each ward has an Activities nurse, and multi-disciplinary staff including therapy and psychology teams working alongside ward staff. Charitable funds have been used to bring in activities and entertainment, including Rubicon Dance, Forget me Not Chorus and Art therapists. East 12 has recently appointed a Natural Waking Rehab Assistant, who supports patients with a dementia to wake up naturally. This has allowed a more flexible meal service, supports restful sleep and an increased focus on ensuring that people who sleep in are encouraged and assisted to eat whenever they wake. A pilot project last year found that staff anecdotally reported fewer episodes of the behavioural and psychiatric symptoms of dementia during the morning period. We hope to expand this post across all dementia wards.

The 5 wards are also supported by two newly appointed Practitioner Psychologist posts, who provide a psychological approach to care, with direct psychological assessments and interventions, cognitive and neuropsychological assessments, staff and multi-disciplinary consultation and supervision, innovation, service/systems improvement work, staff skills training, research and audit, and team reformulations.

Recognising the prevalence of physical health co-morbidities in our patient cohort, we have a Senior Nurse for Physical Health care and support from the Mental Health Salaried GP service.

Due to improvements in community care supporting the Care at Home approach, patients who are admitted tend to be more acutely unwell than they may have been 5-10 years ago, and therefore we have seen an increase in the levels of observations needed on a 24 hour basis across all of our wards. The directorate also has a Young Onset Dementia ward (St Barruc) in Barry, detailed further in this report.

Community Services

Community services are co-located within the Llanfair unit, UHL. There are currently 96 staff working within this service. The teams are:

Community Mental Health Team (CMHT). The CMHTs are separated into Localities; Cardiff North and West, South and East and Vale of Glamorgan. Staff from Cardiff Local Authority, Vale Local Authority and CVUHB are co-located within the Llanfair Unit and provide a multidisciplinary approach to the assessment, support and treatment of individuals with severe mental ill health, using a range of therapies, skills and social interventions; in order to promote and enable a person's recovery and mental wellbeing.

Caseloads within the CMHTs have increased significantly over the last 5 years. Individual caseloads currently average 25, although this has often fluctuated during the period to 28 because of staff vacancies and absence cover.

Outpatients. The MHSOP Medical teams are also based within the CMHT Llanfair Base. Since Covid, the Outpatient clinics that used to be held on St David's Hospital, Barry Outpatients and CRI have not been made available to MHSOP patients therefore outpatient services have been located in Day Hospital, Hafan Y Coed, and Llanfair unit. It is hoped that an expansion of the Community Team base will shortly provide a permanent outpatient facility in-house.

Care Home Liaison Team. The Care Homes Liaison Teams' role is to promote the mental health and well-being of residents in care homes through timely assessment and interventions that include diagnosis, psychological work, medication review, education and training. The ultimate aim is to maintain placements and prevent hospital admission.

Community Liaison Nurses MHSOP. The Community Liaison Nurses bridge the gap between Primary care and Secondary mental health services to enhance the integration between physical, mental health and social care. The ultimate aim is to identify older people with mental health needs at the earliest stage in order to offer timely specialist advice, support and appropriate short–term interventions

REACT. The REACT Team offer high intensity home treatment and crisis support on a short-term basis. Offering rapid assessment and intensive bio-psycho-social interventions to patients in mental health crisis, the aim is to avoid admission and support early or complex discharge. As with the CMHT, caseloads have increased significantly, particularly over the last 6-12 months, with the team currently supporting 43 patients. Staff from 4 other teams are currently supporting REACT to evaluate and manage this high caseload.

GP Helpline. This is a direct telephone line for GPs requesting 4-hour emergency or 48-hour urgent mental health assessment. Patients may be referred to REACT for urgent support, or discussed in the Single Point of Entry meetings, to determine the most appropriate pathway for care and support.

Single Point of Entry (SPOE). The SPOE has been running for two years, and is a daily referral meeting to discuss all new or re-referrals coming into the community teams. This includes patients coming back into

service through part 3 of the Mental Health Measure. There is multi-disciplinary support to the meeting, where referrals are discussed and signposted appropriately, to avoid duplicity or inappropriate referrals.

Other Services

Dementia Care Training Team. This team sits within MHSOP but supports the wider UHB, Local Authority and Third Sector services. The team is funded from the Regional Partnership Board (RPB). The purpose of the team is to consider and develop dementia care training as a structured approach within health, social and third sectors across Cardiff and the Vale of Glamorgan, utilising the Good Work Framework. The Dementia Care Training Team's main aim is to promote evidence-based person-centred care to be embedded within practice, in all dementia care environments, through a structured Dementia Training Plan. The Training Team is supported by the Dementia Care Mapping Team.

Dementia Care Mapping Team. This small RPB-funded team enables Dementia Care Mapping as a person-centred dementia approach process within health, social and third sectors across Cardiff and the Vale of Glamorgan. Dementia Care Mapping will support the Dementia Care Training Team Initiative to promote person centred care to be embedded within practice.

Liaison Team for Older People (LPOP). The LPOP team provides Rapid Assessment Interface and Discharge from general hospital. Working closely with teams across UHW, Barry, St David's and UHL hospitals, they provide expert assessment, advice and support in caring for patients who have mental health needs associated with a dementia or functional mental illness and who often will present with very challenging behaviours. They provide training and support to ward teams as well as direct patient support, and also support Holme Towers.

Solace. The Solace team is based in Park Road in Whitchurch. They support unpaid carers and those they care for, by meeting their changing needs through listening and adapting support that is offered in the form of emotional support, education and information. This is met by means of face-to-face meetings, support groups or by telephone.

Patient Flow. The Patient Flow team consists of a nurse Team Lead and 4 part-time Social Workers who support patients in moving out of hospital and settling into their next residences. The Team lead also works with the UHB Patient Flow team and across MHSOP Community services to identify where flow may need evaluating or improving.

Young Onset Dementia Service. The Young Onset Dementia Service works collaboratively with people diagnosed with young onset dementia (diagnosed before the age of 65) and their families, ensuring continuity of care and responsiveness to often rapidly changing physical, psychological and social needs. The Community team is co-located with the St Barruc inpatient ward in Barry Hospital, and as well as seeing patients and families at home they support patients transitioning in and out of hospital, patients in care home settings and with respite arrangements. St Barruc Ward is a 14-bed ward for patients with a Young Onset Dementia. The ward is split into three separate units; a male, female and mixed unit.

Training and Development

The Directorate encourages innovation and development. The Directorate Management Team includes a **Lead Nurse Practitioner**, with responsibility for facilitating the development and practice of evidence-based care, specifically in the use of psychologically based interventions, and to provide formal and informal teaching, support and clinical supervision to nursing staff and other healthcare professionals. There is also a part-time **Innovation and Transformation Lead**, who provides liaison with Third Sector partners and manages the development and implementation of new posts such as

Peer Workers and manages large-scale innovative training and implementation of Open Dialogue and Care Aims.

There are four part-time **Clinical Nurse Specialists**, for Family Work, Dementia, Depression and Anxiety and Psychosis. These individuals inform and support MHSOP ward and community colleagues in increasing access to psychological care and interventions, whilst promoting patient-centred care for individuals

There are four **Dementia Care Advisors**, who provide specialist assessment, evidence-based intervention, advice and support for service users, carers and families as well as advice and support to professional colleagues on the care management of people with severe and unstable mental health conditions associated with a dementia.

A **Functional Care Advisor** post is currently being advertised and will provide a similar role across community and inpatient services.

MHSOP Peer Workers for Carer Support and the Psychosis service are currently being recruited to. These valuable roles are part of the Recovery and Wellbeing College and use a lived-experience of services to engage with service users and / or carers in a co-productive style to understand their current personal experiences and be able to represent and be a voice for their peers. This will entail supporting other to contribute to service development and in developing links across third sector organisations.

Open Dialogue. The directorate has been supported to participate in the training and implementation of the Open Dialogue approach. This is a ground-breaking approach to working with people embedded, not divorced from, their social context to make sense of their experiences and distress. This approach offers both a way of organising care and a therapeutic practice enabling a strong emphasis on independence and long-term recovery.

Care Aims. The service is working towards a Care Aims approach to outcome identification and measurement. The Care Aims Intended Outcomes Framework is a Service Improvement model and is a population-based, person-centred approach to provision of services that reflects the Prudent Healthcare agenda.

Suicide Mitigation and Awareness. The Suicide Awareness training programme is designed to train staff in the latest evidence-based principles and best practice in suicide awareness and mitigation of risk. The training is comprehensively peer reviewed by international experts in self-harm and suicide prevention, people with lived experience, practitioners and third sector experts.

Cardiff and Vale UHB are the only health board currently rolling out the '4 Mental Health' Training on suicide mitigation, At present, post course feedback from staff has been extremely positive.

Achieving Psychological Wellbeing (APW). The APW course has been developed within MHSOP and is offered to all directorate staff. It provides a multidisciplinary foundation-level introduction to supporting people with functional mental health challenges, particularly those experienced by patients of an older age.

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

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

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

Seal No.	Description of documents sealed	Background Information
1031	Lease of Unit B5, West Point Industrial Estate	A five year lease between (1) MLI NO 1 Propco Limited and (2) CVUHB
1032	Deed of Easement	Deed of easement between (1) CVUHB and (2) The County Council of the City and County of Cardiff for the granting of access rights for a cycle path at the University Hospital of Wales.

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

Date Signed	Description of Document	Background Information
03.01.2023	NEC 3 Short Form Construction Contract	NEC3 - 2D Building - EU Refurbishment (Phase 1) between (1) CVUHB and (2) 2D Building Contractors
03.01.2023	NEC 3 Short Form Construction Contract	NEC3 Short Contract between (1) CVUHB and (2) Jackson Lift Services Ltd for refurbishment of lifts 8 and 9 UHW
06.01.2023	National Institute for Health and Care Excellence ('NICE') Call off Contract	A call of contract between (1) NICE and (2) CVUHB for the provision of External Assessment Centre services.
09.01.2023	NEC 3 Short Form Construction Contract	NEC3 Short Contract between (1) CVUHB and (2) Carter Synergy Limited for Boiler 2 replacement at UHL
10.01.2023	NEC 3 Short Form Construction Contract	NEC 3 Short Contract for the demolition of Park View Health Centre between (1) CVUHB and (2) Bond Demolition Limited
19.01.2023	Investigator Study Agreement	An Investigator Study Agreement between (1) Abbott Laboratories and (2) CVUHB for the supply of materials to support a Health Board led clinical study.
02.02.2023	Research and Development Funding Letter Agreement	A letter agreement between (1) Secretary of State for Health and Social Care and (2) CVUHB to support funding of the PICCOS Clinical Trial (PIPAC in Cancers of the Colon, Ovaries and Stomach).
03.02.2023	NEC 3 Short Form Construction Contract	NEC 3 Short Form Contract between (1) CVUHB and (2) 2D Building Contractors for the refurbishment of the UHW Emergency Department Male Locker Room.

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

Chair's Action was taken in relation to:

Chair's Actions						
Date Received	Chair's Action Details	Background Recommendation Approved	Date Approved	IM Approval		Queries Raised by IMs
				IM 1	IM 2	
05.01.23	Contract for Electrical Generator Surveying Services	Approval of expenditure totaling £719,335.38 Incl VAT	05.01.23	Mike Jones 05.01.23	Ceri Phillips 05.01.23	N/A
06.01.23	Contract for Refurbishment Works at Ward C5 to allow the relocation of Cardiothoracic Services from UHL to UHW.	Approval to incur expenditure totaling: £1,000,974.20 inclusive of VAT	11.01.23	John Union 09.01.23	Mike Jones 10.01.23	N/A
30.01.23	Lease of Unit B5, West Point Industrial Estate between (1) MLI NO 1 Propco Limited and (2) CVUHB	Approval to enter into and apply the UHB Seal to a 5-year lease of Unit B5, West Point Industrial Estate	02.02.23	Rhian Thomas 30.01.23	John Union 30.01.23	N/A
03.02.23	Deed of easement between (1) CVUHB and (2) The County Council of the City and County of Cardiff for the granting of access rights for a cycle path at the University Hospital of Wales.	Approval to enter into easement and apply UHB Seal.	15.02.23	Ceri Phillips 03.02.23	Mike Jones 03.02.23	N/A
08.02.23	Approval of contract increase in relation to the Cardiff Edge Genomics Project.	Approval of expenditure totaling £1.21 million as previously approved by the Capital Management Group.	09.02.23	John Union 08.02.23	Rhian Thomas 08.02.23	N/A
17.02.23	Contract for Clinical Pathways Interface and Implementation Support – Hospital Pathways	Approval of expenditure totaling £1,156,909.00 plus VAT	20.02.23	Mike Jones 17.02.23	Ceri Phillips 20.02.23	N/A

21.02.23	Contract for Non-Hazardous Waste Services	Approval of expenditure totaling £991,678.66	28.02.23	John Union 21.02.23	Rhian Thomas 21.02.23	N/A
21.02.23	Contract for Local Trauma Consumables	Approval of expenditure totaling £2,183,846.64 plus VAT	23.02.23	David Edwards 21.02.23	Michael Imperato 21.02.23	N/A
21.02.23	Contract award for Fixed Wire Services	Approval of expenditure totaling £763,343.83 Incl VAT	28.02.23	Mike Jones 22.02.23	Ceri Phillips 22.02.23	N/A

The Board are requested to:

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

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

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

Report Title:	**Chief Executive's Report to Board**				Agenda Item no.	6.3	
Meeting:	Public Board Meeting		Public	x	Meeting Date:	30th March 2023	
			Private				
Status *(please tick one only):*	Assurance	x	Approval		Information		x
Lead Executive:	Chief Executive						
Report Author (Title):	Head of Corporate Business						

Main Report Background and current situation:

The 30th March 2023 is close to my first anniversary as Chief Executive here at Cardiff and Vale University Health Board (the 'HB') and I thought that this report to Board is an ideal opportunity to spot light some of the key developments and initiatives that have been launched during my first year.

My first year has been so enjoyable and I now feel well and truly part of the team. I have met many new colleagues and joined great teams and I want to thank everyone for your guidance and kindness and for supporting me with such great enthusiasm for sharing your expertise and knowledge.

The last year also presented many challenges which I have covered in some detail in my most recent reports to Board. Some of those challenges continue and no doubt I will return to them in the future but it is important to keep an eye on the "tomorrow", celebrate success and maintain a balanced perspective. The report covers many great initiatives, which reminds us all that so much fantastic work goes on everyday right across the HB. Sadly, it is not possible to mention every success here but those shared below are indicative of the quality of the work and the commitment of Team CAV.

As I have remarked before, I am full of gratitude, admiration and respect for the tremendous dedication, professionalism and creativity shown all across the HB as colleagues respond to the health and care needs of the population in often very demanding circumstances.

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

Genomics. Advances in medical science means that genomics is amongst the most exciting areas of 21st century healthcare, allowing opportunities to better understand illness, improve patient outcomes and transform lives.

Genomics Partnership Wales, of which our All Wales Medical Genomics Service is a key partner, and for which I am very proud to be the Senior Responsible Officer (SRO), has been granted Welsh Government approval and funding to develop the a centre of excellence at Cardiff Edge Life Sciences Park in Coryton, which is due to open later this year and will be home to a national genomic health, research and innovation hub.

It will deliver precision medicine and public health services along with diagnostics and innovations using emerging methods, tools and technologies as we shape the future of modern medicine. The Genomics Delivery Plan for Wales details how Genomics Partnership Wales will continue to harness advances in our understanding and application of genomics to transform public health strategy and delivery of care.

Syndrome Without a Name (SWAN). This year has seen the opening of Britain's first SWAN Clinic at the University Hospital of Wales (UHW) which is huge milestone for our patients, the HB and wider medical research.

The service was commissioned by Welsh Health Specialised Services Committee (WHSSC) and funded by Welsh Government, the SWAN Clinic has been established to improve pathways for people living with rare, undiagnosed conditions across Wales. Although these diseases are by their nature individually rare, they are collectively common with 1 in 17 people being affected by a rare disease at some point in their lifetime - equating to around 175,000 people across Wales. There are thousands of known rare diseases that affect both children and adults, but some are so uncommon and difficult to diagnose they are known as a 'syndrome without a name' or SWAN. This innovative new service gives clinicians, patients and their families the opportunity to make diagnosis and therapeutic and supportive plans together thus improving lives and addressing the distress of being "undiagnosed".

Robotic Surgery. This year saw the first patients undergo robotic assisted surgery in Wales under an innovative national programme. The state-of-the-art surgical robots enable surgeons to perform complex procedures precisely and accurately and are supporting the treatment of colorectal and gynaecological cancer patients in Wales as part of the National Robotic Assisted Surgery Programme.

The National Robotic Assisted Surgery Programme was introduced to improve outcomes for cancer patients by increasing the number of patients across Wales who have access to less-invasive, minimal access surgery (MAS). MAS offers well-recognised benefits to the patients, when compared to open surgery, including reduced pain, scarring and recovery time.

Frailty Zone. This initiative has seen the launch of a new 'Frailty Zone' in University Hospital Wales with 12 beds for patients identified as "frail". It provides specialist consultant geriatrician input to ensure patients get the right support at the front door.

The introduction of the Zone is a new and permanent service that will help to enhance patient experience by identifying and supporting patients in the urgent care pathway who will benefit from this specialist input. The service also promotes independence, avoids unnecessary hospital stays and enables those who need admission to get to the right bed, first time. The Zone will also help to reduce challenging practices, such as night moves for frail patients.

This is the first step to providing specific care to frail patients within the urgent care pathway with an hospital setting and will be followed by other service enhancements in line with the Six Goals for Urgent and Emergency Care Programme.

Vanguard Theatres. In order to accommodate the growing number of patients requiring cataract operations the HB continue to work with regional partners to improve ophthalmology services and models of care. There has been a need to innovate the way services are delivered to reduce waiting times and improve outcomes for patients.

To reduce the overall number of patients waiting for day surgery, the HB took a targeted approach which identified the need for a new ophthalmic hub to significantly reduce the number of patients waiting for cataract operations. After successfully securing funding from Welsh Government the Ophthalmology Team was able to establish two state-of-the-art mobile ophthalmology theatres at UHW.

These bespoke theatres house a reception, consultation room, staff wellbeing facilities and a short-stay ward. This allows the entire patient journey to take place within the hub, with no need to visit the main hospital building enabling an efficient and safe flow of patients. The team are now working to

increase cataract activity through the mobile theatres and to serve an increasing number of patients from across Southeast Wales thus assisting the Planned Care Recovery Programme and ensuring as many patients as possible can benefit in a timely way.

Wellbeing Hubs - Improving the provision of care in the Community. This year has seen Whitchurch Road Surgery and Maelfa Wellbeing Hubs officially open their doors to patients at the new state of the art medical centres.

Whitchurch Road Surgery Wellbeing Hub has introduced additional consulting rooms and capacity, dedicated treatment areas, including space for minor surgery, a spacious and comfortable reception and an on-site pharmacy. Supporting the practice to deliver primary care services for the community, the new building will give the practice team the modern space it needs to expand the range of services it is able to provide to its registered patients.

The new Maelfa Hub, which replaces the Llanedeyrn Health Centre, boasts additional clinical space in the form of fifteen consulting rooms, six treatment rooms and four interview rooms as well as housing a range of specialised health clinics including support services for children and younger people, antenatal care and counselling.

These initiatives are supportive of the HBs strategy and in reinforcing the delivery of treatment and care out of hospital within the heart of the Community.

Urgent Primary Care Centres. Three Urgent Primary Care Centres are now well established across Cardiff and the Vale of Glamorgan and planning is in train to prepare business cases for further centres. Urgent Primary Care Centres are helping patients who require urgent care to receive the right support, from the right place, first time. With a multi-disciplinary team made up of GPs, Advanced Practice Nurses, Pharmacist Independent Prescribers, Physiotherapists and Mental Health Practitioners, patients are able to be seen at an Urgent Primary Care Centre and receive the support they need in a timely manner, thus offering urgent care access closer to home and avoiding the need for a visit to hospital

New Surgical Same Day Emergency Care Unit (sSDEC). My first year has seen a new sSDEC unit open at UHW. The aim of the state-of-the-art multidisciplinary unit is to speed up the process of diagnosis and treatment for patients with acute surgical problems, allowing many patients, who previously would have been admitted to hospital, to return home or on the same day.

The sSDEC was built to allow speciality teams from across General Surgery, Urology, Ear, Nose and Throat (ENT), Maxillo-Facial Surgery and Ophthalmology to receive referrals directly from GPs, NHS 111 Wales, the Emergency Unit (EU) and paramedics, avoiding the need for many of these patients to wait in EU. sSDEC has had a significantly positive impact on the performance of the Urgent and Planned Care systems and has helped set the agenda for the development of further SDEC within the HB and more widely across Wales.

The first baby born in Wales using new climate-friendly gas and air technology. Anne-Marie Leaman was the first in Wales to give birth using new climate-friendly gas and air technology, when she had her child Hudson. The HB is committed to embedding sustainability into healthcare systems and the use of the new green technology marks a significant milestone in reducing nitrous oxide emissions.

Entonox, commonly known as gas and air, is a combination of nitrous oxide and oxygen and it is commonly used in healthcare. Nitrous Oxide is considered a harmful greenhouse gas with studies showing that it has more than 265 times the global warming potential than carbon dioxide.

The HB has worked closely with patients and staff on the implementation of Entonox Reduction Units. Patients and staff have demonstrated great enthusiasm and commitment towards reducing environmental impacts and embracing new methods of care.

Horatio's Garden Launch. Alongside its official charity, Cardiff & Vale Health Charity, the Health Board celebrated the opening of Horatio's Garden in the Spinal Injury and Neuro Rehabilitation Centre at University Hospital Llandough.

To support the creation of the garden, the HB provided the land, and the Health Charity significantly contributed to the development of the site and its upkeep.

The garden was designed by two-time RHS Chelsea Gold Medal winner, Sarah Price, with the patients and families of those with life-changing injuries in mind. Horatio's Garden is the first of its kind in Wales with the accessible garden space available for patients, staff and visitors to enjoy throughout the year. Rugby legend Sir Gareth Edwards, officially open the green sanctuary which helps patients in their recovery and being closer to nature.

Using Artificial Intelligence within Colonoscopy to improve patient outcomes. The HB is leading a landmark clinical research study that is identifying the benefits to both patients and clinicians of using image enhancement and artificial intelligence within colonoscopy examinations.

The research, which is supported by the National Institute of Health Research, Wales Cancer Research Centre, and Cardiff University, is using a computer assisted detection and diagnosis system when conducting bowel screening in an effort to improve polyp and cancer detection rates.

Colonoscopy is an important tool for the identification and removal of pre-cancerous and cancerous polyps, but its effectiveness and quality are highly dependent on polyps not being missed during examinations. As a result, the clinical research study is using artificial intelligence to act as a second pair of eyes during the procedure to identify and diagnose polyps.

The clinical research trial is a 6-year project in which the team hope to demonstrate the effectiveness of the equipment in bowel cancer detection rates to build a healthcare economic case for its further use and spread.

Cardiff Neuro-Oncology Centre awarded Tessa Jowell Centre of Excellence status. The Cardiff Neuro-Oncology Centre has been awarded the Tessa Jowell Centre of Excellence status by the Tessa Jowell Brain Cancer Mission.

The Cardiff Neuro-Oncology Centre, which comprises of UHW, Velindre Cancer Centre and Cardiff University, was recognised for its exemplary commitment to service development and improvement.

The committee praised the rigour and dedication of the team in developing the service, and commended its impressive rehabilitation pathway and enthusiasm. It has shared its best practices through the Tessa Jowell Academy for other centres to learn from. This year, six NHS brain centres across the UK were awarded the status. There are now 17 Centres of Excellence across the UK and the mission hopes that over time, every brain tumour centre in the UK becomes a Centre of Excellence and continues to raise the standards of excellence.

New Pelvic Health Hub at Barry Hospital is first of its kind in Wales. This year has also seen the HB Board launch a new service that will significantly improve treatment for people with pelvic floor disorders.

The Pelvic Health Community Hub is based in the Outpatient Department at Barry Hospital and delivers patient-focused support, advice and treatment options for the management of pelvic organ prolapse, incontinence and bowel dysfunction.

The first of its kind in Wales, the new hub provides a multidisciplinary approach to patient care consisting of consultant colorectal surgeons, uro-gynaecologists, urologists, physiotherapists, dietitians, clinical nurse specialists, continence advisors and a pain management team. The hub is also able to provide Sacral Nerve Stimulation which can successfully treat incontinence in up to 75 per cent of patients and the Pelvic Health Community Hub is the first centre in Wales to offer this treatment option.

Recommendation:

The Board are requested to:

NOTE this overview of first anniversary key achievements headlines.

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

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

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant

Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x

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

Risk: No
Safety: No
Financial: No
Workforce: No
Legal: No

Reputational: Yes	
This report outlines reputationally positive activities and outcomes.	
Socio Economic: No	
Equality and Health: No	
Decarbonisation: No	
Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Report Title:	Board Assurance Framework 22-23 – March 2023				Agenda Item no.	6.4	
Meeting:	Board		Public	x	Meeting Date:	30th March 2023	
			Private				
Status *(please tick one only):*	Assurance	x	Approval		Information		
Lead Executive:	Director of Corporate Governance						
Report Author (Title):	Director of Corporate Governance						

Main Report
Background and current situation:

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

Each year the Management Executive Team agree which significant risks will impact upon the delivery of the Cardiff and Vale UHBs Strategic Objectives. This discussion took place at Management Executives on 9th May 2022 in addition to this a further six risks were added to the BAF and agreed at the November 2022 Board meeting for the financial year 2022/23:

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

These risks are all detailed within the attached BAF.

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

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

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

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

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

Assurance is provided by:

- Discussion with Executive Directors on progress being made against the management and mitigation of risks which they lead upon on the BAF.
- Discussion at the various Committees of the Board on the risks allocated to them for review.

Recommendation:

The Board are requested to:

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

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

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

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant

Prevention	✓	Long term		Integration		Collaboration		Involvement	

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

Risk: Yes/~~No~~

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

Safety: Yes/~~No~~

There is a risk within the BAF on Patient Safety which also details the impact.

Financial: Yes/~~No~~

There is a risk within the BAF on Financial Sustainability which also details the impact.

Workforce: Yes/~~No~~

There is a risk within the BAF on Workforce which also details the impact.

Legal: ~~Yes~~/No

Reputational: Yes/~~No~~

Having a non-approvable IMTP will impact upon the reputation of the Health Board

Socio Economic: Yes/~~No~~
There is a risk on the BAF on Health Inequalities these inequities have significant social and economic costs both to individuals and societies.
Equality and Health: Yes/~~No~~
As above
Decarbonisation: ~~Yes~~/No

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

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 IMTP for 2022-25.

Strategic Objectives	Key Risks Mapped to Delivery of Strategic Objective
1. Reduce health inequalities	• Sustainable Cultural Change • Exacerbation of Health Inequalities • Patient Safety • Delivery of IMTP 22-25 • Planned Care • Cancer • Stroke • Critical Care • Maternity
2. Deliver outcomes that matter	• Patient Safety • Sustainable Cultural Change • Exacerbation of Health Inequalities • Delivery of IMTP 22-25 • Capital Assets • Financial Sustainability • Urgent and Emergency Care • Planned Care • Cancer • Stroke • Maternity
3. Ensure that all take responsibility for improving our health and wellbeing	• Sustainable Cultural Change • Wellbeing of staff • Workforce
4. Offer services that deliver the population health our citizens are entitled to expect	• Workforce • Exacerbation of Health Inequalities • Patient Safety • Delivery of IMTP 22-25 • Urgent and Emergency Care • Planned Care • Cancer • Stroke • Critical Care • Maternity
5. Have an unplanned care system that provides the right care, in the right place, first time.	• Financial Sustainability • Patient Safety • Exacerbation of Health Inequalities • Workforce • Urgent and Emergency Care • Stroke • Critical Care
6. Have a planned care system where demand and capacity are in balance	• Workforce • Exacerbation of Health Inequalities • Patient Safety • Financial Sustainability • Planned Care • Cancer • Critical Care

7. Reduce harm, waste and variation sustainably so that we live within the resource available	• Patient Safety • Exacerbation of Health Inequalities • Capital Assets
8. Be a great place to work and learn	• Workforce • Sustainable Cultural Change • Wellbeing of staff
9. Work better together with partners to deliver care and support across care sectors, making best use of people and technology	• Workforce • Delivery of IMTP 22-25 • Sustainable Cultural Change • Exacerbation of Health Inequalities • Urgent and Emergency Care • Digital Road Map
10. Excel at teaching, research, innovation and improvement.	• Workforce • Sustainable Cultural Change • Wellbeing of staff • Digital Road Map • Delivery of IMTP 22-25

Key Risks

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

Risk	Risk Appetite	Corp Risk Register Ref.	Gross Risk *(no controls)*	Net Risk *(after controls)*	Change from Nov 22	Target Risk (*after actions are complete)*	Context	Executive Lead	Committee
1. Patient Safety	Open	1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 18, 19, 20, 21	**25**	**20**		**10**	Patient safety should be the first priority above all else for the Cardiff and Vale University Health Board. Safer patient care includes the identification and management of patient-related risks, reporting and analysis of patient safety incidents, concerns, claims and learning from such then implementing solutions to minimise/mitigate the risk of them recurring.	Executive Nurse Director/ Executive Medical Director /Executive Director for Therapies and Health Science/ Chief Operating Officer **Last Reviewed:** 03.03.23	Quality, Safety and Experience **Last Reviewed:** 07.03.23
2. Maternity	Cautious	14, 15, 16	**25**	**20**		**15**	The recommendations of the Ockenden Review into maternity services in England were published at the end of March 2022. The Ockenden review and its recommendations is very much in the public domain and attracted significant coverage from the media. Becoming compliant with the Ockenden requirements also brings opportunity benefits such as full compliance with the Cwm Taf and other formal reviews recommendations and achieving BAPM compliance in the Neo-Natal Unit.	Executive Nurse Director/ Executive Medical Director/ Chief Operating Officer **Last Reviewed:** 03.03.23	Quality, Safety and Experience **Last Reviewed:** 07.03.23

3. Critical Care	Cautious	18, 19, 20	**25**	**20**		**10**	For a sustained period prior to the COVID19 pandemic there were recognised critical care capacity challenges in CAV. The sustainability of Critical Care Services in Cardiff is reported in the 2014 unmet needs study WG, and the 2019 FICM external review. Following the COVID19 pandemic these challenges remain and still needs to be addressed. Critical care department capacity is not in a position to deliver a sustainable service to the population it serves.	Executive Nurse Director/ Executive Medical Director/ Chief Operating Officer **Last Reviewed:** 03.03.23	Quality, Safety and Experience **Last Reviewed:** 07.03.23
4. Cancer	Cautious	7, 9	**20**	**15**		**10**	One of the Health Board's Strategic Objectives is to have sustainable cancer services that deliver the single cancer pathway standard to treat patients with a confirmed diagnosis of cancer within 62 days. To achieve this, the system needs to ensure sufficient capacity is prioritised to meet the predicted weekly demand for cancer patients at the outpatient, diagnostic and treatment stages of the pathway whilst also being sufficiently flexible to respond to peaks and troughs in demand. The recently published Welsh Government Planned Care Plan, the Wales Cancer Network's Quality Statement and the emerging Wales Cancer Network's Improving Cancer Services and Outcomes Action Plan reflect the high priority of cancer services.	Executive Nurse Director/ Executive Medical Director/ Chief Operating Officer **Last Reviewed:** 03.03.23	Quality, Safety and Experience **Last Reviewed:** 07.03.23
5. Stroke	Cautious		**20**	**15**		**10**	Stroke services within C&V UHB have declined since the COVID pandemic, caused by a reduction in clinical services, but an increase in demand, most noticeably in patients self-presenting to the Emergency Department. There has been a real drive to improve this service for the patients and improvement has been seen in thrombolysis rates, achieving >10% since June 22 and now at 10.9%. Challenges include patients self-presenting to ED, dilution of stroke cases within the very busy ED leading to delay in recognition of stroke, scanning	Executive Nurse Director/ Executive Medical Director/ Chief Operating Officer **Last Reviewed:**	Quality, Safety and Experience **Last Reviewed:** 07.03.23

							and treatment. Despite increased thrombolysis rates, door to needle times are not improving to pre-pandemic performance. There is often no dedicated Stroke medic at the front door meaning Medics are faced with competing given the capacity constraints within the footprint.	03.03.23	
6. Urgent and Emergency Care	Cautious	6, 8, 10	**20**	**15**		**10**	One of the Health Board's Strategic Objectives is to have a sustainable unplanned (emergency) care system that provides the right care, in the right place, first time. To achieve this, a whole system approach is required with health and social care working in partnership – both together and also with independent and third sector partners. The recently published Welsh Government Six goals for Urgent and Emergency Care span the whole pathway and reflect priorities to provide effective, high quality and sustainable healthcare as close to home as possible, and to improve service access and integration. The impact of the covid pandemic has had many consequences. This includes sustained pressure across the urgent and emergency care system and, whilst underlying actions to progress the plans to achieve the strategy have progressed, covid-19 has impacted on the speed of ongoing action and implementation of plans. The Sustainable Primary and Community Care risk reported in 2021/22 has been incorporated into this newly reported risk for 2022/23.	Executive Nurse Director/ Executive Medical Director/ Chief Operating Officer **Last Reviewed:** 03.03.23	Strategy and Delivery Committee **Last reviewed:** 14.03.23
7. Planned Care	Cautious		**16**	**12**		**8**	One of the Health Board's Strategic Objectives is to have sustainable planned care services that deliver the ministerial measures of no-one waiting >52 weeks for a new outpatient appointment by December 2022 and no-one waiting >104 weeks for treatment (all stages) by March 2023. To achieve	Executive Nurse Director/ Executive Medical Director/	Quality, Safety and Experience **Last Reviewed:** 07.03.23

							this, the system needs to ensure sufficient capacity to meet recurrent demand and to increase capacity and activity sufficiently above pre-Covid levels to make inroads into the backlog. The recently published Welsh Government Planned Care Plan reflects the high priority of planned care services.	Chief Operating Officer **Last Reviewed:** 03.03.23	
8. Exacerbation of Health Inequalities	Open		**16**	**12**		**12**	COVID-19 has compounded existing health inequalities in Wales, which have shown little improvement in the last ten years, based on the gap in life expectancy between the most and least deprived fifth of the population. Although the main disparities have been age, sex, deprivation and ethnicity, there is clear evidence of intersectionality, risk factors compounding each other to further disadvantage individuals with protected characteristics (based on the Equality Act 2010). As the granular level data emerges, there is no evidence to suggest that this pattern is not replicated fully at a Cardiff and Vale UHB level.	Executive Director of Public Health **Last Reviewed:** 03.03.23	Strategy and Delivery Committee **Last Reviewed:** 14.03.23
9. Workforce	Open	4, 6, 11, 16	**25**	**20**		**10**	Across Wales there have been increasing challenges in recruiting healthcare professionals and this situation has got worse over the last two years due to Covid 19. Meeting the requirements of a growing population which is older and with more complex health needs as well as increasing demand on health services has led for an increasing need in clinical staff. Staff costs represent the largest expense for the NHS in Wales. The pay bill has continued to increase year on year, with a significant increase over the last three years.	Executive Director of People and Culture **Last Reviewed:** 02.03.23	Strategy and Delivery Committee **Last Reviewed:** 14.01.23
10. Sustainable Culture Change	Open		**16**	**8**		**4**	In line with UHB's Strategy, Shaping Our Future Wellbeing and aligned to the Healthier Wales plan (2018), the case for change is pivotal to transfer our services to ensure we can meet our future challenges and opportunities. Creating a belief which continues to build upon our values and behaviours framework will make a positive cultural	Executive Director of People and Culture **Last Reviewed:** 02.03.23	Strategy and Delivery Committee **Last Reviewed:** 15.11.22

							change in our health system for our staff and the population of Cardiff and the Vale.		
11. Staff Wellbeing	Open	4, 6, 11, 16,	**20**	**15**		**5**	As a result of the global Covid19 pandemic, our employees have been exposed to unprecedented levels of psychological and physical distress both at home and in the workplace. Evidence indicates that, Healthcare workers are at greater risk of developing mental health problems as a result. The impact of this is unlikely to be experienced equally, with people with existing mental health difficulties and people from Black, Asian and minority ethnic communities among those who are likely to be affected disproportionately	Executive Director of People and Culture **Last Reviewed:** 02.03.23	Strategy and Delivery Committee **Last Reviewed:** 24.01.23
12. Capital Assets	Open	1, 2, 3, 4, 17, 19, 20, 23	**25**	**20**		**10**	The UHB delivers services through a number of buildings across Cardiff and the Vale of Glamorgan, from health centres to the Tertiary Centre at UHW. All NHS organisations have statutory responsibilities to manage their assets effectively: an up to date estate strategy is evidence of the management of the estate. The IT SOP sets out priorities for the next five years and Medical Equipment is replaced in a timely manner within the resources available, though backlogs for a proactive replacement programme remain.	Executive Director of Strategic Planning, Executive Director of Therapies and Health Science, Executive Director of Finance **Last Reviewed:** 01.03.23	Finance Committee & Strategy and Delivery Committee **Last Reviewed:** 24.01.23
13. Delivery of IMTP 22-25	Open	22	**20**	**15**		**10**	The Integrated Medium-Term Plan is the key planning document for the Health Board setting out the milestones and actions we are taking in the next 1 to 3 years in order to progress Shaping Our Future Wellbeing, our ten-year strategy. It is based on the health needs of our population, delivering quality services and ensuring equitable and timely access to services and sets out how we will deliver our mission Caring for People; Keeping People Well, and vision that a person's chance of	Executive Director of Strategic Planning **Last Reviewed:** 01.03.23	Strategy and Delivery Committee **Last Reviewed:** 24.01.23

							leading a healthy life is the same wherever they live and whoever they are.		
14. Financial Sustainability	Cautious	5, 22	**25**	**20**		**5**	Across Wales, Health Boards and Trusts are seeking to manage their financial pressures by driving out inefficiencies, while at the same time looking to derive greater value from their resources through innovative ways of working and practicing prudent healthcare. As well as the NHS, public sector services, the third sector, and the public have significant roles to play to achieve a sustainable health and care system in the future. Covid 19 has had a significant impact on the finances of Healthcare in Wales and the UHB has significant financial pressures to now deal with.	Executive Director of Finance **Last Reviewed:** 03.03.23	Finance Committee **Last Reviewed:** 15.02.23
15. Digital Strategy and Road Map	Cautious	23	**25**	**20**		**15**	CAV UHB board approved a five-year Digital Strategy in 2020 which set out the vision for supporting the organisation, from a digital and data perspective, for the period 2020-2025. Development of the strategy was clinically led and was designed to support the UHB's Shaping our Futures' strategic programmes. To realise the benefits contained with the accompanying roadmap, which sets out what we will do and when, requires significant additional investment to bring the organisation up to a level of digital maturity that can support our agreed strategic objectives.	Director of Digital Health Intelligence **Last Reviewed:** 03.03.23	Digital Health Intelligence Committee **Last Reviewed:** 14.02.23

Lines of Defence

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

Key:

(1) First Line of Defence – Management level assurance

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

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

Risk Appetite

Key:

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

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

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

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

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

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

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

Patient safety should be above all else for the Cardiff and Vale University Health Board. Safer patient care includes the identification and management of patient-related risks, reporting and analysis of patient safety incidents, concerns, claims and learning from such then implementing solutions to minimise/mitigate the risk of them recurring.

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

Actions		Lead	By when	Update since January 2023
1. Review of hospital acquired COVID 19 and COVID deaths (wave 1) being undertaken and monitored through Nosocomial C&V Programme Board.		Jason Roberts	30.04.23	Review has commenced early learning shared with operational colleagues and it is informing the development of the recovery plan Review of deaths continues in line with WG requirements with oversight from Nosocomial National Programme Board
2. Choices framework being utilised due to the quality of care and ability to provide safe care with current demand and pressures		Paul Bostock	31.03.23	Choice framework continues to be utilised
3. Programme of work in place and being led by the Chief Operating Officer, supported by Operational Teams to address the backlog		Paul Bostock	31.03.23 Review October 22	Programme currently been reviewed by COO
Impact Score: 5	**Likelihood Score: 2**	**Target Risk Score:**		**10 High)**

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

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

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

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

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

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

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

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

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

Current Assurances	• Operational position reported into Management Executive (Daily) (1) • Mechanisms in place to monitor key measures being strengthened into visible dashboard.(1) • Key operational performance indicators and progress against plans reported into the Maternity/Neonatal oversight Group being led by Executive Nurse Director. (1)		
Impact Score: 5	Likelihood Score: 4	Net Risk Score:	**20 (Extreme)**
Gap in Controls	• Confirmation of additional funding resource to fill gaps in assurance mapping • Recruitment strategies to sustain and increase multidisciplinary teams (appendix 1). • Developing an effective, high quality and sustainable model of managing intrapartum care and current constraints • Several incidents out of time		
Gap in Assurances	• Data and benchmarking information • Resources to meet the national recommendations		

Actions	Lead	By when	Update since January 2023
1. Ongoing recruitment above establishment, increasing training places	AJ	31/03/23	This action continues to take place.
2. Reviewing current obstetric practice in line with NICE guidance	CR/SZ	01/01/23	This action continues to take place.
3. Senior daily oversight of obstetric /Neonatal capacity and escalation to Executives	AJ	31/03/23	This action continues to take place.
4. Continued maternity / Neonatology oversight meetings with Executive lead	JR/AJ	31/03/23	This action continues to take place.
5. Ongoing review of job planning and consultant establishment	CR/AT	31/03/23	Job planning undertaken further resource required to meet Ockenden recommendations. Supporting revenue case to Board for approval 30/3/23
Impact Score: 5 / Likelihood Score: 3	Target Risk Score:		**15 (high)**

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

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

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

Current Assurances	• Operational position reported into OPAT [1] • Key operational performance indicators and progress against plans reported into the clinical board 6 weekly [1] • ICNARC audit to provide assurance on outcomes [2] • Plans in development to increase level 3 bed capacity by three beds during 2023/24.[1] • Project team established to address medium term infrastructure constraints.[1]		
Impact Score: 5	Likelihood Score: 4	Net Risk Score:	**20 (Extreme)**
Gap in Controls	Development and implementation of a capacity plan to address the 15-bed gap Achievement of standard to step down patients from ICU within 4 hours to improve efficiency and patient flow 24/7 PART team Development of a fit for purpose critical care unit (UHW2)		
Gap in Assurances	Able to meet the needs of the sickest or highest priority cases. Un-met not fully understood across the organisation.		

Actions	Lead	By when	Update since January 2023
1. Secure funding and develop implementation plan for further three ICU beds	PB	30/11/22	Funding not confirmed as at 03.02.23. Focus remains on utilising existing resource to rollout out to further clusters
2. Implementation of 24/7 PART team	PB	31/03/23	Plan developed. Funding not confirmed as at 03.02.23 and implementation on hold.
3. Implementation of the UHW site masterplan and critical care infrastructure programme a. Medium term development of additional cubicles and support facilities b. Development of a new unit as part of UHW2 development. c. Transfer of LTiV services to a bespoke facility in UHL	AH / PB	31.03.23	Implementation of de-escalation plan commenced – but behind timescale due to ongoing operational pressures and recent increase in covid admissions. Awaiting decision from WG on funding of stage 1 of the infrastructure programme
4. Ongoing development of recruitment and retention strategies	JR / RG	31.03.23	This piece of work continues
Impact Score: 5 Likelihood Score: 2	Target Risk Score:		**10 (high)**

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

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

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

Current Assurances	• Operational position reported into Cancer Oversight Meeting weekly tracking improvements(1) • Executive Cancer Board meets quarterly(1) • Mechanisms in place to monitor key schemes in Cancer as part of the Operational Delivery Plan (1) • Key operational performance indicators and progress against plans reported into the Strategy and Delivery Committee (1) • Breach reports produced for every patient treated >62 days (1) • Harm reviews conducted for every patient treated >146 days (1) • Cancer reported as part of the Board Integrated Performance report (1)		
Impact Score: 5	Likelihood Score: 3	Net Risk Score:	**15 (Extreme)**
Gap in Controls	• Continuation of demand/capacity work to inform how much capacity needs to be carved out for cancer • Undertake pathway work to streamline the journey for cancer patients and reduce the downtime between steps on the pathway • Recruitment strategies to sustain and increase multidisciplinary teams (see separate risk on workforce)		
Gap in Assurances	• Whilst a Cancer Oversight Meeting is in place, there is a need to establish a weekly PTL tracking meeting with General Managers/Directorate Managers • Breach reports need to be shared with the Directorates for validation and themes (e.g. risks/issues/constraints) need to be fed through a continuous improvement loop to ensure mitigation/solutions are put in place • The Cancer Strategy needs to be finalised and a workplan developed		

Actions	Lead	By when	Update since January 2023
1. Continue to develop and iterate the demand/capacity work	HE/JC	31.3.23	D&HI team are engaged in the work
2. Undertake a review of the key tumour site pathways with a view to removing constraints and delays in the patients' journey	RL	31.3.23	Support from the WCN to undertake a number of deep dives – focus on lung and urology initially
3. Establish a weekly PTL meeting with General Managers/Directorate Managers	JC	30.01.23	Now in place
4. Finalise the Cancer Strategy and develop a workplan	RL/BW	31.3.23	Draft strategy completed and is on the agenda for Exec Cancer Board in November
5. Development of recruitment and retention strategies	RG	31.03.23	See separate BAF risk on workforce
Impact Score: 5 / Likelihood Score: 2	Target Risk Score:		**10 (High)**

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

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

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

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

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

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

Actions	Lead	By when	Update since January 2023
1. Nursing Uplift Stroke CNS cover to 12 hour shifts 7 days per week. **Benefits** Increased out of hours CNS support to Code Stroke, facilitation of thrombolysis and thrombectomy treatment pathways, 4 hours admit target and nurse assessments. **Interdependencies / Risks** Capacity and flow, medical support	DP/NW/NT/TH	31/01/2023	This is being undertaken

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

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

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

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

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

Current Controls	• Development of Primary Care Support Team to provide proactive support to fragile practices • Plans agreed and implemented for contract resignations and list closures • Rollout of MDT cluster model to further 2 clusters (1 already implemented) • Urgent Primary Care hubs in the Vale – c.2500 appointments per month • Cardiff CRT and Vale CRT support people to remain at home, avoid hospital admission and be discharged from hospital – but challenges do remain on capacity and timeliness • Implementation of CAV24/7 and transition to NHS Wales 111 • Strengthened site-based leadership and management • Urgent & Emergency Care is one of the five delivery programmes in the 2022/23 Operational Plan. Delivery Group in place. Urgent and Emergency Care System Plan developed, aligned to the National six goals – see actions. • Ambulance handover improvement plan developed and being implemented • Workforce team continue to support recruitment and retention • Local Choices Framework governance in place and utilised when appropriate to support operational pressures		
Current Assurances	• Operational position reported into Management Executive (weekly) (1) • Mechanisms in place to monitor key schemes in Urgent & Emergency Care Operational Delivery Plan (1) • Key operational performance indicators and progress against plans reported into the Strategy and Delivery Committee. Specific focus on Six Goals for Urgent & Emergency Care on 12th July 2022. (1) • Urgent and Emergency Care reported as part of the Board Integrated Performance report (1)		
Impact Score: 5	Likelihood Score: 3	Net Risk Score:	**15 (Extreme)**
Gap in Controls	Actively scale up multidisciplinary cluster models Recruitment strategies to sustain and increase multidisciplinary teams (see separate risk on workforce) Developing an effective, high quality and sustainable Acute Medicine model Reconfiguring our in-hospital footprint to improve efficiency and patient flow		
Gap in Assurances	Whilst an Urgent & Emergency Care Delivery Group is in place, the Six Goals Integrated Urgent & Emergency Care Transformation Board is yet to be established		

Actions	Lead	By when	Update since January 2023
1. Secure funding and develop implementation plan for further MDT cluster rollout and Urgent Primary care Centre in Cardiff	LD	30.11.22	UPPC in Cardiff CRI went live in December. Further roll out in Cardiff North planned for Feb. MDT Cluster work is separate and ongoing.
2. Development and implementation of one Urgent and Emergency Care Plan, aligned to the National six goals	PB	31/10/22	Complete - Delivery Board relaunched in January, approach agreed at SLB in December.
3. Introduce Medical Same Day Emergency Care Unit moving to new area whilst introducing senior clinical triaging and hot clinics	PB	30.11.22	Complete -MSDEC moved to interim location.
4. Introducing frail assessment service in emergency and assessment area UHW	PB	30.11.22	Complete - Frail service went live.
5. Develop SOP for A1 (medical short stay ward) and SOP for Zero four-hour ambulance handovers	PB	30.11.22	Complete - Both actions implemented. A1 has led to improved turnaround, reduced length of stay and more patients admitted and discharge.

				Ambulance handover performance improved.
6. Develop cohesive Winter Plan that introduces 150 beds or bed equivalents		PB	30.11.22	Complete - Circa 150 beds / bed equivalents are being delivered through winter plan
7. Develop acute admission protocols		PB	30.11.22	Action ongoing – aim for completion in February.
8. Continued development of joint Health and Social Care strategies to allow seamless solutions and services for patients with health or social needs		AH / PB	31.03.23	Partnership working continues. Joint action plans in place. Work progressing through RPB, SLG and JME with new IMT introduced bi-weekly chaired by SR to increase focus on actions
9. Introduce integrated care assessment unit as part of the Winter Plan to discharge patients into UHW Lakeside for focused social care intervention whilst maintaining care.		PB	31.10.22 - 31.01.23	Complete - IACU opened in LSW. Reduced length of stay for MFFD patients – increasing from 27 to 41 patients in next two weeks.
10. Implementation of the UHW site masterplan, including de-escalation of additional capacity and reconfiguration of the EU		PB	31.03.23	Implementation of de-escalation plan commenced – but behind timescale due to ongoing operational pressures and recent increase in covid admissions.
11. Development of recruitment and retention strategies		RG	31.03.23	See separate BAF risk on workforce
Impact Score: 5	Likelihood Score: 2	Target Risk Score:		**10 (high)**

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

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

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

Current Assurances	• Current position against 52/104weeks monitored via weekly Planned Care Performance meeting (1) • Operational position reported into daily/weekly 'hot' reports(1) • Elective Care Delivery Group in place monthly; suite of metrics reviewed at every meeting (1) • Monthly meeting with the Delivery Unit on Planned Care(1) • Mechanisms in place to monitor key Planned Care schemes as part of the Operational Delivery Plan (1) • Key operational performance indicators and progress against plans reported into the Strategy and Delivery Committee (1) • Planned Care reported as part of the Board Integrated Performance report (1)		
Impact Score: 4	Likelihood Score: 3	Net Risk Score:	**12 (High)**
Gap in Controls	• Further demand/capacity work required together with an indication of the ministerial targets to inform the plan for 23/24 and assess deliverability • Availability of planned care funding may mean that choices need to be made in terms of delivery • Further work required to maximise treat in turn • Solutions required to ensure all specialities can access sufficient capacity to enable a return to pre-Covid levels of activity • Recruitment strategies to sustain and increase multidisciplinary teams (see separate risk on workforce)		
Gap in Assurances	• Since the Operational Plan Delivery Group meeting has been stepped down, there is a need to consider the governance mechanisms by which key risks and messages from the Elective Care Delivery Group are escalated • Whilst a sub-group on supporting patients whilst they are waiting has been established, the group is in its infancy and needs to progress at pace		

Actions	Lead	By when	Update since January 2023
1. Continue to develop and iterate the demand/capacity work for 23/24 to inform the IMTP	AW/JC	31.1.23	Included in development of IMTP
2. Establish key priorities and a work plan for the supporting patients sub-group	EC	31.12.22	Complete. Group is in place and meeting monthly. Two sub-groups have been established with work due to commence in January.
3. Continue to progress plans to maximise activity and monitor via the Planned Care Performance group	JC	Weekly	Complete - Meetings in place
4. Agree formal reporting mechanisms from the Elective Care Delivery group through to SLB	PB/HE	31.12.22	Under consideration as part of review of COO meeting structures Proposal taken to SLB on 22.12.22
5. Development of recruitment and retention strategies	RG	31.03.23	See separate BAF risk on workforce
Impact Score: 4 / Likelihood Score: 2	Target Risk Score:		**8 (High)**

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

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

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

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

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

	are not tailored towards reducing inequalities will fail to address the causes of increasing health inequality • The impact of inflation leading to the 'cost of living crisis' currently being experienced in the UK, with rising prices for energy (gas, electricity) and fuel (petrol, diesel) food and other goods and services has a negative impact on health as real disposable incomes fall with this being more marked in lower income households. High inflation also risks exacerbating mental health challenges with concerns about debt being a leading cause of anxiety
Impact	• The key population groups with multiple vulnerabilities, compounded or exposed by COVID-19, include: ○ Children and young people ○ Minority ethnic groups, especially Black and Asian populations ○ People living in (or at risk of) deprivation and poverty ○ People in insecure/low income/informal/low-qualification employment, especially women ○ People who are marginalised and socially excluded, such as homeless persons • Risk factors interact and multiple aspects of disadvantage come together, increasing the disease burden and widening equity gaps. Underlying chronic conditions, as well as unequal living and working conditions, have been found to increase the transmission, rate and severity of disease including COVID-19 • ~~COVID-19 and its containment measures (e.g. 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 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 • Winter 2022/23 is an uncertain time with concerns about resurgence of COVID-19 and/or influenza which disproportionately impact the most vulnerable in society, together with the economic impact of the rapid increase in inflation. This may mean that health inequalities widen if public policy and local interventions do not act to rectify this imbalance swiftly. However, most levers for economic action are at the UK government level. Warmth and food availability will be key issues locally

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

Current Controls	**1. Statutory function** The Socio-economic Duty places a legal responsibility on public bodies in Wales when they are taking strategic decisions to have due regard to the need to reduce the inequalities of outcome resulting from socio-economic disadvantage. Approaching implementation of the Socio-economic Duty effectively will help us maximise our contribution to addressing such inequalities, and also to meet our obligations under the Human Rights Act 1998 and international human rights law. Of note, but more of a reputational risk, if an individual or group whose interests are adversely affected by our strategic decision, in circumstances where that individual or group feels the Duty has not been properly complied with, they would have the right to instigate a judicial review claim against the UHB **2. Role as an Employer** • In our Equality, Inclusivity and Human Rights Policy, we have an active programme, which sets out the organisational commitment to promoting equality, diversity and human rights in relation to employment, and ensuring staff recruitment is conducted in an equal manner

	• Our Strategic Equality Plan 'Caring about Inclusion 2020-2024' has a number of key delivery objectives and is premised on the basis of embedding equality, diversity and human rights, and Welsh language, into UHB business processes, for example: Recruitment and Selection Policy, Annual Equality Report, Equality reports to the Strategy and Delivery Committee, Reports/Updates to the Centre for Equality and Human Rights, Outcome Report to the Welsh Government Equalities Team regarding sensory loss, provision of evidence to the Health and Care Standards self-assessment, Equality and Health Impact Assessments • All our Executives have taken up a leadership role across the nine protected characteristics specified in the Equality Act 2010 - age, disability, gender identity, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation - our CEO is the lead for race • In August 2022 the Chancellor recognised that support is needed even for staff on wages up to £45,000 and included senior nurses in this description to manage increased energy bills. Staff have been signposted to resources to help them to cope with the cost-of-living crisis this winter **3. Refocused Joint strategic and operational planning and delivery** • The refresh of the UHB Strategy Shaping our Future Well-being continues to shine a light on the issue of equity at the strategic level • Each of our strategic programmes within Shaping our Future Well Being Strategy will consider how our work can further tackle inequalities in health • Our Shaping our Future Public Health strategic programme has a focused arena of work aimed at tackling areas of inequalities. We are working closely with the two local authorities and other partners, through our PSBs and RPB partnerships to accelerate action in our local organisations and communities, particularly in relation to healthy weight, immunisation and screening. This includes building on local engagement with our ethnic minority communities during the Covid-19 pandemic. Such focused work is articulated in 'Cardiff and Vale Local Public Health Plan 2022-25' within our UHB three-year plan, and will be strengthened in 2022/23 by the development of a strategic framework for tacking inequalities • Through our PSB and RPB plans we already prioritise areas of work to tackle inequalities and the refreshed needs assessments for both PSBs and RPB will further identify collective actions • The Youth Justice Board is implementing the recommendations of our Public Injecting & Youth Justice Health Needs Assessments in Cardiff • Cardiff PSB and Cardiff and Vale Substance Misuse Area Planning Board are implementing the recommendations of its Needle Exchange programme review to tackle health inequality as part of COVID-19 substance misuse recovery work • Our Suicide and Self-Harm Prevention Strategy has been published • The multi-agency approach to Seldom Heard Voices, which targeted initiatives towards areas of deprivation during the pandemic e.g. walk in vaccine clinics, will continue as we move through recovery. • The Annual Report of the Director of Public Health (2020), published in September 2021, focusses on reducing inequity and sets out a vision for future partnership working that will enable us to recover strongly and more fairly. • The latest Annual Report of the Director of Public Health report on value, (published January 2023) also contains a chapter which focuses on the relationship between a Value-based approach and reducing inequities.
Current Assurances	We have identified a bellwether set of indicators to help measure inequalities in health in the Cardiff and Vale population through which we will develop further to measure impact of our actions. This formed part of the Annual Report of the Director of Public Health 2020, published September 2021 (1). Examples include: • The gap in healthy life expectancy at birth between the most and least deprived in Cardiff and Vale UHB reduced from 16.6 years in 2017/19 to 14.4 years in 2018/20 for males. In females however, the gap increased from 14.6 years in 2017/19 to

	18.0 years in 2018/20. Neither of these estimates yet takes account of the impact of the pandemic. • As of 10 Dec 2022, the gap in coverage of COVID-19 autumn 2022 booster vaccination between those (all ages) living in the least deprived and most deprived areas of Cardiff and Vale UHB was 29.8%, with fewer people vaccinated from the most deprived groups. This compares to a gap of 23% across the whole of Wales between those in the least deprived groups compared to those living in the most deprived groups. • Discussions with Public Health Wales have been held to support the development and regular monitoring on health inequities. • A gap analysis of health inequalities data has been undertaken as part of a national exercise which indicates that data collection on date of birth and postcode are good but that this drops considerably for other important variables.		
Impact Score: 4	**Likelihood Score: 3**	**Net Risk Score:**	**12 (High)**
Gap in Controls	• ~~Uncertainty around progress of the pandemic due to uncertainly of population spread as we move towards endemicity, and future risk of variants~~ • Unidentified and unmet healthcare needs in seldom heard groups • Capacity of partner organisations to deliver on plans and interdependency of work		
Gap in Assurances	• Monitoring data (often managed via external agencies) and establishing trends difficult to determine over shorter timescales		

Actions	Lead	By when	Update since January 2023
1. Embed a 'Socio-economic Duty' way of thinking into strategic/operational planning, *beyond* complying with our statutory duty	Fiona Kinghorn /Rachel Gidman	Draft framework by March 2023	For 2022/23, we plan to strengthen the strategic response to the Socio-economic Duty, ensuring actions are systematically applied. The EHIA process will be reviewed (when capacity allows) with the aim of simplifying it where possible. The new process will consider proportionality, so that the level and depth of the EHIA undertaken is proportionate to the change being introduced. Our UHB will continue to work collaboratively with our stakeholders to shape our services and culture.
2. Within the UHB and through our PSB and RPB partnerships, develop and deliver a suite of focused preventative actions to tackle inequalities in health	Fiona Kinghorn	March 2023	Suite of preventative actions to tackle inequalities developed with PSB and RPB partnerships. Next step is delivery. Partnership 'Amplifying Prevention' actions are being implemented, for example contact tracers following up families who have not responded to appointments for childhood vaccinations,

		April 2023	agreement to work collectively to reduce High Fat Sugar Salt advertising and translation of bowel screening promotional animation into four locally spoken languages. A partnership communications and training plan has also been developed to ensure we maximise all opportunities to promote immunisation, screening and Move More, Eat Well with both our staff and the patients/clients/citizens that interact with our services. A strategic framework for tacking inequalities is being planned and has had agreement in direction across the Executive team. Following publication of the Population Needs Assessment and the two Wellbeing Needs Assessments, tacking inequalities is recognised as a priority for all local and regional partner organisations. A comprehensive Health Needs Assessment has been completed, a Programme Board for Health Inclusion has been established, and a clinical model is being worked through.
3. Improve the routine data collection in relation to equality and inequity, both across the UHB and with partner organisations, and develop a broader suite of indicators to monitor progress	Fiona Kinghorn	March 2023	Amplifying prevention indicators being developed. Input into National gap analysis of health equity data collection to inform actions to help drive change.
Impact Score: 4	**Likelihood Score: 3**	**Target Risk Score:**	**12 (High)**

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

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

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

Risk **Date added: 6.5.2021**	There is a risk that the organisation will not be able to attract, recruit and retain people to work in our clinical teams to deliver high quality care for the population of Cardiff and the Vale.
Cause	• The pandemic, Winter and the Recovery Plan has placed significant pressure on our workforce. Demand for staff has been significantly higher than the supply which has meant that our existing teams have been placed under extreme pressure since March 2020. • The increased demand across the NHS has left a shortage of people with the right skills, abilities and experience in many professions/roles which has created a more competitive market. • National shortages in some professions has made it difficult to attract people with the right skills/experience and in the numbers required, for example: - Registered Nurses. - Medical staff in certain specialties (e.g., Adult Psychiatry, General & Acute Medicine, Histopathology, Radiology, GP). • Turnover across the UHB has stopped rising but is still at 13%, over 3% higher than the pre-pandemic rate. • Sickness absence ~~has stabilised over the last 2 months but~~ remains high at just over 7% which is 2% higher than pre-pandemic. The situation is still very challenging but we anticipate that the position will improve as we move into Spring/Summer months. Significant operational pressures across the whole system since March 2020 has impacted negatively on the health and wellbeing of our staff. • The development of our existing workforce has reduced as a direct result of the pandemic and the significant operational pressures, which is impacting negatively on retention. • Attraction, recruitment and retention is also being affected by the negative image that is portrayed that NHS staff do not receive the right remuneration for the work that they do. Some Trade Unions have been campaigning and taking industrial actions over the last few months. • The pause in International registered nurse recruitment could potentially exacerbate the high number of vacancies within the UHB.
Impact	• Negative impact on our people and our teams, as a result we are experiencing: - High levels of sickness absence and lack of management capacity to support staff appropriately; - High levels of turnover; - Low morale and poor staff engagement; - Increased reliance on temporary workforce e.g. bank, agency, locums, etc; - Poor compliance with statutory and mandatory training; - Reduced capacity to undertake appraisals, identify development needs, and focus on talent management and succession planning. - Lack of capacity to upskill and develop our current workforce.

	• Negative impact on quality of care provided to the population. Inability to meet on-going demands of both pandemic, Winter and the Recovery plan. • A number of Trade Unions have rejected the WG pay offer and have a mandate to take industrial action up to May 2023.		
Impact Score: 5	Likelihood Score: 5	**Gross Risk Score:**	**25 (Extreme)**
Current Controls	• Commencement of a People and Culture Committee in May 2023 to provide more scrutiny and assurance to Board. • People and Culture Plan with robust processes to monitor progress against the key deliverables. • Heads of People & Culture will be reintroduced into the Clinical Boards from the end of March, to provide additional support with strategic priorities, including delivery of P&C Plan, workforce planning, retention, workforce redesign, sustainability, etc. • Hotspots are identified using our workforce data, plans are developed with the team to support with recruitment, retention, staff wellbeing, etc. • The People Resourcing team continue to improve the way we attract and recruit, they will ensure that any recruitment needed for the remodelling of clinical areas is achieved in a timely manner. • The Staff Bank are focusing on increasing the supply of HCSW and R/N's on the bank which will support the reduction of agency usage and improve quality. They are also increasing the variety of roles employed by the bank to avoid Agencies which has included Geneticists, pharmacists, Allied Health professions etc. • A Retention Toolkit has been developed and a number of bespoke action plans have been initiated in some of the hotspot areas to ensure problems are addressed urgently. • The People Services Team have embedded its operating model, aligned to Clinical Boards, to provide specialist advice and support aligned to the organisation's priorities, e.g. reducing sickness absence, reducing formal ER cases, effective change management, etc. • Focussed recruitment campaigns to improve the diversity of our workforce and to positively benefit the local community. • All Wales International Nurse Recruitment Campaign. • Welsh Government Campaign *Train, Work, Live* to attract for Wales – GP, Doctors, Nursing and Therapies. • Medical International recruitment strategies reinforced with BAPIO OSLER and Gateway Europe. • Medical Training Initiative (MTI) 2-year placement scheme via Royal Colleges. • Medical Workforce Advisory Group (MWAG) progress and monitor employment matters that directly affect our Medical & Dental staff. • Central managed Medical and Dental Staff Bank in place to increase the supply of doctors (using temporary workforce), maintain quality and reduce costs. Fill rate is consistently over 90%. • E-Job Planning system in place to ensure Consultants and SAS Doctors have their job plans reviewed and approved annually. • E-Rostering Programme Board meet monthly to ensure the roll out of the new e-rostering system and Safe Care is progressing as outlined in the implementation plan. • Health & Wellbeing strategy monitored through the strategic Health & Wellbeing Group. • Monthly Executive Performance Reviews with a focus on improving our workforce position are now well established. • Baseline Workforce Plans have been developed for each Clinical Board initially concentrating on our Nursing workforce, which is the staff group		

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

Impact Score: 5	Likelihood Score: 4	**Net Risk Score:**	**20 (Extreme)**
Gap in Controls	~~Ability to on-board International Nurses at pace due to Visa processing.~~ ~~Awaiting Board approval to recruit 147 International Nurses, arriving between May and October 2023.~~ Workforce supply affected by National Shortages.		
Gap in Assurances			

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

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

10. Leading Sustainable Culture Change – Executive Director of People and Culture (Rachel Gidman)

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

Risk	There is a risk that the cultural change required will not be implemented in a sustainable way		
Cause	• There is a belief within the organisation that the current climate within the organisation is high in bureaucracy and low in trust. • Staff reluctant to engage with the case for change as unaware of the UHB strategy and the future ambition, also staff overwhelmed with change and ongoing demands as a result of the pandemic. • Staff not understanding the part their role plays for the case for change due to lack of communication filtering through all levels of the UHB. • Additional complexities as colleagues continuously respond to the challenges of the pandemic, making involvement in, and response to change complex and challenging.		
Impact	• Staff morale may decrease • Increase in absenteeism and/or presenteeism • Difficulty in retaining and recruiting staff • Potential decrease in staff engagement • Increase in formal employee relations cases • Transformation of services may not happen due to staff reluctance to drive the change through improvement work. • Patient experience ultimately affected. • UHB credibility as an employee of choice may decrease • Staff experiencing fatigue and burnout making active and positive engagement in change challenging and buy-in difficult to achieve.		
Impact Score: 4	**Likelihood Score: 4**	**Gross Risk Score:**	**16 (Extreme)**
Current Controls	• Values and behaviours Framework in place • Cardiff and Vale Transformation story and narrative • Leadership Development Programmes, e.g. Acceler8 and CLIMB supporting inclusive, compassionate leadership principles • Management Programmes offering a blended approach to learning and including development around change and transformation • Talent management and succession planning cascaded through the UHB • Values based recruitment / appraisal • Staff survey results and actions taken, including NHS Staff Survey and Medical Engagement Scale. • Involvement in All Wales NHS Staff Engagement Working Group • Increasing the diversity of the workforce through the Kickstart programme, Apprenticeship Academy, Project SEARCH • Patient experience score cards • CEO and Executive Director of People and Culture sponsors for culture and leadership • Raising concerns procedure/Freedom to Speak Up. UHB part of all Wales Group looking at Freedom to Speak Up across NHS Wales • Interviews conducted with senior leaders regarding learnings and feedback from Covid 19 and lessons learnt document completed in September 2020 looking at the whole system. Discovery learning report completed in the Autumn 2020 • Strategic Equality Plan and Welsh Language Standards implementation and monitoring via the Equality, Diversity, Inclusion and Welsh Language Team		

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

Actions	Lead	By when	Update since January 2023
1. Learning from Canterbury Model with a Model Experiential Leadership Programme- Leadership Programmes have been developed: (i) Acceler8 (ii) Collabor8 (iii) Climb Compassionate and inclusive leadership principles will be at the core of all the programmes	Rachel Gidman	May 2023 April 2023 Ongoing Jan-March 2023 July 2023	Acceler8 Senior Leadership Programme Cohort 2 will end in May 2023. Upon completion, Cohort 2 will join Cohort 1 and Climb delegates in the CAV Leadership Alumni. The Collabor8 Leadership programme, Cohort 1 is continuing. The review of a CAV Leadership Development Strategy is underway. Leadership development across the UHB is being mapped to identify gaps in provision, areas of duplication, and opportunities for collaboration. Education, Culture and OD Team (previously LED) continue to facilitate the delivery of 'bite size' leadership and management opportunities including Coaching for Performance; Effective Communication Skills; REACTMH (having effective wellbeing conversations). Workshops are targeted to areas of need throughout Winter months to support focus on retention, wellbeing and recruitment. Enhancement of a coaching and mentoring network continues. Coaches currently supporting Senior Nurses in Phase 1 of development. Access to coaches continues to be challenging. Mentoring training has been acquired and the initial training will support the development of the Anti-Racist Action Plan, in supporting Inclusion Ambassadors to hear from colleagues with lived experience. Identification of mentors to take place March- April

		March - May 2023 June 2023 March-June 2023 Jan-May 2023	2023, including discussions on reverse mentoring. 3 Coaching supervisors have been identified, training delayed to June 2023 due to availability. Simplified VBA process has been communicated and training ongoing to support for both managers and staff. Simplified paperwork agreed and part of communication. All CBs have provided an action plan and trajectory for achieving VBA targets by March 2023 (60%) and June 2023 (85%). VBA training continues to be well attended and compliance is showing an increase in March 2023. There has been an increase in the number of requests to facilitate cultural programmes/OD work within directorates and teams. ALAS work continues utilising Culture and Leadership Programme and Framework and is now at Focus Group stage following a survey response of over 50%. Analysis and recommendations to be provided to DMT early May 2023. OD support for UHB strategic programmes also requested, SOFH, SOFCS etc and challenges to capacity being discussed. HEIW has reserved 8 licenses for CAV on the NHSE/I Culture and Leadership Programme Framework to increase capability and understanding of the tool. CAV will also provide NHSE/I with a case study of the existing programme. 6-month programme of work developed to support EU, has completed stage 1. Evaluation in progress, People and Culture Team to work with SMT to identify next steps. Equity and Inclusion Audit has been completed and initial feedback expected March 2023. Management response by April 2023.
2. Showcase	Rachel Gidman	Oct 2022	Showcase launched via all Staff Comms in October 2022.
3. Equality, Diversity and Inclusion	Rachel Gidman	Dec 2022	Equality Strategy Welsh Language Group is established and taking place

			on a bi monthly basis. Expectations around the Flash Reporting element for Service and Clinical Boards to be reinforced to ensure progress is monitored and reported against. Review of group TOR taking place to ensure all CBs are represented and appropriate governance is in place.
Welsh Language Standard being implemented.		March-May 2023	A robust translation process is in place supported by 2 Welsh Language Translators and an SLA with Bi-lingual Cardiff. Cost effectiveness of SLA currently being reviewed based on costs per word and waiting times. Initial analysis demonstrates savings to be made through increasing in-house translation capacity. To be presented May 2023.
Inclusion - Nine protected Characteristics		May 2023	The UHB continues to receive and respond to inquiries from the Welsh language Commissioner's Office, particularly around recruitment and data. The Welsh language team are supporting Clinical Boards to further understand their responsibilities and are taking a stepped approach to this due to capacity. All 9 protected characteristics including Welsh language are sponsored by an Executive and an independent member. This approach has also been rolled-out across CBs. An 'Inclusion Ambassador' pack has been circulated that support in understanding and learning.
		Ongoing	Training has been identified for mentors to support Inclusion Ambassadors at executive level. Step two will be identification / nominations for mentors, followed by training.
		March-June 2023	Existing networks are collaborating to develop the scope and outline of an 'Ally Network'. Work is at an early stage, initial proposal to be taken to the ESWLSG meeting in June 2023.
		June 2023	The Anti-Racist Wales Action Plan developed by Welsh Government was published in June 2022. Board development has continued following the initial session in August 2022. The Board Development session planned

		Ongoing 2023/24	for Dec 2022 was delayed due to Industrial Action, the session will now take place in April 2023 supported by Race Equality First who have worked in collaboration with the One Voice Network. Development of the draft CAV Anti-Racist Wales Action Plan has been completed via a staff and TU working group. This will be presented to Board in May 2023. The UHB has received the results of the Stonewall Workplace Equality Index and has maintained top 100 status, and gold membership, coming it at position 80. A benchmarking meeting will be scheduled for April 2023. The draft proposal for a framework looking at Equality, Health Inequalities and Safety. A collaboration of areas including the E&I Team; ADOD; PH; Patient Experience; Quality and Safety formed a working group to review existing documentation and benchmarking.
4. CAV Convention	Rachel Gidman	TBC	Action under review and date to be confirmed once known.
Impact Score: 4	**Likelihood Score: 1**	**Target Risk Score:**	**4 (Moderate)**

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

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

Risk	There is a risk that staff sickness will increase and staff wellbeing will decrease due to the psychological and physical impact of the ongoing pandemic. Which together with limited time to reflect and recover will increase the risk of burnout in staff.		
Date added:	6th May 2021		
Cause	• Redeployment with lack of communication / notice / consultation • Working in areas out of their clinical expertise / experience • Being merged with new colleagues from different areas • Increased working to cover shifts for colleagues / react to increased capacity / high levels of sickness or isolation due to positive Covid test results • Shielding / self-isolating / suffering from / recovering from COVID-19 • Build-up of grief / dealing with potentially traumatic experiences • Lack of integration and understanding of importance of wellbeing amongst managers / impact upon manager wellbeing • Conflict between service delivery and staff wellbeing • Continued exposure to psychological impact of covid both at home and in work • Ongoing demands of the pandemic over an extended period of time, minimising ability to take leave / rest / recuperate • Experience of moral injury • Cost of living 'crisis'		
Impact	• Values and behaviours of the UHB will not be displayed and potential for exacerbation of existing poor behaviours • Operating on minimal staff levels in clinical areas • Mental health and wellbeing of staff will decrease, existing MH conditions exacerbated • Clinical errors will increase • Staff morale and productivity will decrease • Job satisfaction and happiness levels will decrease • Increase in sickness levels • Patient experience will decrease • Increased referrals to Occupational Health and Employee Wellbeing Services (EWS) • UHB credibility as an employee of choice may decrease • Potential exacerbation of existing health conditions		
Impact Score: 5	**Likelihood Score: 4**	**Gross Risk Score:**	**20 –(Extreme)**
Current Controls	• Self-referral to wellbeing services • Managerial referrals to occupational health • External support • Wellbeing Q&As and drop ins (ad-hoc and upon request) • Wellbeing Support and training for Line managers • Development of range of wellbeing resources for both staff and line managers • GP self-referral • Values Based Appraisals including focus on wellbeing • Chaplaincy ward rounds • Health Intervention Team (HIT) • Wellbeing champions initiative • Health and Wellbeing Strategic group		

	• Development of rapid access to Dermatology • Post traumatic pathway service • Deployment principles to support staff and line managers • Wellbeing walkabouts to signpost resources • Long Covid Peer Support Group		
Current Assurances	• Internal monitoring and KPIs within the OH&EHWS (1) • Wellbeing champions normalising wellbeing discussions (1) • VBA focussing on individual wellbeing and development (1) • HIT Team recommendation plan completed following UHB engagement, priority actions to be focus (1) • Taking Care of Carers Audit and Action Plan (3) • Internal audit on Staff Wellbeing, Culture and Values (September 2022) Report (3) • Trade unions insight and feedback from employees (2)		
Impact Score: 5	**Likelihood Score: 3**	**Net Risk Score:**	**15 – (Extreme)**
Gap in Controls	• Staff shortages leading to movement of staff and high demand for cover • Transparent and timely Communication especially to staff who are not in their substantive role e.g. redeployed, hybrid working • Health Charity funding for EWS agreed in principal, to be confirmed by the charitable fund trustees September 2022 • Continued increase in referrals to Occupational Health and increased PEHD work to support mass-recruitment • EWS seeing an increase in staff presenting with more complex issues, including a rise in referrals needing a wellbeing check due to the presentation of high risk in the referral		
Gap in Assurances	• Organisational acceptance and approval of wellbeing as an integral part of staff's working life balanced against demand and flow • Awareness and access of employee wellbeing services, particularly for staff without email / internet access • Clarity of signposting and support for managers and workforce		
Actions		**Lead**	**By when**	**Update since January 2023**
1. Health Intervention Coordinator (1) providing reactive and immediate support to employees directly affected by the ongoing impact of the COVID pandemic		Nicola Bevan	March 2023 April – June 2023	The HI Co-ordinator role continues to support the lead counsellor to deliver bespoke support and development in areas of need. This will end at the end of March 2023 when the Health Charity Funding ends. From April onwards, the role will be developed to incorporate OD, Wellbeing and employee experience. As requests are rarely limited to 'wellbeing' only, and often include relationships, behaviours, team working and conflict, moving to a more commissioning and collaborative approach

		March-June 2023	with broader People and Culture Team. EWS have continued to run a series of People and Culture Roadshows, visiting sites across the UHB focusing on signposting information around the Cost of Living and where to access Wellbeing support. These have been delivered with the support of the Working with the Money and Pensions Service (MaPS). In total 12 roadshows have been held to date with an approximate 600 staff engaging with the roadshow reps. including Cardiff Credit Union, Staff representatives, P&C, EWS, Occupational Health, the chaplaincy service. Surveys completed during the roadshows by staff are helping shape future communications, and information being shared on cost of living. Financial Wellbeing packs have been circulated to key leads in primary care and community for cascading through the teams. On line MaPS presentations on 'pensions' and 'pensions and menopause' sessions are being planned for March/April 2023. 'Stop Loan Sharks Wales' provided an online presentation for staff in Feb 2023.

			A staff Financial Wellbeing pathway has been drafted and will be reviewed by the Strategic Wellbeing Group in April 2023. Dedicated staff financial wellbeing and CoL web pages have been established on sharepoint. Ongoing MaPS workshops rolled out across the various network groups, P&C and line managers. Working with ECOD the first training sessions for line managers are taking place and a workshop for the Wellbeing champions ran in Feb 2023.
2. Health Intervention Coordinators (2) conducting research and exploration for long term sustainable wellbeing for the staff of the UHB	Nicola Bevan	Interventions proposed implementation April 22 – 2023 April 2023 March-May 2023 Jan-March 2023	The Health Intervention team Impact Report will be presented at the Strategic Wellbeing Meeting in April 2023. Work has already commenced on some of the priorities mentioned, including the development of a Wellbeing Strategy. This was presented to the Strategic Wellbeing Group in February 2023, but is currently out for further comment. Implementation of works around rest space has been completed with the refurbishment of over 30 staff areas. The Health Charity are supporting colleagues at Whitchurch to fund a water station onsite following completion of a SBAR. Peer support developments – MedTRiM training is partially

			completed. Meeting with provider scheduled for April 2023. Sustaining Resilience at Work Pracitioner Training (StRaW) has been undertaken by Children and Women CB supported by P&C Team. Further work to be completed to ensure that the infrastructure supports the practitioners and the focus targeted to support capability and capacity.
3. Enhance communication methods across UHB - Social media platform - Regularity and accessibility of information and resources - Improve website navigation and resources	Nicola Bevan	31.03.23 April 2023 – March 2024 March – June 2023 April 2023	A variety of communication models including Twitter accounts are being utilised to share Wellbeing updates across the UHB. A 12-month communication plan has been developed to ensure that wellbeing topics are covered throughout the year and will be reviewed and agreed by the Strategic Wellbeing Group in April 2023. Financial Wellbeing Working group continues to review and implement action plan, designing and communicating signposting for all staff. A presentation was given to SLB in February 2023 highlighting the proposed benefits of using Wagestream, a platform that supports financial wellbeing and education and also the ability to 'stream' wages linked to additional hours worked on health roster. A follow-up presentation is planned for SLB April 2023.

		March-April 2023 April-May 2023	Cost of Living action plan has been developed, reviewed weekly to ensure information shared and signposting updated. Internal audit highlighted action for SharePoint pages re: inclusion and signposting to wellbeing resources. Work has now been completed all Sharepoint areas are under monthly review. Analysis of engagement results and feedback from wellbeing surveys has indicated low levels of staff morale, engagement and wellbeing. Dashboard of results has been produced for sharing with CBs, and attendance has been confirmed at meetings throughout March and April 2023. Communications also being developed to thank staff for participation in surveys / platforms; to communicate key themes and to outline actions being taken / planned. This will follow attendance at all meetings.
4. Training and education of management - Integrate wellbeing into all parts of the employment cycle (recruitment, induction, training and ongoing career) - Enhance training and education courses and support for new and existing managers	Claire Whiles	March – June 2023	Leadership and Management development offerings to support staff health and wellbeing added to existing offerings, e.g. REACTMH training; Managing Remote Teams REACTMH train the trainer completed. Roll out plan commenced with information session to CEF Dec 2022. Added to existing training, next steps to roll-out bite-size.

		May 2023 September 2023 March – June 2023 April 2023	Acceler8 Cohort 2 ongoing. Six modules completed to date. Collabor8 Leadership Programme commenced October 2022. EWS working closely with Education, Culture and OD Team (ECOD), and Equity and Inclusion Team to ensure alignment and reduce duplication. OD Commissioning model to be developed to support effective and targeted intervention. ECOD have met with the Innovation and Improvement Team on all leadership programme development. Mapping completed and draft overview to be updated by April 2023.
5. Wellbeing interventions and resources funding bid approved November 2021. Implementation to start December 2021 for completion March 2022. Wellbeing Strategy group to shape with feedback from Cl Boards.	Claire Whiles	March - June 2023 Feb - June 2023 March - June 2023	Work on evaluation metrics underway with support from innovation and improvement team and public health. This will ensure effective monitoring, evaluation and planning of all wellbeing services and interventions. Wellbeing Strategy and Framework draft presented to Strategic Wellbeing Group Feb 2023. Further engagement with staff networks, Tus and CBs to follow. Two of the three Schwartz Round Clinical leads have been agreed, awaiting final nomination. Training for Leads and steering group to take place May 2023. Steering Group

			Membership to be presented to SLB. Identification of facilitators to be positioned to ensure representation of workforce population, collaboration with existing networks essential. Change of focus from 'local pilots' to whole UHB – plan being adjusted accordingly, scheduled to be in a position to confidently roll-out from late summer 2023. Risk re Schwartz Round Administrator role – currently not assigned.
		September 2023	Wellbeing Retreat Pilot commenced July 2022. Retreats until Nov 2022 all completed and evaluation moved to April-June due to challenges with staff release.
		April-June 2023	Room Refurbishment complete, including delivery and installation of artwork. Concerns of WSG and lack of ownership / accountability for water stations. Health Charity continues to support areas wishing to implement. Cost of Living working group meeting regularly to review actions. UHB Wellbeing Strategy / Framework in draft discussed at Strategic Wellbeing Group Feb 2023 and further consultation and engagement required. Management Response to Internal Audit agreed and returned and presented at Audit Committee.

		June 2023 March – June 2023	Focus on staff wellbeing to support retention. Culture Assessment Work being undertaken in identified areas. Collaborative working across P&C Team and CBs, including TU partners.
Impact Score: 5	**Likelihood Score: 1**	**Target Risk Score:**	**5 (Moderate)**

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

The UHB delivers services through a number of buildings across Cardiff and the Vale of Glamorgan, from health centres to the Tertiary Centre at UHW. All NHS organisations have statutory responsibilities to manage their assets effectively: an up to date estate strategy is evidence of the management of the estate. The IT SOP sets out priorities for the next five years and Medical Equipment is replaced in a timely manner.

Risk **Date added:** 12.11.2018	There is a risk that the condition and suitability of the UHB estate, IT infrastructure and Medical Equipment impacts on the delivery of safe, effective and prudent health care for the patients of Cardiff and Vale UHB. The condition of facilities within our main hospitals are impacting on our ability to continue to provide the full range of services, and provide the new treatments WHSSC would like to commission from us. This is as a result of insufficient funding and resource to bring the estate up to the required condition in a timely way.		
Cause	• Significant proportion of the estate is over-crowded, not suitable for the function it performs, or falls below condition B. • Investment in replacing facilities and proactively maintaining the estate has not kept up the requirements, with compliance and urgent service pressures being prioritised. • Lack of investment in IT also means that opportunities to provide services in new ways are not always possible and core infrastructure upgrading is behind schedule. • Insufficient resource to provide a timely replacement programme, or meet needs for small equipment replacement • Lack of timely decisions regarding the development of strategic business cases required to address the significant estates challenges we face.		
Impact	• The health board is not able to always provide services in an optimal way, leading to increased inefficiencies and costs. • Service provision is regularly interrupted by estates issues and failures. • Patient safety and experience is sometimes adversely impacted. • IT infrastructure not upgraded as timely as required increasing operational continuity and increasing cyber security risk • Medical equipment replaced in a risk priority where possible, insufficient resource for new equipment or timely replacement • Staff facilities are inadequate in many areas.		
Impact Score: 5	**Likelihood Score: 5**	**Gross Risk Score:**	**25 (Extreme)**
Current Controls	• Estates strategic plan in place which sets out how over the next ten years, plans will be implemented to secure estate which is fit for purpose, efficient and is 'future-proofed' as much as possible, recognising that advances in medical treatments and therapies are accelerating. Subject to mid-point review as covered in Board Development session in February 2023. • Statutory compliance estates programme in place – including legionella proactive actions, and time safety management actions. • The strategic plan sets out the key actions required in the short, medium and long term to ensure provision of appropriate estates infrastructure. • The annual capital programme is prioritised based on risk and the services requirements set out in the IMTP/annual plan, with regular oversight of the programme of discretionary and major capital programmes. • Medical Equipment prioritisation is managed through the Medical Equipment Group • Business Case performance monitored through Capital Management Group every month and Strategy and Delivery Committee every 2 months.		

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

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

Gap in Controls	• The current annual discretionary capital funding is not enough to cover all of the priorities identified through the risk assessment and IMTP process for the 3 services. • In year requirements further impact and require the annual capital programme to be funded by capital to be re-prioritised regularly. • Traceability of Medical Equipment • The Welsh Government current capital position is very compromised due to size of budget compared with estimated need which will impact significantly on the Capital Programme of the UHB.
Gap in Assurances	• The regular statutory compliance surveys identify remedial works that are required urgently, for which there is no discretionary capital funding identified, requiring the annual plan to be re-prioritised, or the contingency fund to be used. • Medical equipment is also subject to regulatory requirements, and therefore requires re-prioritisation during the year. • Despite the substantial end of year capital, the recurrent position remains unchanged. • Full condition surveys of all buildings have not been carried out so not possible to fully understand the condition of the estate.

Actions	Lead	By when	Update since January 2023
1. The Estates Strategy requires review and refresh and there is a need to ensure that it is future proof. The scoping of this work to understand what is required will take place before Christmas	Catherine Phillips	31.03.23	It has been agreed that this document will be reviewed in 22/23 but there will be some preparatory work to be undertaken beforehand.
2. The Health Board continues to prioritise the use of the discretionary capital budget to target small priority schemes.	Abigail Harris	31.03.23	This continues with discretionary capital.
3. The Health Board continues to progress a number of major capital schemes (including Shaping Our Future Wellbeing in the Community and Shaping Our Future Hospitals Programme) aligned to our prioritised 10-year Capital Programme outlook.	Abigail Harris	31.03.23	Update included under current controls.
4. An acute infrastructure group is overseeing the short – medium term priorities.	Abigail Harris	31.03.23	The group continues to meet to agree priorities.
Impact Score: 5	**Likelihood Score: 2**	**Target Risk Score:**	**10 high)**

13. Risk of Delivery of IMTP 22-25 – Executive Director of Strategic Planning (Abigail Harris)

Between March 2020 and March 2022, the Integrated Medium-Term Plan (IMTP) process was paused due to the pandemic. The requirement for an approvable IMTP was replaced by the need for quarterly plans for 2020-2021 and an annual plan for 2021- 2022, which reflected the need for agile planning to reflect the changing landscape as the pandemic progressed. In October 2021 the Welsh Government signalled a return to a three-year planning approach and accordingly the Health Board has developed a new three-year plan for 2022 to 2025. In March 2022, the Board approved the draft 2022 – 2025 IMTP which was submitted to Welsh Government. In light of the financial position reflected in the draft plan, and with the agreement of Welsh Government, work was undertaken in the first quarter to further develop the financial recovery element of the plan. This work informed the final plan which was approved by the Board on 30th June and submitted to WG. The plan sets out service delivery proposals reflecting the ministerial priorities, the next milestones in the delivery of our strategy and the financial recovery that will be delivered over the next three years. The plan has not yet been formally considered by the Minister.

Risk	There is a risk that the Health Board will fail to deliver the commitments set out in the 22/23 – 24/25 Plan both in terms of service and financial commitments. The plan does not achieve overall financial balance in 2022/2023 and it is unlikely to be approved by the Minister as a fully compliant IMTP. There are a number of factors in play including the impact of unscheduled care pressures in the system, and unforeseen demands of 'cost of living' impact.		
Date added:	May 22		
Cause	Challenging targets have been set for the Health Board in respect of planned care recovery. Detailed and stretching plans have been developed which the Health Board is committed to delivering but, at this stage the Health Board does not have a plan in 10/35 specialties to achieve Welsh Government ambition of eliminating > 52-week new outpatient waits by end of December 2022. The financial recovery plan will also be challenging to delivery, with stretching targets for sustainable improving our overarching financial position. Whilst we are committed to deliver the actions set out in the plan, there may be dependencies of external factors which impact on our delivery – including constraints relating to funding – capital and revenue, workforce and speed with which we can implement the necessary gearing up to increase capacity.		
Impact	A plan that does not fully meet the requirements for an IMTP is categorised as an annual plan set within a three-year context. The failure to have in place a fully compliant plan could result in the Health Board being escalated to the next level of the performance and escalation framework, which could bring with its reputational loss and increased scrutiny by WG. If we are not able to deliver all of the actions set out in our plan, our planned care recovery could take longer to deliver for the populations we serve and quality of care and patient experience could be impacted. Inability to achieve the commitments for 22/23 will impact upon the ability of the Health Board to develop a balanced IMTP for 2023-26.		
Impact Score: 5	**Likelihood Score: 4**	**Gross Risk Score:**	**20 (Extreme)**
Current Controls	An Operational Plan Delivery structure has been established to drive the delivery of the Planned Care Plan and the Emergency and Urgent Care Improvement Plan. The Performance and Escalation Framework for Clinical Boards has been re-introduced to hold CBs to account for delivering their respective service and financial plans. A process is being established to ensure a programme approach to delivery of the actions within the financial recovery plan.		
Current Assurances	Financial performance is a standing agenda item monthly on Senior Leadership Board with escalation to Management Executives Meeting (1) The financial position is reviewed by the Finance Committee which meets monthly and reports into the Board. (1) The Board receive a financial update report from the Executive Director of Finance at each of its meetings. (1)		

	Welsh Government are fully engaged and have been briefed on the Health Board's position. (3) Service delivery performance is tracked through the structures established to oversee planned care recovery and the improvement in emergency and urgent care, with regular reporting into ME and Board on progress. (1) WG also holds monthly Integrated Planning, Quality and Delivery Review meetings with the health board to track progress. (3) Improvement trajectories are being updated quarterly to ensure they remain on track to deliver the agreed targets. (1)		
Impact Score: 5	**Likelihood Score: 3**	**Net Risk Score:**	**15 (Extreme)**
Gap in Controls	Detailed delivery plans are not in place for all elements of the financial recovery plan. Detailed delivery plans are not in place in all specialties to achieve Welsh Government 52-week NOP ambition		
Gap in Assurances	There is currently no assurance on the plan. Once developed assurance will be provided through reporting to Management Executives, Finance Committee and the Board. The Health Boards position has deteriorated in relation to its financial position.		

Actions	Lead	By when	Update since January 2023
1. Ensure detailed plan with programme to drive delivery of financial recovery plan	Catherine Phillips	31/11/22	Revised financial forecast agreed by the Board in November and submitted to Welsh Government.
2. Provide Q4 progress report – including mitigating actions, the Board for scrutiny.	Abigail Harris	31/03/23	This will be presented to Strategy and Delivery Committee and Board in March 2023

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

14. Financial Sustainability – Executive Director of Finance (Catherine Phillips)

Across Wales, Health Boards and Trusts set out plans to manage their financial pressures by driving out inefficiencies, while at the same time looking to derive greater value from their resources through innovative ways of working and practicing Prudent and Value Based Healthcare. In October 2021 the Welsh Government signalled a return to a three-year planning approach and accordingly the Health Board has developed a new three-year IMTP for 2022 to 2025. In March 2022, the Board approved the draft 2022 – 2025 IMTP. In light of the financial position work was undertaken during the Quarter 1 to develop the financial plan. The final plan was approved by the Board on 30th June and submitted to Welsh Government.

Risk **Date added:** 01.04.2022	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. It also has to manage its operational budget.		
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 is being authorised within the governance structure and the UHB Scheme of Delegation. Financial Plan submitted to Welsh Government 30th June to deliver financial balance over the three-year period 2022-2025. An additional Performance Review Meeting is now taking place with CB Teams to focus on Financial Performance		
Current Assurances	The financial position is reviewed by the Finance Committee which meets monthly and reports into the Board (1) Financial performance is a standing agenda item monthly on Senior Leadership Board with escalation to Management Executives Meeting (1) Financial performance is monitored by the Management Executive (1). Finance report presented to every Finance Committee Meeting highlighting progress against mitigating financial risks (1). Assurance from internal audit annual review of core financial controls including budgeting and planning.		
Impact Score: 5	**Likelihood Score: 4**	**Net Risk Score:**	**20 (Extreme)**
Gap in Controls	No gaps currently identified.		
Gap in Assurances	To confirm COVID 19 and exceptional funding assumptions with Welsh Government for response and recovery. Certainty of COVID 19 expenditure and the management of non COVID 19 operational pressures. The financial plan 2022/23 does not achieve overall financial balance during the financial year. Our current forecast outturn does not match our financial plan for 2022/23.		

Actions	Lead	By when	Update since January 2023
1. Continue to work with Welsh Government to manage our recovery and COVID 19 response as well as exceptional cost pressures.	Catherine Phillips	31/03/23	Complete for 2022/23 as fully funded for the year.
2. Allocation letter has been received from Welsh Government and impact upon financial performance is being developed	Catherine Phillips	31/03/23	Board to be advised during Q4 of the actions

				and implications of receipt of allocation letter
3.	To monitor and control additional expenditure and financial performance to ensure that the year-end forecast is in line with financial plan 2022/23	Catherine Phillips	31/03/23	The Board has approved the financial outturn position to £26.9 in November 2022. The Health Board considers that it will meet the revised outturn position.
4.	To understand the impact of responding to the Covid 19 pandemic has had on the organisations underlying position. To deliver on our savings plan recurrently	Paul Bostock	31/03/23	COVID response and recovery costs are being reviewed for plans to sustain in line with Service need. Savings are being managed and monitored with Clinical Boards. An additional Performance Review Meeting is now taking place with CB Teams to focus on Financial Performance. The impact of Covid response costs will be built into the 23/24 financial plan.
Impact Score: 5	Likelihood Score:1	**Target Risk Score:**		**5 (Moderate)**

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

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

Risk	There is a risk that the Digital Strategy and Roadmap will not be implemented, due to lack of resources, resulting in a deficit in infrastructure, applications and informatics capability.		
Date added:	04.10.22 (updated 06.01.23)		
Cause	CAVUHB IT and digital services are known to have been historically underfunded resulting in a significant legacy deficit in infrastructure, applications and informatics capability that has built up over at least a decade (our PMS and the core module that sit on top for UEC, inpatients and outpatients were built c20 years ago). Colleagues need mobile, scalable, agile solutions which are unachievable whilst we are locked into legacy. There are some programmes and plans identified to rectify these issues however they are unachievable with the current resource allocation		
Impact	We have capability in human resources but lack capacity for planning, management and execution of the activities needed to deliver the digital strategy and roadmap. Just to produce the case(s) for change requires capacity we do not have in the current circumstance ○ Delivery on digital maturity would give capability to colleagues that will reduce inefficiency, release clinical time to care, improve safe practice, allow near real time data to be available to support clinical decision making at the point of care by moving from paper and analogue means of capturing and recording information to digital means where data flows seamlessly between settings Recruitment remains a challenge requiring the use of interim agency support in key areas. Existing resources are consumed with tactical short-term fixes given the legacy so we are unable to prioritise those activities that take us forward – we don't have enough people and we don't have enough money to make the changes we want and need to see. There is a risk that the financial savings and improved staff and patient experience expected from the Digital Roadmap plans will not be fully realised, due to the lack of resources, resulting in a deficit in IT infrastructure, applications and informatics capability and consequential adverse impacts.		
Impact Score: 5	**Likelihood Score: 5**	**Gross Risk Score:**	**25 (Extreme)**
Current Controls	• Digital strategy approved by Board in20/21 with roadmap for 21/22/23 • Digital components described in IMTP • Some additional funding secured via the Business Case Advisory Group • IT infrastructure priorities developed and set out for 2022-2025		
Current Assurances	• D & HI have a number of business cases in development which require revenue investment (1) • Risk register articulates the risks of not being able to deliver digital solutions to support delivery of healthcare (1) • Internal audit report highlights the risk in delivering digital strategy citing the investment challenges that will prevent full implementation.		
Impact Score: 5	**Likelihood Score: 4**	**Net Risk Score:**	**20 (Extreme)**

Gap in Controls	• Current annual discretionary funding is insufficient to cover the maintenance upkeep of the core infrastructure.			
Gap in Assurances	• Unable to currently provide assurance that the finance will be provided			
Actions		**Lead**	**By when**	**Update since January 2023**
1. Discussions with DoF to feed into Digital Financial Plan		DT	31.03.23	Complete – see action no.4 and 5
2. HIMSS assessment of our Digital maturity to be carried out in Qtr 4		DT	31.03.23	The assessment will be undertaken in Q4
3. A ten-year investment request developed and submitted to WG outlining capital and revenue requirements.		DT	31.03.23	See action 4 and 5 this is partially completed with the full 10 year investment request been undertaken by financial year end.
4. Additional investment request submitted to WG for Digital SOC development resources		DT	31.03.23	**New action**
5. Detailed case for investment to be presented at private meeting of DHIC committee (Feb 22)		DT	14.02.23	**New action**
6. External assessment of digital maturity of the acute service completed via site visit on 13/3		DT	31.03.23	**New action**
7. Formal report on digital maturity to be published by HIMSS		DT	31.03.23	**New action**
8. Cyber Assessment Framework update and response to Internal Audit report sets out mitigations and plans to manage cyber risks		DT	31.03.23	**New action**
Impact Score: 5	**Likelihood Score: 3**	**Target Risk Score:**		**15 (Extreme)**

Key:

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

Report Title:	Mental Health Legislation and Mental Capacity Act Committee – Chair's Report				Agenda Item no.	6.5.1
Meeting:	Board		Public	x	Meeting Date:	30 March 2023
			Private			
Status *(please tick one only):*	Assurance	x	Approval		Information	
Lead Executive:	Interim Director of Corporate Governance					
Report Author (Title):	Senior Corporate Governance Officer					

Main Report
Background and current situation:

The purpose of this report is to provide the Board with a summary of key issues discussed at the Mental Health Legislation and Mental Capacity Act Committee Meeting held on 31 January 2023.

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

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

1. **Mental Capacity Act**

Mental Capacity Act Monitoring Report – the Committee was advised that Independent Mental Capacity Advocate (IMCA) referral rates had increased to 72.5% over the past two years for the same quarter. It was noted that there was no clear reason for that however, it was likely due to an increased awareness of the types of decisions that required IMCA referral; both as a result of MCA training and the informal training provided to clinicians by the advocacy service themselves when visiting ward areas.

It was noted that the new MCA and Consent Lead had begun in post in November 2022 and was in the process of linking in with each Clinical Board to explore how the Mental Health Clinical Board could make the training more accessible for staff and increase attendance through the provision of bespoke sessions.

The Committee received assurance that compliance levels had increased since November 2022 and that Mental capacity and best interests training (Edge Training) continued to be well received by staff and as a result four further sessions were being arranged to take place between May and June 2023.

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

The Committee was made aware that 66% of applications were within time and 34% had breached, which was expected due to the significant increase in applications as a result of the work in Medicine Clinical Board, resulting in significant backlog. It was noted that the average % breach for the year to date was 27%, and that it was recognised as a national problem and one of the main reasons for the development of the new safeguards under the LPS.

Liberty Protection Safeguards (LPS) – the Committee was advised that the Mental Health Clinical Board continued to await feedback from the Welsh and UK Governments in respect of the Regulations and updated MCA Code of Practice following the end of the consultation in July 2022. As yet, there was no confirmed date for implementation of the LPS.

It was noted that the focus for the Health Board remained on providing training for staff to improve knowledge and confidence in applying the Mental Capacity Act and identifying a digital solution for recording and monitoring purposes.

The Health Board LPS project plan remained on target and progress was in line with other Welsh Health Boards.

The Committee was advised of a number of actions which included:

- A workshop was held in January 2023 to bring together key staff to identify what was required for a digital solution for the recording and monitoring of the LPS.
- A training strategy was currently in development to outline the process for the roll out of LPS training. WG were in the process of procuring a training package that would be made available for use by Responsible Bodies.
- A business case would be submitted in respect of the recruitment of 2.0 permanent MCA Specialist Practitioners, current funding for those posts was WG non-recurrent.

2. Mental Health Act

Mental Health Act Monitoring Exception Report – during the quarter reporting period (October – December 2022) the number of Section 136 referrals had decreased, of which 73.9% were not admitted to hospital. The Committee was advised that that the number that had been received were (i) an appropriate use of Section 136, and (ii) within the appropriate parameters.

The number of those under 18 years old assessed under Section 136 had remained the same from the previous quarter at 8. There were 3 repeat presentations for one Patient.

HIW MHA Inspection Report – the Committee was advised that the report provided them with a summary of the HIW inspection of Beech, Willow and Cedar wards at Hafan Y Coed Hospital, Llandough between 14th and 16th February 2022.

It was noted that the HIW inspection covered a range of areas of interest to the Committee:

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

It was noted that the summary reports included Action Plans, and Immediate Action Plans and that there were no Immediate Actions required and so the action plan was shared with HIW.

x

3. Mental Health Measure

Mental Health Measure Monitoring Report, including Care and Treatment Plans Update Report – Members were informed of the current compliance rates with regards to the Welsh Government targets set in respect of Parts 1-4 of the Measure. It was noted that the service was at full clinical recruitment and sickness absence remained low which allowed for ongoing high levels of assessment activity – Q3 with 2870 referrals (adults only) continued the trend of lower numbers than predicted. PMHSS assessed 1332 people (adults) in Q3, very similar to Q2.

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

The Committee was advised that since April 2021, the volume of referrals had increased and had remained significantly higher than pre-Covid levels and that the average wait for assessment was currently 28 days.

In order to combat challenges the Committee was advised that:-

(i) Active sickness monitoring and wellbeing support to would be provided to the team
(ii) Additional capacity through the use of agency staff would continue to deliver the waiting list initiative.
(iii) A full launch of the assessment team model would occur in April 2023 when all staff in post

4. Part 1 Scheme Report

The Committee was provided with an update on the Part 1 scheme of the Mental Health Act.

It was noted that Mental Health Services had changed significantly since the inception of care and treatment plans in 2005 and so a collaborative piece of work was ongoing with Clinicians to note the future of the service.

5. Items for Approval

The Committee approved the following items at its January 2023 meeting:

- The Committee Annual Report 2022/23
- The Committee Terms of Reference 2023/24
- The Committee Work Plan 2023/24

Recommendation:

The Committee is requested to:

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

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

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

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

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

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

Report Title:	Quality, Safety and Experience Committee – Chair's Report				Agenda Item no.	6.5.2	
Meeting:	Board		Public	x	Meeting Date:	30 March 2023	
			Private				
Status *(please tick one only):*	Assurance	x	Approval	x	Information		
Lead Executive:	Director of Corporate Governance						
Report Author (Title):	Senior Corporate Governance Officer						

Main Report
Background and current situation:

The purpose of this report is to highlight the key issues which were raised and discussed at the Quality, Safety and Experience Committee's meeting held on 7 March 2023.

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

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

Specialist Clinical Board – a Patient Story – It described a patient who had sustained a serious injury whilst riding an off-road vehicle. The Story highlighted a multidisciplinary team journey which the Patient had been through during their time in the Major Trauma Centre for Wales which included:

(i) Pre-Hospital – Emergency Medical Retrieval & Transfer Service (EMRTS)
(ii) Emergency Department
(iii) Theatres
(iv) Critical Care
(v) Polytrauma Unit
(vi) Major Trauma Centre
(vii) Specialist Rehabilitation
(viii) Repatriation to Patient's Local Health Board
(ix) Follow on care

The Committee was advised that the themes that the Patient Story had raised would be taken to the multidisciplinary team for wider discussion and learning.

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

- Critical Care – Bed Capacity.
- Critical Care – Estates
- Haematology and Immunology – Clinical Environment

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

- Welsh Government Quality Delivery Plan for the NHS in Wales
- Clinical Board's Operational Plan and IMTP
- Quality & Safety agenda
- Infection, Prevention and Control Annual work programme

- Health and Care Standards
- Patient Experience
- Financial and Information Governance
- Organisational Development and Workforce Planning
- National Safety Standards for Invasive Procedures (NatSSIPs) and Local Safety Standards for Invasive Procedures (LocSSIPs)

Looked After Children – Assessment Backlogs – The Committee received an updated position regarding assessments for Looked after Children (LAC).

It was noted that performance against Statutory Regulations stipulated that a child being accommodated by the local authority should have a holistic health assessment within 28 days.

The Committee was advised that meeting those regulations was not currently achievable, due to insufficient capacity for both medical and nursing assessments, which had further deteriorated due to the retirement of a Consultant within the team.

It was noted that there had been a consistent increase in children in care in Cardiff and the Vale of Glamorgan, with 1,638 children currently on the LAC database in February 2023, and the increase in numbers of LAC has impacted significantly on the number of Initial & review Health Assessments required each year.

The Committee was advised of actions that had been undertaken or started which included:

- Alternative staffing models being explored to consider options to address the backlog, meet current demand and also to manage caseload in line with recommendations.

- Additional nurses had been appointed and would commence employment in March 2023. It was anticipated this would deliver a total of 1,130 assessments, and reduce the backlog assessments for over 10s.

- There was a medium-term plan to recruit an additional 2.4wte Band 6 nurses to assess all children over 5, and a longer-term plan to deal with expected growth and safe caseload numbers.

- Other modernisation and change of delivery models would continue to be explored with the service to ensure efficiency and best use of resources, with a further expansion in nursing resource to support assessments for over 5s.

Quality Indicators Report – key highlights were:
Nationally Reportable Incidents (NRIs) had seen an improvement, which reflected the focus and hard work of the Clinical Boards and Patient Safety Team.

(i) Hospital Infections – the grouped total C'diff, Ecoli, MRSA and MSSA infections showed no in-year improvement against the baseline, however, Ecoli, MRSA and MSSA were demonstrating an in-year improvement, whereas C'diff in-year had increased, compared to baseline of December 2018. It was noted that C'diff rates were observed to be high across the UK after the first and subsequent waves of Covid, all community cases were now subject to investigation to understand the cause of the infection.

(ii) Mortality – it was noted that the November 2022 Quality Safety and Experience Committee agreed a three-tier model for reporting and monitoring mortality data across the Health Board and data was received by the Committee which included:

- Age-standardised mortality rates in 2022 were significantly lower than most other years since 2001 in Wales and England, although it remained above the rate observed in 2019.
- Alzheimer's and dementia remained the leading cause of death in Wales in December 2022, with a rate higher than the five-year average.
- Cancer mortality rates per 100,000 population had demonstrated a reducing trend in population rates in Wales and in Cardiff and Vale UHB area.
- Still birth rates in the UK fell to 3.9 per 1000 births in 2019 and 2020 with increased rates associated with ethnicity in several populations, in particular, Bangladeshi, Pakistani, Black African and Black Caribbean. Provisional figures from the Office of National Statistics suggested that still birth rates increased in 2021 to 4.2 per 1000 births, with a particular increase noted in the second half of 2021, national rates for 2022 were not yet reported.
- Still birth rates in Cardiff and Vale UHB increased from 4.39 in 2021 to 5.74 in 2022. The presence of a Fetal Medicine Unit, meant that the Health Board could provide specialist diagnosis and treatment of complications which could arise in unborn babies.

Maternity Services – the Committee was advised that Health Inspectorate Wales (HIW) had undertaken an unannounced visit in November 2022. The Health Board had submitted its improvement plan, which would be received by the Committee as soon as the HIW report has been published. Following the Ockenden review, a resource gap analysis had been undertaken and the same was due to be submitted to the Health Board's Investment Group for consideration. Also, a Maternity Neo-Natal group had been established in order to share best practice across Wales.

HIW Activity Overview – the Committee was informed that HIW had undertaken three unannounced visits, namely: -

(i) Maternity Services – as mentioned above
(ii) Hafan Y Coed - HIW undertook an unannounced inspection in Hafan Y Coed from the 9th to the 11th of January 2023. An immediate action plan was submitted in response to the recommendations and an update would be provided following the publication of the report.
(iii) IRMER Inspection - An Ionising Radiation Medical Exposure Regulations (IRMER) compliance inspection was undertaken in the Nuclear Medicine Department at UHL on the 11th and 12th of October 2022. Overall, the feedback was positive, and no immediate concerns were identified. An action plan was submitted and accepted in response to the recommendations and the final report was published on 12th January 2023.

The Committee would receive full reports with regards to each visit once the formal HIW reports have been published.

Community Health Council (CHC) Reports – the Committee received a list of CHC Q2, Q3 &Q4 Announced Scrutiny Visits.

It was noted that to date the CHC had provided the UHB with the final reports and recommendations in the following areas:

- Alcohol Treatment Centre
- Spinal Rehabilitation Unit UHL
- Ward West 1 UHL
- Transport to Health Services

The main themes highlighted in those reports included:

- Lack of Day Room and TV facilities
- Improvement to showering facilities for patients with mobility issues
- Improved storage facilities
- Improve parking availability
- Improve signage

- Improve Menus Mealtime Choices
- Encourage carers to support patient care.

Quality, Safety and Experience Framework - Effectiveness Review – the Committee was advised that in September 2021, the QSE framework was published with its 5-year ambition to improve quality and safety across the Organisation.

It was noted that quality and safety had previously focused on what had gone wrong, what patients were telling the Health Board that they were unhappy about in relation to management of incidents and that while there was no doubt that the learning from these incidents was vitally important, there was also a significant body of evidence that demonstrated that the Health Board QSE agenda was moving into a more contemporary approach to include:

- Psychological Safety
- Staff engagement
- Focus on human factors

The Committee was advised that the development of a whole systems approach to quality and safety would pay dividends and support the Health Board in meeting its statutory requirements in relation to the duty of quality and support as well the duty of candour.

Review of Quality Governance Arrangements - Audit Wales Report and Health Board Management Response – the Committee was reminded that it had asked for regular updates regarding progress with the implementation of the recommendations of the report, as recorded in the Committee action log. The implementation of recommendations continued to be monitored by the Risk and Regulation Team and a number of the recommendations were recognised as longer-term and formed part of the Health Board's preparations for the implementation of the Health and Social Care (Quality and Engagement) (Wales) Act.

The Committee noted that six recommendations had been made by Audit Wales, which formed part of the wider quality improvement programme in place within the Health Board, with specific actions shown against each recommendation.

The Committee was advised that all recommendations were in progress and formed part of the Health Board's preparations for the implementation of the Quality and Engagement Act.

BAF – A number of risks linked to Patient Safety were included on the BAF. They include (i) Maternity (which has a score of 20), (ii) Critical Care (with a score of 20), (iii) Cancer (score of 15), (iv) Stroke (score of 15), and (v) Planned Care (score of 12). This was in addition to those already logged on the BAF – i.e. (i) Patient Safety (with score of 20) and (ii) Urgent and Emergency Care (score of 15).

Corporate Risk Register (CRR) - the Committee noted that 18 extreme risks on the CRR were linked to, or had Patient safety elements associated with them.

Committee Work Plan 2023/24 – the Committee received and approved the QSE Committee Work Plan 2023/24 and recommended it to Board for approval at its March 2023 meeting.

Policies – the following policy was ratified: -

(i) Deteriorating Patient Policy (UHB 502)

The Board is requested to:

a) Note the contents of the Report.

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

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

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

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

Report Title:	Audit and Assurance Committee – Chair's Report				Agenda Item no.	6.5.3	
Meeting:	Board		Public	x	Meeting Date:	30 March 2023	
			Private				
Status *(please tick one only):*	Assurance	x	Approval		Information		
Lead Executive:	Director of Corporate Governance						
Report Author (Title):	Corporate Governance Officer						

Main Report
Background and current situation:

The purpose of this report is to provide Board Members with a summary of key issues discussed at the Audit and Assurance Committee Meeting held on **7 February 2023.**

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

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

Progress and Update reports from Audit Wales and Internal Audit in relation to their respective planned activities and audit reports. The Committee was informed that there had been delay in delivering four of the planned Audits and that they would be removed from the 2022/23 plan.

Updates from the Corporate Governance Directorate regarding the current status of the (i) **Internal Audit Tracker** and (ii) **the Audit Wales Tracker**. With regards to the Audit Wales Tracker, the Committee was advised that there was a strong focus on having a "year-end" clean of the remaining recommendations.

The **Counter Fraud Report** which detailed the work undertaken by the Counter Fraud Team was received by the Committee. It was noted that there were two fraud prevention notices. The Counter Fraud team also continued to receive a steady stream of referrals. Furthermore, Fraud Awareness week had now taken place.

Regulatory Compliance Tracking Report – The Committee was advised that the Health Board was currently Non-Compliant with the two Patient Safety Alerts and continued to be monitored by the patient safety teams and were reported to the QSE meetings. There was regular interaction with Executive leads to ensure these were progressed and moved forward.

Review of Risk Management System – The Committee received the Audit of the Health Board's Risk Management Risk Management procedures in June 2022 which had received an overall Reasonable Assurance rating. As of February 2023, all 3 recommendations were reported as complete with appropriate actions being embedded into Risk Management practice.

Assurance Strategy and Risk Management Strategy - The Committee were presented with the Assurance Strategy and Risk Management Strategy. An action plan had been prepared and agreed internally to ensure that the Assurance Strategy was embedded across the Health Board.

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

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

i) Genomics Partnership Wales – Reasonable Assurance
ii) Capital Systems Management - Reasonable Assurance
iii) UHL Engineering Infrastructure - Reasonable Assurance
iv) Core Financial Systems (Treasury Management) - Reasonable Assurance

v) Assurance Mapping (Advisory) – Assurance not applicable
vi) IT Service Desk System – Reasonable Assurance
vii) Access to In-Hours GMS Service Standards (PCIC Clinical Board) - Reasonable Assurance
viii) Endoscopy Insourcing (Medicine Clinical Board) - Reasonable Assurance
ix) Medical Records Tracking (CD&T Clinical Board) – Limited Assurance
x) Management of Locum Junior Doctors (Children & Women's Clinical Board) - Reasonable Assurance

The Committee also received an update on the Limited Assurance Internal Audit report relating to Medical Records Tracking (CD&T Clinical Board). The Directorate Manager advised the Committee that there was a plan to put a better structure around the governance arrangements. The team were also considering how records were stored on a daily basis.

b) Audit Wales Update

(i) **Charitable Funds Account** – the Committee were informed that the Charitable Fund Accounts would be signed by the Auditor General that week.

(ii) **Structured Assessment Report** – the Committee received the Report which remained positive overall. The Report found that the Health Board's approach to planning was generally effective and inclusive, with good Board-level oversight and stakeholder involvement. Refreshing its long-term strategy and producing an approvable IMTP should remain a key priority for the Health Board.

The minutes of the Audit Committee held on 7 February 2023 contain further details of the above matters highlighted in this report and will be available once formally approved by the Audit Committee in April 2023.

Recommendation:

The Committee is requested to:

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

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

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

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant

Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x

Impact Assessment:

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

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

Report Title:	Digital Health Intelligence Committee – Chair's Report				Agenda Item no.	6.5.4	
Meeting:	Board		Public	x	Meeting Date:	30 March 2023	
			Private				
Status *(please tick one only):*	Assurance	x	Approval		Information		
Lead Executive:	Director of Corporate Governance						
Report Author (Title):	Corporate Governance Officer						

Main Report
Background and current situation:

The purpose of this report is to provide the Board with a summary of key issues discussed at the Digital Health Intelligence Committee Meeting held on **14 February 2023.**

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

At the February 2023 meeting, the Committee received an update on the progress being made with regards to the Digital Strategy and Transformation. An exercise had been completed with the Future Hospitals team and various key learnings were established. The consistent message was that digital was central to transformation. The Committee noted that there were dependencies on several Shaping Our Future programmes. The Committee were also advised that the Health Board were waiting on funding to be approved by Welsh Government. This would allow for more learning from the wider healthcare system and allow them to partner for expertise and look for innovation. The Committee also noted that the Enterprise Architecture work was going really well. The senior management team were really engaged and contributing.

The Committee also received and considered reports regarding other usual matters of business which included: -

a) IG Data & Compliance (SIs, Data Protection, GDPR, FOI, SARs, Staffing & Mandatory Training)

Between September 2022 and December 2022, the Information Governance Department had reviewed a total of 245 information governance related incidents. This was consistent with the number of incidents reviewed during the last period. One of these breaches met the threshold to be reported to the Information Commissioner's Office (ICO). The details of this breach were outlined in the private setting of this Committee.
However, the Subject Access Requests for medical records compliance had risen above the values reported to the last Committee. Concerns still remained regarding the overall compliance, with only just half of requests being responded to within one month. The new digital Subject Access Request system, which was discussed at the last Committee, had now been built and was in the testing phase. It was anticipated that this would be available to patients before the end of the financial year. The purpose of this was to streamline the process and to be able to manage performance and report figures more easily.

b) Framework Policies, Procedures & Controls

The following procedures and guidance had been reviewed and updated:

- Disposal of IT Equipment Guidance
- IM&T Equipment Procurement Guidance

- IT Security Business Continuity Guidance
- IT Security Code of Connection Guidance
- Security of Assets Guidance
- Software Licensing Procedure
- Use Your Own Device Procedure

In addition to these, the following Standard Operating Procedures (SOPs) had been developed:

- Cyber Incidence Response
- Patch and Vulnerability Management

c) Joint IMT & IG Corporate Risk Register

Committee Members were informed that Cyber Security remained a "red" risk. A more detailed discussion regarding this would take place in the private session.

The DDHI advised that the other risks were being mitigated. However, the lack of investment resources and lack of people was making it more difficult to achieve.

d) Clinical Coding

The Committee was advised that compliance had dropped below the Welsh Government target and national target. This was due to continued staff shortages and difficulty in recruiting and retaining staff.

It was also noted that Clinical Coding would now sit with the Quality, Safety and Experience Committee, rather than the Digital Health and Intelligence Committee going forward.

e) Board Assurance Framework – Digital

It was noted that the Board Assurance Framework (BAF) contained one risk at 15 in relation to the Digital Strategy and Road Map. There was a risk that the Digital Strategy and Roadmap would not be implemented, due to lack of resources, resulting in a deficit in infrastructure, applications and informatics capability.

Further details relating to the matters raised in this report will be set out in the minutes (once approved) of the meeting held on 14 February 2023.

Recommendation:

The Board is requested to:

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

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

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

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

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

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes
Yes – as highlighted in the body of the Report the lack of resourcing and /or investment is having an adverse effect on the delivery of some projects identified within the Digital Roadmap.
Safety: No
Financial: Yes
Yes- as above.
Workforce: Yes
Yes- as highlighted in the body of the report.
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation: No

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

Report Title:	Finance Committee Chair's Report				Agenda Item no.	6.5.6	
Meeting:	Board		Public	x	Meeting Date:	30 March 2023	
			Private				
Status *(please tick one only):*	Assurance	x	Approval		Information		
Lead Executive:	Director of Corporate Governance						
Report Author (Title):	Corporate Governance Officer						

Main Report
Background and current situation:

The purpose of this report is to provide the Board with a summary of key issues discussed at the Finance Committee Meetings held on **15 February 2023.**

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

The Committee noted and discussed the following key points: -

Overspend – as at Month 10 the Health Board was reporting an overspend of £22.417 million against its submitted draft plan.

Forecast Deficit – the Health Board had forecast a deficit of £26.9million for 2022-23. This was reflected in the Accountable Officer's Letter which had been submitted to Welsh Government.

Planned versus current EOY Trajectory 2022-2023 Month 1 - it was noted that enhanced action had been taken at Month 7 which had broken the trend. This involved asking the Clinical Boards to firm up forecasts and look for all opportunities. The Finance team had also set a number of control totals. It was noted that some of the Clinical Boards were breaching their control totals and needed extra help and support in meeting their targets.

Exceptional Costs - it was noted that Welsh Government funding to support the National Insurance Levy and Social Care Providers had been confirmed. Welsh Government had also confirmed that funding for the exceptional costs of Energy was no longer at risk.

COVID expenditure – Welsh Government had confirmed that funding for the national Covid Programmes could be assumed. Regarding the financial support for Covid Local Responses, WG had indicated that the Covid Local Responses funding would be capped to the maximum figure the Health Board had forecast at Month 8.

Public Sector Payment Compliance – the Health Board's public sector payment compliance performance remained below the target of 95%. The below target performance was due to the high number of invoices which were on hold and subsequently cleared following work by the Procurement department with those placing orders to clear the backlog of "holds". However, that had contributed to the performance remaining below target, as any "holds" exceeding 30 days had been resolved and paid. Performance was expected to improve and work was ongoing with departments within the Health Board, including training, to address the level of orders not receipted, and the high number of workforce and nursing "holds", which should improve the Health Boards position.

Capital Resource Limit - the Health Board had an approved capital resource limit of £51.675m, in line with the latest capital resource limit received from Welsh Government, which comprised of £10.263m discretionary funding and £41.412m towards specific projects. 53% had been expended

to date of the Health Board's approved Capital Resource Limit. The remaining amount would also be expended.

Further details of matters discussed in the Committee meeting held on 15 February 2023, will be set out in the approved minutes.

Recommendation:

The Committee is requested to:

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

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

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

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

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

Report Title:	Senior Leadership Board - Chair's Report				Agenda Item no.	6.5.7	
Meeting:	Board		Public	x	Meeting Date:	30.03.23	
			Private				
Status *(please tick one only):*	Assurance	x	Approval		Information		
Lead Executive:	Chief Executive						
Report Author (Title):	Head of Corporate Business						

Main Report

Background and current situation:

In August 2022, following consultation with Executives and Clinical Board Triumvirates, a Senior Leadership Board (SLB) was established to ensure representation from Clinical Board leaders as well as Executives. This board replaced the previous Health Services Management Board and Management Executive meeting as the primary formal forum for executive decision making as outlined in Schemes of Delegation and Standing Financial Instructions. SLB operates under agreed Terms of Reference and routinely meets twice per month.

Following discussion between the Chair and Chief Executive it has been agreed to bring a SLB Chair's Report to Board for assurance. Due to the significant volume of SLB activity between August 2022 and March 2023 it has been agreed that this report will cover activity between January and March 2023, with future reports then routinely focusing on the interval between Board meetings. However, if Board members wish to view SLB meeting minutes from the months not covered in this report they are welcome to do so through contact with the Head of Corporate Business.

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

05 January 2023

The following items were approved:

- **UHB 278 Management of Throat Packs**. A revised Policy and Procedure was approved.
- **Wards C3 and C5 Winter Bed Plan**. This plan aimed to use existing discretionary capital, within the financial year, to commence enabling works for the Cardiothoracic service. The refurbishment is a key enabler to the plan to relocate the Cardiothoracic service back to UHW. The proposal to refurbish ward C5 was approved and due to the need for in year expenditure it was agreed to seek Chairs action to award the works contract under the terms and conditions of the NEC Short Form contract at a cost of £1,000,974 inclusive of VAT.
- **Annual Report of the Director of Public Health 2021 (published 2022).** To note that this report is always a year in arrears. The focus of this report was on the concept and application of value. The report was approved and recommended to Board. The progression of a value-based approach in the UHB and through our local partnership system was supported.

The following items were discussed:

- Revenue Allocation 2023/24.
- Air Quality Monitoring on UHB sites.
- Update on People and Culture, Quality and Safety, Public Health, Finance, Digital, Communications, and Innovation and Improvement.

18 January 2023

The following items were approved:

- **Kings Fund Reports on Transformation and Improvement in Cardiff and the Vale of Glamorgan.** These reports were co-commissioned by the Executive Director Public Health and Executive Director Strategy and Plans. This was initiated in 2021 to independently identify what was needed to achieve a systematic approach to prevention and early intervention within our organisation. The reports did not describe the specifics of what was needed and further work would be needed to identify how to best implement the identified themes as part of our strategy over the next 3-5 years. The content of the two reports was noted. It was agreed to hold a workshop with relevant partners in Spring 23 and the priorities identified in the reports would be considered in strategy refresh, IMTP and annual plan development.
- **Acute Referral Policy.** An Acute Referral Policy designed by the Emergency Department was explained. It was written with input from Junior Doctors to clarify how patients are accepted into the hospital, how they are managed between clinical teams and how they are reviewed. The policy contains a 12-point plan focussing on interactions between clinical teams, where responsibilities for patients lie and how a consistent approach across clinical teams could be developed and maintained. The Acute Referral Policy was approved for adoption across the Health Board.

The following items were discussed:

- **Healthy Weight in Children Report.** The Executive Director Public Health brought the report to SLB. The report was in part generated to answer a question at Board regarding waiting lists for children and healthy weight. The report described a whole system approach to healthy weight in children and specific approaches with families and environments. A comprehensive approach had been undertaken, with multiple component parts, illustrated over a number of years in the report. The dietetics team have a key and leading role in this arena of work. The UHB are recognised as leading the way with this work (both for children and adults).
- **Planning for the AGM.** The SLB membership were asked to provide ideas to refresh the approach to the July 23 AGM to better engage with the public, partners, stakeholders and the 3rd sector and showcase new initiatives or achievements.
- **Shaping Our Future Well-Being (SOFW) Strategy Refresh Engagement Pack.** The SOFW Strategy Refresh Engagement Pack was presented to SLB by the Executive Director Strategy and Planning. The core presentation was described and it was identified that this had been tested through exposure to a number of groups. It was emphasised that this phase of the engagement process is about co-production. It allows space to sharpen up our themes and develop our vision. English and Welsh versions are available. New website and links were provided to SLB members to enable them to manage their staff to access the online survey and join workshops and online events.

31 January and 03 February 2023

Extraordinary SLBs were held on these dates to ensure situational awareness of pending industrial actions, coordinate mitigation plans and identify lessons.

02 February 2023

The following items were approved:

- **Timetable for the Production of 2022/23 Annual Accounts and Annual Report.** The process and timetable for the timely production of Annual Accounts and Annual Report was agreed.
- **Post Ockenden Report Investment Proposal.** This item related to proposals for investments to strengthen the safety and quality of obstetric services following gap analysis against the recommendations of the Ockenden Report. The investment proposal had previously been presented to the Investment Group which had recommended a strengthening of the outcome measures before presentation to SLB. SLB suggested further adaptations to the investment proposal and, subject to these adaptations, agreed that the business case should be presented to Board at the earliest opportunity.
- **Strike Action.** Despite the extraordinary SLB on 31 January 2023 there was a need to provide a further update as the situation remained dynamic and challenging. Agreement was reached on further mitigation and contingency plans.

The following items were discussed:

- **Draft Decarbonisation Action Plan.** The Health Board is mandated by Welsh Government to have a Decarbonisation Action Plan. A draft plan was briefed to SLB. It was determined that the draft required amending to include a clearer and more ambitious vision and a clearer series of enabling actions. Once these amendments were made the draft Decarbonisation Action Plan should be brought to SLB for approval to recommend to Board.
- **The Armed Forces Covenant Duty.** It was identified that the Armed Forces Covenant Duty is now a statutory duty and as such there are implications for how the health board designs and manages its services. The duty was described, as were planned actions to produce and disseminate policy.
- **Harassment of HIW Staff.** The CE shared a letter she had received from the HIW Chief Executive that described harassment and poor interactions with HIW staff conducting inspections across NHS Wales. The CE had responded to the letter to provide assurance that such interactions and behaviors would not be tolerated.
- **Cost of Living Impact.** The Director of Operations Mental Health Clinical Board shared evidence of the impact of the cost of living crisis on Mental Health services. The information was derived from input obtained from staff, partners and Trade Unions. It was agreed that this was important evidence that needed to be shared with RPB, and People and Culture Committee.
- **Financial Savings Plan Ambition 23/24**. Initial proposals for a series of savings and efficiencies projects were presented for SLB consideration by the Executive Director of Finance. It was identified that these were early ideas on which feedback was welcome, and that once these projects were more refined they would be brought to future SLB for agreement to pass for Board approval.
- **Cyber-Attack Threat Levels**. It was identified that cyber-attack threat levels remain extremely high, with intelligence that health board websites may be targeted. SLB were asked to disseminate the need for increased vigilance across the organisation.

16 February 2023

The following items were approved:

- **UHB Representation on Medicentre Board.** The Medicentre Constitution requires representation from the Health Board. The current Health Board representatives will shortly relinquish their roles on the Medicentre Board and replacements were agreed.
- **UHL Orthopaedic Theatres Outline Business Case (OBC).** The OBC had been through Investment Group and Capital Management Group. The business case proposes the replacement of the 'German' theatres at UHL, previously used for orthopaedic cases and condemned in 2019. It would replace lost capacity and upgrade the laminar flow to address previously identified IP&C concerns. A strategic case has been previously presented to Welsh Government and supported in principle. SLB agreed to recommend the OBC for submission to Board with a recommendation for subsequent submission to Welsh Government.
- **Assistant Practitioner Proposal & Workforce Resourcing.** A proposal was made to initiate a different approach to the nursing workforce that would reduce or ultimately eliminate the need for overseas recruitment and significantly reduce the run rate for agency staff. The proposal seeks to develop a Band 4 Nursing role which is in line with similar developments across Wales. Built into the project is the training and development capacity and capability to develop Band 4s into registered posts. It was emphasized that whilst this project will commence with supporting Band 4 nurse recruitment and development the team identified to support this transition will also be able to support similar workforce initiatives for other professions. Permission to progress and develop the plan was agreed and an update on progress will be provided to the Investment Committee in six months.

The following items were discussed:

- **WAGESTREAM**. The Executive Director of Nursing (EDN) introduced the item and explained that WAGESTREAM is a private company that provides an opportunity for staff to pull an element of their monthly wage forward early i.e. ahead of their pay day. The company has worked extensively with English NHS trusts and more recently has started working with CTMUHB and HDUHBs. There are a variety of elements to the WAGESTREAM process which can be selected by the UHB – the EDN recommended the element that allows employees early access to pay for any additional hours worked such as bank shifts or overtime. The benefit would be a positive impact on the cost of living impact on staff and a reduction in the number of staff electing to work for agencies who pay with more speed than the standard NHS pay system. Following discussion there was in principle agreement to the proposal but a number of further questions needed to be clarified before SLB was content to approve

the implementation of WAGESTREAM. The item will be brought back to a future meeting for final approval.

- **Regional Ophthalmology Strategy.** This item described to SLB the collaborative work being taken with CTM UHB and AB UHB to develop a regional ophthalmology strategy and model of care. It was identified that the development work is focusing on short to medium term solutions as well as those for the long term. A programme to make use of capacity and Neville Hall Hospital and use the Vanguard capability is currently in the final stage of sign off. There are big potential benefits to be realised from this strategy but for the long term there will need to be significant enablers such as infrastructure and digital. The direction set out in the Regional Ophthalmology Strategy was noted and updates on the development of regional services will be brought back to SLB on a quarterly basis.
- **IMTP Development Review.** SLB were provided with an overview of progress made in forming the IMTP for next year and a description of how the plan will be framed, and the process/activity needed for completion was described. It was also identified that there would be a Workshop for SLB members on 02 March 2023 to enable the gathering of final views before the IMTP was shaped for presentation to March 2023 Board. The IMTP development review was discussed and noted.
- **High Level Resource Map (HLRM).** SLB were reminded of the purpose of the HLRM and that it aids decision making by providing insight into the distribution of resources. It was identified that there is a wealth of information available within the HLRM which enables the production of a long-term financial model which uses a financial framework spanning ten years of historic information to formulate and model current and future financial positions. Two example Long Term Financial Models were described to promote SLB awareness of the utility of HLRM and provoke discussion on the potential use of a long-term financial model. It was agreed that the HLRM would be further explored at the 02 March 2023 SLB Workshop to sense check the financial feasibility of the IMTP proposals.
- **Duty of Candour and Duty of Quality.** Colleagues from Welsh Government briefed SLB on the Duty of Candour and Duty of Quality. It was noted that the Duty of Candour/Quality will be presented to the next Board Development session and further sessions to discuss the UHB implementation plan would be arranged for SLB as well as Board.

02 March 2023

This SLB was dedicated to a workshop to enable SLB members to participate in the finalisation of the 2023/24 IMTP ahead of March 2023 Board. The purpose was:

- To confirm the key content of our 23/24 Annual Plan/IMTP:
  - To agree the operational delivery targets against Ministerial Priorities.
  - To agree the major service changes.
  - To agree the quality lens and associated quality and workforce priorities.
- To agree the detail of the financial plan:
  - To agree the in-year target for reducing our run rate.
  - To agree the priority areas for action.
  - To agree the team approach to ensure delivery.

Recommendation:

The Board is requested to:

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

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

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

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

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

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

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

Report Title:	C&V Integrated Performance Report				Agenda Item no.	6.6	
Meeting:	C&V UHB Board		Public	X	Meeting Date:	30/03/2022	
			Private				
Status *(please tick one only):*	Assurance	x	Approval		Information	X	
Lead Executive:	Fiona Kinghorn, Jason Roberts, Rachel Gidman, Paul Bostock, Catherine Phillips						
Report Author (Title):	Information Manager						

Main Report
Background and current situation:

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

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

Population Health

Immunisation	Standard	Trend	2022 / 23 Qtr 3	
% of children up to date with scheduled vaccines by 4 years of age	95%	na	81.8%	**
	Standard		**Feb-23**	
% of adults aged 50 years and over who have received a Covid-19 Autumn 2022/23 booster vaccination	na	na	73%	*
% of people aged 5-49 years in a clinical risk group who have received a Covid-19 Autumn 2022/23 booster vaccination	na	na	39%	*

Tobacco	Standard	Trend	2022 / 23 Qtr 2	
% of smokers who become treated smokers	5%	na	0.5%	**
% of treated smokers who quit at 4 weeks	40%	na	80%	**

Quality & Safety

Patient Satisfaction	Standard	Trend	Feb-23
30 day complaints response compliance %	75%		81%
Patient Experience			**Jan-23**
Patient Experience	na		77%
Falls			**Feb-23**
Slips Trips and Falls (30 day moving total)	na		268
Slips Trips and Falls with harm - moderate to severe (30 day moving total)	na		37
Serious Incidents	**Standard**	**Trend**	**Feb-23**
Nationally Reportable Incident (SI)**	na		13
Number of Never Events	0	na	0

Mortality	Standard	Trend	Sep-22
Myocardinal Infraction within 30 days of admission, age 35-74 (Rolling 12 Months)	na		4.8%
Stroke within 30 days of admission (Rolling 12 Months)	na		15.0%
Hip Fracture within 30 days of admission, age 65 and over (Rolling 12 Months)	na		2.6%
Crude Mortality (Last Week of the month)	0		41
			Dec-22
Still births (Rolling 12 Months)	na	na	32
Infection Control			**Jan-23**
All Reported Infections (Rolling 12 Months)	743		771

Workforce

	Standard	Trend	Jan-23
Sickness Absence Rate (in-Month)	6%		6.8%
Sickness Absence Rate (12-Month Cumulative)	6%		7.1%
Values-Based Appraisal Compliance	85%		51.4%
Medical Based Appraisal Compliance	85%		80.3%

	Standard	Trend	Jan-23
Turnover Rate	7% - 9%		13.3%
Mandatory Training Compliance	85%		76.1%
Fire Training Compliance	85%		68.4%

Operational Performance

	Standard	Trend	Feb-23
A&E 12 hour waiting times	0		715
A&E 4 hour waiting %	95%		70.9%
Ambulance Handover Times >1 hour	0		548
Ambulance Handover Times >4 hour	0		0
Number of 12 hour trolley waits	0		109
Number of Patients over 24 hours in EU	0		1107
			Jan-23
RTT Waiting less than 26 weeks %	95%		56.1%
RTT Waiting Over 36 Weeks	0		39599
RTT Waiting Over 52 Weeks	0		23950
RTT Waiting Over 104 Weeks	0		4587
RTT Waiting Over 156 Weeks	0		955
Diagnositcs >8 weeks Wait	0		5247
			Jan-23
GP OOH 'emergency' patients requiring an attendance at a primary care centre within 1 hour	90%		100% #
GP OOH 'emergency' patients requiring a home visit within one hour	90%		100%
			Jan-23
#NOF: Time to ward performance (4 hours)	na		1.8%
#NOF: Time to theatre (36 hours)	na		63.2%

	Standard	Trend	Jan-23
Mental Health Part 1a - Assessments within 28 days	80%		98.0%
Mental Health Part 1b - Therapy Commencing within 28 Days	80%		92.0%
			Feb-23
Total number of medically fit for discharge patients	na	na	363
Total number of bed days lost	na	na	11510
Average number of bed days lost per patient	na	na	32
			Feb-23
Number of Patients Delayed over 100% for follow-up Appt	0		51374
			Jan-23
Single Cancer Pathway	75%		55.1%
Total number of patients on Single Cancer Pathway	na		2029
Total number of patients on Single Cancer Pathway over 62 days	0		317
Total number of patients on Single Cancer Pathway over 104 days	0		83
			Jan-23
Stroke: thrombolysed patients door to needle performance <=45 mins	100%		0%
Stroke: CT scan performance 1 hour	100%		61.3%
Stroke: 4 hours to ward	100%		15.4%

Finance

	Standard	Trend	Feb-23
Deliver 2022/23 Draft Financial Plan	£17.1m planned deficit	na	£24.658m deficit
Remain within capital resource limits.	Within planned expenditure £51.675	na	£27.282m
Reduction in Underlying deficit (Forecast)	Under discussion with WG and private fiance committee	na	-
Delivery of recurrent £15.400m 1.5% devolved target (Forecast)	£15.4m	na	£12.721m

	Standard	Trend	Feb-23
Delivery of £4m non recurrent target	£4m	na	£6.622m
Creditor payments compliance 30 day Non NHS (Cumulative)	95%		94.3%
Remain within Cash Limit (Forecast cash surplus)	Within Cash Limit	na	Forecast deficit
Maintain Positive Cash Balance	Positive Cash Bal.	na	£2.025m

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

** *No new data available*

 # No patients recorded within this measure during this time period

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

POPULATION HEALTH

Covid-19 and respiratory infections epidemiology update:

- In the second week of March 2023, most Covid indicators were stable or falling, following a small rise during February 2023.
- This included stable care home clusters and declining incidence recorded by LFD and PCR in Cardiff and the Vale
- Of note, there was a slight increase in hospital clusters in early March, along with hospital admissions, though it is not clear if this is the start of a wider trend.
- The XBB.1.5 variant of Omicron increased in prevalence during February to overtake CH1.1.
- Prevalence of seasonal flu infection remains at a low level.

