Public Board Meeting - Cardiff and Vale University Health Board

Thu 26 May 2022, 12:00 - 17:00

The Village Hotel, CF14 7EF

Agenda

12:00 - 12:02
2 min

1.
Welcome & Introductions

Charles Janczewski

12:02 - 12:04
2 min

2.
Apologies for Absence

Charles Janczewski

12:04 - 12:06
2 min

3.
Declarations of Interest

Charles Janczewski

12:06 - 12:08
2 min

4.
Minutes of the Public Board Meeting held on 31st March 2022

Charles Janczewski

4 Public Board Minutes 31.03.22MD NF.pdf (29 pages)

12:08 - 12:10
2 min

5.
Action Log – 31st March 2022

Charles Janczewski

5 Public Action Log - May 2022MD.NF.pdf (3 pages)

12:10 - 14:25
135 min

6.
Items for Review and Assurance

6.1.
Patient Story

Jason Roberts

10 minutes

Mohamed.Sarah
05/13/2022 16:36:43

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

Charles Janczewski

10 minutes

6.2 Chair's Board Report - May 2022.pdf (10 pages)

6.3.
Chief Executive Report

Suzanne Rankin

10 minutes

6.3 - Chief Executive Board Report - May 2022 Final.pdf (5 pages)

6.4.
Board Assurance Framework

Nicola Foreman

10 minutes

6.4 BAF May 2022 - Covering report.pdf (3 pages)
6.4a BOARD ASSURANCE FRAMEWORK - MAY 2022.pdf (27 pages)

6.5.
Chairs reports from Committees of the Board:

20 minutes

6.5.1.
Finance Committee – 27.04.22

Rhian Thomas

6.5.2.
Health & Safety Committee – 19.04.22

Mike Jones

6.5.2 H&S Chairs Report 19.04.22 MJ.pdf (4 pages)

6.5.3.
Mental Health Legislation and Mental Health Act Committee – 26.04.22

Ceri Phillips

6.5.3 Mental Health Chairs Report CP.pdf (6 pages)

6.5.4.
Quality, Safety & Experience Committee - 12.04.22

Susan Elsmore

6.5.4 QSE Chairs Report SE.pdf (6 pages)

6.5.5.
Strategy & Delivery Committee – 17.05.22

Michael Imperato

Mohamed.Sarah
05/13/2022 16:32:20

6.5.6.
Audit & Assurance Committee – 05.04.22

John Union

6.5.6 Audit Chairs Report JU.pdf (8 pages)

6.6.
Integrated Performance Report:

25 minutes *Jason Roberts / Rachel Gidman / Caroline Bird / Catherine Phillips / Fiona Kinghorn*

- Quality & Safety
- Workforce
- Operational Performance
- Finance
- Public Health

6.6 C&V Integrated Performance Report May 2022 (Final) v2.2.pdf (15 pages)

6.7.
Cancer Progress Report to include a summary of progress against the Nuffield Trust Recommendations.

Abigail Harris

20 minutes

6.7 May Board Cancer services update v2.pdf (6 pages)

6.7.1.
Annex 1 - Nuffield Trust Recommendations

6.7.1 Annex 1 - Nuffield Trust Recommendations.pdf (3 pages)

6.7.2.
Annex 2 Nuffield Trust Recommendations Progress and Plans Summary

6.7.2 Annex 2 Nuffield Trust Recommendations Progress and Plans Summary.pdf (4 pages)
6.7.2a Annex 2 Joint Proposal for a Tripartite partnership.pdf (54 pages)

6.7.3.
Annex 3 AOS Business case agreed by Board in 2021

6.7c Annex 3 AOS Business case agreed by Board in 2021.pdf (70 pages)

6.7.4.
Annex 4 Rapid Diagnostic Centre business case

6.7d Annex 4 Rapid Diagnostic Centre business case.pdf (32 pages)

6.8.
2022 – 2025 IMTP Update

Abigail Harris

20 minutes

6.8 Board IMTP update report - May 22.pdf (3 pages)

6.9.
Break for refreshments (10 minutes)

Mohamed,Sarah
05/13/2022 16:16:25

14:25 - 16:10
105 min

7. Items for Approval / Ratification

7.1.
2022 – 2023 Capital Infrastructure Plan

Abigail Harris / Catherine Phillips

10 minutes

- 7.1 Capital Infrastructure Plan 22.23 - UHB Board.pdf (4 pages)
- 7.1a Capital Plan Appendix 1 26.05.2022.pdf (3 pages)

7.2.
RPB Acceleration Regional Integration Fund Proposal Update

Abigail Harris

10 minutes

- 7.2 RIF acceleration_CVUHB Board_26.05.22(1).pdf (4 pages)

7.3.
UHB/Third Sector Partnership Memorandum of Understanding and 18 months in review

Abigail Harris

20 minutes

- 7.3 Covering MoU Board Paper May 2022.pdf (3 pages)
- 7.3a CAV UHB and Third Sector updated MoU 2022 for May Board.pdf (7 pages)
- 7.3b Final Third Sector and Health 18 months in Review 2022.pdf (16 pages)

7.4.
Development of the Regional SARC Hub and New Links Building at CRI – Business Case

Abigail Harris

10 minutes

- 7.4 SARC Hub OBC Board Report - May 2022.pdf (6 pages)
- 7.4a SARC OBC exec sum v8.1.pdf (33 pages)

7.5.
Annual Assurance Report - Section 25b (adult acute medical and surgical wards and paediatric inpatient) wards

Jason Roberts

10 minutes

7.6.
Board Development Plan

Nicola Foreman

5 minutes

- 7.6 Covering report for Board Development Programme 2022.23.pdf (2 pages)
- 7.6a Board Development Programme 2022.23.NF.2.pdf (26 pages)

7.7.
Standing Orders, Scheme of Delegation, SFIs

Mohamed,Sarah
05/13/2022 16:26:25

Nicola Foreman

10 minutes

- 7.7- Board SOs, SFIs, Scheme of Delegation.pdf (3 pages)
- 7.7a CV UHB Standing Orders Reservation and Delegation of Powers v5 May 2022(5).pdf (94 pages)
- 7.7b LHB Model SFIs May 2022 v5 Final CV.pdf (69 pages)

7.8.
Draft Annual opinion from Head of Internal Audit

Ian Virgil

10 minutes

- 7.8 C&V UHB Draft HIA Opinion & Annual Report 21-22 - Covering Report.pdf (3 pages)
- 7.8a C&V UHB HIA Opinion & Annual Report 21-22 - Draft (For Board).pdf (35 pages)

7.9.
Welsh Language Policy

Rachel Gidman

5 minutes

- 7.9 Corporate Welsh Language Policy Cover Paper.pdf (3 pages)
- 7.9a EHIA Corporate Welsh langauge Policy May 2022.pdf (24 pages)
- 7.9b Corporate Welsh Language Policy May 2022.pdf (16 pages)

7.10.
Break for refreshments (10 minutes)

7.11.
Committee / Governance Group Minutes:

5 minutes

7.11.1.
Emergency Ambulance Services Joint Committee Meeting – 18.01.22

- 7.11.1 Confirmed Minutes EASC 18.01.22.pdf (10 pages)

7.11.2.
Finance Committee – 24.02.22 & 23.03.22

- 7.11.2a Confirmed Public Finance Committee Minutes 16.02.22.pdf (7 pages)
- 7.11.2b Confirmed Public Finance Committee Minutes 23.03.22.pdf (6 pages)

7.11.3.
Audit & Assurance Committee – 08.02.22 & 05.04.22

- 7.11.3a Confirmed Public Audit Minutes 08.02.22.pdf (16 pages)
- 7.11.3b Confirmed Public Audit Minutes 05.04.22.pdf (17 pages)

7.11.4.
Quality, Safety & Experience Committee – 22.02.22

- 7.11.4 Confirmed QSE Minutes 22.02.22.pdf (12 pages)

7.11.5.
Mental Health Legislation and Mental Health Act Committee – 09.02.22

- 7.11.5 Confirmed MHCLC Minutes 09.02.22.pdf (10 pages)

7.11.6.
Strategy & Delivery Committee – 15.03.22

Mohamed.Sarah
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7.11.7.
Health & Safety Committee – 25.01.22

- 7.11.7 Confirmed HS Minutes 25.01.22.pdf (11 pages)

7.11.8.
Stakeholder Reference Group - 25.01.22

7.11.8 Minutes of SRG Meeting 25 January 2022.pdf (4 pages)

7.11.9.
Local Partnership Forum - 17.02.22

7.11.9 LPF minutes 17.02.22.pdf (7 pages)

16:10 - 16:50
40 min

8.
Items for Noting and Information to Report

8.1.
Draft Annual Financial Accounts

Catherine Phillips

10 minutes

8.2.
Draft Annual Report (including Accountability Report and Performance Report)

Nicola Foreman

10 minutes - Draft Annual Report found in Supporting Documents

8.2 Draft Annual Report 2021-2022 CVUHB Board covering report.pdf (5 pages)

8.3.
Naming of Wellbeing Hub@Maelfa

Abigail Harris

5 minutes

8.3 Naming of Wellbeing Hub@Maelfa (new template).pdf (3 pages)

8.4.
Corporate Risk Register

Nicola Foreman

5 minutes

8.4a Corporate Risk Register May 2022 - Board Summary - AF.pdf (1 pages)
8.4 Corporate Risk Register Cover Paper.pdf (4 pages)

8.5.
Chair’s Reports from Advisory Groups and Joint Committees:

10 minutes

8.5.1.
Emergency Ambulance Services Joint Committee – 15.03.22

8.5.1 Chair's EASC Summary from 15 March 2022.pdf (8 pages)

Mohamed.Sara
05/13/2022 16:22:25

8.5.2.
NWSSP Assurance Report – 24.03.22

8.5.2 NWSSPC Assurance Report 24 March 2022.pdf (5 pages)

8.5.3.
Stakeholder Reference Group

8.5.4.
Local Partnership Forum

8.5.4 LPF briefing (April 2022) for May 2022 meeting.pdf (3 pages)

16:50 - 16:50
0 min

9.
Agenda for Private Board Meeting:

i. Approval of minutes
ii. Approval of Private Committee minutes

16:50 - 16:50
0 min

10.
Any Other Business

Charles Janczewski

16:50 - 16:50
0 min

11.
Review of the meeting

Charles Janczewski

16:50 - 16:50
0 min

12.
Date and time of next meeting:

Public Board Meeting - July 28th 2022

16:50 - 16:50
0 min

13.
Resolution re: Private Session

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]

Mohamed.Sarah
05/13/2022 16:36:25

Unconfirmed Draft Minutes of the Public Board Meeting
Held On 31 March 2022
Via MS Teams

Chair:		
Charles Janczewski	CJ	University Health Board Chair
Present:		
Gary Baxter	GB	Independent Member for University
Caroline Bird	CB	Interim Chief Operating Officer
David Edwards	DE	Independent Member - ICT
Susan Elsmore	SE	Independent Member for Local Authority
Abigail Harris	AH	Executive Director of Strategic Planning
Michael Imperato	MI	Independent Member for Legal
Fiona Jenkins	FJ	Executive Director of Therapies & Healthcare Sciences
Meriel Jenney	MJ	Executive Medical Director
Mike Jones	MJ	Independent Member for Trade Unions
Fiona Kinghorn	FK	Executive Director of Public Health
Sara Moseley	SM	Independent Member for Third Sector
Catherine Phillips	CP	Executive Director of Finance
Ceri Phillips	CP	UHB Vice Chair
Suzanne Rankin	SR	Chief Executive Officer
Rhian Thomas	RT	Independent Member - Capital and Estates
Ruth Walker	RW	Executive Director of Nursing
John Union	JU	Independent Member for Finance
In attendance:		
Sam Austin	SA	Stakeholder Reference Group Chair - Llamau
Joanne Brandon	JB	Director of Communications
Lance Carver	LC	Director of Social Services – Vale of Glamorgan Council
Emily Clark	EC	Speciality Registrar in Public Health
Suzanne Clifton	SC	Head of Adults Services - PCIC
Daniel Crossland	DC	Director of Operations – Mental Health Clinical Board
Cath Doman	CD	Programme Director - Integrated Health and Social Care
Lisa Dunsford	LD	Director of Operations - PCIC
Nicola Foreman	NF	Director of Corporate Governance
Darren Griffiths	DG	Audit Wales – Audit Manager
Lianne Morse	LM	Assistant Director – Workforce
Angela Parratt	AP	Director of Digital Transformation
David Thomas	DT	Director of Digital Health & Intelligence
Catherine Wood	CW	Director of Operations for the Children & Women's Clinical Board
Suzanne Wood	SW	Consultant in Public Health Medicine
Observers:		
Jayne Catherall	JC	People Experience Lead
Marcia Donovan	MD	Head of Corporate Governance
Malcolm Latham	ML	Community Health Council - Chair
Daniel Price	DP	Community Health Council
Jeanette Thomas-French	JT	Executive Assistant

Mohammed Ali
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Catherine Thomas	CT	Executive Assistant
Secretariat		
Nathan Saunders	NS	Senior Corporate Governance Officer
Apologies:		
Akmal Hanuk	AH	Independent Member for Community
Rachel Gidman	RG	Executive Director of People & Culture

Item No	Agenda Item	Action
UHB 22/03/001	**Welcome & Introduction** The University Health Board Chair (UHB Chair) welcomed all to the Board meeting in English and in Welsh.	
UHB 22/03/002	**Apologies for Absence** Apologies for absences were noted.	
UHB 22/03/003	**Declarations of Interest** The Independent Member – Third Sector (IMTS) declared an interest as a member of the General Medical Council (GMC). The Executive Director of Therapies & Health Sciences (EDTHS) declared an interest in relation to her joint role as the Interim Executive Director for Therapies Health Science for Cwm Taf Morgannwg UHB. **The Board resolved that:** a) Save for Declarations of Interest noted above, no further Declarations of Interest were noted.	
UHB 22/03/004	**Minutes of the Meeting Held on 24th February 2022** The minutes of the Public Board Meeting held on 24th February 2022 were reviewed for accuracy and matters arising. The Chair of the Community Health Council (CCHC) noted that (i) he had attended the last meeting but was not listed in the attendance, and (ii) Stephen Allen should be recorded as being the Chief Officer of the CHC, rather than the Chair. The Chief Executive Officer (CEO) advised the Board that the title of the Interim Medical Director should reflect that the post was a fixed term position. **The Board resolved that:** a) The minutes of the Public Board meeting held on 24th February 2022 were approved as a true and accurate record pending the above amendments.	
UHB 22/03/005	**Action Log – 24th February 2022**	

Mohammed Sajjad
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	It was noted that the Action Log was up to date and the Director of Corporate Governance (DCG) advised the Board that any duplicate actions would be removed. **The Board resolved that:** a) The Action Log was received and noted.	
UHB 22/03/006	**Patient Story – Emmie's Story** The Patient Story was received. The Executive Nurse Director (END) advised the Board that the story reflected the patient and the services used including major trauma and the various services provided to children and young adults.	
UHB 22/03/007	**Chair's Report and Chair's Action taken since last meeting** The Chair's Report and Chair's Action taken since last meeting was received. The UHB Chair advised the Board that the report included information on the key activities that had taken place since the last Board Meeting on the 24th February 2022. It was noted that within the report an overview of the invaluable work carried out by Mortuary Services and its response to Covid 19 could be seen. The UHB Chair advised the Board that a large number of Chair's Actions could be seen within the report which reflected the late, but welcomed funding from Welsh Government, to allow the Health Board to address important issues across the Organisation. He expressed his thanks to the Estates and Procurement teams. **The Board resolved that:** a) The report was noted. b) The Chair's Actions undertaken were approved. c) The application of the Health Board's Seal and completion of the Agreements detailed within the report, were approved	
UHB 22/03/008	**Chief Executive Report** The Chief Executive Report was received. The Chief Executive Officer (CEO) advised the Board that she had continued a discovery phase since joining the Health Board in February 2022 and noted that it had deepened her understanding of the organisational opportunities and challenges within the Health Board. It was noted that future Chief Executive Reports would take a risk summary assessment approach and the CEO noted that pressures	

Mohamed.Sarah 05/13/2022 16:36:25

	were being seen right across the Health Board which was very challenging. The Board was advised that the Health Board was included in the 2022 Stonewall Workplace Equality Index and that the Health Board had ranked 37th and earned a Gold Award, putting the Health Board in the top three health organisations in the UK. The CEO added that central to the significant positive strides taken forward by the Health Board had been the fantastic work of the LGBTQ+ Staff Network, which worked to make LGBTQ+ issues more visible within the work environment. It was noted that being added to the Workplace Equality Index would be a brilliant legacy to a colleague that was lost under tragic circumstances in 2021. The CEO identfied further key areas within her report which included: • Eye care facilities to reduce waiting times • NHS 111 roll out in Cardiff and the Vale of Glamorgan The CEO advised the Board that she had reflected on the developing situation within Ukraine and noted that there were a number of Asylum Seeker and Refugee schemes already operating within the Health Board and in the community and noted that Wales offered itself as a nation of sanctuary. The Executive Director of Public Health (EDPH) added that there was a lot of work going on around the schemes alongside Local Authority (LA) colleagues as well as at a National level alongside Welsh Government (WG). The CEO concluded that the Health Board had a vibrant, multinational team and that there was a need to be balanced, sensitive and reflective to a range of perspectives. **The Board resolved that:** a) The Chief Executive Report was noted.	
UHB 22/03/009	**Systems Resilience Briefing (Covid and Non Covid):** The System Resilience Briefing (Covid & Non-Covid) was received. The CEO advised the Board that, in order to avoid any duplication, the Executive Team would discuss the System Resilience Briefing and the Integrated Performance report with a view to amalgamating them for future Board meetings. The Board was advised that the pressures seen across the Health Board continued to be extreme and very challenging and it was noted	**NS**

Mohamed.Sarah 05/13/2022 16:36:25

	that there was a rise in community transmission of Covid-19 which had impacted on staffing. • **Quality and Safety section** The END advised the Board that the Emergency Unit (EU) was the area of most concern with 50 live concerns within the department. It was noted that the concerns all related to quality of care, waiting times or outcomes and the END advised the Board that a meeting had been held to support the team. The END advised the Board that staffing continued to be a significant challenge, with Covid-19 being the main reason for staffing shortages. She added that an increase in falls and pressure damage had been identified which could be symptomatic of the staffing situation and that a plan to de-escalate the additional capacity beds was underway . That should help the staffing position but noted that it would be balanced with the current continuing need for capacity to improve flow across the Organisation. It was noted that the Health Board had reported 5 Never Events to the Delivery Unit, since March 2021, 4 of those were reported since December 2021. It was noted that there were no themes or trends within the events. However work was ongoing with the '5 steps to safer surgery'. The END concluded that due to staffing issues, the 7-day service the Concerns Team currently provided had stopped from 28 March 2022. • **Workforce section** The Assistant Director – Workforce (ADW) advised the Board that the report outlined the current workforce position which was very challenging. She added that the metrics in February 2022 showed a stablising position but noted that over the past 2 weeks in March 2022, there had been an increase in Covid related absence which mirrored the transmission within the community. The ADW identified the key issues and priorities within the report which included: • Sickness Absence • Health and Wellbeing of Staff • Occupational Health • Turnover	

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	• Vacancy factor • Health Care Support Workers • Overseas Nurse Recruitment • Enhanced overtime rates • Recovery schemes • **Governance section** The DCG advised the Board that she would take the report as read and no futher information was indentifed . • **Operational section** The Chief Operating Officer (COO) advised the Board that she would take the report as read and highlighted the key operational pressures which included: • System wide operational pressures had continued and the Health Board was still seeing access or response delays at a number of points across the Health and Social Care system. • Unscheduled Care – The Health Board, in conjunction with its Local Authority and Welsh Ambulance Service Trust (WAST) partners, was working hard to alleviate the pressures in the urgent and emergency care system and to improve the quality of care and patient experience through a range of actions agreed and progressing as part of a '2 week reset' that had run from 2nd to 16th March 2022. It was noted that the reset was a national initiative agreed following a Welsh Government led Health and Social Care Risk Summit in February 2022. Actions were agreed on escalation specifically in relation to ambulance handover delay; admission avoidance; front door and ward support; digital enablers and Same Day Emergency Care. The COO advised the Board that since the 2 week reset, the number of patients who were medically fit for discharge had decreased from 350 to 298. She noted that although the numbers had decreased, it was still double the number pre-Covid. It was noted that 34 beds had been de-escalated to help with the Health Board's footprint. The COO offered her apologies to all of the patients who had seen long waits and thanked all of the staff who had been involved in patient care. The Board was advised that whilst pressure had continued in Primary Care and Community services, a lower number of practices were reporting a high level of escalation – 10 compared to 13 in February 2022.	

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	It was noted that there had been 2 GMS contract resignations which had been effectively managed by the Primary Care team with an agreement reached with other practices in the local area for patients to be transferred. The COO concluded that there had been verbal confirmation from WG regarding changes in Infection, Prevention and Control (IP&C) guidance which would allow the Health Board, using a phased approach, to increase capacity within Dental Services. The UHB Chair expressed his apologies to patients on behalf of the Health Board and offered assurance that the Health Board was doing everything it could in relation to long waiting times. • **Public Health section** The EDPH advised the Board that the report was out of date because the data changed daily. She added that the Health Board was currently enacting the WG revised plan, Together for a Safer Future, which addressed living safely with Covid-19, amongst other infectious diseases. She added that within the report, a Covid stable scenario and a Covid Urgent scenario had been presented. The Board was advised that there had been gradual changes around legal requirements for self isolation, although there was still strong guidance in place. The EDPH advised the Board that clusters in care homes had been falling slowly along with hospital clusters, and that Hospital admissions had fluctuated, although overall they had fallen over the past month. The Independent Member – University (IMU) asked for information regarding Staff wellbeing. He noted that the HIT team that had been launched 6 months ago and asked if the Board could be updated on progress made. The ADW responded that the service was temporarily funded and that a progress update would be brought back to the Board for assurance. The Independent Member – Third Sector (IMTS) noted that there had been an increase in the number of complaints regarding patient experience. She asked what would be the impact of closing the 7 day service and how would complaints be responded to. The END responded that the 7 day service was predominently set up to run the helpline for visting and mass vaccination queries. The mass vaccination situation had greatly improved which meant that the service could be stepped down, rather than removed, whilst the team considered how the service could be supported in the future.	**LM**

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	The Chair of the Community Health Council (CCHC) asked for clarity on the current visiting arrangements. He added that EU expectations needed to be managed for patients who assumed they would be seen during the time slot they had been given by CAV24/7. The END responded that communication was a constant issue when dealing with complaints and noted that different routes of communication would be used regularly to help get the right messages out to patients and the community. The CEO concluded that fundamentally, work demand was the biggest driver of team wellbeing and noted that the issue needed to be worked through. **The Board resolved that:** a) The Systems Resilience Briefing Report (COVID and Non COVID) was noted.	
UHB 22/03/010	**Vale Alliance – Update on proposed phased approach** The Executive Director of Strategic Planning (EDSP) advised the Board that they would receive a presentation that set out the proposed governance and partnership arrangements to outline how an alliance model between Health and Social Care services in the Vale of Glamorgan could be implemented. The Director of Social Services – Vale (DSSV) advised the Board that the Vale Alliance was the start of a more formal arrangement, but noted that there had been some incredible integrated arrangements in place in the Vale of Glamorgan for 12 years. It was noted that the proposed Vale Alliance had been positively received by the Vale of Glamorgan Council's Scrutiny Committee. One comment which arose from the Council's Scrutiny Committee was the need for the Vale of Glamorgan Council and the Health Board to operate as equal partners. The Programme Director - Integrated Health and Social Care (PDIHSC) gave a presentation entitled "Establishing an Alliance model for Wellbeing Services in the Vale of Glamorgan (February 2022)" to the Board. It was noted that the Vale Alliance work was an important part of one of the major strategic programmes of the Regional Partnership Board (RPB). It formed part of the @Home – Locally Based Integrated Care Programme which helped to improve outcomes for the local population. The PDIHSC advised the Board that the @Home Programme had a number of key areas and presented those to the Board which included:	

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	• Regional work • Locality work • Cluster work • Neighbourhood work It was noted that the aim of the Programme was to keep people out of hospital, if appropriate, and provide excellent care to people in their own homes. It was noted that that there were a wide range of "out of hospital" services that would make up the system which included: • Access – How people gain access to relevant services • Accelerated cluster development – multidisciplinary working • Health and Wellbeing Centres • Intermediate Care • Vale Alliance Establishment – Development of the organisational model and associated governance. The PDIHSC concluded that the aim of the Vale Alliance was to integrate health and wellbeing services provided by the Council and the Health Board, as seamlessly as, in order to improve the health, social care and wellbeing needs of the whole population of the Vale of Glamorgan. It was noted that to achieve that aim the following had been proposed: • Address the existing temporary and jointly funded elements in a first 'tranche' of services to be aligned. • Incorporate existing integrated services within the first phase that demonstrated the benefits of further integration. • Align the phasing of the proposed Alliance with current demands and pressures using integrated monitoring information from complementary services. • Phase incorporation of 'core-funded' services when the associated risks had been assessed. • Move in a flexible, agile manner in order to take advantage of service developments as they occurred. • Ensure that the level of service provision and quality would not be interrupted nor adversely affected by the development of the Alliance. • Enable citizens and partners time to become engaged with and consult on the proposed development and consideration of what services should be included. The Head of Adults Services – PCIC (HASP) provided the Board with information as to why an Alliance Model was required which included:	

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- Improved Population Health and Wellbeing through a focus on prevention.

- Improved experience and quality of care for individuals and families.

- To enrich the wellbeing, capability and engagement of the workforce.

- Increased value achieved from funding of health and care through improvement, innovation best practice and reducing or eliminating waste.

It was noted that in order to reduce duplication and provide a seamless service in line with the strategic vision of 'A Healthier Wales' it was the ambition that a Vale Alliance would be developed to encompass further integration.

The HASP advised the Board that Wales had legislation and policy to support integrated working which included:

- Social Services & Wellbeing Act (2014)
- Wellbeing of Future Generations Act (2015)
- A Healthier Wales (2018)

It was noted that each organisation involved was strategically committed to taking steps so that the proposed Alliance would complement the following:

- Shaping our future Wellbeing (UHB)
- Shaping our future Clinical Services (UHB)
- @home programme (RPB)
- Vale of Glamorgan Council Corporate Plan
- Digital Health & Care Wales
- Adult Services Reshaping Programme

The HASP presented the Board with the proposed phase one services which included:

- Vale Community Resource Service - Care and Support for Reablement Therapy which would include Occupational Therapy Physiotherapy, Dietetics and Pharmacy, Social Work Assessment and others.

- Wellbeing Matters (Single Point of Access) - Adult Services Intake & Assessment, Adult Services Case Management, Community Triage Service, Customer Relations (Wellbeing) and Telecare.

- Third Sector Commissioned Services - Community Liaison/Third Sector Broker, Housing-related Support, Discharge Support and Specialist Support.

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	It was noted that the proposed Alliance model was in a draft form and that a written Partnership Agreement was required to underpin the proposed Vale Alliance. The Partnership Agreement would address a number of areas which included: • Pooled budget model and finances • Target operating model: service specification, quality and performance • Leadership and workforce model • Communications, consultation and engagement • Information governance, information sharing agreement and business intelligence • Digital and estates requirements The Director of Operations – PCIC (DOP) provided the Board with some closing comments and highlighted that the approval and support (which had already been received by the Vale of Glamorgan Council) was being sought from the Board. She added that Ministerial letters had been received which outlined specific timeline requirements and noted that from April 2022, planned cluster planning groups should be in place. It was noted that an update on the Vale Alliance would be provided to the Board via a Board Development session in June 2022. The Independent Member – Legal (IML) noted that a lot of the outcomes identified appeared to hinge on agreements being made and asked who would draft the relevant documents. The PDIHSC responded that lawyers were lined up and would draft the appropriate documents (including the Partnership Agreement). The CEO advised the Board that there were number of areas that needed review which included: • The partnership agreement would need to be declared in conversations with the LA. • A lot of OD support would be required for the Alliance which would need to be negotiated now to get it in place. • Building in the Health Board measures. The EDSP provided a final point and reiterated what the DSSV had reported that the Vale Alliance needed to be an equal partnership between the Health Board and all other areas. She added that the recommendations in the report noted that the Board were required to note and accept the current progress of the Vale Alliance and asked to change the recommendation to “note and support”.	**NS**

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	The Board resolved that: a) The current progress of the Vale Alliance was noted and supported. b) Future reports for assurance / approval in line with the process suggested within the presentation would be received.	
UHB 22/03/011	**Digital Strategy Update** The Digital Strategy Update was received. The Director of Digital and Health Intelligence (DDHI) advised the Board that the Digital Strategy had been approved by the Board in July 2020 and highlighted the progress that had been made since which included: • 2019 - New Director of Digital & Health Intelligence appointed - New structure created - IT & informatics became a single service - Recruitment paused by the Organisation as deemed unaffordable - Capital grant received from WG to support Windows10 rollout plans. - Replaced a third, upgraded a third, and updated a third of the desktop estate of the Health Board. • 2020/21 - Covid - rapid response rolled out to support virtual/remote working - Dragons Heart Hospital & Lakeside implemented. - Digital roadmap Phase 1 – focused on urgent tactical and some strategic solutions. - Investment case went to the Management Executive team. - Windows10 planning and deployment started in Quarter 4 - Resource gaps were partially offset by one-off Covid funding. • 2021/22 - Some tactical roadmap solutions – funding was identified, procured and mobilised following business case approvals. - Windows10 rollout was completed - Resource shortfall remained – a request for £2.4m revenue, £3.4m capital per annum was required to bring the Health Board up to the relevant baseline. - Non-recurrent Capital funding was used to address legacy IT infrastructure. The Board was presented with the HiMSS Electronic Medical Record Adoption Model and it was noted that the Digital team was using the model to benchmark against. It was noted that there was still a significant investment gap which would need to be filled if the Health Board wanted to reach Digital maturity in line with its plans. It was noted that during phase one between 2020 and 2025 a number of elements would be implemented. That included:	

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- Patient Channel Programme
- Clinician Channel Programme
- Analyst & Platform Channel Programme
- Capabilities Programme

The DDHI advised the Board of some of the areas within Digital that were being actioned following allocated funding were included within the Health Board's IMTP.

The Director of Digital Transformation (DDT) advised the emerging phase two roadmap included:

- The Basics – Cyber, Infrastructure, Applications, Desktop, Communications and Collaboration, Data, Analytics and User Interface.

- The emerging phase two priorities which included the delivery of the current phase one roadmap plus:
  - Recovery programme
  - Outpatients transformation
  - Hybrid EPR BC 2022
  - Data Strategy
  - Internal interoperability
  - LDR – build on LACS data product
  - Access to DHCW data via API gateway
  - Data gateway – Would allow Office 365 tenant to consume PMS data i.e. colleagues could create e-forms, PowerApps and have the ability to transform their service areas.
  - Compliance with new data standards e.g. Emergency Care Dataset (ECDS)

- Other emerging priorities:
  - UEC e-triage
  - RFID *with* Scan4Safety
  - Internal referrals
  - Digital Front Door – expansion e.g. virtual ward management system
  - Do away with generic accounts
  - Mobilisation
  - Adaptive change

The DDT advised the Board that as set out in the digital strategy, the Health Board needed to improve the basic infrastructure, otherwise the roadmap was not achievable.

It was noted that there were not enough IT devices to meet demand in Clinical areas. Some progress was seen in some of the areas that built an enabling digital service that had management of the estate.

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	It was noted that the delivery of digital outcomes was very much in progress and included a number of elements around programme business cases as well as in-house developments. The DDHI concluded that a lot of the Digital Strategy was reliant upon funding. It was noted that there were a number of business cases ready to go which released efficiencies as well as money over the financial year. The Independent Member – ICT (IMICT) advised the Board that it was very important to have sustained investment in the IT infrastructure. If the Health Board did not have appropriate infrastructure in place then the Digital Strategy would not work very well. The CEO advised the Board that the investment gap identified in the presentation was not down to a choice that the Health Board could make. The Health Board would need to make the investment to secure digital maturity. She added that a long-term plan was needed for the Digital Strategy which would include national plans. The DDHI responded that the Digital team was developing a longer-term plan to describe the entire roadmap over a longer period of 5-10 years. That would help inform the long-term financial investment plan needed to support the ambitions of digital transformation and delivering the Health Board's strategic programmes. The CCHC asked how the Digital team would bring patients along on the digital journey. The DDHI responded that there was a role to play by the Community Health Council in helping patients "plug into" Digital services and noted that the Health Board had signed up to the National Charter to ensure that thought would be required about how to engage with all patients. **The Board resolved that:** a) The progress made since the publication of the Digital Strategy was noted.	
UHB 22/03/012	**Joint Escalation and Intervention Arrangements** The Joint Escalation and Intervention Arrangements were received. The CEO advised the Board that under the Joint Escalation and Intervention Arrangements, the Welsh Government met with Audit Wales and Healthcare Inspectorate Wales twice a year to discuss the overall assessment the Health Board in relation to the arrangements. It was noted that the outcome of that tripartite group meeting and the recommendation that the NHS Wales Chief Executive would be making to the Minister would be that Cardiff and Vale University Health Board	

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	remained at 'routine arrangements' for the next 6 months, until the next assessment. It was noted that a number of important concerns had been raised by the NHS Wales Chief Executive in her letter and the CEO advised the Board that she had written back to set out the actions the Health Board were taking in response to those concerns. The Independent Member – Finance (IMF) noted the concerns around the sustainability of GMS and highlighted that a number of practices had handed their GMS contracts back to the Health Board. He asked if any other practices were at risk. The UHB Chair responded that a practice in Penarth had been taken back due to the landlord wanting to sell the building. The matter had been effectively managed by the Primary Care Team with an agreement reached for patients to be transferred to other practices in the local area. **The Board resolved that:** a) Assurance had been received that the concerns raised within the letter from Welsh Government were being dealt with appropriately and that 'routine arrangements' was a positive outcome.	
UHB 22/03/013	**Mental Health Strategy** The Mental Health Strategy was received. The COO advised the Board that she would take the paper as read and noted that the Mental Health Strategy was not a stand-alone one and that it formed part of the overall Health Board strategy whilst also aligning with the WG strategy on Mental Health. It was noted that one of a number of areas required to facilitate the Strategy was strong partnership working with the LA, Third Sector and others. The UHB Chair emphasised the importance of partnership working and noted that it was particularly important between Clinical Boards. The Director of Operations – Mental Health Clinical Board (DOMH) highlighted a number of key points from the Mental Health Strategy report which included: • The operating context in response to, and as a consequence of the Covid 19 pandemic – it was noted that the demand and challenges in the context of post pandemic were very similar in both Children and Adults. • There was still a focus on the transformational agenda. It was noted that the transformations were key developments in delivering the six Welsh Government priorities for Mental Health,	

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and formed the building blocks of the wider transformation agenda within the Clinical Boards over the next years.

- The impact of Covid on Mental Health services had been significant – with increased demand, acuity and complexity. There were challenges balancing Infection, Prevention and control measures with continuity of care.

The DOMH advised the Board that in the short-term the Mental Health inpatient teams were currently engaged in a complex piece of urgent resetting work that was broken into a number of themes:

- Return to footprint. That aimed to ensure that internal hospital moves were minimised, that wards were used for the purposes for which they were designed, that out of area patients in Covid 'surge' beds were returned to their localities and that mitigating actions were in place to improve the safety and scrutiny of any internal moves.

- Suicide prevention training. That contained three work streams, suicide mitigation and awareness, WARRN risk assessment training roll out, roll out of Talking about Suicidal Behaviour clinical workbook with inpatients.

- MDT In-patient reviews. A co-produced work stream that looked at the performance, documentation and attendance of inpatient care planning and review meetings.

- Suicide Cluster Response Plan. Working with the Regional Suicide and Self Harm Coordinator to provide assurance to the national group about the Clinical Board actions in relation to inpatient deaths.

It was noted that the Adult Mental Health Clinical Board had a recovery focused, co-produced, sustainable and integrated approach with three components – Hope, Control and Opportunity.

The Director of Operations for the Children & Women's Clinical Board (DOCW) advised the Board that the pressures seen within the Adult Mental Health service were very similar to those in the Children and Young Adults service and noted that the needs of children and adults were different. Hence the strategy for Children and Young Adults was based on the Nurturing, Empowering, Safe, Trusted (NEST) model.

It was noted that the NEST Framework was a planning tool for Regional Partnership Boards that aimed to ensure a 'whole system' approach for developing mental health, well-being and support services for babies, children, young people, parents, carers and their wider families across Wales.

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The DOCW advised the Board that in an addition to the demand and complexity for Adult inpatient services, other areas had also seen

	significant impact. For example, there had been a 40% increase in CAMHS Crisis services during 2021/2022. It was noted that one of the highest priority collective ambitions for the Clinical Boards was to improve upon transitional care pathways as patients moved from adolescence to adulthood. It was noted that the work would focus largely on the philosophy of care and how that underpinned pathways, as well as a lens on bespoke physical infrastructure for assessment. The Independent Member – Capital & Estates (IMCE) noted the constructive collaboration between the 2 Clinical Boards and asked for information around the transitional piece noted in the report. The DOCW responded that it was a very important part of the service and something that required a new focus. She added that the first Clinical and operational workshop had been held in January 2022 between the 2 Clinical Boards. She commented that it had started to shape the thinking around the transition stage and the scope of the services that needed to change within that "mid" area, as patients transition into adulthood and also noted how the pathways needed to work together. The DOMH responded that some specific areas had been identified regarding patients who had a pressing need which included: • Individuals who had complex Mental Health illness. • Wellbeing and emotional needs. • Complex eating disorders • Areas where the transition points had not aligned He added that the service was keen to avoid a separate transitions team as it meant that patients would move between 3 services which was not beneficial to patients or their care. The IMTS asked for further information regarding the volume of demand and which of the critical areas were still showing problems. The DOMH responded that a recurring theme was the workforce and that nursing shortages was a critical demand. The COO concluded that the challenges and pressures faced by the Mental Health Clinical Board and the Children and Women's Clinical Board were continually being worked upon and noted that the Clinical Boards were moving in the right direction. **The Board resolved that:** a) The Health Board's Mental Health Strategy (as set out in Shaping our Future Wellbeing Strategy) was reviewed and noted.	

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UHB 22/03/014	**Board Assurance Framework** The Board Assurance Framework (BAF) was received. The DCG advised the Board the report would be taken as read. It was noted that the financial risk was removed from the BAF due to the Health Board being on target to deliver within the 2021/22 financial plan. It was noted that a strategy refresh had been discussed at the Strategy and Delivery Committee and that Corporate Objectives would be looked at. The big risks within the BAF affected the delivery of those Corporate Objectives. It was noted that Workforce, Patient Safety and Capital Assets remained the 3 biggest risks on the BAF. **The Board resolved that:** a) The 9 risks to the delivery of Strategic Objectives detailed on the BAF for March 2022 were approved. b) The continuing progress which had been made in relation to the roll out and delivery of effective risk management systems and processes at Cardiff and Vale UHB, were noted.	
UHB 22/03/015	**Integrated Performance Report:** The Integrated Performance Report was received. • **Finance** The Executive Director of Finance (EDF) advised the Board that the Health Board was on target to break even and noted that the Health Board was not in a position to be able to meet the target on recurrent savings for 2021/22 which would increase the underlying deficit slightly going into the new financial year. • **Workforce** The ADW advised the Board of three areas within the plan: - The Health Board had recently completed the Cardiff and Vale contribution to the National nursing workforce plan. - Workforce data, intelligence and analytics had been improved over the past few months and all the data would be easily accessible from April 2022. - A new e-rostering system had been put in place. The first phase was operational for the nursing team and there were plans to implement it into other areas. It was noted that a suitable service for Medical teams would be scoped out.	

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	The UHB Chair identified the low appraisal percentage within the report and asked if a more detailed view could be received by the Strategy and Delivery Committee in relation to appraisals.	RG
	• **Quality & Safety** The END advised the Board of two points within the report: - Phase two of the Nationally Reported Incident (NRI) process. It was noted that the Health Board would start to see benchmarking across Wales so there would be an opportunity for the Board to see relevant information as requested. - Concerns – It was noted that the central concerns team were processing as many concerns under early resolution as possible and that had maintained an overall 30 working day response time at 77% which remained above the WG target of 75%.	
	The CCHC asked the END for a discussion outside of the meeting in relation to patient concerns.	
	The IML asked for an update on pressure damage to be provided at the July Board.	RW
	The CEO asked for a comment on the Ockenden Report because there was no data on the dashboard for still birth and a comment on the risk adjusted mortality indicator on the dashboard. The END responded that there should be a number on the dashboard and it would be reported in the future. It was noted that it was a data set that was driven by WG for maternity services that is also reported directly to WG and so more integration would be required to bring the data set to the Management Executives.	**RW**
	She added that a paper would go to the Quality, Safety and Experience Committee in June 2022.	**RW**
	The Executive Medical Director (EMD) advised the Board that the number of the mortality indicator was 107 and noted that it was still the wrong end of that number. She added that a presentation would be taken to the Quality, Safety and Experience Committee in June 2022.	**MJ**
	• **Operational Performance** The COO advised the Board that referrals for the Local Primary Mental Health Support Service (LPMHSS) remained exceptionally high, with 1,233 referrals in January 2022. Part 1a: The percentage of Mental Health assessments undertaken within 28 days decreased in January 2022 to 21% and 48% for CAMHs.	

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	Part 1b: 94% of therapeutic treatments started within 28 days following assessment at the end of January 2022. It was noted that the total number of patients waiting for planned care and treatment, the Referral to Treatment (RTT) waiting list was 117,410 as of January 2022 which was an increase of 27% from the end of March 2021. The COO advised the Board that the number of patients waiting greater than 8 weeks for a diagnostic test was 7,319 at the end of January That was an increase of 42% since April 2021. It was noted that the volume of patients waiting had started to decrease. It was noted that the overall volume of patients waiting for a follow-up outpatient appointment at the end of January 2022 was 172,109 and the number of follow up patients waiting 100% over their target date had reduced to 42,268, which was a 14% decrease from March 2021. **The Board resolved that:** a) The Integrated Report was noted.	
UHB 22/03/016	**RPB Regional Integration Fund 2022/23** The RPB Regional Integration Fund (RIF) 2022/23 was received. The EDSP advised the Board that from April 2022, the WG was introducing a new funding mechanism to support the work of the Regional Partnership Boards (RPB). It was noted that the fund replaced previous funds including the Integrated Care Fund (ICF) and Transformation Fund. It was noted that the express purpose of the fund was to deliver 6 National care models and to support RPBs to continue to deliver "A Healthier Wales" and to develop, embed and mainstream new integrated care models. The EDSP advised the Board that the Cardiff and Vale RPB would receive a £19.16m contribution from WG in 2022/23. It was noted that the RIF had provided the RPB with the opportunity to 'tidy up' its portfolio of programmes and to ensure that all of its activities, old and new, were aligned to one of those programmes. The programmes included: • Starting Well – Integrated Wellness Model and Integrated Care Model. • Living Well – Learning disabilities strategy, integrated autism service and carers. • Ageing Well – The @Home programme and a national dementia strategy.	

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	The Executive Director of Finance advised the Board that by approving the report, it meant the Board was also approving the forward investment to increase the initiatives and investments that the Health Board believed were important to the future delivery of the strategy. She added that when WG funding withdraws the Health Board would be expected to increase the funding. The UHB Chair advised that a further recommendation be added for Board Members as outlined in the resolution referred to under point f) below. **The Board resolved that:** a) The introduction of the Regional Integration Fund and the proposed approach for the CVRPB was noted. b) The risks associated with the introduction of the fund were noted. c) The portfolio of programmes was approved d) The initial investment plans for the embedding element of the RIF were approved e) The complete investment plans for each programme to include the acceleration element prior to submission to WG in May (date to be confirmed), were received and approved. f) It was noted that upon funding from Welsh Government decreasing from 90% to 50% over the 5-year period, the Health Board would be required to increase their funding.	
UHB 22/03/017	**IMTP** An update on the IMTP was received. The EDSP advised the Board that the draft IMTP was being brought for approval and noted that following discussions with WG it was agreed that a further period of 3 months would be given to look at what actions could be taken to reduce the Health Board's resource/expenditure. It was noted that key areas of the plan which had been refined since the Board received a draft in February included: • The financial plan – which reflected conversations which Finance colleagues had with both WG and the Finance Delivery Unit through February and March. • Base lining of the Health Board's position against the Minister's key priorities. • Greater articulation of key delivery milestones. • Completion of a capital prioritisation exercise.	

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	• Clearer articulation of how the Health Board would continue to work regionally, where clinically appropriate, with Health Board partners. It was noted that since the paper was published minor amendments had been made to the financial section which gave further clarification on the approach being taken. The EDSP added that some of the operational ambitions had also been amended. It was noted that work would be undertaken with the DCG regarding when the final plan would need to be submitted to WG. The EDF advised the Board that the Health Board was entering the 2022/23 financial year with an underlying deficit of £29.8m and noted that the Health Board was planning to exit the year with a deficit of £20.8m, whilst noting that it would not give the Health Board an approvable plan which had been identified by the EDSP in the report. The UHB Chair commended the work that had gone into the draft IMTP and everybody involved. **The Board resolved that:** a) The Welsh Government's support for a draft plan to be received by the UHB on the 31 March 2022 whilst further work was progressed to address the UHB's underlying deficit, was noted. b) The draft 22-25 Integrated Medium Term Plan for submission to Welsh Government was approved.	
UHB 22/03/018	**Population Needs Assessment** The Population Needs Assessment (PNA) was received. The EDPH advised the Board that the PNA aimed to focus on and promote well-being; to empower people in their relationship with social services; and support co-production of solutions in provision of care and support. She added that the aim of the PNA was to provide useful epidemiology and evidence to support the shape of the Health Board's statutory services and future Organisational partnership development and provision. The Speciality Registrar in Public Health (SRPH) advised the Board that the Code of Practice required inclusion of 9 core themes within the PNA. She added that the themes were matched with the RPB programme framing of: • Starting Well • Living Well • Ageing Well	

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	It was noted that dedicated engagement work was conducted, in the form of surveys (for the general public, children and young people, adults resident in HMP Cardiff, and professionals/providers) as well as focus group discussions. It was noted that in line with the Code of Practice, an Equality and Health Impact Assessment (EHIA) of the protected characteristics was completed and was provided as a separate complementary report to the Population Needs Assessment. The SRPH advised the Board of some key overarching findings which included: • Each chapter of the PNA identified changes made since the original PNA report in 2017. • Carer support needs – social isolations, mental health and wellbeing which were already identified in 2017 but had been exasperated with Covid-19 and the restrictions in place. • Inequalities within the population such as the impact of deprivation. The Board was advised of the next steps which included: • The PNA would be considered within the development of the area plan and had already contributed to the market stability report and the Health Board's IMTP. The CCHC advised the Board that one of the issues that faced the Health Board and the LA had been the health inequalities across and within communities and asked how the PNA would help drive more bespoke services within those communities. The SRPH responded that the data was presented within the full PNA which highlighted the health inequalities. It was noted that services could then use the information contained within the PNA as a starting to point to use that as a basis to do more in depth research. The EDSP added that cluster development would play an important part in reducing health inequalities. **The Board resolved that:** a) The Population Needs Assessment for Cardiff and the Vale of Glamorgan 2022 report was noted and approved.	
UHB 22/03/019	**Vale Public Services Boards Well-being Assessment** The Vale Public Services Boards Well-being Assessment was received. The EDPH advised the Board that she would take the report as read and noted that every 5 years, the Public Services Boards (PSBs) in Wales undertook Well-being Assessments, as required under the Well-being of Future Generations (Wales) Act.	

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	It was noted that the assessments covered issues relating to social, economic, cultural and environmental well-being in their local areas and were a study of the experience of life now but also the different factors that may affect life in the future. It was noted that they would inform the development of Well-being Plans which had to be published in 2023. The EDPH provided thanks to LA colleagues for coordinating all of the work. **The Board resolved that:** a) The Vale PSB Well-being Assessment ahead of formal PSB approval on 1st April 2022 and subsequent publication was approved; b) the Leader of the Vale of Glamorgan Council, and Chair of the PSB, had authority to approve any minor changes if the changes would not fundamentally change the analysis and conclusions within the Assessment, was noted; and c) the Cardiff PSB Well-being Assessment which was approved by the Cardiff PSB on 9th March 2022, was noted.	
UHB 22/03/020	**Board Annual Plan** The Board Annual Plan was received. The DCG advised the Board that the plan highlighted the business that needed to be in place to demonstrate that the Board would comply with the Standing Orders. **The Board resolve that:** a) The Board Annual Plan 2022.23 noting that additional items would be added throughout the year to accommodate the delivery of our Strategic Objectives which were undergoing a review and refresh, was approved.	
UHB 22/03/021	**Terms of Reference and Work Plans for Committees of the Board** The Terms of Reference and Work Plans for Committees of the Board were received. The DCG advised the Board that the Terms of Reference and Work Plans highlighted the business that needed to be in place to demonstrate that the Board would comply with the standing orders. **The Board resolved that:** a) The establishment of the following Committees of the Board for 2022-23 were approved: - Audit Committee Remuneration and Terms of Service Committee Charitable Funds Committee	

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	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 Shaping Our Future Hospitals Committee – noting that this Committee is currently paused. b) The Terms of Reference and Work Plans for the following Committees of the Board for 2022-23 were approved: - 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 Shaping Our Future Hospitals Committee – noting that this Committee is currently paused.	
UHB 22/03/022	**Annual Reports for Committees of the Board and Stakeholder Reference Group.** The Annual Reports for Committees of the Board and the Stakeholder Reference Group were received. The DCG advised the reports highlighted the business that needed to be in place to demonstrate that the Board would comply with the standing orders. The UHB Chair thanked all of the Chairs of the Committees and Stakeholder Reference Group for the work undertaken. **The Board resolved that:** a) The Annual Reports from the Committees and Advisory Groups of the Board were approved.	
UHB 22/03/023	**ICF Grant Agreements** The ICF Grant Agreements were received. The EDSP advised the Board that the report was provided in order to maintain good governance in relation to the Health Board hosting the Integrated Capital Fund (ICF). It was noted that the Health Board managed all funding related to the Integrated Care Capital Fund on behalf of the Cardiff and Vale Regional Partnership Board and that over the last few years a range of projects had been successfully completed, the majority of which had been led and owned by other partner organisations.	

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	It was noted that to fulfil requirements of the funding, the Health Board was obliged to: • ensure that it had entered into appropriate back to back grant agreements with those organisations to whom the Health Board was passing on all or some of the ICF grant funding • to ensure that an organisation (other than a LA) which received an amount of the ICF funding over £100,000, entered into a Legal Charge with the Health Board and secured the Legal Charge against the property that was the subject of the grant funding/grant funded partner-owned project. **The Board resolved that:** a) the Back to Back Grant Agreements referred to under paragraph a, b and c of the report and attached as draft to the report were to be entered into, was authorised; b) the execution of the Legal Charge in relation to the Llantwit Major Community Hub project (referred to under Schedule 2 of the Back to Back Grant Agreement to be entered into between the Health Board and Glamorgan Voluntary Services), was authorised; and c) the use of the Health Board's seal in order to execute the three Back to Back Grant Agreements referred to under recommendation a) above, and the associated Legal Charge referred to under recommendation b) above, was approved.	
UHB 22/03/024	**Structured Assessment Phase 2** The Structured Assessment Phase 2 was received. The Audit Wales Audit Manager (AWAM) advised the Board that Audit Wales had examined the Corporate Governance and financial management of the Health Board. It was noted that overall the findings from Audit Wales were positive and that effective Board and Committee arrangements were in place, underpinned by maturing systems of assurance. It was noted that public transparency had improved but could be strengthened further. It was noted that there were clear plans to support recovery of services. The AWAM added that effective arrangements for maintaining oversight of the Health Board's finances were in place. He added that there were 2 recommendations within the report and noted that the Health Board had accepted the recommendations and put an action plan in place to address them.	

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	The UHB Chair thanked the AWAM for the way he had worked alongside the team. **The Board resolved that:** a) The Structured Assessment Phase 2 was noted.	
UHB 22/03/025	**Audit Wales Annual Audit Report** The Audit Wales Annual Audit Report was received. The AWAM advised the Board that the report provided a summary of the findings account audit work as well as the performance audit work. He added that the annual report had been received and discussed by the Audit and Assurance Committee and thanked Health Board colleagues for their cooperation during the year. The IMU advised the Board that the Audit and Assurance Committee would had undertaken a workshop session to go through all of the documents. **The Board resolved that:** a) The Audit Wales Annual Audit Report was noted.	
UHB 22/03/026	**Corporate Risk Register** The Corporate Risk Register was received. The DCG advised the Board that there were currently 17 Risks on the Corporate Risk Register. It was noted that one of the risks (Risk 17) was new and that one of the risks (Risk 6) had been removed due to a reduced score. It was noted that the BAF and the Corporate Risk Register were cross referenced. The DCG advised the Board that the internal audit which was carried out on the risks would be presented to the Audit and Assurance Committee. The IMTS asked if all of the identified Estates risks were related to financial issues. The EDSP responded that they were and that the Estates issues featured very significantly in the case for change. She added that a detailed Capital Plan incorporated into the IMTP would be brought back to the Committees. **The Board resolved that:** a) The Corporate Risk Register and the work in this area which was now progressing as noted.	AH

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UHB 22/03/027	**Committee / Governance Group Minutes:** The Committee / Governance Group Minutes were received. **The Board resolved that:** a) The Committee / Governance Group Minutes were noted	
UHB 22/03/028	**Chair's Reports:** The Chairs Reports for the Committees of the Board and sub-groups were received. The UHB Vice Chair advised the Board that the last Mental Health Legislation and Mental Capacity Act Committee had not been quorate and so the policies noted within the Chairs Report had been brought to the Board for approval. The Board approved the 2 policies and the 2 procedures outlined in the report. **The Board resolved that:** a) The Chair's Reports were noted. b) As per the Mental Health Legislation and Mental Capacity Act Committee Chair's Report: -. (i) the Section 5(2) Doctors Holding Power Policy and Procedure was approved; *(ii)* he full publication of the Section 5(2) Doctors Holding Power Policy and procedure in accordance with the UHB Publication Scheme was approved; (iii) the Section 5(4) Nurses' Holding Power Policy and Procedure was approved; and *(iv)* the full publication of the Section 5(4) Nurses' Holding Power Policy and procedure in accordance with the UHB Publication Scheme was approved.	
UHB 22/03/029	**Agenda for Private Board Meeting:** ***i.*** *Approval of minutes* ***ii.*** *Approval of Private Committee minutes* ***iii.*** *Nosocomial Investigation Position* ***iv.*** *Covid-19 Public Inquiry Legal Representation*	
UHB 22/03/30	**Any Other Business** The Executive Medical Director (EMD) advised the Board that the new Deputy Medical Director had been appointed on a fixed term basis.	
UHB 22/03/031	**Review of meeting** The UHB Chair asked if attendees were satisfied with the business discussions and the format of the meeting, and all Members indicated	

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	that they were happy with the meeting, the updates provided and the meeting format.	
UHB 22/03/032	**Date & time of next Meeting** 26th May 2022 at 12pm.	

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.

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ACTION LOG

Following Public Board Meeting

31st March 2022

(For the meeting 26th May 2022)

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
Actions Completed					
QSE 22/04/013	**Exception Reports**	The CC advised the Committee that a further recommendation be added to ensure the Board would be sighted on the pressures being seen across the system.	**26.05.2022**	Jason Roberts / Meriel Jenney	**COMPLETED** to be raised under the integrated performance report at Board
UHB 24/02/008	**Systems Resilience Briefing (Covid and Non Covid).**	Paper on high turnover rates will be brought back to Board in May.	**26.05.22**	Rachel Gidman	**COMPLETED** To be presented to Board in May 2022 - *Systems Resilience Briefing & Integrated Performance Report have been amalgamated into one paper.*
UHB 22/03/009	**Systems Resilience Briefing (Covid and Non Covid):**	A progress update would be brought back to the Board around the Wellbeing Service including it's funding.	**26.05.2022**	Rachel Gidman / Lianne Morse	**COMPLETED** Report to be presented to May Public Board – *Systems Resilience Briefing & Integrated Performance Report have been amalgamated into one paper.*

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MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
UHB 22/01/011	**Emergency Ambulance Services Committee Update**	Working together conversations had offline to discuss how the Health Board could work together along with the 6 identified goals.	**26.05.2022**	Caroline Bird / Catherine Phillips	**COMPLETED** Update to be provided at May's Board. First conversations had 21.04.22
Actions in Progress					
UHB 22/03/015	**Integrated Performance Report**	An update on pressure damage to be provided at the July Board.	**28.07.2022**	Ruth Walker / Jason Roberts	**In Progress** Due to be presented to the Board in July.
Actions referred to Committees of the Board/Board Development					
UHB 22/03/015	**Integrated Performance Report**	A more detailed presentation on mortality indicators to be taken to the QSE Committee in June	**15.06.2022**	Meriel Jenney	**In Progress -** Added to QSE Action Log & Forward Plan
UHB 22/03/015	**Integrated Performance Report**	A more detailed view on maternity services to be taken to the QSE Committee in June	**15.06.2022**	Ruth Walker / Jason Roberts	**In Progress -** Added to QSE Action Log & Forward Plan
UHB 22/01/009	**System Resilience Briefing (Covid & Non-Covid).**	A further report regarding pressure damage is due to be taken to the Quality, Safety and Experience Committee in June 2022.	**15.06.2022**	Ruth Walker / Jason Roberts	**In Progress -** Added to QSE Action Log & Forward Plan To be brought to QSE meeting on the 15 June 2022.
UHB 22/03/015	**Integrated Performance Report**	A more detailed view on low appraisal percentage to be taken to the Strategy & Delivery Committee.	**17.05.2022**	Rachel Gidman / Lianne Morse	**In Progress**

Mohamed.Sarah
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MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
					Scheduled to be presented at the S&D Committee on 17 May 2022 – agenda item 2.1
UHB 22/03/010	**Vale Alliance Update**	An update on the Vale Alliance would be provided to the Board via a Board Development session in June 2022	**30.06.2022** *(to be confirmed)*	Abigail Harris	**In Progress** Subject to the Board approving the annual plan for the Board Development Sessions in 2022/23, the update will be presented to the Board Development Session on 30 June.
UHB 22/01/007	**Chair's Report and Chair's Action taken since last meeting**	ICOO advised the Board that a more detailed report on the Dental Directorate would be provided to the QSE Committee.	**15.06.22**	Caroline Bird	**In Progress -** Added to QSE Action Log & Forward Plan To go onto QSE June 15 Agenda
UHB 22/01/009	**System Resilience Briefing (Covid & Non-Covid).**	Cluster plans were being drawn into the IMTP and that the same would be looked at in more detail at a Board Development session.	**30.06.2022***(to be confirmed)*	Abigail Harris	**In Progress** Date of Board Development Session to which this item will be brought is to be confirmed once Board Development Plan has been completed for 2022/23

Mohamed.Sarah
05/13/2022 16:36:25

Report Title:	Chair's Report to Board					Agenda Item no.	6.2
Meeting:	Board		Public	x		Meeting Date:	26.05.2022
			Private				
Status *(please tick one only):*	Assurance	x	Approval			Information	
Lead Executive:	Chair of the Board						
Report Author (Title):	Personal Assistant to the Chair						

Main Report
Background and current situation:

This report includes information on the key activities that have taken place since the last Board Meeting on the 31st March 2022. Also featured in this report is an overview of the invaluable work carried out by Capital Estates and Facilities (CEF) Service Board, supporting the clinical services board in the delivery of their services and highlights the impact that COVID19 has imposed upon the teams and patient and service delivery.

The CEF Service Board was established in 2018 and provides a wide range of Hard and Soft FM services. The workforce consists of circa 1200 staff members, a significant number of which are frontline staff, who strive to deliver a service to patients, staff and visitors across the UHB estate. The establishment supports the following areas:



Whilst the Service Board provides a wide range of key services, the principle, 'One Team – One Goal' is encouraged throughout the departments.

Facilities Management

The Soft FM team provide a broad spectrum of services across the UHB most of which are patient facing including housekeeping, portering and linen. COVID brought significant pressure to the Soft FM teams and particularly for the housekeeping staff as enhanced cleaning regimes were introduced across all areas, in line with Welsh Government guidance associated with the infection, prevention and control, measures. This necessitated the staff working in wards and areas affected by the pandemic and exposed them to patients suffering from this virus.

Mohamed Shah
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Despite the added pressures, the teams continued to undertake the monitoring of cleaning activities in line with the WG 'Credits 4 Cleaning' programme which is undertaken by supervisory staff in conjunction with ward managers.

Of course, the portering and linen teams were also stretched during the pandemic but continue to provide the usual level of service throughout the extended period.

A fun fact that porters walk, on average, 6 miles per day during their working hours. Our porters have a 15 minute response time allocation and the performance target is 95%.

Switchboard recently reported receiving in excess of 66,000 calls per day

Catering Services
The Central Food Production Unit at UHW produces patient catering across the UHB. Over the last 12 months the following number of meals including breakfast, lunch, dinner and sandwiches, have been provided to patients via the ward based catering team;

- 849,038 - UHW
- 430,890 - UHL / Hafan Y Coed / Llanfair
- 37,102 – Barry

The ward based catering teams provide an important service, not only to ensure patients nutritional and hydration requirements are met, but they often build up friendly and reassuring relationships with patients.

During the pandemic, the service continued to run and staff were required to work in the high risk areas on a daily basis and were exposed to many of the difficulties that the patients suffering from COVID were experiencing. Despite these unique circumstances, the team has continued to provide a high quality service throughout.

The Aroma brand was introduced to the UHB in 2015, with the first outlets opening at the Women and Children's unit and Childrens Hospital. There are currently 13 units across the UHB in addition to Y Gegin, Bwyd Blasus, and Aroma Coffee Pod at UHW. The income generation scheme was proposed to allow all profits to be returned to the Service Board to improve patient services.

In response to the pandemic and the creation of red and green areas, the CEF Service Improvement Team introduced a trial for a 'click and collect' service for coffees, sandwiches and snacks via the Aroma brand. The trial has continued and will be reviewed to establish its viability going forward as more of the restrictions are lifted.

Estates Maintenance
The estates maintenance team provides building, electrical and mechanical planned and reactive services across the entire estate 24/7 365 days a year. In addition, they are responsible for water safety testing and compliance and grounds and garden maintenance. All of these services continued to be provided throughout the pandemic where the teams also supported the capital department to convert areas for additional inpatient capacity.

In February 2022, 4172 reactive jobs were created on the MiCad system, with 3344 recorded as completed.

The recruitment of skilled workforce is proving extremely difficult with 14 vacancies across mechanical and electrical departments. This appears to be a combination of the proposed cessation of RRP by WG and market forces where the UHB is unable to compete with salaries currently being offered in the private sector and neighbouring health boards offering higher banding in similar roles.

Waste

Mohamed Salim 05/13/2022 16:37:25

Currently, waste services across the health board are managed by the estates department and provide a service 7 days per week across all the major sites. The management of waste is heavily controlled by the environmental agency and this service is frequently audited to ensure compliance with waste management policies, in particular, ensuring segregation of general and clinical waste and its disposal. During the pandemic, the volume of clinical waste that was being processed increased significantly due to PPE etc whilst the general waste reduced. The consequence of this

was that the cost of disposal of clinical waste was significantly greater than general waste and needs to be sent for processing. Significant issues arose, as the process plants struggled with capacity, which meant that the UHB had to provide more storage on site and look at alternative suppliers to deal with the increased volume.

Sustainable Transport and Travel
Sustainable transport and travel support patients, visitors and staff with travel options, for example:

- Park and Ride Service UHW and UHL
- Staff only shuttle bus between UHW and UHL
- OVO Bike, in partnership with Cardiff Council
- Promote and assist with the Cycle to Work scheme
- Promote and assist the NHS Car lease scheme
- Management of car parking

The aim is to reduce traffic to acute hospital sites in line with the pedestrian safety policy and to encourage active travel.

Security Services
The UHB operates its own security services across the UHB with the central monitoring facility located at UHW which is able to view cameras from across the UHB estate. Manned patrols are active across a number of sites with the highest presence at UHW where EU provides its own unique challenges.

The teams deal with a vast array of calls from aggressive behavior, patients or members of the public who threaten to commit suicide, fire response and managing a site traffic and access, particularly when Heli-Med are landing or departing. Whilst often the image of a security officer is forceful, our staff are trained to defuse situations and often have to show compassion to reduce harm to those who they may be dealing with.

Service Improvement Programme (SIP)
The SIP team was established in 2018 to consider opportunities to modernise and improve services CEF provide to support patients and clinical teams. In addition, the SIP team had a remit to identify cost saving programmes and take ideas from staff on the front line and develop them into projects. The team consists of staff that are generally seconded from the shop floor to work on specific projects for which they have the knowledge and experience. Whilst the team are managed by an experienced finance lead, the success of the programmes has been driven by the operational teams.

A number of schemes have been implemented, such as;

- The aforementioned ‘Click and Collect’ Catering app
- Synbiotix – New app for housekeeping schedules and catering with menu options
- Energy efficient hand dryers across the UHB
- Postal reduction costs – franking machine
- Facilities staff Bank

Capital Planning
The Capital Planning team are responsible for the delivery of major projects from inception to completion working with strategic planning colleagues, operational planning leads and clinical boards to develop the projects via the appropriate business case process. Business cases are then considered by Welsh Government fir funding via the All Wales Capital Programme.

Mohamed Salam
6/13/2022 11:16:25

Currently, there are a number of schemes progressing through the various stages of business case process, with two schemes currently on site including Maelfa Wellbeing Hub and Genomics.

During the pandemic the teams focus changed and they were required to deliver a number of projects, converting areas into inpatient facilities including Physiotherapy at UHW etc.

Most recently, the capital planning team delivered the Lakeside Wing Project which was recognised as possibly the largest modular build scheme delivered in the shortest period of time.

Discretionary Capital and Compliance
This multi-disciplinary team includes design engineers, surveyors, construction health and safety professionals and systems management. The team undertake design and management of construction projects as well as managing the estate statutory compliance programme.

In addition, the management of contractors, asbestos, and construction health and safety compliance and assurance plays a significant role in the department.

Most notably during the pandemic, the team delivered the High Consequence Infectious Diseases Unit (HCID) at UHW, managed the works in community facilities for the Mass Testing Units and development of the Mass Vaccination Centres. The team were also required to work closely with the clinical boards to create Red and Green zones to support the recommencement of clinical activity following the height of the pandemic.

Impact of COVID19
During the COVID pandemic, CEF responded to the challenges it faced to support the UHB on several fronts from increased cleaning regimes, 24/7 catering for staff, increased linen and waste services, creation of additional inpatient capacity and ITU, amongst many other priorities passed to them by the clinical boards and operational teams.

The estates and facilities departments played a key role in the establishment and operation of the Dragons Heart Hospital with the capital team responsible for the decommissioning of the facility

Sadly, the Service Board lost a valued member of its porter team, Andrew Woolhouse, to COVID19.

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 1 document since the last meeting of the Board.

Seal No.	Description of documents sealed	Background Information
988	Penarth Health Centre – Surrender of Lease	A Transfer between (1) Cardiff and Vale University Health Board and (2) Messrs Griffin, Khan, Frank and Froom (Penarth Health Care Partnership) to surrender a sub-lease dated 14/02/2003.
989	Lease of Unit 1 – Cardiff Medicentre	A two year lease of Unit 1, the Medicentre, between (1) Cardiff University and (2) Cardiff and Vale University Health Board.
990	A Lease of the Ground and First Floors, Building CD1, Longwood Drive, Forest Farm, Cardiff, CF14 7YT	A 15 year lease between (1) HRSE-Trinity Cardiff Edge Limited and (2) Cardiff and Vale University Health Board.
991	Deed of Variation relating to Building CD1, Cardiff Laboratories, Forest Farm Road, Whitchurch, CF14 7YT	A Deed of Variation between (1) HRSE-Trinity Cardiff Edge Limited and (2) Cardiff and Vale University Health Board.
992	A Licence for Alterations at Unit 4, Ty Glas Industrial Estate	A licence for Alterations at Unit 4, Ty Glas Industrial Estate between (1) Sunflower UK Industrial Property IV

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		LP and (2) Cardiff and Vale University Health Board
993	Deed of Variation relating to Building CD1, Cardiff Laboratories, Forest Farm Road, Whitchurch, CF14 7YT	A deed of Variation between (1) Verraux Proctor JV 2 Ltd (previously known as Garrison Barclay Equity Limited) (2) HRSE-Trinity Cardiff Edge Limited and (2) Cardiff and Vale University Health Board
994	A Consultant form of Collateral Warranty related to works undertaken at Building CD1, Forest Farm Road, Whitchurch, CF14 7YT	A Collateral Warranty agreement between (1) Troika Construct Limited (2) Cardiff and Vale University Health Board and (3) Verraux Proctor JV 2 LTD
995	A Consultant form of Collateral Warranty related to works undertaken at Building CD1, Forest Farm Road, Whitchurch, CF14 7YT	A Collateral Warranty agreement between (1) HTB Consult Limited (2) Cardiff and Vale University Health Board and (3) Verraux Proctor JV 2 LTD
996	A Consultant form of Collateral Warranty related to works undertaken at Building CD1, Forest Farm Road, Whitchurch, CF14 7YT	A Collateral Warranty agreement between (1) Bingham Hall Ltd (2) Cardiff and Vale University Health Board and (3) Troika Construct LTD
997	A Consultant form of Collateral Warranty related to works undertaken at Building CD1, Forest Farm Road, Whitchurch, CF14 7YT	A Collateral Warranty agreement between (1) Expedite Project Services Limited (2) Cardiff and Vale University Health Board and (3) Verraux Proctor JV 2 LTD
998	A Consultant form of Collateral Warranty related to works undertaken at Building CD1, Forest Farm Road, Whitchurch, CF14 7YT	A Collateral Warranty agreement between (1) Overdale Construction Services Limited (2) Cardiff and Vale University Health Board and (3) Troika Construct LTD
999	A Consultant form of Collateral Warranty related to works undertaken at Building CD1, Forest Farm Road, Whitchurch, CF14 7YT	A Collateral Warranty agreement between (1) Triangle Lift Services (2) Cardiff and Vale University Health Board and (3) Troika Construct LTD
1000	A Consultant form of Collateral Warranty related to works undertaken at Building CD1, Forest Farm Road, Whitchurch, CF14 7YT	A Collateral Warranty agreement between (1) Powell Dobson Architects Ltd (2) Cardiff and Vale University Health Board and (3) Troika Construct LTD
1001	A Service Level Agreement relating to the Vale of Glamorgan Council Vale Flying Start Therapeutic Fostering Service as part of the wider Enfys Service	A Service Level Agreement between (1) Vale of Glamorgan Council and (2) Cardiff and Vale University Health Board
1002	A Service Level Agreement relating to the Provision of a Vale of Glamorgan Therapeutic Fostering Service as part of the wider Enfys Service	A Service Level Agreement between (1) Vale of Glamorgan Council and (2) Cardiff and Vale University Health Board

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

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Date Signed	Description of Document	Background Information
10.03.2022	An NEC 3 Construction Contract for the Physiotherapy Outpatients Area at the Lakeside Wing	A contract between (1) Cardiff and Vale University Health Board and (2) E. T. & S. Construction Ltd

10.03.2022	An NEC 3 Construction Contract for the Pre-Operative Assessment Clinic at the Lakeside Wing	A contract between (1) Cardiff and Vale University Health Board and (2) E. T. & S. Construction Ltd
10.03.222	A wayleave agreement for Virgin Media Services at University Hospital Llandough	A wayleave Agreement between (1) (Virgin Media Limited and (2) Cardiff and Vale University Health Board
10.03.2022	An NEC 3 Construction Contract for the provision, delivery and siting of Ten Insulated Shipping Containers to Wedal Road, Cardiff	A contract between (1) Cardiff and Vale University Health Board and (2) E. T. & S. Construction Ltd
10.03.2022	An NEC 3 Construction Contract for the refurbishment of the Main Kitchen Floor at University Hospital Llandough	A contract between (1) Cardiff and Vale University Health Board and (2) E. T. & S. Construction Ltd
15.03.2022	A Notice of Partial Termination of Deployment Orders for GP IT services	A notice signed on behalf of Cardiff and Vale University Health Board addressed to Cegedim Healthcare Solutions
31.03.2022	A Variation Agreement (Number 2) Relating to the Medicentre Joint Venture Agreement	An agreement between (1) Cardiff University and (2) Cardiff and Vale University Health Board
24.03.2022	NHS Wales Health Collaborative Hosting Arrangement – Extension to 31st March 2023	An Agreement Signed On behalf of Cardiff and Vale University Health Board in conjunction with (1) NHS Wales Health Collaborative, (2) Public Health Wales and (3) NHS Wales Health Boards, Trusts and Special Health Authorities.
25.03.2022	An Accelerate Project Funding Agreement for the SEREN and BERTIE Digital Evaluation Project	An Agreement between (1) Cardiff University (2) Rondo Media Cyf (3) Cardiff and Vale University Health Board (4) University Hospitals Dorset NHS Foundation Trust and (5) Cwm Taf Morgannwg University Health Board.
07.04.2022	An NEC 3 Construction Contract for an Endoscopy Expansion at the University Hospital Llandough	A contract between (1) Cardiff and Vale University Health Board and (2) Know & Wells Ltd
21.04.2022	A Services Agreement for Support and Education Services	An Agreement between (1) Camarus Ltd and (2) Cardiff and Vale University Health Board

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	

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10.03.2022	Physiotherapy Outpatients works at the Lakeside Wing	Approval sought for £1.2 million expenditure	15.03.222	Ceri Phillips 11.03.2022	Mike Jones 14.03.2021	N/A
16.03.2022	Sealing of documents and approval to enter deeds for the Lease of Unit 1 Medicentre and the Surrender of a Lease at the Penarth Medical Centre	Approval to enter deeds and apply UHB seal.	16.03.2022	Ceri Phillips 15.03.2022	Mike Jones 15.03.2022	N/A
17.03.2022	Replacement of Phillips MX450 Patient Monitors	Approval to incur expenditure totaling £889,824.00 (incl. of VAT)	18.03.2022	Rhian Thomas 17.03.2022	Gary Baxter 17.03.2022	N/A
21.03.2022	Purchase of Olympus Endoscopy Equipment for Endoscopy Expansion	Approval to incur expenditure totaling £817,826.64 plus VAT	23.3.2022	Ceri Phillips 21.03.2022	Mike Jones 22.03.2022	N/A
24.03.2022	Approval to enter documents and apply the UHB Seal: - Genomics CD1 Lease -Two Deeds of Variation Genomics; and - Licence for Alterations Unit 4 Ty Glas Industrial Estate	Approval sought to apply UHB Seal enter into lease rent amounting to £500,000 Per Annum for 15 years subject to review.	24.03.2022	Ceri Phillips 24.03.2022	Mike Jones 24.03.2022	N/A
28.03.2022	Application of UHB Seal and approval to enter into 7 Collateral Warranties linked to the lease of Unit CD1 which will house the Health Board's Genomics service.	Approval sought for the application of the UHB Seal and to enter into the Warranties	30.03.2022	Rhian Thomas 28.03.2022	John Union 28.03.2022	N/A
28.03.2022	Patient Blood Management Equipment	Approval sought to incur expenditure totaling £872,158.84 (inc VAT)	31.03.2022	Michael Imperato 29.03.2022	Gary Baxter 29.03.2022	N/A
28.03.2022	All Wales Infrastructure Programme Work Packages 25 and 28	Approval sought to incur expenditure totaling £522,072.00	31.03.2022	Ceri Phillips 29.03.2022	Mike Jones 29.03.2022	N/A
28.03.2022	All Wales Infrastructure Programme Work	Approval sought to incur expenditure		Ceri Phillips	Mike Jones	N/A

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	Packages 24, 27 and 30	totaling £708,720.00	31.03.2022	29.03.2022	29.03.2022	
30.03.2022	Insourcing of Endoscopy Procedures	Approval sought to incur expenditure totaling £2,790,122.00	31.03.2022	Ceri Phillips 31.03.2022	Mike Jones 31.03.2022	N/A
30.03.2022	Lease and Associated Services (Franking Machine) and Cycle to Work Scheme	Approval sought to incur expenditure totaling £800,000 plus VAT and £500,010 plus VAT respectively	11.04.2022	John Union 04.04.2022	Rhian Thomas 04.04.2022	N/A
30.03.2022	Marie Curie Palliative Care Services	Approval Sought to Incur Specialist Palliative Care Services in the Vale of Glamorgan totaling £2,410,000.00 and Hospice Inpatient specialist Palliative Nursing Care services totalling £5,075,000.00	05.05.2022	Gary Baxter 19.04.2022	Michael Imperato 05.05.2022	N/A
05.04.2022	Radio Pharmacy Costs Write Off	Approval sought to incur expenditure totaling £527,094.88	08.04.2022	Ceri Phillip 06.04.2022	Mike Jones 06.04.2022	N/A
12.04.2022	Nice Tender Submission - Cedar	Approval sought to bid for work from an framework £5.8 million with an anticipated award value of £770,000 over three years.	21.04.2022	Mike Jones 12.04.2022	Ceri Phillips 12.04.2022	N/A
12.04.2022	Velindre LTA - Summing up costs	Approval sought to incur expenditure totalling £1,416,747.00	21.04.2022	Mike Jones 12.04.2022	Ceri Phillips 12.04.2022	N/A
12.04.2022	CAVOC Theatres - OBC Costs - Award to Wilmott Dixon	Approval sought to incur expenditure totaling £537,557.53 plus VAT	21.04.2022	John Union 19.04.2022	Rhian Thomas 19.04.2022	N/A

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19.04.2022	Permission to enter 7 Project Bank Accounts and apply the UHB Seal	Approval sought to apply the UHB seal.	21.04.2022	Mike Jones 19.04.2022	Ceri Phillips 19.04.2022	N/A
21.04.2022	Approval of a compensation interim payment over £1m	Approval sought for an interim compensation payment totaling £1.5 million	21.04.2022	Mike Jones 21.04.2022	Ceri Phillips 21.04.2022	N/A
25.04.2022	Application of UHB Seal and permission to enter into two Service Level Agreements with the Vale of Glamorgan Council	Approval sought for the application of the UHB Seal	29.04.2022	Mike Jones 25.04.2022	Ceri Phillips 25.04.2022	N/A
25.04.2022	Neurological Consumables	Approval of Contract Procurement Framework with a value of £7,661,696.92	28.04.2022	Mike Jones 25.04.2022	Ceri Phillips 25.04.2022	N/A
25.04.2022	Extension of Existing Building, Refurbishment and Upgrade Framework	Approval sought to extend the value of existing an existing procurement framework by £10million	28.04.2022	Mike Jones 25.04.2022	Ceri Phillips 25.04.2022	N/A
25.04.2022	Contract for Carers Services - Age Cymru	Approval sought to incur expenditure totaling £871,872.00	28.04.2022	John Union 25.04.2022	Rhian Thomas 26.04.2022	N/A
25.04.2022	Provision of Hospital Capacity - St Joseph's Hospital	Approval sought to incur expenditure totaling £9,600,000.00	28.04.2022	John Union 25.04.2022	Rhian Thomas 26.04.2022	N/A

The Board is 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

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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

Mohamed,Sarah
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Report Title:	CHIEF EXECUTIVE'S REPORT			Agenda Item no.	6.3
Meeting:	BOARD MEETING	Public	✓	Meeting Date:	26.05.2022
		Private			
Status *(please tick one only):*	Assurance		Approval		Information ✓
Lead Executive:	CHIEF EXECUTIVE				
Report Author (Title):	EXECUTIVE ASSISTANT TO CHIEF EXECUTIVE				

Main Report Background and current situation:

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

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

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

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

Discovery Phase
I am nearing the end of my initial period of discovery at Cardiff and Vale UHB. Since joining the team, I have been keen to meet as many colleagues as possible, really understand the challenges we face and get to know and build relationships with key partners. Over the past three months I have been fortunate to receive the warmest of welcomes and have been supported along the way by all I have met and I am really grateful for that, thank you. I've also really enjoyed getting to you know you better and making new friends and colleagues and despite all the challenges feel optimistic about the future the ambitions we collectively share for patients and for the organisation more broadly.

NHS 111 Wales Update
NHS 111 Wales is now available in Cardiff and Vale, enabling patients to visit the website or call 111 from anywhere in Wales to access healthcare advice and information. Within Cardiff and Vale, one call does all, as patients can now call 111 to access our #PhoneFirst for EU and Minor Injuries Unit, where, if appropriate, they will be triaged by our CAV 24/7 clinicians and offered a timeslot at the unit. Over the coming weeks and months, it will be important to monitor the impact of the implementation to understand the key benefits and to provide the opportunity to adapt the approach in order to best meet the needs of those using the service.

Phase 1 of Same Day Emergency Care (SDEC) Assessment Unit open to Patients
The new assessment unit, located at University Hospital of Wales (UHW), has been created to allow rapid access to surgical treatment through ambulatory care. This state-of-the-art multidisciplinary unit will allow the surgical teams to provide same day assessment, rapid access to diagnostics and treatment, reducing patient admissions and length of stay in hospital.

Mohamed-Sham
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The assessment unit is part of the Health Board's ongoing work to improve access to surgical services, by providing same day specialist care and improving communication with Primary Care. The unit utilises Consultant Connect and WiFi phones to provide advice and triage of patients, which ensures patients are seen in the right place first time.

This approach to care, known as Same Day Emergency Care (SDEC), was first introduced prior to the pandemic and has been a key part of redesigning how we provide surgical services to patients throughout the pandemic and into recovery.

As a consequence of the reduced length of stay and avoiding unnecessary admissions, the new multi-speciality unit will increase the Health Board's surgical capacity even further. The first phase in the opening of the assessment unit took place recently, with the SDEC Trolley Bay now operational. This will feed into the SDEC Theatre lists, allowing patients to go home under a virtual inpatient system and come back in on the day of their procedure to help prevent inpatient admissions and free up beds for patients requiring an in-patient stay.

SDEC is an important element of the approach to improve urgent and emergency care at CAV and a significant strand within the national programme, 6 Goals for Urgent and Emergency Care. It is anticipated that over the near future increasing numbers of patients will be assessed and treated through SDEC alongside a broadening of specialties using the initiative. This work is one of a number of projects being supported by the Health Board's Recovery and Redesign Programme, which aims to recover services to pre-pandemic levels by increasing activity and improving access to care.

All Wales Dementia Charter
The All-Wales Dementia Charter was launched on 6 April which aims to enable hospitals to create the right environment for people with dementia, their families and carers in Wales. It will focus on improvement and offer a short, accessible and visible statement of principles that contribute to a dementia-friendly hospital.

It was built with people with dementia and their families and carers and will clearly explain what people can rely on in a dementia-friendly hospital. The Charter is based on the foundation offered by the Royal College of Nursing's Staff, Partnership, Assessment, Care and Environment (SPACE) principles.

This will build on the excellent work happening across our region. As you know small changes can make a big difference. The Charter will be supported by top tips about how everyone can help create a hospital environment that is as accessible and friendly to people with dementia. For instance:

- Ask me what I like to eat and drink. Provide examples of choices and give me time to consider the options. Show me the menu in pictures as well as in words
- Comfortable seating in quiet spaces are available in high traffic areas and in wards
- Clear and consistent dementia friendly signage to support a person's orientation throughout the hospital.

Age Friendly City Status
Cardiff has recently received Age-Friendly City Status from the World Health Organisation. Cardiff has been accepted as the first Local Authority to join the Global Network of Age Friendly cities and communities. Work has commenced on an evaluation framework to track the progress of the Action Plan which is a key element of the application process.

A new Age Friendly Cardiff website is now in development and will aim to showcase the fantastic Age Friendly services and activities taking place in the city. Our Health Board worked collaboratively with key partners including Cardiff Council, South Wales Fire and Rescue Service, South Wales Police, educational institutions, and the third sector.

Mohammed Sarah
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The Age Friendly Cities Network was established in 2010, with the aim of connecting cities, communities, and organisations worldwide, with a common vision of making communities a great place to grow older. The aim is to deliver an age friendly vision of Cardiff as a great place to grow older and a place where people are more empowered, healthy, and happy.

New Weight Management and Prevention Services to support Children and Young People
A new weight management and prevention service for children and young people has been launched by Cardiff and Vale University Health Board, supported by Cardiff and the Vale's Public Health Team and regional Public Service Boards.

The Nutrition for Your Little One (NYLO) and Active Families, Active Lives (AFAL) programmes were launched in alignment with Welsh Government's Healthy Weight Healthy Wales strategy, to give children the best start in life. Additionally, the service corresponds with Cardiff and the Vale's Move More, Eat Well 2020-2023 Plan, which strives to ensure that people are moving more and eating well throughout their lives.

Considering wider determinants of health, the children's weight management service offers families, children and young people support and advice from on a range of children's health topics such as: food, activity, sleep, stress, to give families skills and knowledge to support healthier lifestyles.

WINGS Project Success
Colleagues working within the All Wales Medical Genomics Service (AWMGS), hosted by Cardiff and Vale University Health Board were recently featured on the BBC Wales News Today Programme, online and Breakfast radio to highlight recent successes of the Wales Infants and Children's Genome Service, otherwise referred to as WINGS.

Since its implementation in spring 2020, this ground-breaking service (which is still a UK First) has seen approximately 50 acutely unwell babies and infants with a suspected rare genetic condition and remarkably provided a diagnosis in over 40% of cases. Using the Novaseq 6000 and technology referred to as 'whole genome sequencing', our staff are able to scan the entire DNA code of the human body for between 6000 – 8000 known genetic diseases, which can otherwise take several years or longer to identify and many hospital visits which scientists refer to as a 'diagnostic odyssey'.

Through support of Welsh Government capital funding, AWMGS has recently secured a second Novaseq 6000 which will further extend referral eligibility to more patients with suspected genetic illnesses which will be of huge comfort to patients and their families, including Mum and Dad of Baby Thea, who is one of the many to have benefited from the service and is now being treated for EIF5A related disorder, a condition first reported in 2021 said to affect only 6 people worldwide.

Congratulations and thank you to Head of the All Wales Medical Genomics Laboratories, Sian Morgan, Constitutional Scientist Angharad Williams and Consultant in Clinical Genetics Dr Ollie Murch, who were the service representatives.

Demand on services across the Health Board continue to be extreme with particular pressure points being seen in Primary Care, Mental Health and Urgent and Emergency Care but without doubt the high demand is affecting almost all services. Much detailed work continues to mitigate the effects of the continuing surge in need but it is clear the impacts on the quality of patient care and in particular experience alongside the degradation of team resilience are tangible and of great concern. Subsequent papers will provide greater detail but I would wish to assure the Board and stakeholders that addressing the urgency of the situation, supporting Team CAV and responding to needs of patients and the community we serve is my key focus at this time. I continue to be hugely impressed and humbled by the work of my colleagues and the whole CAV team and wish to record my gratitude formally here.

Mohammad Sarah
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Recommendation:

The Board is requested to:

- **NOTE** the report

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant			
1. Reduce health inequalities	✓	6. Have a planned care system where demand and capacity are in balance	✓
2. Deliver outcomes that matter to people	✓	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: No
Safety: No
Financial: No
Workforce: No
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation: No

Mohamed Mahfouz
05/12/2022 08:36:25

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

Mohamed,Sarah
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Report Title:	Board Assurance Framework 22-23 – May 2022				Agenda Item no.	6.4	
Meeting:	Board		Public	x	Meeting Date:	26th May 2022	
			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 and it was agreed the following risks would added to the Board Assurance Framework 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

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 during June the BAF may change to reflect any change made to Strategic Objectives as a result of that review.

The key changes to the risks on the BAF from March 2022 are as follows:

1. The risk in relation to Financial Sustainability has been added back into the BAF due the financial situation entering and new financial year and also the underlying deficit of £20.8m with no current plan to deliver.
2. The risk in relation to Planned Care has been removed as there is a clear plan in place to deliver on this objective for 22/23.
3. The risk in relation to Sustainably Primary and Community Care has been removed as a risk in isolation but is included within the risk on Emergency and Urgent Care as these issues are intrinsically linked.
4. The risk in relation to 'Delivery of the Annual Plan' has been amended to a risk in relation to Delivery of the 22/23 commitments within the IMTP due to the fact that the Health Board does

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not yet have a plan to deliver the underlying financial deficit of £20.8m and hence an IMTP plan which is approvable.

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 regarding the risks at Management Executives on 9th May 2022.
- Discussion at the various Committees of the Board on the risks allocated to them for review.

Recommendation:

The Board are requested to:

- **Approve** the 9 risks to the delivery of Strategic Objectives detailed on the attached BAF for May 2022.

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~~

Mohammed Sarah 03-05-2022 16:36:25

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:	
Management Executives	Date:9th May 2022

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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
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
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
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
6. Have a planned care system where demand and capacity are in balance	• Workforce • Exacerbation of Health Inequalities • Patient Safety • Financial Sustainability
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
10. Excel at teaching, research, innovation and improvement.	• Workforce • Sustainable Cultural Change • Wellbeing of staff • Delivery of IMTP 22-25

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Key Risks

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

Risk	Risk Appetite	Corp Risk Register Ref.	Gross Risk	Net Risk	Change from Jan 22	Target Risk	Context	Executive Lead	Committee
1. Workforce	Open	5, 8,18.	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:** 03.05.22	Strategy and Delivery Committee **Last Reviewed:** 11.01.22
2. Patient Safety	Open	1, 2, 3, 4, 5, 8, 9,1011,12, 13,14.	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 **Last Reviewed:** 03.05.22	Quality, Safety and Experience **Last Reviewed:** 22.02.22
3. 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	Executive Director of People and Culture	Strategy and Delivery Committee

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							behaviours framework will make a positive cultural change in our health system for our staff and the population of Cardiff and the Vale.	**Last Reviewed:** 03.05.22	**Last Reviewed:** 15.03.22
4. Capital Assets	Open	1,2,3,4,5,	**25**	**20**		**10**	The UHB delivers services through a number of buildings across Cardiff and the Vale of Glamorgan, from health centres to the Tertiary Centre at UHW. All NHS organisations have statutory responsibilities to manage their assets effectively: an up to date estate strategy is evidence of the management of the estate. The IT SOP sets out priorities for the next five years and Medical Equipment is replaced in a timely manner.	Executive Director of Strategic Planning, Executive Director of Therapies and Health Science, Executive Director of Finance **Last Reviewed:** 05.05.22	Finance Committee & Strategy and Delivery Committee **Last Reviewed:** 04.11.21
5. Delivery of IMTP 22-25	Open		**20**	**15**		**10**	The Integrated Medium Term Plan is the key planning document for the Health Board setting out the milestones and actions we are taking in the next 1 to 3 years in order to progress Shaping Our Future Wellbeing, our ten-year strategy. It is based on the health needs of our population, delivering quality services and ensuring equitable and timely access to services and sets out how we will deliver our mission Caring for People; Keeping People Well, and vision that a person's chance of leading a healthy life is the same wherever they live and whoever they are.	Executive Director of Strategic Planning **Last Reviewed:** 05.05.22	Strategy and Delivery Committee **Last Reviewed:** 17.05.22
6. Staff Wellbeing Mohamed,Sarah 05/13/2022 16:36:25	Open	5.	**20**	**15**		**6**	As a result of the global Covid19 pandemic, our employees have been exposed to unprecedented levels of psychological and physical distress both at home and in the workplace. Evidence indicates that, Healthcare workers are at greater risk of developing mental health problems as a result. The impact of this is unlikely to be experienced equally, with people with existing mental health difficulties and people from Black, Asian and minority ethnic	Executive Director of People and Culture **Last Reviewed:** 03.05.22	Strategy and Delivery Committee **Last Reviewed:** 17.05.22

							communities among those who are likely to be affected disproportionately		
7. Exacerbation of Health Inequalities	Open		**16**	**12**		**8**	COVID-19 has compounded existing health inequalities in Wales, which have shown little improvement in the last ten years, based on the gap in life expectancy between the most and least deprived fifth of the population. Although the main disparities have been age, sex, deprivation and ethnicity, there is clear evidence of intersectionality, risk factors compounding each other to further disadvantage individuals with protected characteristics (based on the Equality Act 2010). As the granular level data emerges, there is no evidence to suggest that this pattern is not replicated fully at a Cardiff and Vale UHB level.	Executive Director of Public Health **Last Reviewed:** 03.05.22	Strategy and Delivery Committee **Last Reviewed:** 15.03.22
8. Financial Sustainability	Cautious		**25**	**15**		**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:** 04.05.22	Finance Committee **Last Reviewed:** 27.04.22
9. Urgent and Emergency Care Mohamed.Sarah 05/13/2022 16:36:25	Cautious		**20**	**15**	**New risk**	**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	Interim Chief Operating Officer **Added:** 12.05.22	Strategy and Delivery Committee

							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.		

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 – Board and Committee level Assurance

(3) Third Line of Defence – Independent level Assurance

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.

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1. **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 pandemic, mass immunisation programme and urgent service recovery plans has led for an increasing need in clinical staff. There is now a sense that our workforce capacity is being stretched thinly in an attempt to cover the number of competing and simultaneous operational requirements that could be with us for some years to come.

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

Risk **Date added: 6.5.2021**	There is a risk that the organisation will not be able to 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 has increased. Turnover continues to rise across the UHB and is now at 13%, over 3% higher than the pre-pandemic rate. • Sickness absence remains high at just over 7% which is 2% higher than pre-pandemic. The rate is stabilising but is still very challenging. 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.		
Impact	• Negative impact on our people and our teams, as a result we are experiencing: - High levels of sickness absence; - 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.		
Impact Score: 5	Likelihood Score: 5	**Gross Risk Score:**	**25 (Extreme)**

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Current Controls	• People and Culture Plan with robust processes to monitor progress against the key deliverables. • The Workforce Hub Steering Group meet weekly to monitor progress with recruitment to deliver the Recovery and Redesign plan, and provide assurance. • A Workforce Resourcing Team, supported by the well-established Nurse Resourcing Team is now well established. Focusing on improving attraction, recruitment and retention. • Retention Plan. • The People Services Team have changed its operating model 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. • 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. • Medical and Dental Bank in place to increase the supply of doctors, maintain quality and reduce costs. • 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 is progressing as outlined in the plan. • Health & Wellbeing strategy monitored through the strategic Health & Wellbeing Group.
Current Assurances	• Robust monitoring of People and Culture Plan KPI's at Strategy and Delivery Committee and Board. (1) (2) • Effective partnership working with Trade Union colleagues (WPG, LPF). (1) (2)

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 Workforce Supply. Workforce supply affected by National Shortages.		
Gap in Assurances			

Actions	Lead	By when	Update since March 2022
1. International Nurse Recruitment Campaign	Rachel Gidman	31.05.22	75% of the required Nurses have been offered positions.
2. Roll out of the new Nurse E-Rostering System 22/23, including Safe-Care Module and improved Bank App. functionality	Rachel Gidman	31.03.22	Complete

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

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2. **Patient Safety – Interim Medical Director /Interim Executive Nurse Director- (Meriel Jenney/ Jason Roberts)**

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 during COVID 19 creating both longer and ageing waiting lists for planned care. Resources re directed to address planned care demand leaving unplanned care/unscheduled care pathways with lower staffing		
Impact	Worsening of patient outcomes and experience, higher death rate. 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 • Implementation of Organisation and Transformation Centres (OPAT) to focus upon operational deliver across acute sites. • New Quality and Safety and Experience Framework approved by QSE Committee 14/07/21 • Wales wide Risk Summit in March 2022 with a refresh of health and social care actions to assist the current risk in the system with work continuing to be embedded and implemented • Resilience report being reviewed at ME on a weekly basis and reported to WG		
Current Assurances	• Recovery Plans reported to Management Executive, Strategy and Delivery Committee and the Board (1) (2)		

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	• CAHMS position reviewed at Strategy and Delivery Committee (2) • Mental Health Committee aware of more people requiring support(2) • Review of clinical incidents and complaints continues as business as usual and has been aligned with core business and reviewed at Management Executives (1) • Update of situation in EU shared in private session of QSE Committee in Feb 22. (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. Difference in interpretation of IPC guidance reduces timeliness of discharge to care settings.		
Gap in Assurances	Discharging patients is out of the Health Boards control		

Actions	Lead	By when	Update since March 2022
1. Review of hospital acquired COVID 19 and COVID deaths being undertaken	Jason Roberts	30.09.22	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
2. Choices framework being utilised due to the quality of care and ability to provide safe care with current demand and pressures	Jason Roberts/ Caroline Bird	30.09.22	Choice framework continues to be utilised
3. Work Plan currently been developed via Clinical Board for dealing with pressures in EU with oversight from OPAT	Jason Roberts	30.06.22	
Impact Score: 5 **Likelihood Score: 2**	**Target Risk Score:**		**10 (High)**

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3. **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 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 • 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		

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Current Assurances	Engagement of staff side through the Local partnership Forum (LPF) [2] Matrix of measurement now in place which will be presented in the form of a highlight report to Committee [2]		
Impact Score: 4	**Likelihood Score: 2**	**Net Risk Score:**	**8 (High)**
Gap in Controls			
Gap in Assurances			

Actions	Lead	By when	Update since March 2022
1. Learning from Canterbury Model with a Model Experiential Leadership Programme- Three Programmes have been developed: (i) Acceler8 (ii) Integr8 (iii) Collabor8 (iv) Oper8 (for Directorate Managers or equivalent) Compassionate and inclusive leadership principles will be at the core of all the programmes	Rachel Gidman	06.05.22	Acceler8 Senior Leadership Programme launched in March 2022 with 10 delegates from across the UHB. EOI for Cohort 2 to go out end of May 2022. Other leadership development programmes are in development (Collabor8) to support leaders at different levels. Development of a coaching and mentoring network continues, with coaching currently targeted at Senior Nurses. Focus groups in development to engage with colleagues approaching or considering retirement to assess the appetite to become mentors. A programme of communication to support and enhance completion of VBAs will launch in June 2022. VBA paperwork is currently under-review to simplify and minimise perceived complexity.
2. Showcase	Rachel Gidman	06.05.22	Focused work on developing the showcase to communicate the People and Culture Plan is underway. This development will be reviewed by the end of May for launch in Autumn 2022.
3. Equality, Diversity and Inclusion Welsh Language Standard being implemented. Inclusion - Nine protected Characteristics	RG	06.05.22	Equality Strategy Welsh Language Group is now established and taking place on a bi monthly basis with senior leaders across the organisation who can influence this agenda. A robust translation process is in place supported by 2 Welsh Language Translators and an SLA with Bi-lingual Cardiff. This is reviewed regularly. The action plan following the internal Audit on Welsh Language within the UHB is progressing with assurance of action completed. All 9 protected characteristics including Welsh language are

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			sponsored by an Executive and an independent member. This approach is also being rolled-out across CBs. THE EDI and Welsh Language Team are developing a role outline and support pack for Protected Characteristics 'ambassadors / champions. Access into work programmes are progressing well, including Project Search and Kickstart.
4. CAV Convention	Rachel Gidman	06.05.22	
Impact Score: 4	**Likelihood Score: 1**	**Target Risk Score:**	**4 (Moderate)**

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4. 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.		
Cause	• Significant proportion of the estate is over-crowded, not suitable for the function it performs, or falls below condition B. • Investment in replacing facilities and proactively maintaining the estate has not kept up the requirements, with compliance and urgent service pressures being prioritised. • Lack of investment in IT also means that opportunities to provide services in new ways are not always possible and core infrastructure upgrading is behind schedule. • Insufficient resource to provide a timely replacement programme, or meet needs for small equipment replacement		
Impact	• The health board is not able to always provide services in an optimal way, leading to increased inefficiencies and costs. • Service provision is regularly interrupted by estates issues and failures. • Patient safety and experience is sometimes adversely impacted. • IT infrastructure not upgraded as timely as required increasing operational continuity and increasing cyber security risk • Medical equipment replaced in a risk priority where possible, insufficient resource for new equipment or timely replacement		
Impact Score: 5	**Likelihood Score: 5**	**Gross Risk Score:**	**25 (Extreme)**
Current Controls	• Estates strategic plan in place which sets out how over the next ten years, plans will be implemented to secure estate which is fit for purpose, efficient and is 'future-proofed' as much as possible, recognising that advances in medical treatments and therapies are accelerating. • Statutory compliance estates programme in place – including legionella proactive actions, and time safety management actions. • The strategic plan sets out the key actions required in the short, medium and long term to ensure provision of appropriate estates infrastructure. • IT SOP sets out priorities for next 5 years, to be reviewed in early 2019 • The annual capital programme is prioritised based on risk and the services requirements set out in the IMTP, with regular oversight of the programme of discretionary and major capital programmes. • Medical Equipment prioritisation is managed through the Medical Equipment Group • Business Case performance monitored through Capital Management Group every month and Strategy and Delivery Committee every 2 months. • A 10-year prioritised programme has been developed and submitted to Welsh Government and the priorities for the next three years are within the IMTP 22-25.		
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 to secure funding to enable a UHW replacement to be build (1) (2)		

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	• 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 NWIS (2) • Health Care Standard completed annually (3) • Medical equipment risk registers developed and managed by Clinical Boards, reviewed at UHB medical equipment group (1) • Strategy and Delivery Committee continue to oversee the delivery of the Capital Programme (2)		
Impact Score: 5	**Likelihood Score: 4**	**Net Risk Score:**	**20 (Extreme)**
Gap in Controls	• The current annual discretionary capital funding is not enough to cover all of the priorities identified through the risk assessment and IMTP process for the 3 services. • In year requirements further impact and require the annual capital programme to be funded by capital to be re-prioritised regularly. • Traceability of Medical Equipment • The Welsh Government current capital position is very compromised due to COVID 19 expenditure which will impact significantly on the Capital Programme of the UHB.		
Gap in Assurances	• The regular statutory compliance surveys identify remedial works that are required urgently, for which there is no discretionary capital funding identified, requiring the annual plan to be re-prioritised, or the contingency fund to be used. • Medical equipment is also subject to regulatory requirements, and therefore requires re-prioritisation during the year. • Despite the substantial end of year capital, the recurrent position remains unchanged.		