Test, trace and protect (TTP):

- Testing and contact tracing services continue to operate as previously reported through to the end of March 2023.
- UHB and partnership teams have developed a business case to respond to the 2023/24 funding letters received from Welsh Government (which were reported in the last update).
- The UHB testing and vaccination teams have agreed a delivery model for 2023/24.
- Partner organisations have agreed interim arrangement whilst work takes place both regionally and nationally to develop a sustainable and integrated health protection system for the future, which is able to respond to an all hazards remit

Covid-19 2022/23 booster and flu vaccination:

- We are now coming towards the end of the Covid-19 autumn 2022 booster and flu vaccination programmes for the current Autumn/Winter season.
- As of 1st March 2023, uptake for Covid-19 autumn 2022 booster vaccines amongst people aged 65 years and over is 82.9%. C&V UHB has also achieved the national ambition of 75% for flu vaccination amongst people aged 65 years and over with 75.6% vaccinated. However, we have not yet met the 75% ambition for flu vaccine for other eligible groups including those in clinical risk groups, school-aged children and healthcare workers. We are therefore continuing to offer walk-in appointments at Woodland House MVC to all eligible groups (including children) yet to receive their Covid-19 vaccines (1st dose, 2nd dose, 2021 booster, 2022 booster) or flu vaccinations.
- Planning has commenced for the Spring 2023 and Autumn 2023 Covid-19 booster vaccination programmes following Joint Committee for Vaccination and Immunisation (JCVI) interim recommendations published on 25 January. The JCVI has indicated that for a small group of people (e.g., those in older age groups and those who are immunosuppressed) an extra booster vaccine dose may be offered in Spring 2023 whilst for Autumn 2023 persons at higher risk of severe Covid-19 would be offered a booster vaccine dose. Surge responses may also be required should a novel variant emerge.
- Holm View MVC site is now closed. Planning underway for a new Vale provision for Spring and Autumn 2023 programmes.
- An announcement is expected from the JCVI for a new infant vaccination programme (infants aged 6m to 4y in a clinical risk group – to be defined).

Tobacco Control update:

- **Smoking Cessation**

  Tier 1 Smoking Cessation:
  Currently awaiting updates to national performance indicators, there is no updated data since Quarter 2, 2022-2023 - 0.5% of smokers set a firm quit date ('Treated Smokers') and of those, 80% quit smoking at 4 weeks (the highest cumulative quit rate in any quarter since Tier 1 reporting commenced). For all 3 Smoking Cessation Providers, 4 week quit rates exceeded 78%.
  Community Pharmacies delivering the Level 3 (L3) Enhanced Smoking Cessation Service achieved a 90% 4 week quit rate (Quarter 2, 2022-2023) – the highest quarterly rate for L3 since 2018.

- **Model for Access to Maternal Smoking Cessation Support (MAMSS)**

  The most recent data is for Quarter 3, 2022-2023, 51% of pregnant women were referred to MAMSS for stop smoking advice, reflecting a slight decrease from 66%, reported in Quarter 2, and 65% for Quarter 1.
  As part of on-going performance monitoring, and reflecting changes being implemented across all MAMSS programmes in Wales, a revised pilot pathway was introduced in November 2022 to increase engagement levels to quit smoking beyond initial support and advice. 27% of those referred to MAMSS received an initial intervention, but less than a third accepted on-going support to quit smoking (Quarters 1 and 2 combined, 2022-2023). In Quarter 3, 2022-2023, 75% of all pregnant women who received an initial intervention with MAMSS, accepted on-going support – reflecting a significant increase – suggesting the changes implemented are having a positive impact. However, recognising the many varied health and social needs of those within this target group, smoking quit rates remain low. Working with the Midwifery team, recommendations for future delivery following the one-year pilot, may include a generic support worker role, with stop smoking support included within this, as part of a wider patient centred approach.
  MAMSS programmes across Wales contribute to the NHS Performance Ministerial priorities, to reduce smoking in pregnancy rates in Wales. 15% of pregnant women were recorded as smoking at initial assessment in Wales 2021-2022, (9.3%, Cardiff and Vale University Health Board), with 12% smoking at birth (10.8%, Cardiff and Vale University Health Board). Smoking rates both at booking and on delivery are higher in younger women in Wales - 33%, 16-19 years, (initial assessment), compared to 10.6%, 30-34 years. On delivery 29%, 16-19 years are recorded as smokers, compared to 9.5%, 30-34 years (Maternity and Birth Statistics, 2021-2022, Welsh Government).
  A review of all MAMSS programmes in Wales is currently being undertaken by Public Health Wales on behalf of Welsh Government. As part of a consultation process, local and national meetings have taken place, noting our revised delivery model with improved delivery outcomes noted.

  - **Smoking Prevalence**

  National Survey for Wales, annual data. Previously reported on (July 2022). Cardiff and Vale UHB 12% smoking prevalence; 26% smoking rates reported in the most deprived and 11% in the least deprived areas. Next release, July 2023.

QUALITY AND SAFETY

Concerns

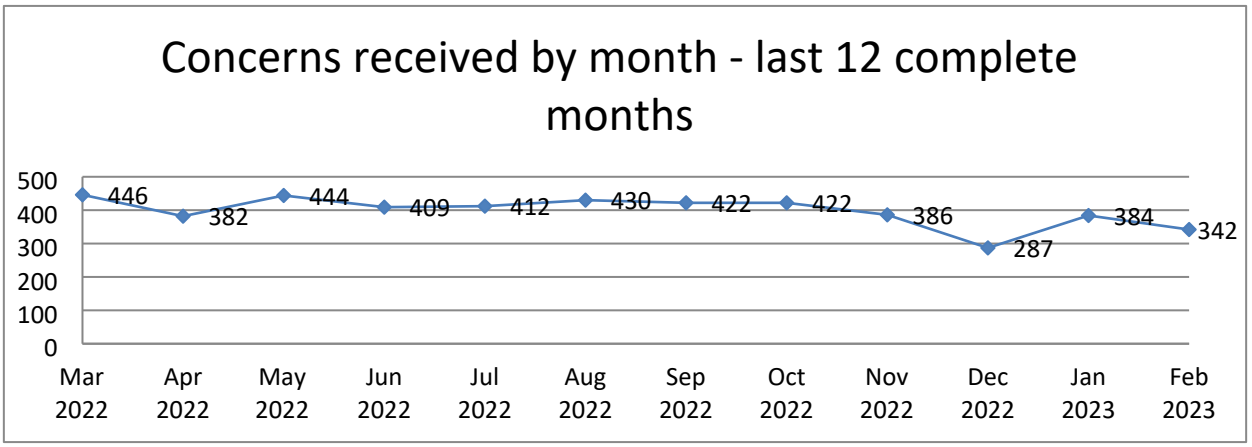
During January and February 23, it is pleasing to note that, despite the current demand on the service, we have achieved a slight improvement in our overall 30 working day response time for all concerns. We closed 77% of concerns in January within 30 working days and 81 % in February.

30-day performance
October 85%
November 77%
December 80%
January 77%
February 81%

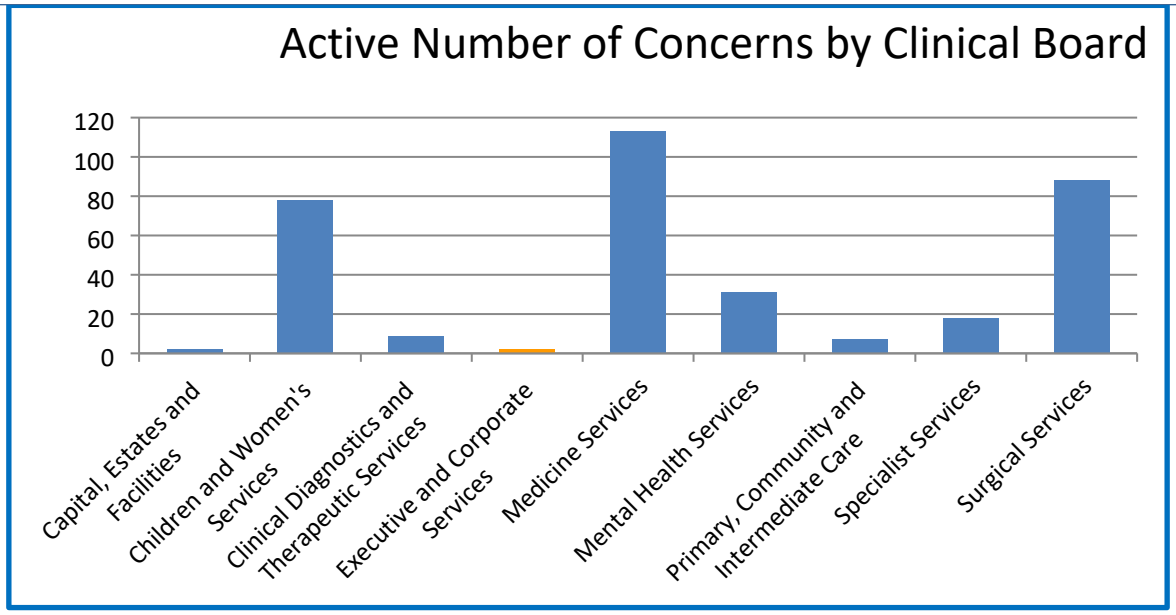
In January and February, we noted a slight increase in the number of concerns processed in line with Early Resolution (ER) (*this process can be utilised dependent upon the nature of the concern*). We managed 65 % of concerns under ER which is an increase of 2% in comparison to December and January. Early Resolution aims to ensure a response is received within 2 working days, if however, we cannot issue a satisfactory response to a concern then the formal process must be used.

It should be noted that previously we have been able to process up to 80% of concerns via the Early Resolution route but it is dependent upon timely response to enquiries and ensuring that a satisfactory resolution for the complainant is achieved. We will continue to monitor the performance and conversion rates from Early resolution to formal process.

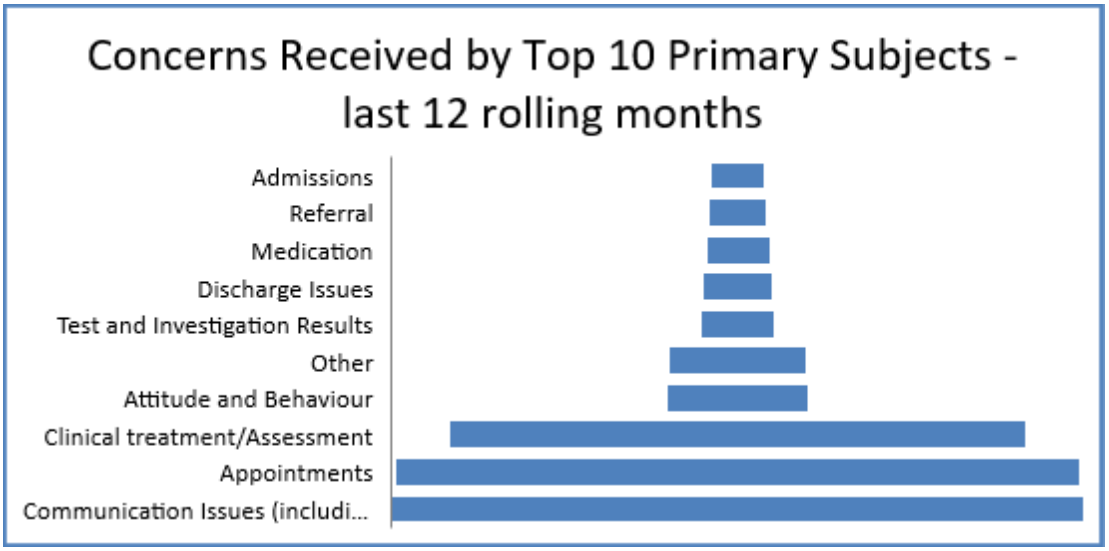
As anticipated, we have noted an increase in concerns since the previously reported decrease during the Christmas holiday period. Whilst the Health Board continues to feel the pressure due to the current demands on the service we continue to be focused upon responding to concerns and improving the response times whenever possible. We continue to feedback to Clinical Boards the themes identified in the concerns (complaints, claims and redress process) aligned with the patient feedback and compliments data.



We currently have 348 active concerns. Surgery and Medicine Clinical Boards consistently receive the highest number of concerns, the high volumes of concerns received in Medicine and Surgery Clinical Board is in line with the number of patient contacts and complex care both Clinical Board's provide. The number of cancellations and delays due to Covid or Industrial action and the significant increase and demand on services like EU are reflected in the numbers and nature of concerns received.



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

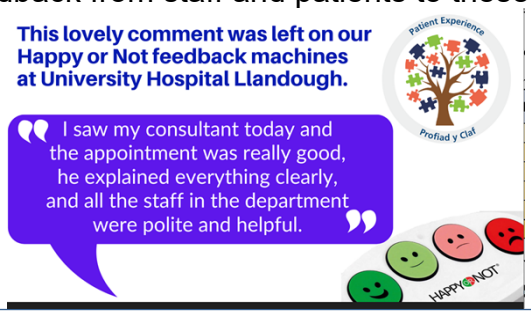


Communication and Clinical treatment have historically been noted as the primary subject in concerns, however, concerns regarding cancellations of appointments have increased and follows closely behind Communication. We continue to see an increase in concerns regarding environment, facilities and attitudes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

Compliments

It is pleasing to note that we are seeing an increase in the number of compliments being shared. We have received 85 compliments during January and February

Every Friday on Social Media we publish some feedback from our Kiosks which receive positive comments on twitter. The feedback from staff and patients to these tweets is very positive



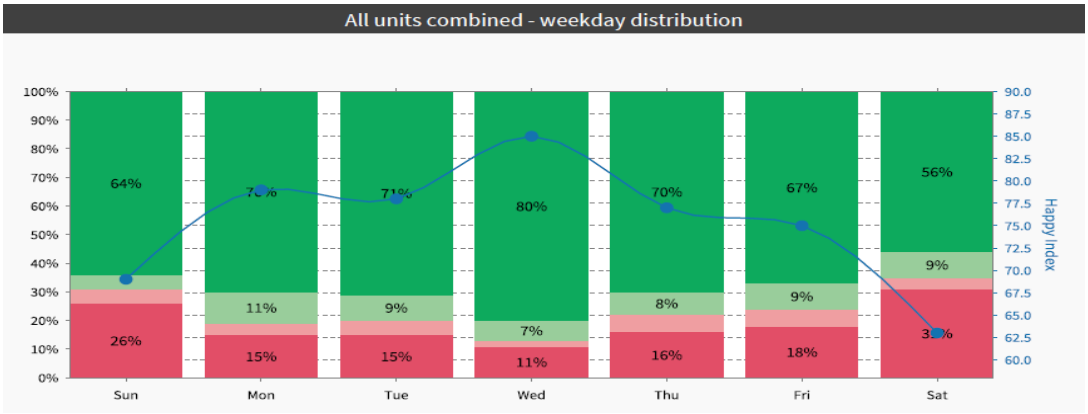
Patient Experience Feedback **HappyOrNot feedback** (All locations)

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

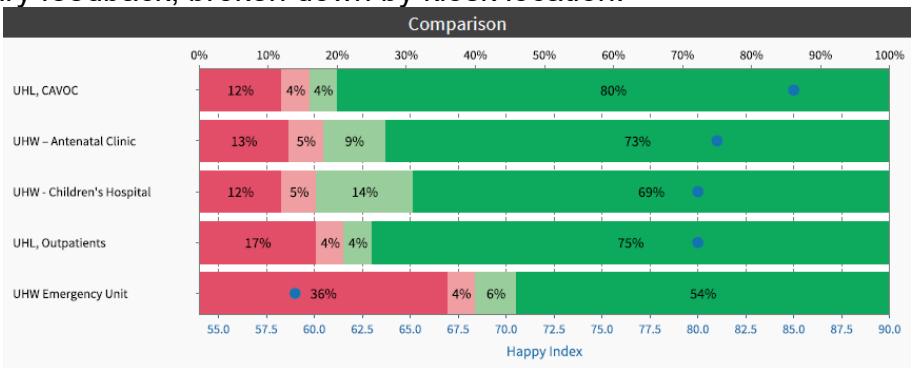
A breakdown of the feedback for December and January is:

Summary values	December	January
Surveys completed	**1669**	**1232**
Response: Very happy button (Excellent/Very	65%	69%
Response: Happy button (Good/Positive)	7%	8%
Response: Unhappy button (Fair/Negative)	4%	5%
Response: Very unhappy button (Poor/Very	24%	18%
Respondents satisfied	**72%**	**77%**

Below Gives the January feedback, broken down by which day of the week the feedback was received:



There is a theme of satisfaction being lowest on a weekend across the UHB
Gives the January feedback, broken down by kiosk location:



HappyOrNot feedback (EU areas only)

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

Summary values	December	January
Surveys completed	803	277
Respondents satisfied	**60%**	**60%**

Civica 'Once for Wales' platform

Our system went live on Friday 28th October and we are currently surveying up to 600 patients daily via SMS. At the time of reporting we have contacted some 37.227 people for feedback via text messaging we are seeing a return rate of 18%. It is our understanding this is higher than many organisations but will be a focus for improvement with more targeted experience data collection over the next year with an aim for a minimum return of 25%.

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

Summary values	December	January
Surveys completed	1148	1599
Respondents satisfied	**88%**	**89%**

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

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

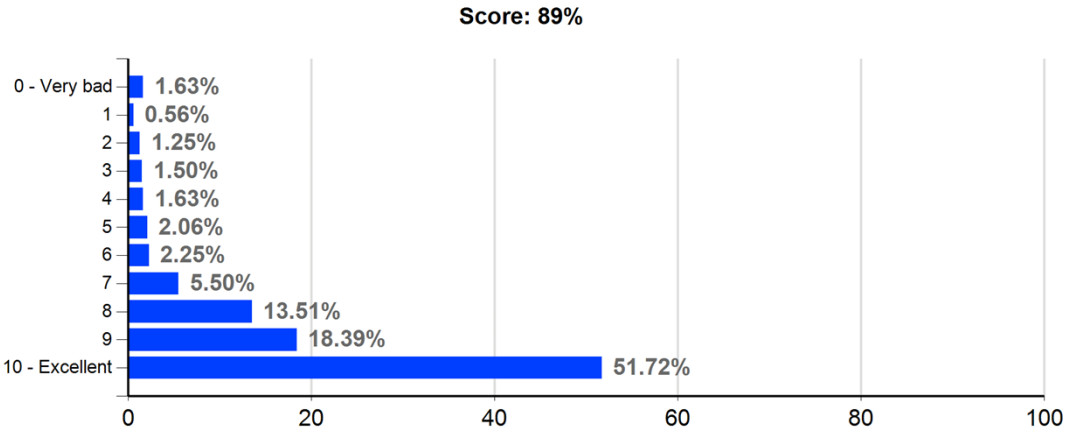
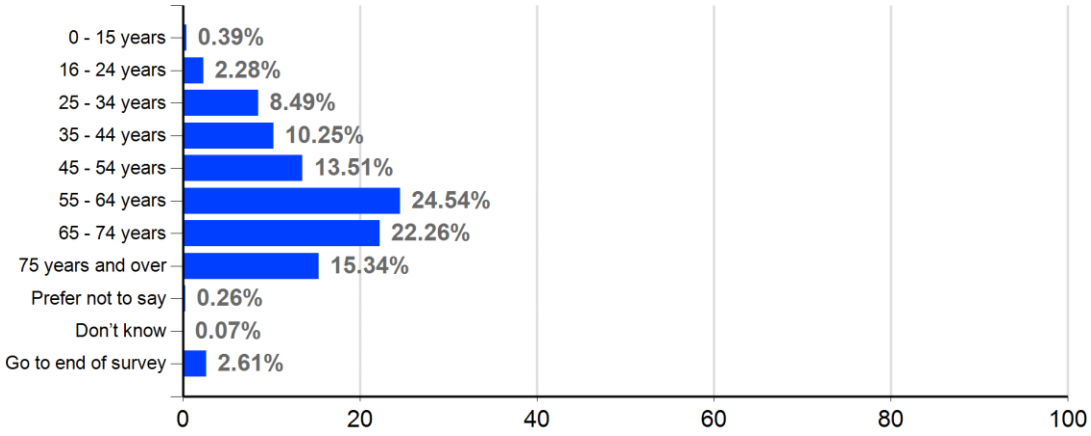


Table below. Gives January's feedback, broken down by age group of respondents.



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

- Survey summary
- Heat map
- Comment report
- Custom reports

It is hoped that in coming months the platform will act as our main 'hub' to collect and collate feedback from various sources e.g. SMS, paper, other links, tablets and kiosks. The system will also enable users to create and deploy their own survey designs and analyse their feedback.

In order to improve the services, we provide, the Patient Experience Team are looking to increase the ways we receive feedback from patients relating to the care they receive. Throughout the month of February, the team including volunteers will be visiting all ward and clinic areas to install the attached stickers/posters.

The Feedback poster will be in A5 size and is a washable adhesive backed sheet which we will place on bedside cabinets, along with this we will place the Feedback Poster at the entrances of all ward areas. Finally, the sticker will be used in communal areas
Embedded within the poster/sticker is a QR code to the survey, along with a contact number and email address for patients who are not able to access the survey digitally. We will monitor the calls to the mobile Patient Experience number and redirect or address queries where appropriate.

The Patient Experience team will review results from the survey which will then be shared with Clinical Boards

We are developing the poster in other languages and will target the areas where we currently know there is a high demand for interpretation services in the specific languages -as the process develops we will also have the BSL survey established

The roll out will be coordinated through our Patient Experience staff and volunteers.

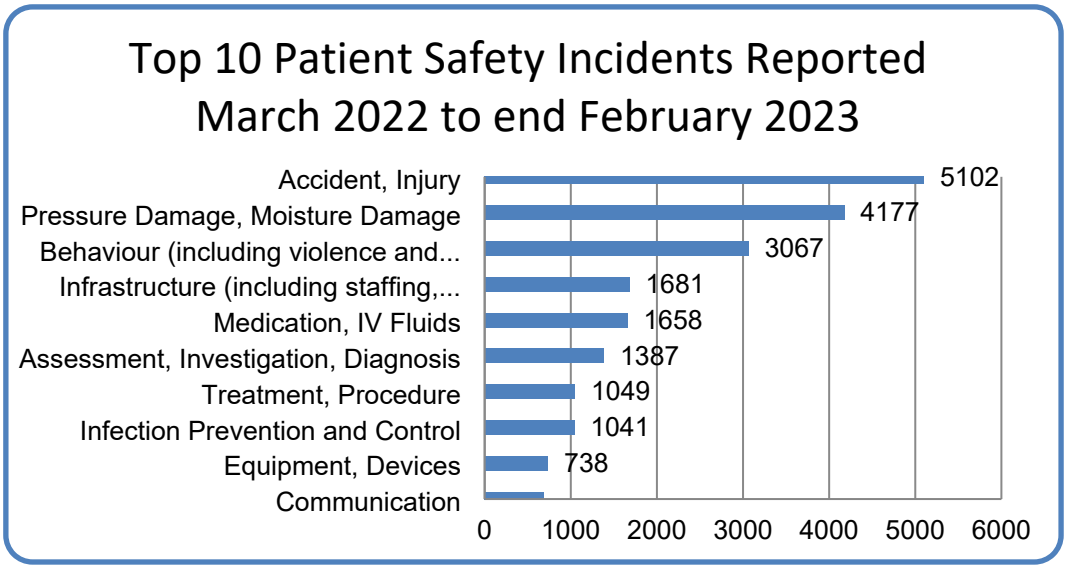
We anticipate this will provide us with more meaningful real time data for ward and clinical areas

PATIENT SAFETY – Incident reporting

The chart below illustrates patient safety incidents reported during February 2023 by incident type. A total of 1490 incidents were reported affecting patients/service users, during this period. As is usual, accident/injury (falls) and pressure damage, are the most commonly reported incidents.

Pressure damage is subject to investigation to establish if there were any modifiable elements or omissions in healthcare. Avoidable pressure damage that is deemed to be associated with healthcare provision are subject to national reporting requirements.

Falls investigations are subject to a scrutiny panel, a new UHB Falls Lead is being appointed within the Corporate Team to lead on this crucial improvement work.



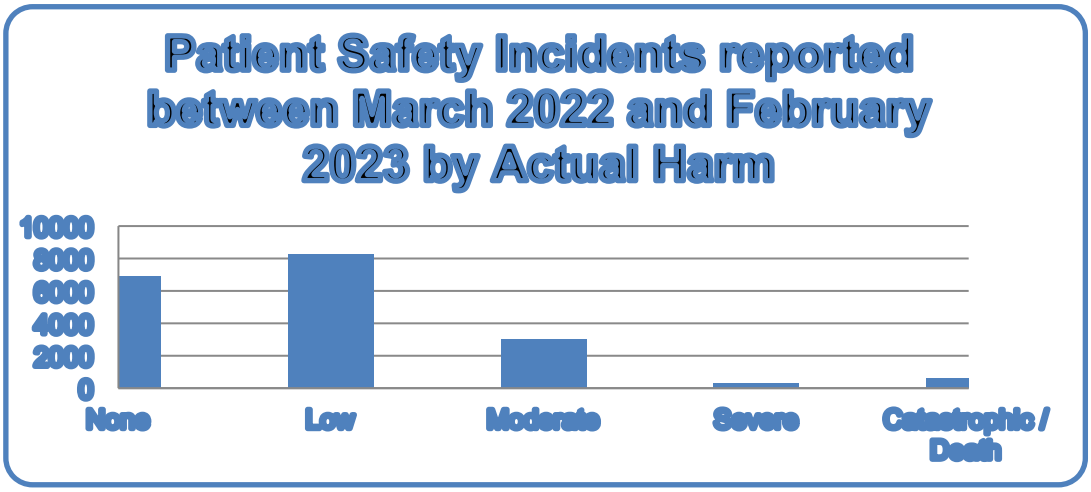


Figure above shows the breakdown of patient safety incidents reported between March 2022 and February 2023 by harm – this is the initial harm grading assigned by the incident reporter. None and low are the highest reported category which is reassuring and demonstrates an open reporting culture that recognises the importance of 'near miss monitoring.

We now have a full years' worth of data entered into the new RL Datix OfWCMS system. Between 1st March 2022 and 28th February 2023, C&V reported 19,184 patient safety incidents, 20% (3,913) of these would have met the criteria for triggering DoC (reported as moderate harm and above), an important consideration when planning for Duty of Candour. We are aware that there will be a significant amount of review required in relation to the grading to ensure that the Duty of Candour is implemented in line with the regulations. The Patient Experience Team have been

working with the Clinical Boards and Primary Care contractors to raise awareness and agree the processes from 1 April 23 .

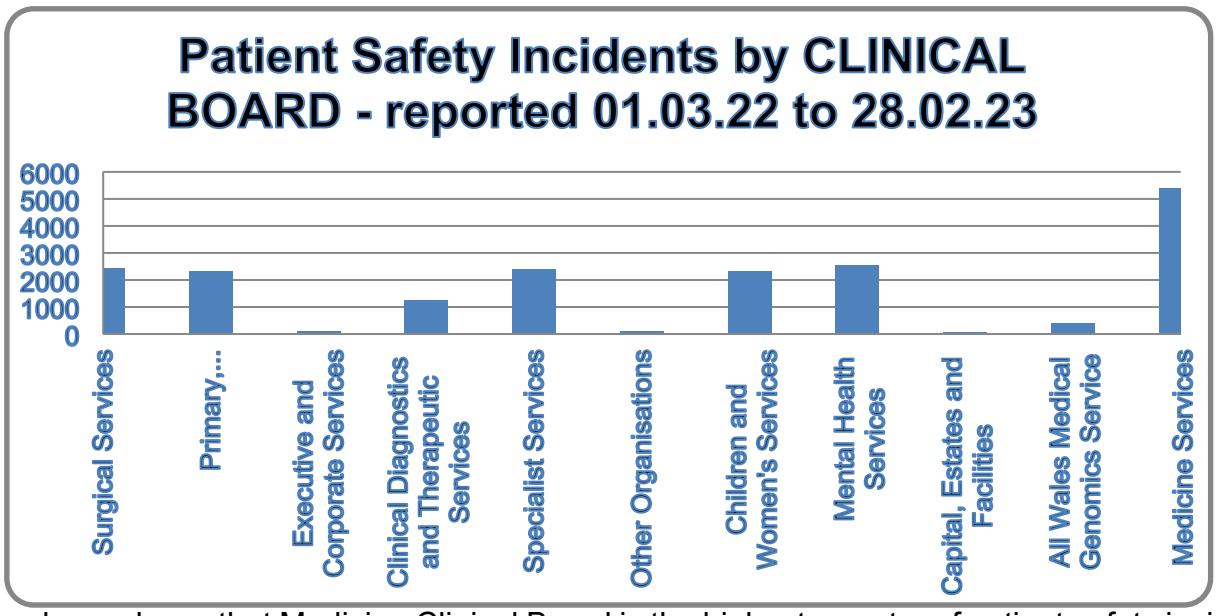
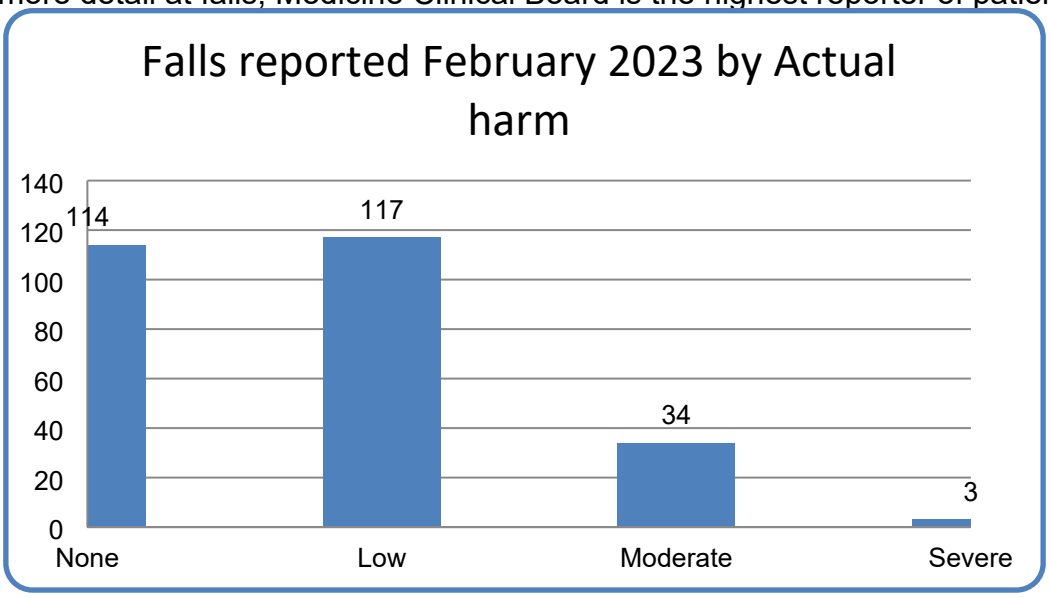


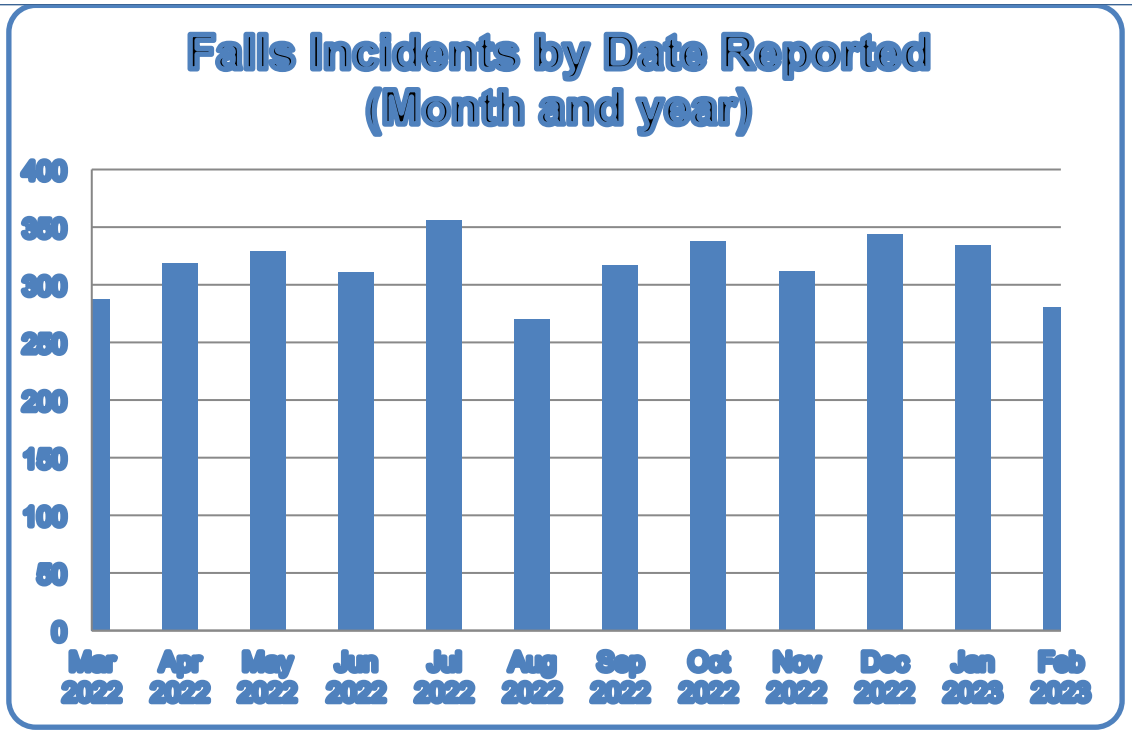
Figure above shows that Medicine Clinical Board is the highest reporter of patient safety incidents reporting 28% of the total for that year, as already highlighted, a significant proportion (21%) of these are reporting falls.

Falls

Looking in more detail at falls, Medicine Clinical Board is the highest reporter of patient falls.



As can be seen above, the majority of falls reported are associated with no or low harm.



The table shows the reporting trend for patient falls between March 2022 and February 2023.

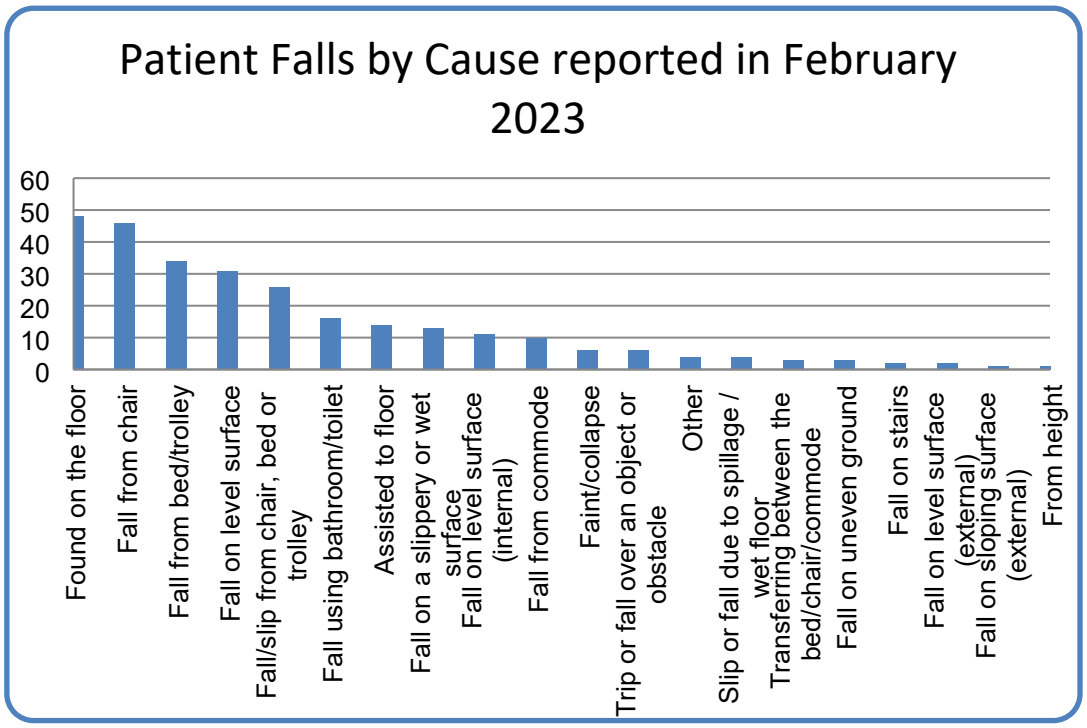
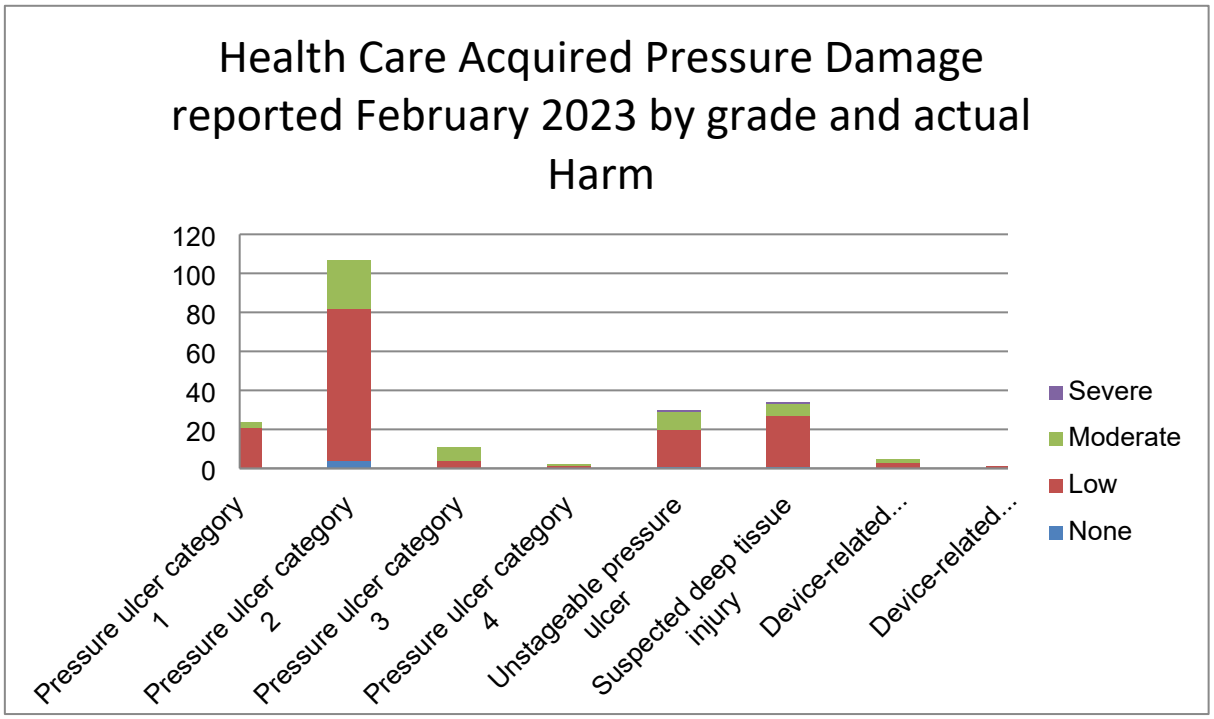
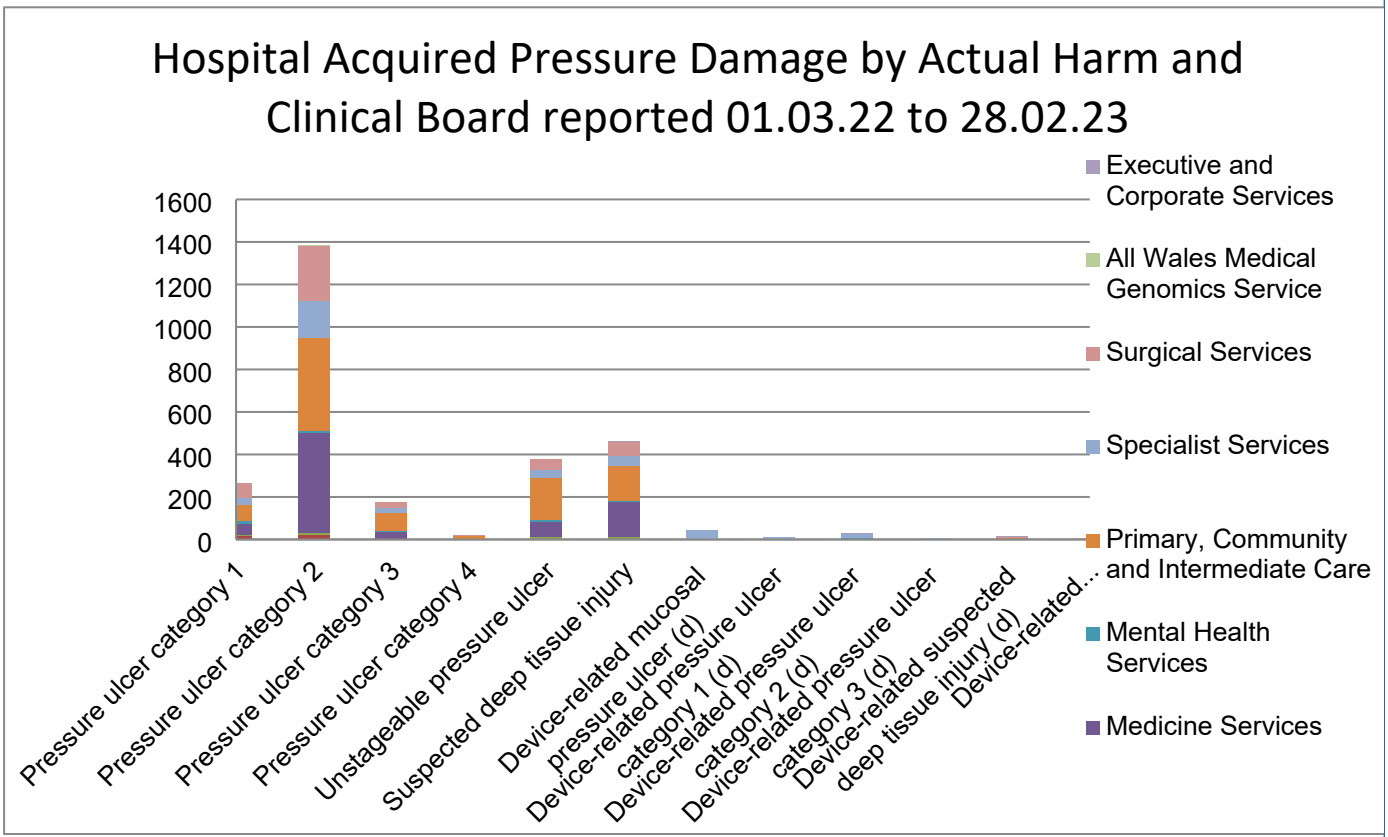


Fig. 7 shows that 'found on floor' is the highest reported patient fall cause.

Pressure Damage



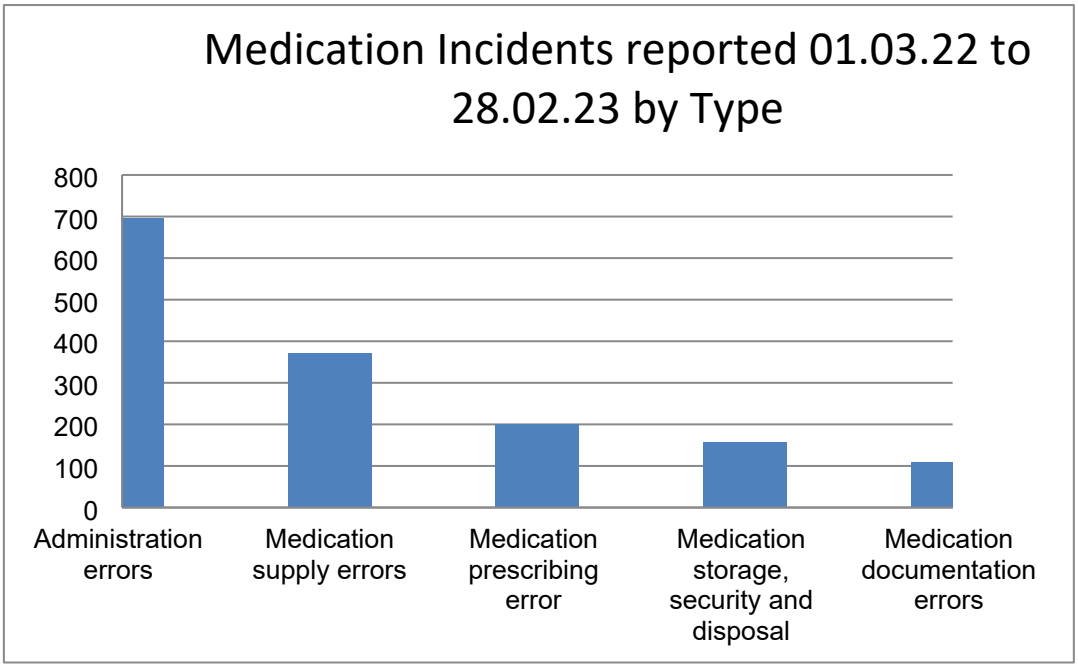
The table shows a breakdown of hospital acquired pressure damage reported in February. Category 2 is the usually the highest reported occurrence.

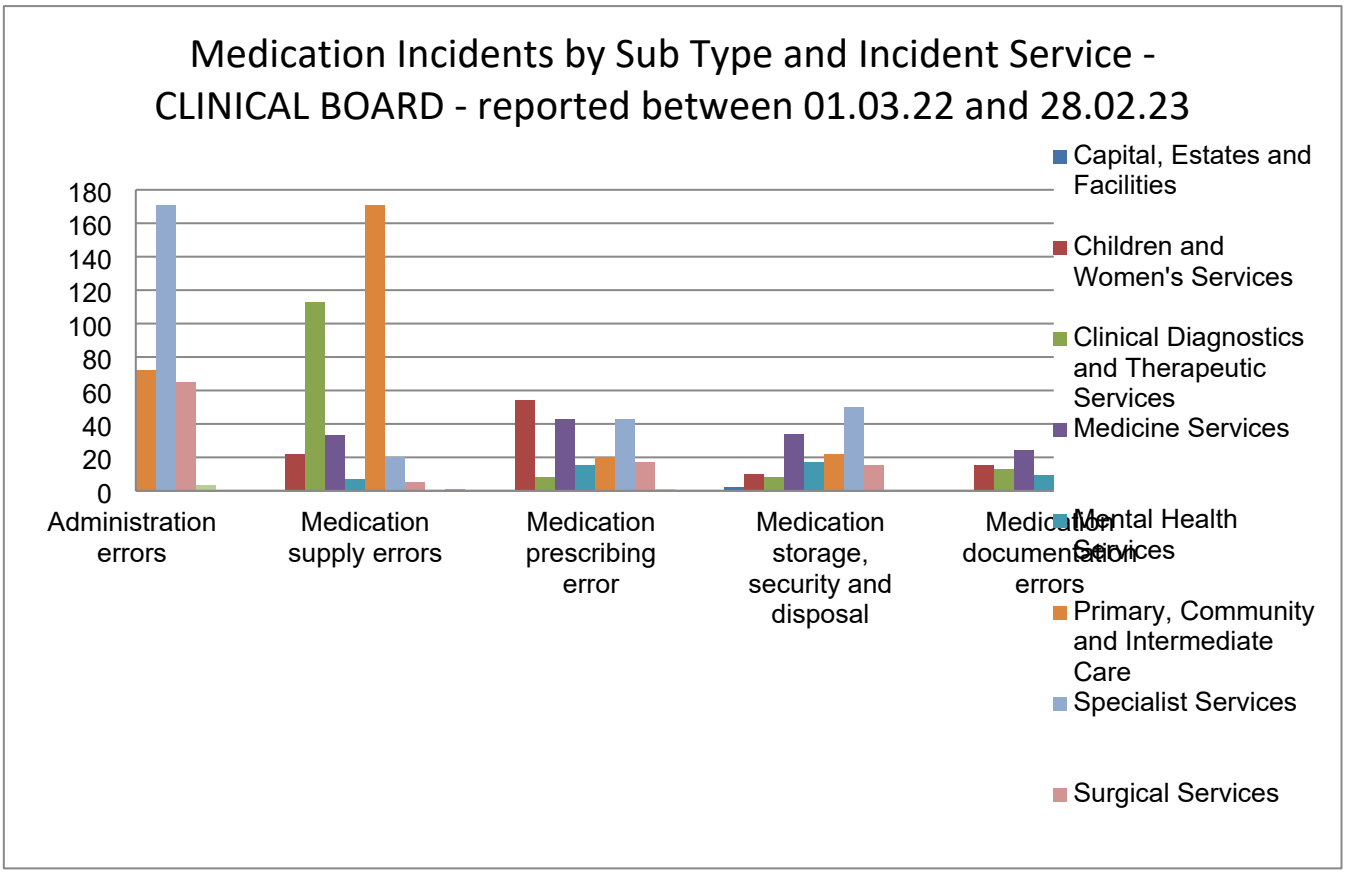


The graph above shows that Medicine and Primary care are the highest reporters of care acquired pressure damage.

Medication Errors

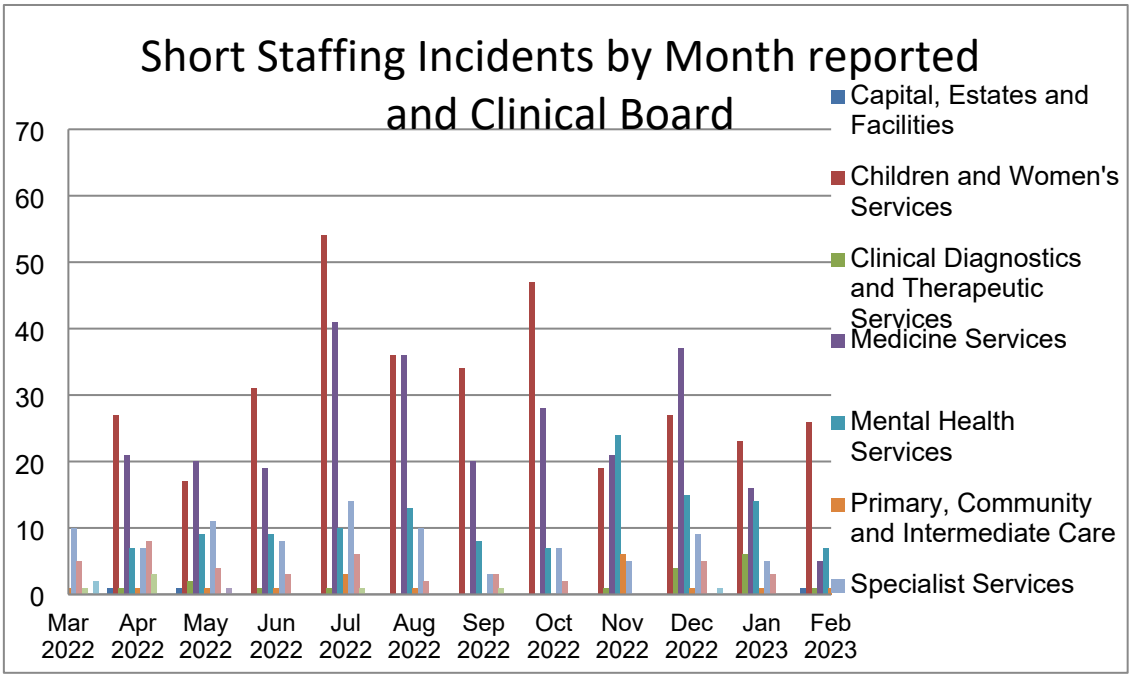
Looking at medication errors for the period of March 2022 to February 2023, administration errors are the most commonly reported medication incident (Fig.9); Medication Safety was the topic of the last World Patient Safety Day.





The table shows that Primary Care and CD&T more commonly report medication supply incidents, whereas Medicine, Specialist and Children and Women more commonly report medication administration incidents.

Staffing



Children and Women and Medicine are the Clinical Boards who report the higher levels of short staffing incidents.

Nationally Reportable Incidents (NRIs)

The table illustrates performance of Nationally Reportable Incidents until 28th February 2023. It is an improving position and reflects the focus and hard work of the Clinical Boards and Patient Safety Team. However, the number of open and overdue NRIs increased in February.

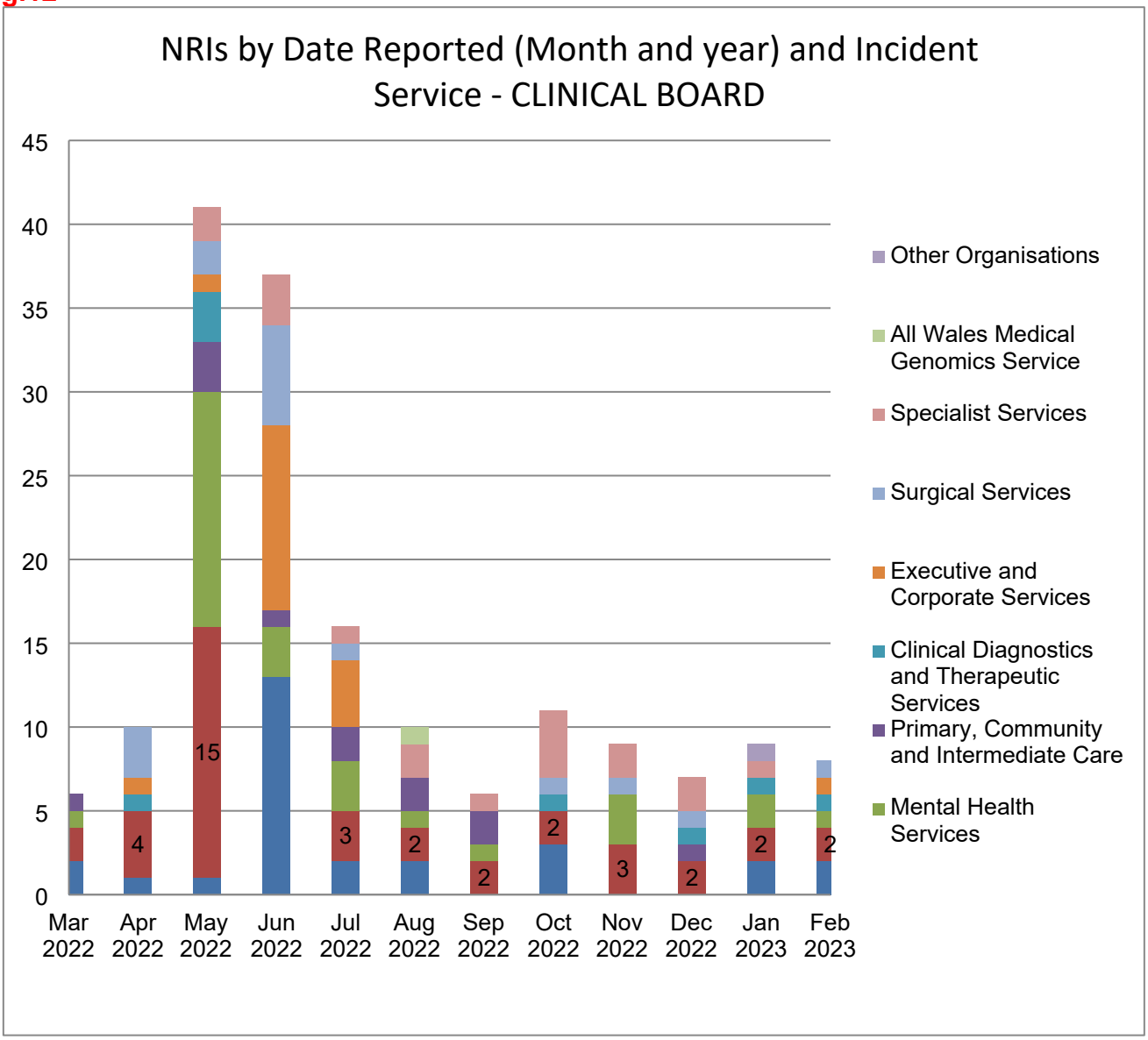
	Open	Overdue
September 2022	53	34
October 2022	48	29
November 2022	51	26
December 2022	43	19
January 2023	46	20
February 2023	57	26

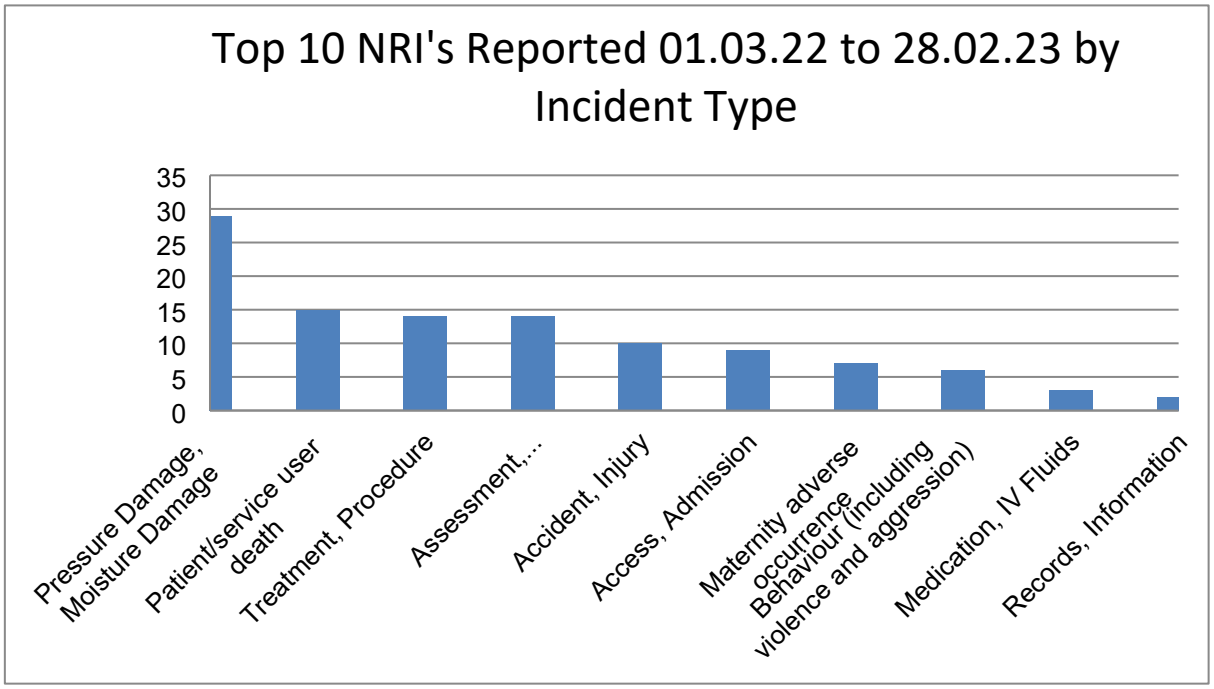
Clinical Board	Open NRIs as of 03.03.23	Overdue NRIs as of 03.03.23
Children and Women	10 ↑	5 ↓
CD&T	4 ↑	0 ↔
Executive	3 ↑	2 ↔
Medicine	7 ↑	3 ↓
Mental Health	12 ↑	6 ↑
Surgery	6 ↓	3 ↔
PCIC	3 ↔	2 ↔
Specialist	10 ↔	5 ↑
Total	**57** ↑	**26** ↑

The above shows that most Clinical Boards have seen an increase in open NRIs over the last month.

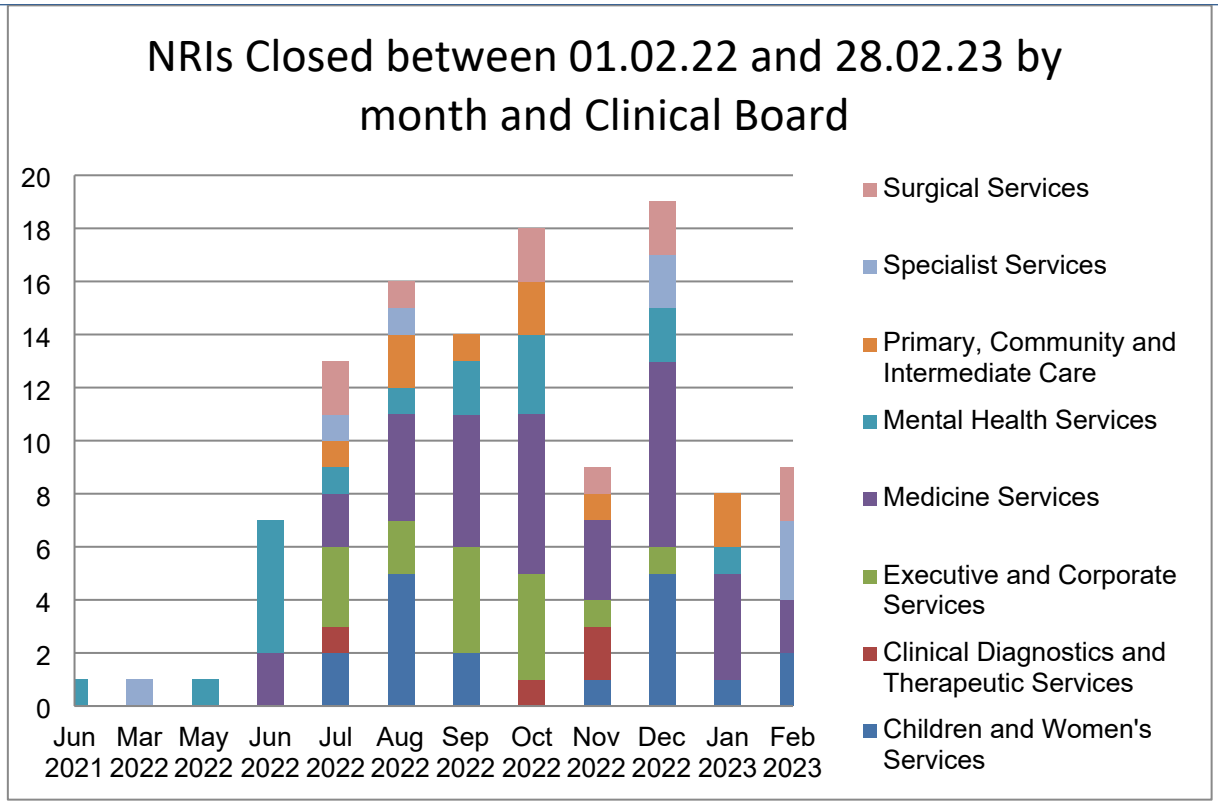
The following chart shows the trend over the last year for NRIs reported by Month and by Clinical Board. The high reporting figures in May and June reflect the requirement for Clinical Boards to migrate their ongoing open NRIs from the old datix system to the new RL Datix OfWCMS. -Once for Wales System

Fig.12





Pressure damage continues to be the highest reported NRI to NHS Wales Delivery Unit.



A significant number of the closure forms submitted by Medicine Clinical Board relates to hospital acquired avoidable pressure damage.

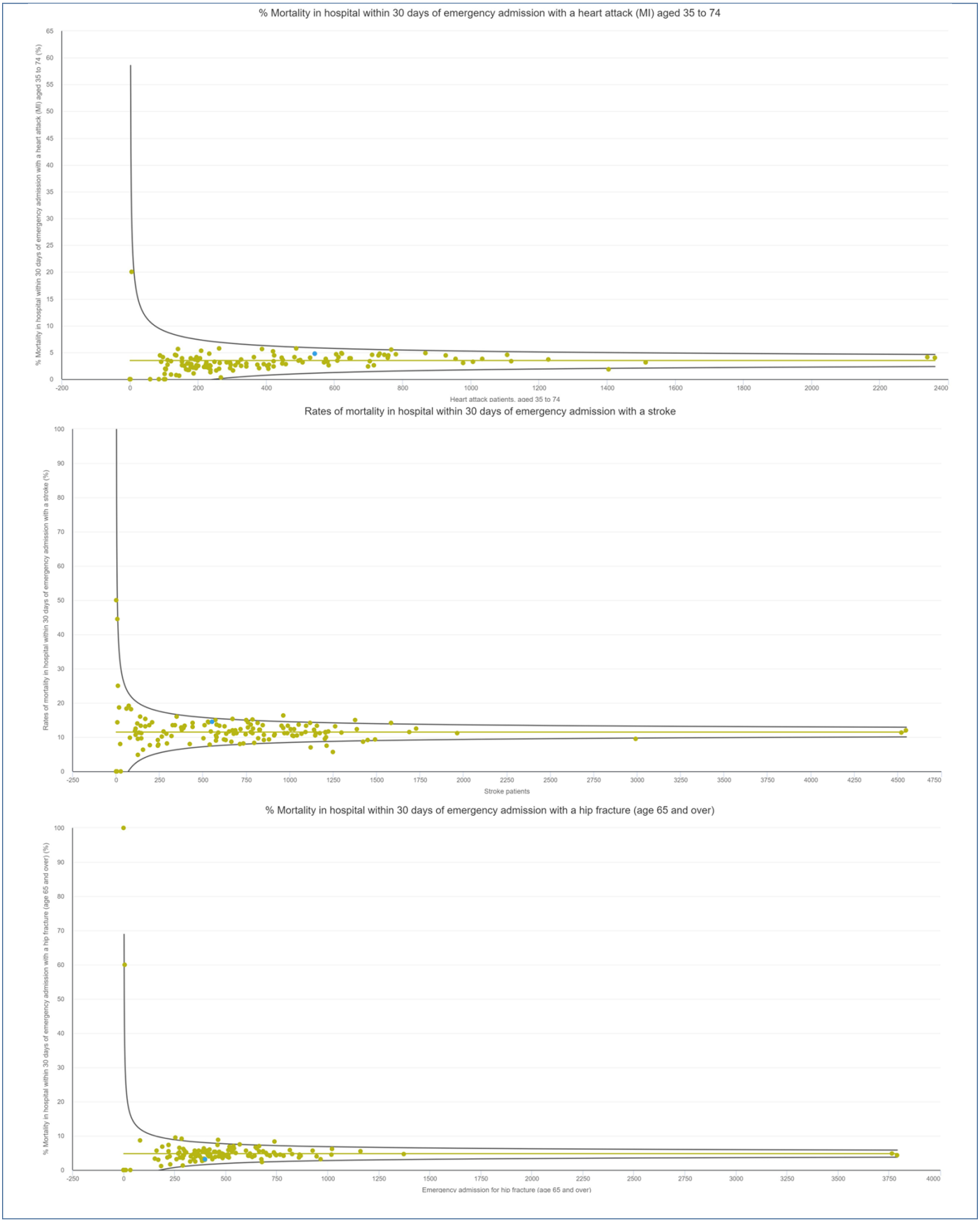
Mortality

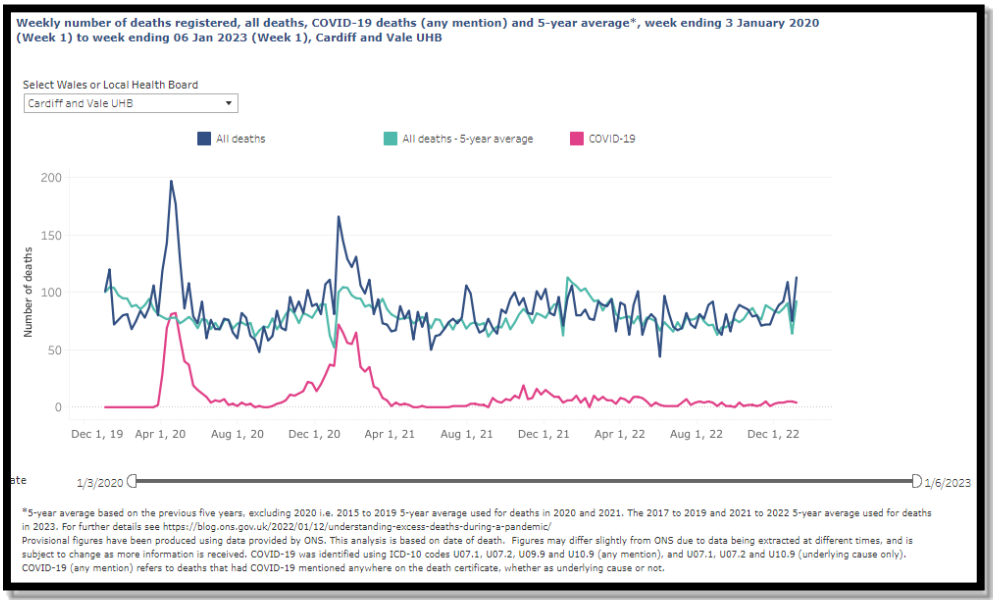
The November 2022 Quality Safety and experience committee agreed a three-tier model for reporting and monitoring mortality data across the Health Board.
Tier 1 Health Board wide mortality measures which will be reported including All-Cause Mortality and Crude inpatient mortality.
Tier 2 - Clinical Board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

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

Tier 1 Mortality
Measuring the actual number of deaths over time (crude mortality) supports the monitoring of trends in mortality rates. The Crude inpatient Mortality chart demonstrates the numbers of inpatient deaths that occur in the Health Board on a weekly basis and compares this measure with the average for the previous 5 years for the same week. The blue line demonstrates a mortality rate that is comparable to the 5-year average for the same reporting week with the exception of March 2020 and December 2020 to February 2021, the first and second waves of covid-19 where inpatient deaths rose above the 5-year average.

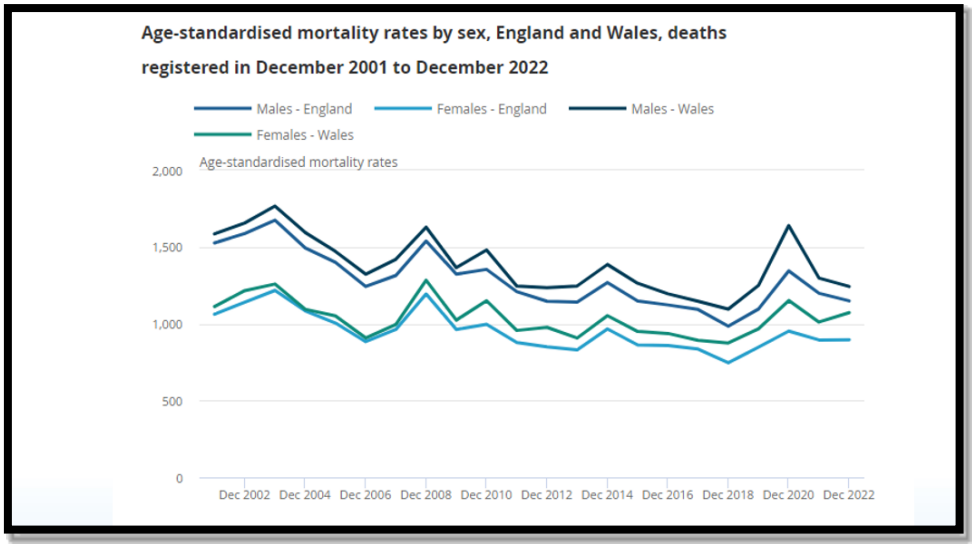
Crude all-cause mortality demonstrates the weekly number of deaths registered in Cardiff and the Vale of Glamorgan regardless of where they occurred. COVID – 19 deaths the pink line illustrates the number of deaths where COVID-19 features anywhere on the death certificate. There is a correlation between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


% Mortality in hospital within 30 days of emergency admission with a heart attack (MI) aged 35 to 74
% Mortality in hospital within 30 days of emergency admission with a heart attack (MI) aged 35 to 74 (%)
Heart attack patients, aged 35 to 74
Rates of mortality in hospital within 30 days of emergency admission with a stroke
Rates of mortality in hospital within 30 days of emergency admission with a stroke (%)
Stroke patients
% Mortality in hospital within 30 days of emergency admission with a hip fracture (age 65 and over)
% Mortality in hospital within 30 days of emergency admission with a hip fracture (age 65 and over) (%)
Emergency admission for hip fracture (age 65 and over)

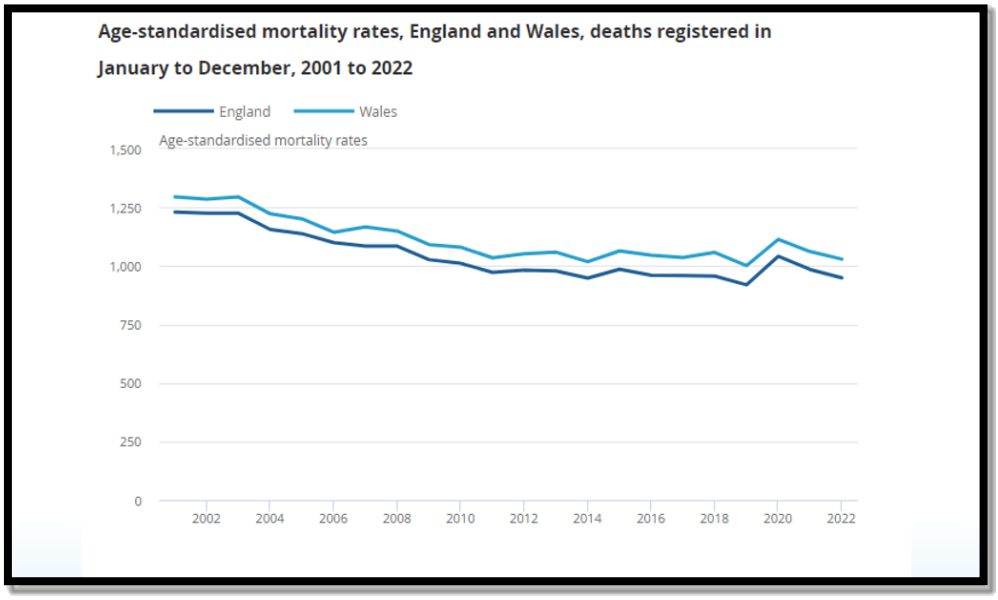


Source: Public Health Wales Covid Dashboard, ONS Mortality (CovidDashboard_ONSmortality | Tableau Public)

Age standardised mortality by sex is shown to be lower in December 2022 (figure 3) when compared to the same period in 2021, although this reduction is not statistically significant in Wales. The age-standardised mortality rates in 2022 were significantly lower than most other years since 2001 in Wales and England (figure 4), although it remains above the rate observed in 2019.

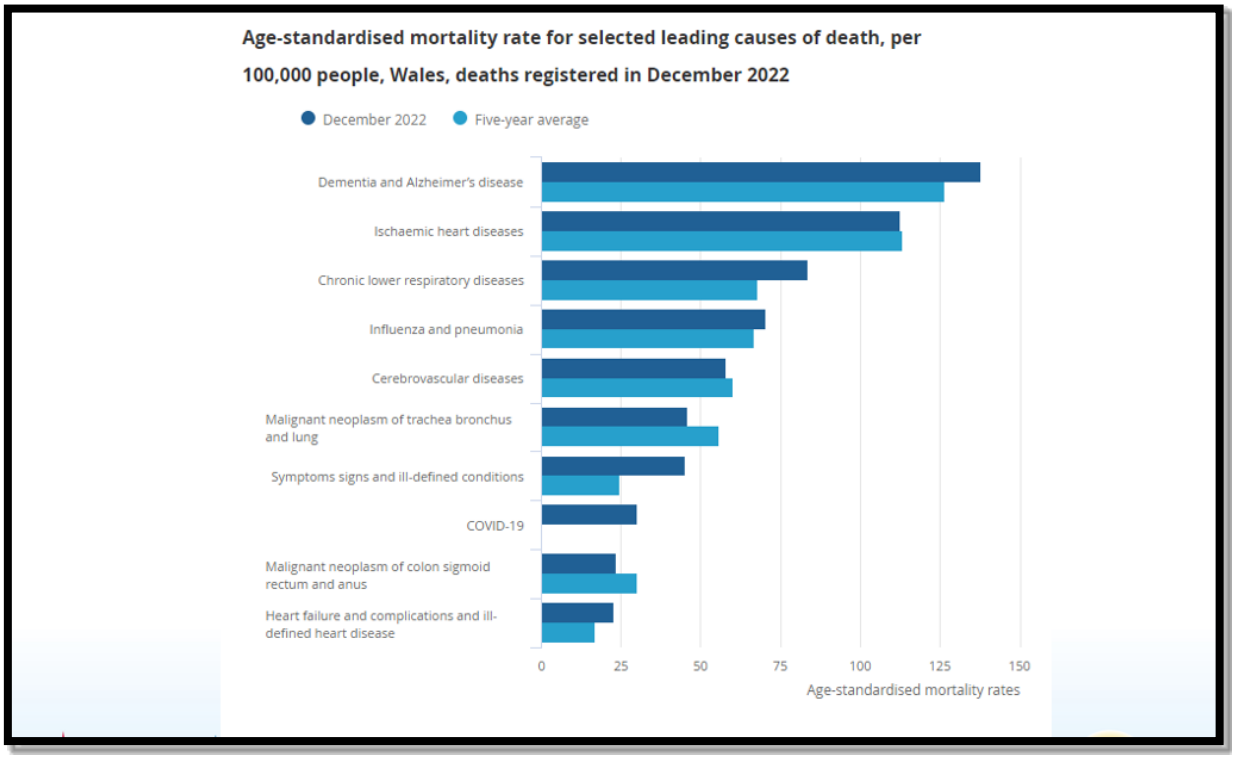


Source: Monthly mortality analysis, England and Wales - Office for National Statistics (ons.gov.uk)



Source: Monthly mortality analysis, England and Wales - Office for National Statistics (ons.gov.uk)

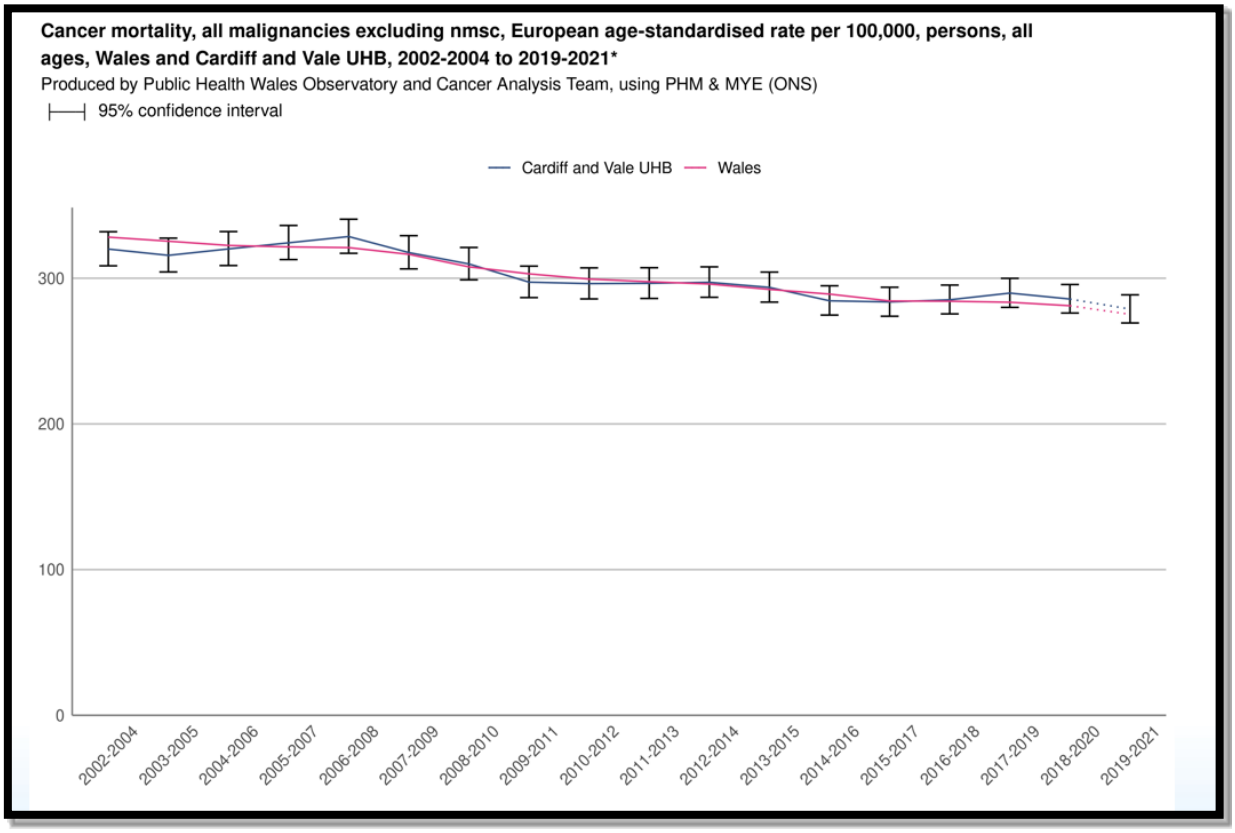
Figure 5 illustrates that Alzheimer's and dementia remains the leading cause of death in Wales in December 2022, with a rate higher than the five-year average.



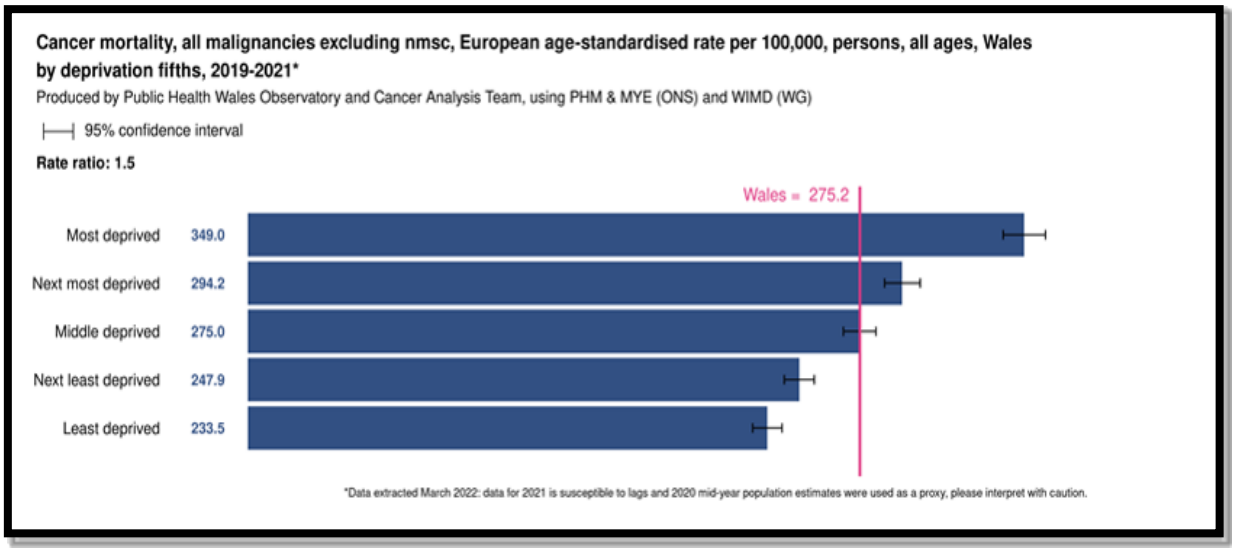
Source: Monthly mortality analysis, England and Wales - Office for National Statistics (ons.gov.uk)

Figure 6 illustrates cancer mortality rates per 100,000 population (excluding non- melanoma malignant neoplasm) and demonstrated a reducing trend in population rates in Wales and in Cardiff and Vale UHB area.

Figure 6



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

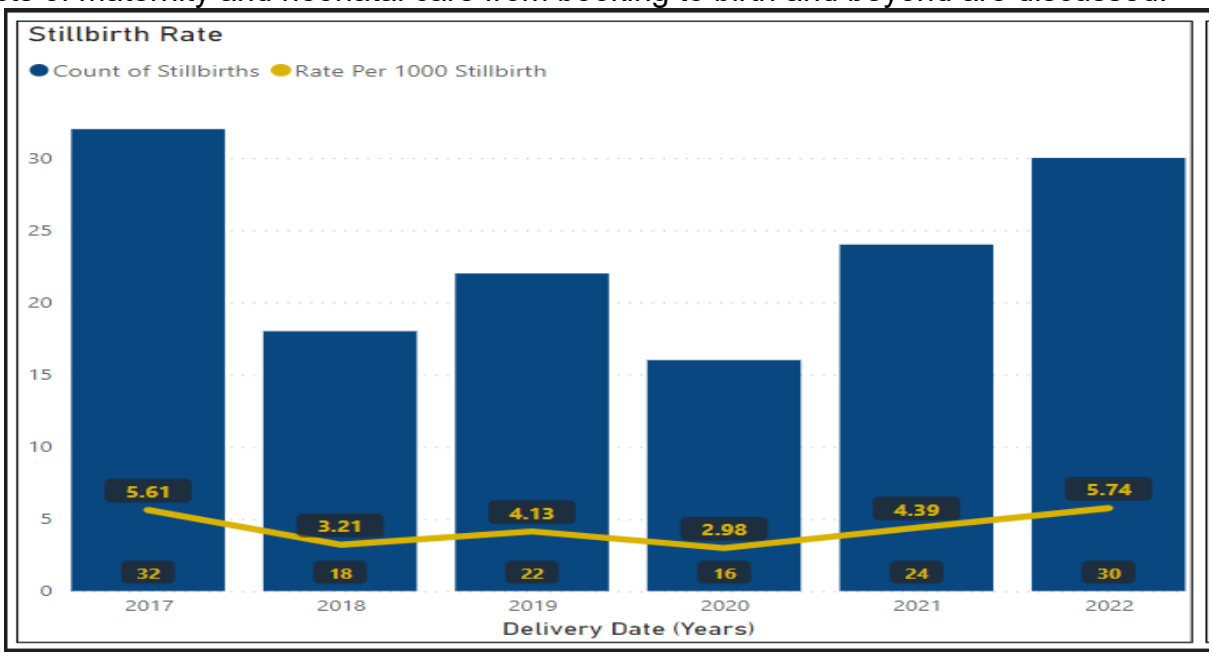


Maternity Outcome

Still birth rates in the UK fell to 3.9 per 1000 births in 2019 and 2020 with increased rates associated with ethnicity in several populations, in particular, Bangladeshi, Pakistani, Black African and Black Caribbean. Provisional figures from the office of National Statistics suggest that still birth rates increased in 2021 to 4.2 per 1000 births with a particular increase noted in the second half of 2021, national rates for 2022 are not yet reported. Still Birth Rates in Cardiff and Vale UHB increased from 2.98 in 2020 to 4.39 in 2021 and to 5.74 in 2022. The presence of

a Fetal Medicine unit means that the Health Board provide specialist diagnosis and treatment of complications which might arise in unborn babies.

All still births and perinatal deaths are reported through the Perinatal Mortality Review Tool (PMRT) and are reviewed at the Health Board Perinatal Mortality Review Meeting, where all aspects of maternity and neonatal care from booking to birth and beyond are discussed.

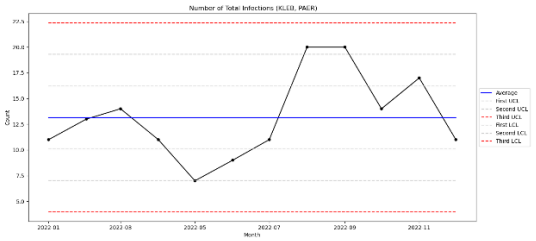


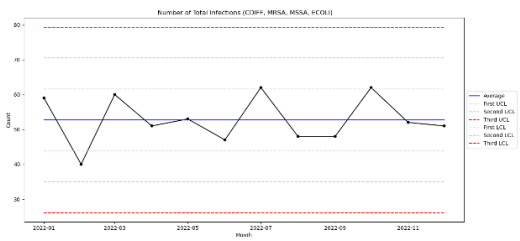
The national still birth rate in 2021 was 4.2 stillbirths per 1000 births (provisional ONS data) and C&V rate was 4.39.
The aim is by 2030 to be at 2.5 still births per 1000 births or less *in line with the aim embedded in Saving Babies Lives –the care bundle for reducing perinatal mortality*

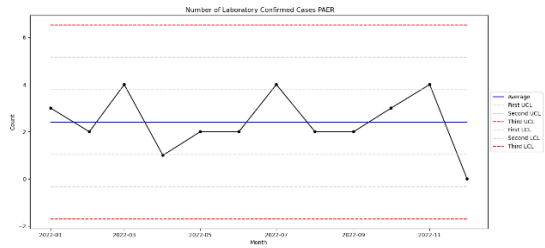
Infection control

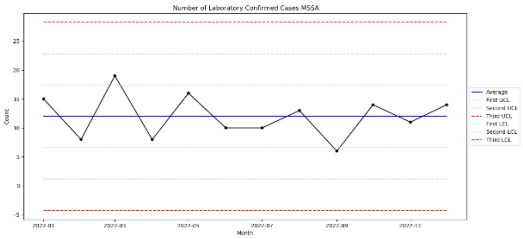
Hospital Infections – the total infection rates are falling. MRSA and E coli have slightly reduced.

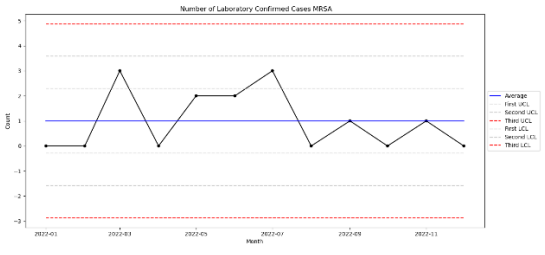
There has been significant investment in the IP&C team in the past 2 years, which has enabled increased audit and review of infections and supports a bespoke approach to supporting wards and primary care reviews.

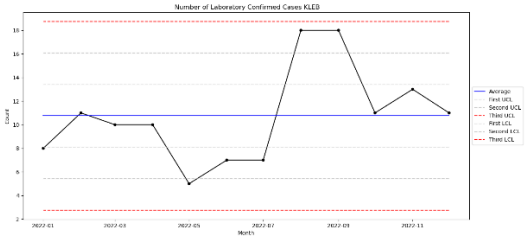


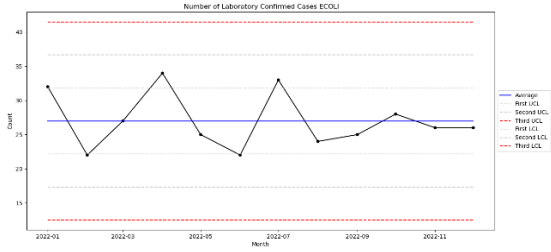


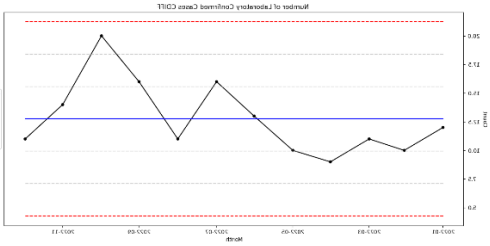


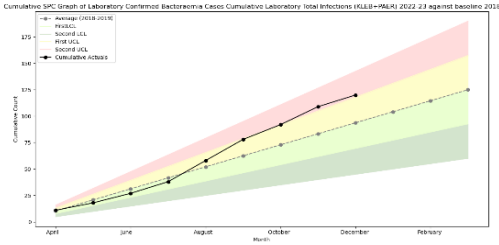


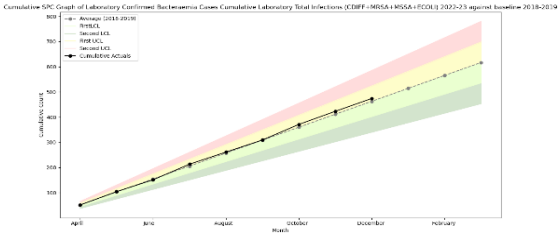

Number of Laboratory Confirmed Cases MRSA
Count
Month

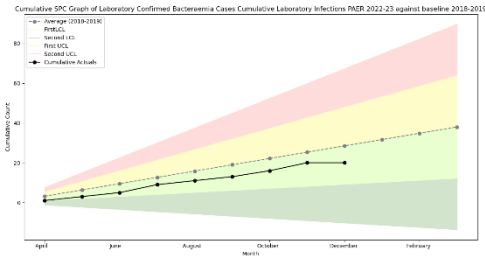

Number of Laboratory Confirmed Cases KLEB
Count
Month

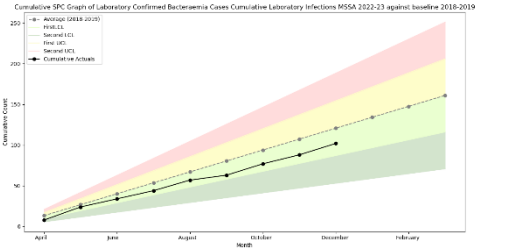

Number of Laboratory Confirmed Cases ECOLI
Count
Month

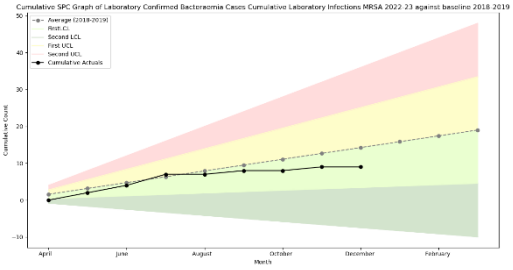


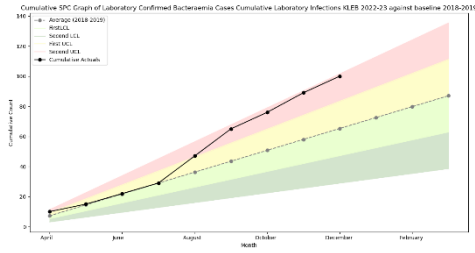

Cumulative SPC Graph of Laboratory Confirmed Bacteraemia Cases Cumulative Laboratory Total Infections (KLEB+PAER) 2022-23 against baseline 2018-2019
Cumulative Count
Month

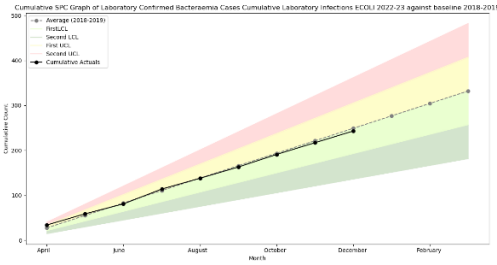

Cumulative SPC Graph of Laboratory Confirmed Bacteraemia Cases Cumulative Laboratory Total Infections (CDIFF+MRSA+MSSA+ECOLI) 2022-23 against baseline 2018-2019
Cumulative Count
Month

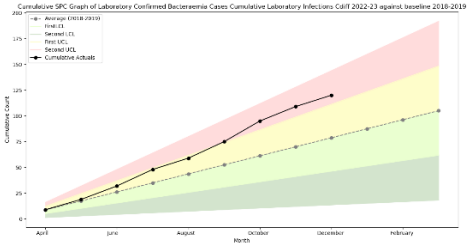

Cumulative SPC Graph of Laboratory Confirmed Bacteraemia Cases Cumulative Laboratory Infections PAER 2022-23 against baseline 2018-2019
Cumulative Count
Month

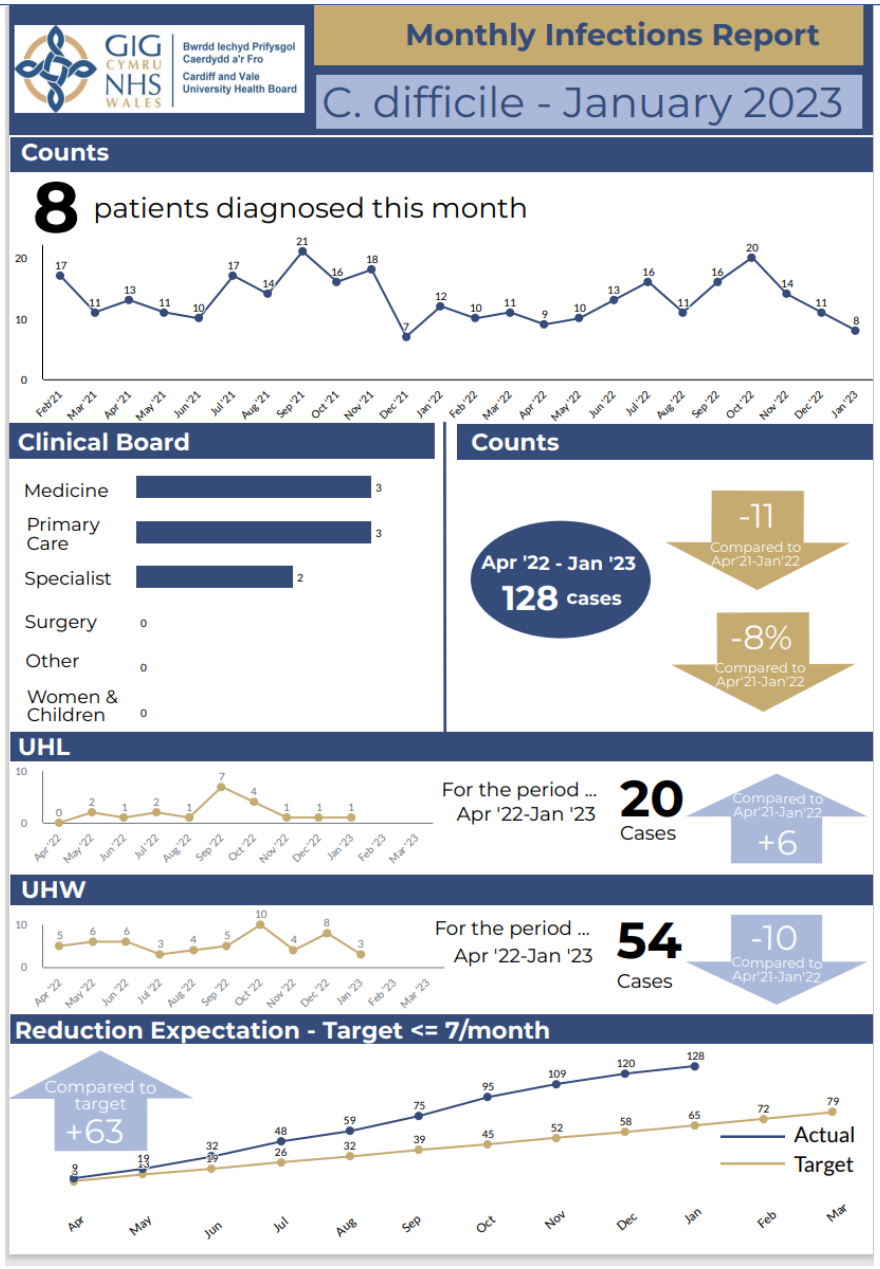

Cumulative SPC Graph of Laboratory Confirmed Bacteraemia Cases Cumulative Laboratory Infections MSSA 2022-23 against baseline 2018-2019
Cumulative Count
Month


Cumulative SPC Graph of Laboratory Confirmed Bacteraemia Cases Cumulative Laboratory Infections MRSA 2022-23 against baseline 2018-2019
Cumulative Count
Month


Cumulative SPC Graph of Laboratory Confirmed Bacteraemia Cases Cumulative Laboratory Infections KLEB 2022-23 against baseline 2018-2019
Cumulative Count
Month


Cumulative SPC Graph of Laboratory Confirmed Bacteraemia Cases Cumulative Laboratory Infections ECOLI 2022-23 against baseline 2018-2019
Cumulative Count
Month


Cumulative SPC Graph of Laboratory Confirmed Bacteraemia Cases Cumulative Laboratory Infections Cdiff 2022-23 against baseline 2018-2019
Cumulative Count
Month



- CAV UHB cannot achieve the expected reduction for 2022/23 however we have 8% fewer cases than the equivalent period 2021/22.
- We are performing 2nd best in Wales (behind Cwm Taff HB).
- The *C'diff* oversight group meetings have commenced with the 1st meeting held in January. The meetings are led by the EDON and Deputy Medical Director supported by the IP+C Consultants and the HOV for IP&C and Clinical teams, are invited to discuss individual cases to identify learning and drive improvement.
- IP&C hold weekly *C'diff* review meetings which are attended by the IP&C nurses and Drs, Clinical Scientists in PHW, Antimicrobial Pharmacists and Microbiology registrars, in person review of new cases are also held.
- Since October 22 we have an IP&C nurse specifically to support PCIC CB. The work will include reviewing community *C'diff* cases and gathering themes from RCA's completed for each case to support learning.
- The IP&C Team are developing new education materials to support clinical teams.

Actions to progress the improvement trajectory

- Weekly Cdiff/SAUR meeting with IP&C, Micro, AMR specialist pharmacists ongoing.
- Plan to reinstate MDT review rounds with the above.

- MRSA RCA review meetings with the EMD, EDON, IP&C and clinical teams.
- IP&C audit plan for 2022/23 includes increased audits of PCV/CVC bundle compliance and insertion pack usage.
- ICNET SSI surveillance to begin within the next month.
- Working with clinical teams to further standardize products/procedures including IV access teams.
- Regular audits of clinical environments and equipment.
- Working with Capital/Estate/Facilities teams to improve clinical environments.
- Build on the existing Education programme to widen staff groups included.

PEOPLE/WORKFORCE

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

- **Turnover** rate trend is upwards since Jan-22; the rates have risen in the past 12 months from 12.57% to 13.33% in Jan-23 UHB wide. This is a net 0.76% increase, which equates roughly to an additional 102 WTE leavers. The top 5 reasons recorded for leaving are; 'Voluntary Resignation - Other/Not Known', 'Retirement Age', 'Voluntary Resignation – Relocation', 'Voluntary Resignation - Promotion' and 'Voluntary Resignation – Work Life Balance'

- **Sickness Absence** rates remain high; the monthly sickness rate for January 2023 was 6.82% The revised rate for December 2023 was 8.37%, which is the highest ever monthly absence rate (higher even than the first month of the COVID-19 pandemic). There is a rising trend since Apr-22 and the current rates are significantly higher than for previous years. The cumulative rate has risen over the past 3 months to 7.05%. This figure is derived from absence since April.

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

  The number of staff on long term sick leave suffering where the absence reason has been identified as 'Anxiety/stress/depression/other psychiatric illnesses' has reduced. On 31/03/22 there was 284 and as at 31/01/23 there were 220 (a reduction of 64 – 22.53%). There are 78 staff on long term absence where Covid-19 has been identified as a Related Reason.

- The **Statutory and Mandatory** training compliance rate has risen, to 76.06% for January, 8.94% below the overall target.

- Compliance with **Fire** training has risen during January, to 68.38%.

- The trend of the rate of compliance with **Values Based Appraisal** has risen over the last 6 months; the compliance at January 2023 was 51.44%. Clinical Boards have been set an improvement target of 60% by the end of March 23, then 85% by the end of June 2023. Capital, Estates & Facilities (74.28%) and Clinical Diagnostics & Therapeutics (64.69%) have exceeded the 60% transitory target, and PCIC are presently at 59%.

Appendix 1 - Workforce Key Performance metrics dashboard for January 2022.

As noted in the last report, over the winter months the People and Culture Team are focusing on the 'Main Effort' and the team are aligned to the following UHB priorities and the People and Culture Plan:

- Wellbeing (including cost of living support)
- Recruitment
- Retention
- Workforce Planning

In addition to these areas, the People Services Team will be supporting managers with operational matters, e.g. Employee Relations, Managing Attendance, Change Management, Terms & Conditions, etc.

The remainder of this report focuses on progress against the above:

Wellbeing

- Activity continues to take place to support staff with their financial wellbeing/cost of living.
- EWS continue to deliver bespoke support and development in areas of need.
- An Employee Health and Wellbeing Strategy and Framework proposal has been developed in collaboration with TU partners and is due to be presentation to the Strategic Wellbeing Group, Clinical and Service Boards senior leadership teams.
- Sustaining Resilience at Work Practitioner (StRaW) training has taken place within Children and Women Clinical Board to support the development of a peer support network. Further development of the network, including the training of four StRaW Managers will follow in March 2023.
- The pilot collaboration between the Occupational Health Department in CAVUHB and CTMUHB continues, with benefits being realised after 12 months. A review will take place in March 2023.
- Analysis of engagement results and feedback from wellbeing surveys has indicated low levels of staff morale, engagement and wellbeing. A dashboard of results is being produced for sharing with CBs.
- Communications also being developed to thank staff for participation in surveys / platforms; to communicate key themes and to outline actions being taken / planned (March 2023).

Recruitment

- 84% of the required skill mix for IACU has been recruited/deployed to support the winter capacity plan.
- The Nursing Hub are continuing to recruit high numbers of HCSW's as part of the ongoing recruitment campaign. The supply of HCSW's onto the internal Staff Bank continues to improve.
- Approval to proceed with further International Recruitment is currently on hold, whilst further workforce redesign takes place. It is likely that a blended approach will be required.
- A communications plan has been implemented to stop use of HCSW agency workers by 1 April 2023. Agency HCSWs are being encouraged to join the internal Staff Bank.
- An open evening was held in January to investigate the recruitment pool for Assistant Practitioner posts and the 'Return to Registration' programme. An accelerated development programme is being developed to support the rapid recruitment of these individuals.

- A Business case and implementation plan has been developed to implement the modernisation of the Ward skill mix with the introduction of Assistant Practitioners (Band 4).

Retention

- The focused work which was taking place within EU/AU has largely been completed, though support will continue and a bespoke coaching framework is to be developed.
- A retention toolkit is being developed and will be made available for managers throughout the UHB to adapt to their own areas. This will include cultural surveys, engagement self-assessment tools, and examples of good practice.
- The team are involved in the All-Wales Retention Group looking at a toolkit as part of the National Workforce Implementation Plan.
- The first Career Clinic for nurses will take place on 1st March with the intention of giving staff advice and support on career pathways, development, education and opportunities to develop careers in UHB without the need to move to neighbouring HBs.
- The 'New Starter' survey is about to be distributed to all newly qualified nurses who started last Autumn. Its aim is to identify how their experience as a new employee of the UHB has gone and to identify any actions need to be taken to improve their experience.
- A Culture and Leadership Programme focusing on cultural assessment to identify good practice and areas for improvement is being trialled in ALAS prior to roll out as part of the wider retention toolkit. The survey element has been completed with a response rate of over 50%, and focus groups will commence in Feb/March 2023 facilitated by the Assistant Director of OD and the Head of ECOD.
- The CAVUHB Anti-Racist Plan draft has been outlined through a co-production approach with colleagues from across the UHB and the One Voice Network. The progress made with the plan will be presented to S&D Committee in March 2022.
- The Welsh Language Commissioner is undertaking an investigation into our compliance with the Welsh Language Standards around registration of the staff with Welsh Language skills. A campaign to improve our workforce data around Equality and Welsh language skills is underway to enable us to we understand the diversity of representation at all levels and our organisational Welsh language skills.
- The amount of formal Disciplinary Investigations has continued to reduce by embedding and promoting Just Culture and Disruptive HR principles and we are currently reporting at just 8 cases (non-medical staff). The People Services Team are continuing to develop a new on demand training course for investigating officers to try and further reduce the length of time that investigations take.
- We have seen an increase in the amount of appeals received for flexible working requests. A trend analysis is being undertaken to identify any actions required.

Workforce Planning

- Engagement with all Clinical Boards to develop a baseline summary of nursing workforce data continues and aims to be completed by 1 March 2023. This will be rolled out to other staff groups at a later date.
- Strategic Workforce Planning training to develop knowledge and capability in longer term planning of our workforce is scheduled for March 2023.
- Activity is taking place to support the introduction and roll out of the Assistant Practitioner role to release the professional expertise of the nurse using prudent healthcare principles ensuring clear communication, engagement and supervision for the benefits to be realised.
- The Physician Associate role continues to increase (20wte) but funding to support recruitment and CPD budgets remain challenging.

Future updates

Work is currently taking place to re-focus the information provided to the Strategy and Delivery Committee and future People & Culture Committee. Rather than providing high level, UHB wide data we will examine the KPIs at a Clinical Board level. Areas performing well or improving will be noted, and we will set out what actions we are taking to provide focused support to directorates/teams who are struggling. As this new style of reporting takes shape we will also change the focus of the People section of the Integrated Performance Report to provide assurance to the Board.

OPERATIONAL PERFORMANCE

System wide operational pressures have continued and we are still seeing access or response delays at a number of points across the health and social care system. Updates with regards to specific service areas are contained within the relevant sections.

There has been no change to national requirements for performance and waiting list reporting and published information since the last Board meeting. The revised NHS Performance Framework for 2022/23 was issued in June 2022, reflecting some of the Ministerial priorities outlined in national plans. Board reports will continue to update on two specific planned care ministerial ambitions – elimination of > 52 weeks new outpatients by the end of December 2022 and elimination of > 104 week waits for all stages of pathway in most specialties by the end of March 2023.

Emergency & Urgent Care

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

There continues to be a challenging position across the urgent & emergency care system, largely driven by high levels of adult bed occupancy, as a result of the high number of patients who are delayed transfers of care (DTOC) and the continued challenge in our ability to achieve timely discharge and create flow for the Emergency Unit. However, the Winter Plan, that was approved at the public board meeting in September, continues to deliver improvements and through this plan over 130 additional beds, or bed equivalents, have been added to the system to help mitigate pressure.

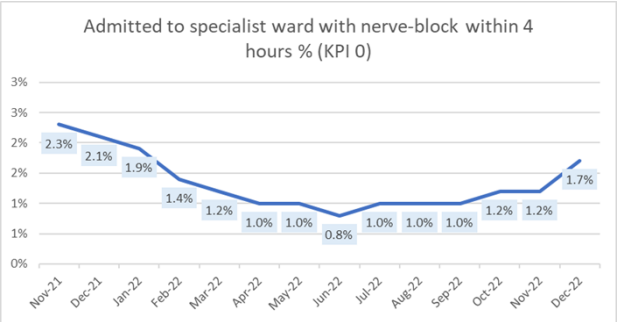
There has been significant improvement in ambulance handover times which has led to an improvement in total number of lost hours and the volume of crews waiting greater than 4 hours to handover. The Health Board continues to be a positive outlier in this regard nationally.

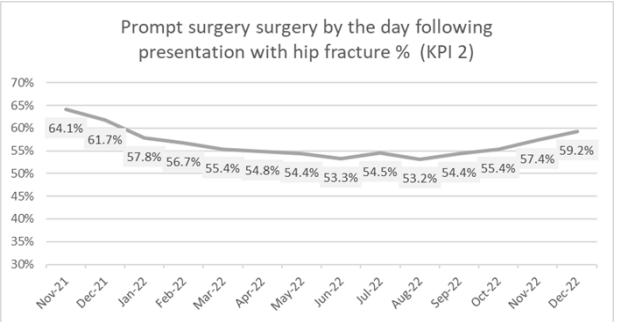
The number of ambulance handovers >4 hours has reduced from 230 in September to 33 in December, 12 in January and 0 reported in February. We have also seen a reduction in the number of ambulance handovers >3 hours, with the 228 reported in December 2022 falling to 17 reported in February 2023. February 2023 represents the first month in which the Health Board has met its ambulance handover improvement commitment, made in February 2022, to reduce average lost time per ambulance arrival to 25% less than the October 2021 baseline.

Fractured Neck of Femur

Performance against the standards within the National Falls and Fragility Fracture Audit Programme (FFFAP) has been poor. In January 2023, 1.8% of patients were admitted to a specialist ward with a nerve block within 4 hours.

In January, 63.2% of patients received surgery within 36 hours, this is reflective of the general trend during 2022 but a slight reduction when compared to October 2021 performance (64.6%). Our performance is above the national average of 56% over the last 12 months.





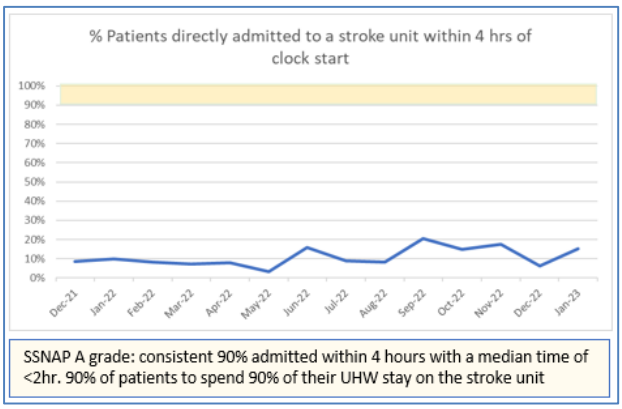
A summit with key stakeholders took place in late February with the ambition for significant increases in our performance moving forwards to make Cardiff and Vale an upper quartile performer when compared to UK peers.

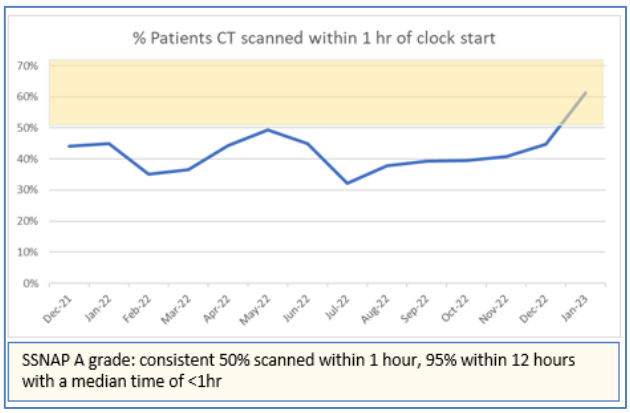
Stroke

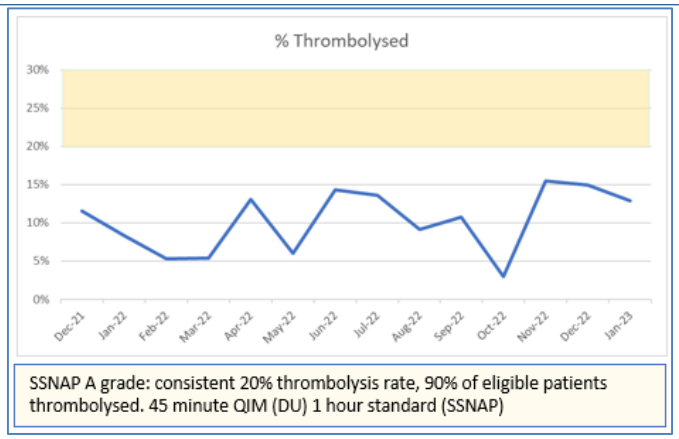
Stroke performance remains below the standards set out in the Acute Stroke Quality Improvement Measures and The Sentinel Stroke National Audit Programme (SSNAP). In January:

- 0% of patients were thrombolysed within 45 minutes of arrival, the All Wales average was 16.2%
- The percentage of CT scans that were started within 1 hour in January was 61.3%, the All Wales average was 54.9%
- The percentage of patients who were admitted directly to a stroke unit within 4 hours was 15.4% in January, the All Wales average was 15.9%

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



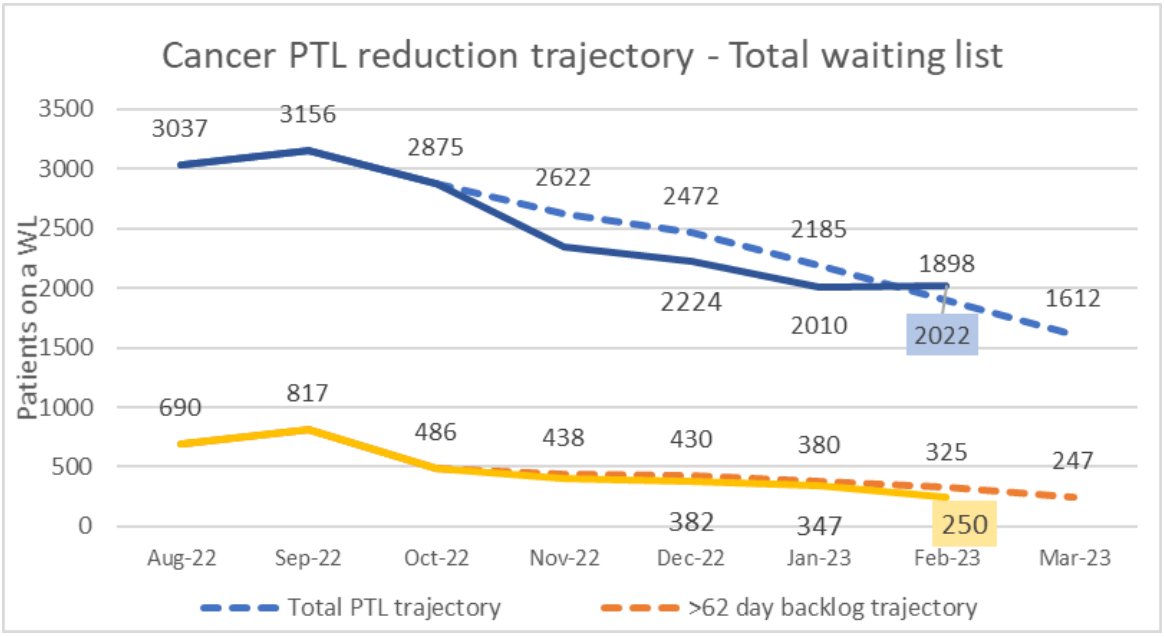




SSNAP A grade: consistent 20% thrombolysis rate, 90% of eligible patients thrombolysed. 45 minute QIM (DU) 1 hour standard (SSNAP)

Cancer

January 2023 saw a 3% drop in compliance with the Single Cancer Pathway standard, with 55.1% of patients receiving their first definitive treatment within 62 days. While we reported an increased number of treatments in month, this includes a higher proportion of long waiting patients being treated which has caused the small drop in SCP performance.



At the time of writing there are a total of 2101 suspected cancer patients on a single cancer pathway. 227 have waited over 62 days, of which 73 have waited over 104 days.

Of these, there are 2033 Cardiff and Vale patients (excluding tertiary patients) of which 182 have waited over 62 days.

There have been a number of actions taken to improve the oversight and operational grip of the process for overseeing patients. Three cancer summits have taken place with the tumour group leads and operational teams to understand the demand, the causes for delay in the 62-day pathway and what actions are required to reduce the delays experienced by our patients. In addition to internal Cancer summits and the demand and capacity exercise discussed at the last meeting, there is a current focus on minimising the number of patients waiting over 104 days to start their definitive treatment to less than 45 by the end of March 2023.

Planned Care

The total number of patients waiting for planned care and treatment, the ***Referral to Treatment (RTT)*** waiting list was 121,687 as at January 2023. The tail of this waiting list breaks down as follows:

- Patients over 156 weeks – January – 955
- Patients over 104 weeks - January – 4,587
- Patients over 52 weeks – January – 23,950

The most recent delivery assessment has determined there will be approximately 3617 patients waiting over 104w of which 810 waiting over 156w by the end of March 2023. Work continues to reduce the number of these long waiting patients.

The number of patients waiting for planned care and treatment ***over 36 weeks*** has decreased to 39,599 at the end of January 2023. 55% of these are at New Outpatient stage.

The overall volume of patients waiting for a ***follow-up outpatient*** appointment at the end of February 2023 was 193,548. 98.6% of patients on a follow up waiting list have a target date, above the national target of 95%. The number of follow-up patients waiting 100% over their target date has increased to 51,374. This is of concern and requires additional focus and support to improve the position over the next few months.

Ministerial Measures

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

Measure	WG Ambition	IMTP commitment	Trajectory shared with DU	April	May	June	July	August	September	October	November	December	January
Number of patients waiting over 52 weeks for a **new outpatient** appointment	0 (end of December 2022)	20,235 (end of December 2022)	15,723 (end of December 2022)	15,588	15,810	16,272	16,584	16,179	15,291	14,697	13,311	11,775	10,951
Number of patients waiting over 104 weeks for **treatment** (all stages)	0 (end of March 2023)	750 (end of March 2023)	6415 (end of March 2023)	9,066	8,820	8,300	8,308	7,687	7,038	6,309	5,553	5,099	4,587

Where we are not able to deliver against the 104-week ambition, we are working to eliminating 3 year waits in these specialties by March 2023. We have some further work to do to give full assurance on this for all specialties, it is estimated that there are 810 patients in this cohort requiring a plan across ENT, Ophthalmology, Spines, General Surgery and Urology. The reduction in this 3 year wait cohort is tracked on a weekly basis and reported monthly:

Cohort	Aug	Sept	Oct	Nov	Dec	Jan
Number of patients who will have waited more than 156 weeks for ***treatment*** (all stages) by end of March 2023	4,995	4,108	3,491	2,704	2,152	1,611

Diagnostics

The volume of greater than eight-week ***Diagnostic*** waits has increased to 5,247 at the end of January 2023 from 3,654 in November 2022, largely driven by increased waits in Radiology (MRI). The number patients waiting over 14 weeks for ***Therapy*** has slightly increased to 1,220 from 1,209 in November 2022, as reported at the December Board Meeting.

Mental Health

Demand for adult and children's Mental Health services remains significantly above pre-Covid levels, with referrals for the Local Primary Mental Health Support Service (LPMHSS) at 1219 referrals in February 2023. As highlighted at the previous Board meetings, this demand increase includes an increased presentation of patients with complex mental health and behavioural needs.

Significant work has been undertaken to improve access times to adult primary mental health and CAMHS services. Part 1a: The overall percentage of Mental Health assessments undertaken within 28 days increased to 99.6% in February 2023, Adult and Older persons performance was 100%, CAMHS performance was 97.9%. Part 1b: 91.1% of therapeutic treatments started within 28 days following assessment at the end of February 2023.

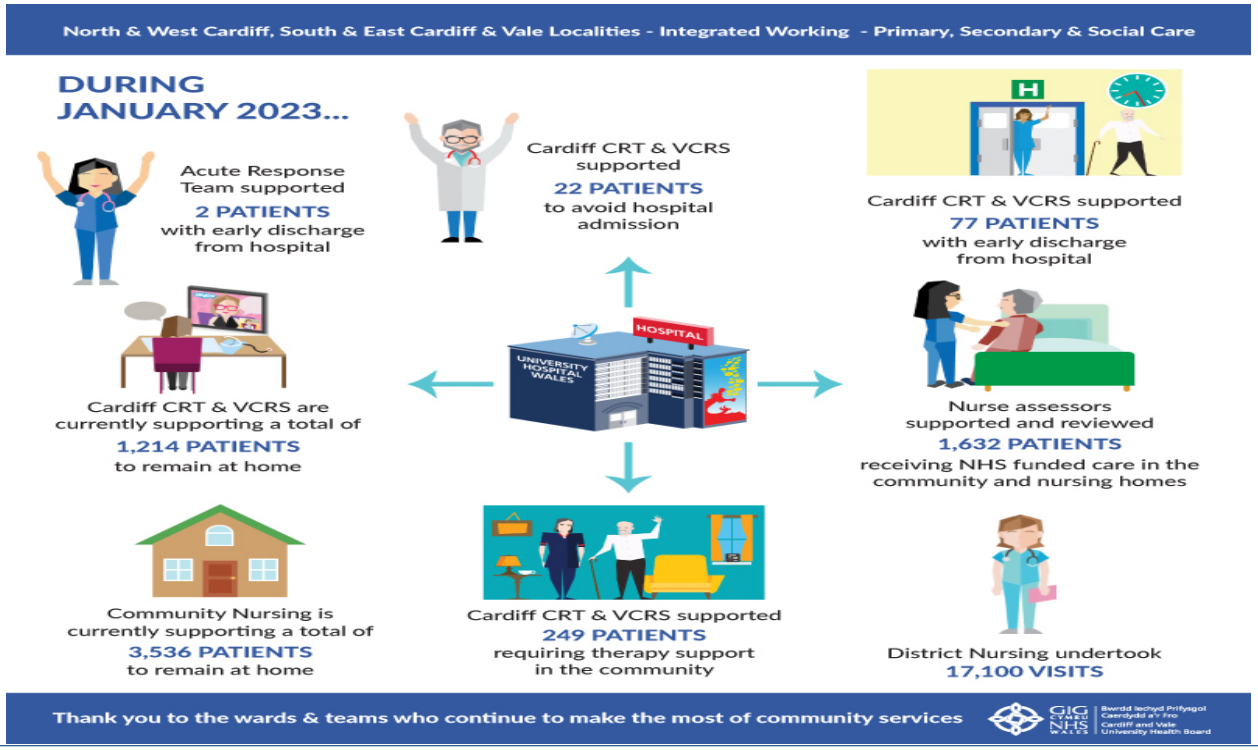
Primary Care

The Health Board was 100% compliant in January 2023 against the standard of 100% for 'Emergency' GP OOH patients requiring a home visit within one hour, with 7 of 7 patients receiving their visit with one hour. For patients that required an 'Emergency' appointment at a primary care centre in January the Health Board was 100% compliant, with 6 of 6 patients receiving an appointment within 1 hour.

Pressure has continued within GMS. There were 8 practices reporting either level 3 or 4 escalation at the time of writing the report. General Dental services are estimated to achieve 90-95% of their contract value by the end of March. Optometry is operating at pre-Covid levels. Community pharmacy has remained open with no issues reported.

Integrated working

Our community teams continue to provide valuable services to the residents of Cardiff and the Vale. Our teams work to care for patients in the community and also provide timely and supportive discharges from secondary care. In December the community nursing team supported over 3,500 patients to remain at home and the District Nursing team undertook 17,100 visits – seeing over 25% more patients than attend the EU each month. A breakdown of our teams' activity across primary, secondary and social care can been seen below:



FINANCE

How are we doing?

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

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

The UHB's core plan incorporated: -

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

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

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

Reported month 11 position

The Welsh Government monthly financial monitoring returns capture and monitor costs due to COVID 19 and exceptional cost pressures that are over and above LHB core plans. The financial position reported to Welsh Government for month 11 is a deficit of £24.658m and this is summarised in Table 1.

Table 1 : Month 11 Financial Position

	Cumulative to Month 11 £m	Forecast Year-End Position £m
Planned deficit	15.675	17.100
Operational position (Surplus) / Deficit	8.983	9.800
Financial Position £m (Surplus) / Deficit £m	**24.658**	**26.900**

The month 11 deficit of £24.658m comprised of the following:

- £15.675m planned deficit (11/12th of £17.100m);
- £8.983m adverse variance against plan.

In line with assumptions in the financial plan, Welsh Government has now confirmed funding to cover the additional costs of the management of COVID and exceptional cost pressures. At month 11, the UHB is projecting additional expenditure due to COVID-19 including local

response and national programmes, to be £56.712m. The exceptional inflationary pressures in relation to Energy, the NI Levy and the Living Wage are forecast to be £20.223m.

Savings Programme

The UHB expects to broadly deliver the revised £19.400m savings target

Creditor payment compliance

The UHB's public sector payment compliance performance was 94.3% at the end of February, which is just below the target of 95%.

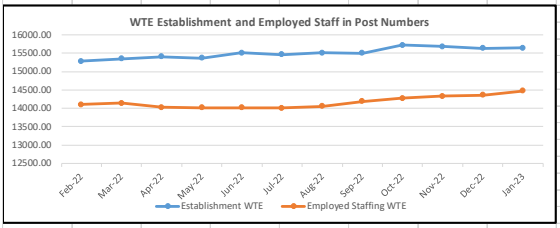
Remain within capital resource limit

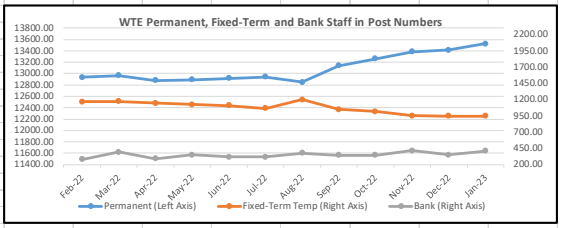
The UHB's approved annual capital resource limit was £51.535m at the end of February 2023. Net expenditure to the end of February was 63% of the UHB's approved Capital Resource Limit.

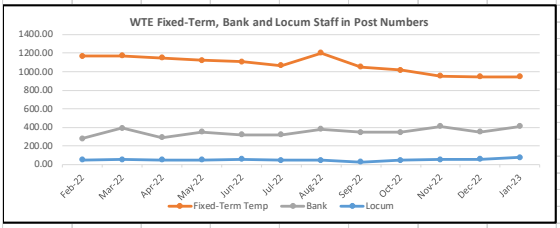
What are the UHB's key areas of risk?

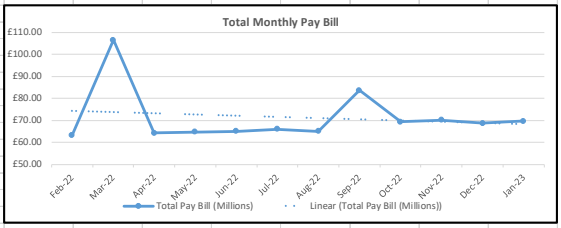
The key risk which feeds the UHB Corporate Risk Register is the failure of the UHB to deliver a breakeven position by 2022-23 year end with a current planned deficit of £17.1m and forecast deficit of £26.900m

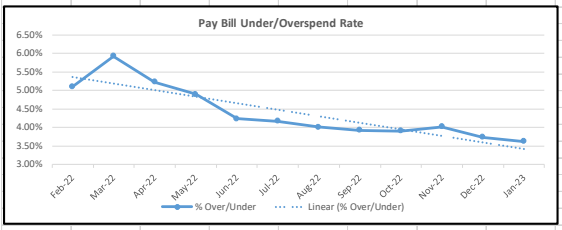
Workforce Key Performance Indicators Trends January 2023

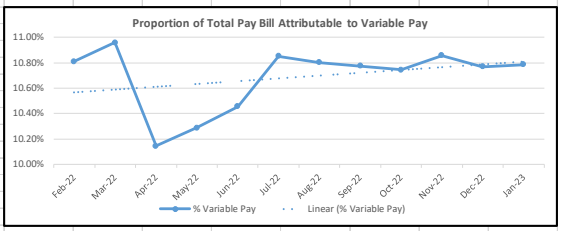


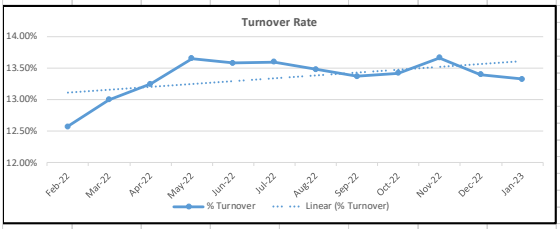


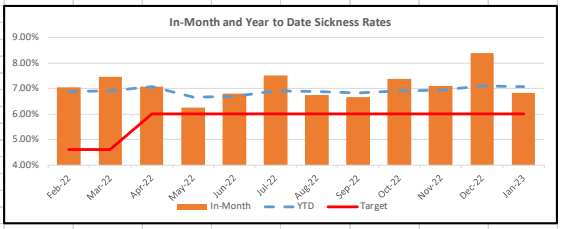


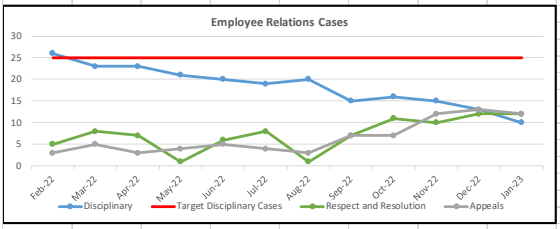


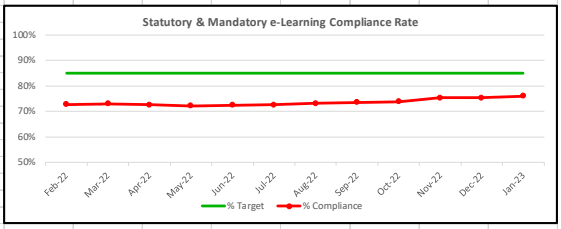


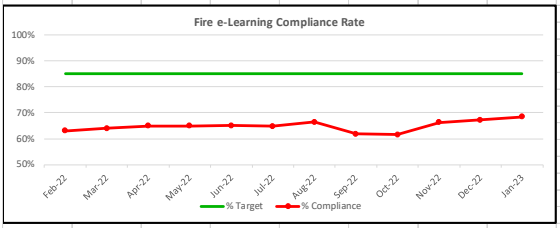


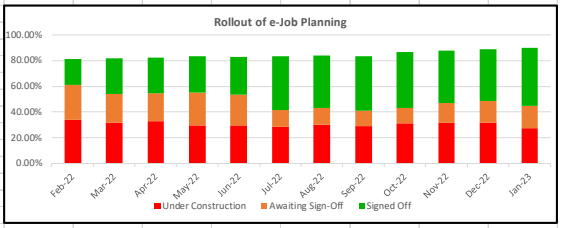


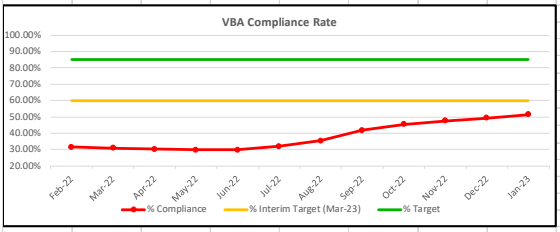


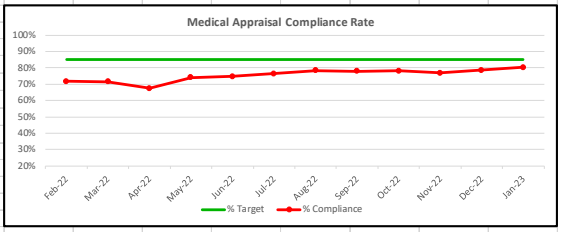


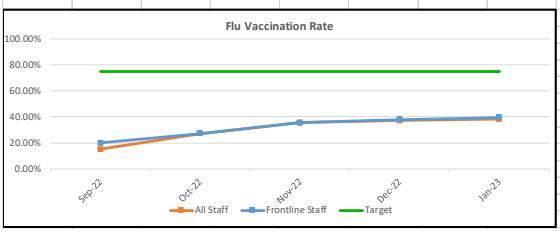












Appendix 1

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

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

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

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

Report Title:	Shaping our Future Wellbeing Strategy Refresh Update				Agenda Item no.	6.8
Meeting:	Board		Public	X	Meeting Date:	30.03.2023
			Private			
Status *(please tick one only):*	Assurance	X	Approval		Information	
Lead Executive:	Abigail Harris – Executuve Director of Strategic Planning					
Report Author (Title):	Marie Davies – Deputy Director of Strategic Planning					

Main Report
Background and current situation:

The Strategy Refresh has successfully launched Phase 1 Engagement which is targeting all internal and external stakeholders seeking their input on the vision, purpose and key strategic priorities. This stage is important to ensure that we are co-producing the next iteration of our strategy with those who will be impacted by it – our patients, the communities we serve and our staff. This is against a backdrop of vacancies in the planning and communication teams.

We successfully launched and promoted our dedicated website at the beginning of Phase 1 with over 650 visitors to the site as at 04/03/2023. We also launched the feedback survey when the website went live. We have held a number of staff and public engagement sessions – face to face and virtual, using the Mentimeter feedback tool to support these events. These sessions have been publicised widely through a number of different mechanisms. In addition to this, clinical boards and corporate departments have also run staff engagement events and the feedback is being collated. The tables below show the scope and scale of the feedback we have received to date, and the reach in terms of people accessing the information available on the strategy refresh.

The website was updated to make it more user-friendly following feedback and a 'calendar' feature was added to make viewing engagement sessions a clearer and more user-friendly process.

Focused engagement with hard to reach and voluntary sector groups is being facilitated by our third sector colleagues, commissioned and coordinated through our health and social care facilitators. We have also linked with specific groups – both staff groups and community groups that relate to the protected characteristics under the equality legislation.

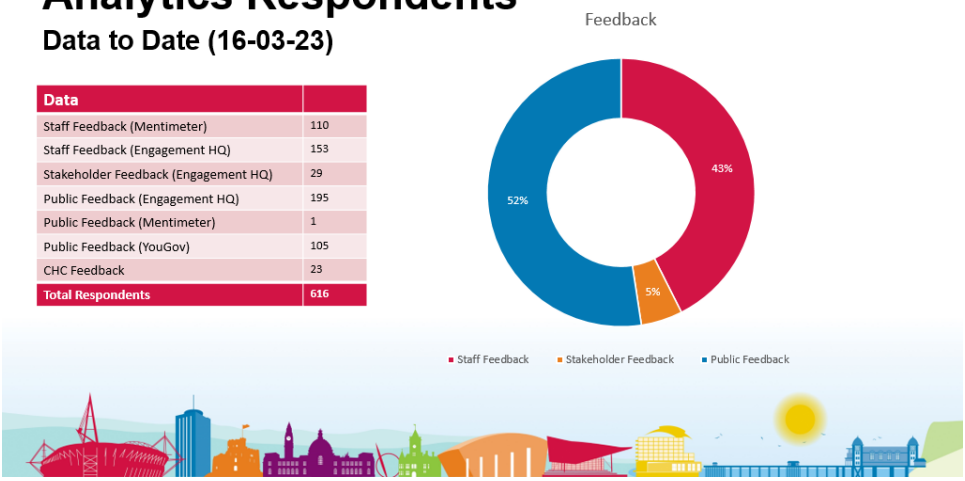
YouGov was also commissioned to enable a wide audience to access the survey and provide feedback.

Phase 1 engagement is planned to conclude week of 20th March (3 weeks later than initially planned) to allow time for the analysis of the feedback from all stakeholders to inform the draft strategy document that will be produced during April and launched for a second round (Phase 2 Engagement) of wide engagement to seek feedback on the draft strategy document. Phase 2 is currently proposed to commence on 1st May and conclude 7 weeks later on 16th June 2023.

Analytics Respondents

Data to Date (16-03-23)

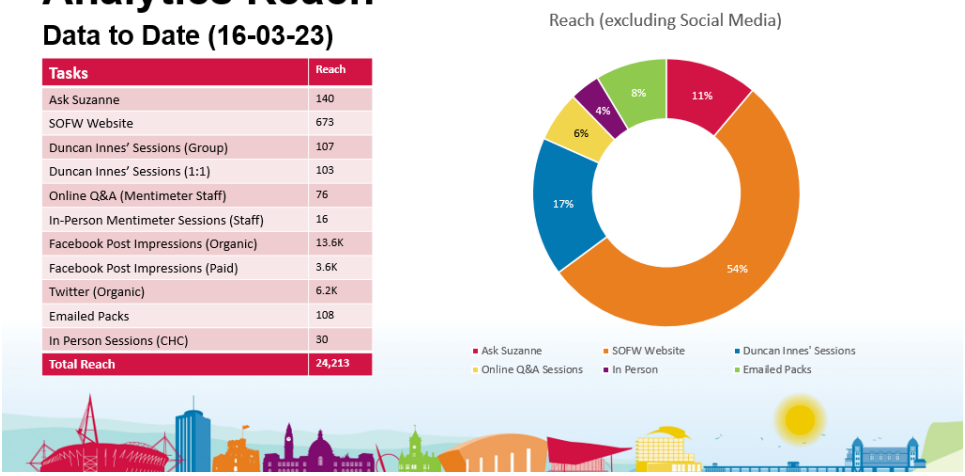
Data	
Staff Feedback (Mentimeter)	110
Staff Feedback (Engagement HQ)	153
Stakeholder Feedback (Engagement HQ)	29
Public Feedback (Engagement HQ)	195
Public Feedback (Mentimeter)	1
Public Feedback (YouGov)	105
CHC Feedback	23
Total Respondents	**616**



Analytics Reach

Data to Date (16-03-23)

Tasks	Reach
Ask Suzanne	140
SOFW Website	673
Duncan Innes' Sessions (Group)	107
Duncan Innes' Sessions (1:1)	103
Online Q&A (Mentimeter Staff)	76
In-Person Mentimeter Sessions (Staff)	16
Facebook Post Impressions (Organic)	13.6K
Facebook Post Impressions (Paid)	3.6K
Twitter (Organic)	6.2K
Emailed Packs	108
In Person Sessions (CHC)	30
Total Reach	**24,213**



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

- The Strategic Planning and Communication teams have overseen an extensive engagement process which has provided our staff, our patients, our communities and our stakeholders with the opportunity to feed in their views as we start to develop the next iteration of our strategy. This was despite capacity issues in both teams due to staff vacancies. The Shaping Change Team has also provided invaluable support to the engagement events.
- We have planned the analysis work requried to ensure we take into consideration all of the feedback we have received. Cedar will be supporting this work.
- The Steering Group reviewed progress on 15th March and concluded that the reach and feedback received was robust and that a further extension to this phase of engagement was not required.
- The proposed date of launch is July 19th 2023 at the Annual General Meeting. There is a four week window between the conclusion of Phase 2 Engagement and the proposed lauch date – this requires tight turnaround of engagment data analysis, feedback report production and strategy amendments and associated production activities e.g publishing, translation etc and governance procedures – this will include scrutiny and endorsement from Senior Leadership Board and through Board Development. The programme plan currently makes provision for these activities but if there are significant amendments required, this timeline may need to be revisited. The Strategy Refersh Steering Group will monitor this risk throughout Phase 2 engagement.
- The Consultation Institute (tCI) is reviewing the approach we have taken to Phase 1 Engagement and our proposed approach to Phase 2 and will provide a comprehensive report on compliance with best practice. The South Glamorgan CHC has also been involved throughout the process providing advice to the engagement programme. A dedicated full

council engagement session took place with the CHC on 15th March, one of the final activities before the new Citizen's Voice (Llais) comes into being on 1st April '23.

-

Recommendation:

The Board is requested to:

1. Note the progress and risks described above and the proposed Strategy Launch date of 19th July 2023 subject to formal Board approval at 27th July Board meeting.

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

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

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes
The timeline poses a potential risk to delivery milestones
Safety: No
Financial:
Some of the constraints are resource related – where there is a financial impact
Workforce:
Not directly related to this report, but workforce engagement will for a core component of responses to the strategy refresh survey
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: Yes
The survey has been designed with the nine protected characteristics in mind. Out Health & Social Care Facilitators are targeting the protected characteristic groups. The Strategy Refresh programme has at its core tacking the health inequalities we see in our population. The EHIA that we have completed will be reviewed by tCI and also continuously updated as our engagement progresses.

Decarbonisation: No	
Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Report Title:	Strategic Planning Update					Agenda Item no.	6.9
Meeting:	Board		Public	X		Meeting Date:	30.03.23
			Private				
Status *(please tick one only):*	Assurance	X	Approval	X	Information		
Lead Executive:	Executive Director of Strategic Planning						
Report Author (Title):	As above						

Main Report
Background and current situation:

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

- The development of the 2023 – 2026 Integrated Medium-Term Plan (IMTP).
- Progress with the strategy refresh – there is a separate board report on the progress to date.
- Progress with the regional planning work programme.
- Progress with our strategic programmes.
- Progress with our partnership planning.

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

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

1. **2023 – 2026 IMTP/Annual:**
   The Board has agreed to develop an annual plan for 23/24, set in a three-year context, because we are not in a position to deliver a plan that balances financially by the end of the financial year. The plan we have developed, which is covered on a separate item on this Board agenda, sets out how what we deliver against each of the Ministerial priorities set out in the Welsh Government Planning Framework. An Accountable Officer letter was submitted to WG by 28th February confirming our position. At the time of writing a response to this letter has not been received.

   The milestones in the Annual Plan will be reported to Board on a quarterly basis, and assurance will also be provided to the Board in key operational delivery targets through the Integrated Performance Report that comes to each Board meeting.

   Work will start shortly on developing the Commissioning Intentions that form the first stage in developing our 2024/2025 IMTP/annual plan. This will also reflect the wellbeing objectives and priority areas for action set out in our refreshed Strategy.

2. **Regional Planning**:

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

2.1 Ophthalmology (led by AB): a regional service strategy has been developed and is attached. **The Board is asked to endorse the strategy.** It sets out how we will work together with Cwm Taf

Morgannwg and Aneurin Bevan Health Boards to develop and deliver a regional ophthalmology service model which reflects both the more specialist services which need to be provided once in a regional hub, and low complexity, high volume services which can be delivered on a regional basis in order to make best use of the resources available to us across the region in order to deliver the target access times for treatment as quickly as possible, and to do this in a way that provides equity of access for the regional populations. A business case is being developed separately which sets out how we plan to operation on a regional basis next year in relation to non-complex cataracts, making use of the temporary theatres we have commissioned at UHW and other regional capacity available to us.

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

Diagnostics (led by CTM): work is progressing at pace to finalise a business case for the commissioning of community diagnostic facilities that would bring additional capacity on board during the first half of 23/24 to support delivery of our planned care and cancer delivery plans.

Stroke services (led by C&V): we are working with CTM to develop a regional model for stroke services that will see the establishment of a hyper-acute stroke centre and supporting stroke units. Currently outcomes for people who suffer a stroke are not as good as they should be, and this is the key driver for this work programme. In addition to this, current service models are not sustainable from a workforce perspective. We have recently appointed a clinical lead from CTM. Visits are taking place to other stroke networks that have developed a regional service model and established a HASU to ensure we learn from others. The next step is to look at the national specification for stroke services which is currently still being developed by the NHS Collaborative.

Any substantial changes to the way services are delivered will need to have been tested through appropriate engagement with people who use our services.

3. Tertiary and Specialist Services:

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

4. Strategic Programmes

Management Executive continues to meet monthly to provide oversight of these programmes. They will need to be reviewed in the Autumn when the refreshed strategy is approved. The Strategy and Delivery Committee receives an assurance report at every meeting via a series of flash reports on these programmes plus the enable programmes (digital enables services, workforce modernisation and infrastructure via the capital report).

- Shaping Our Future Clinical Services: work is progressing with the development of the health board's 10-year clinical services strategic plan. The third meeting of the programme board has taken place and a programme of work agreed. The programme is being tailored to reflect the current operational pressures and the ability to commit the necessary resources.
- Shaping Our Future Hospitals: Welsh Government has agreed the scope of the Strategic Outline Case, confirming that it needs to be a high level SOC that builds on the PBC which was very detailed. The Programme Board now includes the Vice Chancellor of Cardiff University to reflect the independencies between this programme, and the University's

strategic infrastructure programme and longer-term strategy. We understand that we should hear shortly on the resource we have submitted to Welsh Government for the development of the SOC.

- Shaping Our Future in the Community/the RPB @home programme: this programme continues to drive the development of our locality placed-based model of community and intermediate care services. Work is ongoing to ensure this work aligns with the 6 goals emergency and unscheduled care programme, and the development of plan cluster planning groups (on the LA footprints) which are still very much in their infancy. The Area Plan refresh will enable clear milestones and outcomes to be further developed in the RPB annual plan which will be finalised in April.
- Shaping Our Future Population Health: this programme continues to provide a key focus to the work we are doing with a wide range of partners on improving population health, tackling explicitly the health inequities that exit between our communities and to ensure we provide a greater focus on prevention (primary, secondary and tertiary). Whilst not explicitly described in the Ministerial Priorities for 2023/2024, it is critical that the Health Board continues to provide an increased emphasis on health improvement and disease prevention articulated clearly in the commissioning and deliver services, as this is a fundament aspect of our longer-term strategy.

Recommendation:

The Board is requested to:

1. Note the progress being made across our strategic planning portfolio.
2. Endorse the regional ophthalmology service strategic plan, as detailed in Annex 1.

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

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

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant

Prevention	X	Long term	X	Integration	X	Collaboration	X	Involvement	X

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

Risk: No

Safety: Yes/No

No specific safety issues highlighted by this report. There is a general safety issue if we are not able to deliver sustainable services for our population.

Financial: Yes

There will be financial implications in relation so some of the work highlighted in this report, but the details will be developed as part of the ongoing work. Plans for services should look to reflect the Health Board's overarching financial plan that is looking to reduce the cost of delivering services. Where a specific need for investment is determined, a business case will be developed.
Workforce: Ye
There will be workforce implications relating to the introduction of regional service models.
Legal: Yes
There is a legal requirement for the Health Board to work as part of the RPB and two PSBs to work with relevant partners to produce the Area Plan and Wellbeing Plans.
Reputational: No
Socio Economic: Yes
The Wellbeing Plans and the plans for regional service models will explicitly consider the socio-economic duty. In relation to the later, we will be working across a wider footprint to ensure that those who most need to access services are able to do so addressing any 'inverse care law' impacts. *Useful Guidance on the application of the Socio-Economic Duty can be found at the following link: The Socio-economic Duty: guidance | GOV.WALES*
Equality and Health: n/a
EHIAs will be undertaken for the key plans described in this report.
Decarbonisation: Yes
Responding to the climate emergency features strongly in the Wellbeing Plans and our Decarbonisation Plan, which the Board is considering in March '23, is reflected in our Annual Plan.

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

Offthalmoleg Ardal
De-ddwyrain Cymru
South East Wales
Regional Ophthalmology

Regional Ophthalmology Strategy

2022 - 2025

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

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

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Our Vision

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South East Wales Regional Ophthalmology

Ophthalmology Services in South East Wales are sustainable and deliver high quality care and improved outcomes to patients in a timely way.

Upon referral into the service patients are directed to the right place and are seen quickly by the most appropriate clinician for their needs. All treatments and procedures clinically required are undertaken swiftly and safely, within the NHS, in fit for purpose facilities that have up to date equipment and supplies.

Staffing models match service demand and include a forward thinking skill mix of new and complementary roles that enable everyone to work to the top of their licence in integrated teams that communicate well. The Ophthalmology Service in South East Wales is a desirable and rewarding place to work

The Regional Centre of Excellence network enables the region to care for all complex eye care procedures and for specialists to share and enhance their skills, whilst at the same time allows less complex eye care to be delivered closer to the patient. The whole region is a centre of excellence for training, research innovation and development working closely with academic and industry partners to advance practices and create the next generation of Ophthalmic specialists across the wide variety of roles that support Ophthalmology Services.

Our Principles

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South East Wales
Regional Ophthalmology

Learning and Improvement

Reducing Variation and Inequity

Designing Value Based best practice services

Delivering timely and high quality patient centred care

A Regional Eye Care Service for South East Wales

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Regional Ophthalmology

The concept for a Regional Ophthalmology provision has been considered since 2017, however the significant service pressures incurred by the recent Pandemic have escalated and the scale and pace of the programme needs to be increased accordingly.

There is now agreement to establish and implement a regional planning framework for Ophthalmology Services for South East Wales. Regional solutions for Eye Care across Aneurin Bevan, Cwm Taf Morgannwg and Cardiff & Vale Health Boards will be put in place where this adds the most value to patients and staff

Regionalising Services to ensure their sustainability and offer the best services to patients aligns with A Healthier Wales, The National Clinical Framework and Royal College of Ophthalmologists Clinical Guidance and best practice.

The Case for Change

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Regional Ophthalmology

A Patient Story

"I first noticed change in my vision about 2 years ago, I was struggling to read small text in some of my books and I started to lose some of my peripheral vision in my left eye but I could still manage ok. I went to see my optician, they told me I have cataracts and referred me to the hospital for assessment and surgery. I had some letters from the hospital about being on the waiting list but I haven't had any contact for a while now and worry I've been forgotten. My sight is now much worse and I can only see colours and shapes in my left eye and my right eye is becoming cloudy. My husband and my son have to do more and more things for me and don't want to leave my house in case I fall over and loose more of my independence. I'm also finding it increasingly hard see the text on my mobile phone and I really miss the little things like doing my knitting and needlework, reading a book and going for a walk. I'm really scared about losing my sight altogether and how I will cope."

How Patients can expect to receive care in the future

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There are a wide range of Eye Care services that are offered by Ophthalmic Services. A clinical workshop in December 2021 enabled the determination of whether services should be delivered on a regional or local footprint. The Regional services in the list below make up the scope of this regional strategy.

Regional Services – In Scope

- Complex Cases (Glaucoma, Uveitis, Oculoplastics, Medical Retina, Cornea, complex cataracts)
- Neuro Ophthalmology
- Vitreo Retinal Surgical Hub
- Expanding Regional capacity for Cataracts
- Eye Casualty, Out of Hours Care
- Complex Paediatric Care

Local Services - Out of Scope

- Routine outpatient and theatre treatments
- Specialist dependent condition monitoring (Glaucoma, Cornea, Medical Retina)
- Paediatric Care
- Orthoptics

Community Services - Out of Scope

- AHP-led stable and routing condition monitoring (Glaucoma, Cornea, Medical Retina)
- Screening

Specialty	On a regional level	At a local level	Community
Glaucoma	Surgical / complex Glaucoma	Medical Glaucoma	Stable treated Glaucoma, Ocular Hypotension
Uveitis	Complex Uveitis	Anterior Uveitis	Simple recurrent Uveitis
Emergency Eye Care:	Eye Casualty	Follow up clinics	Follow ups, Minor Ailments
Out of hours Care	Out of hours Care		
Cornea	Cross linking	Routine Cornea	Keratoconus Monitoring
Oculoplastic	Orbit, Complex	Lids, Minor ops	
Medical Retina	Retinal Dystrophies, Genetics, complex Medical Retina	Stable monitoring, injection services, stable diabetic eye disease	Diabetic screening and monitoring
Paediatrics and Orthoptics	Complex Paediatrics	Routine Paediatrics,, Adult Orthoptics, Paediatric Orthoptics	Screening
Neuro Ophthalmology	Neuro Ophthalmology		
Vitreo retinal	Emergency and routine procedures		
Cataracts	Cataracts Expansion	Cataracts	Follow ups

Regional and Local Services

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South East Wales Regional Ophthalmology

Regional Services are generally more complex in nature and reliant on other specialties. They are best delivered on a regional footprint, bringing the specialist workforce and equipment together.

Local Services are generally more routine in nature and often involve ongoing patient interactions with specialist trained clinical staff. These service are best delivered more locally where clinicians can get to know their patients and the patient travel is reduced. Delivery is clinician-led with supervised AHP's

Community Services are generally for more stable patients that can be looked after by AHP's. Services include screening and are overseen by a clinician

Our Partners

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South East Wales
Regional Ophthalmology

This vision cannot be delivered by Health Boards alone. The support and input of partners is critical for success. Our key partners include Primary Care teams, Welsh Government, Patient Group including RNIB and other local patient groups, HEIW, Universities, Royal College of Ophthalmology and Royal College of Nursing and the School of Optometry.

Regional Model

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South East Wales
Regional Ophthalmology

Where are we today

Currently all ophthalmic services are delivered on an individual health board basis with only a small number of highly specialised services delivered in Cardiff for patients across the region. Due to increasing demand and workforce complexities it is no longer sustainable for all health boards to run all services. Better patient care and sustainable value for money services will be delivered by bringing services together into a Regional Centre of Excellence network model that will condense delivery of speciality, complex care and an expansion of cataracts services across the region

What will the future hold?

The Regional Centre of Excellence network model will provide expert specialist care for patients, ensuring they are seen quickly be the most appropriate specialist for their needs.

In the Regional Centre of Excellence there will be experts from a wide range of services that can treat complex conditions with links to other tertiary services such as neurology, enabling the best possible care to be provided in Wales.

In addition, the expansion in the regional capacity for cataracts will provide shared assessment and surgical capability for the treatment of cataracts adopting best practice high flow principles. The Regional Centre of Excellence network model will link seamlessly with local and community services. It will be sector leading with a modern skill mix of roles who learn together to drive improvement, and teaching and training facilities to grow the ophthalmic staff of the future.

Target for 2025

By 2025 Plans for the development of the Regional Centre of Excellence network model will be well underway with funding approved in principle and a full business case for a new facility in development.

The expansion in the regional capacity for cataracts will be fully utilised taking patients from all over the region, reducing cataract backlogs and flexing capacity to cope with current and future demands.

Sustainable Services

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South East Wales
Regional Ophthalmology

Where are we today

There are several areas of service delivery that require attention to make them sustainable in the short and medium term, congruent with the overall aim of this strategy to make all Ophthalmic Services sustainable in the long term. Areas requiring more immediate attention are Vitreo Retinal (VR) services, corneal cross linking, and emergency and out of hours cover across the region. Areas for medium term attention are the reduction of routine outsourcing and making the best use of estates and equipment.

What will the future hold?

Services identified above will be delivered effectively on a regional footprint, making the best use of the capacity available and ensuring the services as stabilised and efficient. Outsourcing of routine cases will cease with patients treated out of area on exceptional clinical basis only. The estates and specialist ophthalmic equipment available across the three health boards will be reviewed and optimized.

Target for 2025

By 2025 Vitreo Retinal (VR) services, corneal cross linking, and emergency and out of hours cover will be working well across the region to agreed clinical and funding models. No routine cases will be treated out of the region. The estates review will be finalised and the findings fully implemented.

Workforce

Offthalmoleg Ardal De-ddwyrain Cymru
South East Wales Regional Ophthalmology

Where are we today

The workforce across Ophthalmic services is fragile, with many experienced staff at all levels close to retirement and all health boards struggling to recruit trained staff. Vacancy levels are affecting service capacity and staff are being sought from overseas to fill posts. Training is available but delivery is patchy and requires greater co-ordination across the region with all partners involved.

What will the future hold?

Ophthalmic Services in South East Wales are a great place to work. Qualified and trained staff are attracted to the area and vacancies are quickly filled. Training and development for all staff is co-ordinated and teaching, learning and improvement are central principles of how all ophthalmic services in the region operate. All professionals work to the top of their licence.

Target for 2025

By 2025 regionalised training plans and programs will be in place for all disciplines of staff with tracking and reporting of competencies and achievements delivered in partnership with HEIW and the Universities (CU and USW). Multi-disciplinary teams and skill mix reviewed and new roles filled. Future workforce plans developed and implemented.

Research, Innovation and Development

Offthalmoleg Ardal De-ddwyrain Cymru
South East Wales Regional Ophthalmology

Where are we today

The research innovation and development activities that are currently undertaken with the region are sometimes ad-hoc and led by individual clinicians. There is a strong vision research base in Cardiff University but it is not integrated into Ophthalmology services in the region.

There are relatively few fellowship opportunities within the region and no substantial funding streams for this type of work are accessed routinely. The only industry partnership working is for outsourcing and there are few links with hereditary conditions and genomics.

What will the future hold?

Regional Centre of Excellence network model and the Ophthalmic services provided by Health Boards provide the variety and complexity of cases to attract research fellows and innovation opportunities.
There will be a regional Clinical Research Facility allowing delivery of high quality clinical research trials which will increase income and quality of care for patients whilst building links with industry partners with strong consultant support.
There will be sustainable funding streams for research in the region.
Meaningful and mutually beneficial Industry Partnerships are created and links with genomics are developed and strengthened.

Target for 2025

By 2025 the Regional Centre of Excellence network model will work closely with Clinical and Research Fellows whose work will enhance the services provided. There will be more academic trainees who have both clinical and research aspects to training within the region. All types of clinical and non-clinical roles play an active part in research activities.
At least one industry partner will be engaged with the regional working and an Ophthalmic Genomics working group will be well established.

Enablers

Offthalmoleg Ardal De-ddwyrain Cymru
South East Wales Regional Ophthalmology

Where are we today

The organisational culture, use of data and systems, clinical variation and standards and patient led service design are all critical enablers to the delivery of this strategy.
Connection and sharing of services between health boards is restricted by variation in IT communication and documentation systems. Wales are on the cusp of adopting a new electronic patient record system call Open Eyes that will underpin the regional working, however currently access to routine capacity, demand and activity data is limited in some areas. There is clinical variation across Health Boards and while more recent services have been designed with the patient, not all services are delivered in a patient centred way. There is growing support for regionalisation within the organisational culture but more work needs to be done.

What will the future hold?

All services will be data driven with a full adoption of Open Eyes in every specialty enabling sharing of patient records and data and shared patient treatment lists to inform day to day operations, management and long-term planning. Patient reported outcomes will enable shared decision making with patients. Adoption and inclusion of a regional approach for Eye Care is central to decision making and the services provide equity of access to all patients for treatment and staff for training and opportunities. Clinical variation is minimal in regional services and patients are fully engaged in service design.

Target for 2025

By 2025 Open Eyes will be fully adopted. A Regional Strategy will be fully embedded with Health Boards thinking ‘Regional first’ where appropriate services require support. Shared Patient Treatment Lists (PTL’s) will be in place where appropriate and patient outcomes will be clearly visualised. Clinical variation will be minimised in Vitreo Retinal (VR) services, corneal cross linking, and emergency and out of hours cover across the region. A patient reference group will be participating in service design and change.

High Level Timelines

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South East Wales Regional Ophthalmology

2023

- Regional expansion in capacity for cataracts will be fully utilised
- Regional Vitreo Retinal Service operational
- Regional Eye Casualty and Out of Hours Care in place

2024

- Research, Innovation and Development well established
- Workforce Development Programme in place

2025

- Regional Centre of Excellence network funding agreed

Report Title:	**Maternity Services Update**					Agenda Item no.	6.10
Meeting:	Board		Public	X		Meeting Date:	30.03.2023
			Private				
Status *(please tick one only):*	Assurance	X	Approval			Information	
Lead Executive:	Deputy Executive Nurse Director						
Report Author (Title):	Assistant Director of Quality and Patient Safety						

Main Report
Background and current situation:

Health Care Inspectorate (HIW) Wales commenced an unannounced inspection of maternity services on 8 November 2022. HIW convened an Executive Immediate Assurance Briefing on 9 November 2022 to advise the Executive Team of initial findings. The inspection continued until 10 November 2022 and concluded with a briefing from the inspection team to members of the Executive Team, Children and Women's Clinical Board and the wider maternity services, where a number of immediate assurance recommendations were discussed and these included:

- Compliance with mandatory training
- Equipment maintenance
- Environment
- Staffing levels
- Antenatal, birth and post-natal pathways
- Clinical risk and governance

A comprehensive immediate improvement plan was developed to address all immediate assurance recommendations and a programme of work commenced immediately to progress these improvements. The inspection report and full recommendations has not yet been received and will be reported to the Quality Safety and Experience Committee on publication.

Immediate improvements have included the migration of mandatory training from on-line delivery, an approach implemented during Covid, back to face to face training. From April 2023 all midwives will be rostered to attend an in-person study week where all mandatory training will be undertaken. Mandatory training compliance is now recorded on the Health Board digital roster platforms to provide oversight of training compliance on every shift.

The Health Board rolled out the use of a digital inspection tool in 2022 the suit of core audits is now being used in maternity services and in addition a specialist programme of maternity inspections is being developed and this will be used to provide ongoing assurance in relation to the immediate improvement plan.

The Maternity and Obstetrics Directorate are recruiting to five additional medical trainees that are being funded by the Clinal Board in addition to the established funded medical trainee posts. The required midwifery establishment for the Health Board based on the Birthrate + assessment is 244 Whole Time Equivalent staff form band 5 to band 7. During the summer of 2022 increased short term sickness was observed and the department had 24 vacancies. To mitigate the risk of absence as a result of sickness and maternity leave as well as recruitment delays the directorate have recruited beyond their current establishment and in January 2023 there were 246 whole time equivalent members of staff in post and there are ongoing recruitment efforts to allow for attrition throughout the year.

In July 2022 there were a number of delays in National Reportable Incident (NRIs) investigations as a result of obstetrician capacity to support investigations. There were a total of fourteen investigations ongoing at the time but this had reduced to eight in December 2022 with 15 incidents

investigation completed during that period. Obstetric job plans have been reviewed to ensure adequate resource for NRI investigations.

At the time of the HIW review, the Clinical Board had 13 Nationally Reportable Incidents (NRI) under review with 6 of these overdue and some significant delays observed. At the end of February 2023 this number had reduce to 8 NRIs open of which 5 were overdue. Two of the overdue incidents were subject to external review and the remining three were very close to finalizing.

At the time of the HIW inspection there was a significant backlog in reviewing patient safety incidents. Incidents that were recorded as not being reviewed for 30 days or over have reduced from one hundred and ninety-two in July 2022 to forty-seven in December 2022, however the number of open incidents exceeded One thousand one hundred at this time. Operational managers open and review patient safety incidents and develop brief summaries of the incidents and the requisite actions, these are presented at a weekly Datix meeting to provide assurance in relation to the incident response and to extrapolate themes. Previous delays in the process have led to the delay in closing incidents. The risk midwife has reinstated this patient safety incident governance oversight process and an improvement has been noted in the timeliness of incident management. On 17 March 2023 there were 502 incidents open under obstetrics, of these 29 were new incidents, 334 were under review, 94 under investigation and 45 were awaiting closure.

In response to the Ockenden Review of Maternity Services at Shrewsury and Telford a RAG rated assurance report has been produced benchmarking against the 89 report recommendations. A business case was presented to the Health Board investment group in January 2023 to set out proposed investments to address the requirement. Additional investment was agreed and in response the midwifery establishment was increased 256 whole time equivalents.

A Maternity Oversight Group chaired by the Executive Director of Nursing and attended by the Executive Medical Director as well as Clinical Board representatives convenes every two weeks. The purpose of the group is to oversee see progress with the HIW improvement plan, Ockendon improvement plan and wider quality and patient safety themes. This group continues to meet to oversee nationally reportable incidents, surgical site infections, delays in Caesarian infection and induction of labour and perinatal and maternal mortality rates.

A decision has been made to appoint to a Director of Midwifery and the post is currently out to advert.

The UHB has received the draft HIW maternity report and is in the process of responding in relation to factual accuracy and developing an improvement plan in line with the recommendations in the report. The final report is due to be published on 26 April 2023.

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

Healthcare Inspectorate Wales undertook an unannounced inspection on 8 9 and 10 November 2022 and issued a number of immediate assurance recommendations as a result.

Improvements have included increased compliance mandatory training compliance and oversight of compliance on the Health Board roster platforms to provide assurance of skill mix on each shift.

Rolling midwifery adverts are resulting in successes n recruitment which will support greater resilience in staffing and mitigate for absence including maternity leave. Medical recruitment of additional obstetric trainees will mitigate medical staffing shortages.

The Clinical Board position on the management of patient safety incidents and Nationally Reportable Incidents has improved significantly.

A business plan has been developed to support further service development in line with recommendations made in the Ockenden Review of Maternity Services at Shrewsbury and Telford

Recommendation:

The Board are asked to:

NOTE the recent HIW inspection and outcomes to date and the assurance provided in relation to the response

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

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

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

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

Report Title:	Integrated Annual Plan 2023/2024				Agenda Item no.	7.1	
Meeting:	**Public** Board				Meeting Date:	16th March 2023	
Status *(please tick one only):*	Assurance		Approval	✓	Information		
Lead Executive:	Abigail Harris, Executive Director of Strategic Planning						
Report Author (Title):	Ashleigh O'Callaghan, Head of Strategic Planning						

Main Report

Background and current situation:

Background

Each year, Health Board's in Wales are required to submit a 3-Year Integrated Medium-Term Plan (IMTP) to Welsh Government (WG) as part of their statutory duties under the NHS Finance (Wales) Act 2014.

Powers arising from the Act ensure Health Boards and Trusts must prepare a plan which sets out its strategy for securing that it complies with its 'break even' duty, whilst improving the health of the people for whom it is responsible and the provision of healthcare to such people.

The NHS Planning Framework 2023-2026 recognises the challenges we face this year, with relentless pressure of demand compounded by a number of external factors, including the consequences of Brexit, the cost-of-living crisis and the war in Ukraine, that are all impacting on our health and social care system. As such, it recognises that the extremely volatile planning environment over the coming period means that planning arrangements need to be more targeted to the challenges we face.

Therefore, the Framework directs Health Boards and Trusts to focus on delivery of 16 ministerial priorities.

Current Situation

Last year, we submitted an annual plan in a three-year context, because we were unable to deliver a financially balanced plan in-year.

Since then, the continual pressures as outlined above has meant that, as an organisation, we have been unable to deliver the level of recurrent savings that we set out in our 2022/2023 plan or mitigate a number of escalating cost pressures.

The plan includes a planned deficit for 2023/2024 of £88.4m inclusive of a 4% cost improvement ambition, representing a significant challenge for the organisation.

As such, we are unable to submit a balanced 3 year Integrated Medium Term Plan, and the plan presented is an annual plan, setting out how we will deliver upon a smaller number of delivery priorities alongside an ambitious cost improvement programme with a trajectory to financial balance over the medium term whilst focussing upon improving the quality and value of the services we provide.

The CEO submitted an Accountable Officer letter to Welsh Government on the 27th February to ouline this position – at the time of writing this paper, a formal response has not been received by the Health Board.

The challenging financial and operational context means that we will be unable to fully meet all of the ministerial priorities particularly for the expectations for *52 weeks Outpatient Assessment and 104 weeks treatment recovery milestones to be achieved by 30 June 2023 and maintained throughout 2023/24 moving to "36 weeks RTT standards by March 2024"* for a number of specialties even when productivity and efficiency measures are factored in to our planning.

The UHB has received an allocation of £16.0m to continue to accelerate planned care recovery in 2023/24. This is a reduction of £6.6m on funding received in 2022/23 linked to supporting regional solutions, productivity and transformation. We will continue to aspire towards the achievement of ministerial priorities; our ability to achieve these in 2023/24, within the current financial context, is detailed in our operational measures of success tables in section 2 of the plan.

Progressing regional solutions and accessing funding whilst plans are developed will be key to diving performance in 2023/24.

Plan Approach

Our plan commits to **6 delivery priorities** for the next 12 months:

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

2. To recover, reset and transform **planned care, cancer** and **diagnostic services**

3. To deliver exceptional **specialist and tertiary services** for our local, regional and national populations

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

5. To continue our **mental health** transformation with a focus on the principles of home first, integration, safe hospital care and improving access to psychological support and specialist teams

6. To deliver improved services through the South East Wales **Regional Priority Programmes;** Ophthalmology, Orthopaedics, Diagnostics, Stroke and Cancer.

These priorities have been developed through all Clinical Boards and will be the mechanism for delivering against the ministerial priorities.

Delivery priorities will be underpinned by local delivery of national programmes with our partners; 6 goals for Urgent and Emergency Care, Planned Care, Accelerated Cluster Development and Strategic Programme for Primary Care Wales.

The plan also commits to prioritisation of the Minister's National *Further Faster* Blue Print which is in its infancy nationally but which will be delivered through our @home programme, which is a key area of focus within delivery priority 1.

The plan describes development of an organisational operating model that embeds quality and continuous improvement, learning and a value-based healthcare approach as the means to deliver our ambitions and that delivers the very highest quality of care through prudent use of resources.

The plan also describes programme of both core efficiency and transformational savings, using a quality improvement and value-based approach. Key areas of focus are:

- Length of stay in acute beds
- Operational efficiencies and productivity
- Continuing Healthcare
- Medicines Management
- Procurement
- Workforce
- Scaling back investments (Disinvestment / Choices)

Delivery of a number of these high value opportunities will involve implementing new models of care and the redesign of existing care pathways to reduce the cost base whilst improving quality of service and patient value working with our partners.

Each theme has an Executive lead, supported by senior multi-disciplinary teams across the Health Board driving a collaborative approach to delivery.

In addition to the 4% cost improvement ambition we also need to disinvest in TTP and Mass Vaccination, reducing the current expenditure run rate by £5.4m in order to deliver services within revised allocations. The current recovery programme run rate will also need to be reduced by £3.0m operate within the revised top sliced allocation of £16.0m.

Over the next 12 months and beyond our focus will be on continuing to improve quality of care and experience of our staff and patients, whilst making the most efficient use of available resources. Over the last 3 years our workforce has grown from 13,271wte to 14,488wte, our variable pay, and agency/locum spend has increased. The plan for 23/24 – 25/26, will not show an overall growth in our workforce as in previous years, but will show how we plan to build a more sustainable workforce for the future.

Our infrastructure requirements from both an estates and IT perspective have been prioritised but will require further prioritisation in light of the limited capital available in NHS Wales. There will be an additional prioritisation exercise at a June Board Development session to further ensure that the plan balances realism with ambition in the current climate.

Cluster and Pan-Cluster plans are summarised within the plan, and will be submitted in full to WG alongside the Annual Plan on the 31st March.

Minor updates to be included in the final submission to Welsh Government

The SLB requested that the final version of the plan includes:

- A strengthened position on Value Based Health Care and how this will be embedded next year
- A position on the foundational economy

Timings of the Board Paper submission dates are such that these changes have not been incorporated in to the plan presented today but will be included in readiness for Welsh Government submission.

Governance

The plan has been developed through the Clinical Boards and with corporate leads via the Strategy Development and Delivery Group.

The approach for Delivery Priorities was agreed through Senior Leadership Board (SLB) in December, the wider plan and assumptions agreed on 16th February via SLB and performance ambitions and cost improvement programmes further refined and agreed at a workshop on 2nd March. The SLB endorsed the plan for onward submission to the Board on 16th March.

The plan priorities and financial position was discussed at Board Development sessions on the 23rd January and the 23rd February with the final plan being taken to Board on the 30th March.

The financial plan was discussed at Finance Committee on 18th January and15th February with final plan being taken to committee on 22nd March.

Engagement has taken place at all stages of plan development with Welsh Government and the Finance and Delivery Unit.

Planning conversations will take place with the Local Partnership Forum and the Senior Leadership Group (RPB) in March.

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

The Board are asked to approve the **integrated annual plan**, which can be found under the Supporting Documents Folder on AdminControl and the Cardiff and Vale UHB website, based on the Health Board's inability to deliver a balanced plan and acknowledging that ministerial priorities will not be met for planned care in all specialties due to a number of drivers as articulated above.

The Board are therefore asked to approve the actions taken within the plan to navigate to a sustainable position over the medium term and by doing so the Health Board are putting forward a plan that will **not be approvable** by Welsh Government.

Whilst the formal response to the Accountable Officer has not yet been received, it is important to note that:

- Organisations without an approved plan are placed under greater levels of ongoing scrutiny by Government at all levels and interactions with government
- Organisations without an approved plan are often subsequently at risk of being placed in higher levels of escalation- enhanced monitoring or even special measure.
- Organisations with approved plans are generally better placed in receive any 'in year' monies which may be made available

Recommendation:

The Board are asked to:-

1. **NOTE** the contents of the annual intergrated plan 2023/2024
2. **APPROVE** the plan for onward submission to Welsh Government on 30th March

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

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant

Prevention	✓	Long term	✓	Integration	✓	Collaboration	✓	Involvement	✓

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

Risk: Yes

There are risks inherent within the plan regarding ability to deliver sustainable services within a challenging operational and financial context. These risks will be monitored and managed through the Senior Leadership Board and relevant Clinical Boards.

Safety: Yes

Maintaining and improving quality and safety is a key principle underpinning the plan and the plan describes the operating model through which the quality lens will be embedded in to the planning and business of the organisation.

Financial: Yes

The key financial risks for the health board within this financial plan are set out below:

- Achievement of the efficiency plan target – We will need to give this concerted attention in order to ensure delivery. Savings plans delivering 4% need to be in place as soon as possible. There will be clear lines of accountability in delivering identified high value opportunities.
- Management of Operational Pressures – We will be expecting our budget holders to manage and recover any operational pressures within the totality of resources delegated to them.
- Inflationary pressures – There are considerable inflationary pressures across the health board with pay and energy being the largest. This will affect the UHB directly and also through its supply chain. We will monitor this closely and work with our partners to find a system wide approach to manage the risk.

- Develop and deliver a programme of transformational savings – Delivering a programme of the scale needed to address the underlying deficit is a key priority and will be subject to robust management arrangements.
- COVID National Programmes and Local Response – The UHB will need to exit its COVID 19 response costs in a manageable way for service delivery and within available resources, whilst maintaining the ability to remain dynamic and responsive to changes in COVID demand.

The Health Board recognises the risks in the plan and is taking actions in order to ensure that they are appropriately managed and that financial opportunities to support mitigation are fully explored.

Workforce: Yes

The plan is underpinned by the Our People and Culture plan, prioritisng the recruitment and retention of staff.

Legal: No

Reputational: Yes

The inability to deliver a balanced plan is likely to have a reputational impact for the Health Board both from a public perspective and with Welsh Government

Socio Economic: No

Equality and Health: Yes

Reducing health inequities is a core principle underpinning the plan

Decarbonisation: Yes

Responding to the climate emergency features within the plan

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Finance Committee	22nd March
Board	30th March
Welsh Government	31st March

SECTION 4: APPENDICES

4.1 MINISTERIAL PRIORITY TEMPLATES

#	Priority	Attachment
1	Delayed Transfers of Care	*This document can be found under the Supporting Documents folder on AdminControl and the Cardiff and Vale UHB website.*
2	Improved access to GP and Community Services	*This document can be found under the Supporting Documents folder on AdminControl and the Cardiff and Vale UHB website.*
3	Improved access to dental services	*This document can be found under the Supporting Documents folder on AdminControl and the Cardiff and Vale UHB website.*
4	Improved use of community pharmacy	*This document can be found under the Supporting Documents folder on AdminControl and the Cardiff and Vale UHB website.*
5	Improved use of optometry services	*This document can be found under the Supporting Documents folder on AdminControl and the Cardiff and Vale UHB website.*
6	Implementation of UPC and 111	*This document can be found under the Supporting Documents folder on AdminControl and the Cardiff and Vale UHB website.*
7	Implementation of Same Day Emergency Care services	*This document can be found under the Supporting Documents folder on AdminControl and the Cardiff and Vale UHB website.*
8	Reduce ambulance handover waits/lost hours	
9	52 and 104 week waits	*This document can be found under the Supporting Documents folder on AdminControl and the Cardiff and Vale UHB website.*
10	Outpatient transformation	*This document can be found under the Supporting Documents folder on AdminControl and the Cardiff and Vale UHB website.*
11	Community Diagnostic Hubs	Awaiting from Cwm Taf (regional leads)
12	Straight to Test Model	*This document can be found under the Supporting Documents folder on AdminControl and the Cardiff and Vale UHB website.*
13	Single Cancer Pathway	*This document can be found under the Supporting Documents folder on AdminControl and the Cardiff and Vale UHB website.*
14	Implement national cancer pathways	

15	Recover waiting time performance -mental health	*This document can be found under the Supporting Documents folder on AdminControl and the Cardiff and Vale UHB website.*
16	Implement 111 press 2	*This document can be found under the Supporting Documents folder on AdminControl and the Cardiff and Vale UHB website.*

4.2 Enabling plans

Our infrastructure and workforce priorities are fully integrated in to our plan in both the strategic and delivering our priorities sections, however, a standalone section can be found below outlining our priorities in terms of capital, estates and digital schemes in more detail along with our detailed actions associated with our people and culture plan.

Our Infrastructure Plan	*This document can be found under the Supporting Documents folder on AdminControl and the Cardiff and Vale UHB website.*
Decarbonisation	*This document can be found under the Supporting Documents folder on AdminControl and the Cardiff and Vale UHB website.*
Our People and Culture Plan- detailed actions	*This document can be found under the Supporting Documents folder on AdminControl and the Cardiff and Vale UHB website.*

Report Title:	Cardiff PSB Wellbeing Plan and Vale of Glamorgan PSB Wellbeing Plan			Agenda Item no.	7.2
Meeting:	Board	Public	X	Meeting Date:	30.03.2023
		Private			
Status *(please tick one only):*	Assurance		Approval	X	Information
Lead Executive:	Executive Director of Strategic Planning				
Report Author (Title):	Deputy Director of Strategic Planning				

Main Report
Background and current situation:

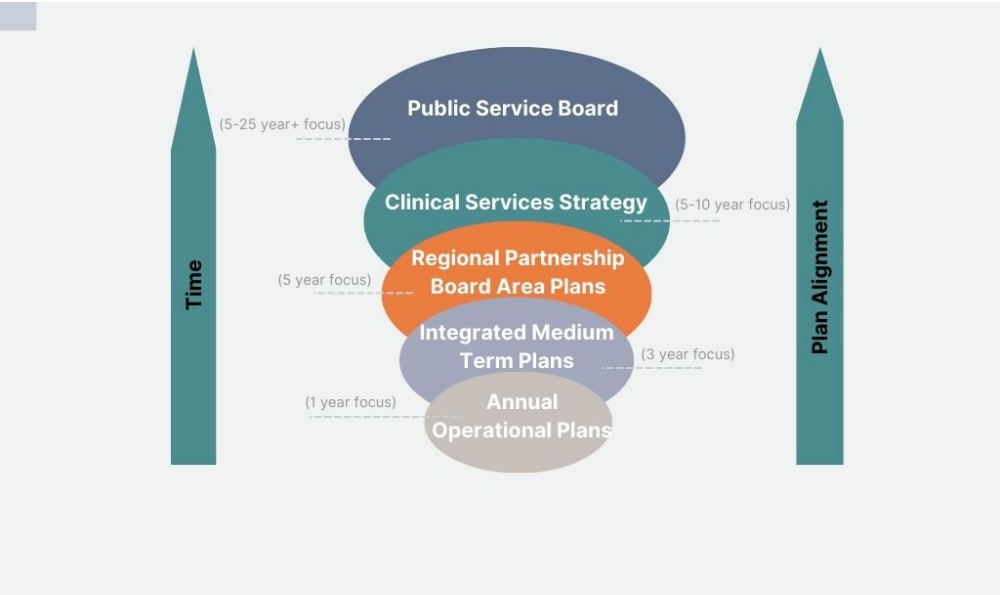
This report introduces the draft Well-being Plans for Cardiff and Vale Public Services Boards (PSBs) respectively:

1. Cardiff - the council cabinet plan to approve Cardiff's Local Well-being Plan on 30 March 2023 (attached at **Appendix 1**, which can be found under the Supporting Documents Folder on AdminControl or the Cardiff and Vale UHB website)
2. Vale – A PSB meeting has been arranged to formally sign off the Vale Well-being Plan for publication on the 3rd May 2023 (Attached at **Appendix 2,** which can be found under the Supporting Documents Folder on AdminControl or the Cardiff and Vale UHB website)

Both publications will be subject to approval by all statutory members of the Cardiff and Vale Public Services Boards.

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

Both PSBs have undertaken local Wellbeing Assessments and Population Needs Assessments in 2022 to inform the development of the Wellbeing Plans. Taking account of these findings, along with advice from the Future Generations Commissioner, the Well-being Plans' objectives and priorities were refreshed and updated and formally consulted upon during October 2022 to January 2023.



As part of the UHB's strategy refresh, we will take account of these Well-being Plans' revised objectives, to ensure that the UHB's refreshed Well-being Objectives are appropriately aligned.

These Well-being Objectives provide the strategic context for the partnerships' priorities and key deliverables.

Cardiff Public Services Board's Well-being Plan contains the following seven Well-being Objectives:

- Cardiff is a Great Place to Grow Up
- Cardiff is a Great Place to Grow Older
- Supporting People out of Poverty
- Safe, Confident and Empowered Communities
- A Capital City that Works for Wales
- One Planet Cardiff
- Modernising and Integrating our Public Services

Vale Public Services Board's Well-being Plan contains the following three Well-being Objectives:

- A more resilient and greener Vale
- A more active and healthier Vale
- A more equitable and connected Vale

To deliver the Well-being Plans' new priorities for partnership working, a review of partnership governance and delivery arrangements on a Cardiff and Vale regional footprint has been undertaken to ensure that they reflect the new priorities identified in the Well-being Plans, that there is clarity over responsibilities and accountabilities for delivering partnership priorities, and that the complex and fragmented statutory arrangements work in a streamlined and connected way.

Recommendation:

The Board is requested to:

1. **Endorse** the draft Wellbeing Plans as the PSBs' statutory partner

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

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

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: ~~Yes~~/No
No risk assessments relevant to the content of this report.
Safety: Yes/No

No specific safety issues highlighted by this report. There is a general safety issue if we are not able to deliver sustainable services for our population.
Financial: Yes/No
Workforce: Yes/No
.
Legal: Yes/~~No~~
There is a legal requirement for the Health Board to work as part of the RPB and two PSBs to work with relevant partners to produce the Area Plan and Wellbeing Plans.
Reputational: Yes/No
No specific risks to highlight.
Socio Economic: Yes/~~No~~
The Wellbeing Plans and the plans for regional service models will explicitly consider the socio-economic duty. In relation to the later, we will be working across a wider footprint to ensure that those who most need to access services are able to do so addressing any 'inverse care law' impacts. *Useful Guidance on the application of the Socio-Economic Duty can be found at the following link: The Socio-economic Duty: guidance | GOV.WALES*
Equality and Health: Yes/No
EHIAs have been undertaken for the Wellbeing Plans
Decarbonisation: Yes/No
Responding to the climate emergency features strongly in the Wellbeing Plans.

Approval/Scrutiny Route:	

Report Title:	2023/24 Decarbonisation Action Plan			Agenda Item no.	7.3
Meeting:	Board	Public	X	Meeting Date:	30/03/2023
		Private			
Status *(please tick one only):*	Assurance		Approval	X	Information
Lead Executive:	Abigail Harris, Executive Director for Strategic Planning				
Report Author (Title):	Ed Hunt, Programme Director, SOFH				

Main Report
Background and current situation:

The purpose of this paper is to present Board with the 2023/24 Decarbonisation Action Plan. The full action plan is provided to Board Members along with this paper. Note that it is being graphically designed into a pdf document suitable for publication.

In preparation for presentation to the Board, this plan has been taken through the Decarbonisation Delivery Group, Senior Leadership Board and Strategy & Delivery Committee. Their feedback has been reflected in the plan provided to Board.

This report asks Board to:

- **Approve the 2023/24 Decarbonisation Action Plan.**

Context

Cardiff and Vale UHB declared a climate emergency in January 2020, with a first 'Sustainability Action Plan' published later that year. In November 2021, the Board approved the second and current Action Plan and defined a series of actions, owned across the UHB. A third action plan for year 23/24 described in this paper builds upon the learning of the last three years and seeks to further mature the carbon literacy of the organisation. A paper was brought to Board in November 2022 explaining the need to refresh the plan and highlighting the kind of new actions being considered. The Strategy and Delivery Committee were updated in January 2023 on the development progress of the plan with the headline actions further matured. The final plan is being taken to Strategy and Delivery Committee in March 2023 and Senior Leadership Board also prior to Board. This paper presents the final action plan to Board members. We have made good progress with delivering the actions set out in our previous sustainability plans and are leading the way in Wales in many areas of carbon reduction activity. We have a group of passionate clinicians leading new approaches to delivery of healthcare which reduces carbon emissions, and our estates teams are already delivering against many of our priorities in relation to the generation of renewable energy and waste management.

Welsh Government has set NHS Wales a target of a 16% reduction in emissions by 2025 and a 34% reduction by 2030, from a 2018/19 baseline. Welsh Government will be reviewing the continued appropriateness of these targets during 2023. It had been previously reported to the Board that we, like others in NHS Wales do not yet have a line of sight to these targets. CVUHB have estimated to have saved 1% of emissions since 2018/19 (excluding supply chain emissions). More needs to be done, but gains will be hard won. For example, consider the following hypothetical scenarios, where even a 50% reduction in electricity use would only deliver a 2% emissions saving. A 5% reduction in pharmacy spend would only deliver a 1% saving. More colleagues than ever are taking on board messaging and participating in improvement activity, however, to achieve meaningful carbon savings will require the organisation valuing and prioritising the time of people to support this agenda making it a core part of peoples' jobs.

Audit Wales

In July 2022, Audit Wales published the Public Sector Readiness for Net Zero Carbon by 2030 report. This report called for an increase in pace of activity amid clear uncertainty about whether it is possible for the Welsh Public Sector to achieve the ambition for net zero carbon emissions by 2030 setting out five calls to action for public bodies:

1. Strengthen your leadership and demonstrate your collective responsibility through effective collaboration;
2. Clarify your strategic direction and increase your pace of implementation;
3. Get to grips with the finances you need;
4. Know your skills gaps and increase your capacity; and
5. Improve data quality and monitoring to support your decision making.

CVUHB have used these five calls to action to ensure the actions set out in the action plan are addressed.

In response to these recommendations, **Welsh Government said that it is expected that public sector organisations should manage the transition within their own budgets.** This presents a challenge balancing ongoing service delivery in the current financial climate with the costs of decarbonisation. The action plan has been written in the

knowledge that **much can still be achieved** with existing resources. Where investment is required, business cases will be presented through the standard channels for consideration and identify how we prioritise using our resources differently.

Executive Director Opinion and Key Issues to bring to the attention of the group:

This section summarises the Decarbonisation Action Plan. The full plan accompanies this paper.

Vision
The plan presents the following vision:
CVUHB will be an exemplar in the delivery of sustainable healthcare, setting the pace that others will follow and learn from. Low environmental impact will be a business as usual consideration where all of our colleagues will be encouraged to make changes to working practices that will see our carbon emissions reduce initiative by initiative.

Ambition
Why is this plan ambitious? Audit Wales is asking public sector organisations to build low carbon behaviours into their day to day activity. This plan asks the organisation to prioritise the time of colleagues into making a positive impact on our carbon footprint such that it is a core part of peoples' day job. Decisions will need to be made taking carbon impact as a factor for consideration, it will be part of leaders' vocabulary, encouraging their teams to add value, our energy efficiency will need to be invested in. Finally, there is a need to provide the education and know-how so that our 16,000 colleagues can each contribute to reducing our emissions through their day to day work and how they travel to our sites. These are not simple changes and will require pan-Health Board prioritisation. The Board has an important role to play in setting the climate within the organisation which results in greater awareness, engagement and participation in reducing our carbon footprint.

Action Plan
The full action plan has been developed through the work of the Decarbonisation Delivery Group and the supporting working group. It contains over 50 actions. The actions are grouped in themes: culture and leadership, infrastructure, sustainable and active travel, procurement and clinical services. Each of them sets out what actions should be taken at Board, clinical board and front-line team level. The actions have been mapped against the Audit Wales recommendations. Furthermore, the actions that have been described generally do not seek to target particular carbon savings up front, rather focus on the right things to do to set and create momentum. What is the point of having an action if you can't describe its impact however? The actions therefore are categorised into five criteria each of which have benefit:

- Direct Saving – where the carbon benefit of an action can be quantified up front
- Direct Saving Non-Quantifiable – where carbon can be saved, but it can't be quantified prior to actioning
- Climate Conscious Leadership – where the action is demonstrating emissions reduction leadership
- Carbon Literacy – where the education of our colleagues has been improved
- Supporting Transition – where the action transitions towards low carbon solutions

There are a number of actions that relate to the Board which will ensure that we are developing the right culture and climate to respond to the climate emergency with urgency, and reflect this in our decision making and risk register.

Costs
In making decarbonisation activities part of our everyday work, many of the actions can be delivered without additional resources. However, there are a number of the actions which have resource implications and where appropriate specific business cases will be developed which will set out why we should prioritise our resources in these areas. The cost of implementation of the plan will be taken through Investment Group. It is anticipated a recurring budget of c£100k in discretionary capital is required to support the Level 2 Healthy Travel Charter. The delivery of the plan will also require revenue funding to support a biodiversity assessment and potentially resource to drive progress. A way to deliver culture change that is part of an existing change programme is being considered with the Shaping Change Team which would offer better value than a standalone programme. Any investment will be subject to the usual business case process.

The above costs aside, the current financial climate has informed the action plan by seeking its delivery within existing resources. Many positive actions such as being mindful of how best to recycle an item, being conscious of avoiding waste or making a decision with carbon as a consideration however do not have any direct cost and should become business as usual activity.

Conclusion
The 23/24 action plan asks the Health Board to further embrace the decarbonisation agenda and act with the urgency that the climate emergency requires. It asks leaders to own the problem, make decisions with carbon in mind and encourage their teams to take action to improve their carbon footprint. Equally, we will need to continue to educate and motivate our 16,000 colleagues to adapt their actions and behaviour to be lower carbon including in the way they work and the way they travel to and from work. This is an ambitious plan because change is being asked for throughout the organisation with time prioritised for people to deliver carbon saving activity committed-to for the first time. It is through a lot of small contributions from all of our colleagues that our carbon emissions will fall significantly.

Recommendation:

This report asks Board to:

- **Approve the 2023/24 Decarbonisation Action Plan.**

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

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

Prevention	x	Long term	x	Integration		Collaboration	x	Involvement	

Impact Assessment:

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

Risk: ~~Yes~~/No

Safety: ~~Yes~~/No

Financial: Yes/~~No~~

To meet the actions in the audit report there is likely to be some financial budget required. This has not yet been defined.

Workforce: Yes/~~No~~

The current workforce is not set up to deliver significant decarbonisation requirements over the period required. Meeting these requirements is likely to need additional posts but also give time to all staff to contribute towards the agenda.

Legal: ~~Yes~~/No

Reputational: Yes/~~No~~

There is a risk that as a public body, not showing leadership on decarbonisation will cause reputational damage amongst our colleagues, Welsh Government, public sector bodies and our population. The mitigation is to demonstrate results and share these successes through internal and external channels.

Socio Economic: ~~Yes~~/No
Equality and Health: Yes/~~No~~
There is a risk that not adapting to the impacts of a changing climate, the health of the most vulnerable in society could decrease. The mitigation is to consider widespread adoption of adaption strategies.
Decarbonisation: Yes/~~No~~
There is a risk that NHS Wales carbon saving targets of 16% by 2025 and 34% by 2030 are not met. Whilst these targets are being reviewed by Welsh Government, the need to make progress against our emissions is still required. The mitigation is to increase and accelerate participation and ownership of decarbonisation across the UHB through this Decarbonisation Action Plan.

Cardiff and Vale University Health Board

Decarbonisation Action Plan

2023/2024

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1. Foreword

The impacts of climate change are already being felt globally including extreme weather events, sea level rises, mass species loss and extinction events. These impacts will have dramatic effects in the UK and Wales impacting infrastructure, food availability, health and migration. Without further urgent action to reduce carbon emissions and reduce the continued heating of the planet, there will be catastrophic and irreversible damage done, threating life as we know it, and potentially the future of mankind.

In 2020 Cardiff and Vale UHB declared a climate emergency to take a stand and show our commitment to tackling climate crisis. This is now our third action plan to tackle our impact on the environment. Each plan reflects our increased maturity from a standing start, but we still emit an estimated 202,000 tonnes of CO2e (carbon dioxide equivalent) – equivalent to the emissions from residential properties in the town of Barry, in our own region – so we need to go much further, faster to take the action needed to reduce our emissions.

Since this declaration, all Health Boards across Wales have committed to supporting the Welsh Government's Net Zero Public Sector emissions ambition by 2030 and targets set by NHS Wales. 'More of the same' therefore is not sufficient and we recognise that simply issuing a statement declaring a climate emergency is, by itself, of limited value unless backed up by action – we know we, as a Health Board, need to do far more. This plan plays a critical role in supporting the organisation improve its infrastructure's reliance on fossil fuels as well as seeking efficiencies in the way products are used thus mitigating our impact on the environment.

The International Panel on Climate Change (IPCC) has warned "Without immediate and deep emissions reductions across all sectors, limiting global warming to 1.5°C is beyond reach" with their Chair, Hoesung Lee saying in their latest report that "We are at a crossroads. The decisions we make now can secure a liveable future. We have the tools and know-how required to limit warming". The Health Board takes these words seriously and we want to play our role in limiting the impacts we create through our operations.

Climate change represents a significant risk to the health board and the health of the populations we support, particularly those already marginalised. If reduction action is not delivered across society, we will see increased demand on our services from extreme weather events, more regular adverse business continuity events and increased air pollution, with impacts on respiratory health in particular. Our infrastructure will require significant investment and adaption to cope with warmer

temperatures and more extreme and volatile weather. Not co-incidentally, action taken to address climate change will lead to many co-benefits to our residents including cleaner air, a more physically active population, and improved mental well-being.

We are already undertaking work across the organisation, with other Health Boards and other Welsh public bodies to develop solutions which enable us to reduce emissions across the health service. For example, we have decommissioned Nitrous Oxide gas manifolds in our two largest sites, saving money and around 500 tonnes of (CO2e) greenhouse gasses caused through the use of this product. This work has led the way for a national transformation, with other Health Boards in Wales now implementing the same initiative. We have played a role in piloting other decarbonisation focused projects and a selection of our staff are integrated into regional and national programmes which aim to develop low carbon change.

We know that this is not a challenge that can be tackled by a few colleagues, but needs everyone to play their part and that is why we are ensuring this plan is owned by the whole health board. We will set the example as a Board and give our colleagues the tools, the space and know how to make a difference.

It will be challenging to make a meaningful difference to our carbon emissions, but it's essential we put more effort than ever behind it. We look forward to working with our colleagues and partners in making a difference to our carbon impact.

Charles Janczewski

Suzanne Rankin

2. Executive Summary

Cardiff and Vale UHB estimated its annual emissions at 202,000 tonnes of CO2e for 2021/22 – this is greater than the household emissions generated by the town of Barry in the Vale of Glamorgan[1]. 81% of these emissions are from the products and services used to operate and deliver health services and roughly 18% from the energy used to provide those services.

This action plan builds upon our previous two action plans from 2020 and 2021. The Health Board has learned much in the last few years, but there is still a long way to go to make a meaningful impact to our emissions levels. One of the aims of this action plan is to become much more mature and carbon literate as an organisation. This plan is focused on the mitigation of actions to reduce our impacts. A separate adaptation plan will be published to manage the risks of the changing climate already being experienced.

Reducing our carbon impact will be challenging as our experience has proven that gains from improvement initiatives tend to be small. There is no small number of initiatives that will save large amounts of carbon. In fact, it is estimated that even a 50% reduction in electricity consumption would reduce total emissions by just 2%. Therefore, action is needed across a wide range of areas in order to have the impact needed.

Decarbonising healthcare is an immature discipline – new knowledge and carbon reducing innovations are becoming available daily. It is known that a cultural shift is needed so that all of us - every one of our 16,000 colleagues, understand the responsibility to take action and make a number of small but frequent acts that make a difference. The Health Board needs to create the environment from the top which will equip and encourage our colleagues to make a difference.

Actions in this plan have been identified through the themes of Leadership, Estates, Transport, Procurement, People and Communications and Clinical Practice. They span the year 2023/24. Actions have also been suggested which lead the organisation towards 2025. This plan should be read alongside our Biodiversity Action Plan and upcoming Adaptation plan.

2.1 Our Vision

Cardiff and Vale UHB will be an exemplar in the delivery of sustainable healthcare, setting the pace that others will follow and learn from. Low environmental impact will be a business as usual consideration where all of our colleagues will be encouraged to make changes to working practices that will see our carbon emissions reduce initiative by initiative.

[1] Assuming 8.1t per household with 22,267 households in Barry (https://www.valeofglamorgan.gov.uk/Documents/Our%20Council/Achieving%20our%20vision/Public-Services-Board/Well-being-Assessment/FINAL-ENGLISH-VERSIONS/Community-Profile-%E2%80%93-Barry-Final-Version-at-March-2017.pdf)

2.2 Summary Of New Commitments

There are actions that have been described in this plan which seek to obtain carbon savings upon completion, though many are focussed upon setting the environment and direction for the organisation to equip itself to deliver savings. What is the point of having an action if you can't describe its impact? This plan seeks to answer that with each action categorised according to five criteria so that impact can be understood:

- Direct Saving – where the carbon benefit of an action can be quantified before the event.
- Direct Saving Non-Quantifiable – where carbon can be saved, but it can't be quantified prior to actioning.
- Climate Conscious Leadership – where the action is demonstrating emissions reduction through leadership and decision making.
- Carbon Literacy – where the education of our colleagues has been improved.
- Supporting Transition – where the action transitions towards low carbon solutions.

Measurement of the overall macro impact of this plan will come through the annual reporting that gets delivered to Welsh Government, where a year on year comparison can be made, looking for carbon reductions. However, an ambition of this plan is also to investigate how a more granular view can be gleaned at an appropriate level of abstraction to understand how changes in practice impacts upon emissions. Qualitative based actions which focus upon putting in enabling measures, changing behaviour or practice to establish their impact.

As part of the 2022 – 2023 Sustainability Action Plan, the Board established an executive led Decarbonisation Delivery Group supported by a cross-health board Working Group to lead the development of the refreshed Decarbonisation Plan and to oversee delivery of the actions. The members will continue to engage others across Cardiff and Vale UHB; spanning estates and facilities, planning, transport, procurement, public health, clinical, and wider stakeholder groups, to ensure that the actions within this Decarbonisation Action Plan are taken forward and implemented. The Group will also share learning with NHS partners, and our partners in our two Public Service Boards

(PSBs), which have both prioritised taking urgent action on climate change within the refreshed Wellbeing Plans.

The PSBs are looking for collaboration opportunities in the following areas:

- Fleet decarbonisation and shared Electric Vehicle charging infrastructure
- Green infrastructure, including better tree planting and biodiversity management across estates.
- Procurement policy to drive out high carbon elements on public service expenditure.
- Behaviour change and seeking consistent ways to embed climate responsive thinking across organisations.
- Understanding and mitigating our impacts on air quality

Given the current financial outlook in Cardiff and Vale UHB and the Welsh NHS, the action plan has been written in the knowledge that much can still be achieved with existing resources, therefore the emphasis is on prioritising the existing resource to support the decarbonisation agenda. Where investment is required, business cases will be presented through the standard channels for consideration. In those instances, the costs and resources required to deliver this plan will be fully assessed and presented to the Health Board's Investment Group for approval. It is anticipated that a minimum of £100,000 per annum recurring discretionary capital budget should be set aside to cover an ongoing programme of active travel improvements, if a Healthy Travel Charter is adopted by the Health Board. There is also anticipated to be a revenue implication to cover additional resources to oversee and deliver the changes required. Finally, the outcomes of feasibility studies will require capital funding where the Health Board will look to bid into Welsh Government funding schemes between now and 2030. These bids are likely to form substantial sums when complex acute infrastructure intervention is explored.

This Decarbonisation Action Plan should be considered a working document by Cardiff and Vale UHB, where costs and funding can be updated as certain actions and policy decisions become clearer.

3. Why Cardiff and Vale UHB Needs to Act Now

It is known that the health sector is a significant emitter of carbon. If the global health sector was a country, it would be the 5th largest carbon emitter. The Welsh NHS is part of the problem in Wales and must take urgent action to reverse the current carbon emission trajectories.

2022 saw extreme weather events, not in remote parts of the world, but also in Wales where temperatures in the summer nudged 37 degrees, with very warm and wet periods at the beginning and end of the year. Wales will also experience severe flooding on a more regular basis causing significant disruption to the delivery of services. These changes to our climate are impacting on both our people and facilities. Our facilities had to deal with temperatures which they were never designed to cope with, having negative implications for our staff and patients. The NHS will be put under increased strain from the impacts of climate change and air pollution, in turn having an impact on the health of people in Wales[2]. People are already feeling the effects of these changes particularly our young and ageing populations who are susceptible to heat and poor air quality related illnesses. As these weather events become more frequent and extreme it will exacerbate the health issues, with heat-related mortality being seen regularly during the summer months, and significant flood-related impacts on physical and mental well-being. Through changing the way healthcare is delivered to make it more resource efficient, Cardiff and Vale UHB is playing its part in mitigating the wider environmental challenges. A separate plan focussing on adapting to the changing climate will be published.

3.1 Welsh Government and NHS Wales Ambitions for Public Sector Decarbonisation

Welsh Government declared a climate emergency in 2019 and set the goal for a net-zero public sector by 2030. The NHS Wales Decarbonisation Strategic Delivery Plan was published in March 2021 with the plan acknowledging the role the NHS in Wales has to play in contributing towards Welsh Government's ambition. It recognises that low carbon must be core to decision making and embedded into processes. This plan also set out a target for NHS Wales of achieving 16% and 34% emissions saving from a 2018/19 baseline by 2025 and 2030 respectively. Since this time, the method of calculating emissions has changed and at the time of writing, the targets are being reviewed. Along with other organisations, Cardiff and Vale UHB does not have a line of sight to 16% savings by 2025 and this plan does not look to set a saving target, rather encourage the right behaviours that over time will see low carbon decision making and solutions embedded into day-to-day operations and contribute towards the net zero public sector.

This action plan is developed as part of our three year Integrated Medium-Term Plan (IMTP), with key actions summarised in that plan.

This plan also reflects the key recommendations made by Audit Wales in the report, Public Sector Readiness for Net Zero Carbon by 2030 published in July 2022[3]. This report called for an increase in pace of activity amid clear uncertainty about whether it is possible to achieve an ambition for net zero emissions by 2030 for the Welsh Public Sector. Audit Wales set out five calls to action:

[2] https://phw.nhs.wales/news/new-resource-highlights-health-impacts-of-climate-change/
[3] https://www.audit.wales/publication/public-sector-readiness-net-zero-carbon-2030

These actions have been taken into consideration throughout the development of this plan.

Cardiff and Vale UHB is committed to embracing the direction set out by Welsh Government through its 2030 route map highlighted below. This action plan has been created commensurate with the 'well on our way' stage, where for example our strategy refresh, Shaping Our Future Wellbeing, is reflecting the climate crisis, efforts will be made with colleagues to make the most sustainable choices in their work and decisions will be made taking carbon into account. This plan builds on the work already delivered and looks to further incorporate the actions into 'business as usual'.

	Society	Individual	System governance	Use of resources	Models of service delivery	Technology
Achieving our goal 2026–2030	**We embed** value over cost. By doing so, society understands, accepts and expects that sustainability and climate action is integral to public services.	**Staff and citizens demand** zero tolerance of unsustainable behaviour as it is socially unacceptable.	**Self regulate** and feedback processes across the public sector. Sustainability is part of life.	**Value** all resources including people's time and the natural environment. Account and profile all resources for a no waste approach.	**Tailor** citizen-centred, low carbon services. The public sector, society and the individual work together to reduce inequalities & improve well-being.	**Require and expect** low carbon technologies to be incorporated in all public sector services and products.
Well on our way 2022–2026	**We integrate** action on climate change into our public facing engagement. We show how we appreciate the value of low carbon products, services and places.	**Staff and citizens expect** to be able to make choices based on sustainability and well-being criteria when considering services and products.	**Account** for climate change future impacts in all decision making processes. Life cycle costing is the norm in the public sector.	**Model** business decisions so entire resource impact is accounted for. All resources need to include full life cycle carbon costings.	**Collaborate** with cross sector partners to prevent disadvantage, promote well-being and develop sustainable joint service plans.	**Enable and support** technology to allow the empowerment, equality and well-being of individuals.
Moving up a gear 2021–2022	**We engage** with the climate change debate. The public sector explains its case for taking sustainability seriously and considers how it can impact on the wider society.	**Staff and citizens understand** what you can do. You know you should act. You know you can make a difference.	**Agree** on responsibilities, mechanisms and measures including legislation, regulation and public reporting of progress.	**Research** how to use all types of resources better to enhance health and minimise waste. Identify, prioritise and address gaps in knowledge.	**Explore** sustainable models. Increase investment to prevent disadvantage and improve well-being. Optimise benefit from nature.	**Adopt and invest** in sustainable technologies. Reduce the risk of investment in new technology. Welcome innovation.
	Behaviours		**Standards**		**Innovation**	

A Route Map to carbon zero for social care that reflects the stages: getting ready, well on our way and achieving the targets. This is shown in Appendix 4.

3.2 Further Influences/ Additional Considerations

There have been a number of further influences which have helped with the production of this action plan. These include The Well-Being of Future Generations Act, the Health Board's Shaping Our Future Wellbeing Strategy and our Director of Public Health's Annual Report for 2021.

As a major local employer and anchor organisation, Cardiff and Vale UHB also has a role as an exemplar in Cardiff and the Vale of Glamorgan, working with our communities and public, third sector, academic and private sector partner organisations.

3.3 Well-being of Future Generations (Wales) Act 2015

The Well-being of Future Generations (Wales) Act 2015 requires consideration is made of the social, cultural, economic and environmental impacts of our decisions, both now and for the long-term. The statutory well-being objectives under the Act are reflected in our 10-year strategy Shaping Our Future Wellbeing[4]. As the Health Board refreshes its strategy for the next ten years, the organisation will need to restate our well-being objectives and demonstrate alignment with the 5 ways of working and 7 well-being goals in the Act, and the objectives of our two Public Service Board's.

Cardiff and Vale UHB is committed to delivering against the requirements set out in the Well-being of Future Generations Act. This plan has been developed taking account the ways of working and will contribute towards a prosperous, resilient, healthier and globally responsible Wales.

3.4 Shaping Our Future Wellbeing - Avoid Harm, Waste and Variation

Our Shaping Our Future Wellbeing Strategy contains a number of objectives. One of those objectives is to Avoid Harm, Waste and Variation which has direct relevance to efforts to reduce our environmental impact by doing things consistently and respectful of the resources available to us. The objective says:

- Adopt best practice, standardising as appropriate.
- Fully use the limited resources available, living within the total
- Minimise avoidable harm
- Achieve outcomes through minimum appropriate intervention

What does this mean? By using treatments that are the most effective, utilising the resources available to the maximum and intervening in a minimal way, our impact on the environment can be minimised.

[4] https://cavuhb.nhs.wales/about-us/our-mission-vision/shaping-our-future-wellbeing-strategy/strategic-objectives/

3.5 Cardiff and Vale's Director of Public Health Annual Report

Cardiff and Vale UHB's Director of Public Health published an Annual Report in January 2023[5] and was based on the theme of value. It advocates that in the current economic circumstances, our services must make best use of public money to meet the needs of local people. It presents four pillars to value: the value that is important to the person from the health services they receive; the allocative value which includes how to distribute resources to best effect; the technical value which asks how well resources allocated are meeting goals; and societal value which considers how services contribute to society. These are in tune with the Health Board's aim to avoid harm, waste and variation plus makes a link to efforts to decarbonise though our impact on society in particular.

This action plan recognises Value Based Healthcare and the need to build sustainability into our services. Clinical colleagues will be influencing the Value Based Healthcare agenda and is highlighted in the clinical actions described in this plan.

4. Our Environmental Impact

As highlighted, Cardiff and Vale UHB has emissions estimated to be 202,000 tonnes of CO2e for 2021/22Our impact on the environment needs to be lower. Emissions are generated through our functions such as energy consumption, over 4,000 tonnes of waste generated each year, the impact on local air quality through our business travel and commuting and the carbon associated with the products and services used every day in the delivery of healthcare. It is this latter category contributes most to our carbon footprint.

The most sustainable form of healthcare is healthcare that doesn't have to be delivered. A preventative approach to avoid ill health and medical treatment in the first place where this is possible is optimal. Our strategic direction is to focus more of our resources over time on health improvement and disease prevention interventions, but will also continue to have a major role in delivering acute and community health services as a result of an ageing population, genetic and hereditary conditions and disease-causing lifestyle choices.

Being conscious of the wider impact healthcare is having on the environment is part of the education journey. Having an understanding of the real cost of medical products, not just financial, will give a greater insight of what should be purchased. Often, it's the case that low-cost products are purchased with only some or no regard of the environmental impact it will have in its lifecycle, for example single use plastic items. The current route for many products starts with creation from virgin plastic, produced in a faraway country, shipped or flown to the UK heavily packaged in more single use plastic, used once then disposed of to be incinerated. This approach is not sustainable.

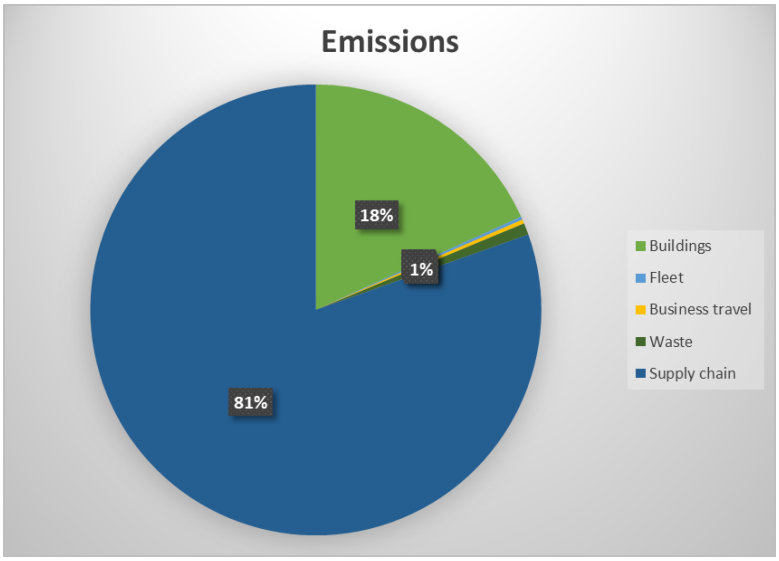
4.1 2021/22 Estimated Emissions Profile in Tonnes (CO2e)

Emissions are generated from various aspects of delivering our business. These are broken down but sector and also scopes.

Sector	KG CO2e	% of total emissions

[5] https://cavuhb.nhs.wales/files/annual-report-of-the-director-of-public-health-2021/?showMeta=2&ext=.pdf

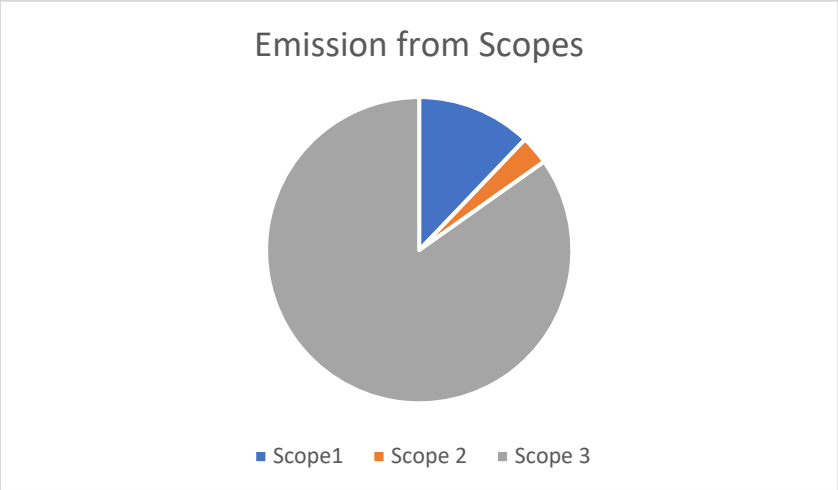
Buildings	36,871,148.88	18.24%
Fleet	457,584.15	0.23%
Business travel	589,493.49	0.29%
Waste	1,690,170.23	0.84%
Supply Chain	162,541,053.31	80.41%



4.2 What Are Scopes?

Emission Scopes are described through three definitions:

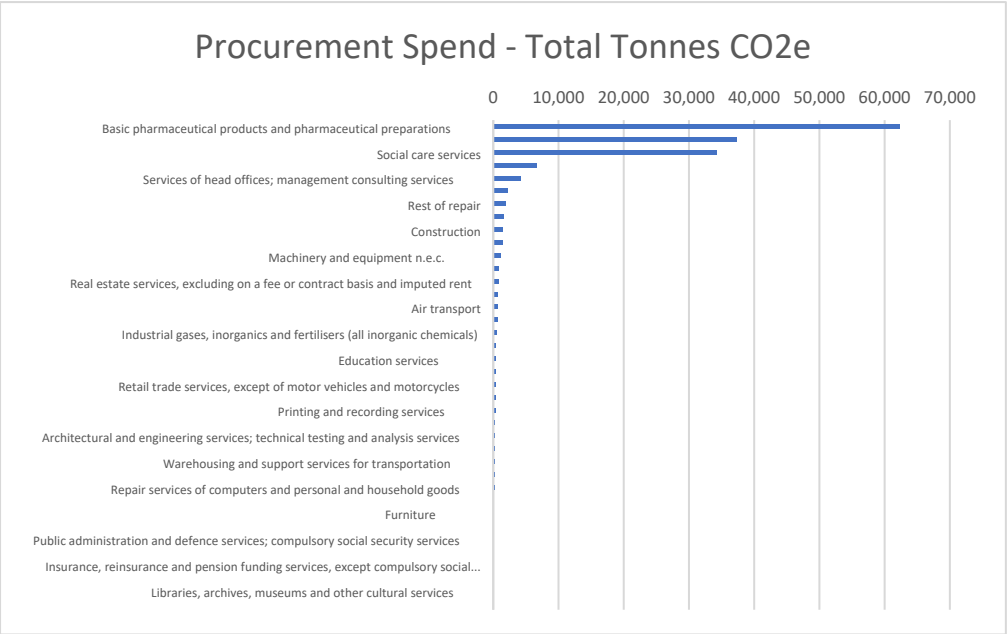
- Scope 1 - Direct emissions of an organisation, including combustion of fuels and fugitive emissions.
- Scope 2 - Indirect emissions of an organisation, including purchased electricity and heat.
- Scope 3 - Other indirect emissions associated with an organisation, including the supply chain, transport and distribution, business travel and commuting, use of products, waste, investments and other leased assets or franchises.



Emissions by scope	KG CO2e
Scope1	24,538,184
Scope 2	6,178,314
Scope 3	171,432,952

19% of our emissions come from the electricity and gas used to run services in our buildings plus the waste generated. 0.5% originating from our fleet and business travel.

Most of our emissions, 80%, are made up of the products that are purchased to deliver healthcare and run a healthcare organisation. Of this 80%, the two biggest categories of emissions are pharmaceuticals and manufactured products as shown in the following graph (based on an interpretation of Standard Industry Codes which is being updated for 2023). A further breakdown of our procurement spend against Standard Industry Codes is in contained in Appendix 2.



The Carbon Emissions from The Products and Services Purchased by Cardiff and Vale UHB

5. People Perspective

5.1 Attitudes and Perceptions - Views of Colleagues

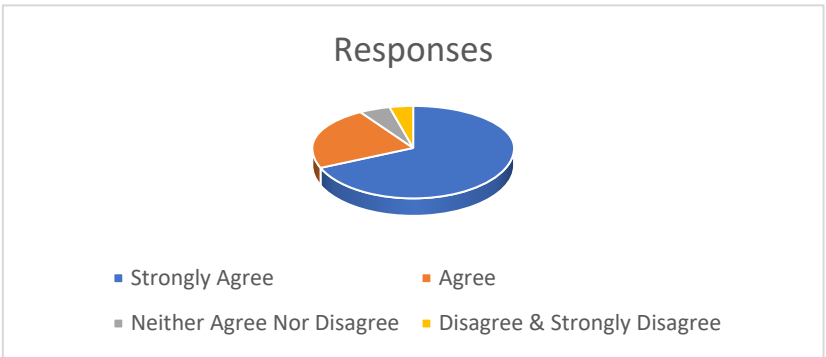
In developing this plan, the views and attitudes of our colleagues has been reflected upon.

In January 2023, a survey was undertaken with our Therapies Department colleagues. It showed people are making small changes, though they tend to be personal in nature where they can directly influence, such as recycling or walking to work. There were also, however, barriers mentioned such as lack of understanding of decarbonisation in the work environment, perceived infection risks associated with the reuse of items in clinical settings and lack of digital records negating the use of paper. Lack of time and headspace to enact change was also highlighted.

The survey also revealed a commonly expressed view about the priority placed on decarbonisation as summarised in the following quote:

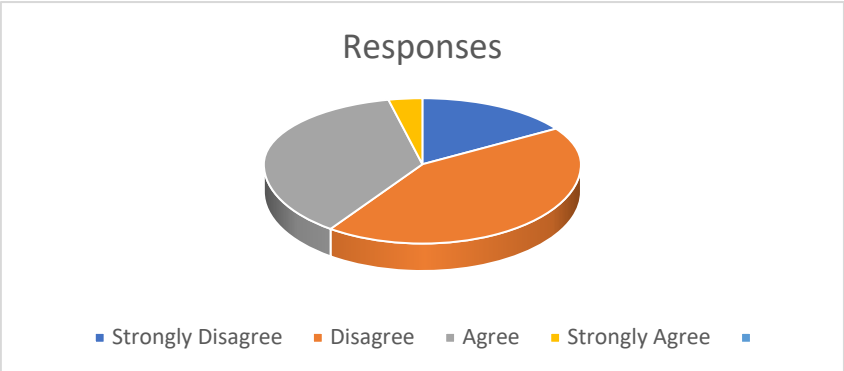
“Looking at sustainability and climate change at a time when different areas of the health board are struggling to manage safe patient care should be aspirational but lower on the scale of priority.”

That said, Therapies colleagues overwhelmingly agreed (90%) that action should be taken to reduce their environmental impact. Only around 30% however agree that enough is being done.



Question: I believe that Therapies should take climate change seriously and should take appropriate action to reduce its carbon emissions/impact

A survey of nurses in autumn 2022 revealed that over 50% of respondents were not aware of CVUHB's sustainability initiatives. Encouragingly, a January 2023 survey of nurses in the Surgery Clinical Board showed that there is a desire to learn more about sustainable practices.



Question: Are you aware of Cardiff and Vale's current sustainability initiatives?

To help change the way people go about their work whilst in the Health Boards, more needs to be communicated about what part people can play and how this can be built into peoples' roles, i.e. take responsibility. Time needs to be set aside for some colleagues to be able to enact improvement initiatives, supported by change management where necessary. Some larger scale initiatives may require dedicated staff input to implement and embed new ways of working.

5.2 Views of the Public

Public Health Wales and Bangor University published a report in 2022 presenting findings from a national survey in Wales on public attitudes towards climate change[6]. It found that:

- Most people (82%) were concerned about climate change.
- Over half (56%) believe that climate change would have mostly negative effects on population health.
- Most people (88%) report always recycling, but levels of engagement in other climate friendly actions (e.g. minimising energy use, buying local products) are much lower and could be improved.

However:

- Almost a quarter of people (23%) believe they can have no personal influence on climate change.
- Almost a third (31%) strongly agreed that it was their responsibility to do something about climate change but almost three quarters (72%) strongly agreed that big business needed to do more to help people change their behaviour.

These findings suggest that more needs should be done to help staff appreciate how their individual actions can contribute to a much larger societal effort towards change.

[6] Climate-Change-and-Health-report-Eng-FINAL.pdf (phwwhocc.co.uk)

6. Progress to Date

Despite the actions taken over the last two years, our emissions continue to rise so actions set out in this plan must be delivered with commitment and urgency. This action plan will be reviewed and updated annually to reflect new knowledge and experience, and forms part of our route map towards achieving zero emissions across public services by 2030.

Despite this overarching position, progress has been made with the actions committed to in our first two plans. This has included:

- An Executive level sponsor is in place, Governance arrangements have been established Board have committed to a Board champion
- Employed a full time sustainability improvement manager
- Each executive director has taken a sustainability objective
- Tracking our emissions annually using a Welsh Government approved method
- Sending no waste to landfill
- Improved our metering to better understand where electricity is being consumed
- We have invested in a new active travel facility at UHW, including secure cycle storage, showers, and a drying room.
- 10 x sustainability scholars had received training from Centre for Sustainable Healthcare in Sustainable Quality Improvement and over a 10 month period saved a total of 40 tonnes of CO2 through a number of initiatives.
- A Nitrous Oxide project closed down the pipework that provided NOX to most of UHW and UHL. This saved 500 tonnes and has been shared by Health Boards across Wales who are looking to replicate.
- Decreased our energy use since 2018 by 1%.
- Installed 300k kwh of renewable energy sources through solar panels at UHW and UHL.
- 3,800 tCO2e saved through energy efficiency measures since 2018.
- Awarded our first staff award for Most Sustainable Team.
- Funded along with HEIW our third Sustainability Fellow.
- Appointed temporary leaders in Nursing, Therapies and Clinical specialisms to act as beacons to their colleagues.
- Formation of the Cardiff and Vale University Health Board Green Group.
- Regular communications about green matters.
- Estimate 960,000 miles of travel saved for patients by holding virtual appointments since April 2020.

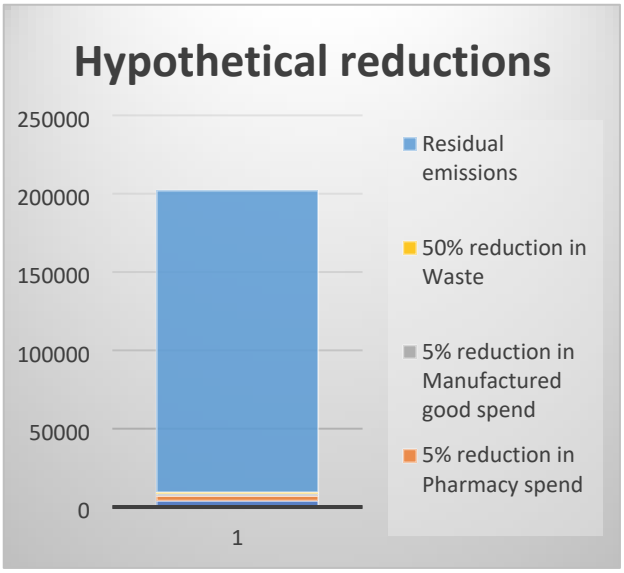
7. Experience To Date

Vast experience has been gained through running the previous two action plans. There is more activity being undertaken, stakeholders are more aware, but still not enough is being done to achieve NHS Wales targets. When assessing and putting into context the 2025 and 2030 targets of a 16% and 34% emission reduction target, a number of red flag findings can be concluded:

- The NHS supply chain business model is largely based upon the consumption of single use/disposable products.
- The existing method for calculating supply chain emissions is immature, being based upon spend rather than a true reflection of carbon contained with products.
- Sustainability is not yet embedded throughout decision making (operational, clinical, corporate).
- COVID-19 recovery focusses on increasing the amount of clinical activity to address the backlog.
- Sustainable healthcare is not a mature discipline and across the globe, decarbonisation remains an emerging science. Many of the innovations and solutions to the challenges the Health Board face do not yet exist.
- Unless dedicated resource and time is provided to already stretched staff, sustainability will continue to be seen as an add-on to existing work and priorities.
- Even if all energy consumption could come from renewable sources so that gas and grid electricity were eradicated, the NHS Wales 34% target by 2030 would still not be met.
- The financial climate is extremely challenging, with the Health Board annual plan for 2023/2024 indicating a substantial deficit to be addressed over the medium term. This makes investing in decarbonisation challenging and investment decisions will need to be prioritised.

Experience and evidence is informing us that at present, there is not a fixed set of actions which can deliver the NHS emissions targets. This means that as new evidence and knowledge emerges, our action plan will need to be updated. To exemplify the scale of the challenge, the following hypothetical scenarios were applied to the 2021/22 Health Board emissions calculation submitted to Welsh Government. These scenarios outline the emissions reductions of various large and challenging actions at a level beyond what could be delivered in the short-term.

- A 50% reduction in electricity use would save 2% of total emissions (4040 tonnes CO2e)
- A 5% reduction in Pharmacy spend would generate 1.5% savings from total emissions (3030 tonnes CO2e)
- A 5% reduction in spend on manufactured goods would generate 0.75% savings from total emissions (1515 tonnes CO2e)
- A 50% reduction in waste would save 0.4% saving of total emissions (808 tonnes CO2e)



All of these hypothetical actions combined would contribute less than 5% emissions saving.

Furthermore, in 2021/22 an initiative titled 'Sferic Scholars' was run, where 10 volunteers undertook a sustainable quality improvement project each and received training in Sustainable Quality Improvement (SusQi) from the Centre for Sustainable Healthcare. The participants came from a range of backgrounds including administration, management, nursing and surgery. Of these 10 initiatives, a combined total of 41 tonnes of carbon was estimated to have been saved. This built our understanding that there aren't small numbers of large projects that will make significant carbon gains, rather many people making small contributions each and every day will be how the dial shifts. This requires the whole organisation to be involved therefore in our transition.

8. Actions

This 2023/24 action plan was built based on the learning from our previous plans, along with the knowledge and views of colleagues who have contributed to devising these actions.

8.1 What Works

The following exemplify the things people can do to conserve energy and resources:

- Reducing consumption of single use plastics
- Switching off idle equipment overnight: PC's, monitors, etc.
- Switching off lights
- Closing windows in cold weather
- Reducing consumption of products
- Using cars less; where cars are used, sharing journeys with others and switching to electric vehicles reduces (but doesn't eliminate) emissions Using public transport more
- Increasing active travel participation
- Reducing meat consumption as part of a balanced and nutritious diet
- Switching to LED lights, insulating hot water pipes and other building efficiency measures

There are also things that relate to the delivery of healthcare that can make a difference and known to work:

- Switching from liquid to tablet based medicines is better for the environment
- Not over intervening and only undertaking what care is necessary
- Use of reusable products generally have a better environmental footprint in the long run
- Focussing on preventative measures to avoid illness or developing a condition is less intensive to treat, reducing the demand for product use and travel to healthcare appointments
- Using technology to reduce patient travel to appointments reduces road traffic and therefore emissions and improves air quality
- Using non-sterile gloves only where required reduces waste

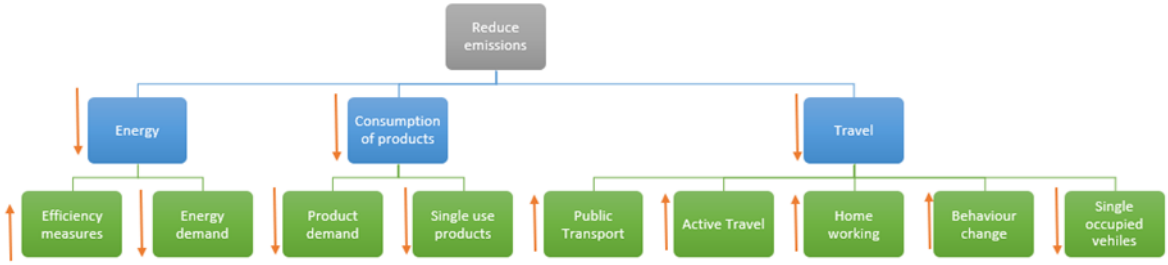
As not all colleagues have the knowledge to make an impact it is therefore necessary to take steps to address this gap.

Despite our leadership and the work undertaken so far, there remains much more to be done to reduce the organisation's carbon footprint. Tackling our carbon footprint requires a broad approach to reducing energy and product demand, plus re-thinking how people travel.

The diagram below simply summarises the actions to be adopted collectively as an organisation and as individuals.

- Energy – whilst there is a need to increase energy efficiency measures (installation of LED lights for example) there is a need to also look to reduce demand such as switching lights off, turning off PCs and equipment when not needed, and automating this wherever possible (e.g. through movement sensors).
- Consumption of products – Reduce product demand (where appropriate) and limit the amount of single use products purchased. Dispose of any products correctly where there is waste, maximising the opportunity for recycling where possible.

- Travel – Decrease the amount of single passenger car journeys whilst increasing our use of public transport, active travel and home working habits. Reduce the carbon emission of fleet vehicles by switching to electric vehicles



Themes

Our key themes for 2023/24 are:

1. Leadership
    - Creating the environment to build low carbon practices into business as usual operation
2. Estates
    - Finding ways to be more efficient in the use of energy resources
3. Travel
    - Encouraging patients and staff to use sustainable means of travel to our sites, and eliminating some journeys (e.g. through remote consultations and flexible working)
4. Procurement
    - Buying low carbon products and contributing to the local economy
5. People
    - Engaging our 16,000 colleagues to make the many small changes required to reduce our impact on the environment
6. Clinical Care
    - As an organisation delivering health services, have the ambition to deliver high quality

A summary of the actions to be delivered by 31st March 2024 are highlighted from section 8.2 – 8.9 of this document. Full details of all actions can be found in Appendix 3.

8.2 Measurement and Impact

Measurement of the overall macro impact of this plan will come through the annual reporting that gets delivered to Welsh Government, where year on year comparisons can be made. However, an ambition of this plan is also to investigate how a more granular view can be gleaned at an appropriate level of abstraction to understand how changes in practice impacts upon emissions more locally within the organisation. Qualitative based actions which focus upon putting in enablement measures, changing behaviour or practice have measures set against them to establish their impact.

In terms of overall impact, this plan asks the organisation to prioritise the time of colleagues into making a positive impact on our carbon footprint such that it is a core part of peoples' day jobs. This creates capacity. Decisions will need to be made taking carbon impact as a factor for consideration,

providing more leadership and increasing pace. It will be part of senior leaders' vocabulary, again showing greater leadership from the top. Finally, leaders will be encouraging their teams to add value and our energy efficiency can be improved creating carbon savings.

The intent therefore, is that by March 2024, the Health Board is more mature in its carbon literacy overall and that carbon emissions are being lowered.

8.3 Leadership – Creating the right climate and activating culture change

The leadership of Cardiff and Vale UHB need to set the example, the direction and tone, encouraging their teams to participate in carbon reduction and reinforce the importance to act. Also, setting out the expectation around decision making that takes environmental impact into account. The actions below set the approach to be implemented from the top of the organisation. All actions that appear in later sections evolve from these commitments. These actions will not have a direct carbon saving per se but will set the structure and culture for the organisation that reducing emissions is taken seriously and valued.

Owned by the Board and the Executive Team:

- We will review the expected carbon and cost savings of this plan by autumn 2023.
- We will ensure decarbonisation and wider sustainability forms part of the Shaping Our Future Wellbeing strategy refresh.
- We will build decarbonisation into our key decision making. Additionally, by amending the Terms of Reference for relevant meetings led by executives we will ensure decarbonisation is given the focus it needs.
- We will explore ways to measure emissions at a more granular level than present, such as by department.
- We will value and encourage our teams to make improvements in carbon emissions. Allocate time for quality improvement initiatives or allocating Green Champions to undertake beneficial research or implementation work.
- We will continue to ask our executive team to take an annual objective to reduce carbon emissions.
- We will take on board the recommended actions articulated by Audit Wales in July 2022.
- We will recommend Board level decarbonisation/carbon literacy training.
- We will consider any emerging collaboration opportunities with our Public Sector Board colleagues.
- We will sponsor a decarbonisation education/behaviour change/communications programme.
- We will support proposals to increase our energy efficiency.
- We will consider a costed proposal to adopt and implement the Level 2 Healthy Travel Charter which will encourage our staff to travel sustainably We will share our experience to any other Health Board in Wales to aid learning.
- We will ensure Decarbonisation is included in any clinical service redesign.

Impact

These actions, taken together will enable us to establish the environment for the organisation to deliver emissions reduction and develop the culture within the organisation. With the aim that every one of our employees is taking action to contribute to the achievement of the carbon reduction targets.

Improvements in carbon literacy, leadership, supporting transition and some carbon savings will be achieved by the end of this plan.

Cost

A costed proposal to support Board and leadership actions will be developed for consideration as part of our annual plan process. This will support a behaviour change programme and develop a method of developing a measurement/reporting method at a more granular level such as by department and training for our Board. The costs associated with this work are estimated to be £70,000.

8.4 Decarbonisation of our Estate

It is estimated that 18% of our 2021/22 carbon emissions came from the electricity and gas used plus the waste generated through the delivery of our services. Our estate accounts for 99% of our scope 1 and scope 2 emissions, i.e. those emissions the Health Board is in control of. Our estate is ageing and will require significant improvements to be truly low carbon. The long-term future of our estate is being considered in the Shaping Our Future Hospitals and Shaping our Future Wellbeing in the Community programmes and will be reflected in a refreshed estates strategic plan but short to medium term optimisation opportunities should be sought to reduce energy usage and save on utilities.

Owned by the Estates Department:

- We will commission a programme of studies to understand the range of energy saving, energy efficiency and renewables opportunities for those buildings that have a long-term future. Those studies that prove viable will be brought forward for implementation using the funding schemes open to the public sector.
- We will complete a programme of work funded through the UHB and EFAB worth £381,000 by financial year 24/25. This is estimated to save around 300 tonnes of carbon.
- We will assess the future of UHW and UHL through a Strategic Outline Case for Shaping Our Future Hospitals programme to inform long term decarbonisation investment proposals.
- We will monitor electricity usage and identify high consumption areas for investigation.
- We will create Green Waste Champions to ensure the correct treatment of clinical waste
- We will continue to monitor water conservation and search for efficiencies across the estate.
- We will commission a specialist biodiversity assessment and audit and will develop prioritised and costed recommendations to receive compliance with Section 6.
- We will consider collaboration opportunities with PSB partners on energy efficiency should they arise, such as district heating proposals in the Vale of Glamorgan.

Delivery challenges to consider

- We are already installing renewable energy schemes where we can and have installed approx. 300,000kwh of renewable energy capacity. Other opportunities across our sites will be searched for and identified. Our highly complex acute hospital sites will require complex and costly solutions that should be considered at the same time as our Shaping Our Future Hospitals Strategic Outline Case that will devise a preferred way forward for this estate.

Impact

Whilst continuing to make inroads into the emissions resulting from the running of our estate, implementing these actions will also provide a view of the cost of decarbonising our estate.

Cost

Revenue funding of around £30k is required to undertake a biodiversity assessment.

£381k has already been committed for energy saving schemes.

Other actions will be managed within the Estates department's existing budget.

Case Study

REFIT

The Health Board through the Re:fit programme has delivered significant energy, carbon and cost reductions and to help support our decarbonisation aims. The first phase of Re:Fit delivered a selection of non-complex energy conservation measures which included:

- Nearly 7,000 lights replaced with LED including emergency light fittings and smart controls.
- Over 100 replacement fans, replacing existing less efficient fan motors, belts and fan assemblies in Air Handing Units.
- Pipework Insulation and other miscellaneous schemes.

The annual estimated carbon emission reduction and energy cost savings are 700 tonnes and £300k - £350k per annum respectively. Furthermore, the measures have also improved environmental comfort conditions in a range of areas of the Estate.

8.5 Healthy and Sustainable Travel

Although the use of vehicles for Cardiff and Vale UHB's own day to day operations contribute just 0.5% to the 202,000 tonnes of carbon produced in 2021/22, it does not mean effort should not be put in to address it. Staff travelled over 1.6 million miles for business use in 2021/22 by car.

Cardiff and Vale University Health Board has a statutory duty to protect and improve the health of our residents and patients. Acute hospitals are likely to be attended by people at higher risk of harm from air pollution, including some people (principally patients) with chronic lung conditions, and older and younger people. The impact of air pollution is unevenly distributed and associated with deprivation, with people in more deprived communities less likely to have access to a vehicle, but more likely to live in an area with worse air pollution.

In addition to reducing air pollution and carbon emissions, encouraging a shift away from private car use to walking, cycling and public transport use has significant health benefits, including reductions in sedentary behaviour, cardiovascular disease, and multiple cancers; improvements in mental well-being and reduction in stress; reduced sickness absence, and increased productivity.

To reduce our impact, there is a need to support staff and visitors to travel shorter distances (for example, through remote consultations and flexible working, where possible), and make public transport and active travel the default way to reach our sites for non-urgent journeys during the normal working day. This will help reduce congestion and improve parking availability on our sites for staff and visitors, where this is essential.

To do this, the Health Board should to support and encourage the use of public transport to reach our sites, including working with our local authority and transport provider partners; and encourage walking and cycling, particularly for shorter journeys or in combination with public transport for longer journeys. Where the use of a car cannot be avoided, to reduce polluting vehicles on site (for example through our Park and Ride facilities), support car sharing, and encourage people to switch to electric vehicles where feasible.

The siting of future healthcare facilities in our area, both community and acute, is an essential consideration in reducing future dependency on cars to reach our services.

Cardiff and Vale UHB employ around 16,000 staff. Supporting their transition away from single passenger vehicles will significantly improve local air quality and reduce traffic volumes. We have made progress improving our cycle storage facilities, and we continue to operate park and ride schemes for our two acute hospital sites.

Shaping Our Future Wellbeing and our outline clinical services plan describe our model of care being centred on ‘at home’, with as much care provided at home or as locally as possible. Where people do need to come to our acute hospitals, their stay should be for the minimum amount of time.

Owned by our Executive Team

- We will consider a costed plan to formally adopt the Level 2 Healthy Travel Charter[7] to encourage sustainable travel to our sites by staff and the public. This charter advocates a rolling programme of investment to improve cycle storage, changing and shower upgrades to increase uptake of sustainable travel.

Owned at Department Level

- We will work with public transport providers in our area, including through the Healthy Travel Charter group, to proactively offer discounts to all staff, and highlight opportunities for improving connections and schedules to meet the needs of staff.
- We will continue to offer an all year around cycle to work scheme.

[7] https://www.healthytravel.wales/level2.html

- We will promote the salary sacrifice scheme allowing staff to obtain an electric vehicle.
- We will transition our fleet to EVs where practical when they need replacing and where vehicles are available.
- We continue and further expand monitoring of air quality at our acute sites, and conduct traffic volume monitoring on our sites, subject to funding availability.

Side pic of Healthy Travel Charter:

Healthy Travel Charter
Level 2

The Level 2 Healthy Travel Charter was launched in September 2022. It is suited to public, private and third sector organisations in Wales who want to show true ambition and leadership in the area of healthy and sustainable travel.

Impact

With our staff, patients and visitors coming to our sites, the improvement in facilities will increase uptake of active and sustainable travel options, making the local air quality better.

Cost

The Healthy Travel Charter requires a recurring budget to be set aside to support healthy and sustainable travel. A costed proposal is being developed and will be considered as part of the delivery of our annual plan. An indicative estimate of £100k per annum.

Case Study **– Supporting Sustainable Travel with The Introduction of A New Cycle Hub at UHW**

Supporting sustainable travel with an introduction of a new Cycle Hub

As part of our commitment to encourage sustainable travel, Cardiff and Vale UHB has opened its new cycle facility at the University Hospital of Wales (UHW) site. The new hub was developed following feedback from staff on how to improve cycling and active travel facilities across the health board. The cycle hub contains two-tier storage for 90 bikes as well as changing facilities, two unisex showers, a toilet and a drying room. The new facility has been designed using the latest technology, is timber clad and well insulated to reduce energy consumption.

8.6 Sustainable Procurement

Procurement, at 80% of our emissions has by far the greatest impact on our carbon footprint. The exacting requirements of healthcare have led to significant volumes of protective packaging and single use devices that are safely discarded after use on a patient. Colleagues will play a key role in coming up with areas for investigation, working with procurement colleagues to understand possibly more sustainable options. Procurement colleagues in NHS Wales Shared Services Partnership have their own action plan[8] to reduce emissions, however Cardiff and Vale UHB in partnership with Procurement colleagues will go further.

Owned at Department level from within Procurement:

- We will review what we buy from some of our top suppliers to assess any carbon savings opportunities.
- We will provide a route for colleagues to suggest low carbon alternatives to products we currently buy so they can be considered.
- We will maximise circular and foundational economy opportunities through our procurement operations.
- We will disqualify any bidder who does not have a decarbonisation plan for contracts of value over £5m.

Impact

- We will search for opportunities to influence suppliers along with English and Scottish colleagues to package products in the minimum safe way.
- We will create a pipeline of products that have the opportunity to be purchased in a more sustainable way.
- We will attempt to spend more money in Wales.
- We will only let large contracts to suppliers who have serious plans to decarbonise.

Cost

There will be no additional cost implications.

8.7 People and Communications

It is through the ingenuity, knowledge and experience of our staff will see Cardiff and Vale UHB reach its carbon reduction ambitions. As one of the largest employers in Cardiff and the Vale of Glamorgan with over 16,000 staff, over 80% of whom live in the area, we have the opportunity for our staff to make a big difference by taking carbon reducing action every day, at work and at home. A few eager participants won't move the dial, rather significant collective action is required. Doing many little things often such as, adapting the way people commute and travel, dispose of waste and

[8] P77, https://www.gov.wales/sites/default/files/publications/2021-03/nhs-wales-decarbonisation-strategic-delivery-plan.pdf

use more sustainable practices. This will not only support emissions reduction but also reduce local environmental impact. At a leadership level we need to create the environment for colleagues to instinctively know what the low carbon thing to do is.

Owned at Department Level:

- We will create a behaviour change and communications programme to equip colleagues with the know-how to make a difference to theirs and their team's carbon footprints and present an implementation proposal to the Health Board. Delivery methods will vary but could include events, corporate messaging, videos, leadership networks, toolkits, etc. Subject matter could include energy reduction, new cycle routes, air quality levels, successes, etc. The aim is to not be prescriptive, rather point people in the right direction and allow them to deliver in their own way. Resources have been gathered by Public Health Wales to assist organisations: https://phw.nhs.wales/news/public-health-wales-launches-resources-for-sustainable-health/resources-for-sustainable-health-e-catalogue/.
- We will include decarbonisation within new employee inductions and newly written job descriptions, expecting colleagues to play their part in the decarbonisation effort.
- We will investigate the practicality of including decarbonisation in the annual appraisal process to support regular and accurate recording of travel mode by employees across the organisation, and encourage colleagues to tell us the good things they've done to reduce our environmental impact.
- We will publicise public transport options/discounts for accessing our main sites, working with bus and train operators.
- Recognise the work our staff do around sustainability through a dedicated Sustainability award.

Owned by our people

- We will encourage staff to undertake decarbonisation training.
- We will encourage membership of our Green Group and Green Health Wales.
- We will ask colleagues to think sustainably in their day to day work.
- We will ask staff to participate in decarbonisation challenges.

Impact

So far, the decarbonisation message has not permeated enough through the organisation, as evidenced by the survey findings referenced earlier in this document. These actions will increase penetration, knowledge and action ranging from the simple actions that everyone can do through to applying successes achieved elsewhere into their areas of specialism. The allocation of champions mentioned elsewhere in this action plan, provide a localised 'go-to' for help and advice.

Cost

A proposal will be costed for consideration by the Health Board as part of the annual planning process, to support behaviour change work, where possible, integrating with existing programmes.

Case Study - Walking Aid Amnesty

In early 2023 Cardiff and Vale UHB relaunched its Walking Aids Recycling Scheme.

As part of our commitment to recycle and prevent unwanted walking aids ending up in landfills, drop zones for medical equipment such as crutches, walking sticks and frames have been set up across our estate where items can be dropped off for cleaning and refurbishment by our Physiotherapy team support staff.

So far, the service team has been able to recycle over 1,500 walking frames and 2,000 pairs of crutches (worth over £28,000) that would have otherwise ended up in landfill sites.

The scheme works in partnership with HM Prisons Probation Service, who provide extra support to clean and refurbish this equipment while also providing the opportunity for ex-offenders to take part in meaningful work and develop their skills.

8.8 Our Clinical Service Model

Our business is to deliver high quality healthcare for our populations and to support our communities to live healthy lives. Around 75% (12,000) of our staff are patient facing. This plan has already set out the actions which will give our people the knowledge to impact on their carbon footprint. There are also things that can be done to the way clinical services are delivered now and in the future, to embed low carbon principles. Clinical colleagues advocate that Value Based Healthcare and Quality and Safety are two key areas to build in low carbon thinking operationally. Whilst our use of pharmaceuticals benchmarks relatively well in Wales, we still spend a significant amount of money annually on drugs and medicinal products. We know that not all prescribing or use of products is evidence-based and there are areas of waste and unwarranted variation that we must target. Therefore, a number of initiatives to reduce waste are going to be trialled. Looking longer term, the Shaping Our Future Clinical Services programme will lay out the future of service delivery and will have low carbon built into it from the ground – the first phases of work start in Q1 2023/24.

Owned at Executive level:

- We will ensure decarbonisation is central to our Value Based Healthcare implementation
- We will embed decarbonisation into quality and safety across nursing, therapies and clinical colleagues.
- We will maintain support for allocated time (a day a week) for a leader in Clinical, Therapies and Nursing disciplines to drive the decarbonisation of our clinical model, working closely with the Shaping Our Future Clinical Services Programme.
- We will allocate time to a limited number of colleagues so they can carry out specialism related research into decarbonisation and/or implement specific improvement projects.

Owned by various departments:

- We will bid for our 4th HEIW Leadership Fellow in Sustainability for a nominated start date of September 2023 for a year.
- Our Shaping Our Future Clinical Services programme will have environmentally sustainable principles embedded into it.
- We will become a Centre for Sustainable Healthcare Beacon Site.
- We will reduce waste in pharmacy, being more efficient in how we stock and track pharmaceutical products.

Impact

These initiatives once delivered will embed environmental sustainability into more working practices. There will be recognised champions within Nursing, Therapies and the Medical communities who will be able to be a focal point and guide their fellow specialists in advancing their knowledge and impact.

Cost

No additional funding is being sought to undertake these actions.

NO2 – Nitrous Oxide Reduction Case Study

Main nitrous oxide manifold decommissioned at University Hospital of Wales - Cardiff and Vale University Health Board (nhs.wales)

The main nitrous oxide manifold at University Hospital of Wales has been successfully decommissioned, marking a huge step forward in the Health Board's commitment to reducing its emissions.

Nitrous oxide was commonly used in healthcare, but has become less so. The pipework used to distribute had also been prone to wastage due to leaks. As it is a harmful greenhouse gas, opportunities were sought to reduce supply and use. Studies show nitrous oxide has more than 265 times the global warming potential than CO2.

Following a successful pilot, a team from across the Health Board decommissioned much of the infrastructure that distributed nitrous oxide around UHW and UHL because it was no longer needed (leaving just the dental hospital and St David's Hospital with a piped supply) and practice changed such that it can be delivered in portable cylinders when it is needed.

The Health Board has projected savings of 1.15 million litres of nitrous oxide or 679 tonnes of CO2e each year. The experience of running this project is also being shared with colleagues across other Welsh Health Boards.

9. Implementation Capacity

The current financial climate has informed the action plan by seeking its delivery within existing resources. This is because many positive actions such as being mindful of how best to recycle an item, being conscious of avoiding waste or making a decision with carbon as a consideration however do not have any direct cost and should become business as usual activity. The organisation will generally need to prioritise existing resource to support this agenda.

Today's implementation capacity comprises a full time Sustainability Improvement Manager, with part time leadership from the Programme Director for Shaping Our Future Hospitals. There are temporary part-time funded positions held by a nurse, two doctors and two therapists to provide leadership within their organisations. These positions need to continue but wherever possible, implementation will be embedded into business as usual, allocating people.

To implement this action plan however, additional resource is anticipated to be required in the following three areas:

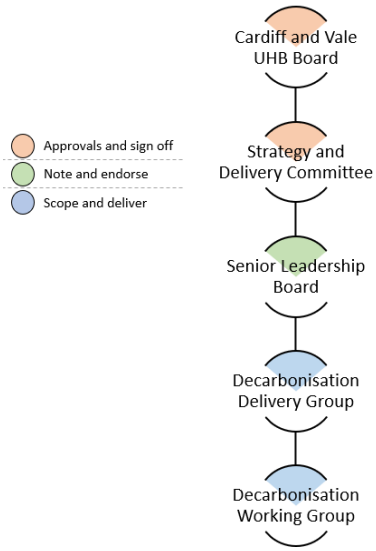
- Culture change leadership and communications.
- Sustainable travel & transport manager to drive the Level 2 charter if implemented.
- Full time strategic leadership.

A costed proposal to increase capacity will be taken to the Health Board for consideration.

10. Governance

Governance was established in 2022.

Reporting into Senior Leadership Board, a Decarbonisation Delivery Group provides oversight of the decarbonisation action plan, embed sustainability into the Health Board and break down any barriers. Members comprise a mix of Executive Directors and Assistant Directors. A Decarbonisation Working Group reports into the Delivery Group, delivering the action plan and acting as advocates within the Health Board.



11. 2024 Onwards

This action plan takes a step beyond the plans that have gone before, but this plan won't be the end. Cardiff and Vale UHB wish to mature its thinking and levels of participation therefore the kind of actions relevant for the years leading to 2025 could include:

2024 – Learn lessons from 23/24 action plan, assessing the impact it has made on carbon emissions and behaviour

2024 – Improve further levels of awareness amongst colleagues leading to action amongst colleagues. People will be more aware they have an individual and team part to play on reducing environmental impact.

2024 – Clinical colleagues view decarbonisation as part of quality improvement and Value Based Healthcare.

2024 – Shaping Our Future Hospitals and Shaping Our Future Clinical Services programmes have decarbonisation as themes through them.

2024 – Maintaining a leadership position amongst Health Boards in Wales

2024 – Departments are making tailored changes to the way they deliver healthcare to make it more sustainable.

2024 – Departmental measurement of emissions becomes available

2024 – Delivery of energy improvement schemes identified during 2023/24 commence

2025 – Light fleet transition to ULEVs

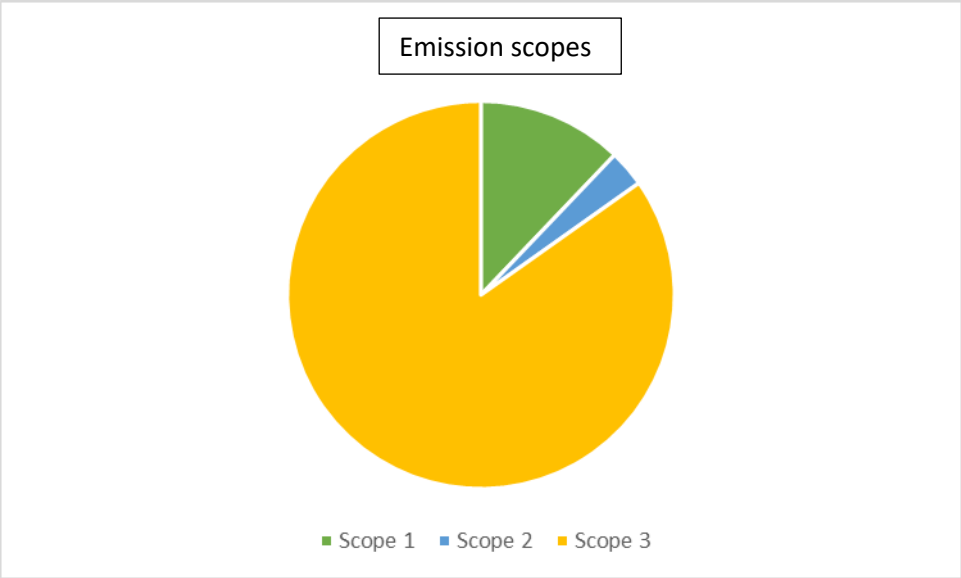
12. Conclusions

As our third action plan, this is the most far reaching yet. It is being driven from the top of the organisation and asking in particular for time to be allocated to colleagues to deliver change. It is also seeking to do more to embed the low carbon thinking into the organisation in order to deliver emissions reductions.

The climate is changing, getting warmer and wetter, not just in far reaches of the world, but locally. Action taken to address climate change will lead to many co-benefits for our population including cleaner air, a more physically active population, and improved mental well-being.
Cardiff and Vale UHB will play its part in reducing its impact on the environment.

Appendices

Appendix 1 – Cardiff and Vale UHB Emissions by Scope



	Scope 1 kgCO2e	Scope 2 kgCO2e	Scope 3 kgCO2e
Buildings	24,167,253	6,178,314	6,525,582
Fleet	370,931	-	86,653
Business travel	-	-	589,493
Waste	-	-	1,690,170
Supply chain			162,541,053
Totals	24,538,184	6,178,314	171,432,953
Total Emissions	202,149,451		
Renewables - on site	297,920	savings (through reduced usage)	
Renewables Purchased	29,097,695	not recognised	

Appendix 2 – Standard Industry Code Breakdown of Procurement Spend in Cardiff and Vale UHB

Product category	Total kg CO2e	Percent of total
Printing and recording services	311,199	0.15%
Industrial gases, inorganics and fertilisers (all inorganic chemicals)	493,146	0.24%
Basic pharmaceutical products and pharmaceutical preparations	62,265,567	30.82%
Computer, electronic and optical products	631,082	0.31%

Machinery and equipment	1,107,978	0.55%
Furniture	65,610	0.03%
Other manufactured goods	37,400,231	18.51%
Rest of repair; Installation	1,902,214	0.94%
Construction	1,497,510	0.74%
Wholesale and retail trade and repair services of motor vehicles and motorcycles	59,138	0.03%
Wholesale trade services, except of motor vehicles and motorcycles	1,559,607	0.77%
Retail trade services, except of motor vehicles and motorcycles	382,891	0.19%
Railway transport	171,364	0.08%
Air transport	659,906	0.33%
Warehousing and support services for transportation	212,568	0.11%
Motion picture, video and TV programme production services, sound recording & music publishing & programming and broadcasting services	452	0.00%
Telecommunications services	269,409	0.13%
Computer programming, consultancy and related services	132,393	0.07%
Insurance, reinsurance and pension funding services, except compulsory social security & Pensions	22,337	0.01%
Services auxiliary to financial services and insurance services	316,066	0.16%
Real estate services, excluding on a fee or contract basis and imputed rent	829,963	0.41%
Legal services	1,407,536	0.70%
Services of head offices; management consulting services	4,175,001	2.07%
Architectural and engineering services; technical testing and analysis services	255,494	0.13%
Advertising and market research services	227,964	0.11%
Other professional, scientific and technical services	890,232	0.44%
Rental and leasing services	2,251,624	1.11%
Employment services	29,475	0.01%
Security and investigation services	433,598	0.21%
Services to buildings and landscape	668,771	0.33%
Office administrative, office support and other business support services	407,301	0.20%
Public administration and defence services; compulsory social security services	50,624	0.03%
Education services	420,723	0.21%
Human health services	6,610,981	3.27%
Social care services	34,237,227	16.95%
Libraries, archives, museums and other cultural services	7,172	0.00%
Repair services of computers and personal and household goods	163,555	0.08%
Other personal services	13,144	0.01%

Appendix 3 – Detailed Action Plan by Theme

Leadership - see paragraph 8.2

Sector	Action	Owner	Team	Support team	Development Cost	Investment Cost	Carbon Benefits	Measure	By when	NWSSP ACTION ref	Audit Wales/Int Audit Ref
Leadership	Decarbonisation to be an agenda item of all relevant executive meetings (with any ToRs amended).	Director of Corporate Governance	Corporate Governance	Decarbonisation team	£0	£0	Direct Saving Non-Quantifiable / Carbon Literacy/ Leadership / Supporting transition	Audit of Exec and Department meetings. Carbon impact of work (KG/tCO2e)	2023	2/3	Strengthen Leadership. Pace
Leadership	Develop an estimate of what 2025 16% reduction would take – effort and money.	Sustainability Manager	Decarbonisation Team	Finance, Estates	£0	£0	Leadership/ Carbon Literacy	Estimate produced of cost and transformation to achieve a 16% saving.	Autumn 2023		Data, Leadership, Finance
Leadership	Decarbonisation to form a part of the SOFW strategy refresh.	Executive Director of Strategy and Planning	Strategy	Decarbonisation Team	£0	£0	Leadership/ Supporting Transition	Included in refreshed strategy having completed public engagement.	8/23	2/3	Leadership/Pace
Leadership	Executive colleagues to continue to take annual objective to impact carbon emissions.	Executives	Executives	Corporate Governance/ Decarbonisation Team /Workforce	£0	£0	Direct Saving Non Quantifiable / Leadership/ Supporting transition/ Carbon Literacy/	Impact as a result of taking an objective. Carbon impact of work (KG/tCO2e)	Ongoing	3	Strengthen Leadership Pace
Leadership	Decarbonisation Identified as a risk on the corporate risk register	Sustainability manager	Decarbonisation team	PHW and Corporate Governance	£0	£0	Leadership/ Carbon Literacy/ Supporting Transition	Board assess the risks of mitigation and adaptation to the Health Board	2023-Ongoing	3	Management action
Leadership	Decarbonisation to be a central pillar of decision making across all leadership functions from Board through to at least department/clinical board.	Executives	All	Department and Clinical Boards	£0	£0	Direct Saving Non Quantifiable / Leadership/ Carbon Literacy	Evidence of decisions made taking decarbonisation into account	2023	3	Strengthen Leadership Pace
Leadership	Investigate how to measure emissions at a departmental level with the aim of monitoring savings and actions for decarbonisation	Sustainability manager	Decarbonisation Team	Departments and Clinical Boards	£60,000	£0	Leadership/ Carbon Literacy	A means to track changes in financial and/or carbon using Health Board data.	Ongoing	2	Data

Sector	Action	Owner	Team	Support team	Development Cost	Investment Cost	Carbon Benefits	Measure	By when	NWSSP ACTION ref	Audit Wales/Int Audit Ref
Leadership	Sponsorship of Climate Champions across the organisation with either dedicated time allocated to research and recommend change or to drive change that is known to have worked elsewhere.	Executives	Executives	Departments and Clinical Boards	£0	0	Direct Saving Non Quantifiable / Leadership/ Carbon Literacy/ Supporting Transition	Each champion to keep a record of delivery against their champion assignment specification. Carbon impact of work (KG/tCO2e)	2023 – Ongoing	1/2	Leadership, Skills
Leadership	Propose Board level training on Decarbonisation to increase awareness and be able to be seen as evangelists to the rest of the organisation.	Sustainability manager	Decarbonisation	Workforce/ Corporate Governance	£0	£4,000 est	Leadership/ Carbon Literacy/ Supporting Transition	TBC	2023	2/3	Leadership
Leadership	Sponsor a decarbonisation behaviour change programme with an associated communications campaign to encourage self participation and increase skills.	Senior Leadership Board	Executives/ Clinical Boards	Workforce/Comms	£20k	£0	Direct Saving Non Quantifiable / Leadership/ Carbon Literacy/ Supporting Transition	Audit and assessment of delivery Carbon impact of work (KG/tCO2e)	2023-2025	2	Skills
Leadership	Leaders are prominent in sharing, promoting, valuing and reinforcing decarbonisation actions to all staff	Executives	Executives/ Clinical Board leads	Comms	£0	£0	Leadership/ Carbon Literacy/ Supporting Transition	TBC	Ongoing	3	Leadership
Leadership	Decarbonisation is included in all clinical service redesign	Executives	Executives/ Clinical Board leads/Operations	Decarbonisation Team	£0	£0	Direct Saving Non Quantifiable / Leadership/ Carbon Literacy/ Supporting Transition	Audit and assessment of delivery Carbon impact of work (KG/tCO2e)	Ongoing		Leadership

Estates (inc Waste) – see paragraph 8.3

Sector	Action	Owner	Team	Support team	Development Cost	Investment Cost	Carbon Benefit	Measure	By when	NWSSP ACTION ref	Audit Wales/Int Audit Ref
Estates	Decisions on estate and new buildings made with decarbonisation as a central pillar	Executives	CEF	Finance	£0	£0	Direct saving/ Leadership/ Supporting transition	Implementation of projects with measures included. Carbon impact of work (KG/tCO2e)	Ongoing	Int 4/ 5/ 6/ 7/8/9/10/11/ 12/13/ 16/ 28	Leadership, Pace
Estates	Assess the future of UHW and UHL through a Strategic Outline Case for Shaping Our Future Hospitals to inform long term decarbonisation investment bids.	Programme Director Shaping our future hospitals	Strategy	Estates	£0	£0	Supporting Transition	Complete pending approval	TBC	11/ 12/13/ 16/36	Pace
Estates	Commit to undertaking a programme of feasibility studies to decarbonise our estate to understand the potential projects, the costs and carbon benefits.	Director of Estates	Energy	N/A	£0	TBC	Direct saving Non Quantifiable/ Leadership/ Supporting transition	Feasibility studies delivered Carbon impact of work (KG/tCO2e)	31/3/24	Int 7/ 8/ 9/ 10/15/ 35	Pace, Finances
Estates	Consider external opportunities such as district heating to reduce estate emissions. An early stage proposal has been developed for Barry.	Director of Estates	Capital estates	Energy Team	TBC	TBC	Supporting Transition	Assessment of viability of proposed Barry scheme	TBC	7	Pace
Estates	Implementation of RE:FIT/ EFAB and other energy conservation and decarbonisation scheme planned for 2023/24 and 24/25.	Director of Estates	Energy	N/A	£381k	TBC	Direct Saving – c300 tCO2e Supporting transition	Delivery of milestones over 2023/24. Carbon impact of work (KG/tCO2e)	31/3/25	4, 5	Pace
Estates	Investigate options to increase sequestration as much as possible across the estate	Sustainability Manager	Decarb	TBC	TBC	TBC	Leadership/ Supporting transition	Proposal developed	31/12/23	33,	Leadership
Estates	Commission a specialist Biodiversity audit across our estates	Director of Estates	Biodiversity	Estates	c£30,000	TBC	Leadership	Complete and action plan adopted	30/9/23	34	Pace
Estates	Allocation of champions and staff training and	Director of Estates	Energy/ Waste /Comms	Clinical Boards/ Workforce (ESR)	£0	£0	Direct Saving Non-	Record of champions and actions taken	6 monthly	2, 44	Leadership/Pace

Sector	Action	Owner	Team	Support team	Development Cost	Investment Cost	Carbon Benefit	Measure	By when	NWSSP ACTION ref	Audit Wales/Int Audit Ref
	support to reduce waste and energy usage.						Quantifiable / Carbon Literacy	Carbon impact of work (KG/tCO2e)			
Estates	Search for savings opportunities as a result of a developing electricity metering programme	Energy Manager	CEF	All departments	£0	£0	Direct saving non-quantifiable / Supporting transition	Closing off of identified opportunities Carbon impact of work (KG/tCO2e)	Quarterly	4, 28	Pace
Estates	Water conservation – Across large estate, work with Welsh Water to identify/avoid/address any instances of leakage.	Energy Manager	CEF	N/A	£0	£0	Direct saving non-quantifiable / Supporting transition	Rectifying any identified leaks. Estimate of water saved.	31/3/24	4	Leadership

Travel/ Fleet – see paragraph 8.4

Sector	Action	Owner	Team	Support team	Development Cost	Investment Cost	Carbon Benefit	Measure	By when	NWSSP ACTION ref	Audit Wales/Int Audit Ref
Transport	Recommend with a costed plan that our SLB formally sign Level 2 Healthy Travel Charter, with agreed capacity to implement.	Executive Team	Executive	PH/ CEF	TBC	TBC	Direct Saving Non Quantifiable / Leadership/ Supporting transition	Approved y/n Carbon impact of work (KG/tCO2e)	30/6/23	14,	Pace/Leadership
Transport	Promotion campaign for new cycleway linking city centre to UHW when opens in 2023	Consultant in Public Health – Lead HTC	PH	Comms	£0	£0	Leadership/ Supporting transition/ Carbon literacy	Promotion campaign run Number of interactions	30/6/23	2	Pace
Transport	Review trend in air quality on UHW and UHL sites	Consultant in Public Health – Lead HTC	PH	CEF	£0	£	Carbon Literacy/ Supporting Transition	Measurement of trend	Quarterly	16, 17 21,39	Pace
Transport	Fleet transitioning to EV as a preference and where practical.	Transport Manager	Transport		TBC	TBC	Direct saving non quantifiable / Supporting transition	All new cars and light goods fleet vehicles procured across NHS` Wales after April 2022 will be battery-electric wherever practically possible Carbon impact of work (KG/tCO2e)	31/3/24	19	Pace

Procurement – see paragraph 8.5

Sector	Action	Owner	Team	Support team	Development Cost	Investment Cost	Carbon Benefit	Measure	By when	NWSSP ACTION ref	Audit Wales/Int Audit Ref
Procurement	Review top suppliers and seek ways to reduce emissions from products/services / packaging in CVUHB to assess high value gains.	Head of Procurement	Procurement	Clinical Boards	£0	£0	Direct Saving Non Quantifiable / Carbon Literacy/ Supporting transition	Number of suppliers reviewed and issues/opportunities fed back Carbon impact of work (KG/tCO2e)	31/3/24	25, 26, 27, 29, 31, 32	Pace/Leadership
Procurement	Clear process for clinical staff and procurement to engage with each other on the purchase and use of more sustainable products	Head of Procurement	Procurement	All	£0	£0	Supporting transition	Operating process and pipeline of opportunities Number of interactions	30/9/24	27, 30, 31	Leadership/Skills
Procurement	Embed circular economy principles in our procurement.	Head of Procurement	Procurement	Waste/ Clinical Boards	£0	£0	Leadership/ Supporting transition	£ Value	31/3/24	25,26,27,29, 30, 31,32	Leadership
Procurement	Embed foundation economy principles in our procurement	Head of Procurement	Procurement	N/A	£0	£0	Leadership/ Supporting transition	£ Value	31/3/24	25,26,27,29, 30, 31,32	Leadership
Procurement	Instant fail on procurement assessment for any organisations who do not have a carbon reduction plan. For tenders > £5m.	Head of Procurement	Procurement	N/A	£0	£0	Direct saving non quantifiable / Leadership/ Supporting transition/ carbon literacy	Implementation y/n and evidence of operation Carbon impact of work (KG/tCO2e)	31/3/24	25,26,27,29, 30, 31,32	Leadership

Clinical – see paragraph 8.7

Sector	Action	Owner	Team	Support team	Development Cost	Investment Cost	Carbon Benefit	Measure	By when	NWSSP ACTION ref	Audit Wales/Int Audit Ref
Clinical	Decarbonisation embedded into Value Based Healthcare	Clinical Sustainability Lead	Clinical	VBH team	£0	£0	Carbon Literacy /Climate Conscious Leadership/Supporting Transition	Embedded and carbon saved Carbon impact of work (KG/tCO2e)	31/3/24	39,40,41,42,43,44,45,46	Skills
Clinical	We will bid for our 4th HEIW Leadership Fellow in Sustainability	Clinical Sustainability Lead	Clinical	N/A	£0	£0	Carbon Conscious Leadership	In place y/n	30/9/23	39,44,45,46	Skills
Clinical	Develop a Sustainable value working group to highlight high carbon areas and product switches (procurement/clinical interface)	Clinical Sustainability Lead	SV team	Clinical Boards	£0	£0	Direct Saving Non-Quantifiable / Carbon Literacy/ Supporting transition/ Climate Conscious Leadership	Implemented y/n Carbon impact of work (KG/tCO2e)	30/9/23	39,44, 45,46	Skills
Clinical	Decarbonisation embed into quality and safety (investigate/propose)	Clinical Sustainability Lead	Clinical	Decarb Team	£0	£0	Carbon Literacy/ Supporting transition/ Climate Conscious Leadership	Embedded y/n	30/6/23	39,44, 45,46	Leadership
Clinical	Allocate time to staff to research and/or implement environmental improvement. This is a limited proposal for specific benefit and not universal to all staff.	Nursing, Clinical, Therapies, Clinical Boards	Nursing, Clinical, Therapies, Clinical Boards	NA	£0	£0	Direct Saving Non-Quantifiable / Leadership/ Carbon Literacy/ Supporting Transition	Body of work demonstrating education, adoption, direct improvement. Carbon impact of work (KG/tCO2e)	31/3/24	2,3	Pace, Leadership
Clinical	Embed sustainable principles into "Shaping our future Clinical services" programme.	Shaping our future Clinical Services lead	SOFCS	All	£0	£0	Climate Conscious Leadership/ Carbon Literacy/ Supporting Transition	Clinical Services Plan complete y/n	31/12/23	11, 12, 13, 14, 15, 16	Leadership
Clinical	Investigate becoming a Beacon site and implementing SusQI	Head of Improvement implementation	Shaping Change	Decarb/Clinical	£0 – see comment	£0	Carbon Literacy	Implemented y/n	31/12/23		Leadership, Skills

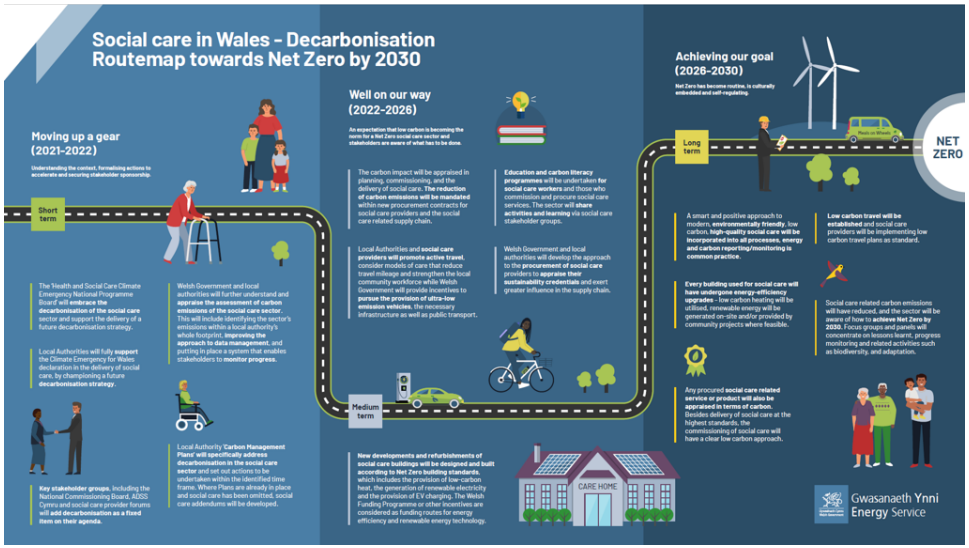
Sector	Action	Owner	Team	Support team	Development Cost	Investment Cost	Carbon Benefit	Measure	By when	NWSSP ACTION ref	Audit Wales/Int Audit Ref
	into Quality Improvement										
Clinical	Create a Digital Strategic Outline Case for the modernisation of the Digital capability in C&V on the condition of WG funding in 23/24.	Director of Digital Transformation	Digital	All	£0	£0	Leadership/ Supporting Transition	Complete and approved y/n	31/3/24	37,38, 39	Pace/Finances
Clinical	Commit to providing time to leaders in Nursing, Therapies and Clinical specialities at least on the scale of that committed to in 22/23.	Executive Medical Director/ Executive Nursing Director / Executive Director of Therapies & Health Science	Clinical, Nursing, Therapies	Clinical Boards	£0	£0	Direct Saving Non Quantifiable / Leadership/ Carbon Literacy/ Supporting Transition	Leaders appointed Carbon impact of work (KG/tCO2e)	30/6/22	2,3	Leadership/Skills/Capacity
Clinical	Establish good linkages/ Robust relationship with PHW on with the impacts of Decarbonisation on public health	Sustainability Manager	Value Based Healthcare/Public Health	N/A	£0	£0	Carbon Literacy/ Supporting Transition	Number of interactions	30/6/22		Leadership
Clinical	Pharmacy – Commence a pilot medicines waste avoidance project, where pharmacy manage and rotate ward stock.	Pharmacy Sustainability Lead	Pharmacy		Existing BAU budget	TBC	Direct saving non quantifiable / Leadership/ Carbon Literacy/ Supporting Transition	Measure of waste avoided Carbon impact of work (KG/tCO2e)	31/3/24	44, 45, 46	Leadership/Pace
Clinical	Introduce Kids Med Cymru – moving from liquid to tablet based products which are more sustainable. Testing in respiratory.	Pharmacy Sustainability Lead	Pharmacy		Existing BAU staff budget (Non staff – Staff lottery funding initial set up for project)	£0	Direct saving non quantifiable /Carbon Literacy/ Supporting Transition	Reduction in use of liquid based drugs across paediatric services Carbon impact of work (KG/tCO2e)	31/3/24	44, 45, 46	Leadership/Pace

People and Communications – see paragraph 8.6

Sector	Action	Owner	Team	Support team	Development Cost	Investment Cost	Carbon	Measure	By when	NWSSP ACTION ref	Audit Wales/Int Audit Ref
People and Comms	Incorporate Decarbonisation into a Culture Change Programme, considering an ERG (Employee Resource Group), proposing a programme if going beyond set aside budget.	Ass Director OD, well-being and culture	Change Hub/Decarb/Workforce/Comms/Clinical	Decarb/Workforce/Comms/Clinical	£10k	TBC	Supporting Transition	Survey results showing movement in level of awareness and ability to act Number of responses	31/3/24	2,3	Pace Leadership Skills
People and Comms	Include decarbonisation in the induction material for all staff.	Sustainability manager/ Clinical Leaders	Decarb	Workforce	£0	£0	Supporting Transition	Complete y/n Number of interactions	30/6/23	2,3	Pace Skills
People and Comms	Feasibility for inclusion of decarbonisation into staff annual appraisals (for VBA community).	Ass Director OD, well-being and culture	Workforce	Decarb	£0	£0	Supporting Transition	Complete in appraisal document y/n Number of interactions	30/6/23	2,3	Pace Skills
People and Comms	Decarbonisation to be included in job descriptions	Sustainability manager	Decarb	Workforce	£0	£0	Carbon Literacy	Integration in template	30/6/23	2,3	Pace Skills
People and Comms	Encourage staff to undertake Decarbonisation training. This may include Welsh e training and other delivery methods including a Masterclass	Sustainability manager	Decarb	Workforce/ Comms	£0	£0	Carbon Literacy	Number of training courses accessed	Quarterly	2,3	Pace Skills
People and Comms	Leadership and Management - Review opportunities to influence internal course materials	Ass Director OD, well-being and culture	Workforce	HEIW	£0	£0	Leadership/ Carbon Literacy/ Supporting Transition	State where included	31/3/24	2,3	Skills
People and Comms	Communicate case studies, successes, energy saving opportunities, events, etc to UHB colleagues.	Sustainability manager	Decarb	Comms/Estates/Clinical	£0	£0	Supporting Transition	Number stories Number of interactions	Monthly	2,3	Skills
People and Comms	Spread the word using existing leadership	Sustainability manager	Decarb	Workforce	£0	£0	Supporting Transition	Number presentations	30/6/23 & 31/3/24	2,3	Pace Skills

Sector	Action	Owner	Team	Support team	Development Cost	Investment Cost	Carbon	Measure	By when	NWSSP ACTION ref	Audit Wales/Int Audit Ref
	networks such as the alumni programme										
People and Comms	Continue sustainability award at annual staff awards	Head of learning	Workforce	Decarb	£0	£0	Climate Conscious Leadership	Judged candidates and award made	31/3/24	2,3	Pace Skills
People and Comms (	Incorporate air quality and climate change impacts into sustainable travel messaging	Consultant in Public Health	PHW	Comms/ Decarb/ Transport	£0	£0	Supporting Transition	At least four updates Number of interactions	30/6/23 & 31/3/24	2,3	Pace Data
People and Comms	Regular cross-channel promotion of public transport discounts and options for reaching main sites, working with bus and train operators	Ass Director OD, well-being and culture	Workforce	Transport / Comms & Workforce (staff discounts)	£0	£0	Supporting Transition	At least 4 quarterly updates Number of interactions	31/3/24	2,3	Pace

Appendix 4 – Social Care Route Map



Report Title:	New Velindre Cancer Centre (nVCC) Full Business Case (FBC)			Agenda Item no.	7.5
Meeting:	Board	Public		Meeting Date:	30th March 2023
		Private	X		
Status *(please tick one only):*	Assurance		Approval	X	Information
Lead Executive:	Executive Director of Strategic Planning and Commissioning				
Report Author (Title):	Deputy Director of Commissioning				

Main Report
Background and current situation:

Purpose of this report

This paper aims to present the Full Business Case (FBC) from Velindre University NHS Trust (VUNHST) for the new Velindre Cancer Centre (nVCC), a replacement hospital to be developed in Cardiff to provide specialist oncology services for the population of South East Wales. The Board are asked to discuss the additional revenue costs associated with the new centre, related to estates, facilities and digital and agree the conditions for approval of the FBC.