Actions	Lead	By when	Update since March 2022
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. PBC for the Future Hospitals Programme revised and submitted to Welsh Government and considered by the Investment and Infrastructure Board. The Minister is due to consider the PBC in January	Abigail Harris	31.07.22	Updates have been provided to Shaping Our Future Hospitals Committee as the PBC was not considered in January. Work in this area continues.

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

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5. 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 IMTP for 2022 to 2025. In March 2022, the Board approved the draft 2022 – 2025 IMTP.

Risk	There is a risk that the Health Board will not deliver the first year of its objectives set out in its IMTP 22-25 due to not having an approvable IMTP due to the underlying financial deficit of £20.8m.		
Date added:	May 22		
Cause	There is currently no plan to deliver the £20.8m underlying deficit. This is due to savings not delivered during 21/22 due to the pandemic response.		
Impact	Unable to deliver an approvable IMTP for 22-25 resulting in the Health Board having to move to an annual planning cycle. Reputational loss.		
Impact Score: 5	**Likelihood Score: 4**	**Gross Risk Score:**	**20 (Extreme)**
Current Controls	Additional expenditure is authorised through governance structures and the Health Boards Scheme of Delegation. The Performance and Escalation Framework for Clinical Boards has been re-introduced to hold CBs to account for delivering their respective financial plans and savings plans.		
Current Assurances	Financial performance is a standing agenda item monthly on Management Executives Meeting (1) The financial position is reviewed by the Finance Committee which meets monthly and reports into the Board. (2) The Board receive a financial update report from the Executive Director of Finance at each of its meetings. (2) Welsh Government are fully engaged and have been briefed on the Health Board's position. (3)		
Impact Score: 5	**Likelihood Score: 3**	**Net Risk Score:**	**15 (Extreme)**
Gap in Controls	Currently no plan to deliver £20.8m so therefore the Health Board doesn't have an approvable IMTP		
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.		

Actions	Lead	By when	Update since March 2022
1. Review of Quality Improvement opportunities to eliminate underlying deficit	Meriel Jenney/Jason Roberts/Caroline Bird	30.06.22	
2. To develop a plan to eliminate the underlying deficit of £20.8m and then republish plan and submit to Welsh Government	Suzanne Rankin	30.06.22	
3. Resubmit IMTP following Board approval	Abigail Harris	30.06.22	
Impact Score: 5 **Likelihood Score: 2**	**Target Risk Score:**		**10 (High)**

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6. 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		
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 • 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		

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	• Wellbeing walkabouts to signpost resources • Long Covid Peer Support Group		
Current Assurances	• Internal monitoring and KPIs within the EHWS(1) • Wellbeing champions normalising wellbeing discussions (1) • VBA focussing on individual wellbeing and development (1) • Commitment from HIT staff to identify priority areas (1) • Trade unions insight and feedback from employees (3)		
Impact Score: 5	**Likelihood Score: 3**	**Net Risk Score:**	**15 – (Extreme)**
Gap in Controls	• Transparent and timely Communication especially to staff who are not in their substantive role e.g. redeployed, hybrid working • Existing proactive interventions to wellbeing • Health Charity funding for EWS ends in July 2022 but new case being put forward to support until March 2023 • 43% increase in referrals to Occupational Health		
Gap in Assurances	• Organisational acceptance and approval of wellbeing as an integral part of staff's working life • Awareness and access of employee wellbeing services • Clarity of signposting and support for managers and workforce		

Actions	Lead	By when	Update since March 2022
1. Health Intervention Coordinator (1) providing reactive and immediate support to employees directly affected by COVID	NB	Immediate April 2021 – April 2022	Complete This post is now working closely with EWS to provide timely support to teams across the UHB. Post included in charity bid to support until end of March 2023 A number of collaborative drop-in sessions with Equality, Diversity and Inclusion colleagues have been run to support Stress awareness in April
2. Health Intervention Coordinators (2) conducting research and exploration for long term sustainable wellbeing for the staff of the UHB	NB	Consultation by August 21 Interventions identified by Jan 22 Interventions proposed implementation April 22 - 2023	The Health Intervention team are now in the implementation phase of their project and are undertaking an analysis of the HIT action plan to ensure it aligns with the People and Culture plan All procurement exercises for MedTRIM. Schwartz rounds and REACTmh have been completed and the projects are now in the early implementation stage, including identifying evaluation metrics and pilot areas
3. Enhance communication methods across UHB - Social media platform	NB	Commenced March 21 and continuing	A variety of communication models

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- Regularity and accessibility of information and resources - Improve website navigation and resources			including Twitter accounts are being utilised to share Wellbeing updates across the UHB. A 12-month communication plan is being developed to ensure that wellbeing topics are covered throughout the year
4. Training and education of management - Integrate wellbeing into all parts of the employment cycle (recruitment, induction, training and ongoing career) - Enhance training and education courses and support for new and existing managers	NB	Post consultation phase	Leadership and Management development offerings to support staff health and wellbeing are being developed to align and enhance existing offerings, e.g. REACTMH training; Managing Remote Teams The Acceler8 Senior Leadership Programme launched March 2022.
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.	CW	Nov 21 - March 2022	Complete - All procurement exercises for peer support and management development have been completed and the projects are now in the early implementation stage, including identifying evaluation metrics and pilot areas Estates work has commenced to support the environmental aspects of the plan which includes staff room improvements and an additional 13 hydration stations.
Impact Score: 3	**Likelihood Score: 2**	**Target Risk Score:**	**6 - Moderate**

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

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

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

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

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

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

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

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	○ 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 COVID-19 infections • 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		
Impact Score: 4	**Likelihood Score: 4**	**Gross Risk Score:**	**16 Extreme**
Current Controls	**1. Statutory function** The Socio-economic Duty places a legal responsibility on public bodies in Wales when they are taking strategic decisions to have due regard to the need to reduce the inequalities of outcome resulting from socio-economic disadvantage. Approaching implementation of the Socio-economic Duty effectively will help us maximise our contribution to addressing such inequalities, and also to meet our obligations under the Human Rights Act 1998 and international human rights law. Of note, but more of a reputational risk, if an individual or group whose interests are adversely affected by our strategic decision, in circumstances where that individual or group feels the Duty has not been properly complied with, they would have the right to instigate a judicial review claim against the UHB **2. Role as an Employer** • In our Equality, Inclusivity and Human Rights Policy, we have an active programme, which sets out the organisational commitment to promoting equality, diversity and human rights in relation to employment, and ensuring staff recruitment is conducted in an equal manner • Our Strategic Equality Plan 'Caring about Inclusion 2020-2024' has a number of key delivery objectives and is premised on the basis of embedding equality, diversity and human rights, and Welsh language, into UHB business processes, for example: Recruitment and Selection Policy, Annual Equality Report, Equality reports to the Strategy and Delivery Committee, Reports/Updates to the Centre for Equality and Human Rights, Outcome Report to the Welsh Government Equalities Team regarding sensory loss, provision of evidence to the Health and Care Standards self-assessment, Equality and Health Impact Assessments • All our Executives have taken up a leadership role across the nine protected characteristics specified in the Equality Act 2010 - age, disability, gender identity, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation - our CEO is the lead for race **3. Refocused Joint strategic and operational planning and delivery** • Each of our strategic programmes within Shaping our Future Well Being Strategy will 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		

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	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 HNAs 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.			
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 inequality gap in healthy life expectancy at birth in Cardiff and Vale UHB for males, increased from 20.4 years in 2005-2009 to 24.4 years in 2010-2014 • The gap in coverage of COVID-19 vaccination between those living in the least deprived and most deprived areas of Cardiff and Vale UHB, aged 80 years and above, reduced from 8.8% to 8.4% between May and June 2021			
Impact Score: 4	**Likelihood Score: 3**	**Net Risk Score:**	**12 (High)**	
Gap in Controls	• Uncertainty around progress of the pandemic due to 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 March 2022**
1. Embed a 'Socio-economic Duty' way of thinking into strategic/operational planning, *beyond* complying with our statutory duty		FK/RG	September 2022	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 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

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			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	FK	November 2022	The Director of Public Health has agreed a collaborative partnership approach to 'Amplifying Prevention' with both local authorities, and an action plan is in development for delivery in 2022/23 the focus will be childhood immunisation, bowel screening and Move More Eat Well. The UHB's Shaping Our Future Population Health Programme prioritises tackling inequalities, and a strategic framework will be developed early in 2022/23 to further strengthen and expand its reach. The Population Needs Assessment was published on 1 April 2022 and will inform future planning across partner organisations. The UHB will be a key partner in delivering the recommendations of the Wellbeing Needs Assessments, when they are published.
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	FK	March 2023	New action for May 2022

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

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8. **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.

Risk **Date added:** 7.09.2020	There is a risk that the organisation will not be able to manage the impact of COVID 19 and other operational issues within the financial resources available.		
Cause	The UHB has incurred significant additional costs arising from managing the COVID 19 pandemic. 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.		
Current Assurances	The financial position is reviewed by the Finance Committee which meets monthly and reports into the Board (2) Financial performance is a standing agenda item monthly on Management Executives Meeting (1) The UHB is now assuming exceptional funding to cover exceptional costs in line with Welsh Government Resource assumptions. Based upon this assumed additional funding, the financial forecast is now an in year break even position at year end (3). Financial performance is monitored by the Management Executive (1). Finance report presented to every Finance Committee Meeting highlighting progress against mitigating financial risks (2).		
Impact Score: 5	Likelihood Score: 3	**Net Risk Score:**	**15 (Extreme)**
Gap in Controls	No gaps currently identified.		
Gap in Assurances	To confirm COVID 19 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.		

Actions	Lead	By when	Update
1. Continue to work with Welsh Government to manage our recovery and COVID 19 response as well as exceptional cost pressures.	CP	30/09/2022	
2. To monitor and control additional expenditure and financial performance to ensure that the year-end forecast is within the resources available.	CP	31/12/2022	
3. 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	CB	30/06/2022	
Impact Score: 5 / Likelihood Score:1	**Target Risk Score:**		**5 (Moderate)**

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9. Urgent & Emergency Care – Interim Chief Operating Officer (Caroline Bird)

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	• 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		
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 • 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)**

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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. A number of schemes are already progressing following agreement in the 2021/22 Recovery and Redesign Programme plan – including Surgical Same Day Emergency Care, extending Medical Emergency Ambulatory Emergency care and implementation of Virtual Wards • 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) and Leadership Group (fortnightly) • Key operational performance indicators and progress against plans reported into the Strategy and Delivery Committee • Urgent and Emergency Care reported as part of the Board Integrated Performance report.		
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	Development of one Urgent and Emergency Care Plan, aligned to the National six goals – and presentation to Management Executive and Strategy and Delivery Committee		

Actions	Lead	By when	Update since March 2022
1. Secure funding and develop implementation plan for further MDT cluster rollout	CB / AH	30/06/22	Funding bids to be submitted for additional WG Value funding and to be considered as part of RIF
2. Development of one Urgent and Emergency Care Plan, aligned to the National six goals	CB	30/06/22	Plan in development
3. Continued development of joint Health and Social Care strategies to allow seamless solutions and services for patients with health or social needs	AH / CB	31.03.23	Partnership working continues. Joint action plans in place. Work progressing through RPB, SLG and JME
4. Implementation of the UHW site masterplan, including de-escalation of additional capacity and reconfiguration of the EU	CB	31.03.23	Implementation of de-escalation plan commenced. Plan in place to reconfigure EU end of May / beginning of June.
5. Development of recruitment and retention strategies	RG	31.03.23	See separate BAF risk on workforce

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

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Key:

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

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Report Title:	**Health and Safety Committee – Chair's Report**				Agenda Item no.	6.5.2	
Meeting:	**UHB Board Meeting**		Public	X	Meeting Date:	**26.05.2022**	
			Private				
Status *(please tick one only):*	Assurance	x	Approval		Information		
Lead Executive:	**Chair, Health and Safety Committee**						
Report Author (Title):	**Corporate Governance Officer**						

Main Report
Background and current situation:

To provide the Board with a summary of key issues discussed at the Health and Safety Committee held on **19 April 2022**.

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

HEALTH & SAFETY OVERVIEW

The Committee was advised of the following areas to note:

- Two Assistant Heads of Health and Safety had been introduced to the department.
- The Fire Safety Team would continue to report to the Head of Health and Safety.
- The Health Board would be marking World Safety Day on 28th April 2022. It was an international campaign to promote safe, healthy work around the globe. There would be a series of 'drop in' MS Teams calls throughout the day.
- The current lone worker contract is due to end on 18th July 2022. There is ongoing work with Procurement to secure the devices.
- The Health and Safety Culture Plan had been drafted. The Plan was one of the most important documents and set the scene for the next three years. It introduced fundamental systems and processes that would embed health and safety into the operations of the Health Board and align it to best industry standards.
- External providers had been chosen to verify the competence of the training team and update courses accordingly.
- There was a lot of work taking place to embed the new Datix Cymru System. The "go live" date was 1st March 2022.

FIRE SAFETY REPORT

The Fire Safety Report was received.

a) Fire enforcement

It was noted that the Head of Health and Safety and the Head of Estates and Facilities had met with South Wales Fire and Rescue Service enforcement team on 8th February 2022 regarding Enforcement Notice EN59/21 against the A4 ward in UHW.

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They had agreed to extend the compliance date until 31st March 2023. It was difficult work to complete as the ward needed to be taken out of service. The Head of Health and Safety requested that the ward was brought out of service this year in order to get the remaining actions from the Enforcement Notice completed.

b) Hafan Y Coed

It was noted that another fire had taken place at Hafan Y Coed on 23rd January 2022.

The Head of Health and Safety, the Executive Director of People and Culture and the Chief Executive Officer met with the Chief Fire Officer of South Wales Fire and Rescue Service on 23rd March 2022 to discuss the Enforcement Notice issued last year.

It was noted that no prosecution decision was made in that meeting but both parties were willing to work closely together.

The attendees of that meeting had also fed back to the senior managers in the Mental Health Clinical Board on 25th March 2022 in order to reaffirm the actions that had been put in place to control ignition sources.

c) Fire Safety and Mental Health

It was noted that the Head of Health and Safety was currently completing a benchmarking exercise against similar Health Boards.

It was noted that a designated Fire Safety Officer had been assigned to Mental Health. It was hoped that this role would be located in Hafan Y Coed. The role would also provide support to other Mental Health facilities such as Barry, Pendine House.

It was noted that a specific Mental Health Fire Safety training course had also been developed. Mental Health was also looking to implement full body scanners.

ENVIRONMENTAL HEALTH FOOD HYGIENE REPORT

The Environmental Health Food Hygiene Report was received.

It was noted that during February 2022 both the ward-based catering service and Aroma Coffee units at University Hospital Wales had been inspected. Both achieved a food hygiene score of 5 and 4 respectively.

It was noted that it was an improved score since both food businesses were last inspected, most markedly ward-based catering whose food hygiene rating score had increased from 3 (satisfactory) to 5 (very good).

ENFORCEMENT AGENCIES REPORT

The Enforcement Agencies Report was received.

It was noted that there was a request for information from the Health and Safety Executive regarding maintenance and agreements of T2 UHW animal house ventilation.

A response had been sent and they were currently awaiting a reply from the Health and Safety Executive.

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It was noted that the Health Board had received a short notice request (3 Days) from the Health and Safety Executive to visit theatres at University Hospital Wales to review the manual handling systems. Concerns of non-essential visits from the Director of Nursing for the Surgery Clinical Board was relayed back to the Health and Safety Executive and as a result the visit had been postponed.

However, information and documents were forwarded to the Health and Safety Executive Inspector for review. The Health Board was currently awaiting a reply.

RISK REGISTER FOR HEALTH AND SAFETY

The Risk Register for Health and Safety was received.

It was noted that the highest current risk rating was 16 and included 3 elements:

(i) Failure to implement a Health Board wide Health and Safety management system

- They were currently on track to deliver that.

(ii) Failure to implement a system to safely manage bariatric patients

- They were currently working with other Clinical Boards.

(iii) Failure to implement a change management process

- That needed to be looked at and put into place.
- It had also been captured in the draft Health and Safety Culture Plan.

MENTAL HEALTH UPDATE (VERBAL)

The Director of Operations for Mental Health Clinical Board (DOMH) advised the Committee on the following:

- There had been a meeting regarding how to target non-smoking areas.
- It was noted that research regarding non-smoking policies in England was also being completed.
- A review of the search policy and ignition control source policy around Wales had been completed.
- The inpatient deaths had flagged many issues. The team was looking at clearer risk assessment and observation policies.
- The Health and Safety Adviser was involved in national work regarding the anti-ligature estate developments that could be applied.

Recommendation:

The Board is requested to:

a) NOTE the report.

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

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

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

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

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

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

Mohamed,Sarah
05/13/2022 16:36:25

Report Title:	**Mental Health Legislation and Mental Capacity Act Committee – Chair's Report**				Agenda Item no.	6.5.3
Meeting:	**UHB Board Meeting**		Public	X	Meeting Date:	**26th May 2022**
			Private			
Status *(please tick one only):*	Assurance	X	Approval		Information	
Lead Executive:	**Chair of the Mental Health Legislation and Mental Capacity Act Committee**					
Report Author (Title):	**Senior Corporate Governance Officer**					

Main Report

Background and current situation:

To provide the Board with a summary of key issues discussed at Mental Health Legislation and Mental Capacity Act Committee held on **26 April 2022.**

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

1. **MENTAL CAPACITY ACT & DOLS MONITORING REPORT**

The Mental Capacity Act Monitoring Report – DoLs Monitoring Report was received.

It was noted that the Mental Capacity Act (MCA) Lead had been in post for 3 months and was prioritising MCA training, and had trained staff groups within:

- HM Prison health staff,
- Physiotherapy,
- Critical Care,
- Endoscopy,
- Mental Health
- North West Locality Community Nurse Leaders.

The Committee was advised that in preparation and utilising the funding from Welsh Government (WG) to support Liberty Protection Safeguards (LPS), 20 places had been secured with Swansea University to attend Level 7 MCA training and an external provider to deliver MCA training to 700 staff.

The Committee was advised that the content within the report would be improved upon for the next Committee meeting and noted that the information would need to be presented more clearly.

2. **LIBERTY PROTECTION SAFEGUARDS**

Key aspects from the received report were highlighted to the Committee which included:

- The Consultation Welsh Government LPS draft Regulations, was launched on 17th March 2022. It was noted that the consultation would last for 16 weeks and the deadline for responses was the 7th of July 2022. It was noted that as part of the consultation there were 4 aspects of the regulations the Health Board were being asked to consult on:

- Appointment of Independent Mental Capacity Advocates (IMCAs).

- The Mental Capacity (Deprivation of Liberty: eligibility to carry out assessments, make determinations and carry out pre-authorisation reviews) (Wales) Regulations 2022. It was noted that these Regulations set out who could undertake assessments, make determinations and carry out pre-authorisation reviews as part of the new process.

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- The Mental Capacity (Deprivation of Liberty: training and criteria for approval as an Approved Mental Capacity Professional) (Wales) Regulations 2022. It was noted that these Regulations set out arrangements regarding the role and approval by local authorities of Approved Mental Capacity Professionals (AMCPs).

- The Mental Capacity (Deprivation of Liberty: Monitoring and Reporting) (Wales) Regulations 2022. It was noted that these Regulations supported the monitoring and reporting of the new system and the implementation of the LPS.

The Committee was advised that the WG funding strategy had been agreed which included £8million transitional costs for the LPS in 2022/23 but noted that it was yet to be decided how much the Health Board would receive.

It was noted that the Health Board was developing an implementation plan and associated staff resources which would be shared with the Committee at the next meeting and which would outline required actions and associated staff resources.

It was identified that there were three monitoring bodies who would be responsible for monitoring and reporting on the new safeguards:

- Care Inspectorate Wales (CIW),
- Health Inspectorate Wales (HIW)
- Her Majesty's Inspectorate for Education and Training (Estyn).

The Independent Member – Third Sector (IMTS) asked for clarity on 2 areas within the report:

- The Health Board currently had no staff resource to manage the implementation of LPS and the required complex ongoing requirements of LPS Regulations.

- Who did LPS legislation affect in relation to the types of people and the numbers of people and who were the Committee seeking assurance for.

The response received noted that that a lead for LPS (band 8A) had been secured for a fixed term of 12 months and that the service was now awaiting the allocation figures of funding that the Health Board was getting from WG to be able to put in more fixed term resources.

3. DOLS AUDIT UPDATE ON RECOMMENDATIONS

The DOLs Audit update on recommendations was received.

The Committee was advised that the internal audit was performed between August 2019 and October 2019.

It was noted that 4 recommendations had been received which included:

- Staff should attempt to ensure that all urgent assessments were undertaken within the stipulated seven days as detailed in the Department of Health Mental Capacity Act 2005 Deprivation of Liberty Standards.

The Committee was made aware that it continued to be a challenge and had been affected by the impact of Covid19. It was noted that there had been resourcing issues and the Committee was provided with an example where there was a 1.5 whole time equivalent (WTE) member of staff doing the reviews at approximately 6 per week while it was noted that to meet current demand, 6 a day would be required.

- The Health Board should ensure that staff are provided with the appropriate DoLs training and where areas had low compliance these areas should be targeted.

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It was noted that DoLs training had been affected by Covid19 with the inability to release staff for training, however there had been some pockets of training targeted at high areas that that had a large number of DoLS patients.

- Staff should attempt to ensure that all standard and further assessments are undertaken within the stipulated 21 days as set out in the Department of Health Mental Capacity Act 2005 Deprivation of Liberty Safeguards.

It was noted that there had been an improvement in timeframes because the Health Board had trained up more capacity with Directors of nurses signing off on training.

- The Health Board need to ensure that they produce a plan for implementing Liberty Protection Safeguards following the Production of the Code of Practice.

It was noted that the Health Board had been unable to plan for implementing LPS due to the delay of issuing the LPS draft Code of Practice and Regulations and it was also important to note that the Health Board had no staff resource to manage the implementation of LPS and it was therefore essential that the resources required were clearly stated to enable a seamless transfer from DoLS and operationalising of LPS.

The Committee expressed concern over the first recommendation where the situation had not changed and asked if assurance could be provided that the Health Board was addressing and planning to address the situation.

The Committee was advised that the recommendation would require resources to improve the situation which would be put into the case around LPS, but noted that if action was required immediately, additional monies would need to be found to resource additional staff.

It was noted that the Management Executive Team would look at the recommendation to establish priorities in relation to budget.

4. MENTAL HEALTH ACT MONITORING EXCEPTION REPORT

The Mental Health Act Monitoring Exception Report was received.

The Committee was advised that the use of the Mental Health Act had remained consistent this period with 53% of inpatients being detained under the Act at the end of quarter 4 with 53% at the end of quarter 3.

It was noted that there had been no fundamentally defective applications, but one legal query had been raised when a patient was transferred to an independent provider. Assurance was provided that legal advice had been obtained which had confirmed the legality of the application.

It was noted that during the period, the use of section 136 had increased with 63.4% of individuals assessed not being admitted to hospital, 51.9% being discharged with community support and 11.5% being discharged with no follow up.

The Committee was advised that overall during the period 32.7% of patients were admitted to hospital following a 136 assessment, which was higher than the previous quarter at 30.7%.

It was noted that the number of patients under the age of 18 assessed under section 136 had decreased from 7 in the previous quarter to 6 in this quarter and there were 4 repeat presentations recorded.

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The Committee was advised that that the Mental Health Review Tribunal (MHRT) had met to discuss issues raised previously and noted that a formal outcome would be received by the end of the week (29th April 2022) around the rollout of Teams as standard for all Tribunal hearings.

It was noted that in the meantime the Health Board had been authorised to request hearings take place via Teams at patient/professional request and that since February 2022, 4 requests for Teams hearings had been put forward to the MHRT and all were granted.

5. MENTAL HEALTH MEASURE MONITORING REPORTING INCLUDING CARE AND TREATMENT PLANS UPDATE REPORT

The Committee was reminded that the Mental Health Measure was split into 4 parts and it was noted that part 1 of the measure related to Primary Care referrals into the Primary Mental Health Support Service (PMHSS).

It was noted that the target was 28-day referral to assessment with a compliance target of 80% for Adults and that referrals for Adults and Children were at an all-time high.

The Committee was advised that regarding the over-18 Part 1a performance, every referral was being seen in under 56 days and referrals were moving steadily towards overall compliance.
It was noted that performance on 08/04/22 was 69% compliant.

It was noted that average waiting times for assessment was 29 days on 31/03/21 which had decreased to 28 days at the time of the meeting (26/04/22).

The Director of Operations – Children & Women's (DOCW) advised the Committee that the position within the Children and Adolescent Mental Health Service (CAMHS) was similar and the impact of Covid19 across teams was significant. Referrals were at an all-time high and it was noted that the referrals received in March 2022 had been the highest number received in over 2 years.

It was noted that the team had worked very hard and had maximised outsourcing to deliver the target of 89% and that the waiting time was currently at 21 days, which was an improvement since the Committee last received the information.

The Committee was advised that a Single Point of Access team was launched at the end of November which had helped to manage referrals through improved processes and use of consultation with referrers. It was noted that it had been a real success in balancing the referrals.

6. HIW MHA INSPECTION REPORTS

The Committee was advised that there had been one HIW inspection for wards at Hafan Y Coed:

Cedar Ward
Oak Ward
Willow Ward.

It was noted that the Health Board had received the draft report but not the final version and that no improvements had been highlighted within the initial findings.

7. SUB-COMMITTEE MEETING MINUTES

The Committee received copies of the following minutes: -

1) Hospital Managers Power of Discharge Minutes – 5 April 2022

2) Mental Health Legislation and Governance Group Minutes – 8 April 2022.

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8. CORPORATE RISK REGISTER

The Committee was advised that the Board in March 2022 had received one extreme risk linked to the Mental Health Legislation and Mental Capacity Act Committee for assurance purposes and noted that the risk remained on the register.

It was noted that it had been hoped that scheduled actions would have led to the de-escalation of the risk prior to the March Board, but a combination of operational pressures and an inability to source suitable private placements meant that the risk continued to be recorded as an Extreme Risk.

The Committee was advised that In May 2022 the Head of Risk and Regulation would meet with the Mental Health Clinical Board to review the advisory recommendations of a recent Internal Audit report to support the implementation of recommendations made and noted that they would be tracked through the Audit and Assurance Committee.

9. POLICIES

The Committee received and **approved** 2 policies:

i) Consent to Examination or Treatment under The Mental Health Act 1983 Policy & Procedure

ii) Hospital Managers' Scheme of Delegation Policy & Procedure.

Recommendation:

The Board is requested to:

- **NOTE** the contents of this report.

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

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention	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
Not Applicable
Safety: Yes/No
Not Applicable

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Financial: Yes/No
Not Applicable
Workforce: Yes/No
Not Applicable
Legal: Yes/No
Not Applicable
Reputational: Yes/No
Not Applicable
Socio Economic: Yes/No
Not Applicable
Equality and Health: Yes/No
Not Applicable
Decarbonisation: Yes/No
Not Applicable

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

Mohamed,Sarah
05/13/2022 16:36:25

Report Title:	**Quality, Safety & Experience Committee – Chair's Report**			Agenda Item no.	6.5.4
Meeting:	**UHB Board Meeting**	Public	X	Meeting Date:	26.05.22
		Private			
Status *(please tick one only):*	Assurance	x	Approval	Information	
Lead Executive:	**Chair of the Quality, Safety & Experience Committee**				
Report Author (Title):	**Senior Corporate Governance Officer**				

Main Report
Background and current situation:

To provide the Board with a summary of key issues discussed at Quality, Safety & Experience Committee held on 12th April 2022.

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

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

MENTAL HEALTH CLINICAL BOARD ASSURANCE REPORT

The Mental Health Clinical Board Assurance Report was received.

The Committee was advised that the Mental Health Clinical Board (MHCB) had encountered, over a relatively short period of time, a number of suicides/unexplained deaths in the acute in-patient environment that was significantly higher than the national average.

It was noted that the deaths constituted a "cluster" according to nationally agreed criteria and the MHCB considered the need to provide a comprehensive, evidence-based series of actions to understand and reduce.

It was noted that the Clinical Board were doing everything possible to understand what had happened and to make changes to address the situation.

The Committee was advised that a thematic Review of the untoward deaths at the request of the Clinical Board had been undertaken and identified recommendations which included:

- A Suicide Cluster Response Plan
- Environmental differences of wards to be understood
- Environmental considerations, for example, door top alarms, and bedroom windows alarms.
- Environmental settings to be improved
- Ward remits / policy reviews to fully understand purposes of wards and risks / benefits of dual functions
- Re-launch of the Complex Care Forum
- Re-launch of Sentinels and Lessons Learned
- Questionnaires to staff
- Skill mix review – psychological input to wards & appointment of shift co-ordinators to get Ward Managers back on their wards
- Away Days
- Ensure ward rounds / MDTs were person centred
- Care Aims in the inpatient setting

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It was noted that the MHCB had identified a series of actions which should tangibly return the acute in-patient environments at Hafan Y Coed, University Hospital Llandough to a level of safety and stability that was disrupted by the need to react to the demands of the COVID pandemic over the past two years.

Those included:

- Returning Hafan Y Coed to its original footprint.
- Review of National Reportable Incident / Sentinels / Lessons Learned systems and processes.
- Suicide Prevention Training
- Royal College of Psychiatrists Review of Adult In-patient Services at Hafan Y Coed

It was noted that the Management Executive Team had supported and commissioned an authoritative and comprehensive review and that the Terms of Reference had recently been agreed.

The Executive Director of Public Health (EDPH) asked about staff morale within the MHCB.

The question response was that that staff morale had been adversely affected by various situations, including Covid-19, and that staff were tired.

It was noted that Health Inspectorate Wales (HIW) had visited Mental Health services and that the verbal feedback provided had been very encouraging. HIW reported that staff showed high levels of enthusiasm and commitment in the face of the experiences people were having.

The Executive Nurse Director commended the MHCB for their hard work.

QUALITY, SAFETY AND EXPERIENCE IMPLICATIONS ARISING FROM IMTP

The Quality, Safety and Experience Implications arising from IMTP were received.

The Committee was advised that the key focus for the coming year was laid out within the received report and aligned to the Framework for Quality, Safety and Experience.

It was noted that the Framework had identified eight key areas and all the actions were aligned to those areas.

It was noted that there were no key performance indicators (KPIs) identified within the paper because the Health Board was waiting for those to be received from WG. Once received, they would be brought back to the QSE Committee.

FEEDBACK FROM THE CLINICAL EFFECTIVENESS COMMITTEE

The Committee was advised that the Clinical Effectiveness Committee (CEC) had been established with the purpose of ensuring Clinical effectiveness across the Health Board by:

- Monitoring the implementation of NICE, national and local evidence, guidelines and standards to ensure best practice across the Health Board.
- Providing strategic direction for the Health Board's national and local Clinical Audit Programme.
- Providing assurance to the Quality and Safety Experience (QSE) Committee on the above points through the production of reports.
- Receiving reports from the subgroups and, following analysis, either escalate issues or provide assurance to the QSE Committee and the Board.
- Contributing to the production of the Annual Quality Statement to be presented to the Board of Directors.

It was noted that a business case was recently submitted to the Business Case Approval Group (BCAG) for Quality Safety and Experience which was successful to procure AMaT (Tracking, Monitoring and Management system) to capture the Health Board's Clinical Audit activity centrally.

Anna Sedgwick
05/12/2022 16:21:29

It was noted that a phased approach would be taken over a 12-month period to roll out the AMaT system across the organisation and that Clinical Boards had been asked to develop an Annual Clinical Audit Forward Plan for 2022/23.

QUALITY INDICATORS REPORT

The Committee was advised that the Lakeside Wing (LSW) remained an area of concern and it was noted that the report received identified the level of concern, the issues and the actions taken to address those issues.

It was noted that there were staffing issues being seen in LSW and across the Health Board and information around the Registered Nurse vacancies position and staff was provided.

It was noted that progress was being made with the recruitment of Registered Nurses and that numbers of students who would qualify in 2022 would be known in the coming weeks.

It was noted that staff morale at the LSW continued to be challenging and it was note highlighted that LSW was opened, because of Covid-19, as an emergency overflow location and thought was required with regards to the longer-term arrangements for the LSW.

The Executive Nurse Director noted that support and development would be offered to staff.

HIW ACTIVITY OVERVIEW

The Committee was advised that reports following the HIW visit to Cardiac Surgery at the University Hospital Llandough (UHL), and Hafan Y Coed had been received and that feedback had been positive but highlighted the environmental concerns at Hafan Y Coed which had already been identified by the MHCB previously.

It was noted that the reports would be circulated to Committee Members.

BOARD ASSURANCE FRAMEWORK – PATIENT SAFETY

The Board Assurance Framework (BAF) – Patient Safety was received.

The Committee was advised that the Executive team looked at the key risks that would impact upon the delivery of the Strategic Objectives of the Health Board every year.

It was noted that Patient Safety would remain on the BAF along with Estates and Workforce.

RECOMMENDATIONS FROM THE NUFFIELD TRUST REPORT

The Committee was advised that the Velindre University NHS Trust (VNHST) was a specialist provider of cancer services in South East Wales and ran the Velindre Cancer Centre. In 2020 it commissioned a report as the Nuffield Trust to provide independent advice on the integrated regionally networked model including analysis and assessment of the benefits and risks of the proposed model of networked cancer care in South East Wales.

In December 2020 they published its findings ‘Advice on the proposed model for non-surgical tertiary oncology services in South East Wales’.

The report’s findings were subsequently accepted by the Velindre Board and partner organisations, including Cardiff and Vale UHB.

The report made 11 recommendations which were received by the Committee.

Mohammed Sarah
05/12/2022 16:56:19

The recommendations broadly fell into three categories:

- Recommendations for VNST to progress
- Recommendations for VNST to progress in collaboration with regional Health Board Partners collectively.
- Recommendations which required a joint response between VNST and a specific Health Board partner.

The focus of the received report was on category two (Recommendations for VNST to progress in collaboration with regional Health Board Partners collectively) and category three (Recommendations which required a joint response between VNST and Cardiff and Vale UHB).

- Recommendation 3: Activity Benchmarking, Oncology Advice for Unscheduled Care and AOS
- Recommendation 4: Revise Velindre Cancer Centre Admission Criteria
- Recommendation 5: Research Hub at University Hospital Wales
- Recommendation 6: Expansion of Haemato-oncology Clinics and provision of wider Diagnostic services
- Recommendation 7: Velindre @ Operating Model
- Recommendation 10: Future proofing' and University Hospital Wales 2

The Committee was advised that a Collaborative Cancer Leadership Group (CCLG) chaired by the CEO of the Health Board met quarterly and consisted of Executive level Officers across South East Wales to provide oversight and leadership in regards to the Cancer services in South East Wales and implementation of the Nuffield report.

It was noted that A CAVUHB / VNHST Executive partnership forum was established to drive forward the specific collaboration agenda between the two organisations.

EXCEPTION REPORTS – VERBAL UPDATE

The Committee was advised that concerns remained around the Emergency Department and it was highlighted that that the whole system remained under pressure.

It was noted that the Executive Nurse Director, the Executive Medical Director and the Chief Executive Officer (CEO) of the Health Board had met to discuss improvement plans due to a large number of distressing concerns being raised and pressures being felt by staff.

The Committee was advised that that the pressures seen across the system could not be overstated and that there were concerns about what was happening to patients and staff. The END assured the Committee that her team and many others were putting in as many systems as they could to mitigate the pressures.

The Committee was advised that the feedback should be received by the Board via Chairs Reports because the quality of care was not where it should be.

MINUTES FROM CLINICAL BOARD QSE SUB COMMITTEES

The Minutes from the Clinical Board QSE Sub-Committees were received and noted.

CORPORATE RISK REGISTER

The Committee was advised that the Corporate Risk Register ('the Register') had been developed to enable the Board to have an overview of the key operational risks from the Health Board's Clinical Boards and Corporate Directorates.

It was noted that there were eleven risks linked to Patient Safety across the various Directorates.

It was concluded that internal audit were currently reviewing the risk management processes which was done every year and noted that the focus for 2022/23 would be on Clinical Boards

Mohamed Elarah
05/13/2022 16:06:25

INFECTED BLOOD INQUIRY UPDATE

The Infected Blood Inquiry Update was received.

The Committee was advised of the legal proceedings timetable and it was noted that the final hearings were scheduled for December with conclusions and finding to be presented approximately 6 months after.

PATIENT SAFETY WALKROUNDS

The Committee was advised that Patient Safety WalkRounds would be reinstated in May 2022.

IMPLEMENTATION OF DATIX OFWCMS

The Implementation of Datix Once for Wales Concerns Management System (OfWCMS) report was received.

The Committee was advised that the Implementation of Datix Once for Wales Concerns Management System (OfWCMS) was a large project that would have an impact on the QSE Committee and it was noted that the new system would come with challenges because the Health Board previously had a mature and stable Datix system, and some of the reporting functionality would be limited in the new system until sufficient data was available to develop reports from.

DUTY OF CANDOUR

The Duty of Candour report was received.

The Committee was advised that the received report identified where the Health Board was against All Wales information and it was noted that it would be taken to the Board when the process developed further.

Recommendation:

The Board is requested to:

a) NOTE the content 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	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	X	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	X

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

Prevention		Long term	X	Integration		Collaboration		Involvement	

Mohamed Farah 05/12/2022 10:36:25

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:

Mohamed,Sarah
05/13/2022 16:36:25

Report Title:	**Audit and Assurance Committee – Chair's Report**				Agenda Item no.	6.5.6	
Meeting:	**UHB Board Meeting**	Public	X		Meeting Date:	**26.05.2022**	
		Private					
Status *(please tick one only):*	Assurance		Approval		Information		X
Lead Executive:	**Chair, Audit and Assurance Committee**						
Report Author (Title):	**Corporate Governance Officer**						

Main Report
Background and current situation:

To provide the Board with a summary of key issues discussed at the Audit and Assurance Committee held on **5 April 2022.**

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

Internal Audit Progress Reports

The IT Service Management Final Report was received. The Committee was advised of the following areas to note:

- Internal Audit were only able to provide 'limited' assurance.
- It was identified that poor controls in relation to the IT service desk function were in place.
- It was acknowledged that there were plans to implement a new call handling system, to restructure the service desk department and to introduce new ways of working.

The Director of Digital & Health Intelligence (DDHI) advised the Committee on the following:

- Four high priority recommendations were made which included the following:

1. Service design

a) To undertake a restructure of the service desk provision which should be based on the ITIL Framework.

- It was noted that the current limited IT support resources would be restructured to provide a skeleton framework of an ITIL service desk structure.
- A business case was currently under review to increase staffing within the service desk, to allow for separation of key tasks and provide a single point of knowledge.

b) Implementation of the new call handling system should incorporate the facility for users to raise calls via an on-line portal.

- The new service desk implementation would provide a digital front door which would include incident and problem management as well as service requests, change and asset management. There would also be a user portal on all user devices.
- The new service desk tool went live internally in March 2022. It would be going live to the entire organisation by 30 April 2022.

Mohamed.Sarah 05/13/2022 10:36:25

c) Existing and new staff should be encouraged to attain ITIL Accreditation.

- Staff ITIL training had started in January 2022.
- 10 members of the IT support/service desk team had successfully passed the ITIL v4 Foundation course and exams to gain their accreditation.

- An additional 6x team members had attended the Advanced ITIL CDS course.

2. Lack of documented guidance

a) Procedures and guidelines should be developed for the Service Desk. These should clarify how to deal with incoming calls, the information to collect, the approval process for proposed resolution actions and the routing of those calls.

- The Health Board had employed the services of a dedicated Ivanti ITSM Implementation Expert.
- As part of the deployment standard operating procedure documents had been created.
- A standalone and dedicated automation server had been set up and the same would provide workflow with approval steps which would provide automation for numerous tasks.

b) As part of those procedures a set of pre-defined calls should be developed for the most common / simple calls and incidents to enable those to be resolved on first contact.

- The ISM implementation also contained an FAQ and Staff Help portal which would continue to be developed and expanded as part of the product use.
- A full set of FAQs would be issued by the end of April 2022.
- There would also be an icon on people's helpdesk which they could click.

3. Call Classification and prioritisation

a) Procedures and guidance on the classification and prioritisation of calls should be drawn up and issued with training provided as appropriate. Staff should be instructed to ensure that calls and incidents were classified and prioritised correctly in accordance with the guidance.

- Automated for call category, call type and priority fields had been implemented as standard.
- Exceptions could be made, although it would require additional approval within the Service Desk management structure.
- That had been populated to ensure prioritisation of calls correctly.

b) The planned replacement for the HEAT system should not allow free text in the call category, call type and priority fields.

- Free Text fields for call category, call type and priority fields had been removed.

c) The call category, type and priority fields should be mandatory to complete with call handlers selecting the appropriate entry from a drop-down menu.

- Call category, call type and priority fields were now all mandatory when creating incidents and service requests.

4. Call status monitoring

a) A formal process to ensure call activity was maintained should be established, and completed calls should be closed appropriately.

Mohammad-Sarah
26/1/2022 16:26:2

- A new single digital portal for staff to create, view and close incidents and service desks had been created.
- Accurate ISM and call metrics would be available.
- Calls and requests for staff would automatically be closed after multiple requests had been ignored.

- Cases which had not been progressed within a timely fashion would be reported automatically and flagged.
- Staff would also have clear visibility of their case progression via the portal.
- The audit found many open calls and this system would help to manage this effectively.

The Internal Audit Progress Report was received.

- It was noted that seven audits had been delayed and not finalised in time for this meeting. Those would be brought to the next Committee meeting.
- The Capital Scheme Genomics audit and the Estates Assurance Waste Management audit had been issued in draft with a reasonable assurance rating.
- There were 34 reviews in the 2021/22 Internal Audit Plan, of which (i) 16 had been finalised and 2 were in the draft stage (ii) 12 were a "work in progress", and (iii) 2 were in the planning stage ready to be formally agreed.
- The delivery of the 2021/22 Plan had been impacted due to the Covid pressures placed on the Health Board. A total of 10 audits had previously been identified for removal/ deferral from the Plan following discussions with management and the Executive Team. Those had been previously approved by the Committee.
- The remaining 32 audits gave sufficient assurance for Internal Audit to give an opinion on the Health Board for the year.
- The proposed adjustments to the Internal Audit Plan for 2021/22 were approved.

The following reports were received:

1. Verification of Dialysis Sessions

- It was a planned audit taken at the request of the Specialist Services Clinical Services Board.
- The outcome was substantial assurance.
- The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to raising staff concerns.
- Although the review highlighted work in that area, three medium priority recommendations were made which included; (i) providing timely and continued communication around the freedom to speak up campaign, (ii) enhancement to the staff concerns held and (iii) how the governance arrangements required alignment.

2. Raising Staff Concerns

- The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place within the Health Board.
- Three low priority recommendations were made which included; (i) providing timely communication around the freedom to speak up campaign, (ii) enhancement to the concerns staff held and (iii) the governance arrangements required an all Wales alignment for staff to raise concerns.

3. Arrangements to Support the Delivery of Mental Health Services

Mohamed Siyah
05/12/2021 10:06:12

- The Advisory Review Report highlighted opportunities and contained no recommendations.
- It also included a data collection tool for the Clinical Board to take forward.
- The Report highlighted that the Clinical Board had a good understanding of the risks and challenges but there should be a focus on what the solutions were.

Review changes to Standing Financial Instructions (SFI) and Accounting Policies

It was noted that it was good governance and practice to review Standing Orders and SFIs on an annual basis.

The all Wales SFIs and Standing Orders were adopted last year and there had been no changes since then.

Review System of Assurance

It was noted that a strategy was brought to the Committee previously, which was then approved by the Board in September 2021.

The purpose of the strategy was to have an overall assurance map across the whole Health Board which would look at areas where there was good or poor assurance. The plan was to present a high-level assurance map to the Board by May 2022.

Review Draft UHB Annual Report

The Draft UHB Annual Report was received and the following was highlighted:

- It was noted that the Annual Report was made up of 3 parts namely (i) the Performance Report (ii) the Accountability Report and (iii) the Financial Statement.
- The draft Annual Report was a “work in progress” and there were a number of gaps in the current draft.
- The draft accounts must be submitted to Welsh Government and Audit Wales by 29 April 2022.
- At the end of April 2022, the draft Annual Governance Statement must to be submitted to Internal Audit for their review and comments
- On 6 May 2022, the draft Performance Report, the draft Accountability Report and the draft Remuneration Report would go to Welsh Government and Audit Wales.
- The Audit Workshop on 12 May 2022, would allow Committee Members to further review the draft document at that stage.
- A Special Audit Committee meeting and Special Board meeting were scheduled on 14 June 2022 to sign off the draft Annual Report in readiness for formal submission to Audit Wales and Welsh Government on 15 June 2022.

Procurement Audit Influenceable Spend Report

The Procurement Audit Influenceable Spend Report was received and highlighted the following:

- The 2020/21 influenced expenditure of 73.8% had increased significantly to 87.5% for 2021/22, due to the Capital construction expenditure moving to Procurement ‘s governance management, and the increased influence within medical and surgical consumables expenditure.
- Within the currently influenced expenditure of £247,414,470, £102,355,374 manual invoice contracts were identified.
- It had been proposed that the expenditure was looked at and popped onto an Oracle catalogue. That should deliver rich data as it would not run through as an Oracle payment but as a contract line. That should give visibility of whether the contracts had been exceeded and if there was additional savings that could be improved.
- Examples of the £102,355,374 include CHC placements, laboratory external tests and continence products.

Morgan, Sarah
05/12/2022 16:26:2

- Within the £138,575,257 not influenced amount, a number of expenditure items would remain out of scope for Procurement influence due to the nature of the transactions, e.g., utilities, rates, personal injury, statutory audit fees and clinical negligence.
- Removing those out-of-scope items left a figure of £115,310,152.07 which represented the opportunity for increasing Procurement influence for non-pay expenditure. A list of the top 20 categories were included in the report.
- A request has been made for Procurement to undertake a "deep dive" analysis on the potential opportunities to increase Procurement influence within non-pay expenditure and return to the Audit Committee in September 2022 with a further update.

Losses and Special Payments Panel Report

The Losses and Special Payments Panel Report was received and highlighted the following:

- The Health Board had established a Losses and Special Payments Panel.
- That Panel met twice yearly and was tasked with considering the circumstances around all such cases and to make appropriate recommendations to the Committee.
- Service improvements were investigated on a case by case basis to see if there were emerging themes that could be improved.
- The losses were also presented in the Annual Accounts and would be presented for full disclosure.
- The write offs outlined in the report were approved.

Declarations of Interest and Gifts and Hospitality Tracking Report

The report was received and highlighted the following:

- There had been a significant increase in the amount of declarations.
- A further 130 declarations had been received since completion of the report.
- The analysis of declarations of interest received suggested reasonable success from the recent advertising campaign. There had been an above average increase in the quantity of declarations made, as well as increased use of ESR rather than the more administratively heavy use of hardcopy forms and email returns.
- The team would continue to work with the Communications team and hold another "power hour" later in the year.
- The team were also working with the Board Members to ensure that their end of year declarations was submitted for end of year reporting purposes.

Regulatory Compliance Tracking Report

- The report contained a breakdown of the external regulatory and outstanding recommendations.
- An update on Patient Safety Notices (PSN) was shared at the last QSE Committee meeting and would be reported twice a year.
- As of 7 March 2022, there were 18 active PSN, 12 of which were overdue. Those were being managed by the Patient Safety Experience team.
- 7 recommendations were removed from the Regulatory Tracker as they were complete. A further 2 would be removed that day as they have also been completed.
- The team continued to work with the recommendation owners.

Mohammed Shah 05/12/2022 16:06:25

Audit Wales Recommendation Report

The Audit Wales Recommendation Report was received and highlighted the following:

- It was noted that there were 20 entries currently reported.
- 9 were added following February's Audit meeting.
- All 20 entries were partially complete and 4 were over 6 months overdue. The team would focus on those entries to ensure that they did not stagnate without being progressed.

Internal Audit Tracking Report

The Internal Audit Tracking Report was received and highlighted the following:

- The Tracker currently recorded 84 entries.
- 18 recommendations had been removed and an additional 7 extra reports would be added to the Tracker at the next Committee meeting.
- An additional 4 reports would be added to the Tracker following the meeting.
- Following discussions with Internal Audit, there was an action plan to move stagnant entries forward. Each Executive Lead had been sent the recommendations, made by Internal Audit, which fell into their respective remits of work.
- There was also an action plan on how to record advisory recommendations.

Internal Audit Annual Plan 22/23

The Internal Audit Annual Plan 22/23 was received and approved.

- The Plan detailed the audits to be undertaken in 2022/23.
- Section 2 of the report set out that the Plan was being developed in accordance with the Public Sector Internal Audit standards. There was also a risk-based approach to developing the Plan.
- Page 5 of the report covered the key elements of the Plan.
- Section 2 set out the plan to audit key risk areas within the Health Board.
- Section 4 would include any work requested on an all Wales basis by Directors of Finance or Board Secretaries.
- Internal Audit met with all the Executives in the Health Board to identify potential audits with risk areas within their individual portfolios. An initial Plan was drafted and discussed with the UHB Chair.
- The Plan would be under review in case of changes to risks or priorities within the Health Board and to ensure it gave appropriate assurance.

Audit Wales Annual Plan

- It was noted that there were four aspects to the performance audit work.
- The Structured Assessment work would be reshaped and refocused this year. Over the last two years there had been a focus on Covid. There would now be a focus on pre-pandemic arrangements.
- There was a plan to undertake a piece of work around workforce risks and workforce planning arrangements at each NHS body. Individual reports would be provided to the Health Board.
- A locally focused piece of work would also be undertaken. The scope of that had yet to be determined with the Executives.

Mohamed Siddiqi
05/13/2022 16:36:03

Audit Enquiries to those charged with governance and management

- It was noted that a letter had been received from Audit Wales which had detailed audit enquiries to those charged with governance.
- A proposed response had been prepared and shared with the relevant colleagues.

- Subject to Committee approval, it would be sent as the formal response as part of the audit process.
- The response provided to the audit enquiries to those charged with governance and management was endorsed.

Recommendation:

The Board is requested to:

a) NOTE the report.

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

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

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

Mohamed Darah
05/13/2022 16:36:25

Equality and Health: No
Decarbonisation: No

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

Mohamed,Sarah
05/13/2022 16:36:25

Report Title:	C&V Integrated Performance Report				Agenda Item no.	6.6
Meeting:	C&V UHB Board		Public	X	Meeting Date:	26 May 2022
			Private			
Status *(please tick one only):*	Assurance	x	Approval		Information	
Lead Executive:	Ruth Walker, Caroline Bird, Rachel Gidman, Catherine Phillips, Fiona Kinghorn					
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 Quality & Safety, Finance, Workforce, Performance and Public Health for the Health Board.

Finance			
	Target	**Trend**	**Mar-22**
Deliver 2021/22 Draft Financial Plan	Break even		£0.216m surplus
Remain within capital resource limits.	£70.989m		£70.948m
Reduction in Underlying deficit (Forecast)	£25.30		£29.7
Delivery of recurrent £12.000m 1.5% devolved target (Forecast)	£12m		£7.576m
Delivery of £4m non recurrent devolved target (Forecast)	£4m		£8.676m
Creditor payments compliance 30 day Non NHS (Cumulative)	95%		93.1%
Remain within Cash Limit (Forecast cash surplus)	Within Cash Limit		Positive cash balance
Maintain Positive Cash Balance	Positive Cash Bal.		£4.607m

Performance			
	Target	**Trend**	**Apr-22**
A&E 12 hour waiting times	0		1196
A&E 4 hour waiting %	95%		63%
Ambulance Handover Times >1 hour	0		689
			Mar-22
Waiting less than 26 weeks %	95%		55%
RTT Waiting Over 36 Weeks	na		44083
Diagnositcs >8 weeks Wait	0		5004
			Mar-22
Mental Health Referrals	na		1495
Mental Health Part 1a - Assessments within 28 days	80%		49%
Mental Health Part 1b - Therapy Commencing within 28 Days	80%		96%
			Mar-22
Patients Delayed over 100% for follow-up Appt	0		41939
			Mar-22
Single Cancer Pathway	75%		62%

Quality & Safety			
Patient Satisfaction	**Target**	**Trend**	**Mar-22**
30 day complaints response compliance %	75%		83%
Patient Experience			**Mar-22**
Patient Experience			78%
Falls			**Mar-22**
Slips Trips and Falls (30 day moving total)	na		277
Slips Trips and Falls with harm - moderate to severe (30 day moving total)	na		27
Serious Incidents			**Mar-22**
Nationally Reportable Incident (SI)**	na		10
Number of Never Events	0		0
Mortality			**Dec-21**
Percentage of Stage 1 Reviews Completed			74%
Risk Adjusted Mortality Index			135.36
			Mar-22
Still births (Rolling 12 Months)			5
Infection Control			**Mar-22**
All Reported Infections (cumulative)	743		776

Workforce			
	Target	**Trend**	**Mar-22**
Percentage of staff (excluding medical) undertaking PADR (Performance Appraisal Development Review)	85%		30.9%
Achieve annual local sickness and absence workforce target (rolling 12 month)	4.60%		6.9%
Voluntary Resignation Turnover Rate	na		8.7%
Mandatory Training Compliance	85%		73.07%
Fire - Mandatory Training	85%		63.94%
Staff Retention	-		83.80%

Population			
Immunisation	**Target**	**Trend**	**2021/22 Qtr 3**
% of children up to date with scheduled vaccines by 4 years of age	95%		85.3%
	Target		**Mar-22**
% Adults (aged 18 years and over) in Cardiff and Vale UHB have received a Covid-19 booster vaccination	na		**0.68**
Of those who have a completed primary course of vaccination*, % of adults aged 18 years and over have received a Covid-19 Booster vaccination	na		**0.83**

Tobacco	**Target**	**2021 / 22 Qtr 3**
% of smokers who become treated smokers	5%	0.4%**
% of treated smokers who quit at 4 weeks	40%	77%**

* *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*

Mohamed Sarah
05/13/2022 12:26:56

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

FINANCE

How are we doing?

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

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

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

The Welsh Government confirmed non-recurrent funding for the brought forward COVID deficit of £21.313m which related to the non-delivery of the savings target that was required to fund inflation and demand growth in 2020/21.

The draft reported financial position for the 12 months to the end of March 2022 is an operational surplus of £0.216m.

Delivery of the core financial plan included a 2% (£16.0m) savings requirement. At month 12, £16.252m Green and Amber savings were identified against the target However, whilst the UHB met the overall £16m target, there was a shortfall of £4.4m against the recurrent element of the target and this in turn increased the planned underlying deficit moving into 2022/23.

The full year gross COVID forecast moved by £0.001m in the month from £119.375m at month 11 to £119.376m at month 12, as the result of additional funding being made available for COVID Therapeutic (Treatment) Medicines and the extended Flu Campaign. The additional funding was partly offset by a reduction in the funding for Urgent and Emergency Care.

Reported month 12 position

The Welsh Government amended the monthly financial monitoring returns to capture and monitor costs due to COVID 19. The draft financial position reported to Welsh Government for month 12 is a surplus of £0.216m and this is summarised in Table 1.

Table 1 : Financial Performance for the period ended 31st March 2022

	Cumulative Month 12 £m
COVID 19 Additional Expenditure	119.376
Welsh Government COVID funding received / assumed	(119.376)
Gross COVID 19 Forecast Position (Surplus) / Deficit £m	0.000
COVID FUNDING for Deficit due to non delivery of 2020/21 recurrent Savings	(21.300)
Operational position (Surplus) / Deficit	21.084
Financial Position £m (Surplus) / Deficit £m	**(0.216)**

Mohamed-Sarah 05/13/2022 16:16:23

The additional COVID 19 expenditure in the year to month 12 was £119.376m.

Welsh Government has confirmed COVID 19 funding. The UHB is reporting a draft operating surplus of £0.216m at year end. COVID 19 allocations met the additional COVID costs and operating pressures which arose from the management of COVID 19 in year. The reductions arising in planned

expenditure as a result of COVID were utilized to offset non COVID operational pressures and support system resilience.

Underlying deficit position

The UHB's accumulated underlying deficit brought forward into 2021/22 was £25.3m which reflected the £21.3m shortfall against the 2020/21 recurrent savings target due to the pandemic. This was offset by non-recurrent COVID 19 funding.

Delivery of the UHB's draft financial plan would have ensured that the underlying position did not deteriorate in 2021/22. The shortfall of £4.4m against the recurrent savings target has left an underlying deficit of £29.7m to carry forward to 2022/23.

Creditor payment compliance

The UHB's public sector payment compliance performance was 93.1% at the end of March, which is just below the target of 95%.

Remain within capital resource limit

The UHB successfully delivered its £70.989m Capital programme in 2021/22 with a surplus of £0.041m against the allocation.

What are the UHB's key areas of risk?

The UHB's provisional year end position is a £0.216m surplus on the revenue and a £0.041m surplus on capital which is subject to External Audit scrutiny and review. At this point in time the UHB does not expect any risks to materially affect the reported year end position.

PEOPLE

The Executive Director of People and Culture provides regular workforce metrics updates to the Committee and going forward will periodically provide an overview report against the seven themes within the People & Culture Plan.

Workforce KPIs

- **Turnover** continues to rise at 13% UHB wide. In March 2020 the rate was 9.58% and then a year later in March 2021 it had risen to 11.10%. Turnover rates vary from month to month, year to year and industry to industry. Most experts suggest a good turnover rate is 10% or below.

- **Sickness Absence** rates remain high at 7.31% in March (these figures are sickness only and do not include COVID self-isolation without symptoms) and are 2% higher than they were 12 months ago. The top 5 reasons for absence for the past 12 months are; 'Anxiety/stress/depression/other psychiatric illnesses', 'Chest & respiratory problems', 'Cold, Cough, Flu – Influenza', 'Other musculoskeletal problems' and 'Other known causes - not elsewhere classified'.

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- **Employee Relations** caseload trend continues to fall as the team embed the 'Restorative & Just Culture' principles. The overall numbers remain within reasonable tolerance levels.

- **Statutory and Mandatory training** compliance has improved slightly during the last 4 months; now just under 13% below the overall target. It is likely that operational pressures continue to adversely affect compliance.

- Compliance with **Fire training** is continuing to improve, although the rate of improvement has slowed. In March the compliance with Fire training was 63.94%.
- The rate of compliance with **Values Based Appraisal** remains very low; the compliance at March 2022 was 33.19%. It is likely that operational pressures continue to adversely affect compliance.

Good progress has been made against the 7 themes of the **People and Culture Plan** since it was approved by Board in January 2022. Examples of actions taken in the last month include:

- Approximately 40 **coaches** are being trained on the ILM level 5 and/or 7 Mentoring/ Coaching programme. 38 coachees, who are Ward Managers and Deputy Ward Managers, have now been assigned a coach. A coaching tool (PushFar) has been procured to help coaches and coachees select and manage the relationships.

- Winning Temp **engagement tool** has been procured, engagement sessions are taking place with Nursing staff, with implementation planned for the end of May 2022.

- All procurement exercises have been completed for the additional investment secured to support the **health & wellbeing** of our staff and spend has been allocated. Projects are now in the early implementation stage, including identifying evaluation metrics and pilot areas. Estates work has commenced to support the environmental aspects of the plan which includes staff room improvements and an additional 13 hydration stations.

- Following the success of the first scheme, a further 10 applicants with learning disabilities or autism have been appointed via **Project Search**. These will start their placements in September 22.

- In total 162 individuals were recruited onto the **Kickstart** scheme. Of these, 33 have now gained employment with the UHB, 2 have joined apprenticeship schemes and 44 are still currently on the scheme. The scheme ended on 31 March 2022.

- A revised process and recruitment campaign have been developed for the **Temporary Staffing Department** to increase the number of staff on the Bank;

- 91 job offers have been made and 59 of these have already started work with Facilities following our **social media adverts and inter work events** since February 22.

- 4 places have been awarded to CAV UHB staff on a **MSc in Digital Transformation** for March 2022 start (1x Senior Nurse, 1x AHP, 1x DH&I and 1x I&I). Promotion for September 2022 (part-funded) cohort has begun.

- The **Acceler8 Senior Leadership Programme** was launched in April 2022 with 12 delegates. Interest in Cohort 2 has already been received and expressions of interest will start to be collated in May 2022. Development of additional leadership development programmes, including Collabor8, has commenced and plan to launch in June 2022.

- 20 UHB HCSW have been progressed to interview for the USW flexible undergraduate programme.

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- 90 managers have been enrolled on ILM level 4 and 5 management **apprenticeship programmes** in the last 6 months which is a significant achievement in light of the pandemic pressures and a significant increase in numbers.

- Recurrent funding has been secured to establish a permanent **e-rostering** team, within the first 12 months the team will focus on:

- implementing the new e-rostering system for the Nursing Workforce;
- embed effective e-rostering principles resulting in significant cost efficiencies;
- improve workforce supply and fill rates for bank and agency;
- provide ongoing education, learning and support for system users;
- data reporting and analytics;
- review and audits to identify further efficiencies.

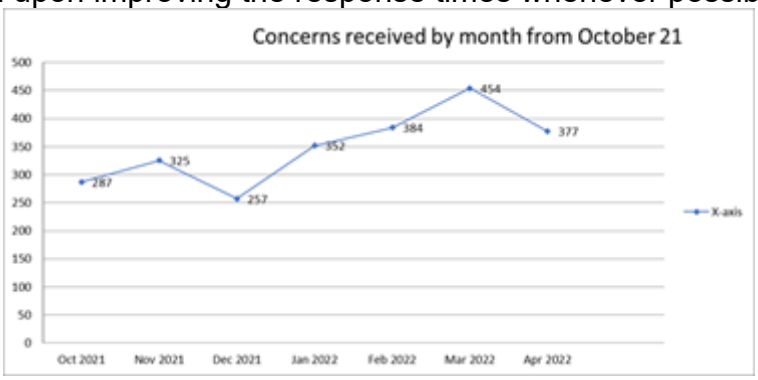
- **Medical & Dental Staff Bank** – Operational performance continues to improve. Total hours fill rate for March is 91.06%. Hours filled by Bank – 79.76% and by Agency – 11.82%. The staff bank has significantly improved our workforce supply.

  People Analytics – Workforce metrics and reporting is currently available for the Nursing workforce via SharePoint. In May this information will be available for all staff groups and all managers will be able to access.

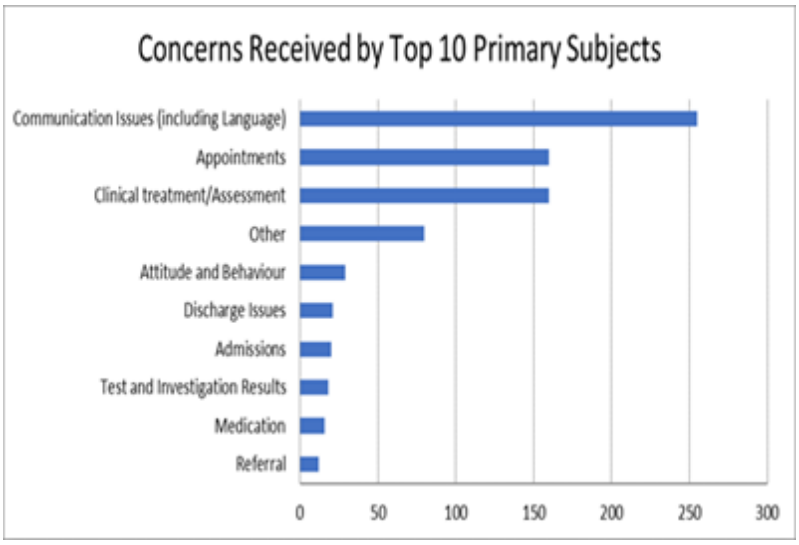
QUALITY AND SAFETY

Concerns –Patient Experience

During March and April, we received 831 concerns. In order to support clinical board, the central concerns team are processing as many concerns under early resolution as possible and this has maintained an overall 30 working day response time at 83%. However, the volume of concerns is challenging and it is appreciated that failure to answer concerns in a timely way is not acceptable and we will be focussed upon improving the response times whenever possible.



The main themes remain as: **Communication:**



Mohamed,Sara
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- Relatives have raised concerns regarding the difficulties they are experiencing when contacting the wards:

The Concerns team make contact with the Clinical Board to facilitate a conversation between the ward/clinicians involved.

- Patients did not know what was happening with their treatment/waiting times

Clinical Boards wrote to patients with updates regarding their services

- Poor communication regarding visiting and guidance on vaccinations

The Concerns Team host a vaccination enquiry line and also support the visiting process by hosting dedicated visiting lines to book visits.

- Patients did not feel involved in their care/discharge

A number of initiatives have been taken to improve communication between patients and staff. The Safer Bundle being piloted on one ward is an example of ward staff actively involving patients in their care. Patients are encouraged to ask:

What is the matter with me?
What is going to happen today?
What is needed to get me home?
When am I going home?

This fits in really well with the QSE framework by starting the “what matters to you” conversation with patients.

Environment:

The impact of Covid on our hospital environment cannot be underestimated. The requirements of social distancing have put a huge pressure on our departments and has led to a number of concerns relating to lack of social distancing and unhygienic conditions being raised.
Whilst it is very difficult to decrease capacity in our busier departments such as the Emergency Unit, we have taken a number of actions to raise awareness of the issues raised and to improve hygiene.

Reminders are sent out via CEO connects and staff emails to remind staff of the importance of maintaining social distancing where possible.

- Designed Materials to help with social distancing
- Enhanced Cleaning procedures and rotas
- Brightened up areas with redecoration

Waiting Times:

As anticipated, we have seen an increase in concerns this year relating to waiting times and a number of initiatives and different ways of working are being implemented to recover from the backlog caused by Covid.

- Encouraged Clinical Boards to reengage with their patient to provide waiting list updates via letter.
- Clinical Boards have redesigned pathways to fast track patents that have been reluctant to access services/care during the pandemic.
- Introduced weekend clinics
- Utilising Primary Care services so patients are seen sooner in Primary Care rather than Secondary Care.

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Patient Experience

In addition to the above, we have continued to gain routine patient feedback from the UHB MVCs and since their introduction in March 2021, have received feedback from **33437** respondents. This

feedback has been very positive, with **97.5%** of respondents (based on 32701 responses from the Viewpoint kiosks) rating their **experience** at the MVC as either 'very good' or 'good'.

Our 'HappyOrNot' kiosks having been gathering feedback from various areas including the Concourse in UHW, Information Centre at UHL and the Emergency Unit. Since their reintroduction in July 2021, of the **20717** respondents that have left feedback, **78%** have given a positive response when asked to rate the care they have received.

Falls

Slips,Trips and Falls- Fractured neck of femurs remain the most commonly reported fall related NRI to the Delivery Unit, closely followed by Head Injuries. Over the last 3 months there has been a reduction in the number of falls reported on Datix. During this period there has been significant staffing pressures so this may have impacted on the ability for nursing staff to mobilise patients. The number of falls whereby the patient suffered moderate or above harm has stayed relatively static with no real deterioration or improvement in position.

Learning from inpatient fall investigations has identified the following factors;

- Lack of knowledge of guidance
- Deviation from guidance
- Need for Training
- Three main themes:
  - Lack of Orthostatic Hypotension Assessment (L&S BP)
  - MFRA not completed at correct times
  - Lack of (evidence of) Medication Review
  - Deviation from bed rails and enhanced supervision guidance

Nationally reportable incidents
Between January 2022 and March 2022 Cardiff and Vale has reported 31 National Reportable Incidents. Except for the spike in December of Serious Incidents reported (this reflects the retrospective reporting in December of a number of reportable pressure damage incidents from PCIC Clinical Board following completion of a number of investigation tools), the number of SIs/NRIs reported has remained fairly consistent. There have been no further never events reported over this period

Within Cardiff and Vale UHB the top reported NRI categories within the 31 reported between January and March 20221, has been:

- Pressure ulcers – 5
- Delayed access/admission (appointments/admission delayed/cancelled) – 9
- Therapeutic Processes/Procedures – 4
- Maternity adverse occurrence (Neonatal Perinatal Care) – 4
- Unexpected death - 2

Pressure damage and falls continue to be the highest reported category of patient safety incidents. Significant work continues to address these high reported incidents. A detailed paper regarding the actions around pressure damage reduction through a collaborative was presented at the December '21 Quality, Safety and Experience committee.

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Hospital Infections – As at March 2022 the grouped total Cdiff, Ecoli, MRSA and MSSA infections is showing no in-year improvement against the 2018/19 baseline. However, Ecoli, MRSA and MSSA are demonstrating an in-year improvement.

Similarly, as at March 2022 Klebsiella has increased the in-year infections above the baseline year whereas P. aeruginosa is running below the 2018/19 baseline average.

We have some work to do and our main focus for the next 6 months is C'diff –
We will revisit the RCA process in PCIC, approximately half of our cases are related to the community therefore the RCA's will be piloted with some GP practices to ensure the tool used is robust enough to capture the required data and is in a usable format for the practices MRSA/MSSA –
We have funded more staff in the IP+C team who will focus on audits of practice related to PVC insertion and ongoing management and review of the RCA's
with the relevant teams in the Clinical Boards

Mortality
The reported increase in Risk Adjusted Mortality Index (RAMI) is a concern and whilst there are recognised limitations in the recording, coding and interpretation of this measure the increasing trend requires urgent review.

The Health Board continues to work closer with the Medical Examiner in reviewing deaths and identifying themes and learning. Further details will be presented through the Quality and Safety Committee and will include the condition specific mortality rate.

PERFORMANCE

Operations continue to be guided by a number of key components focused on minimising the five harms as set out in the national framework.

Operating model – There has been no change to the Health Board's Covid-19 operating model since the last report.

Operational position – 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.

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

There has been no change to national requirements for performance and waiting list reporting and published information since the last Committee meeting

Planned Care

Whilst the operational pressures impacted on the delivery of planned care activity in quarter 4, the implementation of new schemes such as the mobile ophthalmology theatres and recommencement of elective activity in UHW and UHL have resulted in an increase in activity as we move into May.

The total number of patients waiting for planned care and treatment, the ***Referral to Treatment (RTT)*** waiting list was 123,567 as at March 2022. The number of patients waiting for planned care and treatment ***over 36 weeks*** has increased to 44,083 at the end of March 2022. 57% of these are at new outpatient stage.

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The good progress made in increasing ***Diagnostic*** activity and reducing waits continues. The volume of greater than eight-week waits has reduced from its highest point of 7,808 in December 2021 to 5,004 at the end of March. The number patients waiting over 14 weeks for ***Therapy*** was 4,492.

Referrals for patients with suspected ***Cancer*** have now exceeded pre-Covid levels. Performance against the Single Cancer Pathway has improved with 62% of patients seen and treated within 62 days of the point of suspicion.

The overall volume of patients waiting for a ***follow-up outpatient*** appointment at the end of March 2022 was 172,902. 99% 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 reduced to 41,939.

95% of patients waiting for ***eye care*** had an allocated health risk factor in March 2022. 70% of patients categorised as highest risk (R1) are under or within 25% of their target date.

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 1,495 referrals in March 2022. As highlighted at the last Board meeting, 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: Whilst the percentage of Mental Health assessments undertaken within 28 days decreased to 49% in March 2022, CAMHs performance is compliant at 88% and the UHB has a line of sight to compliance in adult services. There were no patients waiting over 57 days in March 2022. Part 1b: 96% of therapeutic treatments started within 28 days following assessment at the end of March 2022.

Unscheduled Care

Attendances at our Emergency Unit department have increased since the first Covid wave but remain lower than previous years. Performance against the 4 and 12 hour waiting time targets and ambulance handover >1 hour is shown in the balanced scorecard.

The challenging position across the urgent & emergency care system as verbally reported at the last Board meeting has continued. Three factors continue to combine to cause current difficulties – high occupancy, with a continued challenge in our ability to achieve timely discharge; sustained workforce challenges; and management of Covid adding an increased layer of complexity in managing patient flow. We saw an increase again in Covid admissions pre-Easter bank holiday weekend resulting in opening of additional Covid capacity. Covid admission have subsequently reduced allowing us to de-escalate the additional covid capacity once more. At the time of writing, the UHB had 137 Covid positive inpatients across its two acute hospital sites.

The Health Board, in conjunction with its Local Authority and WAST partners, continues to work hard to alleviate the pressures and improve the quality of care and patient experience through a range of actions agreed across a number of areas, including admission avoidance, enhanced escalation and more timely discharge. Whilst some of these actions are more short term to address the current challenges we are facing, the Health Board, in conjunction with its partners, is also developing a more sustainable and transformational plan, in line with the national six goals for urgent and emergency care.

Primary Care

The Health Board achieved 100% compliance in March 2022 for the proportion of GP OOH 'emergency' patients attending a primary care centre appointment. The Health Board was 75% compliant against the target for emergency GP OOH patients requiring a home visit within one hour, with three out of four patients seen within one hour.

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Pressure has continued within GMS, with 12 practices reporting high levels of escalation at the time of writing the report. The 2 GMS contract resignations have been effectively managed by the primary care team. Dental services are operating between 40%-50% of pre-Covid activity but we will start to see an increase in activity as we move throughout Q1 driven by new contractual arrangements and

changed IP&C guidance. Optometry is operating at pre-Covid levels. Community pharmacy has remained open with no issues reported.

POPULATION HEALTH

Covid-19 update

- **Epidemiology**

  Covid-19 community prevalence peaked just after the end of the first week of April 2022 in Cardiff and Vale, based on ONS infection survey and wastewater trends. Cases have been falling steadily since in the community. Since the start of April, PCR testing has been focused on vulnerable people or people in high-risk settings. Excluding the period at the end of March and early April where trends couldn't be interpreted due to this change in testing protocol, recent trends suggest a reduction in cases among more vulnerable groups too. Most infections continue to be mild or asymptomatic.

  The number of people being actively treated for Covid-19 in our hospital beds fluctuated during April though declined overall, ending the month with 41 patients being actively treated in Cardiff and Vale (7 day rolling average). The number of people being treated for Covid-19 in critical care has however risen overall and reached its highest rate since the start of 2022 at the end of April. The rate subsequently stabilised and was 9 patients at the end of April (7 day rolling average).

  Clusters in care homes have reduced over the past few weeks, along with hospital clusters. ONS reported mortality has remained broadly stable, below or in line with the five year average.

  The BA.2 sub-variant of omicron remains the dominant strain of Covid-19 in our area.

- **Test, trace and protect (TTP)**

  Demand for PCR testing increased during March, before decreasing again towards the end of the month. Free PCR testing for the general population ended on 31st March 2022, with citizens able to access LFT testing if they are symptomatic. Contact tracing continues to be carried out following both PCR and LFT positive results, as long as the citizen logs the result in the latter case.

  Local and regional changes have been made to TTP services in response to the Welsh Government plan, *'Together for a safer future: Wales' long-term Covid-19 transition from pandemic to endemic',* with a focus on supporting high risk settings. Contact tracing services are following national protocols, and specialist resource within the region has been organised to support these high risk settings. The multiagency regional team has reduced its meeting frequency to twice per week, but continues to monitor new case data to identify clusters or settings of concern. The regional SOP has been revised to ensure escalation mechanisms remain in place to respond to any risks identified. The Regional IMT will meet monthly from April 2022.

  Partnership communication teams continue to work collaboratively to share updates on guidance with the people who live and work in Cardiff and the Vale of Glamorgan.

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- **Covid-19 vaccination**

  Cardiff and Vale UHB has now delivered over 1,131,000 Covid-19 vaccinations to the population. Delivery of the Spring/2nd booster commenced on 14 March 2022. The programme started with delivery to residents of care homes for older adults and is currently

being delivered to people aged 75 years and over and those aged 12 years and over who are immunosuppressed. All eligible individuals will be invited by mid-May to an MVC or Community Pharmacy for their spring booster vaccination. Those unavailable to attend an MVCs will be visited at their home by mobile vaccination team. Home visits for vaccination will be completed by end of May. All care homes for older adults have received at least one opportunity for residents to be vaccinated. There will be multiple visits to homes to ensure all that are eligible receive their vaccine at the appropriate time. We have 35 residents requiring vaccination, these will be vaccinated when they are eligible and before the end of June. At the time of writing there is no data available for spring boosters whilst we await an update of the Welsh Immunisation system. All children aged 5-11 year have now received their first offer of appointment although there is a high DNA rate for this age group of 78%. As at 27th April 2022, 14% of 5-11 year old children (universal offer) had received a vaccination. For those in at-risk groups aged 5-11 years, 42% have received vaccination.

Vaccination teams have been visiting Cardiff University, colleges, refugee centres, homeless settings and drop ins at care homes to ensure nobody is left behind.
We continue to offer walk-in appointments for any person aged 12 and above to receive their first, second or booster dose of vaccination, according to the eligibility criteria. This is being offering across all MVC sites as well as in two Community Pharmacy locations. Under 18s who become eligible for a booster vaccination will receive an appointment when they become eligible (3 months after their second dose).

No further guidance from the JCVI or Welsh Government has been received to date regarding the autumn Covid-19 Vaccination programme. Following a letter written to Health Boards from the NHS Chief Executive, Judith Paget, on 14 February, we are currently planning on the basis of the most likely scenario whilst retaining the flexibility to 'surge' should an urgent response be required. This includes an autumn/winter booster for Priority Groups 1-9 (which includes everyone aged 50 and over, those in clinical risk groups, care home residents and health & social care workers) in addition to an emergency surge response, mirroring delivery during the Omicron booster surge, should there be a need to respond to a variant of concern or should waning prompt urgent action.

The Covid-19 pandemic has exacerbated the inequalities and inequities in health experienced by the population of Cardiff and the Vale of Glamorgan. Significant work is required to address these population impacts, which the UHB will need to do in partnership with other local agencies. Ongoing preventative interventions such as smoking cessation, also need to be delivered, again taking into account the inequities experienced by our population. Specialist public health resource to support the full range of activities continues to be limited due to the ongoing requirements of the Covid-19 response.

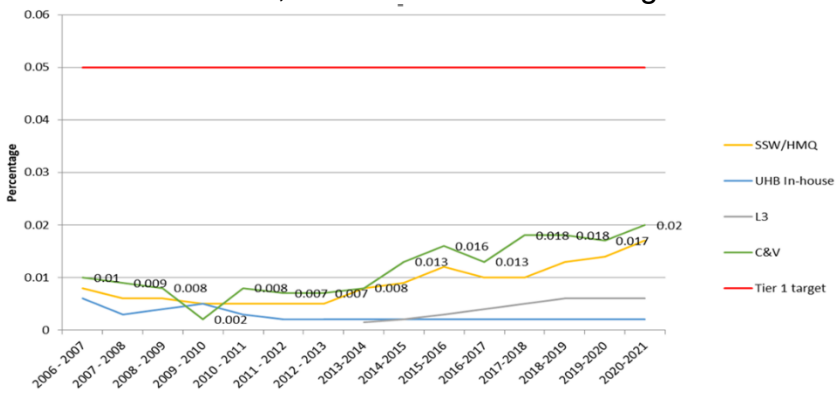
Tobacco Control

- **Smoking Cessation**
  - C&V UHB achieved 2.2% (2020-2021) against a Welsh Government Tier 1 target of 5% (Figure 1). This represents the highest rate achieved to date since Tier 1 commenced and reflects an upward trend from previous year 1.8% (2019-2020 and 2018-2019) and 1.6% in 2017-2018. Wales achieved 3.3% against the 5% target (Figure 1)
  - The Health Board's Help Me Quit (HMQ) smoking cessation service achieved a 78% 4 week quit rate (self- reported), Qtr 3, 2021-2022 - an increase from 74%, Qtr 2
  - Hospital Smoking Cessation Service achieved at 74% 4 week quit rate (self-reported), Qtr 3 2021-2022 and is working with all smoking cessation services to ensure implementation of Welsh Government's integrated 'Ottawa' model which includes routine identification of smokers on admittance to hospital
  - The Level 3 Enhanced Community Pharmacy Scheme for Smoking Cessation achieved a 67% 4 week quit rate (Self-reported), an increase from 56%, Qtr 2

Mohamed Salim
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- In C&V UHB, 9% of pregnant women smoke on booking (2020-2021), Wales 17%. The health board implements a Model for Access to Maternal Smoking Cessation Support (MAMSS) aiming to reduce smoking rates during pregnancy

Figure 1: Percentage of Treated Smokers, Cardiff and Vale Smoking Cessation Services 2006-2021



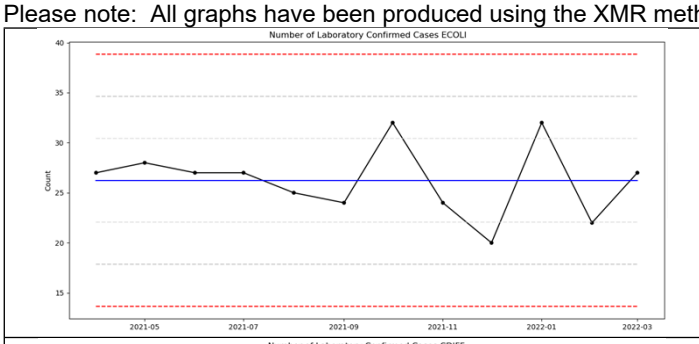
- **Smoking Prevalence**
  - 14% of adults smoke in Cardiff and Vale of Glamorgan (National Survey for Wales, 2019-2020) (a reduction from 17%, 2018-2019). CVUHB has the lowest prevalence of smoking when compared to other health boards in Wales. Welsh Government has set a target of 5% by 2030 as part of their draft Tobacco Control Strategy 2022-2030 which the UHB recently provided a Consultation Response

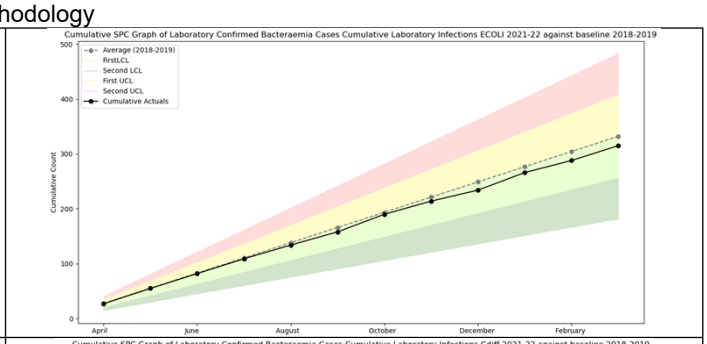
- **Smoking Prevention**
  - A dedicated Children and Young Peoples Tobacco Control Programme has been implemented to help reduce the uptake of tobacco (and e-cigarettes)

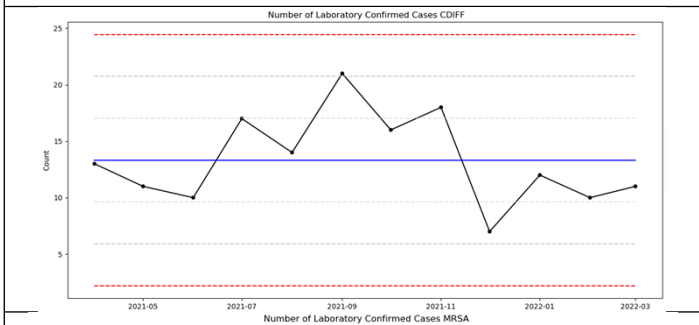
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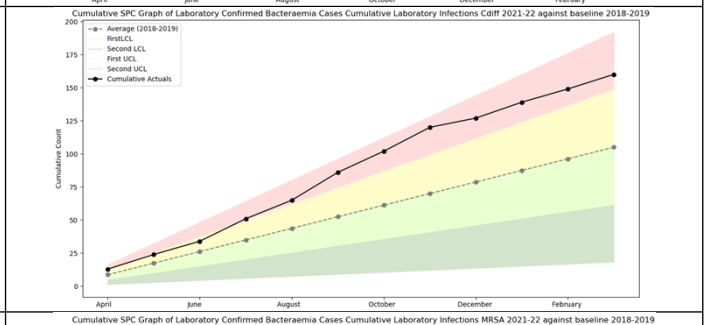
Appendix A – Infection Control Supporting SPC Graphs

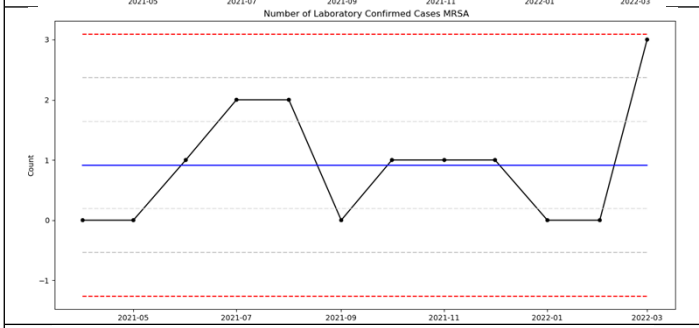
Please note: All graphs have been produced using the XMR methodology

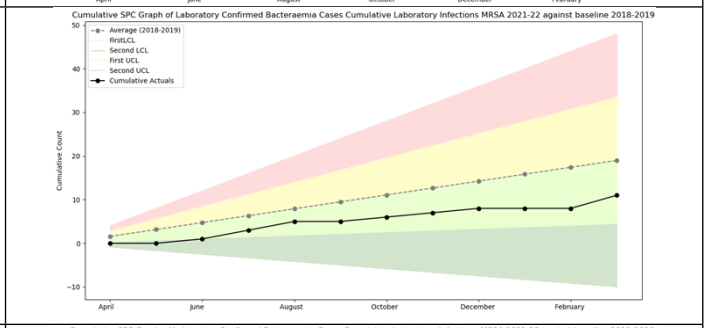


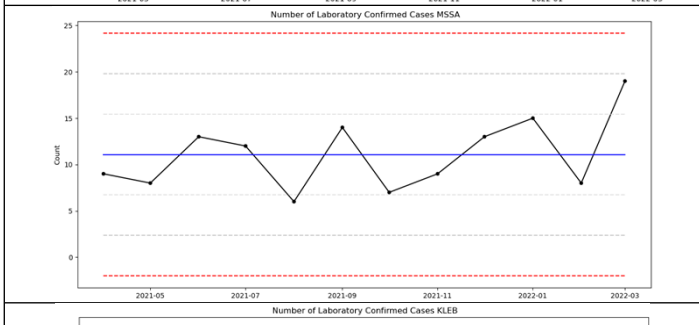


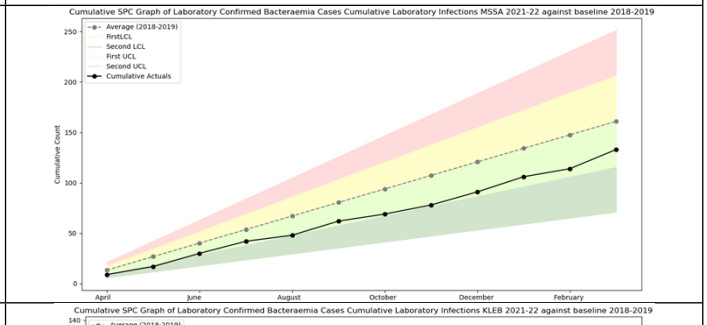


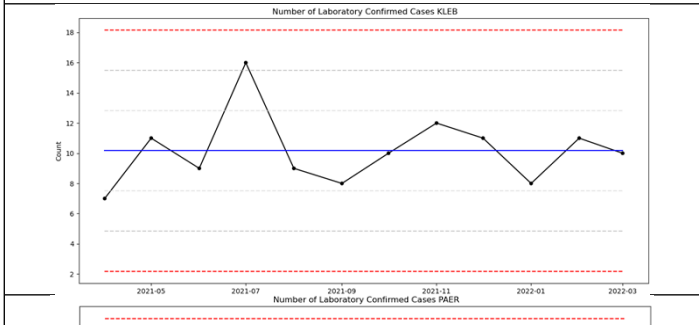


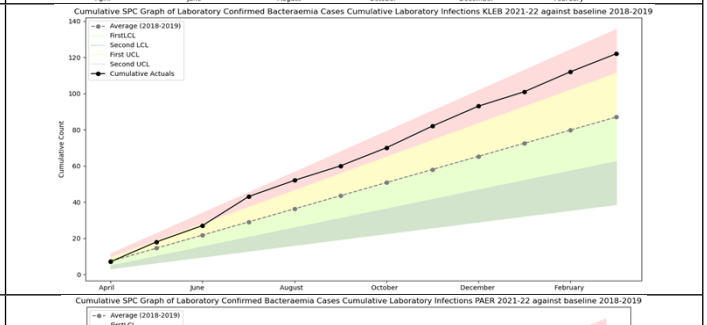


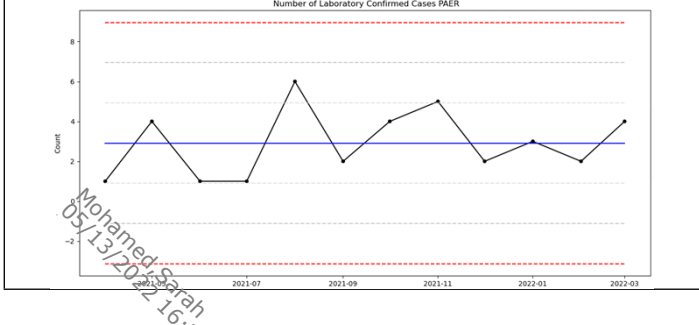


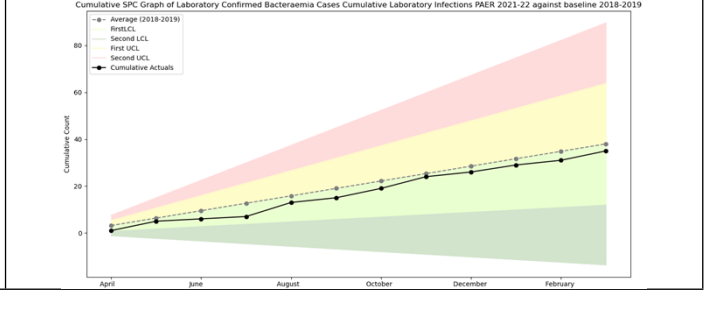












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Recommendation:
The Board is requested to: **Note** the contents of this Report

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	
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	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

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

Mohamed,Sarah
05/13/2022 16:36:25

Report Title:	**Cancer Services - Update**				Agenda Item no.	6.7	
Meeting:	**Board**		Public	x	Meeting Date:	**26.05.22**	
			Private				
Status *(please tick one only):*	Assurance	x	Approval		Information		
Lead Executive:	**Executive Director of Strategic Planning** **Executive Medical Director**						
Report Author (Title):	**Head of Strategic Planning** **Assistant Medical Director (Cancer Services)** **Director of Operations – Recovery & Redesign**						

Main Report
Background and current situation:

Cancer services represent a key priority for the Minister for Health and Social Care. Cancer is also one of the UHBs nine priorities within its 2022-25 Integrated Medium Term Plan (IMTP).

The UHB is pursuing an ambitious operational and strategic agenda across cancer services, both internally and regionally with partners.

Internally oversight of cancer service development is managed by the Cancer Executive Board which is chaired by the Executive Medical Director.

The collaborative service development agenda is driven via:

- A Collaborative Cancer Leadership Group (CCLG) which is chaired by the CEO of Cardiff and Vale UHB CAVUHB and consists of Executive Level Officers across South East Wales to provide oversight and leadership in regards to the cancer services in South East Wales and implementation of the Nuffield report.

- A CAVUHB / VNHST Executive partnership forum which exists to drive forward the specific collaboration agenda between the organisations.

This paper is intended to provide Board with an update across both the internal service development and collaborative service development agendas.

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

<u>The Collaborative service development agenda:</u>

Partners which the UHB is working with across Cancer services include - Velindre NHS Trust (VNHST), Cwm Taf Morgannwg University Health Board (CTMUHB), Aneurin Bevan University Health Board (ABUHB), Powys Teaching Health Board (PTHB) and Cardiff University (CU).

Velindre University NHS Trust (VNHST) is the specialist provider of cancer services in South East Wales and runs the Velindre Cancer Centre. In 2020 it commissioned a report from the Nuffield Trust to provide independent advice on the integrated regionally networked model including analysis and assessment of the benefits and risks of the proposed model of networked cancer care in South East Wales.

In December 2020 the Nuffield Trust published its findings *'Advice on the proposed model for non-surgical tertiary oncology services in South East Wales'*. A copy of the report is publicly available and can be found here: https://www.nuffieldtrust.org.uk/files/1606833630_advice-on-cancer-services-in-se-wales-velindre.pdf

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The report's findings were subsequently accepted by the Velindre Board and partner organisations, including Cardiff and Vale UHB (CAVUHB).

The report made 11 recommendations (summarized in **annex 1**). These recommendations broadly fall into three categories:

I. Recommendations for VNHST to progress.
II. Recommendations for VNHST to progress in collaboration with regional Health Board Partners collectively.
III. Recommendations which require a joint response between VNHST and a specific Health Board partner.

Annex 2 focuses on actions which sit within category two and category three (the actions which require progression between VNHST and CAVUHB) and provides a detailed assessment as to (i) progress which has been made to date (ii) key next steps for the 2022.

The actions which sit within these categories are:

Recommendation 3: Activity Benchmarking, Oncology Advice for Unscheduled Care and AOS
Recommendation 4: Revise Velindre Cancer Centre Admission Criteria
Recommendation 5: Research Hub at University Hospital Wales
Recommendation 6: Expansion of Haemato-oncology Clinics and provision of wider Diagnostic services
Recommendation 7: Velindre @ Operating Model
Recommendation 10: Future proofing' and University Hospital Wales 2

The key headlines within **annex 2** that Board are asked to note include;

Acute Oncology Services (AOS): In July 2021 Board approved the South East Wales regional Acute Oncology Business case. This resulted in £180k funding to support with the implementation of phase 1 (with a commitment to fund future phases).

Reviews of clinical oncology services in South East Wales consistently highlighted the lack of adequate, specialised and responsive oncology support for patients in acute secondary care settings.

The AOS proposal sought to address this shortfall to ensure that patients across South East Wales are able to receive timely specialised clinical inputs by providing an integral enhanced service to patients presenting with:

- **A complication of their cancer** - e.g. rationalise the care of patients suffering from metastatic/relapsed cancer or emergencies such as Spinal Cord Compression.
- **Toxicity from cancer therapy** - e.g. treatment related complications such as sepsis, pain or mucositis.
- **A new diagnosis of cancer** - e.g. assessment and triage of patients with new malignancies, expediting cancer pathways and providing support to patients and carers.

A copy of the AOS business case which was presented to Board can be found in **annex 3** for information.

In the last twelve months the progress made includes;

- **Recruitment to a number of key posts** – to improve ways of working, embed clinical pathways, support education and training and improve the patient experience. Out of 8.7WTE funded, only 0.9WTE is outstanding. The key risk areas are the recruitment to the remainder of the Velindre Oncology sessions to support local reviews of CAVUHB patients (0.4WTE) and Speech and Language Therapy (0.5WTE).

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- **A local implementation board has been established** – the group has been meeting regularly since October 2021 with an initial focus on recruitment, establishment of hot clinics and engagement in the regional working agenda. The key risk area is delays to local approval of the Cwm Taf element of the regional AOS business case which is having an impact on decision making and timeliness of implementation of these aspects of the case at CAVUHB

Regional Research and Development Hub: In April 2022 the UHBs Business Case Advisory Group (BCAG) and subsequently Management Executives (ME) endorsed a proposal for a Regional Research and Development Hub. The proposal has also been formally endorsed by VNHST and CU.

Cardiff has the largest number of cancer Chief Investigators (CIs) in Wales with South East Wales having the largest patient recruitment to cancer clinical trials in Wales.

The 1st solid tumor cancer early phase trials unit in Wales opened at Velindre in 2013. Cardiff and Vale and Velindre have worked closely with Experimental Cancer Medicines Centres (ECMC) to make early phase trials and novel treatments available to patients from across South Wales and a key part of the future is the building of links with Cardiff University for translational research.

However, there are only 30 in-patient beds on the Velindre site (with 10 of these currently out of service due to Covid-19) and the Clinical Research Treatment centre having only 4 beds and 6 chairs. In turn CAVUHB has no dedicated cancer research beds and patients that are admitted whilst having cancer treatments or trial medications will access the hospital via the emergency department, medical assessment unit or as a direct transfer from VCC, if complications arise or medical support is required.

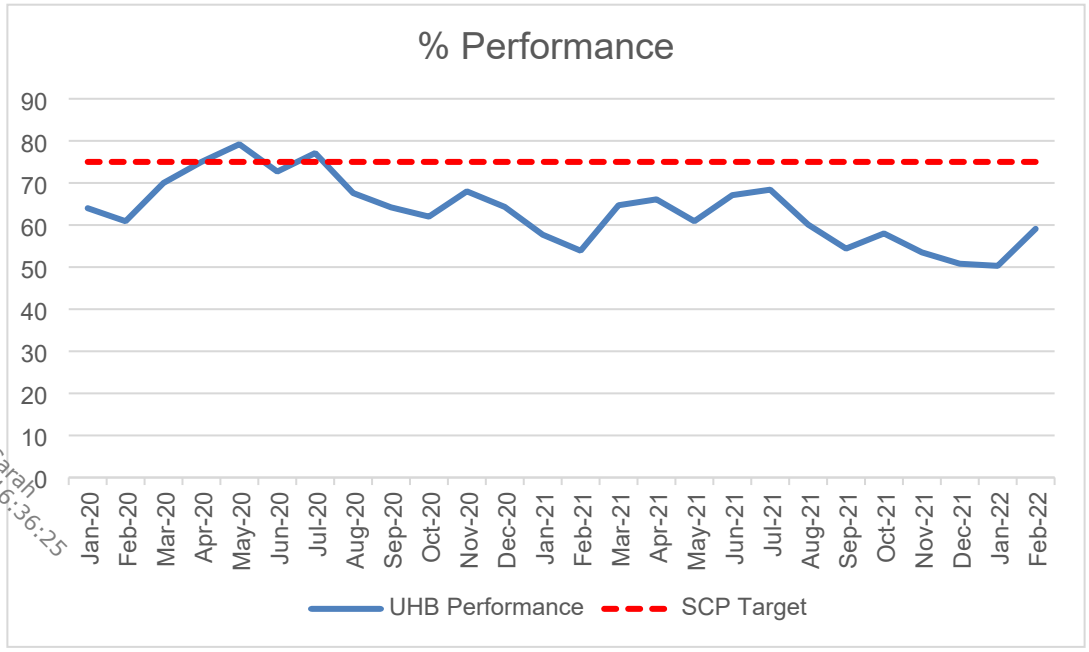
This R&D hub will;

- **Improve patient outcomes by increasing access to novel treatments** in Early Phase & Advanced Therapy clinical trials, solid cancer & haemato-oncology, across South Wales.
- **Strengthen the translational pipeline** by enabling scientists to bring new discoveries through from the laboratory to the clinic & encouraging new scientific discovery.
- **Develop a focus for cancer research excellence in Wales** by enhancing our collective reputation and attracting external funding from 3rd sector & pharma for reinvestment.
- **Enable training, education & innovation** by attracting & retaining staff, developing the next generation of researchers.