The FBC was approved by the VUNHST Board on 31st January 2023

Background

As explained by VUNHST on its website:

"*There are more and more people being diagnosed with cancer. But Wales has some of the lowest survival rates in the western world. The system as it stands is not working as best it should. The NHS is not diagnosing cancer early enough. The 60-year-old Velindre Cancer Centre does not have the facilities or space it needs. We're not giving every patient the best possible service joined up close to home wherever they live and we're not preventing enough cancer in the first place.*

So, across the system, whatever our roles and wherever we are based, organisations are coming together to improve cancer services. The Trust is working to build a new Velindre Cancer Centre with a satellite radiotherapy centre in Abergavenny and to make the most of the opportunities digital technology brings.

In future we will prevent cancer in the first place where we can. We will diagnose cancer earlier to improve the chances of curing it. We will treat more patients and help more people live longer with cancer. And we will treat more patients closer to home."

The key drivers supporting the case for change are articulated in the FBC:

- The Welsh Government's health and cancer policy to improve the quality of cancer treatment and care; to further improve the experience of care; and patient outcomes.
- Continuing growth in the incidence of cancer and the demand for cancer services across Wales; with incidences expected to grow at approximately 2% per annum.
- The role of Velindre Cancer Services and Velindre Cancer Centre in the South-East Wales region as being the sole provider of highly specialist non-surgical tertiary oncology for the resident population.
- The need to keep pace with the advances in treatments and technology which support the provision of cancer care that achieves the required clinical standards.

The limitations of the existing VCC fabric and functionality are stated as:

i. The existing Velindre Cancer Centre has insufficient space and if built on a 'like for like' basis, and in line with Health Building Notes (HBN's), it would have a footprint of circa 28,000m2 compared to the existing building footprint of 17,777m2;

ii. The existing Velindre Cancer Centre (VCC) has no expansion space. For example, the Trust could not install any additional linear accelerators, which limits the Trust's ability to expand its radiotherapy capacity in response to increasing demand for its clinical services.

iii. A high proportion of accommodation at the existing VCC is non-compliant with statutory requirements and creates challenges in maintaining high levels of patient safety and confidentiality.

iv. The existing patient environment at the VCC is sub-optimal in promoting patient dignity, experience and well-being.

v. The existing VCC has limitations in its ability to provide the most up to date treatments for patients to support improved outcomes and quality of life.

vi. There is insufficient car parking at the existing VCC

In 2015, VUNHST established the Transforming Cancer Services in South East Wales Programme. The programme's objectives are to:

- Provide patients and carers with quality services that deliver optimal outcomes
- Deliver sustainable cancer services to the population in the most effective way
- Be a leader in education, research, development and innovation
- Comply with relevant standards

In September 2022, the Health Board gave its support to two capital and revenue investment full business cases related to oncology services:

- Integrated Radiotherapy Solution to replace the existing 8 linear accelerators
- Radiotherapy satellite centre at Neville Hall Hospital in Abergavenny to provide additional capacity to meet future needs

Both of these cases are with Welsh Government for the Minister to decide on. Additionally, enabling works for the new Velindre Cancer Centre have begun, supported by a £28m investment by Welsh Government.

CAVUHB is working closely with Velindre and other regional partners to drive the Transforming Cancer Services programme forward, through the South East Wales Cancer Collaborative and a formal partnership with Velindre, overseeing the implementation of the Nuffield report recommendations. This includes the management of higher risk patients and treatments and development of collaborative research facilities which need to take place on an acute hospital site. Associated with this work programme, a CAVUHB capital business case is in progress to develop the BMT and Haematology services, the Acute Oncology Service and a Joint Centre Research Hub.

Velindre commissioned advice from the Nuffield Trust on the proposed model for non-surgical tertiary oncology services. The Nuffield Report stated that stand alone cancer centres are no longer the preferred model and most new cancer centres are co-located with acute hospitals. However, given the condition of the Velindre estate and the timescales for the new UHW, the nVCC proposal represented the most appropriate solution at the time of the report in December 2020.

It should be noted that a strategic review of Mount Vernon Cancer Centre in Hertfordshire by NHS England, concluded that stand alone cancer centres not on an acute hospital site need more clinical staff to manage the risks associated with patients becoming acutely unwell. It is recognised that with the increasing toxicities associated with innovative new treatments, such as immunotherapy, that this is a growing risk.

Current Situation

The Outline Business Case was approved by health boards in 2018. An update to the OBC was requested by Welsh Government in 2020 and agreed by WG in 2021, although this update was not circulated to health boards until recently. This approval has led to the development of the Full Business Case and progression to procurement using the WG Mutual Investment Model (MIM). A strategic partner has been secured, the ACORN Consortium, and the design phase has been completed enabling the finalisation of the costs for the FBC. Financial close for the deal is scheduled for March 2023, but can only take place once the FBC is approved by the Minister. The MIM funding model for the nVCC is part of a Welsh Government pilot of three schemes and this will enable release of capital funding from the Welsh Government treasury not the Health and Social Services capital budget, and if this scheme is not approved, this funding might not otherwise flow to health schemes. Approval of the capital components of the business case are the responsibility of Welsh Government as they will be responsible for the annual service payment over the 25-year life span of the MIM agreement.

As part of the development of the OBC, the Velindre and Health Board DoFs agreed a Financial Framework that focused on the investment dependent costs to facilitate decisions relating to replacement of the existing Velindre Cancer Centre with a new hospital, i.e. only costs driven by the new hospital investment decision were considered and costs driven by activity demand growth or other factors that are a constant for all options were not considered in the OBC.

This Financial Framework was the model through which the Financial Case in the OBC was constructed and scrutinised. The revenue costs were separated into:
(a) the additional fixed infrastructure costs of the new building; and
(b) the variable clinical costs of modelled demand growth.

The OBC focused on Commissioner funding agreement around (a) and set down an approach to address (b) through the development of the new commissioning Long Term Agreement (LTA) framework, which was agreed separately by DoFs and is now in operation.

The Health Board approval of the Transforming Cancer Services OBC was for support of total additional revenue costs of £3.1m recurrent and £1.7m non-recurrent, of which the CAV UHB share would be £0.9m recurrent and £0.5m non-recurrent. However, this included costs for the Integrated Radiotherapy Solution Business case, which has been approved separately and will be excluded from the nVCC FBC.

There are modest financial benefits of the nVCC, which are articulated in the economic case and these are around improved recruitment and retention, additional income from learning and innovation, improved facilities with greater flexibility and compliance and sustainability benefits from a more energy efficient solution. However, it is recognised that a new build cancer hospital will replace a poorly functioning space that does not meet modern standards. There will be qualitative benefits in terms of a great environment for patients and staff with improved adjacencies and better patient flow and experience. It will provide opportunities to grow learning, training and research and facilitate different models of delivery, such as CAV@Velindre, with other cancer services being delivered from the new facilities. The health board has developed a joint clinical model in line with the Nuffield report recommendations to facilitate improved patient pathways and effective use of shared facilities.

Drivers for additional costs of the nVCC

The majority of the increased costs are associated with the c.70% increase in floor space. The baseline costs represent the current 17,777 sqm of VCC, with the revised costs for the proposed 30,192 sqm. This has been refined with ACORN and is a decrease from the OBC estimate of 30,689 sqm. The increased floorspace is driven by the current capital planning guidance from Welsh Government, plus additional capacity based on the demand modelling for the TCS programme.

The bases for the increased costs are transparent, understood and accepted, albeit that there will be further scrutiny on the detail and the basis for the proposed footprint. Unless the proposed footprint of the centre is reduced, it is unlikely that the costs will reduce significantly and there are likely to be further increases with the current energy price volatility and ongoing inflationary pressure.

The FBC includes three key drivers of increased recurrent revenue costs over and above the OBC relating to the building. These are:

- The switch to a fully electric solution to meet WGs sustainability agenda, which is more expensive than gas.
- Digital Costs to maximise digital potential of the nVCC
- Increased costs associated with equipment maintenance, reflecting new contracts and intelligence from the radiotherapy procurement exercise.

In addition, there are non-recurrent revenue costs associated with the temporary dual running of both sites, connected with senior clinical support specifically for nuclear medicine.

We know from our own experience with the CHfW, that there are increased revenue costs associated with a new hospital and we are likely to be incorporating integrated digital and net zero solutions into our own case to replace UHW, so it might be helpful to embed these principles into the decision-making process for large capital investments.

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

To put the increased costs into context the current annual LTA with Velindre is £23.7m comprising:

- Core services £10.4m
- High Cost Drugs £13.3m

The additional revenue costs outlined in the FBC will not be incurred until 2025-26; if there are no further delays with the build, then there would have been a part year effect in the final year of an IMTP produced this year, but CAVUHB has produced an Annual Plan for the coming year.

The summary recurrent investment requirements are:

• Original nVCC OBC	c£7.5m
• Removal of IRS equipment maintenance	(c£1.0m)
• Adjusted OBC costs	c£6.5m
• Inflation on the OBC costs	c£1.7m
• Additional investment	c£1.7m
• Other (movements)	c£0.8m
• **TOTAL**	**c£10.7m**

The detailed costs associated with the proposal are included in the Full Business Case and summarised in the Velindre Cover Paper (Appendix 1) which is included to provide further information and background. The VUNHST cover paper provides a summary of the whole case for all commissioning health boards and suggests some recommendations. This should be read alongside this paper, which focuses on the implications for CAVUHB and makes recommendations in line with our governance and strategic priorities.

The FBC is made up of five separate cases; Strategic Case, Management Case, Financial Case, Economic Case and Commercial Case. Unlike a usual capital approval process, the MIM process means that VUNHST are still in a live procurement phase with Acorn. This will continue until the final deal is agreed on, along with a translation of this into the corresponding Commercial Case. As such there are parts of the other four cases which the Acorn consortia should not have sight of as it would weaken the NHS's commercial position, or contain information which the procuring authority must keep in commercial confidence. As a result, the Strategic Case, the Management Case plus the appendices for these will be provided for the public session. The Financial Case and the Economic

Case, plus the appendices for these will be provided for the private session. A summary of how the cases will be presented is shown below.

Component Business Cases	
Strategic Case, including appendices	Public - Supporting Papers
Management Case, excluding appendices	Public - Supporting Papers
Strategic Case appendices	Public - Supporting Papers
Management Case appendices	Public - Supporting Papers
Financial Case, including appendices	Private - Supporting Papers
Economic Case, including appendices	Private - Supporting Papers
Commercial Case	Still in negotiation with WG, VUNHST and Acorn. Commissioning health boards will receive the case for noting once agreed.

Summary of the Movement in Recurring Revenue Costs

The movement in recurring revenue costs primarily relate to utility costs (electricity), equipment maintenance, and insurance.

Table 14 - Movement in Recurring Revenue Costs for Commissioners

Cost Category	FBC Costs	OBC Inflated	Movement
	£000	£000	£000
Soft FM	2,905	2,684	222
Hard FM	901	1,026	-125
Utilities	1,880	1,303	577
Rates	1,043	1,297	-254
Equipment Maintenance	1,601	1,129	472
IM&T Maintenance	251	562	-311
Digital	297	0	297
Insurance	450	252	198
Recurring Revenue Costs	**9,327**	**8,252**	**1,075**

Note: All costs are at 2022-23 price levels.

This excludes two key areas of predicted additional expenditure which Velindre are proposing to seek funding from alternative sources. These are:

Premium for a net zero building - £961k
As this is to meet the Welsh Government targets for net zero, Velindre are proposing to seek support from Welsh Government to meet these costs. It is recommended that Board seek assurance of this support and that they approve any tapering arrangements or future transfer of responsibility.

Digital Costs - £456K
Velindre are proposing to seek an additional source of funding for the digital costs from Digital Health and Care Wales (DCHW) via the Digital Priorities Investment Fund (DPIF). These include things like patient flow systems, patient experience, meal ordering, wireless comms, patient systems and connectivity for meeting rooms etc. It is recommended that Board seek assurance of this support and that they approve any tapering arrangements or future transfer of responsibility associated with these areas.

The key movements from the agreed OBC included in Table 14 above are:

Soft FM
Most of the increase is related to the additional costs for a larger square footage and includes domestic services, security, maintenance, portering, catering, waste, laundry, staff residence.

Velindre have highlighted the benchmarking data which shows that Velindre is below the Welsh average costs and these represent a reduction in cost per square metre.

Hard FM
These costs are based on the contract management conditions of the MIMS model, and the majority of additional costs in this area relate to the contract management activity to ensure compliance with the MIM contract. Arguably, this should be included within the annual MIMS payments covered by Welsh Government as part of the funding arrangements as any benefits from the contracts management function will result in reductions in this payment. Overall there has been a reduction in the Hard FM costs from the OBC after adjusting for inflation.

Utilities
The £961k associated with moving to an all-electric building has been excluded from these costs as Velindre are seeking alternative sources of funding from Welsh Government. The remainder of the additional costs over and above that agreed in the OBC relate to utility price increases. There will be some offset of utility costs from some solar energy collected via roof panels on part of the building. No more solar panels can be accommodated on the building due to the location of plant and other equipment on the rest of the roof.

Rates
The new Rateable Value of the larger property will mean that additional rates are due, but in the FBC these are less than the inflated value from the OBC.

Equipment Maintenance
This includes the maintenance of equipment such as the planning systems, the MRI and CT scanners, the Gamma Camera and Chemocare. The maintenance of the Linear Accelerators has been excluded from this case as they are already included in the Radiotherapy Business Case that has previously been approved. The increase in equipment maintenance costs is attributable to improved information on maintenance fees and learning from the rigorous procurement process for the Linear Accelerators.

IM&T
The costs included within IM&T maintenance are related to networking, telephony and multimedia solutions for the new building. This is a reduction from the inflated OBC costs as the old NWIS SLA no longer exists, but excludes any maintenance associated with the new digital solutions outlined for other sources of funding above.

Insurance
These costs are related to the MIMS model and is a requirement of any new builds under the model. The increase in costs in this area have been generated from a general hardening of the insurance market and intelligence from the chosen delivery partner consortium.

<u>Financial Consequences for Cardiff and Vale UHB</u>
Revenue Requirements
Cardiff and Vale UHB contributes 30.90% of the revenue costs, based on population share and historic utilisation included in the funding model. For the additional costs of £1.075m, over and above the inflated OBC, the CAVUHB share would be £331k. These are shown in Table 15 overleaf.

Table 15 - Movement in Recurring Revenue Costs for Commissioners

Health Boards	Commissioner Split	TOTAL
	%	£000
Proposed funding from commissioners:		
Aneurin Bevan	36.52%	391
Cardiff & Vale	30.90%	331
Cwm Taf Morgannwg	28.11%	301
Swansea Bay	1.40%	15
Hywel Dda	1.49%	16
Powys	1.59%	17
Total	**100%**	**1,075**

The overall recurring revenue cost for CAVUHB will be £2.882m as per the table below of the overall additional recurrent revenue requirement of £9.327m. This does include the current baseline position for these elements of the current Velindre Cancer Centre that is already funded as part of the existing contracting model, so the additional recurrent revenue investment over and above current investment would be £1.593m

Table 16 - Summary of Funding Sources

Health Boards	Commissioner Split	TOTAL
	%	£000
Proposed funding from commissioners:		
Aneurin Bevan	36.52%	3,406
Cardiff & Vale	30.90%	2,882
Cwm Taf Morgannwg	28.11%	2,622
Swansea Bay	1.40%	131
Hywel Dda	1.49%	139
Powys	1.59%	148
Total	**100%**	**9,327**

Note: All costs are projected to 2025-26 based on 2022-23 price levels.

Non-Recurrent Revenue Requirements

Non-recurring revenue costs, including accelerated depreciation, dual running, and project support will be funded by the Welsh Government and Commissioners. Dual site running costs mostly relate to the management and delivery of radiotherapy on lineacs on two sites. If patients start their treatment on one machine it is clinically beneficial to complete the course of treatment on the same machine.

Profile of Non-Recurring Revenue Requirement

Cost category	2023-24 £000	2024-25 £000	2025-26 £000	Source of Funding
Accelerated depreciation	10,479	10,479	10,479	Welsh Government
Dual Site Running Costs	0	0	2,412	Commissioners
Total Non-Recurring Revenue Costs	**10,479**	**10,479**	**12,891**	

Note: All costs are based on 2022-23 price levels.

It can be argued that the scheme offers the right solution to the issue of resolving the current substandard accommodation and contribute to improving cancer outcomes for our population. Doing nothing is not an option as facilities will continue to deteriorate. The majority of the business case is the capital funding via the MIM model which will be funded by the treasury and not top sliced from

the Department of Health and Social Services capital budget. Arguably, because of the funding source, the opportunity cost would not be like for like in terms of the health estate and an alternative MIM funding pilot may be sought from elsewhere in the public sector. There is not currently an All Wales framework for capital funding, so it would be difficult to identify prioritisation of other health schemes. It is for Welsh Government to consider the overall value for money in light of the entire business case and the agreed funding model.

The revenue case has been scrutinised and is reasonable in line with benchmarking information, but consideration needs to be given as to whether members would want to seek assurance from Welsh Government on the funding of the excluded elements, i.e. the cost of net zero and digital investment and also whether the insurance costs and the contract management costs should be taken into the MIM model as they relate to the fabric of the building and the minimisation of the annual service payment respectively. Assurance from Welsh Government on the prioritisation of Health and Social Services capital to cover the equipment costs could also be sought.

From an affordability perspective, while recognising that the FBC for the nVCC has been scrutinised by commissioning health boards and the case is clearly articulated and well understood with clear qualitative benefits, the health context and financial environment has changed since the OBC was approved in March 2018. CAVUHB needs to consider the overall affordability of the case balanced with other current priorities. Given that the intention has been signalled for CAVUHB to submit an annual plan for 2023-2024, consideration needs to be made as to how future financial allocations will facilitate this investment in line with future prioritisation as an overspend could not be approved in the current context.

Recommendation:

The Board is requested to:

- Consider the additional revenue consequences of the nVCC
- Consider the patient benefits of a new cancer centre
- Consider and approve the nVCC Full Business Case, subject to:
    - Confirmation of the alternative funding sources for the cost of net zero and the digital transformation
    - Clarification on the rationale for the inclusion of the contract management costs in the revenue case, rather than as an offset for the Annual Service Payment as part of the capital case.
    - Assurance from Welsh Government that Health and Social Services capital will be prioritised to cover the equipment costs.
    - Recognition that CAVUHB is not in financial balance, so the revenue costs would increase the deficit, unless fully funded by Welsh Government.
    - Progression of agreement for shared use of the facilities and delivery of CAVUHB services at nVCC to further research and innovation and improve patient pathways, including ways of working, outcome monitoring and shared space.

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

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

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

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

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: No
No new risks as a result of this paper, but it needs to be considered in the light of the revenue cost pressure, the political environment and the reputational risk.
Safety: No
Proposal will improve the environment for patients, delivering a modern cancer facility, albeit that the facility will not be based on an acute hospital site.
Financial: Yes
An outline of the indicated financial impact has been included within this paper.
Workforce: No
Not for CAV UHB, but an independent report suggests that a standalone cancer centre needs additional clinical staff to support acutely unwell patients, which could increase the cost of activity at Velindre in the future.
Legal: No
Not for CAV UHB. Velindre will have considerable legal and governance considerations for the development of the new centre.
Reputational: Yes
The process for the nVCC has been protracted and contentious. It should be noted that Welsh Government has supported the OBC and invested £28m capital in the enabling works for access to the site. It is a flagship programme, and the first in Wales to use the new MIMS funding model. Not supporting the overall case would generate some difficult political discussions and may have reputational impacts. However, there is scope to scrutinise and challenge the costs, to ensure that the nVCC delivers value for money.
Socio Economic: No
No new services will be provided as a result of this development, but the improved patient environment will make the service more effective.
Equality and Health: No
There are no policy changes as a result of this development.
Decarbonisation: Yes
This is a new build that will have a negative impact on the immediate environment as it is being built on a green field site, but is being proposed to achieve net zero, moving to an electricity only building with gas solely in the laboratories.

Approval/Scrutiny Route:	
Committee/Group/Exec	**Date:**
Investment Group	1st March 2023
Strategic Leadership Board	16th March 2023
Finance Committee	22nd March 2023
Board	30th March 2023

VELINDRE UNIVERSITY NHS TRUST

LHB

nVCC FULL BUSINESS CASE (FBC) APPROVAL

DATE OF MEETING	30.03.2023

PUBLIC OR PRIVATE REPORT	Private

IF PRIVATE PLEASE INDICATE REASON	Commercially Sensitive

PREPARED BY	Mark Ash, nVCC Assistant Project Director
PRESENTED BY	David Powell, nVCC Project Director
EXECUTIVE SPONSOR APPROVED	Steve Ham, Chief Executive Officer

REPORT PURPOSE	Approve

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
TCS Programme Delivery Board	25/01/2023	Endorsed
TSC Programme Scrutiny Sub-Committee	26/01/2023	Endorsed
Trust Board	31/01/2023	Approved

INITIALISMS	
ASP	Annual Service Payment
CAP	Commercial Approval Point
FBC	Full Business Case
FC	Financial Close
LHB	Local Health Board
MiM	Mutual Investment Model

INITIALISMS	
nVCC	New Velindre Cancer Centre
OBC	Outline Business Case
PA	Project Agreement
SP	Successful Participant
VAT	Value Added Tax
WG	Welsh Government

1. INTRODUCTION

1.1 The nVCC Project, supported by the Treasury of the Welsh Government under their MIM Policy, continues to progress through the planning permission and procurement phase. Following the Trust Board approval of the outcome of the nVCC competitive dialogue on the 28th July 2022, two bidders were notified of the outcome and no challenge was received from the unsuccessful bidder. The Acorn Consortium were confirmed as the Successful Participant (SP) and received an SP letter which set out a range of outstanding matters that needed at be resolved between before Contractual and Financial Close (FC) could be achieved.

1.2 The nVCC Project Team have been working closely with Acorn to close down all outstanding matters in order to achieve FC in March 2023, or as soon as possible thereafter.

1.3 The Trust can only progress to FC, and enter into a contract, once the FBC has been approved by the Trust, it's commissioning Local Health Boards (LHB's) and by both Welsh Government Ministers (Treasury and Health).

2. ANALYSIS

The Full Business Case (FBC)

2.1 The FBC consists of 5 cases (Strategic; Economic; Commercial; Management; and Financial) which are inter-connected and set out the case for investment. Off the 5 Cases, four (Strategic; Economic; Management; and Financial) are complete. It should be noted that at the time of this report, the Commercial Case is commercial in confidence and therefore not able to be released to LHBs at this stage.

2.2 The completion of the Commercial Case is the final element to conclude and will close when planning matters and the Project Agreement (PA) are finalised.

2.3 The aim of the Commercial Case is to set out the commercial arrangements i.e., the solution (the nVCC final design), together with the contract (Project Agreement). The nVCC Project is being procured using the Welsh Government Mutual Investment Model (MIM), under WG policy: -

2.4 The Commercial Case is considered a matter for the Trust and Welsh Government. The Case requires commercial confidentially of the arrangements which are at a sensitive stage of the procurement process.

2.5 In this context, it can be highlighted that the Welsh Government (Central Treasury) is the funder for the Annual Service Payment (ASP) - which is the annual revenue payment to the Acorn Consortium for the 25-year term of the PA - and the Welsh Government (Health) is the funder of the NHS capital equipping costs. This clarity is important in respect of the approvals sought from each of the stakeholders. The primary areas of decision-making/approvals for each stakeholder is:-

- Trust: overall approval including PA (commercial aspects); capital costs, revenue costs, management arrangements and retained risk as the contracting party.

- Trust/Local Health Boards: Identified revenue investment (recurring and non-recurring).

- Welsh Government: Treasury all matters relating to the Annual Service Payment and Health Department all matters relating to NHS Capital Equipping Costs.

2.6 The Local Health Boards have agreed the scope of, and approach to, investment in the nVCC (e.g., increased cleaning costs of a bigger floor area, and the costs of transition) within the OBC. The OBC also set down what costs are outside the scope of investment (e.g., the commercial deal with the Acorn consortium which is being funded by the Welsh Government (via the ASP). In respect of the commercial matters within the Commercial Case, the funding position is clear with the Trust planning on investment by the Welsh Government for the ASP.

2.7 The funding role of the ASP by the Welsh Government is, we believe, important to note, as it frames the approval required on the four Cases (Strategic; Economic; Management; and Financial) by commissioning Local Health Boards. The Local Health Boards are not an investment party to any ASP funding requirements that flow from the commercial arrangements with ACORN as set down in any Commercial Case.

2.8 A two-staged approach to FBC approval has been discussed with Welsh Government and the Local Health Boards:-

Stage 1: consideration and approval (or otherwise) of the four Cases (Strategic; Economic; Management; and Financial) by the Trust and Local Health Boards in February 2023.

Stage 2: consideration and approval (or otherwise) of the Commercial Case by the Trust as soon as possible and subsequently the Welsh Government At this stage, the Trust can provide the Local Health Boards with assurance that the commercial arrangements (and subsequent Commercial Case) will be robust and represent an acceptable commercial position. This

assurance will also be demonstrated through the detailed governance arrangements that are in place with Welsh Government to secure approval.

2.9 The two-stage approval process enables the Trust to receive formal approval letters from its Commissioners, which will be required by the WG Scrutiny and approval process.

2.10 This process also facilitates the external assurance reviews required (Gateway 4 and a Commercial Approval Point (CAP) 5) prior to WG approval.

Developing the nVCC FBC: updates from OBC to FBC and assurance

2.11 The FBC has been developed following the Treasury Green Book and Better Business Case Guidance for Public Sector Projects. The four Cases (Strategic, Economic, Management and Financial) are set out in Annexes 1 – 4. A summary of each of the cases is set out below, together with the key issues contained within them and the levels of assurance for each (using the Treasury Green Book checklist).

a) <u>Strategic Case</u>

2.12 The Strategic Case has been reviewed and updated from the Outline Business Case approval in October 2018. The key issues and levels of assurance are set out below in Table 1:

Table 1 – Strategic Case Updates / Assurance

Update	Activity between OBC & FBC	Requirement of Treasury Green Book Achieved Yes / No
Strategic Alignment: is the nVCC project aligned to national/regional/Trust strategy and policy?	Case updated to reflect the changes to national/regional and Trust strategy and policy.	Yes: strategic alignment clear and robust
Existing Arrangements and Business needs	General updates to improve flow and backlog maintenance update.	Yes: case for change clear and robust
Clinical Operating Model	External Independent Advice provided by the Nuffield Trust and regional action plan agreed and being implemented.	Yes: Clinical Operating Model clear and robust action plan being implemented regionally
Forecast demand, activity and capacity	The forecast planning assumptions have been assured with actual activity (up to 2019/2020 pre-covid). This demonstrates that the projections were robust. Further work	Yes: Initial forecast assumptions robust. nVCC sized appropriately against

	undertaken on forecast activity for Day 1 2025 and up to 2032 which demonstrate sufficient capacity on Day 1 of opening and thereafter within the Clinical Operating Model (e.g., home; local; specialist). The footprint/functional/capacity of the nVCC are sized appropriately and elements of the design are flexible.	planning assumptions/actual activity and Clinical Operating Model.
Equipment update	The proposed major clinical equipment in the nVCC has been updated for all equipment and a procurement strategy and commissioning programme developed	Yes: equipment requirements are robust
Environmental Sustainability	The ambition to deliver the Greenest Hospital in the UK has been developed and translated into the nVCC design; this includes options to remove embodied carbon and minimise the carbon once the nVCC becomes operational; and securing support/revenue funding from LHBs and Welsh Government to make the strategic shift from the current hybrid (gas/electric) solution to the electric solution.	Yes: design all electric and plans in place to support the reduction of embodied carbon. Risks remain about ability to fully realise reduction in embodied carbon and funding of strategic shift to electric solution; will be picked up in further discussions with WG/LHBs

2.13 The clinical operating model within the TCS PBC describes how services will be delivered in the future. The founding principles were as follows:

- The service model seeks to promote a new set of relationships which work in partnership to improve the way we collectively design and deliver tertiary non-surgical cancer services around patients' needs and to achieve these improvements in a truly sustainable way.
- Patients are central to our plans with an integrated network of services organised around them. The organising principle seeks to 'pull' high quality care towards the patient, that is accessible in their preferred location and supports them achieving their personal goals during treatment and subsequently as they live with the impact of cancer.
- Patient safety is paramount, and the highest standards will always be met.
- The relationship between patients / families / carers and clinicians / professionals will be an equal and reciprocal one.
- Patients will be provided with the support, information and skills to manage their own needs effectively at, or as close to, home as possible wherever appropriate.
- Optimising information technology, quality improvement systems, patient involvement, education and embracing innovative approaches

to healthcare will all be essential to achieve high levels of service quality in a sustainable way.

2.14 The Clinical Operating Model will see more care delivered within patients' homes; and locally through the development of a number of Velindre@ facilities on Local Health Board sites across South-East Wales, providing chemotherapy, outpatient, and support services; a Radiotherapy Satellite Centre (RSC) in Nevill Hall Hospital, Abergavenny; and the redevelopment of the Velindre Cancer Centre on a new site in Whitchurch, Cardiff.

2.15 It is important to note that the Strategic Case has taken account of the Nuffield Trust Independent Advice Report December 2020, which the recommendations of were accepted by Local Health Boards, Velindre University NHS Trust and the South-East Wales Cancer Collaborative Leadership Group. Given the dynamic nature of cancer care and the evolving regional clinical operating model of cancer, it is important to highlight a number of important areas which have strategic importance for the region and its health partners. There were a number of recommendations which point to the need for the nVCC to support future strategic developments (see Table 2).

Table 2 – Nuffield Trust Independent Advice

Nuffield Trust Independent Advice Recommendation Number	Recommendation
6	The ambulatory care offer at the VCC should be expanded to include SACT and other ambulatory services for haemato-oncology patients and more multidisciplinary joint clinics. Consideration should be given to expanding a range of other diagnostics, including endoscopy, to create a major diagnostic resource for South-East Wales that will be able to operate without the risk of services being disrupted by emergencies and which would also protect these services in the case of further pandemics.
10	Flexibility in design is going to be important both for the new VCC and for whatever is developed at the new UHW due to the rapid change in the nature of treatment and research.
11	There are future strategic development opportunities provided by the development of a new VCC and a proposed UHW2. Working together over the 15- to 20-year window, the health system should look to exploit these development opportunities in light of future service needs.

2.16 These recommendations are important as they are intended to ensure that the nVCC can support the current and future clinical operating models across South-East Wales over its planned life-span (40 – 60 years). Each of these recommendations has been considered in both the design of the clinical operating model and the design of the nVCC as set out below-

Utilisation of nVCC as a regional asset

It is imperative that the nVCC is considered and utilised as a regional asset which is part of a range of service/infrastructure that delivers improved quality of care

and better population outcomes. The nVCC design supports this in a number of ways:

i) **immediate: provision of non-surgical tertiary cancer services as required by LHB commissioners**;

ii) development of a regional clinical operating model which supports the regional clinical needs. This is illustrated in the provision of enhanced assessment/ambulatory care services and additional capacity at nVCC which seeks to reduce the number of patients who unnecessarily attend unscheduled care/emergency services at LHBs**;**

iii) the possibility of using the capacity regionally rather than organisationally. Initial work has identified that clinical pathways can be remodelled which would see a planned shift in patient flows / what care is provided where. An example of this is haematology where there is likely to be range of patients who currently receive treatments in LHB settings who could be treated at nVCC. The V@LHB model therefore can also be seen as Cardiff@nVCC; Aneurin Bevan@nVCC; CTM@nVCC. Initial work has been undertaken to explore this and could be accelerated as the overall demand/capacity and clinical model is developed;

iv) diagnostics: the development of the nVCC has taken account of the potential strategic opportunity with regard to diagnostics across South-East Wales. The nVCC has designed in capacity to address immediate to medium terms needs (CT; MRI etc.) and also flexibility to successfully support potential strategic developments e.g. provision of PET-CT; provision of significant step up in diagnostics services

Flexible Design

The nVCC has been designed to provide maximum flexibility to cope with the changing nature of cancer care and regional strategic developments. The design has a number of aspects which provide future flexibility:

1) Template design allows for design development and any required changes due to service developments.

2) Orientation of the building: the nVCC has been designed to allow maximum flexibility which is achievable with the minimum of disruption/cost. The design consists of two areas of service contained in separate elements of the building.

    a) Service Area 1:

        i) Radiotherapy: the radiotherapy area has been built to future proof future flexibility. The bunkers have been designed to allow different types of manufacturer/machines to be installed as technology advances and the potential for service development;

ii) Imaging/diagnostics block: the major diagnostics and imaging kit is here with additional capacity and development control plans in place to support any strategic requirements to increase capacity/provision;

b) Service Area 2:

i) Assessment/ambulatory/inpatient block: this area of the nVCC provides optimum adjacencies for current service provision together with a template approach to the design. This allows the split of assessment/ambulatory/inpatient capacity to be changed very easily with no building works required for the majority of changes required;

3) Future strategic developments: the nVCC project will also include a strategic service continuity plan which will set out 10 – 15 likely regional cancer system service and non-surgical tertiary service developments that Acorn will be required to develop plans for which will set out how the nVCC building will be able to adapt/be reconfigured/support any additional construction to implement it.

2.17 The benefits of the nVCC are set out below:

- The patient environment at the nVCC will be optimal and promotes patient dignity, recovery and well-being;
- The nVCC will have sufficient patient and family car parking;
- The nVCC accommodation will be compliant with statutory requirements and that will enable high levels of patient safety to be met; and,
- The nVCC will have expansion space that will enable the Trust's to expand its footprint to meet the increasing demand for its clinical services across a range of specialities / departments.

2.18 It is noted that the TCS Programme, that includes Health Boards and the Trust, have achieved significant investment in cancer services for South-East Wales. This relates to the following:

- **Integrated Radiotherapy Solution:** some of the key benefits are reduced risk of service failure due to more up to date machines; reduced risk of obsolescence with improved functionality due to more up to date machines; increased flexibility with better continuity due to the flexibility provided by matched machines; better patient outcomes and safety due to the improved functionality and better compliance with good practice; benefits of increased automation and use of integrated systems resulting in reduced clinical time required for patient scheduling and reduced appointment times; improved patient and carer experience with improved resilience will reduce risk of cancelled appointment resulting in a better experience for patients and carers; improved staff experience due to more up to date machines; increased R&D opportunities as a result of newer equipment and collaboration with a single vendor.
- **Velindre Radiotherapy Satellite Centre:** The Radiotherapy Satellite Centre (RSC) at Nevill Hall has recently had its Full Business Case approved. The centre once implemented will provide radiotherapy treatment for approximately 20% of our patients (provided by two new

Radiotherapy treatment machines and one CT Simulator). The benefits of the RSC investment include better access and reduced travel for patients and less use of transport services. This will mean that fewer patients need to travel to the VCC for their radiotherapy.

- **nVCC Enabling Works:** The FBC approved all enabling works needed to provide primary and secondary access to the new Velindre Cancer Centre Site (including the provision of utilities).

b) Economic Case

2.19 The purpose of the Economic Case at FBC is confirm the preferred option from the OBC is still valid and to reappraise the costs, benefits and risks associated with the proposed investment. The Economic Case does not include VAT, or inflation as it aims to compare the options at today's prices to determine the most economically advantageous option. The Economic Case has been reviewed and updated from the Outline Business Case approval in October 2018. The key issues and levels of assurance are set out below in Table 3:

Table 3 – Economic Case Updates / Assurance

Update	Activity	Achieved Yes / No
Comprehensive Investment Assessment (CIA): was the process robust and in accordance with Treasury Green Book requirements	An external advisor has supported the Trust in developing the CIA. This has required a range of financial inputs that have been modelled. These inputs have been signed off by respective leads and the Assistant Project Director	Yes: professional external advice and all requirements followed
Delivery of a Preferred Option: does the preferred option at OBC still offer the best value at FBC	The CIA (based on current prices) has evaluated the options in the FBC and concluded that the preferred option is the implementation of a new Velindre Cancer Centre, this is aligned to the preceding Outline Business Case (OBC).	Yes: the do minimum plus option still remains the Preferred option as per OBC.

2.20 The nVCC project is utilising the Welsh MIM Policy, which is a Public Private Partnership (PPP) approach. The OBC undertook a Public Sector Comparator (PSC) which compares the public sector (traditional capital scheme) with the PPP scheme to determine which offers the best value-for-money. The MIM scheme offered the best value-for-money at OBC stage and the MIM procurement route was chosen.

c) Management Case

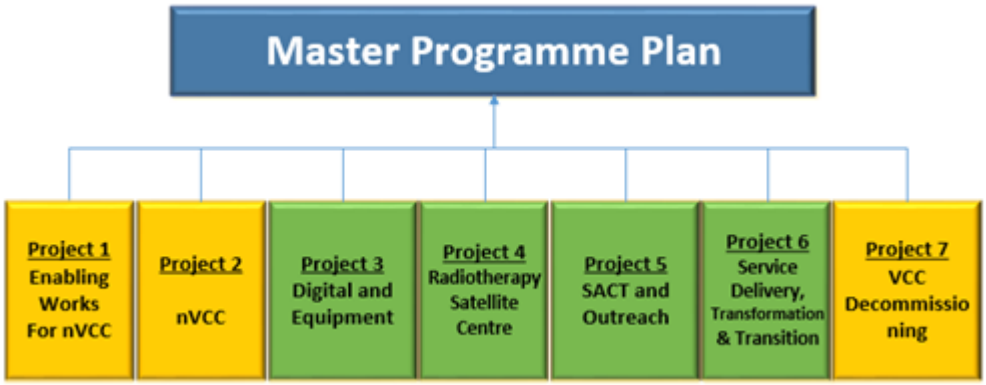
2.21 The Management Case sets out how the Trust will manage the implementation of the nVCC through its construction and in life phases. It also sets out the expected benefits to be realised; the risks to successful delivery and how they will be managed. The Management Case has been reviewed and updated from the Outline Business Case approval in October 2018. The key issues and levels of assurance are set out below in Table 4:

Table 4 – Management Case Updates / Assurance

Update	Activity	Achieved Yes / No
Governance Arrangements:	The Governance Structure has been reviewed and reflects the Trusts new arrangement	Yes
Leadership: Roles and Responsibilities	Roles and responsibilities have been updated from those submitted in the OBC	Yes
Benefits Register: are all of the benefits captured	The benefits register has been updated to reflect the CIA	Yes

2.22 The Transforming Cancer Services Programme sets out the scope, aim and spending objectives for the programme and consists of 7 projects as set out in Fig. 1.

Fig 1 – TCS Programme Projects



The description of the Projects are outlined in Table 5.

Table 5 – TCS Programme Projects Descriptions

Project Number / Name		Description
1	**Enabling Works**	All Enabling works needed to provide Primary and secondary access to the new Velindre Cancer Centre Site (includes the provision of utilities).

2	**New Velindre Cancer Centre**	The re-provisioning of a new Velindre Cancer Centre in the Whitchurch area of Cardiff.
3	**Digital and Equipment**	The provision of integrated Digital Information and Equipment Services across the TCS Programme. This Project oversees the IRS Project.
4	**Radiotherapy Satellite Centre**	Provision of a Radiotherapy Satellite Centre at Nevill Hall Hospital.
5	**SACT and Outreach**	The Provision of SACT and Outpatient services embedded in Local Health Boards.
6	**Service Delivery Transition and Transformation**	This project is responsible for establishing and transforming all service delivery functions across the clinical model. It is also responsible for planning and implementing the transition between the old and new cancer centre.
7	**Site Decommissioning**	The decommissioning of the old Velindre Cancer Centre brownfield Site.

2.23 With regards to benefits, the Programme and Project benefits are outlined in the FBC. The Programme Business Case sets out the range of benefits that are expected to be realised through the delivery of the programme; who is the expected beneficiary; when it is expected to be realised. The 7 projects within the programme are the primary vehicle to deliver the programme benefits and are subject to business cases (OBC/FBC); each of which set out the benefits that are expected to be realised from the specific project. It is important to note each project must clearly scope benefits that can be realised but the project; can only claim the benefit set out within its scope and can only realise a benefit once. This is vital in ensuring the programme/project economic cases are robust and some avoids over-emphasising the benefits and the potential for double counting.

2.24 Within the TCS Programme the following FBC business cases have been approved and these are set out below in Table 6:

Table 6 – TCS Programme Projects Benefits

Project	Title	Benefits include
1	**Enabling works: infrastructure to access nVCC**	• Reduced travel times for patients/families/staff • Reduced carbon emissions
3	**Integrated Radiotherapy Solution**	• Improved clinical care and treatment for patients • Increased levels of efficiency and productivity
4	**Radiotherapy satellite centre: Nevill Hall**	• Increased access to radiotherapy • Care close to home for patients • Reduced travel times for patients and families • Improved integration of cancer care

2.25 With regard to the nVCC FBC, it is important to note that the primary need to for investment is the need to replace the existing Velindre Cancer Centre as it is the only building that provides specialist non-surgical tertiary oncology services in South-East Wales. The building is nearly 70 years old and not considered to be fit-for-purpose now or sustainable in the future (as set out in the Business Needs section of the Strategic Case). Whilst the provision of the

nVCC has a clear strategic importance in the regional clinical model (now and in future years), at its simplest form the FBC sets out the need for investment to replace an old building with a new building.

2.26 Consequently, the FBC nVCC only sets out benefits that are within scope of the business case and does not seek to claim benefits which can only be realised by changes/actions elsewhere in the cancer system. For example, the provision of an nVCC will not directly improve detection of cancer in primary care; or directly assist in moving staging of cancers from 4 to 3 to 2; or improve 1 and 5 year survival rates of itself; these can only be achieved by actions across the whole system

2.27 However, the nVCC will directly contribute to the quality, safety, experience and sustainability of cancer care across SE Wales and 1 and 5 year survival through the tertiary services it provides as part of the pathway of care. There will also be a direct dis-benefit if the nVCC is not built i.e. the ability to meet required demand and quality of care will reduce and this is likely to result in reduced quality of care and 1 and 5 year survival rates.

2.28 The nVCC will also indirectly contribute to the overall improvement of cancer care (e.g. diagnosis; staging; pathway transformation etc.) through collaborative working; the provision of data/insights etc. and multi-disciplinary working.

2.29 The nVCC FBC benefits are set out in Table 7.

Table 7 – TCS Programme Projects Benefits

Project	Title	Benefits include
1	**New Velindre Cancer Centre**	• **Improved productivity**, with improved adjacencies; more flexible facilities and greater ability to comply with standards • **Improved recruitment and retention**, with improved staff recruitment and retention resulting in reduced reliance on overtime, bank and agency • **Centre for Learning and Innovation**, with additional income from Centre for Learning and Innovation • **Direct benefits of the new clinical model**, with reduced length of stay**;** reduced admissions; improved utilisation; less value of reinvestment in capacity to meet demand • **Improved survival rates**, with economic benefit of survivors re-entering employment; economic benefit of survivors providing childcare • **Improved energy efficiency**, resulting in changes to carbon emissions and air quality

d) Financial Case

2.30 The Financial Case sets out the costs relating to the preferred option and takes into account many different financial inputs. These include capital and revenue (recurring and non-recurring) costs. As funding is coming from various sources, the Financial Case sets out the funding requirement from WG and the Trusts Commissioners. It also states a range of financial treatments relating to VAT, CPI and Statistical Treatments. The Financial Case has been reviewed and updated from the Outline Business Case approval in October 2018. The key issues and levels of assurance are set out below in Table 8:

Table 8 – Finance Case Updates / Assurance

Update	Activity	Achieved Yes / No
Update of Costs	All costs have been revisited, revised and input into the Comprehensive Investment Appraisal. A comparative exercise of costs to identify/understand/analyse any material changes in costs from OBC to FBC has been undertaken, validated and documented.	Yes: all costs updated, and changes understood and justified. Support/advice provided by professional advisors
Financial Assumptions	Financial assumptions relating to statistical treatment, VAT, Inflation have been reviewed and remain extant from those considered at OBC.	Yes: all assumptions updated with support of professional advisors
Affordability	The ASP remains within the agreed Welsh Government OBC approval (at this juncture) Revenue affordability: discussions within the Trust and with Local Health Boards have identified a revenue funding position.	Yes: at this juncture

Affordability and Funding

2.31 The funding requirements for the Trust, Local Health Boards and Welsh Government are set out below.

Costs and Funding

2.32 **Capital Costs**

The capital costs are **c£52.6m** and are set out below in Table 9:

Table 9 – Capital Project Delivery Costs

Cost category	Funding requirement £000
Project (nVCC) capital expenditure - Equipment	38,209
Other Capital Costs	1,400
Project 'Delivery Capital' costs	10,478
IRS Implementation Costs	2,515
Total Capital Funding incl. VAT	**52,602**

Note: All costs are at 2022-23 prices

Recurring Revenue Costs

2.33 In October 2018, the Commissioners (LHBs) approved the OBC that set out the funding requirements of **c£7.5m** (at 2016-17 prices) in Table 10.

Table 10 – OBC Recurring Revenue Costs

Cost category	VCC Baseline £000	nVCC £000	Funding source
Soft FM	1,504	2,126	Commissioners
Hard FM	481	813	Commissioners
Utilities	572	1,032	Commissioners
Rates	192	1,027	Commissioners
Equipment Maintenance	1,300	1,900	Commissioners
IM&T Maintenance	300	445	Commissioners
Insurance	0	200	Welsh Govt/Commissioners
Total revenue costs	**4,349**	**7,543**	

2.34 In developing the FBC, the Trust has considered the necessary updates to the OBC costs which is outlined as follows:

- Reduction in OBC requirements due to the IRS maintenance costs being funded in the IRS business case;
- Inflation on adjusted OBC figures;
- Additional 'new' investment:
  - Cost of move to an all-electric cancer centre;
  - Digital

2.35 The updated FBC costs are set out below in Table 11.

Table 11 – FBC Recurring Revenue Costs

Cost Category	Original OBC	Reduction OBC	Adjusted OBC	OBC Inflated	New Investment	Other	TOTAL	Funding Source
	£000	£000	£000	£000	£000	£000	£000	
Soft FM	2,126	0	2,126	558	0	221	**2,905**	Commissioners
Hard FM	813	0	813	213	0	-125	**901**	Commissioners
Utilities	1,032	0	1,032	271	961	577	**2,841**	Commissioners
Rates	1,027	0	1,027	269	0	-253	**1,043**	Commissioners
Equipment Maintenance	1,900	-1,006	894	235	0	472	**1,601**	Commissioners
IM&T Maintenance	445	0	445	117	0	-312	**250**	Commissioners
Digital	0	0	0	0	753	0	**753**	Commissioners
Insurance	200	0	200	52	0	198	**450**	Welsh Govt / Commissioners
Recurring Revenue Costs	**7,543**	**-1,006**	**6,537**	**1,715**	**1,714**	**778**	**10,744**	

2.36 In summary the investment requirement is as follows:

- Original nVCC OBC c£7.5m
- Removal of IRS equipment mtce (c£1.0m)
- Adjusted OBC costs c£6.5m
- Inflation on the OBC costs c£1.7m
- Additional investment c£1.7m
- Other (movements) c£0.8m
- **TOTAL** **c£10.7m**

2.37 Therefore, the recurring revenue costs of nVCC are **c£10.7m** and the funding strategy is set out below in Table 12 together with the Welsh Government, DHCW and Local Health Board funding requirements:

Table 12 – FBC Recurring Revenue Funding

Cost Category	Preferred Option	DHCW (DPIF)	Welsh Government	LHBs
	£000	£000	£000	£000
Soft FM	2,905	0	0	2,905
Hard FM	901	0	0	901
Utilities	2,841	0	-961	1,880
Rates	1,043	0	0	1,043
Equipment Maintenance	1,601	0	0	1,601
IM&T Maintenance	251	0	0	251
Digital	753	-456	0	297
Insurance	450	0	0	450
Recurring Revenue Costs	**10,744**	**-456**	**-961**	**9,327**

Note: All costs are at 2022-23 prices

2.38 The Utility Costs have been agreed with the Collective Commissioners Group as fair and reasonable and reflects the current position. Commissioners have advised that the costs arising from the decision to procure a hospital designed with an electric only energy solution, which is a Welsh Government policy cost, should seek alternative funding sources. This is due to the current financial

deficit of each of the four main Commissioning Health Boards, which are anticipated to worsen over the next three-year IMTP 2023-2026. Whilst LHBs recognise the benefit of an early contribution to meeting the Welsh Government decarbonisation target, that the procurement of an electric only energy solution will help deliver, they note that their own estate also requires significant investment to address the 'green' agenda, which they cannot currently prioritise given the pressures on service funding. These issues have been understood and acknowledged by Velindre Trust. It has, therefore, been agreed that an element (£0.961m current prices) of this cost category, namely the switch to an all-electric solution, should seek an alternative funding source through transitional funding arrangements. It is proposed that the cost of an all-electric advance design to meet Government decarbonisation policy be mitigated by transitional funding relief as an element of the Welsh Government MIM financing support. At this time, based on the above, it has been agreed that Commissioners would not be requested to fund the all-electric solution element of £0.961m in advance of those transitional funding discussions with Welsh Government.

2.39 The revenue digital requirements cover four key areas at a cost of **c£1.2m** and is out below in Table 13:

Table 13 – Digital Costs

Cost Category	Net Costs	VAT	Gross costs
	£000	£000	£000
nVCC Infrastructure Requirements (Day 1)	247	50	297
Strategic Clinical & Operational Requirements	380	76	456
Digitisation of Health Records	370	75	445
Transitional Requirements	38	8	46
TOTAL	**1,035**	**209**	**1,244**

Note: All costs are at 2022-23 prices

In managing the funding of these Digital requirements, the Trust proposes that it takes responsibility for the costs of digitisation of health records and transitional costs through its baseline funding. In respect of the clinical and operational requirements, the Trust has had positive discussions with DHCW, where the structure of a collaborative funding arrangement has been agreed for the 'strategic clinical and operational' elements of the nVCC Project. As such, funding from the Digital Priorities Investment Fund (DPIF) or other Welsh Government digital funding sources is planned to be provided. This collaborative funding approach will continue to be shaped with LHBs. Given the proposed arrangements above, LHBs are only being requested to fund the nVCC infrastructure requirements (Day 1) at this stage in the process. Should the DPIF or other WG digital funding be non-recurrent, further discussions would be necessary to consider ongoing funding for these costs.

2.40 It is important to consider the overall movement in the recurring revenue funding required from Commissioners when compared to the agreed OBC funding inflated to 2022-23 prices. The movement is **c£1.0m** and is set out below Table 14:

Table 14 - Movement in Recurring Revenue Costs for Commissioners

Cost Category	FBC Costs	OBC Inflated	Movement
	£000	£000	£000
Soft FM	2,905	2,684	222
Hard FM	901	1,026	-125
Utilities	1,880	1,303	577
Rates	1,043	1,297	-254
Equipment Maintenance	1,601	1,129	472
IM&T Maintenance	251	562	-311
Digital	297	0	297
Insurance	450	252	198
Recurring Revenue Costs	**9,327**	**8,252**	**1,075**

Note: All costs are at 2022-23 price levels.

2.41 The movement in the recurring revenue costs that will be funded by Commissioners using the agreed Commissioner Shares is **c£1.0m** as set out below in Table 15:

Table 15 - Movement in Recurring Revenue Costs for Commissioners

Health Boards	Commissioner Split	TOTAL
	%	£000
Proposed funding from commissioners:		
Aneurin Bevan	36.52%	391
Cardiff & Vale	30.90%	331
Cwm Taf Morgannwg	28.11%	301
Swansea Bay	1.40%	15
Hywel Dda	1.49%	16
Powys	1.59%	17
Total	**100%**	**1,075**

2.42 The recurring revenue costs that will be **funded** by Commissioners using the agreed Commissioner Shares is **c£9.3m** as set out below in Table 16:

Table 16 - Summary of Funding Sources

Health Boards	Commissioner Split	TOTAL
	%	£000
Proposed funding from commissioners:		
Aneurin Bevan	36.52%	3,406
Cardiff & Vale	30.90%	2,882
Cwm Taf Morgannwg	28.11%	2,622
Swansea Bay	1.40%	131
Hywel Dda	1.49%	139
Powys	1.59%	148

Total	**100%**	**9,327**

Note: All costs are at 2022-23 price levels.

2.43 However, in respect of the increase in funding from Commissioners that is in addition to the baseline, which is already funded, the increase is **c£5.1m** and is set out below in Table 17.

Table 17 - Summary of Additional Funding for Recurring Revenue Costs

Cost Category	Baseline 2021-22	Recurring Revenue	Additional Funding reqd from Commissioners
	£000	£000	£000
Soft FM	1,846	2,905	1,059
Hard FM	454	901	447
Utilities	945	1,880	935
Rates	179	1,043	864
Equipment Maintenance	723	1,601	878
IM&T Maintenance	25	251	226
Digital	0	297	297
Insurance	0	450	450
Recurring Revenue Costs	**4,172**	**9,327**	**5,155**

Note: All costs are at 2022-23 price levels

2.44 The additional funding required from Commissioners is set out below in Table 18.

Table 18 - Summary of Additional Funding from Commissioners

Health Boards	Commissioner Split	TOTAL
	%	£000
Proposed funding from commissioners:		
Aneurin Bevan	36.52%	1,883
Cardiff & Vale	30.90%	1,593
Cwm Taf Morgannwg	28.11%	1,449
Swansea Bay	1.40%	72
Hywel Dda	1.49%	77
Powys	1.59%	82
Total	**100%**	**5,155**

Note: All costs are at 2022-23 price levels

2.45 It is planned that the Welsh Government will fund the Annual Service Payment and increased buildings and equipment depreciation. It should be noted that there is a recurring revenue requirement for Depreciation of **c£10.9m** (at 2022-23 prices). In respect of the Annual Service Payment for the Project, this will not be finalised until the day of Financial Close. Given commercial confidentiality, it has been deemed appropriate not to present an ASP.

Non-Recurring Revenue Funding

2.46 Non-recurring revenue costs, including accelerated depreciation, dual running, and project support will be funded by the Welsh Government and Commissioners and are set out in Table 19.

Table 19 - Summary Non-Recurring Revenue Requirements

Cost category	Funding Reqd £000	Source of Funding
Accelerated depreciation	31,437	Welsh Government
Dual Site Running Costs	2,412	Commissioners
Total Non-Recurring Revenue Costs	**33,849**	

Note: All costs are at 2022-23 price levels.

2.47 Table 20 outlines the non-recurring revenue costs for financial years:

Table 20 - Profile of Non-Recurring Revenue Requirement

Cost category	2023-24 £000	2024-25 £000	2025-26 £000
Accelerated depreciation	10,479	10,479	10,479
Dual Site Running Costs	0	0	2,412
Total Non-Recurring Revenue Costs	**10,479**	**10,479**	**12,891**

Note: All costs are at 2022-23 price levels

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The Clinical Service Model has been approved by commissioners and assured by Nuffield Trust.
RELATED HEALTHCARE STANDARD	Safe Care
	As Above
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
	Completed at Programme Level
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The nVCC Project is part of the WG Mutual Investment Model (MIM).

FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Funding is required from WG and commissioners.

4. RECOMMENDATION

4.1 The [insert Committee name] of [insert LHB name] Health Board is requested to:

- **Note** that the process to develop the FBC from the previously agreed OBC has followed Treasury Green Book Guidance;
- **Note** the updates made from OBC to FBC and the assurance provided by the Collective Commissioning Group (CCG);
- **Note** the movement in recurring revenue funding, from the uplifted OBC approved sum, for the Health Board is £xm;
- **Approve** the investment requested of £xm from the Health Board by Velindre University NHS Trust set out in section 2d;
- **Approve** the Full Business Case, excluding the Commercial Case.

Appendix 1 Strategic Case

Appendix 2 Management Case

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

Full Business Case: March 2023

new Velindre Cancer Centre (nVCC)

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Strategic Case

STRATEGIC CASE

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1 INTRODUCTION AND PURPOSE

Introduction

1.1 The scope of the new Velindre Cancer Centre Project is to develop a new fit for purpose Velindre Cancer Centre (nVCC). The nVCC will deliver the majority of specialist non-surgical cancer services for the population of South-East Wales.

1.2 On the 19th of March 2021, the Welsh Government announced its approval of the nVCC Outline Business Case (OBC), this approval enabled the formal procurement of the nVCC to commence via a competitive dialogue procedure.

1.3 The outcome of the nVCC procurement is nearing Financial Close (FC) and this progress allows for the population of this Full Business Case (FBC) which is aligned to the Successful Participants (SP) tender.

1.4 The nVCC OBC revisited the project's earlier Strategic Outline Case assumptions and identified a preferred way forward. This FBC will also revisit those assumptions and confirm strategic alignment, value for money and a means to implement the preferred solution which is part of Velindre's approved Clinical Operating Model.

1.5 The construction of a new nVCC is currently planned to be completed during 2025.

Purpose

1.6 The purpose of this Full Business Case (FBC), is therefore to:

- Confirm that the Project Spending Objectives (PSOs) have been reviewed and are still valid;
- Confirm that the preferred way forward identified in the nVCC OBC remains unchanged;
- Identify the marketplace opportunity which offers optimum Value for Money (VfM);
- Set out the commercial and contractual arrangements for the negotiated deal(s);
- Confirm the deal(s) are still affordable; and
- Put in place the detailed management arrangements for the successful delivery, monitoring and evaluation of the scheme.

1.7 In seeking approval, this FBC will provide assurance on the points outlined above to the Trust Board, the Trust's Commissioners and Welsh Government.

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2 STRATEGIC CASE STRUCTURE AND CONTENTS

Context of Proposed investment

2.1 The Trust and its partners are committed to providing safe, efficient and effective care to all our patients. To achieve this from a cancer services perspective, it is essential that a nVCC is developed. The key drivers supporting the case for investment are:

- The Welsh Government's health and cancer policy to improve the quality of cancer treatment and care; to further improve the experience of care; and patient outcomes.
- Continuing growth in the incidence of cancer and the demand for cancer services across Wales; with incidences expected to grow at approximately 2% per annum.
- The role of Velindre Cancer Services and Velindre Cancer Centre in the South-East Wales region as being the sole provider of highly specialist non-surgical tertiary oncology for the resident population.
- The need to keep pace with the advances in treatments and technology which support the provision of cancer care that achieves the required clinical standards.

2.2 The bullet point themes above will be explored and introduced as a "golden thread" running through this FBC and are at the heart of the Trust's ambition and business needs.

2.3 Of note, there are currently significant limitations relating to the fabric and functionality of the existing Velindre Cancer Centre which was built in 1956, these are:

i. The existing Velindre Cancer Centre has insufficient space and if built on a 'like for like' basis, and in line with Health Building Notes (HBN's), it would have a footprint of circa 28,000m2 compared to the existing building footprint of 17,777m2;

ii. There is no expansion space on the existing Velindre Cancer Centre. This severely limits, the Trust's ability to expand its footprint to meet the increasing demand for its clinical services across a range of specialities / departments.

iii. A high proportion of accommodation at the existing VCC is non-compliant with statutory requirements and creates challenges in maintaining high levels of patient safety and confidentiality.

iv. The existing patient environment at the VCC is sub-optimal in promoting patient dignity, experience and well-being.

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v. The existing VCC has limitations in its ability to provide the most up to date treatments for patients to support improved outcomes and quality of life.

vi. There is insufficient car parking at the existing VCC.

2.4 Therefore, it is clear that the existing Velindre Cancer Centre is significantly inhibiting the Trust's ability to both maintain and progress its clinical services. Conversely, the nVCC project is critical to the successful delivery of the Trust's long-term Cancer Strategy and the delivery of the benefits set out within the Trusts Transforming Cancer Services in South-East Wales programme (TCS).

2.5 The TCS Programme is an ambitious programme that aims to deliver transformed tertiary non-surgical Cancer Services for the population of South-East Wales. It is described in detail below.

TCS Programme Scope

2.6 It is important for the reader of this nVCC FBC to be able to "locate" where the nVCC Project sits within the wider TCS Programme which has seven interdependent projects that will deliver the Trusts approved strategies and Clinical Operating Model. The projects are led by a number of defined Boards within Velindre University NHS Trust. These arrangements are set out in more detail in the Management Case.

2.7 The wider TCS Programme has been developed to deliver a number of aspects of the Welsh Governments strategic cancer/wider policy requirements (Healthier Wales; Cancer Quality Statement; Well-being for Future Generations (Wales) Act 2015; Decarbonisation Plan) and Velindre Cancer Services Strategy "Building our Future Together 2017 – 2027".

2.8 The seven TCS Projects are briefly described in Table 1 overleaf:

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Table 1 - TCS Projects Described

Project Number / Name		Description
1	Enabling Works	All enabling works needed to provide primary and secondary access to the new Velindre Cancer Centre Site (including the provision of utilities).
2	New Velindre Cancer Centre	The re-provisioning of a new Velindre Cancer Centre in the Whitchurch area of Cardiff.
3	Digital and Equipment	The provision of integrated Digital Information and Equipment Services across the TCS Programme. This Project oversees the Integrated Radiotherapy Solution (IRS) Project.
4	Radiotherapy Satellite Centre	Provision of a Radiotherapy Satellite Centre at Nevill Hall Hospital.
5	SACT and Outreach	The Provision of Systemic Anti-Cancer Therapy (SACT) and Outpatient services embedded in Local Health Boards.
6	Service Delivery Transition and Transformation	This project is responsible for establishing and transforming all service delivery functions across the clinical model. It is also responsible for planning and implementing the transition between the old and new cancer centre.
7	Site Decommissioning	The decommissioning of the old Velindre Cancer Centre brownfield site.

2.9 To implement the TCS Programme, as described in the TCS Programme Business Case (PBC), a suite of Business Cases is required. It is important that these business cases are seen in the context of the other investment cases that are being developed.

2.10 Figure 1 sets out the TCS Programmes Business Case Framework and how it aligns to the seven defined projects.

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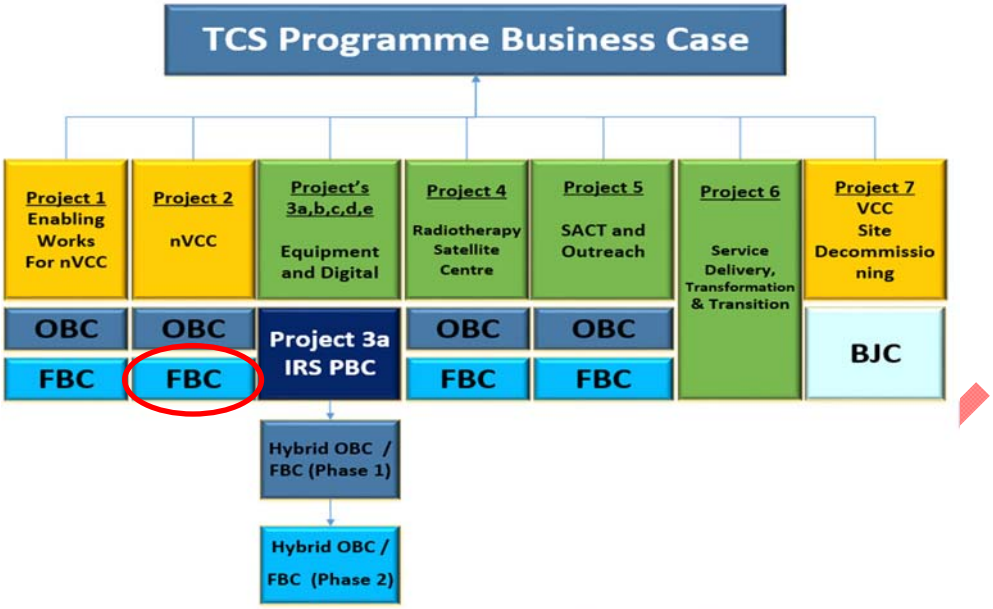
Figure 1 - TCS Programme Business Case Framework



2.11 This FBC seeks investment for the nVCC Project (Project 2 circled above). Other business cases within the TCS Programme have been approved and an update is set out in the Table 2 below:

Table 2 - TCS Programme Business Case Status

Project Number / Name		Approval Status
1	**Enabling Works**	Full Business Case Approved
2	**new Velindre Cancer Centre (nVCC)**	Full Business Case Complete (includes digital)
3	**Digital and Equipment**	Integrated Radiotherapy Solution – Full Business Case approved other digital equipment in this case for nVCC
4	**Radiotherapy Satellite Centre (Lead by ABUHB)**	Full Business Case Approved
5	**SACT and Outreach**	Business Case Process not yet commenced
6	**Service Delivery Transition and Transformation**	No Business Case Required – Transition costs included within nVCC Full Business Case
7	**Site Decommissioning**	Business Justification Case (BJC) will be commenced following this Business Case submission

Business Case Approvals and Timeline

2.12 The approval process for this FBC is outlined in the Table 3 below.

Table 3 - nVCC FBC Approval Timeline

Approval Step	Purpose	Submission Target Date
Phase 1: Draft FBC excl. Commercial Case to Trust Board	For review	January 2023
Phase 1: Draft FBC excl. Commercial Case to Trust Commissioners and Welsh Government	For review	January 2023
Phase 2: Final FBC incl. Commercial Case to Trust Board *(dependent on Financial Close being achieved)*	For approval	February 2023
Phase 3: Final FBC to Health Board Commissioners	For approval	February 2023
Phase 4: Final FBC to Welsh Government	For approval	March 2023

Structure and content of FBC

2.13 The FBC has been prepared in accordance with HMT Green Book and Welsh Government Better Business Case guidance. Table 4 below outlines the approach that has been applied to the Five Case model.

Table 4 - nVCC FBC Structure and Content

Chapter	
Strategic Case	Sets out the strategic context and the case for change, together with the supporting investment objectives for the scheme.
Economic Case	Completes an economic appraisal that outlines the main benefits of shortlisted options. Appraises the economic costs, benefits and risks for the short-listed options based on the results of the procurement process. Demonstrates the preferred option continues to meet the needs of the service and optimises value for money.

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Chapter	
Commercial Case	Describes the procurement process adopted and outlines the content and structure of proposed contract and associated contractual arrangements. Provides the results of the procurement process and final proposed contractual arrangements.
Financial Case	Sets out the financial implications of the preferred option based on the results of the procurement process. Confirms funding arrangements and affordability and explains any Balance Sheet impact.
Management Case	Demonstrates that the scheme is achievable and can be delivered successfully to cost, time and quality.

Strategic context of proposed investment

2.14 This section of the Full Business Case (FBC) summarises the strategic context for the development of a new Velindre Cancer Centre (nVCC) Project by explaining how the nVCC Project supports the delivery of local, regional and national policy goals.

2.15 Specifically, in Figure 2 overleaf it considers the fundamental drivers behind these proposals including:

- Links to national strategy and policy.
- The Trust's enabling Strategies and Programme Arrangements linked to the above National Drivers, and;
- The Service Delivery / Business as Usual needs: the need to maintain business as usual activities and to regularly and routinely replace major medical equipment.

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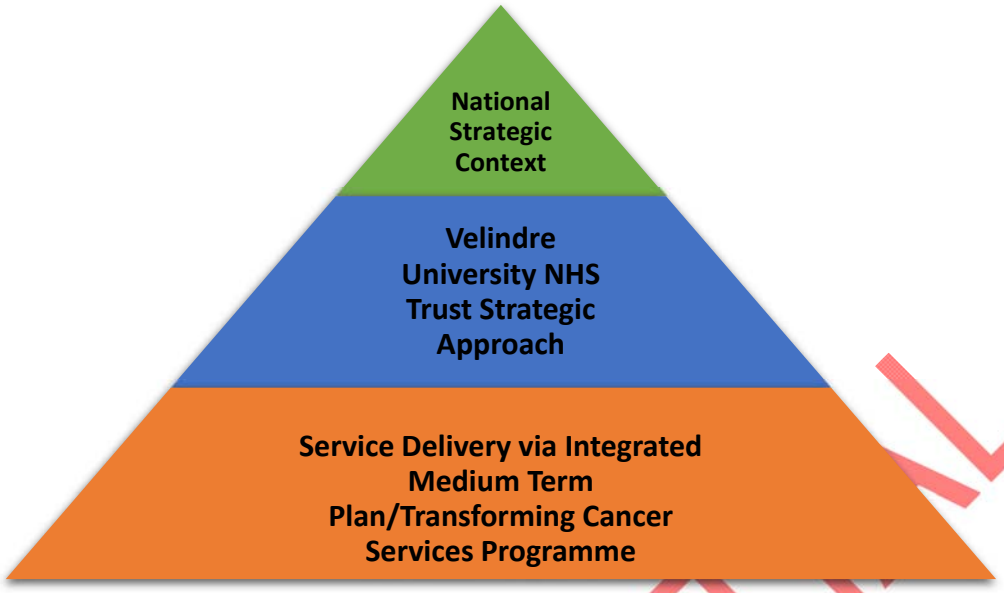
Figure 2 - Fundamental Policy Drivers



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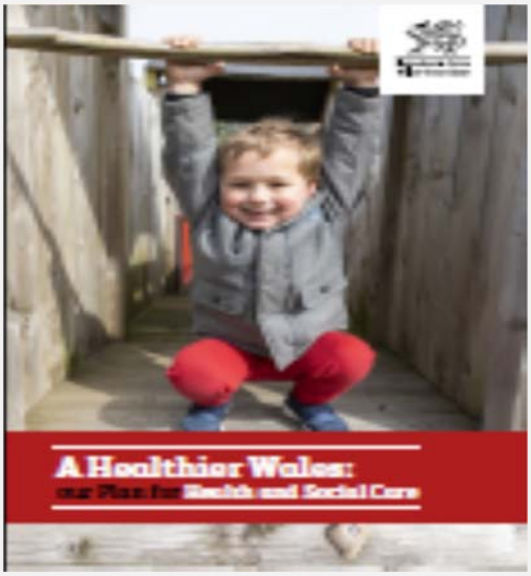
2.16 Figure 3 below summaries the main National strategic drivers linked to this FBC.

Figure 3 - Strategic Context in Wales for Health Services

National Context



Statutory Duties and Key Policies:

- **A Healthier Wales 2018**
- **Well-Being of Future Generations Act (2015)**
- **Health and Social Care (Quality and Engagement (Wales) Act 2020**
- **Public Health Wales Act (2017)**
- **Social Services and Well-being Act (2014)**
- **Nurse Levels (Wales) Act (2016)**
- **Equalities Act 2010**
- **Welsh Language (Wales) Measure (2011)**
- **Equality Act (2010)**
- **Health & Safety at Work Act (1974)**
- **Socio-economic Duty 2021**
- **A Healthier Wales**
- **Prudent Health Care/Value Based Health Care**
- **Working Differently- Working Together**
- **De-carbonisation strategy**
- **WG Digital Strategy**
- **National Clinical Plan and National Clinical Framework (2021)**
- **Cancer Quality Statement (2022)**

Velindre University NHS Trust's Strategic Response

2.17 In response to the regional and national policy drivers Velindre University NHS Trust has developed its Corporate Strategy called 'Destination 2032'. This Strategy sets out a new purpose, vision and set of strategic goals for the Trust and was approved during 2022. The approach is set out in Figure 4 below:

Figure 4 - VUNHST Purpose, Vision and Goals

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2.18 In support of Velindre's, Purpose, Vision and Goals that make up 'Destination 2032', the following divisional service strategies have been developed:

- Welsh Blood Service Strategy 2022 – 2027
- Velindre Cancer Strategy 'Shaping our Future Together 2017- 2027'

2.19 These are also supported by a range of refreshed enabling strategies / frameworks which are available upon request:

- Quality and Safety Framework
- Clinical and Scientific Strategy (being developed)
- Sustainability Strategy 2022 – 2032
- Workforce Strategy 2022 – 2032
- Digital Strategy 2022 – 2032
- Estates Strategy 2022 – 2032.

Alignment with Velindre Cancer Services Strategy 'Shaping our Future Together 2017 – 2027' and the Transforming Cancer Services Programme

2.20 Velindre Cancer Services strategy 'Shaping our Future Together 2017 – 2027' sets out five strategic priorities, these are set out in Table 5 below:

Table 5 – The Five Strategic Priorities and Aims of 'Shaping our Future Together 2017 – 2027'

Priority	Aim
Strategic Priority 1:	**Equitable and consistent care, no matter where; meeting increasing demand.**
Strategic Priority 2:	**Access to state-of-the-art, world-class, evidence-based treatments**
Strategic Priority 3:	**Improving care and support for patients to live well through and beyond cancer**
Strategic Priority 4:	**To be an international leader in research, development, innovation and education**
Strategic Priority 5:	**To work in partnership with stakeholders to improve prevention and early detection of cancer.**

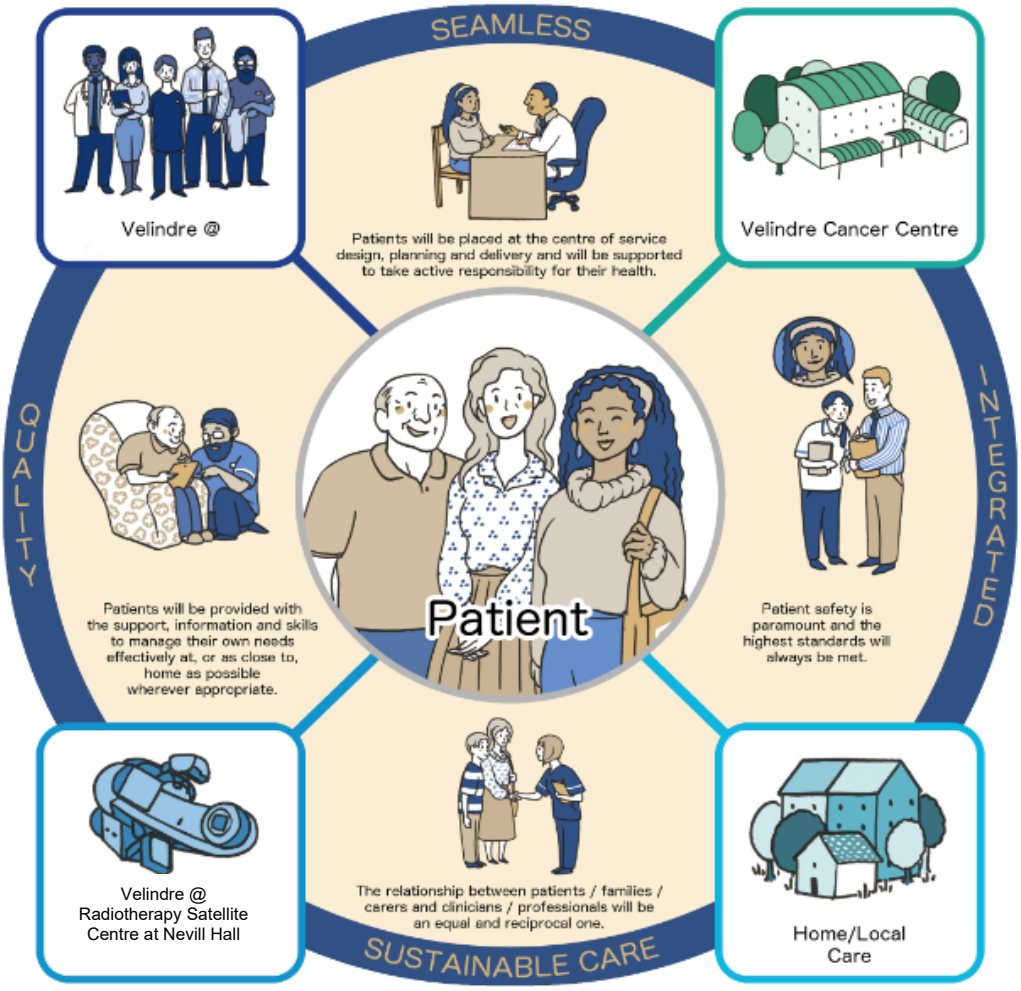
2.21 The Trusts range of strategies, together with the Velindre Cancer Service strategy 'Shaping our Future Together 2017 – 2027', are directly aligned to the Welsh Governments range of strategic policy goals and requirements. The delivery of these strategies (priority; timelines) are managed through the Integrated Medium Term Planning (IMTP) process with delivery managed and

monitored via the Trusts' established performance management and governance arrangements.

Translating Strategic Plans into the delivery of improved quality of care: the Clinical Operating Model

2.22 The TCS Programme used the Velindre Cancer Service strategy 'Shaping our Future Together 2017 – 2027 to support the development of a Clinical Operating Model. This was facilitated through workshops/events/meetings involving more than 400 people - professionals, patients and public from a range of organisations including Health Boards, Third Sector and the Community Health Council (CHC). The clinical model is set out in Figure 5 below:

Figure 5 - Approved Clinical Model



2.23 The clinical operating model within the TCS PBC describes how services will be delivered in the future. The founding principles were as follows:

- The service model seeks to promote a new set of relationships which work in partnership to improve the way we collectively design and deliver tertiary non-surgical cancer services around patients' needs and to achieve these improvements in a truly sustainable way.
- Patients are central to our plans with an integrated network of services organised around them. The organising principle seeks to 'pull' high quality care towards the patient, that is accessible in their preferred location and supports them achieving their personal goals during treatment and subsequently as they live with the impact of cancer.
- Patient safety is paramount, and the highest standards will always be met.
- The relationship between patients / families / carers and clinicians / professionals will be an equal and reciprocal one.
- Patients will be provided with the support, information and skills to manage their own needs effectively at, or as close to, home as possible wherever appropriate.
- Optimising information technology, quality improvement systems, patient involvement, education and embracing innovative approaches to healthcare will all be essential to achieve high levels of service quality in a sustainable way.

2.24 The Clinical Operating Model will see more care delivered within patients' homes; and locally through the development of a number of Velindre@ facilities on Local Health Board sites across South-East Wales, providing chemotherapy, outpatient, and support services; a Radiotherapy Satellite Centre (RSC) in Nevill Hall Hospital, Abergavenny; and the redevelopment of the Velindre Cancer Centre on a new site in Whitchurch, Cardiff.

2.25 To deliver the principles of the new Clinical Operating Model, care will be delivered differently and at different locations. This will require a number of infrastructure and technology projects as well as service change projects to be established.

2.26 These key elements of the model and their functions are described briefly below:

- **Health Boards:** A range of cancer care occurs within the Health Boards, with a proportion of patients having all their care delivered by the Health Board teams. For other patients who need non-surgical treatment, their care needs to be seamlessly planned with the non-surgical aspects of the pathway, as patient care can often transition from one team to another. The Velindre Outreach facilities and collaborative working will support this approach.

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- **Velindre Outreach Centres:** These facilities will provide (if clinically indicated) SACT, outpatient services, education and information provision and ambulatory care procedures within Health Boards.
- **Velindre Radiotherapy Satellite Centre:** The Radiotherapy Satellite Centre (RSC) at Nevill Hall has recently had its Full Business Case approved. The centre once implemented will provide radiotherapy treatment for approximately 20% of our patients (provided by two new Radiotherapy treatment machines and one CT Simulator).

  The benefits of the RSC investment include better access and reduced travel for patients and less use of transport services. This will mean that fewer patients need to travel to the VCC for their radiotherapy.
- **new Velindre Cancer Centre:** The new Velindre Cancer Centre will provide specialist and complex cancer treatment including SACT, radiotherapy (including brachytherapy and unsealed sources) and specialist palliative care, inpatient facilities (being open for admission 24 hours/day, 7 days/week), a specialist acute oncology assessment unit and outpatient services, radiology, and nuclear medicine.

Assurance of the clinical operating model and its ability to deliver high quality, safe services which meet the expectations of patients and families

External advice from the Nuffield Trust

2.27 In December 2020, a number of concerns were raised regarding the ability of the Trust's proposed clinical operating model to achieve the range of expected benefits. The focus of the concerns where primarily related to the proposed regional networked model of care. This was mainly due to the current Velindre Cancer Centre not being co-located on an acute site as this business case proposes.

2.28 In recognition of the concerns raised, the Trust commissioned the Nuffield Trust to provide independent advice on the proposed regionally networked model of care. This advice included the proposed location of the nVCC in Whitchurch as part of that model.

2.29 The Terms of Reference for the advice was jointly agreed between the Trust and Local Health Board partners. The Nuffield Trust published its conclusions in December 2020 in a paper entitled 'Advice on the proposed model for non-surgical tertiary oncology services in South-East Wales' which can be found appended to this business case at **FBC/SC1**.

2.30 The Nuffield Trust's Independent Advice was made publicly available and was considered by Velindre University NHS Trust Board and Local Health Board

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partners who accepted the report in full, together with all of the recommendations contained within it.

2.31 The Nuffield recommendations cover the wider cancer system in South-East Wales and not simply the non-surgical tertiary oncology elements of it. The South-East Wales Collaborative Cancer Leadership Group (CCLG) received the report and accepted the recommendations in full and are providing the regional leadership to deliver them.

2.32 Welsh Government considered the Nuffield Trust report as part of the approval of the Outline Business Case for the nVCC in 2021.

2.33 The CCLG, Local Health Boards and Velindre University NHS Trust continue to make progress against the recommendations. The current position is set out in **FBC/SC2**; which was approved by the CCLG at its quarterly meeting in November 2022.

Programme Enabling Strategies / Ambitions – relevant to nVCC Project

2.34 To support the delivery of the assured Clinical Operating Model there are a number of approved enabling strategies within the TCS Programme that link strongly to this FBC, these are:

Figure 6 - TCS Enabling Strategies / Ambition

TCS Equipment Strategy

2.35 The Equipment Strategy agreed with Welsh Government has been updated since OBC, but primarily remains extant with the main principles as follows in Table 6:

Table 6 - Equipment Strategy Approach

Category	Approved Decision
Replacement Options	• Extend the operational life of some existing equipment assets where possible, preventing replacing this equipment in the existing VCC and then having to transfer into nVCC.

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	• accept some accelerated depreciation where it is not economically viable to consider transferring to the nVCC • replace all other items as new in nVCC.
Transition Options	Replace as many Radiotherapy Treatment Machines as possible in the nVCC, but acknowledge that a minimum of 2 Linacs will have to transfer.
Maintenance Options	Maintenance of major equipment will be delivered via a co-produced model, this will be made up of In-house and Vendor support (as now) for Linacs.
Transfer Options	Transfer major clinical equipment if economically viable (most likely CT Sims).

2.36 The updated TCS Equipment Strategy can be found at appendix **FBC/SC3.**

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Cognitive by Design (Digital Strategy)

2.37 At OBC stage the Trust had outlined its vision for future digital services by producing a strategy called Cognitive by Design. This vision and the Trust's planning and capability in this area had been subject to an external assurance review carried out by a company called Channel 3 (C3) at OBC stage. As part of this FBC submission the digital strategy has been reviewed by Velindre's Chief Digital Officer. The output of this review confirms that Cognitive by Design remains aligned in terms of the Trust's vision and alignment to National Digital Strategies.

2.38 Since the OBC submission, VUNHST has been progressing significant developments in Information Management and Technology (IM&T) systems. These have been a combination of national programmes, internationally used systems and bespoke local developments all of which have enabled an improvement in services for professionals, patients, and donors.

2.39 The Trust has prioritised the development of its IM&T Strategy to support the identified organisational and clinical priorities and to ensure that next generation IM&T is used to transform service delivery.

2.40 At the heart of the informatics delivery are the four principles from the "Informed Health and Care: A Digital Health and Social Care Strategy for Wales" (2015). These are:

a) Information for you (the patient).
b) Supporting Professionals (digital tools).
c) Improvement and Innovation (better use of information / whole systems approach).
d) A Planned Future (joint planning regional and national).

2.41 The VUNHST approach is also aligned to the wider and more recent "Digital Strategy for Wales" (2021) and the missions that deal with:

a) Digital services – deliver and modernise services so that they are designed around user needs and are simple, secure and convenient.
b) Digital inclusion – equip people with the motivation, access, skills and confidence to engage with an increasingly digital world, based on their needs.
c) Digital skills- create a workforce that has the digital skills, capability and confidence to excel in the workplace and in everyday life.
d) Data and collaboration – services are improved by working together, with data and knowledge being used and shared.

2.42 VUNHST has produced an ambitious strategic informatics programme, "Digital Excellence", which up to 2032, will implement a range of national technology solutions, while growing our capacity, capability, and culture to build innovative digital services.

2.43 Since the OBC the Trust has used its assured digital vision, plans and expertise

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to inform, influence and optimise the competitive dialogue process to achieve a digitally enabled nVCC which can support the Trust, its staff and patients in achieving digital excellence.

2.44 The outlined approach is based on the fundamental premise that high quality healthcare in the 21st century cannot be delivered with out of date or obsolete legacy systems, and/or paper-based information recording and delivery.

2.45 By utilising IM&T as a critical enabler to support service transformation, Velindre University NHS Trust aims to fundamentally redesign administrative, operational and clinical processes into simple services around patients, donors and colleagues needs. These will maintain high levels of data quality, and not only ensure information is accurate and up to date, but also embed state of the art technologies to deliver exceptional services.

2.46 The enablement of, and connectivity of patients, donors and colleagues is critical to the success of the Digital strategy. To this end, the Trust is working with colleagues from across NHS Wales to ensure mobile computing requirements, patient engagement systems, as well as digital staff communication tools are at the forefront of the Digital Programme. We will continue to look to national programmes such as Digital Services for Patients and the Public (DSPP) to deliver the strategic framework for digitally transforming our services.

2.47 To ensure the Trust continues to provide the most effective informatics services, we will continue to explore further opportunities for standardisation of processes, rationalising systems and solutions, alignment of resources, where possible, and share best practice both from across the divisions, and also externally, by incorporating the lessons from other Health Board/Sector experiences.

2.48 The updated Trust Digital Strategy 'Digital Vision for the new Velindre Cancer Centre' can be found at appendix **FBC/SC4**.

Environmental / Sustainability (Green Credentials)

2.49 Velindre University NHS Trust has developed a Sustainability Strategy and is aware of its legal obligations under the Well-being of Future Generations Act 2015. Additionally, the Welsh Government Environment Act 2016 mandates that public organisations must be carbon neutral by 2030, five years after the planned go live of the nVCC.

2.50 It has therefore been an imperative that the Trust factored into its procurement process the requirement for the Successful Participant (SP) to deliver a design capable of supporting this future compliance with Welsh Government Policy and relevant Acts. It is anticipated that not preparing for this future legislation now on such a large-scale development would lead to greater costs and disruption in an attempt to retrofit compliance at a later date.

2.51 To enable this approach the bidders were given a brief which was mapped against the seven goals of the Well-being of Future Generations Act (WFGA)

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2015 and their response was evaluated as part of the final tender submissions, specific sections of the Trust Brief are set out in Table 7 below:

Table 7 – nVCC Sustainability Brief

Goal	The Brief
A globally responsible Wales – A nation which, when doing anything to improve the economic, social, environmental, and cultural well-being of Wales, takes account of whether doing such a thing may make a positive contribution to global well-being.	While Velindre is acting primarily to improve the health of the Welsh population the Green section of the nVCC Design Brief takes account of the contribution this might make to global well-being, in particular global warming. The Green section specifically asks for: - • Designs that minimise energy use and the environmental impact of building materials. • Design features which encourage active travel. The practical section calls for designs which will minimise maintenance and avoids where possible reliance on expensive mechanical equipment.

2.52 As a result, the SP's design will deliver one of the "Greenest" hospital developments with further opportunities available to meet the 2030 aspiration to be carbon neutral.

2.53 Therefore, given the importance of the sustainability agenda the green credentials and their benefits will feature strongly in the FBC's Economic, Commercial and Management Cases.

Strategic Alignment: Summary

2.54 Velindre University NHS Trust strategic approach and plans are fully aligned with the Welsh Governments strategy and policy and the Programme for

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Government 2021-26 which prioritises Cancer Treatment and the need to address COVID-19 backlog and waiting times.

2.55 It is also fully integrated and aligned with the South-East Wales regional cancer strategies and plans; with strategic regional leadership provided by the CCLG.

2.56 The nVCC project, and its associated Project Spending Objectives, will support the delivery of national, regional, and local ambition by:

- **Providing effective, high quality and sustainable healthcare** by creating a 21st century NHS that tackles health inequalities and focuses on prevention. Specifically, by improving access to Radiotherapy services.
- **Building an economy based on the principles of fair work, sustainability and the industries and services of the future** by building an economy based on sustainable jobs. Specifically, by creating skilled jobs and apprenticeships.
- **Building a stronger, greener economy as we make maximum progress towards decarbonisation** by developing a modern and productive infrastructure which acts as an engine for inclusive and sustainable growth.
- **Embedding our response to the climate and nature emergency in everything we do by delivering a green transformation**. Specifically, through greater green energy.

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3 EXISTING ARRANGEMENTS

Introduction

3.1 The purpose of this section of the FBC is to provide an overview of Velindre University NHS Trust and the existing arrangements at the current Velindre Cancer Centre.

3.2 The latter will describe the current arrangements for the delivery of services covered within the scope of the nVCC project; provide a description of the existing Velindre Cancer Centre estate and supporting infrastructure; and outline the existing land arrangements. Together, they will provide a baseline for identifying the business needs and for measuring future improvements.

Velindre University NHS Trust Overview

3.3 The purpose of this section is to provide an overview of Velindre University NHS Trust (the Trust) and Velindre Cancer Centre and to summarise the role of the Velindre Cancer Centre in delivering non-surgical specialist cancer services to the population of South-East Wales now and in the future.

3.4 The Trust has evolved significantly since its establishment in 1994 and is operationally responsible for the management of the following two divisions:

- Velindre Cancer Centre; and
- the Welsh Blood Service.

3.5 The Trust is also responsible for hosting the following organisations on behalf of the Welsh Government (WG) and NHS Wales

- NHS Wales Shared Services Partnership (NWSSP); and;
- Health Technology Wales (HTW).

Velindre Cancer Centre (Existing Arrangements)

3.6 Velindre Cancer Centre is located in Whitchurch on the North-West edge of Cardiff and is one of the ten largest regional clinical oncology centres in the United Kingdom (UK Radiotherapy Equipment Survey, 2008), it is the largest of the three cancer centres in Wales. Velindre Cancer Centre is housed in a building – parts of which are almost 70 years old – and therefore it does not

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have the facilities, space or modern infrastructure required to meet future service standards and predicted activity.

3.7 The Velindre Cancer Centre is responsible for the delivery of non-surgical treatment to the catchment population of 1.5 million across South-East Wales. The service provision includes radiotherapy and SACT, recovery, follow-up and specialist palliative care. Following their specialist cancer treatment, Velindre Cancer Centre continues to support patients during their recovery and through follow up appointments. A significant proportion of Outpatient and SACT activity is already delivered in Health Board settings by Velindre Cancer Centre staff, although this did reduce somewhat as a result the COVID-19 pandemic but is now normalising. However, all Radiotherapy activity is currently delivered at the Velindre Cancer Centre.

3.8 Specialist teams provide care using a well-established multi-disciplinary team (MDT) model of service for oncology and palliative care, working closely with local partners and ensuring services are offered in appropriate locations in line with best practice standards of care. The range of services delivered by Velindre Cancer Centre includes:

1. Radiotherapy;
2. Systemic Anti-Cancer Therapies (SACTs);
3. Inpatients;
4. Ambulatory care;
5. Outpatient services;
6. Pharmacy;
7. Specialist radiology/imaging;
8. Nuclear Medicine;
9. Specialist Palliative care;
10. Acute Oncology Service (AOS);
11. Living with the impact of cancer;
12. Education and Learning; and
13. Research, Development and Innovation.

3.9 The following patient services are delivered in outreach settings across South-East Wales from the Velindre Cancer Centre in Health Board settings:

1. SACT delivery;
2. Outpatient appointments;

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3. Inpatient reviews; for patients receiving care and treatment in HB locations
4. Health Board MDTs; and
5. Research and Education.

3.10 The Trust also works in partnership with a wide range of partners to deliver high quality cancer care and undertake clinical research. Partners include:

1. Voluntary sector;
2. Third sector;
3. Higher Education Institutions (HEIs); and
4. Industry/Commercial Partners.

Planning of Cancer Services in South-East Wales

3.11 The planning and delivery of cancer services in Wales is the responsibility of the seven Health Boards as part of their statutory responsibility to meet the health needs of the populations they serve.

3.12 The Health Boards are supported by the Welsh Health Specialist Services Committee (WHSSC), which commissions specialist cancer services on their behalf.

3.13 The four Health Boards in South-East Wales served by Velindre Cancer Centre are:

- Aneurin Bevan University Health Board;
- Cardiff and Vale University Health Board;
- Cwm Taf Morgannwg University Health Board; and
- Powys Teaching Health Board.

3.14 The Health Boards also work in partnership with the Wales Cancer Network, NHS Trusts, Community Health Councils, Voluntary Organisations and Public Health Wales.

Regional Leadership and Collaboration of Cancer Services in South-East Wales

3.15 In 2019, the four South-East Wales Health Boards listed above and Velindre University NHS Trust, in conjunction with other stakeholders including Public

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Health Wales and the Wales Cancer Network (WCN), established the South-East Wales Collaborative Cancer Leadership Group (CCLG).

3.16 The CCLG oversees Collaborative Cancer Programmes across the South-East Wales region, providing leadership and coordination with a focus on benefit delivery for patients. Thus, putting into practice, the national policies, standards and procedures for the benefit of patients. The CCLG functions at a regional level in support of the work of the Wales Cancer Network and other partner organisations.

The Cancer Pathway

3.17 The delivery of cancer services across Wales is set out in a well-defined pathway of care which includes the five key stages outlined below in Table 8.

3.18 The approach is also consistent with the National Optimal Pathways (NOPs) developed by the Wales Cancer Network through their multidisciplinary Cancer Site Groups. The NOPs set out what should happen according to professional guidance and standards for any patient in Wales presenting with a certain type of cancer through their cancer pathways.

3.19 The NOPs are available in Welsh Health Circular (2022) 021.

Table 8 – The National Cancer Pathway Described

Cancer Prevention: Enhancing public awareness and education to make informed decisions about lifestyle choices that promote a healthy, cancer free population.
Cancer Diagnosis: Cancer can be identified through a National Screening Programme or where cancer symptoms are identified by the patient/health care professional. If cancer is suspected the patient is assessed by a multi-disciplinary team in the Health Board (often supported by Velindre Cancer Centre staff) and cancer may be diagnosed.
Treatment: The treatment options for every patient are discussed and considered by multi-disciplinary teams (MDTs). The treatment options include surgery, non-surgical treatment e.g., Radiotherapy or Systemic Anti-Cancer Therapy (SACT), a combination of these treatments and supportive care. Care often straddles organisational boundaries.
Recovery/Follow Up: Regular follow up appointments are important to monitor recovery, manage and reduce the aftereffects of treatment and to ensure any signs of cancer relapse/recurrence are identified at their earliest stage.
End of Life Care: Sadly, not all patients survive cancer – openness about the need to plan end of life care is essential. A focus on living and dying well, early identification of needs and access to fast, effective palliation are important to reduce distress for both the patient and their family.

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Service Delivery Arrangements

3.20 The Trust delivers specialist non-surgical cancer services to a catchment population of 1.5 million people using a hub and spoke service model. Services are currently provided across South-East Wales from:

- **Velindre Cancer Centre:** The hub of the Trust's tertiary cancer services is a specialist treatment, training, research and development centre for non-surgical oncology; and

- **Outreach Centres:** Some services are delivered on an outreach basis within facilities across South-East Wales, including District General Hospitals and from patients' own homes.

3.21 Patients are referred to Velindre Cancer Centre for treatment by the following routes:

- Following referral by a GP to the relevant HB; or

- Following presentation as an emergency at an A&E department.

3.22 Prior to referral to Velindre Cancer Centre, all patients will have been investigated and diagnosed with a solid tumour. Some patients may have already undergone surgery. Velindre Cancer Centre's role is to deliver specialist and tertiary cancer treatment until the patient can be referred back to their host HB for ongoing treatment, management, and follow-up.

3.23 An overview of the core services delivered by the Trust at the Velindre Cancer Centre and the existing functional capacity of the Centre to deliver these services (e.g., number of inpatient beds), is provided in Table 9 overleaf.

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Table 9 – Existing Functional Capacity

Service	Overview	Velindre Cancer Centre	Functional Content (February 2020 Pre-COVID)
Outpatients	• Outpatient services include consultation, examination, follow-up, SACT assessment, phlebotomy, psychology, clinical trials, therapy services and specialist palliative care.	• Outpatient clinics are held five days a week. • Outpatient clinics are distributed across morning and afternoon sessions (2 sessions a day).	• Velindre Cancer Centre has 26 Outpatient consultation rooms.
Radiotherapy	• Radiotherapy services include radical, palliative and emergency planning and treatment, brachytherapy, chemo-radiotherapy and radiotherapy research.	• The radiotherapy service provides core services for 9.5 hours per day, 5 days per week. • The service provides an emergency service at weekends.	• Velindre Cancer Centre has 8 Linear Accelerators (Linacs).
Systemic Anti-Cancer Therapies	• SACT services cover a range of biological therapies and cytotoxic chemotherapies. • SACT services include: o Intravenous, oral and subcutaneous treatments; o Research including early and late phase trials; and o Stratified, targeted and personalised treatments and vaccine therapies.	• The SACT service operates Monday to Friday between 08:00 – 18:00 hrs.	• Velindre Cancer Centre has 19 SACT chairs across two units.

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Service	Overview	Velindre Cancer Centre	Functional Content (February 2020 Pre-COVID)
Inpatients	• Inpatient services cover elective and non-elective admissions including: o Elective SACT admissions; o Toxicity management of SACT; o Outpatients requiring hydration prior to treatment; and o Patients receiving Radiotherapy and SACT treatments.	• The inpatient service operates a 7 day/24-hour service.	• Velindre Cancer Centre has 47 Inpatient beds and 2 isolation beds.

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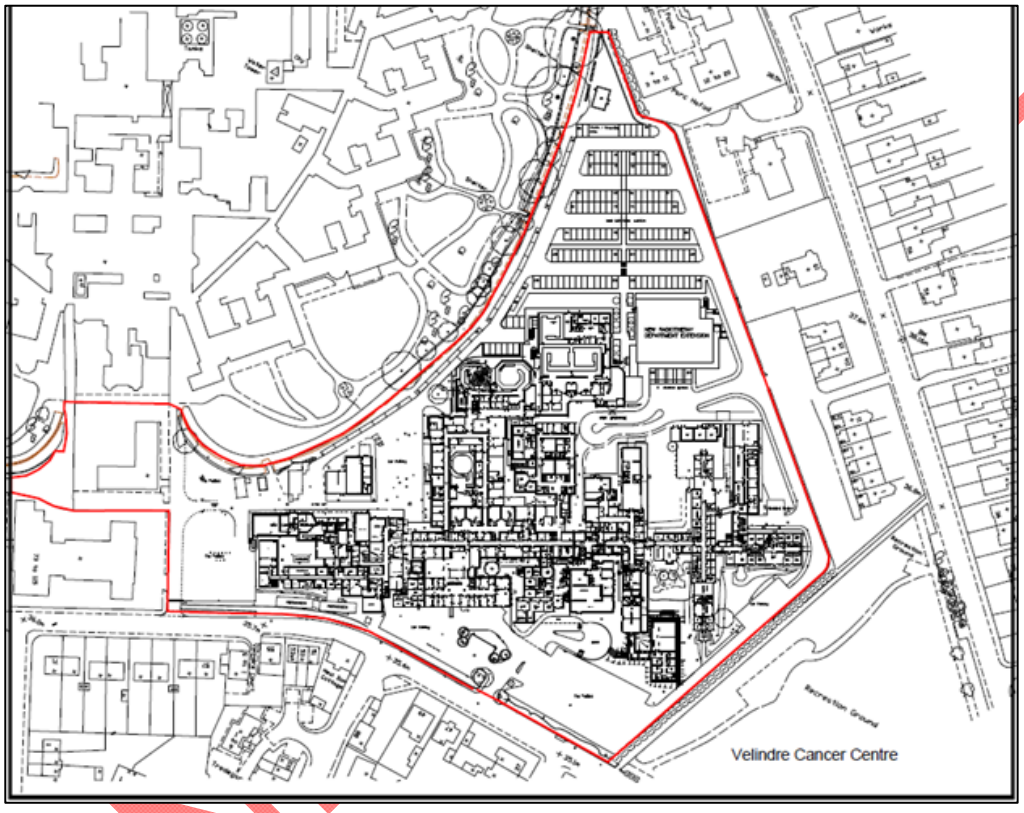
Velindre Cancer Centre Infrastructure

3.24 Velindre Cancer Centre was built in 1956 and in the intervening period has been subject to extension and redevelopment. It consists of traditional build, single and two storey accommodation. The current site plan is provided below in Figure 6.

Figure 6 – Current Velindre Cancer Centre Site Plan



3.25 Approximately 30% of the estate pre-dates 1964 in terms of its construction. This is evident in the value of current backlog maintenance recently recorded in all Wales Estate Facilities Performance Management System (EFPMS). The definition of condition in terms of backlog can be identified as:

- **Condition A:** as new and can be expected to perform adequately to its full normal life;
- **Condition B:** sound, operationally safe and exhibits only minor deterioration;
- **Condition C:** operational but major repair or replacement is currently needed to bring up to condition B;
- **Condition D:** operationally unsound and in imminent danger of breakdown; and
- **Condition X:** supplementary rating added to C or D to indicate that it is impossible to improve without replacement.

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3.26 Tables 10 & 11 below set out the backlog maintenance estimated as of April 2020.

Table 10 – Backlog Maintenance Position (as at April 2020)

Measure	Unit	Value
Cost to eradicate High Risk Backlog	£	85,013
Cost to eradicate Significant Risk Backlog	£	1,623,329
Cost to eradicate Moderate Risk Backlog	£	4,740,688
Cost to eradicate Low Risk Backlog	£	2,496,082
Risk Adjusted Backlog Cost	£	1,875,521
Cost to achieve Physical Condition B	£	1,257,583
Cost to achieve Statutory Health and Safety Compliance Standard B	£	113,121
Cost to achieve Fire Safety Compliance Standard B	£	98,632
Total	**£**	**12,289,969**

Table 11 – Backlog Maintenance Position – Percentage of patient occupied floor area (as at April 2020)

Measure	Unit	Value
Percentage of total occupied floor area in physical condition C plus D	%	35
Percentage of patient occupied floor area not in Statutory Health and Safety compliance	%	5
Percentage of patient occupied floor area not in Statutory Fire Safety compliance	%	5

3.27 From the previous EFPMS submission, the cost to eradicate high risk and significant risk backlog has decreased. This is due to the moderate capital investment associated with water infrastructure at the Velindre Cancer Centre.

3.28 Over 90% of the Estate fire safety is being managed within category B, a very similar position as the previous year. Risk Adjusted Backlog has also shown a small decrease, since 2015/16. It must be stated that the overall condition of the building is condition B. However, space availability and site restrictions prevent future investment from achieving spatial compliance or functional suitability without considerable investment and disruption to the existing facilities and surrounding community.

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3.29 To achieve and maintain overall Physical Condition B investment has increased from £0.735m in 2012/13 to £1.3m in 2020-21. This represents a 71% increase over this time frame.

3.30 Table 12 below provides an overview of the asset profile for the current Velindre Cancer Centre. This demonstrates that there has been little modernisation in the existing infrastructure over recent years. This has led to a reduction in the quality of the patient environment and subsequently in the overall patient experience.

Table 12 - Overview of the Asset Profile

Age and Asset Profile	%
Age Profile – 2005 to present	14
Age Profile – 1995 to 2004	18
Age Profile – 1985 to 1994	22
Age Profile – 1975 to 1984	6
Age Profile – 1965 to 1974	12
Age Profile – 1955 to 1964	29
Age Profile – 1948 to 1954	0
Age Profile – pre 1948	0

Velindre Cancer Centre Footprint

3.31 The existing Velindre Cancer Centre has a footprint of approximately 18,000m2. A breakdown of the space necessary to deliver services is summarised in Table 13 below:

Table 13 – Existing Velindre Cancer Centre Footprint (February 2020 Pre-COVID)

Functional Area	m^2
Radiotherapy	5,126
Inpatients	1,879
SACT & Ambulatory Care	1,024
Outpatients & Therapies	1,280
Imaging and Nuclear Medicine	1,069
Pharmacy	637
Hospital Clinical / Non-Clinical Administration & Support Services	4,369
Hospital Education, Training and Associated Support Services	349
IM&T	144

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Functional Area	m^2
SPR & On Call	12
Staff Facilities	299
Mortuary	47
Catering & Restaurant	377
Hospital Main Entrance	581
Central FM Areas	583
Total Gross	**17,777**

Existing Major Medical Equipment

3.32 The delivery of non-surgical cancer services is dependent upon having access to a range of major medical equipment – this is essential to support the safe and effective delivery of patient care. All major medical equipment which is currently operational at the Velindre Cancer Centre, and which has a unit value of over £0.125m (excl. VAT), is summarised in Table 14 below.

Table 14 – Summary of Major Medical Equipment – Existing Cancer Centre

Department	Equipment	Total
Radiotherapy	Linear Accelerators	8
Radiotherapy	CT Simulators	2
Radiotherapy	Brachytherapy System	1
Radiology	MRI Scanner	1
Radiology	CT Scanner	1
Radiology	Imaging Systems (Plain Film/Fluoroscopy System)	2
Nuclear Medicine	Gamma Camera	1

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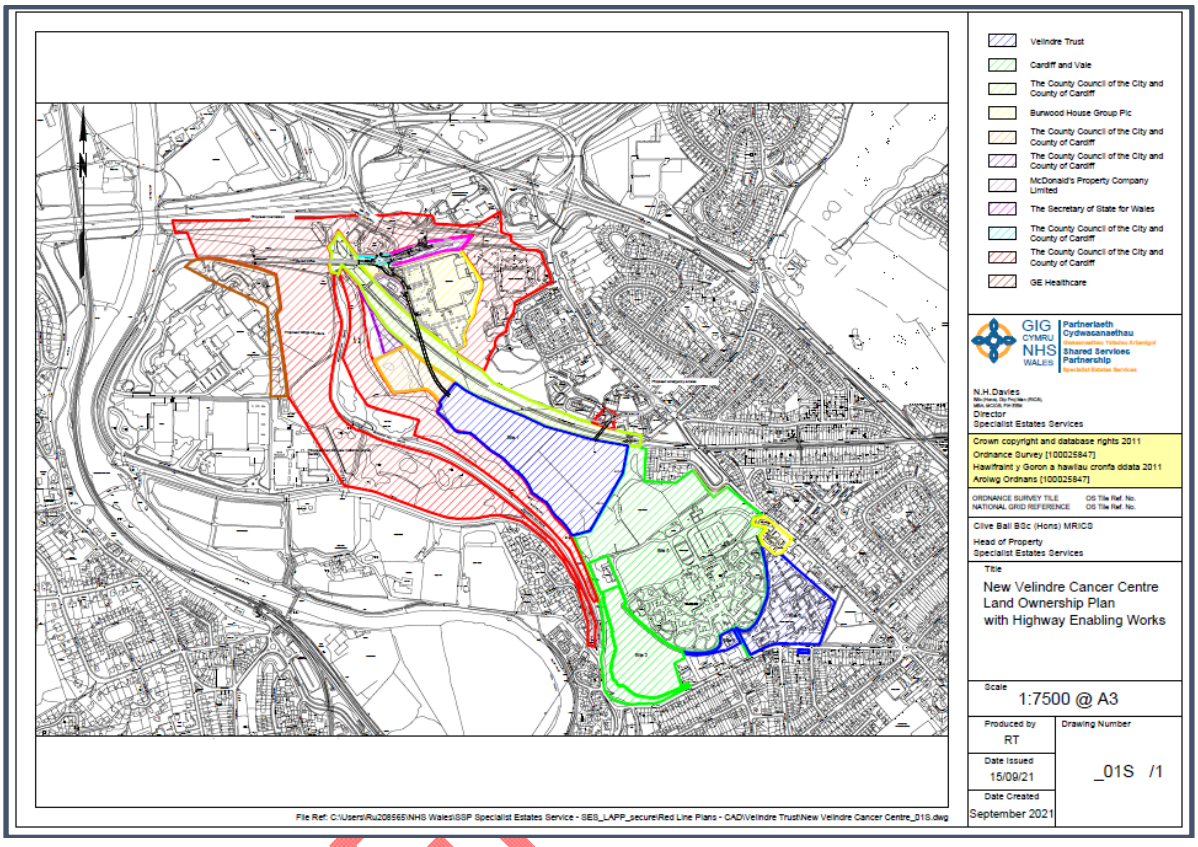
Existing Land Ownership

3.33 The current land ownership arrangements are set down overleaf in Figure 7:

Figure 7 – Current Land Ownership Plan



3.34 The land owned by the Trust is identified in the map above (in blue). It consists of the land transferred from Cardiff and Vale University Health Board (CVUHB) in April 2021 which is the development site for the nVCC and land used by the current Velindre Cancer Centre. The existing VCC site will be decommissioned once the nVCC is operational and the ownership of this land will be transferred to CVUHB.

3.35 The land owned by CVUHB is identified in the map (in green) above and contains the non-operational Whitchurch Hospital site. In addition, the Trust has developed a letter of comfort with CVUHB for a southern emergency and ancillary access being provided to the nVCC site via the Whitchurch Hospital site.

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4 CASE FOR CHANGE

Introduction

4.1 This section of the FBC establishes the case for change for the development of a new Velindre Cancer Centre by:

- Outlining and reaffirming the Project Spending Objectives (PSOs) which provided a basis for appraising potential options and for post-project evaluation; and,

- Providing a clear understanding of the business needs (what is required to close the gap between existing arrangements and what is required in the future). A key aspect will be the 'rightsizing' of the new Velindre Cancer Centre.

Project Spending Objectives

4.2 The following nVCC Project Spending Objectives (PSOs) were developed in partnership at a stakeholder workshop, which was attended by representatives with a broad range of service views. In presenting the nVCC PSOs it is important to emphasise that:

- The scope of the FBC is limited to the replacement of the existing VCC with a new VCC; and

- The FBC for the new VCC will focus only on the additional infrastructure costs directly attributable to the nVCC. The rationale is, that variable workforce costs as a result of modelled demand is a cost pressure that will need to be addressed irrespective of the decision on the replacement of the VCC and can be taken forward with Commissioners as part of the Long-Term Agreement (LTA) commissioning framework.

4.3 Table 15 overleaf sets out the agreed project spending objectives that have been reaffirmed and revalidated as part of the development of this FBC.

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Table 15 – Project Spending Objectives

Project Spending Objective	Description
Project Spending Objective 1	**To build a new hospital that supports quality and safe services.**
Project Spending Objective 2	**To provide sufficient capacity to meet future demand for services.**
Project Spending Objective 3	To **improve patient, carer** and **staff experience.**
Project Spending Objective 4	To provide **capacity** and **facilities** to support the delivery of high-quality **education**, **research**, **technology** and **innovation.**

4.4 The PSOs were approved by the nVCC Project Board who provided assurance to the Trust Board that they were:

- Aligned with the national context for healthcare developments in Wales;
- Aligned with the scope and strategic context of the nVCC Project;
- Specific, measurable, achievable relevant and time-constrained (SMART); and
- Focused on business needs and vital outcomes rather than potential solutions.

4.5 The PSOs were subsequently shared and agreed with Welsh Government officers.

Performance Metrics

4.6 To support the delivery of these objectives a number of key performance metrics have been developed and mapped against the five drivers for investment outlined within the Welsh Governments Business Case guidance. These are set out in Table 16 overleaf.

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Table 16 – nVCC OBC Project Spending Objectives – Key Performance Metrics

Project Spending Objective	Performance Metrics
PSO1 – To build a new hospital that supports **quality** and **safe** services	• Number of Velindre Acquired Healthcare Associated Infections • Percentage compliance with Health Building Notes • Compliance assessment against BREAM • Percentage assessment against WHTM Estate Code (Category A Condition of Buildings)
PSO2 – To provide sufficient **capacity** to meet future **demand** for services	• Percentage of patients receiving radical radiotherapy treated within 28 Days • Percentage of patients receiving palliative radiotherapy treated within 14 Days • Percentage of patients receiving emergency radiotherapy treated within 2 Days • Percentage of non-emergency chemotherapy patients treated within 21 Days • Percentage of urgent therapies outpatients seen within 2 Weeks • Percentage utilisation of equipment / accommodation: o Linear accelerator utilisation o SACT chair utilisation o Inpatient bed utilisation o Non-clinical accommodation utilisation
PSO3 – To **improve patient, carer** and **staff experience**	• Percentage of patients rating their experience as excellent • Distance (m2) between key clinical functions • Percentage staff satisfaction • Percentage recruitment of workforce • Percentage retention of workforce
PSO4 – To provide **capacity** and **facilities** to support the delivery of high-quality **education**, **research**, **technology** and **innovation**	• Percentage of patients who have the opportunity to participate in clinical research trials at VCC • Percentage of VCC Site Specific Teams (SSTs) to include national or international leaders • Percentage of patients recruited into interventional clinical trials for each cancer site • Percentage of patients for each cancer site entered into clinical trials each year • Percentage of clinical trials sponsored by VCC • Percentage of portfolio trials who have a VCC chief investigator

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5 BUSINESS NEEDS

5.1 There are a range of business needs which this FBC seeks investment to address. These are set out below and tend to fall into two main areas. These are:

a) The current VCC infrastructure deficiencies relating to an aging estate and its constraints on service delivery, future expansion and backlog maintenance.

b) The inability of the existing VCC to fulfill future anticipated activity increases and confirmation of the appropriate sizing of the nVCC.

Infrastructure Deficiencies: Overview

5.2 Velindre is widely acknowledged as providing high quality, patient focussed cancer services through a compassionate and caring culture where staff consistently go the 'extra mile' to meet the needs of patients.

5.3 However, the current Velindre Cancer Centre infrastructure is making it increasingly difficult to maintain this high standard of care, particularly in relation to patient and staff safety and welfare, and in patient privacy and dignity. The following section of the FBC focuses on the deficiencies of the existing Velindre Cancer Centre and the key factors influencing the need to replace the existing Velindre Cancer Centre.

The Existing Patient Environment at the Velindre Cancer Centre is Sub-optimal and does not Promote Patient Recovery and Well Being

5.4 It is widely recognised that the physical environment at the Velindre Cancer Centre is not fit-for-purpose and is not appropriate for providing high quality, patient centre services.

5.5 The current estate has also been extensively developed over its lifecycle. This has been in incremental fashion and without a 'development control plan'. This has left the Velindre Cancer Centre with a number of 'add-ons' leading to deficiencies in circulation and service adjacencies, which are not consistent with current health care design standards and efficient means of patient care. For example, Figure 8 overleaf illustrates the current poor adjacency between the current pharmacy and outpatient's department. These would ideally be immediately adjacent to each other.

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Figure 8 – Example of a Typical Inefficient and Inconvenient Patient Journey within the Outpatients Department at the Velindre Cancer Centre

5.6 The example provided, which is replicated across the hospital, shows that:

- There is no separation between patients, visitors, staff and external workers;
- There are multiple crossovers in terms of the movement of patients, visitors, staff and goods. This provides a poor patient and visitor experience, is inefficient for staff and provides a potential safety risk;
- The adjacencies of services are inappropriately located, and this results in poor service flow and workforce inefficiencies;
- The locations of those services, which a patient may need to access, are sub-optimal. Patients are required to make multiple journeys to access such services e.g., to be weighed, and
- The main entrance to the outpatient department is located immediately outside a doctor's consultation room.

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5.7 Examples of the infrastructure deficiencies across the Velindre Cancer Centre estate are provided from Figure 9 through to Figure 11 below.

Figure 9 – Example of Narrow Circulation Space

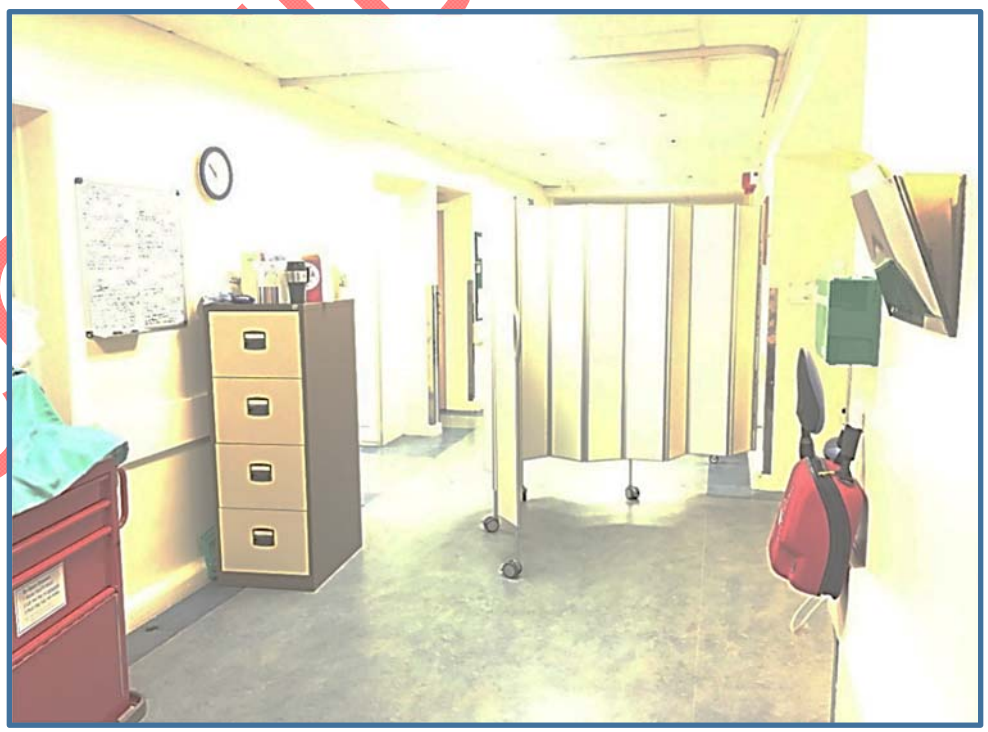

Figure 10 – Example of Crossover of Patient and Working Areas

Figure 11 – Example of Cramped Support Accommodation

A High Proportion of the Accommodation at the Existing Velindre Cancer Centre is Non-Compliant with Statutory Requirements

5.8 If the Velindre Cancer Centre is to maintain standards for the longer term, it will not only need the major arteries of infrastructure to be upgraded and/or replaced, but also the secondary, more localised infrastructure. There are many risks associated with these works. Phasing, decant and isolation issues will have a major impact on patient care and experience. With limited space, decant facilities are not guaranteed to be on the Velindre Cancer Centre site.

5.9 The performance in terms of functional suitability and space utilisation has generally been maintained at status quo over the last three years. However, this does not identify key areas of concern in relation to non-compliance against Health Building Notes (HBN).

5.10 It is evidenced that approximately 75% of the existing estate does not comply with current space standards. As an example, existing outpatient consultation rooms range from as low as 9m² compared to guidance, which identifies a 16m² requirement.

5.11 To demonstrate and evidence the high-level 'non-compliance' of the existing Velindre Cancer Centre, the Trust undertook a comparative sizing exercise. This involved comparing the current hospital footprint against the required footprint for a new hospital as if it was built in compliance with HBNs and current relevant standards. This analysis showed that the footprint of the existing Velindre Cancer Centre would increase from the current footprint of

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17,777m2 to circa 28,000m2 if it was built today on a 'like for like' basis i.e. same functional content number of inpatient beds.

5.12 This analysis, which is summarised in Table 17, has been presented to, and validated by, NHS Wales Shared Services and WG Officers.

Table 17 – Comparison of the Existing Velindre Cancer Centre Footprint versus a New Build Velindre Cancer Centre on an Equivalent Basis

Functional Area	Current VCC (m^2)	VCC built 'in line' with HBNs
Radiotherapy	5,126	8,046
Inpatients	1,879	3,183
SACT & Ambulatory Care	1,024	1,873
Outpatients & Therapies	1,280	1,720
Imaging and Nuclear Medicine	1,069	1,840
Pharmacy	637	1,106
Hospital Clinical / Non-Clinical Administration & Support Services	4,369	4,491
Hospital Education, Training and associated Support Services	349	497
IM&T	144	439
SPR & On Call	12	91
Staff Facilities	299	891
Mortuary	47	171
Catering & Restaurant	377	1,022
Hospital Main Entrance	581	1,380
Central FM Areas	583	1,360
Total Gross	**17,777**	**28,110**

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External Site Constraints

5.13 Another major challenge for the Velindre Cancer Centre site relates to car parking. Table 18 overleaf identifies the current allocation of parking 'on site'.

Table 18 – Parking Arrangements (as at February 2020 Pre-COVID)

Type of Parking Space	No of spaces
Visitor/patients spaces	165
Emergency vehicle parking spaces	4
Visitor Cycle parking	10
Staff parking spaces	176
Consultant parking spaces	25
Staff Cycle parking	25
Total	**405**

5.14 The Trust undertook a traffic analysis. This demonstrated that the Trust has a significant shortfall in the availability of both patient and staff car parking today which is further compounded by the predicted number of patients expected over the coming years.

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Summary – Infrastructure Deficiencies

5.15 In summary, the main physical challenges related to the patient environment include the following:

- 100% of the current inpatient accommodation is well below the required standard for modern healthcare.
- There is no overnight accommodation available for families and visitors.
- The majority of circulation routes are too narrow for the volume of traffic and patients and staff/families have to stand tight to the wall in the main corridor if a trolley or wheelchair is passing, as there is insufficient room for two-way traffic.
- Patients, staff and services have to cover large distances due to the poor adjacencies that have resulted from piecemeal design and developments e.g., the pharmacy department at the furthest point away from the outpatient's department.
- The main outpatient reception area is located in direct visual line with a vast number of consultant rooms leading to privacy issues during consultation/treatment.
- The relatively short distances between patient waiting areas and clinical areas presents difficulties when communicating sensitive or confidential information.
- The hot and cold-water infrastructure across the estate is insufficient and there is no spare capacity to accommodate any increases in demand for services.
- The current backup power generation resilience of the site is insufficient and only covers approximately 55% of the site, mainly clinical areas, but excluding the Linac treatment machines.
- The existing working environment often causes staff to make compromises as they deliver care. For example, using smaller hoists in patient rooms due to the limited space.

5.16 The facilities also present a range of challenges for patients and families:

- The facilities do not always provide patients with their basic and fundamental needs e.g., the showers on the 1st floor ward are shared.
- Patient dignity is compromised due to the lack of space and privacy for inpatients. For example, there is little space between beds on the first floor. There is a similar picture for outpatients where the design of the consulting rooms does not allow for total privacy.
- The majority of the inpatient, outpatient and therapies environment is not synonymous with a Cancer Centre that supports well-being and healing.

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- There is insufficient car parking This results in patients having long waits on occasions trying to find a space to park. This causes additional stress during what can already be a challenging time for patients and families and at worst can result in patients being late for their appointments.

Forecasting Future Activity, Actual Activity, and links to our Service Design

5.17 This section of the Strategic Case concentrates on the methodology used to determine the future forecasting of activity and how this has informed the design of the nVCC and our Clinical Operating Model. The section will set out:

- the methodology which has been applied for forecasting future activity and capacity requirements in relation to the new Velindre Cancer Centre (nVCC)
- Summarise the forecast activity and capacity requirements for the new Velindre Cancer Centre.

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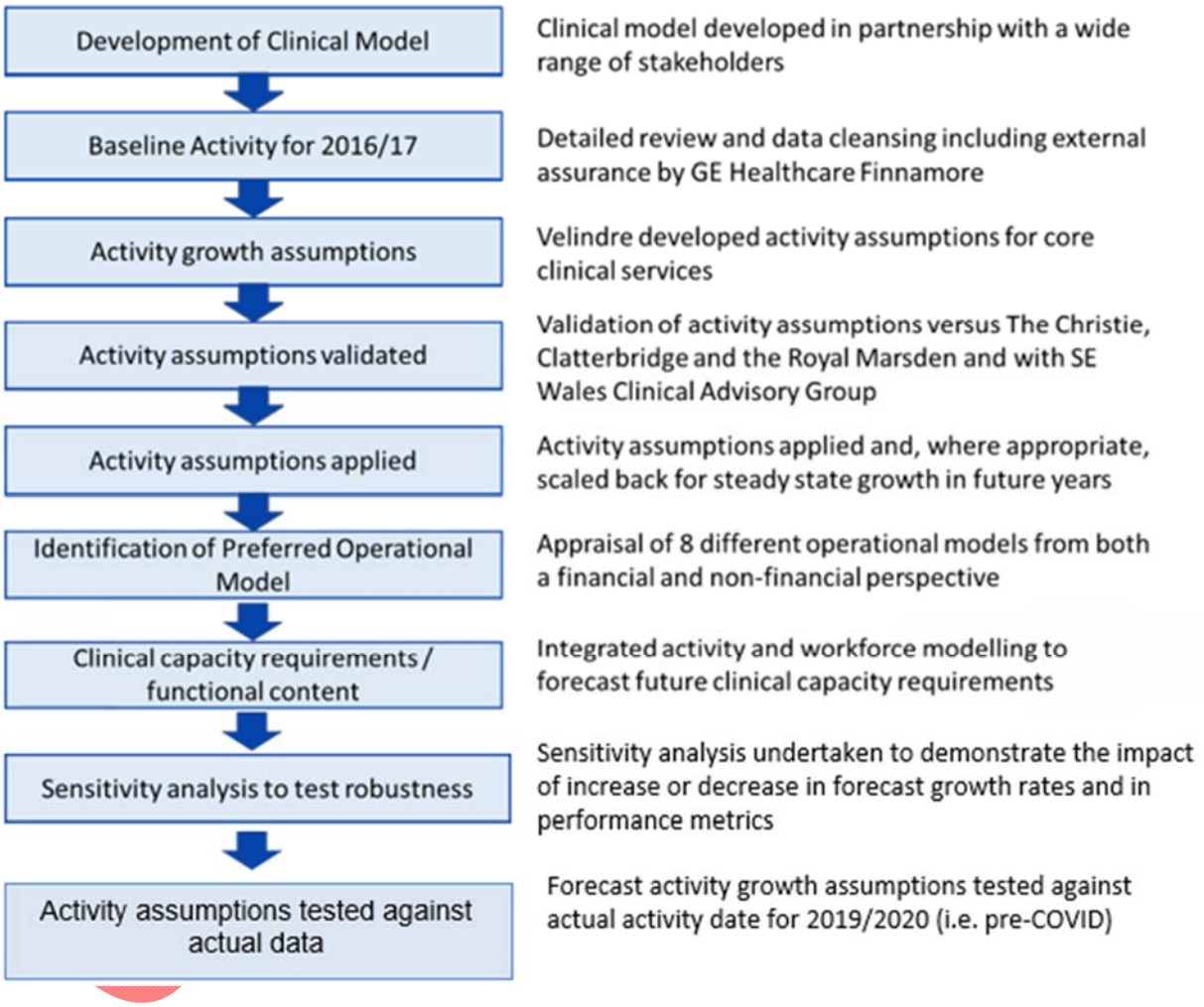
Forecasting Future Activity and Capacity Requirements

5.18 The Trust has developed a comprehensive activity model to forecast future capacity requirements for the nVCC.

5.19 A summary of the process followed in forecasting future activity and capacity requirements is shown in Figure 12 below. This methodology was approved by the nVCC OBC Collaborative Scrutiny Group and remains relevant for FBC purposes.

Figure 12 - Methodology for Forecasting Future Capacity Requirements



Note: *the final step shown above was completed subsequent to the approval of this methodology with the purpose of providing assurance that the capacity outputs detailed within the OBC are still valid*

Activity Assumptions

5.20 The Trust developed a set of activity assumptions for its core services. These clinical growth assumptions were developed in partnership with clinical colleagues from across South-East Wales and were informed by cancer incidence projections provided by the Welsh Cancer Intelligence and Surveillance Unit (WCISU).

5.21 The activity assumptions were set across two-time frames. The first time frame was through to 2021/22 where the Trust, and Health Board colleagues, believed it had a fair degree of certainty in terms of forecasting future activity. The second timeframe was from 2022/23 - 2031/32 where there was, at the time of developing the OBC, less certainty when forecasting future demand (e.g., stratified approach for SACT versus greater incidence of cancer) and the Trust therefore opted to revert to the forecast incidence of cancer (2%) as provided by WCISU in 2016/17 and reconfirmed as a valid planning assumption in 2022/23.

5.22 The clinical growth assumptions were supported by Health Board cancer clinical leads and were agreed by Health Board's Officers as part of the nVCC OBC Collaborative Scrutiny process, they are set out below in Table 19 below.

Table 19 - Clinical Growth Assumptions for Core Services

Service	Annual Clinical Growth Assumption
	2016/17 - 2022/23
▪ Radiotherapy	2%
▪ SACT	5%
▪ Inpatients	2%
▪ Outpatients and Ambulatory Care	2%

5.23 In addition, a validation exercise was undertaken to compare the Trust's activity assumptions against the following Cancer Centres from across the UK:

- The Beatson West of Scotland Cancer Centre
- The Clatterbridge Cancer Centre NHS Foundation Trust
- The Christie Cancer NHS Foundation Trust
- Leeds Teaching Hospital NHS Trust
- The Royal Marsden NHS Foundation Trust.

5.24 The validation exercise demonstrated that the Trust's activity assumptions were in line with those from other Cancer Centres across the UK, where comparable data was available.

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Clinical Operational Model

5.25 The Trust evaluated a number of different operational models which were subsequently approved by the Trust's commissioners and as previously stated and have been subject to external independent assurance by the Nuffield Trust.

5.26 The primary objective of this appraisal was to identify a model which could provide the sufficient levels of service capacity, which responded to the needs of patients and families and which made effective and efficient use of resources.

5.27 At OBC eight different operating scenarios were evaluated by a multidisciplinary group, including the current operational model. The different scenarios considered extended working hours as well as five, six and seven day operational models. The outcome of the options appraisal has then informed the requirement for the new Velindre Cancer Centre and were tested during the competitive dialogue process, which has led to the final design.

5.28 The assessment undertaken was based upon:

- A non-financial assessment of options against the Projects Spending Objectives and Critical Success Factors
- A financial (capital and revenue) assessment of options.

5.29 The preferred operating scenario (Scenario 8) scored the highest based on a combined non-financial and financial score. This scenario included the following components for core patient services:

- **Radiotherapy service** - 5 days a week, 9.5 hours a day (7-day Radiotherapy service for category 1 emergency patients and for urgent palliative patients).
- **Outpatient service** – 5 days a week, 2 sessions a day
- **SACT service** – 5 days a week, 12 hours a day
- **Inpatient service** – 7 days a week, 24 hours a day.

5.30 Once the preferred operating scenario was agreed the Trust developed its Clinical Operating Model which has already been set out in the Section 3 of this Strategic Case.

5.31 In parallel the Trust has undertook a detailed analysis to understand where treatments should be best delivered and what the percentage split should be, this is set out in Table 20 overleaf.

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Table 20 - Percentage Activity Delivered by Location

Service	VCC	Outreach	Home
Radiotherapy	80%	20%	0%
SACT	45%	45%	10%
Inpatients	100%	0%	0%
Outpatients	55%	35%	10%

5.32 This section now further explores the clinical growth assumptions by service area for; Radiotherapy, Systemic Anti-Cancer Therapies, Outpatients and Ambulatory Care and Inpatients. It sets out the growth assumptions and compares these with actual activity since the OBC to ensure there still remains good alignment.

Radiotherapy Service

Clinical Growth Assumption:

5.33 In line with the methodology, outlined in Table 19 above, the forecast clinical growth assumption for radiotherapy services was 2% from 2016/17 through to 2022/23. This was agreed and approved by all commissioning Health Boards as part of the nVCC OBC Collaborative Scrutiny process and set out in Table 21 below:

Table 21 - Radiotherapy Growth Assumption

Service	OBC Annual Clinical Growth Assumption
	2016/17 - 2022/23
Radiotherapy	2%

Actual Radiotherapy Activity Versus 2% Growth Assumption (2019 comparison (pre-COVID)):

5.34 Using our most recent full-year 'pre-COVID' data (2019) this demonstrates that actual radiotherapy activity (fractions) delivered supports our original baseline planning assumption of a 2% increase in activity year-on-year with a variance of less than 1% over the three-year time period. This provides a high level of assurance that the physical capacity (number of linacs) planned within the nVCC is appropriate based upon actual activity recorded post the submission of the nVCC OBC, this figure does not take into account the increasing complexity of Radiotherapy Treatments. The actual and forecasted figures are set in Table 22 overleaf.

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Table 22 - Forecast v Actual RT Activity

Service	Activity Measure	2016/17 (baseline)	Forecast 2019/20	Actual 2019/20	Difference (total / %)
Radiotherapy	Fractions	51,915	55,092	54,899	193 (≤1%)

5.35 The forecast and actual fractions set out in Table 22 above generate a requirement of the following numbers of Linear Accelerators, set out in Table 23 below and these numbers are accommodated in the nVCC design.

Table 23 - Linac Requirement Based on Activity

Service	Description	2016/17 (baseline)	2025/26 (nVCC)
Radiotherapy	Linacs	**8**	**8**

Note: The implementation of the Radiotherapy Satellite Centre (RSC) at Nevill Hall will also provide 2 additional linacs in the community i.e., 20% of total activity.

Actual Radiotherapy Activity (COVID) / Forecast Radiotherapy Activity (Post-COVID):

5.36 Table 24 below sets out actual radiotherapy activity post COVID-19 pandemic.

Table 24 - Post COVID Activity

Service	Activity Measure	Actual 2019/20	Actual 2020/21	Actual 2021/22	Current % increase in 2022/23 (ytd)	Forecast increase in 2023/24
Radiotherapy	Fractions	54,899	36,861	40,507	8%	6%

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5.37 The COVID-19 pandemic, commencing in March 2020, caused a significant fall in radiotherapy activity due to a number of factors including:

- Reduced presentations to GP's
- Reduced LHB referrals
- Disruption to routine screening, and
- Reduced capacity due to social distancing, increased infection control procedures and reduced workforce to deliver services.

5.38 However, actual demand for radiotherapy has increased significantly since March 2021 (circa 10% year-on-year) and is expected to continue to increase over the next year(s).

Radiotherapy Summary and Conclusion

Key Points:

- The 2% activity growth assumption, included within the nVCC OBC, has been reviewed at FBC and id supported by actual activity up to 2019/2020.
- Based upon forecast activity, tested against actual activity to 2019/20, there is an appropriate number of linacs included within the nVCC FBC to meet service demand. This will ensure that the Trust has capacity to meet all relevant performance targets.
- The implementation of the Radiotherapy Satellite Centre (RSC) at Nevill Hall will also enable the achievement of the TCS planning assumption i.e., 80% of activity delivered at nVCC and 20% in the community.

Systematic Anti-Cancer Therapies (SACT)

Clinical Growth Assumption:

5.39 In line with the methodology, outlined in Table 19, the forecast clinical growth assumption for SACT services was 5% from 2016/17 through to 2022/23, noted in Table 25 below. This was agreed and approved by all commissioning Health Boards as part of the nVCC OBC Collaborative Scrutiny process.

Table 25 - SACT Clinical Growth Assumption

Service	OBC Annual Clinical Growth Assumption
	2016/17 - 2022/23
SACT	5%

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Actual SACT Activity Versus 5% Growth Assumption (2019 comparison (pre-COVID)):

5.40 Using our most recent full-year 'pre-COVID' data (2019) demonstrates that actual SACT activity (attendances) delivered supports our original baseline planning assumption of a 5% increase in activity year-on-year with a variance of less than 1% over the three year time period. This provides a high level of assurance that the physical capacity (number of SACT chairs) planned within the nVCC is appropriate based upon actual activity recorded post the submission of the nVCC OBC. The SACT attendances are set out in Table 26 below:

Table 26 - Actual SACT Activity v Growth Assumption

Service	Activity Measure	2016 (baseline)	Forecast 2019	Actual 2019	Difference (total / %)
SACT	Attendances	22,685	26,107	26,282	175 (≤1%)

Forecast Capacity Requirements at the New Velindre Cancer Centre

5.41 The forecast and actual activity set out in Table 26 above generates a requirement of the following numbers of Linear SACT Chairs as set out in Table 27 below.

Table 27 - SACT Chair Requirements nVCC

Service	Description	2016/17 (baseline)	2021/22	2025/26 (nVCC)
SACT	Chairs	17	19	20

Note: *Implementation of the SACT Clinical Operating Model, as outlined in Table 20, will result in 55% of total activity being delivered across South-East Wales.*

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Actual SACT Activity (COVID) / Forecast SACT Activity (Post-COVID):

5.42 The Covid-19 pandemic, commencing in March 2020, caused a significant fall in activity for SACT due to a number of factors, including:

- Reduced presentations to GP's
- Reduced LHB referrals
- Disruption to routine screening, and
- Reduced capacity due to social distancing, increased infection control procedures and reduced workforce to deliver services.

5.43 However, actual demand for SACT services has increased significantly since March 2021, and is expected to continue to climb over the next year(s), and, in line with our forecast growth assumption of 5% through to 2022 and 2% thereafter (Note – not flat line - 'ups and downs'), as set out in Table 28 below.

Table 28 - SACT activity

Service	Activity Measure	Actual 2019	Actual 2020	Actual 2021	Actual 2022	Forecast increase in 2023/24
SACT	Attendances	26,107	20,618	26,001	29,121	6%

Summary and Conclusion:

Key Points:

- The 5% activity growth assumption, included within the nVCC OBC, has been supported by actual activity up to 2019/2020.
- Based upon forecast activity, tested against actual activity though to 2019/20, there is an appropriate number of SACT chairs included within the nVCC FBC to meet service demand. This will ensure that the Trust has capacity to meet all relevant performance targets.
- The implementation of the SACT Clinical Service Model will result in 55% of total activity being delivered across South-East Wales.

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Outpatients and Ambulatory Care

Clinical Growth Assumption:

5.44 In line with the methodology, outlined in Table 19, the forecast clinical growth assumption for Outpatient services was 2% from 2016/17 through to 2022/23. This was agreed and approved by all commissioning Health Boards as part of the nVCC OBC Collaborative Scrutiny process and is set out in Table 29 below.

Table 29 - Outpatients Growth Assumption

Service	OBC Annual Clinical Growth Assumption
	2016/17 - 2022/23
Outpatients and Ambulatory Care	2%

Actual Outpatient Activity Versus 2% Growth Assumption (2019 comparison (pre-COVID)):

5.45 Using our most recent full-year 'pre-COVID' data (2019) demonstrates that actual Outpatient activity (attendances) supports our original baseline planning assumption of a 2% increase in activity year-on-year with a variance of less than 1% over the three-year time period. This provides a high level of assurance that the physical capacity (number of Outpatient rooms) planned within the nVCC is appropriate based upon actual activity recorded post the submission of the nVCC OBC, set out in Table 30 below.