<u>The Internal service development agenda;</u>

Single Cancer Pathway performance:

The Single Cancer Pathway replaced the previous USC and non-USC cancer pathways into a combined approach with a target of 75% of patients to commence treatment within 62 days of referral. The new pathway and target was launched at the start of the pandemic and whilst during this period cancer services have remained a high priority and largely ringfenced from operational pressures, performance against the target has gradually decreased over the last two years.



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There are a number of key areas which the central cancer services team will be focusing on over the coming year to ensure we can meet the delivery ambition set out in our IMTP to achieve >65% compliance with the target by Q4. The priorities are:

- Finalise recruitment to Cancer Tracking posts to escalate delays related to individual patients, ensure validation is up to date and identify issues and trends which may affect future performance.
- Demand and capacity planning and sustainability in a number of tumour site areas such as breast and urology and support services such as radiology and pathology.
- Focus on reducing the backlog of patients waiting >62 days.
- Focus on ensuring first contact is within the 10-day target.
- Ensuring that tumour site performance is visible to clinical leads and operational managers.
- Undertaking harm reviews of patients who breached 146 days for treatment and ensuring lessons learnt from those reviews influence system and process change where required.
- Refresh the governance structure for cancer services ensuring the right membership, terms of reference and performance management systems are in place to achieve the right outcomes for patients.

A Rapid Diagnostic Clinic (RDC):

Early diagnosis of cancer is widely agreed and strongly evidenced to result in better outcomes for patients. But a significant cohort of patients are being diagnosed late, sometimes following delayed presentation, or delayed referral due to "vague" symptoms seemingly attributable to non-cancerous sources or an absence of site-specific symptoms.

The Rapid Diagnostic Clinic (RDC) provides an accelerated diagnostic pathway for patients who present to primary care with vague, but concerning, symptoms which may be indicative of cancer.

The RDC concept was piloted across two Health Boards within Wales (Cwm Taf Morgannwg and Swansea Bay) in 2017. Evaluation data demonstrated significant reductions in cost and time to diagnosis for patients referred to the service when compared with patients downgraded from USC pathways, but subsequently found to have cancer. Following the successful pilot phase, a recommendation was made to the Cancer Network Board for RDCs to be rolled out nationally.

In April 2022 the UHBs BCAG provided funding for the establishment of an RDC in Cardiff with the Wales Cancer Network providing initial eight months funding. More detail on the RDC can be found in **annex 4** via the business case presented to BCAG.

A refresh of the UHB Cancer services strategy:

Following endorsement at the February Cancer Executive meeting, Dr Diane Parry has been appointed as the Deputy Cancer Lead for Medicine and Mr Sandeep Berry as the Deputy Cancer Lead for Surgery at CAVUHB. Dr Emily Johns has been appointed as the GP Cancer lead

It has been recognised that the UHB cancer strategy needs updating this is required to include the developments detailed in this document. Cancer services are keen to include the Cancer leads and their teams to allow them to input into this strategy. Workshops are planned in the near future to put this in action and allow a comprehensive refresh of the cancer strategy. This updated cancer strategy will then be presented at the next Cancer Executive Board meeting for ratification.

There is continued recognition and acceptance that the Nuffield report is recommending the right things for the Health Board and the Health system across South East Wales to focus on. However, there is also the recognition that the Nuffield report was published at a particularly challenging time - mid pandemic meaning that the degree of focus which the organisation would wished to have placed on the agenda, whilst good, could have been even better.

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Capacity (clinical and managerial) to progress such a huge and complex agenda continues to be a challenge and this is recognised by both CAVUHB and VNHST. It is testament to both organisations' commitment to this work agenda that a joint 'senior strategic planning manager' post has been developed and jointly funded. This post has successfully been appointed to with the posted holder expected to start in July 2022. This will create some much-required capacity to support clinicians leading the various workstreams with key planning and project management support.

Recommendation:

Board are requested to:

- **NOTE** the progress being made in regards to the implementation of the Nuffield Report recommendations which are pertinent to Cardiff & Vale UHB.
- **ENDORSE** the Research and Development Hub proposal.
- **NOTE** the development and implementation of the Rapid Diagnostic Centre.
- **NOTE** the working progressing to refresh the UHBs Cancer services 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	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	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**

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Decarbonisation: **No**	
Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Quality and Safety Sub Committee	April 2022 (Nuffield report update element only)
BCAG and Management Executive	April 2022 (Research and Development Hub proposal and RDC business case)

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Annex 1: *Nuffield Trust Recommendations*

1. The planning process for all South East Wales cancer services needs to be reviewed and its coordination improved, with the development of a common dataset and planning approach put in place. Steps have been taken to support this and it is going to be very important that the CCLG is effective – this will help to fill the strategic gap in the planning of cancer services that has existed across South East Wales. There are some lessons from the development of the more successful cancer alliance models in England that could be followed. These take responsibility not only for the planning of cancer services but also for leadership and performance management.

2. Full co-location would have advantages but is not practical for a significant period of time. However, action is required soon to deal with the issues with the estate and linear accelerators at the VCC.

3. In the near future, each LHB needs to:

   • Develop and implement a coordinated plan for:
      - analysing and benchmarking cancer activity against other areas
      - advice and decision support from oncology for unscheduled cancer inpatient admissions via A&E
      - acute oncology assessment of known cancer patients presenting with symptoms/toxicities, with inpatient admission an option on a district general hospital site if needed, complemented by the Velindre@ ambulatory model, bringing models for haematooncology and solid tumour work together

   • Consider the lessons of Covid-19 in terms of remote access for patients and the remote provision of advice, multidisciplinary team meetings and other methods for improving access to specialist opinion.

4. The new model should not admit who are at risk of major escalation to inpatient beds on the VCC. These patients should be sent to district general hospital sites if admission is required, to avoid a later transfer. The admission criteria for inpatient admission to the VCC therefore need to be revised to reduce the risks associated with acutely ill patients. Regular review of admissions and transfers should be used to keep this and the operation of the escalation procedures under review.

5. To support recommendations 4 and 5, and the research strategy, a focus on cancer including haemato-oncology and a hub for research needs to be established at UHW. There would be advantages to this being under the management of the VCC, but in any case, the pathways between specialists need work in order to streamline cross-referral processes. Such a service would provide many of the benefits of co-location – access to interventional radiology, endoscopy, surgical opinion, critical care and so on – albeit without the convenience of complete proximity.

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

7. The Velindre@ model needs further work to describe how it will operate, its interface with acute services and its relationship to the wider pattern of ambulatory care. This should include the integration and development of other ambulatory therapeutic services such as dietetics, occupational therapy, physiotherapy, psychological therapy and speech therapy.

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8. The development of a refreshed research strategy is a priority and further work is required to fully take advantage of the networked model.

9. Organisational development and other work to create a successful cancer network is going to be required but has not featured much in our conversations for this report.

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.

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	Recommendation from Nuffield Trust report	Key Progress to date during 2021	Key Next Steps for 2022
3	***Recommendation 3:*** ***Activity Benchmarking, Oncology Advice for Unscheduled Care and AOS*** *'Develop and implement a coordinated plan for:* o *analysing and benchmarking cancer activity against their areas,* o *advice and decision support from oncology for unscheduled cancer inpatient admissions via A&E* o *acute oncology assessment of known cancer patients presenting with symptoms/toxicities, with inpatient admission an option on a district general hospital site if needed, complemented by the Velindre@ ambulatory model, bringing models for haemato-oncology and solid tumour work together* • *Consider the lessons of Covid-19 in terms of remote access for patients and the remote provision of advice, multidisciplinary team meetings and other methods for improving access to specialist opinion'.*	The Velindre@UHW programme includes a Acute & Unscheduled Care workstream. Good progress has been made with pathway redesign and admission criteria review undertaken. A workshop has been held where VCC presented the results of a one-month audit of admissions against their criteria. A regional Acute Oncology Service (AOS) project board lead by VNHST **has overseen the** development of a regional AOS business case that has subsequently been developed and signed off by all partners (excluding CTMUHB). *N.B. business case was taken to the CAVUHB Board in autumn 2021*	Further discussion on admission criteria now required along with the need to redesign pathways and a plan to change/agree/implement. Development of the Acute Deteriorating Patient Pathway between Velindre Cancer Services and University Hospital Wales. Following the pathway agreement, associated infrastructure and workforce business case requirements will be progressed. To include designated admission/ inpatient area at University Hospital Wales. Further evolution of the Service model and implementation work now needs to take place through 2022 under the wider auspious of the regional AOS implementation Board which is chaired by the Director of Planning ABHB.

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4	***Revise Velindre Cancer Centre Admission Criteria*** *'The new model should not admit those who are at risk of major escalation to inpatient beds on the Velindre cancer centre. These patients should be sent to district general hospital sites if admission is required, to avoid a later transfer. The admission criteria for inpatient admission to the Velindre cancer therefore need to be revised to reduce the risks associated with acutely ill patients. Regular review of admissions and transfers should be used to keep this and the operation of the escalation procedures under review.'*	Criteria for all admissions to Velindre Cancer Centre, both scheduled and unscheduled patients revised and implemented. Agreement to develop an Acute Deteriorating Patient pathway between Velindre Cancer Centre and University Hospital Wales. Pathway redesign undertaken and improvement activities commenced. The establishment of a regional Acute Oncology Service also provides alternatives to admission in the first instance.	Recognition this was an "in house" by VCC which now requires review and further testing with CAVUHB. Subsequently agree an on-going mechanism to review appropriateness of admissions and rolling clinical audit against revised Admissions Criteria. A need for ongoing development of the Acute Deteriorating Patient Pathway between Velindre Cancer Services and University Hospital Wales exploring options, such as on-site support from Velindre Cancer Centre consultants at University Hospital Wales.
5	***Research Hub at University Hospital Wales*** *'To support recommendations 4 and 5, and the research strategy, a focus on cancer including haemato-oncology and a hub for research needs to be established at University Hospital Wales. There would be advantages to this being under the management of the Velindre Cancer Centre, but in any case, the pathways between specialists need work in order to streamline cross-referral processes. Such a service would provide many of the benefits of co-location –*	The Velindre@UHW programme includes a research and development hub workstream. A draft service specification for the V@UHW Research hub has been developed by Velindre University NHS Trust, Cardiff and Vale University Health Board and Cardiff University.	VNHST and Cardiff University have approved service specification. Final scrutiny of the specification is taking place within CAVUHB with the ambition to approve the specification within Qtr1 before moving into phase 1 implementation.

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	access to interventional radiology, endoscopy, surgical opinion, critical care and so on – albeit without the convenience of complete proximity'.		
6	***Expansion of Haemato-oncology Clinics and provision of wider Diagnostic services*** *'The ambulatory care offer at the Velindre Cancer Centre 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.'*	The Velindre@UHW programme includes a Haemato-oncology workstream. There is recognition that this project has failed to gain the traction that the UHB would have liked.	Within Q1 immediate plans to; ○ Review scope and purpose of this workstream with VNHST colleagues ○ Identify clear UHB clinical lead
7	***Velindre @ Operating Model*** *'The Velindre@ model needs further work to describe how it will operate, its interface with acute services and its relationship to the wider pattern of ambulatory care. This should include the integration and development of other ambulatory therapeutic services such as dietetics, occupational therapy, physiotherapy, psychological therapy and speech therapy.'*	• Velindre @ University Hospital Wales Programme (see above) partly addresses this.	There is recognition within CAVUHB that there are further opportunities to exploit in terms of how both organisations operate jointly from a clinical perspective. This will need exploring, scoping sand progressing though 2022

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10	***'Future proofing' and "University Hospital Wales 2"*** *'Flexibility in design is going to be important both for the new Velindre Cancer Centre and for whatever is developed at the new University Hospital Wales due to the rapid change in the nature of treatment and research'.*	VNHST report that flexibility is built into new Velindre Cancer Centre specification.	Ongoing alignment and engagement with the UHBs *Shaping our Future Hospitals* programme as the development of a Strategic Outline case (SOC) is developed during 2022.

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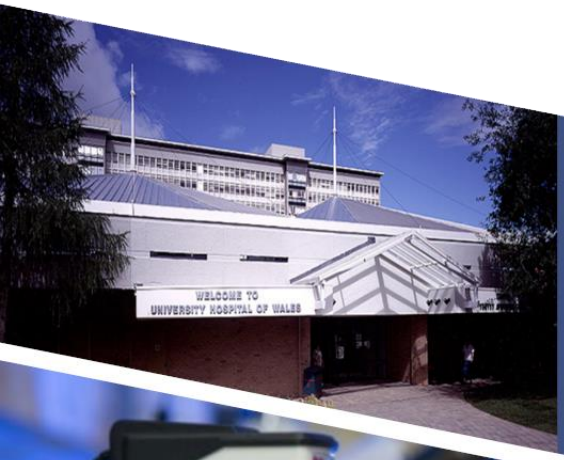
Bwrdd Iechyd Prifysgol Cardiff and Vale University Health Board

Ymddiriedolaeth GIG Felindre Velindre NHS Trust

Cardiff Cancer Research Hub

Proposal for a Tripartite partnership between Cardiff and Vale UHB, Cardiff University and Velindre University NHS Trust

January 2022







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Document control

Joint proposal	Cardiff and Vale UHB, Cardiff University and Velindre University NHS Trust
Archus file ref.	https://archusuk.sharepoint.com/sites/Southwest/Shared Documents/Clients/Velindre/Joint proposal Cardiff Cancer Centre/Joint Proposal_Cardiff Cancer Centre draft v4 2021-08-17.docx
Prepared by	Produced on behalf of the two Trusts by Archus Ltd
Date	January 2022
Checked by	Libby Batt / Dr. Mererid Evans
Date	January 2022

Version control

V.	Status	Date	Brief description of changes	By whom
1	Draft to client – outline	12/7/21	Outline draft proposal 1st draft for adaption	S.Reading
2	Draft to client next phase	29/7/21	Draft proposal 2nd draft after clinical update – awaiting workforce meetings for inputs and infrastructure meeting for project programme and risks	S.Reading
3	Draft pre-workforce requirements - to be added following clinical meetings	9/08/21	Updated following clinical pathway meeting and draft updates from clinical staff	S. Reading
4	Updated draft document	2/09/21	Final document following factual accuracy check	L. Batt / S.Reading
5	Final draft document – issued for comment	18/10/21	Workforce additions added (medical and nursing)	L.Batt / M.Evans
6	Final Draft – to issue to EMB, SDC, VUNHST Board (and to C&VUHB / Cardiff Univesity)	01/12/21	Update workforce requirements (pharmacy)	L.Batt / M.Evans

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1 Executive Summary

This proposal is an iterative document. This version reflects the situation as of August 2021 and is prepared in accordance with the guidance given in developing a joint proposal for the Cardiff Cancer Research Hub – a Tripartite partnership for integrated working in cancer research and education between Cardiff and Vale UHB, Cardiff University and Velindre University NHS Trust.

The proposal is to support an agreed phasing of joint working in ensuring that the Trust's and University are aligned to the current and emerging service need, is safe, of a high quality and providing value for money to the Trust.

This proposal has been produced from an evaluation of existing work and ambition for the future, guidance from key national and regional bodies and an extensive stakeholder engagement programme to understand current challenges and future service strategies for research and education, which have been translated into an agreed 'phasing' approach to meet the overall strategic priorities which the proposals align to.

The proposal assesses:

- Where the services are now and what are the current successes.
- Where do the services want to be a within the Tripartite partnership.
- How to get there using phased approaches that best meets patients and service needs

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2 Purpose of the proposal

2.1 Background and objectives

Health Boards, Velindre University NHS Trust and partners have an exciting vision for world class cancer services which deliver high quality care and clinical outcomes for the population of South-East Wales. In support of this, the Cancer Collaborative Leadership Group is providing strategic leadership and co-ordination to realise the vision at both a regional and local level. Within this, there are a number of major service and infrastructure developments planned in delivery which will assist in accelerating the delivery of enhanced patient benefits.

Within Cardiff, these include the development of cancer treatments and technology. These will be supported by the planned development of UHW2 and the new Velindre Cancer Centre which had Welsh Government approval for the outline business case (OBC) in April 2021. Consequently, a once-in- a lifetime opportunity exists for the region to develop world class services and infrastructure which are sustainable for decades to come. These include world class cancer services, genomics, immunotherapy, precision medicine and research, development and innovation. This will create 'network' effects with generation of strategic and commercial partnerships and support the broader Welsh Government policy aims e.g. economic prosperity; safe and cohesive communities and deliver efficient high quality efficient and effective integrated Cancer pathway access to care that meets the needs of the local and regional population in a safe and sustainable way.

A number of required actions by the Trust and its partners (specified in letter from Simon Dean, Deputy Chief Executive of NHSW), included the establishment of the research hub at UHW for patients requiring complex systemic treatments as well as closer working with haemato-oncology services which would be enabled by the hub and regional research network. Partnership Boards have since been convened between CVUHB, VCC and CU and a key focus of these Boards is the establishment of the tripartite hub, associated work-programmes and workforce models for delivery.

Research and Education across Cardiff and the Vale UHB, Cardiff University and Velindre University NHS Trust work have been working in partnership to deliver cancer services for South Wales populations and the current services are of a high quality with partnerships between the organisations felt to be strong.

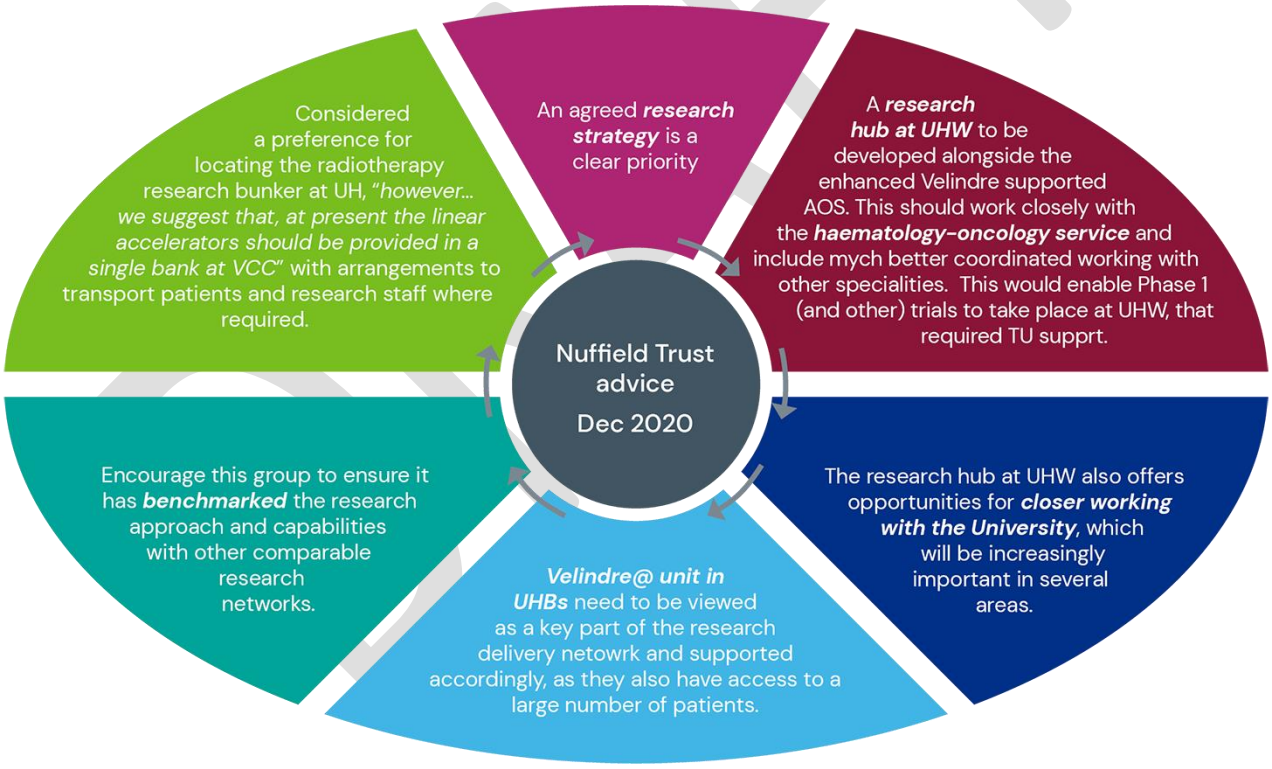
The patient pathways between the organisations for research opportunities are not fully developed and are not yet fully integrated across the system for a number of reasons; allowing for much opportunity for further strengthening services through integrated pathways that will give patients much improved access to research-based treatments whilst allowing services to develop enhanced and new treatments in a safe way through high quality joined up pathways for admissions.

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These discussions are supported by the Nuffield Trust report which was received on 1st December 2020 that set out recommendations for consideration by the regional partners. The ones specific to this proposal are:

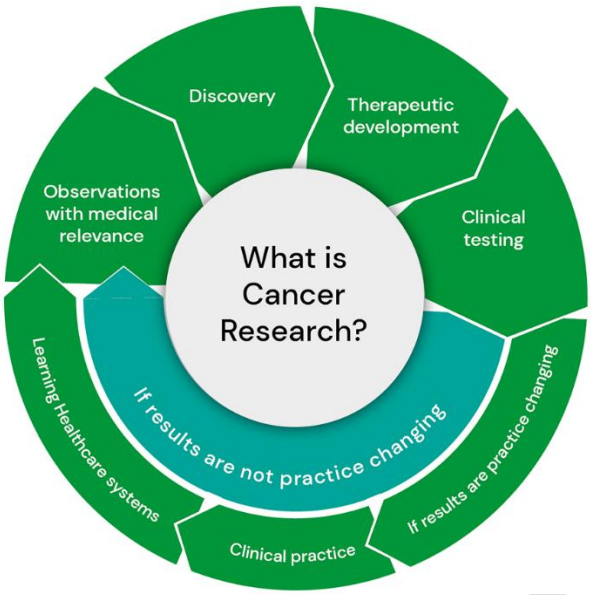
- Recommendation 4: The new model should not admit who are at risk of major escalation to inpatient beds on the VCC. These patients should be sent to district general hospital sites if admission is required, to avoid a later transfer. The admission criteria for inpatient admission to the VCC therefore need to be revised to reduce the risks associated with acutely ill patients. Regular review of admissions and transfers should be used to keep this and the operation of the escalation procedures under review.
- Recommendation 5: To support recommendations 4 and 5, and the research strategy, a focus on cancer including haemato-oncology and a hub for research needs to be established at UHW. There would be advantages to this being under the management of the VCC, but in any case, the pathways between specialists need work in order to streamline cross-referral processes. Such a service would provide many of the benefits of co-location – access to interventional radiology, endoscopy, surgical opinion, critical care and so on – albeit without the convenience of complete proximity.



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3 Strategic objectives

3.1 Strategic background - Oncology Research and Education



Cancer research is research into cancer to identify causes and develop strategies for prevention, diagnosis, treatment, and cure.

Cancer research ranges from epidemiology, molecular bioscience to the performance of clinical trials to evaluate and compare applications of the various cancer treatments.

These applications include surgery, radiation therapy, chemotherapy, hormone therapy, immunotherapy and combined treatment modalities such as chemo-radiotherapy. Starting in the mid-1990s, the emphasis in clinical cancer research shifted towards therapies derived from biotechnology research, such as cancer immunotherapy and gene therapy

Cancer research can be divided into several broad categories:

- **Basic research** is the study of animals, cells, molecules, or genes to gain new knowledge about cellular and molecular changes that occur naturally or during the development of a disease. Basic research is also referred to as lab research or preclinical research.
- **Translational research** describes an approach that seeks to accelerate the application of discoveries in the laboratory to clinical practice. This is often referred to as moving advances from bench to bedside.
- **Clinical research** involves the application of treatments and procedures in patients. Clinical researchers conduct clinical trials, study a particular patient or group of patients, including their behaviours, or use materials from humans, such as blood or tissue samples, to learn about disease, how the healthy body works, or how it responds to treatment.
- **Population research** is the study of causes and patterns of occurrence of cancer and evaluation of risk. Population scientists, also known as epidemiologists, study the patterns, causes, and effects of health and diseases in defined groups. Population research is highly collaborative and can span the spectrum from basic to clinical research.

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Clinical and translational oncology research is a most important factor in the advancement of treatments for different cancers. According to the National Cancer Institute, clinical research studies are crucial for physicians to find new ways to improve cancer treatments. It is critical to understand the role of clinical research in oncology, as it is central for leading, discovering and improving cancer treatments for people both within Wales and across the world.

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Looking at improving net-survival estimates by stage at diagnosis for 1- and 5-years are currently able to be presented following diagnosis for 24 cancer sites. Estimates by stage at diagnosis are not available for brain, non-Hodgkin lymphoma, kidney and urinary tract, pancreas, and leukaemia. This is because of complexities within different subtypes of a cancer site or because staging systems do not exist for all or some subtypes of the cancer.

For the 24 cancer sites with reported survival by stage estimates, there is a known stage for 85.3% of diagnoses. This is an increase 3.2 percentage points higher than in the diagnosis's up to 2016 and reflects the increases developments for diagnosis for each of the 24 cancer sites. As the number of diagnoses with a known stage increases, the survival estimates for each stage captures a more accurate and wider range of patients' survival experiences.

Not only is there much evidence that clinical research within cancer care can provide better treatments, it can also help researchers better understand the causes and nuances of different cancers. When patients participate in clinical trials, they help add to the knowledge about cancer to improve cancer care for future patients. Clinical trials can help researchers find new ways to prevent and detect cancer, and they can also help improve the quality of life for patients during and after treatment.

One of the main benefits of clinical research is that it can allow cancer patients to gain access to new treatments faster, which could be the difference between life and death for many patients. In many situations, participation in a clinical trial is the standard of care recommended by practice guidelines depending on the patient's stage and response to other therapies. It is known that improving diagnosis in the early stages of cancer offers patients a range of treatments that have a greater chance of being curative than if their cancer is diagnosed at a later stage.

Therefore, oncology clinical research not only has a major impact on future patient outcomes, it also plays a significant role in the care of patients who are currently fighting cancer.

The integration of cancer research and education across Velindre, Cardiff and Vales and Cardiff University will push forwards jointly agreed strategies to maximize innovation for cancer clinical research for continually increasing numbers of patients, with physicians from across the country, whilst providing an optimum infrastructure and environment for patients to be provided with the safest and highest quality care.

Further development of research within Cardiff will allow the accumulation of extensive knowledge about the biological processes involved in cancer onset, growth, and spread in the body will allow development of breakthroughs in treatment as a result of research and discoveries made by scientists in a wide array of disciplines over decades and even generations.

The aim of the 'Hub' will enable progressive safe and effective methods to prevent, detect, diagnose, treat, and, ultimately, cure some of the diseases of cancer to transform and saves lives. The better the understanding of these diseases, the more progress services provided for patients across Wales will make toward diminishing the immense human and economic cost of cancer.

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3.2 The story so far - achievements to date

The UK Government sets out bold vision for the future of clinical research delivery and Cardiff and Vale and Velindre are research active organisations.

Figure 1 - Future of Clinical Research Delivery

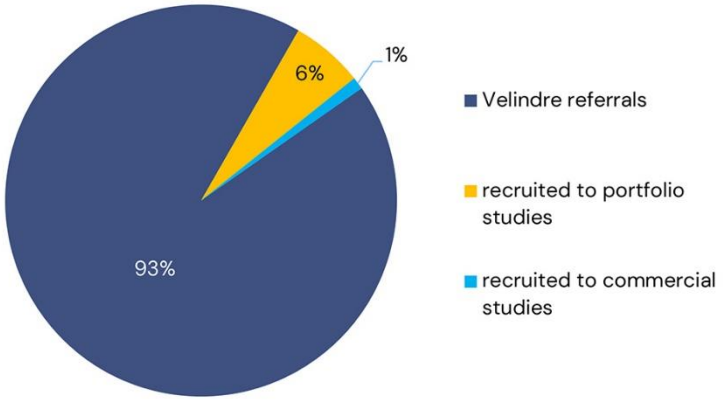


Cardiff has the largest number of cancer Chief Investigators (Cis) in Wales (31/34 CRUK grants in Wales 2013-2019 led by Cardiff CIs)

Southeast Wales has the largest patient recruitment to cancer clinical trials in Wales (149 cancer trials open 2019-20, ~1950 patients recruited)

The 1st solid tumour cancer early phase trials unit in Wales opened at Velindre 2013.

Figure 2 - Velindre referral and recruitment figures



Cardiff and Vale and Velindre have worked closely with Experimental Cancer Medicines Centres (ECMC) to make early phase trials and novel treatments available to patients from across South Wales and a key part of the future is the building of links with Cardiff University for translational research

There are a number of current challenges and, it is felt an immediate need, for the services to increase more widespread opportunity for cancer patient's access to research and current numbers remain less than desired by the clinical and research teams.

The ambition to change this means the services must:

- Enable early phase trials of 1st in human treatments that require access to HDU/ITU/other specialities;
- Streamline R&D processes (mean time to complete feasibility and confirm capacity and capability 2020-21 150 days);
- Develop closer partnerships with academia to enable translational and reverse translational research;
- Build critical mass and the research workforce of the future.

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3.3 Cancer research and development ambitions

Velindre University NHS Trust (VUNHST), Cardiff and Vale UHB (CVUHB) and Cardiff University (CU) have a shared ambition to work in partnership together and with other partners to develop a **Cardiff Cancer Research Hub**. Cancer research in South-East Wales is considered by clinical and academic teams to be at a crossroads and a joined up tripartite approach and investment is needed, to make it competitive on the UK cancer research stage.

This ambition is aligned with the Nuffield Trust recommendations to VUNHST and its University Health Board (UHB) partners (1 Dec 2020) which included, a recommendation to develop a "**strong research hub at UHW**" to bring together patients, NHS researchers (from CVUHB and VUNHST) and academic researchers (from CU School of Medicine) in one location. This tripartite hub will provide focus and facilities for cancer research in Cardiff including:

This tripartite hub (potentially called a Cardiff Cancer Research Hub) will provide focus and facilities for cancer research in Cardiff including:

- Delivery of Early Phase Clinical Trials (EPCTS) and Advanced Cellular and non-Cellular Therapies for solid cancer and haematological malignancies, with access to HDU/ITU and specialist services (e.g. surgery, cardiology, immunology, gastroenterology) to manage the complications of therapy and enabling collaboration between solid cancer and haem oncology research.
- Delivery of complex late phase research trials which require access to specialist services.
- Enabling "closer working with the university", bringing academic and NHS researchers together and creating the translational pipeline required to bring new discoveries from the laboratory to the clinic in Wales.
- Clinic, office and meeting space, with direct links to the laboratory, biobank, surgery, interventional radiology and other specialities.
- An enhanced, integrated, multi-disciplinary Clinical Academic workforce, developing future research and research leaders.
- Education and training, inspiring the next generation of cancer researchers in Wales and potentially housing a School of Oncology.
- Space for associated research infrastructure/partners in Cardiff/Wales.

3.3.1 Main Aims

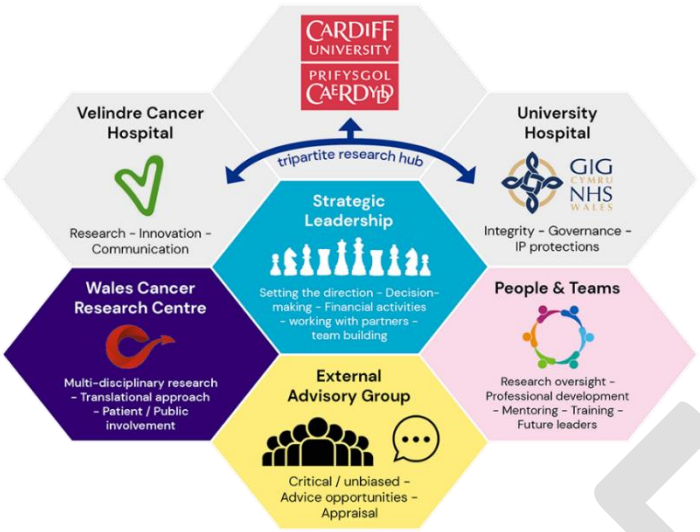
The main aims of a tripartite Cardiff Cancer Research hub will be:

- To **increase patient access to research,** including Early Phase and Advanced Therapies for solid cancer and haematological malignancies
- Enabling scientists to bring new discoveries through to the clinic by **strengthening the translational pipeline**
- Developing a **focus for cancer research** excellence in Wales to enhance the collective reputation and attract future funding, partners and staff.

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3.4 Outputs and principal agreements for integrated service design



A cross-site Research and Development Clinical Design Workshop stakeholder was held on the 8th June 2021 and attended by multi-professional teams across VUNHST, CVUHB and Cardiff University to further develop the concept.

The outputs of the workshop recognised that a hub and the associated areas of research have the scope to improve research access for patients in South Wales and beyond, bringing "benefits and success for all" partners, by:

- Providing a supported environment for the delivery of EPCTs including, those utilising Advanced Therapies (ATs)
- Increasing research options for Welsh patients nearer to home
- Delivering research care in a safe and seamless way
- Providing a pipeline of late phase trials and benefits for future cancer patients
- Building research critical mass, expertise and infrastructure
- Better connecting academic researchers and clinical researchers
- Facilitating both research development and delivery (NHS/Academia)
- Increasing the scope and reach for UK research partnerships and collaborations
- Providing opportunities for shared learning, training, education and career pathways to inspire, train and mentor future clinical and non-clinical cancer research leaders
- Delivering high quality and research-led teaching at both undergraduate and postgraduate level, and to inspire others to pursue excellence in research, teaching and innovation. Producing high quality research measured by publications, impact, income, increased CU impact cases and Research Excellence Framework (REF) status
- Improving income generation (commercial trials, industry investments, grant awards etc)
- Enhancing Cardiff/Wales research competitiveness at UK level and how Cardiff/Wales is perceived by key research funders
- Improving research status and reputation for all partners involved.

3.4.1 Agreed clear principles and next steps.

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There was clear consensus on taking forward a phased approach to the development of a cancer research Hub on UHW site. By adopting a phased approach, it was agreed that the immediate need would be addressed for enhanced access to early phase trials and ATs for solid cancer.

This would then allow the development towards a future-proofed tripartite cancer research hub on UHW site. A number of distinct time phases were suggested:

1. The immediate term classified as the first eighteen months (from July 2021 to Nov 2023). Intermediate term over the following 30 months (Dec 2023 to March 2026) and the long term over years 6-10 (Apr 2026 to March 2031)

In the immediate term work would be completed to agree: The Cardiff Cancer Research Hub (location, partnerships and models of working). The first phase will be to run complex and early phase studies in the existing Clinical Research Facility (CRF) at UHW, whilst at the same time develop plans for the Tripartite Cancer Research Hub, suggested to be operational in 18-24 months' time.

This proposal is to support any future development of an emerging business cases for medical and clinical oncology academics to include the ECMC applications to CRUK and the emerging pipeline of AT trials. As part of this is also suggested that integration for solid tumour and haematological EPTs could be developed in the same stepwise manner.

2. There will be a need to work with all partners to agree the detailed plans for the future Cancer Research Hub and the opportunities it offers.

The ambition is clear for the partnership across CVUHB, CU and Velindre and other partners in the development of a Cardiff Cancer Research Hub including the delivery and development of EPTs and ATs (Haem Onc and Solid Tumour) and a harnessed approach (NHS and Academia) for translational research. The scope to improve research access for patients in South Wales and beyond will be described in the proposal demonstrating how it will bring "benefits and success" for all partners.

3. There will be a need for dedicated resources to enable complex and early phase studies to be run at the CVUHB over the next 12-18 months

It was agreed that the written proposal for the workforce will need, over the next 2 years to demonstrate the need for a flexible and agile research nursing workforce that works together across two locations. The flexibility will be to work to different inductions and SOPS, the current staffing model will need some workforce uplift to be identified.

Agreements for medical capacity, have the opportunity to include Clinical Research Fellows supporting specific research work programmes both in terms of laboratory work as well as patient management within the CRF/Hub and "Out of Hours medical cover". It was felt this could include middle grade staff such as a junior doctor's linking in with the acute oncology service (AOS) work programme, haemato-oncology and with study Principal Investigators (PIs.)

Academic medical oncologists/clinical oncologists will provide leadership and for EPCTs, ATMPs, Early Phase Drug radiotherapy studies (including the Radiotherapy Research Bunker associated with nVCC) and the development of translational research associated with Genomics, Radiation and Immuno-oncology and the workforce to meet the increase of the potential with solid tumour trials ambition to double recruitment and increase portfolio, will be confirmed in the written proposal.

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4. The tripartite hub will be for far more than Early Phase trials and will require phasing of infrastructure to support the outputs

The infrastructure for the tripartite Hub will also be phased to match the immediate need and the intermediate and future plan bringing NHS and academic researchers together to enable translational and reverse translational research. The expanse of the opportunity includes 'Late phase', trial patients who may need biopsies, procedures or monitoring, research allied to AOS and unscheduled care and the creation of a focus for cancer research in Cardiff/Wales to inspire the next generation, education and training.

The clinical facilities from the immediate to the final phase will be described in the proposal. This will not only include the number of beds, couches and chairs; but a description of the research bed requirement in the critical care footprint for highest risk 1st in human cellular therapies, along with Haematology, emergency and patient monitoring equipment access for specialised clinical care, appropriate equipment for PK sampling, and monitoring equipment and access to vaccine treatment room and vaccine investigational medicinal product (IMP) preparation room which will be required in the intermediate stage and also consider the 'hot desk' space and IT facilities for the attending VCC EPT clinician and nurse/s and possible overnight accommodation for an on call clinician.

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4 Scope and service overview

The service overview is described following a review of the current pathway of care for patients taking part in research-based activity across Velindre, Cardiff and Vale and the wider parts of Southeast Wales.

4.1 Service scope – current research activity

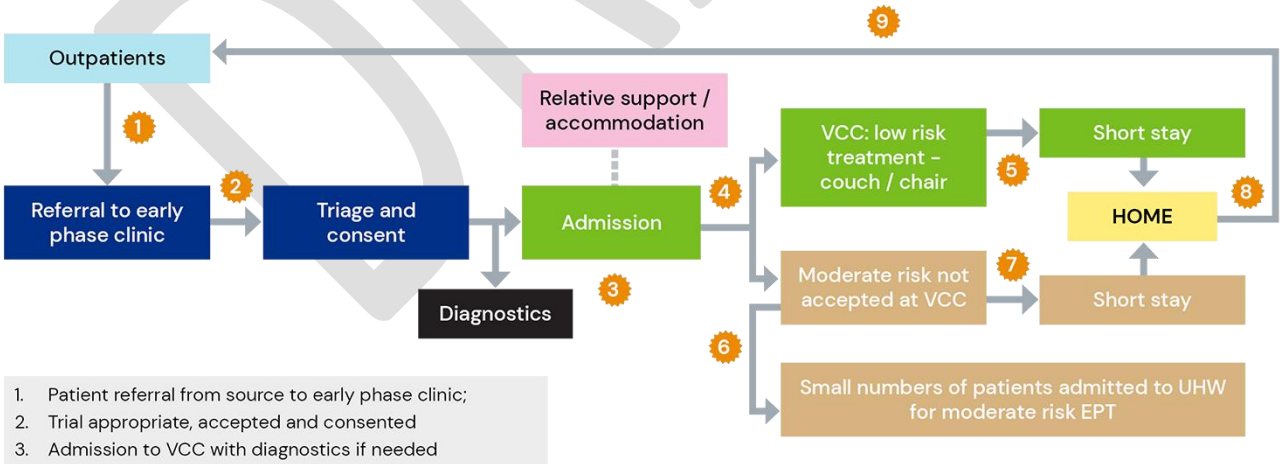
4.1.1 Velindre

Solid cancer EPCTs/Ats

The solid cancer Early Phase Clinical trials (EPCTs) and Advanced therapies (ATs) Unit opened at Velindre in 2012 to allow Welsh cancer patients to access Phase 1 trials closer to home in (in line with Welsh Government policy), as opposed to travelling to Oxford or London. Over the last 6 years Cardiff's ECMC) and the Wales Cancer Research Centre (WCRC) have provided funding to CVUHB and Velindre to support EPCTs and ATs. Since opening, Velindre has conducted 40 EPCTs, and has developed a track record of delivering such trials. This has improved the profile of both Velindre and Wales in cancer research, increasing collaboration between research institutions within Wales to deliver translational cancer research projects. Whilst the research facility is based on the Velindre site, there is no suitable area for patients having higher risk research-based treatment due to a need to be able to access high dependency care (Nuffield report – recommendation)

The current patient pathway for research-based treatment and trials, from admission to transfer home is demonstrated below with early phase trials at VCC. The range of treatments delivered are low risk and therefore limited. A small number of moderate risk trials are now managed at UHW.

Figure 3 – Pathway diagram – current



1. Patient referral from source to early phase clinic;
2. Trial appropriate, accepted and consented
3. Admission to VCC with diagnostics if needed
4. Patient starts treatment: couch / chair / bed - VCC
5. Treatment uneventful - discharge home / short stay
6. Moderate risk not carried out at VCC; small amount of moderate risk trials now taking place at UHW
7. Patient requires short stay following moderate risk trial, remains at UHW
8. Discharge process: Home
9. Patient transfers back to ongoing care

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There are a total of 30 in-patient beds on the Velindre site – with 10 of these currently out of service due to Covid-19. The Clinical Research Treatment centre has 4 beds and 6 chairs.

The usual activity from these beds is being managed through day-case work. The day unit has a total of 12 couches/beds for patients receiving treatment on a daytime only basis.

4.1.2 Cardiff and Vale

There have been no dedicated cancer research beds at UHW and patients that are admitted whilst having cancer treatments or trial medications will access the hospital via the emergency department, medical assessment unit or as a direct transfer from VCC, if complications arise or medical support is required.

Over recent months medical and nursing teams from Velindre have been integrating services across the two sites and supporting patients with treatments that would not be suitable to be delivered at Velindre. This change in practice has given opportunity for the clinical teams to start to look at the wider opportunity for access to more research studies, the type of facilities that will be needed to deliver the clinical care and also work with colleagues to look at the practical and governance related aspects of joint services.

The main cause of concern for further expansion of the services in research development is that without dedicated facilities in UHW, some moderate and all high risk trials will not be able to be undertaken as patients will increasingly require a dedicated area with access to interventional radiology treatment or high dependency care beds.

4.1.3 Research activity

VCC's EPCT portfolio includes Phase1, Phase I/II and Phase II and includes drug EPCT and Drug-Radiotherapy combination EPCTs and includes a mix of commercial and non-commercial studies. These allow Velindre to attract grants from external sources such as Experimental Cancer Medicines Centres (ECMC) and Wales Cancer Research Centre (WCRC), 3rd Sector and income generation from commercial monies.

Over the last 5 years, on average each year:

- 5 new EPCTs are opened (includes Phase I Phase I/II and some Phase II.)
- 120 are patients referred for EPCTs from South Wales and beyond, of which, 64 patients are suitable to be seen in clinic for trial and of those 38 patients are consented and screened.
- There are 760 EPT's patient visits; these visits are associated with screening, consent, delivery of trial treatment and trial related tests and follow up.
- Different EPCTs require different bed/chair hours. As an example, the least intensive EPCT require 3 hours per visit during first cycle of treatment, whilst the most intensive requires 14 hours per visit bed hours during first cycle of treatment. Overall a complex first in human trial can involve 55-60 patient management hours in the first four weeks of treatment, compared to standard care which requires 2-3 hours.

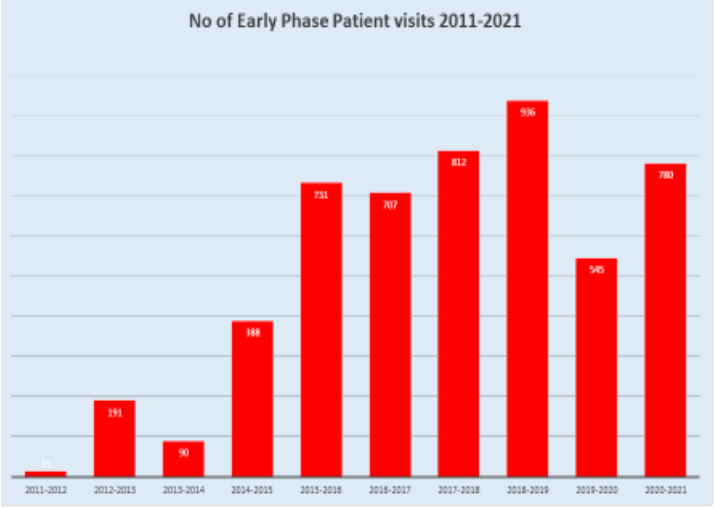
Building on this success, the aim is to increase future research opportunities for patients, enabling access to **novel, potentially life-saving or disease modifying therapies, or treatments** they might not otherwise be offered outside the context of a trial.

Enhancing EPCT's capacity in terms of strategy, focus, delivery, partnerships, reputation and opportunities and outcomes for patients will potentially attract significant income.

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Figure 4 - Current research Activity levels are illustrated in the table showing VCC Early Phase Clincal Trials and number of patient visits



In last 6 years the unit has saved 22,500 patient travel hours

Haemato-oncology EPCTs and ATs

There has been a year-on-year growth in activity in EPCTs for patients with haematological malignancies over the last 5-6 years in terms of the breadth of subtypes of haematological cancers covered by EPCTs, the numbers of open studies and the numbers of patients recruited. The vast majority of these studies are run and administered through the Clinical Research Facility at UHW (CVUHB.) Haemato-oncology studies have also benefitted from CRUK funding (as part of Cardiff ECMC), from the WCRC and also as a well-established Trials Acceleration Programme (TAP) Centre (formerly funded by Bloodwise, now by Cure Leukaemia). The haemato-oncology EPCT portfolio has included a mix of Phase I, Ib and II studies, increasingly featuring first-in-human / first-in-haematology trials, including studies with Cardiff-based Chief Investigators, linked to Cardiff University-based translational research.

There is an increasing focus of activity on haemato-oncology EPCTs involving 'Advanced Therapies' which will continue to grow as a proportion of total activity. Two phase 1 studies of bi-specific antibodies (T-cell engagers) have recently opened and a further adoptive T-cell study in Acute Myeloid Leukaemia is in set-up. The cellular therapy service within Haematology at C&VUHB includes the well-established regional delivery of haematopoietic stem cell transplantation (autologous and allogeneic) and CAR-T therapies and, has just opened its first CAR-T trial (phase III); is now well-positioned to expand into early phase cellular therapy studies, including CAR-T In recent years, there has been growing cross-site collaboration between haematology and solid tumour early phase researchers (ECMC, WCRC) as best exemplified by the TC Biopharma adoptive T-cell study for patients with advanced solid tumours which had joint Principal Investigators (CVUHB and Velindre Cancer Centre [VCC]), utilised haematology apheresis services at UHW and early phase units on both sites.

Expected increase in research activity and future challenges

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VCC Clinical teams are aware that as from 2012-2019, almost every EPCT could be run at VCC however, during the last two years, VCC have been approached to take on more complex EPCTs due to the changing landscape of the novel therapies that are being developed, for example: immunotherapeutic, virotherapies and cellular therapies.

To date, VCC has not yet conducted any ATs (Solid Tumour) trials, however Advanced Therapies Wales' Programme Team have identified from the emerging pipeline of 27 trials (over the next 18 months - 3 years) 45% are oncology trials. There are Haem-oncology ATs being worked up at CVUHB. There is an urgent need to gear up infrastructure and expertise to conduct such trials for solid cancer patients too allowing Welsh patients to gain access to these therapies, as well as informing future ATs that will become standard practice.

EPCTs complexity is partly due to the type of the interventional trial drug, its delivery method and associated patient reaction/clinical risk. To fully optimise EPCT activity, there is an immediate need to treat patients in an NHS location where there is access to level 2 and 3 facilities for those developing critical illness. To illustrate this, in January 2020 – April 2021, Velindre has submitted Expression of Interest (EOIs) for 35 EPCTs. Of these, 14 EOIs (40%) required patients to be dosed at UHW, allowing access to services such as critical care for safe clinical care. [It should be noted that even if such support services were in place, not all 14 EOIs would have progressed to EPCTs setup as Cardiff may not have been a selected site by every Sponsor/commercial company.]

There is requirement to assess the need for adequate infrastructure and workforce models including medical, nurse and research administrative cover to work across both sites, aligning research delivery with the clinical service. Academic Medical and Clinical Oncologist capacity will be necessary to drive and lead, if solid cancer and haemato-oncology EPCTs and ATs targets are to be realised.

Translational Research: Linking academia and the clinic.

The 2021 Cardiff CRUK Centre bid (led by Professor Awen Gallimore and CU's Cancer Theme) focused on the discovery and development of novel immuno-therapeutics, specifically the development of novel T-cell based therapies. Feedback from CRUK highlighted that the bid was unsuccessful for 2 main reasons:

i) The "hand-off" between pre-clinical and clinical work packages (the 'translational pipeline') was not clear in Cardiff.

ii) The bid was "too narrow" highlighting lack of a critical mass of cancer researchers in Cardiff with CRUK programmatic funding.

Despite these issues, the EOI was positively received by CRUK who recognized future opportunities in **advanced T cell therapies** in Cardiff. They also highlighted (in verbal feedback) future opportunities in **cancer vaccines** (building on the UK's success with COVID-19 vaccines).

It is now felt imperative that the pre-clinical to clinical interface is addressed to build critical mass in Cardiff to attract future infrastructural funding from CRUK and other funders, including industry. The Cardiff Cancer Research hub provides this opportunity, bringing NHS, academic and clinical academic ('interface' post holders) together to ensure that new discoveries made in Cardiff/Wales are translated through to the clinic for patient benefit.

For translational research the aims agreed are to:

- Strengthen the "hand-off" between pre-clinical and clinical research in Cardiff enabling our scientists to bring new discoveries through to the clinic (the 'translational pipeline') to benefit Welsh patients.
- Enable reverse translation – using patient samples to inform new discoveries.

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- Focus on opportunities to develop novel immuno-therapeutics including advanced T-cell based therapies in Cardiff and the future potential for cancer vaccines.
- Build critical mass in Cardiff to attract future infrastructural funding from Cancer Research UK (CRUK) and other funders.
- Bring NHS, academic and clinical academic researchers together in the hub to promote collaboration and develop a sustainable workforce.

It is envisaged that the Cardiff Cancer Research Hub will enable closer working with the university, promote a better-connected cancer research community, inspire future cancer researchers and research leaders and become a focus for education and training that will grow the next generation of cancer researchers in Wales. The possibility of co-locating cancer research infrastructure and partners (e.g. WCRC, ECMC, Wales Cancer Bank [WCB]) at the Hub has been supported by teams across sites which aligns with the aims of the Wales Cancer Research Centre (WCRC), that from 2020-25 there is a need to address the **translational gap** between 'discovery' research and delivery of its benefits to patients in routine clinical cancer services. It also is of critical importance to the success of Cardiff's ECMC bid in 2022 and is integral to the success of the themes priorities for future research in the future Cancer Research Strategy (CReSt) for Wales.

Specific exclusions

The main exclusions noted for this proposal are Children under 16 years of age.

4.2 Data and demographics

4.2.1 Population figures and trends

In order to correctly assess cancer services future demand, assessing how the population is changing across Wales is an important fact in evidencing and establishing the numbers of patients with more complex conditions and the likely increases in requirements for cancer services. Specifically in regard to access to research-based treatments in the future so that sensible projections are made that inform the infrastructure for the Research and Education Hub for patients and staff, and also to assess the potential for treatment provision and financial impact of the changes both in income and expenditure terms.

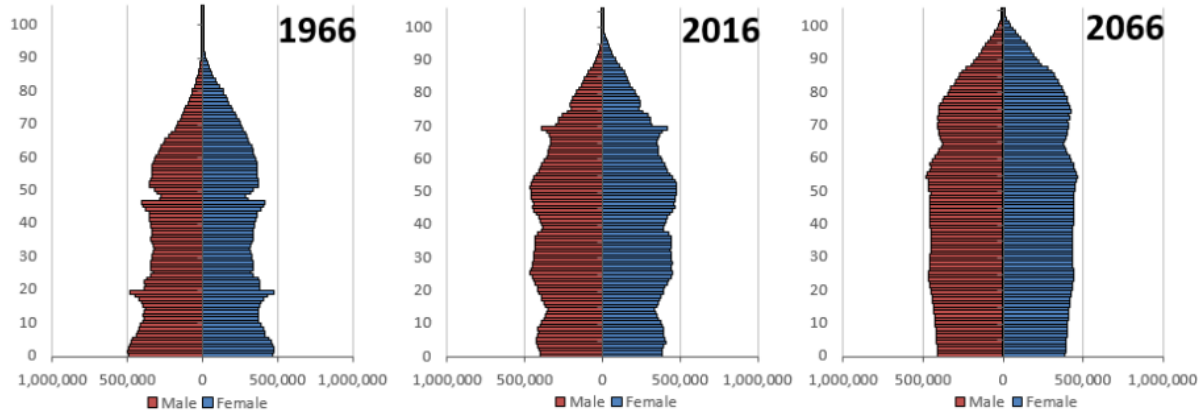
It is well known that population projections have long shown that the UK's overall population is ageing[1]. The population has been steadily getting older and this trend is projected to continue in the future. In 2016, there were 11.8 million residents aged 65 years and over, representing 18% of the total population – 25 years before, there were 9.1 million, accounting for 15.8% of the population.

Looking ahead to 2066, it is estimated there will be a further 8.6 million people aged 65 years and over, taking the total number in this group to 20.4 million and making up 26% of the total population. This increase in numbers is broadly equivalent to the size of the population of London today.

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[1] ONS projections England and Wales 2020

Figure 5 – demographic population projections



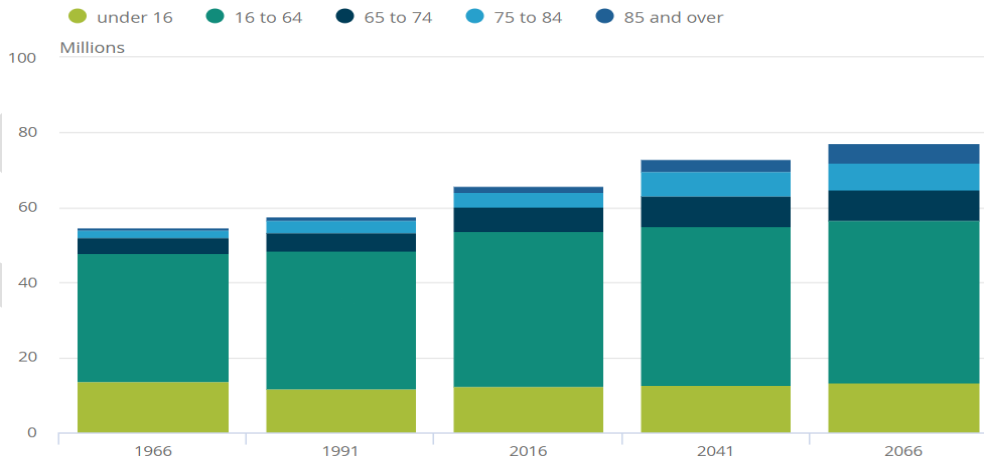
The changing and ageing structure of the population is driven primarily by two factors. Firstly, improvements in life expectancy mean that people are living longer and reaching older ages. Along with this, there has been a decrease in fertility, people are having fewer children and are having children later in life.

The fastest increase will be seen in the 85 years and over age group.

In mid-2016, there were 1.6 million people aged 85 years and over (2% of the total population).

By mid-2041 this is projected to double to 3.2 million (4% of the population) and by 2066 to treble.

Figure 6 - Population by age group



There will be 5.1 million people aged 85 years and over making up 7% of the total population. In contrast, the population aged 16 to 64 years is projected to increase by only 2% over the next 25 years and by 5% by 2066.

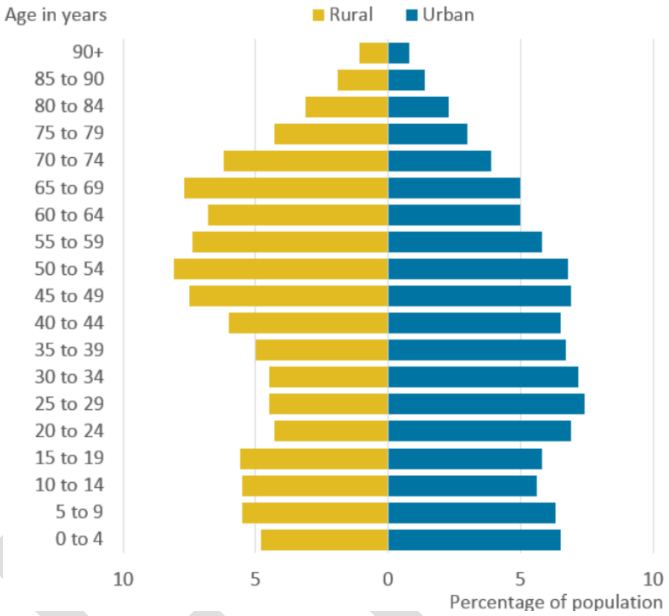
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For Wales, an important note is that the older populations are not equally spread across local areas, with older people making up higher proportions of the populations within rural and coastal areas than urban areas where more than 21.6% of the population are aged 65 years and over.

Looking ahead, the population aged 65 years and over is projected to grow by around 50% in both urban and rural areas between 2016 and 2039.

In comparison, the younger population (aged under 65 years) is only projected to grow by 8% in urban areas, with virtually no increase in the younger population in rural areas. This will result in an increase in the ratio of older to younger people, particularly in rural areas.

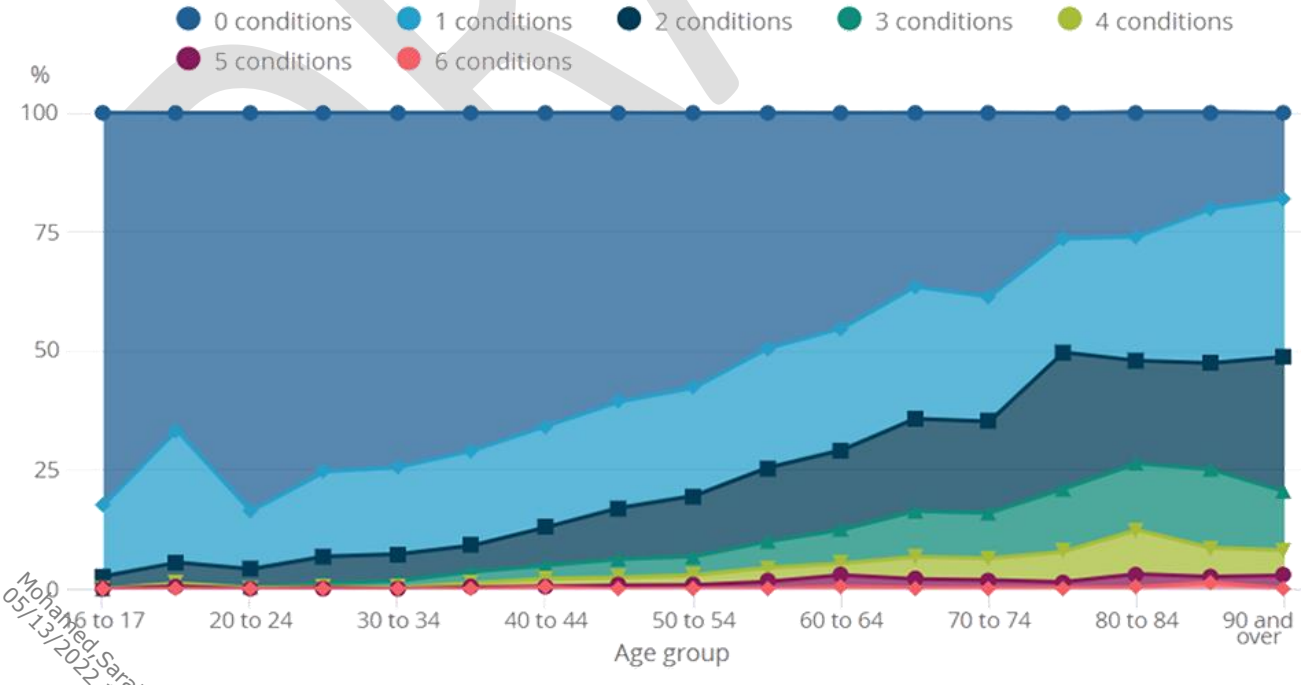
Figure 7 - Percentage of population within age bands by rural-urban classification



4.2.2 Implications for cancer services

Declining mortality rates mean higher life expectancies and with life expectancy projected to continue to increase across Wales, requirements for cancer services and patients able to have equal access to the best therapies and research is of vital importance.

Figure 8 - Growth in service requirements by complex health conditions



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Whilst the chart above demonstrates at age 65 years, both men and women can expect to spend around half of their remaining life expectancy in good health, the likelihood of experiencing multiple chronic and complex health conditions does increase with age.

And as, life expectancy increases, the impact on services providing care across different disease profiles is significant and that new therapies as a result of research will be of increasing value to the population as a whole.

Growth assumptions

The assumptions for increased bed, couch and chair requirements are based on the expected expansion to research and education services and have been discussed during the stakeholder engagement forums. These will be further linked to the overall longer-term requirements and are discussed in Section 6.

Initial requirements suggested:

- 4 Early phase trial beds for treatments increasing to 8 beds initially and then to 12 beds
- 6-8 chairs for early and late phase trial patients needing biopsies/investigations/bloods and linking with laboratory research, increasing to 12 chairs.
- Access to 1-2 research beds in the high dependency (critical care footprint) for highest risk 1st in human advanced therapies, along with Haemato-oncology.

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5 Proposal and requirements

5.1 Case for change

The overall ambition is to work in partnership with Velindre, CVUHB, CU and other partners in the development of a Cardiff Cancer Research Hub. There are key associated clinical research work programmes suggested within the Hub including the delivery and development of EPCTs and ATs (Haem Onc and Solid Tumour) and a harnessed approach (NHS and Academia) for translational research.

Both the Hub and these areas of research have the scope to address the requirements and improve research access for patients in *South Wales and beyond*, bringing "**benefits and success for all**" for all partners.

5.1.1 Joined up tri-partite approach

Clinical teams feel that they are at an important stage in their joint ambitions to create a research 'Hub'. To succeed they need a **joined-up tripartite approach** and **investment** to be competitive on the UK cancer research stage. Cardiff's failed RadNet and CRUK Centre bids (2019, 2021 respectively) identified that lack of critical mass, focus and absence of a clear translational pipeline are barriers to funding. The important Cardiff's ECMC bid in 2021 will need to show future plans and that the barriers have been addressed.

Despite the challenges, it is now an unparalleled time to be involved in cancer research, development and innovation at Velindre, Cardiff and Wales. Led by Health and Care Research Wales (HCRW), the **Wales Cancer Research Strategy (CReSt)** is being developed and it is expected to complete and receive sign-off in the next few months. It will recognise that building on existing research strengths in Wales and building closer links between the NHS and academia to enable the translational pathway from discovery science to the clinic, are fundamentally important developments for Cardiff and Wales.

There is also governmental and organisational commitment to developing the research hub. Furthermore, Welsh Government approval for the outline business case (OBC) for the new Velindre Cancer Centre in April 2021 was contingent on a number of required actions by the Trust and its partners (specified in letter from Simon Dean, Deputy Chief Executive of NHSW) – these included the establishment of the research hub at UHW for patients requiring complex systemic treatments as well as closer working with haemato-oncology services which will be enabled by the hub and regional research network.

Partnership Boards have been convened between CVUHB, VCC and CU and a key focus of these Boards is the establishment of the tripartite hub, associated work-programmes and workforce models for delivery.

5.1.2 Other Partners

ECMC Cardiff funding from CRUK and Welsh Government (WG) funding ceases March 2022. ECMC Cardiff has begun to work up an application in readiness for the CRUK competitive open call in 2022. Given the financial climate, this will be extremely competitive process across the UK. To support such an application, it will be essential to present a joined-up approach for EPCTs across institutions and partners.

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The **Wales Cancer Research Centre** (funded by HCRW till 2025) is set from 2020-25 to address the **translational gap** between 'discovery' research and delivery of its benefits to patients in routine clinical cancer services. Furthermore, it has a EPCTs and ATs work programme (haematological and solid cancer); outcomes from this work-plan are likely to be reviewed by Health and Care Research Wales (HCRW) in the next 18 months.

Research interactions with the Wales Cancer Bank (WCB), CRUK CTR (Cancer), Marie Cure Palliative and Supportive Care Research Centre, CU Schools of Medicine, Biosciences and the Engineering as well as the Systems Immunity Research Institute will be essential. The opportunity to co-locate a number of these Cardiff-based Welsh cancer research infrastructures in the Hub needs to be explored.

Advanced Therapy Wales (funded by Welsh Government) and ATTC Midland/ Wales (funded by Cell and Gene Catapult.) In the last 2 years WG issued a statement of Intent for AT and funds Advanced Therapies Wales programme team that supports the delivery of this intent. In addition, ATTC Midland/Wales (is working up its Phase 2 application for a further 5 years funding.) and the ATW programme team has identified a pipeline of 27 global trials coming through over next 18mths - 3 years; 45% of these are oncology trials and the Cardiff Cancer Research Hub will enable delivery that would otherwise not be possible in Wales.

5.1.3 Leadership and models of working

Enabling increased EPCT solid tumour, AT activity and translational research will require a critical need for additional clinical academics in both medical and clinical oncology.

To address this, Velindre and the Division of Cancer and Genetics (CU) are developing joint business cases to uplift the clinical academic capacity to a further 2 WTE initially, with a clear plan to develop further critical mass within the clinical academic workforce over the next 5-10yrs. Such posts will be vital to the development of the cancer research hub, and will require some individuals to be capable of delivering complex Solid Tumour First in Human and other Advanced Therapy trials, as the team work in partnership (VUNHST, CVUHB and CU.) In addition, scoping the uplift of research nurse and research support staff capacity will be needed and is described in the workforce section below

Over the last three years, VCC and the Clinical Research Facility have worked in collaboration with C&V Haematology in successfully delivering Wales' first ever adoptive T-cell therapy study. Currently both EPT's teams are collaborating to set up 2 trials, providing opportunities for learning that will inform best operational working going forwards, as well as setting foundations in terms of working relationships, contractual arrangements, governance, trial setup, communications, shared workforce models and related financial reimbursements etc. A key part of this is that the increased work for the trials cannot be carried out without some investment in posts (medical nursing and research administrative posts) to allow new and different work across different sites.

In future however, not all of VCC's EPCT portfolio will need to be delivered on the UHW site. Indeed, not all EPCT protocol driven care will need to be delivered at UHW. There is a likelihood that VCC EPCT and AT location for delivery of investigational (drug/vaccine /immunotherapy etc.) will be decided by the *risk* associated with the type trial intervention, its delivery mechanism and risk of side effects/ risk of patient reactions with trial procedures and patient visits moving seamlessly between the two sites in a shared working model.

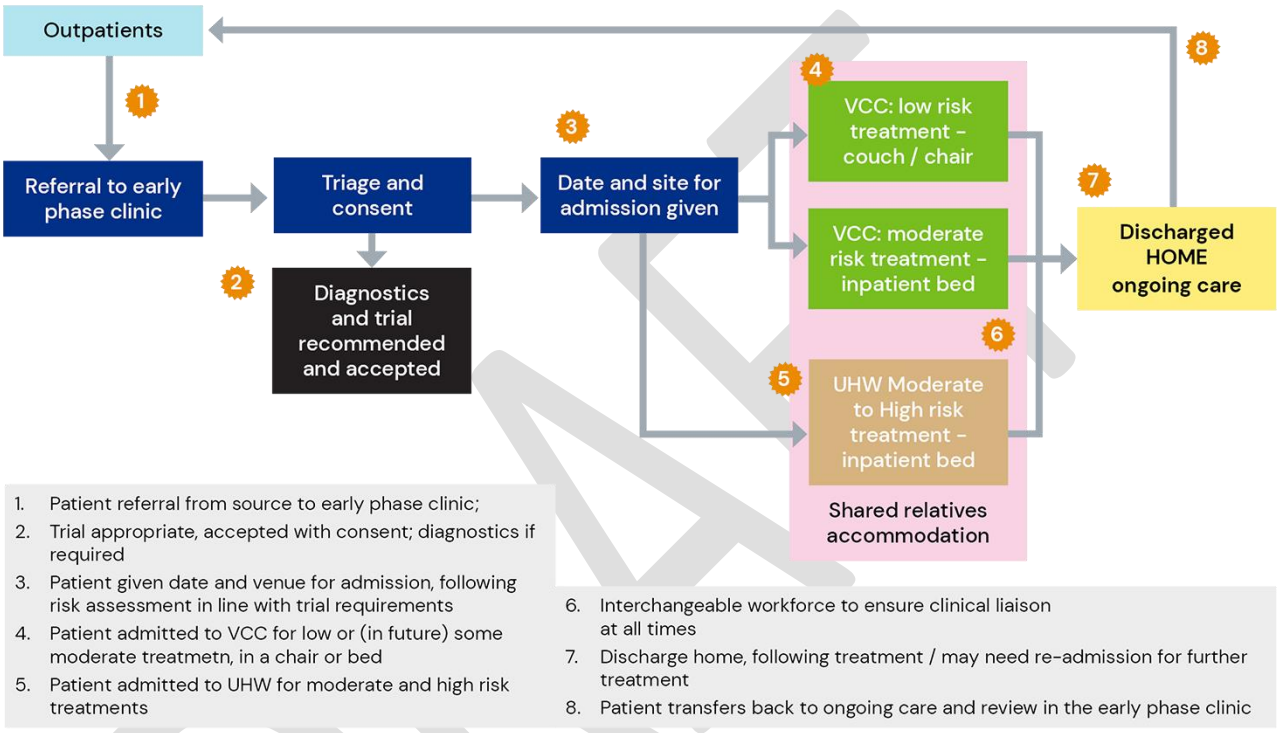
The future joined up pathway changes the way that research services will be delivered.

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As EPCTS and ATs are set up each trial will be assessed for risk and the best location for the delivery of the trial drug will be determined.

Once the patient has consented, has undergone trial screening and met trial eligibility criteria, they will be given a date and time for admission at the appropriate site for trial drug delivery to commence. This will be part of a phased implementation process as the range of treatments and trials grows and admission pathways and bed numbers increase. The changes for patients within the pathway are demonstrated below:

Figure 9 – Pathway diagram– future



5.2 Proposal

5.2.1 Early Phase Trials (EPCTs) and Advanced Therapies (ATs)

For Early Phase Clinical Trials it was noted at the Clinical Design workshop that the aims should be to provide enhanced access to patients with both solid tumours and haematological cancers by:

- Exploring opportunities to work collaboratively between solid cancer and Haemato-oncology, driving plans to deliver EPCTs across Velindre and UHW sites as per the Nuffield recommendations
- Advancing collaborations with Cardiff University scientists, ECMC and the WCRC to deliver bench to bedside projects with Cardiff generated molecules/therapies.
- Designing and delivering investigator-led EPCTs with Welsh Chief Investigators through interaction with Industry, Academic colleagues, Cancer Research UK (CRUK), Cancer Research Wales (CRW) and other funders.

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- Developing a broad, well-balanced EPCT portfolio including both commercial and academic investigator-led studies, aiming to double patient recruitment to EPTs in South Wales within 10 years.
- Expanding the portfolio of solid cancer Early Phase Drug-Radiotherapy Combination studies.
- Expanding EPCTs activity in advanced therapies for both haematological and solid tumour indications (multiple modalities including CAR-T therapies, vaccine therapies, virotherapies and T-cell engaging antibody therapies)
- Taking patient referrals from across South Wales and beyond.

For solid cancer **Advanced Therapies** (ATs), the aims will be to provide enhanced access to patients by:

- Seeking opportunities to lead with partners at CVUHB the delivery of Clinical Trials to test the benefit of ATs in solid cancers (involving gene therapy, vaccine therapies, cell and tissue-based therapies and tissue engineered products) for the population of South Wales.
- Learning from the experience and expertise of haemato-oncology colleagues of delivering ATs (e.g. CAR-T therapy) for haematological malignancies and supporting closer working and co-localisation to expedite necessary knowledge transfer and delivery capability.
- Investing in the infrastructure and workforce required to deliver these therapies.
- Joining a collaborative network of R&D delivery teams across the UK to share experience and best practice in this emerging field of research.
- Pro-actively seeking out and developing links with academic and commercial developers to partner with in ATs clinical translation and trial delivery.
- Utilising the knowledge gained in delivering ATs in a trials setting to facilitate and expedite their adoption and equitable availability as routine standard of care when fully licenced and commissioned.

Notably, within **two years** – to open at least one solid tumour non-cellular advanced therapy trial (for example an oncolytic virus) and one cellular advanced therapy trial annually. Within **five years** – to open two solid tumour non-cellular and cellular advanced therapy trials annually. Within **ten years** to open **five solid tumour non-cellular and up to 5 cellular advanced therapy trials annually**.

5.2.2 Translational Research – Linking academia and the clinic

The 2021 Cardiff CRUK Centre bid (led by Professor Awen Gallimore and CU's Cancer Theme) focused on the discovery and development of novel immuno-therapeutics, specifically the development of novel T-cell based therapies. Feedback from CRUK highlighted that the bid was unsuccessful for two main reasons:

1. The "hand-off" between pre-clinical and clinical work packages (the 'translational pipeline') was not clear in Cardiff.
2. The bid was "too narrow" highlighting lack of a critical mass of cancer researchers in Cardiff with CRUK programmatic funding.

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Despite these issues, the EOI was positively received by CRUK who recognized future opportunities in **advanced T cell therapies** in Cardiff. They also highlighted (in verbal feedback) future opportunities in **cancer vaccines** (building on the UK's success with COVID-19 vaccines).

It is imperative to address the pre-clinical to clinical interface and build critical mass in Cardiff to attract future infrastructural funding from CRUK and other funders, including industry. The Cardiff Cancer Research hub provides us with this opportunity, bringing NHS, academic and clinical academic ('interface' post holders) together to ensure that new discoveries made in Cardiff/Wales are translated through to the clinic for patient benefit.

For translational research it was noted at the Clinical Design workshop that that the aims were to:

- Strengthen the "hand-off" between pre-clinical and clinical research in Cardiff enabling our scientists to bring new discoveries through to the clinic (the 'translational pipeline') to benefit Welsh patients.
- Enable reverse translation – using patient samples to inform new discoveries.
- Focus on opportunities to develop novel immuno-therapeutics including advanced T-cell based therapies in Cardiff and the future potential for cancer vaccines.
- Build critical mass in Cardiff to attract future infrastructural funding from Cancer Research UK (CRUK) and other funders.
- Bring NHS, academic and clinical academic researchers together in the hub to promote collaboration and develop a sustainable workforce.

It is envisaged that the Cardiff Cancer Research Hub will enable closer working with the university, promote a better-connected cancer research community, inspire future cancer researchers and research leaders and become a focus for education and training that will grow the next generation of cancer researchers in Wales. The possibility of co-locating cancer research infrastructure and partners (e.g. WCRC, ECMC, Wales Cancer Bank [WCB]) at the Hub was supported at the workshop.

This aligns with the aims of the Wales Cancer Research Centre (WCRC) which has set from 2020-25 to address the **translational gap** between 'discovery' research and delivery of its benefits to patients in routine clinical cancer services. It also is of critical importance to the success of Cardiff's ECMC bid in 2022 and is integral to the success of the themes priorities for future research in the future Cancer Research Strategy (CReSt) for Wales.

5.2.3 Proposal for implementation

Two principals have been proposed by clinical and operational teams:

1. Dividing studies according to 'risk'
2. Promoting a phased approach to implementation

Dividing studies according to 'risk'

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Future studies (for solid cancer and haem-oncology) should be divided according to 'risk':

- **Low risk EPTs** will continue to be delivered and managed in Velindre Cancer Centre (and/or by the Haematology Clinical Research Group for haem-oncology studies).

- **Intermediate risk EPCTs and ATs** require investigational drug delivery and supportive care and will need to be delivered on UHW site supported by VCC staff (with screening, consent and follow-up managed by VCC team in VCC).
- **High risk EPCTs and ATs** require the investigational drug and specialised supportive care to be delivered in the critical care footprint on UHW site (being led by Dr M P Wise, R&D Director, (CVUHB). This is anticipated to start in next 1-2 months for a haemato-oncology 1st in man bispecific monoclonal antibody being tested. VCC research nurses will support here (with screening, consent and follow up managed by VCC team in VCC).

5.3 Phased implementation

Given the emerging discussions around the Cardiff Cancer Research Hub, development of emerging business cases for medical and clinical oncology academics, the ECMC applications to CRUK, and the emerging pipeline of AT trials, it is suggested that development of the hub and its activities should be developed in a stepwise manner.

By adopting a phased approach, the partnership can address the immediate need (enhanced access to EPCTs and ATs for solid cancer) whilst building towards a future-proofed tripartite cancer research hub on UHW site.

Distinct time phases are suggested:

Term	Stage	Date
Immediate Term	First 18 months	July 2021 to Nov 2023
Intermediate Term	Following 30 months	Dec 2023 to March 2026
Long term	Years 6-10	Apr 2026 to March 2031

In the **immediate term** the proposal is to Use the existing **Clinical Research Facility (CRF)** on UHW site for intermediate risk studies which cannot be delivered at VCC. Also to:

- Utilise the High Consequence Infectious Diseases (HCID) unit at UHW as appropriate for high risk EPCTs which require trial interventions that include vaccinations
- Use a refurbished critical care footprint for high risk early phase & Advanced Therapy studies (solid cancer & haem-oncology [happening in the next 4-8 weeks for haemato-oncology study]).
- Complete a review of the nursing/medical model for clinical cover [clinical research fellows/honorary contracts] and investment in the delivery workforce (

For high-risk Haem-Oncology trials, the appropriate location will be determined on a trial-by-trial basis. In addition to the locations listed above, other locations such as the Bone Marrow Transplant Unit may be utilised.

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In the **intermediate and longer term**, the aim is to develop:

- A Clinical Research Facility (CRF) **in the clinical area** (covering Haematological and solid cancers) known as the Cardiff Cancer Research Hub or **(the "hub"),** to deliver 'intermediate risk' Early Phase studies, provide a focal point and facility for translational research with

university partners, enable late phase studies for Cardiff patients and allow opportunities for education and training. The hub should be located close to the Acute Oncology Service so that research and clinical care can be delivered seamlessly.

- A Clinical Research Facility (CRF) **in the critical care area** – for 1st in human solid cancer and haemato-oncology early phase and advanced therapies. Research and critical care will be delivered seamlessly in this unit.

These will provide a unique selling point for Cardiff and Wales, attracting commercial income, enhancing research reputation & attracting and retaining high calibre staff.

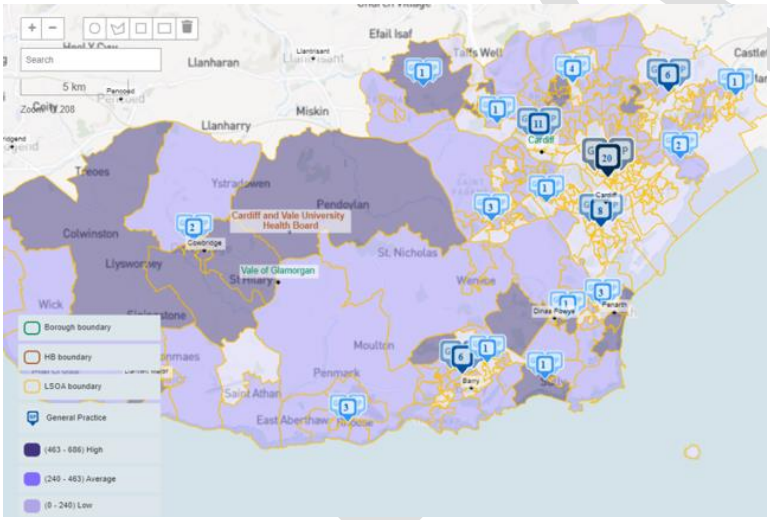
In summary, the workshop agreed clear principles and consensus on a model for the future Cardiff Cancer Research Hub and work is now required to develop a detailed implementation plan and seek investment for it on a tripartite basis.

For details of operational actions to be undertaken for the immediate term see **Appendix 2.**

5.4 Referral and access

5.4.1 Geographical coverage / boundaries

The main geographical coverage will be within Cardiff and Vale Health Board, which will be expected to increase in numbers based on the aging population and particularly where more dense areas of the older populations reside. However, as the research activity grows so will the coverage across Southeast Wales.



Referrals for research-based treatments will be made by the attending Consultant. Patients will be referred to Velindre for specialist treatment from within the Cardiff and Vale Health Board and across the South Wales network and SW England such as Bath and Bristol

As the research-based activity grows it is expected that there will be an increase in cross boundary referrals through consultant-to-consultant referrals.

5.4.2 Days / Hours of operation

The new service will operate

- Day Case Velindre - Monday to Friday 9am-5pm.
- In patient (Velindre and UHW) – Monday to Friday 24/7.

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5.5 Workforce

There is requirement to assess the need for adequate infrastructure and workforce models including medical, nurse and research administrative staff to cover to work across both sites. Academic Medical and Clinical Oncologist capacity will be necessary to drive and lead, if VCC EPCT and A/T targets are to be realised.

It is also presumed that within this is the CRF CVUHB or CVUHB critical care footprint for Solid tumour for intermediate and high risk. Using a phased approach to introduction of the 'Hub', the following requirements have been considered:

5.5.1 Academic Leadership

Uplift WTE academic medical oncologists/clinical oncologists to 3 WTE (staggered and funded by CU with matched funding by VCC). Such posts will provide leadership and for EPT, ATMP, Early Phase Drug radiotherapy studies (including the Radiotherapy Research Bunker associated with nVCC) and the development of translational research associated with Genomics, Radiation and Immuno-oncology.

5.5.2 Medical Workforce

An uplift in medical capacity is required, this will include

- Clinical Research Fellows supporting these specific research work programmes both in terms of laboratory work as well as patient management within the CRF/Hub TBD WTE.
- "Out of Hours medical cover" which will include middle grade staff such as a SHO that would link with the acute oncology service (AOS) work programme, haemato-oncology and with study PIs.

5.5.3 Workforce model

Over the next 2 years there will be a need for a flexible and agile VCC research nursing and administrative staff workforce that is able to provide research care over 2 locations, working with CRF workforce. This will require rotating staff over 2 sites and working to CVUHB inductions and SOPS. In addition to the current EPT /ATMPs VCC research workforce uplift 2 WTE Band 6.

In the intermediate term the workforce capacity will need to be uplifted to include a Lead Nurse for the overall project, research nurses and administrative staff depending on number and type of trials. There will also need to be an agreed uplift to pharmacy capacity. As the trial portfolio grows Lead medical staff, research nurses and research administrative staff to be kept under review.

Pharmacy arrangements such as storage of IMP, reconstitution and drug transportation will be considered by each individual trial. If the IMP can be made at VCC and transported safely we store IMP at VCC, reconstitute and transport via a courier service. If this cannot be done (due to stability and the timings) VCC would have the drug delivered to CRF for all of the above. This would need to be agreed in the trial set up and appropriate Service Level Agreement organised. For the future and looking forward if the drug is delivered at VCC it should be kept and reconstituted at VCC and vice versa if administered at CRF.

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Challenges

The challenge for the service in the longer term is the future requirement to provide 24hr medical clinical cover which will require a change in current service provision, different joint working practices and an opportunity to align the immediate need with the recently established AOS +/- haemato-oncology service.

5.6 Infrastructure

Accommodation for in-patient hospital facilities is described in Health Building Note Standards[2]. Using a phased approach to implementation of the new services the following accommodation will be required:

5.6.1 Immediate - Clinical Facilities

In the first year as a minimum within the CRF VCC will need access to 16 hours (two 8-hour slots bed/chair hours per week. This is based on previous EPCT activity data that identifies difference in bed hours as in the least intensive EPCT require 3 hours per visit during first cycle of treatment whilst most intensive requires 14 hours per visit bed hours during first cycle of treatment.

- VCC will need access to 1-2 research beds in the critical care footprint for highest risk 1st in human cellular therapies, along with Haematology.
- Access to HCID for Vaccine treatment room and vaccine investigational medicinal product (IMP) preparation room/s (required in the next 2 years at UHW)
- Interventional Radiology- current needs and future opportunities will need to be reviewed to inform planning for intermediate stage
- Emergency and patient monitoring equipment access to specialised clinical care.

5.6.2 Other

A shared “space” for the clinical and non-clinical workforce to get together is needed. Lab research is spread across many labs and buildings so a “communal” area (such as a shared office / meeting room / coffee room) will be essential for facilitating interactions, new ideas etc., plus:

- Hot Desk space and IT facilities for attending VCC EPT clinician and nurse/s;
- Overnight accommodation for on call clinician
- Interactions with unscheduled care
- Appropriate equipment for PK sampling, and monitoring equipment;
- Use of UHW’s decontamination infrastructure for vaccinations.

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[2] Health Building Note 04-01 – ‘Adult acute in-patient accommodation’

5.7 Adjacencies

The future requirements are described below and have been phased for the immediate need and intermediate/long term.

5.7.1 In-patient environment for treatment

When considering the infrastructure requirements for patients having cancer treatments within an in-patient facility, it is important to consider the adjacencies needed to meet infection control, spacing requirements and patient privacy and dignity needs which must, for new environments meet the general requirements of an in-patient ward. This is particularly relevant for some vaccine trials require patients to have en-suite facilities to avoid patient cross contamination as the patient will shed virus.

Figure 10 – In-patient bed area with en-suite

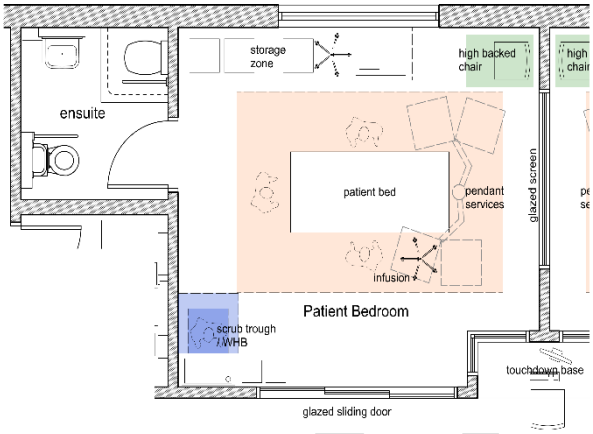
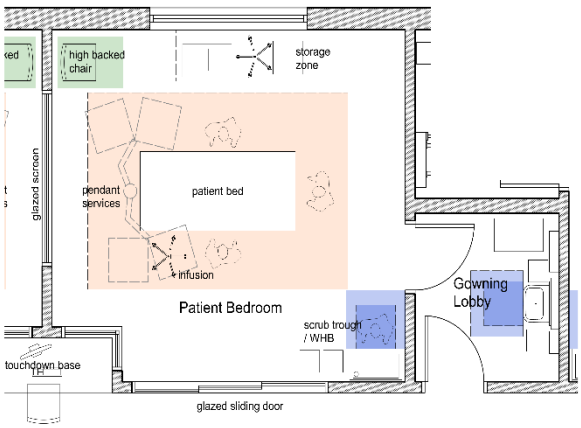


Figure 11 – Inpatient bed area with IPC gowning lobby



For the treatment provided it may be determined that it would be more appropriate to accommodate some patients on reclining chairs rather than in beds. Where this is the case, the room or bay should still be similar in standard to in-patient accommodation with the exception of the bed being replaced by a reclining chair. Facilities should include a shower and provide access to essential medical equipment. A gowning area is also required for staff and the facilities need to separate women from men.

Intermediate Infrastructure Needs – for EPCTs and ATs

This is based on the assumption EPT/AT are managed within a dedicated location within the Cancer Research Hub and have shared facilities with Haem-oncology.

Treatment Areas /Beds/Chairs

Access to 1-2 research beds in the critical care footprint for highest risk 1st in human cellular EPCTs and ATs. In the main ward areas there will need to space to accommodate

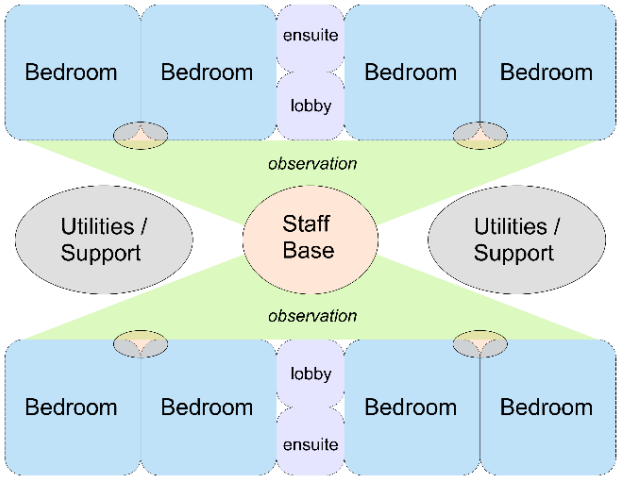
- 8 EPT/AT beds, 2 with en-suite facilities and at least 2 beds that can accommodate overnight stay;
- 8 chairs for early & late phase trial patients needing biopsies/investigations/bloods & linking with laboratory research (flexibility around this is required) Spacing between should be taken into account due to immunosuppression and COVID 19;

Mohamed.Sabry 05/13/2022 6:19:25 PM

- Consulting/examination space(s).

Flexible space within newly designed patient areas would be recommended to allow for growth.

Figure 12 - Flexible space arrangement for beds, couches or chairs



Flexible space also allows for areas to be reallocated based on need so that depending on the level of treatment an appropriate facility is provided that is future-proofed as therapies change and develop.

Toilets and waiting area space will be needed in the intermediate and long term as well as consulting/examination facility.

A treatment area consisting of a Drug cupboard, for emergency support medicines, Refrigerator, that is temperature controlled and monitored, and each chair/bed must have medical oxygen and suction outlets.

Emergency Facilities

Emergency equipment and trolley to allow transfer needs to be able to be stored in the facility, or as nearby as possible and an emergency arrest and resuscitation trolley, with portable medical oxygen and suction is required.

Patients need to be able to be monitored and there should be digital monitoring, height and weight equipment, intravenous pumps and stands, vital signs machines blood pressure, pulse oximetry and temperature measuring ability. Two scalp cooling machines. Two electrocardiogram (ECG) machines, with facilities to print out or transmit readouts to study sponsors. Blood glucose monitoring equipment.

Laboratory Area

Within the laboratory that supports the service there should be access to centrifuge machines for blood specimens (including refrigerated centrifuge). Holding refrigerated/frozen blood, urine or other specimens, prior to transfer to the sponsor's research study laboratory facilities

Storage space for laboratory kits supplied by the sponsor need to be considered. Minus 20°C freezer, temperature controlled and monitored. Minus 80°C freezer, temperature controlled and monitored. A Laboratory hood/laminar flow cabinet, Sink and separate clinical hand-washing facilities and medical sharps bins

Vaccines

Whilst this is a requirement for a dedicated area, it is envisaged that the clinic/consultation rooms will become part of this area within the facility in the intermediate and longer term.

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Treatment room

Appropriate air extraction to meet the relevant standards in managing the preparation of products that is designed for easy cleaning, with self-coved skirting, coved ceiling/wall and wall/wall. Have junctions and the minimum number of projecting ledges, shelves, cupboards and items of

equipment. Have a sealed ceiling in order to prevent potential contamination from the void above. Have piped oxygen and suction.

Within the room there must be a clinical wash-hand basin. Have a wipe clean standard three-section couch. Consultation area. Include desk space for clinical staff and chairs for the research participant and any attending family members. A curtained examination area. The curtain should be located to prevent contamination from the use of the clinical wash-hand basin.

Vaccine Preparation Room

Certain anti-cancer treatments and Advanced Therapy IMPs (e.g., cancer vaccines and genetically modified materials [GMM]) may need some preparation in a separate area prior to administration. The requirements of this area will depend on the type of product to be prepared, and the need to protect both the operator and the product. Includes a Class II microbiological safety cabinet that meets the relevant standards ducted with appropriate air extraction and has appropriate air extraction to meet the relevant standards in managing the preparation of products in the safety cabinet or on the bench top.

The preparation area should be designed for easy cleaning, with self-coved skirting, coved ceiling/wall and wall/wall. Has junctions and the minimum number of projecting ledges, shelves, cupboards and items of equipment. Have a sealed ceiling in order to prevent potential contamination from the void above. Incorporates an observation panel in the door/wall to the room but not have opening windows. The decontamination of facilities and equipment, or inactivation of waste vaccine/IMP should be by autoclave contamination or chemical disinfectant procedures.

Phlebotomy Facilities

There should be a reclining phlebotomy chair, Clinical hand-washing facilities with glove dispenser. Storage for sterile items, Sharps bins Work and storage space for clinical research study specific equipment supplied by the study sponsors to the Trust

Office space

Dedicated work-stations for the people responsible for staffing the unit Doctors, Nurses and Administrative which includes storage for research documentation. Meeting space will also be needed at this stage; a small meeting room for 6 people, room for external trial; monitors, IT requirements for communication needs.

Other patient and relative areas will include reception and waiting area with access to vending machines, toilet facilities for patients and staff and a kitchen facility.

5.7.2 Long Term Infrastructure Needs – Haematology and Solid Tumour

In the longer term there will need to be the uplift to 12 EPT beds, at least four with en-suite facilities and 4 spaces that support overnight stay.

The chairs will also need to increase to 12 for early and late phase trial patients needing biopsies/investigations/bloods and linking with laboratory research

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For Haem oncology patients the number will also need to increase as above. However, the service by this time will be fully integrated and flexibility within the environment will be essential to adapt to treatment changes.

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The access to 1-2 research beds in the critical care footprint for highest risk 1st in human EPTs and ATs is considered to remain the same.

Also at this stage:

- There should be consideration of the requirement for a research support office in the hub – facilitating new research development (grant writing, protocol development, ethical submissions etc) and running investigator-led studies which are not suitable (large enough) for CTR support.
- Facilities needed for translational research with university partners, education and training etc, this also needs to support staff development and opportunities for advanced nurse and nurse prescribing positions that not only support the research development but also the junior medical cover as and when required.
- Consideration of other Welsh research infrastructure to be co-located in the hub (e.g. WCRC, ECMC, WCB).

The uplift to staffing should be phased and will be trial dependant but will be supported through additional income along with Haematology generated income through external grants and commercial income in order to offset staff costs. The mix of staffing required to cover the hub overnight will be a key requirement at this stage.

Other infrastructure considerations for the Research Hub

The mixed model of funding will allow for further innovations and developments and will attract staff to get involved in cancer research. For further developments to take place space allocations for the future should include hot desk space for an agreed number of visiting staff (TBD) and a larger room for research meetings and teaching sessions along with some separate office spaces. Digital IT Whiteboards communications with facilities to go across Wales with tripartite communications, signage and new branding.

At this time consideration for a Hub Manager and Administrative support will need to be made and usual planning for staff facilities and support should be integral to the design. Office Space including agreed storage for research documentation and external trial monitors

5.7.3 Patients and visitors

Key considerations regarding patient and visitor access, parking, recreational and rehabilitation spaces have been considered and will form part of the design work for the changes to the infrastructure in the short, intermediate and longer term.

5.7.4 Statement of requirements

Changes to patients records, reporting, communication by cross site working

- To be explored and described at the follow up research and development meeting

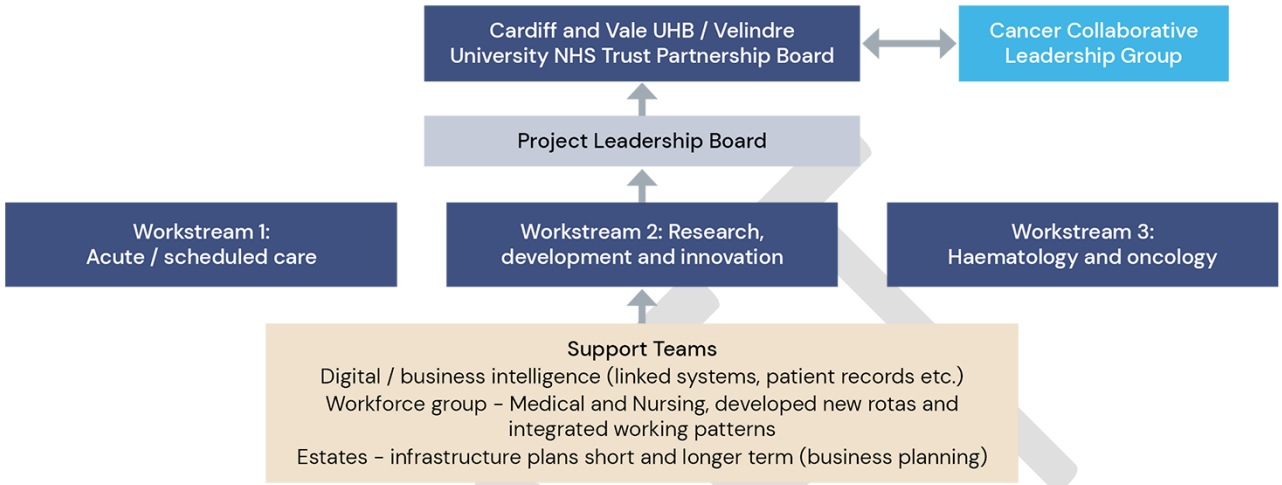
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6 Project management

The management of the project and reporting for implementation of this proposal are demonstrated below.

Figure 13 - Reporting structure for this programme



6.1.1 Project leadership

The project leadership is linked to the different phases for the proposal and described in the overarching project programme.

6.1.2 Governance and key reporting for the proposal

Governance arrangements for the proposal have been considered below along with preliminary agreements on how the project outputs will be monitored and assessed against an appraisal of benefits. These include reporting parameters for:

Quality Performance Indicator	Threshold	Method of measurement	How monitored / reported
Infection Control	National standards for IPC	Trust quality report	Trust quality and safety report
Improving Service Users and Carers Experience	National standards	Patient feedback	Patient engagement/ trust quality report
Reducing Inequalities	National standards	Data reporting	Trust quality report
Reducing Barriers to access	Equality and Diversity	Patient outcomes / Data reporting	Trust quality report
Improving Productivity	Trusts operational performance metrics	Data reporting, income and expenditure	Trust operational performance report
Access to treatment	Trusts operational performance metrics – access to cancer treatments	Trusts divisional operational report/ benchmarking	Trust quality and safety report

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Human Resources (HR) considerations will include MOU Contracts and JRO Governance arrangements including:

- Honorary contracts /Letter of access working to CRF and SOPS oversight by the CVUHB Head of Research delivery;
- Associated HR issues with any changes to contracts;
- Financial reimbursements (HCRW Value Based Funding) developed shared costing template.

6.1.3 Key milestones – project plan

A planned approach to implementation of the phased approach and Research and Education milestones (against increased activity expectations) along with assessment of risks for delivery of the project is included in **Appendix 5.**

6.1.4 Summary of existing strategic documents

- Copy of letter sent to SE Wales Chief Executives from Mr Simon Dean;
- Velindre University NHS Trust, Overarching Cancer Research and Development Ambitions (2021-31).

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7 Conclusion – next steps

In this report we have assessed the needs of cancer research within the health board and the wider opportunity for access to treatments for patients and what is needed to deliver the right level of access to research and trials for patients, that is both inclusive of and accessible to all and meets national standards

The proposal is fully aligned to the principles of improving cancer outcomes and care and seeks to provide a whole system approach that demonstrates integration of clinical services and academia, and has facilitated collaboration and consultation for teams to reach a consensus on the type of care provision required in the future.

The outputs of the proposal meet the aims of a tripartite Cardiff Cancer Research hub to:

- **Increase patient access to research,** including Early Phase and Advanced Therapies for solid cancer and haematological malignancies
- Enable scientists to bring new discoveries through to the clinic by **strengthening the translational pipeline**
- Develop a **focus for cancer research** excellence in Wales to enhance the collective reputation and attract future funding, partners and staff.

Building a baseline understanding of likely future activity and current and future requirements has informed the phased planning. In exploring the range of opportunities for research development has supported agreements for immediate, intermediate and future needs to deliver high quality care for patients safely, the infrastructure needed to be capable of delivering and optimised and accessible service and the likely staffing requirements and opportunities for development.

Central to this has been an extensive engagement programme to ensure the priorities being set for both immediate and longer-term research-based activities meet the teams understanding and requirements. Adopting new ways of integrated working has been central to the outcomes agreed within the proposal along with agreeing what premises or services are needed where. This will require careful planning and implementation and investment in resources that determine how the improvements will be demonstrated.

The ‘next steps’ for the proposal will be documented in an agreed project plan and timeline for development, that will be supported and managed by the project implementation team.

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University Health Board

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GIG Felindre
Velindre NHS Trust

Appendices



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Appendix 1 - Example of improved patient care with Velindre Early Phase Trial success

Without an Early Phase unit @Velindre patients would have had to travel outside Wales Having the Early Phase Unit @Velindre has saved over 16,000 hours of patient travel over the last 4 years (equivalent to almost 2 years of continuous travel)

In the last 3 years we have had 4 trials led by Cardiff based Chief Investigators. This status is recognised by pharma in attracting further research into Velindre.

Results of a Velindre-sponsored multi-centre early phase FAKTION trial led by Rob Jones as Chief Investigator and opened at 18 sites and VCC were a huge success. Orally presented at ASCO in Chicago, receiving significant media coverage including BBC 6 o'clock news. Data was published in the Lancet Oncology, and it became one of Lancet Oncology's highest impact papers of 2020. This put Velindre very much on the international stage and also resulted in significant patient benefit. Given the trial involved the most common cancer in the world (oestrogen positive breast cancer) it may lead to a future change in the standard of care for millions of patients around the world.

Although an Investigator led, this trial also generated significant commercial opportunities as the IP in the data was protected by the Trust as Sponsor. Pharma has already paid over £1m to licence it and is also funding expensive Next Generation Sequencing of DNA extracted from patient samples by internationally respected Foundation Medicine and Guardant Health to look for biomarkers. This biomarker data, and the yet unpublished overall survival data, may generate further high impact publications if the licenced data is used in an application for a marketing authorisation for the trial drug, significant further licence fees will become due.

Global leading recruiter to ARADES phase 1 clinical trial which has led to a Lancet Oncology publication. Welsh patients were some of the first in the world to gain benefit from the drug (ODM-201) which has since progressed through Phase 3 with the drug (darolutamide) is now FDA approved in Prostate cancer. Velindre patients were some of the first people in the World to access this drug. Leading UK recruiter on Olalparib/abiraterone trial, which was published in Lancet Oncology and formed part of data package leading to the FDA approval of Olaparib in the treatment of Prostate cancer. Additional 23 abstracts presented at high profile international meetings.

Significant contributor to the First-in-Human Phase 1/2 Study of Tisotumab Vedotin study (published in Lancet Oncology) which has progressed to a point where the data will be used in an FDA licensing application later this year

We have established a portfolio of early phase Drug RT combinations in tumour sites including Head and Neck, Brain and Oesophagus, with further studies extending to rectal, anal and lung cancer opening in 2021.

The future of advanced medical and cellular therapies might be applied to the delivery of combined RT to complement our current portfolio of Drug-RT combinations in partnership with Early Phase/ECMC.

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Appendix 2 - Immediate action plan

Ref	Actions	Lead and dates
1	VCC to agree with CVUHB using existing Clinical Research Facilities CVUHB for intermediate risk studies, requiring some modifications to existing facilities.	For confirmation following proposal agreement
2	VCC to agree with CVUHB using a refurbished critical care footprint for high risk early phase and advanced therapies (Solid Tumour and Haematological)	
3	Carry forward discussions on the cancer research Hub a hosted Clinical Design Workshop (via Teams) will explore the development of a UHW Research Hub and the 'Velindre@' concept for translational research, advanced therapies research and treatment, and early phase trials	
4	Scope out UK integrated EPT/ATMP workforce models to inform best workforce model approach and associated investment needed	
5	Scope patient numbers and flow, providing scoping report for a shared workforce model Haematological and Solid Cancer EPTs/ATMPs and associated infrastructure, with consideration to the emerging arrangements associated with Acute Oncology Services and translational research requirements	
6	Identify and scope other essential EPT support services and necessary requirements such as the provision of EPT pharmacy services including storage, reconstitution and delivery to CVUHB, Interventional radiology etc.	
7	Develop agreed Tripartite Governance, Leadership and Management structures, setting up a secretariat to set up joint strategic and operational groups for EPT and AT	
8	VCC to formally link with the ATW programme board in particular the ATW RD&I subgroup	
9	Secure academic medical/clinical oncologists, Clinical Research Fellows and out of hours Medical Cover (SHOs) – This Independent SHO level / clinical fellow level cover is needed 24/7.	
10	Prepare business cases to ensure infrastructure requirements to VUNHST Trust Board	
11	Review feasibility of the current CVUHB and CU Joint Research Office (JRO) in terms of joint governance for VCC's early phase trials, Advanced Therapies and translational research studies carried out by Velindre in collaboration with CU and/or CAV.	
12	Nursing Model …In the immediate, Velindre will provide some of the current skilled EPT nurses. They will work with CVUHB honorary contracts, complete CRF inductions and follow CRF standard operating procedures and CVUHB policies. Suggest operational oversight could include CVUHB's Head of Research Delivery and VUNHST's Trial Delivery Manager/EPT Team Lead Nurse.	
13	Velindre EPT nurses will work alongside the nursing team in CRF in the shared clinical management of solid tumour EPT patients. This will include following trial legislation requirements and protocol procedures, including communication and information sharing across the two sites, trial drug administration, patient monitoring, associated care and data collection. The VCC EPT team will manage screening recruitment and follow-up of patients.	

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Ref	Actions	Lead and dates
14	Seek HR advice on VCC workforce issues in relation to workforce models and job contracts related to out of hours working and working across institutions.	
15	Develop trial SOPs for trial emergency out of hours alongside Acute Oncology Service Will (hopefully) share many features with haematology-related emergency SOPs. Should make sure they are aligned as much as possible.	
16	Plan shared Operational management of shared training, induction and SOPs research documentation data and shared information systems	
17	Agree research associated financial reimbursement and tracking. VCC Financial Management support required	
18	Engagement with broader set of key stakeholder groups within their institutions seeking collaborative opportunities for shared care, translational research and partner investment. Explore other partner investment such as 3rd Sector, Industry HCRW etc.	
19	Communicate and promote this Cancer Research Hub EPT/AT initiative with SEW partners and SW England, strengthening patient engagement, information and optimising referral processes to increase research access for EPTs, ATs and translational research.	
20	Scope key partners /stakeholders for Cancer Research Hub and requirements /needs with key stakeholders (partners office space types and size)	
21	Consider joint branding and identity for Cancer Research Hub	

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Appendix 3 – Workforce plans

Table 1. Summary of Posts Needed Over 3 Time Periods

- New posts required during each time period are shown in brackets

Programmes and staff	Immediate 0-18mths	Intermediate 18mths - 5yrs	Long term 6yrs +
Clinical delivery EPTs/ ATMPs	**WTE**	**WTE**	**WTE**
NHS Consultants	1.2	1.6 (0.4)	1.6
Clinical Academics	2.1 (1)	4.1 (2)	4.1
Clinical Research Fellows	2 (1)	4 (2)	4
Nurses 8a	1 (1)	-	-
Nurse Band 7	-	1 (1)	1
Nurse Band 6	3 (1)	7 (4)	8 (1)
Nurse Band 5	1 (1)	3 (2)	4 (1)
Health Care Support Worker Band 3	1 (1)	2 (1)	3 (1)
Lab Technician/Sample Management Band 4	-	1 (1)	1
Research Admin/Data Manager Band 4	2 (2)	3 (1)	4 (1)
Senior Research Admin/Data Management Band 5	-	1 (1)	1
Pharmacy Technician Band 5	1 (1)	TBC	TBC
Pharmacist Band 8a	0.6 (0.6)	TBC	TBC
Translational Research			
Clinical Academics	-	2 (2)	2
Clinical Research Fellow		1 (1)	1
Hub Education			
Leadership Consultant Grade	-	0.5 (0.5)	0.5
Hub Manager Band 8a	-	1 (1)	1
Project Support Band 6	-	1 (1)	1
Hub Administration Band 4	-	1 (1)	1
R&D			
Facilitator Band 6	1 (1)	1	1
Management accountant Band 5	1 (1)	1	1
Contracts Manager Band 7	-	1 (1)	1
Business Partner	--		1 (1)

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Band 8a			
Total	**15.3 (11.6)**	**37.2 (22.9)**	**42.2 (5)**

For Noting:

- The above table combines posts for Haem-Onc (CAV) and Solid Tumour (VCC).

The Hub and associated posts will require a mixed model of funding. Business Cases for Academic posts – to be jointly developed by CU and NHS (VCC or CVUHB.) Other partners will include, Health and Care Research Wales, Wales Cancer Research Centre, ECMC Cardiff, ATTC Midland/Wales/Advanced Therapies Wales, 3rd Sector and Pharma. It is assumed such partnerships (and their associated investment), will deliver levels of ongoing sustainability and growth for this initiative.

Table 2. Capturing Uplift over 3 Time Points

(Fuller Details) Existing posts shown in black, new posts required in blue.

1. Immediate (0-18mths)

Level/Tier	WTE	Hours / Locations	Existing Capacity (Y/N)	Additional / Reduced Requirement
Medical Delivering EPT and ATMP Trials				
Current NHS Consultants Haem Onc	0.4	CVUHB Principal Investigators (PIs) will provide OOH advice for Clinical Research Facility (CRF	Y	
Current NHS Consultants Solid Tumour (0.4 WTE) + New (**0.4WTE**) incoming EPT Solid tumour Consultant Oncologist	0.8	VCC/CVUHB PI's will provide OOH advice for) CRF patients	Y	3 years funding secured for 0.4 WTE post (from VCC Charitable funds) - post will need to be continued past year 3
Current Clinical Academic/Consultant Haem Onc	0.8	CVUHB PI's will provide OOH advice for CRF patients	Y	WTE funded by CU (2x 0.4 WTE)
Current Clinical Academic/Consu	0.3	VCC	Y	0.3WTE funded by CU

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Level/Tier	WTE	Hours / Locations	Existing Capacity (Y/N)	Additional / Reduced Requirement
ltant Solid Tumour		PI's will provide OOH advice for CRF patients		
New Clinical Academic Solid Tumour/Translational	1	CVUHB PI's will provide OOH advice for CRF patients	N/Y	0.5 WTE funded by VCC for 12 months - matched funding opportunities need to be explored with CU for other 0.5 WTE post will need to continue past 12m
Clinical Research Fellow Haem Onc	1	CVUHB Based at CRF On call cover for CRF worked out on a trial-by-trial basis	Y	1 post dedicated to Haematology (jointly WCRC+CVUHB funded) - there are a pool of 2 others non-cancer Fellows who can cross cover in short term
New Clinical Research Fellow Solid Tumour	1	CVUHB/VCC Based mainly at CRF On call cover for CRF worked out on a trial-by-trial basis	N/Y	Velindre funded for 12 months this post will need to continue past 12mths
Nursing / ANP delivering EPTS+ATMPs				
New Senior Research Nurse 8a	1	Some out of hours will be required VCC/CVUHB	N	Velindre funded for **12 months only** to support implementation of collaborative working and harmonisation of processes (**post will not be continued beyond 12m**)
Research Nurse Band 6	2	Some out of hours will be required CVUHB	Y	The CRF (CVUHB) will provide 1WTE Velindre will provide 1WTE
New Research Nurse Band 6	1	Some out of hours will be required VCC/ CVUHB	N	This is **additional** requirement that will be required for out of hours working. Post will need to be continued.

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Level/Tier	WTE	Hours / Locations	Existing Capacity (Y/N)	Additional / Reduced Requirement
New Research Nurse Band 5	1	Some out of hours will be required VCC/CVUHB	N	This is **additional** requirement will allow release of a Band 6 from VCC for out of hours working Post will need to be continued.
Allied Health				
Pharmacy Technician Band 5	1	9-5pm generally	N	To support the pharmacy requirements in terms of Trial Feasibility Setting up trials Ongoing Management of trial portfolio Closure of studies Storage Research and Data Management related to trials Management of trial interventional drug This post will be required to continue
Pharmacist Band 8a	1	9-5 pm generally	N	To oversee all aspects of pharmacy requirements Trial Feasibility Setting up trials Ongoing Management of trial portfolio Closure of studies Storage Research and Data Management related to trials Management of trial interventional drug Interactions with Sponsor /Pharma This post will be required to continue
Other				
New Health Care Support Worker Band 3	1	Some out of hours working required	N	Additional to support the clinical staff including patient monitoring

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Level/Tier	WTE	Hours / Locations	Existing Capacity (Y/N)	Additional / Reduced Requirement
		CVUHB		sample management venepuncture etc. Post will need to be continued.
New Trials/Data Manager Coordinator Band 4	2	9am-5pm CVUHB &VCC	N	Additional 1 WTE to support trial set up, coordination of tests, managing data Second post (1WTE) to come in after 12 months following review & assessment of need. These posts to continue
R&D Business				
New Management Accountant Band 5	1	9am -5pm Joint Research Office (JRO)	N	Manages accounts for R&D (income & expenditure, reporting, negotiate costs with research sponsors and prepare annual R&D budgets. Post will need to be continued.
New Research Governance Facilitator Band 6	1	9am-5pm (JRO)	N	Support to set-up and deliver both commercial and non-commercial research providing complex study oversight. Supports PI's and delivery teams from trial conception to trial completion Post will need to be continued.

Intermediate 18 mths to 5 years

Level/Tier	WTE	Hours / Locations	Existing Capacity (Y/N)	Additional / Reduced Requirement
Medical delivering EPTS & ATMPS				
Current NHS Consultants Haem-Onc	0.4	9am -5 pm 5 days a week CVUHB PI's will provide OOH advice as necessary	Y	
New NHS Consultants Haem Onc	0.4	CVUHB PI's will provide OOH advice as necessary	N	Increase pool of NHS consultants with Haem Onc EPT sessional commitment within their job plans

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Level/Tier	WTE	Hours / Locations	Existing Capacity (Y/N)	Additional / Reduced Requirement
Current NHS Consultants Solid Tumour	0.8	9am -5 pm 5 days a week VCC/CVUHB PI's will provide OOH advice as necessary	Y	Incorporates the additional 0.4 WTE consultant oncologist (originally funded for 3 years) @ yr 4- add into this
Current Clinical Academic /Consultant Haem-Onc	0.8	9am -5 pm 5 days a week CVUHB PI's will provide OOH advice as necessary	Y	CU funded
New Clinical Academic/Consultant Haem Onc	1	9am -5 pm 5 days a week CVUHB PI's will provide OOH advice as necessary	N	Additional development of EPT portfolio Likely to be x2 0.5 WTE Post will need to be continued.
Current Clinical Academic/Consultant Solid Tumour	0.3	9am -5pm VCC/CVUHB PI's will provide OOH advice as necessary	Y	CU funded Post will need to be continued.
New Clinical Academic Solid Tumour	1	9am -5 pm 5 days a week CVUHB/VCC PI's will provide OOH advice as necessary	N	Additional development of EPT portfolio Likely to be x 2 0.5 WTE Post will need to be continued.
New Clinical Academic - ATMP Clinical Leadership	1	9am -5pm 5 days a week CVUHB PI's will provide OOH advice as necessary	N	Additional leadership needed for ATMP trials working across Haem Onc & Solid tumour Post will need to be continued.
Current Clinical Research Fellows	2	9am -5pm 5 days a week CVUHB/VCC	Y	Existing, presumed continued from 0-18mths

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Level/Tier	WTE	Hours / Locations	Existing Capacity (Y/N)	Additional / Reduced Requirement
Haem Onc &Solid tumour		On call cover TBC		
New Clinical Research Fellows cross covering Haem-Onc & Solid Tumour	2	9am-5pm 5 days a week CVUHB On call cover TBC	N	Additional posts working in the Hub managing patients and conducting own translational research (MDs etc.) Post will need to be continued.
Out of Hours Cover	Will be provided by Acute Oncology Service (Velindre & CVUHB) on UHW site	Out of hours working CVUHB	N	Depends on AOS/unscheduled care work plan.
Nursing /ANP delivering EPTS & ATMPs				
New Clinical Lead Nurse Band 7	1	Some out of hours working will be required CVUHB	N	Provides nursing leadership &Management for the clinical area. Post will need to be continued.
Current Research Nurses Band 6	4	Some out of hours working will be required CVUHB	Y	**2 WTE posts need to be funded from 5yrs** Cover out of hours shift working covers 8 bed and 8 chairs
New Research Nurses Band 6	3	Some out of hours working will be required CVUHB	N	Cover out of hours shift working covers 8 bed and 8 chairs Post will need to be continued.
Current Research Nurse Band 5	1	Some out of hours working will be required CVUHB/VCC	Y	**Funding to be found after 5yrs** Cover out of hours shift working covers 8 bed and 8 chairs.
New Research Nurses Band 5	2	Some out of hours working will be required CVUHB	N	Additional Band 5 developmental roles Cover out of hours shift working covers 8 bed and 8 chairs. Post will need to be continued.

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Level/Tier	WTE	Hours / Locations	Existing Capacity (Y/N)	Additional / Reduced Requirement
New Lab Technician /Health Care Support Worker Band 4	1	Some out of hours working will be required CVUHB	N	Additional Oversight of Management of all sample management covering Clinical trials and translational research Post will need to be continued.
Health Care Support Worker Band 3	1	Some out of hours working will be required CVUHB	Y	Funding to be found after 5yrs. Supports the EPT&ATMP Clinical Team and research sample management.
New Health Care Support Worker Band 3	1	Some out of hours working will be required CVUHB	N	Supports the EPT ATMP Clinical Team and research sample management Post will need to be continued.
Allied Health				
Pharmacist Support	TBC	TBC	TBC	
Other				
Trial/Data Management Administrator Band 4	2	9am -5pm CVUHB	Y	Funding to be found after 5 yrs.
New Senior New Trials/Data Manager Band 5	1	9am-5pm CVUHB	N	Additional oversight all of trial coordination and data Management. Ensures collection of performance metrics data metrics.
New Trial /Data Management Administrators Band 4	1	9am-5pm CVUHB	N	Additional support for trial setup coordination of trials and data management.
Translational Research				
New Clinical Academics (developing Translational Research with CU)	2	9am-5pm	N	Driving and developing translational research in partnership with CU.

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Level/Tier	WTE	Hours / Locations	Existing Capacity (Y/N)	Additional / Reduced Requirement
Education and Building Critical Mass				
New Consultant Clinical Leadership for Hub	0.5	9am-5pm	N	Oversight and sets strategic direction of Hub and its research.
New Hub Manager Band 8a	1	9am-5pm CVUHB	N	Oversight of the operational running of the Hub including managements of commercial and strategic partnerships to build in Hub sustainability and growth.
New Cardiff Cancer Research Hub Project Support Band 6	1	9am-5pm CVUHB	N	Supports the hub in terms of business cases, grant application performance metrics annual reports and PPI and E. Post will need to be continued.
New Cardiff Cancer Research Administrative Assistant Band 4	1	9am-5pm CVUHB	N	Additional day to day running of Hub meeting rooms, facilities stock ordering management of training/engagement events Supports operational working and administrative functions Post will need to be continued.
R &D Governance/Business				
Current R&D Facilitator – Band 6	2 WTE	9am -5pm Joint Research Office (JRO)	y	Funding to be found after 5yrs.
Current R&D Management Accountant Band 5	1 WTE	9am - 5pm JRO	Y	Funding to be found after 5yrs.
New R&D Contracts Officer Band 7	1 WTE	9am-5pm JRO	N	Contract management supporting the development, implementation and delivery of the JRO sponsor research contracts service. Post will need to be continued.

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Later, 6+ Years+

All of these posts will be *additional to posts* identified for 18mths to 5 years

Clinical Delivery of ATMP/EPT				
New Research Nurse Band 6	2	Some out of hours working will be required CVUHB	N	Cover out of hours shift working covers 12 beds and 12 chairs.
New Research Nurse Band 5	1	Some out of hours working will be required CVUHB	N	Cover out of hours shift working covers 12 beds and 12 chairs.
New Health Care Support worker Band 3	1	Some out of hours working will be required CVUHB	N	Cover out of hours shift working covers 12 beds and 12 chairs.
New Trials Coordination /Data Manager Band 4	1	9am -5pm CVUHB	N	Additional support for trial setup coordination of trials and data management.
Allied Health				
Pharmacy Support	TBC	TBC	TBC	
R&D Business				
New R&D Finance Business Partner Band 8a		9am -5pm JRO	N	Oversight of financial probity of the R&D Budget, delivering robust financial management process for R&D, including complex financial statutory reports to the JRO and other funders.

For Noting:

- Medical workforce model meeting held 25/8/21.
- Research Support workforce meetings held 4/8/21, 13/9/21 and 7/10/21.
- Discussions excluded Pharmacy to be assessed by ARCHUS.
- Given early discussions it is highly likely that the Cardiff Cancer Research Hub will be supported and governed within the Joint Research Office based on UHW site, therefore have included R&D Governance posts that will naturally sit within the JRO to demonstrate the uplift in capacity here. Therefore, additional uplift for R&D at Velindre to join JRO for Hub activities calculated by Townsend (HOR, VUNHST.)
- Given the nature of research which is fast changing, including, the emerging trial compounds and associated complex protocols/delivery methods/regimes, recommendations from work force model groups are to keep workforce capacity and capabilities requirements *under regular review*.
- Within cancer clinical research there are a number of departments that provide varying levels of support. Each Clinical research protocol determines the types of department and

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areas of support needed it is impossible to assess capacity need, but engagement should occur. Departments include: Pathology, Haematology/ Biochemistry Genetic Labs/Medical Physics/Radiology Nuclear Medicine /Medical Records/ Apheresis Unit /Bone Marrow/ Transplantation Surgery /Cardiology /Audiology /Ophthalmology/ Infection Control /Radiation Protection Respiratory Lung Function/Decontamination Services.

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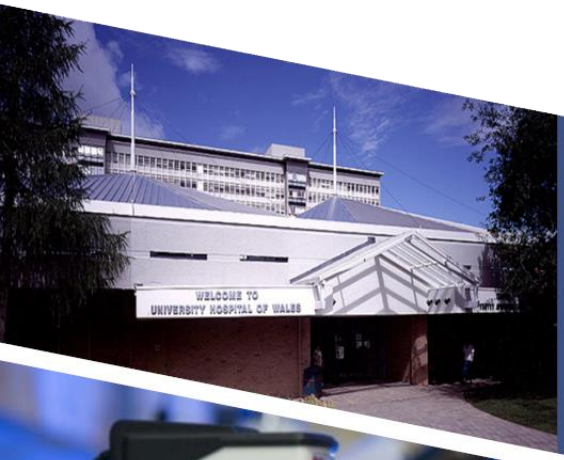
Appendix 4 – Project plan and risk register (next steps for completion by operational leads following approval)

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Cardiff and Vale
University Health Board

Ymddiriedolaeth
GIG Felindre
Velindre NHS Trust







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South East Wales
Acute Oncology Service
Business Case

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FOREWORD

The South East Wales Collaborative Cancer Leadership Group (CCLG) was established with a specific aim of providing effective system leadership for Cancer Services across South East Wales and delivering improvements in outcome and service experience for the catchment population. This is to be achieved through the building and nurturing of a sustainable, collaborative cancer community across the region.

It is recognised that, in order to achieve a transformation in outcomes and experience for patients with cancer in South East Wales, it is essential to have a coordinated and aligned approach to change across the whole cancer system. This will require leadership to address systemic barriers and challenges to improvement for Cancer Services across South East Wales. It will require the coordination of commissioning decisions and investments and facilitate the realignment of pathway resources within and between organisations.

It also requires a change in the behaviours of individuals, individual services and organisational decision makers and that attention be given to the dimensions of change including education, training, language and behaviours, research, digital and improvement science. It requires the development and deepening of trusting relationships and new ways of working. It will, importantly, require the application of the dimensions of change in a focused and coordinated manner. The Group will, therefore, be responsible for leading the required whole system changes at a regional level.

At its meeting on 8 January 2020, amongst other priorities, CCLG specifically requested that work be undertaken in developing a collaborative Acute Oncology Service (AOS) model reflecting a regional solution to be developed by the AOS Project Group along with a delivery plan (including timeline) for submission to the CCLG in September 2020. Coordinated by the AOS Multi Professional Steering Group work was undertaken over the Spring and Summer of 2020. Working with a broad range of healthcare professionals across the region and patients and carers, a model for AOS was developed, reflecting the needs across the entire patient pathway.

This was subsequently was presented to CCLG at its October 2020 meeting and garnered strong support from all members. Following this CCLG requested that partner organisations develop a single, regional business case along similar principles to the clinical model, evaluating alternative approaches to implementing the model across South East Wales, along with an assessment of the likely investment requirements and implementation timetable.

This document presents the results of the collaborative work undertaken in developing the business case and follows established investment appraisal guidance embedded within the 5 Case Model. It has been developed with extensive involvement of all organisations across South East Wales and is presented as a single, regional business case.

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EXECUTIVE SUMMARY

BACKGROUND

This single, regional business case is presented on behalf of Aneurin Bevan University Health Board, Cardiff and Vale University Health Board, Cwm Taf Morgannwg University Health Board and Velindre University NHS Trust. Its purpose is to present a clear set of proposals and investment requirements to enhance Acute Oncology Services (AOS) across South East Wales. In doing so it seeks to present the compelling case for change, a robust options appraisal to assess alternative approaches to implementation, and a set of financial proposals to provide organisations with an estimated level of additional investment required to secure the proposed improvements across the anticipated 3 year timeframe to fully roll out of the clinical model. All of this has been underpinned by an extensive stakeholder engagement exercise combining organisational and professional representation.

Acute Oncology (AO) patients broadly fall into three groups: those whom a first presentation of cancer is suspected in an emergency setting; those with a known cancer who present as an emergency with complications of their treatment; and those with a known cancer who present as an emergency with cancer progression or acute complications of co-morbidities.

AO ensures that cancer patients receive the care they need quickly and in the most appropriate setting. It brings a multitude of benefits to patients, clinicians and the wider system through improved communication, timely access to expert advice, improved patient experience and cost savings through more appropriate use of investigations, early discharge and admission avoidance.[1]

Management of AO challenges the whole health and care system across South East Wales, from primary and community care to tertiary specialist service. However, the scope of this business case is the presentation, triage, assessment and management of patients in an acute setting.

CASE FOR CHANGE

In South East Wales, it is estimated that, AOS patients account for 10,000 admissions per year, many of whom have long lengths of stay (average of 9.4 days), which consumes a total of 93,535 bed days. This has a significant impact on an unscheduled care system that is already under pressure.

Further evidence of the scale and impact of AO is set out below:

- 22% of cancer diagnoses present for the first time in the unscheduled care system;

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[1] *Acute oncology: Increasing engagement and visibility in acute care settings*. Royal College of Physicians. Oct 2020

- 80% of cancer patients presenting to emergency departments are admitted (compared to 25% of non-cancer patients);
- 20% mortality rate within 30 days of referral to AO and 70% mortality rate within 12 months of referral;
- 60% of Metastatic Malignancy of Undefined Primary Origin / Confirmed Carcinoma of Unknown Primary (MUO/CUP) patients are discussed at multiple multi-disciplinary team (MDT) meetings, 40% do not have any MDT discussion, and only 30% receive any oncology treatment;
- 60% of patients on combination immunotherapy treatment have severe autoimmune reactions;
- 80% mortality rate within 12 months following a diagnosis of Metastatic Spinal Cord Compression (MSCC).

The National Standards for AOS[2] (2016) were developed to provide a framework for NHS Wales to plan and deliver high quality services for people with cancer (either know or yet to be diagnosed) who present acutely. These standards covered four areas including: the AOS team; rapid assessment for acutely presenting patients; AOS team review of patient management; and information. A Peer Review (2018) of these standards highlighted a range of gaps in the service, including insufficient nursing and oncology presence in Health Boards across the region. This continues to be the case, making the current AOS in Wales an outlier in comparison to other AOS services in the UK: with limited specialist nursing, the service is potentially unsustainable in terms of clinical governance requirements for nurses to work independently; and the variable and inconsistent oncology advice mean there is little support to manage the more complex patients. The much needed investment in AOS would deliver a service broadly comparable to that provided by other centres (such as The Christie NHS Foundation Trust, The Clatterbridge Cancer Centre, as well as smaller sites like North Devon District Hospital) which currently have significantly more nurses per site, sessions for oncology and acute medicine, and run immunotherapy and MUO/CUP services.

A number of strategic drivers reinforce the need to improve and enhance AOS across South East Wales including: Peer Review (2018) noted above; the Quality Statement for Cancer (2021) has a specific requirement under the Safety theme to ensure that fully integrated Acute Oncology Services are available in all acute hospitals; and the Nuffield Trust review (2020) of planned changes to non-surgical tertiary cancer services across South East Wales noted the limited investment in AOS in South Wales, particularly compared to the rest of the UK, as well as the paucity of accurate data and made several recommendations on acute oncology support in Health Boards.

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[2] *National Standards for Acute Oncology*. Cancer National Specialist Advisory Group. June 2016

PROPOSAL

A regional clinical model has been developed which places stronger emphasis on the specific needs of AOS patients, whilst complementing local wider unscheduled care management with a primary focus on ambulatory pathways as an alternative to inpatient admission.

Enhanced nursing will help manage initial presentations, support ambulatory pathways and act as the key worker throughout acute oncology pathway; specialist oncology advice on the ground at Health Boards will provide face to face clinical reviews, as well as education and training for the wider team. Supported by a dedicated virtual advice service, this will allow consistent and timely opinion no matter where patients are admitted. Further specialist support and local enhancements to ambulatory pathways, will mean the most vulnerable cancer patients are appropriately supported and cared for, with acute hospital admission only where absolutely necessary.

To deliver the proposed clinical model across South East Wales there is a need to invest in the service so that the current gaps can be addressed and the anticipated benefits realised. An option appraisal has been undertaken to evaluate alternative approaches to implementing the model across South East Wales along with an assessment of the likely investment requirements and associated benefits.

The fully implemented preferred option for delivering the required improvements to AOS across the region, requires additional annual investment, across the three Health Boards in the region of £2.55m. It is anticipated that it will take three to four years to fully implement the proposals, with a phased build-up of resources and investment.

EXPECTED BENEFITS

There are significant service quality and safety benefits for patients who have access to a structured AOS in terms of their experience and outcomes. AOS ensures continuity and consistency of care where they would otherwise experience significant delays in diagnosis and treatment. Offering specialist oncology support outside the cancer centre, enable patients to access treatment at a location convenient to them.

To help quantify the benefits, empirical evidence from other centres and systems across the UK who have successfully implemented an AOS model that reflect the proposed approach in South East Wales has been used. Benchmarking with these centres demonstrates significant opportunities for admission avoidance (in the range of 40-60%) and length of stay (3–4 days). [3]

The existing AOS service has already achieved some reductions in length of stay but additional investment will support admission avoidance through staff availability (for rapid assessment of patients), oncology advice, and hot clinics, as well as some further reductions in length of stay.

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[3] *Acute oncology: Increasing engagement and visibility in acute care settings*. Royal College of Physicians. Oct 2020

Therefore, the quantifiable benefits that have been applied are 25% admission avoidance and 10% reduction in length of stay. These have been clinically endorsed and applied to the baseline position in each Health Board to assess the potential improvement and the impact it could have in freeing up acute capacity.

Whilst these benefits are unlikely to be cash releasing, the analysis shown that the scale of this opportunity is in the order 30,000 bed days, or the equivalent of almost 90 freed up beds across the region, with a value of £4.5m, which if released could be used to support the needs of other service areas within acute hospital settings.

RISKS

There are significant challenges around the implementation of a regional clinical model, across different Health Boards and multiple sites within those Health Boards. The AOS remains a regional service within which there is an aspiration to secure equity of access for patients to a common service standard wherever they live and therefore a requirement to secure full implementation. However, it is recognised that Health Boards have different baseline positions in terms of current service and acute configuration, and all face challenging funding constraints which limit the ability to support service developments including AOS. Allied to this, as a largely people based service, there will be challenges in staff recruitment and deployment. To address these factors organisational specific implementation plans and associated resourcing profiles have been developed and aligned to meet each Health Boards' needs, priorities and constraints.

CONCLUSION

The development of this business case and the work that sits behind is the result of a multi-organisational, multi-professional collaboration across South East Wales, underpinned by strong clinical leadership and considerable stakeholder engagement. This degree of collaboration is reflected in the governance structure to support the implementation and delivery of the service, and will ensure the founding principles of equity of access and shared ownership remain central to the service.

Investment in AOS at this crucial time for the NHS would have a huge impact both for those patients presenting acutely with a known or as yet undiagnosed cancer, and the Health Boards receiving them.

> *"The impact upon the patient journey and quality of life is notable; particularly where progressive symptomatic needs are able to be met rapidly whilst keeping the patient in their preferred place of care beside their families."*
> *Isle of Man AOS*[4]

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[4] *Acute oncology: Increasing engagement and visibility in acute care settings*. Royal College of Physicians. Oct 2020

INTRODUCTION

1 Introduction and Background

The purpose of this business case is to set out proposals for enhancing Acute Oncology Services (AOS) across South East Wales. Initially outlining the limitations of the existing service, it will present a clear and compelling case for change and go on to demonstrate how the proposed clinical model and preferred option for implementing this will address the identified gaps in service and deliver the required improvements and benefits. It will set out the process by which the preferred option has been selected along with the level of investment required to deliver the proposed improvements over the implementation period. Finally it will establish the organisational and delivery arrangements required to successfully implement the proposed service improvements.

The options appraisal has been developed with input from a wide range of organisational and professional stakeholders and has been facilitated by an external, independent consultant. The preferred option being put forward to the South East Wales Collaborative Cancer Leadership Group (CCLG) and Health Boards (HBs) for consideration is the result of 12 months of collaborative work with consensus being reached across multiple disciplines and multiple organisations in South East Wales.

This business case is presented as a single case for the region and once endorsed by CCLG, will go through each stakeholder organisation's governance processes to secure local approval.

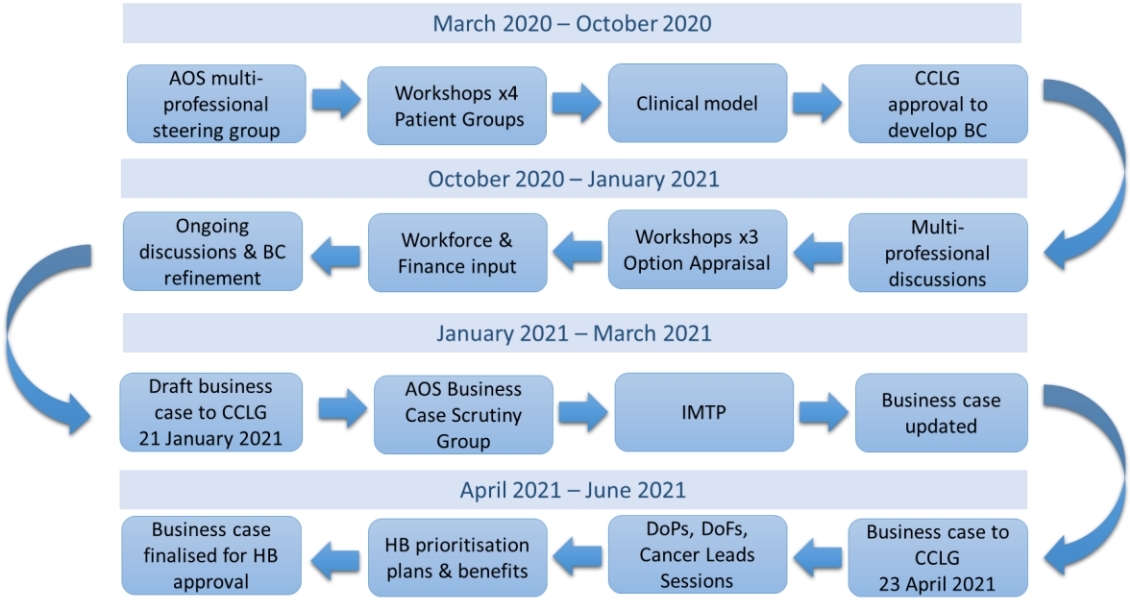
In developing this case it is recognised that stakeholder organisations have different starting points in terms of current baseline AOS and this will impact on the rate and sequence of implementation. However, the clinical model is premised on the dual principles of equity of access, and shared ownership and delivery. These will ensure each organisation delivers a broadly similar clinical model so that patients can expect consistency in their management and available resource irrespective of presenting location.

Management of acute oncology challenges the whole health and care system across South East Wales, from primary and community care to tertiary specialist beds. However, the scope of this business case is the presentation, triage, assessment and management of patients in an acute setting as this is a complex group of patients who would benefit significantly from improved access to acute care, with a focus on ambulatory pathways.

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Commencing in the spring of 2020 a significant amount of collaborative work has taken place to develop the clinical model and translate that into a set of implementation proposals presented within this business case. The figure below is an overview of the wider reaching engagement activities that have taken place and further details of these activities is provided in Appendix A.

Figure 1: Overview of project engagement



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STRATEGIC CASE

2 Introduction

The purpose of the Strategic Case is to make the case for change and to demonstrate how it provides strategic fit across the stakeholder organisations within South East Wales. Making a robust case for change requires a clear understanding of the rationale, drivers and objectives for the proposal and the associated investment by presenting a clear understanding of the existing arrangements: the Business As Usual (BAU), business needs (related problems and opportunities), potential scope (the required service coverage) and the potential benefits, risks, constraints and dependencies associated with the proposal.

2.1 Strategic Context

2.1.1 Cancer Services in South East Wales

The planning and delivery of cancer services in South East Wales is the responsibility of the three Health Boards (HBs) as part of their statutory role in addressing the health needs of the populations they serve. The three HBs in South East Wales are:

- Aneurin Bevan University Health Board (ABUHB)
- Cardiff and Vale University Health Board (CAVUHB)
- Cwm Taf Morgannwg University Health Board (CTMUHB)

A fourth HB, Powys Teaching Health Board does not formally sit within South East Wales but some of its patient population does come into ABUHB and CTM's service provision. In addition, Velindre University NHS Trust (VUNHST) provides non-surgical specialist cancer services to the region through the Velindre Cancer Centre (VCC). A map of organisation across South East Wales is provided below.

Figure 2: Map of South East Wales Health Boards and Velindre University NHS Trust



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A significant proportion of patients have all of their cancer care delivered within the HBs. This is supported by VCC through the delivery of a range of outreach services including: Systemic Anti-Cancer Therapies (SACT); outpatient consultations; and Multi-Disciplinary Teams (MDTs. To further the availability and accessibility of radiotherapy services for patients across South East Wales, an Outline Business Case (OBC) for a Radiotherapy Satellite Centre based at Nevil Hall Hospital (ABUHB) has been developed and approved.

The HBs and VUNHST are supported by the Welsh Health Specialist Services Committee (WHSSC) which commissions specialist cancer services on their behalf. They also work in partnership with the All Wales Cancer Network (WCN), Public Health Wales (PHW), NHS Trusts, Community Health Councils (CHC), and voluntary and charitable organisations. More recently, the four HBs, in conjunction with VUNHST and WCN, have formed the South East Wales CCLG. The purpose of the CCLG is to provide effective system leadership for Cancer Services across South East Wales and deliver improvements in patient outcomes experience for the catchment population.

2.1.2 Acute Oncology Service in South East Wales

Acute oncology (AO) ensures that cancer patients who develop an acute cancer-related or cancer treatment related problem receive the care they need quickly and in the most appropriate setting. It brings a multitude of benefits to patients, clinicians and the wider system through improved communication, timely access to expert advice, improved patient experience and cost savings through more appropriate use of investigations, early discharge and admission avoidance.[5]

The core principles underpinning AOS have been defined as to 'promote education, awareness and early access to specialist oncology input, as well as a more integrated way or working between oncology and acute specialities within hospital trusts'.[6]

In Wales, the AOS has been in development since 2013 and aims to bring together multi-disciplinary clinical expertise to facilitate the rapid identification and appropriate prompt management of patients that present acutely. People living with cancer may need acute or emergency hospital care for a variety of reasons but an admission to acute care often heralds a change in disease trajectory and often leads to uncertainty about the future.

AOS patients broadly fall into three groups as set out below:

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[5] *Acute oncology: Increasing engagement and visibility in acute care settings*. Royal College of Physicians. Oct 2020

[6] Jones, P, Marshall E, Young A. *Acute Oncology: Sharing Good Practice*. Macmillan, 2014

- Type 1: Acutely presenting - patients in whom a first presentation of cancer is suspected in emergency setting, including Metastatic Malignancy of Undefined primary Origin (MUO) and Confirmed Carcinoma of Unknown Primary (CUP) patients.
- Type 2: Complications of treatment – patients with known cancer (including haematological malignancies) who present as an emergency with complications of systemic anti-cancer therapy (SACT) or radiotherapy treatment, and increasingly with immune toxicity.
- Type 3: Patients with known cancer who present as an emergency with acute complications of disease and/or associated co morbidities

These patient groups are very vulnerable and often have poor outcomes either due to a delay in diagnosis and referral, multiple or sometimes unnecessary tests and interventions, and a lack of early specialist input.

Many patients will initially attend the hospital Emergency Department and Acute Surgical Unit. At the front end of emergency care pathway is normally the Medical Assessment Unit (MAU) but providing efficient and effective care to this complex patient group in a busy MAU presents a key challenge. A good working partnership between the MAU and AOS that enables rapid assessment of patients can result in significant improvement in patient care often resulting in avoided inpatient admission and re-admission.

The AOS pathway within the scope of this business case covers the patient journey from acute presentation, diagnosis, treatment through to discharge. However, there are integral elements that can, and do support patients beyond acute care including: pre-hospital triage; primary and community care that helps keep patients at home; and the optimal arrangements for the provision of specialist inpatient beds. These will be considered outside this business case.

2.2 Case for Change

2.2.1 Existing Arrangements

The current service model in South East Wales is variable both between each HB, and between sites within HBs, and collectively it has limited clinical support locally and from VUNHST.
In most HBs, the AOS service is nurse-led by Clinical Nurse Specialists (CNS), normally at a level of one nurse per acute hospital, who are on-site Monday to Friday.

The CNS supports patients and their carers through complex pathways and protocols, acting as the patient advocate. They are responsible for liaising with their local medical teams as well as linking into the on-call team in Velindre Cancer Centre (VCC) via telephone and email, and providing local AO education to other healthcare professionals. Working independently to agreed protocols they can:

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- Recognise, manage and educate in broad range of oncology emergencies;

- Recognise and advise in management of suspected new diagnosis of cancer;
- Support clinical teams in decision making in malignancy unknown origin.

CNSs are supported by clinical colleagues in acute medicine, haematology and oncology. However, as there are only six allocated consultant sessions for AO across South East Wales (which are unevenly distributed), this allow very little clinical time to support the AOS team and patients.

The table below sets out the resource and associated funding for the current service in HBs.

Figure 3: Health Board AOS resources and funding

Health Board	AOS Teams (WTE)	Annual Cost
Aneurin Bevan UHB	4.10	£205,350
Cardiff & Vale UHB	4.50	£232,571
Cwm Taf Morgannwg UHB	4.70	£264,804
TOTAL LHBs	**13.30**	**£702,725**

The VCC AO teams funded remit is to provide acute inpatient care and support the oncology Assessment Unit within VCC. It runs a virtual daily multi-disciplinary team (MDT) with input from consultant oncologists, consultant radiologists, palliative care and oncology nursing to discuss these patients.

The on call doctor is available to HBs for advice but they can often be difficult to get hold of and advice can be variable, depending on their knowledge of AO, as they primarily deal with VCC patients. The table below sets out the current VCC resource and funding.

Figure 4: VCC resources and funding

Service	WTE	Annual Cost
Acute Oncology Assessment Unit & Acute Oncology MDT	8.05	£530,748
SACT Patient Support Phone Service	3.00	£77,812
TOTAL Velindre Cancer Centre	**11.1**	**£608,560**

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In Wales, patients with cancer, particularly in the last months of life, frequently present acutely to emergency services on multiple occasions. Of those that die within 60 days of attending an

Emergency Department (ED), cancer is the most common diagnosis. In many instances these patients are admitted into inpatient beds and can frequently spend more than a month in hospital. Unfortunately a proportion of these patients subsequently die in the acute hospital setting. In developing this business case a range of indicators have been established, drawn from a variety of local and national sources, which demonstrate some of the challenges in managing acute oncology presentations, their impact on resources and key outcome measures. This is summarised in the table below.

Figure 5: Cancer presentations, admissions and mortality

Indicator	Findings
Emergency Department (ED) attendances with a cancer diagnosis[7]	5%
ED admissions with a cancer diagnosis[8]	25%
Cancer patients presenting to ED who are admitted **Non-cancer patients presenting to ED who are admitted 25%*	80%
Patient mortality within 30 days of referral to AO	Approx. 20%
Patient mortality within 12 months of referral to AO	Approx. 70%
Cancer diagnoses that present for the first time in the unscheduled care system	22%
Acute hospital beds are occupied by acute cancer patients[9]	10%
Emergency ambulance calls being made on behalf of people with cancer	10%
Mortality due to cancer in frequent attendance to ED	28%

In South East Wales, data collected shows the breakdown of referrals to AOS which is summarised in the table below. Although the numbers are relatively small and the data is historic, the impact on acute hospital resources can be significant. By far the biggest proportion across all organisations is 'other' which demonstrates the ongoing difficulties in coding and reliably collecting meaningful AOS data. This inevitably means that activity is not being accurately recorded and actual numbers of presentations are under stated. The manual collection of this data, as well as the duplication to enter it into different formats and systems puts an administrative burden on nursing staff.

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7 North Mersey Macmillan Project: *Urgent Care and Cancer & Cancer Care of the Elderly*, 2019

8 *Sharing good practice Acute oncology*, Macmillan Cancer Care, 2014

9 Mansour D, Simcock R, Gilbert D C, Acute oncology service: assessing the need and its implications, *Clinical Oncology*, 2011

Figure 6: Referrals to AOS January to December 2017

Diagnosis / Pathway	ABUHB	CVUHB	CTMUHB*	VCC
Malignancy of Unknown Origin (MUO) / Carcinoma of Unknown Primary (CUP)	66	100	31	31
Neutropenic sepsis	57	24	31	54
Metastatic Spinal Cord Compression (MSCC)	49	57	45	123
Other (no pathway)	1,518	1,660	611	816
Total	**1,690**	**1,841**	**718**	**1,024**

**Data pre-boundary change (does not include Princess of Wales Hospital, Bridgend)*

Many cancer patients are admitted as an emergency across the region and currently have an average length of stay of 9.4 days in hospital. This is often unnecessary, and for many cancer patients, home is the preferred place of care, especially when there is a poor prognosis.

Figure 7: Emergency admissions and length of stay by Health Board 2018/19

Health Board	Admissions	Mean Length of Stay	Total bed-days
ABUHB	3,860	8.3	32,203
CAVUHB	2,702	10.1	27,281
CTMUHB	3,438	9.9	34,051
Total	**10,000**	**9.4**	**93,535**

For patients with Metastatic Malignancy of Undefined Primary Origin (MUO) length of stay is even longer with an average of 25.8 days across the region in 2018. MUO refers to the broad patient group who present with metastatic cancer that do not have an immediately identifiable primary site. As there is no primary tumour identified, these patients often have no specialist team responsible for their care. In the UK, approximately 24 patients are diagnosed with a cancers of unknown primaries every day, with annual new patient case load of around 8,800.[10] In England and Wales it is the fourth most common cause of cancer death.[11] Patients often present at an advanced stage, have complex needs, undergo fragmented pathways and have poor patient experience. In about 15 - 20% of these patients, the primary site remains undetected (Confirmed Carcinoma of Unknown Primary - CUP), and overall, patients have a median survival of four to 12 months.[12] The acute presentation of this patient group often results in multiple investigations,

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[10] CRUK, About cancer of unknown primary, 2017 (www.cancerresearchuk.org.uk)

[11] Metastatic Malignant disease of unknown primary origin in adults: diagnosis and management, NICE Clinical Guideline, 2010

[12] Varadhachary GR et al 2014, Stella GM et al 2012, Hainsworth JD et al 2018

and inappropriate or delayed treatment. Local analysis of CUP/MUO data (2018) demonstrated that despite the majority of new CUP/MUO referrals receiving AO input within the nationally stipulated time frame, only 30% of patients received any oncology treatment; 60% of these were discussed in multiple MDT discussions of different site specific teams; and 40% did not have any recorded MTD discussion. With no current service for these patients, the acute aspects of the MUO/CUP pathway are part of the scope of this business case.

Immunotherapy refers to treatments that use the immune system to destroy cancer. Immuno-oncology (IO) medicines are relatively new treatments which, for many patients, can achieve excellent outcomes. However, they are associated with immune-related adverse events which can have serious side effects, and are relatively unfamiliar to clinical teams.[13]

Immune-related adverse events can be unpredictable and require a very different approach to the management of toxicities related to other types of systemic anti-cancer therapy (SACT), for example, chemotherapy. Immune-related adverse events may be life threatening, potentially occurring at any time during and for up to two years post treatment. Very few patients manage their therapy without experiencing some immune-related side effects, which can include dermatologic, gastrointestinal, hepatic, endocrine, lung, renal and less common inflammatory events such as neurological and cardiac issues. It is well established that failure to recognise and instigate appropriate management for toxicity results in catastrophic consequences including unnecessary termination of treatment and patient deaths. Given the delay in toxicities, many of these patients will present as an emergency and be referred to AOS, hence the need for an IO pathway in this business case.

Metastatic Spinal Cord Compression (MSCC) is a well-recognised complication of cancer and usually presents as an oncological emergency. Life expectancy once a diagnosis of MSCC has been made is poor, with only 28% of patients surviving more than one year.[14] Early diagnosis, treatment intervention and rehabilitation is therefore necessary to prevent paralysis and to ensure the best possible outcome and quality of life.

There is currently an inequitable service, with spinal surgeons operating on MSCC in just one HB across South East Wales. Inconsistency in patient referrals, and a lack of flexibility of radiotherapy planning and treatment often means patients are admitted or require two visits.

The numbers of patients presenting with MSCC are increasing with advancing treatment techniques and as patients live longer with cancer. The outcomes for MSCC patients in South East Wales are currently below the UK average as they face delays in access to radiology, surgical opinion and radiotherapy treatment.

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[13] Good Practice Guideline for Immuno-Oncology Medicines, Royal College of Radiologists et al,

[14] NICE Clinical Guidelines, 75 *Metastatic Spinal Cord Compression: Diagnosis and Management of Patients at Risk of or with Metastatic Spinal Cord Compression*, Nov 2008

2.2.2 Business Needs

The increasing incidence of cancer in Wales (predicted to grow year on year by 1.5%[15]); the changes in clinical practice in oncology (the increased use of radical chemo-radiation); and the unprecedented step changes in the volume/pace of novel and approved anti-cancer treatment (particularly immunotherapy), has, and will continue to result in increased demand for AOS.

The Cancer National Specialist Advisory Group (CNASG) in Wales have developed a set of national standards for Acute Oncology Services (All Wales National Standards for Acute Oncology Services – June 2016) to provide a foundation for the NHS in Wales to plan and deliver effective high quality services for people with cancer, either known, or yet to be diagnosed, who present acutely to the NHS. These standards covered four areas: the AOS team; rapid assessment for acutely presenting patients; AOS team review of patient management; and information.

A Peer Review was undertaken in July 2018 to assess the existing AOS quality and performance against the standards in each HB. The all Wales summary of the findings are directly relevant to the provision of AOS in the South East. The review recognised that whilst significant progress has been made there remain some key gaps in the service which need to be addressed as part of this business case. A summary of the Peer Review findings is provided in the table below and a more detailed report is provided at Appendix B.

Figure 8: Peer Review summary against All Wales National Standards for AOS (July 2018)

Gaps in service
Insufficient oncologist presence in HBs and no specialist oncology Advanced Nurse Practitioners (ANPs) to manage more complex patients with complications of care or cancer progression
CNS presence in each site to cover core service (Mon – Fri 9am to 5pm)
No dedicated lead AOS managers in HBs
Need for additional administrator / co-ordinator time
HBs need daily access to wider dedicated consultant specialist team consisting of oncologist, palliative care consultant, Haemato-oncologist / haematologist, radiologist to help manage complex patients
Insufficient oncologist and no ANP time on site to disseminate knowledge around the management of AO through education
Insufficient oncologist and no ANP time on site to ensure clinical pathways are in place for assessment and management of all patients with complications from cancer or cancer treatment
No MUO or CUP service, supported by regular consultant oncologist support to deal with

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[15] Transforming Cancer Services, Programme Business Case, VUNHST 2019

Gaps in service
concerns
No electronic access to past medical history and treatment received or access to dedicated telephone support
No automatic electronic alerts to VCC when a patient with known malignancy, or undergoing active cancer treatment, presents acutely ill to secondary care
No electronic capture of core AOS dataset at VCC or acute site

The CNSAG recognised the differing configurations and challenges across Wales, such as multiple locations and rurality, which may result in additional local requirements. However, the standards they developed describe the core requirements of AOS. Achieving the care reflected in the standards is not solely the responsibility of the acute oncology team and requires engagement and collaboration at all levels of HBs, with cross-directorate, cross-care sector and cross-boundary working.

In addition to the Peer Review there are a number of specific issues relating to AOS in South East Wales which help to further demonstrate the limitations of the existing arrangements and a focus for prioritising investment in the required service enhancements. These are outlined below.

AOS Team

The AOS CNS team model is an outlier in comparison to other AOS services in the UK with limited specialist nursing, the service is potentially unsustainable in terms of clinical governance requirements for nurses to work independently. Whilst the AOS nursing teams are effective and dynamic, the current model means nurses are working without 'wrap' of consistent medical or senior expertise. This it is a challenge clinically, particularly for them to be involved in complex cases but also for them to take forward service development and ensure they are supported in continuous professional development (CPD).

The limited clinical sessions for physicians to support AO, along with a lack of senior nursing (Advanced Nurse Practitioners - ANPs) means there has not been much support, clinical leadership, education or training for either the nursing or medical teams, and as a result, there has been limited service development since its inception in 2013.

Specialist Oncology

Although daily specialist oncology advice is available through the 'lunchtime AOS MDT meeting', there is limited take up from HBs, and it is largely used to discuss VCC patients. Outside the MDT, there is variable clinician input and support due to insufficient funded time. Often the VCC on-call doctor is the point of contact, and accessing advice can prove cumbersome and onerous for colleagues in HBs. It means that advice is often inconsistent due to a lack of acute oncology knowledge and understanding, and not always timely. There is currently no dedicated oncologist

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time on site in HBs to ensure complex patients with complications from cancer or cancer treatment are assessed and managed appropriately. This also means there are no or few opportunities to disseminate knowledge through education and training.
Benchmarking with other sites such as The Christie NHS Foundation Trust and The Clatterbridge Cancer Centre demonstrate a significantly higher number of nurses per site and up to five direct clinical contact sessions for oncology consultants per site.

Admissions and length of stay

AOS can reduce admissions by providing timely expert advice and patient safety netting, facilitating same day discharge. It is a core component of ambulatory medicine services, allowing patients to receive essential care and advice without being admitted. AOS can also reduce the length of hospital stays, freeing up valuable bed space. This has been demonstrated by other centres and systems across the UK who have successfully implemented an AOS model that reflect the proposed approach in South East Wales, as noted in the table below.

Figure 9: Data from UK AOS sites on admissions and length of stay

Area of AOS	Benefit / outcome	Organisation
Acute admissions	66% of patients same day discharge after AOS established	West Suffolk Hospital[16]
Acute admissions	90% of patients same day discharge with a AO hot clinic	Royal Preston Hospital[11]
Acute admissions	61% of patients same day discharge with an acute admissions unit	VUNHST[11]
Inpatients	Reduced length of stay by 4 days after AOS established	West Suffolk Hospital[11]
Inpatients	Reduced length of stay by 3.1 days (£2m saving) after AOS established	The Clatterbridge Cancer Centre[17]
MUO/CUP	Reduced length of stay by 3.5 days with new MUO/CUP	North West Cancer Centre, Northern Ireland[18]

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[16] *Acute oncology: Increasing engagement and visibility in acute care settings*. Royal College of Physicians. Oct 2020

[17] Neville-Webbe HL et al *The impact of a new acute oncology service in acute hospitals: experience from the Clatterbridge Cancer Centre and Merseyside and Cheshire Cancer Network*. Clinical Medicine. Dec 2013, 13(6) 565-569

[18] Dasgupta.S et al *Integration of a patient-centred MUO/CUP service within a new acute oncology service: challenges and rewards*, Future Healthcare Journal, Vol 8, No1 2021

Area of AOS	Benefit / outcome	Organisation
	service	
Immunotherapy (IO)	40% reduction in admissions after establishing service	The Clatterbridge Cancer Centre[11]

With an average length of stay of 9.4 days across the region, understanding why patients are admitted and how to prevent re-admission is crucial. Developing these skills across different professional groups will require time and investment. Competencies should include the acute medical management of unwell patients, specialist oncology knowledge (new therapies and new presentation of metastatic cancer), radiology and confidence in complex conversations. Supporting patient discharge, with input from Allied Health Professionals (AHPs) and Palliative Care teams, will also help prevent further admissions.

The Royal College of Physicians have identified the following as being essential to avoid unnecessary admissions:

- A rapid oncology assessment (within 24hrs of referral) that will identify patients who are suitable for ambulatory / outpatient-driven services;
- Management of anti-cancer therapy complications, advice on disease complications, symptom management, diagnostic pathways for new cancers and offers alternative routes to admission including access to hot / cold oncology clinics;
- A formal working relationship with community, primary care and specialist services in order to improve the quality and speed of patient discharge and to avoid admissions;
- Capacity and pathways to be in place for day-case procedures to occur, such as paracentesis or rapid-access diagnostics without inpatient admission.

Acute medicine in South East Wales has moved successfully and rapidly towards same day emergency care delivery, and there is a real opportunity by increasing engagement and sharing cancer expertise in the acute setting, that it is possible to reduce admissions, reduce length of stay, improve patient journeys and train future clinicians.

MUO / CUP

The lack of a MUO / CUP service in South East Wales means there is an unmet clinical need in the overall management of these patients. This includes ownership of these patients and defining optimal diagnostic and treatment pathways; addressing patient centred needs (anxiety, uncertainty, symptoms, quality of life, cancer related survival); health resource centred needs (multiple invasive and non-invasive investigations, length of hospital stays, readmission rates, multiple MDT discussions across different tumour sites); as well as research needs (early identification and recruitment to clinical trials).

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The gap analysis identified through the Peer Review (2018) highlighted the need for a streamlined, resilient and well-resourced pathway for these patients, in accordance with national recommendations (NICE 2010) and peer review measures (NHSE 2014).

Intervention via a dedicated CUP team in several different hospitals in the UK (Sheffield Teaching Hospitals Trust, The Royal Free and Western Health and Social Care Trust) have all shown positive and measurable outcomes, with significant reductions in length of stay (3.5 -11 days), statistically significant reductions in re-admission rates and hospital deaths, and significant benefit in overall survival. Proposals to deliver a similar model of care are at the heart of this business case, as are the benefits that will accrue through its successful implementation.

Immuno-Oncology

The numbers of patients treated with immunotherapy is rising. In VCC the number of patients being treated with immunotherapy rose by 49% between 2018 and 2020, with an average of 225 patients per month by late 2020. As new drugs and new indications for drugs are licenced, including the usage of combination treatments, which have the highest rates of reaction, this rise will only get bigger.

The management of patient toxicity is complex and without specialist advice and education, patients can often be misdiagnosed or undergo inappropriate treatment. Approximately 60% of patients on combination treatments develop severe toxicities. Failure to treat promptly results in lengthier and more complex patient admissions and adverse patient outcomes, particularly in the failure to complete active therapy, resulting in reduced survival.

When The Clatterbridge Cancer Centre set up the IO service, they saw a 40% reduction in admissions after introducing a toxicity service, despite a 20% increase in the number of patients commencing treatment.

In South East Wales there is currently no pathway for these patients and the advice and access to specialist input is ad-hoc. As this is a becoming an increasingly common treatment option for cancer patients, there is a need to invest in the development of the acute pathway for patients, including the ambulatory pathway to deliver critical drugs. In doing so, this will help future proof the AOS and the increasing numbers of patients presenting with severe toxicities.

As important however, is raising awareness and educating acute care teams on this new era of drugs and their side effects. North Devon hospitals found that education and training were key to successful implementation, running weekly teaching sessions on oncological emergencies, including IO toxicities to acute teams.[19]

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[19] *Acute oncology: Increasing engagement and visibility in acute care settings*. Royal College of Physicians. Oct 2020

Metastatic Spinal Cord Compression (MSCC)

MSCC is a potentially devastating complication of cancer which requires rapid decision making by several specialists, given the risk of permanent spinal cord injury. Without a specialist single point of contact for advice and management there are delays in diagnosis and treatment, resulting in ineffective and inefficient management of patients including inappropriate diagnostic tests being carried out, increased length of stays in hospital, as well as deterioration in patient's functional ability, which reduce their prognosis and quality of life.

The Peer Review (2018) highlighted the need for a coordinator across South Wales which is in line with NICE guidance (2008), the NICE Quality Standard (2014) and as recommended in the South Wales MSCC Strategy (2016).

To date there has been no dedicated resource to co-ordinate the care and management of MSCC patients in South East Wales. The development of the MSCC pathway is crucial for timely diagnosis and treatment but will also improve system wide efficiencies, including: communication and education; clinical awareness of local MSCC pathways; and identification of risk factors of MSCC. Co-ordination of this pathway, and attendance at spinal MDTs will ensure there is greater collaboration between the AOS teams, clinical oncologists and surgeons to improve functional outcomes for patients.

2.2.3 The Quality Statement for Cancer

The Quality Statement for Cancer replaces the Cancer Delivery Plan for Wales and sets out a five year plan to improve the quality of cancer services and outcomes across Wales. Building on the work of the 2012 and 2016 Cancer Delivery Plans, the next five year phase of cancer service aims to take advantage of the widespread consensus that has emerged on priority areas, bring programmes to fruition, and maintain the national leadership and local engagement that has been achieved. This will ensure that there is a long-term and consistent approach to improving outcomes as envisaged in the Wellbeing of Future Generations Act and demonstrated by international experience.

The Quality Statement sets out a series of attributes it would like to see embedded in cancer services in Wales across a range of themes covering Equity, Safety, Effectiveness, Efficiency, Person Centredness and Timeliness. There is a specific requirement under the Safety theme to ensure that fully integrated Acute Oncology Services are available in all acute hospitals.

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2.2.4 The Nuffield Review

The Nuffield Trust was commissioned by Velindre University NHS Trust to provide independent advice on the clinical model underpinning its planned changes to Velindre's cancer services contained in its Transforming Cancer Services programme.

The work assesses the proposals for the planned changes to non-surgical tertiary cancer services across South East Wales and clinical concerns raised about plans to build the new Velindre Cancer Centre on the proposed site.

Whilst the review made specific recommendations regarding the wider clinical model it also made specific reference to the management and delivery of acute oncology across South East Wales. It documented the limited investment in AOS in South Wales, particularly compared to the rest of the UK, as well as the paucity of accurate data. However, it did acknowledge the collaborative work undertaken as part of this process and many of the recommendations are directly relevant to this case and entirely consistent with the proposed direction of travel set out in this business case. In particular the review recommends that:

- Each local health board (LHB) needs to develop a plan for oncology support for unscheduled cancer patient admissions and acute oncology assessment of known cancer patients, with inpatient admission as an option. This approach will mitigate the risks for inpatients across the network.
- The development of acute oncology services in each LHB is a priority and will help support reductions in acute admissions across the network. A common dataset is required to support the planning of these services.
- Each LHB needs to ensure that there is a plan for providing oncology advice and support for patients admitted via A&E, and for acute oncology assessment of known cancer patients presenting with symptoms/toxicities, with inpatient admission provided as an option on a district general hospital site if needed. The assessment service model should provide for multi-disciplinary input, in particular from palliative care, specialist nursing and allied health professionals.

2.2.5 Spending Objectives

Having outlined the existing arrangements for delivering AOS across South East Wales, and the business needs as highlighted by the peer reviewed and local assessment of service gaps, a set of Spending Objectives were developed. These set out what the project is trying to achieve by way of intended outcomes and what needs to be achieved to deliver the necessary changes highlighted through the business needs.

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The table below sets out the project spending objectives which were developed in partnership with the AOS MDT Steering Group, which has broad representation from all four of the stakeholder organisations.

Figure 10: Spending Objectives

Project Spending Objective	Description
Project Spending Objective 1	Improved patient outcomes and experience delivered consistently irre-spective of presenting location
Project Spending Objective 2	To avoid unnecessary inpatient admissions but where this is necessary to reduce the average length of stay for patients admitted acutely
Project Spending Objective 3	Provide treatment for patients in the most appropriate setting that balances clinical need with personal choice
Project Spending Objective 4	Identified and improved pathways for patients presenting as MUO/CUP
Project Spending Objective 5	Improving services through better data analysis, greater focus on measuring outcomes and dissemination of knowledge around management of acute oncology across the organisation through education provision

The spending objectives will be used to support the development of the benefit criteria to be used in the non-financial aspects of the option appraisal.

2.2.6 Project scope

The scope of this project is to develop a comprehensive clinical model for acute oncology services in South East Wales covering the pathway from point of arrival in acute setting to discharge from hospital including the management of presentation, assessment, treatment and discharge. It was agreed that this would be run as a regional service across South East Wales.

It should be noted that the AOS pathway is broader than this, and includes primary and community care, as well as tertiary specialist beds, which will be considered outside of this business case.

2.2.7 AOS Clinical Model

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In considering the approach to developing the clinical model considerable work has been undertaken by engaging a wider range of stakeholders through a series of workshops which incorporated patient and user input. This informed the development of the clinical model and the founding principles under which it has been developed.

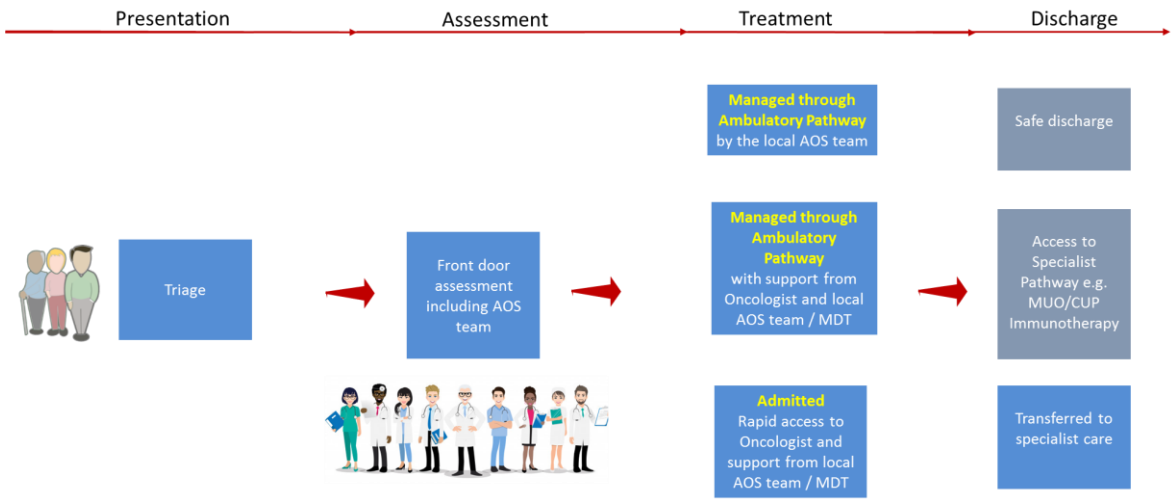
The project was established as a collaboration between Cardiff and Vale, Aneurin Bevan and Cwm Taf Morgannwg and Velindre to ensure a regional perspective of AOS in South East Wales was presented. Two key principles have underpinned the work in developing the clinical approach to enhancing the AOS across South East Wales, namely:

- Equity of access – irrespective of HB of residence, patients presenting to the AOS are assured of equity of access and a common service standard; and
- Shared ownership and delivery – the service model is developed jointly by the three Health Boards (Cardiff and Vale, Aneurin Bevan and Cwm Taf Morgannwg) and Velindre University NHS Trust with clarity around roles and responsibilities.

Recognising the scope of the project, the approach outlined above has developed a clinical model which sets out the key enhancements necessary in delivering the spending objectives and securing the necessary improvements in AOS across South East Wales.

As a starting point, an overview of the high level patient pathway of the project is summarised in the diagram below. This sets out the key and decision points across the patient journey through the AOS.

Figure 11: High level patient pathway



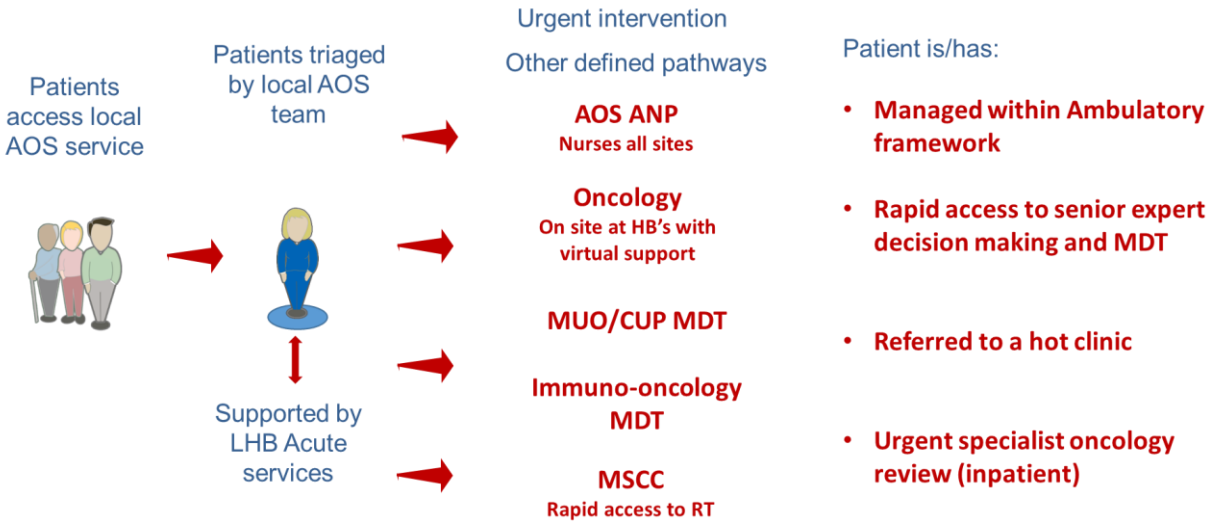
The high level pathway has been used as the foundation for developing the more detailed AOS clinical model which is summarised in the diagram below. This sets out a model which places stronger emphasis on the specific needs of AOS patients whilst complementing local wider unscheduled care management with a primary focus on ambulatory pathways as an alternative to inpatient admission. Where patients do need to be admitted, timely MDT reviews with appropriate specialist oncology input will support reductions in length of stay. It combines

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locally based HB resources with enhanced access to specialist oncology input through a mix of predictable and regular physical on the ground presence and virtual support. Other elements include enhancement of specialist nursing input, a new, structured approach to the management of MUO/CUP patients along with access to other specialist pathways.

The model also recognises that timely intervention and honest conversations by AOS teams with patients and their families makes a real difference in the quality of care and patient outcome. Good working partnerships and arrangements between emergency departments, medical admission units, and acute oncology services are key underpinning elements of the model.

Figure 12: Emerging AOS Clinical Model



The areas highlighted in red show the focus of service enhancements and required investment. Further details relating to the respective elements of the proposed enhancements can be found in the table below with more detailed analysis provided in Appendix C.

Figure 13: Proposed service specifications for the enhanced AOS

Area of Investment	Service Proposal
Nursing and Allied Health Professionals	Enhanced CNSs to manage initial presentations and support ambulatory pathways to help avoid admissions, and take on the key worker role throughout acute oncology pathways; ANP senior nursing to lead AOS teams and independent decision making within areas of competency; AHP support patients and facilitate patient management and effective / timely discharge.
Consultant Sessions	Additional Clinical Lead sessions to support AOS team and provide timely senior clinical advice, and provide education and training; Consultant Palliative Care to provide specialist support to MUO/CUP MDT; and

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Area of Investment	Service Proposal
	additional Consultant Radiologist time to enable enhanced access to timely radiological investigations and facilitate the rapid decision making.
Specialist Oncology Support	Enhanced HB oncology input comprising mix of physical and virtual support. HB direct time - Oncologist (named, integrated with AOS team) lead via presence on the ground at the HBs, providing face to face clinical review via ward rounds (reducing length of stay) and hot clinics (reducing admissions), education and training (delivered in HBs), and regional pathway development. Virtual Support - Complements the HB direct consultant oncologist by providing virtual touch points throughout the day for all hospitals in South East Wales, allowing consistent and timely advice no matter where patient admitted and advoiding unnecessary admissions.
MUO/CUP Service	New service for cancer patients where primary sites of tumour-origin are not immediately apparent. Consultant Oncologist - Named lead who provides expert advice to HB AOS teams (avoiding unnecessary investigations and reducing length of stay) and Chairs the MUO/CUP MDT. CNS - Key worker and point of contact for patients, providing patient education and support, with remit to develop clinical pathways and links with AOS nursing teams. Consultant Palliative Care - Support to the MUO/CUP MDT Consultant Radiologist & Pathologist - Additional time for input into MDT (as a core member) to review the treatment and care of MUO/CUP patients. Collectively, this will mean better patient experience and outcomes, as well as reducing length of stay.
Immunotherapy Toxicity Service	New service for patients with Immuno-oncology (IO) toxicities. Consultant Oncologist - Regional service lead to establish clear pathways for toxicity management, Chair the MDT, provide education with teams in all acute hospitals as well as developing ambulatory pathways to deliver critical drugs. CNS - Key worker and point of contact for patients, to liaise between primary, secondary and tertiary care, with remit to run a triage clinic and ensure prompt and early management of toxicities; work with the oncology and HB AOS teams, and provide training; manage patients on reducing steroid treatments, enabling early discharge. Consultant Specialists - Provide organ system specific toxicity advice to MDT for patients with severe and life threatening immunotherapy toxicity, improving management of complex reactions and enabling access to timely investigations. This will mean better patient experience and outcomes, as well as

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Area of Investment	Service Proposal
	reducing avoidable admissions.
MSCC Pathway	Consultant Clinical Oncologist - Attend spinal MDT and improve communication between spinal surgeons and clinical oncologists. MSCC clinical co-ordination role - Attend spinal MDT and co-ordinate the care and management of MSCC across region as the single point of contact, working alongside AOS consultants and nurses and the spinal surgical team. They will provide strategic regional developments for recognition, investigation, treatment and rehabilitation of patients with MSCC. This will be better for patient experience and outcomes.
Admin support	MDT Co-ordinator (MUO/CUP and Immunotherapy Toxicity) - Provides support to MUO/CUP and Immunotherapy Toxicity MDTs. Ensures discussion conclusions are documented and communicated between organisations including VCC, LHBs and primary care. Medical Secretary - Supports the effective management and planning of patient administration including effective communication and documentation of medical reviews and advice. Administration of MDTs and hot clinics (HBs).

Underpinning the service model are a number of regional enablers, specifically digital and education and training, which are fundamental to the successful delivery of the clinical model and the delivery of the associated benefits. The digital elements include the collection of standardised, structured data using digital forms to improve patient safety, reduce duplication, support data analysis and reporting, and is a key enabler to understanding the impact of service through Patient Reported Outcome Measures (PROMS). The availability of consistent and comprehensive patient data will also support improved mechanisms for communication, facilitating seamless access to specialist advice at point of care, flag admission of diagnosed cancer patients within the region, and enable access to records across the site to facilitate specialist support.

Digital enablement also includes the ability to support virtual clinician to patient and clinician to clinician consultations and engagement. Many of the established video / voice tools are already available (e.g. Attend Anywhere, Consultant Connect and Microsoft Teams) and can be easily deployed into the proposed AOS landscape across South East Wales.

Education and training is recognised a key feature of the service. AOS bridges the gap between oncology and other medical specialties, and the possibility of this shared learning is crucial. In North Devon, weekly teaching sessions for staff working in the emergency department and MAU around oncological emergencies and immune-oncology toxicities have been core to the service.[20] In addition to this sharing of knowledge and expertise, there is a need for more formal education

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[20] *Acute oncology: Increasing engagement and visibility in acute care settings*. Royal College of Physicians. Oct 2020

and training, particularly for nursing and to maintain the principle of equity, the proposal would be to develop a regional education and training programme.

2.2.8 Patient and staff experience

In order to demonstrate the benefit of an AOS for both patients and organisations, the following is an anonymised patient case which depicts their experience now and what it could be like with an enhanced AOS. Alongside the patient story is that of the CNS who took charge of the patient.

Figure 14: Patient experience of AOS now

I had a swelling in my neck and went to my local hospital after feeling unwell for several weeks. I had a scan and the emergency team explained they were 'worried' about it and that it showed some abnormal swellings but not much more than that and I was admitted.

The next day I met a specialist nurse who told me she would stay involved in my care until we understood what was happening, she talked to me and my family together with the ward doctor and they told me it might be cancer. The medical team organised a biopsy of the swelling but I wasn't told the results and I was still in hospital ten days later and feeling worse. I was scared and knew something was not right but too scared to ask too many questions. Everyone was so busy and they didn't seem to know what was happening to me, the specialist nurse came to visit me and told me we were waiting on the results of the biopsy to help decide what the next steps would be.

Eventually, the doctor on my ward told me the biopsy result was ready and that it was lymphoma cancer. I was given some steroids and told that they were arranging an appointment to see a cancer specialist in another hospital. By the time I saw the oncologist I was really ill and I was told I was not fit enough to be treated.

Figure 15: Patient experience of AOS in the future

I had a swelling in my neck and went to my local hospital after feeling unwell for several weeks. The emergency team I saw when I first arrived explained the swelling might be cancer and that I required further investigations, but did not need to be admitted for these. A specialist nurse came to see me in the emergency department and told me she would be acting as my Keyworker whilst I was having these investigations and gave me her contact details. I returned a couple of days later for an urgent biopsy of the swelling, whilst I was there the specialist nurse brought an oncologist to see me. They told me and my family that I probably had lymphoma. They explained what was happening and told me I could go home with an appointment to go back to a clinic and see the cancer specialist.

A week later, I saw a different oncologist who told me the results from the biopsy showed it was an "aggressive cancer" but they were booking me in for chemotherapy that day to give me the best chance to control the disease. It was obviously upsetting news but everything was done so quickly and explained to us, we always felt we knew what was happening.

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Figure 16: CNS experience of AOS now and in the future

The acute team contacted me about a 70 year old lady who had presented with a large gland above her clavicle. The radiologist report suspected cancer and a biopsy was arranged. Despite my advice, for the patient to be discharged, she remained an inpatient for ten days on a medical ward waiting for the result. During this time her performance status deteriorated and she became more and more anxious. Once the result was back she was discussed at an MDT and the specialists advised starting her on steroids. She was discharged and told she would get an appointment with the oncologist in the post.

It was frustrating because I kept getting different advice from different oncologists, when I could get through. Once the patient was discharged, I had to update paper records and several different systems before I could see the next patient.

The acute team contacted me about a 70 year old lady who had presented with a large gland above her clavicle. The radiologist report suspected cancer and I met and assessed her in the emergency department. I introduced myself as her Keyworker and explained my role. I telephoned the oncologist at a time when I knew I could speak to them. They suspected lymphoma and suggested an urgent biopsy and referral to the next available clinic on site. I made sure the patient was fully informed of the plan and discharged them to return for the booked biopsy. I updated the patient records on the system once and I was free to see the next patient.

When she attended for the biopsy I was able to arrange for the oncologist to meet the patient and her family to discuss the probable diagnosis and plan.

The next week the patient returned to the onsite clinic to receive her results and treatment plan.

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2.3 Anticipated benefits

A range of benefits are anticipated to accrue through the successful implementation of the proposed AOS clinical model which will be both direct and indirect as well as quantitative and qualitative.

There are significant service quality and safety benefits for patients who have access to a structured AOS in terms of their experience and outcomes. AOS ensures continuity and consistency of care where they would otherwise experience significant delays in diagnosis and treatment. Offering specialist oncology support outside the cancer centre, enable patients to access treatment at a location convenient to them.

Whilst some benefits will potentially free up acute hospital capacity which can be used for alternative purposes the ability to make these cash releasing will depend largely on local circumstances and the ability to disinvest in existing practices as the clinical model is rolled out. To help quantify the benefits, empirical evidence from other centres and systems across the UK who have successfully implemented an AOS model that reflect the proposed approach in South East Wales have been used. Benchmarking with these centres demonstrates significant opportunities for admission avoidance (in the range of 40-60%) and reductions in length of stay (3–4 days)[21] for patients who require inpatient care. The existing AOS service has already achieved some reductions in length of stay but additional investment will support admission avoidance through staff availability (for rapid assessment of patients), oncology advice, and hot clinics, as well as some further reductions in length of stay. Therefore, the quantifiable benefits that have been applied are 25% admission avoidance and 10% reduction in length of stay respectively. These have been clinically endorsed and applied to the baseline position in each Health Board to assess the potential improvement and the impact it could have in freeing up acute capacity. Further details and quantification of these benefits in relation to this business case are provided within the Economic Case section.

A summary of the anticipated benefits, beneficiaries and, critically, the proposals for assessment and measurement are set out in the table below. Further details, including the anticipated impact these benefits will have, can be found in the Benefits Realisation Plan (Appendix D).

Figure 17: Anticipated benefits of implementing AOS clinical model

Benefit	Beneficiaries	Measurement
Equal access to AOS for those in equal need	Patients, staff, Health Boards	Patients per head population, attendances linked to cancer incidence trends
Improved patient experience and better patient outcomes	Patients, staff, families, carers	PROMS

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[21] *Acute oncology: Increasing engagement and visibility in acute care settings*. Royal College of Physicians. Oct 2020

Benefit	Beneficiaries	Measurement
Patients spend more time at home in their last year(s) of life	Patients, families, carers	PROMS, number of days spent in acute hospital in last year of life, patient preferred place of death, mortality rates within 30 days of treatment, palliative care contacts
More patients receive same day emergency care avoiding the need for hospital admission	Patients, Health Boards	Emergency admission rates, 30-day readmission rates, Nos of AOS patients admitted as inpatients, Nos of patients managed through ambulatory pathways, Cost per case
When admitted patients spend less time in hospital as an inpatient	Patients, staff, Health Boards	Inpatient bed days Average length of stay
Patients are not subject to unnecessary investigations or treatment	Patients, Health Boards	Numbers of investigations Patient outcomes and survival
Enhance links with other hospital based specialists / services	Patients, staff	Staff surveys, referral times
Improve effectiveness of AOS team working	Patients, staff	Staff surveys, number of patient handovers
Better professional AOS education and training	Patients, staff	Increase in critical mass of AOS team, staff surveys, retention, qualifications across the team
Digital interaction between staff / patients and staff / staff	Patients, staff, Health Boards, Velindre NHS Trust	Number of digital interactions, reduced time to access specialist opinion
Better AOS data to improve decision making & accuracy of demand and capacity forecasting	Patients, staff, Health Boards	Staff survey Reports
Efficient collection of AOS data allows for inter-operability and more clinical time spent with patients	Patients, staff	Staff survey Reports

In consideration of the development, assessment and measurement of anticipated bene fits, and ensuring they have a strong focus on outcomes the project team have been, and will continue to, work with the Value Based Healthcare teams across South East Wales and nationally in further developing our approach to benefits measurement and management.

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2.3.1 Risks

Identifying, mitigating and managing the key risks is crucial to successful delivery. Without effective management of the key risks, it is likely that the project would not deliver its intended outcomes and benefits. The Management Case sets out the management of project specific risk, however, the table below sets out the key strategic risks that have been identified to date covering Business, Service and External categories.

Figure 18: AOS project risks

Risk Category	Risk Description
Business	There is a risk that there is a lack of HB support for the preferred model.
Business	There is risk that Health Boards / Commissioners do not agree to support the level of investment required to deliver the model.
Business	There is a risk that to meet the IMTP deadlines for 2021 the business does not go through due diligence and there is a delay in approvals.
Service	There is a risk that a lack of communication with key stakeholders and other disciplines means there is a lack of clinical support.
Service	There is a risk that not considering the whole AOS pathway limits the opportunities to provide a comprehensive, equitable service.
Service	There is a risk that lack of availability of appropriately trained and skilled staff limits the speed of implementation
External	There is a risk that COVID-19 will interrupt the project and take key personnel away from the project.

2.3.2 Constraints

The main constraints in relation to the AOS project are outlined in the table below.

Figure 19: AOS project constraints

Constraint	Overview
Financial constraints	The financial investment of implementing the preferred clinical model will need to be agreed with HBs.
Timescale constraints	The success of the AOS project will be dependent on inclusion in organisational IMTPs after 2021/22.
Service Capacity	The success of the AOS project will be dependent on the capacity of the service to fully implement the model in the agreed timeframe.

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Constraint	Overview
Service Capacity	The success of the AOS project will be dependent on the ability to recruit to key posts.

2.3.3 Dependencies

A number of dependencies have been identified in relation to the AOS project, as outlined in the table below.

Figure 20: AOS project dependencies

Dependency	Overview
Funding Availability	Access to appropriate funding to implement the preferred clinical model.
Partnership Working	Co-production between HBs and VUNHST in the development and implementation of the model is essential to the success of the project.
Digital enablement	The need to have in place effective digital solutions to support virtual consultations / engagement and access to better clinical information / data for AOS patients
HB and CCLG Approval	The Business Case must be endorsed by the CCLG and thereafter seek approval through the HB statutory governance.
Pre implementation planning	Appropriately resourced and coordinated pre-implementation planning is critical to the successful implementation starting in 2021.
Compliance with national and UK guidelines	The AOS clinical model must comply with all relevant national and UK guidelines and recommendations.

2.4 Summary

This section of the business case has set out the background to the South East Wales Acute Oncology Service set in the context of wider cancer service delivery arrangements. It has outlined the existing arrangements for service provision and highlighted a range of gaps supported by an independent Peer Review. A set of objectives have been established to realise the benefits arising from enhanced resources and investment, and the proposed clinical model, once implemented will ensure that these benefits can be realised. Finally, a range of factors covering risks, constraints and dependencies have been identified which are critical in ensuring a successful outcome for the project.

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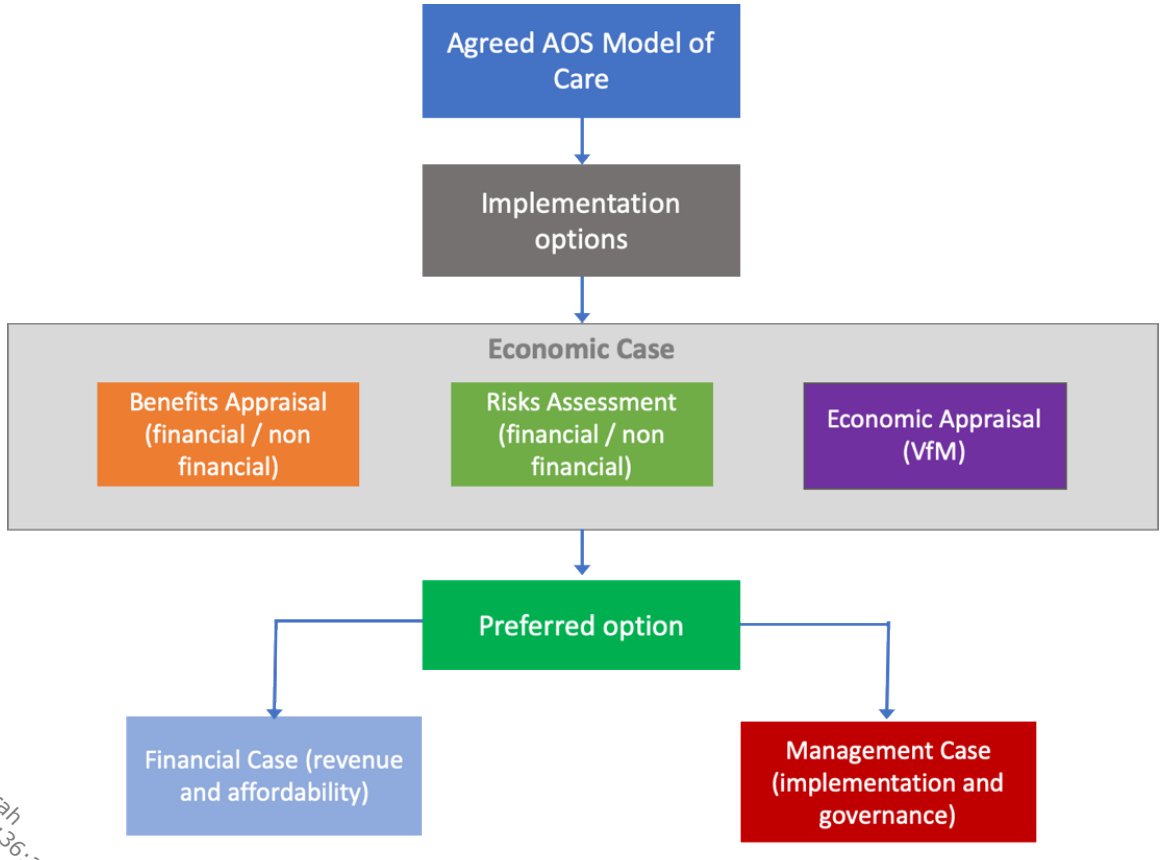
ECONOMIC CASE

3 Introduction

The purpose of the Economic Case is set out the options for implementing the Clinical Model identified within the Strategic Case and then to undertake a detailed analysis of the costs, benefits and risks of these options to ultimately identify a preferred way forward. The objective is to demonstrate the relative value for money of the options in delivering the required outcomes and services and ultimately to identify the solution which secures the optimal balance of costs, benefits and risks.

The Economic Case is set within the context of the wider Option Appraisal which translates the Acute Oncology Service clinical model into a series of alternative delivery solutions culminating in the identification of an agreed way forward. Once identified an assessment of funding and affordability (Finance Case) and deliverability (Management Case) are presented in subsequent sections of the business case. A summary of the process is provided in the diagram below.

Figure 21: AOS option appraisal



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There are a number of steps involved in completing the Economic Case comprising the following:

- The process for developing the shortlist of implementation options
- The development of non-financial benefit criteria used to assess the options
- Scoring of the options against the non-financial benefit criteria
- Undertaking a non-financial risk assessment
- Assessing the monetary costs and benefits of the options over the appraisal period
- Summarising the results of the option appraisal and selecting the preferred option

The remainder of this section of the business case will outline how each of the above areas have been tacked and, critically, how stakeholders have been engaged in key aspects of the option appraisal process.

3.1 Developing the options

Options should be consistent with the project scope set out within the Strategic Case and should reflect different routes to delivering the anticipated benefits. As they reflect alternative choices it is possible to assess the differing extent to which investment objectives and associated benefits are secured, resources are applied, and risks are calibrated. As a minimum, an option that delivers the core project scope should be considered. A further option(s) that provide further optional / desirable coverage and a Do Nothing position which acts as a baseline or reference point against which improvements can be measured.

To aid with option development a framework was used to capture the key variables likely to be relevant in implementing the clinical model. These are phrased in four themes as set out below:

- **Theme 1 – Structure**: how the service would optimise combining specialist oncology expertise with locally based resources
- **Theme 2 – Configuration**: how Acute Oncology Services across SE Wales might be organised with particular emphasis on Health Board acute hospitals
- **Theme 3 – Operating**: over what time period would services be available
- **Theme 4 – Phasing**: consider a 'big bang' or phased approach and, for the latter, what might be quick wins

Using the four themes and working with a group of stakeholders from all of the South East Wales Health Boards and Velindre, representing a wide range of professional backgrounds, a short list of three options was developed. A summary is provided in the table below which also incorporates the 'quick wins' referred to above.

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Figure 22: AOS option shortlist descriptions / components

Theme	Option 1 – Do Nothing (business as usual)	Option 2 – Do Minimum (Core Scope)	Option 3 – More Ambitious (desirable / optional scope)
Structure	Oncology input - daily MDT and on-call Clinical leads - one session/week	Oncologist of the day - balance of physical and virtual presence Clinical leads - additional sessions	Oncologist of the day – more physical than virtual presence Clinical leads - additional sessions with cross cover ANP – managed deployment
Configuration	Inconsistent access to AOS and variable CNS support across sites	AOS presence on all sites, appropriately resourced	Hybrid model: Inpatients (hub), ambulatory care (spoke)
Operating	Core hours but inconsistent across sites	Monday to Friday 9am -5pm	Extended day Monday to Friday 9am - 8pm
Phasing	N/A	Staged approach to implementation	Staged approach to implementation
Quick wins	N/A	MUO/CUP pathway Digital (Business Analyst)	MUO/CUP pathway Digital (Business Analyst)

In developing Options 2 and 3, certain elements were considered 'non-negotiable' as the expectation was they should be present and resourced appropriately in any implementation option, in order to meet the basic requirements of the clinical model. Specialist oncologist support is included in this but because there was a choice to be made about how this could work, it is included in the options above. A summary of the non-negotiables are provided in the table below.

Figure 23: AOS option 'non negotiables'

Element	Description
CNS input	Specialist Cancer Nurse Specialists (CNSs) and associated leadership to help manage initial presentations, support ambulatory pathways and act as a key worker through the inpatient pathway
AHP support	Allied Health Professional support to Acute Oncology patients, in particular to facilitate patient management and effective / timely discharge

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Element	Description
Diagnostics	Rapid access to diagnostics, particularly radiology (and pathology for MUO/CUP) to support diagnosis and on-going patient management
MUO / CUP and Immunotherapy	A structured pathway for the management of patients falling within these distinct groups of AOS patients
Admin support	To support the effective management and planning of patient administration including clinics and MDT meetings

Lastly, as part of the option development process, potential solutions across the four themes were assessed and excluded on the basis that they were not adequately aligned to the proposed clinical model (for example, 100% virtual oncology input) or that there was insufficient evidence to justify the associated use of resources and case for investment (for example, data did not support running a weekend service). The exclusions are summarised in the table below.

Figure 24: AOS option exclusions

Theme	Excluded from all implementation options
Structure	Oncology input provided on fully virtual basis with no physical presence at acute hospital sites
Configuration	Single designated / centralised AOS hospital site per Health Board
Operating	Weekend service (but allowing for urgent, on-call specialist advice)

3.2 Non-financial benefits assessment

The purpose of the non-financial benefits assessment is to consider the extent to which, on a qualitative basis, the shortlisted options meet the objectives and deliver the anticipated benefits arising from the proposed investment in AOS.

In approaching this part of the option appraisal process there was a strong desire to build on the extensive and effective engagement that was present in the development of the clinical model. In this regard the non-financial assessment incorporated a series of stakeholder workshops with representation from all of the Health Boards in South East Wales and Velindre NHS Trust as well as partner organisations including the Welsh Ambulance Service, Macmillan and the Community Health Council. Stakeholders were drawn from a wide range of professional backgrounds including Oncologists, Cancer Leads, Acute Medical representatives, Nursing, Allied Health Professionals, Palliative Care, Finance, Workforce and Planning.

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3.2.1 Developing the benefit criteria

During the workshops a set of six benefit criteria were agreed that would be used to assess the three shortlisted implementation options for AOS. As indicated these reflect both the investment objectives and anticipated benefits highlighted in the Strategic Case. The definition of each criteria have been expanded to provide a more comprehensive indicator of how these would be used to assess and score the options. Further details are provided in the table below.

Figure 25: AOS benefit criteria and descriptors

Criterion	Description
Equity of access	The extent to which the option ensures that the service delivered is available and predictable irrespective of where the patient acutely presents across South East Wales. Patients should expect the range and level of resources provided to be consistent and the outcomes of their care to be at an acceptable standard.
Patient experience and outcomes	The extent to which the option supports a positive patient experience and respects the needs of the individual across the entire admitted care pathway. Patient care and safety is optimised through timely access to care and expertise that reflects where the patient is on their cancer journey and their desired outcome from the intervention. The patient and their carers feel that there has been a measurable benefit from the care received.
Effective and efficient use of resources	The extent to which the option supports optimum patient throughput at an acceptable level of quality whilst making best use of time and resources. This should ensure throughput is optimised and there are no undue delays across the patient pathway from presentation / admission to discharge. This could include avoiding admission into an acute bed and / or where this is required minimizing the amount of time spent in hospital.
MUO / CUP pathways	The extent to which the proposed solution delivers an effective and patient centred approach to the management of MUO / CUP. This would include a structured rapid referral process, a clinical management pathway, CUP/MDT membership, dedicated out-patient clinics and interaction with other professional groups involved in the management of the patient. As a minimum it would be anticipated that access would be provided to an oncologist, a palliative care physician and a specialist nurse or key worker.

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Criterion	Description
Optimising the end of life journey	The extent to which the option supports the patients' last year of life and their preferred place of death. This should be optimised through timely access to care and expertise, as they transition from active treatment to best supportive care. This should be overseen by the acute oncology team working closely with Palliative Care. This will include support to family, carers or other people who are important to the patient being cared for.
Education and training	The extent to which the proposed arrangements support formal and informal education and training across all staff involved in the delivery of Acute Oncology. This should cover all professions inputting to the patient pathway from initial presentation through to discharge but also external education through interaction with primary and community health practitioners.

3.2.2 Scoring the options against the criteria

Having developed the benefit criteria these were then ranked and weighted prior to the scoring of the options to assess the extent to which stakeholders judged the options were able to meet each of the criteria. Options were scored on a scale from 0 (could hardly be worse) to 10 (could hardly be better) and the results aggregated to provide a total score for each option. A summary of the ranking, weighting and scoring assessment is provided in the table below.

Figure 26: AOS non-financial benefit scores

BENEFIT CRITERIA		WEIGHT %	Option 1 - Do nothing		Option 2 - Do Minimum (Core Scope)		Option 3 - More Ambitious (Desirable / Optional Scope)	
		W	SCORE	W x S	SCORE	W x S	SCORE	W x S
1	Equity of access	23.3	3.0	69.8	7.0	162.8	9.0	209.3
2	Patient experience and outcomes	20.9	3.0	62.8	8.0	167.4	9.0	188.4
3	MUO / CUP pathways	18.8	1.0	18.8	8.0	150.7	8.0	150.7
4	Education and training	13.2	1.0	13.2	7.0	92.3	8.0	105.5
5	Effective and efficient use of resources	12.5	4.0	50.1	8.0	100.2	7.0	87.7
6	End of life care	11.3	1.0	11.3	7.0	78.9	8.0	90.2
	TOTAL	100.0		225.9		752.3		831.7
	RANK			3		2		1

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The results of the scoring exercise show that, unsurprisingly, Option 1 – Do nothing returns a low score both at individual criteria and aggregate level with a total returning a score in the 'lower quartile'. This reflects the extent to which the gaps in the current service impact in key areas such as equity of access and patient experience. Options 2 and 3 perform significantly better reflecting the fact that both deliver the key elements of the proposed clinical model. Both options score in the 'upper quartile', indicating that they are likely to be capable of realising the investment objectives and delivering the required benefits. However, Option 3 returns a slightly higher score reflecting its additional scope including such features as extended hours and greater presence of roles such as the ANP.