Table 30 - Outpatient Forecast V Actual

Service	Activity Measure	2016 (baseline)	Forecast 2019	Actual 2019	Difference (total / %)
Outpatient	Attendances	58,403	63,779	63,609	170 (≤1%)

Note: Excludes research, palliative care, clinical psychology and radiotherapy review and planning activity.

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Forecast Capacity Requirements at the New Velindre Cancer Centre

5.46 The forecast and actual activity set out in Table 29 above generates a requirement of the following numbers of Outpatient rooms as set out in Table 31 below.

Table 31 - Outpatient Room Requirements

Service	Description	2016/17 (baseline)	February 2020	2025/26
Outpatients	Rooms	26	26	30

Note: *Implementation of the Outpatient Clinical Operating Model, as outlined in Table 20, will result in 45% of total activity being delivered across South-East Wales.*

Actual Outpatient Activity (COVID / POST-COVID):

5.47 Unlike other service at VCC the Covid-19 pandemic, commencing in March 2020, resulted in a significant increase in activity for Outpatients due to a number of factors, including:

- Increased virtual clinics to support patients who weren't able to attend VCC in person
- Growth in SACT activity which impacted Outpatient capacity requirements
- Reduced capacity within Health Boards
- Increased number of MDT sessions

5.48 The post COVID-19 activity is set out in the Table 32 below.

Table 32 - Outpatient Activity Post COVID-19

Service	Activity Measure	2016 (baseline)	Actual 2020	Actual 2021	Actual 2022
Outpatient	Attendances	58,403	66,583	84,097	88,802

Note: Excludes research, palliative care, clinical psychology and radiotherapy review and planning activity.

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5.49 However, and despite the actual significant increase in demand for Outpatient services over the last three years, we are confident that the annualised (compounded) activity planning assumption used to size the nVCC is still robust and valid as a large proportion of additional Outpatient activity is / will be supported through digital solutions.

Summary and Conclusion:

Key Points:

- The 2% activity growth assumption, included within the nVCC OBC, has been supported by actual activity up to 2019/2020.
- Based upon forecast activity, tested against actual activity though to 2019/20, there is an appropriate number of Outpatient rooms included within the nVCC FBC to meet service demand. This will ensure that the Trust has capacity to meet all relevant performance targets.
- The implementation of the Outpatient Clinical Service Model will result in 45% of total activity being delivered across South-East Wales.

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Inpatients

Clinical Growth Assumption:

5.50 In line with the methodology, outlined in Table 19, the forecast clinical growth assumption for inpatient services was 2% from 2016/17 through to 2022/23. This was agreed and approved by all commissioning Health Boards as part of the nVCC OBC Collaborative Scrutiny process, this is set out in Table 33 below.

Table 33 - Future Growth Assumptions of Inpatients

Service	OBC Annual Clinical Growth Assumption
	2016/17 – 2024/25
Inpatients	2%

Actual Inpatient Activity Versus 2% Growth Assumption (2019 comparison (pre-COVID)):

5.51 Using our most recent full-year 'pre-COVID' data (2019) shows that inpatient activity, as measured by occupied bed days actually reduced from 2016 (nVCC OBC submission) – 2019. However, this was not related to an evidenced reduction in demand for inpatient services at VCC. Instead, a capacity constraint was placed upon the service during this time period as there was a requirement to undertake essential estates works to the inpatient wards in order to improve the patient environment and to ensure compliance with our statutory compliance responsibilities. In order to facilitate these works there was a requirement to close beds / wards for sustained periods of time.

5.52 In addition, and during the same time period, we made significant enhancements to our inpatient service model which resulted in shift towards an enhanced ambulatory / assessment care model; this reduced the number of inpatient admissions at VCC. Table 34 below sets out inpatient activity.

Table 34 - Inpatient Bed Availability

Service	Activity Measure	2016 (baseline)	Forecast 2019	Actual 2019
Inpatients	Oncology Bed Available	43	43	28 (Constraint capacity)

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5.53 Over the course of 2020 – 2022 (COVID impacted timeframe) we continued to experience reduced inpatient activity at VCC. However, and although full-year data for 2022 is not available at the time of producing this FBC, data which we have available for September – November 2022 shows that total inpatient activity is returning in line with pre-COVID levels, this is set out in Table 35 below.

Forecast Capacity Requirements at the New Velindre Cancer Centre

Table 35 - Inpatient Activity Post COVID-19

Service	Activity Measure	Current Capacity at VCC	February 2020	2025/26 (nVCC)
Inpatients	Oncology Beds	34	39	31
	Assessment / Ambulatory Care Spaces	8	8	17
	Isotope Cubicles	2	2	3
	Total	**44**	**49**	**51**

Inpatient Services – An Evolving Service Model

5.54 In line with the recommendations from the Nuffield review in relation to the he VCC / regional clinical model there have been significant changes and enhancements to the inpatient clinical service over recent years and subsequent to the approval of the nVCC OBC (Note: the majority of these improvements were already being progressed prior to the publication of the Nuffield review). Fundamental to these changes has been the transition to a more resourced ambulatory / assessment care model. Key to supporting this service development has been the implementation of a regional acute oncology service. The development of the inpatient service model has, and will continue, to deliver a number of quantifiable benefits. These include:

- Reduced average length of stay at VCC and in Local Health Boards.
- Reduced inpatient admissions at VCC and in Local Health Boards.
- Patients admitted to the most appropriate location for their treatment 'first time'.

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- Increased oncology presence within Local Health Boards.
- Improved patient experience.

5.55 The New Velindre Cancer Centre – A Flexible Inpatient Design Solution which is built around Patient Experience, Quality and Improving Outcomes.

5.56 The design of the Inpatient areas at the nVCC has responded to the feedback received from our clinical teams and other key stakeholders. This feedback emphasised the need for:

- Flexibility in the design covering a range of areas:
  - Ability, on the day of opening the nVCC, to only open the number of beds which are required at that point in time to reduce the risk of any 'non-required' costs
  - Ability to use the space within the designed inpatient areas for alternative uses
  - Ability to continue, over time, the development of our inpatient service model by reducing the number of oncology beds and increasing the number of ambulatory / assessment spaces
- The requirement for additional ambulatory / assessment care spaces and less traditional oncology beds
- The requirement for additional single oncology bedrooms as a proportion of total rooms

Key Points:

- Inpatient activity has been impacted by the following since 2019:
  - Essential estates work to the inpatient wards, requiring the closure of inpatient beds.
  - Workforce shortages due to a variety of reasons and which have been outside of the control of the Trust.
  - Impact of COVID from 2020 – 2022.
- In line with the recommendations from the Nuffield review of the clinical model there have been significant changes and enhancements to the inpatient clinical service. This has been supported by the transition to a more focused ambulatory / assessment care model. Key to supporting this service development has been the implementation of a regional acute oncology service.
- Although the nVCC has space to accommodate 31 oncology beds the hospital has been designed in a way to promote flexibility of use i.e. can increase / decrease the number of beds as appropriate and / or use for alternative uses e.g. increased ambulatory care provision.
- Inpatient beds will only be made available (opened) if and when demand presents.

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Overall Summary and Conclusion of Growth and Activity Assumptions:

5.57 The clinical growth assumptions and actual activity that support the need to replace the existing cancer centre and inform the size of the nVCC have been reviewed and updated between OBC and FBC and have been set out in the preceding section. Despite activity and service delivery changing as a result of the COVID-19 pandemic there is still a compelling case for investment.

5.58 Based on the update activity it remains clear that the existing estate is severely constrained and inhibits the Trust in delivering its services now. The site is landlocked by building and infrastructure owned by the Trust, which renders any expansion of the site boundary unviable. The only possible option for expansion would be onto the staff and patient car park but this has been discounted, as it would impact on an already sub-optimal parking facility.

5.59 This therefore represents a very immediate and high-risk issue for the Trust given the current pressure on the system. This is compounded by the anticipated growth in demand for services. While planning is underway to mitigate capacity limitations in the short term, it is imperative that a long-term solution is established urgently.

5.60 Without significant transformation, the Velindre Cancer Centre faces a very immediate and high risk in our ability to continue to deliver services and to maintain current performance levels.

Sizing of the nVCC

5.61 Following the activity and capacity modelling process outlined above, the Trust has been able to establish its core capacity requirements, referred to hereafter as the 'Do Minimum' requirements, in relation to:

- Building footprint requirement for the nVCC;
- Functional content requirements e.g., number of Inpatient beds, for the nVCC; and
- Major Medical equipment requirements for the nVCC.

Building Footprint for the New Velindre Cancer Centre – Do Minimum

5.62 The activity and capacity analysis has demonstrated that the required building footprint for the nVCC, based upon the Do Minimum service requirements, is 30,689m2 compared to the existing Velindre Cancer Centre footprint of 17,777m2. This analysis, which is summarised in Table 36 overleaf has been presented to, and validated by, NHS Wales Shared Services and WG Officers.

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Table 36 - Do Minimum Building Footprint for the New Velindre Cancer Centre

Functional Area	m²
Radiotherapy	8,090
Inpatients	3,534
SACT & Ambulatory Care	2,067
Outpatients & Therapies	2,034
Imaging and Nuclear Medicine	2,073
Pharmacy	1,518
Hospital Clinical / Non-Clinical Administration & Support Services	4,726
Hospital Education, Training and associated Support Services	669
IM&T	439
SPR & On Call	91
Staff Facilities	1,41
Mortuary	171
Catering & Restaurant	1,022
Hospital Main Entrance	1,855
Total Gross	**30,689**

Functional Content Requirements for the New Velindre Cancer Centre – Do Minimum

5.63 The activity and capacity analysis has demonstrated the following Functional Content requirements for core service delivery at the nVCC, based upon the Do Minimum service requirements. Table 37 summarises these requirements compared against functional capacity, which is currently available at the existing Velindre Cancer Centre (Feb 2020 Pre-COVID).

Table 37 - Functional Content Requirements for Core Services within the New Velindre Cancer Centre

Department	Existing (Feb 2020 Pre-COVID)	nVCC	Variance
Radiotherapy Linear Accelerators	8	8	0
Outpatient Consultation Rooms	26	30	+ 4 rooms
SACT Chairs	19	20	+1 chair

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Department	Existing (Feb 2020 Pre-COVID)	nVCC	Variance
Inpatients	49	51	+ 2 beds

Note: *Inpatient beds reflects capacity that is subject to the confirmation of the clinical model but could represent 'flexible' bed capacity.*

Major Medical Equipment Requirements for the New Velindre Cancer Centre – Do Minimum

5.64 The activity and capacity analysis has identified the Major Medical equipment requirements for the nVCC, based upon the Do Minimum service requirements. The Major Medical equipment requirements for the nVCC, with a unit value of over £0.125m (excl. VAT), compared to Major Medical equipment, which is currently operational at the existing Velindre Cancer Centre (Feb 2019 Pre-COVID) are summarised in Table 38.

Table 38 – Major Medical Equipment Requirements for the New Velindre Cancer Centre

Department	Equipment	Existing (2018)	nVCC	Additionality
Radiotherapy	Linear Accelerator / Treatment Machines	8	8	0
Radiotherapy	CT Simulator	2	2	0
Radiotherapy	Brachytherapy System	1	1	0
Radiotherapy	MR SIM	0	1	1
Radiology	MRI Scanner	1	2	1
Radiology	CT Scanner	1	2	1
Radiology	Imaging System (Plain Film/Fluoroscopy System)	2	2	0
Nuclear Medicine	Gamma Camera	1	2	1
Pharmacy	Robotic Dispensing System	0	1	1

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Conclusion

5.65 In summary, this section of the FBC examined in detail service activity from the original base line, through Covid, to today and compared then with the Trusts approved growth assumptions for all major service areas. This analysis has demonstrated that the Trust's forecast growth assumptions have been accurate to within very small margins of variance against actuals. Therefore, there is a high degree of confidence that the activity and future growth assumptions can be relied upon in terms of the design of the nVCC and wider Clinical Model.

6 POTENTIAL SCOPE OF THE NEW VELINDRE CANCER CENTRE PROJECT

Introduction

6.1 The scope of the Project is limited to the building of a nVCC. In taking forwards this scope, the Trust sought formal approval from commissioners and from the Welsh Government in relation to the Outline Business Case (OBC) for a nVCC. In seeking approval of the OBC, the Trust provided assurance in relation to:

- The need for a nVCC;
- The Preferred Option identified within the OBC;
- The building footprint of the nVCC;
- The additional costs directly attributable to the nVCC; and
- The Project Management and Governance arrangements for delivering the nVCC Project.

6.2 The following has been confirmed as outside of the scope of the nVCC Infrastructure Project:

- All variable clinical costs of modelled demand which will be considered through the development of the commissioning LTA framework and therefore excluded from the nVCC OBC;
- All service development Projects e.g., Acute Oncology Service, which will be subject to separate Business Cases and therefore excluded from the nVCC OBC;
- All outreach capital Projects e.g., Radiotherapy Satellite Centre, which will be subject to separate Business Cases and therefore excluded from the nVCC OBC; and
- All Digital Projects which the Trust needs to complete irrespective of the nVCC Project. These will be the subject of separate Business Cases.

Potential Business Case Options

6.3 Although the scope of the Project is well defined, there was the potential to develop a range of options for delivering the objectives of the Project. The range of options have been considered against a continuum of need ranging from:

- Minimum scope: Core and essential service requirements/outcomes which are currently provided by VCC;
- Intermediate scope: Core and desirable service requirements/outcomes which the Project can potentially justify on a cost/benefit and thus value for money basis; and
- Maximum scope: Core, desirable and optional service requirements/outcomes which the Project can potentially justify on a cost/benefit and thus value for money basis.

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6.4 The outcome of this is outlined in Table 39 and was used as the starting point to develop the longlist of options within the Economic Case of the OBC.

Table 39 - Potential Project scope

Service / Function	Minimum	Intermediate	Maximum
Radiotherapy	✓	✓	✓
SACT	✓	✓	✓
Inpatients	✓	✓	✓
Specialist Palliative Care	✓	✓	✓
Outpatients	✓	✓	✓
Ambulatory Care	✓	✓	✓
Radiology and Nuclear Medicine	✓	✓	✓
Pharmacy	✓	✓	✓
Acute Oncology Service (existing arrangements)	✓	✓	✓
Research and Development (existing arrangements)	✓	✓	✓
Learning, Technology and Innovation (existing arrangements)	✓	✓	✓
Research and Development (enhanced scope)		✓	✓
Learning, Education and Innovation (enhanced scope)		✓	✓
Capacity to introduce PET CT Service		✓	✓
Capacity to introduce Proton Beam Service			✓
Capacity to introduce Advanced Technologies, including: • **Platform specific stereotactic service** • **Cyclotron service**			✓
Relocation of Trust Corporate Function			✓

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7 PROJECT RISKS, CONSTRAINTS, DEPENDENCIES AND ASSUMPTIONS

Risks

7.1 Identifying, mitigating, and managing the key risks is crucial to successful delivery, since the key risks are likely to be that the Project will not deliver its intended outcomes and benefits within the anticipated timescales and spend.

7.2 A full risk register for the nVCC Project has been developed which includes the following categories:

- **Business risks:** Risks that remain 100% with the Trust and include political and reputational risks;
- **Service risks:** Risks associated with the design, build, financing and operational phases of the project and may be shared with other organisations; and
- **External Non-System risks:** Risks that affect all society and are not connected directly with the proposal. They are inherently unpredictable and random in nature.

7.3 The nVCC risk register is managed by the Project Management Office (PMO). The exact role of the PMO in managing risks is described within the Management Case.

Constraints

7.4 The main constraints in relation to the nVCC Project are outlined in Table 40.

Table 40 - Main Constraints of the nVCC Project

Constraint	Overview
Financial Constraints	The infrastructure solution for the nVCC would be ideally deliverable within the affordability threshold of c£299m (including VAT but excluding equipment) at 2021-22 prices funding cap agreed with the WG.
Timescale Constraints	The nVCC must be operational in line with the Programme agreed with the Welsh Government.
Service Continuity	Delivery of patient services must be maintained during the period of construction.
Compliance with Statutory Requirements	The nVCC must be fully compliant with all relevant statutory compliance requirements.

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Dependencies

7.5 A number of dependencies have been identified in relation to the nVCC Project. These are provided in Table 41.

Table 41 - Main Dependencies of the nVCC Project

Dependency	Overview
Capital Funding Availability	Access to capital funding is critical to deliver the Project, especially in relation to the procurement of Major Medical equipment and IM&T.
Revenue Funding Availability	Access to revenue funding is essential to support the recurring revenue implications associated with the nVCC Project.
Welsh Government Approval	The Full Business Case must be approved by the WG.
Partnership Working	Co-production in the design and implementation of the Project that involves all stakeholders from across the health and social care economy is essential to the Project's success.
Wider Health Strategy and Governance	It is important that general health strategy and governance in Wales, that underpins the nVCC Project remains broadly consistent over the period of change.
Site Enabling Works	The site enabling works Project, which is outside of the scope of this FBC, must be completed by the start of construction for the nVCC.

Assumptions

7.6 The key assumptions underpinning the nVCC Project are provided in Table 42

Table 42 - Main Assumptions for the nVCC Project

Assumption	Overview
Implementation of the wider TCS programme	It is assumed that the following capital Projects identified within the TCS Programme are funded and the nVCC has been 'sized' based on this assumption. • Radiotherapy Satellite Centre at Nevill Hall Hospital; and • Non-surgical cancer Outreach centres across South - East Wales delivering SACT and Outpatient services.
Clinical Growth Assumptions	The nVCC has been 'sized' on the basis of a number of clinical growth assumptions, summarised below:

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Assumption	Overview
	• Radiotherapy activity will increase by 2% per annum through to 2025; • SACT activity will increase by 5% per annum through to 2025; • Outpatient activity will increase by 2% per annum through to 2025; • Inpatient activity will increase by 2% per annum through to 2025; and • Radiology and Nuclear Medicine activity will increase by 9% per annum through to 2025.

Flexibility for Expansion on the Site of the New Velindre Cancer Centre

7.7 It is important to highlight that there is approximately 6,500 m2 of expansion space (compared to the approved Outline Planning Application) on the identified site for the nVCC. This expansion capacity is fundamental to the Trust's mitigation strategy in the event that either:

a) The other capital Projects within the TCS Programme are not supported; or
b) The clinical growth assumptions prove to be understated.

7.8 Conversely, the Trust has identified alternative uses for some of the proposed nVCC accommodation in the event that clinical growth assumptions do not fully materialise.

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8 CONCLUSION

8.1 The Strategic Case has demonstrated a compelling case for investment to support the replacement of the existing Velindre Cancer Centre. The key factors supporting the case for investment are:

- The existing patient environment at the Velindre Cancer Centre is sub-optimal and does not promote patient recovery and well-being;
- There is insufficient patient and family car parking at the existing Velindre Cancer Centre;
- A high proportion of accommodation at the existing Velindre Cancer Centre is non-compliant with statutory requirements and creates challenges in maintaining high levels of patient safety;
- The existing Velindre Cancer Centre, built on a 'like for like' basis and in line with Health Building Notes, would have a footprint of circa 28,000m2 compared to the existing building footprint of 17,777m2; and
- There is no expansion space on the existing Velindre Cancer Centre. This severely limits, the Trust's ability to expand its footprint to meet the increasing demand for its clinical services across a range of specialities / departments.

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9 APPENDICIES

For Information

The following appendices are available in support of this chapter.

Appendix Reference	Title
FBC/SC1	Nuffield Trust Report – 'Advice on the proposed model for non-surgical tertiary oncology services in South-East Wales'
FBC/SC2	Nuffield Trust Recommendations and Progress Summary
FBC/SC3	TCS Equipment Strategy (draft)
FBC/SC4	Digital Vision for the new Velindre Cancer Centre

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Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Full Business Case: March 2023

new Velindre Cancer Centre

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Management Case

MANAGEMENT CASE

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1 INTRODUCTION

Approach

1.1 The OBC laid out a proposed Project Management structure and governance approach to ensure the effective delivery of the nVCC Project. This included recruiting and developing a number of skilled and experienced project officers to meet the future demands relating to the implementation of the nVCC Project.

1.2 A resourced structure has been in place to guide the project through the commercial set up, pre-qualification, competitive dialogue and successful participant phases, these arrangements have now been refreshed to support the implementation phase of the nVCC Project.

1.3 As previously set out in the Strategic Case the nVCC Project is one of seven projects that make up the Transforming Cancer Services (TCS) Programme. This Programme has the responsibility to ensure effective co-ordination and congruence with the other elements of the TCS Programme and wider Trust.

1.4 This FBC provides an update to the management arrangements to cover the construction, post-construction and evaluation phases of the nVCC Project to time, cost and quality. This FBC Management Case outlines the approach to the following and is supported with a range of detailed appendices:

- Project Management arrangements;
- External advisors;
- Use of specialist advisors within NHS Wales;
- Project scrutiny and assurance;
- Procurement and contracts management;
- Change control;
- nVCC project plan;
- Benefits realisation;
- Communication and engagement;
- Risk management; and
- Arrangements for post-project evaluation.

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2 PROJECT MANAGEMENT ARRANGEMENTS

Introduction - Project Leadership

2.1 This section of the Management Case provides an overview of the Project Management structure and individual roles and responsibilities as detailed in Appendix **FBC/MC1**.

2.2 Velindre has recruited (and largely retained) a Project Leadership team to deliver the procurement phase of the project. The aim (as set out in this FBC) is to refresh and confirm this structure to cover the effective management of the construction, post-construction and post-project evaluation phases of the nVCC Project.

2.3 The key individual roles and responsibilities in this structure are set out in Table 1 below:

Table 1 - nVCC Project Leadership Team and Roles and Responsibilities

Role	Name/Status	Responsibility
Senior Responsible Owner (SRO)	Steve Ham	The SRO is accountable for the success of the nVCC Project and the wider TCS Programme. The SRO is responsible for enabling the organisation to exploit the new environment resulting from the nVCC Project, meeting the new business needs and delivering new levels of performance, benefit, service delivery and value. The SRO owns the vision for the nVCC Project and is required to provide clear leadership and direction.
Project Director	David Powell	The Project Director reports to the SRO and is accountable for the nVCC Project delivery to time cost and quality. The Project Director will provide leadership and positive team working to create an environment that facilitates effective project delivery across all phases of the project.
Assistant Project Director (APD)	Mark Ash	A senior role that provides professional advice and support to the nVCC Project Director. Responsible for the financial and commercial aspects of the nVCC Project. This includes the financial planning for the project, financial reporting, and financial risk management. This role leads on management of the Mutual Investment Model (MiM) Project Agreement, Service Level Specifications and the Annual Service Payment mechanism.

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2.4 The Project also contains specialist support roles as shown in Table 2 below.

Table 2 - nVCC Project – Specialist Support Roles

Role	Name/Status	Responsibility
Strategic and Commercial Director	Huw Llewellyn	This role provides support and advice on commercial issues as well as providing a bridge to the equipment and digital elements of the TCS Programme.
Technical Director	Phil Morgan (MDA Consult Ltd)	This post oversees the technical elements of the project and ensures oversight of the Developer's technical solutions. This role also links across to the enabling works project within the TCS Programme.
Technical Support Managers	To be Appointed in due course	The Technical Support Managers will report to the Technical Director and have responsibility for monitoring elements of the construction and commissioning of the nVCC and ensuring compliance with all technical obligations.

2.5 The Project Team includes clinical/operational leads as shown in Table 3 below.

Table 3 - nVCC Project - Clinical and Service Leads

nVCC Clinical Leads	Prof Tom Crosby and team	The nVCC Project has a clinical lead responsible for leading a group of clinicians in order to ensure clinical focus on the nVCC Project and that patient experience and quality is always a primary consideration. The role includes 'sense-checking' design solutions and cross-checking these to service requirements, service developments and initiatives elsewhere.
nVCC Service Transformation Director	Andrea Hague and team	The nVCC Project has a Service Transformation Director who will be responsible for delivering the operational requirements of the project. This role, will work closely with the clinical lead and includes responsibility for leading on equipment, digital and hospital transition and commissioning.

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Project Management (The Methodology)

2.6 The delivery of the nVCC Project is managed in accordance with PRinCE2 ('Projects in a Controlled Environment') methodology suitably adapted for local circumstances (in order to meet the needs of this Project).

2.7 The nVCC Project follows a set of principles contained within the TCS Programme Execution Plan (PEP) and Project Initiation Document (PID), these principles are:

- Consideration of the views and interests of patients, staff and all stakeholders in all decision-making;

- Compliance with corporate governance and policy;
- Compliance with good project management practice;
- Open and regular reporting of Project progress and performance.
- Effective monitoring/review processes (continuous Quality Assurance (QA);
- Effective change/issues/problem management;
- Comprehensive acceptance procedures;
- Appropriate documentation and record keeping.

Project Governance and Management

2.8 The nVCC Project controls and co-ordinates a series of workstreams that are updated to reflect each phase of project delivery.

2.9 The nVCC Project also looks outwards to the TCS Programme, Velindre's Corporate Governance arrangements and that of Welsh Government's sponsorship, scrutiny and approvals process. In particular, focus is on timely approvals and the effective escalation of risks and issues to senior sponsors.

2.10 The Project Governance Arrangements work on three levels:

- Welsh Government (Strategy & Policy) – **Level 1**
- Velindre University NHS Trust (Corporate) – **Level 2**
- Velindre University NHS Trust (Operational / Project) – **Level 3**

2.11 The details of the Project Governance Arrangements are in Appendix **FBC/MC2**.

2.12 The governance arrangements include a TCS Programme Scrutiny Sub-Committee that provides assurance to the Trust Board. The terms of reference of this sub-committee are included in Appendix **FBC/MC3**.

2.13 An Integrated Assurance and Approvals Plan (IAAP) for the nVCC Project sets out all the required approvals for the Project and the governance route for each key deliverable. This enables alignment of approval decisions with the Trusts' governance schedule of meetings. The IAAP (v3.0) is set out in Appendix **FBC/MC4**.

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Project Management Office (PMO): Roles and Responsbilities

2.14 The nVCC Project has a central Project Management Office (PMO) to control and co-ordinate activities. The roles within this team are set out in Table 4 below.

Table 4 - Project Management Office (PMO) and Administration Specific Roles and Responsibilities

Role	Name / Status	Responsibility
Principal Project Manager (PPM)	Andrew Davies	The Principal Project Manager has overall responsibility for the delivery of all sub projects/workstreams to time, cost and quality. The Principal Project Manager also ensures the project is aligned to the overarching TCS Programme. Key to the success of this role is the efficient and effective recruitment and use of project resources, the identification and management of, interdependencies, risks and issues, benefits delivery, providing project assurance and ensuring effective decision making through VUNHST internal governance and Welsh Government governance structures.
Authority Construction Surveyor (ACS)	To be confirmed	The Authority Construction Surveyor will oversee delivery of the nVCC Projects construction works in accordance with the Trust's requirements. The ACS will monitor the work of contractors and subcontractors and notify the Client's Agent (CA), Independent Tester / Certifier and contractor of any potential issues. The ACS will review the quality of works on site taking into consideration workmanship, building in accordance with the design/ specification, overseeing the commissioning etc and will be the daily site liaison officer with all site stakeholders.
Senior Project Managers (SPM)	Peter Sowerby *(Additional recruitment TBC)*	The Senior Project Managers have the responsibility for supporting the sub-project leads with the initiation, planning, execution, monitoring, controlling and eventually closure of their sub-projects. They provide a structured approach to support the delivery of the key deliverables and provide an escalation route for risks. They report professionally to the Principal Project Manager.
Project Managers (PM)	Craig Salisbury; Hannah Moscrop; Michelle Pearce *(Additional recruitment TBC)*	The Project Manager(s) are responsible for supporting the PPM with the delivery, monitoring, controlling and eventual closure of the nVCC Project. As with the SPM, they will provide a structured approach to support the delivery of the key products and provide an escalation route for risks.
Finance Business Partner	Eurwen Williams	The Finance Business Partner will provide financial accounting, planning, management and governance advice along with support and information to the Project.

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Role	Name / Status	Responsibility
Role	Name / Status	Responsibility
Project Support Officer (PSO)	Jenny Welsby	The Project Support Officer will provide project support and administration services. This will include co-ordinating meetings, capturing issues, decisions and actions. The post-holder will act as a configuration management librarian and oversee all document control.
Project Administrator (PA)	Sue Poole; Stefan Dale; Ellie Gregory; Jessica Jenkins	The Project administrator's duties include scheduling meeting times and locations, taking meeting minutes, capturing action points and arranging training for project staff. In addition, the project administrators participate in budget administration, providing analysis and maintaining project records and facilitating procurement.

Other Roles

2.15 There are a range of ancillary roles within the nVCC Project which are set out in Table 5 below.

Table 5 - Other Roles

Role	Overview
Project MIM Transactor	The Transactor is a Welsh Government (WG) Officer responsible for Government oversight of the project and managing the interface of the nVCC Project with the WG team.
Chief Digital Officer	The Chief Digital Officer is responsible for delivering the enabling digital requirements for the nVCC ensuring congruence with Velindre and Welsh NHS digital strategies and initiatives.
Communication	The Communication Lead is responsible for managing internal and external communications during the construction, post-construction and evaluation phase.
Engagement	The Engagement Lead is responsible for managing engagement activities with staff, patients, public and key stakeholders.
Estates & FM	The Estates and Facilities Management (FM) Lead is responsible for ensuring the Project addresses the operational requirements of Velindre.

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Project Delivery Model

2.16 nVCC Project's delivery will be managed through a series of workstreams, each supported by a Terms of Reference, led by a member of the nVCC Project Leadership Team as set out in Table 6 below:

Table 6 - Project Delivery Model (workstreams)

Workstream	Lead
Construction Monitoring	Project Director
Hospital (Design Management)	Project Director
Commercial / Legal	Assistant Project Director
Community Benefits	Assistant Project Director
Facilities Management	Assistant Project Director
Transition & Commissioning (All)	nVCC Service Transformation Director
Equipment	nVCC Service Transformation Director
Digital	nVCC Service Transformation Director
Post Project Evaluation / Benefits Realisation	Project Director
Management Forum	Assistant Project Director
Communication & Engagement	Assistant Director of Communications
Enabling Works Alignment	Project Director

2.17 The Project Management Office (PMO) will support the project delivery workstreams. Their roles will migrate through the next stages of the nVCC Project to include all matters pertaining to the implementation and commissioning.

TUPE and Employment Matters

2.18 It is not anticipated that there will be any Velindre University NHS Trust staff transfers under the "Transfer of Undertakings (Protection of Employment) Regulations (TUPE) 2006" as amended by the "Collective Redundancies and Transfer of Undertakings (Protection of Employment) (Amendment) Regulations 2014" to Project Co (or its Sub-Contractors) in respect of the Project.

2.19 This assumption has been made as a result of detailed discussions with service leads within the existing Velindre Cancer Centre and by using their local and detailed knowledge of future service changes and advancement of clinical treatments.

2.20 As the project approaches Financial Close, the Authority will continue to monitor all workforce assumptions, including those relating to TUPE.

2.21 If there are any non-Trust staff identified as being at risk at the end of the 25-year period when the building's ownership is handed over to the NHS the Trust will act in accordance with the TUPE legislation that is applicable at that time.

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Project Tolerances and Delegated Authority

2.22 The nVCC Project tolerances have been approved by the Trust Board as part of the approval of the procurement strategy and will be monitored throughout the project lifecycle. These are set out in Table 7 below:

Table 7 - Project Tolerances

Description	Category	Measure	Escalation trigger
Overall project completion date	**Time**	Plan as approved by Programme Delivery Board	+3months or moves 1st Patient to beyond 4th quarter of 2025
Overall annual cost of solution	**Cost**	Unitary Charge approved in OBC	+5%
Project capital costs	**Cost**	Capital cost approved in OBC	+5%
Project transaction costs	**Cost**	Project costs as approved by WG	+5%

2.23 In addition to the approved tolerances the nVCC Project has a delegation framework, which allows for streamlined approvals and the effective escalation of risks and issues to a level where senior sponsors can intervene as necessary. Any expected breach of the tolerances outside of those specified above will be escalated to the Strategic Capital Board (SCB), or a higher authority.

2.24 Delegation of authority is integrated within, and aligned to, the Trusts' governance arrangements. This will provide clarity in respect of delegated authority for the Leadership Team and ensure that the nVCC Project Board and Trust Board have the appropriate level of scrutiny, oversight and control during the process, and overall accountability throughout the lifecycle of the project.

Equipment and Digital Procurement, Commissioning and Implementation

2.25 The Director of Strategic Transformation, Planning and Digital is the Project Director for Digital and Equipment for the nVCC Project.

2.26 During implementation, oversight of the digital and equipment commissioning process is provided by an Equipment Committee. This Committee is prescribed in the Project Agreement and supported by the Successful Participant, Equipment Advisors, suppliers and NHS Wales Shared Services Partnership (NWSSP) Specialist Estates Service. The Equipment Committee will deal with the detailed planning, coordination and implementation of all equipment at the nVCC.

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2.27 A detailed Digital Activity Plan has been produced to set out the full range of activities required to ensure the digital capability of the new Velindre Cancer Centre. The Digital Activity Plan is included within appendix **FBC/MC5.**

2.28 The equipment for the nVCC divides into a range of groups 1 to 5, each equipment group has different specification, procurement and installation responsibilities which are aligned to the commercial deal with the Successful Participant (SP). A copy of the draft Key Clinical Equipment Outline Commissioning Programme (KCEOCP) is set out at appendix **FBC/MC6**.

2.29 The groups of equipment 1-5 and their respective descriptions and responsibilities are set out below:

Group 1A
This equipment is specified by the Authority and provided and installed by the SP – the programmes and processes for selection and installation are included in the SP's commissioning programme.

Group 1B
This equipment is specified, provided and installed by the SP – the programmes and processes for selection and installation are included in the SP's commissioning programme.

Group 2A
This equipment is provided and installed by the Authority – this relates mainly to the Trusts Integrated Radiotherpay Solution (IRS) equipment. This element of equipment is subject to an interface agreement as laid out in the commercial case. The Authority's IRS team will oversee the management of the commissioning process and use the Equipment Committee to deal with planning and interface issues.

Group 2B
This equipment is specified, procured and delivered by the Authority, but installed by SP. The Trust in collaboration with the relevant procurement frameworks will seek to further enhance the standard framework terms and conditions to include a stronger commercial link with the MiM Project Agreement.

Group 2C
This equipment is specified, procured by the Authority but delivered and installed by the SP. The Trust in collaboration with the relevant procurement frameworks will seek to further enhance the standard framework terms and conditions to include a stronger commercial link with the MiM Project Agreement.

The project procurement documents cover a set of principles in relation to this element of equipping (The SP letter confirms these principles (see appendix **FBC/MC7**).

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Group 3

This equipment is provided and commissioned by the Authority. This breaks down into 3 principle groups:

- **IRS Equipment:** as described above, the IRS equipment co-ordination and installation (mainly Group 2a) will be overseen by the IRS Implementation Board.

- **Furniture and Fittings:** due to the interface with interior design, the Authority design team will oversee the procurement and installation of this element.

- **Miscellaneous equipment including FM equipment:** the Authority equipment team will oversee the procurement and commissioning of this category. It will require co-ordination with the furniture and fittings workstream.

Group 4

This equipment group is predominantly low-cost equipment that often does not have a requirement for fitting or are consumable in nature. This equipment is the responsibility of the Trust to specify and procure. Some Group 3 and 4 equipment will be suitable to transfer.

Group 5

All Group 5 equipment is equipment, that is being transferred from the existing VCC and is further split into two subgroups 5A and 5B

- **5A** – The Authority is responsible for the delivery and installation, via a sub-contractor eg IRS Linacs.

- **5C** – SP is responsible for the delivery and installation and initial technical commissioning eg CT SIMS.

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Management of Programme Interdependencies

2.30 There are a number of key programme interdependencies that need to be managed to ensure successful delivery of the nVCC Project. This relates especially to the major equipment interface.

2.31 These, and other dependencies, currently sit under the TCS Programme overseen by the TCS Programme Delivery Board (PDB). This arrangement has been in place from the inception of the nVCC planning. However, Velindre is currently refreshing these governance arrangements to reflect new Board Structures set out in Table 8 below, as the Trust moves into the implementation phase of the programme:

Table 8 – TCS Governance future arrangements

Strategic Capital Board (SCB) (former PDB)	Velindre Futures
Project 1 – Enabling Works	Project 3a IRS (Implementation)
Project 2 – nVCC	Project 4 – RSC (Clinical Service model only)
Project 3a – IRS (Capital aspects only)	Project 5 – Outreach (Clinical Service Model)
Projects 3b & c – Equipment (Clinical and Non-clinical)	Project 6a – Design of nVCC Clinical Model
Project 4 – RSC infrastructure only	Project 6b – nVCC Clinical Model delivery
Project 5 – Outreach (Capital aspects only)	Nuffield Recommendations for VCS
Projects 7 – VCC Decommissioning	
Digital (content and scope TBC)	
Project 6c Transition to nVCC (to report into both VF and SCB)	

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2.32 The interdependencies and project alignment will be reviewed monthly against the Master Programme, with regular risk reviews and exception reporting also being undertaken.

2.33 The Integrated Assurance and Approval's Plan (IAAP) (see appendix **FBC/MC4**) allows the nVCC Project Board and overarching TCS Programme Delivery Board to coordinate key deliverables and Programme interdependencies with the required levels of scrutiny and governance.

2.34 In order to maintain co-ordination and alignment of these connected initiatives the nVCC Leadership Team have direct links into both projects. The overarching Programme Plan, which includes the nVCC Project, identifies the connections between each Project and the critical path of dependent activities. All the Project Directors are members of the currnet TCS Programme Delivery Board.

2.35 The design of the IRS Project (and the resultant IRS Contract) relates to all facilities. The project also supports the maintenance of operational services at the existing Cancer Centre through the transitional period into the new operating arrangements. Interfaces between each of the projects are monitored and risks managed at both project and programme level. The current TCS Programme Plan sets out the critical interdependencies between the respective Projects within the TCS Porgramme, this is regularly reviewed for alignment and to ensure that the respective projects are on track.

2.36 The nVCC Project also interfaces with projects within Velindre's service change initiative the Velindre Futures Programme, where there are also critical interdepencies.

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3 CHANGE CONTROL AND CHANGE MANAGEMENT

Introduction

3.1 This section of the Management Case sets out the approach to change control and change management.

Change Control

3.2 The Change Control process is managed by the Project Management Office (PMO). The Change Control administration comprises of:

- Change Control Management Document - which gives guidance of version control in regard to documents and the change control procedure;
- Change Management Log - captures all version controlled PMO documents/products;
- Change Form - formal process staff are required to follow to request change to a version-controlled document/products; and
- Change Log - this captures all change requests.

3.3 The Project Team, and external contractors, are expected to comply fully with the Change Control Procedure.

Change Management Principles

3.4 The Change Management principles of the framework are to:

- Recognise the need to maximise the benefits of the change for patients, who should be at the heart of the changes made;
- Take advantage of the time required to complete the development to start the change process immediately and avoid risks related to a 'big bang' approach;
- Test and prove the changes through careful piloting of any aspects of the new models and processes that can be implemented before the new facility is finally commissioned;
- Work in partnership with staff and other stakeholders both within and outside VCC to engage all those involved in the delivery of care in the change process; and
- Focus on staff skills and development required so staff are both capable and empowered to deliver healthcare effectively and to a high-quality standard in the new facility through new models of care.

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The Project Change Management Approach

3.5 The PMO has designed a change management approach that encompasses the framework and principles outlined above.

3.6 The change management process was implemented alongside the development of the OBC.

3.7 Where proposed changes to service impact on the workforce, the NHS Wales Organisational Change Policy will apply. This document makes clear the onus upon the service to consult with staff affected and their individual employment rights.

The Change Management Plan

3.8 A Change Management Plan will be developed. Once the FBC has been approved, three actions will occur:

- The Core Plan will be reviewed to identify other relevant areas that need to be included;
- Detailed plans will be developed for each of the tasks in the Core Plan; and,
- A change timetable will identify the high-level milestones.

3.9 Table 9 below sets out the core plan and the main tasks identified to date.

Table 9 - Change Management Plan

Area	Planned tasks
Planning phase	✓ Appoint key Project roles and Change Managers, confirming responsibilities and leadership ✓ Confirm stakeholders and interested parties both within and outside VCC ✓ Develop core plan in more detail, identifying high level milestones for the Change Management Plan, mapped to the overall Project Plan ✓ Confirm involvement of HR, managers and other individuals/groups in the process
Communications and stakeholder engagement	✓ Confirm communications lead and protocols (route and timing of approval of communications) ✓ Develop communications routes, including face to face briefings bulletins, intranet pages ✓ Formulate and agree key communications messages against high level milestones ✓ Set up stakeholder map and engagement plan ✓ Launch change Programme ✓ Ongoing communications work

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Area	Planned tasks
Training and development	✓ Complete detailed workforce planning to identify 'shadow' structures, roles and competencies for those roles ✓ Work with staff through workshops and other training to clarify the workings of the new Service Models and how these will impact in practice ✓ Identify training and development required to fulfil roles and competencies ✓ Develop training plan, aligned to pilot work and overall milestones in implementation plan ✓ Link training and development into communications plan
Piloting	✓ Identify and confirm areas where piloting of new models and practice will be implemented ✓ Confirm schedule of pilot work, mapped against high level project and change management milestones ✓ Agree feedback arrangements from pilots and how this links into training/development, communications and overall change management plan ✓ Execute pilots, feedback and report progress
Full Implementation	✓ Identify scheduling/phasing of full implementation at VCC ✓ Using results of piloting and training work, develop detailed implementation and transition plan, mapped to project phasing ✓ Discussion and agreement with key staff ✓ Execute implementation and transition plans

3.10 Detailed planning to manage the transition of the current service and operations at the existing Velindre Cancer Centre to the new site will form the basis of a dedicated project (Project 6c Service Transition) under the direction of the Director of Transformation.

3.11 Project 6c reports jointly to both the Velindre Futures Programme Board and Strategic Capital Board to ensure alignment and consistency of planning.

3.12 A comprehensive Transition Plan will be developed as part of this project.

3.13 Assurance of the transition process will also be provided via a Gate 4 Review: Readiness for Service which will be undertaken after the project has been approved as ready for service.

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4 EXTERNAL ADVISORS

4.1 This section sets out the external consultant arrangements that support the delivery of the nVCC Project and their respective roles.

4.2 The contract management arrangement for external advisors is set out in the Procurement Section of this Management Case.

4.3 Table 10 below sets out the Project's external advisory team:

Table 10 - External Advisors

Technical Advisors

Consultant	Roles and Responsibilities	Trust Lead
MDA Limited	Engineering design advice and services	Project Director
JCA Limited	Architectural advice and services	Project Director
Phil Roberts	Design and sustainability consultancy	Project Director
Mott MacDonald	Facilities Management and Energy advice	APD
Hulley & Kirkwood	Mechanical Engineering advice and support	APD
Macgregor Smith	Provide Landscape advice and support	APD
Phil Jones	Environmental design support	APD
Urbanists	Planning advice for the nVCC and associated access	APD
WSP	Civil and Structural engineering support	APD
Simon Fenoulhet	Arts consultancy	APD

Professional Advisors

Consultant	Roles and Responsibilities	Trust Lead
Pricewaterhouse Coopers	Financial and modelling advice	APD
DLA Piper	Provide legal and procurement advice	APD
Willis Tower Watson	Provide specialist insurance advice and services	APD
Archus UK Limited	Business Case and economic modelling services	APD
Faithful & Gould	Cost consultancy	APD

Other Advisors

Consultant	Roles and Responsibilities	Trust Lead
Down to Earth	Environmental design and community benefits advice	APD
Channel 3	Digital advice and support	APD

**APD – Assistant Project Director*

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5 USE OF SPECIALIST ADVISORS WITHIN NHS WALES

5.1 The nVCC Project utilises a number of specialist advisors provided via the NHS Wales Shared Services Partnership (NWSSP) and other areas of the NHS in Wales.

5.2 These include the following:

- NWSSP – Specialist Estates Services;
- NWSSP – Procurement Services;
- NWSSP – Legal and Risk Services;
- Health Education and Improvement Wales (HEIW); and
- Digital Health and Care Wales (DHCW)

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6 EXTERNAL PROJECT SCRUTINY AND ASSURANCE

6.1 To provide project assurance, a range of external reviews and audits will take place. These fall into the following categories:

- Gateway Reviews or Project Assurance Reviews;
- Commercial Approval Points (Mutual Investment Model); and
- Internal Audit.

Gateway Reviews

6.2 The Infrastructure Projects Authority (IPA) Gateway Review process examines Projects at key decision points in their lifecycle. As part of this process, an independent expert team assesses the delivery confidence of a Project or Programme.

6.3 The different gates are identified below in Table 8 and are as follows:

Table 8 - Gateway Review Themes

Gate	Scenario
0	Strategic Fit (Programmes Only)
1	Business Justification
2	Delivery Strategy
3	Investment Decision
4	Readiness for Service
5	Operations Review and Benefits Realisation

Commercial Approval Points (CAPs)

6.4 The Welsh Government MIM assurance framework includes Commercial Approval Points (CAPs).

6.5 A CAP considers the impact of project-specific commercial factors in relation to:

- Affordability;
- Value for Money;
- Deliverability; and
- Commercial and compliance aspects of a Project.

6.6 The sequence and stage of Commercial Approval Points (CAP's) are set out in the Table 9 overleaf.

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Table 9 - CAP Sequence

Description of Procurement Activity	CAP No.
Pre OJEU	1
Pre-Competitive Dialogue	2
Mid Dialogue	3
End of Dialogue	4
Pre-Financial Close	5

Internal Audit

6.7 NHS Wales Shared Services Partnership provides Internal Audit services to Velindre. The nVCC Project forms an integral part of the Trust's annual audit cycle due to its significance to the organisation.

6.8 There is a continuous stream of Internal Audit reviews of the Project and Internal Audit attend the nVCC Project Board.

6.9 Table 10 below sets out the audit and assurance reviews that have been undertaken on the nVCC Project to date. A Gate 3 review "Investment Decision" is due to coincide with the Welsh Government scrutiny of this Full Business Case (see appendix **FBC/MC8** for Welsh Government Gate 2 (Critical Friend Review) report undertaken in April 2018).

Table 10 - Assurance Reviews Summary and Outcomes

Assurance Review	Stage / Title	Date	Outcome
Commercial Approval Point	1	February 2021	Proceed
	2	July 2021	Proceed
	3	February 2022	Proceed
	4	May 2022	Proceed
	5	Feb/Mar 2023	tbc
Gateway	1	N/A*	N/A*
	2	January 2017	Amber
	2 (Critical Friend Review)	April 2018	Amber
	3	Feb/Mar 2023	tbc
	4	tbc	tbc
	5	tbc	tbc
Internal Audit	MIM Procurement	June 2022	Substantial Assurance

*Note * - Gateway 2 in January 2017 was the first gate review of the project.*

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7 PROCUREMENT AND CONTRACT MANAGEMENT

Introduction

7.1 This section of the Management Case describes the Trust's approach to managing the procurement of the nVCC. It will cover the following areas:

- The managerial and governance approach to delivering a successful MIM Competitive Dialogue process;
- Scope of all procurements relating to nVCC;
- The management and oversight of the construction period; and
- The Trust's organisation to manage contractual arrangements during the operational phase.

Procurement Scope

7.2 The overall scope of procurements required to deliver the nVCC are outlined in Table 11.

Table 11 – Scope of Procurements

Project	Procurement Arrangements
Construction of nVCC	Supported by NWSSP – Procurement Service and External Advisors **Route** OJEU/FTS **Process** 1. Project Agreement and Procurement Documents; 2. Competitive Dialogue; 3. Preferred Bidder
Clinical and Non-Clinical Equipment	Supported by NWSSP – Procurement Service and Capital Equipping Team **Route** OJEU for Integrated Radiotherapy Solution Procurement (*See Radiotherapy solution PBC*) Other Major Equipment (OJEU or Framework)
IM&T	Supported by NWSSP-Procurement Service and Capital Equipping Team **Route** Exploit existing IM&T Frameworks

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New Velindre Cancer Centre (nVCC)

7.3 The nVCC will be funded, procured and maintained via Welsh Government's MIM. This model has a standard form Project Agreement (PA) which requires the Trust to personalise it (within agreed parameters) to meet the needs of the specific nVCC Project.

7.4 As outlined in the Commercial Case, the nVCC launched the procurement via an Official Journal of the European Union (OJEU)/ Find a Tender Service (FTS) advertisement.

7.5 The method of procurement was via a Competitive Dialogue process where bidders competed against one another to improve on a reference design. Final tenders were submitted from the bidders and Acorn consortium was selected as the Successful Participant (SP).

7.6 The Acorn consortium team includes Kajima Partnerships, Sacyr, Aberdeen Investment, and Kier Facilities Services.

Method and Approach

Process to Financial Close

7.7 Following appointment of the SP, Acorn and Velindre are working together to secure the following:

- Determination of Reserved Matters;
- Completion of Design to Stage 3;
- Completion of competent set of enabling works;
- Refinement and completion of PA;
- Confirmation of financial and commercial terms;
- Funder sign-off.

7.8 Following these actions, the Trust and Acorn will execute a Financial Close and sign the PA.

Contract Management during Construction

7.9 The Successful Participant will develop agreed plans for the nVCC, have submitted a Reserved Matters application in October 2022 and will commence construction after Financial Close.

7.10 Due to the size and complexity of the build there will be the need to consider the management of change controls throughout the construction. Issues will

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arise, whether these are simply points of clarity, unforeseen design challenges, or omissions in the original design. The Project Agreement makes provision for the formal notification of changes during construction.

7.11 All change controls and early warnings must follow the specified governance arrangements which will remain in place for monitoring and approval purpose throughout the construction, post-construction and evaluation phases.

7.12 To fully control this process the Trust has purchased the Asite sharing portal which was successfully used during the procurement phase. It is proposed Asite will be used to manage all construction change controls as it is a fully auditable system that allows for the mark-up of architect's drawings, recording early warning notifications and compensation events.

7.13 The Trust will provide an internal team to liaise and monitor the performance and delivery of the MIM contractor:

i) The nVCC Project Director (supported by the Project Team) will be accountable for managing all change controls during construction, post-construction and evaluation phases and early warning notifications, thus ensuring the best possible balance of time, cost and quality is achieved.

ii) The team will meet regularly with the MIM contractor to review:

a. Programme;
b. Change Controls;
c. Compliance with external site restrictions imposed;
d. Equipment Commissioning;
e. Medical Equipment Commissioning; and
f. The Independent Tester / Certifier reports.

7.14 The Trust will support the team by the appointment of:

i) The Trust's Legal and Financial Advisors (to advise on any change controls or early warning notifications).

ii) A "Shadow Design" team (to provide engineering, architectural and design consultancy advice) who will be at the Trust's disposal during the construction period to advise on any change controls or early warning notifications.

iii) The Trust will also have access to Shared Services, Specialist Estates Services to provide input into any issues around the Technical functionality of the Design, as and when required, and to provide assurance during the commissioning of the hospital facility working with / alongside the Independent Tester/ Certifier.

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Role of the Independent Tester / Certifier

7.15 The project will use an Independent Tester / Certifier in accordance with the MIM guidance, which is set out in Schedule 13 of the Project Agreement. The Project Agreement specifies the certification requirements, informed by lessons learned from other major schemes such as Edinburgh Schools.

7.16 The role of the Independent Tester / Certifier is to ensure that the project meets completion tests in accordance with the requirements of the contract. The Authority Construction Surveyor will monitor the quality of the work and align closely with the Independent Tester.

7.17 It is a core requirement of Welsh Government that a specialist team of advisers are in place to provide additional levels of assurance. They will undertake an appropriate level of due diligence during the design and construction of the hospital to ensure all aspects are being delivered in accordance with the requirements and terms of the Project Agreement.

7.18 The level of due diligence to be applied will be determined through an informed assessment of the associated risk and the implications of non-compliance.

7.19 The team structure will be developed around the core structure in Figure 1 to ensure robust contract management, record keeping, reporting, escalation and communications protocols are in place:

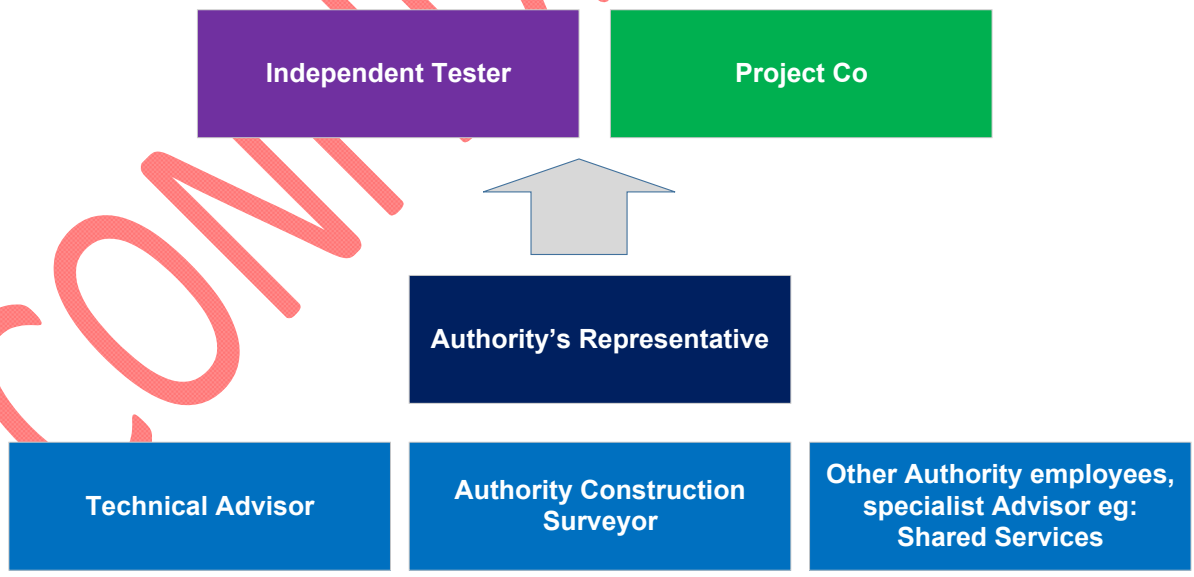

Figure 1 - Structure around Independent Tester / Certifier

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In-life Contract Management

7.20 The Trust has assessed the anticipated requirements of the In-life Contract Management and has formulated a management structure that will ensure the effective management of the operational contract to ensure it is efficient, effective and achieves optimal performance. The Trust has identified the competence and capacity to achieve this, which is set out in Appendix **FBC/MC9**.

7.21 The Trust has recognised that the implementation of this new way of working will require a change in functional capability and structure within the Trust. The Trust will ensure that the knowledge, capacity and expertise to manage the contract and hold the supplier to account is provided through dedicated individuals within the new management team.

7.22 The roles of the team will vary from individuals with technical knowledge of the delivery of services, through to individuals with the knowledge and experience of contract management and have the appropriate and suitable negotiation skills to ensure that the contract is run to its optimal level.

7.23 The Team will be supported by external advisors (as and when required) and agreed reports from the Independent Tester. This will be in addition to the continuous support from colleagues in NWSSP Specialist Estates Services.

7.24 The management of the contract will be mindful of the agreed standards and the monitoring regime required to comply with:

i) Schedule 12, the Service Level Specifications.
ii) Thermal Energy and Efficiency Testing Procedure (Green Credentials).
iii) Building Information Modelling (BIM) requirements.
iv) Community Benefits.
v) Change Procedures.
vi) Hand back Procedures.
vii) Helpdesk performance

7.25 The in-life management team will be fully conversant with the administration and application of the pay mechanism associated with the contract. Agreed protocols for deductions or increases will be agreed with the Welsh Government prior to implementation.

7.26 The management structure will ensure continuous liaison with colleagues in the Welsh Government, to develop protocols around medium to large change procedures within the contractual agreements of the MIM contract and to report on the effective and efficient delivery of the contract.

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8 nVCC PROJECT PLAN

Introduction

8.1 This section sets out:

- The Project Stage Boundaries;
- Project Planning Methodology;
- High Level Planning Assumptions; and
- Estimated Construction Timeline.

8.2 All Projects are effectively split into stages; these stages often reflect the key activities that are being undertaken during the defined time period. Stage Boundaries provide useful review and authority to proceed to points in the Project.

8.3 The nVCC Project comprises five defined stages that are described in the Figure 2 below that illustrates an estimated timeline.

Project Stages	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025	Q1 2026	Q2 2026	Q3 2026	Q4 2026
Design & Planning (Stage 1)	PS1																								
Procurement & Enabling (Stage 2)			Project Stage 2																						
Construction (Stage 3)											Project Stage 3														
Commissioning & Operational (Stage 4)																				PS4					
Consolidation & Closure (Stage 5)																						PS5			
* Table in calendar years / quarters	Q1 - January to March Q2 - April to June Q3 - July to September Q4 - October to December																								

Figure 2 - Project Stage Boundaries

Project Planning Methodology

8.4 To achieve a baseline Project Plan major areas of delivery have been scoped and estimated timescales have been derived with advice from the Trust's technical advisors and Welsh Government colleagues. This has allowed baseline activity durations to be developed. This planning process, based on estimated "earliest time to complete" has allowed the development of a baseline Project Planning position.

8.5 This project planning methodology has not had any adjustment for optimism bias or schedule risk analysis and therefore provides an optimistic project timeline.

8.6 The key milestones of the nVCC Master Programme and enabling projects are outlined in Table 12 overleaf.

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Table 12 - nVCC Project – Key Milestones (Quarters refer to *calendar* year not *financial* year)

Key tasks	Target Completion Date	Complete
Planning Application for the nVCC approved by Cardiff City Council's Planning Committee	**December 2017**	✓
nVCC OBC approved by commissioners	**April 2018**	✓
nVCC OBC approved by Trust Board	**July 2019**	✓
nVCC OBC submitted to Welsh Government	**July 2019**	✓
Asda's Development Agreement approved by Welsh Government	**December 2019**	✓
Pre-procurement activities: Issue Prior Information Notice (soft market testing) for nVCC Project	**January / February 2020**	✓
Asda planning process "triggered"	**February 2020**	✓
nVCC Project Agreement and Procurement Documents approved	**February 2020**	✓
Planning Application for Asda (access) approved by CCC	**September 2020**	✓
SRO requests CAP1 for nVCC Project	**Quarter 4 2020**	✓
Planning Application for Asda access - Reserve Matters and Judicial Review completed	**Quarter 4 2020**	✓
Welsh Government scrutiny of nVCC OBC completed	**Quarter 4 2020**	✓
Welsh Government scrutiny of Enabling Works OBC completed	**Quarter 4 2020**	✓
Easements and land matters (excluding Utilities) complete	**Quarter 1 2021**	✓
nVCC CAP 1	**Quarter 1 2021**	✓
Ministerial Approval of nVCC OBC	**Quarter 1 2021**	✓
Ministerial Approval of Enabling Works OBC	**Quarter 1 2021**	✓
nVCC OJEU publication issued	**Quarter 1 2021**	✓
ITPD Issued	**Quarter 3 2021**	✓
ITSFT Issued	**Quarter 2 2022**	✓
Enabling Works – Phase 1	**Quarter 1 2023**	✓
nVCC Competitive Dialogue concludes (Financial Close)	**Quarter 1 2023**	
Commencement of nVCC construction	**Quarter 2 2023**	
nVCC open (First Patient)	**Quarter 3 2025**	
nVCC Fully Operational after Transition	**Quarter 4 2025**	

Construction Timeline

8.7 The construction timeline has been developed by Acorn. The current construction timeline is 25 months; this overall timeline includes handover of the Imaging Block to happen after 22 months, followed by 5 months of major equipment commissioning. The first patients will be treated at the nVCC in Quarter 3 2025; however other non-clinical areas will still be being finalised up until the 27-month timeline (see appendix **FBC/MC10**).

8.8 Figure 3 below sets out the Project plan for Construction and Commissioning.

P2. nVCC Construction	**810 days**	**Tue 01/11/22**	**Mon 08/12/25**	
IRS Link	**120 days**	**Mon 28/10/24**	**Fri 11/04/25**	
Lead time for radiotherapy treatment machines - order to delivery	120 days	Mon 28/10/24	Fri 11/04/25	14,380FF-240 days
Site preparation and habitat management activities	**261 days**	**Tue 01/11/22**	**Tue 31/10/23**	
On-site activities	**230 days**	**Mon 12/12/22**	**Fri 27/10/23**	
Habitat enhancement / creation (offsite and on site)	80 days	Mon 12/12/22	Fri 31/03/23	
Reptile fencing and winter clearance (Phase A - Southern End)	46 days	Fri 10/03/23	Fri 12/05/23	137,148,146
Reptile translocation (Phase A - Southern End)	35 days	Mon 15/05/23	Fri 30/06/23	374
Stage 2 vegetation clearance (Phase A - Southern End)	75 days	Mon 15/05/23	Fri 25/08/23	374
Reptile translocation and stage 2 clearance (Phase B - Northern End)	40 days	Mon 04/09/23	Fri 27/10/23	376
Construction - Acorn	**709 days**	**Wed 22/03/23**	**Mon 08/12/25**	
Acorn mobilisation and early works	69 days	Wed 22/03/23	Mon 26/06/23	360
Phase 1 Radiotherapy/imaging block (incl. 1a construction - bunkers	467 days	Mon 03/07/23	Tue 15/04/25	144,360,171,48FF,5
1a Exclusive access	34 days	Wed 16/04/25	Mon 02/06/25	380
1a Beneficial access	20 days	Tue 03/06/25	Mon 30/06/25	381
Initial linac commissioning	54 days	Wed 16/04/25	Mon 30/06/25	380
Phase 2 - rest of hospital including landscaping	515 days	Tue 11/07/23	Mon 30/06/25	144,360,171,48FF,5
Service Transition	15 days	Tue 01/07/25	Mon 21/07/25	384,382
Milestone - First Patient Treated	0 days	Mon 21/07/25	Mon 21/07/25	383,385
Phase 1b (bunkers 5-6)	516 days	Mon 03/07/23	Mon 23/06/25	38055
1b Exclusive access	56 days	Tue 24/06/25	Tue 09/09/25	387
1b Beneficial access	15 days	Wed 10/09/25	Tue 30/09/25	388
Phase 1c (bunkers 7-8)	546 days	Mon 03/07/23	Mon 04/08/25	38055
1c Exclusive access	31 days	Tue 05/08/25	Tue 16/09/25	390
1c Beneficial access	10 days	Wed 17/09/25	Tue 30/09/25	391
Commissioning / Transfer of final linacs	120 days	Tue 24/06/25	Mon 08/12/25	387,390FF
Milestone - Fully open - all patients treated	0 days	Mon 08/12/25	Mon 08/12/25	393,386,389,392

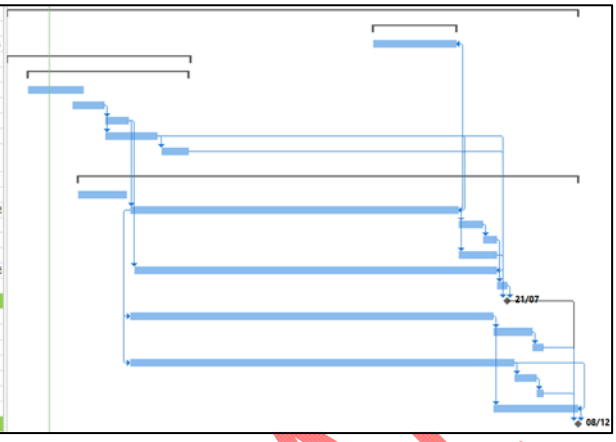

Figure 3 - The Project Plan for Construction and Commissioning

8.9 The Trust is continually reviewing the Master Project Plan for the nVCC Project, part of the TCS Programme, and is in regular contact with the Welsh Government and key stakeholders regarding this matter (see Appendix **FBC/MC11**). There are a range of potential risks that could threaten the current timeline that are currently being mitigated.

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9 BENEFITS REALISATION AND ARRANGEMENTS FOR POST-PROJECT EVALUATION

Introduction

9.1 This section of the Management Case will describe how the Trust will manage the delivery of the benefits associated with the nVCC Project.

9.2 The Outline Business Case outlined the approach to quantified benefits. The quantification of benefits relating to the nVCC include macro benefits / societal benefits from the wider TCS Programme but only where they can be directly attributable to the re-provisioning of the Velindre Cancer Centre, or care pathway attributed to Velindre as an organisation. The Full Business Case assesses the validity of these benefits.

Wider Project Success Measures

9.3 The project has recognised that benefits of successful implementation of the nVCC Project extend further than those articulated/directly quantified in the Economic Case. The project also recognises the value of prospective evaluation (i.e., not waiting until after the Project is complete). This has led the nVCC Project and the TCS Programme Delivery Board to design a dynamic process to evaluate a set of 34 success measures that cover:

- Design outcomes
- Quantifiable benefit outcomes
- Community benefit outcomes
- Commercial outcomes
- Process

9.4 The nVCC Project Initiation Document includes details of these benefits, outcome descriptors, SMART measurement methods, and data sources. They are drawn from the project vision and objectives articulated in the Outline Business Case, Procurement Documents, and the Design Brief.

Dynamic Evaluation and Post-Project Evaluation

9.5 The nVCC Project has established a Research, Development and Innovation (RD&I) group which will lead on the dynamic evaluation of the project during its lifetime as well as facilitating additional benefits arising from the project.

9.6 The RD&I group has already launched a range of projects in partnership with local research institutions. The RD&I group will continue to launch projects during the construction, commissioning and bedding-in phases of the project. The current projects (November 2022) are appended (see **FBC/MC12**).

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9.7 The project will capture the results of this evaluation process in a Benefits Register. The project will build this register throughout the stages of the project and disseminate learning to all interested parties. The register will include the quantified benefits analysed in the economic case as well as the wider benefits (see **FBC/MC13)**.

9.8 The RDI group reviews the projects in delivery, future opportunities and the project list at its monthly meetings.

9.9 The RD&I group reports into the nVCC Project Board.

9.10 Once the project has completed the construction phase, it will undertake a Gate 5 review to review this work.

9.11 The nVCC Project Director will be responsible for delivery of the post-project evaluation (PPE). The Assistant Project Director will be responsible for day-to-day oversight of the PPE process, reporting to the nVCC Project Director.

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10 COMMUNICATION AND ENGAGEMENT

Introduction

10.1 Following the development of the Programme Business Case and the nVCC Outline Business Case, the project developed a communication and engagement strategy (Appendix **FBC/MC14**).

10.2 The strategy identified a list of key stakeholders including the following groups:

- Patients, families and carers;
- Staff and staff representatives;
- Health Boards;
- Higher Education Institutions;
- Potential strategic/commercial partners;
- Local community groups;
- The Local Authority;
- Local Politicians; and
- Welsh Government Ministers.

10.3 The project issues monthly update reports on engagement. The Project Team presents these reports to the Project Board.

10.4 The Programme Team incorporates the project engagement plans into an overall Programme report.

10.5 As part of the approach to Future Generations, the Project Team has referenced all the project activities and objectives to the Future Generations Act.

10.6 The project has tied the Future Generations objectives including method and depth of engagement into its RD&I workstream.

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11 RISK MANAGEMENT PLAN

Introduction

11.1 This section of the nVCC FBC sets out the Projects approach to risk and issues management and presents:

- Risk Management Overview;
- Issue Management and Risk Management Philosophy;
- Recording and Assessment of Risk;
- Risk Management Framework;
- Responsibility for Managing Risk Registers;
- Risk Mitigation;
- Review and Escalation of Risk; and
- Current Risk Register.

Risk Management Overview

11.2 The nVCC Project utilises its governance structure and arrangements to ensure the effective management of risk. The governance structures allow for risks to be escalated from project groups and subgroups, through to the nVCC Project Board, Strategic Capital Board (which replaces the PBD) and onto the TCS Programme Scrutiny Sub-Committee and / or the Trust Board as appropriate.

11.3 All risk registers (which are present in all levels of the nVCC project) are regularly reviewed and updated. A monthly risk report is presented at the nVCC Project Board and Strategic Capital Board. This risk report will highlight new risks, the movement in existing risks and issues and where appropriate it will recommend the closure of resolved risks or issues. Risks and Issues are escalated to the Strategic Capital Board, if applicable.

11.4 The TCS Programme Scrutiny Sub-Committee, upon receiving the nVCC risk register (via the SRO), will consider if the mitigating actions are sufficient and if the identified risks are receiving the right level of treatment. The TCS Programme Scrutiny Sub-Committee will consider the escalation of nVCC Project Risks onto the Trust Risk Register as appropriate, using Datix. The remainder of this section sets out the detailed management of risks and issues.

Issue Management and Risk Management Philosophy

11.5 The nVCC Project Board's philosophy for managing risks is by adopting a holistic approach, seeing effective risk management as a positive way of achieving the project's wider aims. The nVCC Project Board regards risks as the mirror opposite of benefits. Inadequate risk management would therefore reduce the potential benefits to be gained from the delivery of the nVCC Project.

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11.6 Effective Risk Management supports the achievement of wider aims, such as:

- Effective Change Management;
- Enhanced use of resources;
- Better Project Management;
- Minimising waste and fraud; and
- Innovation.

11.7 The Project utilises the Trusts' Risk Management Framework to systemically identify, actively manage and minimise the impact of risk. This is achieved by:

- Identifying possible risks before they manifest themselves and put stringent mechanisms in place to minimise the likelihood of them materialising with adverse effects on the project;
- Putting in place robust processes to monitor risks and report on the impact of planned mitigating actions;
- Implement the right level of control to address the adverse consequences of the risks if they materialise into issues; and
- Having strong decision-making processes supported by a clear and effective framework of risk analysis and evaluation.

11.8 Once risks are identified, the response for each risk will be one or more of the following types of action:

- **Prevention**, where countermeasures are put in place that either stop the threat or problem from occurring, or prevent it from having an impact on the project;

- **Reduction**, where the actions either reduce the likelihood of the risk developing or limit the impact on the project to acceptable levels;

- **Transfer**, where the impact of the risk is transferred to the organisation best able to manage the risk, typically a third party (e.g., via a penalty clause or insurance policy, or contractual responsibility);

- **Contingency**, where actions are planned and organised to come into force as and when the risk occurs; and

- **Acceptance**, where the nVCC Project Board decides to go ahead and accept the possibility that the risk might occur, believing that either the risk will not occur or the potential countermeasures are too expensive. A risk may also be accepted on the basis that the risk and any impacts are acceptable.

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11.9 The nVCC Project Board will adopt a proactive approach to the identification, assessment and management of risks throughout the whole project lifecycle. The effective management of risk and the prevention of issues arising will support the timely delivery of the nVCC Project, by preventing delays, avoiding costs and ensuring quality is upheld.

11.10 The management of nVCC Project risk will be in accord with the principles of the Trust's Risk Management Policy.

Recording and Assessment of Risk

11.11 The nVCC Project will have a Risk Register, which will be updated with all new identified risks being assessed. All risks will have an individual identifier, an assigned owner and be scored using the standard impact v likelihood criteria to ascertain the risk-rating colour.

11.12 It is worth reiterating that as set out in the Commercial Case a number of the risks associated with the MIM procurement will be wholly either transferred or shared with the Successful Participant partner.

11.13 In developing the preferred solution, the Project Management Office examined three categories of risks for each option. These are set out in Table 13 below, together with a summary of how these were assessed.

Table 13 - Risk areas

Area	Description	How assessed
Capital Risks	Capital risks relate to unknown or unidentifiable factors that increase the cost and time of the project construction.	Qualitative and quantitative risks assessed by Quantity Surveyor and / or through workshops.
Optimism Bias	Optimism bias is the demonstrated Systemic tendency for appraisers to be over optimistic about key project parameters. This creates a risk that predicted outcomes do not fully reflect likely costs	Standard methodology to identify extent of optimism bias, with mitigating factors confirmed through nVCC Project assessment
Revenue Risks	These are risks relating to everyday management encompassing cost and activity as well as external environmental factors	Risks identified, with quantitative and qualitative assessment through workshop

11.14 The risk values for the shortlisted options were identified and evaluated as part of the assessment process in choosing the preferred option in the Economic Section. Although the focus of this section is on the approach to managing the risks of the preferred solution, the scope of Risk Management will continue to cover all three areas of risk.

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Risk Management Framework

11.15 Velindre University NHS Trust have designed a Risk Management Framework that focuses on identification, reporting and management of risk.

11.16 The Project Management Office (PMO), led by the nVCC Principal Project Manager (PPM), will oversee the operation of the Risk Management Framework and will be the Risk Management Lead for the Project. It will be the responsibility of the PPM to coordinate the Risk Management Sub-Group and to liaise with project's risk champion to ensure individual risk owners actively manage risk mitigations

11.17 Although overseeing the Risk Management Framework the PPM will not be responsible for the actually taking forward risk mitigating actions (this will be the nominated risk owner). The risk management roles are set out in Table 14 below.

Table 14 - Risk Management Roles

Role	Responsibility	Reporting & accountability
Risk Management Lead	Manages the process for identifying and addressing risk, maintaining the risk register on a day-to-day basis	SRO and Project Board
Risk Management Sub-Group	Brings together key risk owners to co-ordinate the identification and assessment of risks plus the management of key risks	Project Team and Project Board
Risk Owner	Individual or group responsible for developing and implementing risk mitigation measures for individual risks they are responsible for	Risk management lead and Risk Management Sub-Group

11.18 The Trust has recognised and acted upon its responsibility for leading effective risk management throughout each stage of the nVCC project. This is particularly important at FBC stage, to ensure that the risks associated with the preferred solution have been identified and addressed. The paragraphs below set out the work completed to date, demonstrating the proactive approach to risk management.

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Responsibility for Managing the nVCC Project Risk Register

11.19 The nVCC Project Director is accountable for ensuring that there is robust and proportionate risk management for all their accountable projects. To do this it is important that the relevant information on risk is available. The responsibility for managing the nVCC Project Risk Register lies with the nVCC Principal Project Manager who will review the Risk Register and where necessary hold Risk Reduction Meetings as and when required. Otherwise, the Risk Register will be issued monthly with updated changes.

11.20 The Risk Register will be updated and reviewed continuously throughout the course of the nVCC Project lifecycle and capture the following information for each risk:

- Risk Register Risk number (unique within the Register);
- Risk type Author (who raised it);
- Date identified;
- Date last updated;
- Description (of risk);
- Likelihood / Impact;
- Interdependencies (between risks);
- Expected impact;
- Cost;
- Bearer of risk;
- Mitigating actions; and
- Risk status (action status).

11.21 All the risks identified in the Strategic Case and Economic Case sections of the nVCC Project must be accounted for within the nVCC Project Board Risk Register (see Appendix **FBC/MC15**).

Quantification of Project Risks

11.22 The build of quantified risk has been developed in a number of areas within this FBC. Capital risks have been completed as part of the capital risks utilising expert advice from advisors such as PWC.

Mitigation of Risk

11.23 The nVCC Project Board risk register will be formally reviewed monthly at the Project Board meetings. All Project Groups and Sub-Groups will also have their individual risk registers. All Risk Registers must have mitigating actions associated with them. All risks will then be re-evaluated after considering the effect of the mitigating actions, resulting in a post mitigation risk score.

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Review and Escalation of Risk

11.24 The Project Groups and Sub-Groups will consider and mitigate risk and maintain those, which can be actively managed by the Sub-Group. However, when a risk is deemed so potentially severe post mitigation that it could affect the overall delivery of the nVCC (to time, cost or quality) the risk will be escalated to the nVCC Project Board for more senior oversight. The nVCC Project Board will manage risk that directly affects their prescribed deliverables. The members of the nVCC Project Board will review the Risk Register at each meeting adding, reassessing, escalating or closing risks as necessary.

Issue Management

11.25 Issues are Risks that have materialised. Similar to risk, the nVCC Project Board will hold an Issues Register and follow the same escalation path (see Appendix **FBC/MC16**).

11.26 All issues should have an owner and an allied action plan, will be reviewed during all nVCC Project Board meetings, and are categorised as high, medium and low priorities.

11.27 Issues will be regularly reported to the nVCC Project Board and escalated to the TCS Programme Scrutiny Sub-Committee and Trust Board as appropriate.

11.28 Issues that are outside the scope or authority of the nVCC Project Board will be referred to the Strategic Capital Board and / or the Trust Board as appropriate.

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12 APPENDICES

For Information

The following Appendices are available in support of this Case:

Appendix Reference	Title
FBC/MC1	Project Management Structure – Roles and Responsibilities
FBC/MC2	TCS Project Governance Arrangements by Committee or Board
FBC/MC3	nVCC TCS Programme Scrutiny Sub-Committee, Programme Delivery Board and Strategic Capital Board – Terms of Reference
FBC/MC4	Integrated Assurance and Approvals Plan
FBC/MC5	Digital Activity Plan
FBC/MC6	Key Clinical Equipment Outline Commissioning Programme (KCEOCP) – *Acorn's draft submission on 16.01.2023,*
FBC/MC7	Successful Participants Clarification Issues
FBC/MC8	Welsh Government Gate 2 Report (NB - Gate 3 to follow)
FBC/MC9	In-Life Contract Management Role and Responsibilities
FBC/MC10	Acorn Construction timelines
FBC/MC11	MIM Project Plan
FBC/MC12	Benefits Realisation and Project Evaluation
FBC/MC13	Benefits Register
FBC/MC14	Communication and Engagement Plan
FBC/MC15	Project Board Risk Register (February 2023)
FBC/MC16	Project Board Issues Register (February 2023)

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Report Title:	Refurbishment of Mortuary at UHW – Submission of Business Justification Case			Agenda Item no.	7.6.1
Meeting:	UHB Board	Public	✓	Meeting Date:	30th March 2023
		Private			
Status *(please tick one only):*	Assurance		Approval ✓	Information	
Lead Executive:	Executive Director of Strategic Planning				
Report Author (Title):	Director of Capital Estates and Facilities				

Main Report
Background and current situation:

The attached Executive Summay of the Business Justification Case (BJC) sets out the rationale for the redesign/refurbishment of the Mortuary at the University Hospital of Wales (UHW) and makes the case for a capital investment of £3.385m to be funded from the All Wales Capital Programme.

The motuary and post mortem facility was the subject of a regulatory inspection by the Human Tissue Authority (HTA) in August 2017 and the outcome was that the facility was found to be non compliant with the regulatory standards required to maintain a licence under the Human Tissue Act.

A range of factors were found to have contributed to the outcome, including examination tables without integral exhaust ventilation, unsealed floors with unsuitable drainage in the post mortem room. The facility has a number of backlog maintenance issues commensurate with the age of the facility which was constructed in the late 1960's.

Failure against the regulatory standards can result in the suspension of licensed activities ie. storage of the deceased and the undertaking of post mortem examinations, with the potential revocation of the UHB licenece and ultimately prosecution with an unlimited fine.

In addition to the structural defects of the facility, the storage capacity is recognised as being sub optimal for the population demographic changes that have occurred over the last 50 years and which are due to further increase with the impact of Local Development Plans.

The UHB gave a commitment to the HTA that a solution would be identified to ensure a compliant facility that was fit for purpose as a priority. A number of factors have delayed the scheme, including discussions with Coroners office regarding a facility for a wider population and the Covid pandemic.During this period the UHB have maintained dialogue with the HTA to ensure that they were aware of the UHB position and their commitment to delivering the outcome.

The proposed scheme will included a reconfiguration of the facility to allow for increased storageas indicated in the table below, including obese patients, a layout that will support better flow and body handling, improved viewing and identification etc.

	Refrigerated	Obese	Semi-Obese	Bariatric	Freezer	Paediatric	Foetal	TOTAL
Current	93	0		4	5	10		112
Future	68	4	56	7	5	10	9	159

The BJC includes costs to undertake works to the mortuary at University Hospital Llandough to improve its condition to allow it to be used as a temporary facility whilst the buildingworks at UHW are undertaken.

The BJC has been written in accordance with Welsh Government guidance for the development of better business cases. It sets out the strategic context for the development; the case for change,

which summarises the business need for the investment and the need for service improvement; consideration of the options available and identification of the preferred option following economic appraisal; the procurement strategy and intended contractual arrangements; capital and revenue costs, funding arrangements and overall affordability of the scheme; management arrangements for the project, including governance, risk management and benefit realisation.

Capital and Revenue Costs
The capital costs for the preferred option are shown below. The scheme will be funded through the All Wales Capital Programme.

Capital Costs	£'m
Works Costs	2.606
Fees	0.496
Non Works Costs	0.120
Equipment costs	0.030
Planning Contingency	0.302
Total Net	3.554
VAT Recovery	(0.169)
Total Capital Cost/ Cost Forms	3.385

As the project involves the refurbishment of an existing facility it has been estimated that there are no additional recurring revenue costs for the preferred option.

The anticipated capital spend, capital charges and depreciation profile for the extent of the project is shown in the table below:

	2023/24 £000	2024/25 £000	2025/26 £000
Capital (Ex VAT) - DEL	2,538	0,022	0,000
Depreciation	0,000	0,010	0,010
Total	**2,538**	**0,032**	**0,010**

Project Milestones

Milestone	Target Date
Submission of Business Justification Case to Welsh Government	March 2023
WG approval of the FBC	June 2023
Start on Site	August 2023
Completion and Handover	July 2024

The full BJC is available on request.

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

- This project is essential to ensure that the UHB has compliant facilities for body storage and post mortem examinations.
- The HTA are due to undertake a re-inspection of the existing facility and the importance of ensuring that this BJC is supported will provide confidence to the licensing authority that the UHB is committed to the development

- The Business Case has undergone the internal governance process.

At the time of publishing this report, this matter is due to be considered by the Finance Committee on 22 March 2023 with a recommendation , put simply, that Board approves (i) that the Business Justification Case be submitted to the Welsh Government for approval, and (ii) that subject to WG approval of the BJC, the award of the construction contract to Tilbury Douglas Construction to the value of £2.606m (inclusive of VAT) under the terms and conditions of the NEC short form contract.

Recommendation:

Board is requested to:-

a) **Approve** the submission of the UHW Mortuary Refurbishment – Business Justification Case to Welsh Government for capital funding support and approval; and

b) subject to Welsh Government approval of the BJC, **approve** the award of the construction contract to Tilbury Douglas Construction at the value of £2.606m (inclusive of VAT) under the terms and conditions of the NEC short form contract.

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

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

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant

Prevention	✓	Long term	✓	Integration	✓	Collaboration	✓	Involvement	✓

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

Risk: Yes/~~No~~

Risk Potential Assessment has been undertaken, which considered the project risk in relation to strategic alignment, finance/funding, stakeholder engagement, governance, project dependencies, and concluded that the overall risk is **medium**

A project risk register has also been completed.

Safety: Yes/~~No~~

The capital design incorporates statutory health and safety requirements

Financial: Yes/~~No~~

Capital funding for this project is anticipated to come from the All Wales Capital Programme. The BJC sets out the rationale and capital costs.
Workforce: No
Legal: ~~Yes~~/No
Reputational: Yes
Potential for the revocation of HTA licence
Socio Economic: No
Equality and Health: No
Decarbonisation: No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Project Team	
Capital Management Group	6th March 2023
Investment Group	1st March 2023
Finance Committee	22nd March 2023
CAV Board	30th March 2023
Submission to Welsh Government for scrutiny and approval	April 2023

Mortuary at University Hospital of Wales

Business Justification Case: Executive Summary

(Document 1 of 3)

March 2023

CARING FOR PEOPLE
KEEPING PEOPLE WELL

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1.0 EXECUTIVE SUMMARY

1.1 Overview and Introduction

This business case seeks the approval for a capital investment of £3.385m to enable the Health Board to redesign/refurbish the Mortuary at the University Hospital of Wales (UHW).

The mortuary and post mortem facility at UHW was the subject of a regulatory inspection by the Human Tissue Authority (HTA) in August 2017. The facility was found to be non-compliant with the regulatory standards required to maintain a licence under the Human Tissue Act. This project, when complete, will address the issues highlighted in the Human Tissues Authorities inspection report and thereby ensure that the facility at UHW continues to be a licenced site under the HTA requirements.

1.2 Strategic Context

Cardiff and Vale University Health Board is responsible for planning and delivering health services for people in Cardiff and the Vale of Glamorgan, a population of around 502,000 and is the main provider of specialist services for the people of South Wales – and for some services, the whole of Wales and the wider UK. This includes health promotion and public health functions as well as the provision of local primary care services (GP practices, dentists, optometrists and community pharmacies) and the running of hospitals, health centres, community health teams and mental health services. The Health Board employs approximately 15,000 staff and has an annual budget of £1.6 billion.

As a major teaching and research organisation, there are very close links to Cardiff University playing a significant role in the Welsh economy. This is alongside other academic links with Cardiff Metropolitan University and the University of South Wales. Training the next generation of clinical and non-clinical professionals, in order to develop expertise and improve clinical outcomes, is a key priority for the Health Board.

The population served by the Health Board is growing rapidly in size, projected to increase by 10% between 2017-27, higher than the average growth across Wales and the rest of the UK. An extra 36,000 people will live in Cardiff over the next five years who require access to health and wellbeing services.

The Health Board is confident that the strategic drivers for this investment and associated strategies, programmes and plans are consistent with national, regional and local strategy and policy documents.

Some of the key UK national guidance and standards that have shaped this BJC are:

Managing infection risks when handling the deceased (2018)	Code of Practice A – Guiding Principles and the Fundamental Principle of Consent (2020)	Code of Practice B – Post Mortem Examination, Codes of Practice and Standards (2017)

Executive Summary Figure 1: Key Strategies and Policies

This BJC also takes cognisance of the relevant local strategies, these are:

- 2022 – 2023 Integrated Plan (June 2022)
- Shaping Our Future Wellbeing – Future Hospitals Programme Business Case (September 2021)
- Cardiff and Vale People and Culture Plan 2022 – 2025
- Shaping our Future Clinical Services
- Shaping Our Future Wellbeing Strategy 2015 – 2025
- Integrated Medium Term Plan 2022 – 2025
- Cardiff and Vale UHB Delivering Digital: a Five Year Strategy - Building a learning health and care system (July 2020)
- Cardiff and Vale UHB Estates Strategy (2017)

1.3 Case for Change

The specific spending objectives for this business case are:

Spending Objective	Description	Measure	Time
1. Quality of Service	Maintenance of HTA license and improved productivity Storage of relevant materials	HTA License Number of post mortems carried out	This objective will be achieved when new facilities are commissioned
2. Quality of Environment	Improved environment for the deceased Improved local facilities for the bereaved Improved working environment for staff	Compliance with HBN/HTMs User feedback Staff survey	This objective will be achieved when new facilities are commissioned
3. Capacity	To provide sufficient capacity to ensure the demands of the population (both current and future) are met to include support to the Wales Institute of Forensic Medicine, whole Wales specialties and major trauma centre status along with increased demand associated with winter pressures and local emergency planning	Capacity deficient reports – daily	This objective will be achieved when new facilities are commissioned

Spending Objective	Description	Measure	Time
4. Effective Use of Resources	To provide an environment that promotes improved service efficiency through improved flow, productivity and improved patient and relevant material management pathway flows	Reduction in damage sustained to building fabric and infrastructure – reduction in avoidable maintenance costs Avoidance of HTARIs associated with body handling and maintenance of dignity of the deceased and retention of relevant mater	This objective will be achieved when new facilities are commissioned
5. Sustainability	To provide a service within an environment that is sustainable and accreditable, and with particular reference to HTA licensing requirements and reduction of ongoing maintenance costs.	HTA requirements Ability to recruit high quality clinical staff Maintenance costs	This objective will be achieved within 1 year of new facilities being commissioned
6. Practicality of Delivery	Ensure a solution which can be delivered in a timely manner and with services being maintained during construction with minimal disruption	Project programme / delivery date	Business Case approval by CVUHB and WG

Executive Summary Table 1: Spending Objectives

1.3.1 Current Arrangements

The mortuary provides body storage and post mortem facilities to the hospitals of Cardiff and Vale University Health Board and acts as a public mortuary for the South Wales Central coroner, a population of 1.2 million. The service also hosts the Wales Institute of Forensic Medicine (WFIM), supporting home office post mortems for the constabularies of South, Mid and West Wales and Gloucestershire within England. The facility also supports small Disaster Victim Identification incidents.

The mortuary and post mortem service provides Human Tissue Act (HTA) licensed facilities at University Hospital of Wales (UHW) with an unlicensed body storage facility at Llandough Hospital (UHL).

Cardiff University manage the Wales Institute of Forensic Medicine (WIFM) and are strategic partners in the mortuary development programme. Other key stakeholders will include Welsh Government (WG), Welsh Health Specialised Services Committee (WHSSC), Cardiff and the Vale local authorities, coroners across Wales, Welsh and English Police forces and the home office.

The facility at the UHL is an unlicensed body store with the capacity to store 66 deceased patients including 5 bariatric patients. The facility at UHW is a licenced premise under the HTA and holds a licence for post mortem examination. The facility comprises 112 refrigerated storage spaces, including 4 bariatric spaces, 5 freezer spaces for longer term storage of the deceased and a dedicated 10 space paediatric refrigeration unit. Storage is provided across a number of fridge banks and a walk in cold store.

The post mortem facility at UHW has a five table main post mortem suite, comprising three standard post mortem tables, one paediatric table and one high risk table used for neuropathology cases. In addition, there is an adjacent room which is isolated which is used for home office post mortems and to contain 'high risk' post mortems. The post mortem suite is supported with adjacent office accommodation, police briefing rooms and evidence collection rooms.

The post mortem suite is supported by decontamination areas and staff changing rooms.

The facilities on both hospital sites have dedicated areas for viewing the deceased with the associated waiting rooms and support facilities.

Adjacent to the post mortem suite at UHW is a dedicated storage area of relevant materials obtained during post mortem examination including secured cabinets for material held under Police and Criminal Evidence Act (1984) (PACE) or the Criminal Procedure and Investigations Act (1996) (CPIA).

Access to the mortuary facility is highly restricted with TDSi card access and high levels of CCTV coverage. The funeral director vehicle access is partially protected by a descending shutter to protect the dignity of the deceased during transfer. There are two dedicated vehicle bays for the bereaved.

The mortuary service handles approximately 3,000 deceased patients a year and undertakes upwards of 1,600 post mortems on both adults and children.

The service also supports a home office post mortem service for over two thirds of the population of Wales and a Paediatric and Neuropathology service for the whole of Wales a population of 3.3 million people.

1.3.2 Business Need

The mortuary and post mortem facility was the subject of a regulatory inspection by the Human Tissue Authority (HTA) in August 2017. The facility was found to be non-compliant with the regulatory standards required to maintain a licence under the Human Tissue Act.

Examination tables have no integral local exhaust ventilation and are non-ergonomic, flooring is in poor repair and assurance that it is fully sealed and non-permeable cannot be given. Repairs and maintenance commensurate with the age of the facility (building constructed in the 1960's) are reported and addressed as per the standard procedure.

Failure against the regulatory standards will result in suspension of licenced activities i.e. storage of the deceased and the undertaking of post mortem examinations and the potential revocation of the licence with associated regulatory actions. Prosecution could result in an unlimited fine.

Storage capacity is recognised to be suboptimal for the population demographic changes that have occurred during the life time of the current local authority local development plan with the population only growing. The storage capacity has breached on a number of occasions and formal breaches are reportable under the licence conditions to the HTA.

The deceased remain in the care of the mortuary until collected by funeral directors. Length of stay varies from 7 calendar days to many months, dependent on case status and family's ability to facilitate ultimate disposal. On six occasions prior to the Covid pandemic capacity has been close to breaching and would have breached other than for active management and engagement with funeral director support at cost to the organisation.

The impact of the COVID pandemic and operational flow requirements currently indicate a deficit of 80 storage spaces.

The current capacity has been augmented with the procurement of a rapidly deployable Flexmort solution comprising two 12 capacity and one 4 capacity storage units, which are deployable within the current footprint.

The deficit remaining to support surges and increases in short term demand is 56 storage spaces.

The facility also needs to ensure it has appropriate dedicated access for the bereaved, with secure and dignified access.

1.3.3 Proposed Scope

The facilities including, patient storage, viewing and identification, bereaved relatives areas, body handling areas, post mortem examination suites, transfer areas and storage areas for relevant materials as defined by the Human Tissue Act 2004 are within the scope of this project.

1.3.4 Main Benefits

This section describes the main outcomes and benefits associated with the implementation of the investment of the identified scope in relation to the identified business needs.

Benefits are expressed in relation to the developed appraisal criteria that were derived from the spending objectives as follows:

Stakeholder Group	Main Benefits	Measure
Patients	Non QB - Maintenance of dignity in death QB - Rapidity of Post mortem examination Non CRB - Staff time saved (increased capacity - decreased transfers between sites)	HTA Audit compliance outcomes Achievement of KPI against scheduling Non cash releasing – time saving benefit, improved QMS compliance, 'time to care'
Staff	Non QB - Improved Morale QB - Improved productivity	Improved staff satisfaction outcomes decreased short term sickness episodes. Ability to redesign processes.
Health Community	Non QB - Maintenance of dignity in death QB - Rapidity of Post mortem examination	HTA Audit compliance outcomes Achievement of KPI against scheduling

Executive Summary Table 2: Key Benefits

1.3.5 Main Risks

The table below provides a summary of the key business and service risks that might affect any option for the delivery of the project along with their counter measures:

Risk	Mitigation
Capital investment not secured	Ongoing discussions with Welsh Government
Scheme not progressed to programme, impacting on the service delivery and the HTA expectations	Regular programme review with Project Manager and Project Team to identify any potential impacts to the programme
Cost of scheme overruns (unexpected conditions)	Robust interrogation of costs by external advisors to ensure they are valid
Delayed approval by WG and resulting additional costs	Ongoing discussions with Welsh Government
There is a risk that additional capital is needed during construction - this can result from increases in costs for materials due to the global market etc.	The Health Board will endeavour to ensure there is sufficient contingency funding to mitigate reasonable increases in costs due to global markets

Risk	Mitigation
Currently the facility is not compliant with HTA standards. As the facility continues to age, without renovation works, it will continue to deteriorate. The ongoing deterioration and non-compliance presents a risk that the HTA could insist on the facility closing until improvements are complete	The HTA are aware of the efforts to update the facility. The Health Board is in close contact with the HTA to ensure the minimisation of the risk of closure
If the above is realised there is a reputational risk to the Health Board through media exposure	The HTA are aware of the efforts to update the facility. The Health Board is in close contact with the HTA to ensure the minimisation of the risk of closure

Executive Summary Table 3: Main Risks

1.4 Development of Options

Health Board staff from capital and estates, and strategic and service planning identified the following options for assessment:

Long List Options	
Option 0	Business as Usual
Option 1	Joint solution with local authorities
Option 2	Hire in a solution
Option 3a	Refurbishment of the current facilities at UHW (to meet the findings of the HTA report)
Option 3b	Refurbishment of the current facilities at UHW (to meet the findings of the HTA report and provide a wider refurbishment)
Option 4	New build at UHW
Option 5	New build elsewhere within Cardiff

Executive Summary Table 4: Summary of Options

Advantages and disadvantages of each option were considered with options 1, 2 and 5 not carried forward for further investigation since they did not the meet critical timescales required or the principles laid out within the spending objectives for the project.

The options therefore considered as providing sufficient benefits to warrant further non-financial and financial appraisal are set out in the table below. These shortlisted options have been renumbered to aid the appraisal process:

Option	Description
Option 0	Business as usual (carried forward for comparative purposes)
Option 1	Do Minimum - refurbishment of the current facilities at UHW to meet the HTA findings (previously option 3a)
Option 2	Refurbishment of the current facilities at UHW to meet the HTA findings and provide a wider refurbishment (previously option 3b)
Option 3	New build at UHW (previously option 4)

Executive Summary Table 5: Shortlisted Options

1.4.1 Benefits Appraisal

To further establish the preferred way forward from the above available shortlisted options, a qualitative benefits appraisal was undertaken which enabled the Project Team to determine which option satisfied the attributes essential for successful delivery to a greater extent.

The appraisal of the qualitative benefits associated with each option was undertaken during a workshop held on 6th September 2022 whereby the team:

- Identified a list of qualitative benefit criteria (this criteria was derived from further analysis of the spending objectives and main benefits as outlined within the case for change section of this business case);
- Weighted the relative importance (%) of each benefit criteria in relation to each spending objective (noting that all the criteria listed are important but there may be some that are more crucial to the success of the project than others);
- Scored each of the short-listed options against each of the benefit criteria on a scale of 1 to 10;
- Derived a weighted benefit score for each option.

The qualitative benefits criteria were listed and weighted by the Team as follows:

Spending Objective	Benefit Criteria	Weight %
Quality and Safety of Service	1. Enables the Health Board to deliver high quality services that deliver best practice.	15
	2. Provides appropriate departmental adjacencies and minimises journey times both within the department and to end users	6
Quality of Environment	3. Provide safe and appropriate environment for mortuary services	14
	4. The facilities meet the relevant HTA regulatory standards and guidelines	17
Access/Capacity	5. Provides sufficient capacity to meet the current and future demands of the patient population, supporting the Wales Institute of Forensic Medicine, Neuropathology and Paediatric post mortem services for the whole of Wales and the UHW major trauma centre status	11
Effective use of Resources	6. Enables the Health Board to improve productivity and provide a service that supports patients, families and other stakeholders	13
	7. Maximise use of existing accommodation to enable estate rationalisation and improved utilisation	4
Sustainability	8. Maximise flexibility of facilities to enable the delivery of safe, sustainable and accessible services in the short to medium term.	8
Practicality and Timeliness of Delivery	9. Deliverable within an acceptable timescale to satisfy the requirements of the HTA inspection schedule	12
TOTAL		100%

Executive Summary Table 6: Qualitative Benefits

The Team reviewed each of the shortlisted options against every qualitative benefit criteria listed above and then allocated a score of 1-10 (rising scale) based upon how well the option met each of the criteria. The Team scored on the following basis:

- 1 or 2 Option does not meet the criteria
- 3 or 4 Option meets the criteria to a very limited extent
- 5 or 6 Option partially meets the criteria but is acceptable
- 7 or 8 Option meets the criteria to a greater extent
- 9 or 10 Option fully meets the criteria

The score for each option was agreed through rigorous discussion by the workshop participants to confirm what had been applied was fair and reasonable. Following the conclusion of the scoring, each score is then multiplied by the weighting given to that criteria to provide an overall total score.

The summary results of this exercise were as follows:

Benefit Criteria	Weighted Scores			
	Option 0	Option 1	Option 2	Option 3
1. Maximising access to services	60	75	120	135
2. Improving the clinical quality of services	36	36	36	36
3. Optimising the environmental quality of services	70	70	112	126
4. Improved strategic fit of services	136	153	153	153
5. Meeting training, teaching and staff support needs	22	22	77	99
6. Making more effective use of resources	52	52	91	117
7. Providing flexibility for the future	28	28	36	4
8. Optimising the sustainability of services	16	16	56	72
9. Practicality and timeliness of delivery	12	84	72	24
TOTALS	**432**	**536**	**753**	**766**
RANK (weighted)	**4**	**3**	**2**	**1**

Executive Summary Table 7: Benefits Scoring

Some of the key considerations that influenced the scores achieved by the various shortlisted options were as follows:

- Option 0: Business as Usual - this option ranked 4th due it not fulfilling the HTA requirements and to the current issues described earlier within this business case and in particular the lack of sufficient capacity to meet the anticipated demand
- Option 1: Do Minimum - refurbishment of the current facilities at UHW, this option ranked 3rd as there is only a small improvement over the current position and whilst this option would meet the HTA requirements it would not provide sufficient capacity or resolve some of the workflows currently experienced within the department
- Option 2: Refurbishment of the current facilities at UHW to meet the HTA findings and provide a wider refurbishment, this option ranked 2nd as it meets the HTA

requirements, increases capacity and improves the internal flows within the department

- Option 3: New build at UHW, this option ranked 1st as it is anticipated that a new build would meet all required standards and provide fit for purpose, flexible accommodation

Sensitivity analysis was undertaken by changing the ranking of the benefit criteria to evaluate the impact on the overall score for each option. The analysis included applying reverse, high, low and no weightings to the criteria.

The results indicated that when the options where no weighting was applied or if the weightings were reversed then option 2 becomes the preferred option.

1.4.2 Economic Appraisal

The principles and assumptions used in the BJC are:

- Capital costs prepared to OB1 forms by Gleeds QS (dated October 2022) at BJC project Cost which has been used for the economic appraisal and a project outturn cost
- Optimism bias has been assessed according to the national formula with appropriate mitigations and has been included in the economic analysis and the table below. The OB forms do not include this and therefore the table below gives the full estimated capital cost
- Indicative Lifecycle costs prepared and included for FM engineering to QS parameters, a 7 year equipment lifecycle has been assumed for all options
- The economic model has been run for 60 years using discount rates of 3.5% for years 0-30 and 3.00% thereafter
- Revenue costs for each option as prepared by the Health Board reflecting the impact of each
- Planning risk has been included within the economic model

These are summarised below:

Capital Costs at approval PUBSEC	Option 0	Option 1	Option 2	Option 3
	£000	£000	£000	£000
Works Costs	758.1	2896.7	3142.3	4826.5
Fees	0.0	547.5	593.9	912.2
Non-Works	0.0	0.0	0.0	0.0
Equipment Costs	0.0	25.0	25.0	297.6
Planning Contingency	0.0	294.7	318.1	512.9
Optimism Bias	0.00	439.7	485.7	972.2
Total Approval Capital Cost excl VAT	**758.1**	**4418.6**	**4780.0**	**7896.3**
VAT	151.61	486.7	526.3	1389.0
Total Approval Capital Cost	**909.7**	**4905.2**	**5306.3**	**9285.3**
Inflation	0.0	363.4	392.9	859.8
Total Outturn Capital Cost	**909.7**	**5268.6**	**5699.2**	**10145.0**

Executive Summary Table 8: Capital Costs for Shortlisted Options

Economic Appraisal Outputs

Details of the economic appraisal are summarised in the table below:

Economic Cost	Option 0	Option 1	Option 2	Option 3
	£000	£000	£000	£000
Net Present Value (NPV)	12,267	17,281	17,105	22,246
Equivalent Annual Cost (EAC)	499	645	638	830
Ranking of Development Options		2	1	3
EAC Margin Development Options		(1.0%)	0.0%	30.1%
NPC Switch Value		(155)	155	(5,368)

Executive Summary Table 9: Summary of Economic Appraisal Outputs

On the basis of the economic appraisal undertaken option 3 is the preferred financial solution but only by 1% over and above option 1. This is due to the lower revenue costs over the life of the project more than offsetting the higher initial capital and lifecycle costs. Option 3 is 30% worse than option 2 due to higher revenue costs and the additional capital investment.

Sensitivity testing indicates therefore a small change only is required to move between option 1 and 2. Option 3, however, is over 40% worse than option 2 on either revenue or capital.

Economic Cost Sensitivity	Option 0	Option 1	Option 2	Option 3
	£000	£000	£000	£000
Base Cost Change needed (Lower)/Higher				
Capital Costs		(3.1%)	2.8%	(55.4%)
Revenue Costs		(1.3%)	1.3%	(42.7%)
NPC Change Needed		**(155)**	**155**	**(5,368)**

Executive Summary Table 10: Economic Cost Sensitivity

Option 2 is therefore confirmed as the preferred option from a quantitative appraisal perspective but only very marginally to Option 1.

Combined Appraisal

The outputs of the Non-Financial and Economic Appraisals have been combined to assess which option offers the best benefit/cost outcome based on the number of benefit points delivered per EAC £000.

Combined Appraisal	Option 0	Option 1	Option 2	Option 3
Weighted Non-Financial Scores	432	536	753	766
Margin Preferred				1.7%
Non-Financial Ranking of Options	4	3	2	1
EAC	498.0	645.0	638.5	830.4
Benefits Points Per EAC		0.83	1.18	0.92

Combined Appraisal	Option 0	Option 1	Option 2	Option 3
Combined Ranking		3	1	2
Difference		(29.5%)	0.0%	(21.8%)

Executive Summary Table 11: Summary of Combined Appraisal Outputs

The output of the combined option appraisal means that option 2 moves well ahead of option 1 due to the additional non-financial benefits provided by option 2. Option 1, however, moves closer to option 3 because of the higher non-financial benefits of option 3 and becomes the lowest ranked option from the three options.

Sensitivity analysis showed that either option 2 or 3 would have to change the non-financial scores by over 20% to switch the preferred option.

1.5 The Preferred Option

The preferred option is Option 2. It comprises the general refurbishment of the post-mortem suites, body stores and staff areas at the existing mortuary at the University Hospital of Wales. The mortuary is located on the lower ground floor of the existing west tower block. The project also includes the general refurbishment of the post-mortem suite at the existing mortuary at University Hospital Llandough.

The scope of works is:

- The Mortuary at the University Hospital of Llandough (UHL) will be re-conditioned as part of the development's scope of work. The existing building will work as a temporary facility during the building works in the University Hospital of Wales (UHW) Mortuary
- This proposal includes the redevelopment of the Mortuary department at the University Hospital of Wales (UHW). It improves the body storage capacity and Post-Mortem facilities including the provision of new office space, beverage room, accessible WC and reconditioning of the staff changing rooms.

The following tables shows the changes to permanent body storage capacity as a result of this project:

	Standard	Obese	Semi-Obese	Bariatric	Freezer	Paediatric	Foetal	TOTAL
UHW - Current	93			4	5	10		112
UHW - Future	68	4	56	7	5	10	9	159
UHL - Current	61			5				66
UHL - Future	61			5				66

Executive Summary Table 12: Changes to Body Storage Capacity

NB: A temporary body store will be provided at UHL with a capacity of 40 whilst the refurbishment is taking place at UHW.

Whilst there is an increase in body storage capacity, the Health Board recognises that in times of extreme demand the Health Board will work with partners to provide a temporary increase in storage capacity.

1.6 Procurement Route

Due to the specialist nature of the scheme, the procurement route to be utilised will be as follows:

- Scape Built Environment Consultancy Services ("BECS") Framework for design - RIBA Stage 2 – 4;
- NHS SBS Construction Consultancy Service (NHS Shared Business Services) for RIBA Stage 5 – 7;
- The Building Framework (Contractor).

The procurement strategies are in line with the procedures and practices as laid down in the varying frameworks. The construction elements of the proposed scheme were formally competitively tendered as part of the production and agreement of the target price. An open book approach to prices was adopted in line with the Framework and all costs were closely scrutinised to ensure that the Health Board is getting the best value for money. As a result of this process Tilbury Douglas have been appointed as the contractor as they demonstrated that they have considered the scheme and the nature of the works required.

The Health Board intends to make payments in respect of the proposed products and services as follows:

- The contract will be managed by Cardiff and Vale University Health Board under the NEC3 Option A

1.7 Funding and Affordability

This Business Case seeks approval to invest £3.385m from the All Wales Capital Programme, a breakdown of the capital costs is summarised in the table below:

	£000
Building/Engineering	3.355
Equipment Costs	0.030
Total Capital Costs	**3,385**

Executive Summary Table 13: Capital Costs for the Preferred Option

1.7.1 Overall Affordability and Balance Sheet Treatment

A summary of the capital and depreciation for the project is as follows:

	£000
Impairment	2,528
Building / Engineering Depreciation	0,010
Equipment Depreciation	0,000
Accelerated Depreciation	0,000
Total Capital Charges/Depreciation	**2,538**

Executive Summary Table 14: Capital Charges and Depreciation

The following is a summary of the total impact of impairment by year until the planned opening of the new facility:

	2023/24 £000	2024/25 £000	2025/26 £000
DEL Impairment	0,000	0,000	0,000
AME Impairment	2,528	0,000	0,000
Total Impairment	**2,528**	**0,000**	**0,00**
Depreciation – Build	0,000	0,010	0,010
Depreciation - Equipment	0,000	0,000	0,000
Total Depreciation	**0,000**	**0,010**	**0,010**

Executive Summary Table 15: Impairment and Depreciation by Year

This BJC assumes all capital charges and depreciation will be funded by Welsh Government in each of the years as per the above.

There are no additional revenue costs per year expected on the preferred option. The staff requirement will remain unchanged as whilst the storage capacity increases, the layout will be more efficient and less spread out. There will not be any additional equipment required as that is already in place, so no additional costs associated with that. To note the newer

equipment is more energy efficient. The footprint of the mortuary does not change, therefore no change to estates and facilities costs are expected.

The anticipated capital spend, capital charges and depreciation profile for the extent of the project is as follows:

	2023/24 £000	2024/25 £000	2025/26 £000
Capital (Ex VAT) - DEL	2,936	0,026	0,000
Depreciation	0,000	0,010	0,010
Total	**2,936**	**0,036**	**0,010**

Executive Summary Table 16: Impact on Income and Expenditure Account

All assets will be shown on the Health Board's balance sheet. The asset will be valued on completion and recorded on the balance sheet at that value. Subsequently it will be treated as per the Health Board's capital accounting policy.

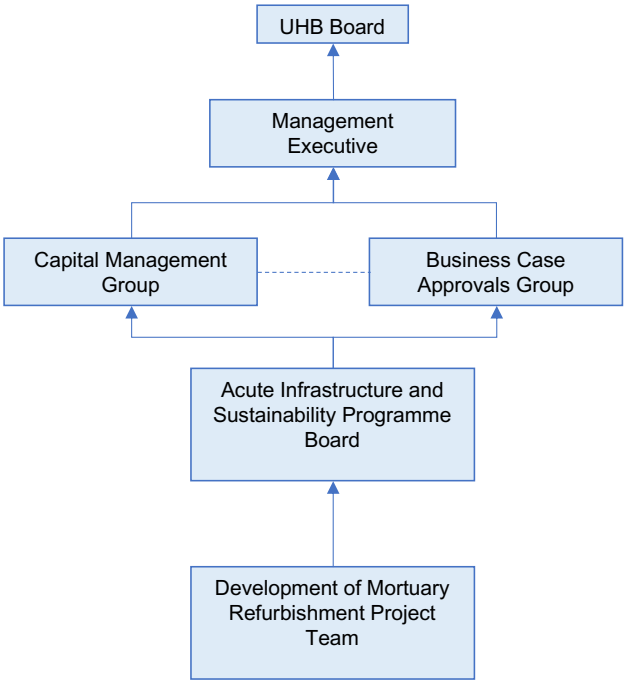
1.7.2 Project Bank Account

The Health Board can confirm that a Project Bank Account will be prepared at the appropriate stage as the project exceeds the Welsh Government value threshold for the mandatory use of Project Bank Accounts.

1.8 Management Arrangements

Robust project management arrangements are vital to ensure the implementation of the overall project and that effective control is maintained over the capital scheme.

The reporting organisation and the reporting structure for the whole of the project is shown as follows:



Executive Summary Figure 2: Project Structure

The dates detailed below highlight the proposed key milestones of the project:

Milestone Activity	Date
BJC submission to WG	February 2023
WG approval of the BJC	April 2023
Commence construction	May 2023
Completion and handover	April 2024

Executive Summary Table 17: Project Plan

1.8.1 Communication and Engagement

The Cellular Pathology Services Manager has liaised with both Cardiff University and the Coroner to ensure that any plans they may have do not impact on the project and that they are kept up to date with progress. The latest discussion have taken place during December 2022 and March 2023.

1.8.2 Benefits Realisation and Risk Management

A benefits realisation plan has been developed that outlines the key objectives, benefits and measures, which will be used to evaluate the project, it also shows who has the accountability for its realisation.

The risk management strategy has been integrated into the project management procedures, with responsibility for implementation of the strategy resting with the Project Director. The key risks of the preferred option have been assessed and strategies for managing them outlined. A risk register has been developed for the preferred option which includes all risks identified to date.

1.8.3 Post Project Evaluation Arrangements

The Health Board is committed to ensuring that a thorough and robust post-project evaluation (PPE) is undertaken at key stages in the process to ensure that positive lessons can be learnt from the project. The lessons learnt will be of benefit to Cardiff and Vale University Health Board, other key local stakeholders and the NHS more widely.

All processes will be managed by the project team and endorsed by the appropriate boards.

1.9 Recommendation

This project, when complete, will address the issues highlighted in the Human Tissues Authorities inspection report issued in 2017 and thereby ensure that the facility at UHW continues to be a licenced site under the HTA requirements.

In addition, the project will address a number of other improvements to the facility including increased storage capacity, which recognises the increase of obese patients, remodelling the internal space to improve the flow and body handling and enhancement of the viewing and identification areas.

The Health Board would therefore, recommend that WG give due consideration to the request for funding and approve the BJC, thereby ensuring that the facility at UHW can retain its licenced Mortuary facility for the foreseeable future, serving the communities of Cardiff and Vale in addition to our neighbouring authorities as required.

Report Title:	UHW Lift Refurbishment scheme			Agenda Item no.	7.6.2
Meeting:	UHB Board	Public	√	Meeting Date:	26 January 2023
		Private			
Status *(please tick one only):*	Assurance		Approval √	Information	
Lead Executive:	Director of Finance				
Report Author (Title):	Director of Capital, Estates and Facilities				

Main Report
Background and current situation:

The purpose of this report is to set out a summary of proposals and associated capital and revenue implications for the refurbishment of nineteen lifts on the University Hospital of Wales site.
The Board is asked to approve the submission of the Business Justification Case (BJC) to Welsh Government (WG) for £9.32m, as part of the process to access capital funding.

Approval of this business case will enable the refubishment of 19 Lifts within Tower Block 1, Tower Block 2 and Ward areas of the University Hospital of Wales to ensure the continued provision of safe services for patients and staff.

The majority of the lifts located on the site are over fifty years old and have not been updated or upgraded since they were first installed. Due to the age of the equipment the lifts are prone to breakdowns with replacement parts not readily available and difficult to source within a reasonable time frame resulting in lifts being out of service for extended periods of time awaiting repairs. There are increased costs associated with purchasing replacement parts as they have to be specifically manufactured for the lifts due to the age of the equipment. The attached schedule (Appendix 1) shows the 19 lifts proposed for refurbishment, the age of the equipment and the number of breakdowns in 2022. The important date to consider is the reference G in the column which is the age of the control gear and motors. The date identified against the reference C in the column relates to the refurbishment of the lift car only.

Whilst there are over 80 lift across the UHB site many of these are in the peripheral buildings, whilst a number are located in more recent development eg. Childrens Hospital. The UHB have over the last 6 years refurbished 5 lifts with funding from discretionary capital with a further 2 (maternity) in progress, with a financial commitment of £1.472m.

The proposed programme of refurbishment prioritises those lifts that are, high usage, impact on the delivery of clinical services, provide access for patients to wards, clinics etc. and support the delivery of supplies to the wards and departments. The timescale for the completion of the works will be dependent on agreement with the operational team on the number and location of the lifts that can be withdrawn from service but is expected to be circa 3 years.

The UHB have recognised the issues with the existing vertical transportation installations and are committed to providing new lifts which are fit for purpose, reduce breakdowns and entrapments and are more efficient.

The capital cost figures included within the document have been prepared following a comprehensive procurement process as required as part of the WG process for BJC development.

The replacement programme will be phased over a number of years to ensure minimum disruption to the operation of the site.

A summary of the projected capital costs is shown below:

	£000
Works costs	7,633
Fees	487
Non-works costs	235
Equipment	0
Risk provision	360
Inflationary Increase	668
Total Net	9,383
VAT Reclaim	81
Total Gross	**9,302**

The Business Justification Case is available on request

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

- The BJC has been developed to refurbish the passenger lifts through the main areas of the UHW site to provide improved reliability and patient experience.
- Reduce costs associated with constant breakdown and downtime for clinical and ancillary support services while lifts are out of service.
- The revenue consequences relate only to the annual maintenance of the plant installed and will be managed within the existing budget.
- The BJC has undergone the internal governance process

Recommendation:

The Board is requested to:

A) APPROVE;

1. the submission of the UHW Lift refurbishment Scheme – Business Justification Case to the UHB Board for approval to submit to Welsh Government for capital funding support
2. the awarding of the construction contract, subject to Welsh Government approval of the BJC, to Otis Lifts Ltd at a value of £7.64m (inclusive of VAT) under the terms and conditions of the NEC short form contract
3. the appointment of Gleeds Management Services as the Project Manager, subject to Welsh Government approval of the BJC, at the cost of £174k (inclusive of VAT) under the terms and conditions of the SBS Framework
4. the appointment of Gleeds Cost Management as the Cost Advisor, subject to Welsh Government approval of the BJC, at the cost of £111k (inclusive of VAT) under the terms and conditions of the SBS Framework
5. the appointment of specialist vertical transportation works Supervisors, subject to Welsh Government approval of the BJC, at the cost of £104k (inclusive of VAT) under the terms and conditions of Health Board SFI's and NEC short form contract

B) APPROVE the Health Board to enter into the said contracts, subject to recommendation 2,3,4&5

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

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

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes
Lack of capital funding to deliver the scheme has implications on clinical service delivery.
Safety: Yes
The scheme has clinical safety implications with lift entrapment issues and breakdowns will impede clinical service delivery and patient safety.
Financial: Yes/No
Workforce: Yes/No
Legal: Yes
Statutory obligations require investment and the lack thereof can lead to exposure to risk and legal challenge.
Reputational: Yes
The UHB's ability to reduce waiting times and deliver services in an appropriate setting being cognisant of patient's privacy and dignity.
Socio Economic: No
Equality and Health: Yes
Increasing the overall reliability of the Lifts will ensure clinical staff are able to appropriately perform intensive clinicals activities.
Decarbonisation: Yes
Although not been specifically, new equipment installed will be more energy efficient.

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Capital Management Group	19.12.2022

APPENDIX 1

C&V UHB Daily Lift Update Capital

UHW- UNIVERSITY HOSPITAL OF WALES

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

OTIS- LIFT REFERNCE IDENTIFICATION	UHW- LIFT REFERENCE NUMBE	LOCATION/AREA	LIFT AGE (IF KNOWN)	NUMBER OF BREAKDOWNS 2022 (12 MONTHS)	USAGE (OPERATION	RISK ASSESSMENT (Y/N)
H3846	1	Ward Block A	C=1993 G=1967	5	High	
H3849	2	Ward Block A	C=1993 G=1967	8	High	
H3848	5	Ward Block C	C=1992 G=1969	11	High	
H3851	6	Ward Block C	C=1992 G=1969	4	High	
H3859	12	TB1 South (A) Block	C=1992 G=1968	2	Moderate	
H3858	13	TB1 South (A) Block	C=1992 G=1968	10	High	
H3857	14	TB1 South (A) Block	C=1992 G=1968	7	High	
H3860	15	TB1 Centre (B) Block	C=1992 G=1967	7	High	
H3861	16	TB1 Centre (B) Block	C=1992 G=1967	6	High	
H3862	17	TB1 Centre (B) Block	C=1992 G=1967	11	High	
H3863	18	TB1 Centre (B) Block	C=2018 G=2018	10	High	
H3864	19	TB1 Centre (B) Block	C=2018 G=2018	4	High	
H3865	20	TB1 Centre (B) Block Theatre	C=2007 G=1967	6	Moderate	
H3866	21	TB1 North Block	C=1992 G=1968	5	High	
H3867	22	TB1 North (C) Block	C=1992 G=1968	6	High	
H3868	23	TB1 North (C) Block	C=1992 G=1968	7	High	
H3869	24	TB2 Morgue	C=1993 G=1970	1	Low	
H3870	25	TB2 Morgue	C=1993 G=1970	2	Low	
H3872	27	Theatre (Dirty lift)	C=1993 G=1969	3	Moderate	

Modernisation of Passenger Lifts at the University Hospital of Wales (UHW)

Business Justification Case: Executive Summary

January 2023

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1.0 INTRODUCTION

This business case seeks the approval for a capital investment of £9.302m to enable the modernisation of nineteen passenger lifts located throughout the University Hospital of Wales (UHW) site.

2.0 STRATEGIC CONTEXT

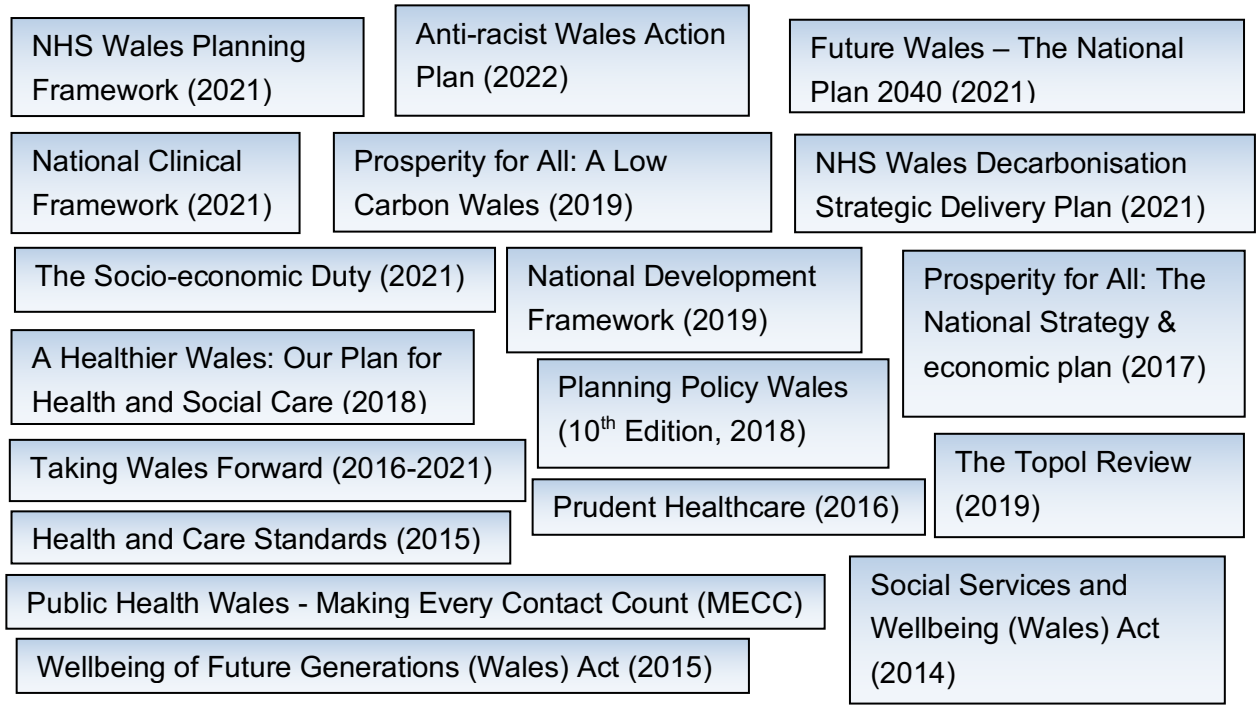
Cardiff and Vale University Health Board is responsible for planning and delivering health services for people in Cardiff and the Vale of Glamorgan, a population of around 502,000 and is the main provider of specialist services for the people of South Wales – and for some services, the whole of Wales and the wider UK. This includes health promotion and public health functions as well as the provision of local primary care services (GP practices, dentists, optometrists and community pharmacies) and the running of hospitals, health centres, community health teams and mental health services. The Health Board employs approximately 15,000 staff and has an annual budget of £1.6 billion.

As a major teaching and research organisation, there are very close links to Cardiff University playing a significant role in the Welsh economy. This is alongside other academic links with Cardiff Metropolitan University and the University of South Wales. Training the next generation of clinical and non-clinical professionals, in order to develop expertise and improve clinical outcomes, is a key priority for the Health Board.

The population served by the Health Board is growing rapidly in size, projected to increase by 10% between 2017-27, higher than the average growth across Wales and the rest of the UK. An extra 36,000 people will live in Cardiff over the next five years who require access to health and wellbeing services.

The Health Board is confident that the strategic drivers for this investment and associated strategies, programmes and plans are consistent with national, regional and local strategy and policy documents.

Some of the key Welsh Government policies that have shaped this BJC are:



Executive Summary Figure 1: Overarching National Policies considered within this BJC

This BJC also takes cognisance of the relevant local strategies, these are:

- 2022 – 2023 Integrated Plan (June 2022)
- Shaping Our Future Wellbeing – Future Hospitals Programme Business Case (September 2021)
- Cardiff and Vale People and Culture Plan 2022 – 2025
- Shaping our Future Clinical Services
- Shaping Our Future Wellbeing Strategy 2015 – 2025
- Integrated Medium Term Plan 2022 – 2025
- Cardiff and Vale UHB Estates Strategy
- Cardiff and Vale UHB Delivering Digital: a Five Year Strategy – Building a learning health and care system (July 2020)

3.0 CASE FOR CHANGE

The specific investment objectives for this business case are:

Investment Objective 1: Quality and Safety of Lift Services	
Specific	Services that deliver to appropriate quality and safety standards
Measurable	Evidenced by: ▪ Lift services meeting all applicable regulatory requirements
Achievable	Providing functionally suitable lifts to appropriate quality and safety standards
Relevant	This objective ensures the service will: ▪ Provide compliance with legislation, regulations and accreditation standards / performance; ▪ Support rapid adoption of best practice.
Time-bound	Service remains open throughout the development of the new facility and meets regulatory requirements upon commissioning
Investment Objective 2: Provide Sufficient Capacity to Meet Demand	
Specific	To ensure that the changing needs at UHW are met
Measurable	Evidenced by: ▪ Facility meeting current demand; ▪ Providing increased capacity to ensure growth in demand is met; ▪ Providing resilience to provide short term capacity when required
Achievable	Providing functionally suitable equipment with sufficient capacity to meet the demands both now and in the future.
Relevant	This objectives will ensure access to services is optimised with: ▪ Service capacity that will meet demand in a timely way; ▪ Services delivered in an appropriate manner.
Time-bound	Upon commissioning of the new equipment
Investment Objective 3: Effective Use of Resources	
Specific	To maximise the use of available resource and provide equipment that delivers improved service efficiency
Measurable	Evidenced by: ▪ Meeting capacity
Achievable	By providing sufficient lift capacity through the installation of modern equipment
Relevant	This objective will promote improved service efficiency through improved resilience
Time-bound	Upon commissioning of the new equipment

Investment Objective 4: Sustainability	
Specific	To provide a solution that will ensure the reputation of the Health Board and will support the delivery of safe and sustainable services both in the short and medium term
Measurable	Evidenced by: ▪ Utilising new / modern lifts that are energy efficient
Achievable	By providing new equipment specified to modern standards and in line with best practice in regard to the green agenda and move towards zero carbonisation
Relevant	This objective will ensure built-in resilience to adapt to changing needs
Time-bound	One year after commissioning the new equipment

Executive Summary Table 1: Investment Objectives

3.1 Current Arrangements

The majority of the lifts located on the UHW site are over forty years old and have not been updated or upgraded since they were first installed. Due to the age of the equipment the lifts are prone to breakdowns and provide a very poor level of service and ride quality for staff, patients and visitors. Replacement parts are not readily available and difficult to source within a reasonable time frame resulting in lifts being out of service for extended periods of time awaiting repairs. There are increased costs associated with purchasing replacement parts as they have to be specifically manufactured for the lifts due to the age of the equipment.

3.2 Business Need

The Health Board has embarked on its own refurbishment programme however due to the quantity of lifts onsite within the main central core of the Hospital it has been realised that substantial investment is required to meet the need of clinical services to improve the quality of the lifts.

Refurbishment of the existing lifts will reduce the number of breakdowns currently being encountered, help reduce costs associated with purchasing of obsolete parts, increase the response times which in turn will increase clinical services transfer times moving patients between wards, out-patients departments and Theatres blocks. It will increase the speed at which facilities and portering teams are able to respond to calls and will provide a better ride quality and service for staff, patients and visitors.

3.3 Proposed Scope

With regards to this business case there is only one scope that is possible and that is to refurbish nineteen of the existing lifts located through the main Ward and Tower Block areas of the UHW site.

3.4 Main Benefits

This section describes the main outcomes and benefits associated with the implementation of the investment of the identified scope in relation to the identified business needs.

Investment Objective	Stakeholder Group	Main Benefits
Investment Objective 1: Quality and Safety of Lift Services	Service Users and wider Health Board	Non QB - High quality, safe and timely services to patients, visitors and staff QB - Facilities that meet all applicable regulatory requirements, Lift Regulations 2016
Investment Objective 2: Provide Sufficient Capacity to Meet Demand	Service Users and wider Health Board	QB - Provision of sufficient capacity to meet the demands both now and in the future at UHW QB – Reducing pressures on other facilities and provide resilience in the short term
Investment Objective 3: Effective Use of Resources	Service Users and wider Health Board	QB – Improved efficiency
Investment Objective 4: Sustainability	Service Users, Health Board and wider societal economy	QB – Provides a reduction in emissions, promotes best practice in regard to the green agenda and move towards zero carbonisation

Executive Summary Table 2: Main Benefits

3.5 Main Risks

The table below provides a summary of the key risks that might affect the delivery of the project along with counter measures:

Risk Description	Counter Measure
Costs and delays to delivery of equipment due to current world events and effects on world ecomony	Review of market place thoughout scheme
Risk of interruption to hospital operational services during construction stage	Ongoing engagement with Users during design and construction
Interaction of site constraints upon construction	Review of restrictions between the Health Board and Contractor on a live hospital site
Interruption to existing services (utilities) during construction	Review current capacity of infrastructure and assess demand
Delays to access to work sites (lift shafts)	Site access and location of welfare and storage to be considered by the Contractor

Executive Summary Table 3: Main Risks

4.0 AVAILABLE OPTIONS

Due to the specific nature of this business case, there is only one viable option, that is to:

- Refurbish nineteen of the existing lifts located through the main Ward and Tower Block areas of the UHW site. The Health Board has already invested in the refurbishment of seven of the existing lifts over the last five years and wants to continue with this refurbishment to further improve services in these areas.

Therefore no option appraisal has been undertaken.

5.0 PREFERRED OPTION

The scope of works includes refurbishing nineteen of the existing lifts located through the main Ward and Tower Block areas of the UHW site.

6.0 PROCUREMENT ROUTE

Due to the specialist nature of the scheme, the procurement route utilised was an open market tendering process in conjunction with NWSSP Procurement department to identify a suitable SCP. As a result of this process Otis have been appointed as the main contractor as they specialise in this area of works.

The procurement strategies are in line with the procedures and practices as laid down in the varying frameworks. The construction elements of the proposed scheme were formally competitively tendered as part of the production and agreement of the target price. An open book approach to prices was adopted in line with the Framework and all costs were closely scrutinised to ensure that the Health Board is getting the best value for money.

7.0 FUNDING AND AFFORDABILITY

7.1 Capital Costs

This Business Case seeks approval to invest £9.302m from the All Wales Capital Programme, a breakdown of the capital costs is summarised in the table below:

	£000
Works Costs	7,634
Fees	487
Non-works Costs	235
Equipment Costs	0
Risk Allowance	360
Allowance for Inflationary Pressures	668
Total (pre VAT Recovery)	**9,384**
Recoverable VAT	(81)
Forecase Project Out-turn Cost	**9,302**

Executive Summary Table 4: Capital Costs for the Preferred Option

7.2 Overall Affordability and Balance Sheet Treatment

This BJC assumes all capital charges and depreciation will be funded by Welsh Government in each of the years.

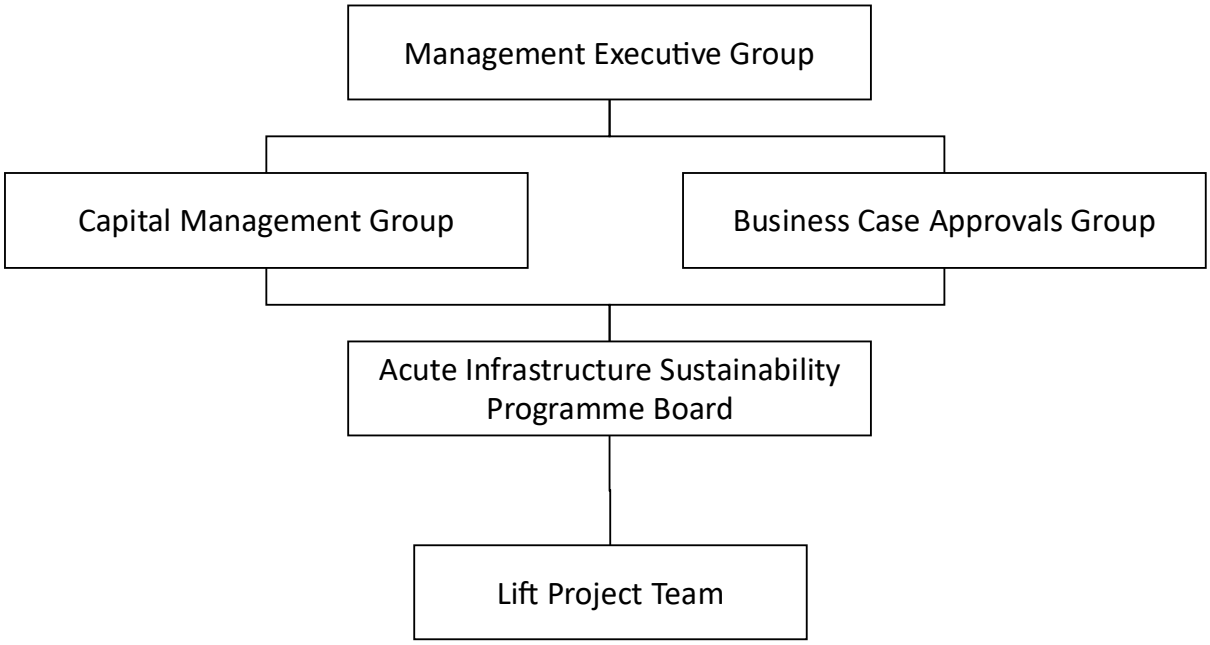
It is not anticpated that there will be any additional revenue costs. In fact, there may be the opportunity to make small savings.

All assets will be shown on the Health Board's balance sheet. The asset will be valued on completion and recorded on the balance sheet at that value. Subsequently it will be treated as per the Health Board's capital accounting policy.

8.0 MANAGEMENT ARRANGEMENTS

Robust project management arrangements are vital to ensure the implementation of the overall project and that effective control is maintained over the capital scheme.

The reporting organisation and the reporting structure for the whole of the project is shown as follows:



Executive Summary Figure 2: Project Reporting Structure

The dates detailed below highlight the proposed key milestones of the project:

Milestone Activity	Date
BJC submission to WG	January 2023
Start of Works	March 2023
Works completion	August 2025

Executive Summary Table 5: Project Plan

8.1 Benefits Realisation and Risk Management

Benefits are anticipated when a change is conceived and there are measurable improvements that result from the outcome which is perceived as an advantage by the organisation and/or stakeholders. Benefit management and realisation therefore aims to identify, define, track, realise and optimise benefits within and beyond the project. A framework has been established and is overseen by the Project Board. This is in order that a meaningful assessment can be made of the benefits yielded by the project and to benchmark the assessment criteria themselves so that lessons learned can be fed back into future projects. It ensures that the project is designed and managed in the right way to deliver quality and value benefits to patients, staff and visitors to the site.

The risk management strategy has been integrated into the project management procedures, with responsibility for implementation of the strategy resting with the Project Director. A project risk register has also been established and is subject to review and update on a regular basis.

8.2 Post Project Evaluation

The Health Board is committed to ensuring that a thorough and robust post-project evaluation (PPE) is undertaken at key stages in the process to ensure that positive lessons can be learnt from the project. The lessons learnt will be of benefit to:

- Cardiff and Vale University Health Board – in using this knowledge for future projects including capital schemes
- Other key local stakeholders – to inform their approaches to future major projects
- The NHS more widely – to test whether the policies and procedures which have been used in this procurement are effective

Post Project Evaluation (PPE) is a part of the total quality process and the Health Board acknowledges its contribution towards a successful outcome in terms of:

- Greater assurance of total performance in terms of cost, time and quality
- Clearer definitions of responsibilities
- Reduced exposure to risk, and
- Improved value for money

The Health Board has identified a robust plan for undertaking PPE in line with current guidance, which is fully embedded in the project management arrangements of the project. All processes will be managed by the project team and endorsed by the appropriate boards.

8.3 Recommendation

Cardiff and Vale UHB patients, staff and visitors would benefit substantially from the approval and financial support for this project. The proposed programme of refurbishment prioritises those lifts that are, high usage, impact on the delivery of clinical services, provide access for patients to wards, clinics etc. and support the delivery of supplies to the wards and departments. The timescale for the completion of the works will be dependent on agreement with the operational team on the number and location of the lifts that can be withdrawn from service but is expected to be circa 3 years.

The UHB would therefore, recommend that WG give due consideration to the request for funding and approve the BJC enabling the scheme to progress to the construction stage.

Report Title:	Revenue Cases for Board Approval			Agenda Item no.	7.6.3
Meeting:	Board	Public	X	Meeting Date:	30.03.2023
		Private			
Status *(please tick one only):*	Assurance		Approval	x	Information
Lead Executive:	Executive Director of Finance				
Report Author (Title):	Head of Strategic Planning				

Main Report
Background and current situation:

The Investment Group Decision Reports attached summarises the decisions made on cases presented and considered at the March Investment Group meeting.

The following cases were endorsed at Senior Leadership Board (SLB) on the 16th March but the values exceed SLBs financial limits and therefore require Board level approval:

- Investment to meet the Ockenden Recommendations
- Critical Care Expansion and Patient at Risk Team 24/7
- Regional Health Protection Service

These cases can be found under the Supporting Documents Folder on AdminControl or the Cardiff and Vale UHB website.

Cases will be considered at finance committee on the 22nd March but due to the timing of paper submission deadlines for Board pre-dating the finance committee, recommendations will be updated verbally at the meeting.

Recommendation:

The Board are requested to:

Consider and **approve** the cases

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

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

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant

Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x

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

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
IG	1st March
SLB	16th March
Finance Committee	22nd March
Board	30th March

1. **Executive Summary -** Case to fulfil gaps in Obstetric and Neonatal Service Provision against the **Ockenden Recommendations**

This business case sets out the resource requirements for the first of a two-phase response to recommendations from the Ockenden Review into Shrewsbury and Telford 2022 and following a recent Health Inspectorate Wales (HIW) inspection. It is predicated on a gap analysis against the recommendations and is cross-referenced with narratives regarding compliance with these.

The case has been prepared further to discussion and agreement in principle through Senior Leadership Board. The proposal aims to deliver a significant quality, training and governance improvement whilst realising system-wide benefits and longer-term financial savings.

The benefits of investment outlined in this case include:

- Improvement in caesarean section rates towards the UK standard
- Reductions in length of stay, to improve patient experience and quality
- Ambitions to reduce all still births, aligned to NHS England targets
- A reduction in unplanned admissions to neonatal critical care
- The goal of longer-term financial savings from clinical negligence claims

The financial impact to the UHB is summarised below, and provisions for this are made within the draft IMTP 2023/24.

Annual Revenue Requirement	**Current Year (£000's)**	**Next Year (£000's)**	**Recurrent (£000's)**
	84	1,441	2,727
Capital Requirement (£000's)			

The Full Business Case can be located under the Supporting Documents folder on AdminControl or the Cardiff and Vale UHB website.