A range of sensitivity tests were undertaken including applying equal weighting to all of the criteria and eliminating the scores for the highest ranked criterion – Equity of access. A summary of theses sensitivity tests is shown in the table below.

Figure 27: AOS non-financial benefit scores

Scenario	Option 1 – Do nothing	Option 2 – Do minimum	Option 3 – More ambitious
Baseline scores	225.9	752.3	831.7
Ranking	3	2	1
Equal weighting applied to criteria	216.7	750.0	816.7
Ranking	3	2	1
Exclude scores for top ranked criterion	156.2	589.5	622.4
Ranking	3	2	1

As can be seen from the analysis none of the sensitivities materially alter the relativity of the scoring or the ranking of the options in terms of their non- financial benefits.

3.3 Non-financial risk assessment

In parallel with the non-financial benefits assessment, a review and assessment of non-financial risks associated with implementing the proposed clinical model was undertaken, specifically to consider how these might differ across the shortlist of options. As was the case with the non-financial benefits assessment work with a range of stakeholders in identifying and assessing the key risks was undertaken. The outputs of this work form a part of the wider option appraisal but also help to inform the mitigation and management actions outlined in the risk management plan provided as part of the Management Case.

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3.3.1 Developing the risk register

An initial risk register for AOS has been developed focusing on the key areas of risk likely to impact on the successful delivery of the proposals set out within the Strategic Case. These risks have been developed covering three key service themes, namely Strategic Risks, Planning Risks and Operating Risks – a definition of each of these areas is provided below.

- **Strategic risks**: those risks associated with the strategic context in which the project is set and managed
- **Planning risks**: those risks associated with the planning parameters / assumptions used for the project
- **Operating risks**: those risks associated with service delivery and resourcing

In terms of specific risks covered by each theme the table below provides the appropriate analysis. The approach has been to focus on key risks rather than breaking down into larger numbers of individual components - this results in a relatively small number of risk areas concentrating on factors critical to successful implementation.

Figure 28: AOS risks

Risk theme	Risk no	Risk description
Strategic	1.1	Health Boards are unable to prioritise required investment in AOS
	1.2	AOS governance is not adequate to maintain shared ownership and delivery
	1.3	Further phases of AOS model are not taken forward
Planning	2.1	Estimated revenue is unable to meet full costs of implementation
	2.2	AOS demand outstrips capacity resulting in unmet need
	2.3	A lack of adequate pre-go live planning impacts adversely on AOS implementation
Operating	3.1	Inability to access required numbers of adequately trained / skilled Oncologists
	3.2	Inability to access required numbers of adequately trained / skilled nursing staff
	3.3	Digital enablers are not of a standard required to support key elements of the solution(s)

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3.3.2 Assessing the risks

All risks have been assessed to establish the likely consequences should they arise (their impact) and the likelihood of them arising (their probability). The assessment scale and associated calibration for each element of the assessment is shown in the table below.

Figure 29: Risk assessment scale

Risk consequence		**Risk likelihood**	
Score	Rating	Score	Rating
1	Negligible	1	Rare
2	Minor	2	Unlikely
3	Moderate	3	Possible
4	Major	4	Likely
5	Extreme	5	Almost certain

The risk rating is assessed by multiplying together the likelihood and consequence scores. Risks are then classified as Red, Amber, Yellow or Green based on the chart below.

Figure 30: Risk rating

Likelihood	**Potential Consequences**				
	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Almost Certain (5)	**Medium**	**High**	**High**	**Very High**	**Very High**
Likely (4)	**Medium**	**Medium**	**High**	**High**	**Very High**
Possible (3)	**Low**	**Medium**	**Medium**	**High**	**High**
Unlikely (2)	**Low**	**Medium**	**Medium**	**Medium**	**High**
Rare (1)	**Low**	**Low**	**Low**	**Medium**	**Medium**

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3.3.3 Scoring the risks to assess impact

A workshop was convened to assess the risks using the rating scale highlighted above. The assessment was initially based on a review of Option 2 – Do minimum and then a judgement made on the relative rating of the other options against this position. The results of the risk assessment are shown in the table below with each risk score and rating highlighted along with the relative position for the Do Nothing and More ambitious options.

Figure 31: Risk assessment results

Risk	Score / rating	Option 1 - Do nothing	Option 3 - More ambitious
Health Boards are unable to prioritise required investment in AOS	12	↓	↑
AOS governance is not adequate to maintain shared ownership and delivery	9	↓	↔
Further phases of AOS model are not taken forward	9	↓	↔
Estimated revenue is unable to meet full costs of implementation	9	↓	↔
AOS demand outstrips capacity resulting in unmet need	9	↑	↓
A lack of adequate pre-go live planning impacts adversely on AOS implementation	6	↓	↔
Inability to access required numbers of adequately trained / skilled Oncologists	12	↓	↑
Inability to access required numbers of adequately trained / skilled nursing staff	12	↓	↑
Digital enablers are not of a standard required to support key elements of the solution(s)	12	↔	↔

↓ Lower risk. ↔ Similar risk. ↑ Higher risk

As can be seen from the results of the risk assessment there are a number of areas where a 'High' rating has been determined (in some instances this may be greater depending on which option is pursued) indicating these could have a significant bearing on the overall success of the project. Careful mitigation measures will be required to ensure that these risks and their potential impact can be managed. Further analysis is provided as part of the Risk Management Plan highlighte d in the Management Case.

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3.4 Monetary costs and benefits

This element of the Economic Cases focusses on the assessment of the quantifiable monetary costs and benefits associated with the AOS implementation options. It uses Net Present Value (NPV) analysis to establish the overall economic impact of the options across an appraisal period rather than a single financial year. This allows us to review the economic impact of the alternative AOS delivery solutions and, when combined with the non-financial elements of the options appraisal, identify the 'preferred option' to be taken forward into the Finance and Management cases.

Recognising, at this stage, there is further work to be undertaken on the detailed implementation arrangements within each stakeholder organisation, for the purposes of this business case it is necessary to develop a range of planning assumptions that underpin the estimated costs and benefits associated with each of the options. Whilst these will be subject to review and update, they do reflect the latest position with regard to dialogue between professional groupings / functions and planning and finance colleagues from all of the stakeholder organisations across South East Wales. Further analysis of costs and benefits is provided within the Financial Model which supports the business case and has been shared with relevant personnel from each of the stakeholder organisations.

3.4.1 Monetary costs

Monetary costs broadly reflect the components of the options as set out in Section 3.1 of the business case, however, the tables below sets out more detailed assumptions used to develop the analysis. Note that the resourcing assumptions are closely linked to the service specification outline in section 2.2.7 of the Strategic Case.

Figure 32: Cost analysis assumptions

Input	Assumption
Phasing	Largely reflects Health Board investment prioritisation across a series of 'Implementation Phases' (further detail provided within the Finance Case) combined with the challenges of recruitment across different staff groupings with 4 months as the minimum recruitment time. Consultant level posts are assumed to be the most difficult to recruit and phased over a longer timescale.
Demand growth	This reflects NHS Wales cancer incidence which is rising at an annual rate 1.5-2%. This has been applied to the resource requirements as a proxy for the impact of increases in AOS demand.
Oncologist input	Provides for a combination of regular and predictable physical on the ground support within the Health Board acute sites combined with virtual support via "oncologist of the day" to be available for a full working day 5 days a week. Costs include allowances for annual leave and Supporting Professional Activities (SPAs). Physical support provision incorporates an

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Input	Assumption
	allowance for Education and Development to support local teams. Under the more ambitious option the level of on the ground support is expanded.
Other consultant input	This includes allowances for Clinical Leads input within the Health Boards. Allowance is also incorporated for additional resource to support enhancements to the management of immunocology toxicity through a range of specialty inputs from HBs Allowance for Consultant Palliative Care support to the CUP/MUO MDT There is also provision for additional Pathology and Radiology input to support enhanced access to diagnostics for AOS patients
Nursing input	CNS/ANP whole time equivalents (WTE) are based on each HB's assessment of requirements to meet its local implementation across its acute hospital sites. The more ambitious option allows for a longer working day, with a greater proportion of ANP input. Registered nurse and healthcare assistant to provide treatment or support in hot clinics is also incorporated.
AHP input	AHP requirements are based on each HBs assessment of requirements to meet its local implementation across its acute hospital sites. The more ambitious option allows for a longer working day and input to hot clinics.
Other clinical	This includes MSCC coordination and, for the more ambitious option only, some Therapeutic Radiography input.
Admin support	Additional Medical Secretary support reflects an estimate of requirements to support the management of MDT and hot clinics. Call handler input relates only to the more ambitious option and supports a dedicated helpline for patients and GPs
Project management	This allows for dedicated support to manage the implementation of the project across the region.
Digital	IT and business intelligence expenditure has been shaped by discussions with digital leads across the stakeholder organisations. It reflects the need for a time limited scoping study (Discovery phase) combining business analysis and system architecture to further inform requirements and a cost allowance to support the on-going requirements. This will be further developed in line with the more detailed requirements specification.
Training and education	Training and Education expenditure reflects a cost allowance to support formal support for AOS staff across the region. This is in addition to the less formal input provided through the Consultant Oncology input.

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The table below provides an analysis of the yearly costs for each of the options across the categories set out in the table above and reflects a fully implemented position which is anticipated to be reached in financial year 2024/25.

Figure 33: Option expenditure analysis

Expenditure heading	Option 1 – Do Nothing £000	Option 2 – Do Minimum £000	Option 3– More Ambitious £000
Consultant Oncologists	175.4	716.9	979.2
Other Consultant input	137.2	350.9	485.9
ANPs	249.7	402.1	613.9
CNSs	446.3	995.2	1,243.7
Other Nursing	-	94.0	182.2
AHPs	98.6	679.9	979.9
Other Clinical	-	77.9	114.2
Admin support / PM	227.4	442.0	547.1
Digital (IT/Business Intelligence)*	-	150.0	166.7
Education and training	-	40.0	90.0
Total	**1,334.7**	**3,948.9**	**5,402.8**

* Includes non-recurrent scoping costs to cover 'Discovery' phase

3.4.2 Monetary benefits

As set out in the Strategic Case there are significant service quality and safety benefits for patients who have access to a structured AOS in terms of their experience and outcomes. AOS ensures continuity and consistency of care where they would otherwise experience significant delays in diagnosis and treatment. Offering specialist oncology support outside the cancer centre, enable patients to access treatment at a location convenient to them. These benefits have largely been assessed through the non-financial appraisal and their measurement incorporated within the Benefits Realisation Plan. However, In addition to these qualitative benefits there are a range of quantitative benefits arising from the implementation of the clinical model which can be assessed and measured in terms of acute hospital capacity released and ultimately valued in cash terms through the application of resource assumptions.

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To help quantify the benefits, empirical evidence from other centres and systems across the UK who have successfully implemented an AOS model that reflect the proposed approach in South

East Wales has been used. Specific focus has been given to the impact of an effective AOS on avoiding admissions and, where admission is required, reducing acute length of stay. The benchmarks show us that improvements could be delivered which reflect a range of 40% - 66% of patients discharged the same day, reducing acute admissions; and where acute admission is necessary, patient length of stay has reduced by 3 to 4 days.

As part of the South East Wales AOS business case these benchmarks have been reviewed and clinical consideration given to the potential level of improvement likely to be delivered through the implementation of the proposed model – it is considered realistic to expect a 25% reduction in acute admissions combined with a 10% reduction in length of stay for patients requiring specialist inpatient care. These are then applied to the baseline position in each Health Board to assess the potential improvement and the impact it could have in freeing up acute capacity.

To quantify these benefits, benchmarks have been applied to the baseline position in each Health Board to assess the potential improvement and the impact it could have in freeing up acute capacity which, if released, could be used to support the needs of other service areas within acute hospital settings. Whilst these benefits are unlikely to be cash releasing, for the purposes of the Economic Case an assessment of the cash value of these benefits has been made by applying a direct cost allowance to the bed days released which can then be translated into a value to be incorporated into the overall cost benefit analysis.

In terms of calculating the benefit associated with these improvements for each Health Board the approach set out below has been adopted. This recognises the limitations of existing AOS data capture in establishing a robust baseline, however, proxy measures using Patient Episode Data Wales (PEDW) have been used as the basis for estimating current AOS activity in acute care settings across the region. In summary the approach incorporated four stages, namely:

- Establish an AOS baseline activity position by looking at emergency admissions where cancer is within the top 3 diagnostic codes
- Apply the clinically validated improvement metrics arising from the proposed AOS arrangements within South East Wales (25% admission avoidance / 10% reduction in average length of stay). It is anticipated that a further 5% reduction in length of stay could be achieved through the more ambitious option.
- Translate the improvement potential into bed days (and capacity) released
- Apply a unit cost of £150 reflecting the potential direct cost benefits associated with the bed day reductions

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A summary of the results of this analysis is provided in the table below.

Figure 34: Analysis of quantified benefits by Health Board (2018/19 baseline)

Health Board	Baseline AOS bed days	Bed days freed up			Capacity released (Beds)	Annual financial impact
		Avoided admissions	Reductions in LOS	Total		
ABUHB	32,203	8,051	2,344	10,395	30.0	£1,559,250
CAVUHB	27,281	6,820	2,011	8,831	25.5	£1,324,650
CTMUHB	34,051	8,513	2,507	11,020	31.8	£1,653,000
Total	**93,635**	**23,384**	**6,862**	**30,246**	**87.3**	**£4,536,900**

The analysis shows that, across South East Wales, the scale of this opportunity is in the order of 30,000 bed days / 90 beds, which if released could be used to support the needs of other service areas within acute hospital settings across the three Health Boards.

For the purposes of the Economic Appraisal the cashable benefits have been incorporated into the Economic Appraisal as set out below. Cash benefits are phased in a manner which reflects the profile of investment with an appropriate lag factor to recognise the timing between resource deployment and benefit realisation.

3.4.3 Cost benefit analysis results

Applying the assumptions set out above an NPV analysis has been undertaken to provide an economic cost for each of the options based on the approach set out below.

Figure 35: Economic Appraisal assumptions

Input	Assumption
Price base	All costs and benefits are priced at 2020/21 rates
Appraisal period	10 years from initial implementation starting in April 2021
Discount factor	3% in line with investment appraisal guidance

The analysis incorporates the anticipated profile of costs and benefits across the 10 year appraisal period. The Net Present Cost (NPC) for each option is presented as a quantitative assessment of the value for money associated with each option. By incorporating the non-financial benefit scores outlined in section 3.2 the net economic cost to quality score can be assessed. A summary of the analysis is provided in the table below.

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Figure 36: Cost / benefit analysis

Heading	Option 1 – Do Nothing £000	Option 2 – Do Minimum £000	Option 3 – More Ambitious £000
Discounted costs	11,830	29,559	42,291
Discounted benefits	-	29,517	38,170
Net present cost (NPC)	11,830	42	4,121
Non-financial benefit score	225.9	752.3	831.7
NPC per benefit point	52.4	0.1	5.0

This shows that across the appraisal period, of the two options other than the Do Nothing, Option 2 – Do Minimum delivers the best balance of monetary costs and benefits returning an overall neutral ratio of economic costs to benefits. When incorporating the non-financial benefit scores it also delivers the best ratio of net economic costs to quality benefits.

3.5 Options appraisal summary

Having concluded the non-financial and financial aspects of the option appraisal process, an overview of each of the shortlisted implementation options can be provided. A summary of the option appraisal is provided in the tables below. Advantages and disadvantages summarise the assessment of the extent to which the option will deliver the main benefits (Section **Non-financial benefits assessment** refers) and incur the main risks (Section **Non-financial risk assessment** refers). Conclusion indicates if the option is likely to meet the **Spending Objectives** and additional requirements set out in the Strategic Case.

Figure 37: Summary of option appraisal

OPTION 1	Do Nothing – Business as Usual (BAU)
Description	*This maintains the existing arrangements for AOS*
Net Economic Cost	*£11,830k (£52.4k per non-financial benefit point). Reflects existing investment with no additional benefits*
Advantages	*Relatively low economic cost when compared with other options and lower overall risk.*
Disadvantages	*Does not support the Spending Objectives as indicated by the non-financial benefits score being in the lower quartile. Does not deliver any additional monetary benefits.*
Conclusion	*Does not meet the Spending Objectives nor deliver the proposed clinical model.*

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	Does not address the service gaps as identified in the Peer Review.
OPTION 2	**Do minimum**
Description	*This delivers the core scope of the project and the AOS clinical model on a phased basis recognising the challenges around staff recruitment. Addresses gaps in service as identified in the Peer Review. Consistent with the recommendations of the Nuffield Review*
Net Economic Cost	*£42k (£0.1k per non-financial benefit point). Reflects benefits arising from capacity freed up through avoided admissions and reductions in length of stay*
Advantages	*Supports the Spending Objectives as indicated by the non-financial benefits score being in the upper quartile. Delivers significant non-cash releasing monetary benefits and potential to free up resources for other service priorities*
Disadvantages	*Risk profile shows mainly medium risks with some assessed as high requiring careful management.*
Conclusion	*Meets the Spending Objectives for the project*
OPTION 3	**More ambitious**
Description	*This delivers the core scope of the project and the AOS clinical model on a phased basis recognising the challenges around staff recruitment. Addresses gaps in service as identified in the Peer Review. Consistent with the recommendations of the Nuffield Review. It delivers some additional scope including an extended working day which provides for some additional benefits.*
Net Economic Cost	*£4,121 k (£5.0k per non-financial benefit point). Reflects benefits arising from capacity freed up through avoided admissions and reductions in length of stay*
Advantages	*Supports the Spending Objectives as indicated by the non-financial benefits score being in the upper quartile.*
Disadvantages	*Risk profile shows mainly high risks with some assessed as medium requiring careful management.*
Conclusion	*Meets the Spending Objectives for the project*

3.6 Recommended option

Using the results of the option appraisal summary set out above the option that offers the best overall combination of costs and benefits and is best able to meet the project spending objectives is Option 2 – Do Minimum. At this point in time, and for the purposes of this business case, Option 2 – Do Minimum will be taken forward into the Finance and Project Management sections of the business case to demonstrate how it will be funded and implemented.

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3.7 Summary

The Economic Case has allowed a set of options to be developed providing different solutions to implementing the AOS clinical model and subsequently assessed their value for money through an option appraisal incorporating non-financial and financial elements. Following a robust process involving a wide range of stakeholders combining organisational and professional perspectives a preferred option has been identified with is Option 2 – Do Minimum - this approach to implementing the AOS clinical model meets the following:

- Supports the key Spending Objectives
- Addresses key gaps in service identified by independent peer review
- Delivers the best combination of costs, benefits and risks

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FINANCIAL CASE

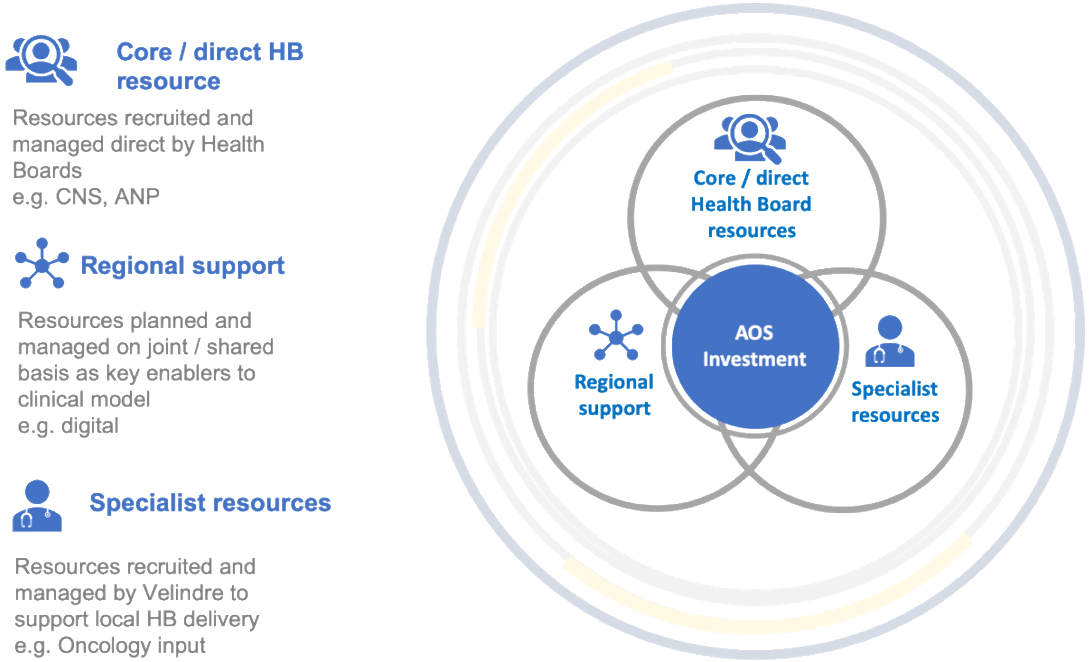
4 Introduction

The purpose of the Financial Case is to demonstrate the affordability of the preferred option, both in the context of the financial profile and funding consequences and the implications for South East stakeholder organisation's financial plans. This section of the business case sets out the following:

- Arrangements for phasing the proposed investment across the implementation period for the preferred option
- Revenue analysis for preferred option for years 1 to 4 against baseline AOS costs
- The proposed approach to apportioning costs / investment to Health Boards
- The estimated impact of the proposed AOS investment by stakeholder organisation
- Details of further work to be undertaken post business case

In developing the Finance Case it is recognised that the investment requirements cover a range of 'cost pools' including locally managed, regional and specialist support. As such funding arrangements need to reflect the likely combination of direct Health Board investment with expanded commissioning arrangements to secure the full range of resources required to successfully implement the proposed service arrangements. This is illustrated in the diagram below.

Figure 38: AOS cost and funding components



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4.1 Phasing of investment

In order to implement the proposed clinical model in a manner which is both deliverable and affordable it is necessary to assign a degree of priority to the AOS service lines and associated investment requirements. Working closely with stakeholders from the partner organisations a phased approach has been negotiated which reflects the individual needs of the Health Boards balanced against the challenges in delivering the specialist elements of the service model. It also seeks to priorities investment into areas of greatest need and to ensure that associated benefits are delivered as early as possible in the implementation. In practical terms, phases will not be discrete and there may well be a degree of overlap in their implementation.

As part of this process, working closely with key stakeholders, a three phase approach to implementation has been developed and the service priorities aligned to these which can then be used to profile the associated resources and investment.

Although there are different organisational viewpoints there is a broad consensus on prioritisation, particularly in relation to what should be incorporated within Phase 1. Where organisational priorities are different and this related to the directly managed cost pool it is entirely practical to reflect this in local implementation. However, where there are differences in the priority associated with services which are part of specialist / regional arrangements this presents some practical challenges if organisations wish to operate at different speeds. Although some differences have emerged from the dialogue it has been possible to develop a set of assumptions that can be used to shape investment requirements for all aspects of the proposed service solution.

For the purposes of the business case the table below sets out how investment priorities have been mapped into phases.

Figure 39: AOS investment prioritisation

Area of investment / service line	Phase 1	Phase 2	Phase 3
Clinical Nurse Specialists	✓		
Specialist Oncology (virtual)	✓		
Specialist Oncology (on site)	✓		
MUO / CUP service	✓		
Patient administration	✓		
Project management	✓		
Digital (discovery phase)	✓		

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Area of investment / service line	Phase 1	Phase 2	Phase 3
Allied Health Professionals		✓	
Immunotherapy Toxicity		✓	
Advance Nurse Practitioners			✓
MSCC Pathway			✓

4.2 Revenue analysis

By using the assumptions set out in the table above it is possible to show how the investment requirements map out across the proposed service lines and phases of implementation and the additional investment required. These can then be mapped to financial years up to 2024/25 when it is anticipated the model will be fully implemented. Note the mapping to financial years takes into account lead times to implement (particularly in relation to recruitment) the relevant part of the service solution. This analysis is shown in the tables below.

Figure 40: AOS additional investment profile by service line £000

Cost heading	Year 1 – 2021/22	Year 2 – 2022/23	Year 3 – 2023/24	Year 4 – 2024/25
Clinical Nurse Specialists	107.8	367.3	445.0	445.0
Oncologist support	51.3	246.5	426.4	471.7
Other consultant input	19.7	72.8	102.7	119.2
AHPs	30.3	231.6	499.0	581.3
ANPs	29.7	59.4	113.7	152.4
Other nursing	4,.3	35.9	82.5	94.0
MUO / CUP	51.8	155.5	155.6	155.6
Immuotherapy Toxicity	0	110.0	142.6	142.6
MSCC	0	0	52.4	89.9
Admin support	26.0	85.5	100.2	103.9
Regional investment*	147.2	245.3	245.4	196.2
Total additional investment	468.2	1.609.8	2,365.5	2,551.6

** Includes Project Manager, Digital and Education and Training some of which id non recurrent*

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Figure 41: AOS additional investment by phase £000

Phase	Year 1 – 2021/22	Year 2 – 2022/23	Year 3 – 2023/24	Year 4 – 2024/25
Phase 1	468.2	1,288.0	1,535.3	1,499.4
Phase 2	-	321.8	707.1	836.4
Phase 3	-	-	123.1	215.8
Total	**468.2**	**1,609.8**	**2,365.5**	**2,551.6**

The analysis shows that the invest requirements are relatively modest in year 1 (2021/22) and increase thereafter in years 2 to 4 reflecting the phased implementation of the clinical model and supporting investment across the region.

4.3 Apportionment of costs and investment requirements

By way of further analysis it is useful to break down the total AOS additional investment across the three 'cost pools' highlighted in the diagram above. This shows the comparative level of additional investment in AOS and demonstrated that the Core / Direct cost pool takes up the greatest proportion of the requirement. Further details are provided in the table below.

Figure 42: AOS additional investment by cost pool £000

Cost pool	Year 1 – 2021/22	Year 2 – 2022/23	Year 3 – 2023/24	Year 4 – 2024/25
Core / Direct	217.8	852.4	1,343.4	1,495.8
Specialist Support	103.2	512.0	777.0	859.7
Regional Support	147.2	245.4	245.4	196.2
Total additional investment	**468.2**	**1,609.8**	**2,365.5**	**2,551.6**

In terms of apportioning the additional investment required in AOS the approach recognises the different ways in which expenditure will materialise, depending on the cost pool in which they sit. In developing the business case a set of principles have been established which are aimed at securing an equitable basis for allocating investment to Health Boards reflecting both local implementation planning and likely levels of service demand. These apportionment principles for each cost pool are as follows:

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- Core / Direct – apportioned directly to the Health Board based on existing expenditure and local investment intentions. This includes all ANP / CNS and AHP costs and a proportion of Other Consultant and Admin costs
- Specialist Support – where this can be reflected in measurable inputs at Health Board level e.g. 'on the ground' Oncologist time / input then this has been used to apportion costs. Other aspects including MUO / CUP and MSCC coordination are allocated on the basis of cancer incidence
- Regional support – allocated to Health Boards on the basis of cancer incidence covering Project Management costs, Digital investment and Education and Training.

Applying these principles to the AOS costs allows an analysis of the additional investment required within each organisation across South East Wales reflecting a combination of the three areas outlines above and the proposed phasing of implementation – this is shown below.

Figure 43: AOS additional Health Board investment by phase and financial year£000

Health Board / Phase	Year 1 – 2021/22	Year 2 – 2022/23	Year 3 – 2023/24	Year 4 – 2024/25
Aneurin Bevan UHB				
Phase 1	167.2	436.5	510.8	496.6
Phase 2	-	147.9	349.1	421.0
Phase 3	-	-	52.0	93.9
Total	**167.2**	**584.4**	**911.9**	**1,011.4**
Cardiff and Vale UHB				
Phase 1	180.4	537.7	669.2	658.8
Phase 2	-	49.1	70.1	70.1
Phase 3	-	-	15.2	26.1
Total	**180.4**	**586.8**	**754.4**	**755.0**
Cwm Taf UHB				
Phase 1	120.5	313.9	355.4	344.1
Phase 2	-	124.8	287.9	345.2
Phase 3	-	-	55.9	95.9
Total	**120.5**	**438.7**	**699.2**	**785.2**

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It should be noted that through the established commissioning arrangements Powys Teaching Health Board would be responsible for a proportion of the required investment, however, this is unlikely to reflect a material value.

4.4 Post business case activities

Resource and cost estimates to support AOS have been developed over a relatively short period of time, however, every effort has been made to engage with clinical, planning and finance teams across the stakeholder organisations. It is recognised that further work is required to develop and refine these and to ensure that the requirements reflect local circumstances whilst recognising the need to deliver a sustainable and consistent AOS model across the region. Furthermore there is a need to ensure that the resource estimates can be developed to a level that proves adequate certainty of required investment in AOS to be incorporated within local Integrated Medium Term Plan (IMTP) development for 2021/22 and beyond.

Further work relating to the operational detail of the proposed specialist and regional services will be undertaken to ensure they accurately reflect the local organisational arrangements for delivering AOS within the Health Boards. Final investment requirements will reflect this process although maintaining equity across the region will continue to be a fundamental aspect underpinning this work.

Consideration will also need to be given to developing commissioning and financial control arrangements for the Specialist and Regional aspects of the AOS investment and specifically how these can be aligned to / incorporated within existing mechanisms. At the heart of this will be the need to ensure transparency and assurance that investment is directed to the core elements of the clinical model. Further details are provided within the Management Case section of the business case.

4.5 Summary

The Finance Case has set out the required level of additional investment in AOS to support the implementation of the preferred option identified through the Economic Case. Recognising that costs will build up in a phased manner reflecting, in particular, challenges around recruitment, the investment has been presented over a 3 to 4 year implementation period.

Further consideration needs to be given to developing and agreeing an approach to allocating costs and funding to the Health Boards in South East Wales recognising that this combines elements of direct service provision with commissioning of specialist Oncology support and other shared investment.

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It is recognised that further work will be required post business case development to refine and adapt resources to reflect local circumstances and align with IMTP processes.

MANAGEMENT CASE

5 Introduction

The purpose of the Management Case is to demonstrate that robust arrangements are in place for the delivery, monitoring and evaluation of the project and that the organisational stakeholders are ready and capable of delivering a successful outcome. In doing so, it sets out the governance and processes that will sit behind the implementation of the clinical model across the region. The objective is to demonstrate how the preferred option will deliver the clinical model (including realising benefits and managing risks), the approach to implementation (including change management) and the associated timescales.

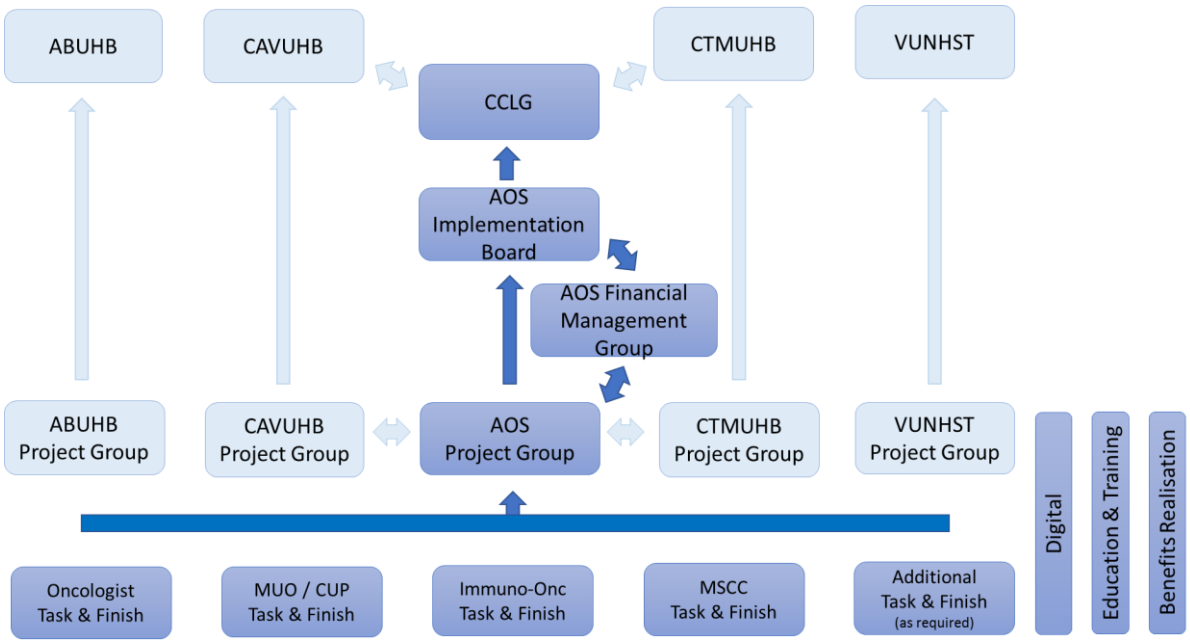
5.1 Governance

The development of this business case and the work that sits behind is the result of a multi-organisational, multi-professional collaboration across South East Wales. The governance around implementation and delivery of the clinical model will continue to reflect this degree of collaboration, ensuring the founding principles of equity of access and shared ownership continue.

As the commissioners of this work, CCLG own the successful delivery of the project but HBs have the statutory authority for any investment in the service. Operationally, the project will be overseen by an AOS Implementation Board which will be supported by a Financial Management Group and AOS Project Group, which in turn will be informed by task and finish groups. Further details are provided in the supporting text and diagram below which reflects both the core AOS requirements (depicted in dark blue) and the local HB structures (depicted in light blue).

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Figure 44: AOS Implementation Governance



South East Wales Collaborative Cancer Leadership Group (CCLG)

The CCLG provides effective system leadership for Cancer Services across South East Wales, in delivering improvements in outcome and service experience for the catchment population. The Group are responsible for leading whole system changes at a regional level which require the coordination of commissioning decisions and investments and facilitate the realignment of pathway resources within and between organisations. As Project Sponsor, the CCLG will provide regional oversight of the implementation of this project but will refer to HB and Trust Board teams to ensure appropriate and statutory governance is followed.

Health Board and Trust Board

Although the CCLG will provide regional oversight to the AOS project, any local decision making will need to be made through the internal governance processes of the Health Board and Trust Executive teams. HBs will have the statutory authority for any investment in both the local enhancements to AOS, as well as commissioned services from VUNHST.

AOS Implementation Board

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The AOS Implementation Board will have overall responsibility for the delivery of the project. This will be a relatively small, discreet group with the Cancer Leads from the four organisations (ABUHB, CAVUHB, CTMUHB and VUNHST) as well as a number of multi-professional representatives, patient representatives and external stakeholders. They will to provide strategic

leadership to the AOS project, as well as monitor progress against the implementation plan, ensure project risks are managed appropriately and that the benefits set out in this business case are realised. The Implementation Board will receive monthly highlight reports from the AOS Project Group, and liaise with HB and Trust Board teams to ensure appropriate and statutory governance is followed.

Financial Management Group

As noted in the Finance Case the investment requirements for AOS have been categorised into three areas: direct (resources under the direct management of HBs); regional (resources supporting the region such as digital, education and training, and project management); and specialist (resources largely deployed by VUNHST, predominantly specialist oncology support).

In order to support the regional and specialist elements it is proposed that an AOS Financial Management Group is established, operating within a robust financial control mechanism, to provide financial scrutiny, and manage and monitor the flow of investment for specialist and regional resources, ensuring that resources are released appropriately once firm deployment plans are in place. This group will have financial representatives from the HBs and act on behalf of these organisations. It will ensure that:

- There is alignment between the resources identified within the business case and implementation of the clinical model
- Funding will only be released into the system once there was a clear plan to deploy the required resources
- Phasing of funding reflects the speed of implementation across the region balanced against the need to ensure equity of service access
- Benefits can be measured reflecting a focus on return on investment and value based healthcare

AOS Project Group

The AOS Implementation Board will be supported by an AOS Project Group which will include advisors and leads from the HBs across a number disciplines (clinical and nursing), as well as project and business support. This group will drive the operational implementation of an enhanced AOS across the region, lead the delivery of project outcomes and benefits, escalate project risks and issues to the Board, and facilitate effective communication and engagement across the region and organisations. The regional and cross cutting elements of the service will also report directly into the Project Group.

Health Board / VUNHST AOS Project Groups

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There will be direct, local enhancements to AOS in each HB and these will need to be managed separately by them, ensuring they are in line with the principles of the clinical model of equity of access and shared ownership. Effective and ongoing communication and engagement with each

of the four organisations is crucial. Having these in place (either through existing or new groups) so that the Project Group can feed into and receive information from them, will be key in managing progress against the plan. HB leads sitting on the AOS Project Group will be responsible for this two-way communication but will be supported by the project team.

AOS Task and Finish Groups

Task and finish groups will be established with a remit to refine service models and pathways for each area of investment. They will consider the operational requirements to implement, develop job descriptions and job plans, and determine the most appropriate roll out. The outputs of these groups will be passed up through the AOS governance structure for approval, after which the investment will be released.

Most of the task and finish groups will be clinically led but all will have regional representation, and will draw on expertise from other areas as appropriate. Although they will be established as separate groups, there will some shared themes and possibly resources between the groups and this will be the responsibility of the Project Group to ensure these links are maintained and coordinated appropriately.

Cross-cutting Groups

There are some elements of implementation which will cover multiple elements of the service and will need to both feed into and take information from the task and finish groups and local HB/Trust groups. These areas, such as digital, education and training, and benefits realisation will also inform the AOS Project Group to ensure the outputs across the multiple groups are aligned and consistent.

5.2 Project Management

Successful implementation of the clinical model will require project management input for the co-ordination of the Delivery Groups and their outputs, reporting progress against the plan, as well as escalation of risks and issues. Of particular importance is the close collaboration and liaison with HB colleagues.

The project team will include a Programme Manager who has responsibility for the delivery of the project, making sure it is delivering against the plan, to time and within budget; and a Project Manager who will be responsible for the day to day running of the project with a particular focus on the delivery groups.

Figure 45: Roles and Responsibilities

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Role	Name	Responsibility
Senior Responsible Officer (SRO)	To be identified (CCLG)	The SRO is accountable for the success of the AOS implementation project. The SRO owns the vision for the AOS project and is required to provide clear

Role	Name	Responsibility
(Chair - Implementation Board)		leadership and direction.
Project Director (Chair – Project Group)	To be identified	The Project Director reports to the SRO and is operationally accountable for project delivery of the AOS project. They will provide leadership and are responsible for enabling effective project delivery.
Clinical Leads (Implementation Board)	Ian Williamson (ABUHB) Meriel Jenney (CAVUHB) Calum Forrester-Paton (CTMUHB) Hilary Williams (VUNHST)	The Clinical Leads will be responsible for providing leadership within their organisations, and ensuring a clinical focus is maintained in all aspects of the project and that patient experience and quality is always a primary consideration.
Programme Manager	Jenny Stock	The Programme Manager has overall responsibility for the delivery of the project and ensure it is delivered to time, cost and quality. Key to this will be the efficient and effective use of project resources, and the identification and management of, interdependencies, risks and issues, and benefits delivery.
Project Manager	TBC	The Project Manager will be responsible for the day to day running of the project including support for the task and finish delivery groups.

5.3 Implementation

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There are significant challenges around the implementation of a regional clinical model, across different HBs and multiple sites within those HBs. It is recognised that individual HBs have different baselines in their current AOS and therefore, different priorities. Some elements of the implementation plan will occur at different times and be delivered in different ways, but all aspects of the clinical model should be achieved within the designated timeframe.

As noted in the Financial Case, phased investment plans for each HB have been developed and these will shape the detailed implementation plans for each HB. There were strong similarities between the HB plans, most notably with nursing and oncology support prioritised for immediate investment. Other areas also recognised as key included the MUO / CUP pathway and digital enablers (which also reflected the quick wins identified in the option appraisal process). Where services are required to be delivered across the region (with investment from all three HBs to ensure equal access for patients) the decision was been made to move to that service in line with the majority view.

An overview of the regional phases is set out in the table below. In reality the phases will overlap with each other (phase 2 will start before phase 1 has been completed), and this is based on the premise that some services could take years to fully implement (such as the specialist oncology support).

Figure 46: Health Board Investment Phases

Phase 1	Phase 2	Phase 3
Clinical Nurse Specialists Specialist Oncology - Virtual Specialist Oncology – Onsite MUO/CUP Service AOS Lead (ABU) Consultant Sessions – Clinical Lead (ABU / CAV) Patient administration Education and training Digital discovery Project management	Allied Health Professionals Immunotherapy Toxicity Service Consultant Sessions – Other (CAV)	Advanced Nurse Practitioner (ABU / CTM) MSCC Pathway

Lead times for recruitment have also been applied to the investment plan, which again will be reflected in the implementation plans. The table below is a high level implementation plan and it pulls together the individual HB phasing plans into one so it remains a regional programme which can be held to account through the AOS governance.

Work to develop the operational implementation plans will be picked up by the task and finish groups and will run in parallel with the business case approval process.

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Figure 47: High Level Implementation Plan

Element	Phase 1	Phase 2	Phase 3
Nursing / AHPs	CNS recruitment plan	AHP recruitment plan	ANP recruitment plan
Oncology	Virtual support for HBs and on-site presence (including hot clinics)		
Consultant Sessions	Increased sessions to support AOS team	Sessions to support Immuno-oncology service	
MUO/CUP	New MUO/CUP service – develop pathways and establish MDT		
Immuno-oncology	*Immuno-oncology service – develop pathways and guidelines (Macmillan funding)*	Immuno-oncology service developed, MDT established	
MSCC			Scope MSCC pathways
Patient Administration	Recruited as required	Recruited as required	
Digital / Business Analysis	Discovery and design – scope baseline (process, pathways, data items, methods of documentation, duplication)	Informed by outputs from phase 1.	Informed by outputs from phase 1.
Education & training	Regional education and training programme		
Project management	Project Manager recruited		

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5.4 Workforce

A critical part of the implementation will be the workforce strategy. A high level workforce plan including associated costing will be developed and aligned to the clinical model.

The proposed service model will be appropriately resourced by a team of skilled nurses and AHPs, with specialist oncology support. This requires a change in the current workforce model. The intention of the workforce plan will be to ensure that an equitable service can be provided across the region, aligned with the clinical model, in order to ensure the delivery of quality and safe care and will seek to address future clinical and workforce challenges.

The high level plan will be created to capture the workforce requirements taking into account the future and existing skills and capabilities required to deliver an equitable AOS service in the short, medium and longer term. It is intended that workforce planning will support the clinical model through:

- Creating a more flexible workforce, sharing staff across locations within HB's with additional support provided by the AOS Lead and administrators;
- Developing and implementing a structure for career progression, learning and development to support succession planning and to provide wider service development of skills in acute oncology;
- The more detailed workforce plan being developed will address any future recruitment and skills gaps;
- Using the workforce flexibility to manage workload pressures within HBs;
- Retention of highly skilled and experienced staff within Specialist Oncology Services;
- Increased opportunities to develop clinical expertise - training and opportunities for medical and nursing, occupational therapists and AHP in acute oncology;
- The opportunity to develop the right skills for the future;
- Greater opportunities to share learning and best practice between teams and wider services.

Improvements to the quality of service and pathways for patients will be achieved as a result of more collaborative working appropriate services, reducing risk and improving patient experience. The challenges ahead in having a workforce that can effectively and efficiently provide care in an AOS are recognised.

Expansion of the AOS as a regional approach is an opportunity to make increased efficiencies in delivering services. The plan will help ensure that the right staff are in the right place at the right time, aligned with the long term model of care for AOS across South East Wales. Acknowledging the differences and difficulties in recruitment across the region, and to maintain the equitable and collaborative nature of the project, a regional nursing recruitment plan will be developed.

5.5 Change Management

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Change can be challenging but by taking a systematic approach clinical teams will be supported in seeing where change has been affective. The change process is underpinned by a number of principles:

- Recognise the need to maximise the benefits of change for patients, who should be at the heart of the changes made;
- Take advantage of the pre-implementation phase to start the change process;
- Work in partnership with stakeholders to engage all those involved in the delivery of care in the change process;
- Focus on staff skills and development so they are both capable and empowered to deliver the service effectively and to a high quality standard.

A full Change Management Plan will be developed during the implementation phase.

5.6 Communication and Engagement

Effective communication and engagement with all stakeholders is vital in the delivery of a successful project.

The development of the clinical model and this business case has been the result of a huge amount of collaboration, with clear and effective communication key to reaching a consensus across four organisations and many professional disciplines. Continuing a high level of communication and engagement will be even more important during implementation, with an increasing number of stakeholders involved as the enhanced service is rolled out.

A communication plan will be developed during the implementation phase.

5.7 Benefits Management

Benefits management is the identification, optimisation and tracking of expected benefits from the implemented change. A benefit realisation plan will help assess whether the identified benefits set out in the Strategic Case (and below) deliver the project spending objectives (also set out in the Strategic Case) and are able to meet the agreed measures of success.

The benefit management process includes the following stages:

- Identification – selection of appropriate and significant benefits
- Planning – how, when and by whom the benefits will be delivered (ownership, accountability and timeframe)
- Deliver – successful delivery of the benefits plan
- Review – continuous improvement through incremental change or new projects

Measuring and monitoring the delivery of benefits is key in assessing the extent to which they are being delivered against the plan. A proportion of the benefits will be 'hard' or quantifiable (such as admissions and length of stay) but many will require 'soft' or qualitative measures to assess their delivery. In some instances, measurement can be achieved through existing systems and information sources. However, there is a recognition that these existing sources can be unreliable,

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and in other instances there is a gap which will require new arrangements to effectively monitor them.

Given the complexity of working across the region and multiple organisations, management of the benefits throughout the life of the project will be led by the AOS Project Group. The following table sets out the anticipated benefits of implementing the AOS clinical model but further details, including the anticipated impact these benefits will have can be found in the Benefits Realisation Plan (Appendix D).

Figure 48: Anticipated benefits of implementing AOS clinical model

Benefit	Beneficiaries	Measurement
Equal access to AOS for those in equal need	Patients, staff, Health Boards	Patients per head population, attendances linked to cancer incidence trends
Improved patient experience and better patient outcomes	Patients, staff, families, carers	PROMS
Patients spend more time at home in their last year(s) of life	Patients, families, carers	PROMS, number of days spent in acute hospital in last year of life, patient preferred place of death, mortality rates within 30 days of treatment, palliative care contacts
More patients receive same day emergency care avoiding the need for hospital admission	Patients, Health Boards	Emergency admission rates, 30-day readmission rates, Nos of AOS patients admitted as inpatients, Nos of patients managed through ambulatory pathways, Cost per case
When admitted patients spend less time in hospital as an inpatient	Patients, staff, Health Boards	Inpatient bed days Average length of stay
Patients are not subject to unnecessary investigations or treatment	Patients, Health Boards	Numbers of investigations Patient outcomes and survival
Enhance links with other hospital based specialists / services	Patients, staff	Staff surveys, referral times
Improve effectiveness of AOS team working	Patients, staff	Staff surveys, number of patient handovers
Better professional AOS education and training	Patients, staff	Increase in critical mass of AOS team, staff surveys, retention, qualifications across the team
Digital interaction between staff / patients and staff / staff	Patients, staff, Health Boards, Velindre NHS	Number of digital interactions, reduced time to access specialist opinion

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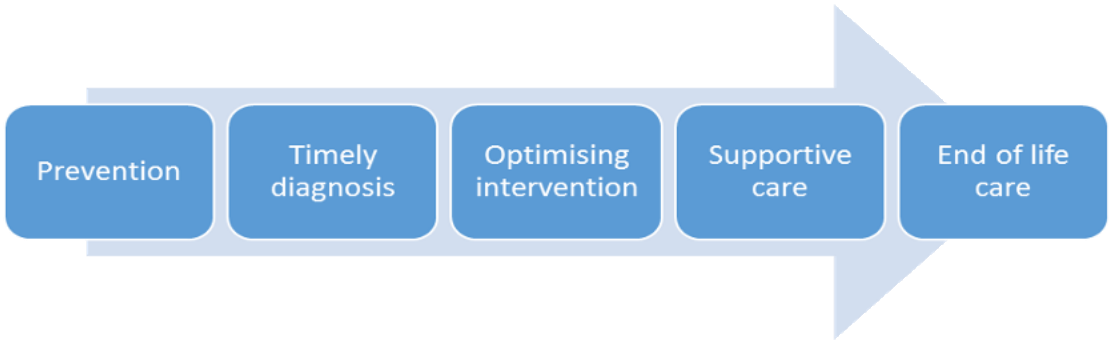
Benefit	Beneficiaries	Measurement
	Trust	
Better AOS data to improve decision making & accuracy of demand and capacity forecasting	Patients, staff, Health Boards	Staff survey Reports
Efficient collection of AOS data allows for inter-operability and more clinical time spent with patients	Patients, staff	Staff survey Reports

5.8 Value-based Healthcare approach to acute oncology

Identifying the benefits, and the approach to delivering and measuring them, are enshrined in the principles of value based healthcare (VBHC). VBHC seeks to improve the health outcomes that matter most to the people by asking people about their outcomes and creating a data-driven system which seeks to provide the timely information to citizens, clinical teams and organisations to inform the decision-making that leads to those outcomes in a way that is financially sustainable.[22]

Achieving the outcomes that matter to patients requires a population health, whole system approach as indicated below.

Figure 49: Elements of patient pathway



Although this business case considers only part of the above pathway, it is recognised in the Strategic Case that acute oncology covers the whole pathway and these elements will be picked up outside of this business case. Translating this pathway for acute oncology patients is set out below:

- Preventing acute oncological emergency presentations as far as is possible. Fully equipping patients with knowledge of what to look out for and what to do. Linking this to advance care planning so that intervention is appropriate to the patient's context and preferences.

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[22] Value based Healthcare

- Clear pathways and points of contact for all professionals likely to encounter acute oncological emergencies (along with continuing education on presentations).
- Early intervention to maximise recovery and quality of life.
- Supportive care – use PROMs as assessment of symptom burden.
- Advance care planning to ensure appropriate response and palliation in the community where this is needed.

Embedding VBHC in the delivery of AOS will support benefit realisation. In doing so, it is important to think about the costs associated with as many examples of acute oncology emergency as possible, and that clinical outcomes and PROMs are considered alongside each other. There is an ongoing commitment to link the identified benefits with VBHC.

5.9 Risk Management

A risk is the possibility of a negative event occurring which adversely impact on the project. Identifying, mitigating and managing the key risks is crucial to successful delivery.

The risk management process includes the following stages:

- Identification – ascertain what the possible risks are
- Assessment – determine the likelihood and impact of the risk occurring
- Control – identify ways that can reduce the likelihood and impact of the risks occurring (mitigate)
- Monitoring – review whether the situation has changed and whether the mitigation measures working

The Economic Case set out the key implementation risks, their likelihood and impact. The risks will be managed through a risk register and a full risk register can be found in Appendix E. The Project Manager is responsible for continuous review of the risks throughout the life of the project and the governance structure allows for risks to be escalated from the Project Group to the Implementation Board, who will oversee them during the life of the project.

5.10 Summary

The Management Case has set out the regional governance that will oversee the regional implementation, and the project processes, including management of risks, benefits and change. It has demonstrated that with appropriate governance structures, well developed plans and project management, the implementation of this clinical model will be successful in meeting the two core principles of equity of access and shared ownership and delivery across the region and organisations.

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Cardiff and Vale University Health Board Business Case

This template should be used for as the document for revenue investment proposals greater than £75,000 and capital up to £500,000

Title	Vague Symptom Pathway Clinic (Rapid Diagnosis Clinic)		
Ref No.		**Date Last Updated** (dd/mm/yyyy)	04/04/2022
Sponsor	Meriel Jenney	**Lead / Project Manager**	Rachel Lee
Clinical /Service Board or Department		Medicine	

1. Executive Summary

Annual Revenue Requirement	**22-23**	**23-24**	**Recurrent (£)**
	£172,848 Sep 22-Mar 23 £172,848 externally funded C&VUHB £0	£303,435 Apr 23-Mar 24 £61,284 externally funded C&VUHB £242,151	£317,338 C&VUHB £317,338
Capital Requirement (£)			

This should provide an informative summary of the case. This section should be a summary of the subject, scope, proposal, resource implications, benefits and risks. It should clearly state the purpose of the business case

Early diagnosis of cancer is widely agreed and strongly evidenced to result in better outcomes for patients. But a significant cohort of patients are being diagnosed late, sometimes following delayed presentation, or delayed referral due to "vague" symptoms seemingly attributable to non-cancerous sources or an absence of site-specific symptoms that meet the referral criteria for NG12 (NICE Urgent Suspected Cancer GP Referral Guidelines).

The Rapid Diagnosis Centre (RDC) provides an accelerated diagnostic pathway for patients who present to primary care with vague, but concerning, symptoms which may be indicative of cancer. Neal, Din & Hamilton et al (2014) found that 50% of cancer patients in general practice did not present with NICE guideline symptoms suspicious for cancer in their patient record, indicating that a large cohort of patients are likely to fit into the vague symptom bracket.

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Value Based Healthcare (VBHC) is predicated on facilitating the best possible outcomes for the population with the right interventions and contacts at the right time and place within the resources available, reducing waste, harm and variation. From a VBHC perspective and demonstrable from other Health Board Pilots, an RDC would mean patients are seen in a more timely manner with the right diagnostics to support better patient outcomes from less delayed presentation, faster diagnosis better survival and quality of life, less patient anxiety and a reduction in unnecessary interventions. Further benefits to the Health Board include areas such as cost effectiveness and clearer pathways to primary care, this will support sustainability. Outcome collection is a key part of evaluating value and the Wales Cancer Network (WCN) has an agreed set of outcome measures to report and demonstrate effectiveness of RDC's.

The RDC concept was piloted across two Health Boards within Wales (Cwm Taf Morgannwg and Swansea Bay) in 2017. Evaluation data demonstrated significant reductions in cost and time to diagnosis for patients referred to the service when compared with patients downgraded from USC pathways, but subsequently found to have cancer. Following the successful pilot phase, a recommendation was made to the Cancer Network Board for RDCs to be rolled out nationally. This was approved in 2019 and as of March 2022 apart from Cardiff and Vale UHB, all Health boards excluding Powys now have RDCs.

This is an initiative that is being driven by both the Wales Cancer Network and Welsh Government. The repeated question in the monthly Cardiff and Vale UHB Cancer performance meetings with Welsh Government is to ask when Cardiff and Vale will open its RDC. With the recent success of the RDCs in other Health Boards there is considerable political attention over the lack of provision in Cardiff and Vale UHB.

Recent cancer performance figures have shown a fall in performance with the Single Cancer pathway (SCP), Cardiff and Vale is consistently below the required 75% target for almost all cancer sites. The WCN has ratified to introduce "vague symptoms" as an SCP this year with the target for diagnosis being made within 7 days. Without an RDC this will exacerbate Cardiff and Vale UHB's poor performance against SCP targets with 100% of patients likely to breech this target. The average time for a patient to be diagnosed with vague symptoms noted in the Swansea Bay pilot was over 80 days.

The Cardiff and Vale UHB RDC will have a specific aim of replicating the experience from other Wales RDCs - significantly reducing time from suspicion of cancer to point of diagnosis. This is likely to mean a reduction in the numbers of unnecessary or duplicated diagnostic tests, streamlining and improving patient experience and supporting GPs who currently struggle to identify the suitable referral pathway for their patients with non-specific but concerning symptoms.

There will be cost and workforce implications to setup. However, evidence from other RDCs clearly indicates that there are likely to be positive opportunity financial savings for the system, at the same time as meeting national strategic commitments and improving holistic patient experience and cancer outcomes.

The evidence from Welsh Pilots highlighted benefits to implementing the RDC service included:

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- Providing a patient-centred service which exemplifies the principles of prudent healthcare and Value Based Healthcare.
- A rapid diagnosis pathway for complex patients with non-specific but concerning symptoms, with benefits for both cancer and non-cancer diagnoses. Right place, right time resulting in better patient outcomes.
- At pilot stage conversion rates of 9.6%, with almost 30% patients receiving a non-cancer diagnosis.
- A clinically and cost-effective model – from the pilot, the mean cost per patient noted in Swansea Bay is £646,which is £1,751 less than those patients downgraded from the USC pathway and subsequently given a cancer diagnosis. Those costs are at 2017 prices.
- Reduced diagnosis waiting times – the pilot noted a mean waiting time of 5.9 days from point of suspicion compared to 84.22 days for patients downgraded from the USC pathway and subsequently given a cancer diagnosis. This represents a reduction of 78.3 days.
- Excellent patient feedback - 96% of patients in the pilot rated the service as good or excellent.
- High levels of GP satisfaction – 88% of GPs in the pilot reported being either satisfied or very satisfied with the RDC experience.

In the absence of auditable robust data within Cardiff and Vale UHB it is assumed that the findings of the Welsh pilots are applicable to the current practice in Cardiff and Vale UHB.

Resource implications:

The WCN is looking to pump prime the Cardiff and Vale RDC by providing funding until April 2023. There is a requirement for Cardiff and Vale UHB to guarantee recurrent funding from April 2023.

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The costs for Cardiff and Vale are detailed in the table below:

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Description	Band	WTE for 2 clinics per week/year	Year 1 (part yr) 22-23	Year 2 23-24	Year 3 24-25
RDC Co-ordinator	B5	1	23,648	41,755	43,008
CNS*	B7	1	34,708	61,284	63,122
HCSW	B2	0.1	1,467	2,590	2,667
Radiologist	Consultant	0.4	32,773	57,868	59,604
Physician/GP	Consultant	0.4	32,773	57,868	59,604
Clinical Lead	Consultant	0.3	24,580	43,401	44,703
Radiology services	Radiographer B6	0.3	8,832	15,595	16,063
Radiology services	Radiology Admin B3	0.3	4,831	8,530	8,786
Medical Records Support	B2/B3	0.03 / 0.18	3,183	5,619	5,788
Total Pay			**166,794**	**294,510**	**303,345**
Estates Support		R	1,750	3,090	3,183
IT Charges year 3		R			4,800
Equipment		NR	1,000		
Non-pay		R	3,305	5,835	6,010
Total Expenditure		**4.01**	**172,848**	**303,435**	**317,338**
Income	MacMillan funding CNS post yrs 1 and 2		(34,708)	(61,284)	0
Income	WCN Pump Prime to April 2023		(138,140)	0	0
Total Revenue Costs			**0**	**242,151**	**317,338**

* Macmillan Cancer Support Grant Years 1 and 2 only

*Macmillan have agreed to fund the CNS (Clinical Nurse Specialist) for 2 years if Cardiff and Vale UHB guarantees funding after year 2.

There are some risks associated with the project, for example difficulties sourcing the required infrastructure or staffing resource, as well as the interdependency RDCs have with Radiology. Action to mitigate these risks is already in progress and outlined fully in Section 11. There is also a risk of not establishing an RDC – outcomes are well evidenced, and the concept is proven to be both clinically and cost effective, whilst contributing to achievement of the Single (Suspected) Cancer Pathway target. Without an RDC within the Health Board there is a risk sustained poorer patient outcomes, increased cost and longer timeframes from referral to diagnosis for patients with vague symptoms.

The purpose of this business case is to secure funding to establish an RDC in the Cardiff and Vale Health Board. It is intended that the RDC would run two clinics per week, with a total of 10 patients being seen.

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2. Introduction and Background

This section should describe the setting and background to the business case and should serve to clarify the subject matter. What is the high level aim / purpose and timeframe for this business case?

The purpose of this business case is to secure funding for the development and implementation of a Rapid Diagnosis Clinic (RDC) within the Cardiff and Vale UHB. Rapid Diagnosis Clinics provide a specific referral pathway for patients with vague but concerning symptoms, which could be indicative of cancer. They promote a personalised, accurate and rapid diagnosis of the patients' symptoms by integrating diagnostic provision and a networked multidisciplinary clinical team, enabling an earlier diagnosis and onward management and better patient outcomes.

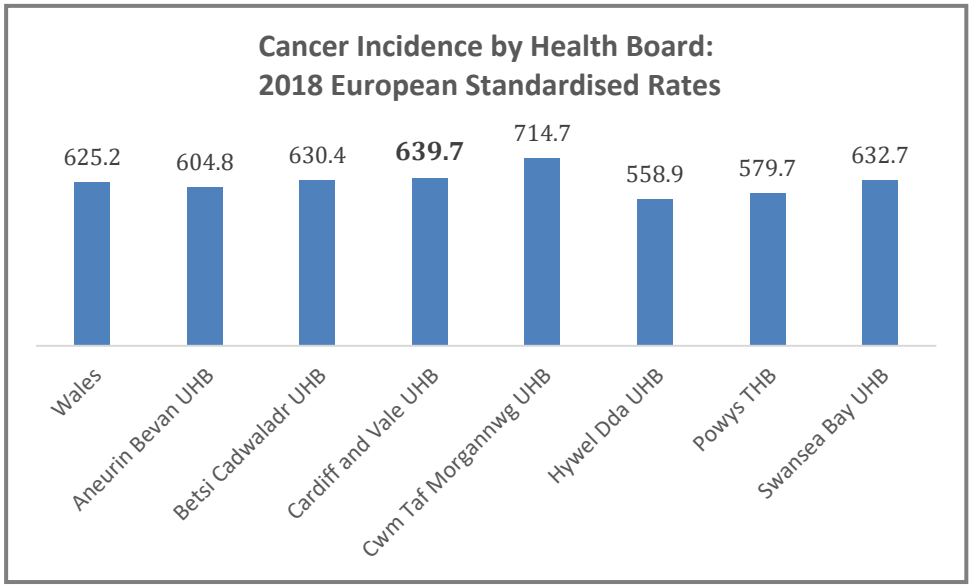
Pending approval of funding, it is intended that the RDC would be launched and operational by the end of 2022, with two clinics running per week and 10 clinic slots for patients.

Background:

Across Wales the incidence of Cancer is rising, with over 20,000 new cases of cancer a year in Wales alone *(Welsh Cancer Intelligence and Surveillance Unit, 2018 data).* It is predicted that half the UK population will develop cancer at some point in their lifetime.

Wales consistently has the second highest rate of cancer incidence across the UK countries and one of the highest rates across Europe (7th out of 45 countries as estimated by the European Cancer Information System).

As of 2018, Cardiff and Vale had a European Age-Standardised Rate (EASR) per 100,000 population for new diagnosis of cancer (all cancers except non melanoma skin cancer (NMSC)) **2.3%** higher than the Wales average. This was also the second highest rate when compared with all Health Boards in the country:

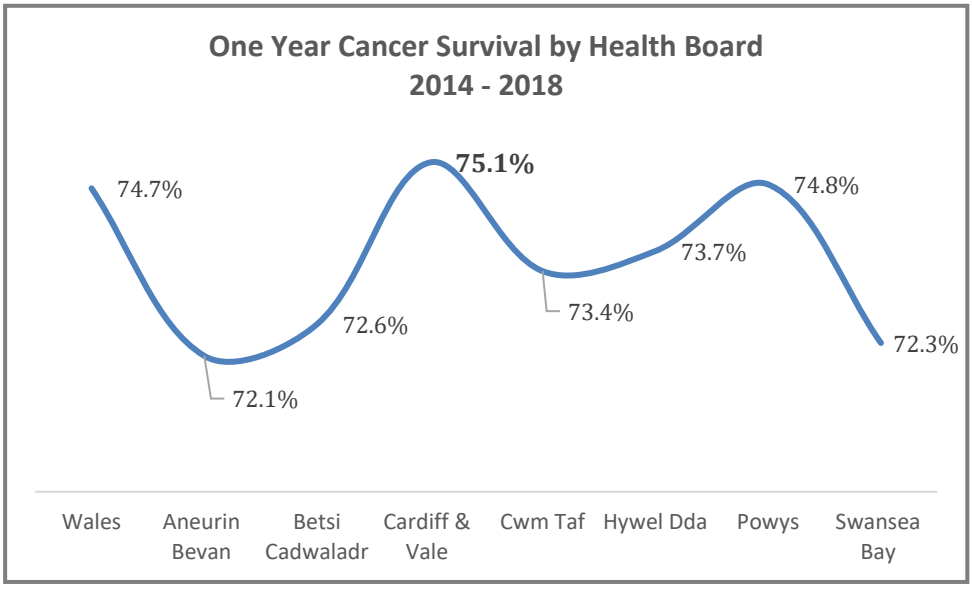


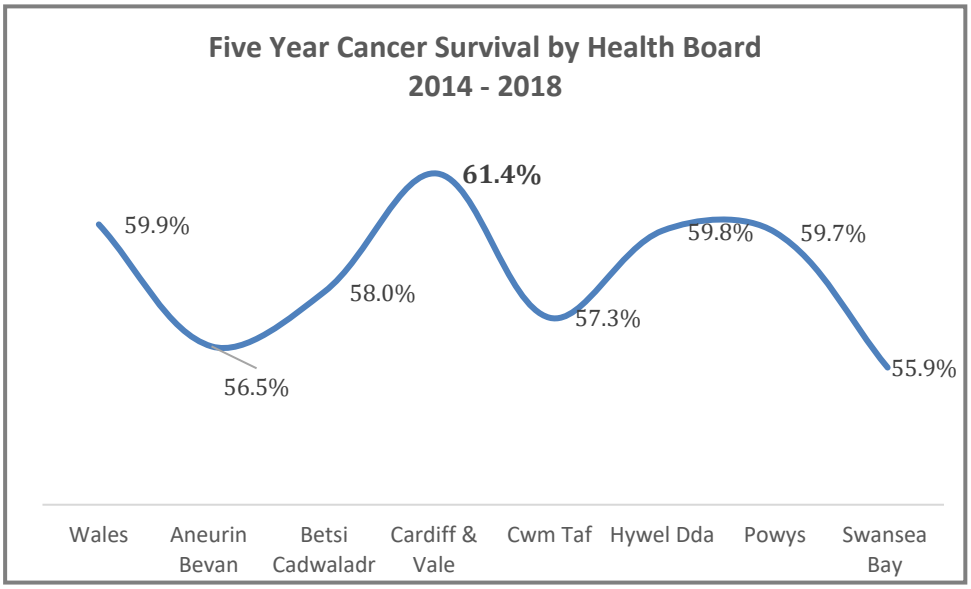
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Rates of cancer diagnosis are also high nationally, Wales has the highest European age-standardised rate (EASR) per 100,000 population for new diagnosis of cancer (all cancers except non melanoma skin cancer (NMSC)).

In addition, Wales also has the lowest overall one year and five-year all-cancer survival and highest cancer mortality rates in certain cancer types as published by the International Cancer Benchmarking Programme (ICBP), defined by a persistent late presentation of disease, a poor primary – secondary care interface, difficulty accessing and long-time intervals in the diagnosis pathways.

Notably within the country, Cardiff and Vale have the highest one- and five-year survival rates:





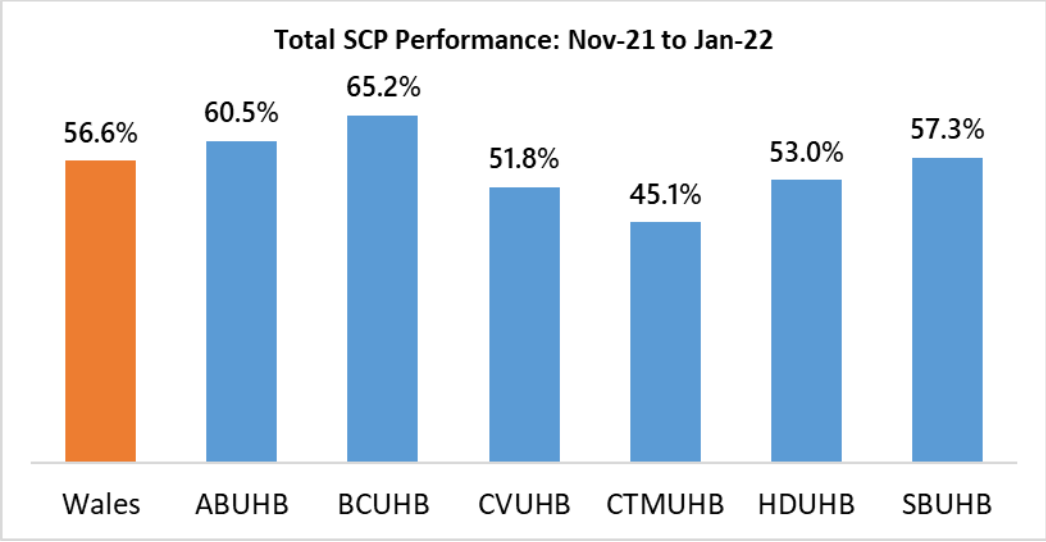
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In Wales, only 35 – 45 % of all cancers are diagnosed via the accelerated USC route. Most patients present via non accelerated routes, with a significant proportion experiencing vague symptoms. Neal, Din & Hamilton et al (2014) found that 50% of cancer patients in general practice did not present with NICE (NG12) guideline 'red flag' symptoms suspicious for cancer in their patient record, indicating that a large cohort of patients are likely to fit into a vague symptom bracket.

Where the underlying condition is not obvious and patients don't present with 'red flag' symptoms, the GP usually must coordinate a series of diagnostic investigations, choose a specialty to refer to, or use time as a diagnostic tool. This can result in delayed diagnosis; unnecessary investigations and consultations being performed; unnecessary or prolonged distress for the patient and, ultimately, potentially poorer long-term clinical outcomes.

Patients diagnosed via a non-USC pathway often have a much longer journey between initial presentation and diagnosis, with multiple investigations undertaken prior to diagnosis, which can have a detrimental effect on the clinical and patient outcome. These patients are usually referred to a USC pathway by their GP but subsequently downgraded as they don't meet the criteria. The Swansea Bay pilot found that these patients wait on average 84 days from referral to diagnosis.

In November 2018 the Welsh Government confirmed that a Single (Suspected) Cancer Pathway would be implemented in Wales that would replace the USC and non-USC pathways. As a result, Health Boards must ensure that most of their patients, from the very first point where cancer might be suspected, receive cancer diagnostic tests and start treatment within 62 days. Timely access to the right tests and expertise for prompt diagnosis is therefore a key priority across Wales, with a target of 75% patients receiving treatment within 62 days being set by Welsh Government. As of September 2021, Cardiff and Vale UHB were 21% below the compliance target with 54% - the second lowest figure of all Health Boards. Most recent figures just released have shown that this performance figure has decreased further:



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Rapid Diagnosis Clinics:

The Rapid Diagnosis Clinic (RDC) aims to support the Single (Suspected) Cancer Pathway by providing an accelerated diagnostic pathway for patients presenting in primary care with vague but concerning symptoms which may be indicative of cancer. These patients do not fit into a standard Urgent Suspected Cancer (USC) pathway because of the absence of clear "red flag" symptoms.

Based on a model developed in Denmark, the RDC project was established by the Wales Cancer Network (WCN) to test a new model for cancer detection. In partnership with the WCN, Swansea Bay and Cwm Taf Morgannwg Health Boards piloted RDCs across 2017 – 2019, demonstrating that they offer a cost-effective solution to improving outcomes for patients with vague, non-specific symptoms. They also proved effective at quickly diagnosing a range of other chronic health conditions and provided prompt reassurance to those with no serious diagnosis and therefore in support of the ambitions of "A Healthier Wales".

Evidence gleaned from South Wales RDC Pilot Evaluations demonstrated significant financial and efficiency savings when compared with patients who had been downgraded from USC pathways but subsequently received a cancer diagnosis:

Economic Evaluation of :

The Economic Evaluation of Swansea Bay compared RDC patients to a comparator cohort of patients with vague and/or non-specific symptoms that could be due to cancer This comparator cohort were referred by their GP to the USC pathway but were then downgraded due to the lack of red flag symptoms.

Following implementation across all GP clusters, the RDC clinics had 5 patient slots however during the evaluation period an average of 4 patients were seen per clinic.

The economic evaluation used the proportions of patients seen by the RDC during a 1 year period classified into one of four outcomes. The cost incurred by the comparator cohort were micro costed using those resources utilised (as obtained through the hospital records) with standard unit costs allocated. Both elements summarised as follows:-

			Cost per Patient for RDC	
	Observed Probability	**Cost per Comparator Cohort pathway**	**4 Patients per Clinic**	**5 Patients per Clinic**
Patients with an eventual cancer diagnosis	12%	£2,397	£778	£646
Patients with other diagnoses,	16%	£871	£778	£646
Patients with no serious pathology found	36%	£515	£778	£646
Patients requiring further investigations	36%	£953	£1,168	£1,036
	100%			

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The figures included in the table above were used to calculate the cost impact of the RDC. The Table below, sourced from Swansea Bay's Economic Report, (undertaken by the

Swansea Centre for Health Economics) summarises the impact of the RDC assuming 12% overheads for all sessional staff cost and an assumed 100 clinics per year.

Number of patients per clinic	Cost with RDC (including RDC staff overheads)	Cost without RDC (comparator group)	Cost impact
4 patients	£367,442.81	£382,231.22	**-£14,788.**
5 patients	£393,307.52	£477,789.03	**-£84,481.**

The report estimated that at full capacity of 5 patients per half-day clinic, the RDC would cost £84,482 less compared to the USC downgrade pathway while at 4 patients per clinic provision of the RDC would cost £14,788 less

The economic evaluation also considers the potential Incremental Cost Effectiveness Ratio (ICER) per Quality Adjusted Life Years (QALY). Whilst no routine utility data was available, published research findings were used to identify the decrease in quality of life as the wait for diagnosis increases. These indexes were available for each category of patient outcome.

The evaluation of the pilot found when using a mean number of 4 patients per half day RDC clinic, the ICER (Cost per QALY) is £2,812 less than the alternative of no RDC. Using the full capacity of 5 patients per half day clinic per half day RDC clinic, the ICER (Cost per QALY) is £17,161 less than the alternative of no RDC.

NICE recommends a willingness to pay threshold of an additional £20,000 per QALY. The pilot's evaluation using 4 or 5 patients per clinic presents an extremely cost-effective change in service for an increase in QALYs.

The evaluation concluded that "provision of RDC services can therefore be considered potentially excellent value for money being less expensive and more effective than usual care when clinics are run at or near full capacity".

It was noted that whilst these are notional cost reductions, in practice, this is unlikely to be cash releasing.

RDC = average of 5.9 days
Downgraded USC Patient (subsequently diagnosed with cancer) = average of 84 days
Reduction of 78.1 days (93%)

As well as demonstrating improved patient outcomes with regards to earlier diagnosis of cancer (average conversion rate of 9.6% during the pilot phase), the RDCs also enable the identification of other non-cancer serious conditions. In the two pilot RDCs, 29% patients received a significant non-cancer diagnosis which needed management by either secondary care or their GP. Again, from a VBHC perspective, facilitating best possible outcomes for these patients by expediting the right contacts and interventions.

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Following the success of the pilot programmes a recommendation was made to the Cancer Network Board (formerly the Cancer Implementation Group) for RDCs to be rolled

out across all Health Boards within Wales. This recommendation was approved and as of January 2022, four of the seven Health Boards within Wales have operational RDCs. All four operational RDCs are now fully funded by their individual Health Boards' core budget.

The WCN are proposing to fund the first 7 months for the Cardiff and Vale RDC, however require assurance of recurrent funding from April 2023 from Cardiff and Vale UHB.

Attached is the Economic Evaluation of the ABMU's pilot undertaken by Swansea Centre for Health Economics.



Economic Evaluation of the ABMUHB Pilot I

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3. Summary Strategic Context

This section should outline the strategic context and be clear how the case meets Shaping Our Future Wellbeing / IMTP priorities and national priorities and / or whether the case addresses current legislative requirements

Developing ways to achieve early cancer diagnosis to improve outcomes for people with cancer in Wales is central to recent national level strategies:

Wellbeing of Future Generations (Wales) Act 2015:

The Act is designed to improve the social, economic, environmental and cultural well-being of Wales. It states that public bodies in Wales must take action to implement sustainable development, setting specific objectives to ensure the seven wellbeing goals identified in the Act are achieved.

The sustainable development principle ensures that public body decisions take into account short term needs, whilst also considering the impact these decisions may have for people in the future. Involving our communities in informing, shaping and implementing plans; acting to prevent problems occurring or getting worse and maximising people's physical and mental wellbeing are also key parts of the Act.

The principles and goals outlined in the Act guide and underpin both a national and local commitment to improve cancer outcomes. Identifying and delivering innovative solutions to achieve earlier diagnosis and better patient outcomes are fundamental elements of this commitment.

A Healthier Wales:

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A Healthier Wales sets out the ambition for rapid service redesign and a whole systems approach to health and social care, focused on health and wellbeing. Transformation, innovation and delivery are the primary tools identified for achieving this vision.

The approach drives equitable services and support, with everyone in Wales receiving the same high quality of care and achieving more equal health outcomes. Change will be embedded to better meet future challenges and opportunities, with local innovations being scaled up to regional and national levels.

The Cancer Network Board and WCN ambition is for each Health Board to have an operational RDC, which would support A Healthier Wales's ambition of equitable service provision for the people of Wales and more equal health outcomes. The principles of the RDC also strongly align with the five NHS Wales core values outlined in the document:

1. Putting Quality and Safety above all else – RDCs are evidence based programmes that place patients at the core of service delivery
2. Integrating Improvement – RDCs have demonstrated reduced patient waiting times for diagnosis and treatment
3. Focusing on prevention, health improvement and inequality – With the goal of an RDC in each Health Board, patients should be able to access locally delivered services
4. Working in true partnerships – RDCs drive cross functional and collaborative working across the Primary and Secondary sectors for patients with vague symptoms
5. Investing in our staff – RDCs aim to provide excellent learning and development opportunities for staff with new ways of working and a diverse range of patients referred

The Quadruple Aim is central to the Healthier Wales approach and will underpin the development and implementation of the Cardiff and Vale RDC.

Value Based and Prudent Healthcare:

Value Based Healthcare is about achieving the best possible outcomes for individuals and population as a whole, within the resources available, reducing waste and variation
An RDC puts patients at the centre of its care by providing a patient centred service to support early interventions by the right clinicians at the right time and evidenced by pilots in other Health Boards results in earlier diagnosis of cancer as well as significant non-cancer diagnosis. This earlier diagnosis results in better patient outcomes and the reduction in unnecessary interventions reduces wasted resource.
Crucial to the implementation of Value Based Healthcare is the measurement of outcomes, including patient reported outcomes. Under the Wales Cancer Network, a national tool enables collection of 13 outcome measures to allow RDC pathways to be monitored and measured (see section 12). In additions PROMS will be collected at key stages in the RDC pathway.
Prudent healthcare is at the heart of A Healthier Wales. It aims to shape the Welsh NHS to ensure it is sustainable, always adding value and contributing to improved outcomes. The

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principles of prudent healthcare will help to reform health services and rebalance the relationship between individuals and health professionals to help us all live healthy lives for as long as possible.
Four principles underpin the concept:

1. Public and professionals must work as equal partners through co-production.
2. Those with the greatest needs have their care prioritised, with resources and skills used effectively.
3. Do only what is needed and do no harm.
4. Reduce inappropriate variation by using evidence based approaches consistently and transparently.

Early cancer diagnosis interventions improve patient outcomes, promote good health and support individuals to stay-well. Enhanced diagnostic pathways and communication between Primary and Secondary care ensures that the right services can be accessed quickly, and resources are used effectively, reducing unnecessary interventions.

The RDC model supports earlier cancer diagnosis and therefore fits well with the ethos of A Healthier Wales and prudent healthcare, with the pilots noting an average time of 5.9 days from GP referral to cancer diagnosis compared to the 84 days of comparator group.

Cancer Delivery Plan:

The Cancer Delivery Plan (2016-20) described a shared vision for the people of Wales where risk is minimised and cancer incidence, mortality and survival rates are improved and comparable with the best. The next phase of cancer service development must build on the widespread consensus that cases of cancer are detected at an earlier, more treatable stage, diagnostics are streamlined and made more accessible, and complex treatment pathways are optimised. Throughout this process it remains vitally important that patients' holistic needs are properly supported, and they are empowered to co-produce their own care.

Early cancer diagnosis is a key priority being taken forward across Wales, the UK and Europe. Within Wales, the Wales Cancer Network and the National Cancer Network Board are progressing early cancer diagnosis as a key strategic programme of work as defined in the Cancer Delivery Plan 2016 - 2020.

In March 2021 Welsh Government launched their Quality Statement for Cancer, which replaces the 2016 Cancer Delivery Plan. This builds on the work of the Cancer Delivery Plan, aiming to maintain the leadership and engagement achieved so far and ensure a long term, consistent approach to achieving outcomes. There is a strong emphasis on prevention opportunities and diagnosing cancers earlier, supported by Detecting Cancer Early and Macmillan Framework for Cancer programmes.

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Introduced during the Covid-19 pandemic, the quality statement brings together a short-term focus on recovery with a longer-term focus on innovations. In the medium term, service development will be the primary focus and the main priority within the statement.

The Quality Statement sets out the required professional standards and quality attributes Health Boards must adhere to when planning and delivering cancer services around the following themes:

- Equitable
- Effective
- Person Centred
- Safe
- Efficient
- Timely

At the heart of the quality statement is the focus of nationally optimised pathways to support local improvement in the quality of service delivery. The implementation of the Single (suspected) Cancer Pathway is the vehicle that will support the delivery of consistent, high quality care and improved cancer outcomes.

Single (Suspected) Cancer Pathway):

A key step towards improving patient experience and outcomes from cancer is the implementation of the Single (Suspected) Cancer Pathway (SCP) in Wales. Health Boards are now in the process of developing plans to ensure that all patients, from the point at which cancer is first suspected, will receive diagnostic tests and start their first definitive treatment within 62 days. Prior to the introduction of the SCP, patients diagnosed via non-urgent pathways may have to wait up to 56 days for a radiological investigation or 126 days for a clinic appointment, which can have a detrimental effect on clinical and patient outcomes.

The ethos of the RDC fits well with that of the SCP by improving efficiency through the patient journey. By reducing variation in patient pathways for those with vague symptoms, improving the transition between primary and secondary care, and providing direct access to diagnostic services, the RDC and SCP will work to improve both patient experience and cancer outcomes. Results from the pilot programmes have already evidenced this, with average times of referral to diagnosis of 5.9 days and average costs per patient reducing by 73%. More recent RDC outcomes further demonstrate the effectiveness of the model in supporting the aims of the SCP.

Local Health Needs:

NHS Wales has estimated that cancer accounts for about 7.1% of all its expenditure, amounting to £463 million in 2017-18. Allocating limited NHS resources efficiently and equitably is crucial to achieve the best outcomes for people affected by cancer in Wales. These costs will continue to rise, and delayed diagnosis not only results in worse patient outcomes but increased health care costs due to more expensive treatments, high toxicity and symptom burden and other costs associated with the care of an individual with advanced cancer.

Late or missed diagnosis is implicated as a major contributor to the UK's poor position in international league tables of cancer outcomes. Alongside cancer survival, extended time to cancer diagnosis and therefore diagnosis at an advanced stage can have a substantial impact on survival, quality of life and patient experience. The economic burden of cancer

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will also reach beyond direct healthcare costs, including costs to the patient, family, public services, third sector and society.

Population changes will further impact on the provision and cost of cancer services. By 2039 the population in Wales is projected to increase by 5%, with the largest increase of 127% seen in those aged 85+ years. The 65-84 age groups are also projected to increase by 27% (Future for Wales Report PHW, 2018).

On a local level, the population in Cardiff and the Vale of Glamorgan is predicted to increase by 90,800 from 2014 - 2039. This represents a population increase of 16%. It was noted in the document that whilst people are living longer, they are not necessarily living healthier lives. These projections will have significant implications for the way in which we design and provide health and social care services, with an increasing need to provide services which are efficient, timely and well integrated.

The RDC evaluation report calculated the median age of an RDC patient to be 69.3 years, with a range of 18-98 years. A significant portion of RDC patients will therefore fall into the age categories predicted to have the highest population increases over the coming years. As the population increases, so will the number of patients presenting with vague symptoms, making the RDC service even more essential to meet the growing demand placed on public services.

Vague Symptom Pathway:

The RDC evaluation recommended that a National Optimal Pathway was developed as part of the Single (Suspected) Cancer Pathway Programme for patients with vague symptoms, who GPs suspected may have cancer or a serious diagnosis but do not fit into current urgent suspected cancer referral pathways.

The Cancer Network Board approved this recommendation, and a Vague Symptom Pathway was subsequently developed by the Wales Cancer Network RDC and SCP Teams. In November 2021 the pathway was presented to the Cancer Network Board, who ratified the document and supported it being mandated across Wales. The Vague Symptom Pathway has a suggested maximum time of 7 days from GP point of suspicion to diagnosis, which RDCs will contribute towards achieving.

The Cardiff and Vale Cancer IMTP has an RDC as one of its main priorities, this is an essential element in the drive to improve cancer outcomes and improve the performance of the Health board against the Single Cancer Pathway. Having an RDC will enable earlier diagnosis and better treatment outcomes in patients with vague symptoms of whom a significant number have cancer. It will avoid long delays in this group of patients that currently often present acutely in hospital before the diagnosis is made, with later stage disease.

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4. Summary Current Service Provision

This section should outline the current service provision – model / pathway, activity, existing workforce (skill mix and WTEs) and cost

There is currently no RDC operating in the Health Board, however across Wales four out of the seven Health Boards now have at least one operational RDC, one Health Board has just launched three separate RDCs in March 2022.

CAN10:

To facilitate site specific cancer pathways, the Radiology department have developed a pathway to create rapid access to staging CT scans and same day reporting – CAN10. Funding from the WCN and Single Cancer Pathway went towards expanding the service in 2019 to encompass all cancer sites. This service is also used for urgent referrals by GPs for those who do not fit in a site specific pathway where there is a suspicion of cancer.

Patients placed on this pathway are assigned a 'CAN10' level of urgency and placed in the CAN10 reporting pool, where it is aimed that the scan will be performed within 10 days and results reported on the same day. Whilst it is likely that a proportion of "vague symptom" patients are referred to the CAN10 pathway, without doubt a proportion will not be.

Unlike the RDC pathway, CAN10 does not include a triage at point of referral. This results in site specific USC patients being scanned through CAN10, rather than being redirected to the relevant site-specific pathway prior to scanning. This can also result in inappropriate or excess scans being done if insufficient clinical information is provided by GPs.

Through the CAN10 pathway GPs can get rapid access to scans but no input into the next steps for diagnosis with these often complex patients. This can cause delay and uncertainty if the initial scan does not provide an answer. There are also difficulties obtaining secondary care input to patients who do not have an obvious site-specific cancer but may have an alternative diagnosis requiring a referral to secondary care.

CAN10 Activity:

Between Oct 20 and Oct 21: 22% of all CAN10 scans were ordered directly by GPs, the other 78% were for staging scans for those on site specific pathways.

This 22% was then analysed. Using the Radiology RIS system to search for all GP requested body scans (Neuro, Head and Neck and MSK CT scans were not included). Data was collated on all scans performed using the CAN10 pathway:

- 816 patients scanned via CAN10 USC Pathway
- 99 flagged as new cancer
- 12.1% conversion rate
- 26 scans flagged other significant findings

Note - It is thought that the inclusion of some USC patients in the CAN10 pathway is partly attributable for the high conversion rate.

Cost:

Existing workforce and cost of CAN10:

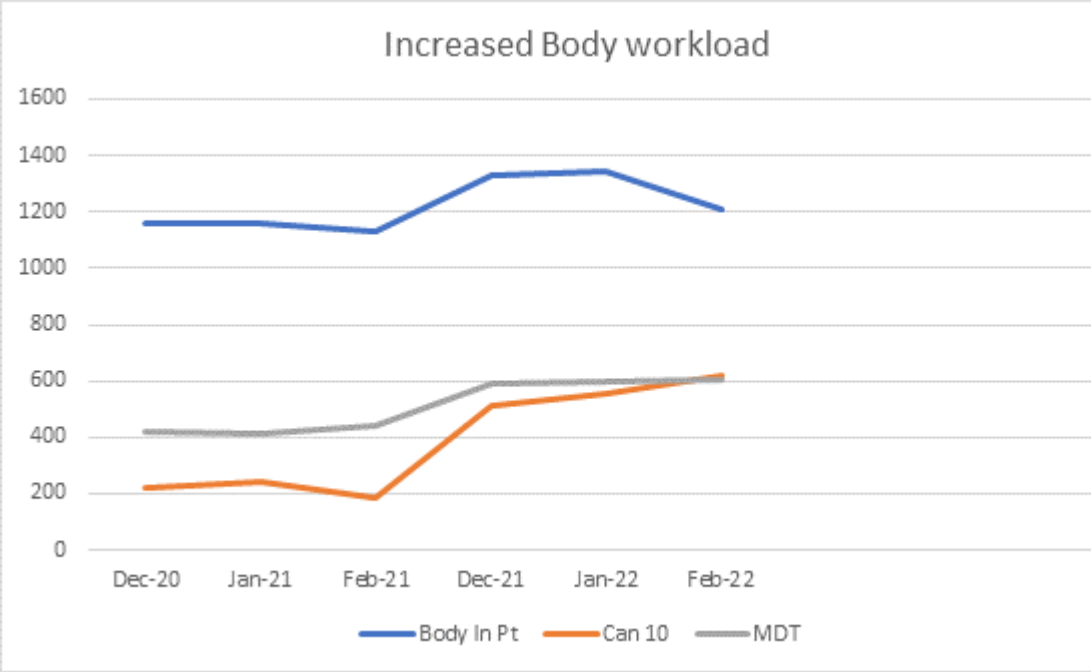
1 WTE consultant radiologist CT reporting sessions/week - £120k
1.2 WTE band 7 radiographer - £59k

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1.2 WTE band 6 radiographer - £49k
Total - £228k

The demand on the CAN10 pathway has increased recently, indicating that a slight increase in resource would be needed if there is an introduction of an RDC, to keep up with demand.

The graph below show the recent increase in scans:



Recommendation:

It is anticipated that GPs using the CAN10 pathway to investigate patients should instead be accessing an RDC and following the Vague Symptom Pathway. Those referred to the RDC and thus needing scans, would still be scanned using current CAN10 infrastructure to provide the rapid turnaround and reporting of the scans needed in the RDC process. By going through the RDC first, all referrals would go through a triage process, reducing the number of ineligible referrals (including redirecting to relevant USC pathways where appropriate). There would also be direct links with secondary care and onward referral processes for patients with a non-cancer diagnosis.

5. Case for Change

Supplementary to the business case, supporting analysis of the current service demand and capacity and performance should be appended:

- *Demand - analysis and trends of demand on the service, benchmarking and supported with a summary of the actions taken to address variations and, where necessary, improve efficiency.*
- *Capacity – analysis of the workforce, staffing levels, variations and actions being taken to address and, where necessary, improve efficiency.*
- *Current performance and benchmarking – summary of the achievement against the targets and efficiency indicators of the service. Identify service*

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performance against which the proposed service change should be benchmark favourably and summarise benchmarking and opportunities.

This section should outline the case for change, describing specific issues in existing arrangements.This section should indicate how the proposal will help reduce strategic and operational risks identified as part of the risk assessment.

The primary aim of introducing a Rapid Diagnosis Clinic service for patients with vague, non-specific but serious symptoms indicative of cancer in the Cardiff and Vale area is to improve patient outcomes, both in terms of earlier diagnosis of cancer and other non-cancer serious conditions.

This will contribute to the wider aims of the continued work incorporating the Single Cancer Pathway principles across the Health Board, improving relationships between primary and secondary care clinicians and improving holistic patient experience.

As indicated in earlier sections, the RDC will have a specific aim of replicating the experience from other Wales RDCs - significantly reducing time from suspicion of cancer to point of diagnosis. This can mean a reduction in the numbers of unnecessary or duplicated diagnostic tests, streamlining and improving patient experience and supporting GPs who currently struggle to identify the suitable referral pathway for their patients with non-specific but concerning symptoms.

The SCP requires Health Boards to ensure that from the first point of suspicion of cancer, at least 75% of patients receive cancer diagnostic tests and start treatment within 62 days. As of January 2022, Cardiff and Vale UHB were achieving a rate of 51.8% - 23.2% below the compliance target and the second lowest figure of all Health Boards. With the introduction of the Vague Symptom pathway as an SCP, and without an RDC, Cardiff and Vale UHB are extremely likely to drop their cancer performance more. The introduction of an RDC will be essential in achieving the 75% target.

Over 50% of cancers are diagnosed via non accelerated routes with the majority of patients experiencing vague symptoms. At present, this means they are likely to experience delays in accessing the correct pathway and will be moved around the system whilst this is being identified. The RDC is designed to target these patients, providing a single referral route for investigation and diagnosis. With a recommended timeframe of 7 days from referral to diagnosis, the introduction of an RDC would contribute towards reduced waiting times for patients and improve current SCP performance.

The CAN 10 pathway was introduced to provide rapid access to staging scans for patients found to have cancer as part of a site specific USC pathway, this has since been used also as a referral route for GPs investigating patients suspected of having cancer but who do not fit into a site specific USC pathway.

Referral triage is not built into the CAN10 pathway, and often the quality of information given for referrals is poor. This means it also absorbs patients that should have been referred to a USC pathway and those who may not need scans. The RDC will triage each referral received and has a strict referral criterion to ensure only eligible patients are seen. Patients not eligible for the RDC will either be referred to an appropriate USC pathway or returned to the GP with an explanation as to why they weren't accepted. With current GP requests the amount of clinical information varies hugely, often with very little clinical information. This makes it harder for the radiologist to report the scans without

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indication of the reason for the scan, and it maybe that with more clinical detail such as that needed for an RDC referral more prudent use can be made of the scans required.

CAN10 patients with a clear site specific cancer found on imaging are referred to the appropriate speciality for ongoing treatment and support. For CAN10 patients without an obvious site specific cancer, there is a lack of Secondary Care input which can delay access to required treatment. The RDC works closely with Secondary care to ensure all patients access timely treatment and support (where required), with established referral pathways for both USC and other serious non cancer diagnoses. Approximately 30% of RDC patients receive a non-cancer diagnosis, where they will be immediately referred on to the appropriate Secondary Care service.

RDC evaluations demonstrate that they are both clinically and cost effective. Further evidence of the outcomes and benefits of introducing an RDC can be found in Section 8.

6. Option Appraisal

This section should provide the details of the option appraisal. In developing the options, a do-nothing or do-minimum option must be retained. Do nothing may not be feasible but in this event should act as the baseline.

In some cases, where there is clearly only one realistic way forward, this can be explained, giving the reasons. In other cases, a range of options exist. These should be set out and then explored via a value for money appraisal whereby costs, benefits and risks of each option are compared.

The recommended option is then carried forward into section 7.

The outcome of the option appraisal should be presented with conclusions and the recommended option clearly stated. The impact of the proposal on demand and capacity should be outlined.

Do Nothing:

Without the introduction of an RDC in the Health Board, GPs do not have a direct and specific referral pathway for patients presenting with vague but concerning symptoms. They would need to continue making multiple referrals to different specialities, with patients 'bouncing' round the system and undergoing numerous and often unnecessary tests. There is also the possibility of increased presentations at Emergency Department and increased time to diagnosis resulting in poorer patient outcomes.

The RDC concept represents an innovative and transformative service, which has been recommended to be rolled out on a national scale by the Cancer Network Board. In addition to this, the recently ratified Vague Symptom Pathway will require Health Boards to work within the 7 day referral to diagnosis parameters identified in the document. Without the introduction of an RDC, the Health Board will not be aligned with agreed national models of care and will struggle to work in accordance with the Vague Symptom Pathway.

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Furthermore, the Health Board will not benefit from the expected significant opportunity cost savings, and reduced time to diagnosis outcomes evidenced in the evaluation.

Establish a 2 stop RDC:

The RDC model is well evidenced to provide improved outcomes for patients, with significant financial savings for the Health Board and reduced times to diagnosis, which will support with meeting the requirements of the Single (Suspected) Cancer Pathway. Working in partnership with Radiology it is clear there is a demand for the service. Based on their analysis of CAN10 patients, it is estimated there would be around 14 patients referred to the RDC per week. This aligns with data from existing RDCs who receive a regular stream of eligible referrals. The 2 clinic RDC would have 10 patient slots and run over a 52-week period, with approximately 520 patients seen per year. It is expected that 10 patient slots should be sufficient to meet demand as not all referrals will be eligible for the service.

To support the RDC service a staffing team will need to be recruited, which is outlined in Section 7. As this will be a new team, it means that excluding Radiology, there will be no impact on existing capacity or additional demand placed upon services. Conversely, it is intended that the introduction of an RDC will reduce pressure on existing services and GPs by providing a specific referral pathway for patients with vague symptoms. Conversations have already taken place with Radiology confirming they have capacity to support the proposed RDC service. In view of the recent increased demand on the CAN10 pathway there will be a slight increase in resource needed for radiology to account for this. This is detailed in the costs.

Establish a 1 stop RDC:

The initial RDC pilots were based on a one stop model. This would mean that the patient would have their investigations, clinical review and diagnosis on one day. This model would be hard to achieve at present in Cardiff and Vale UHB due to the constraints with radiology and the quick turnaround needed for reporting. This one stop model may be the model the RDC could be adapted to in the future.

Use the Community diagnostic Hubs to deliver the RDC:

The RDC could be delivered as part of the proposed Community Diagnostic Hubs. However, there is a need for GPs to have more than just rapid access to investigations, the multidisciplinary approach for these complex patients is key at achieving an early diagnosis. The need for the RDC is urgent especially with the Vague Symptom pathway recently being ratified to be an SCP putting more pressure on the Cardiff and Vale UHB Cancer performance. At present Community Diagnostic Hubs are in the early stage of development thus the infrastructure would not be available in time to satisfy the urgent need for an RDC. In the future, the RDC could move to sit within community diagnostic hubs which would bring care for patients closer to home. In the interim, whilst the Community Diagnostic hubs are developed and implemented, the preferred option is to develop and establish a two-stop model. In the future, it is recommended that the RDC is transferred to operate within the Community Diagnostic hub.

Phased implantation:

The RDC could be phased to start within 1-2 Clusters initially then expand to all Clusters, Using this model the need for extra radiographer funding could be delayed until

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expansion. As patient numbers would be lower, staff could be employed for fewer sessions initially. The risk would be an inequity of care depending on the postcode of the patient. The RDC is a model that has been piloted and proven. Due to collaboration and support from other health boards delivering RDCs, Cardiff and Vale will have the advantage of learning from previous issues experienced in the setup of other RDCs. There would potentially be no benefit in piloting this model again.

Recommendation:

It is recommended that the Health Board approve funding for a two stop RDC model to be established.

7. Resource Implications and Affordability of the Recommended Option

The supplementary excel finance template should be completed including:

- *Workforce implications – this section should set out the workforce implications, if relevant. This should include details by profession, band and WTEs.*
- *Capital requirements – this should be identified and detailed and, if known, whether this is agreed as part of the UHB's Capital Programme.*
- *Revenue implications – this section should summarise the financial implications, with a more detailed breakdown provide in an appendix. Any assumptions made should be clearly stated.*

Described here should be: options to mitigate additional investment or re-alignment of monies; whether the case secures sustainable improvement; the opportunity to release resources for alternative uses and the opportunity costs for other services

. The experience and evaluation of Welsh Pilots has shown that without an RDC patients with "vague symptoms "often experience long delays to get a diagnosis. The pilot noted on average of 84 days compared to the 5.9 days that an RDC would provide. Patients do not fit into a recognised pathway and may have more diagnostic tests than needed as the GP is unsure what is appropriate. As time progresses these patients will become acutely unwell and they often end up being admitted to hospital as delays cause deterioration in their condition and an urgent need to get a diagnosis, causing avoidable bed days.
The RDC will streamline the diagnostic process, the MDT approach will result in more prudent healthcare and a speedier diagnosis will avoid inappropriate testing, the risk of hospital admission and better access to curative treatment. The RDC underpins the Value Based Healthcare approach of facilitating the best possible outcomes by ensuring patients are seen in a timely manner with earlier diagnosis, avoiding waste, harm and variation. Whilst utilising resources in a sustainable manner, avoiding the consumption of greater resources later on in the patient's journey. The economic evaluation of Swansea Bay's RDC concludes that "provision of RDC services can therefore be considered potentially excellent value for money being less expensive and more effective than usual care when clinics are run at or near full capacity".