Executive Summary - Phased Critical Care Expansion - Initial 3 Bed Expansion

Annual Revenue Requirement	2023/24 (£m)	Recurrent (£m)
	1.151	2.176
Capital Requirement (£)	N/A for this case.	

The sickest patients in hospital are reliant on time critical access to the critical care team and the Intensive Care Unit (ICU). Without this their mortality is increased and both the patient and family experience, in what is already a traumatic life event, is made worse.

The capacity of the ICU has a major impact on this early access. The main unit at UHW has a recognised 31 commissioned ICU beds. The majority of these are tertiary commissioned beds that support major trauma, neurosurgery, tertiary cardiac, renal, CAR-T Therapy, haematology, and vascular, amongst others.

There is a consilience of evidence from over a decade presented below, that makes the case that the ICU at UHW should have a bed base of closer to 50 beds.

It is the secondary care commissioned bed component of capacity that is the dominant contributor to the inadequate capacity. When compared to Wales and international data, this secondary care bed capacity is a distant outlier for the demand it serves, and the result is limited access to critical care at the optimum point.

The Full Business case document aims to present the case for investment in a phased expansion of intensive care beds, to close the demand, capacity gap at Cardiff Intensive Care Unit.

The Full Business Case can be found under the Supporting Documents folder on AdminControl or the Cardiff and Vale UHB website.

Executive Summary Phased Critical Care Expansion: 24/7 P@RT

Annual Revenue Requirement	2023/24 (£m)	Recurrent (£m)
	433	1,024
Capital Requirement (£)	N/A for this case.	

This business case seeks approval to invest in a 24/7 patient-at-risk team (P@RT) across Adult hospital wards for seriously deteriorating patients treated at Cardiff and Vale University Health Board (CAV UHB).

Patients admitted from hospital wards to an intensive care unit (ICU) have a higher overall percentage mortality than patients admitted from other areas of the hospital. Despite being on a hospital ward, often for several days, a high percentage of these admissions receive cardiopulmonary resuscitation (CPR) before their ICU admission. Before cardiac or respiratory arrest, ward patients often have severe physiological abnormalities. Similarly, many patients admitted from the wards to ICU have abnormal physiological values in the hours preceding ICU admission.

A 'patient-at-risk team' (P@RT), similar to the medical emergency team, was established in order to respond to these patients. The P@RT assess patients who fulfil certain physiological criteria, as well as other patients causing concern to medical and nursing staff. The P@RT objectives are aimed to improve care for these patients by providing advice and support to those responsible for them on the wards, by facilitating early ICU admission when appropriate, and by preventing unnecessary ICU admissions, thereby releasing valuable beds for use by patients in greater need.

At present, the service provision is a 7-day daytime service only. As a result of this, gaps in P@RT have negative consequences on the most important outcomes and experience for our patients, their families and our team, as well as the operational running and service development of those other specialties that rely on critical care.

The Full Business Case can be found under the Supporting Documents Folder on AdminControl or the Cardiff and Vale UHB website.

Executive Summary - Regional Health Protection Service Business Case

The national, Welsh Government (WG) led response to the COVID-19 pandemic saw the development of 'Test, Trace and Protect (TTP)', a comprehensive and multifaceted programme which enabled testing of those who were symptomatic of the disease, tracing of their contacts, and support to both to isolate. Delivered at an unprecedented scale and pace, these mechanisms enabled management of the initial waves of infection, and support those identified as most vulnerable. Once an effective vaccine was developed, an again unprecedented system was rapidly deployed to vaccinate all eligible groups, ultimately leading to a significant reduction in the impact of the infection at a population level and eventually enabling all restrictions to be lifted.

All regions across Wales were tasked with establishing local TTP services that met these requirements. In Cardiff and the Vale of Glamorgan, the Health Board worked with a range of partners to deliver these functions, most notably both Local Authorities, Shared Regulatory Services (SRS) and Public Health Wales (PHW). There were national requirements and expectation for immunisation and TTP services and budgets were allocated separately from Welsh Government to the Health Board for the two programmes. In addition, Welsh Government directly commissioned Cardiff Council to provide a National Contact Tracing Team to offer resilience at times of high demand (thus often referred to the surge team) and to respond to specific needs as the pandemic progressed (for example, the management of international travellers). The funding for this team formed part of the C&V TTP budget allocation and was passed through from the Health Board to Cardiff Council.

We are now three years on from the first cases of COVID-19 arriving in the UK. Although the pandemic is not over, and some protective measures are still likely to be required e.g. booster vaccination campaigns, we are learning to manage Covid-19 more routinely alongside other communicable diseases. Welsh Government has indicated that all regions need to draw on the skill, experience and learning from the pandemic and that they expect Health Boards to work with their local government partners 'to build agile, integrated teams who work on a Health Board footprint to support health protection measures and respond to future threats'. They see 2023/4 as a transition year during which sustainable arrangements are put in place for an 'all-hazards' approach to health

protection, supported by all partner agencies. These could include for example blood borne viruses, TB and HIV.

Welsh Government has also signalled its intention to commission a National Team from Cardiff Council. Although funding for this team will continue to be included in the C&V Testing and Tracing allocation, it will operate entirely separately and to a national remit; it therefore does not form part of the developing model for the C&V integrated regional health protection team described in this paper. The team will, however, feature in the budget statements.

This paper has been developed in response to the 2023/24 Funding for Public Health Response including Covid-19 letter, from Sioned Rees, Director of Health Protection, Welsh Government, dated 22 December 2022 and an updated letter received on 8 February 2023. These letters confirm the region's 2023/24 grant funding allocation to support its public health response, including Covid-19, confirming a Health Board allocation of:

- Testing and Tracing = £3.2m.
    - £0.740m for delivery of the National Team, hosted by Cardiff Council
    - £2.46m for local health protection services (partnership monies)
- Vaccination = £5.6m

The letters confirm that grant funding for the Public Health Response including Covid-19 has been reduced. The allocations for the two programmes continue to be calculated separately, with Test and Trace (for wider health protection services) as a proportion of last year's expenditure, and Vaccination based on per capita formulae. WG have stated they see 2023/4 as a transition year, during which sustainable arrangements are expected to be put in place for 2024/5 and beyond.

Additional letters received from Welsh Government on 3 February 2023 and 7 February 2023, both entitled '2023/24 Public Health Response including Covid-19', reiterate the importance of health protection and the need to build upon tried and tested approaches to ensure we are able to effectively respond to ongoing and future threats. They articulate a series of core principles to be used in planning this approach, and commit to coproducing a National Framework for Health Protection to maximise consistency across Wales. Welsh Government acknowledge that in order to establish a sustainable multiagency system and team, Health Boards need clarity over the funding approach from April 2024 and confirm that

they are planning on the basis there will be recurrent funding available beyond 2023-24 which they will aim to include in Health Board funding baselines as part of the main NHS allocation.

The purpose of this paper is to seek approval of the proposed regional costed model required to deliver the transitional Cardiff and Vale Health Protection System within the allocated funding. In this context, the health protection system includes all teams and services that play a role in preventing and managing the risks posed by communicable disease and environmental hazards; this will therefore include communicable disease specialist control teams (Public Health Wales and Shared Regulatory Services), vaccination (all vaccination programmes), testing, microbiology, epidemiology, IP&C and infectious disease clinicians (list not exhaustive). This paper outlines the regional added value requirement, taking account of the specialist health protection role & thresholds for involvement of PHW specialist health protection services. In view of this strategic intention, the paper is framed in terms of the future health protection system. Some of the workforce required to deliver elements of this integrated system are employed by partner organisations, specifically Cardiff Council and Vale of Glamorgan Council, and a proportion of the funding from this allocation will support these roles.

The Full Business Case can be found under the Supporting Documents Folder on AdminControl or the Cardiff and Vale UHB website.

Report Title:	Scheme of Delegation and Earned Autonomy			Agenda Item no.	7.7
Meeting:	Board	Public	x	Meeting Date:	30th March 2023
		Private			
Status *(please tick one only):*	Assurance		Approval	x	Information
Lead Executive:	Chief Executive				
Report Author (Title):	Director of Corporate Governance				

Main Report
Background and current situation:

The Chief Executive is required to propose a Scheme of Delegation and Earned Autonomy to Officers which sets out the functions they will perform personally and which functions will be delegated to other officers. The Board must formally agree this scheme and any changes to the scheme.

It is also good governance that the framework of delegation is kept under active review and, where appropriate, will be revised to take account of organisational developments, review findings or other changes.

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

Since the review of governance in Capital and Estates it has come to light that the Director of Capital, Estates and Facilities can only sign off allocation of capital contract contingency of <£25k which means anything above this amount is signed off by the Executive Director of Strategic Planning. To support the Executive Director in Strategic Planning in this process and reduce the number of capital contract contingency payments which she is currently having to sign it is proposed that the Director of Capital, Estates and Facilities capital contract contingency value of sign off is increased to <75k.

The same principle applies to the Executive Director of Finance who can sign off allocation of capital contract contingency of <£125k with the Chief Executive signing all off allocation of capital contract contingency over that value and up to <£500k. It is therefore proposed that the Executive Director of Finance's value to sign off allocation of capital contract contingency of be increased to <£250k to reduce the number of contract contingency increases been signed by the Chief Executive.

These changes have been discussed and agreed by the Executive Director of Finance and the Chief Executive but, due to the fact they are changes to the Scheme of Delegation, also require the approval of the Board.

If approved, the changes will then be incorporated into the Scheme of Delegation and Earned Autonomy.

Recommendation:

The Board are requested to:

(a) Approve that the Director of Capital, Estates and Facilities can approve allocation of capital contract contingency of <£75k.

(b) Approve that the Executive Director of Finance can sign off allocation of capital contract contingency of <£250k.

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

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

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: ~~Yes~~/No
There is very low risk in increasing the values of sign off for the Director of Capital, Estates and Facilities and Executive Director of Finance due to the other controls in place. The purpose of the change is to facilitate a more streamlined and timelier sign off of contracts and stage payments.
Safety: ~~Yes~~/No
Are there any Staff or Patient safety implications associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)
Financial: ~~Yes~~/No
Are there any Financial implications associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)
Workforce: ~~Yes~~/No
Are there any Workforce implications associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)
Legal: ~~Yes~~/No
Are there any legal implications that arise from the content and proposals contained within this report? If so, has advice been sought and what was the outcome? (If this has been addressed in the main body of the report, please confirm)
Reputational: ~~Yes~~/No
Are there any reputational risks associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)
Socio Economic: ~~Yes~~/No
The Socio-Economic Duty is to designed to encourage better decision making, ensuring more equal outcomes. Do the proposals within this report contain strategic decisions, such as setting objectives and the development of services. If so has consideration been given to how the proposals can improve inequality of outcome for people who suffer socio-economic disadvantage? Please include detail. *Useful Guidance on the application of the Socio-Economic Duty can be found at the following link: The Socio-economic Duty: guidance | GOV.WALES*

(If this has been addressed in the main body of the report, please confirm)
Equality and Health: ~~Yes~~/No
Equality Health Impact Assessments (EHIA) are typically undertaking when developing or reviewing Health Board strategies, policies, plans, procedures or services. Do the proposals contained within the report necessitate the requirement for an EHIA to be undertaken? If so, please include the detail of any EHIA undertaken or the plans are in place to do so. *Useful guidance on the completion of an EHIA can be found at the following link: EHIA toolkit - Cardiff and Vale University Health Board (nhs.wales)* *(If this has been addressed in the main body of the report, please confirm)*
Decarbonisation: Yes/No
If appropriate, has consideration been given to the delivery of proposals in accordance with NHS Wales Decarbonisation Plans. If so, please confirm the detail of issues considered and plans made. *(If this has been addressed in the main body of the report, please confirm)*

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Chief Executive / Executive Director of Finance	13th September 2022

Report Title:	The Armed Forces Covenant Duty Policy			Agenda Item no.	7.8
Meeting:	Board	Public	X	Meeting Date:	30.03.23
		Private			
Status *(please tick one only):*	Assurance		Approval	X	Information
Lead Executive:	Director of Corporate Governance				
Report Author (Title):	Head of Corporate Business				

Main Report
Background and current situation:

The Armed Forces Covenant was established in 2011 and was seen as a promise by the nation that the Armed Forces Community should be treated fairly and face no disadvantage when accessing public and commercial services, with special provision made in appropriate cases for those who have sacrificed the most. Since its establishment thousands of different organisations, including Cardiff and Vale University Health Board, have chosen to sign a pledge to honour the Covenant and support their Armed Forces Community. As a result, there have been many examples around the UK of good practice to remove, mitigate, or prevent incidents of disadvantage from occurring.

However, despite the commitment of so many organisations there remains strong evidence that the Armed Forces Community continue to suffer disadvantage, particularly in receipt of services from public bodies. For this reason, the Armed Forces Act 2021 amended the Armed Forces Act 2006 to create a legal obligation on specified bodies in all four home nations of the UK; with NHS organisations being designated as a specified body. This is known as the Armed Forces Covenant Duty and it requires that:

'When a specified body exercises a relevant function, it must have due regard to: (a) the unique obligations of, and sacrifices made by, the Armed Forces; (b) the principle that it is desirable to remove disadvantages arising for Service people from membership, or former membership, of the Armed Forces, and (c) the principle that special provision for Service people may be justified by the effects on such people of membership, or former membership, of the Armed Forces.'

UHB 501 – The Armed Forces Covenant Duty Policy has been written to explain this statutory duty and provide the conditions in which the Health Board can meet the duty.

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

A draft of UHB 501 (and its associated EHIA) has been subject to the normal internal and external circulation process. In addition, the policy has been presented to the Senior Leadership Board, the Executive Armed Forces Champion, the Independent Member Armed Forces Champion, the Veterans Commissioner for Wales and the Cardiff and Vale Armed Forces Covenant Group. All feedback from this consultation process has been incorporated into the final draft presented for Board approval.

Recommendation:

The Board are requested to:-

a) approve the Armed Forces Covenant Duty Policy (UHB 501) and the associated EHIA.

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

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

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

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

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: ~~Yes~~/No
Safety: ~~Yes~~/No
Financial: ~~Yes~~/No
Workforce: ~~Yes~~/No
Legal: Yes/~~No~~
The Armed Forces Covenant Duty is a statutory requirement.
Reputational: ~~Yes~~/No
Socio Economic: ~~Yes~~/No
Equality and Health: ~~Yes~~/No
Decarbonisation: ~~Yes~~/No

~~Approval~~/Scrutiny Route:	
Senior Leadership Board	Date: 02.02.23

Reference Number: UHB 501 **Version Number:** 1	**Date of Next Review:** April 2024 **Previous Trust/LHB Reference Number:** Not Applicable

The Armed Forces Covenant Duty Policy

Policy Statement

Cardiff and Vale University Health Board ('the UHB') recognises its position as a specified body under the Armed Forces Act 2021 ('AFA 21') and our statutory duty to meet the Armed Forces Covenant Duty as described within AFA 21.

Policy Commitment

In exercising our relevant functions as described in AFA 21 we will maintain due regard to:

a. The unique obligations of, and sacrifices made by, the armed forces;

b. the principle that it is desirable to remove disadvantages arising for Service people from membership, or former membership, of the armed forces; and,

c. the principle that special provision for Service people may be justified by the effects of such people of membership, or former membership, of the armed forces.

Supporting Procedures and Written Control Documents

This Policy should be read alongside:

- UHB 083: Equality, Diversity and Human Rights Policy.
- UHB 440: All Wales Reserve Forces Training and Mobilisation Policy.

Scope

This policy applies to all of our staff in all locations including those with honorary contracts. It should also be referred to when ensuring effective business arrangements are in place when working with contractors, partner organisations and other stakeholders.

This policy and its EIA/HIA will be reviewed annually or sooner if there is a substantial change to AFA 21.

The effectiveness of the policy will be determined by an annual survey of Clinical Board's experience of implementing the policy.

Equality Impact	An Equality Impact Assessment (EqIA) has been completed

Assessment	and this found there to be a positive impact.

Health Impact Assessment	A Health Impact Assessment (HIA) has been completed and this found there to be a positive impact.
Policy Approved by	Board
Group with authority to approve procedures written to explain how this policy will be implemented	Not Applicable
Accountable Executive or Clinical Board Director	Director of Corporate Governance

Disclaimer

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

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1	Approved by Board dd/mm/yyyy	TBA *[To be inserted by the Gov. Dept]*	New Document
2			

DRAFT

Background

1. The Armed Forces Covenant ('the Covenant') is a promise by the nation that the Armed Forces Community should be treated fairly and face no disadvantage when accessing public and commercial services. Within the Covenant there is also special provision made, in appropriate cases, for those who have sacrificed the most. The Covenant was established in 2011 and since then, thousands of different organisations (including the UHB) chose to sign a pledge to honour the Covenant and support their Armed Forces Community. As a result of this, there have been many examples around the UK of good practice to remove, mitigate, or prevent incidents of disadvantage.

2. However, despite the progress made, the Armed Forces Community continued to face disadvantage when accessing public services. Therefore, the AFA 21 amended the Armed Forces Act 2006 to create a legal obligation on specified bodies across the UK to meet the Armed Forces Covenant Duty ('the Covenant Duty').

The Covenant Duty

3. AFA 21 describes the Armed Forces Covenant Duty:

> *"When a specified body exercises a relevant function, it must have due regard to: (a) the unique obligations of, and sacrifices made by, the Armed Forces; (b) the principle that it is desirable to remove disadvantages arising for Service people from membership, or former membership, of the Armed Forces, and (c) the principle that special provision for Service people may be justified by the effects on such people of membership, or former membership, of the Armed Forces".*

4. Under AFA 21 the specified bodies subject to the Covenant Duty are any bodies providing local services in the areas of healthcare, education and housing. From a UHB perspective, the Covenant Duty applies to the settings of NHS Primary[1] and Secondary Care[2] across the functions of:

- Provision of services.
- Planning and Funding.
- Co-operation between bodies and professionals[3].

[1] Includes general practice, community pharmacies, NHS dental, NHS optometry services and public health screening services.
[2] Including urgent and emergency care, hospital and community services, specialist care, mental health services and additional needs services.
[3] With regard to the wider determinants of health out with UHB direct control, it is worth noting that Covenant Duty also applies to local authorities' provision of education (including child

5. Private and 3rd Sector healthcare providers are not within the scope of the duty. However, the UHB should have due regard to the Armed Forces Covenant Duty if commissioning services from private or third sector healthcare providers.

The Covenant Duty does not supersede or replace any other statutory requirement. Those subject to the Duty must balance the requirements of the Duty with the need to deliver services more generally and the need to satisfy other statutory requirements, such as the Public Sector Equality Duty in England, Scotland and Wales.

6. **Due Regard**. The Act does not specify what the UHB must do in order to have due regard. How we meet the Covenant Duty, and how the Duty is reflected in relevant policies, procedures, and service delivery are therefore matters for the UHB. Having due regard is about informed decision making:

- Ensuring that decision makers assess how their decisions on access to healthcare, provision of services, planning, funding and cooperation might impact on service users from the Armed Forces Community in scope of the Duty.
- Eliminating or reducing as low as reasonably practicable any identified disadvantage identified from this analysis.
- In a sense the Act operates in a similar way to the consideration of the nine protected groups in the Equality Act.

7. **Disadvantage**. "Parity not Priority". Most members of the Armed Forces Community will have health and social needs in common with the general population. However, many of the unique characteristics of military life (see Appendix 1) may create a disadvantage.

A disadvantage is when the level of access a Service Person has to services, or the support they receive, is comparatively lower than that of someone in a similar position who is not a member of the Armed Forces Community, and this difference arises from one (or more) of the unique obligations and sacrifices of Service life.

It is notable that disadvantage is also recognised in the NHS Constitution, which states:

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wellbeing and additional needs support), housing functions and local authority delivered healthcare services.

"The NHS will ensure that in line with the Armed Forces Covenant, those in the Armed Forces, reservists, their families and veterans are not disadvantaged in accessing health services in the area they reside".

8. **Special Provision.** This is the taking of actions that go beyond the support provided to reduce or remove disadvantage. Special provision may be justified by the effects of the unique obligations and sacrifices of Service life, especially for those that have sacrificed the most, such as the bereaved and the seriously injured (whether that injury is physical or mental).

9. **Service People.** Section 343B (1) of AFA 21 provides specific definition of the 'Service People' in the scope of the act [4]. The title 'Service People' in this context covers a broad range of individuals and groups and it may be necessary to confirm the applicability of the Covenant Duty to individuals or groups when applying 'due regard' assessments; a full description of 'Service People' is provided at Appendix 2 to this policy. However, 'Service People' can be broadly described as:

- Currently serving members of the UK regular and reserve forces.
- Currently serving members of British Overseas Territories' Armed Forces who are subject to UK Service Law.
- Former members of the UK regular and reserve forces and British Overseas Territory Forces, who are ordinarily resident in the UK (often described as 'veterans').
- The 'relevant family members' of people in these groups.

Considerations for taking Due Regard in the Provision of Healthcare

10. **Priority treatment**. Members of the Armed Forces Community might suffer physical or mental injuries caused by the unique obligations and sacrifices of danger and stress. The prioritisation of their care by healthcare providers is always subject to clinical need and will be determined by the most appropriate clinician. Members of the Armed Forces Community are not entitled to jump the queue ahead of someone with a higher clinical need. However, there is a commitment that veterans in Great Britain may be considered for priority access to NHS services that could provide focused treatment for conditions arising from their Service, compared to non-Service patients with the same level of clinical need. This is a clinical decision made by the relevant physician or clinician, often following a recommendation by the referring physician/clinician.

[4] It is notable that AFA 21 also uses the phrase 'Armed Forces Community' – this has the same functional meaning as Service People

11. **Waiting lists to start treatment**. Service families will on average re-locate every 3 years but more frequent re-location is not unusual. Due to this geographical mobility service families on a waiting list for treatment or other health services in one area might be required to move to another area before they are treated. If they are placed at the back of their new waiting list, the Service family might experience delays in receiving treatment, and they might have to wait significantly longer for treatment compared to non-Service families with geographical immobility. Notably these waits may be further exacerbated by subsequent moves, leading to an increasing disadvantage. While the fundamental NHS principle of treatment on the basis of clinical need remains paramount, healthcare staff should be aware that patients from the Armed Forces Community might have already waited a considerable time for treatment in another locality and their re-location is seldom made by personal choice. As such, healthcare staff may wish to consider total time spent on waiting lists, both inside and outside the local area, and ensure that the Service family keeps its relative place on the waiting list in their new area, when possible.

12. **Waiting lists to resume treatment**. Some health conditions or treatments are of long duration, and the Service family might have to re-locate while in the middle of receiving the course of treatment, or other health services. In this case, the treatment could be interrupted if they have to join a waiting list to resume the treatment in their new location. Healthcare bodies will find it useful to consider how treatment plans can continue with minimal disruption, and how continuity of care can be maintained after re-locations.

13. **Reassessments**. If a Service family re-locates to a new area due to geographical mobility, the health professionals in the new location might decide to conduct a reassessment of a family member's condition. Health professionals should be aware that the family member might have already experienced a prolonged wait time for treatment, and so any decision to conduct a new assessment, or 'go back to square one', could add additional delays to their treatment, or cause them additional stress. In some cases, the Service family member might subsequently be required to move again before treatment can commence or resume. This can be a particular concern for Service children with additional needs. Delays to assessments or reassessments associated with the authorisation of statutory plans can see Service children with such needs suffer a delay in the provision of support.

14. **Local variability in healthcare services**. The provision of healthcare services varies locally and across the different home nations of the UK, to reflect different local approaches to healthcare, and different needs and priorities. Therefore, when members of the Community are required to re-locate, they could move to an area with different healthcare services or access criteria. This could lead to a lack of access to special services, such

as Speech and Language Therapy, Occupational Therapy, and Child and Adolescent Mental Health Services, that were being provided to the Service family in their previous location. The local variability in services, along with the possibility of unfamiliarity with the new local area or civilian life, could also lead to a lack of knowledge amongst the Armed Forces Community of the healthcare and support services available to them in their new local area, thereby affecting their ability to access local healthcare services.

15. **Relationship with healthcare professionals**. Due to geographical mobility, Service families might have to leave a location where they have an established relationship with local healthcare professionals. While Service families could continue to see the same healthcare professionals after they move, in practice this can be unrealistic, and they will usually need to receive care from new healthcare staff, and register with a new GP practice. Where that is the case, although medical records are transferred between healthcare providers, the Service family can lose access to healthcare professionals with whom they have an established relationship, and who have experience of treating them and understand their individual healthcare needs. Should they subsequently return to the area, they might find they are unable to re-register with their original GP if the register is full.

16. **Provision of tailored services**. Sometimes, bespoke healthcare services or care pathways may be justified to meet the distinct needs of the Armed Forces Community (e.g. Veterans Mental Health services). Alternatively, it may be beneficial to tailor health advice to members of the Armed Forces Community to take account of the unique obligations and sacrifices of Service life.

17. **Planning and funding**. Due to geographical mobility, Service families might be posted abroad. If local service provision abroad is inadequate, overseas Service families might have their healthcare delivered by the Ministry of Defence, through the Defence Medical Services. If local service provision is adequate, international agreements might be in place for free or discounted healthcare services to be provided to the Armed Forces and their families. When Service families overseas are then posted back to the UK, they might experience delays in receiving treatment, or a refusal of treatment, if it is not clear which funding arrangements should apply to them. The rules for what services are available, and who is eligible for them, might also differ within different areas, and between the four nations of the UK.

18. **Co-operation between bodies and professionals**. If, when Service families are required to re-locate, insufficient information is passed between health systems and healthcare staff, or if there are delays in passing on information, this can cause distress, impact continuity of care, and cause

delays in receiving treatment, or the Service family might even have to start treatment again.

Guidance on Access and Referrals for the Armed Forces Community

19. **Veterans.** A veteran is an individual that has served in the Regular Armed Forces, The Reserve Armed Forces, or the British Overseas Territories' Armed Forces for one day or longer and who is normally resident in the UK – this includes individuals conscripted (into the Armed Forces) during World War 2, those who performed National Service and any member of the Merchant Marine who served in a War Zone such as the Falklands Conflict and the Gulf Wars. It is useful to note that within the UK Armed Forces community the title 'Veteran' has historically been used to indicate individuals who saw active service/combat and therefore some individuals with previous military service, particularly older citizens, may not immediately recognise themselves as veterans.

To avoid such confusion all new patients should be asked 'have you ever served in the Armed Forces?'[5].

New registrations with the practice should identify veteran status through the GMS1W registration form, which was revised in 2015 to include this information. However, it may be prudent to ask the question to identify any veterans who joined the practice prior to this revision.

Personnel leaving the Armed Forces are provided with advice and support for their 'transition' to civilian life and a component of this relates to accessing NHS care. When registering with a GP, newly discharged veterans should present 3 documents to assist in the transfer of armed forces medical records:

- An NHS welcome letter explaining the process of transferring from military healthcare to an NHS GP surgery and civilian dentist.
- A Form (FMed 133A) that includes important details for the GP surgery, including a summary of medical treatments, vaccinations and specialist care received whilst serving. Crucially this form also provides the practice with the details needed to request complete military GP medical records from the Defence Medical Services (DMS).
- A paper copy of the Veterans medical records summary.

[5] Further questioning may allow other sources of support to be signposted and the health and well-being can be seen in context; Which service were you in – Army, Royal Navy, Royal Marines, Royal Air Force?; For how long did you serve? How long ago did you leave? What was your job/role? Where in the world did you serve? Did you have any health problems whilst you were serving, or after you left?

Further information on this process is available to the Veteran at this link Step-by-step guide for service leavers. The Royal College of GPs also provides advice to GP Practices at this link Veterans' healthcare toolkit: Guidance for GPs (rcgp.org.uk).

20. GPs referring a veteran will consider if in their clinical opinion, the condition may be related to the patient's previous military service. Where this is the case, with the patient's consent, the Armed Forces Community status should be made clear in the referral to enable due regard/special provision considerations by the Trust or Health Board receiving the referral. Relevant, consistent clinical codes or phrases should be included in the referral:

- 13q3: 'Served in Armed Forces'.
- Ua0T3: 'Served in Armed Forces' (the 0 is a zero)
- Or 224355006 which is the SNOMED-CT ID equivalent.

When referring a veteran for further care, the following wording may be used to request priority treatment:

"This patient is an Armed Forces veteran. I consider that his/her current condition is probably related to military service. This referral should be considered for priority treatment under the due consideration aspects of the Armed Forces Covenant Duty".

21. **The Regular Armed Forces**. Members of the Regular Armed Forces (Royal Navy/Royal Marines/Army and the Royal Air Force) usually receive primary and occupational health (including dental and community mental health support) from the DMS[6]. When a service person requires care in a secondary or tertiary health facility the Defence Medical Services will refer the service person to that level of NHS care[7]; this referral process should clearly identify the individual as a member of the Regular Armed Forces and enable due regard/special provision considerations by the Health Board.

22. Members of the Regular Armed Forces, as with all citizens, may require access to urgent and emergency care and as such their membership of the Armed Forces Community may not be immediately apparent. However, as soon as membership of the Armed Forces Community is known there should, where relevant, be consideration of due regard/special provision by the UHB.

[6] Other than on operational deployments or large overseas exercises the MOD no longer has 'firm base' hospital level care.
[7] The DMS will often have commissioning arrangements with specific NHS organisations for the more commonly encountered secondary/tertiary health care needs of their population.

23. **The Reserve Forces.** Members of the Reserve Forces will usually receive their primary health care from NHS GPs[8]. Members of the Reserve Forces are not obliged by the MOD to inform their GP that they are members of the Armed Forces Community although they are advised to do so. Therefore, when making a referral to secondary or tertiary health care providers, the GP should consider if the condition is relatable to military service. If it is considered relatable to military service this should be included in the referral (see para.20), to enable due regard/special provision considerations by the receiving NHS trust/health board.

24. **Armed Forces Families**. Relevant family members will usually receive their primary care from NHS GPs. GPs referring a patient they have identified as a family member are asked to consider if, in their clinical opinion, any conditions of disadvantage could occur in the ongoing management of care as a result of their forces connection (for example geographical mobility adversely impacting on waiting list). Where this is the case, with the patient's agreement, the Armed Forces Community status should be made clear in the referral to enable due regard/special provision considerations by the receiving clinician or health care organisation.

Armed Forces Issues

25. While the Duty is not prescriptive about the action's bodies should take in order to promote awareness of the Duty and the issues faced by the Armed Forces Community, the UHB have adopted the existing good practice of those bodies already working to deliver the Armed Forces Covenant in their local area.

26. The UHB has a lead executive Armed Forces Champion and an Independent Member Armed Forces Champion.

27. The UHB is a member of the Cardiff and Vale Armed Forces Covenant Forum where it is able to liaise with local Armed Forces representatives, service charities, public sector representatives, and other Armed Forces Covenant networks and organisation champions. Membership of this group enables:

- The sharing of awareness, data and good practice on the Armed Forces Community within the UHB.

[8] Unless deployed on operations/overseas exercises or if injured on duty. If injured on duty the DMS will manage on going care until the service person is rehabilitated or medically discharged from the service – following the same clinical pathways that are applied to members of the Regular Forces.

- Consistent understanding the make-up of the Armed Forces Community in the local area.

Useful Information

Veteranstraumanetwork@wales.nhs.uk

Healthcare for the Armed Forces Community (NHS)

Veterans Wales (NHS)

Veterans' Survey - Office for National Statistics (ons.gov.uk)

Armed Forces Covenant (GOV.UK)

Veterans Covenant Healthcare Alliance

Veterans UK (GOV.UK)

The Armed Forces Covenant: 10 years on (senedd.wales)

Veterans' healthcare toolkit: Veteran friendly GP practice accreditation (rcgp.org.uk)

The Royal British Legion | Armed Forces Charity

Mental Health Services for Veterans | Combat Stress

SSAFA, the Armed Forces charity

Armed Forces Covenant Veterans Support and Advice

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Appendix 1

The Unique Characteristics of Service Life

1. Service life often places significant demands on the Armed Forces Community – requiring them to meet obligations and make sacrifices at different times, and some cases after, their Service career. These unique obligations and sacrifices are broadly described in this appendix in order to inform decisions related to disadvantage when required by the Armed Forces Covenant Duty.

2. **Danger**. Serving Personnel (SP) may be exposed to a wide range of threats of violence and/or exposure to austere environments. In solation or together these factors can create a danger of death, or short- or long-term physical/mental ill health. Some ill health might be temporary but it can also be career ending and life altering. The SPs family can also suffer significantly in these circumstances.

3. **Geographical Mobility**. SPs are required to be highly geographically mobile and ready to move according to the Service need – often at short notice. This may be due to a live military operation but may also be part of routine regular re-locations around the country or abroad; in these circumstances family members often move with the SP. It is likely that the SP will lack much choice on the timing of such moves or the location, and such moves are likely to happen multiple times in a career. The frequency of moves is often higher for Army personnel. The Armed Forces will try to avoid frequent or rapid moves where it might create undue impact on the welfare of the SP or their family but ultimately the 'service need' may take priority and the SP cannot, within Service Law, opt out of an assignment if it inconveniences them.

4. **Separation**. SPs are likely to spend significant periods away from their family. Operational requirements might mean that some SP (particularly Royal Naval personnel such as submariners) cannot contact their families for months at a time and this can increase the impact of separation. Some service families may decide not to follow the SP if they are posted overseas or to different locations in the UK. This approach has the benefit of building local roots and local support, and often enable better continuity of education and healthcare, but it can also increase the separation between the SP and the family.

5. **Unfamiliarity with Civilian Life**. The Armed Forces provide a variety of essential services to SPs which include accommodation, primary (and occupational) health, training, sports and elements of transport. There is also a separate Service Justice System. Therefore, SPs and the families that

accompany them might lack detailed knowledge or experience of civilian life. They might be unaware of what services are available to them, or how to access them, or they might feel a general sense of disconnection from civilian society.

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Appendix 2

Defining Service People

1. The Duty applies to the following members of the Armed Forces Community, collectively defined in the Act as 'Service people':

a. members of the regular forces and the reserve forces;

b. members of British overseas territory forces who are subject to Service law;

c. former members of any of Her Majesty's forces who are ordinarily resident in the UK; and,

d. relevant family members [of those in (a) to (c) above].

2. These are therefore the groups of people that must be considered when complying with the Duty. These four groups are described below. The term 'Armed Forces Community' is used more commonly than 'Service people' in the context of the Covenant. Therefore, this Guidance uses the term 'Armed Forces Community', or just 'the Community', to mean the same four groups of people. Note that the functions carried out by specified bodies could have the potential to affect the whole of this Community, or groups or individual members within it.

3. **Members of the regular forces and the reserve forces.** Under the Act, the 'regular forces' are the Royal Navy, the Royal Marines, the regular Army and the Royal Air Force. This group therefore includes all currently serving members of these forces. Citizens of some other countries can join these forces (for example Gurkhas, and Commo9nwealth Citizens), and they are included in this group.

4. This group also includes all currently serving members of one of the volunteer reserve forces (the Royal Naval Reserve, the Royal Marines Reserve, the Army Reserve and the Royal Auxiliary Air Force) or the ex-regular reserve forces (the Royal Fleet Reserve, the Regular Reserve and the Royal Air Force Reserve). Reservists are liable to be compulsorily mobilised for set periods of full-time service, during which time they can be deployed in the same way as regulars; in practice reservists are mostly selected for mobilisation only if they agree to this in advance. Reservists do active service on operations alongside regulars, normally when they are serving under particular types of commitment or have been mobilised. People in this group are in scope of the Duty wherever they are located – in the UK or abroad.

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5. **Members of British Overseas Territory Forces who are subject to Service law.** A 'British Overseas Territory Force' is 'any of Her Majesty's forces that is raised under the law of a British Overseas Territory'. This group therefore comprises the currently serving members of the British Overseas Territories' Armed Forces. For example, a member of the Royal Bermuda Regiment or the Royal Montserrat Defence Force. People in this group are not members of the UK Armed Forces. They are also not to be confused with British Forces Overseas, who are members of the UK Armed Forces that have been posted to other countries. People in this group are in scope of the Duty when they are subject to UK Service law. This is while they are 'undertaking any duty with or training with a [UK] regular or reserve force'. There are times when a member of a British Overseas Territory Force is deployed to the UK for a period, for example, to receive training from UK Armed Forces. They might also be accompanied by their family members depending on the duration of the posting. The UK Armed Forces take care of British Overseas Territory personnel in the UK. While it might be rare for specified bodies in the UK to encounter these personnel, specified bodies should regard the British Overseas Territory Forces who are subject to Service law as part of the Armed Forces Community in terms of the Covenant Duty.

6. **Former members of any of Her Majesty's forces who are ordinarily resident in the UK.** Under the Act, 'Her Majesty's forces' means the UK regular and reserve forces and the British Overseas Territories' Armed Forces. Therefore, included in this group are: former members of the UK regular and reserve forces (noting this includes those who served in the UK Armed Forces as part of Wartime Conscription and National Service); and former members of British Overseas Territories' Armed Forces. A former member of any of these forces is anyone who has served for at least one day. People in this group are in scope of the Duty if they are ordinarily resident in the UK. The Act does not provide any further definition of 'ordinarily resident in the UK'. These individuals are also known as 'veterans' or 'ex-Service personnel'. There are several reasons why someone might leave the Armed Forces, such as expiration of contract, resignation, medical and compassionate reasons, and misconduct. No matter the reason for discharge, all such veterans benefit from the Covenant Duty.

7. **Relevant family members.** The definition of 'relevant family members' for the purposes of the Duty is set out in the Armed Forces (Covenant) Regulations 2022. Service life primarily impacts on family members as a result of their cohabitation with, or dependency on, a member or former member of the Armed Forces. It is this connection that is therefore the basis of the definition. Functions carried out by specified bodies can affect different groups in different ways. Some functions may have the potential to affect some categories of family members more than others or not at all. The

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following people are prescribed in the Regulations as relevant family members:

a. *Partners.* This comprises the current and former spouses and civil partners of Service members, and any person whose relationship with a Service member is or was formerly 'akin to a relationship between spouses or civil partners', such as a cohabiting couple in a committed relationship. It should be remembered that Service members might be required to live away from their partner on posting or deployment for a considerable period but this should not be taken as affecting whether they are in such a relationship. This group includes former partners as they can continue to be impacted by Service life following a break-up from a Service member, particularly if they have children together. Including former partners ensures they can receive appropriate consideration as they become independent of the Service member, for example, to take account of the former partner's first re-location after the end of the relationship.

b. *Children*. This comprises children (including adopted children) under the age of 18 who are children of Service members or Service partners, and any other children under the age of 18 that are otherwise the responsibility of Service members or Service partners. A child is the responsibility of a Service member or Service partner if the Service member or Service partner has parental responsibility for the child, if the child is wholly or mainly financially dependent on the Service member or Service partner, or if the child is someone for whom the Service member or Service partner has assumed regular and substantial caring responsibilities (such as a foster child). Whilst the impact of Service life on children of serving members of the Armed Forces may be more easily apparent, children of veterans are included as they can experience disadvantages arising from Service life after their parent(s) have left Service. This could be the continuation of a disadvantage first experienced while their parent(s) were in Service, or a new disadvantage experienced due to the family's resettlement out of the Armed Forces into civilian life.

c. *Relatives* This comprises the relatives (including through adoption) of Service members or Service partners that are:

(i) living in the same household as the Service member. Service members might be required to temporarily live elsewhere, either for a set period of time or during the working week, due to postings or deployments. In such cases, where the relative would otherwise be living with the Service member (but for the fact the Service member is away for Service reasons) they are

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still to be considered a member of the Service member's household;
(ii) wholly or mainly financially dependent on the Service member or Service partner;
(iii) someone for whom the Service member or Service partner has assumed regular and substantial caring responsibilities, such as those with additional needs who may be otherwise unable to care for themselves.

The term 'relative' means:

(i) a parent, step-parent, son, daughter, stepson, stepdaughter, grandparent, step-grandparent, great-grandparent, step-great-grandparent, grandchild, step-grandchild, great-grandchild or step-great-grandchild;

(ii) the brother, sister, uncle, great-uncle, aunt, great-aunt, niece, great-niece, nephew, great-nephew or first cousin (whether of the full blood or of the half blood or by marriage or civil partnership);

(iii) any person aged 18 or over who was the responsibility of the Service member or Service partner as a child. Being the responsibility of a Service member or Service partner has the same meaning as in the 'Children' category above. This ensures this group will continue to be relevant family members when they are adults if there is a retained level of dependency.

d. *Bereaved family members*. When a Service member is deceased, this comprises any person who was a relevant family member under one of the above categories immediately before the Service member's death.

8. **Groups not within scope of the Duty** For the purposes of the Duty, the Armed Forces Community includes only the four groups above. Some groups are not within scope of either the Duty or the broader Covenant:

- The Armed Forces of other nations, such as NATO and Commonwealth countries, are not within scope of either the Duty or the broader Covenant (the only other countries in scope are British Overseas Territories).

- Cadets and Adult Volunteers in the Cadet Forces are not members of the UK Armed Forces, and are not within scope of either the Duty or the broader Covenant.

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Equality & Health Impact Assessment for

Generic EHIA for Administrative Type Policies

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	This EHIA supports (draft) UHB Policy 501 - The Armed Forces Covenant Duty Policy.
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Corporate Governance Head of Corporate Business – Tim Davies – 2074 36381
3.	Objectives of strategy/ policy/ plan/ procedure/ service	To recognise Cardiff and Vale University Health Board's position as a specified body under the Armed Forces Act 2021 ('AFA 21') and our statutory duty to meet the Armed Forces Covenant Duty as described within AFA 21.
4.	Evidence and background information considered.	• MOD PSED Assessment for the Armed Forces Covenant Duty • Veterans UK (Veterans UK - GOV.UK (www.gov.uk)) • Senedd Report: The Armed Forces Covenant – 10 years On. • Stakeholders through the Cardiff and Vale Armed Forces Covenant Forum • Feedback obtained following the Policy Consultation.
5.	Who will be affected by the policy?	Members of the Armed Forces Community (as described and identified by the Armed Forces Act 2021).

6. EQIA / How will the strategy, policy, plan, procedure and/or service impact on people?

Questions in this section relate to the impact on people on the basis of their 'protected characteristics'. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.1 Age The Armed Forces Community (as described in the Armed Forces 2021) comprises of children and adults, including the elderly.	Those at the oldest (65+) and youngest age ranges (0-15) are more likely to need healthcare services. This policy seeks to ensure equitable access of the community to healthcare at all age ranges – as such it is a positive impact.	N/A	N/A
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning	Those members of the Armed Forces Community with disabilities are more likely to require access to healthcare, not just for their	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	disability, but also due to the increased risk of developing other health problems over the course of their lives. This policy seeks to ensure equitable access of disabled members of the community to healthcare – as such it is a positive impact.		
6.3 People of different genders: Consider men, women, people undergoing gender reassignment	Based on previous and current demographic profiles of the Armed Forces Community the majority of currently serving armed forces personnel, and veterans, are male.	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	However, the Armed Forces demographic shows a trend towards an increasing number of female personnel and veterans. Current demographics show that the balance of partners and children within the Armed Forces Community are predominantly female. Transgender individuals may require disproportionately more access to healthcare services for those who undergo hormone treatment or surgery as well as related health issues, for example metabolic syndrome.		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	This policy seeks to ensure equitable access of community members to healthcare irrespective of gender– as such it is a positive impact.		
6.4 People who are married or who have a civil partner.	It is assessed that this policy has no impact on persons solely because of their marriage or civil partnership status.	N/A	N/A
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding.	This group has a dependency on healthcare services to support pregnancies to term and post-natal child	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	development. This policy seeks to remove any disadvantage that any members of this group from the armed forces community may have in accessing healthcare. Therefore, a positive impact is assessed.		
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	People from certain nationalities are excluded from serving in the Armed Forces. However, people of all nationalities may become family members of personnel serving in the Armed Forces and as such these individuals would form part of the Armed Forces community.	Translations of this policy may need to be made available on request to members of the public.	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	Thus, the UHB policy makes no differentiation on the grounds of race, nationality, colour or ethnic origin and it is assessed that the policy has no negative impact on people with these characteristics.		
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	There are no barriers to membership of the Armed Forces Community on grounds of religion or belief. The Armed Forces Duty Covenant and the UHB Policy makes no association with the religion or belief of the Armed Forces Community. Therefore, it is assessed that the policy has	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	no negative impact on people from this group.		
6.8 Sexual Orientation: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)	There are factors that may have affected the makeup of sexual orientations of current and former serving persons, such as the historical ban on LGB+ persons serving in the Armed Forces, which was lifted in 2000. However, persons affected in this manner remain eligible for incorporation into the Armed Forces Community as defined in the Armed Forces Act 2021. Therefore, it is assessed that the policy has no impact on the basis of sexual orientation.	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language	The Armed Forces Covenant Duty legislation is available in Welsh and UHB 501 will be made available in Welsh once approved.	N/A	N/A
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	The Armed Forces Duty Covenant and UHB 501 seeks to ensure equitable access of community members to healthcare irrespective of income– as such it is a positive impact.	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities	The Armed Forces Duty Covenant and UHB 501 seeks to ensure equitable access of community members to healthcare irrespective of home location – as such it is a positive impact.	N/A	N/A
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	None identified.	N/A	N/A

7. **HIA / How will the strategy, policy, plan, procedure and/or service impact on the health and well-being of our population and help address inequalities in health?**

Questions in this section relate to the impact on the overall health of individual people and on the impact on our population. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales	This policy will improve the ability of the Armed Forces Community to access services.	N/A	N/A
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active,	More equitable access of the Armed Forces Community to health services will positively influence the improvement and maintenance of healthy lifestyles.	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
no smoking /smoking cessation, reducing the harm caused by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc Well-being Goal – A healthier Wales			
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility	This policy will have no adverse impact on income and employment status.	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
of work, paid/ unpaid employment, wage levels, job security, working conditions Well-being Goal – A prosperous Wales			
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and	This policy will have no adverse impact on peoples' use of the physical environment.	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales			
7.5 People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities	This policy will have no adverse impact on the social and community influences on health.	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate Well-being Goal – A globally responsible Wales	This policy will have no adverse impact on macro-economic, environmental and sustainability factors.	N/A	N/A

Please answer question 8.1 following the completion of the EHIA and complete the action plan

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	Overall, there appear to be potentially positive impacts and no negative impacts.

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	Nil Required			
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	Nil Required			
8.4 What are the next steps?	The Policy remains unchanged. Policy and EHIA will be reviewed 12 months after approval.	Head of Corporate Business	1 Year	

Report Title:	Assurance Strategy 2021-4 and Risk Management Strategy				Agenda Item no.	7.9	
Meeting:	Board		Public	x	Meeting Date:	30.03.2023	
			Private				
Status *(please tick one only):*	Assurance	x	Approval		Information		x
Lead Executive:	Interim Director of Corporate Governance						
Report Author (Title):	Head of Risk and Regulation						

Main Report
Background and current situation:

All Appendices referenced in this document can be located in the Supporting Documents Folder on AdminControl and the Cardiff and Vale UHB website.

At the April 2021 Meeting of the Audit and Assurance Committee approval was given to develop an Assurance Strategy ("the Strategy") for the implementation of a Framework of Assurance.

The paper in April 2021 described that the organisation had a number of tools which provided assurance but no overarching strategy which pulled those tools together to give an overall view on assurance.

A copy of the newly developed Strategy was shared at the July 21 meeting of the Audit and Assurance Committee which recommended the Strategy to Board for approval. The Strategy was subsequently reported to, and Approved by the Board at the September 2021 Board Meeting.

It is hoped that the implemention of the Strategy will improve the overall governance of the organisation and the assurance provided to the Board by identifying gaps or limited assurance. This in turn will enable better targeting of resources in order to obtain assurance where required.

Due to competing Clinical and Pandemic response pressures, it has proven difficult to secure the time of colleagues to move the Strategy and the development of an Assurance Map forward following approval in September 2021, however work in this area has recommenced and the Head of Risk and Regulation has had the opportunity to meet with Clinical and Corporate colleagues to re-engage and begin populating the Health Board's Assurance Map.

Coupled with this Internal Audit have undertaken an Advisory Review of the Strategy which was reported to the Audit and Assurance Committee at its February 2023 Committee meeting.

Within the Advisory Review the following recommendations/opportunities were identified by Internal Audit:

1) Consideration should be given to reviewing and revising the Health Board's approach to the 'Three Lines of Defence' model, so that it aligns to risk, governance and assurance best practice.

2) The Health Board should consider reviewing and revising the current Assurance Map template, appended to the Assurance Strategy, so that the layout and content takes a risk based approach, which will assist in prioritising areas to take forward.

Both recommendations were reported as complete at the February 2023 Audit and Assurance Committee.

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

The output of completion of these advisory opportunities are included within the following updated documents which are shared with the Board for approval and ratification:

1) Updated Assurance Strategy (with Tracked Changes) (Opportunity 1). Also included within this document is the updated Assurance Map (Opportunity 2) which can be found at Appendix 6 of the document;
2) Updated Risk Management and Board Assurance Framework Strategy with tracked changes to identify changes made.

Both documents were approved at the February 2023 Audit and Assurance Committee and referred to Board for ratification.

Alongside amendments made to the Assurance Strategy and Risk Management and Board Assurance Framework Strategy, work has also been undertaken to embed the delivery of the Strategy across the Health Board, starting with the population of an Assurance Map that is aligned to the Corporate Risk Register.

Attached as Appendices 3(a) to (c) are extracts from the Assurance Map that continues to be populated following preparation of the Corporate Risk Register for the January 2023 Board meeting. This document is attached for reference purposes at this stage, a full, working version of the Assurance Map will be shared at the May 2023 Board meeting.

- Appendix 3(a) is a copy of the updated Assurance Map shared at the February 2023 Audit and Assurance Committee;
- Appendices 3(b) and (c) are evidence of the detailed feedback and assurance that is held in relation to specific risks, in this instance, risks CRR3 and CRR10.

Recommendation:

The Board is requested to:

a) **NOTE** the progress made against the Advisory Recommendations made by Internal Audit; and

b) **APPROVE** the updated Assurance Strategy 21-24 and Risk Management and Board Assurance Framework Strategy.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

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

5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

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

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes
The Health Board's Assurance Strategy forms part of a suite of documents that support the Health Board's Risk Management and Assurance processes. No specific Impact assessment has been undertaken, however by its very nature, the development of the Assurance Strategy will consider risk and the areas detailed below.
Safety: No
Financial: No
Workforce: No
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation: No

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

Report Title:	Board Committee Arrangements for 2023/24			Agenda Item no.	7.10
Meeting:	Board	Public	x	Meeting Date:	30th March 2022
		Private			
Status *(please tick one only):*	Assurance		Approval	x	Information
Lead Executive:	Director of Corporate Governance				
Report Author (Title):	Director of Corporate Governance				

Main Report
Background and current situation:

The Health Board's Standing Orders and Reservations and Delegations of Powers 3.4 states that the Board shall establish a Committee Structure that it determines best meets its own needs, taking account of any regulatory or Welsh Government requirements. As a minimum, it must establish Committees which cover the following aspects of Board business:

- Quality and Safety
- Audit
- Information Governance
- Charitable Funds
- Remuneration and Terms of Service
- Mental Health Act requirements

The Health Board will continue to have these Committees in place during 2023/34 in accordance with its Standing Orders and Reservations of Delegations of Powers.

It is important to keep the effectiveness of the Board's Committees under constant review to ensure that they are fit for purpose and support the Board in discharging its functions. The Board has a well-established cycle of reporting from each Committee to the Board, together with annual reporting and Committee effectiveness self-assessment. In addition, the Chair periodically attends Committee meetings to observe their performance and meets with Committee chairs and meets with all board members regularly.

It is also important to ensure that the Board's Committee arrangements reflect the risk profile of the organization which will change over time and as a result the requirements that the Board has of its Committees will also change. The Board Assurance Framework highlights significant risks for the Health Board to achieving its objectives most notably in the areas of People, Quality and Performance.

Proposed Changes to Board Committee Arrangements from 1 April 2023

Taking these matters into account, the Chair, in consultation with the Director of Corporate Governance proposes the following changes to Committee arrangements from 1 April 2023:

1. The Strategy and Delivery Committee ceases with strategy becoming a standing item for the first 1.5 hours of each Board Development session. This will provide the Board as a whole greater opportunity to develop and review the Health Board strategy and supporting strategic plans.
2. The delivery/performance element that was previously reported to the Strategy and Delivery Committee will be included in the business of a newly constituted Finance and Performance Committee. This will meet monthly for the foreseeable future with its first meeting on 19 April 2023 in recognition of the financial and delivery challenges that the Health Board faces.

3. A newly established People and Culture Committee meets for the first time on 16 May 2023 and will met bi-monthly thereafter in order to apply specific focus to the people agenda.
4. The Health and Safety Committee will become a sub-committee of the People and Culture Committee, through which it will report to the Board and there will be increased focus on capital, estates and facilities assurance.
5. The Quality, Safety and Experience Committee will meet monthly for the foreseeable future in order to ensure sufficient time is afforded to quality improvement.
6. The Digital and Health Intelligence Committee will move from three times per year to quarterly in order to provide greater opportunity to explore whether the Health Board is making the most of digital opportunities.

The Terms of Reference and work plans for these Committees are subject to the established annual review and approval by the Board with the newly established Committees discussing their draft Terms of Reference, operating arrangements and work plans at their first meetings.

Proposed Membership of Board Committees from 1 April 2023

In order to ensure that Board Committees operate as effectively as possible the skills and experience of Independent Members should be applied in those areas where they will have the greatest impact and support to the Board. The Chair has considered this and the following membership of Committees is proposed:

Board Committees:

Committee	Members	Chair	Vice Chair	Executive Lead
Audit & Assurance	John Union Ceri Phillips Mike Jones David Edwards Rhian Thomas	John Union	David Edwards	Catherine Phillips
Quality, Safety and Experience	Ceri Phillips Mike Jones Akmal Hanuk Rhian Thomas Keith Harding	Ceri Phillips	Rhian Thomas	Jason Roberts Meriel Jenney
Finance and Performance	Michael Imperato John Union David Edwards Ceri Phillips Keith Harding	Michael Imperato	John Union	Catherine Phillips Paul Bostock
People & Culture	Sara Mosely Susan Elsmore Rhian Thomas Akmal Hanuk Mike Jones	Sara Moseley	Susan Elsmore	Rachel Gidman
Mental Health and Capacity Legislation	Ceri Phillips Sara Mosely Susan Elsmore Rhian Thomas	Ceri Phillips	Sara Moseley	Paul Bostock

Digital Health and Intelligence	David Edwards Michael Imperato Akmal Hanuk Keith Harding	David Edwards	Michael Imperato	David Thomas
Charitable Funds	John Union Sara Mosely Susan Elsmore Keith Harding Fiona Jenkins Catherine Phillips Rachel Gidman	John Union	Susan Elsmore	Catherine Phillips
Remuneration and Terms of Service	Jan Janczewski Ceri Phillips John Union Michael Imperato Sara Moseley David Edwards (Co-opt as necessary)	Jan Janczewski	Ceri Phillips	Suzanne Rankin

Sub Committee:

Health and Safety (3 Independent Members)	Mike Jones Michael Imperato Akmal Hanuk	Mike Jones	Akmal Hanuk	Rachel Gidman

Currently Suspended Committee:

Shaping our Future Hospitals Committee	Rhian Thomas John Union David Edwards Keith Harding	Rhian Thomas	John Union	Abigail Harris

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

Robust arrangements are in place to keep Board Committees under review and it is important that changes are made on a timely basis in order to ensure that the Committee arrangements support the Board to achieve its objectives, noting the risks and assurances required that are articulated in the Board Assurance Framework. The proposed revised Committee arrangements from 1 April 2023 reflect this and a renewed emphasis on the many significant challenges the Health Board faces.

The Membership of all Committees of the Board is determined by the Board based upon recommendations from the Chair. Executive Directors should not be appointed as Committee Chairs, neither should they be appointed to serve as members on any Committees set up to review the exercise of functions delegated to officers. Executive Directors and designated Officers shall be in attendance at such Committees as appropriate.

Taken together, the revised Committee arrangements and membership are intended to ensure that the Board makes the best use of the resources available to it and will be subject to further review as they progress during 2023/24.

Recommendation:

The Board are requested to:

(a) Approve the establishment of the following Committees of the Board for 2023/24:

- Audit Committee*
- Remuneration and Terms of Service Committee*
- Charitable Funds Committee*
- Mental Health Legislation and Mental Capacity Act Committee (Mental Health Act requirements) *
- Digital and Health Intelligence Committee (Information Governance) *
- Quality, Safety and Experience Committee*
- Finance and Performance Committee
- People and Culture Committee
- Shaping Our Future Hospitals Committee – noting that this Committee is currently paused.

(b) Approve the membership of Committees of the Board for 2023/24

***denotes a statutory Committee**

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

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

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: ~~Yes~~/No
Safety: ~~Yes~~/No

Financial: ~~Yes~~/No
Workforce: ~~Yes~~/No
Legal: Yes/~~No~~
It is a statutory requirement of the Health Board to ensure that is establishes a Committee Structure to meets its needs and in line with other regulatory and legal requirements from Welsh Government
Reputational: ~~Yes~~/No
Socio Economic: ~~Yes~~/No
Equality and Health: ~~Yes~~/No
Decarbonisation: ~~Yes~~/No

Approval/Scrutiny Route:	
Committee/Group/Exec	Management Executive
Committees of the Board	

Report Title:	Terms of Reference and Work Plans for Committees of the Board			Agenda Item no.	7.11
Meeting:	Board	Public	x	Meeting Date:	30th March 2022
		Private			
Status *(please tick one only):*	Assurance		Approval	x	Information
Lead Executive:	Director of Corporate Governance				
Report Author (Title):	Director of Corporate Governance				

Main Report
Background and current situation:

The Health Board's Standing Orders and Reservations and Delegations of Powers 3.4 states that the Board shall establish a Committee Structure that it determines best meets its own needs, taking account of any regulatory or Welsh Government requirements. As a minimum, it must establish Committees which cover the following aspects of Board business:

- Quality and Safety
- Audit
- Information Governance
- Charitable Funds
- Remuneration and Terms of Service
- Mental Health Act requirements

The Health Board will continue to have these Committees in place during 2023/34.

A review of Committee arrangements led by the Chair has led to the following proposed changes from 1 April 2023:

1. The Strategy and Delivery Committee ceases.
2. The delivery/performance element that was previously reported to the Strategy and Delivery Committee will be included in the business of a newly constituted Finance and Performance Committee.
3. A People and Culture Committee is to be established.
4. The Health and Safety Committee will become a sub-committee of the People and Culture Committee.
5. The Quality, Safety and Experience Committee will meet monthly for the foreseeable future in order to ensure sufficient time is afforded to quality improvement.
6. The Digital and Health Intelligence Committee will move from three times per year to quarterly.

Draft terms of reference and workplans for the Finance & Performance and People & Culture Committees will be considered at their first meetings and will be submitted to the May meeting of the Board for approval.

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

Terms of Reference and Work Plans for the Committees of the Board are reviewed on an annual basis in line with Standing Orders and good governance. All the Committees of the Board have had the opportunity to review their Terms of Reference, have ratified them and are now with this report recommending to the Board for approval.

Each Committee established by the Board must have its own detailed terms of reference which must be formally approved by the Board. The Terms of Reference must establish Committee Governance and ways of working.

The Work Plans for each Committee must reflect the Terms of Reference to ensure that the Committee is discharging its responsibilities appropriately.

Each continuing Committee has reviewed its Terms of Reference and 2023/24 Work Plans at a recent meeting, resulting in the attached Terms of Reference and Work Plans for Committees of the Cardiff and Vale University Health Board 2023/24 and is recommended to the Board for approval.

Recommendation:

The Board are requested to:

(a) Approve the attached Terms of Reference and Work Plans for the following Committees of the Board for 2023-24:

- Audit Committee*
- Remuneration and Terms of Service Committee*
- Charitable Funds Committee*
- Mental Health Legislation and Mental Capacity Act Committee (Mental Health Act requirements) *
- Digital and Health Intelligence Committee (Information Governance) *
- Quality, Safety and Experience Committee*
- Shaping Our Future Hospitals Committee – noting that this Committee is currently paused.

(b) Note that the Terms of Reference and Work Plans for the Finance & Performance and People & Culture Committees will be reported to the May meeting of the Board following ratification by those Committees.

***denotes a statutory Committee**

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

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

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant

Prevention		Long term	x	Integration		Collaboration		Involvement	

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

Risk: ~~Yes~~/No
Safety: ~~Yes~~/No
Financial: ~~Yes~~/No
Workforce: ~~Yes~~/No
Legal: Yes/~~No~~
It is a statutory requirement of the Health Board to ensure that is establishes a Committee Structure to meets its needs and in line with other regulatory and legal requirements from Welsh Government
Reputational: ~~Yes~~/No
Socio Economic: ~~Yes~~/No
Equality and Health: ~~Yes~~/No
Decarbonisation: ~~Yes~~/No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Committees of the Board	During January, February and March 2023

TERMS OF REFERENCE AND WORKPLANS FOR COMMITTEES OF THE

CARDIFF AND VALE UNIVERSITY HEALTH BOARD

2023/24

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AUDIT AND ASSURANCE 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 **Audit and Assurance Committee**. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set out below.

2. PURPOSE

2.1 The purpose of the Audit Committee ("the Committee") is to:

- ***Advise*** and ***assure*** the Board and the Accountable Officer on whether effective arrangements are in place - through the design and operation of the UHB's assurance framework - to support them in their decision taking and in discharging their accountabilities for securing the achievement of the UHB's objectives, in accordance with the standards of good governance determined for the NHS in Wales.

2.2 Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its assurance framework may be strengthened and developed further.

3. DELEGATED POWERS AND AUTHORITY

3.1 With regard to its role in providing advice to the Board, the Committee will comment specifically upon:

- the adequacy of the UHB strategic governance and assurance framework and processes for risk management and internal control designed to support the Accountable Officer's statement on internal control, providing reasonable assurance on:

  - the organisations ability to achieve its objectives;
  - compliance with relevant regulatory requirements, standards and other directions and requirements set by the Welsh Government and others;
  - the reliability, integrity, safety and security of the information collected and used by the organisation;
  - the efficiency, effectiveness and economic use of resources; and

- the extent to which the organisation safeguards and protects all its assets, including its people
- the adequacy of the arrangements for declaring, registering and handling interests at least annually
- the adequacy of the arrangements for dealing with offers of gifts or hospitality
- to ensure the provision of high quality, safe healthcare for its citizens;

- the Board's Standing Orders, and Standing Financial Instructions (including associated framework documents, as appropriate);
- the accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of error identified, the ISA 260 Report 'Communication with those charged with Governance' and managements' letter of representation to the external auditors;
- the Schedule of Losses and Compensation;
- the planned activity and results of internal audit, external audit and the Local Counter Fraud Specialist (including strategies, annual work plans and annual reports);
- the adequacy of Executive and Managements response to issues identified by Audit, Inspection and other assurance activity;
- anti-fraud policies, whistle-blowing processes and arrangements for special investigations; and
- any particular matter or issue upon which the Board or the Accountable Officer may seek advice.

3.2 The Committee will support the Board with regard to its responsibilities for governance (including risk and control) by:

- reviewing the ***comprehensiveness*** of assurances in meeting the Board and the Accountable Officers assurance needs across the whole of the UHB's activities, both clinical and non-clinical;
- reviewing the ***reliability and integrity*** of these assurances; and
- considering and approving policies as determined by the Board.

3.3 To achieve this, the Committee's programme of work will be designed to provide assurance that:

- there is an effective Internal Audit function that meets the standards set for the provision of Internal Audit in the NHS in Wales and provides appropriate independent assurance to the Board and the Accountable Officer through the Committee;
- there is an effective Counter Fraud Service that meets the standards set for the provision of counter fraud in the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee;
- there is an effective clinical audit and quality improvement function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Quality, Safety and Experience Committee;
- there are effective arrangements in place to secure active, ongoing assurance from management with regard to their responsibilities and accountabilities, whether directly to the Board and the Accountable Officer or through the work of the Board's Committees

- the work carried out by key sources of external assurance, in particular, but not limited to the UHB External Auditors (Audit Wales), is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace) internal assurance activity
- the work carried out by the whole range of external review bodies is brought to the attention of the Board, and that the organisation is aware of the need to comply with related standards and recommendations of these review bodies, and the risks of failing to comply;
- the systems for financial reporting to the Board, including those of budgetary control, are effective; and that
- the results of audit and assurance work specific to the UHB, and the implications of the findings of wider audit and assurance activity relevant to the UHB's operations are appropriately considered and acted upon to secure the ongoing development and improvement of the organisation's governance arrangements.

Authority

3.4 The Committee is authorised by the Board to investigate or have investigated any activity (clinical and non-clinical) 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.

3.5 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.

Access

3.6 The Head of Internal Audit and the Engagement Partner/Audit Manager of External Audit (Audit Wales) shall have unrestricted and confidential access to the Chair of the Audit Committee.

3.7 The Committee will meet with Internal and External Auditors (Audit Wales) and the nominated Local Counter Fraud Specialist without the presence of officials on at least one occasion each year.

3.8 The Chair of Audit Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.9 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.

4. MEMBERSHIP

Members

4.1 A minimum of three (3) 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 *[one of which should be the member of the Quality and Safety Committee (or equivalent)]*

The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

Attendees

4.2 In attendance

Chief Executive
Director of Finance (Lead Executive)
Director of Corporate Governance
Head of Internal Audit
Local Counter Fraud Specialist
Representative of External Auditor (Audit Wales)
Other Executive Directors will attend as required by the Committee Chair

4.3 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

4.4 Secretary - As determined by the Director of Corporate Governance

Member Appointments

4.5 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.

4.6 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.

Support to Committee Members

4.7 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.

5. COMMITTEE MEETINGS

Quorum

5.1 At least two members must be present to ensure the quorum of the Committee, one of whom should be the committee Chair or Vice Chair.

Frequency of Meetings

5.2 Meetings shall be held no less than quarterly, and otherwise as the Chair of the Committee deems necessary – consistent with the UHB annual plan of Board Business.

Withdrawal of Individuals in Attendance

5.3 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.

6. RELATIONSHIP AND ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 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.

6.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference.

6.3 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.

6.4 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.

6.5 The Committee shall embed the UHB's corporate standards, priorities and requirements, e.g., equality and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 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.

7.2 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, specifically commenting on the adequacy of the assurance framework, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the committee's self-assessment and evaluation.

7.3 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.

7.4 The Director of Corporate Governance, 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.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 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)
- Notifying and equipping Committee members – Committee members shall be sent an Agenda and a complete set of supporting papers at least seven (7) clear days before a formal Committee meeting (unless specified otherwise in law).
- Notifying the public and others – at least seven (7) clear days before each Committee meeting a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed on the Health Board's website

together with the papers supporting the public part of the agenda (unless specified otherwise in law).

9. REVIEW

9.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee with reference to the Board.

Audit and Assurance Committee Work Plan 2023 - 24								
App. -Approval Ass.- Assurance Inf. - Information	**Exec Lead**	**04-Apr**	**11-May**	**13-Jun**	**04-Jul**	**05-Sep**	**07-Nov**	**06-Feb**
Agenda Item								
Governance								
Review the system of assurance	JQ	Ass.					Ass.	
Review the risk management system	JQ							Ass.
Note the business of other Committees and review inter-relationships	JQ							Ass.
Review Draft Quality Statement (not required for 22.23)	RW	Ass.	Ass.	App.				
Review the UHB Draft Annual Report and Accounts	JQ	Ass.	Ass.	App.				
Review of Standing Orders	JQ							Ass.
Report on Declarations of Interest and Gifts and Hospitality	JQ	Ass.			Ass.	Ass.	Ass.	Ass.
Receive relevant reports from Regulatory Bodies	JQ	Ass.			Ass.	Ass.	Ass.	Ass.
Receive tracking report from Regulatory Bodies	JQ	Ass.			Ass.		Ass.	
Receive tracking report from internal audit recommendations	JQ	Ass.			Ass.		Ass.	
Receive tracking report from Audit Wales recommendations	JQ	Ass.			Ass.		Ass.	
Financial Focus								
Agree final accounts timetable and plans	CP							App.
Review of audited annual accounts and financial statements	CP		Ass.	App.				
Review changes to SFIs and changes to accounting policies	CP/JQ	Ass.						
Review losses and special payments	CP	Ass.	Ass.	App.			App.	
Single Tender Actions	CP	Ass.			Ass.	Ass.	Ass.	Ass.
Review of Draft Charitable Funds Annual Report and Accounts	CP						Ass.	
Internal Audit								
Review and approve annual internal audit plan	IA	App.						
Review the effectiveness of internal audit	IA						Ass.	
Review of internal audit progress reports	IA	Ass.			Ass.	Ass.	Ass.	Ass.
Receive internal audit reports undertaken during the period	IA	Ass.			Ass.	Ass.	Ass.	Ass.
Receive annual internal audit report and associated opinions (HoIA)	IA		Ass.	App.				
Audit Wales								
Agree Auditor General's Audit Plan	AW							App.
Review the effectiveness of external audit	AW						Ass.	
Review External Audit Progress Reports	AW	Ass.			Ass.	Ass.	Ass.	Ass.
Receive the Auditors report to those charged with governance	AW		Ass.	App.				
Receive the Auditors Annual Audit Report	AW							App.
Receive Annual Structured Assessment Report	AW						Ass.	
Clinical Audit								
Review annual Clinical Audit Plan	JR/MJ						Ass.	
Counter Fraud								
Review and approve annual counter fraud plan	CF	App.						
Review counter fraud progress reports	CF	Ass.			Ass.	Ass.	Ass.	Ass.
Review the effectiveness of Counter Fraud Specialist	CF						Ass.	
Receive counter fraud annual report	CF	Ass.		App.				
Audit Committee								
Annual Work Plan	JQ							App.
Self assessment of effectiveness	JQ	Ass.						
Induction Support for Committee Members	JQ	Ass.						
Review Terms of Reference	JQ							App.
Produce Audit Committee Annual Report	JQ							App.
Minutes of Audit Committee Meeting	JQ	App.	App.	App.	App.	App.	App.	App.
Action log of Audit Committee Meeting	JQ	Ass.	Ass.	Ass.	Ass.	Ass.	Ass.	Ass.

REMUNERATION AND TERMS OF SERVICE COMMITTEE

TERMS OF REFERENCE AND OPERATING ARRANGEMENTS

1. INTRODUCTION

1.1 The University Health Board (UHB) Standing Orders provide that "*The Board may and, where directed by the Welsh Government must, appoint Committees of the UHB 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 (and the UHB Scheme of Delegation), the Board shall nominate annually a committee to be known as the **Remuneration and Terms of Service Committee**. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set out below.

2. PURPOSE

2.1 The purpose of the Remuneration and Terms of Service Committee is to:

- Advise and Approve on behalf of the Board on remuneration and terms of service for the Chief Executive, Executive Directors and other senior staff within the framework set by the Welsh Government; and
- Provide ***Assurance*** to the Board in relation to the UHB arrangements for the remuneration and terms of service, including contractual arrangements, for *all staff*, in accordance with the requirements and standards determined for the NHS in Wales
- Perform certain, specific functions on behalf of the Board.

2.2 The Committee shall have no powers to develop or modify existing pay schemes.

3. DELEGATED POWERS AND AUTHORITY

3.1 With regard to its role in providing advice and assurance to the Board, the Committee will comment specifically upon the:

- Remuneration and terms of service for the Chief Executive, Executive Directors and other Very Senior Managers (VSMs) not covered by Agenda for Change; ensuring that the policies on remuneration and terms of service as determined from time to time by the Welsh Government are applied consistently;
- Objectives for the Chief Executive and Executive Directors and their performance assessment;
- Proposals to make additional payments to medical consultants; and

- Proposals regarding termination arrangements, ensuring the proper calculation and scrutiny of termination payments in accordance with the relevant Welsh Government guidance.

3.2 The Board has delegated the following specific powers to the Committee:

- To consider and approve Voluntary Early Release scheme applications, redundancy payments and severance payments;
- To approve any exceptions to the Relocation Expenses Policy
- To approve the engagement of any Board members via an agency or as a contractor in line with Standing Orders and extant Welsh Government guidance.

3.3 Note on an annual basis the engagement of agency workers or individual self-employed contractors into senior posts, as described in the Off-Payroll Procurement Process (n.b. This information is reported to the Audit Committee as part of the compliance report and is for noting only)

Authority

3.4 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.

3.5 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.

Sub Committees

3.6 The Committee does not have any sub-Committees.

Chairs Action

3.7 The Chair can, with the support of two other Independent Members, act on behalf of the Committee in urgent matters or in relation to routine applications for Voluntary Early Release. All actions taken by the Chair must be ratified at the next Committee meeting.

4. MEMBERSHIP

Members

4.1 A minimum of four (5) members, comprising:

Chair	Chair of the Board

Vice Chair	Independent member of the Board
Members	At least three other independent members of the Board The Chair of the Audit Committee will be appointed to this Committee either as Vice Chair or member.

Attendees

4.2 The Committee Chair may invite:

- the Director of Corporate Governance
- the Chief Executive
- the Director of People and Culture (Lead Executive)
- 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 (except when issues relating to their personal remuneration and terms and conditions are being discussed).

Secretariat

4.3 The Secretary of the Committee is the Director of Corporate Governance. In the event that this is not appropriate the Executive Director of Workforce will nominate a secretariat

Member Appointments

4.4 The membership of the Committee shall be determined by the Board, based on the recommendation of the UHB Chair, and subject to any specific requirements or directions made by the Welsh Government.

Support to Committee Members

4.5 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 development for committee members in conjunction with the Director of Workforce and Organisational Development.

5. COMMITTEE MEETINGS

Quorum

5.1 At least three members must be present to ensure the quorum of the Committee, one of whom must be the Chair or Vice Chair.

Frequency of Meetings

5.2 The Chair of the Committee, in agreement with Committee Members, shall determine the timing and frequency of meetings, as deemed necessary. It is expected that the Committee shall meet at least once a year, consistent with the UHB's annual plan of Board Business.

Meeting Papers

5.3 The Chair and Director of Corporate Governance will check the agenda and papers prior to each meeting

Withdrawal of Individuals in Attendance

5.4 The Committee may ask any member or individual who is normally in attendance but who is not a member to withdraw to facilitate open and frank discussion of any particular matter.

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 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.

6.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.3 The Committee, through its Chair and members, shall work closely with the Board's other 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 appropriate 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 assurance framework.

6.4 The Committee shall embed the UHB values, corporate standards, priorities and requirements, e.g., equality and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- report formally and on a timely basis to the Board on the Committee's activities, in a manner agreed by the Board;
- bring to the Board's specific attention any significant matter under consideration by the Committee;
- ensure appropriate escalation arrangements are in place to alert the Board, 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.

7.2 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.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in the UHB's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- quorum (set within individual Terms of Reference)
- Notifying and equipping Committee members – Committee members shall be sent an Agenda and a complete set of supporting papers at least seven (7) clear days before a formal Committee meeting (unless specified otherwise in law).
- Notifying the public and others – at least seven (7) clear days before each Committee meeting a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed on the Health Board's website together with the papers supporting the public part of the agenda (unless specified otherwise in law).

9. REVIEW

9.1 These Terms of Reference and operating arrangements shall be reviewed on an annual basis by the Committee with reference to the Board.

Remuneration Committee Work Plan 2023-24			
A -Approval D- discussion I - Information	**Exec Lead**	**Apr-23**	**Nov-23**
Agenda Item			
Standard Items			
Approve Voluntary Early Release Scheme applications	RG	A	A
Approve Redundancy Payments	RG	A	A
Approve Severance Payments	RG	A	A
Appove exceptions to the Relocation Expenses Policy	RG	A	A
Approve engagement of any Board Member via an agency or contractor	SR/CJ	A	A
Advice and Assurance to the Board			
Remuneration and Terms of Service for CEO, Executive Directors and other Very Senior Managers	CJ/SR	A	A
Approve Objectives for CEO and Executive Directors	CJ/SR	A	
Review Performance Assessment for CEO and Executive Directors	CJ/SR		D
Approve proposals regarding termination arrangements	RG	A	A
Note Engagement of Agency Workers or self employed contractors in senior posts	RG	I	I
Approve appointments of Executive Directors and other Senior Managers.	CJ/SR	A	A
Approve appointments of Executive Directors	CJ/SR	A	A
Governance			
Annual Work Plan	JQ	A	
Self assessment of effectiveness	JQ		D
Induction Support for Committee Members	JQ		
Review Terms of Reference	JQ	A	
Produce annual RaTS Committee Annual Report	JQ	A	
Minutes of RaTS Committee Meeting	JQ	D	D
Action log of RaTS Committee Meeting	JQ	D	D

CHARITABLE FUNDS COMMITTEE

TERMS OF REFERENCE AND OPERATING ARRANGEMENTS

1. INTRODUCTION

1.1 The University Health Board (UHB) standing orders provide that *"The Board may and, where directed by the Welsh Government must, appoint Committees of the UHB 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 accordance with standing orders (and the UHB Scheme of Delegation), the Board shall nominate annually a Committee to be known as the **Charitable Funds Committee**. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set out below.

2. PURPOSE

2.1 Cardiff and Vale University Health Board was appointed as Corporate Trustee (herein after referred to as Charity Trustee) of its charitable funds and the Board serves as its agent in the administration of the charitable funds held by the UHB.

2.2 The purpose of the Charitable Funds Committee (the Committee) is to:

- Provide advice to the Charity Trustee in the discharge of its duties and responsibilities for charitable funds
- Discharge delegated responsibilities from the Charity Trustee for the control and management of Charitable Funds.

2.3 Provide advice and assurance to the Charity Trustee on the delivery of the Charitable Funds Strategy, including fundraising, budgets, priorities and spending criteria.

2.4 Within the strategy and budget determined by the Trustee and consistent with the requirements of the Charities Act 1993, Charities Act 2006 (or any modification of these acts) to apply the charitable funds in accordance with their respective governing documents and the UHB Charitable Funds Governance Framework.

2.5 To ensure that the policies and procedures for charitable funds investments are followed. To make decisions involving the sound investment of charitable funds in a way that both preserves their value and produces a proper return consistent with prudent investment and ensuring compliance with: -

- The Trustee Act 2000
- The Charities Act 1993
- The Charities Act 2006
- The Charities Act 2011
- The Charities Act 2016
- Terms of the Funds' Governing documents

2.6 To receive at least twice a year, reports for ratification from the Executive Director of Finance on investment decisions and action taken through delegated powers upon the advice of the investment adviser.

2.7 To oversee and monitor the functions performed by the Executive Director of Finance as defined in Standing Financial Instructions.

2.8 To monitor the progress of Charitable Appeals where these are in place and considered to be material.

2.9 To monitor and review the Scheme of Delegation for Charitable Funds expenditure and to set and reflect in Financial Procedures the approved delegated limits for expenditure from Charitable Funds.

2.10 To monitor the work of the Charitable Bids Panel

3. DELEGATED POWERS AND AUTHORITY

Delegated Powers and Duties of the Director of Finance

3.1 The Executive Director of Finance has financial responsibility for the UHB Charitable Funds as defined in the UHB Standing Financial Instructions. The specific powers, duties and responsibilities delegated to the Executive Director of Finance are: -

- Administration of all existing charitable funds;
- To identify any new charity that may be created (of which the UHB is trustee) and to deal with any legal steps that may be required to formalise the trusts of any such charity;
- Provide guidelines with regard to donations, legacies and bequests, fundraising and trading income;
- Responsibility for the management of investment of funds held on trust;
- Ensure appropriate banking services are available;
- Prepare reports to the Trustee including the Annual Accounts;

Authority

3.2 The Committee is empowered with the responsibility for: -

- Overseeing the day to day management of the investments of the charitable funds in accordance with the investment strategy set down from time to time by the Trustee and the requirements of the UHB Standing Financial Instructions;
- The appointment of an investment manager to advise it on investment matters and may delegate day-to-day management of some or all of the investments to that investment manager. In exercising this power, the Committee must ensure that:

  a) The scope of the power delegated is clearly set out in writing and communicated with the person or persons who will exercise it;
  b) There are in place adequate internal controls and procedures which will ensure that the power is being exercised properly and prudently;
  c) The performance of the person or persons exercising the delegated power is regularly reviewed;
  d) Where an investment manager is appointed, that the person is regulated under the Financial Services Act 1986;
  e) Acquisitions or disposal of a material nature must always have written authority of the Committee or the Chair of the Committee in conjunction with the Executive Director of Finance;

- Ensuring that the banking arrangements for the charitable funds are kept entirely distinct form the UHB NHS funds;
- Ensuring that arrangements are in place to maintain current account balances at minimum operational levels consistent with meeting expenditure obligations, the balance of funds being invested in interest bearing deposit accounts;
- The amount to be invested or redeemed from the sale of investments shall have regard to the requirements for immediate and future expenditure commitments;
- The operation of an investment pool when this is considered appropriate to the charity in accordance with charity law and the directions and guidance of the Charity Commission. The Committee shall propose the basis to the UHB for applying accrued income to individual funds in line with charity law and Charity Commissioner guidance;
- Obtaining appropriate professional advice to support its investment activities;
- Regularly reviewing investments to see if other opportunities or investment services offer a better return;
- Overseeing the work of the Charitable Funds Bids Panel

3.3 The Committee is authorised by the Charity Trustee to:

- Investigate or have investigated any activity within its Terms of Reference and in performing these duties shall have the right, at all reasonable times, to inspect any books, records or documents of the UHB relevant to the Committee's remit. It can seek any relevant information it requires from any employee and all employees are directed to co-operate with any reasonable request made by the Committee;
- Obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject to the Charity Trustee's budgetary and other requirements; and
- By giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Charity Trustee at any meeting of the Committee.

Access

3.4. The Head of Internal Audit shall have unrestricted and confidential access to the Chair of the Committee.

Sub Committees

3.5. The Charity Trustee has approved the following sub-committees of the Charitable Funds Committee:

- Charitable Funds Bids Panel
- Staff Benefits Group

4. MEMBERSHIP

Members

4.1 A minimum of six (6) members, comprising:

Chair	Independent Member of the Charity Trustee
Vice Chair	Independent Member or Members of the Charity Trustee
Members	A minimum of 4 other members of the Charity Trustee as follows: Independent Member Executive Director of Finance (Lead Executive) Executive Nurse Director Executive Director of People and Culture Executive Director of Therapies and Health Science

At least half of the overall membership must be Independent Members.

Attendees

4.2. The Committee may require the attendance for advice, support and information routinely at meetings from:

- Director of Communications, Arts, Health Charity and Engagement
- Director of Corporate Governance
- Deputy Director of Finance
- Charitable Funds Accountant
- UHB Investment Advisor
- Chair of Charitable Funds Bids Panel
- Chair of Staff Benefits Group / Vice Chair of Charitable Bids Panel

4.3. By invitation:

The Committee Chair may extend invitations to attend committee meetings to others from within or outside the organisation who the committee considers should attend, taking account of the matters under consideration.

Secretariat

4.4 Secretary: as determined by the Director of Corporate Governance

Member Appointments

4.5 The Membership of the Committee shall be determined by the Charity Trustee, based on the recommendation of the Chair of the Charity Trustee- 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.

4.6 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Charity Trustee, based upon the recommendation of the Charity Trustee Chair {and, where appropriate, on the basis of advice from the UHB Remuneration and Terms of Service Committee}.

Support to Committee Members

4.7 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 development for committee members in conjunction with the Executive Director of Finance and Executive Director of People and Culture.

5. COMMITTEE MEETINGS

Quorum

5.1 At least three members must be present to ensure the quorum of the Committee. Of these three, two must be Independent Members (one of whom is the Chair or Vice Chair) and one must be the Executive Lead for Charitable Funds.

Frequency of Meetings

5.2 Meetings shall be held quarterly and otherwise as the Committee Chairs deems necessary - consistent with the UHB annual plan of Board Business.

Withdrawal of Individuals in Attendance

5.3 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.

6. RELATIONSHIP AND ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 The Committee is directly accountable to the Board, in its capacity as Trustee, for its performance in exercising the functions set out in these terms of reference.

6.2. The Committee, through its Chair and members, shall work closely with the Board's other committees and groups to provide advice and assurance to the Board through the:

- Joint planning and co-ordination of Board and Committee business; and
- Appropriate 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 UHB overall risk and assurance framework.

6.3 The Committee shall embed the UHB's values, corporate standards, priorities and requirements, e.g., equality, diversity and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall agree arrangements with the UHB Chair to report to the Board in their capacity as Trustee. This may include, where appropriate, a separate meeting with the Board.

7.2 The Director of Corporate Governance, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 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)
- Notifying and equipping Committee members – Committee members shall be sent an Agenda and a complete set of supporting papers at least seven (7) clear days before a formal Committee meeting (unless specified otherwise in law).
- Notifying the public and others – at least seven (7) clear days before each Committee meeting a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed on the Health Board's website together with the papers supporting the public part of the agenda (unless specified otherwise in law).

9. REVIEW

9.1 These terms of reference and operating arrangements shall be reviewed on an annual basis by the Committee with reference to the Charity Trustee.

Charitable Funds Committee Work Plan 2022/23					
App. -Approval Ass. - Assurance Inf. - Information	**Exec Lead**	**15-Jun**	**19-Sep**	**05-Dec**	**19-Mar**
Agenda Item					
Standing Items					
Staff Lottery Bids Panel Report	JB	Inf	Inf	Inf	Inf
Finance Monitoring Report	CP	Ass	Ass	Ass	Ass
Staff Benefits Group Report	RG	Inf	Inf	Inf	Inf
New Charitable Fund Applications	JB	App	App	App	App
Feedback on approved successful CFC Bids	JB	Ass	Ass	Ass	Ass
Health Charity Fundraising Report	JB	Ass	Ass	Ass	Ass
Charitable Funds Strategy Review - fundraising - budgets - Priorities - spending Criteria - investment decisions	JB		Ass		Ass
Health Charity Annual Report	JB				App
Legacy Updates	JB				Ass
Walk for Africa	JB			Ass	
Food Sense Wales	FJ				Ass
Change Account	JB		Ass		
Arts Annual Report	JB				Ass
Investment Update	CP	Ass		Ass	
Events Planner	JB				App
Scheme of Delegation	CP		App		
Annual Accounts	CP				App
Appeals					
Breast Centre Appeal	JB			Ass	

Prop Appeal	JB	Ass			
Orchard Appeal	JB				Ass
Better Life Appeal	JB		Ass		
Charitable Funds Committee Governance					
Annual Work Plan	JQ				App
Self assessment of effectiveness	JQ	Ass			
Review Terms of Reference	JQ				App
Produce Charitable Funds Committee Annual Report	JQ				App
Minutes of Charitable Funds Committee Meeting	JQ	App	App	App	App
Action log of Charitable Funds Committee Meeting	JQ	Ass	Ass	Ass	Ass

MENTAL HEALTH LEGISLATION AND MENTAL CAPACITY ACT COMMITTEE

TERMS OF REFERENCE AND OPERATING ARRANGEMENTS

1. INTRODUCTION

1.1 The University Health Board's (UHB) Standing Orders provide that "*The Board may and, where directed by the Welsh Government must, appoint Committees of the UHB 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 (and the UHB Scheme of Delegation), the Board shall nominate annually a Committee to be known as the **Mental Health Legislation and Mental Capacity Act Committee.** The detailed terms of reference and operating arrangements agreed by the Board in respect of this Committee are set out below.

1.3 The principal remit of this Committee is to consider and monitor the use of

the Mental Health Act 1983 (MHA), Mental Capacity Act 2005 (which includes the Deprivation of Liberty Safeguards (DoLS)) (MCA) and the Mental Health (Wales) Measure 2010 (the Measure) and any subsequent amendments to the legislation.

Mental Health Act

1.4 The Mental Health Act 1983 covers the detention of people deemed a risk to themselves or others. It sets out the legal framework to allow the care and treatment of mentally disordered persons. It also provides the legislation by which people suffering from a mental disorder can be detained in hospital to have their disorder assessed or treated against their wishes.

1.5 The MHA introduced the concept of "Hospital Managers" which for

hospitals managed by a Local Health Board are the Board Members. The term "Hospital Managers" does not occur in any other legislation.

1.6 Hospital Managers have a central role in operating the provisions of the

MHA; specifically, they have the authority to detain patients admitted and transferred under the MHA. For those patients who become subject to a Community Treatment Order (CTO), the Hospital Managers are those of the hospital where the patient was detained immediately before going on to CTO - i.e. the responsible hospital or the hospital to which responsibility has subsequently been assigned.

1.7 Hospital Managers must ensure that patients are detained only as the

MHA allows, that their treatment and care is fully compliant with the MHA and that patients are fully informed of and supported in exercising their statutory rights. Hospital Managers must also ensure that a patient's case is dealt with in line with associated legislation.

1.8 With the exception of the power of discharge, arrangements for authorising day to day decisions made on behalf of Hospital Managers have been set out in the UHB Scheme of Delegation.

Mental Health Measure

1.9 The Mental Health (Wales) Measure received Royal Assent in December 2010 and is concerned with:

- providing mental health services at an earlier stage for individuals who are experiencing mental health problems to reduce the risk of further decline in mental health;
- making provision for care and treatment plans for those in secondary mental health care and ensure those previously discharged from secondary mental health services have access to those services when they believe their mental health may be deteriorating;
- extending mental health advocacy provision.

Mental Capacity Act

1.10 The MCA came into force mainly in October 2007. It was amended by the

Mental Health Act 2007 to include the Deprivation of Liberty Safeguards (DoLS). DoLS came into force in April 2009.

1.11 The MCA covers three main areas –

- The process to be followed where there is doubt about a person's decision-making abilities and decisions may need to be made for them (e.g. about treatment and care)
- How people can make plans and/or appoint other people to make decisions for them at a time in the future when they can't take their own decisions
- The legal framework for caring for adult, mentally disordered, incapacitated people in situations where they are deprived of their liberty in hospitals or care homes (DoLS)

Thus, the scope of MCA extends beyond those patients who have a mental disorder.

2. PURPOSE

2.1 The purpose of the Mental Health Legislation and Mental Capacity Act Committee (the Committee) is to seek and provide assurance to the Board or to escalate areas of concerns and advise on actions to be taken in relation to:

- Hospital Managers' duties under the Mental Health Act 1983;
- the provisions set out in the Mental Capacity Act 2005, and
- in the Mental Health Measure (Wales) 2010

are all exercised in accordance with statute and that there is compliance with:

- the Mental Health Act 1983 Code of Practice for Wales
- the Mental Capacity Act 2005 Code of Practice
- the Mental Capacity Act 2005 Deprivation of Liberty Safeguards Code of Practice
- the associated Regulations

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3. DELEGATED POWERS AND AUTHORITY

3.1 The Committee will:

- ensure that those acting on behalf of the Board in relation to the provisions of Mental Health Act and Capacity legislation, have the relevant skills, competencies and knowledge to discharge the Board's responsibilities;
- identify matters of risk relating to Mental Health and Capacity legislation and seek assurance that such risks are being mitigated;
- consider and approve relevant policies and control documents in support of the operation of Mental Health and Capacity legislation;
- monitor the use of the legislation and consider local trends and benchmarks;
- consider matters arising from the Hospital Managers' Power of Discharge sub-committee;
- ensure that **all** other relevant associated legislation is considered in relation to Mental Health and Capacity legislation;
- consider matters arising from visits undertaken by Healthcare Inspectorate Wales Review Service relating to legislation issues and get assurance that actions identified have been responded to appropriately in particular, issues relating to Mental Health Act 1983;
- The Quality, Safety and Experience Committee will advise the Mental Health Act and Capacity Legislation Committee of any complaints in relation to the Mental Health Act and Capacity legislation received from within reports from Public Services Ombudsman for Wales;
- consider any other information, reports related to the legislation that the Committee deems appropriate.

Authority

3.2 The Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference, concentrating on the governance systems in place and indicators of their effectiveness, particularly in the management of risk. 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, ensuring patient/client and staff confidentiality, as appropriate. It may seek any relevant information from any:

- employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and
- other Committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

3.3 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 UHB's procurement, budgetary and other requirements.

Sub Committees

3.4 In accordance with Regulation 12 of the Local Health Boards

(Constitution, Procedure and Membership) (Wales) Regulations 2003 (SI 2003/149 (W.19), the Board has appointed a Sub-Committee, to be known as the Power of

Discharge Sub-Committee. Three or more members drawn from the Sub-Committee will constitute a panel to consider the possible discharge or continued detention under the MHA of unrestricted patients and those subject to

CTO.

The Mental Health Legislation and Governance Group is also a sub Committee. The purpose of this group is to monitor use of the MHA and deal with operational issues. Therefore, allowing the MHACLC to focus on policy.

3.5 The Committee has authority to establish short life working groups which are time limited to focus on a specific matter of advice or assurance as determined by the Board or Committee.

Retention of Board Responsibility

3.6 The Board retains final responsibility for the performance of the Hospital

Managers' duties delegated to particular people on the staff of Cardiff and Vale University Health Board, as well as the Power of Discharge Group**.**

4. MEMBERSHIP

Members

4.1 A minimum of three (3) members, comprising:

Chair	Vice Chair of the Board
Vice Chair	Chosen from amongst the Independent Members on the Committee
Members	A minimum of two 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

4.2. The following officers and partners are expected to be in attendance so that the Committee can obtain appropriate assurances on compliance with mental health and mental capacity legislation across its breadth of statutory responsibilities:

- Chief Operating Officer (Lead Executive)
- Chief Executive Officer
- Executive Nurse Director
- Executive Medical Director
- Director of Corporate Governance
- Clinical Board Director - Mental Health Clinical Board
- Director of Nursing - Mental Health Clinical Board
- Director of Operations- Mental Health Clinical Board
- Service users

The Director of Operations – Women's and Children's Clinical Board and the Mental Capacity Act Manager will attend the Committee in relation to specific items on the agenda as and when required.

4.3. By invitation:

The Committee Chair may extend invitations to attend Committee meetings to others from within or outside the organisation who the Committee considers should attend, taking account of the matters under consideration.

Secretariat

4.4 The Director of Corporate Governance shall attend every meeting and the meeting will be serviced by a member of the Corporate Governance team.

Member Appointments

4.5 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.

4.6 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the UHB Chair (and, where appropriate, on the basis of advice from the UHB Remuneration and Terms of Service sub-committee).

Support to Committee Members

4.7 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 overall OD programme developed by the Director of People and Culture.

5. COMMITTEE MEETINGS

Quorum

5.1 Two Independent Members, one of whom should be the Committee Chair or Vice Chair.

Frequency of Meetings

5.2 Meetings shall be held no less than three times a year or as the Chair of the Committee deems necessary – consistent with the UHB Annual Plan of Board Business.

Withdrawal of individuals in attendance

5.3 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.

Format of agenda

5.4 The agenda for the meeting will be split into three parts comprising:

- Mental Health Act 1983;
- Mental Health Measure (Wales) 2010;
- and Mental Capacity Act 2005.

The proportion of time to be spent at each meeting on the respective parts will be set out in the Committee meeting planner, alternating the focus during the cycle of meetings and according to need.

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 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 the safety, security and use of information to support the quality and safety of healthcare for its patients through the effective governance of the organisation.

6.2 The Committee is directly accountable to the UHB for its performance in exercising the functions set out in these Terms of Reference.

6.3 The Committee, through its Chair and Members, shall work closely with the Board's other 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, it will contribute 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.

6.4 The Committee shall embed the UHB values, corporate standards, priorities and requirements, for example equality and human rights, through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity, the submission of Committee minutes and written reports, as well as the presentation of an annual report;
- bring to the Board'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 or Chairs of other relevant Committees/groups of any urgent/critical matters that may affect the operation and/or reputation of the UHB.

7.2 The Board may also require the Committee Chair to report upon the Committee's activities at public meetings, for example the Board's Annual General Meeting, or to

community partners and other stakeholders, where this is considered appropriate, for example where the Committee's assurance role relates to a joint or shared responsibility.

7.3 The Director of Corporate Governance, 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.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 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)
- Notifying and equipping Committee members – Committee members shall be sent an Agenda and a complete set of supporting papers at least seven (7) clear days before a formal Committee meeting (unless specified otherwise in law).
- Notifying the public and others – at least seven (7) clear days before each Committee meeting a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed on the Health Board's website together with the papers supporting the public part of the agenda (unless specified otherwise in law).

9. REVIEW

9.1 These Terms of Reference shall be reviewed annually by the Committee with reference to the Board or sooner if required e.g. change in legislation.

Mental Health Legislation and Mental Capacity Act Committee Work Plan 2023- 24					
App. -Approval Ass.- Assurance Inf.- Information	**Exec Lead**	**02-May**	**01-Aug**	**31-Oct**	**30-Jan**
Agenda Item					
Mental Health Act					
MHA Monitoring Exception Report	PB	Ass.	Ass.	Ass.	Ass.
Section 17 Compliance	PB	Ass.	Ass.	Ass.	Ass.
Section 138 Partnership Arrangements	PB	Ass.	Ass.	Ass.	Ass.
Policies in support of operation of MHCL	PB	Ass.	Ass.	Ass.	Ass.
Hospital Managers Power of Discharge Sub Committee Minutes	PB	Ass.	Ass.	Ass.	Ass.
Mental Health Measure Act Monitoring					
Mental Health Measure Monitoring Report	PB	Ass.	Ass.	Ass.	Ass.
Care and Treatment Plans Update Report	PB	Ass.	Ass.	Ass.	Ass.
Mental Capacity Act					
MCA Monitoring Report	PB	Ass.	Ass.	Ass.	Ass.
DOLs Monitoring Report	PB	Ass.	Ass.	Ass.	Ass.
DOLs Audit	PB			Ass.	
Inspection Reports					
HIW MHA Inspection Reports (where they relate to legislative compliance)	PB	Ass.	Ass.	Ass.	Ass.
Public Service Ombudsman Wales Reports (where they relate to legislative compliance)	PB	Ass.	Ass.	Ass.	Ass.
Annual Reports					
Hospital Managers Power of Discharge Sub Committee Annual Report	PB		Ass.		
HIW MHA Annual Report	PB		Ass.		
MHCL Committee Governance					
Annual Work Plan	JQ				App.
Self assessment of effectiveness	JQ	Ass.			
Review Terms of Reference	JQ				App.
Produce Committee Draft Annual Report	JQ				App.
Minutes of MHL&MCA Committee Meeting	JQ	App.	App.	App.	App.
Action log of MHL&MCA Committee Meeting	JQ	Ass.	Ass.	Ass.	Ass.

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 and Information Governance. 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

To achieve its 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 processing of data and information to meet legislative responsibilities.
- Accepted recommendations 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.

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. ACCESS

5.1 The Chair of Digital & Health Intelligence Committee shall have reasonable access to Executive Directors and other relevant senior staff.

6. 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 two 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 and Health Intelligence

Director of Digital Transformation

Chief Clinical Information Officer

		Director of Corporate Governance Head of Information Governance/Cyber Security 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 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.

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)
- Notifying and equipping Committee members – Committee members shall be sent an Agenda and a complete set of supporting papers at least seven (7) clear days before a formal Committee meeting (unless specified otherwise in law).
- Notifying the public and others – at least seven (7) clear days before each Committee meeting a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed on the Health Board's website together with the papers supporting the public part of the agenda (unless specified otherwise in law).

12. REVIEW

12.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee with reference to the Board.

Digital and Health Intelligence Committee Work Plan 2023-24				
App. - Approval Ass.- Assurance Inf. Information and noting	**Exec Lead**	**30-May**	**03-Oct**	**13-Feb**
Agenda Item				
Assurance				
Review and delivery of Digital Strategy	DT	Ass.	Ass.	Ass.
Assurance Review on processes and sysems for Data, Information management	DT		Ass.	
Assurance on Information Governance Training, Communications and Engagement Plans	DT		Ass.	
Review of the framework of policies , procedures and controls	DT	Ass.	Ass.	Ass.
Internal Audit Reviews	DT/JQ	Ass.	Ass.	Ass.
WAO Reviews	DT/JQ	Ass.	Ass.	Ass.
Other external reviews	DT	Ass.	Ass.	Ass.
Risk Register	DT/JQ	Ass.	Ass.	Ass.
Development, procurement and implementation of national and Local IMT systems (as and when required)	DT			Ass.
Statutory and Mandatory Requirements				
Assurance that Caldicott Guardian requirements are met	MJ	Ass.	Ass.	Ass.
Assurance that Freedom of Information requirements are met	DT	Ass.	Ass.	Ass.
Assurance that GDPR Compliance is met	DT	Ass.	Ass.	Ass.
Data Breach Reports: Serious Reportable Data Breaches to the ICO Sensitive Information FOI Subject Access Requests Data Quality Incidents	DT	Ass.	Ass.	Ass.
Digital and Health Intelligence Committee Governance				
Annual Work Plan	JQ			App.
Self assessment of effectiveness	JQ	Ass.		
Induction Support for Committee Members	JQ			
Review Terms of Reference	JQ			App.
Produce Digital and Health Intelligence Committee Annual Report	JQ			App.
Minutes of Digital and Health Intelligence Committee Meeting	JQ	App.	App.	App.
Action log of Digital and Health Intelligence Committee Meeting	JQ	Ass.	Ass.	Ass.

QUALITY, SAFETY AND EXPERIENCE COMMITTEE

TERMS OF REFERENCE AND OPERATING ARRANGEMENTS

1. INTRODUCTION

1.1 The University Health Board (UHB) Standing Orders provide that "*The Board may and, where directed by the Welsh Government must, appoint Committees of the UHB 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 (and the UHB Scheme of Delegation), the Board shall nominate a Committee to be known as the **Quality, Safety and Experience Committee**. This Committee's focus is on ensuring patient and citizen quality and safety including activities traditionally referred to as 'clinical governance'. The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are set out below.

2. PURPOSE

2.1 The purpose of the Quality, Safety and Experience Committee "the Committee" is to provide:

- evidence based and timely ***advice*** to the Board to assist it in discharging its functions and meeting its responsibilities with regard to quality, safety and experience of health services;

- ***assurance*** to the Board on the setting of local organisational Quality and Safety standards and supporting an organisational safety culture.

- evidence based and timely ***advice*** to the Board to assist it in discharging its functions and meeting its responsibilities with regard to the quality, safety and experience of public health, health promotion and health protection activities;

- ***assurance*** to the Board in relation to the UHB arrangements for safeguarding and improving the quality and safety of patient and citizen centred health improvement and care services in accordance with its stated objectives and the requirements and standards determined for the NHS in Wales;

- ***assurance*** to the Board in relation to improving the experience of patients, carers citizens and all those that come into contact with our services including those provided by other organizations or in a partnership arrangement

3. DELEGATED POWERS AND AUTHORITY

3.1 The Committee will, in respect of its ***provision of advice*** to the Board:

- oversee the initial development of the UHB plans for the development and delivery of high quality and safe healthcare and health improvement services consistent with the Board's overall Strategy and any requirements and standards set for NHS bodies in Wales;

- consider the implications for quality, safety and experience arising from the development of the UHB Strategy, Integrated Medium Term Plan or plans of its stakeholders and partners, including those arising from any Joint Committees of the Board;
- consider the implications for patient and citizen experience arising from internal and external review/investigation reports and actions arising from the work of external regulators;
- consider the outcomes for patient feedback methodologies in line with the National Clinical Services Framework: A Learning Health and Care System.
- review achievement against the Health and Care Standards in Wales to inform the Annual Quality and Annual Governance Statements;
- consider and approve policies as determined by the Board.
- Review and monitor the implementation of the Health Board's Quality, Safety and Experience Framework and oversee the necessary developments to deliver the eight key areas:
  - Organisational Safety Culture
  - Leadership and the prioritisation of quality, safety and experience
  - Patient experience and involvement in quality, safety and experience
  - Patient safety learning and communication
  - Staff engagement and involvement in safety, quality and experience
  - Patient safety, quality and experience data and insight
  - Professionalism of patient safety, quality and experience
  - Quality governance arrangements
- Ensure that the Health Boards Framework aligns to the Welsh Government Quality and Safety Framework 2021: Learning and Improving and that the organisation functions as a quality management system to ensure that care meets the six domains of quality; care that is safe, effective, patient centred, timely, efficient and equitable.

3.2 The Committee will, in respect of its ***assurance role***, seek assurances that quality governance arrangements are appropriately designed and operating effectively to ensure the provision of high quality, safe healthcare and improvement services across the whole of the UHB activities and responsibilities.

3.3 To achieve this, the Committee's programme of work will be designed to ensure that, in relation to all aspects of quality, safety and patient and citizen experience:

- there is clear, consistent strategic direction, strong leadership and transparent lines of accountability;
- the organisation, at all levels has a citizen centred approach, putting citizens, patients and carers, patient safety and safeguarding above all other considerations;
- the care planned or provided across the breadth of the organisation's functions is consistently applied, based on public health principles, sound evidence, clinical effectiveness and meets agreed standards;
- the organisation, at all levels has the right systems and processes in place to deliver, from a patient, carer and citizen perspective - efficient, effective, timely and safe services;
- the organisation has effective systems and processes to meet the Health and Care Standards;
- the workforce is appropriately selected, trained, supported and responsive to ensure safe, quality and patient centred services ensuring that regulatory

arrangements, professional standards and registration/revalidation requirements are maintained;

- there is an ethos of continual quality improvement and regular methods of updating the workforce in the skills needed to demonstrate quality improvement throughout the organisation;
- there is good team working, collaboration and partnership working to provide the best possible outcomes for its citizens;
- risks are actively identified and robustly managed at all levels of the organisation;
- decisions are based upon valid, accurate, complete and timely data and information including accurate and timely clinical coding;
- there is continuous improvement in the standard of quality and safety across the whole organisation – continuously monitored through the Health and Care Standards in Wales;
- all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality and safety of care provided, and in particular that:

  - sources of internal assurance are reliable, e.g., internal audit and clinical audit teams have the capacity and capability to deliver;
  - recommendations made by internal and external reviewers are considered and acted upon on a timely basis; and
  - appropriate review is carried out and corrective action is taken arising from incidents, complaints and claims, known collectively as 'concerns.'

3.4 The Committee will advise the Board on the adoption of a set of key indicators of safety, quality and patient and citizen experience against which the UHB performance will be regularly assessed and reported on through the Annual Quality Statement (if required).

Authority

3.5 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 any relevant information from any:

- employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and
- other Committee, Sub Committee or group set up by the Board to assist it in the delivery of its functions.

3.6 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.

Access

3.7 The Chair of the Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees and Groups

3.8 Within the Quality, Safety and Experience Framework the Board has approved the following Sub-Committees shall report into the Quality, Safety and Experience Committee:

- 7 Clinical Board Quality and Safety Sub-Committees
- Clinical Effectiveness Committee
- Clinical Safety Group
- Learning Committee
- Concerns Group
- Operational Groups (by exception)

These Committees will report in the Quality, Safety and Experience Committee on a rolling programme as set out in the Annual Work Plan of the Committee and after each of their respective meetings.

3.9 Other Quality, Safety and Experience Committee related Groups will also report into the Committee, once established, and as and when required.

3.10 The Committee has authority to establish short life task and finish groups which are time limited to focus on a specific matter of advice or assurance as determined by the Board or Committee.

4. MEMBERSHIP

Members

4.1 A minimum of four (4) members, comprising:

Chair	Independent Member of the Board
Members	3 other Independent Members of the Board, to include a Member of the UHB Audit Committee. The Committee may also co-opt additional independent 'external' members from outside the organization to provide specialist skills, knowledge and expertise.

Attendees

4.2. The following officers **are required to be in attendance**:

- Executive Nurse Director (Joint Lead)
- Executive Medical Director (Joint Lead)
- Executive Director of Therapies and Health Sciences
- Chief Operating Officer
- Executive Director of Public Health
- Director of Corporate Governance
- Associate Medical Director for Safety and Governance

- Assistant Director of Patient Safety, Quality and Improvement
- Assistant Director of Patient Experience

Key Directors should be represented if they are unable to attend a meeting.

Other Executive Directors or deputies should attend from time to time as determined by the Committee Chair.

4.3. By invitation:

The Committee Chair may extend invitations to attend Committee meetings as required from within or outside the organization to whom the Committee considers should attend, taking account of the matters under consideration at each meeting. This may include:

- 2 x Staff Representatives and
- the Cardiff and Vale of Glamorgan Community Health Council.

Secretariat

4.4 Secretary of the Committee: as determined by the Director of Corporate Governance.

Member Appointments

4.5 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.

4.6 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the UHB Chair and, where appropriate on the basis of advice from the UHB Remuneration and Terms of Service Committee.

Support to Committee Members

4.7 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 development for Committee members in conjunction with the Director of Workforce and Organizational Development.

5. COMMITTEE MEETINGS

Quorum

5.1 At least three members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice Chair.

Frequency of Meetings

5.2 Meetings shall be held no less than bi-monthly, and otherwise as the Chair of the Committee deems necessary – consistent with the UHB Annual Plan of Board Business.

Withdrawal of individuals in attendance

5.3 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.

6. RELATIONSHIPS AND ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 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. The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference.

6.2 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 organization, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

6.3 The Committee shall embed the UHB values, corporate standards, priorities and requirements, for example, public health, equality, diversity and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity, the submission of Committee minutes and written reports, as well as the presentation of the Annual Quality Statement.
- bring to the Board'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 or Chairs of other relevant Committees of any urgent/critical matters that may compromise patient care and affect the operation and/or reputation of the UHB.

7.2 The Board may also require the Committee Chair to report upon the Committee's activities at public meetings, for example, AGM, or to community partners and other stakeholders, where this is considered appropriate, for example, where the Committee's assurance role relates to a joint or shared responsibility.

7.3 The Director of Corporate Governance, 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 Quality and Safety Committee Handbook.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 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)
- Notifying and equipping Committee members – Committee members shall be sent an Agenda and a complete set of supporting papers at least seven (7) clear days before a formal Committee meeting (unless specified otherwise in law).
- Notifying the public and others – at least seven (7) clear days before each Committee meeting a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed on the Health Board's website together with the papers supporting the public part of the agenda (unless specified otherwise in law).

9. REVIEW

9.1 These Terms of Reference and operating arrangements shall be reviewed on an annual basis by the Committee with reference to the Board.

Quality Safety and Experience Committee Work Plan 2023 - 24													
App -Approval Ass- Assurance Inf - Information	Exec Lead	11-Apr	09-May	06-Jun	12-Jul	08-Aug	13-Sep	10-Oct	15-Nov	12-Dec	09-Jan	08-Feb	05-Mar
Agenda Item													
Standing Items													
Quality, Safety and Experience Implications arising from IMTP	MJ/JR	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass
Quality Indicators	MJ/JR	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass
Quality, Safety and Effectiveness Assurance Reports from Clinical Boards (programme to be agreed with CBs)	PB	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass
Sub Groups to Quality, Safety and Experience Committee : **Clinical Effectiveness Committee** (consent MCA, DoLS, National Clinical Audit, NICE, NCEPOD, Patient Information, EOL Care, Dementia and delirium, Transition, Organ Donation, Peer Reviews.)	MJ/JR												
Concerns Group (concerns and complaints, incident reporting, Duty of candour, patient/user experience and feedback in line with National Clinical Services Framework: A Learning Health and Care System, claims, datix system.)	MJ/JR												
Clinical Safety Group (Consent MCA, DoLS, Patient Information, Dementia and delirium, Transition, Organ Donation, IP&C, Pressure Damage Group, IRMER, End of Life Care, Falls Delivery Group, JAG, Medicines Management Group, Mortality Review Group, Blood Transfusion, patient Safety Solutions, Medical Devices Group. Nutrition and Hydration, RADAR)	MJ/JR												
Learning Committee	MJ/JR	Ass								Ass			
Operational Groups by Exception (IP&C, Cleanliness, Decontamination, Medicines Management, Safeguarding, Research, Patient Safety Solutions, Medical Devices, Nutrition and hydration, Falls, Health Records, Blood Transfusion, Resus, VTE, Pressure damante, Mortality, Suicide Prevention, Point of Care Testing)The operational groups will feed into the Clinical Safety Group when established with exception reporting only to QSE Committee	MJ/JR	Inf	Inf	Inf	Inf	Inf	Inf	Inf	Inf	Inf	Inf	Inf	Inf
Patient Story	JR	Children and Women; Mental Health		CD&T		Medicine				PCIC		Surgery	
Quality Governance													
Quality, Safety and Experience Framework -effectiveness review	MJ/JR	Ass								Ass			
Health Care Standards Strategy and Action Plan	MJ/JR			App								App	
Policies	MJ/JR	App		App		App				App		App	
Health and Social Care (Quality and Engagement) (Wales) Act 2020- Annual Compliance	MJ/JR												
Key External Reports from CHC, Internal Audit, Audit Wales	MJ/JR	Ass		Ass		Ass				Ass		Ass	
HIW Activity Overview	JR	App		App		App				App		App	
HIW Primary Care Contractors	JR			App						App			
Health Promotion Protection and Improvement													
Public Health Promotion activities	FK	Ass											
Quality, Safety and Experience of Public Health Services	FK									Ass			
Quality, Safety and Experience Committee Governance													
Chairs Action	CP	Inf	Inf	Inf	Inf	Inf	Inf	Inf	Inf	Inf	Inf	Inf	Inf
Annual Work Plan	DCG											App	
Review of Meeting	DCG	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass
Self assessment of effectiveness	DCG												Ass
Review Terms of Reference	DCG											App	
Produce Committee Annual Report	DCG											App	
Minutes of Quality, Safety & Experience Committee Meeting	DCG	App	App	App	App	App	App	App	App	App	App	App	App
Action log of Quality, Safety and Experience Committee Meeting	DCG	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass	Ass

FINANCE AND PERFORMANCE COMMITTEE

To be considered by the first meeting of the Finance and Performance Committee prior to submission to Board for approval.

PEOPLE AND CULTURE COMMITTEE

To be considered by the first meeting of the People and Culture Committee prior to submission to Board for approval.

SHAPING OUR FUTURE HOSPITALS COMMITTEE

[Note: Currently Paused]

TERMS OF REFERENCE AND OPERATING ARRANGEMENTS

1. INTRODUCTION

1.1 The Cardiff and Vale University Health Board (UHB) Standing Orders provide that: "The Board may and, where directed by the Welsh Government must, appoint Committees or sub Committees of the 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 Shaping Our Future Hospitals Committee. The detailed terms of reference and operating arrangements set by the UHB Board in respect of this committee are set out below.

2. PURPOSE

2.1 The Committee will oversee, scrutinise and provide assurance to the UHB Board on the work of the Shaping Our Future Hospitals Programme Board by:

- Providing assurance that the leadership, management and governance arrangements are robust and appropriately discharged to deliver the outcomes and benefits of the programme.
- Providing oversight and scrutiny of project business cases, including oversight of external advisors engaged to support UHB.
- Reviewing and where appropriate, approving reports, papers and business cases prior to them being submitted to the UHB Board and Welsh Government.
- Scrutinising the progress of the Programme Board and providing the UHB Board with assurance that any deliverables and outputs are produced on time, to budget and in accordance with all professional standards.

3. DELEGATED POWERS AND AUTHORITY

The Shaping Our Future Hospitals Committee will carry out the following duties and responsibilities:

- Provide assurance to the UHB Board that Shaping Our Future Hospitals Programme has a clear and consistent strategic direction of travel, which is aligned to Shaping our Future Wellbeing and Wellbeing of Future Generations act; strong and effective leadership; transparent lines of accountability and responsibility; and effective and timely reporting to key internal and external decision-makers.
- Consider and approve the overall scope of Shaping Our Future Hospitals Programme and its delegated authority to make decisions.

- Scrutinise and recommend approval to the Board relevant Shaping Our Future Hospitals Programme Board decisions in particular those decisions which are outside the delegated authority limits (decisions over £500k) of the Programme Board.
- Scrutinise Shaping Our Future Hospitals Programme Board to ensure the direction of the programme remains within the scope set by the UHB Board and is consistent with wider system plans and political environment.
- Review the stakeholder management strategy and specific plans to ensure buy-in from key internal and external stakeholders and recommend approval to the UHB Board.
- Review and recommend approval, where necessary, business cases for Shaping Our Future Hospitals programme and provide assurance to the UHB Board that they will be delivered within the time, cost and to required quality, as specified by the UHB Board and the Welsh Government, and in line with the Health Board's capital governance arrangements.
- Recommend approval to the Board and/or monitor the ongoing progress of:
  - **(a)** The overall programme plan, including objectives, key milestones, resource plan and performance monitoring for key deliverables
  - **(b)** The appointment of all external project advisors and contractors where the value exceeds the delegated limit of the Programme Board
  - **(c)** All procurement decisions where the value exceeds the delegated limit of the Programme Board
  - **(d)** Any deviation from the timelines and report any concerns to the UHB Board as and when necessary.
- Ensure that an effective risk management system is in place and regularly scrutinise key Programme risks.
- Scrutinise and assure that the Board that Programme expenditure against the budget allocated is appropriate and managed effectively.

4. AUTHORITY

4.1 The Committee is authorised:

- To seek any information it requires, or request attendance at a meeting, from an employee of the UHB or any other person in order to effectively discharge its duties;
- To obtain professional advice on any matter within its terms of reference, subject to Management Executive approval. UHB Procurement team will be consulted prior to procurement of external advice;
- To appoint sub-committees or Working Groups with such membership and terms of reference as the Committee may determine, and delegate any of its responsibilities to such a sub-committee or working group.

5. ACCESS

5.1 The Chair of Shaping Our Future Hospitals Committee shall have reasonable access to Executive Directors and other relevant senior staff.

6. 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.

6.2 Shaping Our Future Hospitals Programme Board is a Sub Committee to the Shaping Our Future Hospitals Committee.

7. MEMBERSHIP

7.1 Members

The Committee is appointed by the UHB Board to ensure representation by key stakeholders involved in the programme development, as well as representation of the views of service users and staff.

A minimum of four (4) Independent Members, comprising:

Chair	Independent Member – Capital and Estates
Vice Chair	Independent Member - Finance
Members	A minimum of 2 other Independent Members of the Board

At the invitation of the Committee Chair any Independent Member who is not a member of the Committee is entitled to attend Committee meetings.

7.2 Attendees

The following officers to be in attendance:

- Chief Executive;
- Executive Director of Strategic Planning
- Executive Medical Director;
- Executive Director of Finance
- Programme Director for Shaping Our Future Hospitals Programme;
- Director of Corporate Governance.

7.4 By invitation:

The Committee Chair may extend invitations to appropriate persons to attend Committee meetings as required from within or outside the organisation who the committee considers should attend, taking account of the matters under consideration at each meeting.

7.5 Secretariat

Secretary of the Committee: as determined by the Director of Corporate Governance.

7.6 Member Appointments

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.

Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the UHB Chair.

7.7 Support to Committee Members

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 development for committee members in conjunction with the Director of Workforce and Organisational Development.

8. COMMITTEE MEETINGS

8.1 Quorum

The quorum for meetings is 3 members, including either the Chair or the Vice Chair.

Two Executive Directors should also be in attendance to include either the Chief Executive or Deputy Chief Executive. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the duties or powers vested in or exercisable by the Committee.

8.2 Frequency of Meetings

The Committee will meet quarterly and the agenda will be agreed by the Chair and Executive Lead with agenda and papers to be circulated 7 working days before the meeting, unless by exception and agreed with Chair of meeting in advance. The Chair can agree extraordinary meetings if an urgent item of business needs to be considered.

8.3 Withdrawal of individuals in attendance

The Committee may require any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

8.4 Decisions and disputes

Decisions will normally be reached by consensus. In the event of a disagreement, a member vote will be taken. In the event of a tie, the Chair will have the casting vote.

In the event of further disagreement, decisions will be referred to the Board.

9. RELATIONSHIPS 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. The Committee is directly accountable to the UHB Board for its performance in exercising the functions set out in these terms of reference.

9.2 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.

9.3 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 UHB Board on the Committee's activities. This includes verbal updates on activity, the submission of Committee minutes and written reports, as well as the presentation of an annual report;
- bring to the UHB Board'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 or Chairs of other relevant Committees of any urgent/critical matters.

10.2 The UHB Board may also require the Committee Chair to report upon the Committee's activities at public meetings, for example, AGM, or to community partners and other stakeholders, where this is considered appropriate, for example, where the Committee's assurance role relates to a joint or shared responsibility.

10.3 The Director of Corporate Governance, 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.

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)
- Notifying and equipping Committee members – Committee members shall be sent an Agenda and a complete set of supporting papers at least seven (7) clear days before a formal Committee meeting (unless specified otherwise in law).
- Notifying the public and others – at least seven (7) clear days before each Committee meeting a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed on the Health Board's website together with the papers supporting the public part of the agenda (unless specified otherwise in law).

12. REVIEW

12.1 These terms of reference and operating arrangements shall be reviewed on an annual basis or as required by the Committee with reference to the Board.

Report Title:	Annual Plan of Board Business			Agenda Item no.	7.12
Meeting:	UHB Board	Public	x	Meeting Date:	31st March 2022
		Private			
Status *(please tick one only):*	Assurance		Approval	x	Information
Lead Executive:	**Director of Corporate Governance**				
Report Author (Title):	**Director of Corporate Governance**				

Main Report
Background and current situation:

Standing Orders 7.2 states that 'The Board Secretary, on behalf of the Chair, shall produce an Annual Plan of Board Business.

The Board should agree the Annual Plan for the forthcoming year by the end of March, and the plan shall be published on the Health Boards website.

The Board Annual Plan for 2023/24 is attached at the appendix.

The attached Annual Plan has been developed by the Director of Corporate Governance. It details the items which the Board should review and are items which are detailed within the Board's Scheme of Reservation (decisions reserved for the Board). The Plan also, where appropriate, details which Committee / Group where the items should be considered prior to presentation to the Board and who the Executive Director lead is.

It should be noted that any Board Annual Plan should be flexible enough to accommodate additional items that will be added throughout the year. It should also be noted that revised Committee arrangements are proposed from 1 April 2023 and greater use of Board Development sessions for the Board to develop and discuss progress with its strategy and supporting strategic plans. As these arrangements are put in place they may result in proposed changes to Board business which will need to be approved by the Board.

With regard to Strategies and Annual Reports, in line with Standing Orders, there are a number of Strategies and Annual Reports which should be presented to the Board. The UHB has just one strategy which is 'Shaping Our Future Wellbeing' which is undergoing a refresh. There are also some specific strategies which do need Board approval e.g. Estates. Likewise Shaping Our Future Wellbeing will also cover off some of the strategies and need to be cross referenced rather than create duplication.

Areas highlighted in blue – There are no timescales against these items as they would be presented to the Board on an 'as and when' basis but should remain in the plan so the Board are aware of their responsibilities.

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

The draft Annual Plan has been developed with due regard to:

- the UHB's Standing Orders and Scheme of Reservation and Delegation of Powers;
- the UHBs Shaping Our Future Wellbeing Strategy;
- the UHB's Draft IMTP;
- key risks and areas where scrutiny is required by the full Board; and
- key statutory, national and best practice requirements and reporting arrangements.

Recommendation:

The Board are asked to **approve** the Board Annual Plan 2023/24 noting that changes may result from the embedding of proposed revised Committee arrangements and additional items will be added throughout the year to accommodate the delivery of our Strategic Objectives which are undergoing a review and refresh.

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

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

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant

Prevention	x	Long term		Integration		Collaboration		Involvement	

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

Risk: Yes/~~No~~

There is a risk that non-delivery the Board's Annual Plan could result in non-compliance with the Health Boards Standing Orders.

Safety: ~~Yes~~/No

Financial: ~~Yes~~/No

Workforce: ~~Yes~~/No

Legal: ~~Yes~~/No

Reputational: ~~Yes~~/No

Socio Economic: ~~Yes~~/No

Equality and Health: ~~Yes~~/No

Decarbonisation: ~~Yes~~/No

Approval/Scrutiny Route:

Committee/Group/Exec	Date:

Cardiff and Vale University Health Board - Board Plan of Business 2023-24								
App - Approval Ass - Assurance Inf - Information	Committee/ Group	Lead	25-May	27-Jul	28-Sep	30-Nov	25-Jan	28-Mar
Agenda Item								
Strategy and Strategic Plans								
Determine/ review UHBs aims, objectives and priorities (as part of SoFW Strategy)	Management Executives/SLB/ Board Dvpt	CEO		App				
Approve / Review Values and Standards of Behaviour Framework (part of SoFW Strategy)	P&C	CEO/EDSP		App				
Approve / review action required on delivery of strategic objectives	Board Dvpt	CEO			App			
Approve IMTP	F&P/Board Dvpt	EDSP						App
Approve/ review development and delivery of patient centred clinical services (as part of SoFWS)	Q,S&E/Board Dvpt	MD/EDSP		App				
Approve/ Review citizen, partnership and stakeholder engagement and involvement strategies	Board Dvpt	EDSP				App		
Approve / Review Quality, Safety and Experience Framework	Q,S&E/Board Dvpt	MD/END				Ass		
Approve / Review People and Culture Plan	P&C/Board Dvpt	EDPC					Ass	
Approve/ Review Estates Strategy	Board Dvpt	DoF			App			
Approve / Review Digital Health Intelligence Strategy	DHIC	DT	Ass					
Approve / review Capital Strategy (including investment and disposal plans)	F&P/Board Dvpt	DoF/EDSP		Ass				
Approve/ Review Framework and Strategy for Performance Management	F&P	CEO		App				
Approve Population Health Needs assessment and Commissioning Plan	Q,S&E	EDPH/EDSP						App
Approve Joint Area Plan (prepared under direction of RPB in response to Population Needs Assessment)	Board	CEO	App					
Approve / review Wellbeing objectives in accordance with requirements of Wellbeing of Future Generations Act (as part of SoFW Strategy)	Board Dvpt	EDPH/EDSP		Ass				
Approve Wellbeing Plan agreed by Public Service Board	Board	CEO				Ass		
Standing Items								
Patient Story	Board	MD/END	Inf	Inf	Inf	Inf	Inf	Inf
Minutes of the previous meeting	Board	DCG	App	App	App	App	App	App
Action Log	Board	DCG	Ass	Ass	Ass	Ass	Ass	Ass
Ratify urgent decisions of the Chair/CEO	Board	CCG	App	App	App	App	App	App
Chairs Report	Board	CHR	Ass	Ass	Ass	Ass	Ass	Ass
Chief Executive's Report	Board	CEO	Ass	Ass	Ass	Ass	Ass	Ass
Integrated Performance report (including quality, finance, activity and workforce)	QSE /F&P/P&C	END/MD/EDPC/ COO/DoF	Ass	Ass	Ass	Ass	Ass	Ass
Board Assurance Framework	Audit	DCG/CEO	App	App	App	App	App	App
Corporate Risk Register	Audit	DCG	Ass	Ass	Ass	Ass	Ass	Ass

Chair's Committee Reports to Board:								
-Audit and Assurance Committee	Audit	DCG	Ass	Ass	Ass	Ass	Ass	Ass
-Quality, Safety and Experience Committee	Q,S&E	DCG	Ass	Ass	Ass	Ass	Ass	Ass
-People and Culture Committee	P&C	DCG	Ass	Ass	Ass	Ass	Ass	Ass
- Finance and Performance Committee	F&P	DCG	Ass	Ass	Ass	Ass	Ass	Ass
- Mental Health and Mental Capacity Act Committee	Mental Health	DCG		Ass		Ass	Ass	
- RaTS Committee	RaTS	DCG	-	-	-	-	-	-
- Charitable Funds Committee	CF	DCG	Ass		Ass	Ass		Ass
-Digital Health and Intelligence Committee	DHIC	DCG		Ass		Ass		Ass
-Shaping Our Future Hospitals Committee	SoFH	DCG						
Minutes of Committees of the Board:								
-Audit and Assurance Committee	Audit	DCG	App	App	App	App	App	App
-Quality, Safety and Experience Committee	Q,S&E	DCG	App	App	App	App	App	App
-People and Culture Committee	P&C	DCG	App	App	App	App	App	App
- Finance and Performance Committee	F&P	DCG	App	App		App	App	
- Mental Health and Mental Capacity Act Committee	Mental Health	DCG		App		App	App	
- RaTS Committee	RaTS	DCG	-	-	-	-	-	-
- Charitable Funds	CF	DCG	App		App	App		App
-Digital Health Intelligence Committee	DHIC	DCG	App	App		App		App
-Shaping our Future Hospitals Committee	SoFH	DCG						
Minutes of Joint Committee:								
- EASC	EASC	DCG	Ass	Ass	Ass	Ass	Ass	Ass
- WHSCC	WHSCC	DCG	Ass	Ass	Ass	Ass	Ass	Ass
Minutes of Advisory Groups:								
- Stakeholder Reference Group	SRG	EDSP	App		App	App		
- Local Partnership Forum	LPF	EDPC	App	App	App	App	App	App
- Healthcare Professional Forum	HPF	EDPC			App	App	App	App
Governance								
Approve Standing Orders, Scheme of Delegation, SFIs	Audit	DCG	App					
Ratify in public failure to comply with SO's	Audit	DCG	App	App	App	App	App	App
Authorise the use of the seal	Board	DCG	App	App	App	App	App	App
Approve proposals for action on litigation (as and when required)	Board	DCG	App	App	App	App	App	App
Receive and determine action in relation to Board Member declarations of interests (and when required)	Audit	DCG	Ass					
Approve the top level organisation structure	Management Executives	CEO			App			
Approve corporate policies (as and when required)	Management Executives	DCG	App	App	App	App	App	App
Appoint and revise Committees of the Board	Board	CHR						App
Note the appointment of Executive Directors including Board Secretary (as and when required)	RaTS	CHR	Inf	Inf	Inf	Inf	Inf	Inf
Approve TOR for all Committees	All Board Committees	DCG						App
Appoint, equip, review and where appropriate dismiss the Chair and any members of any Committee, Joint Committee or Group set up by the Board (as and when required)	Board	CHR	As required					
Appoint, equip, review and where appropriate dismiss individuals appointed to represent the Board on outside bodies and group (as and when required)	Board/RaTS	CHR/CEO	As required					
Approve arrangements relating to responsibilities as a corporate trustee for funds held on trust	Charitable Funds	CHR						App
Approve Risk Management Strategy and Plans	Audit	DCG					App	
Approve Civil contingency and business continuity update	F&P	EDSP			App			

Receive reports on performance from external regulators and inspectors e.g. WAO, CHC, HIW which raise an issue or concern impacting on ability to delivery objectives (as and when required)	Audit Q,S&E	MD/END/DCG	As required for assurance						
Receive annual opinion from Head of Internal Audit (HoIA) and approve action required	Audit	DCG	Ass						
Receive annual report from Auditor General for Wales and approve action required	Audit	DCG					Ass		
Receive WAO Structured Assessment	Audit	DCG					Ass		
Approve Annual Report (including Accountability Report and Performance Report)	Audit	DCG		App					
Approve audit and assurance arrangements	Audit	DCG					App		
Approve policies for dealing with complaints and incidents (as and when required)	Q,S&E	MD/END	As required						
Annual Cycle of Business	Board	DCG						App	
Board Development Plan	Board	DCG	App						
Annual consultations summary	Q,S & E/ F&P /P&C / Audit	DCG					Ass		
AGM Minutes	AGM	DCG				App			
Annual Reports of Board Committees	All Board Committees	DCG						App	
Financial									
Approve cases for write off of losses (as and when required)	F&P	DoF	As required						
Approve cases for making special payments above limits of delegation of CEO (as and when required)	F&P	DoF	As required						
Approve Medium Term Financial Plan	F&P	DoF						App	
Approve budget and financial framework	F&P	DoF						App	
Approve individual contracts/ business cases above the limit delegated to the CEO	F&P	CEO	App	App	App	App	App	App	
Approve Capital Plan	ME	DoF/EDSP	App						
Approve Annual Financial Accounts	F&P	DoF		App					
Primary Care Contracts (new awards)	F&P	COO	As required						
Approve reduction in significant activity or operation (as and when required)	F&P	COO	As required						
Annual Reports									
Approve Director of Public Health Annual Report	F&P	EDPH					App		
Approve Health and Safety Annual Report	H&S	EDPC		App					
Approve Safeguarding updates and Annual Report	Q,S&E	END		App					
Approve Tissue and Organ Donation Annual Report	T&OD	MD			App				
Approve Welsh Language Annual Report	P&C	EDPC				App			

Key:
Chair - CHR
Chief Executive - CEO
Executive Director of Finance - DoF
Executive Medical Director - MD
Executive Nurse Director - END
Chief Operating Officer - COO
Executive Director of Strategic Planning - EDSP
Executive Director of Therapies and Health Science - EDTHS
Executive Director of Public Health - EDPH
Executive Director of People and Culture - EDPC
Director of Corporate Governance - DCG
Director of Digital Health Intelligence - DDHI

Report Title:	Committees and Advisory Groups Annual Reports 2022023			Agenda Item no.	7.13
Meeting:	Board	Public	x	Meeting Date:	30 March 2023
		Private			
Status *(please tick one only):*	Assurance		Approval	x	Information
Lead Executive:	Director of Corporate Governance				
Report Author (Title):	Head of Corporate Governance				

Main Report
Background and current situation:

The purpose of this report is to seek the Board's approval to the Annual Reports of the Board's Committees and Advisory Groups.

Committee and Advisory Group's Annual Reports

The Board must ensure that the Chairs of all Committees and Advisory Groups operating on its behalf formally, regularly and on a timely basis report to the Board on their activities.

Attached at the appendices (which can be found in the Supporting Documents Folder on AdminControl or the Cardiff and Vale UHB wesbite) are Annual Reports for the following Committees and Advisory Groups of the Board:

- Audit Committee*
- Remuneration and Terms of Service Committee*
- Charitable Funds Committee*
- Mental Health Legislation and Mental Capacity Act Committee (Mental Health Act requirements) *
- Digital Health and Intelligence Committee (Information Governance) *
- Quality, Safety and Experience Committee*
- Finance
- Strategy and Delivery Committee
- Health and Safety Committee
- Stakeholder Reference Group
- Local Partnership Forum

*denotes a statutory Committee

These have all been reviewed by the respective Chairs and/or Committees prior to submission to the Board for approval.

The Shaping our Future Hospitals Committee was stood down for the whole of the 2022-23 reporting year, and hence an Annual Report has not been produced for that Committee.

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

Chairs of Committees/ Advisory groups report to the Board after each of their meetings in a document called 'Chairs report to the Board'. This is to ensure the Board is aware of discussions at a Committee as soon as possible after the Committee but before the minutes are actually approved

by the Board. This provides timely assurance to the Board that the Committee/ Advisory Group is adhering to its duties set out in its Terms of Reference.

In addition to the regular reporting to the Board Chairs of Committees and Advisory Groups are required to do an Annual Report to the Board. This report is written by the relevant Corporate Governance Officers for the Committee and approved by each Committee Chair prior to submission to the Board.

At the time publishing this report, the Committee Annual Reports for the Charitable Funds Committee and the Finance Committee could not be finalised (in particular, in relation to the Committee Members' attendance rates) given that the last meetings of 2022/23 were due to take place the week following publication of the Board papers. Accordingly, the Committee Annual Reports for both of those Committees will be updated as soon the respective Committee meetings have taken place and it is therefore acknowledged that those final draft Annual Reports will be published after the Board publication date of 17 March 2023.

Final Annual Report and Account – Submission date

The Welsh Government has issued, as in previous years, guidance for the preparation of annual reports and accounts. This guidance is based upon HM Treasury's Government Financial Reporting Manual (FReM)1 and is intended to simplify and streamline the presentation of the annual reports and accounts.

The Board is asked to note that at the time of writing this covering report, the reporting timescales set out in the 2022/23 Manual for Accounts have not yet been confirmed and are likely to change. Whilst the current draft guidance states that the Final Annual Report and Accounts are to be submitted to the Welsh Government and Audit Wales by 14 June 2023, a submission date of 31 July has been proposed by Audit Wales. Until written confirmation of the submission date is received from Welsh Government and/or the final guidance is issued, the Health Board is working towards a submission date of 14 June 2023. Should the end of July date be confirmed, the dates of the Special Audit Committee and Special Board meeting (currently scheduled on 13 June 2023) and the AGM (provisionally scheduled for 18 July 2023) will need to be rearranged. If the Welsh Government confirms the submission date is postponed to 31 July 2023, the Health Board (along with the other Welsh Health Boards and Trusts) will not be able to comply with Standing Order 7.2.5 (which requires the Health Board to hold an AGM in public no later than 31 July each year). In that event, the Health Board will require a variation to Standing Order 7.2.5 from the Welsh Government. Members of the Audit Committee and the Board will be updated should there be a change to the current proposed submission date for the Annual Report and Accounts.

Recommendation:

The Board is requested to:

a) **Approve** the Annual Reports from the Committees and Advisory Groups of the Board; and
b) **Note** the proposed submission date for the Health Board's Annual Report and Accounts may be subject to change as referred to in the body of this report.

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

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

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

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

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes
Potential breach of Standing Order 7.2.5 as highlighted in the body of the report
Safety: No
Financial: No
Workforce: No
Legal: Yes
Potential breach of Standing Order 7.2.5 as highlighted in the body of the report
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation: No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Board Committees	During December 2022 to March 2023
Audit Committee	7 February 2023

Report Title:	Hosting Agreement Extension with National Imaging Academy Wales			Agenda Item no.	7.14
Meeting:	Board	Public	x	Meeting Date:	30th March 2022
		Private			
Status *(please tick one only):*	Assurance		Approval	x	Information
Lead Executive:	Chief Executive				
Report Author (Title):	Director of Corporate Governance				

Main Report
Background and current situation:

Cwm Taf Morgannwg University Health Board (CTMUHB) currently hosts the National Imaging Academy Wales (NIAW) on behalf of Health Bodies in Wales. The current hosting agreement expires on 31 March 2023 and therefore the CTM Board, and other Health Bodies Boards in NHS Wales, are being asked to extend the hosting agreement for a further 3 years to 31 March 2026.

Phillip Wardle, Director of the Imaging Academy is seeking support from all Health Bodies in Wales to agree a three year extension for CTMUHB to continue to host the NIAW. Phillip Wardle has confirmed the support of Steve Moore, lead Chief Executive Officer (CEO) in Wales for Imaging for this agreement.

The hosting agreement, attached, has been updated to accurately reflect references, but the detail of the main document remains unchanged from the original hosting agreement signed by all CEOs.

The updated hosting agreement has been shared with all Directors of Governance in partner Health Boards and Trusts, seeking their CEOs signatures and securing Board approvals where necessary to allow the continuation of hosting from 1 April 2023.

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

At its Board meeting in May 2022, CTMUHB approved a Hosting Assurance Framework. The Framework was developed in collaboration with the organisations hosted by CTMUHB, to summarise and deliberately distinguish between the accountabilities for operational delivery and governance. The Framework details the arrangements and requirements for organisations hosted by CTMUHB to support effective governance and provide clarity of roles of individuals and in particular, of the CTMUHB Audit and Risk Committee.

The extension of the hosting agreement does not pose any new risks to the Health Board.

Recommendation:

The Board is asked to;

a) **APPROVE** the extension to the hosting agreement for the national Imaging Academy for Wales until 31 March 2026.