The additional costs to Cardiff and Vale UHB are detailed below:

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REVENUE	WTE	Band / Scale	Recurrent / Non Rec	Cost Year 1 Part Year	Cost Year 2	Cost Year 3
Direct Pay Costs - Staff Type	**WTE**		**R / NR**	**£**	**£**	**£**
RDC Co-ordinator	**1.00**	**B5**	**R**	**23,648**	**41,755**	**43,008**
CNS*	**1.00**	**B7**	**R**	**34,708**	**61,284**	**63,123**
HCSW	**0.10**	**B2**	**R**	**1,467**	**2,590**	**2,667**
Radiologist	**0.40**	**onsulta**	**R**	**32,773**	**57,868**	**59,604**
Physician/GP	**0.40**	**onsulta**	**R**	**32,773**	**57,868**	**59,604**
Clinical Lead	**0.30**	**onsulta**	**R**	**24,580**	**43,401**	**44,703**
Radiology services	**0.30**	**ographe**	**R**	**8,832**	**15,595**	**16,063**
Radiology services	**0.30**	**ogy Ad**	**R**	**4,831**	**8,530**	**8,786**
Impact on Support Departments						
Pharmacy						
Therapies						
Outpatients/Medical Records	0.03/0.17	B2/B3	R	3,183	5,619	5,788
Facilities and estates (catering, portering, domestics, security)				1,750	3,090	3,183
TOTAL PAY	**0.00**			**168,545**	**297,600**	**306,528**

* Macmillan Cancer Support Grant Years 1 and 2 only

*Macmillan have agreed to fund the CNS (Clinical Nurse Specialist) 2 years if the CVUHB agrees to pick up funding after year 2.

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pment			NR	1,000		
tenance						
related non-pay (travel, training etc)				**3,305**	**5,835**	**6,010**
r (specify)						
act on Support Departments						
macy						
apies						
atients/Medical Records						
ology						
cal Physics						
ratory Medicine						
tres						
sthetics						
ities - catering, domestics, waste, linen						
r - specify including overheads (inc finance /						
tc)						
structure						
tes Maintenance / Premises						
ies						
s						
nation Technology /Telecoms			R			4,800
nue Consequence of Capital spend below						
AL NON PAY				**4,305**	**5,835**	**10,810**

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REVENUE	WTE	Band / Scale	Recurrent / Non Rec	Cost Year 1 Part Year	Cost Year 2	Cost Year 3
TOTAL EXPENDITURE (not formuala driven - complete)						
(INCOME / SAVING) MacMillan Funded CNS Post WCN Pump Prime Funding to April 2023 xx xx	1.00	7	NR	(34,708) (138,140)	(61,284)	0
TOTAL INCOME				**(172,848)**	**(61,284)**	**0**
NET COST / (SAVING)				**(172,848)**	**(61,284)**	**0**

CAPITAL	Year 1 £	Year 2 £	Year 3 £
xx			
xx			
xx			
TOTAL	0	0	0

	Year 1 £	Year 2 £	Year 3 £
TOTAL RECURRENT (not formula driven - complete)	**0**	**242,151**	**317,338**
TOTAL NON RECURRENT (not formula driven - complete)	**0**		

Assumed start date	
Funding Source Revenue:	
Funding Source Capital:	

FINANCE CASE SIGN OFF

	Signature	Date
Relevant Sponsor		

Business Case Lead - Director of Operations		
Business Case Lead - Head of Finance		

Director of Operations - CD&T		
Director of Capital, Estates and Facilities		
Director of Operations PCIC (if impacted)		
Director of Operations Surgery (if impacted)		
Director of Operations Specialist (if impacted)		

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8. Outcomes and Benefits

The outcomes and benefits could include:

- *Clinical effectiveness – How will this service or intervention promote, safeguard or improve the quality and effectiveness of clinical services*
- *Health gain – How will case have a positive effect on saving life, prolonging life, health related quality of life or wider population health*
- *Population impact – How many people are likely to benefit?*
- *Patient experience – How will the case improve patient experience and access?*
- *Health equality impact – Will the case contribute to reducing or widening health inequalities amongst our local population?*
- *Risk mitigation – What risks will the case mitigate?*
- *Performance – How will the case deliver a sustainable improvement in performance*
- *Integration and whole systems working – How does the case maximise integration and/ or whole systems working.*

Describe here a summary of the outcomes and benefits

There are many short term and longer-term outcomes and benefits proposed by the introduction of an RDC into the Health Board:

Key benefits are summarised in the table below:

Benefits	How measured	Baseline	Target KPI	Timescale	Owner	Key delivery risks
All Patients referred to RDC with vague symptoms to be diagnosed or cancer excluded within 7 days of referral	Interval between referral date and diagnosis measured.	Assumed average time to diagnosis/ exclusion of cancer is consistent with pilot over 84 days on average	100% by 8 months	Monthly	Clinical lead RDC	Inappropriate referrals System over whelmed.
Positive patient experience when going through the RDC	PROMs and PREMs Patient feedback questionnaire	No baseline data anecdotal negative experience due to delays	75% return by 6 months for questionnaires/ PROMs and PREMs 90% of responses received rate as good or excellent	Monthly	Cancer nurse lead	Poor compliance by patients for completing the questionnaire
Improved one Year and Five Year Cancer Survival Rates	Number of Patients alive at one year and five years from diagnosis of cancer via RDC	No Baseline Data	Improvements in survival numbers over time	Improvements in survival numbers over time2 years	cancer manager	
Better cancer outcomes for those presenting with vague symptoms.	Evidence of patients presenting at earlier stage of cancer, with better outcomes.	Stage of patients presenting acutely with cancer not on a SCP	50% of those diagnosed with cancer via the RDC to be at an earlier stage	1 year	Cancer manager/ Lead clinician	Difficulty finding direct comparison of like with like Resource to identify them

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Reduction in presentation of patients to the Emergency Unit (EU) who are then diagnosed with cancer.	Audit of EU admissions with new diagnosis of cancer for year before RDC compared to year of opening.	No of patients presenting in the Emergency Unit who are then diagnosed with cancer in the year pre RDC	50% reduction in EU admissions for new diagnosis of cancer after 1 year	1 year	Cancer manager/ lead clinician	Difficulty accessing this data, depends on coding as new cancer in EU.
Compliance with the Vague Symptom SCP when introduced.	Tracking of these patients from point of suspicion.	.No pathway currently 100% will breach	Compliance of 75% achieving the 62 day target of the SCP	6 months	Cancer manager	Limited resource for tracking a new pathway.
Staff Satisfaction	Brief Staff Questionnaire	No Baseline Data	80% of Staff reported as Satisfied or Very Satisfied with RDC experience	1 Year	Cancer Manager	Limited resource for collection. Poor Compliance
GP Satisfaction	Brief GP Questionnaire	No Baseline Data	80% of GPs reported as Satisfied or Very Satisfied with RDC experience	1 Year	Cancer Manager	Limited resource for collection. Poor Compliance

Short Term:

- Patient-centred service which exemplifies the principles of Value based healthcare and prudent healthcare.
- Earlier detection of cancer and other serious non cancer health conditions (Evidence suggests an average wait time of 5.9 days from referral to diagnosis at pilot stage – a reduction of 78.32 days when compared to downgraded USC patients) resulting in better patient outcomes.
- A clinically and cost effective model – Evidence suggests opportunity cost savings of £1,751 when compared with patients downgraded from the USC pathway and subsequently given a cancer diagnosis.
- Average conversion rate of 9.6% at pilot stage, with higher conversion rates now being reported by Health Boards.
- An improved experience for patients presenting with vague symptoms – at evaluation 96% patients rated the service as good or excellent.
- Fewer patients diagnosed with cancer via a non-USC pathway or following an emergency admission resulting in a reduction in unnecessary interventions.
- An increase in the number of cancers diagnosed at earlier stages (I & II), and reduction in the number diagnosed at later stages (III & IV).
- An increased number of late-stage patients (III & IV) receiving active treatment).
- More efficient use of resources – patients with vague symptoms have a clear referral pathway and are not referred for multiple assessments or to multiple pathways that are unsuitable.

Longer Term:

- Improved one year and five year cancer survival rates.
- An increase in the number of cancers diagnosed at early stages (1 & II) and reduction in the number of cancers diagnosed at late stages (III & IV).

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Changes to Service Provision:

- A change of culture and working practice within primary care.
- A patient-centred service individually tailored to meet need.
- Responsibility is retained for patients until the point of diagnostic resolution (for both cancer and non-cancer diseases).
- Diagnostic tests, results and consultations are conducted in quick succession.
- Individual patient support and continuity of care is provided from referral to diagnosis (and to onward referral/treatment if applicable).
- Greater multi-disciplinary collaboration and a reduction in organisational/clinical boundaries around the patient.

For Patients:

- Single point of access for support and advice across the pathway.
- Reduced clinical investigations and appointments.
- Faster and improved care for patients with vague symptoms.
- Improved outcomes
- Prompt identification of the cause of the patients' symptoms, whether cancer related or not.
- Patients receiving a non-cancer diagnosis at an earlier stage – At evaluation almost 30% of RDC patients received a non-cancer diagnosis and were referred to secondary care for ongoing support.
- Reduced worry or concern for patients with no diagnosis.
- Improved patient experience and outcomes – at evaluation 99% patients felt they were treated with dignity and respect.

For GPs:

- Ability to refer to a multidisciplinary clinical review and diagnostic investigation.
- Improved communication between primary and secondary services.
- Respecting the clinical expertise of GPs who usually have an in-depth knowledge of their patient population.
- Access to an efficient service providing a timely outcome.
- Preventing numerous referrals to achieve a diagnosis reducing wasted GP time.
- Improved GP satisfaction – evaluation data demonstrates 88% GPs were either satisfied or very satisfied with the RDC experience.
- Benefits reported by GPs include speed of referral and diagnosis, a straightforward process and reduction of stress by having a clear referral pathway for patients with vague symptoms.

Feedback obtained from other Welsh RDCs demonstrates that being involved in supporting an RDC clinic will be a valuable and rewarding experience for clinicians of all backgrounds and specialisms.



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9. Impact on Other Services and Engagement

Assessment of the impact on other services should be detailed. Where appropriate, evidence should be provided that key stakeholders (public, patients, staff, 3rd Sector, LAs etc) have been involved in service designing and if the CHC are supportive.

There will be significant positive impacts within Primary Care with reduced pressure on GPs and efficiency savings in relation to time. As GPs will have a specific referral route and pathway for patients with vague symptoms, they no longer need to spend time making multiple referrals or arranging a series of tests that may or may not be appropriate for the patient's needs avoiding waste and potential harm to the patient. There will also be improved links and communication between Primary and Secondary Care with the introduction of the RDC service. Based on the pilot's evaluation, it is anticipated that as a result of earlier diagnosis there will be a significant reduction in patients who present to secondary care at an acute stage avoiding significant avoidable costs.

It is also anticipated that the introduction of an RDC should reduce demand on the Radiology CAN10 referral pathway, as most of the patients currently referred to CAN10 by their GPs would instead be referred via the RDC route. With a triage process being built into the RDC pathway, any patients that would be eligible for a USC referral will be transferred to the appropriate speciality, which will ensure that more patients enter the correct pathway at the point of referral. Those fitting into the vague symptom pathway would have been triaged by the RDC referral criteria, ensuring sufficient clinical information is obtained and appropriate scans are done.

The RDCs have been extensively piloted and evaluated, with proven results in clinical and financial effectiveness. The Cancer Network Board have been involved in the programme from the outset and following the evaluation in 2019, approved the recommendation that there should be a model for rolling out RDCs on a national scale. More recently in 2021, the Cancer Network Board ratified the Vague Symptom Pathway and RDC Service Specification, both of which were sent for consultation and review by all Health Boards before being presented to the Board.

To support with the development and implementation of the RDC concept in Cardiff and Vale, a Steering Group was formed in August 2021. This includes representatives from departments across the Health Board, ranging from Cancer Services to Digital and Health Intelligence, as well as colleagues from the Wales Cancer Network and wider stakeholders. Work is also underway to recruit patient representatives to sit on the group.

This is a formal group working to an agreed Terms of Reference, with the aim of facilitating the design, delivery and evaluation of the RDC project in Cardiff and Vale UHB. With representation from staff with such a broad range of expertise and experience, we can be confident the development process will be properly aligned and integrated with appropriate specialities, with strong lines of communication established to ensure a robust and high quality service.

The service will sit under the Medical Clinical Board but will have a clear governance structure led by Cancer s=Services, with clinical governance, oversight accountability and support provided by the Lead Cancer Nurse and Associate Medical Director for Cancer Services. Operational support to be provided by the Cancer Manager.

Mohamed,Sarah
05/13/2022 16:36:25

The CHC are supportive of this initiative and when engaged in other meetings about cancer services have enquired when Cardiff and Vale will be opening their RDC. The implementation phase of the RDC will include a presentation to the CHC and LMC.

10. Interdependencies

The section should summarise service and other dependencies, which if not in place may affect the outcome. This includes commissioner and other stakeholder support; capital funding; other project outcomes..etc.

Integral to the implementation of RDCs will be the support of the national endoscopy, pathology and imaging networks to ensure the best available use of existing capacity. Provision for regular rapid access testing, scanning, and live reporting will require flexibility and workforce planning.

The role of GPs is also central to the operation of the RDC as they are the gatekeepers. Their perception of it as a service fulfilling a useful role which is clinically effective and well-regarded by their patients is therefore crucial to its success.

Whilst this is a service aimed at diagnosing cancer earlier and thus improving cancer outcomes, there is a significant potential benefit outside cancer. It is estimated that around 30% of RDC referrals will result in a significant but non-cancer diagnosis. Effective collaboration, strong and regular communication and effective onward referral processes will be essential in the successful implementation of the RDC project in Cardiff and Vale UHB.

As part of the RDC development work the Vague Symptom Pathway was created in partnership with the Single (Suspected) Cancer Pathway Team in the WCN. Following approval of the pathway by the Cancer Network Board, Health Boards will soon be required to work towards the timescales and process outlined in the document. The RDC will be critical to the success of Health Boards meeting these targets.

Vague Symptom Pathway Overview:



NOPCC_VagueSymp
toms_20210804_0e (

11. Risks

Where the recommended option is sensitive to risks, which may materially affect the outcome, a summary should be provided of the risk – including consequence, likelihood and mitigating action(s)

Risk	Consequence	Likelihood	Mitigating Actions
Inadequate resource to deliver the programme	Programme cannot be delivered according to required specification	If funding is agreed, low likelihood	Ensure adequate resources are requested in business case.

Mohamed,Sarah
05/13/2022 16:36:25

			Planned promotional work regarding RDC launch to raise awareness and support with recruiting staff.
Interdependence with Radiology	Insufficient capacity to support RDC service	Low	Meetings held with Radiology to confirm capacity and agree model of support.
Resistance to change across the organisation	RDC experiences barriers to development or the concept is not approved	Low	Stakeholder group has confirmed appetite for RDC development and will support the process. Ensure benefits of the RDC are well communicated so the value of the service is understood.
Infrastructure constraints	Difficulties sourcing suitable accommodation	High	Alternative options being investigated e.g. sharing workspace with AOS.
Long term recurrent commitment to funding in an already constrained financial environment	Funding allocated to support service is insufficient	Medium	Financial resource required is thoroughly investigated and agreed. Financial ask in business case is clear. Additional funding streams considered.
Service demand	Demand for RDC service outweighs capacity, or is lower than anticipated	Low	Agreed clinic numbers is based on learning from established RDCs as well as profiling from Radiology's CAN10 patients.
Impact on Health Board outcomes if RDC is not established	Without an RDC, patients with vague symptoms will continue to experience delays with diagnosis, resulting in poorer patient outcomes. Performance against the SCP pathway will be very poor.	High if RDC is not approved	Evidence of RDC performance is well documented in the business case to ensure outcomes are highlighted and the benefits of the service are communicated.

Mohamed,Sarah
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12. Implementation Plans and Measurement

Supplementary to the business case, a project plan and profile of delivery and outcome measures should be appended.

A summary of how the case will be managed and implemented should be included. This should include key milestones. The section should also include details of how success of the proposal will be measured

Project Management and Implementation – Key Milestones:

Summary of anticipated project management and key developmental milestones

The RDC will be launched in early September 2022
A steering group has been set up and runs monthly, all key stake holders except patient representation are engaged. The next step will be to include a patient representative. This will continue monthly, then will move to quarterly after launch.
An implementation group will be set up and will initially run weekly and then fortnightly as progress is made.

Primary care:
A template for the GP computer system with embedded outcome measures for the vague symptom pathway and referral template for RDC has been developed.
GP education will be provided in the form of webinars July, Aug and Sept, and emails with RDC briefing circulated.
The LMC have been approached and are supportive of the RDC. When launch is closer a detailed presentation will be made to them.
A presentation will be made in July to the PCIC CD forum which includes all Cluster leads.
A presentation to be made to the CHC when launch is closer.
The vague Symptom pathway and referral to the RDC will be put on the Cardiff and Vale HealthPathways

Secondary Care:
Confirmation re Macmillan for agreeing funding for first 2 years of the CNS post: April
Advert will go out for the Clinical Lead in early May.
Adverts for all other posts will go out in early June.
Clinic space to be agreed.
Specific PROMs and PREMs to be agreed for the RDC
Code for the RDC (812000) to be implemented within WCCG to allow GP referrals to RDC.
Pathway workshop to be help, mapping out the patient journey.
UHB Communications department to announce the RDC launch late August and early September.
Liaison with Cancer team to check key data areas will be collected.
RDC launched beginning September 2022.

Outcomes Measurement:

The Wales Cancer Network (WCN) has introduced a nationwide Outcome Recording Tool capturing key patient outcomes, enabling Health Boards to demonstrate the effectiveness of their RDCs.

Mohamed.Salim 05/13/2022 16:08:25

There are 13 outcome measures Health Boards are required to report on (see embedded document below). These are based on the measures used to monitor the pilot RDCs. Each

measure has undergone thorough analysis and was agreed by the RDC stakeholder group, which comprises of colleagues in the WCN, Swansea Bay University Health Board and key stakeholders across each participating Health Board. The National Data Resource Team was also consulted and invited to feedback. Each of the 13 measures focuses on a different element of the RDC pathway, which collectively will enable a full and detailed understanding of how each clinic is operating.as well as record and review the outcomes of patients 1 year on.

Using a set of national measures enables RDCs to be analysed in a fair and consistent manner both on an individual and national scale. The WCN collate and analyse the data from each Health Board on a quarterly basis, producing a national dashboard to encourage a shared language and understanding of each measure. Building on the accomplishments of the existing RDCs, the outcomes tool allows achievements to be highlighted, as well as enabling identification of how RDC development can be further supported.

The Cardiff and Vale RDC would collate data according to the requirements of the WCN outcomes tool, providing quarterly submissions to the WCN via their in-house recording template. This would be the primary vehicle for monitoring and measuring the outcomes achieved by the RDC. Discussions are already underway with the Digital Team to ensure appropriate systems are in place for recording the required information.



RDC Outcome Measures _Feb2022.x

Mohamed,Sarah
05/13/2022 16:36:25

13. Approval

Name : ……
Clinical / Service Board Director or Departmental Director

Signature : _____ Date : _____

Business Case Approval Group	
Decision	**Date**

Name : ……
Chair Business Case Approval Group

Signature : _____ Date : _____

Capital Management Group	
Decision	**Date**

Name : ……
Chair Capital Management Group

Signature : _____ Date : _____

Mohamed,Sarah
05/13/2022 16:36:25

Report Title:	**2022-25 Integrated Medium Term Plan (IMTP)**				Agenda Item no.	6.8	
Meeting:	**Board**		Public	x	Meeting Date:	**26 May 2022**	
			Private				
Status *(please tick one only):*	Assurance	x	Approval		Information		**x**
Lead Executive:	**Executive Director of Strategic Planning and Commissioning**						
Report Author (Title):	**Head of Strategic Planning**						

Main Report
Background and current situation:

Between March 2020 and October 2021 the statutory requirement for the Health Board to develop a full three-year IMTP was stood down in response to the Covid-19 pandemic, replaced instead by the requirement for quarterly, and then latterly annual plans.

Welsh Government signaled the return to a three-year approach to planning with the publication of the 22-23 NHS Wales planning framework in October 2021.

On the 31st March 2022 Board approved a draft 2022-25 Cardiff and Vale UHB IMTP on the assumption that there would be ongoing work through the first quarter of 22-23 to address the planned deficit of £20.8M which was identified in the draft plan. This was an approach agreed with Welsh Government as they are unable to accept an IMTP that does not financially balance

The draft plan was subsequently submitted to Welsh Government following the Board's endorsement of the draft document, also on the 31 March.

Ensuring that the UHB has an approved plan is of critical significance to the UHB. The risk / issue for the UHB not having an approved plan is threefold;

- Unapproved organisations are placed under greater levels of ongoing scrutiny by Government at all levels and interactions with government
- Unapproved organisations are often subsequently at risk of being placed in higher levels of escalation- enhanced monitoring or even special measures.
- Organisations with approved plans are generally better placed in receive any 'in year' hypothecated funding which is almost always made available.

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

The UHB has yet to receive formal feedback on the draft submission although informal conversations have taken place with both the Director and Deputy Director Strategic Planning in Welsh Government.

Informal feedback received indicates that WG welcome the level of ambition which the plan is describing and that the single key issue that will currently prevent the UHB receiving approval is the unsustainable financial position within which the plan is being set.

Mohamed-Salim 05/23/2022 16:16:02

No other material issues with the plan have been feedback on with the suggestion that whilst there will inevitably always be areas of a plan that can be sharper those areas would be highlighted in any accountability letter which the UHBs CEO would be issued from the Chief Executive of NHS Wales as areas which the UHB must continue to reflect on as part of planned delivery.

Some points of clarity have also been sought on the minimum data set (MDS) submission which accompanied the IMTP. These have been clarified with the respective policy leads with no indication that further work needs to be done at this stage on the document. The MDS described some of the activity trajectories for the UHB against the ministerial priority areas.

The UHB awaits clarification from WG as to whether a revised MDS will be required with the submission of the final IMTP.

Management Executives (ME) have subsequently agreed a programme of work to develop a suite of transformational savings to address the deficit over the period of the IMTP. The programme of work is aligned to the Health Board strategy and the UHB's Operational Plan.

The scope of this programme of work has been agreed as per the summary table below.

Area	Budget (£m)	Target %	Target (£m)
Reducing acute beds – investment out of hospital, reducing LOS, frailty, diabetes Other secondary care – GIRFT, O/P transformation, standardised pathways		(Note 180 beds equates to £10m)	£12m
Continuing Healthcare	£65m	3%	£2m
Medicines management	£200m	3%	£6m
Procurement	£170m	3%	£5m
TOTAL			**£25m**

This programme is jointly sponsored by the Executive Directors of Strategic Planning and Finance which each of the key projects being led by an Executive.

At the time of this Board paper each project is being asked to adopt the following approach:

- Confirm the size of the opportunity
- Identify the key actions to achieve the transformational saving
- Establish the timeframe
- Highlight any dependencies
- The output to specify, which budgets are targeted for savings
- Develop a detailed schedule by clinical/service board to ensure all schemes are captured and to avoid double counting

It is the ambition that once the programme content has been agreed (by the 06 June) then the UHB will develop and adopt governance arrangements to ensure delivery of the transformational savings

Board are asked to note that they will be asked to consider and approve a final version of the IMTP at a special board meeting at the end of quarter 1.

Mohamed Farah 05/13/2022 16:39:25

Recommendation:

The Board is requested to:

a) Note the informal feedback received to date regarding the submission of the draft 2022-25 IMTP; and

b) Note the work which continues to be progressed to address the financial position within the plan.

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

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

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

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Management Executives	25th April 2022

Unnamed,Sarah
05/13/2022 16:36:25

Report Title:	Capital Infrastructure Plan 2022/23			Agenda Item no.	7.1
Meeting:	UHB Board	Public	X	Meeting Date:	26th May 2022
		Private			
Status *(please tick one only):*	Assurance		Approval √	Information	
Lead Executive:	Executive Director of Strategic Planning				
Report Author (Title):	Director of Captial, Estates and Facilities				

Main Report
Background and current situation:

Capital Plan 2022/23

The purpose of this report is to provide the Board with details of the Health Board's Capital programme for the financial year 2022/23.

The UHB receives an allocation of Capital funding from Welsh Government (WG) via our Capital Resource Limit (CRL). This year's allocation across Wales has been cut by 25% resulting in the UHB's discretionary capital funding reducing from £14.871m to £10.263m. This reduction will significantly impact on the UHBs ability to progress infrastructure schemes and replace aging plant and equipment.

The funding is allocated across a number of schemes, many of which are supporting rolling programmes of work including estate compliance, with a percentage of the available funding being provided for estate, medical equipment and IM&T backlog.

The latest CRL, issued by WG dated 28th March 2022 indicates a CRL of £46.366m which includes £10.263m Discretionary Capital Funding (Group A), £36.103m Capital Projects with Approved Funding (Group B). There are currently no Forecast Capital Projects Without Approved Funding (Group C).

The CRL is a live document which is updated as, business cases are approved, national funded programmes are identified or where the cash flows for projects are adjusted, and is monitored by the UHB Capital Management Group (CMG) at their monthly meeting.

As part of the ongoing capital programme planning process, the UHB continuously reviews and update its annual capital programme plan as part of the IMTP planning process. This process also takes account of the context of the 10-year longer-term proposed capital investments required to meet the UHB's operational and strategic objectives and also in response to the requirement of Welsh Government to prioritise our existing identified and future capital investment needs.

Appendix 1 provides an over view of the capital schemes, together with the funding source and anticipated spend. The plan indicates our current commitments with a limited available balance of £1.027m. If the Outline Business Case (OBC) for Cardiff Royal Infirmary, the Full Business Case (FBC) for Safeguarding MEP works and the OBC for Park View are approved within year then the UHB will benefit from a further £3.2m which will be available for discretionary capital.

Mohammed Shah 05/12/2022 16:06:18

The UHB are progressing the following schemes, at risk, without approved funding support;
All Wales Capital Schemes

- Outline Business Case - CRI Health and Wellbeing Centre
- Full Business Case- CRI Safeguarding works
- Outline Business Case – Park View Wellbeing Hub

The Health Minister issued a letter to all Health Boards which recognises the significant reduction in discretionary capital for 2022/23, but it is important to note that the Ministers expectation is '*that discretionary funding is targeted across all healthcare settings including mental health, community and primary care, for replacement equipment, to promote a safe clinical environment and to support statutory compliance works. We will expect to see demonstrable improvement in organisations' estate performance although we are aware of the challenges brought on by the reduction in discretionary funding. Improvements will be reviewed through your annual estate performance returns and through our regular meetings with your team.'*

In addition, the Minister is advising;

- that UHBs continue to develop capital proposals in the event of capital funding becoming available during the financial year.
- that organisations do not hold onto capital funding where it is clear that it will be required within the year (principally this relates to major capital schemes which will be subject to business case approval.)
- that there will be no funding available for the estates funding advisory board in 2022/23, whilst it is intended to re-introduce this in 2023/24 and organisations should develop bids in readiness.

10-year plan

The UHB, were requested by WG to submit a 10-year plan with schemes prioritised and programmed across the period. The purpose of the plan was to assist WG with their internal planning to support developments across NHS Wales.

The UHB submitted the plan by the 31st March 2022, as requested, and will hold a series of discussions with WG on how this is taken forward.

Operational Master Planning – Estate and Space

In order to provide the appropriate space and configuration of physical capacity to deliver the operational priorities in the IMTP, an Acute Sites Master Planning Group (reporting to CMG) has been established to manage the complex programme of strategic and operational service and estates planning across the acute sites in order to ensure:
- effective prioritisation of scare resources to meet operational priorities
- operational work arounds are deployed if capital is not available in a timely way
- risks and interdependencies are identified and actively managed
- operational infrastructure plans are aligned with the UHB's strategic programmes
- effective and consistent planning and operational process and communication.

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

- The capital plan 2022/23 has been endorsed by both Capital Management Group at their meeting held 25th April 2022 and Strategy & Delivery Committee at their meeting held 17th May 2022
- It is recognised that the funding for 2022/23 will again pose significant challenges for the UHB to deliver the commitments and priorities particularly as the allocation across Wales has been reduced
- The Health Minister is expecting the UHB to demonstrate their improvements to estate performance throughout the year at their regular meetings and annual estate performance returns.

Meeting Version
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Recommendation:

The Board is requested to:

a) **NOTE** the content of the paper including the reduced level of funding, which will be challenging to manage in year.

b) **NOTE** the Health Minister's expectation and advice.

c) **APPROVE** the proposed Capital Plan attached as Appendix 1.

d) **NOTE** that all Business Cases will follow the appropriate approvals process with consideration by the respective Project Team/Board, CMG, the Business Case Advisory Group (BCAG), ME and Board.

e) **NOTE t**he schemes that the UHB are developing through the Business Case process pending WG approval.

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

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

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes
The UHB have a considerable backlog relating to estates, medical equipment and IM&T, a reduction in capital funding could result in a number of schemes not being delivered.
Safety: Yes
The estate infrastructure is some 50 years old and essential plant and equipment is at the end of its useful life. Whilst every effort is made to support and maintain the infrastructure, the chance for failure is increasing year on year.
Financial: Yes
25% reduction in discretionary capital will result in a number of schemes identified in the clinical boards IMTP not being undertaken and therefore impacting upon delivery of clinical services.
Workforce: No

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Legal: Yes
Potential if capital works or replacement of equipment cannot be undertaken
Reputational: Yes
Failure of any plant equipment, IM&T or Medical Equipment may impact upon delivery of clinical services
Socio Economic: No
Equality and Health: No
Decarbonisation: Yes
Unable to implement decarbonisation schemes

Approval/Scrutiny Route:	
Capital Management Group	Date:25/04/2022
Strategy & Delivery Committee	Date:17/05/2022

Mohamed,Sarah
05/13/2022 16:36:25

	Description	Cost		
		Major Capital	Funded Disc Cap	O'Turn
		£k		£k
FUNDING:				
Major Capital				
	Maelfa - Primary Care Pipeline - FBC	2,268		**2,268**
	National Programme - Imaging P2	5,880		**5,880**
	Covid Recovery Funding	300		**300**
	Genomics	12,550		**12,550**
	CAVOC Theatres	350		**350**
	Hybrid Theatres / MTC	503		**503**
	UHL Electrical Infrastructure	3,466		**3,466**
	Eye Care - e-referral system (funded through DPIF)	643		**643**
	Endoscopy Unit UHL	5,720		**5,720**
	Refit - Phase 2	4,020		**4,020**
	Rookwood reprovision at Llandough	750		**750**
Major Capital Total		**36,450**	**0**	**36,450**
Discretionary Capital & Sale of Properties				
	Discretionary Capital Allocation		10,263	**10,263**
Discretionary Capital & Sale of Properties Total		**0**	**10,263**	**10,263**
TOTAL CAPITAL ALLOCATION		**36,450**	**10,263**	**46,713**

COMMITTMENTS:

MAJOR CAPITAL

					Comments
	Rookwood (St Davids)	750		**750**	
	Genomics	12,344		**12,344**	
	UHL New Substation & Upgrade Med Gases	3,948		**3,948**	
	Endoscopy Expansion UHL	4,703		**4,703**	
	Refit	2,421		**2,421**	
	Eye Care - e-referral system	821		**821**	
	Wellbeing Hub Maelfa	2,999		**2,999**	
	National Programmes – Imaging	5,880		**5,880**	
	Telephone Handling and Enquiry Management systems (MIAS)	205		**205**	
	ICF - Barry Hospital Feasibility	59		**59**	
	ICF - respite accommodation - Complex Health Needs	19		**19**	
	ICF - North Cardiff H&WB Centre	59		**59**	
	SDEC	500		**500**	
	Physio UHW (SDEC enabler) / Hydro	250		**250**	
	Lakeside Wing Physio (Including Gym)	82		**82**	
	Lakeside Wing PAOC	146		**146**	
	Hybrid/MTC Theatres (FBC)	503		**503**	
	CAVOC (OBC)	550		**550**	
	SARC Interim	18		**18**	
	Cycle Hub	50		**50**	

Muhamed.Sarac@wales.nhs.uk
05/23/2022 16:39:36

	National Programmes – Decarbonisation	100		**100**	
MAJOR CAPITAL COMMITMENTS		**36,407**	**0**	**36,407**	
OTHER MAJOR CAPITAL					
MAJOR CAPITAL COMMITMENTS		**0**	**0**	**0**	**0**
TOTAL MAJOR CAPITAL		**36,407**	**0**	**36,407**	**0**
DISCRETIONARY CAPITAL & PROPERTY SALES					
Annual Commitments:					
	UHB Capitalisation of Salaries		500	**500**	would impact on revenue if not funded
	UHW 2 Capitalisation of Salaries		200	**200**	would impact on revenue if not funded
	UHB Revenue to Capital		1,215	**1,215**	would impact on revenue if not funded
Business Cases funded via Discretionary Capital					
	Wellbeing Hub CRI		698	**698**	
	Refurbishment of Mortuary UHW (BJC)		216	**216**	Fees for BDP to complete BJC
	Lift Upgrade (BJC)		300	**300**	
	Haematology Ward & Day Unit			**0**	
	Tertiary Tower Infrastructure			**0**	
	Critical Care Expansion			**0**	
	Pet Scanner			**0**	
				0	
Statutory Compliance:					
	Fire Risk Works		200	**200**	
	Asbestos		400	**400**	
	Gas infrastructure Upgrade		300	**300**	
	Legionella		450	**450**	
	Electrical Infrastructure Upgrade		150	**150**	
	Ventilation Upgrade		500	**500**	
	Electrical Backup Systems		250	**250**	
	Upgrade Patient Facilities		350	**350**	
	Dedicated Team		200	**200**	
Other:					
	Backlog Estates		1,000	**1,000**	
	Backlog IM&T		500	**500**	
	Backlog Medical Equipment		1,000	**1,000**	
	Ward Upgrade (A4)		850	**850**	
DISCRETIONARY CAPITAL & PROPERTY SALES COMMITMENTS		**0**	**9,279**	**9,279**	
Total Commitment		**36,407**	**9,279**	**45,686**	

Reviewed Sarah
10/13/2022 16:31:25

UNCOMMITTED

Discretionary Capital

	UHB Accommodation Strategy		200	**200**	
	UHB Misc / Feasibility Fees		100	**100**	
	Contingency	43	684	**727**	
Discretionary Capital Uncommitted		**43**	**984**	**1,027**	
Total Commitment		**36,450**	**10,263**	**46,713**	
	Over / Under Commitment	**0**	**0**	**0**	

Mohamed Sarah
05/13/2022 16:36:25

Report Title:	RPB Acceleration Regional Integration Fund Proposal Update			Agenda Item no.	7.2
Meeting:	Board meeting	Public	✓	Meeting Date:	26.05.22
		Private			
Status *(please tick one only):*	Assurance		Approval	x	Information
Lead Executive:	Abigail Harris, Exexutive Director of Strategic Planning				
Report Author (Title):	Cath Doman, Director of Health and Soicial Care Integration				

Main Report

Background and current situation:

In April 2022, Welsh Government introduced the Regional Integration Fund (RIF) which is a new funding mechanism to support the work of the Regional Partnership Boards (RPBs). The fund replaces previous funds including the Integrated Care Fund and Transformation Fund, which ceased on 31.03.22.

Welsh Government's express purpose for the fund is to deliver 6 national care models and to support RPBs to continue to deliver *A Healthier Wales* and to develop, embed and mainstream new integrated care models.

Cardiff and Vale RPB will receive a £19.16m contribution from Welsh Government in 2022/23. There is an expectation that the partners contribute in the region of £5.72m towards the programmes of work in matched resources or funding.

Funding from Welsh Government tapers from 90% to 50% over the 5-year period. Partners will need to deliver robust business plans to ensure replacement funding is planned and delivered over that period. A Memorandum of Understanding between the statutory partners setting this out is required as part of the submission.

The RIF is comprised of:

i. RPB infrastructure costs to enable the RPB to deliver its duties as set out in Part 9 of the Social Services and Wellbeing (Wales) Act 2014, funded at 75%
ii. National priorities fund: Integrated Autism Service, Dementia and Unpaid Carers, funded at 100%
iii. Accelerating change fund, to develop and test emerging new care models, funded at 90%
iv. National delivery model embedding fund, to move already proven projects towards mainstream funding and business as usual, funded at 70%

At the RPB on 01.03.22, the infrastructure investment, national priorities and the embedding fund were approved. This paper sets out the proposals for the 'accelerating change' part of the RIF, based on agreed PRB priorities.

The accelerating change element of the RIF is to enable the partnership to develop new care models that have not been tested beforehand. These should contribute to the delivery of the 6 national new care models.

The accelerating change fund allocation for Cardiff and Vale RPB is £2.93m in 22/23. There is an expectation that the partnership will contribute match funding of 10% of the cost of the schemes, as a direct financial contribution or through alignment of wider resources.

Morgan, Sarah (ST/1491) 19/05/2022 16:36:05

There is a requirement to ensure that 20% of the funding creates social value, this includes delivery through the third sector. There is also a requirement to ensure that 5% supports unpaid carers. Each of the prioritized programmes have the potential for this to be achieved.

The following areas of development to receive accelerating change funding are supported by the partners:

- **Starting Well portfolio**: establishment of a Joint Recovery Service for children and young people with emotional wellbeing problems. The Senior Responsible Owner (SRO) is Deborah Driffield, Director of Children's Services, Cardiff Council.

  c. £1.4m full year effect

- **Living Well portfolio**: support to deliver transformational elements of the Learning Disability strategy focusing on day opportunities and transition. The SRO is Lance Carver, Director of Social Services, Vale of Glamorgan Council.

  c. £0.8m full year effect

- **Ageing Well portfolio**:
  - as part of the first stage of the development of a comprehensive integrated intermediate care service, strengthen the Acute Response Team and the access points to community services in both Cardiff and Vale. The SRO is Anna Llewellyn, Director of Nursing, Primary, Community and Intermediate Care Services, CAVUHB
  - Continue to roll out the cluster-based multi-disciplinary team approach, based on the successful South West Cluster model, adapted to meet the local context and needs.

  c. £1.0m FYE (plus Recovery funding to support cluster roll-out)

The accelerating change fund covers two years, after which and subject to evaluation including demonstration of impact, the relevant project moves into the embedding fund for the remaining 3 years of the project's life.

Development of the CVRPB RIF plans have been overseen by the Strategic Leadership Group and also the Joint Management Executive. Service leads from across the partnership have been instrumental in the development of the proposals and will lead implementation and delivery.

Partners have advised that the acceleration fund should be used on a small number of proposals that can support a significant step-change in service transformation and integration and are aligned to the priorities of the RPB.

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

The proposals for the Regional Integration Fund reflect the agreed priorities of the RPB and its member partners and contribute to the delivery of its major programmes:

i. @home (also a CVUHB strategic programme)
ii. Children and Young People's Emotional Wellbeing and mental health programme
iii. Learning disability partnership board commissioning strategy delivery

The investment will also support local implementation of national programmes, including the 6 Goals for Urgent and Emergency Care and the National Primary Care Programme.

Mohamed Sarah
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There are a number of risks which the Board need to be sighted on:

1. Tapering funding model: national funding for the accelerating change programme will reduce from 90% in years 22/23 and 23/24, to 70% by year 24/25. By year 5 of the fund (27/28) this reduces again to 50%.

2. The projects included for funding will need to demonstrate impact and outcomes for patients/citizens, including quality of care, activity and cost reduction/avoidance to be able to build a comprehensive business case for continuing funding through the statutory organisations.

3. Return on investment: it is anticipated that successful implementation of new care models may reduce costs elsewhere, for example reducing high cost placements, unplanned admissions or long lengths of stay. However, this is likely to manifest itself as a reduction against increasing overall demand, flattening growth rather than reducing it. It is unlikely therefore that the projects will release funds for long-term investment in new care models.

4. Employment risk: the funding will enable partners to recruit staff, without certainty regarding permanent funding. This risk will lie with the employing organisation should long-term funding not be secured.

5. Social value and unpaid carers contribution: the terms of the fund expect a contribution of 20% to increase social value and 5% to support unpaid carers, overall. The projects supported through this fund will need to demonstrate that this is being achieved.

6. The funding allocated for 22/23 is in excess of the £2.93m available for this part of the fund. This will be managed through project slippage during 22/23. Adjustments will need to be made in the funding allocation for 23/24 to bring the allocation in line with the funding available.

Recommendation:

The Board is requested to:

1. **note** the progress of the RPB in determining priorities for the new partnership funding;

2. **note** the priority areas for funding;

3. **note** the risks associated with the new funding model, including tapering of Welsh Government funding over the lifetime of the RIF and expectations of a commensurate increase in local funding;

4. **delegate authority** to the Executive Director of Strategic Planning to finalise and agree the Regional Integration Fund funding plan in so far as it relates to Cardiff and Vale University Health Board, subject to the value of the same not exceeding £2.9million; and

5. **note** that the RIF funding of £2.9million is to be allocated across the RPB partners and that the RIF funding plan is to be ratified by the RBP once it has been through each of the respective RBP partners' internal decision making processes.

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	✓

Approved-Sarah 25/07/2022 10:36:25

		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

See above and also the risks referred to below.

Safety: No

Financial: Yes

i. Tapering of funding over the period of the fund and the expectation that local investment will increase.
ii. Overcommitment of funding in 22/23, managed through anticipated project cost slippage
iii. Continuing workforce costs when funding reduces, or if the project is withdrawn from the funding portfolio.

Workforce: Yes

i. The ability to recruit to addition capacity needed to deliver the projects
ii. Continuing workforce costs when funding reduces, or if the project is withdrawn from the funding portfolio.

Legal: No

Reputational: No

Socio Economic: No

Equality and Health: No

Decarbonisation: No

Approval/Scrutiny Route:

Subgroup of the Joint Management Executive	Date: 03.05.22 and 11.05.22
Approval	Strategic Leadership Group 18.05.22
Ratification	Regional Partnership Board 29.07.22

Mohamed-Sarah
05/07/2022 16:36:25

Report Title:	**UHB/Third Sector Partnership Memorandum of Understanding and 18 months in review**			Agenda Item no.	7.3
Meeting:	Board Meeting	Public	X	Meeting Date:	26.05.22
		Private			
Status *(please tick one only):*	Assurance		Approval x	Information	X
Lead Executive:	Executive Director of Strategic Planning and Third Sector Independent Board Member				
Report Author (Title):	Strategic Partnership and Planning Manager				

Main Report
Background and current situation:

In April 2019, the Health Board and the County Voluntary Councils (CVCs) in Cardiff and the Vale of Glamorgan agreed a Memorandum of Understanding (MoU) between the UHB and the local Third Sector. The MoU was designed to reflect the 'new' partnership arena established via key pieces of legislation and Welsh Government policy, and provides a written statement of our joint commitments and intentions. It replaced the UHB Framework for Working with the Third Sector, recognising that this had embedded a collaborative partnership approach into the way we work together strategically and operationally.

The MoU includes a commitment to an annual review involving the key signatories, namely the UHB Directors of Strategic Planning and Public Health, the Board's Independent Third Sector Member, and the Chief Executive Officers of the CVCs – Cardiff Third Sector Council and Glamorgan Voluntary Services. A report on the outcome of the first annual review (delayed because of the pandemic) was brought to Board in November 2020. A second review meeting took place on 4th April, where it was agreed that a refreshed MoU would be brought to Board for information alongside an '18 month in review' publication celebrating the wealth of collaborative work undertaken in 2020 – 2022. This provides an opportunity to demonstrate the added value that the Third Sector brings to the work and vision of the Board, in enhancing the lives of individuals, communities and the wider population in Cardiff and the Vale of Glamorgan.

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

The MoU demonstrates the parties' commitment to working together to deliver the UHB's Shaping Our Future Wellbeing strategy and key partnership plans, recognising that improvements in population health will only be achievable if we work differently and work more collaboratively with communities and partners. The approach reflects shared ambitions for building relationships between the UHB and the Third Sector, working strongly with local authorities and other partners, and is based on a joint agreement of strategic objectives and outcomes and shared ownership of priority areas for co-delivery.

The annual review meeting provided a forum for having an honest and open conversation about the opportunities and challenges in the strategic relationship.

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As a result, the MoU has been updated to reflect the need to work collaboratively to meet the challenges of operating in a Covid-ready state and to learn the lessons from the past two years of delivering during the pandemic as well as recognition of the climate emergency and the importance of working together on the decarbonisation agenda. It has also been strengthened to provide additional focus on working with the Third Sector to support those in crisis or whose challenges or

life choices mean they do not easily engage with traditional service offerings. The refreshed MoU is attached for information.

While the focus of the MoU is the relationship between the Third Sector and UHB, it is clearly recognised that much of the agenda is a shared one and that future opportunities need to be set in the context of wider partnership collaboration delivered via the Regional Partnership Board (RPB) and the Public Services Boards. For that reason, the Programme Manager for Health and Social Care Integration was also involved in the review meeting. This enabled an exploration of the role of the Third Sector in a period of re-set. These ideas will be progressed through the RPB.

In reflecting on the importance of ensuring that there are ongoing opportunities for optimising the value and potential of the Third Sector, it should be noted that key interfaces where the involvement of the Third Sector is well established and continue to grow include: the Regional Partnership Board and the Public Services Boards and their joint working infrastructures e.g. ICF and Transformation boards; Shaping Our Future Wellbeing: In Our Community programme; UHB business continuity planning mechanisms e.g. winter planning, mass vaccination planning; and UHB Stakeholder Reference Group. The local Third Sector is involved in a host of joint planning, commissioning and service redesign work across public services, demonstrating that a collaborative approach is very much embedded into the way we work together strategically and operationally, in recognition of the Third Sector's unique contribution to improving health and wellbeing outcomes.

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

Assurance is provided by joint agreement of the way forward by key stakeholders following discussions led by the Director of Strategic Planning at the formal MoU annual review meeting.

No risks identified.

Recommendation:

The Board is requested to:

- **ENDORSE** the updated Memorandum of Understanding between Cardiff and Vale University Health Board and the Third Sector in Cardiff and the Vale of Glamorgan
- **NOTE** the 18 months in review publication

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

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

Meeting Date 29/11/2017 16:56:21

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
Not Applicable
Safety: Yes/No
Not Applicable
Financial: Yes/No
Not Applicable
Workforce: Yes/No
Not Applicable
Legal: Yes/No
Not Applicable
Reputational: Yes/No
Not Applicable
Socio Economic: Yes/No
Not Applicable
Equality and Health: Yes/No
Not Applicable
Decarbonisation: Yes/No
Not Applicable

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

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Memorandum of Understanding

Between Cardiff and Vale University Health Board

and

The Third Sector in Cardiff and the Vale of Glamorgan

April 2022

Mohamed.Sarah
05/13/2022 16:36:25

1. Purpose and Scope

1.1 This Memorandum of Understanding (MoU) forms the basis of a shared understanding and a relationship between the Third Sector in Cardiff and the Vale of Glamorgan and Cardiff and Vale University Health Board (UHB). The Third Sector is represented in this context by Cardiff Third Sector Council (C3SC) and Glamorgan Voluntary Services (GVS) as the local County Voluntary Councils (CVCs).

1.2 The MoU is intended to demonstrate the parties' commitment to working together to deliver the UHB's 'Shaping Our Future Wellbeing' strategy and key strategic partnership plans, recognising that improvements in population health will only be achievable if we work differently and work more collaboratively with communities and partners.

1.3 The MoU supports but is independent of any other agreements or contracts signed by or between the organisations concerned.

1.4 The approach reflects shared ambitions for building relationships between the UHB and the Third Sector, working strongly with local authorities and other partners, and is based on a joint agreement of strategic objectives and outcomes and shared ownership of priority areas for co-delivery.

1.5 Key legislation and policy which provide the context for this MoU include 'A Healthier Wales: our Plan for Health and Social Care', the Wellbeing of Future Generations (Wales) Act, and the Social Services and Wellbeing (Wales) Act.

1.6 In signing this MoU, each party undertakes to build on the strength of existing relationships and the strong foundations already established through implementation of the UHB's Framework for Working with the Third Sector 'Working Together for Our Future Wellbeing'.

2. Status of the MoU

2.1 The partners acknowledge that it is not their intention for this MoU to have a binding legal effect. Rather it is a statement of their shared intention to work together in the spirit of partnership and cooperation for the benefits of the residents of Cardiff and the Vale of Glamorgan.

2.2 This MoU is designed to complement and support other key working relationships which operate at a strategic partnership level within the area of Cardiff and the Vale of Glamorgan, including the Regional Partnership Board and the Public Services Boards.

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2.3 This MoU will help to optimise the CVCs' role in providing third sector support and development at local level, nurturing local group development, hosting Volunteer Centres, and engaging with statutory sector partners to improve local community health and wellbeing outcomes.

3. Objectives

To work effectively together to improve services and health outcomes for the people of Cardiff and the Vale of Glamorgan.

3.1 To develop a co-productive approach working collaboratively as equal partners in helping the health and care system make decisions and develop a shared understanding of the ways in which the Third Sector can contribute to improvements and the sustainability of health, care and wellbeing services. A specific focus of this work will be upon ways to enhance social value and promote the wellbeing and preventative agenda wherever possible.

3.2 To promote and use the talent, reach and social value of Third Sector organisations to support prevention and improvement and advocate for people who are otherwise 'seldom heard', recognising that service provision must reflect the needs of individuals whose life choices and challenges can mean that they do not easily engage with traditional service offerings.

3.3 To share best practice models between the Third Sector and the UHB, and build evidence of sustainable, scalable solutions to prevent and mitigate inequalities that impact on the health and wellbeing of communities.

3.4 To enable members of the Third Sector to contribute to the development of new models of care, as appropriate, and encourage co-production in the creation of person-centred, community-based health and care which promotes equality for all.

3.5 Through CVC networks, to better understand and involve people and communities in the transformation of health, care and wellbeing services, enabling the voice of people with lived experience and those experiencing health inequalities to inform and shape policy and the delivery of services.

3.6 To involve the third sector in estate management strategies, recognising the added value the sector can bring by offering premises and venues within communities or taking on public buildings through asset transfer.

3.7 To support the H&SC Networks to be the "first point of call" for engagement with the third sector to facilitate the work outlined above, to offer a point of informal policy discussion to key statutory sector partners and to facilitate third sector representatives chosen by their peers to represent them at strategic boards and working groups.

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3.8 To work collaboratively to meet the challenges of operating in an ever-changing environment, using existing partnership mechanisms to identify additional opportunities to support vulnerable groups and local communities. In the 2022/23 context this relates to:

3.8.1 *Continuing to operate in a Covid-ready state while dealing with the significant effect of the pandemic on public and third sector services and the need to work together to minimise its impact on the health and wellbeing of our communities.*

3.8.2 *Building on what we have learnt during the pandemic to meet the ambitions set out in 'Shaping our Future Wellbeing' and meet the needs of our communities.*

4. Strategic Principles and Outcomes

4.1 The MoU provides an overview of how the UHB and Third Sector will work together to deliver the strategic principles and outcome ambitions set out in Shaping Our Future Wellbeing and strategic partnership plans:

4.2 **Empower the Person:** The Third Sector plays a crucial role in supporting health and wellbeing and its relationship with the most vulnerable in our communities means it can play a key role in building community resilience:

- We will make the most of third sector relationships and knowledge of communities to influence behaviours and support people in choosing healthy behaviours
- We will optimise opportunities to develop the role of the third sector in the prevention of ill health and the creation of healthy environments and ensure that engagement with the third sector is inclusive, engaging with organisations interested in the life course and whole person as effectively as those working to improve the treatment of individual conditions
- We will work collaboratively in a way that ensures provision of high quality support to those in crisis, particularly at points of transition between services, by effective referral between services to reduce risks for those at vulnerable points in their lives and by sharing information appropriately including in emergency situations
- We will work together to unlock the value of volunteering in the community, develop champion roles which support health and wellbeing and support UHB staff to volunteer in recognition of the mutual benefit gained

4.3 **Home First:** Enabling people to maintain or recover their health in or as close to home as possible means we need greater plurality of provision as part of more integrated community delivery models:

- We will work together to commission and deliver third sector services as part of integrated health and social care provision in the community
- We will adopt asset-based community development approaches to understand and facilitate connections between people, groups and communities within localities and primary care clusters

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- We will optimise opportunities for relevant third sector organisations to become embedded into Whole Care Pathways.

4.4 **Outcomes that Matter to People:** To deliver outcomes that matter to people, we need co-production with citizens to design and transform our services to achieve our vision for seamless care:

- We will draw on third sector expertise to plan and design services with health and social care partners, which are centred around the person

- We will work together to support the involvement of service users and carers in planning health, care and wellbeing services, finding ways to improve engagement with those who are otherwise 'seldom heard'

- We will optimise collaborative opportunities to establish a social referral model to support access to a wide network of wellbeing services

4.5 **Avoid Harm, Waste and Variation:** The serious health challenges that face our population can only be tackled by taking a long term approach and finding new ways of working with the Third Sector as a key partner in developing solutions that are responsive to local need:

- We will fully use local Third Sector networks and the Health & Social Care Facilitators to create new alliances, build capacity and develop innovative solutions, including digital opportunities, based on rebalancing the existing health and social care system towards prevention, community resilience and self-help

- We will strengthen operational links between Third Sector and front line NHS staff to explore potential collaborations to improve outcomes for people

-We will support adoption of best practice in commissioning and procurement of services, working with CVCs to develop and strengthen underpinning mechanisms and processes, and on implementing social value and social innovation

- We will share learning, resources and skills across the sectors

4.6. Finding ways to support the climate emergency and de-carbonisation agendas: we know that adverse climate changes and the high use of carbon have the ability to impact upon the long term health and well being of our population.

-We will seek to work with local Third Sector networks in developing a long term approach to help address the climate emergency

- We will look to share learning, resources and skills across the sectors, adopting best practice wherever possible to reduce our carbon footprint and make long term, sustainable choices for the environment.

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5. Ways of Working

5.1 The Wellbeing of Future Generations (Wales) Act puts in place a sustainable development principle that describes how public service organisations must meet their duties under the Act. The following five ways of working, which define this principle, will underpin the way the UHB and Third Sector work together: long term; prevention; integration; collaboration; and involvement.

5.2 The relationship will be based on mutual respect and trust.

5.3 The relationship will be based on open, timely and transparent communications.

5.4 There will be a shared commitment to making the best use of resources.

5.5 The CVCs will work together to develop shared approaches across the area of Cardiff and the Vale of Glamorgan, wherever appropriate.

5.6 The CVCs will ensure a continuing relationship with key third sector partners, including Cavamh, the infrastructure agency with responsibility for working with third sector groups with an interest in mental health.

5.7 There will be an acknowledgement of different approaches to working together in the context of relationships established as part of delivery of formally commissioned functions or outcomes, to relationships developed as part of the wider partnership landscape of health and care collaboration.

6. Disagreement Resolution

6.1 Any disagreement will normally be resolved at working level between the relevant officers. If this is not possible, it may be referred for discussion between the Chair and Chief Executive of the UHB and the Chairs and Chief Officers of the CVCs.

7. Duration of the MoU

7.1 All parties accept the dynamic environment in which this MoU operates and that priorities will be subject to change. This is particularly relevant in the context of the evolving integration agenda. In recognition of this, the MoU will be reviewed and amended annually by mutual agreement. The date for the review of the MoU is annually in April of each year. It is recognised that due to the emergence of the COVID-19 pandemic in March 2020, the review was postponed in 2020 to September. The ongoing pressures of the pandemic in 2021 resulted in the next review taking place in April 2022.

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7.2 An annual review meeting will be convened by the UHB and will involve:

- UHB Director of Strategic Planning
- UHB Director of Public Health
- UHB Independent Member (Third Sector)
- C3SC Chief Executive Officer
- GVS Chief Executive Officer

Signatories

The MoU is agreed by the following:

Organisation	Name	Designation	Signature	Date
Cardiff and Vale UHB	Abigail Harris	Director of Strategic Planning		
Cardiff and Vale UHB	Fiona Kinghorn	Director of Public Health		
Cardiff and Vale UHB	Sara Moseley	Independent Board Member		
Cardiff Third Sector Council	Sheila Hendrickson-Brown	Chief Executive Officer		
Glamorgan Voluntary Services	Rachel Connor	Chief Executive Officer		

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Working Together for Health and Wellbeing Cardiff and Vale University Health Board and the Third Sector

An 18 Month Review September 2020 to March 2022



Image above: Volunteer created garden at CF61, Llantwit Major, Vale of Glamorgan.

Image below: C3SC's new location in the heart of the community in Cardiff



Introduction

The Third Sector and Cardiff and Vale University Health Board (UHB) work together to plan and deliver services and improve the health and wellbeing of the people of Cardiff and the Vale of Glamorgan.

A Memorandum of Understanding (MoU) underpins this relationship, demonstrating a shared commitment to working together. The Third Sector in this context is represented by Cardiff Third Sector Council (C3SC) and Glamorgan Voluntary Services (GVS).

The UHB funds a Health and Social Care Facilitator post (H&SCF) in both C3SC and GVS to strengthen the role and contribution of the Third Sector to work in partnership to support delivery of improved health, social care and wellbeing outcomes, in line with the objectives of the MoU.

This update has been written by the H&SCFs in C3SC and GVS, with additional input from Cardiff and Vale Action for Mental Health (cavamh), and demonstrates how the Third Sector has contributed to the wider aims of the UHB. While the focus of this publication is to demonstrate how the Third Sector and UHB are working together to put the MoU into action, these efforts are very much set in the context of wider partnership collaboration delivered via the Regional Partnership Board and the Public Services Boards.

Assisting Third Sector frontline staff and volunteers to access the COVID-19 vaccination and provision of support for frontline services

GVS and C3SC have played a very active role in supporting the local Third Sector during the COVID-19 crisis. To keep crucial support services running, it was vital to ensure that Third Sector priority front line staff and volunteers were able to access the COVID-19 vaccination at the same time as priority front line health and social care staff. This involved liaising with a wide range of Third Sector organisations to identify priority roles and identify the staff in those roles, and working with public health colleagues to respond to any queries or concerns about the vaccination. Over 3,500 staff and volunteers from over 100 Third Sector organisations were invited to have the vaccination. The support of the Cardiff and Vale Public Health Team was essential in making this a smooth process.

"Many thanks for this update and all your hard work getting our frontline staff recognised as key workers for the vaccine. Much appreciated."

"GVS were incredibly useful and helpful when it came to arranging Covid vaccination for Health and Social Care staff."

Mohammad Ali
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Commencing at the height of the pandemic, C3SC coordinated volunteers to assist with prescription delivery to Pharmacies for people who were self-isolating and had no relatives or friends to collect their prescriptions. Using an App and COVID-19 safety guidance provided by Welsh Government and NHS Wales, volunteers helped

families, picking up prescriptions and delivering them to their homes or their pharmacy of choice.

Really great piece of work…re support for families self-isolating (and) help with picking up prescriptions. Thank you
(Member of staff, Cardiff and Vale UHB)

Making information about Third Sector services available to all

During the pandemic, it has been even more important than ever to enable people to access information they can trust and to find advice and services that support their health and wellbeing. C3SC, GVS and the Third Sector have been active in making sure their details are on the website Dewis Cymru and on localised websites/social media such as the Vale Heroes webpage hosted by Vale of Glamorgan Council.

As well as supporting and signposting as many people as possible to update their details of local health and care services on the Dewis Cymru website, C3SC produced a series of directories as an easily accessible route for signposting people to relevant services open during the pandemic; these included

- Shopping and food delivery
- Key safe and adaptations
- Emotional Wellbeing
- Domestic Abuse services
- Transport services
- Advice services - Benefits and legal
- Bereavement services
- The annual Christmas/New Year directory of support and services available during the festive period.

Positive feedback and website statistics indicate these resources were well received.

GVS has also ensured that their Directory of Services for Older People, which feedback tells us is a valued resource, has been updated and circulated. GVS has also produced regular briefings about Third Sector services in the Vale so that health and social care staff have an up to date picture of services.

During COVID-19 the e-bulletins circulated by GVS and C3SC to its Networks have enabled the H&SCFs to share timely and accurate information about COVID-19 and about the delivery of local health, social care and Third Sector services.

"Thanks for the information and everything you do!"
(C3SC Network member)

Mohamed, Sarah
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"Thank you as ever. Full of interesting and heartening news as always. So much happens!"
(GVS Network member)

Third Sector Community Liaison Officers (CLOs) helping people access services in the Vale of Glamorgan

GVS and Age Connects Cardiff and the Vale have Community Liaison Officers who are available to help people access a wide range of services. These roles have been developed in partnership with the Vale of Glamorgan Council and the Health Board. The CLOs are able to visit clients in their homes and fully assess their needs. The referrals are often complex so having one point of contact is invaluable. The GVS CLO has helped people get tenancy support, claim benefits, access food banks, collect prescriptions, support them to their GP appointments, access cleaning services and much more.

Developing Health and Wellbeing Centres and Wellbeing Hubs in Cardiff and the Vale of Glamorgan

A key focus of the UHB's Shaping Our Future Wellbeing strategy is the @Home programme which focusses on providing care closer to home through the development of integrated community services. This involves the development of locality-based Health and Wellbeing Centres and cluster-based Wellbeing Hubs in the region. The H&SCFs are closely involved in these developments, working with UHB colleagues to identify opportunities to involve a range of Third Sector organisations in planning and development, and to support wider community engagement as the plans progress.

Help to Name the Former Chapel at Cardiff Royal Infirmary (CRI)

C3SC worked with diverse local community groups and organisations to share a survey and recruit focus group participants to help choose the name for the former Chapel. Groups with an interest in the CRI development as well as those groups working with local Minority Ethnic communities, young people, people with learning disabilities etc. were targeted and supported with a small barriers fund.

Working in partnership with ProMo-Cymru, 65 community members were engaged via focus groups, and a further 108 via a survey. As well as positive feedback from those involved, representatives from Cardiff and Vale Regional Partnership Board confirmed -

''We would like to thank C3SC and ProMo-Cymru for helping us to make sure that the name of this much-loved building will connect its past as a Chapel to its future as a core part of the community.''

Working with the Public Health team

The H&SCFs have assisted the Public Health Campaign Move More Eat Well by promoting the campaign to the Third Sector Health, Social Care and Wellbeing Network. A Move More Eat Well Healthy Workplace Principles Road Map is being developed with input from all sectors including the Third Sector. These Healthy Workplace Principles will allow organisations from all sectors to improve the overall health and wellbeing of staff. Members from all sectors have started to meet to

Mohamed Ahmed-Farah 05/13/2016 11:16:43

discuss and plan how to improve their organisations over the next year using the priorities.

Work is ongoing with the Public Health Move More Cardiff Physical Activity and Sport Strategy and the C3SC H&SCF is contributing a Third Sector perspective.

C3SC also administered the Move More Eat Well (MMEW) grant which has been helping groups through the uncertain times of the pandemic. Given the unprecedented challenges, it was important to make sure guidance and support was available to members, adopting a flexible approach. Additional engagement activities were introduced to encourage virtual participation and feedback to help encourage applications from less traditional groups who are close to some of the most vulnerable communities. Volunteer and community groups were offered online training and workshops, including around safeguarding and COVID-19 safety and rules to help the groups adapt their projects to the new circumstances.

Once restrictions were lifted, groups were supported with grants to fund various new face to face activities and address the challenges in opening up and extending existing provision - ranging from accessible sports teams and facilities, cooking and exercise classes, physical activity programmes, creative workshops and community gardens. Work is now underway to liaise with the MMEW partnership to promote case studies and learn from the scheme, produce information on their website, and to further support the MMEW campaign.

Developing health and wellbeing activities in the Western Vale – development of CF61 and Illtud House

Two community venues have been developed by GVS in Llantwit Major; to create opportunities for local community groups to provide services and for much needed office space.

The CF61 centre was opened in 2019 and continues to be accessible to community organisations and voluntary groups. CF61 was used as a vaccination centre by three local GP practices.



The building lies in central Llantwit Major and close to public transport. The centre hosts classes like Happy Hands, Pilates, Story and Song (bilingual session), Amser Stori, Tai Chi, Drama Bach Y Fro, Taekwondo and Chatty Café.
The CF61 centre also has a small sensory garden designed by the CF61 garden volunteers who have plans to grow food at the location.

Image to the left: Volunteer created garden at CF61, Llantwit Major.

The centre also hosts a Foodshare every Thursday to help stop food waste. This has been a vital service during the pandemic.

Illtud House (the old WVICC centre) is within the same vicinity as CF61 and has become the new base office of GVS. This building has been undergoing building work but will soon be open as office space, community space and meeting space for the community.

Future plans for the site are to move Age Connects Cardiff and the Vale into the building. This will allow the organisations to create a partnership to help their respective service users.

GVS has also just taken on the lease for a new community space in Penarth called St Paul's Community Centre.





Images above: Left image - CF61 building in Llantwit Major, Vale of Glamorgan. Right Image - Illtud House in Llantwit Major, Vale of Glamorgan.



Image above: St Paul's Community Centre in Penarth, Vale of Glamorgan.

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Image above: Butetown Community Centre in Butetown, Cardiff

Supporting inclusive preventative activities in the heart of the City.
Following the sale of C3SC's former premises at Baltic House in Cardiff Bay, C3SC has undertaken a review of its future premises' plans. The first step has been to co-locate in a Centre which is based in one of the most deprived and diverse areas of Wales. This move will not only increase C3SC accessibility and visibility amongst some of the most seldom heard communities, it has also enabled a contribution to the cost of running the building, helping to sustain the provision which is very much valued by local people. In addition, Groups who use the building have been supported, helping them with governance and funding advice and recruitment of volunteers and access to resources to help vulnerable groups tackle hardship, increase connection and reduce isolation, including supporting the food bank which is based here.

'*We are so glad to have you in the community and look forward to working with you.*'
(Local Minority Ethnic community led group)

Working with the Cardiff and Vale Integrated Health and Social Care Partnership (IHSCP)

GVS and C3SC continue to work with the IHSCP on initiatives overseen by the Cardiff and Vale Regional Partnership Board (RPB) to allow Third Sector to contribute to the delivery of objectives and ambitions of the IHSCP.

The Regional Outcomes Framework (ROF)

This is an online tool for the collation and interpretation of data related to health and wellbeing. Third Sector data will help contribute to the picture of health and wellbeing in the region and help inform the commissioning of services. C3SC and GVS worked in liaison with the IHSCP to promote the ROF to the Third Sector and helped to organise a Third Sector workshop, which was well attended. The workshop was

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attended by 26 people from a variety of organisations (16 representing Third Sector organisations) which will give a comprehensive view of Third Sector services.

Developing the Cardiff and Vale Population Needs Assessment (PNA)

The PNA is an assessment of need for care and support in the region and is divided into sections relating to service areas, e.g. unpaid carers, older people, mental health etc. Membership of the steering group ensured that the H&SCFs were able to promote the PNA surveys to the Third Sector and were able to feed Third Sector views into the process. C3SC coordinated the running of the twenty two PNA focus groups during the autumn of 2021, the outcomes of which fed into the PNA.

Right Sizing services in Cardiff and Vale – developing a framework for Intermediate Care Services

The Third Sector have been involved in the right sizing work in liaison with the IHSCP. This work will help operational delivery of Intermediate Care Services and provide a prioritised plan for ongoing investment. These services are provided to people, usually older people, after leaving hospital or when they are at risk of being admitted to hospital. An element of this work focussed on assessing the Third Sector contribution to hospital admission avoidance and hospital discharge and sharing this with statutory colleagues.

Supporting the Third Sector voice in the Regional Partnership Board (RPB) and sub groups

The RPB, and other partnerships such as the Starting Well and Ageing Well groups, benefit from having a range of partners involved, including the Third Sector. Third Sector representatives have been recruited to these partnerships. This has been achieved by C3SC and GVS working with statutory partners to develop, and promote, the representative role to the wider Third Sector. This means that Third Sector expertise is included in discussions about services.

Helping the Third Sector access new sources of funding

GVS and C3SC have continued to provide funding schemes for the Third Sector in Cardiff and the Vale.

C3SC has worked in liaison with statutory partners to advocate for and administer a range of small grant schemes, including the Hau Third Sector Fund, the Supporting People with Learning Disabilities fund, a Winter Pressures funding scheme, Unpaid Carers Funding Scheme and Food Poverty Grant. The range of schemes have been instrumental in enabling investment in a diverse range of groups to develop, re-open and start a diversity of activities aimed at supporting vulnerable groups. Over 90 projects have received support to provide invaluable services and activities, many of which would have struggled to get off the ground or re-commence delivery, including

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- Provision for survivors of Domestic Abuse
- Support for people leaving care
- Support for people with learning disabilities and their carers
- Preventing Loneliness and Isolation – including for older people from Minority Ethnic communities
- Reducing isolation for deaf and hearing impaired children and young people
- Mental health support – including for young people from minority ethnic backgrounds
- Tackling food poverty and hardship

We have definitely benefitted hugely from our membership of C3SC, and funding we have received from grants administered by C3SC (such as Move More Eat Well (MMEW)) have made a huge difference for our organisation. Thanks to grants like MMEW, we have had the opportunity to continue improving the well-being and health of our disabled beneficiaries, despite the Covid pandemic (which took an especial toll on the marginalised groups we represent).
(Exercise For All)

Many thanks for all your help and support…much appreciated
(Care and Repair)

GVS has worked in liaison with statutory partners to provide the ICF Third Sector Capital Investment Fund, the ICF Vale Older People's Fund, worked with the Health Charity to provide funding schemes, facilitated a social isolation and loneliness fund and provided a Winter Pressures funding scheme.

The ICF Third Sector Capital Investment Fund 2021 awarded funding to 18 organisations to allow organisations to pilot new approaches, support innovation and extend existing services.

The funding was used to purchase a variety of items to support Third Sector organisations to assist their projects. Examples include:

- Additional Toilets to support a children's centre focused on supporting children with cerebral palsy and their families.
- Developing a garden to include raised beds, picnic benches, compost and tools creating a community space.
- Sports equipment, laptops, garden tools and furniture to create new services. Projects include supporting people with non-visible injuries, improve emotional wellbeing and support carers of people with non-visible disabilities.
- Sport equipment, litter picking equipment, musical instruments and gardening equipment to support activities for adults with learning disabilities.

This funding has been essential for Third Sector organisations, especially as they respond to the financial pressures of providing Covid safe services or changing delivery of services in response to COVID-19.

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"We have received funding to restart community classes. Without this funding our Vale classes would not have been able to return and it has ensured they can continue into the future."
(Vale Third Sector organisation)

Bringing the Third Sector together - Health, Social Care and Wellbeing Networks

The Health, Social Care and Wellbeing networks in Cardiff and the Vale provide a vital link between the Third Sector and statutory partners. They help to share information and ensure that the Third Sector is able to have a voice in the development of services.

The Cardiff and Vale Carers Support and Information Network Group (CSING), supported by GVS and the Carers Trust South East Wales, brings together front line unpaid carer services. It has developed close ties with the Health Board and the local Councils to support the sharing of information between organisations and sectors, and to enable the carer voice and experience to be part of service planning and development.

C3SC is Co-Chair of the MEC (Minority Ethnic Community) Health Fair Steering Group, bringing together a network of mostly BME (Black Minority Ethnic) led organisations aiming to help tackle health inequality by providing accessible support and information. The Steering Group delivered 2 virtual MEC health fairs during the pandemic, attracting over 100 people from communities more negatively impacted by COVID-19 who were able to discuss issues of concern with a panel of health professionals, as well as access relevant trustworthy information around vaccination, keeping well and other health issues through the workshops at the events.

Work is now taking place with the Group to help organise and deliver a face to face health fair event in June 2022, with the H&SCF providing support with planning, promoting and facilitating connections with statutory sector partners.

Food Vale

Food has become a more pressing issue during the last year. Food Vale is made up of various partners that seek to build a sustainable food system in the Vale of Glamorgan. The Food Vale Network contains various organisations, individuals, community groups and businesses working together giving a voice to all sectors including Third Sector organisations like cavamh.

The Facilitators attend the steering group to make sure the Third Sector is an integral part of Food Vale and keep the steering group up to date on Third Sector schemes.

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Input from the Third Sector helped with the creation of the Food Vale action plan detailing how the group will go forward and grow. Food Vale Action Plan 22/23 - Food Vale

Food Cardiff

C3SC is an active member of the Food Cardiff Network and the Food Poverty subgroup working with a diverse range of partners to support the aim of tackling food poverty, mapping food provision and identifying gaps in the system which make help and support more difficult to access, particularly during the pandemic.

We worked with the Subgroup to produce the *New Cardiff Covid-19 Food Response report published | Food Cardiff* and support the *Good Food Cardiff Autumn Festival tackles food insecurity and isolation | Food Cardiff* and the *Cardiff Good Food Strategy 2021-24 | Food Cardiff*

Promoting the Voice and Contribution of the Third Sector

A vital element of the H&SCF role is to provide information about Third Sector services and advice about partnership working. During 2020/2022 this involved the H&SCFs having over 200 meetings with people working in health, social care, wellbeing and the Third Sector.

The Third Sector is very diverse with approximately 3,000 organisations working across the Vale of Glamorgan and Cardiff. They provide services for older people, children and young people, people with a learning disability, people experiencing mental health issues and in a whole range of other service areas.

It is important that the Third Sector's contribution is acknowledged. The Third Sector helps alleviate pressures and provides insights into different, new and innovative ways of working. The strength of the Third Sector is the ability to work in partnership with other Third Sector organisations and other sectors. Examples of partnership working include, working on the wards in University Hospital Llandough, having a presence in the emergency unit in the University Hospital of Wales (Heath), being an integrated partner in the discharge support service and working closely with the CRTs and VCRS.

The C3SC and GVS H&SCFs have attended regular multi-organisational meetings and updates associated with the pandemic and have been proactive in distributing updates and information from these meetings via their respective networks. In addition to this they have played an active role in these meetings and forums representing issues and concerns from the Third Sector and in so doing have ensured that the Third Sector has had a voice in the on-going response to the pandemic.

Health and Social Care Facilitators – changes in staff

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Linda Pritchard has worked as the Health and Social Care Facilitator at GVS for eleven years and will retire from the role in April 2022. She will continue to work on a part time basis for GVS.

"It's been a real pleasure working in GVS for the last eleven years. One of the benefits of the Facilitator role has been that I've worked with so many people over

the years. I'm constantly impressed with what the Third Sector and statutory sectors can do in the face of many challenges and especially how they've continued to support people during COVID-19. There has been some excellent partnership working over the years resulting in setting up much needed services. It's been one of the most enjoyable aspects of the role to see the positive outcome of this."

GVS, C3SC and the UHB would like to take the opportunity to wish her all the best on her future endeavours.

Lani Tucker, who has been job-sharing with Linda, will be taking over the role of GVS Health and Social Care Facilitator on a full-time basis. She worked on previous projects at GVS such as the Wellbeing in Action project, Third Sector Locality project and Dewis Cymru.

Duncan Innes took over as the C3SC Health and Social Care Facilitator in January 2021, having worked for C3SC since 2019. Prior to this he was working on the Third Sector Locality Project, managing the Dewis Cymru project and also has Public Health experience having managed the local Making Every Contact Count (MECC) Programme.

"The key thing about this role is that it acts as a link between the UHB and the third sector. The last two years have shown how important this is – organisations working in partnership and with a sense of trust between each other is the way forward, and I'm pleased to take on the H&SCF role which is there to promote that partnership working in all its forms"

Contact Details of the Health and Social Care Facilitators
Duncan Innes, Cardiff Health and Social Care Facilitator, Cardiff Third Sector Council (C3SC), email: duncan.i@c3sc.org.uk

Lani Tucker, Vale Health and Social Care Facilitator, Glamorgan Voluntary Services (GVS), email lani@gvs.wales

Cardiff and Vale Action for Mental Health (cavamh)

cavamh – Cardiff and Vale Action for Mental Health – is a development service that supports third sector groups, and people with mental health lived experience, to have a voice in planning and delivering mental health services. Funded by the Cardiff and Vale UHB's Mental Health Clinical Board, Cardiff Council and Vale of Glamorgan Council and charitable trusts, they promote and facilitate service user, carer and third sector involvement in shaping mental health services in Cardiff and the Vale of Glamorgan so that they are co-produced with the people who use them.

They believe in a person-centred approach to involvement, as reflected in combined Recovery and Co-Production Principles and in the Cardiff and Vale Charter for Mental Health. They have distilled their values as person-centredness, inclusion, equality, empowerment, hope and positivity, independence, and collaboration.

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This is achieved through:

- **Information and Training –** Directories, newsletters, e-bulletins, courses
- **Voice –** networks, - supporting involvement, dialogue, representation, shaping services - such as the third sector Mental Health Forum - and lived experience involvement development groups,- Sefyll, Nexus, Join the Dots.
- **Development –** support for third sector mental health organisations and groups
- **Wellbeing –** anti-stigma promotion**,** creative and positive engagement

cavamh as a hub - building connections

Over the last 18 months, work has as ever, been influenced by stakeholders and the response to COVID-19 as it continues to unfold. Building connections to improve services and service development has been the key constant; requested by Mental Health Forum members, this has enabled interactivity, partnerships and development.

Distributing up to date information in a rapidly changing service environment has stood out as the cornerstone of shared, joined up services for agencies and the people they support.

- **Mental Health Forum (MHF) news bulletins** – twice weekly initially and settling down to a fortnightly format over the last 18 months, building connections between MH services, signposting and community activity.
- **Local MHF COVID-19 services summary -** *an up to the moment list of local MH & wellbeing services and activities,* distributed and available on the cavamh website, complementing the cavamh wellbeing page.
- **The Mental Health Forum noticeboard listing latest community events and activities, available on the cavamh website**

Also during this time, cavamh:

- Researched and developed the out of hours and emergency crisis services leaflet within MH third sector for Community Mental Health Teams
- Reviewed the co-produced Access to Help in a Crisis leaflet
- Updated the themed services leaflets for young people and counselling services.
- Reached out to new community contacts
- Has been updating the main **MH Services Directory** and **Nexus Directions Handbook** for people living with dementia, in line with the development of a new website
- Launched '**Involvement Matters'** - a new co-produced newsletter for all stakeholders'- people with lived experience, providers, planners.

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- **Online Socials such as 'Tea and Cake' and outside 'Squash in the Park'** have enabled third sector groups to share information about services and activities in an informal interactive way with people with lived experience.

These have been with statutory colleagues through presentations in Cardiff and the Vale, through forum meetings open to all providers and planners, and on social media to reach as many people as possible.

Feedback indicates this has been greatly valued at a time of rapid service change… 'Many *thanks …for this wonderful digest of interesting and useful stuff!* … '*such good info & updates, - my word you didn't miss a beat.'. 'The updates are fab as usual and really keeps me connected to what is going on in the community.'…Counselling Services leaflet. 'this is very helpful!'*

In terms of training, cavamh has fundraised for a suite of **free training** for the third sector in relation specifically to Suicide and Self Harm amongst other things, whilst Sefyll and Nexus have maintained the 'Standing Up speaking Out' course for people with lived experience. Cavamh has also been pleased to support the Recovery College in its onward development and success.

Voice and Development

Cavamh has brought people together to share information, unmet needs and to develop new services together through networks such as the Mental Health Forum (MHF) and its interest groups, such as BAME, Co-occurring Substance Use, Counselling Services etc.

Sefyll - linking with adults; Nexus - linking with older people, and Join the Dots - linking with younger people - have continued through various and creative means to connect and work together with people with lived experience of all ages and with planners and providers, to ensure people can both be involved and co-produce services which make a difference to the people who receive them. Building ways to connect and converse, the teams have coordinated veterans' arts classes, regular liaison with the Forget Me Not Chorus, co-ordinated focus groups, the Service User Engagement Group and most recently a show on Radio Cardiff. Diversity is a keen and constant focus and cavamh has appointed a Diversity Involvement worker to connect and broaden its work.

Cavamh has also worked with the UHB's Mental Health Clinical Board on two specific peer research projects and reviews, following on from the My Say Peer Research Project in 2019.

Working Together

Cavamh has coordinated at least 3 surveys with MHF members to establish COVID-19 impact, needs, responses and direction of travel; collating and presenting MHF reports that contributed to the Clinical Board's Recovery Plan and the Integrated Medium-Term Plan (IMTP).

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Over the year, cavamh has contributed to nearly 70 local joint planning MH meetings, 6 national meetings and 19 other local joint working networks.

Together with Sefyll, Nexus and Join the Dots, this included co-ordination of the Mental Health Partnership Board online, co-produced by people with lived experience, and including the Mental Health Forum and statutory sector.

Cavamh has continued for the third year and fourth years, to manage the Dementia Friendly Communities Small Grants Fund (part of ICF funding and on behalf of the Regional Partnership Board), providing seed funding and support to new local initiatives.





Prevention

Cavamh has continued to work together with the Minority Ethnic Communities Health Fair and through World Mental Health Day and MH Awareness Week to build wellbeing awareness and promotion and embed wellbeing learning from lockdown.

Stakeholder Events

With a hardworking group of people with lived experience, planners and providers, cavamh has been working over the last year to bring together a 3 day 'We Can Do It Together' MH Co-Production event.

Held online at the beginning of March this year, this brought together local, national and international speakers, workshops, and creative activity exploring co-production across a wide range of topics - providing inspiration, direction and 'oomph' for the next couple of years. Cavamh and the Stakeholder Group are now taking forward recommendations from the event and developing connections, resources and tools for future use.

See programme here https://mailchi.mp/3b3501261c98/mhf-finalised-programme-for-co-pro-event

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Mental Health Action Wales- MHAW.

In October 2020, working with local mental health development services around Wales, cavamh relaunched online Mental Health Action Wales - the national network of local mental health networks. Meeting quarterly, this has linked with over 40 local agencies across Wales in its first meeting - and growing, to contribute to a broader picture of local mental health services around Wales- the needs, achievements, issues and priorities. This will enable local agencies to have a voice at national level with Welsh Government and the National MH Forum, working in partnership with the network of national mental health voluntary sector agencies.

Contact Details for cavamh
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Report Title:	Development of the Regional SARC Hub/New Links Building at CRI - OBC				Agenda Item no.	7.4	
Meeting:	Public Board Meeting				Meeting Date:	26th May 2022	
Status *(please tick one only):*	Assurance		Approval	X	Information		
Lead Executive:	Executive Director of Strategy and Planning						
Report Author (Title):	Deputy Director of Strategy and Planning						

Main Report
Background and current situation:

The Outline Business Case (OBC) Executive Summary sets out the rationale and plans for:-

- The development of the South East Wales Regional SARC Hub at CRI;
- The consequent provision of new facilities for the Community Addictions Unit (CAU), the Dispensing and Treatment Service/Needle Exchange (DATT/NEX) and community based mental health services within a new purpose built facility on the CRI site.

A copy of the Executive Summary is attached. The full OBC document is available for viewing should this be required.

The Ynys Saff Sexual Assault Referral Centre (SARC) is currently located within the main building on the CRI site. It provides a service to all victims of sexual violence in Cardiff and Vale, whether they are acute referrals or historical referrals, offering forensic medical examinations (FME), advocacy support and counselling.

A Strategic Outline Case for the development of the SARC on the CRI site was endorsed by Welsh Government in December 2019. Included as part of the project was the associated relocation of the Community Addictions Unit, the demolition of the Links building and construction of an interim accommodation solution for associated community mental health services, pending a permanent solution as part of the wider plans for the CRI site.

However, since the SOC was endorsed by WG, there have been a number of developments which impact on the scope of the project:-

- In 2019, a new regional SARC model for South East Wales was agreed by appropriate partner organisations, including Health Boards, Police and Crime Commissioners and Police Authorities. The SE Wales Regional SARC service will be delivered through a hub and spoke model, with Cardiff being the Regional Hub supported by Merthyr and Risca SARCS as Spokes. As a consequence, acute SARC services/FME activity will transfer from Risca and Merthyr to the Cardiff SARC during the summer of 2022 into ISO accredited interim facilities at CRI (see below);
- In 2019, new Forensic Science Regulator (FSR) Codes were developed setting out the requirements for compliance of FMEs, including facilities, culminating in the need for FME facilities to fully meet ISO 15189 accreditation by October 2023. Interim arrangements are in the process of being implemented at CRI to achieve ISO accreditation, until a long term sustainable accommodation solution can be delivered as set out in the attached OBC; and
- The Links building, which accommodated the CMHT and DATT/NEX service, suffered major storm damage in 2018, was declared no longer fit for purpose and services moved into alternative interim accommodation on the CRI site. The Planning Authority have since indicated that before they will give permission for the demolition of the Links building, they require plans for its replacement with a building of similar mass and position on the site.

  In discussion with colleagues in Welsh Government, it has been agreed that the replacement of the Links building be incorporated into the OBC. It is proposed that the new Links building

Automated Translation

accommodate the CAU, DATT/NEX and a range of community mental health services including the Links and Hamadryad CMHTs, and services for specialist eating disorders (SHED), perinatal and Headroom. Other mental health services, including psychology and psychological therapies will continue to be delivered in the main CRI building.

The OBC is currently being assurance tested within the UHB, to include SOFW: IOC Delivery Group/Project Board, CMG, BCAG, ME Team, CAV Board). The Wales SARC Assurance and Oversight Board, which is led by the NHS Wales Health Collaborative have indicated their support for the proposed capital development of the Regional SARC Hub at CRI and submitted a stakeholder letter to this effect.

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

Option Appraisal - Short Listed Options
A number of options were short listed for consideration: -

Option 1 – Do minimum (public sector comparator)		• SARC – refurbish current location in CRI (blocks 9 & 10), as a subsequent phase to the interim ISO accreditation works • Permanent solution for DATT • Demolish Links building
Option 2 – Relocate SARC to Houses 54/56 **Preferred Option**	**Option 2a**	• Re-furb, re-model, extend houses 54/56 • New build for CAU & DATT • Community MH services to new community location
	Option 2b	• Re-furb, re-model, extend houses 54/56 • New build for CAU, DATT, community MH services
Option 3 – SARC to New Build Replacement Links	**Option 3a**	• New build for SARC, CAU & DATT • Community MH services to new community location
	Option 3b	• New build for SARC, CAU, DATT, & community MH services

Economic Appraisal

A summary of the capital and revenue costs for each of the options is shown below.

Capital Costs – OB Forms £'000	Option 1	Option 2a	Option 2b	Option 3a	Option 3b
Total Capital Costs (incl. VAT)	6.462	54.470	45.783	49.633	46.163
Total Revenue Costs	8.269	8.488	8.461	8.454	8.428

A summary of the economic appraisal which combines the financial scores with the non-financial scores is presented in the table below. This demonstrates that **Option 2b** is favoured on a combined basis over option 3b due to the weighted non-financial appraisal being higher.

Combined Appraisal	Option 1	Option 2a	Option 2b	Option 3a	Option 3b
Weighted Non-Financial Scores	679	865	973	850	925
Margin Preferred			5.2%		

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NON-FINANCIAL RANKING OF DEVELOPMENT OPTIONS	5	3	1	4	2
EAC Impact of Option (£'000)	8,473	10,766	10,480	10,590	10,456
ECONOMIC RANKING OF DEVELOPMENT OPTIONS	1	5	3	4	2
Benefit Points per EAC (£000)	0.080	0.080	0.093	0.080	0.088
COMBINED RANKING OF DEVELOPMENT OPTIONS	5	3	1	4	2
DIFFERENCE (% below Preferred Option on Combined Score Basis)	-13.7%	-13.5%	0.0%	-13.6%	-4.7%

Capital Costs of Preferred Option

The capital sum to be sought from the All Wales Capital Programme will be **£45.783m** including VAT.

The development of the SARC and new Links facilities are intricately linked with the development of the Health and Wellbeing Centre on the CRI site (H&WC@CRI). In the event that the project to develop the Health and Wellbeing Centre at CRI (H&WC@CRI) does not progress beyond OBC, or in line with the current programme expectations, a sum of **£1.365m (incl. VAT)** will be required to be transferred from the H&WC@CRI project costs to the SARC/Links project to enable it to proceed.

Revenue Implications

Revenue costs for the preferred option against the current costs are shown below, and indicate that there will be a recurring increase of £192k:

Revenue Costs £'000	Current	Option 2b
Pay	7.113	7.113
Non Pay	0.891	0.891
FM	0.265	0.587
Hamadryad	-	(130)
Houses 54/56	-	-
Total Revenue Costs	8.269	8.461

SARC service revenue costs to support the establishment of the South East Wales Regional SARC Hub, and how these will be split across Commissioners and Health Boards, are the subject of a separate Revenue Business Case to be agreed in spring 2022, prior to the phased transfer of acute Forensic Medical Examinations to the Cardiff SARC interim ISO accredited facilities during summer 2022.

CAU, DATT/NEX, community mental health service revenue – the key change for these services is a relocation and it is anticipated that services will be delivered within current available resources

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In relation to the facilities associated costs, SARC, substance misuse and community mental health services will re-locate into refurbished and new build accommodation which has been sized to meet the current HBN standards. Consequently, the area of build, plant and equipment is larger than the area currently occupied. This is reflected in the facilities costs, which indicates that there is an additional cost of £0.192m at 2022/23 prices. This figure includes anticipated savings of £0.13m, which relate to the transfer of the CMHT from the Hamadryad Centre into the new Links building. A proportion of this increase, relating to the delivery of the Regional SARC Hub will be recovered from Police Commissioners and Health Boards. The remaining cost pressure will be managed by the UHB through the IMTP process in the period leading up to the opening of the new facilities.

H&WC@CRI Context

In agreement with WG, plans for the project have been developed within the context of the whole CRI site, which is currently the subject of a separate OBC to be submitted to Welsh Government in July 2022 and sets out the rationale for the development of the CRI as a Health & Wellbeing Centre (H&WC) for residents of the South & East Cardiff Locality as per the SOFW: In Our Community Programme Business Case endorsed by Welsh Government in 2019.

The redesign of the CRI site will see the main entrance repositioned to the rear of the site to reflect patient flow from public transport stops on Newport Road and the main car/bicycle park, and also the development of the 'heart' of the H&WC. The development of the regional SARC Hub and replacement of the Links building to accommodate substance misuse and mental health services will be key features in the redesign of the rear of the CRI site and positively contribute to future plans for the site.

Benefits

Key benefits will include:-

- Regional SARC Hub established in Cardiff with appropriate acute and FME clinical resources;
- In keeping with the name of the SARC – Ynys Saff/Safe Island - the planned location and environment will offer safety, privacy, confidentiality and dignity for clients;
- The accommodation will provide discrete, age appropriate facilities with separation of flows to provide care and treatment to support the children and adult pathways;
- FME facilities in the new Cardiff Hub will be compliant with requirements of the ISO 15189 accreditation;
- The house accommodation will provide less formal, more homely and relaxed facilities for clients away from the clinical environment in the new extension;
- Increased capacity to support an increase in demand for SARC service in Cardiff and Vale and also the new South East Wales regional SARC service model;
- Modern, fit for purpose facilities will be provided for a range of addiction and mental health services;
- The development of the area to the rear of the CRI site will positively contribute to the masterplan for the development of the H&WC@CRI and the requirements of a grade II listed building; and
- It will demonstrate to the local community that we are making real progress with plans for the H&WC@CRI, that have been the subject of engagement for some years.

Risks

A Risk Potential Assessment has been undertaken and this can be found in **the supporting documents**.

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Equality Health Impact Assessment (EHIA)

An EHIA has been undertaken for the SARC proposals and approved by the Project Team in December 2021. Both positive and negative impacts have been identified and recommended actions noted where appropriate. An EHIA has also been undertaken in relation to the proposal to relocate the Hamadryad CMHT to the New Links building as part of the move towards alignment of service delivery with the Localities and will help the Mental Health Clinical Board to understand

potential impacts for service users and assist conversations with stakeholders about how we can deliver a coordinated service aligned across Localities while providing accessible services and a positive experience for service users.

Governance

The OBC has been approved for submission to the Board by:

- Capital Management Group (CMG) – approved the capital case on 25th April
- Business Case Approval Group (BCAG) – approved the facilities' revenue consequences of the capital case on 4th May

Recommendation:

The Board is requested to:

- **NOTE** and **SUPPORT** the Outline Business Case for the development of the Regional SARC Hub at CRI and consequent replacement of the Links building as set out in the attached document, which includes the associated capital and revenue costs, and assessed risks and benefits.

- **NOTE** that CMG and BCAG have approved the OBC to progress to Full Business Case (FBC).

- **APPROVE** the submission of the OBC to Welsh Government for scrutiny and approval to proceed to FBC.

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please tick as relevant*			
1. Reduce health inequalities	X	6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	X
3. All take responsibility for improving our health and wellbeing	X	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	X
4. Offer services that deliver the population health our citizens are entitled to expect	X	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	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.
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 low
Safety: Yes

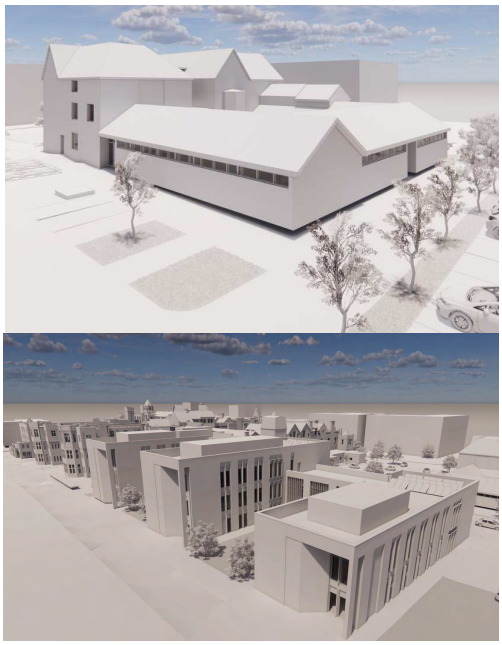
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The capital design incorporates statutory health and safety requirements
Financial: Yes.
Associated facilities revenue impact identified and included in the financial case of the OBC
Workforce: Yes.
The key impact will involve a change in location for Hamadryad CMHT staff to the new Links building on the CRI site. For other SARC and mental health staff, the project will be restricted to a relocation on CRI site.
Legal: No
Reputational: No
Socio Economic: Yes
Socio-economic assessment undertaken as part of the EHIA
Equality and Health: Yes
EHIA undertaken for both SARC and mental health services and mitigation actions identified to be implemented throughout the duration of the project
Decarbonisation: Yes
The capital design incorporates required decarbonisation measures

Approval/Scrutiny Route:	
Committee/Group/Exec:	Date:
Project Team	14 March 2022
SOFW: IOC Delivery Group/Project Board	21st April 2022
Capital Management Group	25th April 2022
Business Case Approval Group	5th May 2022
Management Executive Team	9th May 2022
CAV Board	26th May 2022
Submission to Welsh Government for scrutiny and approval	30th May 2022

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Development of a Regional Sexual Assault Referral Centre (SARC) and Accommodation for the Community Addictions Team (CAU), Dispensing and Treatment Team (DaTT), Community Mental Health Team (CMHT) at Cardiff Royal Infirmary



Executive Summary

April 2022 – Final v8.1

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Draft v2	August / September 2021	Updates made throughout document	Alex Evans
Draft v3	November 2021	Updates to management case	Alex Evans
Draft v4	December 2021	Updates to economic, commercial, financial and management case	Alex Evans
Draft v5	January 2022	Updates to economic, commercial and management cases. Review of new strategies	Alex Evans
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GLOSSARY OF ABBREVIATIONS AND ACRONYMS *(SUPPORTING MAIN DOCUMENT)*

ABUHB	Aneurin Bevan University Health Board
AEDET	Achieving Excellence Design Evaluation Toolkit
AI	Artificial Intelligence
AIP	Agreement in Principle
AME	Annually Managed Expenditure
AOB	Assurance and Oversight Board
BJC	Business Justification Case
CA	Cost Advisor
CAMHS	Child and Adolescent Mental Health Services
CAU	Community Addictions Team
CCS	Considerate Construction Scheme
CHAP	Cardiff Health Access Practice
CMATS	Clinical Musculoskeletal Assessment and Treatment Service
CMHT	Community Mental Health Team
CRB	Cash Releasing Benefits
CRI	Cardiff Royal Infirmary
CRL	Capital Resource Limit
CSA	Child Sexual Abuse
CSF	Critical Success Factors
CTMUHB	Cwm Taf Morgannwg University Health Board
CVUHB	Cardiff and Vale University Health Board
CYP	Children and Younger People's
DASV	Domestic Abuse & Sexual Violence
DATT	Dispensing and Treatment Team
DEL	Departmental Expenditure Limit
DGH	District General Hospital
DNA	Deoxyribonucleic Acid
DOH	Department of Health
DOSH	Department of Sexual Health
DS	Dental Services
DTC	Design Team Consultants
EAC	Equivalent Annual Cost
ECG	Electrocardiogram
EFPMS	Estates and Facilities Performance Management System
EHIA	Equality and Health Impact Assessment
FBC	Full Business Case
FM	Facilities Management
FME	Forensic Medical Examinations
FSR	Forensic Science Regulator
GEM	Generic Economic Model
GFM	General Forensic Medicine
GP	General Practitioner
H&WC	Health and Wellbeing Centre
HM	Her Majesty's
HMP	Her Majesty's Prison
ILAC	International Laboratory Accreditation Cooperation
IM&T	Information Management & Technology
IMTP	Integrated Medium Term Plan
IP&C	Infection Prevention and Control
ISO	International Organisation for Standardisation
ISVA	Independent Sexual Violence Advisors
IT	Information Technology

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LA	Local Authority
MECC	Making Every Contact Count
MH	Mental Health
MSK	Musculoskeletal
NDF	National Development Framework
NEC	New Engineering Contract
NEDS	New and Emerging Drugs
NEX	Needle Exchange Service
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NPSC	Net Present Cost
NWSSP-SES	NHS Wales Shared Services Partnership – Specialist Estates Services
OBC	Outline Business Case
OECD	Organisation for Economic Co-operation and Development
OOH	Out of Hours
OTC	Over The Counter
PBA	Project Bank Account
PBC	Programme Business Case
PCIC	Primary, Community and Intermediate Care
PER	Project Evaluation Reviews
PIR	Post Implementation Review
PM	Project Manager
POM	Prescription Only Medicines
PPE	Post Project Evaluation
PPW	Planning Policy Wales
PRINCE	PRojects IN Controlled Environments
PSC	Professional Services Contract
PSOM	Paediatric Sexual Offence Medicine
QB	Quantifiable Benefits

R&D	Research and Development
RDS	Room Data Sheets
RPA	Risk Potential Assessment
RPB	Regional Partnership Board
RSAB	Regional Safeguarding Adult Board
RSCB	Regional Safeguarding Children Board
SARC	Sexual Assault Referral Centre
SCP	Supply Chain Partner
SE	South East
SEW	South East Wales
SOC	Strategic Outline Case
SOFW	Shaping Our Future Wellbeing
SOM	Sexual Offence Medicine
SOW:IOC	Shaping Our Future Wellbeing: In Our Community Programme
SRO	Senior Responsible Owner
SW	South Wales
TUPE	Transfer of Undertakings (Protection of Employment)
UHB	University Health Board
UK	United Kingdom
UKAS	United Kingdom Accreditation Service
VAWDASV	Violence Against Women, Domestic Abuse and Sexual Violence
VFM	Value for Money
WAO	Welsh Audit Office
WFG	Wellbeing for Future Generations (Wales) Act
WG	Welsh Government
WHBN	Welsh Health Building Note
WHC	Welsh Health Circular
WHTM	Welsh Health Technical Memorandum

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1.0 OVERVIEW AND INTRODUCTION

This Outline Business Case (OBC) seeks the approval for a capital investment of £45.783m to enable Cardiff and Vale University Health Board (CVUHB) to redevelop the following services on the Cardiff Royal Infirmary (CRI) site:

- Ynys Saff Sexual Assault Referral Centre (SARC);
- Community Addictions Unit (CAU);
- Dispensing and Treatment Team (DaTT) and Needle Exchange (NEX);
- Community Mental Health Team (CMHT) and other co-located mental health services.