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

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

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

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

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: ~~Yes~~/No
Safety: No
Financial: ~~Yes~~/No
Workforce: ~~Yes~~/No
Legal: Yes/~~No~~
The recommemdation is to seek Board approval to agree the extension of the existing hosting agreement in place for the national Imaging Academy until 31 March 2026. This is to ensure there is an appropriate written hosting agreement in place to govern the hosting arrangement beyond 31 March 2023.
Reputational: ~~Yes~~/No
Socio Economic: ~~Yes~~/No
Equality and Health: ~~Yes~~/No
Decarbonisation: ~~Yes~~/No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Committees of the Board	

Cwm Taf Morgannwg University Health Board
&
NHS Wales Health Boards & Trusts

Hosting Agreement
1st April 2023 – 31st March 2026

Date: March 2023	**Version:** Final Draft

Purpose and Summary of Document:

This agreement is to enable and facilitate the hosting of the NHS Wales National Imaging Academy Wales by Cwm Taf Morgannwg University Health Board (CTMUHB) on behalf of NHS Wales Chief Executives.

The agreement is intended to ensure that hosting arrangements are clear and transparent and that the rights and obligations of all parties are documented and agreed. The agreement sets out appropriate financial arrangements and the obligations of all parties to the agreement.

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1. Parties to this agreement

The parties to this agreement are:

1. Cwm Taf Morgannwg University Health Board (CTMUHB), which is the host body.
2. The NHS Wales National Imaging Academy Wales (the NIAW), which is the hosted unit and, for the purposes of this agreement, includes all subsidiary functions, teams and services forming part of the NIAW.
3. All NHS Wales Health Boards and Trusts, on whose behalf the National Imaging Academy Wales will work.

The signatories to this agreement are:

Name	Designation	Signing on behalf of:	Signature	Date
Paul Mears	Chief Executive	Cwm Taf Morgannwg University Health Board (Host)		1.4.2023
Phillip Wardle	Director	National Imaging Academy Wales		
Nicola Prygodzicz	Chief Executive	Aneurin Bevan University Health Board		
Gill Harris	Interim Chief Executive	Betsi Cadwaladr University Health Board		
Suzanne Rankin	Chief Executive	Cardiff & Vale University Health Board		
Steve Moore	Chief Executive	Hywel Dda University Health Board		

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Name	Designation	Signing on behalf of:	Signature	Date
Carol Shillabeer	Chief Executive	Powys Teaching Health Board		
Mark Hackett	Chief Executive	Swansea Bay University Health Board		
Jason Killens	Chief Executive	Welsh Ambulance Service NHS Trust		
Steve Ham	Chief Executive	Velindre University NHS Trust		
Tracey Cooper	Chief Executive	Public Health Wales Trust		

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1 Named points of contact

The following individuals will act as the primary points of contact in relation to any issues that may arise under this agreement:

- For CTMUHB:
  - Executive Director of Therapies and Health Sciences
  - Executive Director of Strategy & Transformation
- For the NIAW:
  - Director

2 Purpose and scope of this agreement

This agreement is to enable and facilitate the hosting of the National Imaging Academy Wales by CTMUHB on behalf of NHS Wales Chief Executives.

The agreement is intended to ensure that hosting arrangements are clear and transparent and that the rights and obligations of all parties are documented and agreed.

The National Imaging Academy Wales' annual work plan and performance management arrangements are agreed between the Director of the National Imaging Academy Wales and the Collaborative Executive Group, prior to final sign off by the Collaborative Leadership Forum.

3 Status of this agreement

This agreement is not legally binding and no legal obligations or legal rights arise between the parties from it. The parties enter into this agreement intending to honour its content and spirit.

This agreement is one which is subject to S.7 of the NHS (Wales) Act 2006.

The parties agree that they shall act:

- in the spirit of good faith
- in the interests of minimising costs to themselves
- in the interests of maintaining quality at all times
- in accordance with any applicable statute, directions, orders, guidance or policy.

4 Duration of this agreement

This agreement commences on 1 April 2023 and will run for a period of three years until 31 March 2026.

5 Monitoring and review of this agreement

The Director of the National Imaging Academy Wales will liaise regularly with either CTMUHB's Executive Director of Therapies and Health Sciences or Executive Director of Strategy & Transformation, to monitor the operation of this agreement and to address and resolve any practical issues that may emerge.

5.1 Six monthly formal review meetings

The Chief Executive, CTMUHB and the Director of the NIAW (or nominated deputies) will meet six monthly to discuss current/live issues, the NIAW's progress on establishing governance arrangements with the NHS, and any particular issues relating to hosting arrangements. They will also include early discussions on possible changes or additions to the NIAW's role and remit.

5.2 Review meetings

The named points of contact (section 1) will meet at least six monthly to discuss hosting arrangements and any particular areas of concern. These meetings will include discussion of:

- matters relating to workforce, finance, procurement, facilities and any other corporate support services (note IT requirements will be met via a separate agreement with Digital Healthcare Wales (DHCW)

- possible changes to the NIAW's remit and any other matter which is likely to impact on the corporate support provided by CTMUHB.
- financial performance and any variance against budget, in particular potential over or underspends.

The NIAW will provide a short written report before each quarterly meeting confirming compliance with policies and procedures (e.g. statutory and mandatory training compliance), highlighting any areas of non-compliance.

5.3 Audit & Risk Committee

The Director of the NIAW will attend the CTMUHB Hosted Bodies Audit & Risk Committee at least annually, or as requested by the Audit & Risk Committee, to provide assurance to the Committee that the NIAW is complying with the Hosting Agreement and to highlight and discuss any areas of risk or non-compliance.

5.4 Annual Assurance Statement

The National Imaging Academy Wales will provide an annual Governance Compliance/Assurance Statement to CTMUHB, to confirm that they have complied with the hosting arrangements, highlighting any areas of concern, risk or non-compliance. This statement will inform CTMUHB's Governance Statement which forms part of the Annual Accountability Report.

5.5 Review

The agreement will be reviewed in the fourth quarter of each year by all parties to ensure that it is operating effectively and amendments will be agreed as required.

6 Termination and notice period

The parties acknowledge that if one of the signatories to this document withdraws or otherwise terminates its responsibilities this agreement will terminate twelve months after that event and a new agreement will be drafted and agreed by all the parties that wish to continue to engage with each other in respect of NIAW.

7 Background

In 2016, NHS Wales Chief Executives confirmed their intention to establish an NHS Wales National Imaging Academy Wales to primarily increase the number of Radiology trainees in NHS Wales (with increased classroom training within a dedicated and appropriately equipped facility, significantly enhancing the training capacity, with an economy of scale for required trainer time).

In April 2017 Cwm Taf University Health Board was formally requested to host the National Imaging Academy Wales and its Director and staff. This request was formally accepted on 7 July 2017, subject to confirming hosting arrangements via the hosting agreement. This agreement has been continued by Cwm Taf Morgannwg University Health Board since its formation in April 2020.

The current Director was appointed as Director of the National Imaging Academy Wales on 1st November 2018.

An extension to this agreement was approved by Health Boards and Trusts in March 2021 to be effective for the period 1st April 2021 to the 31st March 2023.

A review of this agreement was initiated in February 2023 to support an extension to the agreement for a further three year period.

8 Nature of the hosting arrangement

CTMUHB will provide services and facilities as agreed with Health Boards and NHS Trusts under this hosting agreement to enable the smooth running of the NIAW. However, CTMUHB will not be responsible or accountable for setting the direction of the NIAW or for the quality of the work undertaken by the NIAW. This rests with the Director of the NIAW reporting directly through the NHS Wales Chief Executive Officer Lead for Imaging to the Collaborative Executive Group and Collaborative Leadership Forum.

9 Appointment of the Director of the National Imaging Academy Wales

The Director of the NIAW and the Academy staff are employed by CTMUHB, but the Director will be appointed by the Chief Executive of the Host Body (on behalf of NHS Boards and Trusts) on recommendation and appropriate scrutiny through interview led by the Chief Executive Lead for NHS Wales, NHS Wales Chief Executive Officer Lead for Imaging, who are also responsible for ensuring continuity of leadership for NIAW.

10 Financial arrangements

10.1 Setting of and responsibility for the National Imaging Academy Wales budget

Whilst complying with CTMUHB's Standing Orders and Standing Financial Instructions (see below), the Director of the NIAW will be accountable through the Host Body Chief Executive to the Collaborative Executive Group.

The Director of the NIAW will have an authorisation limit of £100,000 (equivalent to a Care Group Director at CTMUHB) and will specify an appropriate scheme of delegation for the management of the NIAW's budget. Expenditure over £100,000 will need authorisation from the Chief Executive, CTMUHB (following discussion with the Director of the NIAW and the Lead Chief Executive for Imaging).

CTMUHB will provide the NIAW with monthly financial budget/expenditure reports. The NIAW will be responsible for checking the accuracy of these reports and for reporting and explaining any variance of expenditure against budget profile.

Recurring and non-recurring changes to the NIAW's core budget will be agreed between the Director of the NIAW and the Collaborative Leadership Forum. Such

changes may include in-year recurring or non-recurring uplifts contributed by health boards and trusts to cover agreed additional activities.

10.2 Additional funding

In addition to its core budget, the NIAW may receive additional recurring or non-recurring income from individual NHS Wales bodies or from other sources, for specific work undertaken.

The NIAW will inform CTMUHB of all arrangements for additional funding, and the terms under which the funding is being provided. Any external funding from industry partners must be compliant with any related host body Policies.

Any additional capital funding required for the initial project, on-going maintenance and developments, will need to be provided from within the partner organisations' discretionary capital allocations or if significant, be presented via a joint capital bid to the Welsh Government.

10.3 Financial variances

The Director of the NIAW must achieve a break-even position each financial year.

The Director of the NIAW is responsible for informing the Lead Chief Executive for imaging and the CTMUHB Chief Executive, at the earliest practicable stage, of any significant forecast variances and, in particular, of risks that may result in the underwriting provisions described in section 11 below being required.

In the event that there is a predicted under or overspend against the budget for the NIAW in any year, the parties to this agreement shall consider:

- in the case of an under-spend, whether there are any alternative uses to which the funds can be put consistent with the role of the NIAW, or whether funds should be returned to contributing bodies
- in the case of an over-spend, what steps can be taken to prevent the overspend arising
- any liability that exists as a result of any overspend will be shared on a joint and several basis between the parties signed to this agreement on an agreed risk sharing basis.

10.4 Financial liabilities

CTMUHB shall be the responsible legal entity in relation to liabilities to third parties, save where excepted in this agreement.

The activities of the NIAW will be covered by the Welsh Risk Pool, via CTMUHB; however, will be subject to the normal excess arrangements.

The NHS Wales Chief Executives will collectively underwrite the financial liabilities of the NIAW (on agreed risk sharing basis), where such liabilities cannot be met from within the NIAW's budget or are not covered by the Welsh Risk Pool. This includes any costs associated with redundancy, termination or breaches of employment contract, disputes and health and safety matters.

10.5 Levy to cover the costs of hosting the National Imaging Academy Wales

An agreed annual recurring revenue requirement will be provided to CTMUHB, to cover its 'core' hosting costs.

These costs will need to be reviewed and adjusted upwards on confirmation of any additional support required by the NIAW from the host body and in recognition of any inflationary pressures.

The 'core' hosting costs will be reviewed each year, as part of the overall review of this agreement (see section 5.5) and any additional 'core' hosting costs would need to be managed within the overall agreed NIAW revenue allocation.

With the exception of the agreed hosting costs and any agreed costs arising from issues detailed in section 11, no deductions will be made from the NIAW's budget by CTMUHB and CTMUHB's Cost Reduction Programme / savings targets will not be applied.

CTMUHB will not fund or be liable for any NIAW cost pressures, which must be funded within the agreed NIAW budget.

11 Obligations of CTMUHB under this agreement

11.1 General obligations of CTMUHB

CTMUHB shall be responsible for providing services and facilities to enable the smooth running of the NIAW.

In general, unless otherwise specified, these services and facilities will be equivalent to those provided to teams and services directly managed by CTMUHB. NIAW staff are expected to comply with CTMUHB's policies and procedures.

The services and facilities covered by this agreement may be provided directly by CTMUHB or may be procured from third party providers, including, but not limited to the NHS Wales Shared Services Partnership and Digital Health Care Wales (DHCW)

In hosting the NIAW, CTMUHB shall not be required to in any way act outside its statutory powers, duties, Standing Orders, Standing Financial Instructions or governance and legal obligations.

The NIAW undertakes to indemnify CTMUHB for any liability, losses, costs, expenses and claims that might arise in relation to the management of financial resources and the risk when discharging its duties and it will hold CTMUHB harmless in respect of any claims made by any third party arising out of the operations of the NIAW. The management of any such claim will be undertaken by CTMUHB, in liaison with the NIAW. However, any such claims that arise as a result of CTMUHB not meeting its hosting duties (as detailed in this agreement), then CTMUHB would be held accountable and manage the claim.

CTMUHB will not be responsible for the validity, efficacy or approval of the NIAW's budget or other plans and the NIAW will in fulfilling its obligations not place CTMUHB in a position whereby it breaches any Statute, Regulation, Standing Order, Direction, Measure or any other corporate governance requirement.

Specific services and facilities to be provided are set out below:

- Access to some Committees of the CTMUHB Board as appropriate, in order to discharge elements of the Academy's governance arrangements. These include:
- Quality, Safety & Risk Management – Reporting via the CTMUHB Quality & Safety Committee.
- Audit & Assurance – Reporting periodically to the CTMUHB Audit & Risk Committee
- Remuneration & Terms of Services Committee (RATS)
- IR(Me)R and other Imaging Governance – Reporting via Radiation Safety Committee including Ultrasound Governance.
- Clinical/Corporate Business Meeting(s) – six monthly reviews, including oversight of delivery of hosting agreement

As well as the following:-

- Governance advice and support
- Information Governance, managing overseeing any related Data Subject Access; Freedom of Information requests and related training
- Workplace health & Safety advice & support, including incident reporting and access to Datix
- Limited ad-hoc occasional communications/media support/advice.

11.2 Workforce

CTMUHB will act as the appointing and employing body for all directly employed and existing seconded staff of the NIAW, including the Director. The following services will be provided to the NIAW:

- Payroll services (for employed staff), including processing of expenses claims etc.
- Recruitment and selection support (including provision of selection/assessment tools)
- General people resources advice, with first line advice being provided by a named People Services point of contact
- Access to occupational health services
- Access to and support of the Electronic Staff Record system
- Access to statutory and mandatory training

Any financial liabilities resulting from the direct employment of staff of the NIAW (e.g. costs associated with advertising, redundancy, termination or breaches of employment, disputes and health and safety matters) will be met from the core budget agreed for the NIAW.

In the event that the core budget has insufficient funds to meet or cover the liability, NHS Wales Chief Executives (and not CTMUHB) will collectively underwrite the financial liabilities of the NIAW (on an agreed fair shares basis).

11.3 Finance and procurement

The NIAW's budget will be included within the CTMUHB ledger and the Director and any other NIAW budget holders will be provided with an income and expenditure account and the following on the same basis as provided to CTMUHB budget holders:

- Specified budget codes for the sole use of the NIAW
- Budget holder reports and information
- Management accountancy support and advice, with first line advice being provided by a named member of the finance team
- Payment of invoices
- Internal and external audit
- Access to procurement advice and support
- Appropriate access to the Oracle finance/procurement system

CTMUHB will act as the legal entity which enters into contracts and related agreements for goods and services procured on behalf of the NIAW.

11.4 Accommodation

The NIAW's core recurring budget includes provision for accommodation. The NIAW will occupy premises procured as part of the business case, agreed with NHS Wales Chief Executives and Welsh Government. The maintenance and running costs of premises will be funded from within the NIAW's core budget.

CTMUHB as host will own and maintain the NIAW Building on behalf of NHS Wales. A separate recharge over and above the hosting fee will be charged for buildings maintenance and facilities management, as per the agreed business case.

11.5 Digital Technology

The NIAW will develop a Service Level Agreement (SLA) direct with Digital Health Care Wales to provide the following:

- network infrastructure
- file servers for document storage
- the NHS Wales network and internet
- desktop IT support
- access to mobile services (which may be charged for separately on an 'at cost' basis)
- procurement of new and replacement IT equipment
- hosting of the NIAW's internet and/or intranet sites and technical support in relation to their ongoing maintenance and development

11.6 Other corporate support services

CTMUHB will provide the NIAW with access to various services / support when required. At times there may be a requirement to charge additional costs over and above the core hosting fee for items or levels of support that are not covered within the above arrangements.

This will either be based on the time spent on the activity, or if external advice is required then that will be recharged to NIAW.

This may include, but is not limited to the following:-

a. Strategic and planning support, including help with development of business plans, etc.
b. Finance support for Business case development (both revenue and capital)
c. Additional workforce support/advice above the basic core level outlined above, including any costs associated with redundancy, termination or breaches of employment contract;
d. Welsh language / translation services
e. Legal Assistance (this will be provided by NWSSP Legal & Risk Services and recharged)
f. Internal and external audit fees, for audit & assurance purposes
g. A lease car scheme for staff meeting eligibility criteria
h. All aspects of any additional Health Board based IT support, as this is all being provided directly by DHCW to the NIAW, through a separate Service Level Agreement.

12 Reporting

Hosting reporting shall be undertaken as follows:

12.1 Responsible Officer

The Responsible Officer will be the Director of the NIAW and this person will report to the Chief Executive at CTMUHB.

12.2 Accountable Officer

The Accountable Officer will be the Chief Executive of CTMUHB, who will liaise closely with the lead NHS Wales Chief Executive for Imaging.

12.3 Variation

No variation to the Agreement will be valid unless made in accordance with the Change Control Procedure found at Annex A.

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13 Obligations of the National Imaging Academy Wales under this agreement

The NIAW will comply with CTMUHB's:

- Standing Orders
- Standing Financial Instructions
- All policies and procedures where they are applicable to the activities of the NIAW as a hosted body (e.g. Health and Safety, workforce etc.)

The Director of the NIAW will have overall responsibility for the appointment of NIAW staff, whilst acting within CTMUHB's recruitment policies. Other than the provision of People Services advice and selection tools, or as specifically requested by the NIAW, CTMUHB will have no role in the appointment of staff.

The Director of the NIAW will be responsible for ensuring that all NIAW staff undertake applicable statutory and mandatory training, which will be made available by Cwm Taf Morgannwg University Health Board. With the exception of statutory and mandatory training, the responsibility for the organisation and funding of the training and development of NIAW staff will rest with the NIAW.

The Director of the NIAW is responsible for the management of risk within the National Imaging Academy Wales and its activities. The NIAW will follow CTMUHB's Risk Management Strategy and Risk Management Policy and will monitor and maintain a risk register for the NIAW on the CTMUHB Datix system. Any potential risks which could impact on the business and safety of CTMUHB will be escalated to the Chief Executive and the Executive Lead with responsibility for risk in CTMUHB. The Director of the NIAW will also ensure that the Chief Executives are apprised of any high risks and the arrangements for providing assurance regarding their management.

CTMUHB can request access to the NIAW's risk register as required, to inform and provide assurance that the overall governance arrangements of CTMUHB are being maintained.

The Director of the NIAW will be responsible for ensuring any additional pieces of work taken on by the NIAW, including expansion in workforce and budget are to be discussed and agreed with CTMUHB.

14 Intellectual property

Unless otherwise agreed (see below) all intellectual property developed or legitimately acquired by the NIAW, shall be owned collectively by the NHS Wales Health Boards and Trusts.

If the intellectual property is to be exploited in any way then terms will be agreed between all the parties in this respect.

In some circumstances, the NIAW may (through CTMUHB) enter into agreements (such as joint working agreements with industry partners) where specific conditions relating to the ownership and exploitation of intellectual property may apply.

15 Data Protection and Freedom of Information

For the purposes of information governance, data protection and freedom of information activity, all data and information held by the NIAW will be deemed to be held by CTMUHB. As a result, any requests for information under relevant legislation will be processed according to CTMUHB's Policies and Procedures. However, the Director of the NIAW will be informed as soon as possible of any relevant requests received and discussion will take place with the Director before any of the NIAW's information is released to a third party. The Director of the NIAW will be responsible for sharing relevant requests, and responses provided, with Health Boards and Trusts as appropriate.

The NIAW may enter into data sharing agreements with Health Boards and Trusts to facilitate the carrying out of its functions. As the host body, CTMUHB will need to be a signatory to such agreements and must be satisfied with their content.

16 Disputes and matters not covered by this agreement

It is inevitable that issues will arise that are not explicitly covered by this agreement. In such cases, and in the event of any disputes, all parties will seek to address these issues and identify appropriate solutions in the common interest of NHS Wales and the public served.

If any party has any issues, concerns or complaints about Hosting, or any matter in this Hosting Agreement, that party shall notify the other parties and the parties shall then seek to resolve the issue by a process of consultation. If the issue cannot be resolved within a reasonable period of time, the matter shall be escalated to the Accountable Officer and the Responsible Officer, who shall decide on the appropriate course of action to take. If the matter cannot be resolved by the Accountable Officer and the Responsible Officer within 21 days, the matter may be escalated to the Welsh Government in accordance with the NHS (Wales) Act 2006.

If any party receives any formal inquiry, complaint, claim or threat of action from a third party (including, but not limited to, claims made by a supplier or requests for information made under the Freedom of Information Act 2000) in relation to Hosting, the matter shall be promptly referred to the Accountable Officer and Responsible Officer (or their nominated representatives). No action shall be taken in response to any such inquiry, complaint, claim or action, to the extent that such response would adversely affect Hosting, without the prior approval of them (or their nominated representatives).

17 Governing law and jurisdiction

This Agreement shall be governed by and construed in accordance with the laws of England and Wales and, without affecting the escalation procedure set out in section 17, each party agrees to submit to the exclusive jurisdiction of the courts of England and Wales.

Annex A

Annex A – Change Control Procedure

1. Changes may be proposed by any party to the Responsible Officer who will then discuss them with the Accountable Officer.
2. The Changes may be agreed or rejected by both of those individuals.
3. All parties will be notified of the decision and any resulting change will be recorded in writing and annexed to this agreement.
4. Any dispute regarding the proposed changes will be dealt with by the escalation procedure except in that different officers of each body will deal with the dispute.

Date of change	**Section No.**

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Report Title:	Vagal Nerve Stimulators Procurement Request			Agenda Item no.	7.15
Meeting:	Board Meeting	Public	x	Meeting Date:	Public Board
		Private			
Status *(please tick one only):*	Assurance		Approval	X	Information
Lead Executive:	Director of Finance				
Report Author (Title):	Claire Salisbury, Assistant Director of Procurement Services and Executive Procurement Lead – C&V				

Main Report
Background and current situation:

The Neurosciences Directorate currently purchase Vagal Nerve Stimulator (VNS) products which has been renewed annually due to the supplier monopoly for this market.

VNS therapy is delivered through an implanted device that sends mild pulses to the vagus nerve at regular intervals throughout the day in an effort to reduce and/or prevent seizures. Patients are referred to this type of therapy when drugs have failed to provide a more manageable treatment. These devices are programmable for a personalised therapy approach and the technology is highly specialised.

Livanova UK Limited is the only company that manufacture and supply these devices and therefore, have the monopoly in this market field. Despite a prolonged discussion period with Livanova on costing structures, the company were only willing to provide fixed pricing for an annual, two or four year option.

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

Upon review of the options, Procurement Services and the Consultant determined that the two year offer was more beneficial rather than the four year proposal as the four year unit pricing had an estimated inflation cost for four years included and this had been calucated at the current rate of inflation.

Whilst Procurement Services have challenged all proposed costing options, there has been no compromise from the supplier on pricing or other financial incentives due to their monopoly status and as such, Procurement Services are recommending that a two year contract is awarded to Livanova with a ceiling value for the contract of £720,000.00.

Attached to this report, as appendix 1, is a copy of the NHS Shared Services Partnership Procurement Report which sets out the further detail of this contract and the procurement formalities followed.

It should be noted that a VEAT (Voluntary Ex Ante Transparency) notice was issued by Procurement Services in order to contract with Livanova and there were no challenges from the market on this intention.

In awarding this contract, the below benefits realised will be;

- VNS is NICE recommended for patients who have drug resistant epilepsy (still have seizures after trying 2 anti-seizure drugs) both in term of efficacy for the patient and in terms of cost effectiveness for the healthcare system, therefore, providing improved patient care and outcomes
- Products loaded via the Oracle catalogue for quicker purchase order turnaround.
- A compliant route to market
- Fixed pricing for the contract period

Recommendation:

The Board / Committee are requested to:

- **Approve** the award of a two-year contract to Livanova UK Ltd for the supply of Vagal Nerve Stimulators at a value of £720,000.00 including VAT

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

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

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: ~~Yes~~/No
Safety: ~~Yes~~/No
Financial: ~~Yes~~/No
The expenditure for these consumables is via the Specialist, Neurosciences revenue budget, however, it should be noted that this activity is commissioned and funded by WHSSC.
Workforce: ~~Yes~~/No
Legal: ~~Yes~~/No
Reputational: ~~Yes~~/No
Socio Economic: - ~~Yes~~/No
Equality and Health: ~~Yes~~/No
Decarbonisation: : ~~Yes~~/No

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

DocuSign Envelope ID: 97542420-0BCF-41D0-810A-E3C4E190ED70

PROCUREMENT REPORT

CONTRACT TITLE	Vagal Nerve Stimulators
CONTRACT REFERENCE	CAV-DCO (22-23) 147
PERIOD	From award of contract for a two-year period
CLINICAL BOARD	Specialist Services
TENDER CLOSING DATE	VEAT Notice closed on 24th February 2023

1. INTRODUCTION

The Neurosciences Directorate currently purchase Vagal Nerve Stimulator (VNS) products. VNS therapy is delivered through an implanted device that sends mild pulses to the vagus nerve at regular intervals throughout the day in an effort to reduce and/or prevent seizures.

Patients are referred to this type of therapy when drugs have failed to provide a more manageable treatment. These devices are programmable for a personalised therapy approach and the technology is highly specialised.

2. BACKGROUND

Livanova UK Limited are the only company that manufacture and supply these devices and therefore, have the monopoly in this market field.

Despite a prolonged discussion period with Livanova on costing structures, the company provided fixed pricing for an annual, two or four year option. Upon review of the options, the two year offer was more beneficial because they have added an estimated inflation cost year on year to the quotation price.

Procurement Services also requested if Livanova would provide any rebates, discounts or free of charge products, unfortunately, LivaNova would not provide any form of discount.

Due to this, a VEAT (Voluntary Ex Ante Transparency) notice was issued by the Procurement department via the sell2wales portal stating that they were intending to award a contract for these products to LivaNova. The VEAT notice was issued on the 14th February 2023, closing on the 24th February 2023 for the value up to £600,000 excl VAT as a ceiling value for flexibility in purchasing.

There were no challenges to this notice and therefore, Procurement Services are seeking approval to award a two year contract, the supplier was engaged to provide an official quotation for the consumable.

3. CONTRACT FINANCIALS

a. CURRENT CONTRACT VALUE

	Excluding VAT	Including VAT
Annual Value	£353,361.00	£424,033.20

b. NEW CONTRACT VALUE

	Excluding VAT	Including VAT
Annual Contract Value	£283,493.00	£340,191.60
Total 2 Year Value	**£566,986.00**	**£640,383.20**
Ceiling Value Threshold	**£600,000.00**	**£720,000.00**

DocuSign Envelope ID: 97542420-0BCF-41D0-810A-E3C4E190ED70

Financial Notes
This expenditure is an estimated spend due to fluctuation in the number of patients the Health Board need to treat. The total two year value is the proposed estimated cost, however, the ceiling threshold has been included to allow for flexibility in expenditure over the two years.
Proposed estimated cost - the Directorate purchased 10 Generators in early March 2023 under the current contract and prior to the increase in pricing. This has reduced the value anticipated to be spent in year one of the contract.
The expenditure for these consumables is via the Neurosciences revenue budget, however, it should be noted that this activity is commissioned and funded by WHSSC.

4. ANY OTHER RELEVANT INFORMATION

The Clinical Board will need to monitor activity under this arrangement to ensure that the contract approval threshold in this report is not breached. If any breach should be foreseeable the Procurement Department must be contacted to ensure provision is made to confirm compliance with Procurement Regulations and Health Board Standing Financial Instructions.

5. BENEFITS REALISED FROM AWARD

In awarding this contract, the below benefits realised will be;

- A compliant route to market
- Fixed pricing for the contract period
- Products loaded via the Oracle catalogue for quicker purchase order turnaround.
- VNS is NICE recommended for patients who have drug resistant epilepsy (still have seizures after trying 2 anti-seizure drugs) both in term of efficacy for the patient and in terms of cost effectiveness for the healthcare system

6. RECOMMENDATION

On the basis of the foregoing it is recommended that the contract for **Vagal Nerve Stimulators** should be awarded to **LivaNova UK Limited.**

Prepared By:	Nicola Arnold
Contact Details:	029 21508277
Date:	14th March 2023

Procurement Approval	
Approved By:	Emma Lane
Date:	14-Mar-23

DocuSign Envelope ID: 97542420-0BCF-41D0-810A-E3C4E190ED70

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

SIGNED Mathew Price .....

PRINT NAME Mathew Price .....

(Matthew Price, Clinical Director, or Directorate Manager)

DATED 16-Mar-23 .....

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

SIGNED Sarah Lloyd .....

PRINT NAME Sarah Lloyd .....

(Sarah Lloyd, Director of Operations and Delivery)

DATED 16-Mar-23 .....

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

SIGNED .....

PRINT NAME christopher markall .....

(Christopher Markall, Head of Finance)

DATED 16-Mar-23 .....

DocuSign Envelope ID: 97542420-0BCF-41D0-810A-E3C4E190ED70

Appendix One

Supplier Item	Description	year 2 Offer Price
10-0012-5002	SENTIVA ™ GENERATOR, MODEL 1000 SINGLE PIN RECEPTACLE, VOLUME 8CC (EACH) (10-0012-5002)	£13,183.00
10-0011-2101	ASPIRESR SEIZURE RESPONSE GENERATOR, MODEL 106 (SINGLE PIN RECEPTACLE, VOLUME 14CC (EACH) (10-0011-2101)	£13,056.00
10-0011-1204	PERENNIADURA™ LEAD, MODEL 303-20 SINGLE PIN 2MM COIL (EACH) (10-0011-1204)	£3,007.00
10-0011-1206	PERENNIADURA™ LEAD, MODEL 303-30 SINGLE PIN 3MM COIL (EACH) (10-0011-1206)	£3,007.00
10-0011-1304	PERENNIAFLEX™ LEAD, MODEL 304-20 SINGLE PIN 2MM COIL (EACH) (10-0011-1304)	£3,007.00
10-0011-1306	PERENNIAFLEX™ LEAD, MODEL 304-30 SINGLE PIN 3MM COIL (EACH) (10-0011-1306)	£3,007.00
10-0012-4601	TUNNELER, MODEL 402 (EACH) (10-0012-4601)	£171.00
10-0011-2401	ACCESSORY PACK, MODEL 502 (EACH) (10-0011-2401)	£585.00
10-0011-0601	PROGRAMMING WAND, MODEL 2000 (EACH) (10-0011-0601)	£3,105.00
10-0011-6200	SOFTWARE MODEL 3000 WITH PROGRAMMING TABLET (EACH) (10-0011-6200)	£2,893.00
10-0011-2201	PATIENT ESSENTIALS PATIENT KIT, MODEL 220 (EACH) (10-0011-2201)	£117.00
10-0012-4202	SENTIVA ™ GENERATOR, MODEL 1000-D DUAL PIN RECEPTACLE, VOLUME 10CC (EACH) (10-0012-4202)	£13,183.00
MPC – 10-0010-9201	SENTIVA GENERATOR, MODEL 1000, (SINGLE PIN RECEPTACLE, VOLUME 8CC) (EACH) (MPC – 10-0010-9201)	£13,183.00

Confirmed Minutes of the Charitable Funds Committee
20 September 2022 12.30pm
Via Microsoft Teams

Present:		
Rachel Gidman	RG	Executive Director of People and Culture
Mike Jones	MJ	Vice Chair / Independent Member – Trade Union
Catherine Phillips	CP	Executive Director of Finance
In Attendance:		
Charles Janczewski	CJ	Chair of the Cardiff & Vale University Health Board
Angela Hughes	AH	Assistant Director of Patient Experience
Joanne Brandon	JB	Director of Communications
Emma Cooke	EC	Deputy Director of Therapies and Health Sciences
Nicola Foreman	NF	Director of Corporate Governance
Rob Mahoney	RM	Interim Deputy Director of Finance
Secretariat:		
Nathan Saunders	NS	Senior Corporate Governance Officer
Observers:		
Marcia Donovan	MD	Head of Corporate Governance
Jayne Gibbons	JG	Internal Audit Manager
Apologies:		
Akmal Hanuk	AH	Committee Chair / Independent Member – Community
Susan Elsmore	SE	Independent Member – Local Council
Fiona Jenkins	FJ	Executive Director of Therapies and Health Sciences
Sara Moseley	SM	Independent Member – Third Sector
John Union	JU	Independent Member – Finance

CFC22/09/001	**Welcome & Introductions** The Committee Vice Chair (CVC) welcomed everyone to the meeting.	**Action**
CFC22/09/002	**Framing of the Charitable Funds Strategy Review Session** The Executive Director of Finance (EDF) advised the Committee that following the Charitable Funds Committee's Strategy (the Strategy) review session earlier that day, it would be of benefit to summarise the session within the meeting. It was noted that the Strategy had been reviewed following in depth discussions where it was agreed that amendments would be required to the Strategy as a result of the Covid-19 pandemic and all of the learnings and changes that had come from it. The Committee was advised the actions would be written up following the session and brought back to the Charitable Funds Committee (CFC) in December. Further, it was suggested that a Task and Finish Group should be set up to progress the Strategy review work. The EDF noted that the new Strategy should be finalised for the start of 2023 or the start of the new financial year. The Chair of the Cardiff and Vale University Health Board (UHB Chair) suggested that the new financial year would be appropriate as it allowed actions from the Strategy review session to be embedded.	**CP/JB**

	The Executive Director of People & Culture (EDPC) advised the Committee that the discussions around the cost of living crisis held at the Strategy review session should be raised as a priority. The EDF responded that there were mechanisms in place via the Employee Wellbeing Service (EWS) that would commit to those areas discussed. The Director of Communications (DC) advised the Committee that all other Committees of the Board would be made aware that the cost of living crisis had been discussed at the Charitable Funds Committee Strategy Review session. The EDF concluded that the Strategy would be finalised by the new financial year and there would be a focus on the cost of living crisis over the winter months. **The Committee resolved that:** a) Completion of the new Health Charity Strategy by the new financial year was supported.	**Committee Chair**
CFC22/09/002	**Apologies for Absence** Apologies for Absence were noted.	
CFC22/09/003	**Declarations of Interests** No declarations of interests received.	
CFC22/09/004	**Minutes of the Committee Meeting held on 21 June 2022** The Committee reviewed the minutes of the meeting held on 21 June 2022. The Interim Deputy Director of Finance (IDDF) provided an amendment to the Health Meadow item and noted that the recommendation required changing as it did not go to the Board of Trustees meeting. The Executive Director of People & Culture advised of an amendment to be made around the Employee Wellbeing Service (EWS) and noted that she would send to the Senior Corporate Governance Officer. **The Committee resolved that:** a) The minutes of the meeting held on June 21 2022 were approved as a true and accurate record pending the amendments discussed.	
CFC22/09/005	**Committee Action Log** The Committee reviewed the Action Log. The EDF advised the Committee that the Health Meadow Action (CFC22/06/009 and CFC 22/06/014) was a phased action and noted that the next phase costings was £1.5m for the build on the health meadow and noted it would be a Health Board commitment as opposed to a Health Charity commitment. The Chair of the Cardiff & Vale University Health Board asked if the EDF was in a position to quantify the recurrent cost on the project. The EDF responded that it was about £200k. The CC asked if an extraordinary meeting could be called for discussion around the Health Meadow and its costs and to provide recommendations to the Board of Trustees. **The Committee resolved that:** a) The Action Log was noted.	**NF/NS**

CFC22/09/006	**Chair's Action** No Chair's Actions to note.	
CFC22/09/007	**Health Charity Financial Position & Detailed Investment Update** The Health Charity Financial Position Update was received. The Interim Deputy Director of Finance (IDDF) advised the Committee that there had been a fairly major update since the previous Committee (CFC) but noted that the most recent update had been received by the Board of Trustees on 1 September 2022. It was noted that the Cardiff and Vale Health Charity (the Charity) had generated £0.474m of income and spent £0.812m for the first five months of the financial year which had resulted in net expenditure of £0.338m. It was noted that the Charity also had market value loss on its investments of £0.251m for the period compared to the April 2022 valuation which also took into consideration the cash withdrawal of £0.350m. The combined effect of those results was a net decrease in fund balances for the period ending August 2022 of £0.589m. The IDDF advised the Committee that the investment portfolio had started the financial year with a market value of £6.569m and that the value had now decreased to £5.968m for the period ending August 2022. That had included a £0.350m cash withdrawal in May 2022. It was noted that this had resulted in a market value loss of £0.251m for the period ending August 2022 compared to the opening balance of £6.569m. In summary the value of the Charitable Funds had decreased by £0.589m in the current year to £8.399m and it was noted that the decrease represented net expenditure of £0.338m and market value losses of £0.251m. The Committee was advised that there had been a reduction in the donations received in comparison to the financial year 2020/21 which had included some significant acts of generosity from individuals and a large contribution from NHS Charities together. It was noted that the fund balances had decreased by £0.589m in the period to £8.399m and that of the closing fixed asset balance £2.479m related to Rookwood Hospital, with the balance of £5.968m relating to the investment portfolio. The IDDF advised the Committee that the investment portfolio data had been significantly updated because the IDDF had reviewed previous reports to look at the commitments and noted that most of the outstanding commitments were for this financial year He added that as a result of that, there was almost no general reserve available and there were commitments of around £1m. It was noted that a piece of work would be undertaken around cashflow to see what could be done to regenerate cash. The UHB Chair thanked the IDDF for being open and transparent with regards to the current status of the Charity's funds. He added that he had been given assurance that the Charity was looking at the data through the correct financial lens. The EDF advised the Committee that she would pick up the action of listing the outstanding commitments and would work with the IDDF and the DC to look at the commitments that had not been started or could be paused/stopped or covered via another fund (for example, the endowment fund). The Executive Director of People and Culture (EDPC) advised the Committee that the staff recognition awards could be taken out of the commitments and that it could revert back to a sponsorship model.	**CP/RM/JB**

	The Committee resolved that: a) The financial position of the Charity was noted. b) The performance of the investment portfolio was noted c) The over commitment of the general reserve was noted d) The overspend and the actions recommended to address that overspend were noted.	
CFC22/09/008	**Over £25k bids for approval** None for this period.	
CFC22/09/009	**Health Charity Fundraising Report** The Health Charity Fundraising Report was received. The DC advised the Committee that the report provided a summary of the progress and activities of the Health Charity Appeals for the period 1st March - 31st May 2022. It was noted that Irene Hicks, who had been a staunch fundraiser for the Breast Centre Appeal, was retiring and leaving the Health Charity. It was noted that in August 2022, Irene and team had reached their goal of £200,000 raised for the Breast Centre Appeal since they started supporting in 2014. The DC advised the Committee that a formal letter would be sent from the UHB Chair and the Chair of the CFC to thank Irene. The Therapy Services Lead asked if Irene had been nominated in the King's Honours List. The DC responded that she had been nominated before and that it would be looked at again. The Committee was advised that £43,384.46 had been received in Legacy donations since 1st April 2022. It was noted that the next Health Charity 'SuperMegaDraw' would take place in November 2022 with a single prize winner of £22,000, in addition to the regular four weekly £1,000 winners. The DC advised the Committee that the cost of living crisis had been discussed during the Strategy review session and noted that the Charity would work alongside Human Resources to make sure areas were being promoted sensitively. The EDPC agreed and noted that the careful messaging was required around pensions and the loss of certain benefits if members of staff were considering withdrawing from the Health Board pension scheme. It was noted that the Charity had been successful in obtaining a further grant from stage 2 of the NHS Charities Together (NHSCT) monies to the sum of £121,409. It was noted that the Charity was liaising with NHSCT to comply with some conditions of the grant allocation in relation to Our Health Meadow: • Our Health Meadow - £41,488.00 • Arts social prescribing project - £79,921.00 The UHB Chair advised the Committee that he had recently obtained a 'Blue Light Card' and noted that it offered discounts on a number of items. The EDPC responded that the Charity did promote the use of the Blue Light Card. The Assistant Director of Patient Experience (ADPE) added that the Communications team could put messages out about specific discounts, such as 10% off at certain	**NF**

	supermarkets, which could potentially help to alleviate some of the concerns around the cost of living crisis. The DC advised the Committee that in order to use the Blue Light Card, a workplace email was required which some of the lower band staff did not have and so work would need to be done to address that and look at the mechanisms to get those staff the discounts. She added that pre-Covid, offers and information was often posted to various Clinical Boards for distribution but due to Infection, Prevention and Control (IPC) systems, that was stopped. It was noted that the lack of distribution was a large issue and so the Charity would look at posting again now that IPC measures had been lifted. **The Committee resolved that:** a) The fundraising report was reviewed. b) The progress and activities of the Health Charity as advised were noted.	
CFC22/09/010	**Reporting Feedback on Successful CFC bids** The DC advised the Committee that she would take the report as read. It was noted that the paper aimed to provide assurance to the Committee on the spend and the associated impact/improvement of bids. It was noted that there had been 2 successful bids for the quarter: • Staff Outdoor areas - £79,800.00 • Our Health Meadow - £80,000.00 **Staff Outdoor areas:** The DC advised the Committee that following the extreme pressures on NHS colleagues over the past 2 years, the Health Charity team had listened carefully to comments and suggestions from Health Board staff who had expressed the need for dedicated outdoor areas to enable them to take time away from the stresses of their daily working lives. With funding received from NHSCT, the Charity was able to progress a project to create outdoor staff haven spaces at University Hospital of Wales, University Hospital Llandough, Cardiff Royal Infirmary, St David's Hospital and Barry Hospital, all with the purpose of enabling staff to access an outdoor environment to rest and reflect. It was noted that the feedback from staff had been incredibly positive and that perhaps the Charity had become a victim of its own success because more and more people were now asking for an outdoor area. **Our Health Meadow:** The DC advised the Committee that Our Health Meadow site was provided to assist in the improvement of the health and wellbeing of patients, staff, visitors and the community of the Health Board. She added that it also offered clinically recognised therapeutic benefits and involved co-production with a Clinical Board. It was noted that funds were secured from General Reserves (approved by the Committee in March 2022) to provide the project with a secure financial platform and ensuring that the staff wellbeing provision, and design requirements were established prior to commencing the 'on site' construction / building work. The DC concluded that the Charity was currently co-working with the Finance Team to further inform the Committee and the Board of Trustees of the future funding requirements to deliver the capital build scheme. **The Committee resolved that:**	

	a) The report was received as assurance of the appropriate use of the allocated charitable funds	
CFC22/09/011	**Health Charity Puppy Proposal update** The Health Charity Puppy Proposal update was received. The DC advised the Committee that she would take the paper as read and summarised that the original proposal had been withdrawn. She was liaising with existing and specialised pet therapy organisations which were currently working with the Health Board to support charity events. **The Committee resolved that:** a) The Health Charity's decision to not proceed with the proposed project was noted.	
CFC22/09/012	**Events Planner 2022 Update** The Events Planner 2022 Update was received. The DC advised the Committee that an updated events planner list would be brought to the Committee at each meeting. She asked Members for support and commented that their presence at events would be greatly appreciated. The CC asked if the events planner could be circulated to all Board Members. **The Committee resolved that:** a) The updated Health Charity Events Planner 2022 was approved	**NF/NS**
CFC22/09/013	**Third Sector Grant Scheme update** The Third Sector Grant Scheme update was received. The DC advised the Committee that the report had already been submitted to the CFC previously but further detail was sought. She added that the report provided a more detailed evaluation on how the money had been spent and the impacts seen by the local community. It was noted that the amount of money Third Sectors requested was very small in comparison to what the Health Board received back by way of services. The DC advised the Committee that one of the requests raised was for the invitation to the CFC to be extended to Third Sector colleagues to provide a verbal update on the impacts seen by the funding provided. The ADPE concurred that the amount the Health Board received was phenomenal. The EDF added that the Third Sector Grant Scheme should continue to support annually initiatives where we can see demonstrable benefit in continuing to support initiatives for our population. We would also need to ensure that each scheme worked on how to become sustainable and self-funding. The DC advised the Committee that community engagement was discussed in depth at the Strategy review session and agreed that asking Third Sector partners to present to the CFC about the targeted interventions, their benefits and sustainability to the CFC annually. The IDDF asked if there were any communication plans moving into the next financial year because the Third Sectors would be expecting a commitment.	**JB/NF**

	The EDF responded that how that was managed would require discussion because it was something that definitely required support. The IDDF highlighted that communication with the partners was important due to the funds balance and EDF said it was important we tried to sustain this work through the sustainability model. The UHB Chair concluded that the Third Sector fund added so much value to the representation of the Health Board and noted that some careful consideration was required with regards to how the Health Board could support GVS ensure support was sustainably delivered to communities. **The Committee resolved that:** a) The further communications with GVS in relation to the delivery and evaluation of the Third Sector Grants Scheme 2022/23 were noted.	
CFC22/09/014	**Staff Benefits Group Report** The Staff Benefits Report was received. The EDPC advised the Committee that she would take the paper as read. It was noted that the Staff Benefits Group continued to support all employees of the Health Board by engaging and partnering with local businesses and suppliers who wished to support NHS staff, and by actively promoting those and national staff discounts/offers via staff engagement platforms, including CAVUHB Internet /Staff Connects/social media platforms and digital screens. The EDPC added that the Staff Benefits Group discussed and agreed the 'best deals' for staff and, in governance terms, reported their work to the CFC and the Local Partnership Forum. **The Committee resolved that:** a) The Staff Benefits Group Report was noted.	
CFC22/09/015	**Staff Lottery Bids Panel Report** The Staff Lottery Bids Panel Report was received. The DC advised the Committee that she would take the paper as read. She added that the paper gave members an indication of how much value the Staff Lottery was bringing into the Charity. It was noted that the Staff Lottery continued to grow year on year and that as of July 2022 5,340 numbers had been allocated to staff. It was noted that the paper also covered the good work the Staff Lottery Bids Panel undertook in awarding not only the bigger items of up to £10k, but also the fast track small bids. It was noted that that the speed and agility in which the small bids were turned around was greatly appreciated. The DC advised the Committee of two areas for noting which included: • Supporting the Specialist Services Staff Recognition Event - The Staff Lottery Bids Panel recently approved a bid to support the Specialist Services Recognition Event, which was delayed for a year due to the Covid-19 pandemic. The funds were used to purchase awards, decorations and refreshments for the event, directly supporting the Specialist Services staff by showing the appreciation of their hard work and dedication. • Maternity Summer Sports Day - Maternity Services had recently been under intense pressure due to severe staff shortages. The pressure had never been greater and the need to improve staff morale reached critical point. The Staff	

	Lottery Bids Panel were delighted to support the bid to purchase equipment for the fun-filled day. Some of the items included tug-of-war rope, kangaroo jumping sacks, and spoons for the egg and spoon race. The event was a huge success with engagement from all members of the multidisciplinary team. **The Committee resolved that:** a) The content of the Staff Lottery Bids Panel Report was noted.	
CFC22/09/016	**Any Other Business** The UHB Chair thanked the Committee for the way in which business was conducted and noted how positive it had been to see Committee Members engaged with the genuine efforts to support staff whilst also looking at how the CFC managed its affairs. **The Committee resolved that:** a) All other business was noted and agreed.	
CFC22/09/017	**Review of the meeting:**	
	Date and Time of Next Meeting Tuesday 6 December 2022, 9:00am	

Confirmed Minutes of the Public Audit & Assurance Committee Meeting
Held On 8 November 2022 at 9am
Via MS Teams

Chair:		
John Union	JU	Independent Member for Finance and Committee Chair
Present:		
Mike Jones	MJ	Independent Member for Trade Union
David Edwards	DE	Independent Member for ICT and Committee Vice Chair
In Attendance:		
Nicola Foreman	NF	Director of Corporate Governance
Catherine Phillips	CP	Executive Director of Finance
Meriel Jenney	MJ	Executive Medical Director (from 10.20 a.m.)
Ian Virgil	IV	Head of Internal Audit
Robert Mahoney	RM	Interim Deputy Director of Finance (Operational)
Gareth Lavington	GL	Lead Local Counter Fraud Specialist
Aaron Fowler	AF	Head of Risk and Regulation
Urvisha Perez	UP	Audit Wales
Rachel Gidman	RG	Executive Director of People & Culture
Ceri Phillips	CP	UHB Vice Chair
Claire Whiles	CW	Assistant Director of OD, Wellbeing and Culture
Ed Hunt	EH	Programme Director - Redevelop
Marcia Donovan	MD	Head of Corporate Governance
Alex Scott	AS	Assistant Director of Quality Safety
Observers:		
Tim Davies	TD	Head of Corporate Business
Secretariat		
Sarah Mohamed	SM	Corporate Governance Officer
Apologies:		
Wendy Wright-Davies	WW	Deputy Head of Internal Audit

Item No	Agenda Item	Action
AAC 8/11/22 001	**Welcome & Introduction** The Committee Chair (CC) welcomed everyone to the meeting.	
AAC 8/11/22 002	**Apologies for Absence** **The Committee resolved that:** a) Apologies were noted.	
AAC 8/11/22 003	**Declarations of Interest** **The Committee resolved that:** a) No Declarations of Interest were noted.	
AAC 8/11/22 004	**Minutes of the Meeting Held on 6 September 2022**	

	The Minutes were received. The Independent Member for Trade Union (IMTU) requested that "Committee Chair" be taken out of his title. **The Committee resolved that:** a) Except for the comments made above, the draft minutes of the meetings held on 6th September 2022 were a true and accurate record of the meeting.	
AAC 8/11/22 005	**Action Log – Following Meeting held on 6 September 2022** The Action Log was received. Re Action Number AAC 6/9/22 008 – the Head of Internal Audit confirmed that this report was underway and should be finalised for the next Committee meeting. **The Committee resolved that:** a) The Action Log was discussed and noted.	
AAC 8/11/22 006	**Any Other Urgent Business** **The Committee resolved that:** a) No other urgent business was noted.	
	Items for Review and Assurance	
AAC 8/11/22 007	**Internal Audit Progress Report** The Head of Internal Audit (HIA) presented the Internal Audit Progress Report and highlighted the following: <u>Section 2</u> • 4 audits were planned for the November Committee but had not yet been completed. Table 2 gave the reasons for the delay. • There were delays in receiving information from Management to be able to complete the Administration Services in Mental Health Audit. <u>Section 3</u> • 7 reports were finalised and included within the Committee papers. • Executive summaries from the final reports were included under section 6. <u>Section 4</u>	

	• There was a total of 47 audits in the 2022/23 Internal Audit plan, of which 10 had been finalised and 1 had reached the draft report stage. • There were 10 audits that were currently “work in progress”, with a further 9 at the planning stage. <u>Section 5</u> • There were queries from the Independent Members in the previous meeting about the deliverability of the plan, given the potential pressures that may be faced by the Health Board over the Winter period. • It was proposed that the 4 identified audits which were at risk would initially be rescheduled to the end of the 22/23 plan, but with the possibility that they could be removed or deferred into 23/24 if required. • It was confirmed that the changes had been presented to the Senior Leadership Board (SLB). The Executive Director of People and Culture (EDPC) commented that Workforce was one of the biggest risks. The caveat was that the People and Culture Plan would be taken to different Committees of the Board. It could wait because there was assurance in place. <u>Section 6</u> • The Executive summaries for 7 reports had been finalised. 1. Staff Wellbeing – Culture and Values – The objective of this audit was to evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to ‘Staff Wellbeing - Culture and Values’. – Reasonable assurance was awarded. – The findings of the audit had highlighted that the Health Board had clear plans in place of how it intended to support staff wellbeing, principally driven by the People and Culture Plan 2022 – 2025. – Further recommendations around references within the Board Assurance Framework, and the need to verify source material signposted on the new SharePoint site were made. 2. Follow-up: 5 Steps to Safer Surgery – The objective of this audit was to provide the Health Board with assurance regarding the implementation of the agreed Management actions from the ‘Five Steps to Safer Surgery’ Audit (CVU-2122-16) that was undertaken as part of the 2021/22 work programme, which reported ‘Substantial’ assurance.	

	– Significant progress had been made in addressing the seven recommendations arising from the previous internal audit, completed in October 2021. 3. Implementation of National IT Systems (WNCR) – The purpose of this audit was to evaluate and determine the adequacy of the systems and controls in place within the Health Board for the implementation and use of national IT systems. – Reasonable assurance was awarded. – The audit highlighted improved processes in collaboration. – 4 medium priority matters were highlighted. – Management had agreed actions. 4. Digital Strategy – The purpose of this audit was to ensure that the refreshed Digital Strategy met the needs of the Health Board and that there was a Roadmap for delivery. – Reasonable assurance was awarded. – The Health Board had an appropriate strategy in place which met the needs and objectives of the Health Board. The Strategy had recently been refreshed and was also supported by a Roadmap. – Whilst reasonable assurance had been provided, the audit report had provided that some priority matters should be taken forward. Those were (i) the need to provide greater detail with regard to the delivery of the Roadmap (ii) the need to clearly define the resources required to deliver the Roadmap, and (iii) a recommendation that the Health Board consider the overall funding because Internal Audit had looked at some comparable health organisation and best practice and had identified that the funding available to deliver the Health Board's Digital Strategy was potentially on the low side. It was also noted that the report had recommended that it was good practice to have Clinical Board attendance at the Digital Health Intelligence Committee meetings. – Management had agreed the report and would provide recommendations. 5. Medical and Dental Staff Bank – The overall objective of the audit was to review the effectiveness of the processes and controls operating within the Health Board's new Medical and Dental Staff Bank managed by Medacs Healthcare. – Substantial assurance was awarded. – The outcome reflected that there was a Framework in place for operating the Bank. 6. Medical Equipment & Devices	**DCG**

	– The overall objective of this audit was to review the arrangements in place for recording, monitoring and replacing medical equipment and devices. – Reasonable assurance was awarded. 7. University Hospital Llandough – Endoscopy Expansion – The purpose of the audit was to review the delivery and management arrangements for the University Hospital Llandough (UHL) Endoscopy Expansion Project, and the performance, against its key delivery objectives i.e., time, cost, and quality. – Reasonable assurance was awarded. – A robust project governance structure was in place with continual liaison and effective reporting to the relevant forums. The UHB VC queried whether consideration was given to recommendations made by Health Technology Wales in terms of new equipment used to adjust the way care was undertaken. The HIA responded that it was not covered as part of the audit but they would look into this. **The Committee resolved that:** a) The Internal Audit Progress Report, including the findings and conclusions from the finalised individual audit reports were considered. b) The proposed contingency adjustments to the 2022/23 plan and proposed amendments to timings were approved.	**HIA**
AAC 8/11/22 008	**Taking Care of the Carers Update** The Assistant Director of OD, Wellbeing and Culture (ADODWC) presented the Taking Care of the Carers Update Paper and highlighted the following: • In October 2021 Audit Wales published the report. It discussed how NHS bodies supported staff in the Pandemic. • 6 recommendations were made on how to continue to support staff wellbeing in the Pandemic. <u>Progress update on actions</u> • The Audit Wales tracker had outlined the work undertaken and any future work to be completed. • Lots of work had been undertaken since February. • Staff room refurbishments had been completed which included 26 rooms across UHL, UHW and community sites.	

	• The Health Board was part of the All Wales Staff Welfare Group. • Enhanced bespoke and targeted training was being provided. • Wellbeing retreats had started. • There was network development including the LGBT group and One Voice. • The cost of living was high on the agenda and there were lots of concerns. There have been several roadshows across sites to signpost staff. • There was a need to ensure that actions aligned with the People and Culture Plan and the Shaping our Future Wellbeing Strategy. <u>Next steps</u> • There was ongoing recruitment, retention and wellbeing to help with Winter pressures. • The People and Culture team (the Team) continued to capture and learn from the messages received from staff in order to ensure key themes and recommendations were captured. • The Team was looking at the accessibility of signposting and support. • Peer support had been introduced and embedded. • EHIA development had been improved. • Staff networks were being developed following the Wales Anti -Racist action plan. The Director of Corporate Governance (DCG) commented that the 6 recommendations from the Audit Wales report were on the Health Board Audit Wales tracker. She queried that since some of the recommendations were ongoing and could continue for long periods, could timescales be provided so that the tracker could be updated. The ADODWC would come back to the DCG. Urvisha Perez (UV) commented that it was good to see the progress that had been made against the recommendations and alignment with the Health Board strategies. The UHB VC advised that the Team could reach out to him to look at anything to do with evaluation. The EDPC responded that she would take up the UHB VC offer on evaluations to ensure that staff feel supported. **The Committee resolved that:** a) The progress update to date was noted.	**ADODWC**
AAC 8/11/22 009	**Audit Wales Update to include:**	

	UP presented the Audit Wales Update and highlighted the following: <u>Financial audit update</u> – Exhibit 1 summarised the status of current and upcoming financial audit work. – The Audit of the Health Board's 2021-22 Charitable Financial Statements would be started around late November, pending receipt of the draft Financial Statements. – The Charity Commission's deadline for the certified Financial Statements was 31 January 2023. – Audit Wales also expected to start audit planning the Audit of the Health Board's 2022-23 Performance Report, Accountability Report and Financial Statements in January 2023. <u>Performance audit update</u> – The Review of Estates: Follow-up of Recommendations was complete. The management response was included in the paper. – Exhibit 3 showed the work currently underway. – The NHS Structured Assessment findings would be presented at the Board Development in December and the final results would be presented in February 2023. The field work was underway. – The Audit Wales team was preparing an All Wales summary report and considering preparation of a discrete Annex for each Health Board. – Exhibit 4 showed planned work that had not been started yet. – Exhibit 5 showed NHS related national reports. The Equality Impact Assessment: More than a Tick Box Exercise report had required actions from the Health Board. – That audit report had made several recommendations for Welsh Government to address and one to Public Bodies requiring them to review their approach to Equality Impact Assessments considering the findings within the report and detailed guidance available on the Equality and Human Rights Commission and Practice Hub. **The Committee resolved that:** a) The Audit Wales Update was noted.	**AW**
AAC 8/11/22 010	**Declarations of Interest, Gifts and Hospitality Report** The Head of Risk and Regulation (HRR) presented the Declarations of Interest, Gifts and Hospitality Report and highlighted the following:	

	• The Risk and Regulation Team had worked with Corporate Communications to design and implement a Communication Plan that informed staff members of the following: - The requirement now was to submit a Declaration of Interest once, but, reinforcing the requirement to update if personal circumstances changed. - That Declarations of Interest could now be made on ESR, and signposted to User and Manager guides. - The continuing need to declare Gifts, Hospitality and Sponsorship with specific emphasis being given in the Autumn (for Autumn International Rugby Tickets) and the Christmas/New Year period (for seasonal gifts). In addition to this plan the Risk and Regulation Team and the Health Board's ESR Lead had delivered a 'Declarations of Interest Power Hour' and would continue to deliver further sessions to provide guided examples of how to make use of ESR to declare interests and also to answer queries raised by those in attendance. The DCG commented that the dual process of declaring Declarations of Interest on ESR and paper needed to be stopped. Everything needed to be done on ESR and assurance taken from it. The HRR stated that regular communications would go out to encourage people to declare interests. The EDPC advised that a campaign done periodically throughout the year with Workforce would be useful. **The Committee resolved that:** a) The ongoing work being undertaken within Standards of Behaviour was noted. b) The proposal for a complete move to ESR for the recording of Declarations of Interest, Gifts, Hospitality and Sponsorship was approved.	
AAC 8/11/22 011	**Internal Audit Tracking Report** The HRR presented the Internal Audit Tracking Report and highlighted the following: • Time was taken to refresh the view of the Tracker and focus on aged entries. • As of 25th October 2022, the Tracker recorded 104 recommendations, 17 of which were High Priority, 59 were Medium Priority, and 28 were Low Priority. • Following more direct dialogue with aged High Priority Recommendation Owners, five aged High Priority Recommendations were reported as complete. That had also prompted a review of linked aged	

	recommendations and a further 14 aged (medium and low priority) entries being recorded as complete. The IMI advised that some of the outstanding IT recommendations would take time to implement/eliminate. He added that care should be taken regarding Cyber related recommendations and should be discussed in Private forums as good practice. **The Committee resolved that:** a) The work underway and plans in place to proactively monitor aged High Priority Internal Audit Recommendations in accordance with the revised Workplan timetable for Internal Audit Recommendation Tracker Report, was noted. b) Whether a further Progress Report should be shared by the Director of Digital Health at the February 2023 Committee meeting, was considered.	
AAC 8/11/22 012	**Audit Wales Tracking Report** The HRR presented the Audit Wales Tracking Report and highlighted the following: • A meeting took place with Audit Wales to review aged recommendations on the Tracker and to make sure the Tracker was progressed. • There were 35 current entries which would increase after today. • A revised version of the Health Board's Template Assurance Map had also been prepared and shared with Internal Audit Colleagues for comment. The revised map had been designed so that it specifically mapped Assurance Levels in relation to risks that were reported within the Corporate Risk Register. • Once agreed with Internal Audit, the revised Assurance Map would be embedded within the Strategy and shared with the Audit and Assurance Committee Board for Approval. **The Committee resolved that:** a) Assurance from the ongoing work which continued in relation to the completion of Audit Wales recommendations was received and noted.	
AAC 8/11/22 013	**Assurance Mapping Phase 2** The HRR presented the Assurance Mapping Phase 2 Paper and highlighted the following: • The Assurance Strategy was approved by Board. • Due to Winter pressures and the Pandemic it had not progressed as hoped.	

	• It was a large task. • Support had been secured from Internal Audit. **The Committee resolved that:** a) The progress made against the Advisory Recommendations made by Internal Audit was noted; b) The proposed action plan detailed at point 3 above was approved; and c) It was agreed that a further Assurance Strategy update, to include an updated Assurance Strategy and Risk Management and Board Assurance Framework Strategy for approval, be shared at the February 2023 Audit and Assurance Committee Meeting.	**DCG/HRR**
AAC 8/11/22 014	**Regulatory Compliance Tracking Report** The HRR presented the Regulatory Compliance Tracking Report and highlighted the following: • 7 reports had been added to the Tracker. • The HRR met with colleagues regularly to ensure progress was being made. • A further update would be shared at the Audit meeting in February. **The Committee resolved that:** a) The updates shared and the continuing development and review of the Legislative and Regulatory Compliance Tracker were noted.	
AAC 8/11/22 015	**Procurement Compliance Report** The EDF presented the Procurement Compliance Report and highlighted the following: • Non-compliant breaches were starting to improve this year, following the work undertaken by the Head of Procurement to ensure that all procurement and non-pay went through Procurement Services. • Single tender actions were increasing and that would need to be kept under review. • A move to “whole life” procurement for securing pieces of equipment should help to reduce single tender actions. • That would take more time to complete. **The Committee resolved that:** a) The contents of the Report were noted, approved and agreed.	

AAC 8/11/22 016	**Counter Fraud Progress Report** The Lead Local Counter Fraud Specialist (LLCFS) presented the Counter Fraud Progress Report and highlighted the following: • Staffing was still below the desired numbers. There had been a successful recruitment campaign and interviews would be taking place this Thursday. • The annual plan was on track. • There had been few Fraud Prevention notices issued in the reporting period. • The Counter Fraud team continued to carry out awareness sessions. Three had been carried out since the last reporting period. Thought was being given to conducting lunch time sessions or pre-recorded sessions. • It was "Fraud Week" next week. The Counter Fraud team would be going out and holding pop up stores. • There was a breakdown in Appendix 1 of investigations that were currently open. • A meeting was held with the Counter Fraud compliance team in October to discuss Fraud risk management compliance. • That would be going ahead on an All Wales basis. • At the moment, they would be moving with a local Fraud register. **The Committee resolved that:** a) The content of the report was noted.	
AAC 8/11/22 017	**Net Zero Carbon Report** The Programme Director Redevelop (PDR) presented the Net Zero Carbon Report and highlighted the following: • This was created, in light of the Audit Wales report (Public Sector Readiness for Net Zero Carbon by 2030) published in January 2022. • Audit Wales have "5 calls for actions" around decarbonisation to meet the Welsh Government's (WG) ambition of a net zero Public Sector by 2030. • NHS Wales had targets – a 16% reduction by 2025 and a 24% reduction by 2030. • In 2021/22 Cardiff and Vale's emission was 202,000. • Governance structures were now in place, with the first meeting to be held this month. • There would be funding from WG to fund nurses and therapists to provide leadership on the decarbonisation agenda. • Colleagues were also working with the Medical School and embedding it into curriculum. • The diagram showed that 81% of carbon emissions came from supply chains and 18% from buildings.	

	• Currently the Health Board did not have line of sight to the 16% target by 2025. • The way supply chain data was reported was flawed. What decarbonisation meant to the Workforce needed to be defined. <u>Next actions</u> • The Shaping our Future Wellbeing Strategy refresh needed to have a strong commitment to mitigation. • Decision making across the Health Board could include carbon as a consideration. • More healthy travel initiatives should be considered. • Grant funding to address energy efficiency might be available. The EDF stated that an action plan was required. The PDR responded that the action plan should set out the Health Board's direction and where the carbon reductions could come from. The EDF responded that supply chain was a big part of the carbon reduction agenda and should be targeted to make a difference. The EMD stated that a Clinical lead had been appointed for 6 months. Clinical leadership was essential to drive the decarbonisation agenda forward. It would be good for other areas to identify their decarbonisation leads. The PDR advised that the agenda would go to the Strategy and Delivery Committee and then to Board in November. **The Committee resolved that:** a) The action CVUHB have taken regarding decarbonisation set against the calls for action so far, was noted; b) A new decarbonisation action plan was in the early stages of development which would form part of the next IMTP, was noted; and c) That there was no line of sight to the 2025 target of a 16% reduction in carbon emissions and that radical action was needed, was noted.	
AAC 8/11/22 018	**Review of Draft Charitable Funds Annual Report and Accounts** The Assistant Director of Finance (ADOF) presented the Review of Draft Charitable Funds Annual Report and Accounts and highlighted the following: • The Draft Annual Accounts were provided to the Charitable Funds and Audit and Assurance Committees for endorsement on an annual basis.	

	• The draft accounts cover the activities of the Health Charity for the period 1st April 2021 - 31st March 2022. As the Draft Annual Accounts were still being audited by Audit Wales, they were subject to change. • The Final Audited Accounts, ISA260 report and Letter of Representation would be taken to the Board of Trustee at its January 2023 meeting for formal approval. • The Audit and Assurance Committee was asked to receive and consider for endorsement the Health Charity Draft Accounts 2021/22 and the draft response provided to the audit enquiries to those charged with governance and management. • Assurance could be provided on the accuracy of the Draft Annual Accounts and associated documents by: - The response given to the audit enquiries to those charged with governance and management which had been endorsed by the Chair, Chief Executive, Chair of the Charitable Funds Committee, Chair of the Audit and Assurance Committee, Director of Corporate Governance and Director of Finance. - On completion of the audit of the Financial Statements, further assurance would be given on the annual accounts by the work that would be completed by Audit Wales in determining whether the Health Charity's Annual Report and Accounts give a true and fair view. • The Draft Annual Accounts of the Charity had been prepared in accordance with recommended practice and would be subject for external review by Audit Wales. Should any misstatements or errors be identified during the course of the audit those would be noted in the ISA 260 audit report. The key points to note were: – Donations and legacies had decreased by £0.5m in 2021/22 to £1.3m. The Health Charity had received higher donations in 2020/21 as a result of a number of generous donations during the Pandemic. – The Health Charity investments saw growth of £0.5m in 2021/22 which reflected the continuation of post Covid gains. – The value of the Health Charity had reduced slightly by £0.1m in 2021/22 to £9.0m. **The Committee resolved that:** a) The Draft Annual Accounts were reviewed. b) The reported financial performance contained within the Draft Annual Accounts was noted. c) The response of the audit enquiries to management and those charged with governance, was noted. d) Subject to any further amendments, the Draft Annual Accounts was supported and endorsed.	

AAC 8/11/22 019	**Annual Clinical Audit Plan Review** The Assistant Director of Quality Safety (ADQS) presented the Annual Clinical Audit Plan Review and highlighted the following: • In October 2021 the Health Board Clinical Audit processes were subject to an internal audit and were awarded limited assurance. • The audit had identified that: – there was adequate overall leadership of Clinical audit within the Health Board. However as a result of under resourcing of the Clinical Audit team, audit training was not being delivered to the Health Board. The Health Board was missing key documents to direct, mandate and ensure constancy of clinical audit approach. – The Clinical Audit team and the Clinical Boards were not provided with the adequate tools to effectively enable them to monitor clinical audit outcomes and the improvements taken. • Significant progress had been made. The Health Board had procured AMaT, a clinical audit quality management tool, in May 2022. That digital platform would support a systematic approach to audit proposal and approval, oversight and reporting of results and the development and monitoring of associated improvement plans. • The Clinical Audit Team was delivering AMaT training to Clinical Boards to support the use of the system. It was anticipated that all Clinical Boards would have been trained by December 2022 and would be using the system to register their local audits. • A Clinical Audit Policy and strategy had been developed to define the rationale for clinical audits and to provide a framework to support a prudent clinical audit programme designed to provide assurance to drive improvement around quality and safety priorities. **The Committee resolved that:** a) The assurance provided by the progress made against the Internal Audit recommendations, was noted.	
AAC 8/11/22 020	**UHB Policies and Procedures Review** The Head of Corporate Governance (HCB) presented the UHB Policies and Procedures Review Paper and highlighted the following:	

	• It was a large piece of work and there were several strands that were being progressed in parallel. • The plan set out a number of actions that had been completed, partially completed or needed to be commenced. • The policies on the Health Board's website and Share Point were not all accurate. • The Corporate Governance team was working with the Executive Leads to prioritise the policies that were not up to date and/or obsolete. The Committee Chair queried if this matter was listed on the Corporate Risk Register. The HCB said she would check and report back to the next Committee. **The Committee resolved that:** a) The action taken to date to address the audit recommendations as set out in this report, together with the proposed actions and timescales set out in Appendix 1 were noted.	**HRR**
	Items for Approval / Ratification	
AAC 8/11/22 019	**Internal Audit reports for information:** i. Follow-up: 5 Steps to Safer Surgery Final Report – Substantial Assurance ii. Medical & Dental Staff Bank Final Report – Substantial Assurance iii. Staff Wellbeing: Culture & Values Final Report – Reasonable Assurance iv. Implementation of National IT Systems (WNCR) Final Report - Reasonable Assurance v. Digital Strategy Final Report – Reasonable Assurance vi. Medical Equipment & Devices Final Report – Reasonable Assurance vii. UHL Endoscopy Expansion Final Report – Reasonable Assurance	
AAC 8/11/22 20	**Agenda for Private Audit and Assurance Committee** i. Private Audit Minutes – 6 September 2022 ii. Counter Fraud Progress Update iii. Workforce and Organisational Development Compliance Report iv. Overpayment of Health Board Salaries – Verbal v. Self-assessment of Internal Audit and Audit Wales	
AAC 8/11/22 021	**Any Other Business** No Other Business was discussed.	
	Review and Final Closure	
AAC 8/11/22 022	**Items to be deferred to Board / Committee** No items were deferred to Board / Committees.	

	Date and time of next committee meeting Tuesday 7 February 2023 at 9am via MS Teams	

Confirmed Minutes of the Public Digital & Health Intelligence Committee Meeting
Held On 4 October 2022 at 9 am
Via MS Teams

Chair:		
David Edwards	DE	Independent Member - Digital
Present:		
Gary Baxter	GB	Independent Member - University
Michael Imperato	MI	Independent Member - Legal
Sara Moseley	SM	Independent Member – Third Sector
In Attendance:		
Suzanne Rankin	SR	Chief Executive Officer
Nicola Foreman	NF	Director of Corporate Governance
Angela Parratt	AP	Director of Digital Transformation
David Thomas	DT	Director of Digital & Health Intelligence
Daniel Jones	DJ	Information Governance Manager
James Webb	JW	Information Governance Manager
Bryn Harries	BH	IT Project Manager
Russel Kent	RK	Head of Digital Operations
Observers:		
Timothy Davies	TD	Head of Corporate Business
Marcia Donovan	MD	Head of Corporate Governance
Secretariat		
Sarah Mohamed	SM	Corporate Governance Officer
Apologies:		
Hywel Pullen	HP	Assistant Director of Finance
Mark Wardle	MW	Consultant Neurologist

Item No	Agenda Item	Action
DHIC 04/10/001	**Welcome & Introduction** The Committee Chair (CC) welcomed everyone to the public meeting and confirmed the meeting was quorate.	
DHIC 04/10/002	**Apologies for Absence** Apologies for absences were noted. **The Committee resolved that:** a) The apologies were noted.	
DHIC 04/10/003	**Declarations of Interest** **The Committee resolved that:** a) No Declaration of Interest were noted.	

DHIC 04/10/004	**Minutes of the Meeting Held 7 June 2022** **The Committee Resolved that:** a) The Minutes of the Meeting held on the 7 June 2022 were confirmed as a true and accurate record.	
DHIC 04/10/005	**Action Log – Following the Meeting held on 7 June 2022** The Action Log was received. **The Committee Resolved that:** a) The Action Log was discussed and noted.	
DHIC 04/10/006	**Chair's Action taken since the Committee Meeting held on 7 June 2022** **The Committee Resolved that:** a) There were no Chair's Action.	
	Items for Review and Assurance	
DHIC 04/10/007	**Digital Transformation Progress Report** The Director of Digital Transformation (DDT) presented the Report and highlighted the following: • It included a list of projects that were reported against in the IMTP. • At the last DHIC meeting in June, there was a discussion about the draft Roadmap. • The report had been made a lot more explicit this time. • Projects in train included this year's Roadmap items as reported in Appendix 1. • There was good progress with PROMS. Four services were live. The Digital PROMS team was in discussion regarding the next 10 services. That team had been fully funded. Integration started in Q1 and it was planned to be completed in Q3. • It was noted that the Power BI project was "off track" at the moment due to a lack of resourcing which had prevented it from being up and running. • Recruitment was ongoing. However, there was competition with many others for similar resources.	

	The Independent Member – University (IMU) commented that the update was helpful and the format was easy to read. The IMU queried if there was a better way to track the progress of projects. The DDT responded that she would prepare a presentation which included previous trends of projects. The Independent Member – Third Sector (IMTS) commented that it was good to see that progress was being made in many projects. The IMTS queried whether any of the projects that were going "off track" were critical. The DDT responded that everything on the Roadmap was important and was on the Roadmap for a reason. For example, Power BI was important because it put capability into the hands of colleagues and allowed them to serve up their own data. The DDT added that WIFI was hugely critical for many items referenced in the Roadmap, such as Welsh nursing care records to enable nursing staff to move away from paper. The interoperability was also critical to progress digital maturity. The Director of Corporate Governance (DCG) noted that based upon the priorities that the DDT had raised, a number of those were "off track" due to resources. The DCG queried whether the lack of resources was covered in the business case in the Private session, and, if so, did the business case resolve the lack of resource. The Director of Digital & Health Intelligence (DDHI) responded that there was a combination of matters in relation to resources. There were some unfunded business cases and longstanding issues around investment. The Independent Member – Digital (IMD) commented that whilst it was good to see so many projects "on track", where there were underlying issues with other projects those should be brought to the attention of the Board. **The Committee Resolved that:** a) The Digital Transformation Progress Report was noted.	**DDT** **IMD/DCG**

DHIC 04/10/008	**Digital Strategy - Update on Roadmap and Associated Funding** The Director of Digital Transformation (DDT) presented the Report and highlighted the following: • The report explained where the Health Board was at in terms of digital maturity. • At the DHIC meeting in June 2022, there was a discussion about 3 key pieces of work. That included the following: - A new relationship with the organisation, building on the Digital Strategy core principle of co-production. - An enterprise architecture that would give the Health Board a blueprint for the changes and modernisation needed in the technology stack, including infrastructure, applications and data to meet the Health Board's needs and aspirations. - EPR business case. • The Roadmap had been separated into strategic and tactical items. • The EPR could not be progressed at the moment in the desired way. There was still activity ongoing that contributed to the EPR business case. • It was noted that Digital Directors (all Wales) have made a commitment that all Health Boards would undertake a HIMMS EMRAM assessment on digital maturity in the next few months. <u>2022/23 roadmap</u> • Several items had been completed. • In terms of EPR, the solution architecture had been completed. Enterprise architecture would be next. • PROMS had been noted as a strategic item because it was part of value-based healthcare. **The Committee Resolved that:** a) The paper and presentation and recommendations for improvement were discussed and noted.	
DHIC 04/10/009	**IG Data & Compliance (SIs, Data Protection, GDPR, FOI, SARs, Staffing & Mandatory Training)**	

	The Head of Information Governance and Cyber Security (HIGCS) presented the Report and highlighted the following: • The Information Governance (IG) department continued to operate at stable but limited resources. • There were 5 whole time equivalents which was low for an organisation of this size. That continued to be addressed. • The IG team continued to review a large number of Health Board data incidents via the Datix system. • There had been a total of 257 information governance related incidents. 4 data breaches had met the threshold to be reported to the Information Commissioner's Office (ICO). Details of those breaches would be outlined in the Private section of the Committee meeting. • The average number of FOIs received during the last 12 months remained at 48 requests per month and an average compliance of 86%. That did not represent much of a change and was over the expectations for compliance. • As requested, since the last Committee meeting, the IG team had analysed the requests received. Out of the 53 requests received during July 2022, 22 (42%) were submitted by members of the public, 22 (42%) were submitted by the private sector (including solicitors), 7 (13%) by political parties and the remaining two requests (4%) by a journalist and a charity. • Compliance for requests made for medical records had dropped beneath the 50% mark during the last three months. That was being addressed urgently by the digital front door. That would allow the Health Board to streamline requests and to understand where delays existed. A lot of the requests were currently paper based and could not be monitored properly. • It was noted that during July 2022, 57% of healthcare record requests came from solicitors on behalf of patients.19% were made directly by the patient and 9% were made by the police. • It was noted that the number of complaints received was low. The backlog was also relatively small. The IML queried how health care record requests could avoid being passed from department to department. The HIGCS responded that the requests received from patients were more direct and specific. However,	

	requests received from solicitors had tended to use a more generic letter to allow any department to respond. The HIGCS added that no single department should be responsible for subject access requests. The new Digital front door that was being developed should make the process smoother. It would also allow crucial identity checks to be performed. Under the GDPR, requests could be made in any way so people could not be forced to use specific means. The IML queried whether communication regarding the Digital front door could go out via the Law Society's Cardiff office. The HIGCS responded that as part of their analysis, the IG team would identify which law firms were making the most requests. The success of that would come down to communication. The DCG queried the data breaches to the ICO. The DCG stated that only four breaches were reported for the whole of last year and there were now four reported in just one quarter of reporting. The HIGCS responded that he would go into more detail in the Private session. However, it was linked to the NIAS monitoring. There had been an increase in breaches which were considered reportable to the ICO. The Chief Executive Officer (CEO) queried those breaches where there had been inappropriate access to records by staff. The CEO queried whether the actions, such as communication and letters issued to staff, had improved the position. The HIGCS responded that it was a much better position and he would discuss this in the Private session. The DDT stated that part of the challenge was that information was being held in lots of different places. The IMTS stated that 57% of FOI requests were being made by solicitors. Law firms were commercial organisations and the process was free. The IMTS queried whether the scope could be tightened up and made narrower together with other Health Boards. The HIGCS responded that requests could be received by any means and the Health Board could not charge for it. The GDPR meant that requests could not be narrowed down. **The Committee Resolved that:**	

	a) A series of updates relating to significant Information Governance issues was received and noted.	
DHIC 04/10/010	**Review on processes and systems for Data, Information Management Report** The DDHI presented the Report and highlighted the following: • This was part of the plan to move away from too much paper and towards more visual digital presentations of the work being done. • The local data repository was being used for Looked After Children assessments and to share information between the Health Board and local authorities. • A digital care region had been established. • It was noted that the Health Board did apply for digital priority investment money from WG to move this at pace but the application was not successful. • Another WG bid would be made in January 2023. • This had also been discussed with DHCW. The Head of Digital Operations (HDO) highlighted the following: <u>Ivanti Service Management Background</u> • The previous HEAT help desk had been replaced because of the end of support for adobe flash player, an old interface and limited functionality. • Instead the Health Board had opted to use an extension of the Ivanti product. • A cloud-based solution had been adopted. • It was modular in design and would give flexibility on multiple devices. <u>Highlights</u> • 7 Digital and Health Intelligence departments had migrated to Ivanti. • Change management had started to be used. • A key benefit was that a new starters NADEX which had previously taken 1-3 days to set up, now took less than 5 minutes. <u>Future / potential enhancements</u> • Customisable reporting functionality via dedicated Ivanti Reporting Server was available.	

	• Asset management had been extended beyond workstations to the Digital operations team. • A service desk mobile application launch was being looked into. • The Digital team was in the adoption phase of the new service desk. A lot of the reports were generic reports which contained many fields that were not being used. • It was noted that there were no fixed SLAs yet. The Digital team was looking to create more meaningful SLAs. • An Ivanti reporting server had been purchased. That allowed for reports to be more customised, using common query designer formats, and would give more flexibility going forward. The IMTS queried what the impact of the service desk was on users' working lives and morale. The HDO responded that they have been trying to collect feedback of the service desk and the practical elements of using a Digital front door. The CEO commented that many teams would not have an idea about what the new Ivanti system could do. It would be useful to put out information on CAV Connects, such as positive user case studies. The HDO advised that the Digital team wanted people to report the problems and make it as easy as possible. The DDHI updated the Committee on the data to knowledge programme. The Health Board was about to start the partnership with Cardiff University to look at the data modelling capacity and capability. The IT Project Manager (IPM) updated the Committee on the MS Office 365 Programme. It was noted that since the last DHIC meeting, the Board and Finance Committee had approved the renewal of the all Wales Microsoft Enterprise Agreement. It was noted that the local and national teams had since coordinated to move all staff across to the new licencing model. The Board had also asked for feedback on the realisation of benefits through the agreement to ensure the organisation was seeing value from the expenditure. In addition, the case for a permanent resource to support Office 365 specifically had been agreed. The six posts outlined would make up a core team supporting the adoption and utilisation of new features and functionality. Those posts were currently in recruitment, and the agency staff who had supported	**HDO**

	adoption for the last 2 years remained in place until the recruitment was completed. **The Committee Resolved that:** a) Progress against the workplan and the areas of exception which required further attention and consideration were noted.	
DHIC 04/10/011	**Information Governance Training, Communications and Engagement Plans Presentation** The DDHI highlighted the following to the Committee: • Information governance training was one of 13 training modules that staff were required to complete. It could be completed annually or on a 3-year cycle. • There was a struggle to reach the higher levels of compliance. • There was discussion about whether some modules could be prioritised over others. • The compliance rate across the Health Board was 66%. • There was a challenge on how to increase the information governance compliance rate. • The main challenge created by this was that as soon as a breach was reported to the ICO, the ICO would query what was the compliance rate. The HDO advised that a new SharePoint had been created to replace the aging intranet and to make it more readily accessible for staff. It allowed for videos to be imbedded into it. The DDHI stated that they would work with Comms to target low information governance levels. The IMU queried whether the mandatory training was a one size fits all training package or could it be adapted to different working groups within the organisation. The DDHI responded that it was a one size fits all and that could cause part of the problem. The modules were available on ESR. There were other ways to conduct the training which could be looked at. **The Committee Resolved that:** a) Progress against the workplan and the areas of exception which required further attention and consideration was noted.	

DHIC 04/10/012	**Framework Policies, Procedures & Controls** The DDHI presented the Framework Policies, Procedures & Controls Paper. It was noted that the Information Governance and Cyber Security Department had identified two specific SOPs that were not included. Those had now been prioritised over the updating of existing long-standing policy documents. Those SOPs included Cyber Incident Response and Patch and Vulnerability Management. It was noted that the DDHI had been notified of 28 policies that were out of date. The Digital team was currently working through those and they would be reflected in the next report. **The Committee Resolved that:** a) Progress was noted and the verbal update at the Committee meeting was noted and received.	**DDHI**
DHIC 04/10/013	**Joint IMT & IG Corporate Risk Register** The DDHI presented the Joint IMT and IG Corporate Risk Register Paper. It was noted that there was one risk at “red” which related to Cyber Security. Most of the risks on the Register had stayed the same. There were two to be removed from the Risk Register. Two risks that were a “yellow” status had been reduced to zero. The DDHI proposed to remove these from the Risk Register because there had been mitigations. **The Committee Resolved that:** a) Progress and updates to the Risk Register report were noted.	
DHIC 04/10/014	**Clinical Coding Performance Data** The DDHI presented the Clinical Coding Performance Data Paper. The DDHI would speak with the CEO and Executive Medical Director about where clinical coding should sit within the Board’s Committees. It would be more suitable to sit within the QSE Committee.	**DDHI/DCG**

	The HIGCS stated the clinical coding performance levels were above WG requirements but had remained low. The IMU stated that DHCW was due to audit clinical coding that month and asked whether it would place extra stress on an already understaffed team. The HIGCS responded that it would. However, clinical coding was only useful when it was complete and accurate. **The Committee Resolved that:** a) The performance of the UHB's Clinical Coding Department was noted.	
DHIC 04/10/015	**Policies** No policies were presented to the Committee for approval.	
DHIC 04/10/016	**Minutes: Digital Directors Peer Group** **The Committee Resolved that:** a) The Minutes of the Digital Directors Peer Group of the meetings held on 7th March 2022 and 4th April 2022 were received and noted.	
DHIC 04/10/0017	**Agenda for Private Digital & Health Intelligence Meeting** *i. Minutes from the Private DHIC Meeting held in June 2022* *ii. Digital Strategy Case for Investment Update* *iii. Caldicott Report* *iv. Cyber Update*	
DHIC 04/10/018	**Any Other Business** No Other Business was discussed.	
DHIC 04/10/019	**Items to bring to the attention of the Board / Committee** No Items were brought to the attention of the Board / Committee.	
	Date & Time of next Meeting: 14 February 2023 via MS Teams	

Confirmed Minutes of the Health & Safety Committee
Held On 18th October 2022 at 09:00 am
Via MS Teams

Chair:		
Mike Jones	MJ	Independent Member – Trade Union / Committee Chair
Present:		
Ceri Phillips	CP	UHB Vice Chair
Michael Imperato	MI	Independent Member – Legal
Akmal Hanuk	AH	Independent Member – Local Community
In attendance:		
Rachel Gidman	RG	Executive Director of People & Culture
Fiona Kinghorn	FK	Executive Director of Public Health
Robert Warren	RW	Head of Health and Safety
Janice Aspinall	JA	Safety Representative RCN
Rachael Daniel	RD	Assistant Head of Health and Safety
Jonathan Strachan-Taylor	JS	Safety Representative GMB
Geoff Walsh	GW	Director of Estates, Capital and Facilities
Marcia Donovan	MD	Head of Corporate Governance
Secretariat		
Sarah Mohamed	SM	Corporate Governance Officer
Apologies:		
Charles Janczewski	CJ	UHB Chair
Catherine Phillips	CP	Executive Director of Finance
Fiona Jenkins	FJ	Executive Director of Therapies
Nicola Foreman	NF	Director of Corporate Governance
Rachel Sykes	RS	Assistant Head of Health and Safety

Item No	Agenda Item	Action
HS 18/10/001	**Welcome & Introduction** The Committee Chair (CC) welcomed everyone to the meeting.	
HS 18/10/002	**Apologies for Absence** Apologies for absence were noted.	
HS 18/10/003	**Declarations of Interest** No Declarations of Interest were noted.	
HS 18/10/004	**Minutes of the Meeting Held on 19 July 2022**	

	The Minutes of the Committee Meeting held on 19 July 2022 were received. **The Health & Safety Committee resolved that:** a) The minutes of the meeting held on 19 July 2022 were approved as a true and accurate record.	
HS 18/10/005	**Action Log – Following Meeting Held on 19 July 2022** The Action Log was received. HS 19/07/007 - The Executive Director of People & Culture (EDPC) confirmed that she would speak with the Chief Executive (CEO) about including the increase in smoking and fire incidents in the Staff bulletin/newsletter. HS 19/07/014 - The Head of Corporate Governance (HCG) advised that she had looked back at the results of the Committee self-effectiveness survey. There was only one item that was flagged as inadequate. That was in relation to agenda setting and feedback had been provided to the Committee at that time. The HCG added that the comments in the survey results were also not picked up by Survey Monkey. It was likely that another tool would be used for all of the Board Committees self-effectiveness surveys next year and that this was being looked into. The HCG would update the Committee in due course. **The Health & Safety Committee resolved that:** a) The Action Log was noted.	EDPC HCG
HS 18/10/006	**Chair's Action taken since last meeting** No Chair's Actions were noted.	
	Items for Review and Assurance	
HS 18/10/007	**Health & Safety Overview (Verbal)** The Head of Health & Safety (HHS) presented the Health and Safety (H&S) Overview and highlighted the following: <u>Manual handling</u> • There had been a lot of good work carried out behind the scenes.	

	• The Health and Safety team was working with various Directorates and external manufacturers to trial equipment used for management and rehabilitation of bariatric Patients. • His team was also looking for a supplier for proning patients. • A lot of the work had been carried out in a collaborative way with Clinical staff. • Further sessions were planned for wider Clinical staff, including Nursing staff <u>Lone worker</u> • A new contract had been negotiated and signed. <u>Training</u> • A training needs assessment was being conducted for Manual Handling and Violence and Aggression for roles across the Health Board. • Staff who had not completed that training yet had been identified. • The training team had completed an external verification on their competence to deliver Violence and Aggression training. That followed on from Manual Handling which was completed in June. <u>UHB Classroom Training Compliance</u> • The figures were low at 16.57 % in October 2021. In September 2022 it had increased to 46.3%. It was still in the red category but had slightly increased. <u>Health and Safety Culture Plan Update</u> • His team was progressing the Health and Safety Culture Plan. By the next meeting the team should have a few more themes closed out. • The actions were quite considerable and required a lot of work and detail. The EDPC advised the Committee that there was a lot of “noise” regarding the demand for Manual Handling and Aggression training because staff would not be able get a pay progression unless they had gone through the	

	mandatory training. The EPDC was working through this with the educational team. The Independent Member – Local Community (IMLC) queried if there were any good practices that could be adopted to increase training. The HHS responded that training people who did not need to be trained was one area that was being considered. The Director of Estates, Capital and Facilities (DECF) commented that that there was constant positive reminder that staff were not going through paygrades and increments unless they had completed mandatory training. One issue regarded managers finding time to release staff to undertake the mandatory training. The EDPC stated that it was about reinforcing safety of the staff. It had also been noted, from looking at individual staff records, that many people were duplicating training by attending face to face and online training. More should be done to streamline the training on ESR. <u>Gas Cylinder Incident</u> • There were difficulties in tracing the original users of the cylinder. • The investigation turned to Oracle. It was seen that three purchases had been made. • An assumption was made, on the balance of probability, that the single use purchaser did not know the correct disposal route. • Further investigation found that the department did have the correct disposal processes in place. However the cylinder had rolled off the storage shelf and into the bin below it <u>UHB RACI</u> • 1- 22 elements would be rolled out by the Clinical Boards. • It included all types of responsibilities and arrangements. • It would provide unambiguous ownership of responsibilities in relation to health and safety.	

	The EDPC stated that it would be good to show the RACI document to the Senior Leadership Board so that Clinical Boards could take ownership within their domains. The Executive Director of Public Health (EDPH) commented that it made it clear who had responsibility for the different areas. The EDPH queried where the IPC team was included? It was agreed that the HHS would take it away and consider where the IPC team would go. <u>Staff smoking</u> • The Health Board was under significant pressure from South Wales Fire & Rescue Service (SWFRS). • Staff smoking or vaping on the Health Board sites or inside a building was unsafe. • It was a deliberate violation and should be treated through the consequence management route. • The Health Board's No Smoking Policy which, was underpinned by Welsh Government law, needed to be enforced. • Communication needed to be circulated stating that the Health Board was taking a zero-tolerance approach in relation to any staff found to be smoking on the Health Board's premises. The Independent Member – Trade Union (IMTU) stated that he was worried about the 96 unnecessary fire service calls and that something should be done about enforcing the No Smoking Policy urgently. The EDPC stated that there were pockets of areas where staff were smoking. There should be stronger communication. The EDPH stated that there should be a zero-tolerance policy to smoking. The Health Board had the most progressive policies in Wales. When there was a regular Enforcement Officer at the site, data could be collected. The EDPH added that she was a strong advocate of enforcement. Communications on the issue to Staff had been tried for a long time.	HHS/EDPC

	The Independent Member – Legal (IML) advised that it would be useful to talk about corporate manslaughter. The IMTU requested that the topic of corporate manslaughter should be put on the next Committee's agenda. The EDPH advised that it would be useful to take the smoking item to Management Executive and the Senior Leadership Board (SLB) to emphasise the seriousness of the situation. The EDPH stated that the HHS was due to attend the Senior Leadership Board on 3rd November and that this matter could be raised then. The UHB Vice-Chair queried whether communication reached locums and staff. It might not reach agency staff who work nights. He added that smoking on site also had major cost implications and that point should also be made to SLB. The IMLA queried whether more security cameras could be placed at sites. The DCEF responded that there were many security cameras on site but smokers were likely to find another place on site to smoke. The IMTU advised that he would like to meet with the EDPC, EDPH, and HHS as soon as possible to consider this issue further and to discuss the next steps. The EDPH advised that there needed to be a pan organisation approach and that the matter should be tied in with the Health and Safety Culture Plan. **The Health & Safety Committee resolved that:** a) The Health and Safety Overview was noted.	DCG/IML DCG/HHS DCG
HS 18/10/008	**Fire Safety and Enforcement Report**	

	The HHS presented the Fire Safety and Enforcement Report and highlighted the following: • Mal Perrett, the UHB Senior Fire Safety Advisor, had sadly passed away. • The HHS was currently advertising for two Fire Safety Advisors, one of these was for the Senior Fire Safety Advisor role. • That would increase the team by one. • His team had secured the services of the retired Fire Safety Advisor from Aneurin Bevan University Health Board (ABUHB) for 3 days a week for 3 months. • Fire Safety Week was taking place between 17th October and 21st October. • There was a meeting with the Assistant Chief Fire Officer today to discuss the Letter under Caution. <u>Fire Enforcement</u> • The A4 North handover meeting was the next day. • A4 South would then be removed from operation. <u>Whitchurch Hospital Water Main</u> • There had been two fire events. Firstly, there was a fire in Llanrumney which was extinguished by the Fire Service team. • Another fire was started by a Mental Health Patient in the Emergency Unit toilets. <u>HYC Smoking Incident</u> • A fire alarm was sounded in Hafan Y Coed. A Patient was found smoking in their room. • Despite a detailed search, an ignition source was not found. It was likely that the cigarette was lit in the garden using the Ozzy lighters and brought into the building. • The SWFRS was called and following an onsite meeting, reassurance was provided and no further enforcement notices were issued. The event was recorded as a case note on the Health Board file. <u>Unwanted fire signals</u>	

	• There had been a total of 196 unwanted fire signals to date. • SWFRS have attended the Health Board site 158 times. • This represented a 30% increase in the last 3 months. • Those were largely avoidable events attributed to behaviours. <u>Permit to work</u> • All relevant permit documentation was in place for the work being conducted. • The current hot work permit was generally very good. Suggestions were made to improve hazard identification and documentation governance. • The Director of Estates, Capital and Facilities (DCEF) will specifically review the feedback loop from the work party to the person responsible for removing relevant isolations. • This was likely to involve a phone call and signature. **The Health & Safety Committee resolved that:** a) The report was noted.	
HS 18/10/009	**Environmental Health Food Hygiene Report** The Environmental Health Food Hygiene Report was received. The DECF advised the Committee that the following units were recently inspected: - Hafan Y Coed Unit at University Hospital Llandough (June 2022); - the Teddy Bear Nursery at the University Hospital of Wales (July 2022); - University Hospital Llandough main kitchen, wards and restaurant (September 2022) and - Aroma Unit, University Hospital Llandough (September 2022). All of those units had received a food hygiene score of 5.	

	The EDPH congratulated the team on their focus and leadership in gaining that score. **The Health & Safety Committee resolved that:** a) The achievement of those food businesses with a food hygiene rating of 5 and the associated action plans, were noted.	
HS 18/10/010	**Regulatory and Review Body Tracking Report** The Regulatory and Review Body Tracking Report was received. The Assistant Head of Health and Safety (AHHS) stated that the Report was received by the Committee twice a year. The Report tracked that relevant Board Committees were receiving reports and information regarding inspections undertaken by the various inspection/review bodies as a key source of assurance. Although the Report looked at inspections for the new financial year, it also included those from previous financial years so they did not lose track of them. The AHHS advised that she would add EHO to the tracking report too. **The Health & Safety Committee resolved that:** a) The content of the report was noted.	AHHS
HS 18/10/011	**Risk Register for Health and Safety** The Risk Register for Health and Safety was received. The HHS updated the Committee that the highest current risk ratings were 16, of which two were covered by the Health and Safety Culture Plan. Discussions were currently taking place to determine ownership of the third risk which related to the management of bariatric Patients. The HHS had proposed that this last point be taken	

	forward with an All Wales approach. **The Health & Safety Committee resolved that:** a) The findings of the new identified risks and the actions in place to reduce the risk rating, were noted.	
HS 18/10/012	**Fire Safety Compliance Report** The Fire Safety Compliance Report was received. The IMLA queried whether the Fire Safety training figures had increased. The HHS responded that the Fire Safety training was being held that week. Last year they had trained 3,000 people in under a week. The HHS added that they would not be training the same numbers this year because the venues were not as large enough. **The Health & Safety Committee resolved that:** a) The on-going efforts to meet the requirements of enforcement action and C&V UHB's statutory and mandatory fire safety obligations were considered.	
	Items for Approval/Ratification	
HS 18/10/013	**No items were noted.**	
	Items for Noting and Information	
HS 18/10/014	**Sub Committee Minutes:** i. Operational Health and Safety Group – 06/06/22	
HS 18/10/015	**Any Oher Business** The Safety Representative RCN (SR) informed the Committee that there were housekeeping staff who tidied up Health Board areas in their own time. The SR requested clarification as to whether they were covered under the voluntary aspect of their employment contract.	

	The CC responded that it was very good work by the team and congratulated them. It was his understanding that if their management knew they were doing this, then it was covered under the insurance policy. The EDPH advised that this query should be checked with the EDPC. **The Health & Safety Committee resolved that:** a) Any Other Business was noted.	EDPC
HS 18/10/016	**Items to bring to the attention of the Board/Committee** It was noted that the following should be highlighted to the Board: - Training rates - Unwanted fire signals - RACI document - Staff smoking The HCG advised that she would include these items in the Chairs report. **The Health & Safety Committee resolved that:** a) Items to bring to the attention of the Board/Committee were discussed and noted.	DCG/HCG
	Review of the meeting	
	Date and time of next meeting 17th January 2023 at 09:00am MS Teams	

Confirmed Minutes of the Public Finance Committee Meeting
Held On 14 December 2022 at 2pm
Via MS Teams

Chair:		
Rhian Thomas	RT	Independent Member - Capital and Estates
Present:		
John Union	JU	Independent Member – Finance
In Attendance:		
Charles Janczewski	CJ	UHB Chair
Abigail Harris	AH	Executive Director of Strategic Planning
Catherine Phillips	CP	Executive Director of Finance
Nicola Foreman	NF	Director of Corporate Governance
Robert Mahoney	RM	Deputy Director of Finance (Operational)
Andrew Gough	AG	Deputy Director of Finance (Strategy)
Paul Bostock	PB	Chief Operating Officer
Observers:		
Marcia Donovan	MD	Head of Corporate Governance
Secretariat		
Sarah Mohamed	SM	Corporate Governance Officer
Apologies:		
David Edwards	DE	Independent Member – ICT
Tim Davies	TD	Head of Corporate Business
Jason Roberts	JR	Executive Nurse Director

Item No	Agenda Item	Action
FC 14/12/001	**Welcome & Introduction** The Committee Chair (CC) welcomed everyone to the meeting.	
FC 14/12/002	**Apologies for Absence** **The Finance Committee resolved that:** a) Apologies were noted.	
FC 14/12/003	**Declarations of Interest** **The Finance Committee resolved that:** a) No Declarations of Interest were noted.	
FC 14/12/004	**Minutes of the meeting Held on 16 November 2022** The minutes of the meeting held on 16 November 2022 were received. **The Finance Committee resolved that:**	

	a) The minutes of the meeting held on 16 November 2022 were held as a true and accurate record of the meeting.	
FC 14/12/005	**Action Log following the meeting held on 16 November 2022** The Action Log was received. FC 16/11/007 - The Executive Director of Finance (EDF) stated that the Director of Corporate Governance (DCG) wrote an Accountable Officer's letter for the cash element and the revised deficit. That had been submitted to Welsh Government (WG). **The Finance Committee resolved that:** a) The Action Log was up to date.	
FC 14/12/006	**Chairs Action since previous meeting** There had been no Chair's Actions taken since the last meeting.	
	Items for Review and Assurance	
FC 14/12/007	**Financial Report – Month 8** The Deputy Director of Finance (Operational) (DDFO) presented the Financial Report – Month 8 and highlighted the following: • The Health Board had forecast a £26.9m deficit for 2022-23. • The reasons for that had been included in the Accountable Officer's letter to WG which had requested cash to cover the deficit. <u>Core Financial Plan – Month 8 Cumulative Position</u> • The Health Board had overspent by £18.147m against its core financial plan. Of that overspend, £11.400m was planned as part of the underlying financial deficit, and £6.747m was unplanned, as an overspend in delegated and central positions. • The rate of unplanned overspend increased in month, by £1.192m from the cumulative Month 7 unplanned overspend of £5.455m. • Table 3 provided a summary of the Month 8 position. It was noted that a number of cost pressures had emerged or increased in the year to date that were not foreseen in the original financial plan. Table 4 summarised the year to date	

	position across the Clinical Boards and delegated areas of the Health Board. Those placed the Health Board's ability to remain within the revised plan's forecast £17.1m deficit under severe pressure and had caused the Health Board to reassess the most likely year end out-turn. Those concerns were shared with WG colleagues in the mid-year review meeting with the Financial Delivery Unit on the 10th November 2022 and were discussed through the Health Board's governance structure, including the Finance Committee and Board, during November. The Health Board had now forecast a deficit of £26.9m. The Independent Member – Finance (IMF) queried whether the £26.9m forecast had been agreed by WG. The DDFO responded that WG had not agreed it. In the meetings with WG, it was acknowledged and stated that an Accountable Officer's letter was required. The DDFO added that in yesterday's JET meeting, WG had acknowledged that they had a requirement to reply to the Accountable Officer's letter. The UHB Chair queried the cost pressures that were not in the original financial forecast plan as noted on page 2 of the papers. The UHB Chair queried what had not been foreseen, what had the Health Board learnt from that, and what actions had been taken to address that. The DDFO responded that the table on page 5 explained the cost pressures. The DDFO stated that nurse/staff recruitment was a difficult area to address. The international nurse recruitment costs had been far more than had been anticipated. A lot of the unforeseen cost pressures related to macro-economics, massive inflation caused by the war in Ukraine and changes in the relationship between the UK and other countries. In addition, the Health Board was still dealing with the consequences of Covid. The UHB Chair stated that it would be useful for the Committee to look at the lessons learnt and putting actions into place as the Health Board entered next year. The Chief Operating Officer (COO) added that the amount of additional capacity had not been foreseen and had driven up a lot of the costs. The EDF stated that it had been hoped that investing in Urgent Care would have reduced the bed base, but that has not been the case. She agreed that a "lessons learnt" exercise would be	**DDFO**

	valuable because the Health Board had just gone back to planning after two years of not planning (due to Covid). The EDF added that the Health Board should stop looking at historic budgets and look at the "run rate" instead. The UHB Chair stated it would be a good opportunity to build that into the Board Development session in February. It would be helpful for the Board to look at the forecast for the next financial year in a meaningful light. The Independent Member – Finance (IMF) queried whether the cost of prescribing was a national UK issue. The DDFO responded that the movement in prescribing had reflected the volatility within that area. There had been major supply issues for drugs in the UK and that had caused the pharmacists to source drugs "out of contract" which was more expensive than purchasing the drugs via their standard contracts. <u>Table 4: Financial Performance for the period ended 30th November 2022</u> • The operational deficit of £11.117m against delegated budgets was offset by a £4.370m underspend against central budgets leaving a total operational & Covid overspend of £6.747m before the addition of the cumulative £11.400m planned deficit to leave a total overspend of £18.147m. The UHB Chair queried the increasing Mental Health CHC placements figure. The DDFO responded that the Finance team had hoped it would be a corporate led initiative to reduce Mental Health CHC placements. However, that had not happened yet and was in progress. There had also been a massive increase in demand for Mental Health services. The UHB Chair stated that it was important that the Nurse Director led initiatives to reduce the Mental Health CHC placements. From having spoken to Mental Health colleagues, it was apparent that they are obliged to find placements externally and the cost could be higher than thought. The COO stated there was a meeting planned that week between the relevant Executive Directors and Local Authority colleagues to understand how to arrange and fund the Mental Health CHC placements and the high cost Children's' placements. The END had been involved. There was currently an intensive individual in Hafan Y Coed who was taking a lot of	**DCG**

	capacity from the intensive care unit and that had been forecast into the Medicine Clinical Board's costs. The UHB Chair queried the WHSCC situation. It seemed inequitable to introduce punitive financial measures when the Health Board was the major Tertiary provider and was under pressure. The UHB Chair queried if better arrangements could be negotiated. The DDFO responded that there had been pressure from WG and other Health Boards. The arrangements were as good as the Health Board could achieve by negotiating with others to have a hybrid model. The UHB Chair queried what the Executive performance reviews with Clinical Boards had delivered in additional savings so far. The DDFO responded that each Clinical Board had a programme of long-term actions and short-term actions they could take. The COO stated that they had reinstated more discipline with regards to finance and had created targets that they could deliver against. There was also an understanding of the risks associated with meeting those targets. The UHB Chair stated it would be good to have the remedial actions that are being undertaken quantified for the Committee. The DDFO responded that he could share a list of actions that had contributed to the control totals. The UHB Chair stated that looking at the quantitative data and context in a deep dive would be more useful. The EDF added that there was a list of ideas to start driving next year's savings now and to accelerate them. The UHB Chair queried how confident was the Finance team that the Health Board could deliver the £26.9m deficit or less. The EDF responded that her team was highly confident that they would be able to hit that figure. The CC queried the patient catering in the EU column in the covering report. The mitigation measure stated it would benefit from "throughput initiatives" and queried what that meant. The DDFO responded that it could mean increased activity on site or marketing to staff. It was hoped that as activity picked	**DDFO/COO**

	up, there would be more demand at the Aroma outlets. However, the food inflation had been significant. The CC queried if there were any plans to save money on the security arrangements at the Rockwood and Whitchurch Hospitals. The EDF responded that a report was due to be presented to Board of Trustees in January for discussion concerning those sites. However, it would not resolve the situation in the next 12 months but would provide a way forward. <u>Table 6 – Exceptional Cost forecast for 2022-23</u> • There was the assumption that it would be funded. • Energy prices were starting to reside slightly. <u>Table 7: Summary of Forecast COVID 19 Net Expenditure</u> • WG had acknowledged the assumption of financial support for Covid response costs by Health Boards in the 2022-23 financial year but had been consistent in stating that assumption was carried at risk. • WG had recently indicated to Health Boards that local Covid response funding support would be capped at a maximum of Month 6 reported costs for each Health Board. • Based on the month 8 assessment, that potentially carried a £1.269m financial risk for the Health Board based on forecast out-turn for Covid Response. • That ongoing risk would be mitigated through a review of the risks and opportunities facing the Health Board and sat outside the forecast £26.9m operational deficit for the Health Board. The CC queried whether any regular forums existed which looked at cost reduction ideas. The DDFO responded that it was being monitored carefully to reduce it to £1.269m. <u>Table 9: Risk Register at November 2022</u> At month 8, the Health Board was forecasting £19.343m of savings to deliver against the revised £19.400m savings target which left a further £1.057m schemes to identify. The Health Board expected to finalise the balance of savings plans required to deliver the revised forecast deficit of £26.9m. **The Finance Committee resolved that:**	

	a) The reported year to date overspends of £18.147m and the forecast deficit of £26.900m were noted. b) The financial impact of forecast COVID 19 Response costs which was assessed at £36.822m with assumed Welsh Government funding of £35.553m, was noted. c) The financial impact of forecast COVID 19 National and Specific Programme costs which was assessed at £22.605m with assumed Welsh Government funding of £22.605m were noted. d) The financial impact of forecast Exceptional Inflationary Pressures which was assessed at £20.174m with assumed Welsh Government funding of £20.174m, was noted. e) The forecast deficit of £26.900m, which comprised of the £17.1m planned deficit identified in the Final Financial plan and £9.800m of additional operational pressures recognised by the UHB Board, was noted. f) The 2021/22 brought forward Underlying Deficit of £29.7m and the planned forecast carry forward of £20.0m to 2023/24, was noted.	
FC 14/12/008	**Financial Performance of Clinical Boards** The COO covered the discussion in the earlier part of the meeting and would provide a further update at January's Committee meeting. **The Finance Committee resolved that:** a) The Financial Performance of Clinical Boards was noted.	**COO**
	Items for Information and Noting	
FC 14/12/009	**Financial Monitoring Return – Month 8** The Financial Monitoring Return – Month 8 was received. **The Finance Committee resolved that:** a) The extract from the UHB's Monthly Financial Monitoring Return was noted.	
	Agenda for Private Finance Committee Meeting	
FC 14/12/010	i. Approval of Private Minutes ii. Update on the Financial plan	
FC 14/12/011	**Any Other Business** No Other Business was discussed.	

	Review and Final Closure	
FC 14/12/012	**Items to be referred to Board / Committee** No Items to be referred to Board / Committee.	
	Date & time of next Meeting Wednesday 18th January 2022 at 2:30pm Via MS Teams	

Confirmed Minutes of the Public Finance Committee Meeting
Held On 18th January 2023 at 2:30pm
Via MS Teams

Chair:		
John Union	JU	Independent Member – Finance
Present:		
In Attendance:		
Charles Janczewski	CJ	UHB Chair
Suzanne Rankin	SR	Chief Executive Officer
Abigail Harris	AH	Executive Director of Strategic Planning
Catherine Phillips	CP	Executive Director of Finance
Nicola Foreman	NF	Director of Corporate Governance
Robert Mahoney	RM	Deputy Director of Finance (Operational)
Andrew Gough	AG	Deputy Director of Finance (Strategy)
Paul Bostock	PB	Chief Operating Officer
Jason Roberts	JR	Executive Nurse Director
Observers:		
Marcia Donovan	MD	Head of Corporate Governance
Tim Davies	TD	Head of Corporate Business
James Quance	JQ	Interim Director of Corporate Governance
Secretariat:		
Sarah Mohamed	SM	Corporate Governance Officer
Apologies:		
David Edwards	DE	Independent Member – ICT
Rhian Thomas	RT	Independent Member - Capital and Estates

Item No	Agenda Item	Action
FC 18/01/001	**Welcome & Introduction** The Committee Chair (CC) welcomed everyone to the meeting.	
FC 18/01/002	**Apologies for Absence** It was noted that the Independent Members for ICT and Capital and Estates had given their apologies and therefore the meeting was not quorate. The Committee acknowledged that no formal decisions for approval/ratification were on the Committee's agenda that day. **The Finance Committee resolved that:** a) Apologies were noted.	

FC 18/01/003	**Declarations of Interest** **The Finance Committee resolved that:** a) No Declarations of Interest were noted.	
FC 18/01/004	**Minutes of the meeting Held on 14 December 2022** The minutes of the meeting held on 14 December 2022 were received. The Executive Director of Finance (EDF) stated that a list of actions that contributed to the control totals would be picked up in the deep dive. **The Finance Committee resolved that:** a) The minutes of the meeting held on 14 December 2022 were held as a true and accurate record of the meeting.	
FC 18/01/005	**Action Log following the meeting held on 14 December 2022** The Action Log was received. The EDF stated that FC14/12/007 would be picked up as part of the planning exercise for this year and the feedback from the lessons learnt exercise would be brought back to the Committee in quarter 4. **The Finance Committee resolved that:** a) The Action Log was up to date.	**EDF**
FC 18/01/006	**Chairs Action since previous meeting** There had been no Chair's Actions taken since the last meeting.	
	Items for Review and Assurance	
FC 18/01/007	**Financial Report – Month 9** The Deputy Director of Finance (Operational) (DDFO) presented the Financial Report – Month 9 and highlighted the following: • At month 9 the Health Board was reporting an overspend of £20.491m against the submitted draft plan. • That was comprised of £7.666m of operational overspend and the planned deficit of £12.825m (nine twelfths of the annual planned deficit of £17.1m set out in 2022/23 financial plan). • The Health Board had forecast a £26.9m deficit for 2022-23.	

	• The Health Board had submitted an initial draft financial plan to Welsh Government (WG) at the end of March 2022 and a revised plan on 30 June 2022. • That had resulted in an initial 2022-23 planning deficit of £20.8m. The revised plan submitted in June incorporated additional savings totalling £3.7m, resulting in a revised planning deficit of £17.1m. The DDFO stated that the performance indicators remained in line with what was previously reported. The creditor payments had improved and was closer to the 95% target. <u>Table 3: Financial Performance for the period ended 31st December 2022</u> The operational deficit of £10.468m against delegated budgets was offset by a £2.803m underspend against central budgets leaving a total operational & Covid overspend of £7.666m before the addition of the cumulative £12.825m planned deficit to leave a total overspend of £20.491m. <u>Table 4: Key Cost pressures and risks within delegated positions as at Month 9</u> The DDFO advised that a lot of the cost pressures had arisen. A deeper dive into lessons learnt would be discussed in future meetings. <u>Planned versus current trajectory 2022-23 month 9</u> It was noted that the Health Board was heading along the orange line on the trajectory shown in the covering report. However, actions taken had made an impact on “sloping” the grey line which had resulted in a lower forecast outturn. The CC queried whether there were any risks in relation to the fact that WG had not yet confirmed funding of exceptional costs. The DDFO responded that £14.693m had been spent on those exceptional costs to date. Due to the volatility of the energy prices, some of the forecasting had been increased because it was based on spot pricing. WG was awaiting clarity on the energy costs before confirming the funding in relation to the same. The UHB Chair queried the unfunded medical staffing costs within table 4 of the covering report and requested a clearer line of	**EDF/DDFO**

	assurance on what the Health Board planned to do about it. He also queried how the workforce strategy aligned to the financial plan. The DDFO responded that it was not aligned to the plan yet. However, going forward, as HR and Clinical Boards developed their strategies it would become more accurate. The UHB Chair responded that further clarity would be appreciated. The CEO stated that she did not think that the Health Board had sufficient operational grip on workforce resourcing. She had asked the EDPC and EDF to establish a workforce efficiency Programme Board in order to discuss and draw up a detailed workforce plan, trajectories and deliverables alongside the financial plan. The UHB Chair queried the non-recurrent unforeseen excess costs noted in the papers and stated that it should not be unforeseen and should form part of the workforce strategy. The EDF responded that the excess costs under international nurse recruitment needed some challenge. The issue was that it was expected that they would fall in the last financial year. Due to the operational issues, more beds had been opened and operational services had been managed in a way that had caused cost inflation. Footfall issues along with estates had caused the most variants to the plan. The COO advised that they were still discovering where money was spent and why it was being spent in that way. That had been due to lack of oversight by the Clinical Board teams. As more meetings were being held with the Clinical teams, further details were being obtained. <u>Table 6 - Summary of Year to Date COVID 19 Net Expenditure</u> WG had previously confirmed that the maximum that they would fund was the forecast cost at month 6. It was noted that the Covid costs were fluid and the cap did put pressure on the ability to deliver the forecast. In month 9, it was confirmed that WG would cap funding at the month 8 forecast. <u>Key Financial Assumptions and Risks</u> The working assumption was that since those were WG programmes, they would be funded in full. <u>Funding for exceptional cost pressures which were deemed to be outside of the UHB's direct control.</u>	**EDF/EDPC**

	The forecast cost of exceptional cost pressures would be subject to review as the year progressed, mainly driven by the unpredictable nature of energy costs. <u>Underlying Financial Position</u> The underlying position needed to be updated and an update would be provided in the Private session of the Committee meeting. <u>Cash flow forecast</u> That was a live piece of work and the Finance team was liaising with WG to ensure there was correct cash flow support. WG would be supporting the deficit of £26.9m. <u>Public Sector Payment Compliance</u> The Health Board's public sector payment compliance performance remained below the target of 95%. Performance for the 9 months to th end of December was 94.6%. Whilst that had remained below the target, it represented an improvement of 0.1% in month. **The Finance Committee resolved that:** a) The reported year to date overspend of £20.491m and the forecast deficit of £26.900m was noted. b) The year to date financial impact of forecast COVID 19 costs which was assessed at £43.855m with assumed Welsh Government funding of £43.855m was noted. c) The financial impact of year to date Exceptional Inflationary Pressures which was assessed at £14.693m with assumed Welsh Government funding of £14.693m, was noted. d) The forecast deficit of £26.900m, which comprised of the £17.1m planned deficit identified in the Final Financial plan and £9.800m of additional operational pressures recognised by the UHB Board, was noted. e) The 2021/22 brought forward Underlying Deficit of £29.7m and the planned forecast carry forward of £20.0m to 2023/24, was noted.	
	Items for Information and Noting	
FC 18/01/008	**Financial Monitoring Return – Month 9** The Financial Monitoring Return – Month 9 was received. **The Finance Committee resolved that:**	

	a) The extract from the UHB's Monthly Financial Monitoring Return was noted.	
	Agenda for Private Finance Committee Meeting	
FC 18/01/009	i. Approval of Private Minutes ii. Financial plan 2023/24 Presentation iii. Deep Dive on Financial performance of Clinical Boards	
FC 18/01/010	**Any Other Business** No Other Business was discussed.	
	Review and Final Closure	
FC 18/01/011	**Items to be referred to Board / Committee** No Items to be referred to Board / Committee.	
	Date & time of next Meeting Wednesday 15th February 2023 at 2pm Via MS Teams	

Confirmed Minutes of the Mental Health Legislation and Mental Capacity Act Committee
Held on 25 October 2022 – 10am
Via MS Teams

Chair:		
Ceri Phillips	CP	UHB Vice Chair and Committee Chair
Present		
Akmal Hanuk	AH	Independent Member - Community
Sara Moseley	SM	Independent Member – Third Sector
In Attendance:		
Paul Bostock	PB	Chief Operating Officer
Jeff Champney-Smith	JCS	Chair, Powers of Discharge sub-Committee
Daniel Crossland	DC	Deputy Director of Operations - Mental Health
Nicola Foreman	NF	Director of Corporate Governance
Neil Jones	NJ	Clinical Board Director – Mental Health
Robert Kidd	RK	Interim Clinical Director Psychology & Psychological Therapies
Jason Roberts	JR	Executive Nurse Director
David Seward	DS	Mental Health Act Manager
Rose Whittle	RW	Directorate Manager – Child Health
Observers		
Timothy Davies	TD	Head of Corporate Business
Marcia Donovan	MD	Head of Corporate Governance
Secretariat		
Nathan Saunders	NS	Senior Corporate Governance Officer
Apologies:		
Catherine Wood	CW	Director of Operations – Children & Women

Item No	Agenda Item	Action
MHLMCA 22/10/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everybody to the meeting.	
MHLMCA 22/10/002	**Apologies for Absence** Apologies for Absence were noted	
MHLMCA 22/10/003	**Declarations of Interest** No Declarations of Interest were noted.	
MHLMCA 22/10/004	**Minutes of the Meeting held on 26 July 2022** The Minutes of the Meeting held on 26 July 2022 were received. **The Committee Resolved that:** a) The minutes of the meeting held on 26 July 2022 were agreed as a true and accurate record.	
MHLMCA 22/10/005	**Action Log from the meeting held on 26 July 2022** The Action Log was received and discussed. **The Committee Resolved that:**	

	a) The Action Log was noted.	
MHLMCA 22/10/006	**Chair's Action taken since last meeting** **The Committee Resolved that:** a) No Chair's Actions were taken since the last meeting.	
MHLMCA 22/10/007	**Any Other Urgent Business Agreed with the Chair** **The Committee Resolved that:** a) No other urgent business was agreed with the Chair.	
MHLMCA 22/10/008	**Mental Capacity Act Monitoring Report and DoLS monitoring** The Mental Capacity Act Monitoring Report and DoLS monitoring was received. The Executive Director of Nursing (END) advised the Committee that he would take the paper as read. It was noted that the paper outlined the Independent Mental Capacity Advocacy (IMCA) referrals from April 2021 until June 2022 and July 2022 until September 2022. It was noted that Mental Capacity Training had continued to raise anxieties with poor overall compliance and that it had been discussed by the Strategy & Delivery Committee in relation to the issues with overall mandatory training and compliance. The END advised the Committee that the Health Board had utilised Welsh Government (WG) Liberty Protection Safeguards (LPS) funding to provide training from an external provider (Edge Training) which would educate staff on assessing mental capacity and best interest decision making. It was noted that seven sessions had been provided to date and that it had been well received by staff and that due to the training's apparent success, provision had been made to add 4 additional sessions in the New Year. The END advised the Committee that five Health Board staff would begin the Level 7 MSc module provided by Swansea University, entitled 'Assessing Decision Making Capacity', with representation from Mental Health, PCIC, Medicine and Children and Women's Clinical Boards in January 2023. It was noted that following an internal review within the Medicine Clinical Board in late August 2022, it had been identified that there was considerable variability in the practices surrounding DoLS applications and ongoing management. The END added that a large piece of work had been undertaken to address the concerns and that the Clinical Board had worked hard to raise staff awareness and ensure compliance with the Safeguards was going forward. It was noted that due to the raised awareness, there had been a significant increase in the number of DoLS applications, and that in September the	

	Health Board had received 166 DoLS applications which had increased from 76 in previous months. The Independent Member – Third Sector (IMTS) noted that the training compliance had been identified as 27% for Medical and Dental staff. She asked if the END knew where the biggest gaps were in the staff training and if that had any obvious impact or consequences. The IMTS asked for further clarity on the number of breaches identified within the paper around DoLS applications. The END responded that breaches had occurred due to the significant increase in applications as a result of the work in the Medicine Clinical Board and noted that measures were in place to double the assessment capacity to reduce the current backlog. He added that one of the reasons for breaching was due to the very limited number of people who were unable to undertake the approvals which included: • the END • The Interim Deputy Executive Nurse Director • The Director of Nursing for PCIC It was noted that the above individuals could not approve DoLS applications for their own respective Clinical Board and that had compounded the issue. The IMTS asked if the delay in legislative change was a cause for the issues being seen within DoLS. The END responded that it was and noted that if Liberty Protection Safeguards (LPS) did not progress in 2023 as planned, the Health Board would have to train more approvers to carry it through the period. The Independent Member – Local Community (IMLC) asked how training was delivered and what mechanisms were in place for the training. The END responded that an LPS lead had been appointed and that they were delivering the MCA training as well as an MCA and Consent Lead who had also been recently appointed to offset the training. He added that face to face training was being held with various Clinical areas and that the Level 2 training formed part of the mandatory training on the Electronic Staff Record (ESR). The IMLC asked if any percentages could be shared to assure the Committee with regards to training compliance. The END responded that he would include the data in the next report for the meeting held in January 2023.	**JR**

	The CC noted it would be useful to understand why there was an anomaly with Medicine and Dental compliance in comparison to other areas and asked if there were things that could be done specifically to combat the low compliance level. He added that it could be beneficial for the Strategy & Delivery (S&D) Committee to receive the data for discussion in relation to overall training compliance with the Executive Director of People & Culture leading on the discussion. The END advised the Committee that he could provide assurance from the Clinical Board reviews that had been undertaken with the Executives and noted that there had been an increased focus on staff appraisals and that as a result of increased appraisals there would be an automatic increase in training because it formed part of the appraisal process. The Director of Corporate Governance advised the Committee that she would ensure the S&D Committee would receive the information with relevant data included. **The Committee resolved that**: a) The contents of the report and the current compliance and actions with Mental Capacity Act and Deprivation of Liberty indicators were noted.	**JR** **NF/RG**
MHLMCA 22/10/009	**Liberty Protection Safeguards Monitoring Report** The Liberty Protection Safeguards (LPS) Monitoring Report was received. The END advised the Committee that he would take the report as read. He added that Members would be aware that LPS was supposed to be implemented and in practice by now, but that there were significant challenges across the whole of Wales which had hindered progress at a national level. It was noted that there were 2 areas that the Committee should focus on which included: • An LPS facilitator was now in place and they were currently supporting the Mental Health Act (MCA) training. • The Health Board continued to work with Welsh Government (WG) and Local Authority (LA) colleagues on what LPS would look like. The END advised the Committee that it would be a case of waiting and continuing to move along as best as the Health Board could with the implementation of LPS until advice could be given by WG. He added that the focus on MCA training would be important because once implemented, any health professional would be required to undertake the MCA.	

	The IMTS noted that the digital solution for recording and monitoring purposes was in the scoping phase of the LPS implementation. She asked if the Health Board had the support and resource in place for that, given that other Committees of the Board had identified issues with a lack of digital capacity. The END responded that LPS had predominantly been funded by WG monies and that the Health Board had received £226k to implement LPS across the Organisation. That sum had been used, but due to the delay in LPS being implemented WG had asked for any unspent monies to be returned. It was noted that the Health Board would be returning the underspend of £16,229. The END advised the Committee that it was too difficult to plan until outcomes from the consultation for LPS were received. The Interim Clinical Director Psychology & Psychological Therapies advised the Committee that the first meeting of the LPS Implementation Board had taken place where a discussion had been held regarding how the Health Board would proceed with the paperwork for LPS. It was noted that the development of a bespoke mechanism would require digital solutions. The CC advised the Committee that the paper mentioned the underspend of funding. He queried whether the underspent money could still be used in a more appropriate manner. The END added that when WG provided funding, it was usually attached to specific spend and assured the Committee that the team would look at how it could legitimately be spent. **The Committee resolved that:** a) The contents of the report and the current progress to implementation of Liberty Protection Safeguards were noted.	
MHLMCA 22/10/010	**Mental Health Act Monitoring Exception Report** The Mental Health Act Monitoring Exception Report was received. The Mental Health Act Manager (MHAM) advised the Committee that there had been 1 fundamentally defective Section 2 application. He added that the Patient had been assessed in London by an Approved Mental Health Professional (AMPH) and the application was completed for detention under Section 2 to Hafan Y Coed with the Patient being transferred straight there. It was noted that the English regulations differed to Welsh regulations, and that the application had been signed electronically whereas that electronic	

	signature process was not available in Wales and so the team had tried, unsuccessfully, to get hold of the AMPH. The MHAM advised the Committee that during the quarter there had been 1 fundamentally defective Section 5(2) report. It was noted that the Patient had been on Ward C7 in the University Hospital of Wales (UHW) where a doctor had completed a report under Section 5(2) which was sent to the generic e-mail account of the Mental Health Act Office. It could not be accepted because the doctor had typed their name in the signature box and again, as mentioned, in Wales a 'wet' signature was still required. The CC asked why Wales still required wet signatures. The MHAM responded that he had spoken to WG colleagues about the advancement of the English regulations but noted that WG did not have the resource to look at the issues around electronic and wet signatures. It was noted that the use of Section 136 had increased for the period and that 69% of individuals assessed were not admitted to hospital, with 48.1% being discharged to community services and 20.9% being discharged with no follow up. The Committee was advised that the number of Patients aged under 18 assessed under Section 136 had decreased from 19 in the previous quarter to 8 in the current quarter. The IMTS asked if there was a reason for the increase in Section 136 referrals. The MHAM responded that there was no specific reason but noted that the Section 136 referrals being received were within the appropriate parameters and were all an appropriate use of Section 136. The Committee was advised that discussions had been held with the Senior Operations Manager at the Tribunal and that it had been confirmed that hearings via TEAMS would be provided as a default for all hearings being listed. He added that it had been briefly discussed as to whether observers were allowed to attend hearings, although he was not aware of any requests being made by staff and, as such, was unable to take that further with the Tribunal without any data. It was noted that the MHA office continued to run MHA awareness sessions, including a monthly MHA training day which was available to all staff within the Health Board. The MHAM advised the Committee that there was a high "Did Not Attend" rate at the training which was being looked into by Senior Nurses in order to increase staff attendance.	

	The Deputy Director of Operations - Mental Health (DDOMH) concluded that when looking at all of the trends and themes within the Mental Health service it was clear that challenges were ongoing. He assured the Committee that all of the data was being considered on a regular basis and would be reported, as appropriate, to the Committee. **The Committee resolved that:** a) The approach taken by the Mental Health Clinical Board to ensure compliance with the appropriate Mental Health legislation as set out in the report, was noted.	
MHLMCA 22/10/011	**HIW MHA Inspection Reports (verbal)** The Health Inspectorate Wales (HIW) MHA Inspection Reports verbal update was received. The DDOMH advised the Committee that the Mental Health team had received a "red file" back from HIW and that the Mental Health Clinical Board (MHCB) had provided a response to that. He added that they were awaiting the full report to be published and noted that he would bring that back to the Committee once received. The DCG advised the Committee that HIW recommendations were now being tracked through the Audit Committee and all recommendations were completed through that Committee. **The Committee Resolved that:** a) The HIW MHA Inspection Reports were received.	**DC**
MHLMCA 22/10/012	**Section 49 Activity Update** The Section 49 Activity Update was received. The DDOMH advised the Committee that the Health Board was receiving increasing numbers of Court of Protection Section 49 instructions for Capacity assessments, for which, to date, it had no system in place to either administrate and commission, or undertake internally. It was noted that the Health Board had dealt with requests on an ad hoc basis, with a small number of psychiatrists undertaking the work and that in the case of capacity assessments deemed to require a Learning Disabilities psychiatrist, the Health Board had usually paid for private assessments. The DDOMH advised the Committee that quite often, the person in question was usually not known to the MHCB and that the associated assessment work was considerable and required:	

	• Reading of a court bundle and any separate accompanying assessments, • A review of diagnoses, • Working to agree the information needed to be retained and weighed up by the subject. The Committee was advised that a number of recommendations had been made which included: The Health Board should pursue both internal and external capability for assessments through private providers as for expert reports and by training and supporting its own Clinicians, so they and the Health Board could be assured that reports were of the required quality. • Periodic training- It was noted that the MHCB had already provided one round of training with the support network • Time / money – It was noted that the consultant body was approached around an offer of time to do the relevant work or direct payment of extra sessions, with further allowance for any court attendance. • Develop and maintain a list of interested and willing individuals with the appropriate expertise. It was noted that the Health Board may want to consider writing into future job descriptions criteria to reflect the necessity for report preparation, if requests became more frequent • Improved access to legal advice. The Directorate Manager – Child Health (DMCH) advised the Committee that it was slightly different from CAMHs staff but noted that a lot of the staff had to attend court and so access to legal advice would be essential. The DCG advised the MHCB team to get in touch with the Health Board's Head of Risk and Regulation as he led on sourcing legal advice. The CC advised the Committee that they should be kept abreast of court demand that had been put onto Health Board. The DDOMH responded that he would look at comparative data against other Health Boards and that he would coordinate with CAMHs as well and present the data, where appropriate. **The Committee Resolved that:** a) The Section 49 recommendations were noted.	
MHLMCA 22/10/013	**Mental Health Measure Monitoring Reporting including Care and Treatment Plans Update Report.** The Mental Health Measure Monitoring Reporting including Care and Treatment Plans Update Report was received.	

	The DDOMH advised the Committee that the report was separated into 4 parts and he would take the report as read. **Part 1a – target: 28-day referral to assessment compliance target of 80% (Adult)** It was noted that referrals into the service were slightly lower than forecast, with 2866 referrals during quarter 2. It was noted that the service was at full clinical recruitment and sickness absence remained low which had allowed for ongoing high levels of assessment activity. That had meant that that service had maintained Part 1a compliance. **Part 1a – target: 28-day referral to assessment compliance target of 80% (Children & Young People)** The DMCH advised the Committee that there had been a significant dip and underperformance during the quarter but noted that the CAMHs service was now back to performing at 95% compliance against part 1a. **Part 1b – 28 day assessment to intervention compliance target of 80% (Adult)** The DDOMH advised the Committee that against Part 1b, the MHCB were 100% compliant and a really good performance had been seen. **Part 1b – 28-day assessment to intervention compliance target of 80% (Children & Young People)** The DMCH advised the Committee that CAMHs had struggled with Part 1b and noted that compliance against the target had not been achieved since December 2021 as a result of focus on the external waiting list for assessment and reduced capacity over school holiday periods. She added that there were ongoing plans to get back into compliance and noted that a brief intervention pathway would be created to ensure that young people were seen within 28 days of the commencement of their treatment, following assessment. The CC noted that it was really pleasing to see such high compliance in the various areas discussed and thanked the teams for their hard work. **Part 2 – Care and Treatment Planning (over 18)** The DDOMH advised the Committee that discussions had been held with the Delivery Unit (DU) around how the report was designed and reported. He added that the Committee had received a more accurate report locally which referred to active reports for each individual Patient who was open in the system.	

	It was noted that to manage, the Part 1 Scheme (a document each Health Board holds to define what services are included as a Part 1 service) needed to be revisited and adjusted and that a multidisciplinary working group had been formed to develop and present the document for ratification at the Committee. **Part 2 – Care and Treatment Planning (Children & Young People)** The DMCH advised the Committee that the service continued to underperform against the target and that challenges to achievement had included poor engagement from Patients in the CTP process and a high number of new Patients requiring one. She added that work was being undertaken on assessment and that the Intervention Team would make it much clearer as to who should be on a Part 2. **Part 3 - Right to request an assessment by self –referral.** The DDOMH advised the Committee that the Part 3 target related to self-referred service users receiving a confirmation letter regarding the outcome of their assessment within 10 days. He added that three breaches were reported at 11 days and noted that teams were receiving an automated report indicating eligible Patients for Part 3 sent on a weekly basis and that teams who had breached had been notified for improvement. **Part 4 – Advocacy – standard to have access to an IMHA within 5 working days** The DDOMH advised the Committee that the MHCB were 100% compliant on Part 4. **The Committee Resolved that:** a) The contents of the report were noted.	
MHLMCA 22/10/014	**Draft Mental Health Bill** The Draft Mental Health Bill was received. The MHAM advised the Committee that the paper received highlighted key changes in the draft legislation and that in early 2023, the MHCB would have more knowledge of where it stood in terms of the draft Bill and the changes it covered. He added that one area to highlight was around: • Grounds for detention and community treatment orders	

	It was noted that the criteria currently stated that the Patient was suffering from a mental disorder of a nature or degree which warranted the detention in hospital for assessment and ought to be so detained; - In the interests of the Patient's own health - In the interests of the Patient's own safety - With a view to the protection of other persons. It was noted that two amendments would be made to include: • The criteria for detention under Section 2, 3 and 5 and criteria for renewal under Section 20. • Two new tests that must be met to fulfil the criteria for detention: a. Firstly, that 'serious harm may be caused to the health or safety of the Patient or of another person'; and b. secondly, that the decision maker must consider 'the nature, degree and likelihood of the harm, and how soon it would occur'. The MHAM concluded that he had attended a Mental Health conference and that the Head of the Reform Group had stated that the new reform would be brought into the system in phases. **The Committee Resolved that:** a) The key legislative changes proposed by the Draft Mental Health Bill, as set out in the report were noted.	
MHLMCA 22/10/015	**Corporate Risk Register** The Corporate Risk Register (CRR) was received. The DCG advised the Committee that there was one risk on the CRR for the Mental Health Clinical Board. She added that the Mental Health Team had hoped that the risk would have been de-escalated but noted that the reasons the risk remained at a score of 20 was outlined within the report received. It was noted that as part of their performance reviews, Clinical Boards were being asked what their top 5 risks were which raised the profile risk management across the Health Board. The DCG concluded that the risk would get reported to the Board in November. **The Committee Resolved that:** a) The Corporate Risk Register risk entries linked to the Mental Health Legislation and Mental Capacity Act Committee and the Risk Management development work which was now progressing with Clinical Board were noted.	

MHLMCA 22/10/016	**Sub-Committee Meeting Minutes:** The Committee received copies of the Sub-Committees' meeting minutes: • Mental Health Act Hospital Managers Power of Discharge Sub Committee The Chair of the Powers of Discharge sub-Committee (CPDSC) advised the Committee that in light of the Tribunal it was decided to return to offering Patients the choice of a face to face hearing of a hybrid or a virtual hearing and that one had taken place so far. The MHAM added that another request to do a face to face had been received and that as of beginning of November 2022 the team would be offering those to all Patients. The CPDSC noted that it appeared that Care and Treatment plans had improved and that the Mental Health Act Hospital Managers Power of Discharge Sub Committee were looking forward to seeing the data on it at future meetings. • Mental Health Legislation and Governance Group (MHLGG) **The Committee Resolved that:** a) The Sub-Committee Meeting Minute were noted.	
MHLMCA 22/10/017	**Policies** The Review of Detention & Community Treatment Order Policy and Procedure were received. The Patient Rights Information to Detained & Community patients' Policy and Procedure were received. Application for Admission under Part II of the Mental Health Act Policy and Procedure were received. **The Committee Resolved that:** a) The Review of Detention & Community Treatment Order Mental Health Act 1983 Policy and the Review of Detention & Community Treatment Order, Mental Health Act 1983 Procedure were approved. b) The Patient Rights Information to Detained & Community Patients' under Mental Health Act 1983 Policy and & Patient Rights Information to Detained & Community Patients' under Mental Health Act 1983 Procedure were approved.	

	c) The application for Admission to Hospital under Part II of the Mental Health Act Policy and the application for Admission to Hospital under Part II of the Mental Health Act Procedure were approved. d) The full publication of the Policies and Procedures referred to under recommendation a) above, in accordance with the Health Board's Publication Scheme was approved.	
MHLMCA 22/10/018	**Mental Health Legislation and Governance Group Terms of Reference** The Mental Health Legislation and Governance Group Terms of Reference were received. The MHAM advised the Committee that in line with the Health Board's Standing Orders, Terms of Reference for Sub-committees of the Board should be reviewed on an annual basis and noted that the report provided the Committee with the opportunity to approve the Terms of Reference after review by the Mental Health Legislation and Governance Group (MHLGG). **The Committee Resolved that:** a) The Terms of Reference for the Mental Health Legislation Governance Group were approved.	
MHLMCA 22/10/019	**Any Other Business** **MHLMCA 22/10/011** He added that he been approached by a number of groups within the community and wished to feedback that work and any opportunities. The DDOMH responded that he would welcome that conversation. **The Committee resolved that:** a) All other business was noted.	**DDOMH**
	To note the date, time and venue of the next meeting: January 31 2023 at 10am Via MS Teams	

Confirmed Minutes of the Public Strategy and Delivery Committee Meeting
Held On 15th November 2022 at 09:00am
Via MS Teams

Chair:		
Michael Imperato	MI	Independent Member – Legal/ Committee Chair
Present:		
Sara Moseley	SM	Independent Member - Third Sector
Rhian Thomas	RT	Independent Member - Capital & Estates
In Attendance:		
Nicola Foreman	NF	Director of Corporate Governance
Abigail Harris	AH	Executive Director of Strategic Planning
Ceri Phillips	CP	Vice Chair of the UHB
Suzanne Rankin	SR	Chief Executive Officer
Jason Roberts	JR	Executive Director of Nursing
Geoff Walsh	GW	Director of Capital & Estates
Rachel Gidman	RG	Executive Director of People and Culture
Fiona Kinghorn	FK	Executive Director of Public Health
Hannah Evans	HE	Programme Delivery Director – Non-Acute
Ed Hunt	ED	Programme Director – Redevelopment
Richard Skone	RS	Deputy Medical Director
Observers:		
Marcia Donovan	MD	Head of Corporate Governance
Secretariat:		
Sarah Mohamed	SM	Corporate Governance Officer
Apologies:		
Paul Bostock	PB	Chief Operating Officer
Timothy Davies	TD	Head of Corporate Business
Gary Baxter	GB	Independent Member - University
David Edwards	DE	Independent Member - ICT

Item No	Agenda Item	Action
S&D 15/11/001	**Welcome & Introduction** The Committee Chair (CC) welcomed everyone to the meeting.	
S&D 15/11/002	**Apologies for Absence** Apologies for absence were noted.	
S&D 15/11/003	**Declarations of Interest** The Independent Member – Third Sector (IMTS) declared an interest as a member of the General Medical Council.	
S&D 15/11/004	**Minutes of the Meeting Held on 27 September 2022** The minutes of the Committee meeting held on 27 September 2022 were received.	

	The CC advised the Committee that **The Committee resolved that:** a) The minutes of the Committee meeting held on 27 September 2022 were approved as a true and accurate record of the meeting.	
S&D 15/11/005	**Action Log following the Meeting held on 27 September 2022** The Executive Director of Strategic Planning (EDSP) advised the Committee that action 12/09/007 was regarding the conversation in relation to engaging Patients in the most deprived communities and the Engagement Lead vacancy. The EDSP added that the Engagement Lead would be an expert in engagement and an advisor to the Board. It was also a role that leaned into the Public Service Board. The EDSP was working with the People and Culture Team to ensure the job description was articulated properly. The EDSP expressed concern that she would not have someone in place when starting conversations regarding the Shaping our Future Wellbeing Strategy ("the Strategy") and that more external capacity may be required. The EDSP added that she had also received the refreshed guidance yesterday. It looked similar to the previous one. **The Committee resolved that:** a) The Action Log from the meeting held on 27 September 2022 was noted.	
S&D 15/11/006	**Chairs Action** The Adoption of the All Wales Guidelines for Managing Industrial Action was received. **The Committee resolved that:** a) The Chair's Action taken to formally adopt the NHS Wales Guidelines for Managing Industrial Action on 2 November 2022, noting that the Guidelines have been very slightly amended as stated in the body of the report, was ratified.	
	Items for Review and Assurance	
S&D 15/11/007	**Shaping Our Future Wellbeing Strategy** The EDSP advised the Committee members that the Strategy update work was progressing and questions were being tested. There was a steering group in place, with the view that more detailed engagements would start in January 2023. The refreshed Strategy would go to Board in March 2023.	EDSP

	The Committee resolved that: a) The Shaping Our Future Wellbeing Strategy was noted	
S&D 15/11/008	**Strategic Delivery Programme updates - Flash Reports** The EDSP presented the Strategic Delivery Programme updates - Flash Reports and highlighted the following: 1. Shaping our Future Population Health • That was currently at a green status. 2. Shaping our Future Community Services/ at Home Programme • That was currently at a green status. 3. Shaping our Future Clinical Services • That was at an amber status. • The Programme Board had met for the first time a few weeks ago and good discussions had taken place regarding the 10-year strategic plan for the service. • A series of workshops would take place to discuss high-level Clinical service plans. • Welsh Government (WG) wanted to undertake a review of the Clinical service model as described in the business case for Our Future Hospital. The terms of reference were drafted and should be signed off by WG. That would mean that WG would fund the review. • The Tertiary service work was at an amber status due to the volume of work. There had been a delay in getting a joint workshop with Swansea Bay which was now taking place next week. 4. People and Culture • That was at an amber status. 5. Digital • That was at an amber status. The IMTS queried whether WG, having commissioned a review, was hopeful in their likely support for the Future Hospitals plan. The EDSP responded that was correct. WG have said that the Health Board should proceed with the Strategic Business Outline Case (SOC). However, resources had not yet been received from WG to start the SOC. That would be kept at a high level.	

	The Independent Member - Capital & Estates (IMCE) queried to what extent did the Health Board have the internal expertise that could be developed to do that work. Also, what costs would be entailed. The EDSP responded that the Health Board had good programme capability in-house but not programme capability with expertise in this field. There was also good capability within the Clinical side. A Project Director with expertise in construction and funding models was required. The Vice Chair of the UHB (VCUHB) queried whether there was a "plan b" if the current Shaping our Future Hospital was not successful and WG decided it was not the right approach. The EDSP responded that there was no plan b. However, the space the hospital currently occupied was designed in a different era and was far removed from current hospital compliance requirements which would need to be highlighted. The VCUHB stated that when the Minister visited the site, she was pleased that the Cardiff University had strong links with the Health Board. It would be good to give some thought involving the University in the Future Hospital programme. The EDSP responded that the Future Hospital Programme Board now included the Vice Chancellor of Cardiff University. Grant Thornton had undertaken work setting out the joint vision between the academic health sciences and Cardiff University. **The Committee Resolved that:** a) The Strategic Delivery Programme updates - Flash Reports were discussed and noted.	
S&D 15/11/009	**Key Workforce Performance Indicators -** *Deep Dive on statutory training & Values Based Appraisals* The Executive Director of People & Culture (EDPC) presented the Key Workforce Performance Indicators and highlighted the following: • The Health Board was trying to decrease fixed term roles and have more permanent roles instead. • Recruitment, retention and wellbeing were being worked on. • The retention rate was currently at 13%, which was high. There were areas in Surgery which were down to 11%. The People and Culture Team was focusing on what would make an individual stay and make their working lives better. A cultural piece of work was being undertaken in the Emergency Unit (EU). • There was a downward trend for sickness. It was coming down but not as low as hoped. • The People and Culture roadshow was being launched in the organisation. A series of masterclasses were being run regarding living costs.	

	• There was a focus on VBAs and mandatory requirements. The IMTS queried whether exit interviews were being used and whether the information and trends gained from the same were being analysed. The EDPC responded that a piece of work was being done in the EU which her team was hoping to standardise across all Clinical Boards. The EDPC added that exit interviews were not as useful and instead staff would be asked at 3 months how they felt about the role. A more flexible approach was being undertaken. The IMTS responded that there are different types of exit questionnaires. For example, having more detailed discussions to be able to get richer information and data. That should be done in a manner that is confidential and safe. The EDPC responded that was done in the EU and staff were able to open up more about why they were leaving. The CC queried whether bench marking KPIs against other Health Boards could be done. The EDPC responded that she had the all Wales position. However, she would like to go broader and would bring that to the next Committee meeting. <u>Industrial action</u> • Many Unions had gone out to ballot as a result of the pay awards. • The Royal College of Nursing's ballot had come out first. • Unison, the Royal College of Midwives and others would close shortly in December. • There was a potential 3,500 RCN members that could vote in the organisation. 2,000 had voted and the majority at 93% have said yes to strike action. • The Health Board came out at 59.74% in favour of strike action. • The END and EDPC have been working on potential strike action for a number of weeks and a Task and Finish group had been initiated. • The Operations team have been working with Clinical Boards to see how strike action would affect the working day. • There were areas that could be exempt from striking and highlighted to the RCN. That would be agreed nationally and would then be adopted by the Health Board with its own nuances since it was a Tertiary hospital. • The RCN had to give 2 weeks' notice. • There was a good contingency plan in place which would be taken to SLB that week. • If Unison came out with a positive strike action, then RCN would go on strike again. That could affect 8,000 staff. That would mean	EDPC

	that services could not be provided and WG would be informed of that. The CEO commented what was worrying was that it was not a marginal vote. That said something about how nursing staff were feeling. The CEO added that the Intensive Care Unit and Emergency Unit would not allow strikes. Some electives would also be taken down to support patients. **The Committee Resolved that:** a) The contents of the report were discussed and noted. b) The current position of the UHB and the steps outlined to achieve targets in both Values Based Appraisals and Statutory and Mandatory Training were noted.	
S&D 15/11/010	**Key Operational Performance Indicators** *a) Deep Dive on Cancer Services* *b) Deep Dive on Musculoskeletal & Primary liaison workers – Verbal* The Programme Delivery Director – Non-Acute (PDDNA) presented the Key Operational Performance Indicators and highlighted the following: <u>Urgent and emergency care system</u> • Attendances had continued to rise. There were 3,000 in October. • In order to help better manage the risk in the community, a zero-tolerance approach to 4-hour delays in ambulances had been initiated. • From early September, 30 Patients were waiting a week for 4 hours. That had now started to move focus to 3 hours. <u>Planned care</u> • There had been a focus on Ministerial targets to reach 52 outpatients by the end of December and 104 weeks by the end of March. • Since the last meeting, a new request had come from WG. That was - if the Health Board was unable to deliver the 52-week outpatient target by December, could assurances be given that no one would be waiting over 104 weeks. • There were 1,500 Patients that would be waiting over two years by the end of December. • The Operations team was engaged in national work and was speaking to other Health Boards so that they could support each other. <u>Deep dive on Cancer services</u> a) Internal Cancer standards: our ambition	

	• Internal standards have been set. The teams were not there yet. However, to become sustainable, they would need to be achieved. b) Cancer performance • The Health Board's performance had deteriorated. • In 2019 and before Covid, the total waiting list was 800 patients. That had increased to 3,000 after Covid and was now at 2,400 Patients. • Focus should be on a single pathway performance whilst the backlog was also tackled. c) Immediate actions • Strengthened oversight and visibility of Cancer services across the Health Board. A weekly oversight group had been established with the Directors of Operations in attendance and chaired by the COO. Roles and responsibilities across Cancer services have been confirmed. • Better information and insight would be provided. For example, regular breach reports analysing main breach blockages in pathways would be produced. • Immediate action on improving processes and pathways. There was a planned increase in Radiology and Pathology capacity to reduce backlog and turn around time. d) Progress to date • On 15 November the number of Patients waiting over 62 days was 429, a reduction from 800 at the end of September. Therefore, improvements were being made. The IMCE queried how sustainable the efforts were and what the medium to long term plans were to resource Pathology properly. The PDDNA responded that additional resources had been parachuted in. However, the Operations team was working on a plan to make it more sustainable. For example, the appointment of a new Pathologist. The challenge for the longer term depended upon where the regional work would land. The IMTS stated that relationships needed to be built between the different teams. The IMTS also requested assurance that the dip was not taking place elsewhere. The PDDNA responded that the eye was taken off the ball during the pandemic. The Health Board was not an outlier in that. The Health Board had been in a better place in terms of Cancer treatment and the focus was on getting back to that. The PDDNA also added that staff were welcoming the opportunity and renewed focus.	PDDNA

	The UHBVC queried to what extent could the diagnostic centres contribute to the sustainability of the trajectory and in moving forward. The PDDNA responded that she would need to look into that and come back. The CEO stated there has been four different COOs in the Health Board, which had brought incoherence in that area of work. There was a more coherent leadership team this Autumn. The CEO added that the indicators were being looked at, whilst noting that they were being evolved all the time. There were assurance mechanisms in place. The CEO added that if there was a request about a dip in specific areas, that could be looked at but not as a whole as it was too broad. **The Committee Resolved that:** a) The year to date position against key organisational performance indicators for 2022-23 and the update against the Operational Plan programmes were noted. b) The Cancer Deep Dive was noted.	
S&D 15/11/011	**Shaping Our Future Wellbeing – IMTP 2023-2026** The EDSP presented the Shaping Our Future Wellbeing – IMTP 2023-2026 and highlighted the following: <u>Process</u> • It was agreed that the 2022-23 Annual Plan would be built upon. • This year would be different because of a new area plan for the RPB and new wellbeing plans from the service boards. • It would also need to reflect the re-invigorated regional planning focus. • WG was streamlining the planning guidance and more templates in a standardised format were expected from WG. • It was anticipated that the Annual Plan would be set out within a 3-year context. • The draft was due by early January 2023 for Board consideration. • The final draft would go to Board in March for submission to WG. <u>Priorities</u> • Cancer pathway needed to be improved to ensure timely access to definite diagnostics and treatment. • The whole system response to emergency and urgent care needed to be improved to ensure people were treated in the right place at the right time. • Maternity care and services for children with complex needs was a demanding area that was putting pressure on the system.	EDSP

	• There needed to be a focus on partnership actions and services to reduce the prevalence of preventable diseases and premature death. • Inclusion and diversity required embedding the anti-racist action plan and actively promoting inclusivity and diversity in the workforce to ensure Patients were cared for appropriately. Overall, the Annual Plan should be a document that the organisation could "own" and staff could see how they fit in. The DCG advised that the four priorities mentioned were risks on the BAF. The Cancer services and Maternity services had been added recently and that would be shared with the Board next week. **The Committee Resolved that:** a) The Shaping Our Future Wellbeing – IMTP 2023-2026 update was noted.	
S&D 15/11/012	**Capital Programme Update on Delivery 2022/23** The Director of Capital, Estates and Facilities (DCEF) presented the Capital Programme Update on Delivery 2022/23 and highlighted the following: • £750k was allocated to the Health Board by the Minister to complete work in the EU to improve the Patient and staff environment. • The Health Board had also received £750k for UHL boiler installation. • The Capital and Estates team had submitted a substantial bid of £14m to WG. It was unlikely that would be awarded and feedback was likely be received in December. That would mean pressure to spend by the end of the year. • The Capital and Estates team recently submitted a bid under the EFAB programme. That included an allocation of £20m by WG over 2 years. • The Capital and Estates team was hoping to hear the outcome of successful schemes in December. • The Genomics business case was in construction. It had been delayed over several months. • The Fracture Clinic was approved by the Board. Tenders had come in over where they were expected to be. A paper would be going to Capital Management Group on Monday. • The Minster was focused on schemes to do with Cancer and Orthopaedic services. The IMCE queried what was the risk regarding the overspend on Genomics and would that be received from WG. The DCEF responded that he was in discussions with WG about options to give £650k into this financial year. The Health Board might need to bring something from next year's discretionary capital forward.	

	The CEO queried when the EU work would be done. The DCEF responded that the Patient showers would be completed at the end of the month. He was in discussion with users regarding their items. **The Committee Resolved that:** a) The content of the paper and the challenges faced by the Health Board as a result of the reduced level of funding, were noted. b) The in-year changes to the capital programme were noted. c) All Business Cases would follow the appropriate approvals process with consideration by the respective Project Team/Board, CMG, the Business Case Advisory Group (BCAG), ME and Board, was noted. d) The schemes that the UHB was developing through the Business Case process pending WG Approval, were noted.	
S&D 15/11/013	**Decarbonisation Sustainability Action Plan** 2.4.1 - Summary of submission to Welsh Government 2.4.2 - Draft Carbon Reduction Plan The Programme Director – Redevelopment (PDR) presented the Decarbonisation Sustainability Action Plan and highlighted the following: • The Plan was created, in light of the Audit Wales report (Public Sector Readiness for Net Zero Carbon by 2030) published in January 2022. • Audit Wales have “5 calls for actions” around decarbonisation to meet the Welsh Government’s (WG) ambition of a net zero Public Sector by 2030. • NHS Wales had targets – a 16% reduction by 2025 and a 24% reduction by 2030. • In 2021/22 Cardiff and Vale’s emission was 202,000. • Governance structures were now in place, with the first meeting to be held that month. • There would be funding from WG to fund Nurses and Therapists to provide leadership on the decarbonisation agenda. • Colleagues were also working with the Medical School and embedding decarbonisation into curriculum. • The diagram showed that 81% of carbon emissions came from supply chains and 18% from buildings. • Currently the Health Board did not have line of sight to the 16% target by 2025. • The way supply chain data was reported was flawed. What decarbonisation meant to the Workforce needed to be defined. <u>Next actions</u>	

	• The Shaping our Future Wellbeing Strategy refresh needed to have a strong commitment to mitigation. • Decision making across the Health Board could include carbon as a consideration. • More healthy travel initiatives should be considered. • Grant funding to address energy efficiency might be available. <u>Health and wellbeing impact of climate change</u> • The impacts of carbon emissions would mostly be felt by the older and younger population. Also, people with disabilities and long-term health conditions. The Executive Director of Public Health (EDPH) stated there was lots of work to do to join up the strategic approach to climate. The IMCE queried whether sustainability and decarbonisation should be a part of the value-based appraisals. The EDPC responded that it would be useful to shape it under the Wellbeing Future Generation Act. Executives also had a sustainability responsibility. **The Committee Resolved that:** a) CVUHB's carbon emissions was noted. b) The submission made to WG regarding progress against the Sustainability Action Plan was noted. c) The most significant actions CVUHB taken regarding decarbonisation set against the Audit Wales calls for action were noted. d) A new decarbonisation action plan was in the early stages of development which would form part of the next IMTP and that early thinking on what that would contain was presented in the paper set against the Audit Wales 5 Calls for Action, was noted. e) There was no line of sight to the 2025 or 2030 targets and that radical action was needed to embed sustainability as a core responsibility and ensure delivery of the action plan, was noted.	
S&D 15/11/014	**Update on Kings Fund Report Early Intervention – Verbal** The EDPH advised the Committee on the following: • The Kings Fund was an independent charity. • The Health Board had requested a report on preventative approaches in Primary Community Care. It had taken this long to get a final report because there were challenges with some of the experts. • The final version would be brought to January's S&D meeting. **The Committee Resolved that:**	EDPH

	a) The Kings Fund Report Early Intervention – Verbal Update was noted.	
S&D 15/11/015	**Winter Plan Update** The PDDNA presented the Winter Plan Update and highlighted the following: • Work had started in the Summer and lessons learnt had been considered. • There were a few summits in Autumn. It was signed off by SLB and Board in September. • The plan in place aligned with the policy directives in the 6 Goals for urgent and emergency care. • The plan was developed with the following indicators in mind: system performance challenges, long length of stay, medically fit patients. pressure outside the front door and the EU. • The roadshow involved going to different sites at the UHW. It did not reach as many people as desired but there were lots of good conversations and feedback. • A number of factors would affect the Winter including industrial action, future Covid waves, flu/respiratory demand, living costs and workforce availability. • A worst-case scenario of a 152-bed gap had been predicted between November and March. There would also be an approximate number of patients (circa 320) in hospital awaiting discharge. • It was predicted that ED demand would be higher than 2021, but lower than pre-Covid. <u>Addressing the challenges</u> • The plan was made up of a blended approach of capacity. • A key part of the plan is to look at different models of care. • Focusing on frailty was also key. A Frailty zone had opened in UHW. • There would be a focus on acute medicine model. Medical SDEC had been moved. • There was additional capacity for Third Sector organisations to help support Dementia Patients and their families.	

	The UHBVC stated the Health Board should establish what actually happens and what can be implemented. The PDDNA responded that the challenge was recording new models of care. A dashboard focusing on that would be useful. **The Committee Resolved that:** a) The Winter Plan Update was noted.	
S&D 15/11/016	**Board Assurance Framework** The Board Assurance Framework (BAF) was presented. The DCG advised the Committee that the Committee had already discussed a lot of the items listed on the BAF and those items would need to remain on the BAF. The DCG added that 6 additional risks would be added to the BAF. Some of those would fall to this Committee to provide assurance to the Board. **The Committee resolved that:** **a)** The attached risks in relation to Emergency and Urgent Care, Workforce and Leading Sustainable Culture Change were reviewed. **b)** Assurance would be provided to the Board on 24th November 2022 on the management /mitigation of those risks.	
	Items for Approval / Ratification	
S&D 15/11/017	**Policies for approval** The following Policies for approval were received: • Business Continuity Policy • Adverse Weather – Heatwave Plan • Adverse Weather – Cold/Snow Plan **The Committee resolved that:** a) The Business Continuity Policy (UHB 50 Version 6) and associated Business Continuity Planning Guidance was approved; b) The Severe Adverse Weather Plan: Heatwave (UHB 063 Version 6) was approved; and c) The Severe Adverse Weather Plan: Cold Weather (UHB 095 Version 4).	
	Items for Information and Noting	

S&D 15/11/018	**Corporate Risk Register** The Corporate Risk Register (CRR) was received. **The Committee resolved that:** a) The Corporate Risk Register risk entries linked to the Strategy and Delivery Committee and the Risk Management development work which was now progressing with Clinical Boards and Corporate Directorates, was noted.	
	Review and Final Closure	
S&D 15/11/019	**Any Other Business**	
	Date & time of next Meeting 24 January 2023 at 9am via MS Teams	

Confirmed Minutes of the Quality, Safety & Experience Committee
Held on 10.01.2023 at 09.00am
Via MS Teams

Chair:		
Ceri Phillips	CP	Vice Chair of Cardiff and Vale University Health Board
Present:		
Akmal Hanuk	AH	Independent Member – Community
Mike Jones	MJ	Independent Member – Trade Union
In Attendance		
Paul Bostock	PB	Chief Operating Officer (in attendance until 10am)
Sandeep Berry	SB	Deputy Clinical Board Director – Surgical Clinical Board
Emma Cooke	EC	Deputy Director of Therapies & Healthcare Sciences
David Scott-Coombes	DSC	Clinical Board Director - Surgical Clinical Board
Marcia Donovan	MD	Head of Corporate Governance
Angela Hughes	AH	Assistant Director of Patient Experience
Meriel Jenney	MJ	Executive Medical Director (in attendance until 11am)
Fiona Kinghorn	FK	Executive Director of Public Health
Jason Roberts	JR	Executive Nurse Director
Alexandra Scott	AS	Assistant Director of Quality and Patient Safety
Richard Skone	RS	Deputy Medical Director
Clare Wade	CW	Director of Nursing - Surgical Clinical Board
Aaron Fowler	AF	Head of Risk and Regulation
Observing		
Tina Bayliss	TB	Interim Director of Operations – Surgical Clinical Board
Timothy Davies	TD	Head of Corporate Business
Claire Dunstan	CD	Quality & Safety Assistant Director – Surgical Clinical Board
Secretariat		
Nathan Saunders	NS	Senior Corporate Governance Officer
Apologies		
Susan Elsmore	SE	Independent Member – Local Authorities / Chair of the Committee
Nicola Foreman	NF	Director of Corporate Governance
Fiona Jenkins	FJ	Executive Director of Therapies and Health Sciences
Stephen Allen	SA	Community Health Council

QSE 23/01/001	**Welcome & Introductions** The Committee Vice Chair (CVC) welcomed everyone to the meeting in English & Welsh.	**Action**
QSE 23/01/002	**Apologies for Absence** Apologies for absence were noted. The Executive Medical Director (EMD) advised the Committee that she would need to leave the meeting early to attend another meeting. The Chief Operating Officer (COO) advised the Committee that he would need to leave at 10am to attend the Trauma Network Group.	
QSE 23/01/003	**Declarations of Interest** No declarations were noted.	
QSE 23/01/004	**Minutes of the Committee meeting held on 29 November 2022** The minutes of the Committee meeting held on 29 November 2022 were received. The Executive Nurse Director advised the Committee that minute number QSE 22/11/007 had noted that the Deputy Medical Director (DMD) and himself had co-chaired the Cdiff group and that the root cause analysis of the increase in Cdiff cases would be undertaken and learnings shared with the relevant areas and brought back to the Committee via the Quality Indicators report.	

	He added that the root cause analysis had not been undertaken and that he would pick that up for the meeting being held in March 2023. **The Committee resolved that:** a) The minutes of the meeting held on 29 November 2022 were approved as a true and accurate record of the meetings	**JR**
QSE 23/01/005	**Action Log following the Meeting held on 29 November 2022** The Action Log following the Meeting held on 29 November 2022 was received. The Head of Corporate Governance (HCG) advised the Committee that there were a number of actions that had been completed and a number in progress which included: • QSE 22/11/007 – It was noted the action log would be updated to reflect the END's comments about the item coming to the next Committee meeting in March 2023. • QSE 22/11/009 – It was noted the item would be received at the meeting. • QSE 22/11/014 – It was noted the item would be received at the meeting. • QSE 22/08/013 – It was noted the item would be received at the March 2023 Committee meeting. The EMD advised the Committee that a conversation had been held with the Executive Director of Public Health around fatal drug poisoning and the link towards the mortality framework in relation the action QSE 22/11/014. She added that the data was collated by the substance misuse APB commissioning team and that a decision would be required as to how the Committee would like to receive the data. The Executive Director of Public Health (EDPH) added that the nature of mortality data differed as some data was within the Clinical Board's gift within the inpatient setting and the fatal drug poisoning data, which was reviewed, was a partnership endeavour. The CVC advised the Committee that a way in which to present the mortality data needed to be decided offline and brought back to the Committee in March 2023. **The Committee resolved that:** a) The Action Log from the meeting held on 30 August 2022 was noted.	**MJ/FK**
QSE 23/01/006	**Chair's Actions** The Chair's Action around the Approval of the Research Governance Policy (UHB 099) was received. **The Committee resolved that:** a) The Chair's Action was noted.	
QSE 23/01/007	**Surgical Clinical Board Assurance Report (including a Patient Story).** The Surgical Clinical Board Assurance Report was received. The END introduced the Director of Nursing for the Surgical Clinical Board (DNS), the Clinical Board Director for the Surgical Clinical Board (CBDS) and the Interim Director of Operations for the Surgical Clinical Board (IDOS). The DNS also introduced the Quality & Safety Assistant Director for the Surgical Clinical Board (QSADS) and the Deputy Clinical Board Director for the Surgical Clinical Board (DCBS). The DNS advised the Committee that the report was long and that the Surgical Clinical Board (SCB) had tried to outline everything that had happened over the past 12 months. She added that a lot more data regarding quality and mortality had been included within the report via the Nursing dashboard that was available and via the new Datix system.	

It was noted that last year the Committee had received detailed information regarding the opening of the Same Day Emergency Care Unit (SDEC) and hence the latest report contained early data in relation to admissions and length of stay at the SDEC.

The END thanked Surgery for the comprehensive assurance report and noted that it was good to see the move away from large narrative reports to a more refined data driven report.

He added that the SCB had been pleased to report there have been no cases of MRSA since January 2022.

The Independent Member – Community (IMC) asked how the workforce data from September 2022 compared with last year's data.

The DNS responded that with regards to recruitment and the SCB's vacancies, it had remained static for the 12-month period.

She added that a lot of overseas recruitment had been undertaken for the perioperative care and wards.

It was noted that the SCB was proactive and would look at all options on how Nurses and Operating Department Practitioners (ODPs) could be brought into the SCB. It was noted that that there was a good recruitment and retention programme in place, which included bespoke areas, such as keeping in touch days for new starters.

The DNS added that turnover was challenging and that the SCB had a high turnover rate which reflected the general tone within health care over the past 2 years.

It was noted that to try and improve the turnover rate, lots of opportunities had been provided for staff and internal promotion was instigated, if appropriate.

It was noted that sickness and absence rates were an ongoing issue for the SCB and that the sickness data had increased since September 2022.

The DNS advised the Committee that work was being undertaken to try and manage the issue.

She added that Values Based Appraisals (VBAs) uptake was 39.1% in September 2022, but noted that the SCB was on an improvement trajectory and that it was hoped that by March 2023, at least 65% of VBAs would be completed.

The EMD thanked the team for the report and noted that the data was very informative.

She added that the SCB's successes should also be drawn out from the report. For example, the Same Day Emergency Care (SDEC) unit had opened and was in operation during a period of remarkable pressures and that should be celebrated.

The EMD asked if the large piece of work undertaken around the 5-Steps to Safer Surgery was still working and if there was any follow up.

The DNS responded that the SCB was audited again 6 months ago and that the auditors had been content with the actions that the SCB had put in place.

She added that Theatreman system was near the end of its life and noted that basic changes were made so that it captured the data and noted that it would not let the "inputter" proceed with the theatre case until all of the relevant checklist was completed.

The Clinical Board Director - Surgical Clinical Board (CBDSCB) advised the Committee that the SCB was aware that they had protected beds for Protected Elective Surgery Unit (PESU).

The Assistant Director of Patient Experience (ADPE) highlighted to the Committee that 2 areas within the SCB (Duthie Ward and the Stoma Care department) had recently become accredited Autism aware areas following an Ombudsman's case (where a concern had been raised regarding communication with a patient who had autism).

She commended the SCB for their commitment and for being an exemplar in changing things for the better.

The Executive Director of Public Health (EDPH) thanked the SCB for their report and noted it was positive to see such a data driven representation.

She added that patient-reported outcome measures (PROMs) were still collected and noted that it would be good to see if there were opportunities to draw out upstream value on elective pathways and to see if all of the programmes were being connected.

The CBDSCB responded that Surgeons were all engaged with National audits.

He added that the DNS would draw up a spreadsheet to demonstrate how much national registries and audits are valued.

The Deputy Clinical Board Director – Surgical Clinical Board (DCBDS) presented the Committee with a Patient Story in relation to the Trans Oral Robotic Surgery (TORS) for head and neck cancers.

The Committee was advised of the journey undertaken around TORS so far and the development of the service from 2015 to 2023:

- A Business Case
- Simulation Training
- Observer Cases
- Online Modules
- Wet lab training
- Accreditation and Governance
- MDT TORS pathway
- Service Modelling
- Database implementation
- A dedicated TORS clinic.

The DCBDS presented the Committee with how the TORS machinery worked and provided visuals around it.

The Committee was advised of the TORS indications which included:

- Mucosectomy for Carcinoma Unknown Primary
- Primary Oropharyngeal resection for T1/2 Tumours
- Primary Surgery for radioresistant disease or when radiotherapy could not be given
- Salvage surgery for recurrent disease
- Surgery for other Head & Neck cancers and benign disease.

The DCBDS advised the Committee of the current status of TORS.

It was noted that it had led to a clear pathway which consisted of:

- Referral criteria’s and patient suitability
- Preoperative work-up and planning
- Admission arrangements
- Day of Surgery and immediate postoperative period
- Length of hospital stay at UHW and the discharge home
- Postoperative follow ups.

The Committee was presented with a case, where it was noted that the patient had been referred by his GP with a lump on his neck, and the actions taken from referral through to treatment.

The DCBDS presented the Committee with a video of the patient’s microdiscectomy which showed the techniques used during TORS.

He concluded by noting that the three essential elements of TORS were:

- “Coming together is the beginning”
- “Keeping together is progress”
- “Working together is success”

	The Assistant Director of Quality and Patient Safety (ADQSP) asked if any variation or improvements had been seen since the use of TORS. The DCBDS responded that there had been improvements and patients treated did not require further treatment. He added that another element was that cancers had been found in the patient that would not have been identified without TORS. The END noted that patients fears, concerns and experience would need ongoing management. The CVC concluded that the TORS journey had been very interesting to see and asked for the Clinical Board to keep the QSE Committee updated on that journey. **The QSE Committee resolved that:** a) The progress made by the Clinical Board to date was noted b) The content of the report and the assurance given by the Surgery Clinical Board was noted	
QSE 23/01/008	**COVID Investigations** The COVID Investigations information was received. The ADQSP advised the Committee that investigations had been underway for over a year and a review of the care provided had been undertaken. She added that the reviews were held under the umbrella of the final 'NHS Wales National Framework - Management of Patient Safety Incidents following Nosocomial Transmission of COVID-19 (2021) which supported the Communicable Disease Outbreak Plan for Wales (2020) by identifying, reviewing and reporting patient safety incidents, complaints or claims relating to nosocomial transmission of Covid-19 in line with the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 – Putting Things Right (PTR). It was noted that the Health Board had a fully established Covid Investigation Team and was implementing all aspects of the National Framework. The Committee was advised that as of 14th December 2022, 3,229 patients would require scrutiny. The ADQSP noted that as of 19th December the Covid Investigation Team had undertaken 1,191 proportionate investigations and reviews. She added that the availability of patient records was the main risk impacting on the ability to progress the investigations and that additional medical records resource (ie staff hours) was being funded from the Covid investigation budget until the end of the financial year. The CVC asked when the additional medical records resource would end. The ADQSP responded that would be in March 2024 and that potentially the team had front loaded the work, but that it was the right thing to do. The Independent Member – Trade Unions (IMTU) noted that the report mentioned that each Clinical Board had a scrutiny panel and asked what the makeup of that was. The ADQSP responded that the purpose of the scrutiny panel was to consider all elements of the Covid investigations, to agree the level of harm and to establish if there was any breach of duty of care in the context of the pandemic at the time. She added that the makeup of the panels included: • The Clinical Board involved • An Independent Clinical Board acting as a critical friend to challenge discussion • Infection, Prevention and Control representation • Corporate representation The Executive Medical Director (EMD) asked whether the Health Board was benchmarking against other Health Boards.	

	The ADQSP responded that the Health Board had made very good progress early on in the investigations and noted that the Health Board had been key in steering some of the National direction. She added that for openness and transparency purposes, it would be important to note that the Health Board's progress had been slower over the past few months. **The QSE Committee resolved that:** a) The assurance provided by the progress against the framework was noted.	
QSE 23/01/009	**Quality Indicators Report** The Quality Indicators Report was received. The Assistant Director of Patient Experience (ADPE) advised the Committee that she would take the report as read. She added the report had been set out in line with the Duty of Quality and the domains that the Health Board would be asked to report under. It was noted that a lot of information around Duty of Candour had been included because it would be implemented in April 2023. The ADPE advised the Committee that she would pull out key points from the report which included: • A reduction in Nationally Reported Incidents (NRIs) - It was noted that the reduction in NRIs was interesting because the reduction of overdue NRIs each month had been a trend over the last few months and reflected the focus and hard work of the Clinical Boards and Patient Safety Team. • Concerns – It was noted that the Health Board had seen a relatively quiet December period and that concerns had begun to increase in January 2023. It was noted that the Health Board had maintained an overall 30 working day response time for all concerns at 80%. However, a 8% decrease had been observed in November 2022 due to the operational pressures being experienced by the Clinical teams to undertake the investigations. • The Welsh Risk Pool, at the request of Welsh Government (WG), had undertaken a validation exercise of the 2022-23 Q2 quarterly complaints data prepared for submission by the Health Board. It was noted that it had been pleasing to receive substantial assurance regarding the Health Board's data collation and performance information. • Work continued to develop the dashboard for presentation at the Quality, Safety and Experience Committee. The END advised the Committee that, for assurance, development days had been set up in relation to the Duty of Quality and Duty of Candour and noted that the Senior Leadership Board (SLB) would receive a presentation from the centralised WG team. He added that the Board would receive a repeat session as its February Board Development session to ensure that the Independent Members also received the presentation. It was noted that with regards to Infection, Prevention and Control measures, there had been no hospital MRSA infections since January 2022. The EDPH noted that it was positive to see another data driven report to create change/improvement and asked that an "inequity lens" be used when looking at some of the data held to develop the equality and inequity framework. The ADPE responded that a lot of meetings had been held on inequity and a lot of discussions nationally and locally about what could be done. She added that she had spoken to WG colleagues and noted that one of the opportunities identified was to collect ethnicity data with the CIVICA patient system.	

	The ADQPS advised the Committee that in relation to the mortality data, at the last meeting, a paper was presented on the proposed model for reporting and considering mortality data across the Health Board in three tiers: • Tier 1 - Health Board level - Measuring the actual number of deaths over time (crude mortality) supported the monitoring of trends in mortality rates. • Tier 2 - Clinical Board level - The identification of Clinical Board mortality indicators would further support the proposed approach to mortality oversight and learning from death could be achieved by identifying trends in mortality data that supported additional actions and scrutiny. • Tier 3 - Speciality level A brief synopsis of the performance data and statistics regarding fractured neck of femur, Myocardial infraction and stroke, as referred to in the covering report, was presented to the Committee. The ADQPS advised the Committee that it was the first time that still birth data had been presented. She added that it had been an ongoing challenge to get the data and that her team would work with the Obstetrics team to break the data down further to understand variation. The EMD advised the Committee that the still birth data needed to be presented to the Committee but that it also needed to be benchmarked in terms of the population the Health Board was caring for. The CVC noted that the approach was a welcome one and that moving forward, the Committee could be selective as to what data was presented and that when the Health Board were within the benchmarking range, it did not necessarily need to be reported. The ADQPS agreed and noted that that there were a number of groups and Committees across the Health Board that were tasked with Clinical Governance and so the Committee should not take away from their responsibility and function. **The QSE Committee resolved that:** a) The content of the report and the developing process to monitor Quality Indicators was noted.	
QSE 23/01/010	**HIW Activity Overview** The HIW Activity Overview was received. The ADQPS advised the Committee that they would take the report as read and noted that there was little to report as no further unannounced inspections had occurred. She added that Health Inspectorate Wales (HIW) had attended Mental Health Services at Hafan Y Coed the night previously and that any pending reports would be received by the Committee at the point of publication. The ADQPS concluded that an update on HIW's visit to Opthalmology could be provided because all actions had been completed. She added that an audit of compliance with the GMC consent standards was planned for February 2023 and work was underway to develop a bespoke Ophthalmology patient experience survey which would be completed by February 2023. **The QSE Committee resolved that:** a) The assurance provided by the response to HIW inspections and progress against existing improvement plans was noted.	**JR/AH**
QSE 23/01/011	**Community Health Council Reports** The END advised the Committee that there had been no inspections undertaken by the Community Health Council since the previous meeting.	
QSE	**Internal Audit Reports – Verbal**	

23/01/012	It was noted that there had not been any further internal audit reports.	
QSE 23/01/013	**Pressure Damage Verbal Update** The verbal Pressure Damage Update was received. The END advised the Committee that the Pressure Damage Collaboration was supposed to provide an annual paper but noted that due to operational pressures within the Health Board, the paper had been pushed back to March 2023. He added that he would provide the Committee with information prior to the full report in March and noted that a gradual increase in trajectory had been observed within pressure damage and that had been partly due to capacity issues. It was noted that the main focus of the Pressure Damage Collaborative was to reaffirm the actions that had already been implemented. **The QSE Committee resolved that:** a) The verbal Pressure Damage Update was noted.	**JR**
QSE 23/01/014	**Maternity Services – Verbal Update** The verbal Maternity Services Update was received. The END advised the Committee that an unannounced visit from the Health Inspectorate Wales (HIW) had been undertaken in November 2022 and that the Committee had received the information at its November 2022 meeting. He added that following the inspection, an immediate assurance report had been undertaken and noted that the final report was yet to be received by the Health Board. It was noted that the work had continued with Maternity services and that a Maternity Oversight Group had been implemented and it met every 2 weeks. The END advised the Committee that following the Ockenden Report, the Health Board undertook a gap analysis which was shared with the Committee and the Board. He added that it would be taken to the Business Case Approval Group (BCAG) for consideration to complete the gap analysis and actions. It was noted that the Maternity Neonatal group had come together and was established so that the Health Board could identify not only poor practice across Wales but also good practice that could be shared across Wales. The END concluded that a full maternity update paper would be provided to the Committee at its March 2023 meeting. **The QSE Committee resolved that:** a) The Maternity Services Update was noted.	**JR**
QSE 23/01/015	**Board Assurance Report – Patient Safety** The Board Assurance Report – Patient Safety was received. The Head of Risk and Regulation (HRR) advised the Committee that Board Assurance Framework provided Members of the Quality, Safety and Experience Committee with the opportunity to review the risks on the Board Assurance Framework (BAF) which impacted upon Patient Quality, Safety and Experience. He added that the BAF had been shared with the Board at its meeting in November 2022 and had outlined risks which included: • Patient Safety	

	• Maternity • Critical Care • Cancer • Stroke • Urgent and Emergency Care • Planned Care. It was noted that the highest scoring net risks were Patient Safety (20), Maternity (20) and Critical Care (20). The HRR advised the Committee that full details of each risk could be found within the BAF. **The QSE Committee resolved that:** a) The risks in relation to Patient Safety, Quality and Experience were reviewed and noted - to enable the Committee to provide assurance to the Board when the Board Assurance Framework was reviewed in its entirety.	
QSE 23/01/016	**Corporate Risk Register** The Corporate Risk Register (CRR) was received. The HRR advised the Committee that since the July 2021 Board meeting, the Register had recorded only those risks scoring 20 and above. It was noted that at the Health Board's November 2022 Board meeting a total of 17 (from a total of 22 risks scoring 20 or above) extreme risks reported to the Board related to Patient Safety and were linked to the Quality, Safety and Experience Committee for assurance purposes. The HRR advised the Committee that he continued to meet with the Clinical Board triumvirates and their risks were reviewed. The Independent Member – Community (IMC) asked for further assurance on the risks that had remained static in score and asked if there was anything that the Committee could do to help reduce the scores. The HRR responded that the scores had remained static, but that it did not mean that actions were not being undertaken on those risks. He added that the risks were continually reviewed and noted that the scores were difficult to reduce due to operational pressures. The Chief Operating Office (COO) added that the Health Board now had a more joined up approach to risk management and that had helped when with those risks identified at the Clinical Board monthly reviews. The CVC commended the work undertaken around the risks and thanked staff for their hard work. a) The Corporate Risk Register risk entries linked to the Quality, Safety and Experience Committee and the Risk Management development work, which was now progressing with Clinical Boards and Corporate Directorates, were noted.	
QSE 23/01/017	**Committee Annual Report** The Committee Annual Report was received. The Head of Corporate Governance (HCG) advised the Committee that the purpose of the Annual Report item was to provide Members with the opportunity to discuss the draft Committee Annual Report prior to its submission to the Board for approval. She added that all of the Board's Committees produced an Annual Report to demonstrate that they had undertaken the duties set out in their respective Terms of Reference and were able to provide assurance to the Board. It was noted that updates would be made to the Annual Report following the meeting to reflect key matter discussed that day. **The QSE Committee resolved that:**	

	a) The draft Annual Report 2022/23 of the Quality, Safety & Experience Committee was reviewed. b) The Annual Report was recommended to the Board for approval.	
QSE 23/01/018	**Committee Terms of Reference** The Committee Terms of Reference were received. The HCG advised the Committee that a review of the Terms of Reference was held annually and noted that the Director of Corporate Governance had reviewed them. She added that the draft terms were set out within the Terms of Reference and that they would be received by the Board in March 2023 for formal approval. It was noted that there were some comments within the Terms of Reference that were awaiting confirmation. **The QSE Committee resolved that:** a) The Terms of Reference were reviewed b) The Terms of Reference were ratified subject to confirmation c) The Terms of Reference were recommended to the Board on 30th March 2023 for approval.	
QSE 23/01/019	**Policies for ratification including:** The Referrals by Non-Medical Practitioners for Diagnostic Imaging Investigations (Excluding Clinical Trials and Research) Policy and Procedure (UHB 330 and UHB 331) were received. **The QSE Committee resolved that:** a) The Referrals by Non-Medical Practitioners for Diagnostic Imaging Investigations (Excluding Clinical Trials and Research) Policy and Procedure (UHB 330 and UHB 331) were approved.	
QSE 23/01/020	**Joint Research Governance Group Report** The Joint Research Governance Group Report was received. The EMD advised the Committee that she would take the report as read. She added that the report drew attention to the Joint Research Office, the Governance around it and the reporting mechanisms. It was noted that a number of policies ran alongside the JRO that that should assure the Committee that that the way in which research was delivered was fit for purpose. The EMD noted that the Quality Assurance group would develop and review Standard Operating Procedures and that the Clinical Trial Governance Group would overview the governance of higher risk studies. **The Committee resolved that:** a) The establishment of the Joint Research Governance Group, which would report to the QSE Committee as necessary was noted. b) The Group's Terms of Reference and Organogram were noted.	
QSE 23/01/021	**Minutes from Clinical Board QSE Sub Committees:** **Exceptional Items to be raised by Assistant Director Patient Safety & Quality:** The Minutes from Clinical Board QSE Sub Committees were received. **The Committee resolved that:** a) The Minutes from the Clinical Board QSE Sub-Committees were noted.	

QSE 23/01/022	**Items to bring to the attention of the Board / Committee**	
QSE 23/01/023	**Agenda for Private QSE Meeting** i) Private Minutes - ii) Any Urgent / Emerging Themes – Verbal iii) Inpatient Suicides iv) Acute Pressures – UHB response	
QSE 23/01/024	**Any Other Business** The CVC advised the Committee that the response to ongoing acute pressures required discussion and invited the COO and EMD to provide further comment. The EMD responded that the pressures had been identified when discussing the risks and noted that it would be appropriate to mention the enormous pressures being seen across the Organisation, particularly in Unscheduled Care. She added that it was a UK wide challenge and the pressures were an ongoing concern for herself, the END and the COO. It was noted that there was constant ongoing work to manage the pressures, and that much of the work was being driven by the COO's team to address the issues around ambulatory waits, bed pressures as well as many others across the system. The EMD noted that the risks were being reviewed on a daily basis, and that managing the patients as quickly as possible was key, whilst ensuring patient safety. She added that getting urgent patients, who were waiting for specialist care, into the hospital was challenging as well as repatriating patients into other organisations, and so it required really close scrutiny on a multiple daily basis to achieve what was required. It was noted that the Health Board were an exemplar for other Health Boards and that other Health Boards would be visiting Cardiff and Vale that week to explore the ways in which the Health Board was approaching the ongoing pressures. The END noted that he had nothing further to add but thanked all of the staff and acknowledged the work that was being undertake. The CVC reiterated the Committee's thanks to staff and his thanks as the Vice Chair of the Board. **The Committee resolved that:** a) The ongoing pressures within the Health Board were noted.	
QSE 23/01/025	**Review of the meeting.** The EDPH noted that the meeting had been shorter than previous meetings with accurate and sharper data. She thanked everybody for their support. The CVC noted that 4 hours had been set aside for the meeting which was a long time and that it could be shortened. The EMD advised the Committee that with the frequency of the meetings being increased to monthly, the number of hours could decrease.	
	Date & Time of Next Meeting: Tuesday, 7 March 2023 via Teams	

GIG CYMRU NHS WALES
Pwyllgor Gwasanaethau Ambiwlans Brys
Emergency Ambulance Services Committee

EMERGENCY AMBULANCE SERVICES JOINT COMMITTEE MEETING

'CONFIRMED' MINUTES OF THE MEETING HELD ON 6 DECEMBER 2022 AT 13:30HOURS VIRTUALLY BY MICROSOFT TEAMS LIVE

PRESENT

Members:	
Chris Turner	Independent Chair
Stephen Harrhy	Chief Ambulance Services Commissioner (CASC)
Nicola Prygodzicz	Chief Executive, Aneurin Bevan ABUHB (in part)
Suzanne Rankin	Chief Executive, Cardiff and Vale CVUHB
Steve Moore	Chief Executive, Hywel Dda HDUHB
Carol Shillabeer	Chief Executive, Powys PTHB
Sian Harrop-Griffiths	Director of Strategy, Swansea Bay SBUHB
Associate Members:	
Jason Killens	Chief Executive, Welsh Ambulance Services NHS Trust (WAST)

In Attendance:	
Elizabeth Beadle	Deputy Director of Planning, Cwm Taf Morgannwg University Health Board
Rachel Marsh	Director of Planning, Strategy and Performance, Welsh Ambulance Services NHS Trust (WAST)
Matthew Edwards	Head of Commissioning & Performance EASC Team, National Collaborative Commissioning Unit (NCCU)
Colette Rees	National Collaborative Commissioning Unit (NCCU)
Gwenan Roberts	Committee Secretary

Part 1. PRELIMINARY MATTERS		**ACTION**
EASC 22/132	**WELCOME AND INTRODUCTIONS** Chris Turner (Chair), welcomed Members to the virtual 'Teams Live' meeting (using the Microsoft Teams platform) of the Emergency Ambulance Services Committee and gave an overview of the arrangements for the meeting.	Chair
EASC 22/133	**APOLOGIES FOR ABSENCE** Apologies for absence were received from Gill Harris, Paul Mears, Mark Hackett, Steve Ham and Tracey Cooper.	Chair
EASC 22/134	**DECLARATIONS OF INTERESTS** There were none.	Chair
EASC 22/135	**MINUTES OF THE MEETING HELD ON 8 NOVEMBER 2022** The minutes were **confirmed** as an accurate record of the Joint Committee meeting held on 8 November 2022. Members **RESOLVED** to: • **APPROVE** the minutes of the meeting held 8 November 2022.	Chair
EASC 22/136	**ACTION LOG** Members **RECEIVED** the action log and **NOTED** that it would be discussed in more detail at the EASC meeting on 17 January 2023. Members were invited to raise any specific issues, there were none. Members **RESOLVED** to: **NOTE** the Action Log.	Chair
EASC 22/137	**MATTERS ARISING** There were no matters arising from the minutes.	Chair
EASC 22/138	**CHAIR'S REPORT** The Chair's informed the meeting that he did not have any specific issues to raise.	Chair
Part 2. ITEMS FOR DISCUSSION AND APPROVAL		**ACTION**
EASC 22/139	**PERFORMANCE REPORT** The Performance Report was received.	

	In presenting the report Stephen Harrhy gave an update on the current emergency ambulance performance and an overview of the range of actions and processes that had or would be implemented to support performance improvement. The report also presented information in line with the most recent publication(s) of the Ambulance Service Indicators. Members noted that the report presented a picture of a system that was under severe and sustained pressure. It was reported that ambulance performance was well below levels that the Committee would want delivered and the actions being taken to improve performance were included within the report. Members were reminded that a proposal had previously been approved by Committee to alter a number of dispatch codes and that the likely consequence was that an increase the number of red calls would be received. It was noted that the service had started to see this impact. Members noted the current position with record numbers of handover delays at hospital sites across Wales. Most members had been present at the recent Ministerial Summit that took place on 28 November, with the aim of discussing ongoing concerns around ambulance handover delays that were causing harm to patients. It was noted that the Minister for Health and Social Services opened the Summit by outlining her concerns around handover delays and reminded those in attendance of their organisational commitments to reducing delays. Examples of improvements were shared by Walsall Healthcare NHS Trust, with key messages in relation to the organisational ownership of patients from the time they call 999 and take leadership for their care within the organisation. In addition, Cardiff and Vale University Health Board shared their experience of improving handover delays, following a focus on the 4-hour red line and further work was planned to further reduce delays. Each health board provided an update on their handover improvement plans and commitments at the Summit. It was agreed that the presentation by Walsall NHS Trust provided a helpful focus on areas of learning. It was proposed that further contact would be facilitated via the Chief Ambulance Services Commissioner rather than through a number of separate discussions and that this would be in line with the work in Goal 4 of the Six Goals for Urgent and Emergency Care Programme.	ALL / Stephen Harrhy

	Members noted that: • Fortnightly handover improvement plan meetings continued to be helpful and constructive and ensured specific consideration of the agreed trajectories • Conveyance rates were reducing, while it was noted that this impact must be considered in light of a reduction in attendance in response to escalation decisions it was also noted that this reflected the increasing role of 'hear and treat' and the impact of recent investment in both staff and technology within the clinical support desk. Close relationships with NHS Wales 111 were also felt to be an important factor in reducing conveyance. • Members noted the 'hear and treat' efficiency target of 10.2% of daily volume and that the Welsh Ambulance Services NHS Trust (WAST) had set an internal target of 15% by the end of the calendar year, it was reported that 16% had been reported on some days. The impact of new video technology and staff use of the ECNS (Emergency Nurse Communication System) to support decision-making was noted. • The level of risk and harm to patients across the system was widely recognised and the additional need to protect ambulance resources out of area, particularly for rural areas at a distance from emergency departments • Actions making a significant impact across the system included use of alternative pathways and services other than conveyance to emergency departments where appropriate to do so, a focus on the effective use of falls services and strengthened liaison between health boards and WAST to ensure effective communication, handover and release, particularly against the four-hour trajectory • Work continued in partnership with local authorities to increase community care capacity with in excess of 450 bed/bed equivalents extra reported to date. Members were in agreement that this was significant, however, this would not solve the problems across the system with further work required on longer term provision, including additional care packages and support for people leaving hospital. The Chair summarised and noted the key messages of the Minister for Health and Social Services in her closing remarks including the need for organisational commitment to the agreed actions, a focus on fewer key actions and the sharing of the key actions already having an effect. Members **RESOLVED** to: • **NOTE** the content of the report. • **NOTE** the Ambulance Services Indicators	

	• **NOTE** additional actions that the Committee could take to improve performance delivery of commissioned services • **NOTE** the handover improvement Ministerial summit discussion and the specific requirements of organisations.	
EASC 22/140	**UPDATE ON PROGRESS RELATED TO THE SERVICE DEVELOPMENT PROPOSAL FROM THE EMERGENCY MEDICAL RETRIEVAL AND TRANSFER SERVICE (EMRTS CYMRU)** The report on progress related to the Service Development Proposal from EMRTS Cymru was received. This update provided Members with an overview of the progress made since the Committee meeting on 8 November 2022. The EASC Team was asked to progress on: • clarifying the position regarding resource implications • responding to the significant comments raised and views regarding the importance of response times • understanding how the air and road response model works, recognizing that for urban and rural areas it would be different • further work required regarding the impact of weather • consideration of the data reference period to ensure that this is appropriate and not unintentionally biased • understanding any seasonal variation • improving the understanding of the options available, including to consider whether changing bases is necessary, identifying further options and understanding why options have been discounted • working with health board colleagues to consider the modelling undertaken. It was noted that, given the above requirements and the challenges raised by Committee members and stakeholders and in order to avoid protracted discussions over the process, content and transparency of the original proposal, the EASC Team had undertaken to start the process of undertaking this analysis afresh. Members noted that the scrutiny in key areas would continue. The report focused on a description of the current service provision and the historical activity that had been delivered, including an overview of four specific areas related to base activity, these were: • Geographical coverage • Rapid Response Vehicle Usage (RRV) • Utilisation • Unmet need.	

	Members noted there were potential opportunities for service improvement to be explored. The utilisation of all resources was included and, as an example to amplify this issue, both Caernarfon and Welshpool bases were reported as having lower levels of utilisation than the bases in Dafen and Cardiff. It was understood that an element of this would be related to the rural position and lower population density in these areas but options to provide equitable services should be explored. It was proposed that, when combined with unmet need, this would demonstrate that the EMRT service could potentially do more within its existing resource if changes were implemented to increase utilisation and reduce unmet need. Members agreed that there was a need to explore and maximise the additional activity that could be achieved from existing bases and also to explore how any options to reconfigure the service could reduce the number of patients who require a critical care response from EMRTS but currently do not receive one (unmet need). The report also provided clarity on the role and purpose of modelling and Committee members noted that modelling outputs would be part of a robust evaluation process, not used as a sole determinant. As per the request at the last meeting, activity data from 2022 and weather probability information had been integrated into the preparation for the modelling, and this in turn would support further scenario modelling. The outputs of modelling were determined by the assumptions that would be placed upon the modelling scenarios and, in order to do this, an understanding of the constraints that should be applied to any development process would be required. Members noted that the report EMRTS 24/7 Service Expansion Review (received at the EASC meeting on 13 November 2018) provided the constraints that were adopted as part of the work and it was suggested that a similar a set of constraints would be appropriate and helpful for this current review. The report also included the investment objectives that were used as part of the original case for the establishment of the 24-hour EMRTS service and the weighting that was applied to these objectives to inform the decision-making process for the 24/7 expansion review.	

	The investment objectives were: • Health Gain • Affordability • Clinical Skills and Sustainability • Equity • Value for Money. The Committee was asked to consider that the initial engagement process with the public, individual health boards and the Wales Air Ambulance Charity Trust should explore the appropriateness of the constraints, investment objectives and weighting presented, as part of a robust option appraisal process to inform discussion once further modelling and analysis was complete. Stephen Harrhy gave an overview of the engagement activity that had been undertaken by the EASC Team since the last EASC meeting which included: • Activities undertaken with many stakeholders both face to face and virtually • Ongoing collation of, and responses to, over 60 stakeholder comments and questions • Circulation of the latest stakeholder Briefing Note 2 • Updates to Community Health Councils (CHCs) and confirmation of the agreed key principles of engagement • Fortnightly meetings with health board engagement, communication and service change leads. The report proposed that the EASC Team would need to work closely with health board engagement, communication and service change leads and with Community Health Council (CHCs) colleagues in the development and agreement of appropriate engagement materials including the engagement document and the stakeholder engagement timetable. It was proposed that the formal public engagement process could commence in early January, subject to agreement of engagement materials by health boards and CHCs. The proposed engagement would include two phases, these were: **Phase 1:** • Explain how the current service works • Test the constraints, investment objectives and weightings **Six-Week Review** • Agree options to be modelled	EASC Team

	Phase 2: • Undertake the modelling and use to inform a robust option appraisal process • Make a recommendation to EASC Members. Members discussed: • The importance of utilisation of resources and the need for a balance in terms of availability of resources against the efficiency and effectiveness of service delivery (not over or underutilised) • The need to explore reasonable utilisation levels considering population densities, urban vs rural locations etc • EMRTS as a national service, not covering a geographical area like road-based ambulances • The need to understand the current co-ordination and deployment process • The need to review operating hours when looking at options to maximise additional activity that could be achieved from existing bases and the options to reconfigure • The impact of the announcement of the preferred bidder for the new aircraft contract; it was confirmed that this process had been ongoing for sixteen months and that the only agreement in place was for four aircraft plus the back-up capability. Members noted that there had been no pre-determination on the number of or location of bases, this was pending the outcome of the EASC processes (engagement) • The need for a range of engagement material, including the need for them to be bilingual and easy to understand • the need to develop an effective engagement approach that asked the right questions and reached as many people as possible. It was agreed that this would need to be a collaborative effort with health boards and CHC colleagues and that local leads would be able to inform this, e.g. the positive Powys experience utilising drop-in sessions was noted • The two phases of engagement proposed, including the review at six-weeks; Members supported this approach • Questions had been raised by Swansea Bay University Health Board ahead of the meeting asking for additional clarification on the engagement process, the work with health boards and the community health councils and the need for Equality Impact Assessments • The need for a pragmatic approach in terms of signing off the engagement materials, involving Engagement or Service Change Leads working with Board Secretaries. Members noted Gwenan Roberts would be the point of contact from the EASC Team	Gwenan Roberts

	• Formal public engagement could commence 9 January if the required agreed documents were in place • Consideration be given regarding short term support for the EASC Team. The Chair confirmed that he would ensure the required assurance was in place ahead of undertaking Chair's Action (on behalf of the Committee) to commence the formal engagement process. Members resolved to: • **NOTE** the high-level overview provided and the variation in service delivery from the existing bases • **AGREE** that the issues highlighted by this paper require further exploration and options appraisal process to deliver improvements • **APPROVE** the service development constraints to be engaged upon • **APPROVE** the EMRTS key investment objectives and weightings to be engaged upon • **APPROVE** the commencement of a formal public engagement process as agreed • **APPROVE** the use of the agreed constraints to inform subsequent modelling and development of options • **APPROVE** the use of agreed EMRTS key investment objectives and weightings in the options appraisal process • **APPROVE** Chair's action to commence the formal engagement process when documentation agreed.	
EASC 22/141	**FORWARD LOOK AND ANNUAL BUSINESS PLAN** The Forward Look and Annual Business Plan was received. The Chair asked Members to forward any suggestions for future 'Focus on' sessions. Members **RESOLVED** to: **APPROVE**.	
Part 3. OTHER MATTERS		**ACTION**
EASC 22/142	**ANY OTHER BUSINESS** There was no other business raised. The Chair closed the meeting by thanking Members for their contribution to the discussions.	
DATE AND TIME OF NEXT MEETING		
EASC 22/143	The next scheduled meeting of the Joint Committee would be held at 13:30 hrs, on Tuesday 17 January 2023 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 ……

Archwilio Cymru
Audit Wales

Annual Audit Report 2022 – Cardiff and Vale University Health Board

Audit year: 2021-22

Date issued: January 2023

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Summary report

About this report

1 This report summarises the findings from my 2022 audit work at Cardiff and Vale University Health Board (the Health Board) undertaken to fulfil my responsibilities under the Public Audit (Wales) Act 2004. That Act requires me to:

- examine and certify the accounts submitted to me by the Health Board, and to lay them before the Senedd;
- satisfy myself that expenditure and income have been applied to the purposes intended and are in accordance with authorities; and
- satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources.

2 I report my overall findings under the following headings:

- Audit of accounts
- Arrangements for securing economy, efficiency, and effectiveness in the use of resources

3 This year's audit work took place at a time when NHS bodies continued to respond to the unprecedented and ongoing challenges presented by the COVID-19 pandemic. Health bodies were not only tackling the immediate challenges presented by the public health emergency but were also seeking to recover and transform services to respond to the significant numbers of people who are waiting for treatment and improve population health. My work programme, therefore, was designed to best assure the people of Wales that public funds are well managed. I have considered the impact of the current crisis on both resilience and the future shape of public services.

4 I aimed to ensure my work did not hamper public bodies in tackling the crisis, whilst ensuring it continued to support both scrutiny and learning. We largely continued to work and engage remotely where possible through the use of technology, but some on-site audit work resumed where it was safe and appropriate to do so. This inevitably had an impact on how we deliver audit work but has also helped to embed positive changes in our ways of working.

5 As was the case in the previous two years, the delivery of my audit of accounts work has continued mostly remotely. The success in delivering it reflects a great collective effort by both my staff and the Health Board's officers.

6 I have adjusted the focus and approach of my performance audit work to ensure its relevance in the context of the crisis and to enable remote working. I have commented on how NHS Wales is tackling the backlog of patients waiting for planned care. My local audit teams have commented on how governance arrangements have adapted to respond to the pandemic, and the impact the crisis has had on service delivery.

7 This report is a summary of the issues presented in more detailed reports to the Health Board this year (see **Appendix 1)**. I also include a summary of the status of work still underway, but not yet completed.

8 **Appendix 2** presents the latest estimate of the audit fee that I will need to charge to cover the costs of undertaking my work, compared to the original fee set out in the 2022 Audit Plan.

9 **Appendix 3** sets out the audit of accounts risks set out in my 2022 Audit Plan and how they were addressed through the audit.

10 The Chief Executive and the Director of Finance have agreed the factual accuracy of this report. We presented it to the Audit and Assurance Committee on 7 February 2023. The Board will receive the report at a later Board meeting and every member will receive a copy. We strongly encourage the Health Board to arrange its wider publication. We will make the report available to the public on the Audit Wales website after the Board have considered it.

11 I would like to thank the Health Board's staff and members for their help and co-operation throughout my audit.

Key messages

Audit of accounts

12 I concluded that the Health Board's 2021-22 accounts[1] were properly prepared and materially accurate and I therefore issued an unqualified true-and-fair opinion on them. My work did not identify any material weaknesses in the Health Board's internal controls (as relevant to my financial audit).

13 However, I qualified my regularity opinion because the accounts include an accounting provision (and corresponding expenditure) of £2.193 million, which I deem to be irregular. The amount relates to the Health Board's estimated liability arising from a Ministerial Direction in 2019 to the Permanent Secretary of the Welsh Government. This matter also affected other Welsh health boards.

14 I found no other regularity matters of a material adverse nature. In terms of financial performance, the Health Board achieved financial balance for the three-year period ending 31 March 2022, against both its revenue and capital resource limits.

15 I reported eight audit issues, together with my audit recommendations, to officers and the Health Board's Audit and Assurance Committee. Officers formally accepted all the recommendations and agreed management actions and dates of

[1] I audit and certify the Health Board's Performance Report, Accountability Report and Financial Statements. 'Accounts' is a generic term.

implementation. I will review the Health Board's progress with the actions as part of my 2022-23 audit.

Arrangements for securing efficiency, effectiveness, and economy in the use of resources

16 My programme of Performance Audit work has led me to draw the following conclusions:

- despite the additional investment in waiting-list recovery, the significant growth in the numbers of people waiting is likely to mean that waiting lists will not return to pre-pandemic levels for many years.
- the Health Board has agreed quality and safety priorities at all levels of the organisation. Corporate and operational structures for quality governance are reasonably effective. However, there are opportunities to strengthen aspects of culture and quality improvement. Further investment is required to enable the Health Board to fully roll out and embed planned quality and safety improvements.
- the Health Board has increased its strategic focus on the future configuration of its estate, but there is insufficient Board-level visibility of the condition of the existing estate.
- generally, the Health Board's corporate arrangements support good governance and the efficient, effective, and economical use of resources in most areas. Plans to refresh the Health Board's long-term strategy present opportunities to strengthen these arrangements further by ensuring key structures, processes, and resources are fully aligned to strategic objectives and risks.

17 These findings are considered further in the following sections.

Detailed report

Audit of accounts

18 Preparing annual accounts is an essential part of demonstrating the stewardship of public money. The accounts show the organisation's financial performance and set out its net assets, net operating costs, gains and losses, and cash flows. My annual audit of those accounts provides an opinion on both their accuracy and the proper use ('regularity') of public monies.

19 My 2022 Audit Plan set out the key risks for audit of the accounts for 2021-22 and these are detailed along with how they were addressed in **Exhibit 4** in **Appendix 3**.

20 My responsibilities in auditing the accounts are described in my Statement of Responsibilities publications, which are available on the Audit Wales website.

Accuracy and preparation of the 2021-22 accounts

21 I concluded that the Health Board's accounts were properly prepared and materially accurate (true and fair) and I issued an unqualified audit opinion on them. My work did not identify any material weaknesses in the Health Board's internal controls (as relevant to my financial audit).

22 I reported eight audit issues, together with my audit recommendations, to the officers and the Health Board's Audit and Assurance Committee. Officers formally accepted all the recommendations and agreed management actions and dates of implementation.

23 I must report issues arising from my work to those charged with governance (the Members of Board), for their consideration before I issue my audit opinion on the accounts. My audit team reported these issues to the Board on 14 June 2022. **Exhibit 1** summarises the key issues set out in that report.

Exhibit 1: issues reported to the Board

Issue	Auditors' comments
Uncorrected misstatements	There is one area of uncorrected misstatements. It relates to the value of the Health Board's buildings, with their disclosed value as at 31 March 2022 being understated by £10.280 million. Three associated disclosures were also misstated, by amounts of £8.184 million, £2.096 million, and £331,000.

Issue	Auditors' comments
	I judge the four misstatements not to be material to my audit opinions on the 2021-22 accounts.
Corrected misstatements	I reported a number of important corrected misstatements, which mainly relate to accounting classifications and disclosures.
Other significant issues	I reported eight recommendations for improvement, with management's formal responses. The Health Board's Audit and Assurance Committee considered them on 6 September 2022.

24 I also undertook a review of the Health Board's Whole of Government Accounts return. I concluded that the counterparty consolidation information was consistent with the Health Board's financial position at 31 March 2022 and the return was prepared in accordance with the Treasury's instructions.

25 My separate audit of the charitable funds' financial statements is currently ongoing. I am due to report my findings to the Health Board's Board of Trustees on 9 February 2023.

Regularity of financial transactions

26 I qualified my regularity opinion because the 2021-22 accounts include an accounting provision (and corresponding expenditure) of £2.193 million, which I deem to be irregular. The amount relates to the Health Board's estimated liability arising from a Ministerial Direction in 2019 to the Permanent Secretary of the Welsh Government. This matter also affected other Welsh health boards.

27 The Ministerial Direction covered the need for interim remedial action to address the impact of HM Treasury's changes to the tax arrangements on senior clinicians' pension contributions. I placed an explanatory narrative report alongside my audit report on the accounts.

28 The Health Board's financial transactions must be in accordance with authorities that govern them. The Health Board must have the powers to receive the income and incur the expenditure. Our work reviews these powers and tests that there are no material elements of income or expenditure which the Health Board does not have the powers to receive or incur.

29 Where a Health Board does not achieve financial balance, its expenditure exceeds its powers to spend and so I must qualify my regularity opinion. **Exhibits 2 and 3** show that the Health Board met both its revenue and capital resource allocations.

30 Except for the £2.193 million, I found no material financial transactions that were not in accordance with authorities nor used for the purposes intended. In terms of financial performance, the Health Board achieved financial balance for the three-year period ending 31 March 2022. Since the introduction of the National Health Services Finance (Wales) Act 2014, this outcome is the first time that the Health Board achieved a three-year financial balance, across both revenue and capital resource limits.

Exhibit 2: financial performance against the revenue resource allocation

	2019-20 £'000	2020-21 £'000	2021-22 £'000	Total £'000
Operating expenses	1,025,612	1,205,955	1,213,676	3,445,243
Revenue resource allocation	1,025,670	1,206,045	1,213,908	3,445,623
Under (over) spend against allocation	58	90	232	380

Exhibit 3: financial performance against the capital resource allocation

	2019-20 £'000	2020-21 £'000	2021-22 £'000	Total £'000
Capital charges	58,070	95,343	70,948	224,361
Capital resource allocation	58,159	95,447	70,989	224,595
Under (over) spend against allocation	89	104	41	234

Source: audited 2021-22 accounts

Arrangements for securing efficiency, effectiveness, and economy in the use of resources

31 I have a statutory requirement to satisfy myself that the Health Board has proper arrangements in place to secure efficiency, effectiveness, and economy in the use of resources. I have undertaken a range of performance audit work at the Health

Board over the last 12 months to help me discharge that responsibility. This work has involved:

- undertaking a high level review of how NHS Wales is tackling the planned care backlog;
- reviewing the effectiveness of the Health Board's quality governance arrangements;
- undertaking a follow-up review of the recommendations made in my 2017 review of the Health Board's arrangements for managing its estates; and
- undertaking a structured assessment of the Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically.

32 My conclusions based on this work are set out below.

Tackling the planned care backlog in Wales

33 In May 2022, I published a report that set out the extent of the planned care backlog in NHS Wales, and the key actions the system needs to take to start to tackle the backlog. My report highlighted the continued growth of the overall waiting list numbers month on month, whilst noting the rate of growth was slowing. It also noted that the inevitable drop in referrals seen during the pandemic would likely result in this latent demand eventually coming back into the system. Taking these and other factors into account, my work estimated that it could be as much as seven years before overall waiting list numbers in Wales returned to pre-pandemic levels.

34 The Welsh Government has produced a national recovery plan for planned care with key milestones for health boards to achieve, including an initial focus on those patients facing very long waits. However, those milestones are already proving difficult to achieve.

35 In line with the key actions I set out in my report, the Health Board, along with others in Wales, will need to both build and protect capacity for planned care, and continue to maintain a focus on efficiency and productivity.

36 The Health Board will also need to ensure that it actively manages the clinical risks to patients that are facing long waits for treatment, and enhance its systems for communicating with patients to help them manage their condition whilst they are waiting and inform them of what to do if their condition deteriorates.

Quality governance arrangements

37 My review examined whether the organisation's governance arrangements support delivery of high quality, safe and effective services. The review focused on both the operational and corporate approach to quality governance, organisational culture and behaviours, strategy, structures and processes, information flows and reporting.

38 My work found **that the Health Board has agreed quality and safety priorities at all levels of the organisation. Corporate and operational structures for quality governance are reasonably effective. However, there are opportunities to strengthen aspects of culture and quality improvement, and further investment is required to enable the Health Board to fully roll out and embed its planned quality and safety improvements. Arrangements for clinical audit need significant improvement and there is scope to enhance the effectiveness of the Quality, Safety and Experience Committee by ensuing it provides greater oversight of risks related to quality and safety.**

39 Although the Health Board has agreed quality and safety priorities at all levels of the organisation, we found they were not sufficiently aligned with each other. We also found that the Health Board's arrangements for monitoring and reporting on their delivery need to be strengthened. There is effective collective responsibility for quality and safety amongst Executive Leadership, and corporate and operational structures and processes for quality and safety are improving.

40 There are reasonable corporate and operational arrangements in place for monitoring and managing risk. However, there is scope to ensure the corporate Quality, Safety, and Experience Committee maintains greater oversight of risks overseen by other committees where there is a clear quality and safety impact. Agendas for corporate and operational quality and safety meetings provide a wide coverage of quality and safety issues for discussion. However, the agenda of corporate Quality, Safety, and Experience Committee meetings could be more dynamic to reflect new and emerging quality risks and issues.

41 The Health Board produces sufficient information to support scrutiny and assurance at both corporate and clinical board levels. The Health Board's use of quality data is maturing, and its arrangements for monitoring mortality and morbidity are developing. The Health Board has effective arrangements to monitor and track progress with complaints, where it consistently achieves performance targets. Its arrangements for capturing patient experience are reasonably effective. However, arrangements for clinical audit require significant improvement.

42 The Health Board has a well-established values and behaviour framework, which is embedded in workforce processes. However, it needs to ensure that staff feel able to raise concerns.

Estates Follow-up Review

43 My work considered the Health Board's progress in implementing the recommendations arising from my 2017 review of the Health Board's arrangements for managing its estates. I found **that the Health Board has made reasonable progress against the recommendations made in my 2017 report. The Health Board has increased its strategic focus on the future estate but there is insufficient Board-level visibility of the condition of the existing estate**.

44 In 2017, we made seven recommendations. My follow-up review found that the Health Board had implemented two recommendations, two had been superseded, and one was ongoing. No progress had been made against two recommendations. My follow-up review made three recommendations, designed to enable the Health Board to address outstanding issues.

45 Specifically, I found the Health Board has commenced work to develop a new estate strategy, which will be linked to the Health Board's refreshed ten-year strategy and capital plan. However, there is little Board level oversight and scrutiny of issues related to the condition of the existing estate.

46 The Health Board has implemented structural and process changes to enable more effective estate service delivery, but local and national workforce shortages and pay differentials present significant and immediate risks to maintaining a safe and effective service. In the longer term, this presents potential risks to the Health Board's ability to sustain its existing estate while it delivers on its programme of replacement and redevelopment.

Structured assessment

47 My 2022 structured assessment work took place at a time when NHS bodies were not only continuing to tackle the challenges presented by COVID-19 but were also seeking to recover and transform services to respond to the significant numbers of people who are waiting for treatment and improve population health.

48 My team focussed on the Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically, with a specific focus on the organisation's governance arrangements; strategic planning arrangements; financial management arrangements; and arrangements for managing the workforce, digital assets, the estate, and other physical assets. Auditors also paid attention to progress made to address previous recommendations.

Strategic planning arrangements

49 My work considered the Health Board's strategic planning arrangements, with a particular focus on the organisation's:

- vision and strategic objectives;
- integrated medium-term plan;
- planning arrangements; and
- arrangements for implementing and monitoring the delivery of corporate strategies and plans.

50 My work found **that the Health Board's approach to planning is generally effective and inclusive, with good Board-level oversight and stakeholder involvement. Refreshing its long-term strategy and producing an approvable IMTP must remain key priorities for the Health Board**.

51 The Health Board has a well-established vision and long-term strategy, underpinned by a clear programme for transforming clinical services. However, it recognises the vision and strategy need to be refreshed to reflect current opportunities, and challenges. The Health Board's planning arrangements are generally effective, with good evidence of stakeholder involvement and engagement in the development of corporate plans and strategies. There is also evidence of good Board-level oversight of the Health Board's planning arrangements. However, the Health Board has been unable to produce a financially balanced and Welsh Government approved Integrated Medium Term Plan (IMTP) for 2022-2025. The Health Board has taken positive steps to improve its arrangements for implementing corporate plans and strategies and monitoring their delivery. This should provide the needed assurances at Board level.

Governance arrangements

52 My work considered the Health Board's governance arrangements, with a particular focus on:

- Board and committee effectiveness;
- the extent to which organisational design supports good governance; and
- key systems of assurance.

53 My work found **that the Health Board is generally well led and well governed with maturing systems of assurance, an appropriate organisational structure, and a stable executive team. Plans to refresh governance structures and align them to revised strategic objectives provide opportunities to further enhance Board and committee effectiveness and systems of assurance**.

54 The Health Board's systems of assurance continue to mature at a corporate level, and work is underway to strengthen arrangements at an operational level. However, there is scope to make greater use of the Board Assurance Framework to shape Board and committee business. Whilst the Board and its committees provide good oversight of the Health Board's performance, reports do not always provide sufficient assurances that appropriate action is being taken to sustain or improve performance.

55 The Health Board has good arrangements in place to conduct Board business effectively and transparently. There is a full Executive Team in place which now appears stable following a period of operating with interim appointments. The organisational structure remains stable and appropriate; however, it will need to be kept under constant review as the Health Board refreshes its long-term strategy, and rolls-out new clinical and workforce models.

Managing financial resources

56 My work considered the Health Board's arrangements for managing its financial resources, with a particular focus on the organisation's:

- arrangements for meeting key financial objectives;
- financial controls; and
- arrangements for reporting and monitoring financial performance.

57 My work found **that there are adequate arrangements in place to support financial planning, management, and control. Whilst finances are well scrutinised, improving its longer-term financial position must remain a key priority**.

58 The Health Board achieved its financial duties for 2021-22. However, it failed to produce a financially balanced IMTP for 2022-2025. It also risks not achieving its financial duty to break even at the end of 2022-23 due to the need to manage its underlying deficit and address growing cost pressures.

59 The Health Board's arrangements for financial management and control are adequate. It has taken positive steps to enhance public transparency by ensuring detailed papers on counter fraud and procurement are discussed in public, rather than in private Audit and Assurance Committee meetings, where this is appropriate.

60 Financial reports are regularly scrutinised by the Finance Committee, and provide a clear and open overview of the Health Board's financial performance, challenges, and risks.

Managing the workforce, digital resources, the estate, and other physical assets

61 My work considered the Health Board's arrangements for managing its wider resources, with a particular focus on the organisation's:

- arrangements for supporting staff wellbeing;
- arrangements for managing its digital resources; and
- arrangements for managing its estate and other physical assets.

62 My work found **that whilst there is good Board-level oversight of matters relating to the workforce and digital resources, there is scope to increase the Board's focus on matters relating to the current estate and physical assets**.

63 There is good Board-level oversight of the arrangements in place to support staff wellbeing. However, the Board receives little assurance on the impact of the Health Board's staff wellbeing initiatives. The Health Board recognises this and is in the process of developing a way of effectively measuring and reporting the impact of wellbeing activities.

64 The Health Board has a clear Digital Strategy which is aligned to its current long-term strategy. There are good arrangements in place for ensuring Board-level

oversight of digital matters. However, a lack of detailed delivery plans, limited funding, and staffing challenges is hampering the Health Board's pace in implementing its digital priorities.

Appendix 1

Reports issued since my last annual audit report

Exhibit 4: reports issued since my last annual audit report

The following table lists the reports issued to the Health Board in 2022.

Report	Date
Financial audit reports	
Audit of Financial Statements Report	June 2022
Opinion on the Financial Statements	June 2022
Audit of Financial Statements Report Addendum	August 2022
Charitable Funds (2020-21 Accounts)	January 2022
Performance audit reports	
Tackling the Planned Care Backlog in Wales	May 2022
Review of Quality Governance Arrangements	June 2022
Estates Follow-up Review	November 2022
Structured Assessment 2022	December 2022
Other	
2022 Audit Plan	March 2022

My wider programme of national value-for-money studies in 2022 included reviews that focused on the NHS and pan-public-sector topics. These studies are typically funded through the Welsh Consolidated Fund and are presented to the Public Accounts Committee to support its scrutiny of public expenditure. Reports are available on the Audit Wales website.

Exhibit 5: performance audit work still underway

There are a number of performance audits that are still underway at the Health Board. These are shown in the following table, with the estimated dates for completion of the work.

Report	Estimated completion date
Orthopaedics	February 2023
Unscheduled care – patient flow out of hospital	March 2023
Primary Care Services – Follow-up Review	June 2023
Review of workforce planning arrangements	June 2023
Unscheduled care – access to unscheduled care services	September 2023

Appendix 2

Audit fee

My 2022 Audit Plan set out my fee estimate of £394,965 (excluding VAT, which is not chargeable). I will write to the Director of Finance soon to confirm the actual chargeable fee relating to the above fee estimate; and for the separate fee estimate and actual fee for my audit of the Health Board's 2021-22 charitable account (the audit is due to conclude in February 2023).

Appendix 3

Audit of accounts risks

Exhibit 6: audit of accounts risks

My 2022 Audit Plan set out the risks for the audit of the Health Board's 2021-22 accounts. The table below lists these risks and sets out how they were addressed as part of the audit.

Audit risk	Proposed audit response	Work done and outcome
The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.31-33].	I will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for biases; • evaluate the rationale for any significant transactions outside the normal course of business; and • add additional procedures to address any specific risks of management override which are not addressed by the mandatory work above.	I reviewed a number of the accounting estimates and a sample of transactions that included journal entries. My audit findings were materially satisfactory.
Under the NHS Finance (Wales) Act 2014, health boards ceased to have annual resource limits with effect from 1 April 2014. They instead	I will continue to monitor the Health Board's financial position for 2021-22 and the cumulative three-year position to 31 March 2022, for both the	As set out in this report, my audit confirmed that the Health Board met its three-year resource allocations for both revenue and capital.

Audit risk	Proposed audit response	Work done and outcome
moved to a rolling three-year resource limit, with a limit for revenue and another limit for capital. The first three-year period ran to 31 March 2017. The Health Board has exceeded its rolling three-year revenue limit in the past five years, and I have therefore qualified my regularity opinion on the financial statements for those years. For 2021-22 and the three years to 31 March 2022, Health Board forecasts[2] to operate within its revenue and capital resource limits, subject to anticipated 2021-22 COVID-19 funding of £21.3 million from the Welsh Government. If the Health Board receives the anticipated funding, and maintains its forecast position, it would support an unqualified regularity opinion. Your current financial pressures do, however, increase the risk that management's judgements and	revenue and capital-resource limits. This review will also consider the impact of any relevant uncorrected misstatements over the three years. If the Health Board fails to meet the three-year resource limits for revenue and/or capital, I would expect to qualify my regularity opinion on the 2021-22 financial statements. I may also place a substantive report on the financial statements to explain the basis of the qualification and the circumstances under which it had arisen. I will focus some of my testing on areas of the financial statements which could contain reporting bias.	

[2] Based on the Month 11 year-end forecast, which the Health Board has reported to the Welsh Government.

Audit risk	Proposed audit response	Work done and outcome
estimates could be biased in an effort to achieve the financial duty.		
The implementation of the 'scheme pays' initiative in respect of the NHS pension tax arrangements for clinical staff is ongoing. Last year we included an 'emphasis of matter' paragraph in the audit opinion drawing attention to your disclosure of the contingent liability. Applications to the scheme will close on 31 March 2022, and if any expenditure is made in-year, I would consider it to be irregular as it contravenes the requirements of Managing Welsh Public Money.	I will review the evidence one year on around the take-up of the scheme and the need for a provision, and the consequential impact on the regularity opinion.	As set out in this report, for 2021-22, the Health Board provided for an estimated liability and costs of £2.193 million and, as advised in the 2022 Audit Plan, I qualified my regularity opinion accordingly.
While COVID-19 restrictions are due to be removed in Wales on 28 March 2022, there have been ongoing pressures on staff resource and of remote working that may impact on the preparation, audit and publication of the financial statements. There is a risk that the	I continue to discuss your closedown process and quality monitoring arrangements with the relevant officers.	I continued my discussions with officers and monitored the arrangements in place and I am pleased to report that no significant problems arose.

Audit risk	Proposed audit response	Work done and outcome
quality of the accounts and supporting working papers may be compromised, leading to an increased incidence of errors.		
There continues to be increased funding streams and expenditure in 2021-22 to deal with the COVID-19 pandemic. They could have a significant impact on the risks of material misstatement and the shape and approach to our audit. Examples of issues include: fraud, error and regularity risks of additional spending; valuation (including obsolescence) of year-end inventory, including PPE; and the estimation of year-end annual leave balances.	I will identify the key issues and associated risks and plan my work to obtain the assurance needed for my audit.	I reviewed transactions and balances relating to COVID-19, and tested them where appropriate. My audit findings were satisfactory.
I audit some of the disclosures in the remuneration report to a far lower level of materiality, such as the remuneration of senior officers and independent members. The disclosures are therefore inherently more prone to material misstatement. In past audits I have identified	I will examine all entries in the remuneration report to verify that it is materially accurate.	I examined all entries and misstatements were corrected where necessary.

Audit risk	Proposed audit response	Work done and outcome
material misstatements in the draft remuneration report submitted for my audit, which the Health Board had to correct. I therefore judge the 2021-22 disclosures to be at risk of misstatement.		
I also audit the disclosure of related party transactions and balances to a far lower level of materiality. Last year I identified a number of material disclosures that had been omitted and had to be added.	I will verify that all the necessary signed declarations have been received, evaluated, and disclosed appropriately and accurately. My examinations also include other means of testing, such as my review of Companies House records using data analytics.	I reviewed all the disclosures and undertook my intended tests for completeness. I found some anomalies that were corrected, and my overall testing was therefore satisfactory.

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Report Title:	Corporate Risk Register				Agenda Item no.	8.2	
Meeting:	Board Meeting		Public	x	Meeting Date:	30/03/2023	
			Private				
Status *(please tick one only):*	Assurance	x	Approval		Information		x
Lead Executive:	Director of Corporate Governance						
Report Author (Title):	Head of Risk and Regulation						

Main Report
Background and current situation:

The Corporate Risk Register ("the Register") has been developed to provide the Board with an overview of the key operational risks from the Clinical Boards and Corporate Directorates.

The Register includes those extreme risks which are rated 20 (out of 25) and above but, it may also include risks of a lower score when required to inform the Board of specific risks with the potential to affect the achievement of UHB strategic objectives.

The Board has oversight of the Health Board's Strategic Risks via the Board Assurance Framework and its extreme Operational Risks via the Register.

The Register Summary is attached at Appendix A. The Board are asked to note that the Register Summary lists risks in order of highest to lowest risk scores, whilst retaining reference numbers from the detailed Register to enable cross referencing between the two documents. The detail of each risk listed is also discussed and reviewed at the appropriate Committee of the Board.

The Health Board's Risk Management and Board Assurance Framework Strategy and the Health Board's Risk Management procedures have been reviewed by Internal Audit and received a reasonable assurance rating at the July 2022 Committee meeting of the Audit and Assurance Committee. A further review of the Health Board's Risk Management Strategy is underway and it is anticipated that a positive Assurance rating will be achieved following continued development of Risk Management processes throughout the 2022/23 financial year.

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

The Risk and Regulation Team ("the Team") continue to work alongside Clinical Boards and Corporate Directorates to ensure that risks are clearly defined and appropriately scored in line with the Health Board's Risk Management and Board Assurance Framework Strategy and associated procedures.

The Team's predominant focus of support to Clinical Boards/Corporate Directorates has been to provide advice and guidance to risk leads/risk owners in their assessment and management of complex risks, and the refinement of their internal risk management processes. In addition, the Team continue to support requests from senior risk managers to deliver risk assessment and risk management training to their teams and newly appointed risk managers. The Board should note that Clinical Board risks are also monitored and scrutinised at Bi-Monthly Clinical Board Review Meetings.

Operating within the three 'Lines of Defence', the team have continued to provide risk register 'check and challenge' feedback reports to Clinical Boards/Corporate Directorates detailing recommendations for the improvement of their risk registers and, where relevant, the rationale for not placing candidate risks onto the Register. The team have maintained the assurance of this process by adopting a 'whole team' peer review approach prior to providing feedback to risk leads.

The Team are also working alongside Clinical Board Triumvirates and Corporate Directorates to embed the Health Board Assurance Strategy within existing Risk Management practices. Initially this includes the development of an Assurance Map that will identify what Assurance can be taken in relation to those risks included within the Register alongside a refresh of the strategy itself. An updated version of the Health Board's Assurance Strategy is shared for ratification at this Board meeting (see agenda item 7.8) following approval at the February 2023 Audit and Assurance Committee meeting.

There are currently 30 Extreme Risks recorded on the Register, 3 of which (risks 7, 9 and 15) will be removed from the Register following the March 2023 Board meeting. These risks will be removed because they have been superseded or because they have been mitigated to a score below 20/25 and will continue to be managed locally. The risks to be removed from the register are coloured grey for ease of identification.

The remaining 27 risks within the Register remain unchanged following the January 2023 Board Meeting. All 27 Risks will continue to be recorded on the Register beyond the March Board meeting.

The Board are asked to note that some of the risks within the Corporate Risk Register are amalgamations of separate risks:

- Risks CRR1 and CRR4 on the Corporate Risk Register are amalgamations of risks within the Capital Estates and Facilities Risk Register;
- Risk CRR 22 is an amalgamation of risks within the Children and Women Clinical Board Register in relation to maternity services; and
- Risk CRR26 is an amalgamation of Estates and Infrastructure risks originating within Critical Care settings.

The amalgamation allows for ease of incorporation onto the Corporate Risk Register and does not detract from the description, impact, score or management of the original entries.

Candidate risks were accepted from Capital Estates and Facilities and the Medicine, Children and Women, CD&T and Specialist Services Clinical Boards. Due to their nature, those risks previously reported by Finance and Digital Healthcare have been carried forward this month. The Strategic Planning and Health and Safety Corporate Directorates reported no Extreme Risks.

Returns were received from Surgery, Mental Health and PCIC Clinical Boards with no reported risks added to the Register on this occasion. It is possible that reported risks may be added to the Register at a subsequent Board meeting however on this occasion it is felt that the reported risks need to be considered in further detail and refined before being added to the Register.

The present position is therefore as follows:

January 2023	March 2023
• 1 Risk rated 25 (Extreme Risk) in relation to Nursing Workforce within the Medicine Clinical Board • 21 Risks rated 20 (Extreme Risk), 2 of which are new entries. • 2 risks to be removed from the Corporate Risk Register.	• 27 Risks rated 20 (Extreme Risk), 8 of which are new entries. It should be noted that Risk 6, in relation to Nursing Workforce, has been de-escalated to a 20 having previously recorded a score of 25. • 3 risks to be removed from the Corporate Risk Register.

Trend Analysis. Staff shortages, particularly within the Nursing Workforce, and Capital and Estates issues, remain a dominant feature of a number of risks. Operational level mitigations appear to be reducing the impact of these risk types on patient safety but they are adversely impacting on Urgent and Planned care capacity. Notably an increased number of risks linked to Maternity Services have been reported on this occasion.

Each risk on the Register can be linked to the Strategic Risks detailed upon the BAF and are grouped as follows:

Board Assurance Framework Risk	Corporate Risk Register Entry
Patient Safety	1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27
Capital Assets	1, 2, 3, 4, 12, 16, 23, 26, 27, 30
Workforce	4, 6, 11, 14, 20, 21
Financial Sustainability	5, 28, 29
Staff Wellbeing	4, 6, 11, 24
Critical Care	24, 25, 26
Planned Care	7, 9, 13, 14
Cancer	7, 9, 13, 14
Maternity	15, 16, 17, 19, 22
Urgent and Emergency Care	6, 8, 10
Digital Strategy and Road Map	30
Delivery of IMTP 22-25	28, 29

ASSURANCE is provided by:

- Ongoing discussions with Clinical Boards and the Corporate Directorates regarding the scoring of risk.
- The Risk and Regulation Team's 'check and challenge' of Clinical Board/Corporate Directorate candidate risks.
- The programme of education and training that is being implemented by the Risk and Regulation team to ensure that the Health Board's Risk Management policy is engrained and followed within Clinical Boards and Corporate Directorates.
- Increasing routine dialogue on risk issues between Clinical Board/Corporate Directorate Risk Leads and the Team.
- The Reasonable Assurance rating provided by Internal Audit for the Health Board's Risk Management processes.

Recommendation:

The Board are requested to:

Note the Corporate Risk Register and the work in this area which is now progressing.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

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

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

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

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes
The management and maintenance of the Health Board's Corporate Risk Register contributes to the Health Board's Risk Management processed and procedures.
Safety: No
Financial: No
Workforce: No
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation: No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Quality Safety and Experience Committee	11.04.2023
Mental Health Capacity and Legislation Committee	02.05.2023

CORPORATE RISK REGISTER SUMMARY MARCH

Risk Ref	Risk (for more detail see individual risk entries)	Clinical Board / Corporate Directorate	Link to BAF	Initial Risk Score	Risk Score November 22	Risk Score January 23	Risk Score March 23	Target Risk Score
CRR1	Risk of patient harm due to obsolete Oxygen and Nitrous Oxide medical gas Plant and Equipment at various UHB sites	Estates	Patient Safety Capital Assets	5x4=20	5x4=20	5x4=20	5x4=20	5x1=5
CRR2	Risk of patient harm due to interruption of oxygen supply to the whole of UHW resulting from a corroded oxygen pipeline.	Estates	Patient Safety Capital Assets	5x4=20	5x4=20	5x4=20	5x4=20	5x1=5
CRR3	Risk of loss of heating throughout UHL due to serious corrosion of Main Boiler F&E Tanks	Estates	Capital Assets Patient Safety	5x4=20	5x4=20	5x4=20	5x4=20	5x1=5
CRR4	Risk to staff safety and regulatory compliance due to non-compliance with HTMs for ventilation - multiple locations UHW	Estates	Workforce, Capital Assets Staff Wellbeing, Patient Safety	5x4=20	5x4=20	5x4=20	5x4=20	5x1=5
CRR5	Risk to estimated expenditure in financial plans due to significant increases in energy tarrifs	Estates	Financial Sustainability	4x5=20	4x5=20	4x5=20	4x5=20	4x4=16
CRR6	Risk of staff and patient harm due to difficulties recruiting sufficient numbers of nursing staff.	Medicine	Workforce, Staff Wellbeing Patient Safety Urgent and Emergency Care	5x5=25	5x5=25	5x5=25	5x4=20	5x3=15
CRR7	Risk of patient harm due to patients with suspected (Basal cell carcinoma) BCC being added to Routine waiting lists secondary to increased Referal to Treatment times.	Medicine	Patient Safety Cancer Planned Care	5x5=25	5x4=20	5x4=20	5x3=15	5x3=15
CRR8	Risk of patient harm due to delays to patient treatment and flow following a speciality referral from the Emergency Unit	Medicine	Patient Safety Urgent and Emergency Care	5x5=25	5x4=20	5x4=20		5x3=15
CRR9	Risk of patient harm due to delayed cancer diagnosis secondary to accumulation of therapeutic and surveillance case numbers.	Medicine	Patient Safety Planned Care Cancer	5x5=25	5x4=20	5x4=20	5x3=15	5x2=10
CRR10	Risk of patient harm and breaches of Welsh Government waiting time guidance due to delays admitting patients from WAST	Medicine	Patient Safety Urgent and Emergency Care	5x5=25	5x4=20	5x4=20	5x4=20	5x2=10
CRR11	Risk of delay in the assessment of patients leading to clinical risk and poor patient experience due to an inability to provide medical cover across the Medicine Clinical Board.	Medicine	Patient Safety Workforce, Staff Wellbeing	5x5=25	5x4=20	5x4=20	5x4=20	5x2=10
CRR12	Risk of overcrowding in the Emergency and Acute Medicine footprint resulting in an ability to meet key quality standards impacting on patient experience, quality of care and discharge.	Medicine	Patient Safety Capital Assets	5x5=25	5x4=20	5x4=20	5x4=20	5x2=10
CRR13	Risk of patient harm due to the progression of conditions from benign to malignant disease due to increased waiting times for surveilance and planned recall endoscopy procedures.	Medicine	Patient Safety Cancer Planed Care	5x5=25			5x4=20	5x2=10
CRR14	Risk of patient harm due to workforce and capacity constraints across Gastroenterology & Endoscopy	Medicine	Patient Safety Cancer Planed Care Workforce	5x5=25			5x4=20	5x2=10
CRR15	Risk of harm to compromised fetuses and reduced options for termination of pregnancy due to capacity shortfalls witin Fetal Medicine	Children and Women	Patient Safety Maternity	5x5=25	5x4=20	5x4=20	Closed	5x2=10

CRR16	Risk of harm to mothers and babies due to delayed lift replacement works and inadequate repairs within the Maternity Services lifts	Children and Women	Patient Safety Maternity Capital Assets	5x5=25			5x4=20	5x1=5
CRR17	There is a risk of harm and poor patient experience as a result of lack of available provision for emergency gynaecology care.	Children and Women	Patient Safety	4x5=20			4x5=20	4x2=8
CRR18	Risk of harm to Children and young people due to increased demand for CAHMS services	Children and Women	Patient Safety	5x5=25			5x4=20	5x2=10
CRR19	Risk of patient harm and experience and reputational damage due to non-compliance against Ockenden Report recommendations	Children and Women	Patient Saferty Maternity	4x5=20			4x5=20	4x2=8
CRR20	Risk of patient harm within Child and Adolescent Learning Disability Services due to staff vacancies.	Children and Women	Patient Safety Workforce	4x5=20			4x5=20	4x2=8
CRR21	Risk of failure to comply with regulatory requirements and patient harm due to delays in assessment within Children Looked After Services.	Children and Women	Patient Safety Workforce	4x4=16			4x5=20	4x2=8
CRR22	Risk of patient harm and poor patient experience due to staffing difficulties and shortages within maternity services.	Children and Women	Patient Safety Maternity	5x5=25	5x4=20	5x4=20		5x2=10
CRR23	There is a risk to the delivery of modern, safe and sustainable healthcare due to suboptimal estate across the Clinical Board	CD&T	Patient Safety Capital Assets	5x5=25	5x4=20	5x4=20		5x2=10
CRR24	Risk to patient safety causing serious incidents due to patients not being admitted to Critical Care Department in a timely manner due to insufficient nursing workforce	Specialist Services	Patient Safety Critical Care Staff Wellbeing Workforce	5x5=25	5x4=20	5x4=20	5x4=20	5x2=10
CRR25	Risk to patient safety causing serious incidents due to patients not being admitted to Critical Care Department in a timely manner due to insufficient bed capacity.	Specialist Services	Patient Safety Critical Care	5x4=20	5x4=20	5x4=20	5x4=20	5x2=10
CRR26	Risk that patients will not receive care in a suitable environment due to a number of shortcomings in Critical Care facilities.	Specialist Services	Patient Safety Critical Care Capital Assets	4x5=20	4x5=20	4x5=20	4x5=20	4x2=8
CRR27	Risks to harm to haematology patientx (including bone marrow transplant) due to cross infection hazards created by an inadequate clinical environment.	Specialist Services	Patient Safety Capital Asstes	5x5=25	5x4=20	5x4=20	5x4=20	5x1=5
CRR28	Risk failure to achieve revenue statutory duty breakeven duty and achieve an approved three year IMTP	Finance	Financial Sustainability Delivery of IMTP 22-25	5x4=20	5x4=20	5x4=20	5x4=20	5x2=10
CRR29	Risk of failure to achieve an approved Three Year IMTP due to a planned defecit of £17.1 million	Finance	Financial Sustainability Delivery of IMTP 22-25	5x4=20	5x4=20	5x4=20	5x4=20	5x2=10
CRR30	Risk of service interuption and potential patient harm due to cyber security threats	Digital Health	Capital Assets Digital Strategy and Road Map	5x5=25	5x4=20	5x4=20	5x4=20	5x3=15

Report Title:	**Stakeholder Reference Group Report**			Agenda Item no.	8.3.5
Meeting:	**UHB Board**	Public	X	Meeting Date:	**30th March 2023**
		Private			
Status *(please tick one only):*	Assurance		Approval		Information
Lead Executive:	Executive Director of Strategy and Planning				
Report Author (Title):	**Sam Austin, Chair of Stakeholder Reference Group**				

Main Report
Background and current situation:

BACKGROUND
This is a report provided to the Board by the Chair of the UHB SRG.

ASSESSMENT
The SRG considered the following.

Reflections of UHB Chief Executive
Suzanne Rankin explained that her initial positive impressions of the UHB had been proved correct and indeed they had deepened. She now had a much greater understanding of the very complex underlying challenges and now felt far more emotionally connected to the Health Board and its population. Suzanne Rankin then briefly outlined what she perceived to be the UHB's strengths, weaknesses, opportunities and threats

Suzanne Rankin explained that the UHB would focus on delivering best value healthcare and there would be an emphasis on strategic interventions to prevent people requiring healthcare e.g. public health initiatives. There have been a number of significant recent improvements in the care that the UHB delivers. Ambulance handover times have improved greatly with many patients being handed over within an hour. Cancer performance has improved and post-COVID planned care recovery is well underway with no planned admissions being cancelled over the Christmas/New Year period. The UHB's Mental Health Service is doing some extraordinary outreach work and signposting citizens to other potential services e.g. those provided by the third sector

The SRG enquired whether there were lessons to be learned from the industrial action and whether there was anything that the UHB could do to prevent further action. Suzanne Rankin explained that the UHB recognised the right of staff to strike. It was always possible to learn lessons but the UHB is unable to influence pay scales and the cost of the pay demands are unaffordable to Welsh Government.

It was agreed that Suzanne Rankin would return to the SRG later in the year.

Decarbonisation Plan
The SRG received a presentation from Calum Shaw on the development of the UHB's Decarbonisation Plan which will be published in March 2023. The context in which the Decarbonisation Plan would be developed was explained. Welsh Government has set a target of a net zero carbon Wales by 2050 and a net zero carbon public sector by 2030. The UHB through the NHS Wales Shared Services Partnership Decarbonisation Strategic Delivery Plan, also has emission reduction targets of 16% by 2025 and 34% by 2030. The UHB's 2021/22 emissions profile was outlined and the challenges faced by the UHB if it was to meet this target were explained. Although calculation of supply chain emissions is immature, it is estimated that 81% of the UHB's emissions can be attributed to its supply chain which has a single use business model. It is worth noting that even a 50% reduction in electricity use would save just 2% of carbon emissions. A lot of different initiatives undertaken by many people will therefore be required to make significant progress with reducing carbon emissions. The UHB was not developing its Decarbonisation Plan in isolation as both Cardiff and Vale of Glamorgan Public Services Boards have carbon reduction in their respective draft Wellbeing Plans. The UHB Strategy and Delivery Committee had discussed how decarbonisation could be embedded in the organisation and there was extremely good clinical leadership with one of the UHB's Associate Medical Directors championing decarbonisation. The SRG was then asked some specific questions

- Do you have any advice or suggestions around the Decarbonisation Plan process?
- Do you have any comments/thoughts on the approach?

- Has anyone had any experience of decarbonisation behaviour change with their organisation? What worked well/not so well?
- Any other comments?

The SRG then made a number of observations and suggestions.

- It will not be possible to achieve the desired reduction in emissions unless individuals relate to decarbonisation in their everyday lives
- Can pharmaceutical regulations be revisited to reduce waste?
- Drugs should only be prescribed if they will benefit patients rather than patients obtaining automatic repeat prescriptions.
- Further work needs to be undertaken on the way staff and patients travel to the UHB's sites and more sustainable means of transport must be encouraged.

Strategy Refresh

The SRG was thanked for the role it had played in the development of the Strategy Refresh Engagement pack. The SRG then received a presentation on the engagement pack and was updated on the proposed timeline for launching the refreshed strategy. Cardiff Third Sector Council would help with rolling-out the engagement to the third sector networks and harder to reach groups. The Community Health Council would also run a number of public engagement sessions. Members of the SRG were encouraged to complete the online survey themselves and to take the engagement pack out to their own organisations and networks.

Future Provision of Cochlear Implant and Bone Conduction Hearing Implant Device Services for Children and Adults in South East Wales, South West Wales, South Powys

The SRG was encouraged to participate in Welsh Health Specialised Services Committee's engagement on the Future Provision of Cochlear Implant and Bone Conduction Hearing Implant Device Services for Children and Adults in South East Wales, South West Wales, South Powys, a link to which would be issued to SRG members.

Recommendation:

The Board / Committee are requested to:

- **NOTE** this report

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

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

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

Prevention	X	Long term	X	Integration	X	Collaboration	X	Involvement	X

Impact Assessment:

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

Risk: Yes/No

N/A
Safety: Yes/No
N/A
Financial: Yes/No
N/A
Workforce: Yes/No
N/A
Legal: Yes/No
N/A
Reputational: Yes/No
N/A
Socio Economic: Yes/No
N/A
Equality and Health: Yes/No
N/A
Decarbonisation: Yes/No
N/A

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

Report Title:	Local Partnership Forum Report			Agenda Item no.	8.3.2
Meeting:	UHB Board	Public	x	Meeting Date:	30 March 2023
		Private			
Status *(please tick one only):*	Assurance		Approval		Information x
Lead Executive:	Executive Director of People and Culture				
Report Author (Title):	Deputy Head of People Assurance and Experience				

Main Report
Background and current situation:

The UHB has statutory duty to "take account of representations made by persons who represent the interests of the community it serves". This is achieved in part by three Advisory Groups to the Board and the Local Partnership Forum (LPF) is one of these.

LPF is co-chaired by the Chair of Staff Representatives and the Executive Director of People and Culture. Members include Staff Representatives (including the Independent Member for Trade Unions) and the Executive Team and Chief Executive. The Forum usually meets 6 times a year.

LPF is the formal mechanism for the Health Board and Trade Union/Professional Organisation Representatives to work together to improve health services. Its purpose, as set out in the Terms of Reference, fall into four overarching themes: communicate, consider, consult and negotiate, and appraise.

Key items discussed at the meeting held on 8 February 2023 can be summarised as follows:

The Executive Director of Finance, deputising for the Chief Executive, provided an **update report** to the Forum. Key points included:

- Winter pressures – the organisation experienced tough times in the autumn quarter and though these difficulties remain, we are starting to see some signs of better flow within our urgent care system and our ability to maintain planned care.
- Industrial action – this is ongoing around securing a pay award for 2023-24 that meets the needs of our staff. The operational implications are being handled in a systematic way though this in turn creates pressure on our services, staff and patients.
- Strategy refresh – we are renewing our strategy to address the long-term effects the pandemic has had on our services and population.

The Deputy Director of Strategy and Planning shared the **Shaping Our Future Wellbeing Refresh** engagement presentation and asked the Forum to provide feedback on the proposals. Staff representatives raised concerns about equitable access to health services and asked what we are doing to address this. The Executive Director of Public Health advised that while there is a lot of work in place around preventative services, there is still more to do around equitable access to services particularly amongst our ethnic minority communities. She advised that work has begun around developing a framework that looks at the overlaps between equality, equity of access and patient safety led by the Public Health team

The Deputy Director of Strategy and Planning also provided an update on the **Integrated Medium Term Plan**. She advised that it will be a fairly short, focused document outlining how our operational plan will be delivered against key strategic pillars like access to care and improving health inequalities. It will also set out how we will deliver against the 16 priorities set out by the Minister.

The Deputy Director of Therapies and Health Sciences delivered a presentation on the **Rehabilitation Programme** which was very well received. The presentation showed how the

Programme had developed to incorporate Covid rehabilitation and has been refreshed using digital resources to make virtual delivery more accessible. The is a four-tiered approach:

- Level 1 is around keeping people well using self-management community guidance
- Level 2 focusses on enabling people to live well, using brief interventions to allow them to move back quickly to Level 1.
- Level 3 supports people to live well through complex group-based interventions, delivered by people with lived experience to support behavioural changes.
- Level 4 is professionally led holistic support delivered on a one-to-one basis.

A 'meaningful conversation' model has been developed and all AHPs trained in having conversations that might traditionally be outside of their scope of practice, but that allow patients to discuss things they may have problems or need help with; in some cases, this will mean they don't need referring on to another healthcare professional. The Programme includes elements such as support for long covid, recovering well from surgery, 'food wise' and 'escape pain' among others. We have seen significant improvements in people's health and wellbeing from running these programmes, with 83.7% of service users reporting a clinically significant positive change. Over 12,000 visits that would traditionally have taken place in a hospital setting have instead been delivered in the community and unnecessary travel reduced by 130,000 miles. We have received an AHP award for the rehabilitation model and were amongst the digital finalists for the 'Keeping Me Well' website.

The Assistant Director of Quality, Safety and Improvement and Head of Risk and Regulation were present to give a presentation on **the learning from covid-19 and the UHB response to the Covid inquiry**. Key points included:

- the process followed for hospital acquired Covid-19 and when it is subject to a proportionate investigation.
- the significant changes over time in our knowledge, evidence and guidance, and an acknowledgement that in the early months, guidance was often changing on a daily basis
- it has been identified that the movement of patients across our sites has been associated with increased COVID outbreaks
- The inquiry launched last year involves 3 different modules – our involvement is with module 3 which is looking at the impact of the COVID-19 pandemic on healthcare systems in England, Wales and Scotland. The organisation is prepared to participate with support from an internal team of archivists, COVID-19 steering group and solicitors. Regular updates will be provided to the LPF.

The Deputy Director for People and Culture provided a **review of year one of the People and Culture Plan**. Despite the challenging workforce position a lot has been achieved in year 1; in year 2 we need to continue to embed the People and Culture plan across the organisation to ensure these actions and responsibilities are shared across the clinical boards and other departments. From April onwards, the People and Culture team will be focusing on strategic priorities with operational issues dealt with by the People Services team. We will continue to focus on the 7 themes with an added emphasis on improving how we attract, recruit and retain staff. We will also look at our workforce models, considering new and extended roles and reducing our reliance on temporary work force. Though sickness and turnover remain high, we have seen some improvement in VBAs and statutory and mandatory training across the health board. With such a large organisation, progress is often hidden by the overall position and future reports will aim to break down this data to show the variance between our clinical boards. The Chair of Staff Representatives agreed that exploring the narrative behind this data would help with understanding the impact of our improvement work, but re-iterated previous requests for staff representatives to be more involved in progressing the work set out in the Plan.

The Local Partnership Forum received a copy of the **Integrated Performance Report** which had previously been considered by Board.

The **Employment Policy Sub Group minutes** from the meeting held on 20 January 2023 were noted.

Executive Director Opinion and 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 8 February 2023.

Recommendation:

The Board is requested to:

- NOTE the contents of this report

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

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

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

Prevention		Long term		Integration		Collaboration	x	Involvement	

Impact Assessment:

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

Risk: Yes/No No

Safety: Yes/No Yes

Patient Safety, Quality and Experience is included in the Integrated Performance Report

Financial: Yes/No Yes

The financial situation is included in the Integrated Performance Report and was also referred to in the CEO Update and IMTP Update

Workforce: Yes/No Yes

Key WOD KPIs and workforce actions are included in the Integrated Performance Report

Legal: Yes/No No
Reputational: Yes/No No
Socio Economic: Yes/No No
Equality and Health: Yes/No No
Not explicitly but the Local Partnership Forum takes a keen interest in the EDI agenda
Decarbonisation: Yes/No No

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

Pwyllgor Gwasanaethau Ambiwlans Brys
Emergency Ambulance Services Committee

Reporting Committee	**Emergency Ambulance Services Committee**
Chaired by	Chris Turner
Lead Executive Directors	Health Board Chief Executives
Author and contact details.	Gwenan.roberts@wales.nhs.uk
Date of last meeting	17 January 2023

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

An electronic link to the papers considered by the EAS Joint Committee is provided via the following link:
https://easc.nhs.wales/the-committee/meetings-and-papers/january-2023/
The minutes of the EASC meeting held on 6 December were approved.

PERFORMANCE REPORT
The Performance Report was received which included the Ambulance Service Indicators and the EASC Action Plan.

Noted that:

- the report provided an update on current emergency ambulance performance and an overview of the range of actions and processes that have been, or are being, implemented to support performance improvement;
- the report presented information in line with the most recent publication of the Ambulance Service Indicators (November information), the publication of December performance data would take place on 19 January;
- Chart 1 – significant challenge in relation to call volume and answer times;
- Chart 3 – the impact of remote clinical support for patients, the increasing numbers of patients receiving an outcome of "hear and treat" and the collection of more granular data on patient outcomes as a result of investment in both staff and technology within the clinical support desk;
- while there has been a reduction in the number of incidents receiving a response overall, there has been an increase in Red incident volume and that by their nature red incidents often require multiple responses at scene (Chart 4);
- the addition of the Cymru High Acuity Resource Unit (CHARU) [a new type of resource that is replacing rapid response vehicles (RRVs), focused on improving clinical outcomes for the sickest patients] to the chart illustrating the total level of emergency medical services (EMS) hours produced (Chart 5);
- that CHARU is a key driver of improved outcomes for sicker patients;
- the continued challenges regarding red and amber performance (Chart 7 & 8);
- the unprecedented levels of ambulance handover lost hours and how these posed a real and significant challenge to the delivery of timely, safe and effective emergency ambulance provision for the population (Chart 10);
- the Ministerial Summit held on 28 November 2022 related to handover delays with the aim of discussing ongoing concerns around impact of delays on patient harm.

Each health board provided an update on their handover improvement plans and commitments;
- further, the Minister closed the meeting by asking attendees to continue to work with the Chief Ambulance Services Commissioner (CASC) and the EASC team to update handover improvement plans and to make immediate improvements to reduce the risk to patients in the community;
- the EASC Action Plan including the actions that had been agreed to improve the current position. This is also taken through the Cwm Taf Morgannwg UHB Audit and Risk Committee.

Agreed that:
- a summary of the Briefing Session on emergency ambulance performance that took place prior to the EASC Committee meeting would be presented with the minutes.

Members **RESOLVED** to:
- **AGREE** to consider all additional actions that could be taken to improve performance and delivery of commissioned services.

LOCAL INTEGRATED COMMISSIONING ACTION PLANS (ICAP) UPDATE

Noted that:
- progress has been made against the development of Integrated Commissioning Action Plans (ICAPs) aligned to the Emergency Ambulance Services Collaborative Commissioning Framework Agreement;
- the EASC Team have been working collaboratively with health boards and WAST in the development of the ICAPs;
- each health board has submitted outline ICAPs which have been reviewed by the EASC Team;
- going forward meetings will be held with health boards and WAST to review performance data relating to ambulance handover delays and data aligned to the delivery of actions set out in the health board's ICAP, also to consider any operational or strategic matters arising. Performance data will be monitored via the weekly performance dashboard that is circulated to all health boards and WAST;
- meetings will also be held to focus on the delivery of joint actions (health board and WAST) and individual actions set out in the ICAPs as well as to consider opportunities for shared learning, again these will include both health boards and WAST;
- the actions and outputs of the ICAP process will provide direction and content for the development of each organisation's IMTPs;
- updated ICAPs will also be included within the EASC Action Plan.

Members **NOTED** the report as presented.

UPDATE ON PROGRESS RELATED TO THE SERVICE DEVELOPMENT PROPOSAL EMERGENCY MEDICAL RETRIEVAL AND TRANSFER SERVICE (EMRTS CYMRU) AND WALES AIR AMBULANCE CHARITY

Noted that:
- the report updates members on the progress made with the EMRTS Service Review and specifically that the review would be independent of the assumptions, comparisons and modelling included within the original EMRTS Service Development Proposal, previously received by the Committee;

- members had agreed to explore opportunities for service improvement, particularly utilisation and the impact of rurality and population density on levels of utilisation;
- members had also agreed to explore and maximise the additional activity that could be achieved from existing bases and to explore options to reconfigure the service;
- in relation to the formal public engagement process, Members agreed the need to engage upon the constraints, investment objectives and weightings as part of Phase 1, and that those applied as part of the decision-making process for the EMRTS 24/7 Service Expansion Review in 2018 would also be appropriate for this process;
- while Members had approved Chair's Action to commence the formal engagement process once engagement materials were agreed by all parties (but not before 9 January), the EASC Team had been supporting the NHS response to the current system pressure and therefore the required materials were not yet ready;
- nevertheless, the EASC Team had continued to work with health board engagement, communication and service change leads to draft the required engagement materials for development with CHC colleagues and this work would now continue apace;
- there was a high level of public interest in the service and in taking part in the engagement process. The work would ensure that materials are agreed in a timely manner;
- further, there was a commitment to get the engagement process right, not to rush the process and to ensure that plenty of notice is provided to ensure that those that want to participate would be provided with the opportunity to do so;
- an overview of the activities and engagement undertaken by the EASC Team was provided including responding to the comments and questions received from stakeholders, preparing and circulating briefing notes, updating CHC lead representatives and ongoing meetings with health board communication and engagement leads;
- following discussion at the December meeting, the team had been successful in securing dedicated communication and engagement support from a health board;
- a Senedd debate had taken place on Wednesday 11 January and that the approach being taken has been endorsed by Senedd Members. Key points raised by Members during the debate would be considered in this engagement work.

Agreed that
- (as at previous meeting), Chair's Action would be taken to commence the formal engagement process once engagement materials are agreed by all parties, expected to be in early February.

Further noted that
- members recognised the impact of supporting the wider system during times of unprecedented pressure on the NHS over recent weeks and months;
- key stakeholders were keen to understand when the formal public engagement process was likely to commence, even an indicative date would be helpful;
- early February was being worked towards, and that if further support was required from health boards during this period this would be forthcoming.

The Chair reported that he had been closely briefed on the work being undertaken in recent weeks and was keen to ensure that due process was undertaken. The Chair would continue to track the progress being made and would undertake Chair's Action when he has the required assurance that all materials and arrangements were in place.

Members **RESOLVED** to:

- **NOTE** the report as presented
- **AGREE** that Chair's Action will be taken to commence the formal engagement process once engagement materials are agreed by all parties, expected to be early February in line with agreement at EASC meeting on 6 December 2022.

QUALITY AND SAFETY REPORT

Noted that:

- report provided Members with an update on the quality and safety matters for commissioned services currently being supported by the EASC Team;
- responding to the Healthcare Inspectorate Wales (Welsh Ambulance Services NHS Trust) Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover. Following feedback from HIW a further update was provided. During 2023, the EASC Team would be required to develop a final output response for HIW on the recommendations. Input from Health Boards and WAST would be essential in the development of this response;
- establishing and coordinating a task and finish group to review the Appendix B process, to make recommendations for improvement and to monitor the impact of these. While the pilot process was live across Wales, the group continued to meet to share learning and good practice, alongside evaluating the impact of the new process. EASC Management Group will be asked to endorse the approach at their next meeting (see Action Log 'EASC 22/120');
- that the pilot process was felt to be working well and that it would be useful to have a performance framework to track the progress of investments made and the improved outcomes for patients;
- work would also now be undertaken to include key quality and safety matters relating to Non-Emergency Patient Transport Services and the Emergency Medical Retrieval and Transfer Service within the EASC Quality & Safety Report;
- there has been a growth in the levels of adverse incidents, media interest, HM Coroner inquests and subsequent Regulation 28 reports, Prevention of Future Deaths. This was likely to increase as a result of the deteriorating performance and escalation position that had been seen since the autumn of 2021;
- the EASC team would continue to work with WAST and HB colleagues to understand the level of harm within the system and to develop additional processes for the committee to assure itself that it is discharging its statutory responsibilities for the planning and securing of emergency ambulances;
- the intention to develop the report to include more metrics and performance measures to sit alongside the existing Performance Report and to enhance the Committee's knowledge in terms of quality, outcomes and harm.

Members **NOTED** the report as presented.

EASC INTEGRATED MEDIUM TERM PLAN UPDATE

Noted that:

- the private briefing session held prior to the Committee meeting had been helpful in discussing performance matters and the actions in place to improve these
- the briefing session would ensure that similar ambitions and assumptions aligned to EASC Commissioning Intentions would be built in to the EASC, WAST and health board IMTPs

- IMTPs would now be drafted and developed via the EASC governance arrangements and peer groups for discussion at the February meeting of the EASC Management Group and agreement at the March meeting of EAS Committee
- IMTPs would need to be submitted to Welsh Government by end of March 2023.

Members **NOTED** the update provided.

WELSH AMBULANCE SERVICES NHS TRUST REPORTS
WAST Provider Report
Noted that:
- this provided an update on key issues affecting quality and performance for Emergency Medical Services (EMS) and Ambulance Care (including Non-emergency Patient Transport Services NEPTS) and provided an update on commissioning and planning for EMS and Ambulance Care (including NEPTS);
- work is currently being undertaken to reduce the length of the Provider report;
- there is concern regarding red and amber response times and patient waits, as reported in the EASC Performance Report;
- progress had been made with 'consult and close' rates as a result of investment in the Clinical Support Desk during 2021-22 and this was currently close to the 15% benchmark, hopefully working towards 17/18% next year.

Members **NOTED** the report as presented.

Immediate Release
Noted that:
- the All Wales Immediate Release Protocol was approved in July 2022 subject to a review after 3 months;
- feedback from partners (Chief Operating Officers) had now informed a review of the protocol as requested;
- from a commissioning perspective, this was felt to be a sensible approach.

Members **RESOLVED** to:
- **NOTE** the report as presented
- **APPROVE** the amendments to the All Wales Immediate Release Protocol as set out in paragraph 2.2, Appendix 1 and Appendix 2.

Manchester Inquiry Recommendations
Noted that:
- the report was prepared following an initial review of the emergency response to the Manchester Arena bombing;
- the WAST Emergency Preparedness, Resilience & Response (EPRR) team would need to develop the capacity to receive, review, consider and plan a response to the 149 recommendations contained in volumes 2 and 3 of the report;
- the Inquiry recommendations (specifically drawn to recommendations R105 and R106) are clear that ambulance trusts should make recommendations to NHS commissioners about additional resources required to ensure an effective response to mass casualty incidents.

Agreed that:

- WAST would collaborate with the CASC and the EASC team and bring forward recommendations to EASC.

Members **RESOLVED** to:
- **NOTE** the report as presented
- **AGREE** that WAST collaborate with the CASC and the team and bring forward recommendations to EASC.

Meeting requirements of the Civil Contingencies Act
Noted that:
- the operational and clinical pressures were worsening across health and social care in Wales;
- WAST were concerned about its ability to provide a major incident and/or mass casualty incident response to the people of Wales in a way that met the obligations as established within the Civil Contingencies Act (CCA) and as a Category 1 responder;
- during prolonged periods, WAST had seen more than 50% of its conveying capacity being unavailable to respond to patient incidents due to extreme handover delays with some handovers reaching over 48 hours;
- when business continuity and critical incidents were declared by WAST last month, due to WAST's inability to respond to patients categorised as immediately life threatening, no meaningful improvements to ambulance availability were seen;
- WAST were concerned that the health system would not be able to release ambulances held at emergency departments without delay should a major incident be declared. This would delay arrival of life saving care to those sadly caught up in any incident;
- WAST had developed a new risk for entry on its corporate risk register covering this issue and intended to raise this at the next public Trust Board meeting on Thursday 26 January 2023. It was anticipated that this risk would score as HIGH.

Members **RESOLVED** to:
- **NOTE** the report as presented
- **NOTE** the system risk that WAST may fail to meet its Civil Contingency Act Category 1 responder responsibility if inhibited from sending its pre-determined attendance to a declared major incident or mass casualty incident due to emergency department handover delays
- **AGREE** that Health board CCA officers engage with WAST to confirm WAST/health board CCA arrangements and for any issues arising to be escalated where needed to EASC Management Group.

WAST Integrated Medium Term Plan (Oral)
Noted that:
- the WAST IMTP would need to be consistent with Commissioning Intentions and financial constraints;
- there were 3 key areas:
  - actions to improve the quality of service and to improve patient outcomes
  - staff (recognising the pressure that staff have been under in recent years)
  - financial sustainability including reducing costs, improved efficiency and generating additional income with the aim to deliver a balanced financial plan

- the WAST team were meeting with the EASC Team fortnightly as they develop the IMTP;
- the WAST IMTP would be taken to the EASC Management Group in February, presented to the WAST Board and then EAS Committee for approval at the March meeting;
- there was an appropriate balance of strengthening core services and the longer-term strategic view.

Members **NOTED** the report as presented.

CHIEF AMBULANCE SERVICES COMMISSIONER'S UPDATE REPORT

Noted that:

- the 'Plurality Model' was operated as part of the commissioning arrangements for Non-Emergency Patient Transport Services (NEPTS). As part of this approach, WAST was the provider of choice with other providers commissioned as appropriate. A tender process had recently been completed and was currently in the novation and implementation phase, this would ensure consistent standards of service delivery, cost efficiencies and savings. WAST were commended for the successful tender exercise;
- a review was being undertaken by NEPTS relating to access to dialysis and oncology services to ensure that these were in line with the expectation, this would be taken through the NEPTS Delivery Assurance Group (DAG);
- there was much information available relating to NEPTS and that a NEPTS Dashboard was currently being developed, again this would be taken through the NEPTS DAG and would become part of the EASC performance management mechanism;
- one of the Commissioning Intentions related to the development of a National Transfer and Discharge Service to support service changes at a health board level and to improve patient flow. This work was ongoing and would be developed and shared via the NEPTS DAG, EASC Management Group and EAS Committee;
- there was a responsibility to firstly ensure best use of current resources ahead of seeking additional resources;
- WAST had recently commissioned work to model how best to use resources as part of this work;
- there were a number of patient transport services operating in Wales and the need to ensure robust oversight, coordination and management of these and the avoidance of duplication.

Members **NOTED** the report as presented.

EASC COMMISSIONING UPDATE

Noted that:

- progress had been made against the key elements of the collaborative commissioning approach;
- the EASC team had developed a process through the framework mechanism to enable this collaborative approach to transition and transformation through the development of local Integrated Commissioning Action Plans (ICAPs), update against Agenda item 2.2;
- the EASC IMTP Quarter 2 Update was presented at the previous meeting. A Quarter 3 Update would be provided at the February meeting of the EASC Management Group and then to the EASC Committee in March 2023;

- a Quarter 2 Update against Commissioning Intentions for 2022-23 was provided at the November meeting. A Quarter 3 update against the EASC Commissioning Intentions (EMS, NEPTS and EMRTS Cymru) would be provided at the February meeting of the EASC Management Group and then to the EASC Committee in March 2023;
- Commissioning Intentions for 2023-24 were currently being reviewed as part of the IMTP Process for 2023-26, however it was anticipated that the majority of intentions would remain extant. These would be considered for endorsement at the February meeting of the EASC Management Group and then approved at the EASC Committee.

Members **NOTED** the report as presented.

EASC FINANCIAL PERFORMANCE REPORT MONTH 8 2022/23

Noted that:

- there was a current break-even position with no significant variance;
- work would continue on the income received from Welsh Government;
- health board Directors of Finance would be involved as appropriate;
- work would being undertaken in relation to WHSSC and EASC Standing Financial Instructions.

Members **RESOLVED** to:

- **NOTE** the current financial position and forecast year-end position.

EASC SUB GROUPS

The Non-Emergency Patient Transport Services (NEPTS) Delivery Assurance Group notes from 6 October 2022 were received.

Members **APPROVED** the notes.

EASC GOVERNANCE

Noted that:

- the Risk Register had been reviewed and updated by the EASC Team during January 2023 in response to issues raised at the Cwm Taf Morgannwg University Health Board Audit and Risk Committee meeting on 12 December (as the host body). Additional information had been included and related to the ongoing system pressures and the impact on patients and the increasing risk of harm;
- the EASC Assurance Framework would be updated for the next meeting in line with the changes above approved for the Risk Register;
- the EASC Standing Orders were due for review at the November 2022 meeting. However, there was ongoing work with the Standing Financial Instructions related to the Welsh Health Specialised Services Committee (WHSSC) /EASC and it would be helpful to receive both sets of Standing Orders and Standing Financial Instructions at the same meeting;
- the Standing Financial Instructions for WHSSC were presented for approval at the meeting on 10 January 2023 and the EASC version would be presented alongside the Standing Orders at the next meeting in March 2023;
- the term of the Vice Chair would be completed in February 2023 and a new Vice Chair would need to be agreed at the meeting in March;
- the Chair thanked Steve Moore, the current Vice Chair, for his help and support over the last two years;

- a letter was received on 22 November 2022 from the Welsh Language Commissioner (WLC) which indicated that a member of the public had concerns regarding documentation on the EASC website and related to the EMRTS Service Development Proposal. The member of the public had visited the website on 11 November 2022 and had been unable to find a Welsh language version of the EMRTS Service Development Proposal on the website. This occurred due to annual leave of a member of the EASC Team with responsibility for the website;
- further, arrangements had been made to avoid this happening again. The EASC website had been reviewed to ensure compliance with the Welsh Language standards including ensuring that Welsh was not treated less favourably than English and also that the Welsh website is of the same standard as the English website in terms of content;
- a further update would be provided as the investigation continued.

Members **RESOLVED** to:

- **NOTE** the report as presented
- **APPROVE** the updated risk register.

Key risks and issues/matters of concern and any mitigating actions

- Red and amber performance
- Handover delays (and the development of handover improvement plans in HBs with trajectories) and the impact on WAST
- Structured approach relating to the engagement process for the EMRTS Service Review.

Matters requiring Board level consideration

- To acknowledge the significant risks for patients in relation to handover delays and the need for health boards to implement the local handover improvement plans and identified trajectories) for every emergency department against the 25% reduction on the minutes lost per arrival and no handover delays over 4 hours
- Opportunity for health boards to take part in the public engagement process related to the potential changes to EMRTS Cymru working in partnership with the Wales Air Ambulance Charity.

Forward Work Programme

Considered and agreed by the Committee.

Committee minutes submitted	Yes	✓	No	
Date of next meeting	**14 March 2023**			

WELSH HEALTH SPECIALISED SERVICES COMMITTEE (WHSSC)
EXTRAORDINARY JOINT COMMITTEE MEETING BRIEFING –
13 FEBRUARY 2023

The Welsh Health Specialised Services Committee held its latest public meeting on 13 February 2023. This briefing sets out the key areas of consideration and aims to ensure everyone is kept up to date with what is happening within the Welsh Health Specialised Services.

The papers for the meeting can be accessed at:
2022/2023 Meeting Papers - Welsh Health Specialised Services Committee (nhs.wales)

1. Integrated Commissioning Plan (ICP) 2023-2024
Members received a presentation and report presenting the Integrated Commissioning Plan (ICP) 2023-2024 for approval.

Members noted that the ICP had been updated following the Joint Committee ICP workshop on 10 January 2023 and the Management Group (MG) meeting on 26 January 2023 during which the MG considered the Clinical Impact Assessment Group (CIAG) process and horizon scanning prioritisation, strategy planning assumptions, performance assumptions and contingency planning to cover in year pressures and risks. After consideration, a significant number of disinvestments and recommissioning actions were identified, and an assessment of associated risks had also been undertaken as a consequence of the revised position.

Members noted that the indicative 1% shared system savings target was presented in addition to the financial core uplift of 3.11% and that this would be managed through a set of cross cutting commissioning schemes that will be developed and impact assessed. To support this a programme will be developed focussing on further planning and recommissioning work across pathways, working closely with Health Boards (HBs) to firm up schemes, and to explore the opportunities of the new Clinical Networks structure concerning pathway redesign.

Members agreed to approve the ICP in readiness for inclusion in HB Integrated Medium Term Plans (IMTPs). Members requested that an outline governance system and process for the Joint Committee to monitor achievement of the 1% WHSSC and HB shared pathway savings target be brought back to the Joint Committee for approval on 14 March 2023.

Members (1) **Noted** that the Plan has been finalised following the Joint Committee meeting on 17 January 2023, and subsequent discussions at Management Group, (2) **Approved** the Integrated Commissioning Plan (ICP) 2023-2024 for submission to Welsh Government; and
(3) **Approved** the requirements of the Integrated Commissioning Plan (ICP) for inclusion in Health Board Integrated Medium Term Plans (IMTPs); (4) **Agreed** that an outline governance system and process for the Joint Committee to monitor achievement of the 1% WHSSC and HB shared pathway savings target be brought back to the Joint Committee for approval on 14 March 2023.

2. Any other Business

Members also **noted** updates on other matters of business as follows:

- **WHSSC proposed policy changes to Specialist Fertility Services** - **CP37, Pre-implantation Genetic Testing-Monogenic Disorders, Commissioning Policy & CP38, Specialist Fertility Services: Assisted Reproductive Medicine, Commissioning Policy –** members noted that in an effort to provide better fertility service provision for Wales and more effective outcomes for patients, two fertility policies had been reviewed and were issued for consultation in accordance with the process outlined in the WHSSC 'Policy for Policies' (which aligns to the process used by NICE and the All Wales Medicines Strategy Group (AWMSG)). The consultation documents were sent directly to a wide stakeholder group via email and the consultation was also signposted on the WHSSC website. Some of the proposals had roused concern amongst affected patient groups, which resulted in negative inaccurate reporting in the press. In addition, the Board of Community Health Councils (CHCs) in Wales had written to WHSSC concerning the policy consultation process and their interpretation that the process related to a service change for patients and that Section 183 of the National Health Services (Wales) Act 2006 applied. WHSSC had discussed the matter with them and the interpretation of public law and that WHSSC were seeking legal advice regarding this complex area and the potential implications for other policy consultation processes undertaken by NICE and NHSE.
- **TransVision Cymru – Letter and WHSSC Response –** members noted that Transvision Cymru had written to a number of Joint Committee members advising that they wanted Welsh Government to help resolve issues faced by transgender children and young people in Wales by extending the Welsh Gender Service (WGS) to under 18s. WHSSC had issued a response letter advising that WHSSC commissions gender identity services for children and young people through NHS England (NHSE) and at this time had no plans to change the commissioning arrangements in the absence of the conclusion of the Cass Review. In line with the

recommendations of the Cass Review interim report and in recognition that the needs of children and young people are very different to those of adults, any service in Wales would need to be led by a Specialist Children's Hospital. This would mean that the Children's Hospital for Wales would be the lead and not the Adult WGS. Early preparatory discussions had commenced with Cardiff and Vale University Health Board (CVUHB) regarding future proposals. In addition, the interim NHSE Specialist Service for Children & Young People with Gender Dysphoria (Phase 1 providers) service specification was consulted upon in 2022 and the outcome of the consultation report and final service specification are awaited.

ASSURANCE REPORT

NHS WALES SHARED SERVICES PARTNERSHIP COMMITTEE

Reporting Committee	**Shared Service Partnership Committee**
Chaired by	Tracy Myhill, NWSSP Chair
Lead Executive	Neil Frow, Managing Director, NWSSP
Author and contact details.	Peter Stephenson, Head of Finance and Business Development
Date of meeting	19 January 2023

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

Chair's Report

The Chair updated the Committee on attendance at recent meetings, both within NWSSP and externally. The Chair also summarised the content, outcome and next steps for the development day held with the Committee in November. This had been very successful and further development sessions would be held during 2023/24.

The Committee **NOTED** the update.

Managing Director Update

The Managing Director presented his report, which included the following updates on key issues:

- Technology has been successfully implemented to allow pre-employment checks to be undertaken virtually for all UK and Irish passport holders. A reduction in time to hire has been noted since its implementation, however the level of recruitment activity continues to be a challenge across Wales;
- Following a recent national Penicillin V shortage, CIVAS@IP5 medicines unit utilised its national portfolio and MHRA wholesale dealer licence to procure significant quantities of Penicillin direct from the manufacturer to meet Health Board demands;
- From the 1st April 2023 management of all emergency planning/medicines storage of Welsh Government owned stock will transfer to NWSSP;
- From the 1st April 2023 the Low Vision Service Wales will transfer to NWSSP;
- Work is continuing to progress on the establishment of the Citizen Voice Body. A number of back-office support services will be provided via NWSSP to the new body going forward;
- Securing capital funding for the Laundry Services Modernisation Programme

continues to be an issue, NWSSP are currently considering alternative options to progress the work needed to meet the minimum standards and laundry rationalisation; and
- Neil Davies is retiring as Director of Specialist Estates Services; his deputy Stuart Douglas has been appointed and will commence in post in February.

The Committee **NOTED** the update.

Items Requiring SSPC Approval/Endorsement

IMTP 2023-26

The NWSSP IMTP and the Divisional plans reflect priorities identified by Welsh Government, NHS Wales organisations and professional peer groups. In line with the direction from the Minister for Health and Social Care, there is a focus on a smaller number of priorities for 2023-24. The IMTP and the Divisional plans reflect priorities identified by the Welsh Government where we are playing a lead national role; our customers, to support delivery of their local plans; and professional peer groups such as Directors of Workforce and Finance, as follows:

- Decarbonisation and Climate Change;
- Digital Strategy;
- Financial sustainability and good governance; and
- Employee Wellbeing.

While it is a balanced financial plan, there are a number of income assumptions and significant financial risks that need to be managed to achieve this aim.

Committee members commented favourably on both the format and the content of the plan and time timeliness in which it had been produced.

The Committee **APPROVED** the IMTP for submission to Welsh Government.

Digital Strategy

The Chief Digital Office presented the Digital Strategy setting the direction for the future provision of digital services, the approach and methodology and the desired outcomes.

The Committee **APPROVED** the Strategy.

Building Construction Frameworks

The Head of Building for Wales in Specialist Estate Services presented a paper to obtain approval for the development of the NHS Building for Wales construction frameworks which are required to be operational by the end of April 2024 when the current arrangements cease and will support expenditure of circa £1 billion during their duration.

The Committee **APPROVED** the development of the Framework and the placing of the tender notices.

Risk Appetite Statement

The overall risk appetite statement was reviewed in detail at the SSPC Development Day in November, and prior to that by the Senior Leadership Group. The outcome of these reviews was for NWSSP to be bolder in its appetite to risk and this is reflected in the revised Statement.

The Committee **APPROVED** the Statement.

Finance, Performance, People, Programme and Governance Updates

Finance –The distribution to NHS Wales has been increased to £2m and the year-end forecast outturn remains at break-even with the assumption of full funding of exceptional energy pressures and Covid costs from Welsh Government. The forecast outturn for the Welsh Risk Pool remains on track with the budget.

Performance – The in-month (November) performance was generally good with 34 out of 38 KPIs achieving target. Action is being taken to address the four amber indicators.

Project Management Office Update – The Legal & Risk Case Management System and the Laundry Transformation Projects are both currently red-rated and are also included as red risks on the Corporate Risk Register. All other projects are on track.

People & OD Update – Sickness absence rates remain very low, and there has been an increase in Statutory and Mandatory Training compliance to 91%. PADR completion has dropped slightly to 83%

Corporate Risk Register – There are now seven red-rated risks covering areas such as energy costs and provision, industrial action, insufficient staff resource, the Legal and Risk and Laundry project risks, and an issue with the roof of Brecon House that may require the lease to be terminated.

Health and Care Standards – The response to the standards have been updated to reflect the additional services taken on recently by NWSSP but remain overall at Level 4.

The Committee **NOTED** the above Reports.

Papers for Information

The following items were provided for information only:

- TRAMs Update;
- Counter Fraud Management Arrangements;
- Audit Committee Annual Report 2021/22;
- Audit Committee Assurance Report;
- Counter Fraud Annual Report 2021/22;
- Wales Infected Blood Support Scheme Annual Report 2021/22;

• Welsh Language Annual Performance Report 2021/22; • IMTP Q2 Progress Report; and • Finance Monitoring Returns (Months 6, 7, 8 and 9).	
AOB	
N/a	
Matters requiring Board/Committee level consideration and/or approval	
• The Board is asked to **NOTE** the work of the Shared Services Partnership Committee.	
Matters referred to other Committees	
N/A	
Date of next meeting	23 March 2023