The project will support the development of the Regional SARC Hub at CRI and is a key component of the South Wales Regional SARC Programme, agreed by Health Boards, Police Authorities, Police and Crime Commissioners and relevant third sector organisations in December 2019. This development, while being a standalone scheme, also provides the opportunity to positively contribute to the redesign and development of the CRI site to accommodate the proposals set out in the Outline Business Case (OBC) for the development of the Health and Wellbeing Centre @ CRI (for submission to Welsh Government (WG) May 2022).

This scheme remains a fundamental priority for the Health Board and enabling the redevelopment of these facilities will not only provide much needed specialist support services to those who need it most but also support the implementation of the Health Board's plan *Shaping our Future Clinical Services* to shift delivery of services, where appropriate, from acute hospitals into the community via the development of the overarching masterplan for the iconic and historic CRI site which is being restored and redeveloped into a Locality Health and Wellbeing Centre (H&WC) for the local population and wider community.

Revenue costs associated with the regional SARC service and how these will be split across Commissioners, are the subject of a separate business case to be agreed by the South Wales SARC Assurance and Oversight Board (AOB) and is due for completion in Spring 2022.

1.1 Progress since Development of the Strategic Outline Case (SOC)

The Strategic Outline Case (SOC) was approved by Cardiff and Vale University Health Board in November 2018 and Welsh Government in December 2019.

However, since submission of the SOC to the Welsh Government, a number of changes to the scope of services has arisen and due to the condition and extreme deterioration of the Links Building at CRI, with all services that occupied the building having had to vacate to other areas of the CRI site to continue service delivery.

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Whilst the SOC proposed the SARC was not delivering a regional service, a revised model of care has now been agreed and is being developed with recommendations in place for hub and spoke services across South, Mid and West Wales with a vision for Ynys Saff at CRI to provide both Adult and Children's acute service in and out of hours within a Regional SARC Hub. In effect, all adult acute forensic medical examinations (FME) that currently take place in Merthyr and Risca SARCs, would instead come to Ynys Saff at CRI in line with the recommendations with the South Wales Regional SARC Programme.

New forensic quality and safety standards have been set for FME facilities and procedures at the Ynys Saff facility will be required to comply with the Forensic Science Regulator (FSR) codes to gain the relevant International Organisation for Standardisation (ISO) accreditation. An interim solution to accommodate this at CRI whilst a regional SARC hub is developed is currently taking place.

Interim solutions for both the Dispensing and Treatment and the Community Mental Health Teams are also in place due to the deterioration of the Links Building as outlined above, and while the replacement of facilities for the Links Community Mental Health Team (CMHT) was progressed as an urgent Business Justification Case (BJC), the safety of the building remains an issue and agreed plans for replacement of the building are required by the Planning Authority before permission to demolish will be given. This provides an exciting opportunity to reconsider the options for the development of the masterplan for the CRI site in its entirety and further facilitate the prospect of delivering sustainable facilities for these services but also link into the future vision for a collaborative locality-based integration of services across CRI.

2.0 STRATEGIC CASE

2.1 The Strategic Context

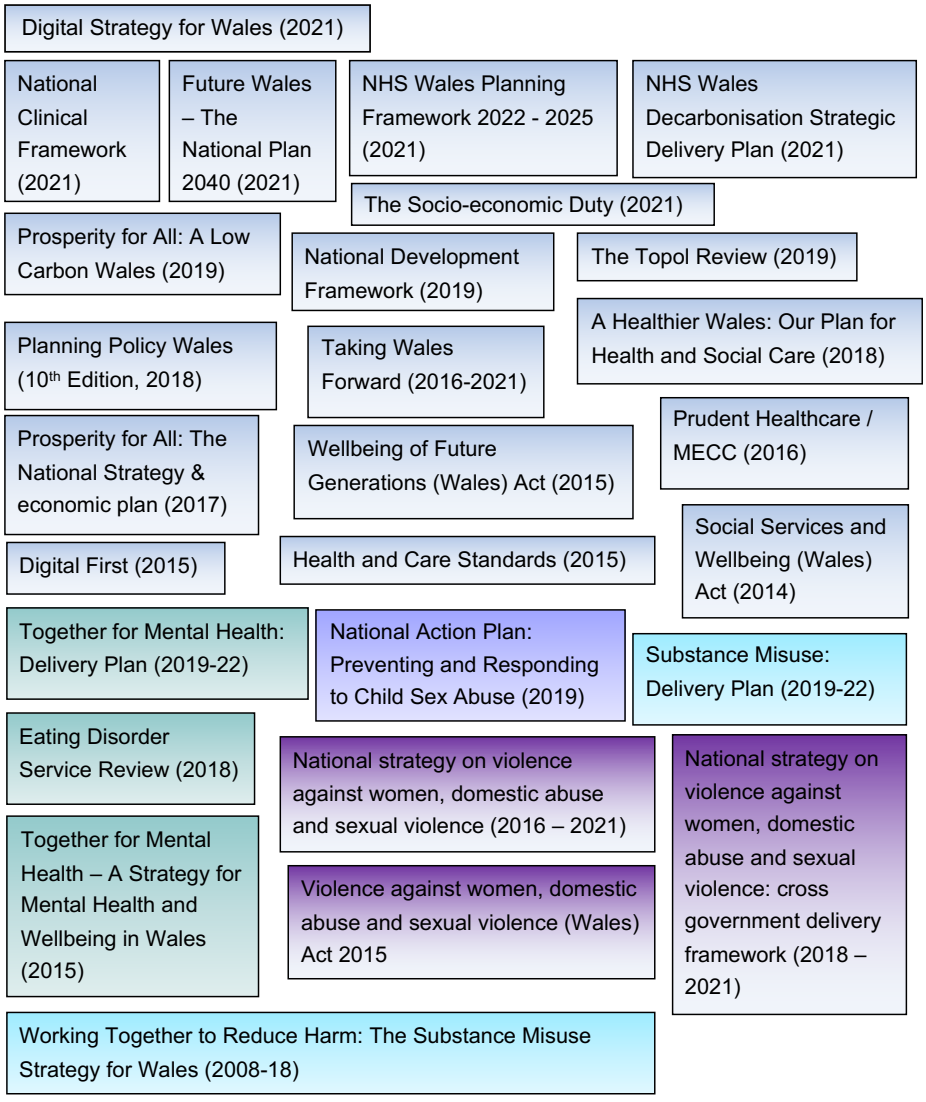
Cardiff and Vale University Health Board (CVUHB) is responsible for planning and delivering health services for people in Cardiff and the Vale of Glamorgan, a population of around 502,000 and is the main provider of specialist services for the people of South Wales – and for some services, the whole 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.

Since its establishment, Cardiff and Vale UHB's priority has been to provide safe, high quality and sustainable services that compare well with the best in the world, with a focus on developing centres of excellence that support the actions needed to progress and deliver the strategic mission '*Caring for People, Keeping People Well*' with a vision that a person's chance of leading a healthy life is the same wherever they live and whoever they are.

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Throughout the development of the Outline Business Case (OBC), the Health Board has been mindful to ensure it continues to consider and take account of local and national drivers for the health and wellbeing of the community. The Health Board is confident that the strategic drivers for this investment and associated strategies, programmes and plans are therefore consistent with national, regional and local strategy and policy documents.

Some of the key Welsh Government policies that have shaped the OBC are:



Executive Summary Figure 1: Overarching National Policies considered within the OBC

Key regional strategies taken into consideration within the OBC include:

Proposal for Regional Sexual Assault Referral Centre (SARC) Model for South, Mid and West Wales – Final Report and Recommendations (Dec 2019)

Significant service planning work, facilitated by Cardiff and the Vale University Health Board and undertaken in partnership with multiple agencies, supporting the implementation of a

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service model for adults and children who may have suffered a sexual assault across South, Mid and West Wales. The multi-agency Project Board have now detailed the recommendations for the reconfiguration of Sexual Assault Referral Centres (SARCs) that together will significantly benefit the victims, survivors and their families who use SARC services across the region. This report is the culmination of work that commenced in 2013 in response to a Welsh Government review looking at the unmet need in SARC services and the lack of integration between services.

The proposed model agreed in 2019 will provide a more integrated service model that is driven by the needs of service users, supports the provision of services that meet clinical, forensic, quality and safety standards and guidance, and ensures that robust governance arrangements are in place.

The SE Wales Regional SARC service will be delivered through a hub and spoke model, with Cardiff being the Regional Hub supported by Merthyr and Risca SARCS as Spokes. The key difference between the hub and spokes, will be that the Regional Hub will provide acute services and ISO accredited FME facilities for child and adult residents of the South East Wales region (Cardiff and Vale, Aneurin Bevan, Cwm Taf Morgannwg and Powys Teaching Health Boards).

Cardiff and Vale of Glamorgan Violence against Women, Domestic Abuse and Sexual Violence Strategy (2018-2023)

This regional strategy sets out how all partners will shape and deliver responses to all forms of violence against women, domestic abuse and sexual violence across the region. It sets out a number of ambitious aims and activities to be undertaken over five years including:

Aim 1 – PREPARE
Improve strategic planning and commissioning of VAWDASV services through a more co-ordinated partnership approach across the region

Aim 2 – PURSUE
Address perpetrators of VAWDASV by improving intelligence sharing across services and the use of legal powers to disrupt and convict

Aim 3 – PREVENT
Pro-actively address negative attitudes and behaviours that have the potential to result in VAWDASV, recognising this is everyone's business

Aim 4 – PROTECT
Improve the multi-agency response and support to all victims and their children regardless of risk level and needs

Aim 5 – SUPPORT
Ensure that innovative, flexible and evidence-based services are available to meet the needs of victims experiencing any form of VAWDASV

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Executive Summary Figure 2: Cardiff and Vale of Glamorgan VAWDASV aims 2018-2023

Key local strategies taken into consideration within the OBC are:

- The Shaping our Future Wellbeing Strategic Programme Portfolio including Shaping our Future Clinical Services and Shaping our Future Communities;
- Integrated Medium Term Plan 2020 – 2023;
- Cardiff and Vale People and Culture Plan 2022 – 2025;
- Cardiff and Vale UHB Estates Strategy 2018 - 2028;
- Cardiff and Vale UHB Delivering Digital: a Five Year Strategy - Building a learning health and care system 2020.

2.2 The Case for Change

Cardiff Royal Infirmary (CRI) is a major landmark in Cardiff and represents a huge historical and heritage significance within the local community and beyond. The hospital opened in 1883 and is Grade ll listed having ceased to function as a District General Hospital (DGH) in 1999. The facility then became a community resource, delivering health services to meet the particular needs of the local community, with the ongoing future of CRI being debated over many years.

In later years successive planning exercises, health needs assessments and public consultations all established a vision for a complete phased re-development of CRI. The vision was for the CRI to be developed as a centre of excellence for the delivery of integrated health and social care to meet the needs of a complex and growing population working as part of a network of primary and community services. It would provide a wider resource for the community with opportunities for joint working with the third sector being at the core of the development.

The CRI site itself consists of three physical buildings, all in very close proximity to each other, namely the main building, the Links Building, including Angove Unit and Houses 54/56. However, over the last few years, the Links Building and Angove Unit have suffered extreme deterioration with major storm damage suffered in 2018 resulting in the accommodation being no longer fit for purpose therefore services have temporarily moved into other areas of the site to enable continued service delivery as part of emergency interim works. Houses 54/56 are also in need of repair if they are to continue providing quality facilities to enable sustainable service delivery for the future.

The multiple issues with the Links Building include:

- The roof to the entire building has failed completely. The slab and covering have deteriorated and need significant repairs. The entire roof has been covered in polythene, and there are water catchers internally diverting the water into the drainage system, these are emptied weekly. This is the only thing protecting the internal fabric;
- The windows all need upgrading and the majority don't close or lock causing significant heat loss and security issues;
- The flooring needs replacing throughout and redecorating;

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- From workplace inspections the feedback is that the toilets need structural work to remove walls to make them compliant;
- There are issues with ducting requiring replacing but there are Asbestos impactions therefore only repairs can be made;
- There are issues with the fire alarm system;
- The electrical distribution boards and lighting also require replacement;
- There are constant issues with the entrance doors being damaged, and regular calls to re-glaze the building due to vandalism as it is only single glazed.

The current role of CRI is focussed on delivering community based services to the local population however much of the current building (save for the Phase 1 works) is currently in a poor state of repair and unoccupied. However, whilst the current condition of a large proportion of CRI is poor and unsafe and requires significant remedial and refurbishment works, it has been established that the site can provide the development capacity to extend the current range of services and enable the further transfer of activity from hospital settings into the community, as well as look at new models of care for local primary, community, mental health that are currently fragmented across different locations.

Therefore the iconic and much loved Cardiff Royal Infirmary is being restored and redeveloped into a Health and Wellbeing Centre for residents of the wider Cardiff South and East Locality to provide invaluable localised services, in line with the needs identified across the SOFW strategy and as referred to in the SOFW:IOC Programme, endorsed by Welsh Government in 2019 thus providing an exciting opportunity to reconsider the CRI site in its entirety and further facilitate the prospect of delivering sustainable facilities for services linked into the future vision for a collaborative locality-based integration of services.

In order to allow the Health Board to provide this revised social model of health, a number of safeguarding / remedial works will need to be undertaken at CRI to bring the entire site up to the standard of the phase 1 works already undertaken. Separate business cases are being developed to ensure these works continue however it is felt that the derelict Links Building will require immediate attention therefore it is included in this business case/ scope of works to ensure timely provision in relation to safety of the site.

The works described within this OBC aim to be fully compatible with the future plans for the CRI site and will align closely with the requirements of the planning authorities. Most importantly, this project will not compromise any future developments, but will look to provide and enhance further opportunities for models that support collaboration and service integration for seamless care.

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Sexual Assault Referral Centre's

SARC services for South East Wales are currently delivered from three SARCs through a mix of third sector and NHS Wales, in collaboration with police organisations:

- Cardiff SARC – Ynys Saff (CVUHB);
- Risca (New Pathways);
- Merthyr (New Pathways).

Each of these SARCs currently offer FME facilities. However, none of these sites meet the latest requirements of the FSR codes, leading to serious consequences for cases that go to court and the verification of forensic evidence presented. If accredited procedures are not followed, DNA integrity could be questioned by the legal system leading to a case collapsing at Court or may not even reach the court process. The accreditation places more accountability on the SARC acute process from the Crisis Worker, FME and Police perspective. A lack of accredited facilities and procedures will impact on the Health Board's ability to operate a SARC.

The Ynys Saff or 'Safe Island' Sexual Assault Referral Centre (SARC) is currently located within the main building on the CRI site and provides acute specialist services to all victims of sexual violence in Cardiff and Vale, whether they are acute referrals or historical referrals, whether they choose to report to the police or not. The staff provide support for victims from the initial reporting of the assault, crisis support during the acute stage and where a forensic examination is required and support during a police interview or statement. Independent Sexual Violence Advisors (ISVA) support is provided to help clients access and navigate appropriate services up to, and including, any pending or potential court case. Follow-on counselling is also provided for those affected by the trauma caused by rape and sexual violence.

There are a number of issues with the current SARC accommodation in relation to the existing estate and location on the CRI site as detailed within the Strategic Outline Case, nevertheless the service is, in the process of implementing the agreed model of care for residents of the South East Wales area as per the '*Regional Sexual Assault Referral Centre (SARC) Model for South, Mid and West Wales – Final Report and Recommendations*' paper outlined earlier, however this will require expansion of the current service space to support the proposals to provide increased capacity and the necessary separation of flows for adults and children. The recommendations also require compliance to the Forensic Science Regulator (FSR) Codes for forensic medical examinations, including facilities, culminating in the need for FME facilities at CRI to fully meet ISO 15189 accreditation by October 2023.

In the long term, the implementation of the South East Wales regional SARC model will see all FMEs being delivered from the planned Regional SARC Hub at Ynys Saff, while the SARC spokes at Risca and Merthyr will continue to deliver follow-on ISVA and counselling services for clients in their respective areas. However, although this OBC is proposing new

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FME facilities as part of the development of the Regional SARC Hub at CRI and these will be constructed to comply with the FSR Codes, they will not be available within the required timescale for accreditation. The process for achieving ISO accreditation indicates that the FME facilities will need to be available in early 2022 to allow for the appropriate operational processes to be put in place, tested and then assessed by UKAS before ISO accreditation can be confirmed by the deadline of October 2023. Therefore, an interim solution is being currently progressed by the Health Board, funded by Welsh Government, to enable this to happen within the current location of SARC at CRI until a more permanent, sustainable solution within a new Regional SARC hub can be achieved to support the longer term regional model of care and aspirations.

This OBC for the future regional SARC hub also looks to address the increase in service needs over time and address any concerns with regards to maintaining safety, security, privacy, dignity and confidentiality the service faces whilst being located in the heart of a busy site with the aim of providing non-clinical where possible client areas to provide an environment that promotes a safe, secure and relaxed ambience.

The interim proposal has been shared with the forensic regulator who has indicated that this, in combination with the implementation of appropriate processes and quality standards and a firm plan to create a longer term solution within the new Regional SARC Hub, will be an acceptable way forward to achieve ISO accreditation.

Community Addictions, Dispensing & Treatment Team and Needle Exchange Service

Services for Community Addictions and the Alcohol & Drug teams are dispersed across the CRI site due to the ever present estate issues across the site. The services are growing rapidly and currently an alternative, more sustainable solution is required to support this growth along with the need to provide quality, safe and efficient care. The aim is therefore to create a central hub for Cardiff that will provide a national centre and model of excellence in the field of substance misuse, supported through the development of research & development (R&D) and teaching functions, as well as the provision of frontline services. By bringing the CAU, DaTT and NEX services together in one principal location, it will deliver a primary hub for integrated substance misuse and community addiction services across tiers 1-4 including:

- NHS Addiction Services
  - Clinical casework within a multidisciplinary setting;
  - Onsite substitute prescribing and dispensing;
  - Alcohol Team including clinic based alcohol detoxification;
  - Coordination and management of primary care based substance misuse;
  - Treatment and support (GP Shared Care).

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Mental Health Teams

Community Mental Health Teams (CMHTs) in Cardiff are jointly operated by the Health Board in partnership with Cardiff Council. They offer a specialist multi-disciplinary service for individuals suffering with mental health. CMHTs form part of an integrated whole system approach that is delivered in conjunction with inpatient, crisis and specialist mental health services.

Currently, CMHTs in Cardiff are delivered across five sites, some of which are in generally poor condition across the community. In the Southern Arc of Cardiff, CMHT services are delivered by two teams, one from interim accommodation at the CRI and one from the Hamadryad Centre, located in Cardiff Bay.

The building block for the planning and delivery of community-based services is recognised as the GP practice. However, networks of practices working together, at a Cluster and Locality level, would better support the provision of community-based services that meet wider need.

To support this model, better integration of community services is a major objective of the service and the Health Board and the current masterplan developments at CRI now present an exciting opportunity to consider the delivery of CMHT and co-located services to residents in the South and East of Cardiff within a locality H&WC.

By supporting a co-location of substance misuse and mental health services with physical health and wellbeing services, it will promote integration, collaboration and sharing of expertise across multiple partners and care providers.

2.2.1 Scope, Objectives and Benefits

In line with Welsh Government guidance, the scope of this business case has been assessed against a continuum of need ranging from:

- A minimum – essential or core requirements/outcomes;
- An intermediate – essential and desirable requirements/outcomes;
- A maximum – essential, desirable and optional requirements/outcomes.

Minimum	Intermediate	Maximum
Resolve SARC only Potential to demolish Links Building	Resolve SARC Demolish Links Building and replace to provide fit for purpose, quality accommodation	Resolve SARC Demolish Links Building and replace to provide fit for purpose, quality accommodation Further facilitate the development of the H&WC at CRI by promoting greater integration and collaboration
Sized to meet demand of regional hub model	Sized to meet demand of regional hub model and projected future demand	Sized to meet demand of regional hub model and projected future demand

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Executive Summary Table 1: Potential Scope

This business case aims to take forward the maximum scope which will see the Ynys Saff SARC deliver the Regional Hub for South East Wales, sized to meet current and projected future demand and the demolition of the unfit for purpose Links Building on the CRI site with the services previously housed within it being re-provided in suitable, more sustainable accommodation to meet the growing needs of the population whilst providing opportunities across service integration to promote seamless, quality care.

Spending Objective	Main Benefits
1: Sustainability and Access	▪ Residents of SE Wales have equity of access to acute SARC services within sustainable and appropriately designed facilities consistent with the agreed Regional SARC Model; ▪ Development of sustainable community addiction services within which statutory, voluntary, and service user led interventions will be co-located and delivered; ▪ Co-location of the CMHT including other localised mental health services allowing working in close collaboration.
2: Capacity	▪ Sustainable and fully compliant facilities secured to deliver the acute SARC capacity for residents of SE Wales; ▪ Sustainable facilities secured to deliver follow-on counselling and ISVA support for clients from Cardiff Vale; ▪ Improved access to, and co-ordination of, services for clients with co-occurring mental health and addiction problems
3: High Quality Environment and Compliance	▪ Clients have access to FMEs which fully comply with relevant forensic, quality and safety standards, ensuring integrity of forensic medical evidence for victims within the court process; ▪ Availability of facilities which are functional, modern and fit for purpose
4: Quality and Safe Care	▪ Clients cared for in more appropriate setting offering safety, privacy, dignity and confidentiality, whilst maintaining links with appropriate services; ▪ Improved condition and functionality of facilities including age appropriate separation of patient flows ▪ Improved client experience for those accessing a range of addiction and mental health services; ▪ Improved staff working experience
5: Strategic Alignment – Health & Wellbeing Centre @ CRI	▪ SARC and MH clients and staff will have access to a range of services to support physical, emotional and social wellbeing within the H&WC, e.g. DOSH, RISE, health and wellbeing information and advice; ▪ Capital proposals positively contribute to the redesign and development of the CRI site as per the masterplan; ▪ Timely resolution identified for a number of interim accommodation solutions.

Executive Summary Table 2: Spending Objectives and Main Benefits

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In aiming to deliver these benefits, the scheme will not only to look deliver modern, fit for purpose and clinically safe accommodation for those who need it the most at the right time but also provide the right care and enhanced support mechanisms, privacy and dignity to client's, service users and their families beyond initial point of contact.

The project will support the Health Board's vision to transform the CRI site into a centre of excellence and provide quality care relevant to the needs of the local and wider community but also provide a conducive environment for staff, patients, visitors and the community alike. It will also demonstrate to the local community that the Health Board are making real progress with plans for this important site, which has been the subject of extensive engagement for some years.

The project will also support additional workforce benefits in relation to *The People and Culture Plan* by providing first class facilities and seamless workforce models that will not only attract and recruit but also retain the right people with the right skills for the Health Board.

3.0 ECONOMIC CASE

3.1 The Long List

The delivery of the service model for SARC, will see the Ynys Saff deliver the Regional Hub for South East Wales, therefore, the identification of the long list of options focuses on the creation of appropriate infrastructure to support delivery of this service whilst also recognising the current significant estate issues across the CRI site and innovative opportunities to enhance collaborative working across sectors through co-location of other services such as the CAU, DaTT, NEX, CMHT and other mental health services.

The long listed options presented within the SOC have therefore been re-appraised in the context of the OBC and were generated re-utilising the options framework.

The table below provides a summary of the findings of the long list option appraisal:

Option	Finding
1.0 Scope	
Option 1.1: Business as usual;	Discounted
Option 1.2: 'Minimum Scope' - Resolve SARC only. Size accommodation to meet demand of regional hub model	Discounted
Option 1.3: 'Intermediate Scope' - Resolve SARC, demolish Links Building and replace to provide fit for purpose, quality accommodation. Size accommodation to meet demand of regional hub model and projected future demand	Discounted
Option 1.4: 'Maximum Scope' - Resolve SARC, demolish Links Building and replace to provide fit for purpose, quality accommodation whilst further facilitating the development of the H&WC at CRI promoting greater integration and collaboration. Size accommodation to meet demand of regional hub model and projected future demand	Preferred
2.0 Service Solutions	
Option 2.1: Refurbish current accommodation for SARC as a subsequent phase to interim ISO accreditation works. CAU and Mental Health teams would remain unaltered where possible however a permanent solution for DaTT/NEX may be considered. Demolish Links Building	Discounted but carried forward as a comparator

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Option	Finding
Option 2.2: Refurbish and extend the current accommodation for all services within the scope	Discounted
Option 2.3: Relocate SARC into Houses 54 and 56 providing a remodelled and extended solution, demolish Links Building and re-provide CAU and DaTT/NEX services in a replacement facility. Mental Health teams may require alternative accommodation	Possible
Option 2.4: Relocate SARC into Houses 54 and 56 providing a remodelled and extended solution, demolish Links Building and re-provide CAU and DaTT/NEX services in a replacement facility to include accommodating a CMHT team base and co-location with other mental health / primary care services	Preferred
Option 2.5: Demolish Links Building and relocate SARC into a new build replacement facility. CAU remains unaltered. DaTT/NEX and Mental Health teams may require alternative permanent accommodation	Discounted
Option 2.6: Demolish Links Building and relocate SARC, CAU and DaTT/NEX services into new build replacement facility. Mental Health teams may require alternative accommodation	Possible
Option 2.7: Demolish Links Building and relocate SARC, CAU, DaTT/NEX services, CMHT team base and other mental health services into new build replacement facility	Possible
3.0 Service Delivery	
Option 3.1: In-house;	Preferred
Option 3.2: Partial Outsource;	Discounted
Option 3.3: Strategic Partnership.	Discounted
4.0 Implementation	
4.1 Big Bang	Not possible
4.2 Phased	Preferred
5.0 Funding	
Only public funding has been considered as it has been agreed with Welsh Government that this project will be supported	

Executive Summary Table 3: Summary of Inclusions, Exclusions and Possible Options

3.2 The Short List

The 'preferred' and 'possible' options identified in the table above have been carried forward into the short list for further appraisal and evaluation. All the options that were discounted as impracticable have been excluded at this stage with the exception of Do Minimum.

On the basis of this analysis, the recommended short list for further appraisal within the OBC is as follows (renumbered to aid the qualitative, economic and financial appraisals):

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	Shortlisted Option Description	Other Implications
Option 1	Do minimum ▪ SARC - Refurbish current location in CRI (Blocks 9 & 10), as a subsequent phase to the interim ISO accreditation works ▪ Demolish Links Building ▪ Provide permanent solution for DATT	CAU and community mental health teams services would remain unaltered with backlog maintenance undertaken
Option 2 – relocate SARC to houses 54/56	Option 2a ▪ SARC to be remodelled into Houses 54/56 (currently CAU), refurbished and extended ▪ Demolish Links Building ▪ New build replacement for CAU & DATT	Community Mental Health services will move to a new build community location to accommodate required capacity
	Option 2b ▪ SARC to be remodelled into Houses 54/56 (currently CAU), refurbished and extended ▪ Demolish Links Building ▪ New build replacement for CAU, DATT, Community Mental Health Services	
Option 3 – SARC to new build replacement links	Option 3a ▪ Demolish Links Building ▪ New build to accommodate SARC and also CAU & DATT	▪ Community Mental Health services will move to a new build community location to accommodate required capacity ▪ Houses 54/56 will be available to provide accommodation for other healthcare or wellbeing services
	Option 3b ▪ Demolish Links Building ▪ New build to accommodate SARC and also CAU, DATT, Community Mental Health Services	Houses 54/56 will be available to provide accommodation for other healthcare or wellbeing services

Executive Summary Table 4: Shortlisted Options Summary

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3.3 Qualitative Benefits Appraisal Key Findings

The evaluation of the qualitative benefits associated with each of the shortlisted options was undertaken at the Project Team meeting in March 2021.

Benefit scores were allocated on a range of 1-10 (rising scale) for each option and agreed through rigorous discussion by the workshop participants to confirm that the scores were agreed as fair and reasonable. The summary results of this exercise were as follows:

Benefit Criteria	Weighted Scores				
	Option 1	Option 2a	Option 2b	Option 3a	Option 3b
1. Improving the clinical quality of services	200	225	250	225	225
2. Optimising the environmental quality of services	120	180	200	180	180
3. Improved strategic fit of services	144	162	180	162	180
4. Making more effective use of resources	105	120	135	105	120
5. Providing flexibility for the future	60	108	108	108	120
6. Facilitating the development of the H&WC@CRI in a practical and timely manner	50	70	100	70	100
TOTALS	**679**	**865**	**973**	**850**	**925**
RANK (weighted)	**5**	**3**	**1**	**4**	**2**

Executive Summary Table 5: Summary Results of Non-Financial Option Appraisal

Key considerations that influenced the scores achieved by the various options were as follows:

- Option 1 – Do Minimum: Ranked 5th - This option would see a further refurbishment of the SARC services current location within the main CRI building and although the interim works would meet the standards for ISO accreditation, it is felt that the quality of service may be hindered due to the potential constraints in future capacity and flexibility within the current block. The location within the main building may also create issues as the service grows and hinder the confidentiality/ privacy and dignity aspects that the SARC service aims to achieve. This option doesn't promote the collaborative working arrangement for the CAU and Mental Health teams. This option would not ultimately meet many of the project spending objectives or critical success factors.
- Option 2a – Ranked 3rd - This option would see the SARC service relocate into Houses 54/56 with CAU vacating and moving to a new build replacement for the Links Building which would also house the DaTT/ NEX. This option would provide the required model of care for the SARC regional service and create a secure, safe environment for clients accessing services but it would also provide good co-location and communication links for the CAU and DaTT services, however a new build facility to accommodate the CMHT and other mental health services will be required in an alternative community location and therefore the vision for co-located mental health services at CRI to support seamless health and wellbeing services would not be realised.
- Option 2b – Ranked 1st - This option would see the SARC service relocate into Houses 54/56 with CAU vacating and moving to a new build replacement for the

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Links Building. This replacement building would also house the DaTT/ NEX and CMHT as well as co-locate some other mental health services. This option would provide the required model of care for the SARC regional service and create a secure, safe environment for clients accessing services with the ability to increase capacity but it would also provide the opportunity to fully integrate the CAU, DaTT, CMHT and other mental health services resulting in greater collaborative opportunities and communications across sectors. This option would also help to facilitate the wider CRI Health and Wellbeing Centre masterplan by releasing space within the main building whilst promoting seamless integration of health and wellbeing services on the CRI site.

- Option 3a – Ranked 4th - This option would see the SARC, CAU and DaTT/ NEX be relocated into a new build replacement facility for the Links Building. This option would meet the necessary standards, capacity and accreditation required by SARC however the regional service model may be compromised by physical co-location with the other services due to privacy and security sensitivities with addiction services. A new build facility to accommodate the CMHT and mental health services will be required in an alternative community location and therefore the vision for co-located mental health services at CRI to support seamless health and wellbeing services would not be realised.
- Option 3b – Ranked 2nd - This option would see the SARC, CAU, DaTT/ NEX, CMHT base and other mental health services be relocated into a new build replacement facility for the Links Building on the CRI site. This option would provide the opportunity to fully integrate the CAU, DaTT and CMHT / other mental health services resulting in greater collaborative opportunities and communications across sectors and would meet the necessary standards, capacity and accreditation required by SARC however the regional service model may be compromised by physical co-location with the other services due to privacy and security sensitivities with addiction services. This option would also help to facilitate the wider CRI Health and Wellbeing Centre masterplan by releasing space within the main building whilst promoting seamless integration of health and wellbeing services.

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 even if the weighting of the benefit criteria were to be changed there is no scenario in which Option 2b is not the preferred option.

3.4 Economic Appraisal Key Findings

3.4.1 Introduction

The economic appraisal incorporates the following cost inputs and assumptions:

- Capital costs at approval level of MiPS 265 with optimism bias calculated for each option in line with national guidance;
- Interest rate of 3.5 % for 1-30 and 3.0% for year 30-60 have been assumed in the economic analysis;
- The economic model has been run for 64 years with supporting lifecycle assumptions and risk including in the economic analysis;
- Revenue costs for facilities and buildings have been assessed for each option;

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- Revenue costs for services have been assumed to be consistent across all options.

Capital costs for each option are shown in the table below:

Capital Costs – OB Forms £'000	Option 1	Option 2a	Option 2b	Option 3a	Option 3b
Works Costs	4.904	39.000	34.217	34.510	33.827
Fees	0.679	5.709	5.070	5.916	5.582
Non-Works	0.284	4.323	1.716	4.096	1.793
Equipment	0.186	1.539	1.610	1.495	1.610
Planning Contingency	0.605	5.057	4.225	4.602	4.281
VAT Reclaim	(0.195)	(1.158)	(1.055)	(0.986)	(0.930)
Total Capital Costs	**6.462**	**54.470**	**45.783**	**49.633**	**46.163**
Approval Level	250	265	265	265	265

Executive Summary Table 6: Capital Costs for all Options based upon OB forms

Capital Costs £'000	Option 1	Option 2a	Option 2b	Option 3a	Option 3b
Works Costs	4.332	32.500	28.514	28.759	28.189
Fees	0.599	4.757	4.225	4.930	4.652
Non-Works	0.251	3.603	1.430	3.414	1.494
Equipment	0.164	1.282	1.342	1.245	1.342
Planning Contingency	0.535	4.214	3.521	3.835	3.568
Sub Total Net OB Forms	**5.880**	**46.357**	**39.031**	**42.182**	**39.245**
Optimism Bias	1.403	7.616	6.725	5.812	5.408
Capital Costs (Excl. VAT)	**7.284**	**53.974**	**45.757**	**47.995**	**44.653**
VAT	1.201	9.446	7.914	8.478	7.862
Total Capital Costs	**8.485**	**63.419**	**53.670**	**56.473**	**52.515**
Approval Level	265	265	265	265	265
GIA M2	819	6,703	6,703	6,471	6,471

Executive Summary Table 7: Capital Costs including Optimism Bias and Inflated Approval Level for Economic Analysis

**the above table includes optimism bias and inflates option 1 to approvals level 265 for comparison purposes within the economic model.*

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The economic model has been run for 64 years and the outputs are detailed in the table below:

Economic Impact £'000	Option 1	Option 2a	Option 2b	Option 3a	Option 3b
Capital Costs incl Lifecycle	6.583	63.209	56.117	58.096	55.073
Revenue Costs	220,423	225,227	224,645	225,626	225,040
Transitional Costs	0	0	0	0	0
Externality Costs	0	0	0	0	0
Net Contribution (Benefit)	0	0	0	0	0
Total Net Present Cost (NPC) excluding Risk	227,006	288,436	280,761	283,722	280,113
NPC Risk	500	3,888	3,233	3,521	4,965
Total NPC including Risk	227,505	292,324	283,995	287,243	285,078
EAC	**8,473**	**10,766**	**10,480**	**10,590**	**10,456**
Rank		**4**	**2**	**3**	**1**

Executive Summary Table 8: Net Present Cost Findings

The financial rankings show that from the development options excluding do minimum that option 3b provides the best EAC and is ranked first but is closely matched to option 2b with a difference of only 0.2% required to switch NPC value. Option 3a is third ranked with option 2a ranked fourth. Do minimum remains the financial cheapest option but fails to deliver the qualitative outcomes.

Sensitivity Analysis £'000	Option 1	Option 2a	Option 2b	Option 3a	Option 3b
Total NPC including Risk	227,505	292,324	283,995	287,243	285,078
EAC	8.473	10.766	10.480	10.590	10.456
Rank Development Options	1	5	3	4	2
Margin	18.9%	-3.0%	-0.2%	-1.3%	0.0%
NPC Switch Value	**56,489**	**(8,329)**	**8,329**	**(3,248)**	**2,164**

Executive Summary Table 9: Net Present Cost Sensitivity Analysis

This is demonstrated as movement of NPC switch value using option 1 as the benchmark:

Economic Sensitivity £'000	Option 1	Option 2a	Option 2b	Option 3a	Option 3b
Capital Costs	858.1%	-13.2%	14.8%	-5.6%	0.0%
Residual Value	0.0%				
Revenue Costs	25.6%	-3.7%	3.7%	-1.4%	0.0%
NPC Change Needed	**56,489**	**(8,329)**	**8,329**	**(3,248)**	**2,164**

Executive Summary Table 10: Economic Sensitivity Analysis

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3.5 Overall Findings – Conclusion

Combining the financial scores with the non-financial scores is presented in the table below. This demonstrates that Option 2b is favoured on a combined basis over option 3b due to the weighted non-financial appraisal being higher and the qualitative benefits it creates. This also acknowledges the costs in relation to the development of the regional SARC hub being on the curtilage of the CRI and its grade II listed building status.

Combined Appraisal	Option 1	Option 2a	Option 2b	Option 3a	Option 3b
Weighted Non-Financial Scores	679	865	973	850	925
Margin Preferred			5.2%		
NON-FINANCIAL RANKING OF DEVELOPMENT OPTIONS	**5**	**3**	**1**	**4**	**2**
EAC Impact of Option (£'000)	8,473	10,766	10,480	10,590	10,456
ECONOMIC RANKING OF DEVELOPMENT OPTIONS	**1**	**5**	**3**	**4**	**2**
Benefit Points per EAC (£000)	0.080	0.080	0.093	0.080	0.088
COMBINED RANKING OF DEVELOPMENT OPTIONS	**5**	**3**	**1**	**4**	**2**
DIFFERENCE (% below Preferred Option on Combined Score Basis)	**-13.7%**	**-13.5%**	**0.0%**	**-13.6%**	**-4.7%**

Executive Summary Table 11: Combined Economic and Non-Financial Appraisal Scoring

Option 2b is therefore confirmed as the preferred option overall.

3.6 Preferred Option

The preferred option (Option 2b) includes provision for the relocation of the SARC service into remodelled Houses 54/56 on the CRI site with the Community Addictions Unit (CAU) vacating and moving into a new build replacement for the Links Building which would also house the DaTT/ NEX and CMHT base including co-location with other mental health services via a phased solution.

Both facilities on the site will provide high quality, modern, fit for purpose accommodation and would not only provide the required model of care, capacity and security for the SARC regional hub but would also provide the exciting opportunity to fully integrate Community Addictions and other Mental Health services resulting in greater collaborative opportunities and communications within sustainable and safe accommodation.

The SARC preferred solution will provide purpose built clinical/ FME facilities, while the re-modelled houses will also enable interviews and ongoing counselling to be undertaken within a more relaxed and comfortable environment.

The proposed new facility for the Community Addictions and Mental Health service will be connected to the existing CRI main building. Co-location of substance misuse and mental health services with physical health and wellbeing services will promote integration, collaboration and sharing of expertise. It will help to promote a holistic approach to wellbeing

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and supporting people with a dual diagnosis. There will also be an opportunity to improve the way services ae delivered through co-ordinated clinics across specialties, reducing the need for multiple visits for clients, flexible delivery of appointments, including face-to-face and virtual appointments to support people's working and family commitments.

The preferred option will also provide the opportunity to redesign the rear of the CRI site within the context of the masterplan for the whole site as part of the development of the Health and Wellbeing Centre, which is a key component of the Health Board's vision to create a modern and fit for purpose community infrastructure to support the transfer of activity from hospital settings to the community and crucially provide for the rapidly growing population.

The capital proposals for this project have been developed in partnership with clinical service leads and the police. Service proposals for the implementation of the Regional SARC Hub have been developed with clinicians and partners from relevant Health Boards, third sector organisations, the police and the NHS Collaborative.

3.6.1 Facilities

An outline of the proposed facilities are shown below:

Sexual Assault Referral Centre
Entrance and Clinical Zone
▪ Adult Area including zoned FME facilities ▪ Children's Area including zoned FME facilities Support Accommodation such as: ▪ Entrance, reception and waiting and sanitary facilities ▪ Counselling facilities ▪ Advocacy facilities ▪ Utilities ▪ Storage
Administration Zone
▪ Police office ▪ General administration area ▪ ISVA desks ▪ Sanitary facilities ▪ Meeting and training facilities
Staff Support Zone
▪ Staff changing area and sanitary facilities ▪ Locker bay ▪ Staff rest and mini kitchen

Executive Summary Table 12: Overview of proposed facilities for the SARC Regional Hub

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CAU, DaTT/NEX and Mental Health Services	
Community Addictions Unit	
Entrance including: ▪ Reception, waiting, sanitary facilities ▪ Group room ▪ Office accommodation ▪ Storage ▪ Utilities	Clinical Zone including: ▪ Treatment rooms ▪ Interview rooms ▪ Sanitary facilities ▪ Utilities ▪ Storage ▪ Pantry / refreshment area

Dispensing and Treatment Team / Needle Exchange	
Entrance including: ▪ Reception, waiting, sanitary facilities ▪ Group room ▪ Utilities	Clinical Zone including: ▪ Dispensing room ▪ Treatment rooms ▪ Interview rooms ▪ Storage ▪ Utilities
Administration Accommodation for CAU / DaTT/ NEX	
▪ Administration area ▪ Seminar / Training room ▪ Storage	
Community Mental Health Team	
▪ Reception, waiting and sanitary facilities ▪ Interview rooms ▪ Treatment rooms ▪ Group rooms ▪ Therapeutic kitchen ▪ Art therapy room ▪ Storage ▪ Utilities ▪ Administration area	

Other Mental Health Services (SHED, Perinatal, MHSOP, Headroom)
▪ Reception, waiting and sanitary facilities ▪ Interview rooms ▪ Consulting / examination room ▪ Group room ▪ Storage ▪ Administration area ▪ Utilities
Shared Staff / Building Support for all Links Building Services

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- Staff changing area and sanitary facilities
- Staff rest and mini kitchen
- Pantry / refreshment area
- Facilities management area
- IT Hub

Executive Summary Table 13: Overview of proposed facilities for the CAU, DaTT/NEX and Mental Health Services hub

3.6.2 Prioritised Plan of Phasing

The Cardiff Royal Infirmary site-wide masterplan referenced throughout the business case (separate OBC currently in development) aims to integrate the requirements of the various project investments into a holistic overarching strategy which enables different elements of the scheme to be delivered to different timelines without negatively impacting each other and as such, in order to provide construction costs and timescales for inclusion within the OBC, a construction phasing and strategy options appraisal was undertaken for the whole site. Following this consultation exercise, Phasing Option 5A was selected as the preferred solution. This option was assessed against other proposals with the relative benefits being that the construction period is comparatively short and the retention of staff and public car parking is maximised.

It must be noted however that a number of inclusions have been made within the main CRI Health and Wellbeing Centre scheme which directly affect the delivery of this project in relation to phasing. In order to mitigate the risk of delay to the progression of this project during NHS Stage 3 (construction), in the event the CRI Health & Wellbeing Centre does not proceed, a detailed review of these items has been undertaken by the Health Board, Project Manager, Cost Advisor and Supply Chain Partner to quantify the time and cost increase.

The SCP has submitted a draft programme, including the works elements that may be required, which shows an increase to the overall SARC/ Links construction programme of 13 weeks. This has been scrutinised by the Project Team and found to be reasonable and in line with the timescales included within the CRI Health & Wellbeing OBC. The costs submitted by the SCP have been reviewed by the Cost Advisor and found to be acceptable. More information can be found in the Financial Case later within this document.

4.0 COMMERCIAL CASE

4.1 Procurement Strategy

The redevelopment of facilities will be procured through the NHS Wales Shared Services Partnership – Specialist Estates Services (NWSSP-SES) established NHS 'Building for Wales' Framework. The Supply Chain Partner (SCP) Willmott Dixon Construction Limited has been appointed under the framework to develop both the design and construction of the proposed facilities.

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Contractual Arrangements have been entered into with all parties for the OBC stage using the NEC contract as prescribed under the Framework. For the Project Manager and Cost

Advisor, the NEC 3 Professional Services Contract has been used, and for the SCP, the NEC Option C (Target Cost) contract has been used.

4.2 Required Services

The scope of services required within this OBC is for project management, cost advice and the design and redevelopment of two facilities on the CRI site namely:

- Accommodation for a regional hub for SARC comprising of appropriate acute and FME clinical resources for Adults and Children, staff team base and shared support facilities;
- Accommodation to house a collaborative community addictions and mental health service comprising of appropriate clinical accommodation, staff team base and support accommodation for CAU, DaTT/ NEX, the CMHTs and other mental health services.

Cardiff Royal Infirmary is a major landmark in Cardiff and a Grade II Listed Heritage asset, therefore Outline Planning Approval cannot be obtained, as such the approach to the design of any refurbishments, new buildings, interventions and landscaping on the site must take due consideration of this and align with Cadw guidance for working with Listed Buildings.

It was agreed that a Masterplan Strategy for the site in its entirety would be prepared which would then be used to secure an Agreement in Principle (AiP) from Cardiff Council, thereby giving sufficient confidence to allow WG to determine approval of this OBC.

4.3 Potential for Risk Transfer and Potential Payment Mechanisms

The Health Board have indicated that it will apportion risk in the design and build phase as per the following table, however this will be appraised and reviewed at subsequent stages to ensure there is an appropriate allocation of risk:

Risk Category	Potential Allocation		
	Public	Supply Chain Partner	Shared
Design Risk			✓
Construction & Development Risk			✓
Transition & Implementation Risk			✓
Availability and Performance Risk			✓
Operating risk	✓		
Variability of Revenue Risks	✓		
Termination Risks	✓		
Technology & Obsolescence Risks			✓
Control Risks	✓		
Residual Value Risks	✓		
Financing Risks	✓		
Legislative Risks			✓

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Risk Category	Potential Allocation		
	Public	Supply Chain Partner	Shared
Other Project Risks			✓

Executive Summary Table 14: Transfer of Risk

SARC services associated with the project will be managed by the Health Board in conjunction with the NHS Wales Health Collaborative and the South Wales SARC Assurance and Oversight Board with CAU, DaTT/NEX and Mental Health services remaining Health Board led, although the Local Authority and third sector partners may help to deliver support services, as appropriate. The proposal for any shared facilities, if necessary, will be agreed during FBC stage.

The Health Board intends to make payments in respect of the proposed products and services as follows:

- Charging will be completed under the 'Building for Wales' Framework terms and conditions;
- The contract will be managed by Cardiff and Vale University Health Board under the NEC 3 Option C Target Cost Contract.

It is anticipated that the total construction duration will run for 26 months and subject to approvals it is anticipated that the opening of the new facilities will take place in March 2026.

5.0 FINANCIAL CASE

5.1 Capital Financial Expenditure

A summary of the capital costs and depreciation for the preferred option is as follows:

Capital Costs	£'000
Building/Engineering	45.683
Equipment costs	0.100*
Total Capital Cost/ Cost Forms	**45.783**

Executive Summary Table 15: Capital Costs for the Preferred Option

* The capital equipment costs refer to a 5 year useful life.

	£'000
Impairment	28.706
Depreciation – Building/Engineering	0.349
Depreciation – Equipment	0.020
Total Capital Charges/Depreciation	**29.08**

Executive Summary Table 16: Summary of Capital Charges and Depreciation

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Impairment is calculated based on advice from the District Valuer. The asset value post impairment has been depreciated over the estimated useful economic life provided by the District Valuer.

The following is a summary of the total impact of impairment and depreciation by year until the planned opening of the facilities:

	2024/25 £'000	2025/26 £'000	2026/27 £'000
DEL Impairment	0	0	0
AME Impairment	0	28.706	0
Depreciation	0	0	0.369
Total	**0**	**28.706**	**0.369**

Executive Summary Table 17: Summary of Total Impact of Impairment / Depreciation Year on Year

This OBC assumes all capital charges and depreciation will be funded by Welsh Government in each of the years provided in the table above.

5.2 Revenue Costs

Service revenue to support the Regional SARC Model is being managed by the Health Board in conjunction with the NHS Wales Health Collaborative and the South Wales SARC Assurance and Oversight Board. A separate revenue business case is in preparation setting out the workforce and running costs to deliver the regional model and how this will be split across Health Board and Police commissioners. It is anticipated that this process will be completed in the spring of 2022.

The service costs in relation to the CAU, DATT and community mental health services is a relocation change rather than service change and it is anticipated the services will be delivered within current available resources. Information relating the costs for the services has been taken into consideration during the economic appraisal.

5.2.1 Facilities Costs

The indicative estates and facilities costs for the preferred option across all services within the scope are summarised below:

Estates & Facilities Costs	Current £'000	Option 2b - Preferred £'000
Catering Provisions	0	9,000
Domestics staff	50,000	120,000
Domestics consumables	3,000	6,000
Waste	11,000	24,000
Estates	52,000	112,000
Portering	0	0
Security (Inc CCTV & TDSi)	8,000	18,000
Post	0	0

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Estates & Facilities Costs	Current £'000	Option 2b - Preferred £'000
Reception Cover	0	0
Patient Transport Service	0	0
Linen	5,000	10,000
Sub- Total	**129,000**	**299,00**
Utilities	115,000	241,000
Rates	21,000	47,000
Total	**265,000**	**587,000**
Revenue Cost Saving – Hamadryad CMHT		-130,000
Net Revenue Costs	**265,000**	**457,000**

Executive Summary Table 18: Revenue Costs for the Preferred Option

The SARC, substance misuse and community mental health services will re-locate into refurbished and new build accommodation which has been sized to meet the current HBN standards. Consequently the area of build, refurbishment, plant and equipment will be larger in the preferred option than the area's currently occupied by the services within the scope. This is reflected in the facilities costs table above, which have been rounded but indicates that the additional cost to the Health Board will be circa £192,000 at 2022/23 prices. This figure includes anticipated savings of circa £130,000 which relate to the transfer of the CMHT from the Hamadryad Centre into the new Links building.

The resulting cost pressure will be managed by the Health Board through the IMTP process in the period leading up to the opening of the new facilities however a proportion of the additional facilities revenue associated with the SARC regional hub will be recovered from SARC partner organisations with the details included within the separate revenue business case to be agreed with the other commissioners/ SARC AOB as outlined above.

5.3 Overall Affordability and Balance Sheet Treatment

The anticipated capital spend, capital charges and depreciation profile for the extent of the project is as follows:

	2020/21 £'000	2021/22 £'000	2022/23 £'000	2023/24 £'000	2024/25 £'000	2025/26 £'000	2026/27 £'000	2027/28 £'000
Capital (excl. VAT)	0.234	0.317	2.213	5.823	19.701	10.743	0.000	0.000
CRL Funding (incl. VAT)	0.278	0.368	2.633	6.625	23.090	12.789	0.000	0.000
Depreciation	0.000	0.000	0.000	0.000	0.000	0.000	0.369	0.369

Executive Summary Table 19: Impact on Income, Expenditure Account and Balance Sheet

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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.

The assumption in this Outline Business Case is that there will be no VAT recovery for the new build elements of the project and circa 20% recovery as a basis for the refurbishment works, however, further discussions regarding the finalisation of management and equipment arrangements for the project will be worked upon during the development of the Full Business Case with the Health Board advisors to ensure that any opportunities for VAT recovery is conducted as efficiently as possible.

As highlighted above, it is assumed the impairment and recurrent charges for depreciation will be funded by Welsh Government. The net additional revenue costs and funding are followed by the transfer of the acute service from Risca and Merthyr SARCs, as required by the new South East Wales Regional SARC model, phased in over the summer months of 2022. The delivery of the proposals set out in this OBC, will purely relate to the re-location of the SARC service from the main CRI building into the new accommodation, with no additional service revenue required at the time this takes place.

	£'000
WG Impairment funding	28.706
WG Depreciation funding	0.369
Facilities Revenue (to be managed by the Health Board)	0.192

Executive Summary Table 20: Overall Affordability

As detailed above, the resulting facilities cost pressure will be managed by the Health Board through the IMTP process in the period leading up to the opening of the new facilities.

5.3.1 Cardiff Royal Infirmary Site Phasing Implications

As outlined above, as part of the Health Board's wider development of the CRI site masterplan, referenced throughout this business case, a number of inclusions have been made within the main CRI Health and Wellbeing Centre scheme (separate OBC currently in development) which directly affect the delivery of this project in relation to phasing. In order to mitigate the risk of delay to the progression of this project during NHS Stage 3 (construction), in the event the CRI Health & Wellbeing Centre does not proceed, a detailed review of these items has been undertaken by the Health Board, Project Manager, Cost Advisor and Supply Chain Partner to quantify the time and cost increase. The SCP has submitted a draft programme, including the works elements that may be required, which shows an increase to the overall SARC/ Links construction programme of 13 weeks.

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The outturn costs for the inclusion of these additional works is £1,364,881 (inclusive of VAT and VAT reclaim of fees). The outturn costs include for Project Manager, Cost Advisor and Supervisor for the additional 13 week construction period and include costs for 1% of the works cost for Inhouse Sponsorship and 0.2% of the works cost for Business Case writer. A

nominal sum of £50,000 has also been included for additional surveys which are likely to be required. The Risk (contingency) figure currently allowed for within the SARC OBC is also increased, this is calculated at 9.92% of the Works Fees and Non Works costs.

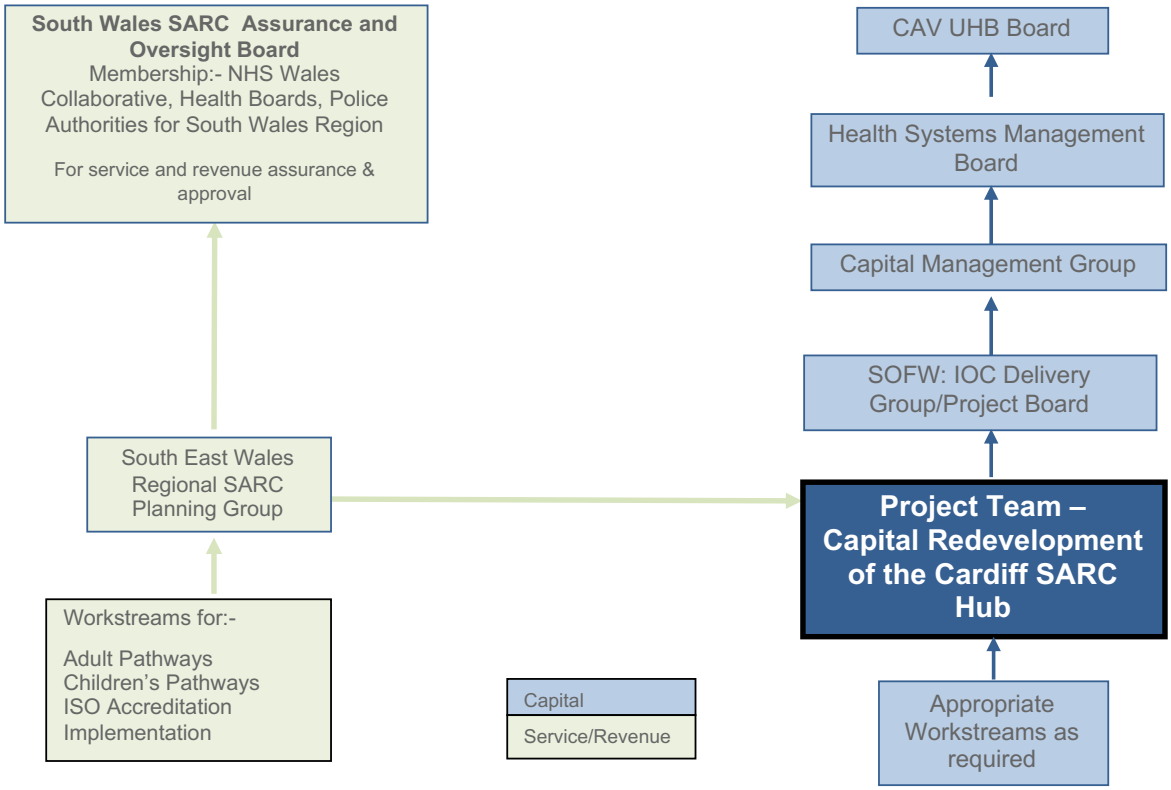
It must be noted however, that the above additional costs would only apply in the event the CRI Health and Wellbeing Centre project does not progress beyond Full Business Case or in line with the current programme expectations.

6.0 MANAGEMENT CASE

6.1 Project Management Arrangements

The project is an integral part of the Health Board's Programme Business Case (PBC) which comprises a portfolio of projects for the delivery of the *'Shaping Our Future Wellbeing: In Our Community*' strategy. However, the success of the Programme relies significantly on the development and delivery of integrated services with partner organisations such as the Regional Partnership Board (RPB), and the South Wales SARC Programme via the Health Board led South East Wales (SEW) Regional Service Delivery Group.

The reporting organisation and the reporting structure for the whole of the project is shown as follows:



Executive Summary Figure 3: Project Reporting Structure

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The dates detailed below highlight the proposed key milestones of the project:

Milestone Activity	Date
OBC submission to WG	May 2022
FBC submission to WG	May 2023
Design completion and commence construction	September 2023
Construction completion	December 2025
Facilities operational	March 2026

Executive Summary Table 21: Project Plan

6.2 Communication and Engagement

A stakeholder engagement and communication plan has been developed during this OBC stage which summarises the engagement activities undertaken to date, the results of which all inform or influence the development as far as possible. Moving forwards, a record of all engagement activities will be kept and reported on at regular intervals during the lifespan of the project.

6.3 Benefits Realisation and Risk Management

A benefits realisation plan has been developed that outlines the key objectives, benefits and measures, which will be used to evaluate the project, it also shows who has the accountability for its realisation. The plan will ensure that the project is designed and managed in the right way to deliver quality and value benefits to clients, service users, families/ carers, staff and the local community.

The risk management strategy has been integrated into the project management procedures, with responsibility for implementation of the strategy resting with the Project Director. The key risks of the preferred option have been assessed and strategies for managing them outlined. An initial risk register has been developed for the preferred option which includes all risks identified to date.

6.4 Post Project Evaluation Arrangements

The Health Board is committed to ensuring that positive lessons are learned through full and effective evaluation of key stages of the project. This learning will be of benefit to the Health Board in undertaking future projects, and potentially to other stakeholders and the wider NHS. The Health Board has therefore identified a robust plan for undertaking PPE in line with current guidance, which is fully embedded in the project management arrangements of the project.

7.0 RECOMMENDATION

It is recommended that approval be given for the Cardiff and Vale University Health Board to develop the preferred option of this vital project to progress to Full Business Case stage.

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The preferred option for approval is the relocation and remodel of the SARC service into Houses 54/56 on the CRI site with the Community Addictions Unit (CAU) vacating and moving into a new build replacement for the Links Building which would also house the DaTT/ NEX and CMHT base including co-location with other mental health services via a phased solution.

This option would not only provide the required model of care for the SARC regional hub as per the plans set out within the South Wales Regional SARC Programme to deliver quality care that meets accepted best practice in terms of clinical, quality and safety standards but the planned location on the periphery of the CRI would create a secure, safer environment for clients accessing this crucial service. This option also assists in delivering the wider benefits of the *Shaping Our Future Communities* programme and related *Shaping Our Future Clinical Services* strategy, to provide the appropriate community infrastructure to shift delivery of services, where appropriate, from acute hospitals into the community but also fully comply with Welsh Government strategies such as *Wellbeing for Future Generations Act*, *Taking Wales Forward, Prosperity for All and A Healthier Wales*.

This project is a fundamental priority for the Health Board, not only to deliver modern, fit for purpose and clinically safe accommodation for those who need it the most at the right time but also provide the right care and enhanced support mechanisms to client's, service users and their families beyond initial point of contact.

The project will support the Health Board's vision to transform the CRI site into a centre of excellence and provide quality care relevant to the needs of the local and wider community but also provide a conducive environment for staff, patients, visitors and the community alike. It will also demonstrate to the local community that the Health Board are making real progress with plans for this important site, which has been the subject of extensive engagement for some years and build on its approach to the foundational economy of Wales by seeking re-investment in the local area as it moves through the development process for the site as a whole.

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Report Title:	Board Development Programme 22-23			Agenda Item no.	7.6
Meeting:	Board	Public	x	Meeting Date:	26th May 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 purpose of the report is to enable Board Members to discuss and approve the attached Board Development Programme for 2022/23.

The attached Board Development Programme has been developed for the financial year 2022/23. The Board Development Programme is a requirement of the UHBs Standing Orders to ensure that Board Members maintain the knowledge skills and competencies to be a high performing Board.

The attached Board Development Plan has been developed by the Director of Corporate Governance with input from the Chair, Chief Executive and Executive Director for People and Culture.

Appendix 1 details the Board Development sessions which have already been agreed for this financial year. However, there is capacity for items to be added and or deferred dependent upon other commitments and priorities.
Appendix 2 details the Board Development sessions which were delivered during the last financial year.
Appendix 3 details an Action Plan to implement the overall Board Development Programme 22/23
Appendix 4 is the Independent Member Induction which can be delivered and customised to the individual depending upon skills and expertise already obtained.

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

The Board Development Programme has been designed to support and equip Board Members with the knowledge and skills they need in order deliver their responsibilities as set out within the IMTP 2022-25 and the Health Boards 10 Year Strategy 'Shaping our Future Wellbeing'.

Recommendation:

The Board are requested to:

- Review and approve the attached Board Development Programme for 2022/23.

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	✓

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		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
Safety: ~~Yes~~/No
Financial: Yes/~~No~~
There may be some costs associated with the delivery of this plan but where possible resources to support and facilitate will be kept to a minimum.
Workforce: ~~Yes~~/No
Legal: ~~Yes~~/No
Reputational: ~~Yes~~/No
Socio Economic: ~~Yes~~/No
Equality and Health: ~~Yes~~/No
Decarbonisation: ~~Yes~~/No

Approval/Scrutiny Route:	
Chair/CEO/Executive Director of People and Culture	Date: Various times throughout April 22.

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BOARD DEVELOPMENT PROGRAMME 2022-23

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1. INTRODUCTION

It is important for Boards to develop a framework of knowledge, skills and competencies that fit the requirements and context of the organisation and can serve as the basis for whole Board and individual Board Member appraisal. Alongside whole Board Performance Evaluation, Board Members should undergo an Annual Appraisal of their individual contribution and performance. This appraisal should focus on the Member's contribution as a Member of the Corporate Board; in the case of Executive Directors this is distinct from their functional leadership role. The appraisal of the Chief Executive by the Chair is particularly important because the effective performance management of the Chief Executive is critical to the success of the organisation and sets the benchmark for other Executive Directors and Senior Managers. Independent Member Appraisals are undertaken by the Chair of the Board and the Chair's Appraisal is undertaken by the Minister for Health and Social Services.

The pre-requisites of effective and continuous Board development are:

- Chair and Chief Executive commitment
- Board appetite for development
- Good appraisal and personal development planning processes

2. CARDIFF AND VALE UHB CONTEXT

Between March 2020 and March 2022, the Integrated Medium-Term Plan (IMTP) process was paused due to the COVID-19 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. Whilst our planning needed to remain dynamic, we also paid attention to the priorities set out in the 2020-2021 IMTP which was approved by the Board in January 2020, and which was deemed approvable by Welsh Government, before the pandemic hit.

In October 2021 the Welsh Government signaled 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.

It is important that the Board is supported to deliver this agenda and provided with opportunities to develop as a team and as individuals, therefore in developing this Board Development Programme the following were considered and link to the IMTP 2022-25 (See Appendix 1 for Programme of Board Development Sessions 22-23):

- Shaping our Future Wellbeing;
- The Cardiff and Vale UHB 2022-25 Integrated Medium Term Plan;
- The Cardiff and Vale University Health Boards Standing Orders;
- Board Assurance Framework;
- Key National developments;

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- Areas requested by Board Members; and
- Requests from outside bodies.

(a) Shaping our Future Wellbeing

Cardiff and Vale University health Board's (UHB's) ten-year strategy, *Shaping our Future Wellbeing* states that **Caring for People; Keeping People Well** is why we exist as a UHB, with a vision that **a person's chance of leading a healthy life is the same wherever they live and whoever they are**.

The Strategy is based upon a number of design principles, all of which are aligned with the Principles of Prudent Healthcare introduced by the Welsh Government. It focuses on:

- Empowering the person.
- Home First.
- Delivering outcomes that matter to people.
- Avoiding unwarranted variation and reduce harm and waste.

The UHB's collective ambition for the people of Cardiff and Vale is high and we will continue to push hard to innovate and develop, and to be leaders in Wales.

(b) The Cardiff and Vale UHB 2022-25 Integrated Medium Term Plan

In 2015 we published our first ten-year strategy, Shaping Our Future Wellbeing, which set out the actions we would take with partners to give everyone in our communities the same chance of leading a healthy life, and providing the best quality services possible within the resources available to us, adopting the prudent health care principles to ensure that services derive optimal benefit for our patients. The strategy was developed as the Well-being of Future Generations (Wales) Act was passing through the Senedd and has the sustainable development principle and the well-being goals at its core, including a focus on prevention and long-term thinking. Whilst many of the objectives underpinning our strategy continue to have relevance for this plan, we recognise that, at the end of this IMTP period, we will be coming to the end of our strategy's timeframe. We will use the next 3 years to engage with all our stakeholder to review the delivery against our strategy and develop a programme of engagement and co-production to develop a strategy for 2025-35.

The sessions for Board development 2022/23 will support Board Members in their understanding of some of the areas described within the 2022-25 Integrated Medium Term Plan.

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(c) The Cardiff and Vale University Health Boards Standing Orders, Standing Financial Instructions, Schedule of Powers and Scheme of Delegated Authorities

LHBs are required by law to develop Standing Orders, which regulate the way in which the proceedings and business of the LHB will be conducted.

Standing Orders, including the Standing Financial Instructions, Schedule of Reservations of Powers and Scheme of Delegated Authorities identify who in the LHB is authorised to do what.

- The documents provide a source of the key rules under which the LHB is managed and governed.
- The regulations which determine the way that the Board operates and is governed are spelt out in the Standing Orders.
- Financial responsibilities and authorities are described in the Standing Financial Instructions and Scheme of Delegated Authorities
- All employees of the LHB need to be aware of their responsibilities and authorities described in these documents.

(d) Board Assurance Framework

The Board Assurance Framework (BAF) is a well embedded document and is presented to every Board Meeting. It highlights to the Board the key risks to the achievement of Strategic Objectives. The risks for 2022/23 have been identified as:

- Workforce
- Patient Safety
- Sustainable Culture Change
- Capital Assets
- Delivery of 22/23 commitments within the IMTP
- Staff Wellbeing
- Exacerbation of Health Inequalities
- Financial sustainability
- Urgent and Emergency Care

These risks if not properly managed or mitigated could impact upon the delivery of our strategy.

(e) Key National Developments

Key National Developments from Welsh Government and NHS Wales will be presented to Board Development sessions by the relevant Executive Director who will inform the Board of areas of importance and the impact of any national developments on the LHB. These developments may also require formal reporting to the Board and will be timetabled to be presented to the Board when most appropriate.

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(f) Areas requested by Board Members

The outcomes from Executive Director appraisals and from the current round of Independent Member appraisals will be reviewed to identify if there are any common themes coming through where Board Members have identified areas and issues that they consider worthy of further exploration at a Board Development Session.

(g) Requests from outside bodies

A number of requests are received each year from outside bodies and Joint Committees, who wish to present to the Board at an informal session, these include:

- The Bevan Commission
- The Emergency Ambulance Services Committee
- NHS Wales Shared Services Partnership
- Welsh Health Specialised Services Committee
- Community Health Council
- WAST
- Digital Health and Care Wales

(h) Other Leadership Development Programmes

Independent Members will also get the opportunity to be involved in wider Leadership and Management Programmes taking place at Cardiff and Vale.

3. BOARD MEMBER INDUCTION PROGRAMME

A Board Member Induction Programme has been developed (see Appendix 4) and was used to induct newly appointed Board Members over the last 12 months. The Induction Programme can be easily customised to each Board Member needs and will be delivered at a pace which suits each individual.

In addition to the Induction Programme for new Board Members, induction will also be provided when Independent Members change the Committees they serve upon. This will be done on an individual basis and will be undertaken by the Director of Corporate Governance in conjunction with the Chair of the relevant Committee.

4. DEVELOPING THE BOARD

Once a year, a focused session will be delivered with Board Members to support and develop the Board to ensure they are acting as a highly performing team. This session will be facilitated by an external expert practitioner in the field of Organisation Development. Exploration of the team's dynamics including behaviors, diversity, and skills will be undertaken. The first of these sessions will take place in October 2022 when the new appointments of Executive Nurse Director and Chief Operating Officer are in post.

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Following this annual session further time will be dedicated to each Board Development sessions to follow up on the Annual Session and ensure that as a Board we are continuing to develop on an ongoing basis.

(a) Need for flexibility

The Board Development Plan is a fluid document and additional training/ development sessions will be added into the plan throughout the year and as priorities emerge.

(b) Personal Development

All Board members (Executive Directors and Independent Members) participate in an appraisal process on an annual basis. The process for Independent Members is led by the Chair of the Board and the process for Executive Directors is led by the Chief Executive. The Chief Executive is appraised by the Chair of the Board and the Chair of the Board is appraised by the Minister. A summary of the key outputs from this process for Executive Directors will be shared at the Remuneration and Terms of Service Committee meeting. In addition to this any collective development needs that are identified will be included within the development programme for 2022/23.

The identification of individual development needs, including continuing professional development, and implementation of any follow up action is undertaken as part of the appraisal process.

(c) Coaching

All Board members will be encouraged to take up coaching and/or mentoring support this year, in addition to utilising informal networks, and professional support groups.

(d) Academi Wales Programme

Academi Wales deliver a wide range of leadership and management development across the public service in Wales. They specifically undertake:

- Governance and Board Development
- Leadership and Organisation Development
- Talent and Succession Planning

Regular updates on the programme, including podcasts and webinars can be found at https://academiwales.gov.wales/events and learning resources at https://academiwales.gov.wales/Repository.

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(e) Shadowing and external learning opportunities

The Board will work with other NHS organisations, inside and outside of Wales, to

identify opportunities for shadowing and learning.

(f) Reverse Mentoring

Reverse mentoring is when a junior team member establishes a professional relationship with a senior team member, exchanging knowledge, skills, and understanding. It can also be known as upward mentoring. As with traditional mentoring, the sessions are confidential and the pairs make their own arrangements about meeting type and frequency, provided they meet monthly as a minimum. There are no fixed outcomes – this is fundamentally about deepening understanding and allowing mentees to think about how the sessions will influence or change their approach. As Board Members we should consider and engage with this approach to strengthen our sponsorship around the 9 protected characteristics

(g) Statutory and Mandatory Training

The following statutory and mandatory training sessions should be undertaken by all Board Members. The Director of Corporate Governance will ensure that Board Members are made aware of when training sessions are taking place and will organise the booking of Board Members onto sessions as requested.

- Equality and Diversity
- Infection control
- Safeguarding
- Information Governance
- Health and Safety
- Finance
- Fire Safety

5. SUCESSION PLANNING

Over the next twelve months a succession plan will be developed by the Executive Director of People and Culture and the Director of Corporate Governance. The plan will be developed and agreed for both Independent Members whose terms of office are coming to an end and for Executive Directors. This will identify high risk areas and will be aligned to Leadership and Management Development Programme currently in place.

(a) Skills Analysis

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In support of the succession plan a skills analysis will also be undertaken to identify the full range of skills/qualifications and experiences on the current Board but also to identify where there are any gaps or future gaps which are likely to occur.

6. DELIVERY AGAINST THE BOARD DEVELOPMENT PROGRAMME SESSIONS FOR 2021/22

The Board Development sessions which were delivered during 2021/22 are shown in the attached Appendix 2.

7. ACTION PLAN TO DELIVER THE BOARD DEVELOPMENT PROGRAMME

The attached action plan (Appendix 3) details the specific actions within the programme which need to be implemented alongside the Lead and the timescales for completion.

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Appendix 1

Board Development Programme Sessions 2022-23

Before the commencement of the calendar year dates for a series of Board development sessions to be held on a bi-monthly basis are agreed. The development sessions are structured around the areas identified in paragraph 2 of the plan but also with some sessions be used to develop the skills of the Board as described in paragraph 4.

Board Development Session Date	Areas to be covered	Purpose	Executive/IM Lead	Status
28th April 2022	Arts for Wellbeing	To show how the Health Boards Arts Programme supports the wellbeing of staff and patients	Suzanne Rankin	Session completed 28th April 2022
	Integrated Performance Report	To review the Health Boards Integrated Performance Report	Executive Directors	Session completed 28th April 2022
	Spread and Scale	To brief the Board on the Spread and Scale Academy and how large-scale change can be achieved.	Jonathon Gray	Session completed 28th April 2022
	Cyber Awareness	To provide the Board with an understanding on Cyber Awareness including security arrangements	David Thomas	Session completed 28th April 2022

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	Green Book and understanding Business Case process and stages	To provide the Board with an overview of Major Capital Business Cases and Treasury Green Book Guidance.	Abigail Harris	Session completed 28th April 2022
	Update on IMTP	To provide an update on the progress which has been made on the IMTP and Financial Plan 22-25 prior to final submission to Welsh Government	Abigail Harris	Session completed 28th April 2022
27th June 2022	Regional Partnership Board and Locality Based Model of Care	To provide the Board with an understanding of the RPB to oversee integrated strategic approaches to deliver integrated Health and Social Care	Abigail Harris	
	Strategy Review of 'Shaping our Future Wellbeing'.	To review the current Strategy and Strategic Objectives.	Abigail Harris	
25th August 2022	Charitable Funds and Legal Duties	For the Charity Trustee to gain an understanding of the responsibilities associated with being a Corporate Trustee.	Nicola Foreman	
	Duty of Candour, National Quality Framework, Healthcare Standards and Annual Quality Statement	To understand how the Quality Framework is being implemented to provide improved Quality Governance for the Health Board.	Jason Roberts	
	Socio Economic Duty	To gain and	Fiona Kinghorn	

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		understanding of where the Health Board is against its statutory responsibilities associated with the Socio-Economic Duty.		
	Better Outcomes through Patient Centred Services – EPMA Project	For the Board to gain an understanding of how EPMA can improve patient care	David Thomas/ Ifan Evans	
27th October 2022	Developing the Board 1st Session – see paragraph 4 of Plan	Exploration of the Board's dynamics including behaviours, diversity and skills	Chair	
22nd December 2022	Developing the Board – 2nd session	Follow up session	Chair	
	Learning disabilities	To gain an understanding of the work which has been undertaken and the progress made of how the Health Board is supporting people with learning disabilities into employment.		
23rd February 2023	Developing the Board – 3rd session	Follow up session	Chair	

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Appendix 2

Board Development Programme Sessions Delivered during 2021-22

Before the commencement of the calendar year dates for a series of Board development sessions to be held on a bi-monthly basis are agreed. The development sessions are structured around the areas identified in paragraph 2 of the plan.

Board Development Session Date	Areas to be covered	Purpose	Executive/IM Lead	Status
29th April 2021	Equalities and Diversity – Nine Protective Characteristics - Race		Len Richards	Session completed 29th April 21
	Youth Board and Children's Rights and Wellbeing		Steve Curry	Session completed 29th April 21
	Management of Clinical Coding across Wales	Session undertaken by Audit Wales on findings of Management of Clinical Coding	John Union	Session completed 29th April 21
25th June 2021	Equalities and Diversity – Nine Protective Characteristics -age -disability	To enable Board Members to gain an understanding of the Equality Act 2010 and the Nine Protected Characteristics. The session will include what work is taking place within the Health Board aligned to the characteristics	Steve Curry & Michael Imperato Charles Janczewski, Nikki Foreman, Fiona Jenkins	Session completed 24th June 2021 but covered disability and race
	Children and Adolescent Mental Health Services	To enable the Board to get an understanding of the breadth of the issues what	Steve Curry	Session completed 24th June 2021

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		part the Health Board plays and how other organisations should support		
	Health and Wellbeing Board Session	Facilitated by a psychologist	Rachel Gidman	Session completed 24th June 2021
	Performance Dashboard		Michael Imperato & David Thomas	Session completed 24th June 2021
	Broad aims of Quality, Safety and Patient Experience	To enable the Board to understand the aims and what this means for the Health Board	Ruth Walker and Stuart Walker	Carried forward to December 2022
	Risk Appetite	Session to review the Health Boards 'risk appetite' and to ensure on track and moving in the right direction.	Nicola Foreman	Session completed 24th June 2021
26th August 2021	Equalities and Diversity – Nine Protective Characteristics -gender reassignment -marriage and civil partnership	To enable Board Members to gain an understanding of the Equality Act 2010 and the Nine Protected Characteristics. The session will include what work is taking place within the Health Board aligned to the characteristics	Ruth Walker & Susan Elsmore Catherine Phillips	Session completed 26th August but covered transgender awareness Session on marriage and civil partnership completed on 28th October 2021
	Resource Allocation	To enable the Health Board to gain and understanding of how WG is funded and how the Health Board is funded. The session will also provide Members with what the Health Board	Charles Janczewski	Session completed on 28th October 2021

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		spends its money on.		
	UHB and RPB Outcomes Framework	To gain and understanding of what aligning and embedding the outcomes frameworks means for the Health Board	Abigail Harris	Session completed on 28th October 2021
	Health Intervention Team		Rachel Gidman	Session completed 28th October 2021
	Cardiff and Vale Local Public Health Plan	To understand what is within the programme of work and outcome measures prior to review	Fiona Kinghorn	Session took place on 24th February 2022
	Board Champions	Session to explain the role of Board Champions and to agree allocation of who was covering each champion role off.	Nicola Foreman	Session completed on 26th August 2021
	Sustainability	Session to describe actions been undertaken as part of the Sustainability Action Plan	Abigail Harris	Session completed 26th August 2021
28th October 2021	Spread and Scale Academy for Wales	To enable the Board to gain an understanding of the work of the Life Science Hub and Bevan Commission	Jonathon Gray	Session took place on 28th April 2022
	Equalities and Diversity – Nine Protective Characteristics - Pregnancy and maternity - Religion or belief	To enable Board Members to gain an understanding of the Equality Act 2010 and the Nine Protected Characteristics. The session will include what work is taking place within	Catherine Phillips Rachel Gidman & Rhian Thomas	

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		the Health Board aligned to the characteristics		
	Rehabilitation Model	For the Board to gain an understanding of the emerging rehabilitation model	Fiona Jenkins	Session completed 24th February 2022
	Regional Partnership Board and Locality Based Model of Care	For Board Members to gain an understanding of the integrated locality model.	Abigail Harris	Carried forward to June 2022
	HEIW	Update for the Board on the HEIW key strategic programmes and the development of an integrated performance report	Colleagues form HEIW delivered presentation	Session completed 28th October 2021
16th December 2021	Covid 19 Public inquiry	Session led by Innovo Law to describe the preparation required for the UHB going into a Public Inquiry on Covid 19.	Nicola Foreman	Session completed 16th December 2021
	Structured Assessment	Audit Wales presented Phase II of the Structured Assessment which focused upon Governance and use of Resources	Nicola Foreman and Audit Wales	Session completed 16th December 2021
	Population Needs Assessment	Session in preparation for report which was presented to the Board in January 2022	Fiona Kinghorn	Session completed 16th December 2021
	IMTP	Session to describe early thoughts and process regarding the IMTP 2022-	Abigail Harris	Session completed 16th December 2021

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		25		
	Shaping Our Future Wellbeing	Session to describe delivery of the Health Boards Strategy	Abigail Harris	Session completed 16th December 2021
	SO's SFI and Procurement Regulations	Session for Board Members after the issues arose as part of the Capital and Estates and Procurement review	Nicola Foreman / Catherine Phillips	Session completed 16th December 2021
24th February 2022	Equalities and Diversity – Nine Protective Characteristics - Sex - Sexual orientation	To enable Board Members to gain an understanding of the Equality Act 2010 and the Nine Protected Characteristics. The session will include what work is taking place within the Health Board aligned to the characteristics	Fiona Kinghorn & John Union Stuart Walker & Gary Baxter	
	Taking Care of the Carers		Rachel Gidman	Session took place on 24th February
	Minister Priority Measures		Caroline Bird	Session took place on 24th February
	Safeguarding		Ruth Walker	Session took place on 24th February

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Appendix 3

BOARD DEVELOPMENT PROGRAMME ACTION PLAN

Action	Lead	Timescale for Completion	Comments	Status
1. Develop **succession plan** (paragraph 5 above) for the Board to ensure that the Health Board continues to run smoothly after Executive Directors and Independent Members leave or retire.	Executive Director of People and Culture and Director of Corporate Governance	End of March 2023	This work commenced with the Executive Team prior to the pandemic and was led by the Executive Director of People and Culture. This work can now be revisited in order to complete the work and develop a succession plan for the whole Board	
2. Undertake a **skills analysis** (paragraph 5a above**)** of the Board to identify what skills the Board has to offer but also to identify any gaps which require filling.	Director of Corporate Governance	End of October 2022	This work should be undertaken to help support the delivery of a succession plan	
3. Review the outcomes of appraisals for Executive Directors and Independent Members (paragraph 1 and paragraph 2f) to identify any common themes for Board development to be added into future Board Development sessions	Chair & CEO supported by Director of Corporate Governance	End of July 2022	Appraisals for IMs are currently underway and appraisals for Executive Directors are due to take place over the next couple of months.	

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4. Consider engaging with individuals around the 9 Protected Characteristics to undertake **reverse mentoring** (paragraph 4f)**.**	All Board Members	End of March 2023	All Board Members are allocated to the 9 Protected Characteristics and individuals should seek out opportunities for reverse mentoring. Some are already undertaking this approach.	
5. Undertake **statutory and mandatory training** (paragraph 4g) sessions	All Board Members	End of December 2022.	There are some key areas where the Health Board is significantly below target in its statutory and mandatory training. E.g. Information Governance, Fire Safety. It is important that there is a focus on increasing compliance in this area.	
6. Appointment of external expert facilitator to support the delivery of **Developing the Board** (paragraph 4) sessions.	Chair supported by Executive Director of People and Culture	End of September 2022	Developing the Board session to explore the dynamics, behaviours, diversity and skills on the Board to become a high performing Team.	

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Cardiff and Vale University Health Board

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Independent Member Induction

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- 3.2 Board Issues
- 3.3 Nature of Health Board
- 3.4 Building a link with the Health Boards People
- 3.5 The Health Boards main relationships
- 3.6 Board Committee Induction

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1.0 Introduction

The governance arrangements in Health Boards are unique, with each Health Board comprising a Board of Executive Directors and Independent Members. All have a role to play in the governance of the organisation.

Independent Members have a range of roles to fulfil incorporating legal, oversight and governance responsibilities. They have strategic and leadership responsibilities, stewarding vast public resources, and are expected to act in the best interest of the NHS. It is therefore essential that Independent Members are fully aware of their legal duties, and of the values, vision and behaviours the Health Board seeks to promote among staff, members, patients and the wider public. For this reason it is essential that a Health Board offers and provides a comprehensive induction programme for new Independent Members. This will be complimented by the programme run by Welsh Government for new Independent Board Members. However, the Welsh Government Programme only runs on an annual basis so it will be important for new Independent Members to undertake some form of local induction with their Health Board once they have commenced in post.

2.0 Overall purpose

For an Independent Member to be effective it will be necessary to provide the individual with sufficient information about the Health Board to be able to contribute to discussions in a meaningful manner as soon as possible. It is unrealistic for each and every Independent Member to be fully versed in the issues facing the Health Board at their first board meeting, but each Independent Member should be working towards gaining that comprehensive knowledge. The induction pack is just one method by which necessary information can be imparted.

As individuals absorb information in different ways a number of methods should be used for inducting each Independent Member. These include:

- an induction pack that uses both text and graphics to display contextual and performance data
- site visits to observe the Health Board in action
- meetings with key members of staff, Executive Directors and other individuals
- observing board or committee meetings to gain an overview of the scope of the Health Boards activities
- a buddying/partnering system with a more experienced Independent Member

The time taken to complete an induction will depend on the Health Board its size and complexity, and it may take 12 months in order to cover a full board cycle.
The following outlines all the information about a Health Board a new Independent Member may require in the first months in office. By staggering the approach of when and what kind of information is provided, it is hoped that the new Independent Member will not be overwhelmed by the sheer volume of information to be absorbed.

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The objective of induction is to provide a new IM with the information he or she will need to become as effective as possible in their role within the shortest practicable time. The induction process should aim to achieve four things:

- Build an understanding of the nature of the Health Board, its objectives and the communities in which it operates
- Develop the new Independent Members understanding of the role, including legal duties
- Build a link with the Health Boards people – executive directors, staff and users
- Build an understanding of the Health Boards external main relationships.

3.0 Induction design

To ensure that the Independent Member receives the information s/he requires in the most appropriate format it is advisable to consult the new Independent Member before devising the induction. This conversation should inform how the programme should be tailored, in relation to both content and delivery. Previous Independent Member experience and knowledge is of course relevant to the induction design, as the Independent Member may already be aware of the legal and regulatory aspects of the Independent member role in an NHS Health Board. An update of any developments may however, be advisable.

The Director of Corporate Governance, in consultation with the Chair, should prioritise the information to be provided to the Independent Member and schedule the various induction elements over an extended period. Meetings with employees, Executive Directors, advisors, other Independent Members and patients can be arranged over an extended period but ideally this will take place within 6 months. However, Independent Members should see the whole induction plan at the start so s/he has the option to request certain elements earlier, or to have access to certain documents sooner. Vary the delivery of information, and limit the amount of data presented as reading material (whether in hard copy or via a board platform), for example by designating meetings with staff, Executive Directors and fellow Independent Members to cover certain Health Board matters, making use of advisors, other stakeholders, external training courses and organising site visits.

Take account of any relevant training and development programme in place or planned when drawing up the induction programme, so as to complement other activities and avoid any unnecessary duplication. It might be worth thinking about whether some training and development activities could be delivered to the whole board, thereby providing a useful refresher to established Independent Members and developing the relations of the entire board. For example:

- consider asking an existing Independent Member to bring their experience to bear by commenting on the content and design of the draft induction intended for an incoming Independent Member to maximise the time of Independent Members and Executive Directors and staff, the Director of Corporate Governance should consider arranging induction meetings and site visits around existing board, committee and other meetings

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- a buddying system may be beneficial to a new Independent Member in order to speed up the IMs understanding of the Health Board's values and softer aspects of the IM board, such as informal behaviours and ways of working. It may also be worthwhile identifying an Executive Director buddy where the new Independent Member will be Chairing a Committee of the Board. The IM should be encouraged to contact the Director of Corporate Governance for any other guidance and information s/he may require.

Equally important to the induction process is receiving feedback from the IM as to the effectiveness of the package provided. Feedback should be sought midway through the process, at the end and about six months afterwards to gain a balanced view of the IMs experience. Any suggestions for improvement should be given due consideration and incorporated into the design of the next induction process.

The expectation is that the induction will be tailored to the needs of the particular Independent Member to avoid repeating information the Independent Member is already well aware of, and that the content will be delivered using a variety of methods, over an extended period.

Many of the topics listed below will be best conveyed by making the Independent Member aware of the source document, while providing a summary of the key points and how they relate to the Health Board, where appropriate.

This list should not be seen as exhaustive.

3.1 Role of the Independent Member

Document	Time Frame
A brief outline of the role of the Independent Member and a summary of his or her responsibilities and continuing obligations	Upon appointment
Code of Governance	Upon appointment
An outline of the role of the Director of Corporate Governance / Board Secretary in supporting the Independent Member	Upon appointment
The Health Boards Standing Orders	Upon appointment
Personal Development Programme	Three to six months
Welsh Government Good Governance Guide Publication	Three to six months

3.2 Board issues

Document	Time Frame
Board structure and schedule of meeting dates	Upon appointment
Scheme of delegations	Upon appointment
The biographical and contact details of other Independent Member and Executive Directors and key employees	Upon appointment
The minutes of the meetings of the last six meetings and agendas for board meetings held in the last three years	Upon appointment

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A description of the procedures to be adopted at board meetings. These would normally cover details such as: • when the papers are sent out • normal location of meetings • how long they last • an indication of the routine business transacted • procedure for raising items for consideration • board etiquette policy • domestic arrangements e.g. access, parking, lunch, child care and other expenses, • process for how to send apologies for meetings you cannot attend	Upon appointment
Declarations of Interest Policy and register of interests	Upon appointment
Training in use of Admin Control plus point of contact for issues e.g. password reset	Upon appointment
Corporate calendar which details important dates for the Board, including annual returns, general meetings etc.	Upon appointment
Details of relevant Committees, for example Quality, Safety and Experience, Audit, Strategy and Delivery etc. with • Terms of Reference for each Committee, specifications of those responsibilities delegated by the Board to any committees, reporting requirements, • Names of the Independent Members and Executive members serving on any Committees incl. Secretariat • Biographical details of any Independent Members serving on committees	Upon Appointment
Board, committee and individual evaluation processes	Three to six months
Board training and development programme	Three to six months
Most recent Structured Assessment Report	Three to six months
Board composition, Board renewal, succession plans and policy on Independent Member /reappointment	After six months
Details of procedure for resigning or	After six months

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removal from office, where appropriate	

3.3 Nature of the Health Board

Document	Time Frame
Copy of the Health Board Strategy – Shaping our Future Wellbeing which includes: Mission Vision Values	Upon appointment
Brief History of the Health Board and the area/demographics it serves.	Upon appointment
How the finances work in a Health Board	Three to six months
Annual Report and Accounts	Three to six months
Annual Quality Statement	Three to six months
Board Assurance Framework	Three to six months
A Healthier Wales	Three to six months
Prosperity for All	Three to six months

3.4 Building a link with the Health Board's people

Document	Time Frame
An organisational chart – including staff and premises	Upon appointment
The contact details of key contacts	Upon appointment
Meetings with Executive Directors, Independent Members and key personnel, where appropriate	Upon appointment
Site visits and programme	Three to six months

3.5 The Health Board's main relationships

Document	Time Frame
Summary of relevant media coverage, of a positive nature or otherwise	Three to six months
List of stakeholders and any agreed engagement plan for each group	Three to six months
Copy of complaints procedure, including a précis of major complaints and incidents resolved in past two years	Three to six months

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3.6 Board Committee Induction

Where the Independent Member will be joining a Committee, he or she should be provided with copies of the committee minutes from the preceding 12 months.

Document	Time Frame
Name, role, remit and Terms of Reference of Committee	Upon appointment if Chairing a Committee or three to six months otherwise

Link between Committee policy and the Board's strategic objectives	Three to six months
Members of the Committee, and those regularly invited to attend meetings	Three to six months
Meeting schedule with work plan of forward items or an indication of when routine business is transacted	Three to six months
Main business and financial dynamics and risks	Three to six months
Current issues affecting the committee's business	Upon appointment if Chairing a Committee or three to six months
Technical training on key matters, tailored according to level of expertise	Three to six months

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Report Title:	Standing Orders, Scheme of Delegations and Standing Financial Instructions			Agenda Item no.	7.7
Meeting:	Board	Public	x	Meeting Date:	26 May 2022
		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:

NHS Bodies in Wales must agree Standing Orders ("SOs") that, together with a set of Standing Financial Instructions ("SFIs") and a scheme of decisions reserved to the Board, a scheme of delegations to officers and others, and a range of other framework documents, set out the arrangements within which Welsh Health Bodies make decisions and carry out their activities.

The SFIs detail the financial responsibilities, policies and procedures adopted by the Health Board. They are designed to ensure that the Health Board's financial transactions are carried out in accordance with the law and with Welsh Government policy in order to achieve probity, accuracy, economy, efficiency effectiveness and sustainability.

The Model Standing Orders, Reservations and Delegation of Powers ("Model SO's") were last reviewed by Welsh Government in March 2021 for Local Health Boards, Trusts, the Welsh Health Specialised Services Committee (WHSSC) and the Emergency Ambulance Services Committee (EASC). On the 7 April 2021 the Welsh Government wrote to the Chair of the Health Board to inform him that the Health Board was required to incorporate and adopt the latest review of the NHS Wales model Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions into the Health Board's own SOs. This updated version of the Welsh Government's Model SO's is incorporated and set out in the Welsh Health Circular (WHC (2021) 010) which was issued on 16 September 2021.

In line with the letter issued by the Welsh Government in April 2021, and following formal Board approval in May 2021, the Health Board incorporated and adopted the Welsh Government's updated Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions (which form part of the Standing Orders).

Since the review undertaken by Welsh Government in March 2021 and the instructions issued to the Health Board in April 2021 to update its SOs, the Welsh Government has not carried out any further reviews of the Model SO's. Accordingly, no further amendments to the Health Board's SOs and SFIs are required by Welsh Government at present.

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

The Health Board's SOs and SFIs are based upon the model standing orders and model standing financial instructions issued by Welsh Ministers to Local Health Boards. There is a requirement to keep the SOs and SFIs under review to ensure they remain accurate and current.

Williams, Sarah (NWSSP) 06/12/2022 16:56:13

A review of the SOs and the SFIs has been undertaken recently and a report was taken to the Audit Committee (i) in February 2022 in relation to the review of the SOs, Reservation and Delegation of Powers and the SFIs, and (ii) in April 2022 in relation to the SFIs and Accounting Policies. Save for some very minor updates to reflect the current Additional Areas of Responsibilities Delegated to the

Chair, Vice Chair and Independent Members (including updates to the current Board Champion Roles), and reference the full title of the Mental Health Legislation and Mental Capacity Act Committee, no further amendments have been made to the SOs or the SFIs. The current draft updated version of the SOs, Scheme of Delegations and SFIs (Version 5) are attached as Appendix 1 to this report.

In line with paragraph 4 of the Schedule of Matters Reserved to Board (Schedule 1 to the SOs), the purpose of this report is to request Board to note the update provided in this report and to approve draft Version 5 of the SOs and SFIs.

Recommendation:

The Board is requested to:

a) **Note** the update, as set out in the body of this report, with regards to the Health Board's Standing Orders, Scheme of Delegations and Standing Financial Instructions; and

b) **Approve** the updated draft version (namely Version 5) of the Standing Orders, Scheme of Delegations and Standing Financial Instructions attached as Appendix 1 to 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

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

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

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Cardiff and Vale University Health Board

STANDING ORDERS AND RESERVATION AND DELEGATION OF POWERS FOR CARDIFF AND VALE UNIVERSITY LOCAL HEALTH BOARD

Version 5 (Final 1): May 2022

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro yw enw gweithredol Bwrdd Iechyd Lleol Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board is the operational name of Cardiff and Vale University Local Health Board

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Foreword

These Standing Orders are based on the Model Standing Orders issued by Welsh Ministers to Local Health Boards using powers of direction provided in section 12 (3) of the National Health Service (Wales) Act 2006. Local Health Boards (LHBs) in Wales must agree Standing Orders (SOs) for the regulation of their proceedings and business. When agreeing SOs LHBs must ensure they are made in accordance with directions issued by Welsh Ministers.

These SOs are designed to translate the statutory requirements set out in the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 (S.I. 2009/779 (W.67)) into day to day operating practice, and, together with the adoption of a Scheme of decisions reserved to the Board; a Scheme of delegations to officers and others; and Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of the LHB.

These documents form the basis upon which the LHB's governance and accountability framework has been developed and, together with the adoption of the LHB's Values and Standards of Behaviour framework, are designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

All LHB Board members and officers must be made aware of these Standing Orders and, where appropriate, should be familiar with their detailed content. The Board Secretary will be able to provide further advice and guidance on any aspect of the Standing Orders or the wider governance arrangements within the LHB.

All supporting schedules adopted by the LHB shall be considered to be incorporated in to these Standing Orders.

Further information on governance in the NHS in Wales may be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/.

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Section A – Introduction

Statutory framework

i) The Cardiff and Vale University Local Health Board (the LHB) is a statutory body that was established on 1 June 2009 and became operational on the 1 October 2009 under **The Local Health Boards (Establishment and Dissolution) (Wales) Order 2009 (S.I. 2009/778 (W.66))**, "the Establishment Order".

ii) The principal place of business is – Cardiff and Vale University Local Health Board, Headquarters, 2nd Floor, Woodland House, Maes-y-Coed Road Cardiff CF14 4HH.

iii) All business shall be conducted in the name of Cardiff and Vale University Health Board, as the operational name of the LHB, and all funds received in trust shall be held in the name of the LHB as a corporate Trustee.

iv) LHBs are corporate bodies and their functions must be carried out in accordance with their statutory powers and duties. Their statutory powers and duties are mainly contained in the **NHS (Wales) Act 2006 (c.42)** which is the principal legislation relating to the NHS in Wales. Whilst the **NHS Act 2006 (c.41)** applies equivalent legislation to the NHS in England, it also contains some legislation that applies to both England and Wales. The NHS (Wales) Act 2006 and the NHS Act 2006 are a consolidation of the NHS Act 1977 and other health legislation which has now been repealed. The NHS (Wales) Act 2006 contains various powers of the Welsh Ministers to make subordinate legislation and details how LHBs are governed and their functions.

v) Under powers set out in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006, the Minister has made **the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 (S.I. 2009/779)** ("The Constitution Regulations") which set out the constitution and membership arrangements of LHBs, which includes a requirement for LHB's to make SO's for the regulation of its proceedings and business

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including provision of the Boards suspension.

vi) Sections 12 and 13 of the NHS (Wales) Act 2006 provide for Welsh Ministers to confer functions on LHBs and to give directions about how they exercise those functions. LHBs must act in accordance with those directions. Most of the LHB's statutory functions are set out in the **Local Health Boards (Directed Functions) (Wales) Regulations 2009 (S.I. 2009/1511).**

vii) **The Welsh Health Specialised Services Committee (Wales) Directions 2009 (2009/35)** provide that the seven LHBs in Wales will work jointly to exercise functions relating to the planning and securing of specialised and tertiary services and for the purpose of jointly exercising those functions will establish the Welsh Health Specialised Services Committee ("the Joint Committee"). Under powers set out in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006, the Minister has made **The Welsh Health Specialised Services Committee (Wales) Regulations 2009 (S.I. 2009/3097** (as amended) which make provision for the constitution and membership of the Joint Committee including its procedures and administrative arrangements.

viii) **The Emergency Ambulance Services Committee (Wales) Directions 2014 (2014/8)** as amended by the **Emergency Ambulance Services (Wales) Amendment Directions 2016 (2016/8)** provide that the seven LHBs in Wales will work jointly to exercise functions relating to the planning and securing of emergency ambulance services and for the purpose of jointly exercising those functions will establish the Emergency Ambulance Services Committee. Under powers set out in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006, the Minister has made **The Emergency Ambulance Services Committee (Wales) Regulations 2014 (2014/566)** which make provision for the constitution and membership of the Joint Committee including its procedures and administrative arrangements.

ix) In addition to directions the Welsh Ministers may from time to time issue guidance which LHBs must take into account when exercising any function. However, in some cases the relevant function may be contained in other legislation. In exercising their powers LHB's must be clear about the statutory basis for exercising such powers.

x) As a statutory body, the LHB has specified powers to contract in its own name and to act as a corporate trustee. The LHB also has statutory powers under sections 194 and 195 of the NHS (Wales) Act 2006 to fund projects jointly planned with local authorities, voluntary organisations and other bodies.

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xi) The **National Health Service Bodies and Local Authorities Partnership**

Arrangements (Wales) Regulations 2000 (S.I. 2000/2993) made under section 33 of the NHS (Wales) Act 2006 enable LHBs, NHS Trusts and Local Authorities to enter into any partnership arrangements to exercise certain NHS functions and health-related functions as specified in the Regulations. The arrangement can only be made if it is likely to lead to an improvement in the way in which NHS functions and health-related functions are exercised, and the partners have consulted jointly with all affected parties, and the arrangements fulfil the objectives set out in the Area Plan developed in accordance with the **Social Services and Well-being (Wales) Act 2014 (2014).**

xii) Section 72 of the NHS Act 2006 places a duty on NHS bodies to co-operate with each other in exercising their functions. NHS bodies includes the NHS bodies in England such as the NHS Commissioning Board, NHS Trust and NHS Foundation Trusts and, for the purpose of this duty, also includes bodies such as NICE, the Health and Social Care Information Centre and Health Education England.

xiii) Section 82 of the NHS Act 2006 places a duty on NHS bodies and local authorities to co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales.

xiv) Further duties and powers placed on health boards in relation to co-operation, partnership and pooled funds with local authorities and other partners are set out in the **Social Services and Well-being (Wales) Act 2014.** This Act establishes the legal framework for meeting people's needs for care and support and imposes general strategic duties on local authorities and LHBs in order to effectively plan and provide a sufficient range and level of care and support services. The **Partnership Arrangements (Wales) Regulations 2015 (2015 No.1989),** made under Part 9 of the **Social Services and Well-being (Wales) Act 2014** set out the arrangements made and provides for LHBs and local authorities to pool funds for the purpose of providing specified services**.**

Guidance on the provisions of Part 9 can be found at https://gov.wales/sites/default/files/publications/2020-02/part-9-statutory-guidance-partnership-arrangements.pdf

xv) The **Well-being of Future Generations (Wales) Act 2015** also places duties on LHBs and some Trusts in Wales. Sustainable development in the context of the Act means the process of improving economic, social, environmental and cultural well-being of Wales by taking action, in accordance with the sustainable development principle, aimed at achieving the well-being goals.

xvi) **The Welsh Language (Wales) Measure 2011** makes provision with regards to the development of standards of conduct relating to the Welsh

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language. These standards replace the requirement for a Welsh Language Scheme previously provided for by Section 5 of the Welsh Language Act 1993. The Welsh Language Standards (No.7) Regulations 2018 (2018/411) came into force on the 29 June 2018 and specifies standards in relation to the conduct of Local Health Boards. The Local Health Board will ensure that it has arrangements in place to meet those standards which the Welsh Language Commissioner has required by way of a compliance notice under section 44 of the 2011 Measure.

xvii) LHBs are also bound by any other statutes and legal provisions which govern the way they do business. The powers of LHBs established under statute shall be exercised by LHBs meeting in public session, except as otherwise provided by these SOs.

NHS framework

xviii) In addition to the statutory requirements set out above, LHBs must carry out all business in a manner that enables them to contribute fully to the achievement of the Welsh Government's vision for the NHS in Wales and its standards for public service delivery. The governance standards set for the NHS in Wales are based upon the Welsh Government's Citizen Centred Governance principles. These principles provide the framework for good governance and embody the values and standards of behaviour that are expected at all levels of the service, locally and nationally.

xix) Adoption of the principles will better equip LHBs to take a balanced, holistic view of their organisations and their capacity to deliver high quality, safe healthcare services for all its citizens within the NHS framework set nationally.

xx) The overarching NHS governance and accountability framework incorporates these SOs; the Schedules of Reservation and Delegation of Powers; SFIs together with a range of other frameworks designed to cover specific aspects. These include the NHS Values and Standards of Behaviour Framework*; the *'Doing Well, Doing Better: Standards for Health Services in Wales'* (formally the Healthcare Standards) Framework, the NHS Risk and Assurance Framework, and the NHS planning and performance management systems.

* The NHS Wales Values and Standards of Behaviour Framework can be accessed via the following link: https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/living-public-service-values/values-and-standards-of-behaviour-framework/

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xxi) The Welsh Ministers, reflecting their constitutional obligations and legal duties under the **Well-being of Future Generations (Wales) Act 2015,**

have stated that sustainable development should be the central organising principle for the public sector and a core objective for the NHS in all it does.

xxii) Full, up to date details of the other requirements that fall within the NHS framework – as well as further information on the Welsh Government's Citizen Centred Governance principles - are provided on the NHS Wales Governance e-manual which can be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/. Directions or guidance on specific aspects of LHB business are also issued electronically, usually under cover of a Welsh Health Circular.

Cardiff and Vale University Local Health Board's Framework

xxiii) Schedule 2 provides details of the key documents that, together with these SOs, make up the LHB's governance and accountability framework. These documents must be read in conjunction with these SOs and will have the same effect as if the details within them were incorporated within the SOs themselves. The Standing Financial Instructions form Schedule 2.1 of these SOs.

xxiv) The LHB will from time to time agree and approve policy statements which apply to its Board members and/or all or specific groups of staff employed by Cardiff and Vale University LHB and others. The decisions to approve these policies will be recorded in an appropriate Board minute and, where appropriate, will also be considered to be an integral part of the LHB's SOs and SFIs. Details of the LHB's key policy statements are also included in Schedule 2.

xxv) LHBs shall ensure that an official is designated to undertake the role of the Board Secretary (the role of which is set out in paragraph xxxiii below).

xxvi) For the purposes of these SOs, the members of the LHB shall collectively to be known as "the Board" or "Board members"; the officer and non-officer members shall be referred to as Executive Directors and Independent Members respectively; and the Chief Officer and the Chief Finance Officer shall respectively be known as the Chief Executive and the Director of Finance – SOs 1.1.2 refers.

Applying Standing Orders

xxvii) The SOs of the LHB (together with SFIs and the Values and Standards of Behaviour Framework), will, as far as they are applicable, also apply to meetings of any formal Committees established by the LHB, including any Advisory Groups, sub-Committees, joint-Committees and joint sub-Committees. These SOs may be amended or adapted for the Committees

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as appropriate, with the approval of the Board. *Further details on committees may be found in Schedule 3 of these SOs, and further details on joint-Committees may be found in Schedule 4.*

xxviii) Full details of any non-compliance with these SOs, including an explanation of the reasons and circumstances must be reported in the first instance to the Board Secretary, who will ask the Audit and Assurance Committee to formally consider the matter and make proposals to the Board on any action to be taken. All Board members and LHB officers have a duty to report any non-compliance to the Board Secretary as soon as they are aware of any circumstance that has not previously been reported.

xxix) **Ultimately, failure to comply with SOs is a disciplinary matter that could result in an individual's dismissal from employment or removal from the Board.**

Variation and amendment of Standing Orders

xxx) Although these SOs are subject to regular, annual review by the LHB, there may, exceptionally, be an occasion where it is necessary to vary or amend the SOs during the year. In these circumstances, the Board Secretary shall advise the Board of the implications of any decision to vary or amend SOs, and such a decision may only be made if:

- The variation or amendment is in accordance with regulation 15 of the Constitution Regulations and does not contravene a statutory provision or direction made by the Welsh Ministers;
- The proposed variation or amendment has been considered and approved by the Audit and Assurance Committee and is the subject of a formal report to the Board; and
- A notice of motion under Standing Order 7.5.14 has been given.

Interpretation

xxxi) During any Board meeting where there is doubt as to the applicability or interpretation of the SOs, the Chair of the LHB shall have the final say, provided that his or her decision does not conflict with rights, liabilities or duties as prescribed by law. In doing so, the Chair shall take appropriate advice from the Board Secretary and, where appropriate the Chief Executive or the Director of Finance (in the case of SFIs).

xxxii) The terms and provisions contained within these SOs aim to reflect those covered within all applicable health legislation. The legislation takes precedence over these SOs when interpreting any term or provision covered by legislation.

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The role of the Board Secretary

xxxiii) The role of the Board Secretary is crucial to the ongoing development and maintenance of a strong governance framework within LHBs, and is a key source of advice and support to the LHB Chair and other Board members. Independent of the Board, the Board Secretary acts as the guardian of good governance within the LHB. The Board Secretary is responsible for:

- Providing advice to the Board as a whole and to individual Board members on all aspects of governance;
- Facilitating the effective conduct of LHB business through meetings of the Board, its Advisory Groups and Committees;
- Ensuring that Board members have the right information to enable them to make informed decisions and fulfil their responsibilities in accordance with the provisions of these SOs;
- Ensuring that in all its dealings, the Board acts fairly, with integrity, and without prejudice or discrimination;
- Contributing to the development of an organisational culture that embodies NHS values and standards of behaviour; and
- Monitoring the LHB's compliance with the law, SOs and the governance and accountability framework set by the Welsh Ministers.

As advisor to the Board, the *Board Secretary's* role does not affect the specific responsibilities of Board members for governing the organisation. The Board Secretary is directly accountable for the conduct of their role to the Chair in respect of matters relating to responsibilities in respect of the Board, its Committees and Advisory Groups, and reports on a day to day basis to the Chief Executive with regard to the wider governance of the organisation and their personal responsibilities.

xxxiv) Further details on the role of the Board Secretary within Cardiff and Vale University LHB, including details on how to contact them, are available at https://cavuhb.nhs.wales/about-us/our-board/our-board-members/

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Section B – Standing Orders

1. CARDIFF AND VALE UNIVERSITY LOCAL HEALTH BOARD

1.0.1 The Cardiff and Vale University Local Health Board's (LHB's) principal role is to ensure the effective planning and delivery of the local NHS system, within a robust governance framework, to achieve the highest standards of patient safety and public service delivery, improve health and reduce inequalities and achieve the best possible outcomes for its citizens, and in a manner that promotes human rights.

1.0.2 The LHB was established by the **Local Health Boards (Establishment and Dissolution) (Wales) Order 2009** (S.I. 2009/778) and most of its functions are contained in the **Local Health Boards (Directed Functions) (Wales) Regulations 2009** (S.I. 2009/1511). The LHB must ensure that all its activities are in exercise of those functions or other statutory functions that are conferred on it.

1.0.3 To fulfil this role, the LHB will work with all its partners and stakeholders in the best interests of its population.

1.1 Membership of the Local Health Board

1.1.1 The membership of the LHB shall be no more than 24 members comprising the Chair and the Vice Chair, non-officer members (appointed by the Minister for Health and Social Services), Associate Members, the Chief Executive (appointed by the Board with the involvement of the Chief Executive, NHS Wales) and officer members (appointed by the Board).

1.1.2 For the purposes of these SOs, the members of the LHB shall collectively to be known as "the Board" or "Board members"; the officer and non-officer members (which will include the Chair) shall be referred to as Executive Directors and Independent Members respectively; and the Chief Officer and the Chief Finance Officer shall respectively be known as the Chief Executive and the Director of Finance. Officer and non-officer such members shall have full voting rights. Associate Members do not have voting rights.

Officer Members [to be known as Executive Directors]

1.1.3 A total of 9 (including the Chief Executive), appointed by the Board, whose responsibilities include the following areas: Medical; Finance; Nursing; Primary Care and Community and Mental Health Services; Strategic and Operational Planning; Workforce and Organisational Development; Public Health; Therapies and Health Science. Executive Directors may have other responsibilities as determined by the Board and set out in the scheme of delegation to officers.

Non-Officer Members [to be known as Independent Members]

1.1.4 A total of 9, appointed by the Minister for Health and Social Services, including: an elected member of a local authority whose area falls within the LHB area; a current member or

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employee of a Third Sector organisation within the LHB area; a trade union official; a person who holds a post in a University that is related to health; and five other Independent Members who together have experience and expertise in legal; finance; estates; Information Technology; and community knowledge and understanding.

1.1.5 In addition to the eligibility, disqualification, suspension and removal provisions contained within the Constitution Regulations, an individual shall not normally serve concurrently as a non-officer member on the Board of more than one NHS body in Wales.

Associate Members

1.1.6 A total of 4 associate members may be appointed to the Board. They will attend Board meetings on an ex-officio basis, but will not have any voting rights.

1.1.7 No more than three Associate Members may be appointed by the Minister for Health and Social Services. This may include:

- Director of Social Services (nominated by local authorities in the LHB area)
- Chair of the Stakeholder Reference Group
- Chair of the Healthcare Professionals' Forum

1.1.8 The Board may appoint an additional Associate Member to assist in carrying out its functions, subject to the agreement of the Minister for Health and Social Services.

Use of the term 'Independent Members'

1.1.9 For the purposes of these SOs, use of the term 'Independent Members' refers to the following voting members of the Board:

- Chair
- Vice Chair
- Non-Officer Members

unless otherwise stated.

1.2 Joint Directors

1.2.1 Where a post of Executive Director of the LHB is shared between more than one person because of their being appointed jointly to a post:

i Either or both persons may attend and take part in Board meetings;
ii If both are present at a meeting they shall cast one vote if they agree;
iii In the case of disagreement, no vote shall be cast; and
iv The presence of both or one person will count as one person in relation to the quorum.

1.3 Tenure of Board members

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1.3.1 Independent Members and Associate Members appointed by the Minister for Health and

Social Services shall be appointed for a period specified by the Welsh Ministers, but for no longer than 4 years in any one term. These members can be reappointed but may not hold office as a member or associate member for the same Board for a total period of more than 8 years. Time served need not be consecutive and will still be counted towards the total period even where there is a break in the term.

1.3.2 Any Associate Member appointed by the Board will be for a period of up to one year. An Associate member may be re-appointed if necessary or expedient for the performance of the LHBs functions. If re-appointed they may not hold office as an Associate Member for the same Board for a total period of more than four years. Time served includes time as a Ministerial appointment (if relevant) which need not be consecutive and will still be counted towards the total period even where there is a break in the term. An Independent or Associate Member appointed by the Minister for Health and Social Services who has already served the maximum 8 years as a Ministerial appointment to the same Board will not be eligible for appointment by the Board as an Associate Member.

1.3.3 Executive Directors' tenure of office as Board members will be determined by their contract of appointment.

1.3.4 All Board members' tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements, so far as they are applicable, as specified in Schedule 2 of the Constitution Regulations. Any member must inform the Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office. The Chair will advise the Minister in writing of any such cases immediately.

1.3.5 The LHB will require Board members to confirm in writing their continued eligibility on an annual basis.

1.4 The Role of the LHB Board and responsibilities of individual members

Role

1.4.1 The principal role of the LHB is set out in SO 1.0.1. The Board's main role is to add value to the organisation through the exercise of strong leadership and control, including:

- Setting the organisation's strategic direction
- Establishing and upholding the organisation's governance and accountability framework, including its values and standards of behaviour
- Ensuring delivery of the organisation's aims and objectives through effective challenge and scrutiny of the LHB's performance across all areas of activity.

Responsibilities

1.4.2 The Board will function as a corporate decision-making body, Executive Directors and Independent Members being full and equal members and sharing corporate responsibility for all the decisions of the Board.

1.4.3 Independent Members who are appointed to bring a particular perspective, skill or area of expertise to the Board must do so in a balanced manner, ensuring that any opinion

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expressed is objective and based upon the best interests of the health service. Similarly, Board members must not place an over reliance on those individual members with specialist expertise to cover specific aspects of Board business, and must be prepared to scrutinise and ask questions about any contribution that may be made by that member.

1.4.4 LHBs shall issue an indemnity to any Chair and Independent Member in the following terms: “A Board [or Committee] member, who has acted honestly and in good faith, will not have to meet out of their personal resources any personal liability which is incurred in the execution of their Board function. Such cover excludes the reckless or those who have acted in bad faith”.

1.4.5 Associate Members, whilst not sharing corporate responsibility for the decisions of the Board, are nevertheless required to act in a corporate manner at all times, as are their fellow Board members who have voting rights.

1.4.6 All Board members must comply with their terms of appointment. They must equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes, engaging fully in Board activities and promoting the LHB within the communities it serves.

1.4.7 **The Chair** – The Chair is responsible for the effective operation of the Board, chairing Board meetings when present and ensuring that all Board business is conducted in accordance with these SOs. The Chair may have certain specific powers delegated by the Board and set out in the Scheme of Delegation.

1.4.8 The Chair shall work in close harmony with the Chief Executive and, supported by the Board Secretary, shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

1.4.9 **The Vice-Chair** – The Vice-Chair shall deputise for the Chair in their absence for any reason, and will do so until either the existing chair resumes their duties or a new chair is appointed.

1.4.10 In addition to their corporate role across the breadth of the Board’s responsibilities, the Vice-Chair has a specific brief to oversee the LHB’s performance in the planning, delivery and evaluation of primary care, community health and mental health services ensuring a balanced care model to meet the needs of the population within the LHB’s area.

1.4.11 **Chief Executive** – The Chief Executive is responsible for the overall performance of the executive functions of the LHB. They are the appointed Accountable Officer for the LHB and shall be responsible for meeting all the responsibilities of that role, as set out in their Accountable Officer Memorandum.

1.4.12 **Lead roles for Board members** – The Chair will ensure that individual Board members are designated as lead roles or “champions” as required by the Welsh Ministers or as set out in any statutory or other guidance. Any such role must be clearly defined and must operate in accordance with the requirements set by the LHB, the Welsh Ministers or others. In particular, no operational responsibilities will be placed upon any Independent Member

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fulfilling such a role. The identification of a Board member in this way shall not make them more vulnerable to individual criticism, nor does it remove the corporate responsibility of the other Board members for that particular aspect of Board business.

2. RESERVATION AND DELEGATION OF LHB FUNCTIONS

2.0.1 Subject to any directions that may be given by the Welsh Ministers, the Board shall make arrangements for certain functions to be carried out on its behalf so that the day to day business of the LHB may be carried out effectively and in a manner that secures the achievement of its aims and objectives. In doing so, the Board must set out clearly the terms and conditions upon which any delegation is being made.

2.0.2 The Board's determination of those matters that it will retain, and those that will be delegated to others shall be set out in a:

i Schedule of matters reserved to the Board;
ii Scheme of delegation to committees and others; and
iii Scheme of delegation to officers.

all of which must be formally adopted by the Board in full session and form part of these SOs.

2.0.3 Subject to Standing Order 4, the LHB retains full responsibility for any functions delegated to others to carry out on its behalf.

2.1 Chair's action on urgent matters

2.1.1 There may, occasionally, be circumstances where decisions which would normally be made by the Board need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Board. In these circumstances, the Chair and the Chief Executive, supported by the Board Secretary as appropriate, may deal with the matter on behalf of the Board - after first consulting with at least two other Independent Members. The Board Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Board for consideration and ratification.

2.1.2 Chair's action may not be taken where either the Chair or the Chief Executive has a personal or business interest in an urgent matter requiring decision. In this circumstance, the Vice-Chair or the Executive Director acting on behalf of the Chief Executive will take a decision on the urgent matter, as appropriate.

2.2 Delegation of Board functions

2.2.1 The Board shall agree the delegation of any of their functions, except for those set out within the 'Schedule of Matters Reserved for the Board' within the Model Standing Orders (see paragraph 2.0.2.(i)) to Committees and others, setting any conditions and restrictions it considers necessary and following any directions or regulations given by the Welsh Ministers. These functions may be carried out:

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i By a Committee, sub-Committee or officer of the LHB (or of another LHB or Trust);

or

ii By another LHB; NHS Trust; Strategic Health Authority or Primary Care Trust in England; Special Health Authority; or

iii Jointly with one or more bodies including local authorities through a joint-Committee, sub-Committee or joint sub-Committee.

2.2.2 The Board shall agree and formally approve the delegation of specific executive powers to be exercised by Committees, sub-Committees, joint-Committees or joint sub-Committees which it has formally constituted.

2.3 Delegation to officers

2.3.1 The Board may delegate certain functions to the Chief Executive. For these aspects, the Chief Executive, when compiling the Scheme of Delegation to Officers, shall set out proposals for those functions they will perform personally and shall nominate other officers to undertake the remaining functions. The Chief Executive will still be accountable to the Board for all functions delegated to them irrespective of any further delegation to other officers.

2.3.2 This must be considered and approved by the Board (subject to any amendment agreed during the discussion). The Chief Executive may periodically propose amendments to the Scheme of Delegation to Officers and any such amendments must also be considered and approved by the Board.

2.3.3 Individual Executive Directors are in turn responsible for delegation within their own directorates/departments/localities in accordance with the framework established by the Chief Executive and agreed by the Board.

3. COMMITTEES

3.1 LHB Committees

3.1.1 The Board may and, where directed by the Welsh Ministers must, appoint Committees of the LHB 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. The Board shall, wherever possible, require its Committees to hold meetings in public unless there are specific, valid reasons for not doing so.

Use of the term 'Committee'

3.1.2 For the purposes of these SOs, use of the term 'Committee' incorporates the following:

- Board Committee
- Joint-Committee
- Sub-Committee
- Joint sub-Committee

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unless otherwise stated. The Board's Advisory Groups are referred to separately.

3.2 Joint Committees

3.2.1 The Board may, and where directed by the Welsh Ministers must, together with one or more LHBs or NHS Trusts or the local authorities operating within the LHB's area, appoint joint-Committees or joint sub-Committees. These may consist wholly or partly of the LHB's Board members or Board members of other health service bodies or of persons who are not LHB Board members or Board members of other health service bodies. Any such appointments must be made in accordance with the Board's defined requirements on membership (including definition of member roles, powers and terms and conditions of appointment) and any directions given by the Welsh Ministers.

3.2.2 The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out by others on its behalf. The Board shall wherever possible determine, in agreement with its partners, that its joint-Committees hold meetings in public unless there are specific, valid reasons for not doing so.

3.2.3 The Board shall establish, as a minimum, the following joint-Committees:

- The Welsh Health Specialised Services Committee (WHSSC).
- The Emergency Ambulance Services Committee

Joint Committee Standing Orders, terms of reference and operating arrangements

3.2.4 The Board shall formally approve SOs or terms of reference and operating arrangements for each joint-Committee established. These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership (including member appointment and removal; role, responsibilities and accountability; and terms and conditions of office) and quorum;
- Meeting arrangements;
- Communications;
- Relationships and accountabilities with others (including the LHB Board its Committees and Advisory Groups);
- Any budget, financial and accounting responsibility;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

3.2.5 In doing so, the Board shall specify which aspects of these SOs are not applicable to the operation of the joint-Committee, keeping any such aspects to the minimum necessary. The detailed SOs or terms of reference and operating arrangements for those joint-Committees established by the Board are set out in Schedule 4.

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3.3 Sub-Committees

3.3.1 A Committee appointed by the Board may establish a sub-Committee to assist it in the conduct of its business provided that the Board approves such action. Where the Board has authorised a Committee to establish sub-Committees they cannot delegate any executive powers to the sub-Committee unless authorised to do so by the Board.

3.4 Committees established by the LHB

3.4.1 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; and
- Mental Health Act requirements.

3.4.2 In designing its Committee structure and operating arrangements, the Board shall take full account of the need to:

- Embed corporate standards, priorities and requirements, e.g., equality and human rights across all areas of activity; and
- Maximise cohesion and integration across all aspects of governance and assurance.

3.4.3 Each Committee established by or on behalf of the Board must have its own SOs or detailed terms of reference and operating arrangements, which must be formally approved by the Board. These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership and quorum;
- Meeting arrangements;
- Relationships and accountabilities with others (including the Board its Committees and Advisory Groups)
- Any budget and financial responsibility, where appropriate;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

3.4.4 In doing so, the Board shall specify which aspects of these SOs are not applicable to the operation of the Committee, keeping any such aspects to the minimum necessary.

3.4.5 The membership of any such Committees - including the designation of Chair; definition of member roles and powers and terms and conditions of appointment (including

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remuneration and reimbursement) - will usually be determined by the Board, based on the recommendation of the LHB Chair, and subject to any specific requirements, directions or regulations made by the Welsh Ministers. Depending on the Committee's defined role and remit, membership may be drawn from the LHB Board, its staff (subject to the conditions set in Standing Order 3.4.6) or others not employed by the LHB.

3.4.6 Executive Directors or other LHB officers shall not normally be appointed as Committee Chairs, nor should they be appointed to serve as members on any Committee set up to review the exercise of functions delegated to officers or to review Mental Health Tribunals (in accordance with the Mental Health Act 1983). Designated LHB officers shall, however, be in attendance at such Committees, as appropriate.

Full details of the Committee structure established by the Board, including detailed terms of reference for each of these Committees are set out in Schedule 3.

3.5 Other Committees

3.5.1 The Board may also establish other Committees to help the LHB in the conduct of its business.

3.6 Confidentiality

3.6.1 Committee members and attendees must not disclose any matter dealt with by or brought before a Committee in confidence without the permission of the Committee's Chair.

3.7 Reporting activity to the Board

3.7.1 The Board must ensure that the Chairs of all Committees operating on its behalf report formally, regularly and on a timely basis to the Board on their activities. Committee Chairs' shall bring to the Boards specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

4. NHS WALES SHARED SERVICES PARTNERSHIP

4.0.1 From 1 June 2012 the function of managing and providing Shared Services to the health service in Wales was given to Velindre NHS Trust. The Trust's Establishment Order has been amended to reflect the fact that the Shared Services function has been conferred on it.

4.0.2 The **Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012** (S.I. 2012/1261) ("the Shared Services Regulations") require the Velindre NHS Trust to establish a Shared Services Committee which will be responsible for exercising the Trust's Shared Services functions. The Shared Services Regulations (as amended) prescribe the membership of the Shared Services Committee in order to ensure that all LHBs, Trusts and Special Health Authorities in Wales have a member on the Shared Services Committee and that the views of all the NHS organisations in Wales are considered when making decisions in respect of Shared Services activities.

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4.0.3 The Director of Shared Services will be designated as Accountable Officer for Shared

Services.

4.0.4 These arrangements necessitate putting in place a Memorandum of Co-operation Agreement and a Hosting Agreement between all LHBs and Trusts setting out the obligations of NHS bodies to participate in the Shared Services Committee and to take collective responsibility for setting the policy and delivery of the Shared Services to the health service in Wales. Responsibility for the exercise of the Shared Services functions will not rest with the Board of Velindre NHS Trust but will be a shared responsibility of all NHS bodies in Wales.

4.0.5 The Shared Services Committee is to be known as the Shared Services Partnership Committee for operational purposes.

5. ADVISORY GROUPS

5.0.1 The LHB has a statutory duty to take account of representations made by persons and organisations who represent the interests of the communities it serves, its officers and healthcare professionals. To help discharge this duty, the Board may and where directed by the Welsh Ministers must, appoint Advisory Groups to the LHB to provide advice to the Board in the exercise of its functions.

5.0.2 The LHB's Advisory Groups include a Stakeholder Reference Group, Healthcare Professionals' Forum and Local Partnership Forum. *The membership and terms of reference for these groups are set out in Schedule 5.*

5.0.3 The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out by others to advise it in the conduct of its business. The Board shall, wherever possible, require its Advisory Groups to hold meetings in public unless there are specific, valid reasons for not doing so.

5.1 Terms of reference and operating arrangements

5.1.1 The Board must formally approve terms of reference and operating arrangements for the Advisory Groups. These must establish the governance arrangements and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership (including member appointment and removal, role, responsibilities and accountabilities, and terms and conditions of office) and quorum;
- Meeting arrangements;
- Communications;
- Relationships with others (including the LHB Board, its Committees and Advisory Groups) as well as other relevant local and national groups);
- Any budget and financial responsibility;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

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5.1.2 In doing so, the Board shall specify which of these SOs are not applicable to the operation of the Advisory Group, keeping any such aspects to the minimum necessary. The detailed terms of reference and operating arrangements are set out in Schedule 5.

5.1.3 The Board may determine that the Advisory Group shall be supported by sub-groups to assist it in the conduct of its work, or the Advisory Group may itself determine such arrangements, provided that the Board approves such action.

5.2 Support to the Advisory Groups

5.2.1 The LHB's Board Secretary, on behalf of the Chair, will ensure that the Advisory Groups are properly equipped to carry out their role by:

- Co-ordinating and facilitating appropriate induction and organisational development activity;
- Ensuring the provision of governance advice and support to the Advisory Group Chair on the conduct of its business and its relationship with the LHB and others;
- Ensuring the provision of secretariat support for Advisory Group meetings (for specific arrangements relating to Local Partnership Forum see Schedule 5.3, paragraph 1.7.1);
- Ensuring that the Advisory Group receives the information it needs on a timely basis;
- Ensuring strong links to communities/groups/professionals as appropriate; and
- Facilitating effective reporting to the Board

enabling the Board to gain assurance that the conduct of business within the Advisory Group accords with the governance and operating framework it has set.

5.3 Confidentiality

5.3.1 Advisory Group members and attendees must not disclose any matter dealt with by or brought before a Group in confidence without the permission of the Advisory Group Chair.

5.4 Advice and feedback

5.4.1 The LHB may specifically request advice and feedback from the Advisory Groups on any aspect of its business, and they may also offer advice and feedback even if not specifically requested by the LHB. The Groups may provide advice to the Board:

- At Board meetings, through the SRG and HPF Chair's participation as Associate Members;
- In written advice;
- In any other form specified by the Board.

5.5 Reporting activity

5.5.1 The Board shall ensure that the Chairs of all Advisory Groups report formally, regularly and on a timely basis to the Board on their activities. Advisory Group Chairs shall bring to the Board's specific attention any significant matters under consideration and report on the

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totality of its activities through the production of minutes or other written reports.

5.5.2 Each Advisory Group shall also submit an annual report to the Board through the Chair within 6 weeks of the end of the reporting year setting out its activities during the year and detailing the results of a review of its performance and that of any sub-groups it has established.

5.5.3 Each Advisory Group shall report regularly on its activities to those whose interests they represent.

5.6 THE STAKEHOLDER REFERENCE GROUP (SRG)

Role

5.6.1 The SRG's role is to provide independent advice on any aspect of LHB business. This may include:

- Early engagement and involvement in the determination of the LHB's overall strategic direction;
- Provision of advice on specific service proposals prior to formal consultation; as well as
- Feedback on the impact of the LHB's operations on the communities it serves.

5.6.2 The SRG provides a forum to facilitate full engagement and active debate amongst stakeholders from across the communities served by the LHB, with the aim of reaching and presenting a cohesive and balanced stakeholder perspective to inform the LHB's decision making.

5.6.3 The SRG's role is distinctive from that of Community Health Councils (CHCs), who have a statutory role in representing the interests of patients and the public in their areas. The SRG shall represent those stakeholders who have an interest in, and whose own role and activities may be impacted by the decisions of the LHB. Membership may include community partners, provider organisations, special interest and other groups operating within the LHBs area.

5.6.4 It does not cover those stakeholders whose interests are represented within the remit of other Advisory Groups established by the LHB, e.g., the Healthcare Professionals' Forum and Local Partnership Forum.

5.6.5 In addition to the provisions above the Board must set out, the relationships and accountabilities with others, such as the Regional Partnership Board.

5.7 Relationship with the Board

5.7.1 The SRG's main link with the Board is through the SRG Chair's membership of the Board as an Associate Member.

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5.7.2 The Board may determine that designated Board members or LHB officers shall attend

Advisory Group meetings. The SRG's Chair may also request the attendance of Board members or LHB officers, subject to the agreement of the LHB Chair.

5.7.3 The Board shall determine the arrangements for any joint meetings between the LHB Board and the SRG.

5.7.4 The Board's Chair shall put in place arrangements to meet with the SRG Chair on a regular basis to discuss the SRG's activities and operation.

5.8 Relationship between the SRG and others

5.8.1 The Board must ensure that the SRG's advice represents a balanced, co-ordinated stakeholder perspective from across the local communities served by the LHB. The SRG shall:

- Ensure effective links and relationships with other advisory groups, local and community partnerships and other key stakeholders who do not form part of the SRG membership;
- Ensure its role, responsibilities and activities are known and understood by others; and
- Take care to avoid unnecessary duplication of activity with other bodies/groups with an interest in the planning and provision of NHS services, e.g., Regional Partnership Boards.

5.9 Working with Community Health Councils

5.9.1 The SRG shall make arrangements to ensure designated CHC members receive the SRG's papers and are invited to attend SRG meetings.

5.9.2 The SRG shall work together with CHCs within the area covered by the LHB to engage and involve those within the local communities served whose views may not otherwise be heard.

Refer to Schedule 5.1 for detailed Terms of Reference and Operating Arrangements

5.10 THE HEALTHCARE PROFESSIONALS' FORUM (HPF)

Role

5.10.1 The HPF's role is to provide a balanced, multi-disciplinary view of healthcare professional issues to advise the Board on local strategy and delivery. Its role does not include consideration of healthcare professional terms and conditions of service.

5.10.2 The HPF shall facilitate engagement and debate amongst the wide range of clinical interests within the LHB's area of activity, with the aim of reaching and presenting a cohesive and balanced healthcare professional perspective to inform the LHB's decision

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making.

5.11 Terms of reference and operating arrangements

5.11.1 In addition to the provisions in 5.2.1 above the Board must set out, the relationships and accountabilities with others, as well as the National Professional Advisory Group.

5.12 Relationship with the Board

5.12.1 The HPF's main link with the Board is through the HPF Chair's membership of the Board as an Associate Member.

5.12.2 The Board may determine that designated Board members or LHB officers shall attend Advisory Group meetings. The HPF's Chair may also request the attendance of Board members or LHB officers, subject to the agreement of the LHB Chair.

5.12.3 The Board shall determine the arrangements for any joint meetings between the LHB Board and the HPF.

5.12.4 The Board's Chair shall put in place arrangements to meet with the HPF Chair on a regular basis to discuss the HPF's activities and operation.

5.13 Rights of Access to the LHB Board for Professional Groups

5.13.1 The LHB Chair, on the advice of the Chief Executive and/or Board Secretary, may recommend that the Board afford direct right of access to any professional group, in the following, exceptional circumstances:

i) Where the HPF recommends that a matter should be presented to the Board by a particular healthcare professional grouping, e.g., due to the specialist nature of the issues concerned; or
ii) Where a healthcare professional group has demonstrated that the HPF has not afforded it due consideration in the determination of its advice to the Board on a particular issue.

5.13.2 The Board may itself determine that it wishes to seek the views of a particular healthcare professional grouping on a specific matter, in accordance with Standing Order 7.5.7.

5.14 Relationship with the National Professional Advisory Group

5.14.1 The HPF Chair (or HPF Vice-Chair) will be a member of the National Professional Advisory Group.

Refer to Schedule 5.2 for detailed Terms of Reference and Operating Arrangements

5.15 THE LOCAL PARTNERSHIP FORUM (LPF)

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Role

5.15.1 The LPF's role is to provide a formal mechanism where the LHB, as employer, and trade unions/professional bodies representing LHB employees (hereafter referred to as staff organisations) work together to improve health services for the citizens served by the LHB - achieved through a regular and timely process of consultation, negotiation and communication. In doing so, the LPF must effectively represent the views and interests of the LHB's workforce.

5.15.2 It is the forum where the LHB and staff organisations will engage with each other to inform, debate and seek to agree local priorities on workforce and health service issues; and inform thinking around national priorities on health matters.

5.16 Relationship with the Board and others

5.16.1 The LPF's main link with the Board is through the Executive members of the LPF.

5.16.2 The Board may determine that designated Board members or LHB staff shall attend LPF meetings. The LPF's Chair may also request the attendance of Board members or LHB staff, subject to the agreement of the LHB Chair.

5.16.3 The Board shall determine the arrangements for any joint meetings between the LHB Board and the LPF's staff representative members.

5.16.4 The Board's Chair shall put in place arrangements to meet with the LPG's Joint Chairs on a regular basis to discuss the LPF's activities and operation.

5.16.5 The LPF shall ensure effective links and relationships with other groups/fora at a local and, where appropriate, national level.

Refer to Schedule 5.3 for detailed Terms of Reference and Operating Arrangements

6. WORKING IN PARTNERSHIP

6.0.1 The LHB shall work constructively in partnership with others to plan and secure the delivery of an equitable, high quality, whole system approach to health, well-being and social care for its citizens. This will be delivered in accordance with its statutory duties and any specific requirements or directions made by the Welsh Ministers, e.g. the development of population assessments and area plans.

6.0.2 The Chair shall ensure that the Board has identified all its key partners and other stakeholders and established clear mechanisms for engaging with and involving them in the work of the LHB through:

- The LHB's own structures and operating arrangements, e.g., Advisory Groups; and
- The involvement (at very local and community wide levels) in partnerships and community groups – such as such as Regional Partnership and Public Service Boards – of Board members and LHB officers with delegated authority to represent

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the LHB and, as appropriate, take decisions on its behalf.

6.0.3 The Social Services and Well-Being (Wales) Act 2014 sets out duties for working in partnership with local authorities complementing existing duties under section 82 of the NHS Act 2006 (duty to cooperate with local authorities) and sections 10 (arrangements with other bodies) and 38 (duty to make services available to enable the discharge of local authority functions) of the NHS (Wales) Act 2006. This includes "Partnership Arrangements" established under the direction of Regional Partnership Boards and under which the LHB may carry out any of the specified functions on behalf of the partnership body and may established pooled funds for specified purposes. An advice note on partnership working – implications for health boards and NHS Trusts from the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015 has been published and it can be found here: https://socialcare.wales/cms_assets/hub-downloads/Partnership-working-–-implications-for-health-boards-and-NHS-Trusts.pdf

6.0.4 The Board shall keep under review its partnership arrangements to ensure continued clarity around purpose, desired outcomes and partner responsibilities. It must ensure timely action to change, adapt or end partnerships where they no longer serve a useful purpose, in accordance with its statutory duties; any specific requirements or directions made by the Welsh Ministers; and the agreed terms and conditions for the partnership.

6.1 Community Health Councils (CHCs)

6.1.1 The **Community Health Councils (Constitution, Membership and Procedures) (Wales) Regulations 2010** (S.I. 2010/288) (as amended) and the **Community Health Councils (Establishment, Transfer of Functions and Abolition) (Wales) Order 2010** (S.I. 2010/289) place a range of duties on LHBs in relation to the engagement and involvement of CHCs in its operations.

6.1.2 In discharging these duties, the Board shall work constructively with the CHCs working jointly within the LHB's area by ensuring their involvement in:

- The planning of the provision of its healthcare services;
- The development and consideration of proposals for changes in the way in which those services are provided; and
- The Board's decisions affecting the operation of those healthcare services that it has responsibility for

and formally consulting with those CHCs working jointly within the LHB's area on any proposals for substantial development of the services it is responsible for.

6.1.3 The Board shall ensure that each relevant CHC is provided with the information it needs on a timely basis to enable it to effectively discharge its functions.

Relationship with the Board

6.1.4 The Board may determine that designated CHC members shall be invited to attend Board meetings.

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6.1.5 The Board shall make arrangements for regular joint meetings between the CHC members and the Board, to be held not less than once every three calendar months and ensuring attendance of at least one third of the Board's members.

6.1.6 The Board's Chair shall put in place arrangements to meet with the relevant CHC Chair(s) on a regular basis to discuss matters of common interest.

7. MEETINGS

7.1 Putting Citizens first

7.1.1 The LHB's business will be carried out openly and transparently in a manner that encourages the active engagement of its citizens, community partners and other stakeholders. The LHB, through the planning and conduct of meetings held in public, shall facilitate this in a number of ways, including:

- Active communication of forthcoming business and activities;
- The selection of accessible, suitable venues for meetings;
- The availability of papers in English and Welsh languages and in accessible formats, such as Braille, large print, easy read (where requested or required) and in electronic formats;
- Requesting that attendees notify the LHB of any access needs sufficiently in advance of a proposed meeting, and responding appropriately, e.g., arranging British Sign Language (BSL) interpretation at meetings; and
- Where appropriate, ensuring suitable translation arrangements are in place to enable the conduct of meetings in either English or Welsh,

in accordance with legislative requirements, e.g. Disability Discrimination Act, as well as its Communication Strategy and provisions made in response to the compliance notice issued by the Welsh Language Commissioner under section 44 of the Welsh Language (Wales) Measure 2011.

7.1.2 The Chair will ensure that, in determining the matters to be considered by the Board, full account is taken of the views and interests of the communities served by the LHB, including any views expressed formally to the LHB, e.g. through the SRG or CHCs.

7.2 Annual Plan of Board Business

7.2.1 The Board Secretary, on behalf of the Chair, shall produce an Annual Plan of Board business. This plan will include proposals on meeting dates, venues and coverage of business activity during the year, taking account that ordinary meetings of the Board will be held at regular intervals and as a minimum six times a year. The Plan shall also set out any standing items that will appear on every Board agenda.

7.2.2 The plan shall set out the arrangements in place to enable the LHB to meet its obligations to its citizens as outlined in paragraph 6.1.1 whilst also allowing Board members to contribute in either English or Welsh languages, where appropriate.

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7.2.3 The plan shall also incorporate formal Board meetings, regular Board Development

sessions and, where appropriate, the planned activities of the Board's Committees and Advisory Groups.

7.2.4 The Board shall agree the plan for the forthcoming year by the end of March, and this will be published on the LHB's website.

Annual General Meeting (AGM)

7.2.5 The LHB must hold an AGM in public no later than the 31 July each year.
At least 10 calendar days prior to the meeting a public notice of the intention to hold the meeting, the time and place of the meeting, and the agenda, shall be displayed bilingually (in English and Welsh) on the LHB's website.

The notice shall state that:

- Electronic or paper copies of the Annual Report and Accounts of the LHB are available, on request, prior to the meeting; and
- State how copies can be obtained, in what language and in what format, e.g. as Braille, large print, easy read etc.

The AGM must include presentation of the Annual Report and audited accounts, together with (where applicable), an audited abridged version of the annual accounts and funds held on trust accounts, and may also include presentation of other reports of interest to citizens and others.

7.2.6 A record of the meeting shall be submitted to the next ordinary meeting of the Board for agreement.

7.3 Calling Meetings

7.3.1 In addition to the planned meetings agreed by the Board, the Chair may call a meeting of the Board at any time. Individual Board members may also request that the Chair call a meeting provided that at least one third of the whole number of Board members, support such a request.

7.3.2 If the Chair does not call a meeting within seven days after receiving such a request from Board members, then those Board members may themselves call a meeting.

7.4 Preparing for Meetings

Setting the agenda

7.4.1 The Chair, in consultation with the Chief Executive and Board Secretary, will set the Agenda. In doing so, they will take account of the planned activity set in the annual cycle of Board business; any standing items agreed by the Board; any applicable items received from the Board's Committees and Advisory Groups; and the priorities facing the LHB. The Chair must ensure that all relevant matters are brought before the Board on a timely basis.

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7.4.2 Any Board member may request that a matter is placed on the Agenda by writing to the

Chair, copied to the Board Secretary, at least 12 calendar days before the meeting. The request must set out whether the item of business is proposed to be transacted in public and shall include appropriate supporting information. The Chair may, at their discretion, include items on the agenda that have been requested after the 12-day notice period if this would be beneficial to the conduct of board business.

Notifying and equipping Board members

7.4.3 Board members shall be sent an Agenda and a complete set of supporting papers at least 10 clear days before a formal Board meeting. This information may be provided to Board members electronically or in paper form, in an accessible format, to the address provided, and in accordance with their stated preference. Supporting papers may, exceptionally, be provided, after this time provided that the Chair is satisfied that the Board's ability to consider the issues contained within the paper would not be impaired.

7.4.4 No papers will be included for consideration and decision by the Board unless the Chair is satisfied (subject to advice from the Board Secretary, as appropriate) that the information contained within it is sufficient to enable the Board to take a reasonable decision. This will include evidence that appropriate impact assessments have been undertaken and taken into consideration. Impact assessments, shall be undertaken on all new or revised policies, strategies, guidance and or practice to be considered by the Board, and the outcome of that assessment shall accompany the report to the Board to enable the Board to make an informed decision.

7.4.5 In the event that at least half of the Board members do not receive the Agenda and papers for the meeting as set out above, the Chair must consider whether or not the Board would still be capable of fulfilling its role and meeting its responsibilities through the conduct of the meeting. Where the Chair determines that the meeting should go ahead, their decision, and the reason for it, shall be recorded in the minutes.

7.4.6 In the case of a meeting called by Board members, notice of that meeting must be signed by those members and the business conducted will be limited to that set out in the notice.

Notifying the public and others

7.4.7 Except for meetings called in accordance with Standing Order 7.3, at least 10 clear days before each meeting of the Board a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed bilingually (in English and Welsh):

- On the LHB's website, together with the papers supporting the public part of the Agenda; as well as
- Through other methods of communication as set out in the LHB's communication strategy.

7.4.8 When providing notification of the forthcoming meeting, the LHB shall set out when and how the Agenda and the papers supporting the public part of the Agenda may be accessed, in what language and in what format, e.g. as Braille, large print, easy read, etc.

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7.5 Conducting Board Meetings

Admission of the public, the press and other observers

7.5.1 The LHB shall encourage attendance at its formal Board meetings by the public and members of the press as well as LHB officers or representatives from organisations who have an interest in LHB business. The venue for such meetings shall be appropriate to facilitate easy access for attendees and translation services; and shall have appropriate facilities to maximise accessibility.

7.5.2 The Board and its committees shall conduct as much of its formal business in public as possible. There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g. business that relates to a confidential matter. In such cases the Chair (advised by the Board Secretary where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Board shall resolve:

> *That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).*

7.5.3 In these circumstances, when the Board is not meeting in public session it shall operate in private session, formally reporting any decisions taken to the next meeting of the Board in public session. Wherever possible, that reporting shall take place at the end of a private session, by reconvening a Board meeting held in public session.

7.5.4 The Board Secretary, on behalf of the Chair, shall keep under review the nature and volume of business conducted in private session to ensure such arrangements are adopted only when absolutely necessary.

7.5.5 In encouraging entry to formal Board Meetings from members of the public and others, the Board shall make clear that attendees are welcomed as observers. The Chair shall take all necessary steps to ensure that the Board's business is conducted without interruption and disruption. In exceptional circumstances, this may include a requirement that observers leave the meeting.

7.5.6 Unless the Board has given prior and specific agreement, members of the public or other observers will not be allowed to record proceedings in any way other than in writing.

Addressing the Board, its Committees and Advisory Groups

7.5.7 The Board will decide what arrangements and terms and conditions it feels are appropriate in extending an invitation to observers to attend and address any meetings of the Board, its Committees and Advisory Groups, and may change, alter or vary these terms and conditions as it considers appropriate. In doing so, the Board will take account of its responsibility to actively encourage the engagement and, where appropriate, involvement of citizens and stakeholders in the work of the LHB, (whether directly or through the activities of bodies such as CHCs and the LHB's Advisory Groups representing citizens and other

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stakeholders) and to demonstrate openness and transparency in the conduct of business.

Chairing Board Meetings

7.5.8 The Chair of the LHB will preside at any meeting of the Board unless they are absent for any reason (including any temporary absence or disqualification from participation on the grounds of a conflict of interest). In these circumstances the Vice Chair shall preside. If both the Chair and Vice-Chair are absent or disqualified, the Independent Members present shall elect one of the Independent Members to preside.

7.5.9 The Chair must ensure that the meeting is handled in a manner that enables the Board to reach effective decisions on the matters before it. This includes ensuring that Board members' contributions are timely and relevant and move business along at an appropriate pace. In doing so, the Board must have access to appropriate advice on the conduct of the meeting through the attendance of the nominated Board Secretary. The Chair has the final say on any matter relating to the conduct of Board business.

Quorum

7.5.10 At least six Board members, at least three of whom are Executive Directors and three are Independent Members, must be present to allow any formal business to take place at a Board meeting.

7.5.11 If the Chief Executive or an Executive Director is unable to attend a Board meeting, then a nominated deputy may attend in their absence and may participate in the meeting, provided that the Chair has agreed the nomination before the meeting. However, Board members' voting rights cannot be delegated so the nominated deputy may not vote or be counted towards the quorum. If a deputy is already a Board member in their own right, e.g. a person deputising for the Chief Executive will usually be an Executive Director, they will be able to exercise their own vote in the usual way but they will not have any additional voting rights.

7.5.12 The quorum must be maintained during a meeting to allow formal business to be conducted, i.e. any decisions to be made. Any Board member disqualified through conflict of interest from participating in the discussion on any matter and/or from voting on any resolution will no longer count towards the quorum. If this results in the quorum not being met that particular matter or resolution cannot be considered further at that meeting, and must be noted in the minutes.

Dealing with motions

7.5.13 In the normal course of Board business items included on the agenda are subject to discussion and decisions based on consensus. Considering a motion is therefore not a routine matter and may be regarded as exceptional, e.g. where an aspect of service delivery is a cause for particular concern, a Board member may put forward a motion proposing that a formal review of that service area is undertaken by a Committee of the Board. The Board Secretary will advise the Chair on the formal process for dealing with motions. No motion or amendment to a motion will be considered by the Board unless moved by a Board member and seconded by another Board member (including the Chair).

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7.5.14 **Proposing a formal notice of motion –** Any Board member wishing to propose a motion must notify the Chair in writing of the proposed motion at least 12 days before a planned meeting. Exceptionally, an emergency motion may be proposed up to one hour before the fixed start of the meeting, provided that the reasons for the urgency are clearly set out. Where sufficient notice has been provided, and the Chair has determined that the proposed motion is relevant to the Board's business, the matter shall be included on the Agenda, or, where an emergency motion has been proposed, the Chair shall declare the motion at the start of the meeting as an additional item to be included on the agenda.

7.5.15 The Chair also has the discretion to accept a motion proposed during a meeting provided that the matter is considered of sufficient importance and its inclusion would not adversely affect the conduct of Board business.

7.5.16 **Amendments -** Any Board member may propose an amendment to the motion at any time before or during a meeting and this proposal must be considered by the Board alongside the motion.

7.5.17 If there are a number of proposed amendments to the motion, each amendment will be considered in turn, and if passed, the amended motion becomes the basis on which the further amendments are considered, i.e. the substantive motion.

7.5.18 **Motions under discussion –** When a motion is under discussion, any Board member may propose that:

- The motion be amended;
- The meeting should be adjourned;
- The discussion should be adjourned and the meeting proceed to the next item of business;
- A Board member may not be heard further;
- The Board decides upon the motion before them;
- An ad hoc Committee should be appointed to deal with a specific item of business; or
- The public, including the press, should be excluded.

7.5.19 **Rights of reply to motions –** The mover of a motion (including an amendment) shall have a right of reply at the close of any debate on the motion or the amendment immediately prior to a vote on the proposal.

7.5.20 **Withdrawal of motion or amendments –** A motion or an amendment to a motion, once moved and seconded, may be withdrawn by the proposer with the agreement of the seconder and the Chair.

7.5.21 **Motion to rescind a resolution –** The Board may not consider a motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six months unless the motion is supported by the (simple) majority of Board members.

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7.5.22 A motion that has been decided upon by the Board cannot be proposed again within six

months except by the Chair, unless the motion relates to the receipt of a report or the recommendations of a Committee/Chief Executive to which a matter has been referred.

Voting

7.5.23 The Chair will determine whether Board members' decisions should be expressed orally, through a show of hands, by secret ballot or by recorded vote. The Chair must require a secret ballot or recorded vote if the majority of voting Board members request it. Where voting on any question is conducted, a record of the vote shall be maintained. In the case of a secret ballot the decision shall record the number voting for, against or abstaining. Where a recorded vote has been used the Minutes shall record the name of the individual and the way in which they voted. Associate Members may not vote in any meetings or proceedings of the Board.

7.5.24 In determining every question at a meeting, the Board members must take account, where relevant, of the views expressed and representations made by individuals or organisations who represent the interests of the community and healthcare professionals within the LHB's area. Such views will usually be presented to the Board through the Chairs of the LHB's Advisory Groups and the CHC representative(s).

7.5.25 The Board will make decisions based on a simple majority view held by the Board members present. In the event of a split decision, i.e. no majority view being expressed, the Chair shall have a second and casting vote.

7.5.26 In no circumstances may an absent Board member or nominated deputy vote by proxy. Absence is defined as being absent at the time of the vote.

7.6 Record of Proceedings

7.6.1 A record of the proceedings of formal Board meetings (and any other meetings of the board where the Board members determine) shall be drawn up as 'minutes'. These minutes shall include a record of Board member attendance (including the Chair) together with apologies for absence, and shall be submitted for agreement at the next meeting of the Board, where any discussion shall be limited to matters of accuracy. Any agreed amendment to the minutes must be formally recorded.

7.6.2 Agreed minutes shall be circulated in accordance with Board members' wishes, and, where providing a record of a formal Board meeting shall be made available to the public both on the LHB's website and in hard copy or other accessible format on request, in accordance with any legislative requirements, e.g. Data Protection Act 2018, the General Data Protection Regulation 2018 and the LHB's Communication Strategy and Welsh language requirements.

7.7 Confidentiality

7.7.1 All Board members (including Associate Members), together with members of any Committee or Advisory Group established by or on behalf of the Board and LHB officials must respect the confidentiality of all matters considered by the LHB in private session or set out in documents which are not publicly available. Disclosure of any such matters may

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only be made with the express permission of the Chair of the Board or relevant Committee, as appropriate, and in accordance with any other requirements set out elsewhere, e.g., in contracts of employment, within the Values and Standards of Behaviour framework or legislation such as the Freedom of Information Act 2000, etc.

8 VALUES AND STANDARDS OF BEHAVIOUR

8.0.1 The Board must adopt a set of values and standards of behaviour for the LHB that meets the requirements of the NHS Wales Values and Standards of Behaviour framework. These values and standards of behaviour will apply to all those conducting business by or on behalf of the LHB, including Board members, LHB officers and others, as appropriate. The framework adopted by the Board will form part of these SOs.

8.1 Declaring and recording Board members' interests

8.1.1. ***Declaration of interests –*** It is a requirement that all Board members must declare any personal or business interests they may have which may affect, or be perceived to affect the conduct of their role as a Board member. This includes any interests that may influence or be perceived to influence their judgement in the course of conducting the Board's business. Board members must be familiar with the Values and Standards of Behaviour Framework and their statutory duties under the Constitution Regulations. Board members must notify the Board of any such interests at the time of their appointment, and any further interests as they arise throughout their tenure as Board members.

8.1.2. Board members must also declare any interests held by family members or persons or bodies with which they are connected. The Board Secretary will provide advice to the Chair and the Board on what should be considered as an 'interest', taking account of the regulatory requirements and any further guidance, e.g. the Values and Standards of Behaviour framework. If individual Board members are in any doubt about what may be considered as an interest, they should seek advice from the Board Secretary. However, the onus regarding declaration will reside with the individual Board member.

8.1.3. ***Register of interests –*** The Chief Executive, through the Board Secretary will ensure that a Register of Interests is established and maintained as a formal record of interests declared by all Board members. The register will include details of all Directorships and other relevant and material interests which have been declared by Board members.

8.1.4. The register will be held by the Board Secretary, and will be updated during the year, as appropriate, to record any new interests, or changes to the interests declared by Board members. The Board Secretary will also arrange an annual review of the Register, through which Board members will be required to confirm the accuracy and completeness of the register relating to their own interests.

8.1.5. In line with the Board's commitment to openness and transparency the Board Secretary must take reasonable steps to ensure that the citizens served by the LHB are made aware of, and have access to view the LHB's Register of Interests. This may include publication on the LHB website.

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The LHB's Register of Interest can be accessed via: https://cavuhb.nhs.wales/about-us/governance-and-assurance/register-of-interests-gifts-and-hospitality/

8.1.6 ***Publication of declared interests in Annual Report*** – Board members' directorships of companies or positions in other organisations likely or possibly seeking to do business with the NHS shall be published in the LHB's Annual Report.

8.2 Dealing with Members' interests during Board meetings

8.2.1 The Chair, advised by the Board Secretary, must ensure that the Board's decisions on all matters brought before it is taken in an open, balanced, objective and unbiased manner. In turn, individual Board members must demonstrate, through their actions, that their contribution to the Board's decision making is based upon the best interests of the LHB and the NHS in Wales.

8.2.2 Where individual Board members identify an interest in relation to any aspect of Board business set out in the Board's meeting agenda, that member must declare an interest at the start of the Board meeting. Board members should seek advice from the Chair, through the Board Secretary before the start of the Board meeting if they are in any doubt as to whether they should declare an interest at the meeting. All declarations of interest made at a meeting must be recorded in the Board minutes.

8.2.3 It is the responsibility of the Chair, on behalf of the Board, to determine the action to be taken in response to a declaration of interest, taking account of any regulatory requirements or directions made by the Welsh Ministers. The range of possible actions may include determination that:

i) The declaration is formally noted and recorded, but that the Board member should participate fully in the Board's discussion and decision, including voting. This may be appropriate, for example where the Board is considering matters of strategy relating to a particular aspect of healthcare and an Independent Member is a healthcare professional whose profession may be affected by that strategy determined by the Board;
ii) The declaration is formally noted and recorded, and the Board member participates fully in the Board's discussion, but takes no part in the Board's decision;
iii) The declaration is formally noted and recorded, and the Board member takes no part in the Board discussion or decision;
iv) The declaration is formally noted and recorded, and the Board member is excluded for that part of the meeting when the matter is being discussed. A Board member must be excluded, where that member has a direct or indirect financial interest in a matter being considered by the Board.

8.2.4 In extreme cases, it may be necessary for the member to reflect on whether their position as a Board member is compatible with an identified conflict of interest.

8.2.5 Where the Chair is the individual declaring an interest, any decision on the action to be taken shall be made by the Vice-Chair, on behalf of the Board.

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8.2.6 In all cases the decision of the Chair (or the Vice-Chair in the case of an interest declared by the Chair) is binding on all Board members. The Chair should take advice from the Board Secretary when determining the action to take in response to declared interests; taking care to ensure their exercise of judgement is consistently applied.

8.2.7 ***Members with pecuniary (financial) interests –*** Where a Board member, or any person they are connected with[1] has any direct or indirect pecuniary interest in any matter being considered by the Board, including a contract or proposed contract, that member must not take part in the consideration or discussion of that matter or vote on any question related to it. The Board may determine that the Board member concerned shall be excluded from that part of the meeting.

8.2.8 The Constitution Regulations define 'direct' and 'indirect' pecuniary interests and these definitions always apply when determining whether a member has an interest. These SOs must be interpreted in accordance with these definitions.

8.2.9 ***Members with Professional Interests -*** During the conduct of a Board meeting, an individual Board member may establish a clear conflict of interest between their role as an LHB Board member and that of their professional role outside of the Board. In any such circumstance, the Board shall take action that is proportionate to the nature of the conflict, taking account of the advice provided by the Board Secretary.

8.3 Dealing with officers' interests

8.3.1 The Board must ensure that the Board Secretary, on behalf of the Chief Executive, establishes and maintains a system for the declaration, recording and handling of LHB officers' interests in accordance with the Values and Standards of Behaviour Framework.

8.4 Reviewing how Interests are handled

8.4.1 The Audit Committee will review and report to the Board upon the adequacy of the arrangements for declaring, registering and handling interests at least annually.

8.5 Dealing with offers of gifts[2] and hospitality

8.5.1 The Values and Standards of Behaviour Framework adopted by the Board prohibits Board members and LHB officers from receiving gifts, hospitality or benefits in kind from a third party which may reasonably give rise to suspicion of conflict between their official duty and their private interest, or may reasonably be seen to compromise their personal integrity in any way.

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[1] In the case of persons who are married to each other or in a civil partnership with each other or who are living together as if married or civil partners, the interest of one person shall, if known to the other, be deemed for the purpose of this Standing Order to be also an interest of the other.
[2] The term gift refers also to any reward or benefit.

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8.5.2 Gifts, benefits or hospitality must never be solicited. Any Board member or LHB officer who is offered a gift, benefit or hospitality which may or may be seen to compromise their position must refuse to accept it. This may in certain circumstances also include a gift, benefit or hospitality offered to a family member of a Board member or LHB officer. Failure to observe this requirement may result in disciplinary and/or legal action.

8.5.3 In determining whether any offer of a gift or hospitality should be accepted, an individual must make an active assessment of the circumstances within which the offer is being made, seeking advice from the Board Secretary as appropriate. In assessing whether an offer should be accepted, individuals must consider:

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- **Relationship:** Contacts which are made for the purpose of information gathering are generally less likely to cause problems than those which could result in a contractual relationship, in which case accepting a gift or hospitality could cause embarrassment or be seen as giving rise to an obligation;

- **Legitimate Interest:** Regard should be paid to the reason for the contact on both sides and whether it is a contact that is likely to benefit the LHB;

- **Value:** Gifts and benefits of a trivial or inexpensive seasonal nature, e.g. diaries/calendars, are more likely to be acceptable and can be distinguished from more substantial offers. Similarly, hospitality in the form of a working lunch would not be treated in the same way as more expensive social functions, travel or accommodation (although in some circumstances these may also be accepted);

- **Frequency:** Acceptance of frequent or regular invitations particularly from the same source would breach the required standards of conduct. Isolated acceptance of, for example, meals, tickets to public, cultural or social events would only be acceptable if attendance is justifiable in that it benefits the LHB; and

- **Reputation:** If the body concerned is known to be under investigation by or has been publicly criticised by a public body, regulators or inspectors, acceptance of a gift or hospitality might be seen as supporting the body or affecting in some way the investigation or negotiations and it should always be declined.

8.5.4 A distinction may be drawn between items offered as hospitality and items offered in substitution for fees for broadcasts, speeches, lectures or other work done. There may be circumstances where the latter may be accepted if they can be used for official purposes.

8.6 Sponsorship

8.6.1 In addition to gifts and hospitality individuals and the organisation may also receive sponsorship. Sponsorship is an offer of funding to an individual, department or the organisation as a whole from an external source whether in cash, goods, services or benefits. It could include an offer to sponsor a research or operational post, training, attendance at a conference, costs associated with meetings, conferences or a working visit. The sponsorship may cover some or all of the costs.

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8.6.2 All sponsorship must be approved prior to acceptance in accordance with the **Values and Standards of Behaviour Framework** and relevant procedures. A record of all sponsorship accepted or declined will also be maintained.

8.7 Register of Gifts, Hospitality & Sponsorship

8.7.1 The Board Secretary, on behalf of the Chair, will maintain a register of Gifts, Hospitality & Sponsorship to record offers of gifts, hospitality & sponsorship made to Board members. Executive Directors will adopt a similar mechanism in relation to LHB officers working within their Directorates.

8.7.2 Every Board member and LHB officer has a personal responsibility to volunteer information in relation to offers of gifts, hospitality & sponsorship, including those offers that have been refused. The Board Secretary, on behalf of the Chair and Chief Executive, will ensure the incidence and patterns of offers and receipt of gifts, hospitality & sponsorship are kept under active review, taking appropriate action where necessary.

8.7.3 When determining what should be included in the Register with regards to gifts and hospitality, individuals shall apply the following principles, subject to the considerations in Standing Order 8.5.3:

- **Gifts:** Generally, only gifts of material value should be recorded. Those with a nominal value, e.g. seasonal items such as diaries/calendars would not usually need to be recorded.

- **Hospitality:** Only significant hospitality offered or received should be recorded. Occasional offers of 'modest and proportionate[3]' hospitality need not be included in the Register.

8.7.4 Board members and LHB officers may accept the occasional offer of modest and proportionate hospitality but in doing so must consider whether the following conditions are met:

- Acceptance would further the aims of the LHB;
- The level of hospitality is reasonable in the circumstances;
- It has been openly offered; and,
- It could not be construed as any form of inducement and will not put the individual under any obligation to those offering it.

8.7.5 The Board Secretary will arrange for a full report of all offers of Gifts, Hospitality & Sponsorship recorded by the LHB to be submitted to the Audit Committee (or equivalent) at least annually. The Audit Committee will then review and report to the Board upon the adequacy of the LHB's arrangements for dealing with offers of gifts, hospitality & sponsorship.

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[3] Examples of 'modest and proportionate' hospitality that need not be included in a Hospitality register include a working sandwich lunch or a buffet lunch incidental to a conference or seminar attended by a variety of participants.

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9 SIGNING AND SEALING DOCUMENTS

9.0.1 The common seal of the LHB is primarily used to seal legal documents such as transfers of land, lease agreements and other important/key contracts. The seal may only be fixed to a document if the Board or Committee of the Board has determined it shall be sealed, or if a transaction to which the document relates has been approved by the Board or Committee of the Board.

9.0.2 Where it is decided that a document shall be sealed it shall be fixed in the presence of the Chair or Vice Chair (or other authorised independent Member) and the Chief Executive (or another authorised individual) both of whom must witness the seal.

9.1 Register of Sealing

9.1.1. The Board Secretary shall keep a register that records the sealing of every document. Each entry must be signed by the persons who approved and authorised the document and who witnessed the seal. A report of all sealings shall be presented to the Board at least bi-annually.

9.2 Signature of Documents

9.2.1 Where a signature is required for any document connected with legal proceedings involving the LHB, it shall normally be signed by the Chief Executive, except where the Board has authorised another person or has been otherwise directed to allow or require another person to provide a signature.

9.2.2 The Chief Executive or nominated officers may be authorised by the Board to sign on behalf of the LHB any agreement or other document (not required to be executed as a deed) where the subject matter has been approved either by the Board or a Committee to which the Board has delegated appropriate authority.

9.3 Custody of Seal

9.3.1 The Common Seal of the LHB shall be kept securely by the Board Secretary.

10 GAINING ASSURANCE ON THE CONDUCT OF LHB BUSINESS

10.0.1 The Board shall set out explicitly, within a Risk and Assurance Framework, how it will be assured on the conduct of LHB business, its governance and the effective management of the organisation's risks in pursuance of its aims and objectives. It shall set out clearly the various sources of assurance, and where and when that assurance will be provided, in accordance with any requirements determined by the Welsh Ministers.

10.0.2 The Board shall ensure that its assurance arrangements are operating effectively, advised by its Audit Committee (or equivalent).

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10.0.3 Assurances in respect of the services provided by the NHS Wales Shared Services Partnership shall primarily be achieved by the reports of the Director of Shared Services to the Shared Services Partnership Committee, and reported back by the Chief Executive (or their nominated representative). Where appropriate, and by exception, the Board may seek assurances direct from the Director of Shared Services. The Director of Shared Services and the Shared Services Partnership Committee shall be under an obligation to comply with any internal or external audit functions being undertaken by or on behalf of the LHB.

10.0.4 Assurances in respect of the functions discharged by WHSSC and EASC shall be achieved by the reports of the respective Joint Committee Chair, and reported back by the Chief Executive. Reference should be made to paragraph 3.2 above regarding the governance arrangements which should be agreed for each of the Joint Committees.

10.0.5 Arrangements for seeking and providing assurance is respect of any other services provided on behalf of or in association with the LHB shall be clearly identified and reflected within the practice of the organisation and within the relevant agreements.

10.1 The role of Internal Audit in providing independent internal assurance

10.1.1 The Board shall ensure the effective provision of an independent internal audit function as a key source of its internal assurance arrangements, in accordance with NHS Wales Internal Auditing Standards and any other requirements determined by the Welsh Ministers.

10.1.2 The Board shall set out the relationship between the Head of Internal Audit (HIA), the Audit Committee (or equivalent) and the Board. It shall:

- Approve the Internal Audit Charter (incorporating the definition of internal audit) and adopt the Internal Auditing Standards (incorporating the code of ethics);
- Ensure the HIA communicates and interacts directly with the Board, facilitating direct and unrestricted access;
- Require Internal Audit to confirm its independence annually; and
- Ensure that the Head of Internal Audit reports periodically to the Board on its activities, including its purpose, authority, responsibility and performance. Such reporting will include governance issues and significant risk exposures.

10.2 Reviewing the performance of the Board, its Committees and Advisory Groups

10.2.1 The Board shall introduce a process of regular and rigorous self-assessment and evaluation of its own operations and performance and that of its Committees and Advisory Groups. Where appropriate, the Board may determine that such evaluation may be independently facilitated.

10.2.2 Each Committee and, where appropriate, Advisory Group must also submit an annual report to the Board through the Chair within 6 weeks of the end of the reporting year setting out its activities during the year and including the review of its performance and that of any sub-Committees it has established.

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10.2.3 The Board shall use the information from this evaluation activity to inform:

- The ongoing development of its governance arrangements, including its structures and processes;
- Its Board Development Programme, as part of an overall Organisation Development framework; and
- The Board's report of its alignment with the Welsh Government's Citizen Centred Governance Principles.

10.3 External Assurance

10.3.1 The Board shall ensure it develops effective working arrangements and relationships with those bodies that have a role in providing independent, external assurance to the public and others on the LHB's operations, e.g. the Auditor General for Wales and Healthcare Inspectorate Wales.

10.3.2 The Board may be assured, from the work carried out by external audit and others, on the adequacy of its own assurance framework, but that external assurance activity shall not form part of, or replace its own internal assurance arrangements, except in relation to any additional work that the Board itself may commission specifically for that purpose.

10.3.3 The Board shall keep under review and ensure that, where appropriate, the LHB implements any recommendations relevant to its business made by the Welsh Government's Audit Committee, the Senedd Cymru/Welsh Parliament's Public Accounts Committee and other appropriate bodies.

10.3.4 The LHB shall provide the Auditor General for Wales with any assistance, information and explanation which the Auditor General thinks necessary for the discharge of their statutory powers and responsibilities.

11 DEMONSTRATING ACCOUNTABILITY

11.0.1 Taking account of the arrangements set out within these SOs, the Board shall demonstrate to the communities it serves and to the Welsh Ministers a clear framework of accountability within which it:

- Conducts its business internally;
- Works collaboratively with NHS colleagues, partners, service providers and others; and
- Responds to the views and representations made by those who represent the interests of the communities it serves and other stakeholders, including its officers and healthcare professionals.

11.0.2 The Board shall, in publishing its strategic and operational level plans, set out how those plans have been developed taking account of the views of others, and how they will be delivered by working with their community and other partners.

11.0.3 The Board shall also facilitate effective scrutiny of the LHB's operations through the publication of regular reports on activity and performance, including publication of an

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Annual Report.

11.0.4 The Board shall ensure that within the LHB, individuals at all levels are supported in their roles, and held to account for their personal performance through effective performance management arrangements.

12 REVIEW OF STANDING ORDERS

12.0.1 The Board Secretary shall arrange for appropriate impact assessments to be carried out on a draft of these SOs prior to their formal adoption by the Board. The results of which will be presented to the Board for consideration and action, as appropriate.

12.0.1 These SOs shall be reviewed annually by the Audit and Assurance Committee, which shall report any proposed amendments to the Board for consideration. The requirement for review extends to all documents having the effect as if incorporated in SOs, including the appropriate impact assessments.

Schedule 1

MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS

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This Schedule forms part of, and shall have effect as if incorporated in the Local Health Board Standing Orders

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MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS

Introduction

As set out in Standing Order 2, the Board - subject to any directions that may be made by the Welsh Ministers - shall make appropriate arrangements for certain functions to be carried out on its behalf so that the day to day business of the LHB may be carried out effectively, and in a manner that secures the achievement of the organisation's aims and objectives. The Board may delegate functions to:

i) A Committee, e.g. Quality, Safety and Experience Committee

ii) A sub-Committee, e.g. the Equality, Diversity and Human Right sub-Committee taking forward matters within a defined area. Any such delegation would, subject to the Board's authority, usually be via a main Committee of the Board;

iii) A joint-Committee or joint sub-Committee, e.g. with other LHBs established to take forward matters relating to specialist services; and

iv) Officers of the LHB (who may, subject to the Board's authority, delegate further to other officers and, where appropriate, other third parties, e.g. shared/support services, through a formal scheme of delegation)

and in doing so, must set out clearly the terms and conditions upon which any delegation is being made. These terms and conditions must include a requirement that the Board is notified of any matters that may affect the operation and/or reputation of the LHB.

The Board's determination of those matters that it will retain, and those that will be delegated to others are set out in the following:

- Schedule of matters reserved to the Board;
- Scheme of delegation to Committees and others; and
- Scheme of delegation to officers.

all of which form part of the LHB's SOs.

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DECIDING WHAT TO RETAIN AND WHAT TO DELEGATE: GUIDING PRINCIPLES

The Board will take full account of the following principles when determining those matters that it reserves, and those which it will delegate to others to carry out on its behalf:

- ***Everything is retained by the Board unless it is specifically delegated in accordance with the requirements set out in SOs or SFIs***

- ***The Board must retain that which it is required to retain (whether by statute or as determined by the Welsh Ministers) as well as that which it considers is essential to enable it to fulfil its role in setting the organisation's direction, equipping the organisation to deliver and ensuring achievement of its aims and objectives through effective performance management***

- ***Any decision made by the Board to delegate functions must be based upon an assessment of the capacity and capability of those to whom it is delegating responsibility***

- ***The Board must ensure that those to whom it has delegated powers (whether a Committee, partnership or individuals) remain equipped to deliver on those responsibilities through an ongoing programme of personal, professional and organisational development***

- ***The Board must take appropriate action to assure itself that all matters delegated are effectively carried out***

- ***The framework of delegation will be kept under active review and, where appropriate, will be revised to take account of organisational developments, review findings or other changes***

- ***Except where explicitly set out, the Board retains the right to decide upon any matter for which it has statutory responsibility, even if that matter has been delegated to others***

- ***The Board may delegate authority to act, but retains overall responsibility and accountability***

- ***When delegating powers, the Board will determine whether (and the extent to which) those to whom it is delegating will, in turn, have powers to further delegate those functions to others.***

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HANDLING ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS: WHO DOES WHAT

The Board

The Board will formally agree, review and, where appropriate revise schedules of reservation and delegation of powers in accordance with the guiding principles set out earlier.

The Chief Executive

The Chief Executive will propose a Scheme of Delegation to Officers, setting out the functions they will perform personally and which functions will be delegated to other officers. The Board must formally agree this scheme.

In preparing the scheme of delegation to officers, the Chief Executive will take account of:

- The guiding principles set out earlier (including any specific statutory responsibilities designated to individual roles);
- Their personal responsibility and accountability to the Chief Executive, NHS Wales in relation to their role as designated Accountable Officer; and
- Associated arrangements for the delegation of financial authority to equip officers to deliver on their delegated responsibilities (and set out in SFIs).

The Chief Executive may re-assume any of the powers they have delegated to others at any time.

The Board Secretary

The Board Secretary will support the Board in its handling of reservations and delegations by ensuring that:

- A proposed schedule of matters reserved for decision by the Board is presented to the Board for its formal agreement;
- Effective arrangements are in place for the delegation of LHB functions within the organisation and to others, as appropriate; and
- Arrangements for reservation and delegation are kept under review and presented to the Board for revision, as appropriate.

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The Audit and Assurance Committee

The Audit and Assurance Committee will provide assurance to the Board of the effectiveness of its arrangements for handling reservations and delegations.

Individuals to who powers have been delegated

Individuals will be personally responsible for:

- Equipping themselves to deliver on any matter delegated to them, through the conduct of appropriate training and development activity; and
- Exercising any powers delegated to them in a manner that accords with the LHB's values and standards of behaviour.

Where an individual does not feel that they are equipped to deliver on a matter delegated to them, they must notify the Board Secretary of their concern as soon as possible so that an appropriate and timely decision may be made on the matter.

In the absence of an officer to whom powers have been delegated, those powers will normally be exercised by the individual to whom that officer reports, unless the Board has set out alternative arrangements.

If the Chief Executive is absent their nominated Deputy may exercise those powers delegated to the Chief Executive on their behalf. However, the guiding principles governing delegations will still apply, and so the Board may determine that it will reassume certain powers delegated to the Chief Executive or reallocate powers, e.g. to a Committee or another officer.

SCOPE OF THESE ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS

The Scheme of Delegation to officers referred to here shows only the "top level" of delegation within the LHB. The Scheme is to be used in conjunction with the system of control and other established procedures within the LHB.

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SCHEDULE OF MATTERS RESERVED TO THE BOARD[4]

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
1	FULL	GENERAL	The Board may determine any matter for which it has statutory or delegated authority in accordance with SOs[5] (except for those decisions delegated to the Welsh Health Specialised Services Committee (WHSSC) or Emergency Ambulance Services Committee (EASC).
2	FULL	GENERAL	The Board must determine any matter that will be reserved to the whole Board. These are: sections 3-49 (unless specified otherwise in this Schedule).
3	FULL	OPERATING ARRANGEMENTS	Approve the LHB's Governance Framework
4	FULL	OPERATING ARRANGEMENTS	Approve, vary and amend: ▪ SOs; ▪ SFIs; ▪ Schedule of matters reserved to the LHB; ▪ Scheme of delegation to Committees and others; and ▪ Scheme of delegation to officers In accordance with any directions set by the Welsh Ministers.

[4] Any decision to reserve a matter, and the manner in which that retained responsibility is carried out will be in accordance with any regulatory and/or Assembly Government requirements

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5	FULL	OPERATING ARRANGEMENTS	Ratify any urgent decisions taken by the Chair and the Chief Executive in accordance with Standing Order requirements
6	NO – Audit & Assurance Committee	OPERATING ARRANGEMENTS	Formal consideration of report of Board Secretary on any non-compliance with Standing Orders, making proposals to the Board on any action to be taken.
7	FULL	OPERATING ARRANGEMENTS	Receive report and proposals regarding any non-compliance with Standing Orders, and where required ratify in public session any action required in response to failure to comply with SOs.
8	FULL	OPERATING ARRANGEMENTS	Authorise use of the LHB's official seal
9	FULL	OPERATING ARRANGEMENTS	Approve the LHB's Values and Standards of Behaviour framework
10	NO - Chair on behalf of Joint Committee, Vice-Chair on behalf of Joint Committee if Chair is declaring interest	ORGANISATION STRUCTURE & STAFFING	Require, receive and determine action in response to the declaration of Board members' interests, in accordance with advice received, e.g. From Audit Committee or Board Secretary
11	FULL	STRATEGY & PLANNING	Determine the LHB's strategic aims, objectives and priorities
12	FULL	STRATEGY & PLANNING	Approve the LHB's key strategies and programmes related to: ▪ Population Health Needs Assessment and Commissioning Plan ▪ The development and delivery of patient and population centred health and care/clinical services ▪ Improving quality and patient safety outcomes

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			▪ Workforce and Organisational Development ▪ Infrastructure, including IM &T, Estates and Capital (including major capital investment and disposal plans)
13	FULL	STRATEGY & PLANNING	Approval of Joint Area Plan prepared under the direction of the Regional Partnership Board and in response to the population assessment
14	FULL	STRATEGY & PLANNING	Agreement of Well-being objectives in accordance with the requirements of the Well-being and Future Generations (Wales) Act 2015
15	FULL	STRATEGY & PLANNING	Approval of Well-being Plan prepared and agreed by the Public Service Board
16	FULL	STRATEGY & PLANNING	Approve the LHB's Integrated Medium Term Plan, including the balanced Medium-Term Financial Plan
17	FULL	STRATEGY & PLANNING	Approve the LHB's budget and financial framework (including overall distribution of the financial allocation and unbudgeted expenditure)
18	FULL	OPERATING ARRANGEMENTS	Approve the LHB's framework and strategy for performance management.
19	FULL	STRATEGY & PLANNING	Approve the LHB's framework and strategy for risk and assurance.
20	FULL	OPERATING ARRANGEMENTS	Ratify policies for dealing with raising concerns, complaints and incidents in accordance with the Putting Things Right and health and safety requirements.
21	FULL	OPERATING ARRANGEMENTS	Agree the arrangements for ensuring the adoption of standards of governance and performance (including the quality and safety of healthcare, and the patient experience) to be met by the LHB, including standards/ requirements determined by Welsh Government, regulators, professional bodies/others, e.g. National Institute of Health and Care Excellence (NICE)
22	FULL	STRATEGY &	Approve the LHB's patient, public, staff, partnership and stakeholder engagement

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		PLANNING	and co-production strategies.
23	FULL	OPERATING ARRANGEMENTS	Approve the introduction or discontinuance of any significant activity or operation. Any activity or operation shall be regarded as significant if the Board determines it so based upon its contribution/impact on the achievement of the LHB's aims, objectives and priorities
24	FULL	ORGANISATION STRUCTURE & STAFFING	Appointment of officer members of the Board (Chief Executive and Directors) in accordance with the provisions of the Regulations and in accordance with Ministerial Instructions
25	NO – Remuneration and Terms of Service Committee	ORGANISATION STRUCTURE & STAFFING	Termination of appointment and suspension officer members in accordance with the provisions of the Regulations and in accordance with Ministerial instructions
26	NO – Remuneration and Terms of Service Committee	ORGANISATION STRUCTURE & STAFFING	Consider appraisal of officer members of the Board (Chief Executive and Directors)
27	NO – Remuneration and Terms of Service Committee	ORGANISATION STRUCTURE & STAFFING	Approve the appointment, appraisal, discipline and dismissal of any other Board level appointments and other senior employees, in accordance with Ministerial Instructions e.g. the Board Secretary
28	NO – Remuneration and Terms of Service	ORGANISATION STRUCTURE & STAFFING	Consider and approve redundancy and Early Release Applications, noting that where the settlement is £50,000 or above subsequent agreement of Welsh Government is required.

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	Committee		
29	FULL	ORGANISATION STRUCTURE & STAFFING	Approve, [arrange the] review, and revise the LHB's top level organisation structure and corporate policies
30	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, [arrange the] review, revise and dismiss LHB Committees, including any joint-Committees directly accountable to the Board
31	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss the Chair and members of any Committee, joint-Committee or Group set up by the Board
32	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss individuals appointed to represent the Board on outside bodies and groups
33	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the standing orders and terms of reference and reporting arrangements of all Committees, joint-Committees and groups established by the Board
34	NO – Audit Committee	OPERATING ARRANGEMENTS	Approve arrangements relating to the discharge of the LHB's responsibility as a bailee for patients' property
35	FULL - except where Chapter 6 specifies appropriate to delegate to a committee, Chief Executive or Officers	OPERATING ARRANGEMENTS	Approve individual compensation payments in line with the provisions of Annex 4 to Chapter 6 of the Welsh Government Manual for Accounts
36	FULL - except	OPERATING	Approve individual cases for the write off of losses or making of

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	where Chapter 6 specifies appropriate to delegate to a committee, Chief Executive or Officers	ARRANGEMENTS	special payments above the limits of delegation to the Chief Executive and officers
37	FULL	OPERATING ARRANGEMENTS	Approve proposals for action on litigation on behalf of the LHB
38	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the arrangements relating to the discharge of the LHB's responsibilities as a corporate trustee of funds held on trust in accordance with the provision of Paragraph 20 of the Standing Financial Instructions.
39	FULL	STRATEGY & PLANNING	Approve new contracts for the LHB to provide, or to secure provision from providers for Personal Medical; Dental; Pharmacy; Optometry services to some or all of the LHB's population where the value exceeds the delegated limit of the Chief Executive
40	FULL	STRATEGY & PLANNING	Approve individual contracts (other than NHS contracts) above the limit delegated to the Chief Executive set out in the Standing Financial Instructions
41	FULL	PERFORMANCE & ASSURANCE	Approve the LHB's audit and assurance arrangements
42	FULL	PERFORMANCE & ASSURANCE	Receive reports from the LHB's Executive on progress and performance in the delivery of the LHB's strategic aims, objectives and priorities and approve action required, including improvement plans, as appropriate
43	FULL	PERFORMANCE & ASSURANCE	Receive reports from the LHB's Committees, groups and other internal sources on the LHB's performance and approve action required, including improvement plans, as appropriate
44	FULL	PERFORMANCE & ASSURANCE	Receive reports on the LHB's performance produced by external regulators and inspectors (including, e.g., Audit Wales, HIW, etc) that raise significant issue or concerns impacting on the LHB's ability to achieve its aims and objectives and

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			approve action required, including improvement plans, taking account of the advice of Board Committees (as appropriate)
45	FULL	PERFORMANCE & ASSURANCE	Receive the annual opinion of the LHB's Chief Internal Auditor and approve action required, including improvement plans
46	FULL	PERFORMANCE & ASSURANCE	Receive the annual management report from the Auditor General for Wales and approve action required, including improvement plans
47	FULL	PERFORMANCE & ASSURANCE	Receive assurance regarding the LHB's performance against the Health and Care Standards for Wales and the arrangements for approving required action, including improvement plans.
48	FULL	REPORTING	Approve the LHB's Reporting Arrangements, including reports on activity and performance locally, to citizens, partners and stakeholders and nationally to the Welsh Government where required
49	FULL	REPORTING	Receive, approve and ensure the publication of LHB reports, including its Annual Report and annual financial accounts in accordance with directions and guidance issued

ADDITIONAL AREAS OF RESPONSIBILITY DELEGATED TO CHAIR, VICE CHAIR AND INDEPENDENT MEMBERS	
CHAIR	Chair of Remuneration and Terms of Service Committee Chair of the Board of Trustees Putting Things Right Champion (jointly with Executive Nurse Director) Wellbeing of Future Generations Act Champion
VICE CHAIR	Chair of Mental Health Legislation & Mental Capacity Act Committee Vice Chair of Remuneration and Terms of Service Committee Vice Chair of Quality, Safety and Experience Committee Member of Strategy and Delivery Committee

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ADDITIONAL AREAS OF RESPONSIBILITY DELEGATED TO CHAIR, VICE CHAIR AND INDEPENDENT MEMBERS	
	Member of Health and Safety Committee Member of Audit and Assurance Committee Mental Health Champion
INDEPENDENT MEMBER – FINANCE	Chair of Audit and Assurance Committee Vice Chair of Finance Committee Vice Chair of Shaping Our Future Hospitals Committee Member of Remuneration and Terms of Service Committee
INDEPENDENT MEMBER - INFORMATION COMMUNICATION & TECHNOLOGY	Member of the Mental Health Legislation & Mental Capacity Act Committee Vice Chair of the Audit and Assurance Committee Member of the Finance Committee Chair of the Digital Health Intelligence Committee Member of Shaping Our Future Hospitals Committee
INDEPENDENT MEMBER – UNIVERSITY	Member of Quality, Safety and Experience Committee Member of the Digital Health Intelligence Committee Member of the Strategy and Delivery Committee Member of the Shaping Our Future Hospitals Committee Older Persons Champion
INDEPENDENT MEMBER - THIRD (VOLUNTARY) SECTOR	Vice Chair of Mental Health Legislation and Mental Capacity Act Committee Member of Charitable Funds Committee Member of Remuneration and Terms of Service Committee Vice Chair of the Strategy and Delivery Committee Member of the Digital Health Intelligence Committee

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ADDITIONAL AREAS OF RESPONSIBILITY DELEGATED TO CHAIR, VICE CHAIR AND INDEPENDENT MEMBERS	
	Equality Champion
INDEPENDENT MEMBER – CAPITAL & ESTATES	Member of the Strategy and Delivery Committee Member of Remuneration and Terms of Service Committee Chair of the Finance Committee Chair of the Shaping Our Future Hospitals Committee Children and Young People Champion (jointly with the Executive Nurse Director)
INDEPENDENT MEMBER - LOCAL GOVERNMENT	Chair of Quality, Safety and Experience Committee Member of the Charitable Funds Committee Member of Remuneration and Terms of Service Committee Social Services and Wellbeing (Wales) Act Champion
INDEPENDENT MEMBER - LEGAL	Member of Health & Safety Committee Vice Chair of the Digital Health Intelligence Committee Chair of the Strategy and Delivery Committee Member of Remuneration and Terms of Service Committee
INDEPENDENT MEMBER - COMMUNITY	Vice Chair of Health and Safety Committee Chair of the Charitable Funds Committee Member of Quality, Safety and Experience Committee Member of Mental Health Legislation and Mental Capacity Act Committee

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ADDITIONAL AREAS OF RESPONSIBILITY DELEGATED TO CHAIR, VICE CHAIR AND INDEPENDENT MEMBERS	
	Infection prevention and control Champion
INDEPENDENT MEMBER - TRADE UNION	Member of Quality, Safety and Experience Committee Chair of Health & Safety Committee Member of Audit and Assurance Committee Member of Charitable Funds Committee Raising Concerns Champion

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DELEGATION OF POWERS TO COMMITTEES AND OTHERS[6]

Standing Order 2 provides that the Board may delegate powers to Committees and others. In doing so, the Board has formally determined:

- the composition, terms of reference and reporting requirements in respect of any such Committees; and
- the governance arrangements, terms and conditions and reporting requirements in respect of any delegation to others, including the approval of policy documents and associated written control procedures in line with their individual remits and responsibilities.

in accordance with any regulatory requirements and any directions set by the Welsh Ministers.

The Board has delegated a range of its powers to the following Committees and others:

- Audit and Assurance Committee
- Charitable Funds Committee
- Health and Safety Committee
- Healthcare Professionals Forum
- Local Partnership Forum
- Mental Health Legislation and Mental Capacity Act Committee
- Shaping our Future Hospitals Committee
- Strategy and Delivery Committee
- Quality, Safety and Experience Committee
- Remuneration and Terms of Service Committee
- Stakeholder Reference Group
- Welsh Health Specialised Services Committee
- NHS Wales Shared Services Partnership Committee
- Emergency Ambulance Services Committee

The scope of the powers delegated, together with the requirements set by the Board in relation to the exercise of those powers are as set out in i) Committee Terms of Reference, and ii) formal arrangements for the delegation of powers to others. Collectively, these documents form the Board's Scheme of Delegation to Committees.

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[6] As defined in Standing Orders

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SCHEME OF DELEGATION TO EXECUTIVE DIRECTORS, OTHER DIRECTORS AND OFFICERS

The LHB SOs and SFIs specify certain key responsibilities of the Chief Executive, the Director of Finance and other officers. The Chief Executive's Job Description, together with their Accountable Officer Memorandum sets out their specific responsibilities, and the individual job descriptions determined for Executive Director level posts also define in detail the specific responsibilities assigned to those post holders. These documents, together with the schedule of additional delegations below and the associated financial delegations set out in the SFIs form the basis of the LHB's Scheme of Delegation to Officers.

The table below sets out those matters that the Board has agreed to delegate, whether supplementary delegations are allowable and the control documents that must be in place prior to supplier supplementary delegations being made.

*The Detailed Scheme of Delegation and Earned Autonomy Framework is the title of the "authorisation matrix".

Delegated matter	High level delegation	Further Delegation Allowable?	Control Documents required to be in place prior to further delegation of matters
Management of budgets	Directors	Yes	Financial delegations set out in Section 3. Further delegations subject to authorisation matrix*.
Management of cash and bank accounts	Director of Finance	Yes	Authorisation matrix. Financial policies & procedures
Approval of petty cash	Directors	Yes	Authorisation matrix. Financial policies & procedures
Reimbursement of patient monies	Directors	Yes	Authorisation matrix. Financial policies & procedures
Engagement of staff within funded establishment	Directors	Yes	Authorisation matrix. HR policies and procedures
Engagement of staff outside funded establishment	Chief Executive	Nominated deputy	In absence of Chief Executive
Staff re-grading and awarding	Director of Workforce &	Yes	Written authority to suitably qualified HR staff

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Delegated matter	High level delegation	Further Delegation Allowable?	Control Documents required to be in place prior to further delegation of matters
of incremental points	OD		
Approval of overtime	Directors	Yes	Authorisation matrix. HR policies and procedures
Approval of annual leave	Directors	Yes	Authorisation matrix. HR policies and procedures
Approval of compassionate leave	Directors	Yes	Authorisation matrix. HR policies and procedures
Approval of maternity and paternity leave	Directors	Yes	Authorisation matrix. HR policies and procedures
Approval of carers leave	Directors	Yes	Authorisation matrix. HR policies and procedures
Approval of leave without pay	Directors	Yes	Authorisation matrix. HR policies and procedures
Extension of sick leave on full or ½ pay • Directors • Other staff	Reserved for Board Directors	Yes	Authorisation matrix. HR policies and procedures
Approval of study leave < £2k	Directors	Yes	Authorisation matrix. HR policies and procedures
Approval of study leave > £2k	Directors	No	
Approval of relocation costs	Director of Workforce & OD	Yes	Authorisation matrix. HR policies and procedures
Approval of lease cars & phones • Directors • Other staff	Reserved for Remuneration and Terms of Service Committee Directors	No Yes	Authorisation matrix. HR policies and procedures
Approval of redundancy, early retirement and ill-health	Chief Executive	Yes	Authorisation matrix. HR policies and procedures

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Delegated matter	High level delegation	Further Delegation Allowable?	Control Documents required to be in place prior to further delegation of matters
retirement			
Dismissal of staff	Director of Workforce & OD	Yes	Authorisation matrix. HR policies and procedures
Management of clinical and other operational capacity	Directors	Yes	Authorisation matrix. Annual Operating Framework and operational plans
Approval to procure goods and services within budget	Directors	Yes	Standing financial instructions. Authorisation matrix. Procurement & finance policies and procedures.
Approval to procure goods and services outside of budget that would result in a budgetary overspend	Chief Executive	Yes	Authorisation matrix. Commissioning policies and procedures
Approval to commission healthcare services from other NHS bodies	Chief Executive	Yes	Authorisation matrix. Commissioning policies and procedures
Approval to commission healthcare services from voluntary sector	Chief Executive	Yes	Authorisation matrix. Commissioning policies and procedures
Approval to commission healthcare services from private and independent providers	Chief Executive	Yes	Authorisation matrix. Commissioning policies and procedures
Approval to enter into primary care contracts for GMS, dental, ophthalmology and pharmaceutical services	Chief Executive	Yes	Authorisation matrix. Commissioning policies and procedures
Approval to enter into pooled	Chief Executive	Yes	Authorisation matrix. Commissioning policies and

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Delegated matter	High level delegation	Further Delegation Allowable?	Control Documents required to be in place prior to further delegation of matters
budget arrangements under section 33 of the NHS (Wales) Act 2006			procedures
Approval to amend the drugs formulary	Medical Director	No	
Approval to prescribe drugs outside the formulary	Medical Director	Yes	Prescribing policies and procedures
Authorisation of sponsorship	Directors	No	
Approval of clinical trials	Medical Director	Yes	Clinical policies and procedures
Approval of research projects	Chief Executive	Yes	Research policies & procedures
Management of concerns	Chief Executive	Yes	Complaints policies & procedures
Provision of information to the press, public and other external enquiries	Chief Executive	Yes	Communication policies & procedures
Approval of use of charitable funds	Charitable Funds Committee	Yes	
Investment of charitable funds	Director of Finance	Yes	Authorisation matrix. Financial policies & procedures
Approval to condemn and dispose equipment	Directors	Yes	Authorisation matrix. Disposal policies and procedures
Approval of losses and compensation (except for personal effects)	Directors	No	Within authorised limits set by WG as detailed within the Annual Accounts Manual.
Approval of compensation for staff and patients' personal			

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Delegated matter	High level delegation	Further Delegation Allowable?	Control Documents required to be in place prior to further delegation of matters
effects • Up to £1000 • £1,000 > £10,000 • £10,000 > £50,000 Over £50,000	 Small Claims Panel Director of Nursing Chief Executive Approval by WG	 No No No No	
Approval of Clinical negligence and personal injury claims	Chief Executive	Yes	Authorisation matrix and within limits set by WG.
Approval of staff tenancy agreements	Directors	Yes	Authorisation matrix. HR policies and procedures
Approval of capital expenditure	Chief Executive / Director of Planning	Yes	Authorisation matrix and within limits set by WG.
Approval of capital expenditure	Chief Executive / Director of Planning	Yes	Authorisation matrix and within limits set by WG.
Approval to engage external building and other professional contractors	Director of Planning	Yes	Authorisation matrix and within limits set by WG.
Approval to seek professional advice and ensure the implementation of any statutory and regulatory requirements	Chief Executive	Yes	Authorisation matrix and within limits set by WG.

This scheme only relates to matters delegated by the Board to the Chief Executive and their Executive Directors, together with certain other specific matters referred to in SFIs.

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Each Executive Director is responsible for delegation within their department. They shall produce a scheme of delegation for matters within their department, which shall also set out how departmental budget and procedures for approval of expenditure are delegated.

FINANCIAL DELEGATIONS

Contracts over £1m

The UHB must gain written consent from the Welsh Government (WG) to enter into a contract where an individual contract exceeds £1m in any one financial year. There is also a requirement to notify the WG of contracts awarded between £250,000-£500,000 and £500,000-£1m. This requirement for consent or notification does not apply to any contract entered into pursuant to a specific statutory power and therefore does not apply to:

i. Contracts of employment between LHBs and their staff;
ii. Transfers of land or contracts effected by Statutory instrument following the creation of the LHB.
iii. Out of Hours Contracts; and
iv. All NHS contracts i.e. where one health service body contracts with another health service body.

These remain in the delegated authority of the LHB.

Each contract must be considered on a case by case basis and independent legal advice sought where appropriate.

Further detail regarding approval and notification arrangements are contained within the Standing Financial Instructions.

Framework for the delegation of financial commitments

The following matrix sets out the framework for financial delegations to the Chief Executive, Directors and other delegated budget holders. All financial commitments above £0.5m must be approved by the Board either specifically or as part of the approval of the UHB's financial plan.

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Delegation	Delegated financial limit £'000
Reserved for Board	>£500
Chief Executive	500
Directors	125
Officers below Director level	Max 75

The following principles apply to this framework: -

- Financial limits can be reduced at the discretion of the Board.
- In an officer's absence, financial limits can be delegated in part or in total either generally or for specific items.
- Directors can limit delegated budget holders to less than £75k at their discretion.
- These limits apply to requisition authorisation, which is where the control lies.
- In exceptional circumstances the Chair may have delegated authority on behalf of the Board. Any use of delegated authority to the Chair must be included in the minutes of the next meeting of the Board.
- Each director has the responsibility of cascading the delegation within their area and ensuring that authorised signatories are in place. It may be appropriate for some areas of expenditure to be notified to the Board even if they are within the budget holder's limits.

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- Further detail regarding these delegations is contained within the Detailed Scheme of Delegation and Earned Autonomy Framework.

Each Executive Director is responsible for delegation within their department. They shall produce a scheme of delegation for matters within their department, which shall also set out how departmental budget and procedures for approval of expenditure are delegated.

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Schedule 2

KEY GUIDANCE, INSTRUCTIONS AND OTHER RELATED DOCUMENTS

This Schedule forms part of, and shall have effect as if incorporated in the Local Health Board Standing Orders

LHB framework

The LHB's governance and accountability framework comprises these SOs, incorporating schedules of Powers reserved for the Board and Delegation to others, together with the following documents:

- ***SFIs (See Schedule 2.1 below)***
- ***Values and Standards of Behaviour Framework***
- ***Risk and Assurance Framework***
- ***Key policy documents***

agreed by the Board. These documents must be read in conjunction with the SOs and will have the same effect as if the details within them were incorporated within the SOs themselves.

These documents may be accessed by Contacting the Board Secretary or via https://cavuhb.nhs.wales/about-us/governance-and-assurance/

NHS Wales framework

Full, up to date details of the guidance, instructions and other documents that together make up the framework of governance, accountability and assurance for the NHS in Wales are published on the NHS Wales Governance e-Manual which can be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/. Directions or guidance on specific aspects of LHB business are also issued in hard copy, usually under cover of a Welsh Health Circular (WHC).

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Schedule 2.1

MODEL STANDING FINANCIAL INSTRUCTIONS FOR LOCAL HEALTH BOARDS

The Standing Financial Instructions (SFI's) can be accessed on this web link:
https://cavuhb.nhs.wales/about-us/governance-and-assurance/policies-procedures-and-guidelines/

This Schedule forms part of, and shall have effect as if incorporated in the Local Health Board Standing Orders

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Schedule 3

BOARD COMMITTEE ARRANGEMENTS

This Schedule forms part of, and shall have effect as if incorporated in the Local Health Board Standing Orders

The Terms of Reference and Operating Arrangements for each Committee are outlined below:

Audit Committee
https://cavuhb.nhs.wales/about-us/governance-and-assurance/committees-and-advisory-groups/audit-committee/
Charitable Funds Committee
https://cavuhb.nhs.wales/about-us/governance-and-assurance/committees-and-advisory-groups/charitable-funds-committee/
Digital Health Intelligence Committee
https://cavuhb.nhs.wales/about-us/governance-and-assurance/committees-and-advisory-groups/digital-and-health-intelligence-committee/
Finance Committee
https://cavuhb.nhs.wales/about-us/governance-and-assurance/committees-and-advisory-groups/finance-committee/
Shaping Our Future Hospitals Committee
https://cavuhb.nhs.wales/about-us/governance-and-assurance/committees-and-advisory-groups/shaping-our-future-hospitals-committee/
Health & Safety Committee
https://cavuhb.nhs.wales/about-us/governance-and-assurance/committees-and-advisory-groups/health-and-safety-committee/
Mental Health Legislation and Mental Capacity Act Committee
https://cavuhb.nhs.wales/about-us/governance-and-assurance/committees-and-advisory-groups/mental-health-and-capacity-legislation-committee/
Quality, Safety and Experience Committee Safety
https://cavuhb.nhs.wales/about-us/governance-and-assurance/committees-and-advisory-groups/quality-safety-and-experience-committee/
Remuneration & Terms of Service Committee
https://cavuhb.nhs.wales/about-us/governance-and-assurance/committees-and-advisory-groups/

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Strategy and Delivery Committee
https://cavuhb.nhs.wales/about-us/governance-and-assurance/committees-and-advisory-groups/strategy-and-delivery-committee/

Schedule 4

JOINT COMMITTEE ARRANGEMENTS

This Schedule forms part of, and shall have effect as if incorporated in the Local Health Board Standing Orders

Schedule 4.1 – Welsh Health Services Specialised Services Committee
https://whssc.nhs.wales/publications/governance/

Schedule 4.2 – Emergency Ambulance Services Committee
https://easc.nhs.wales/

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Schedule 5

ADVISORY GROUPS

Terms of Reference and Operating Arrangements

This Schedule forms part of, and shall have effect as if incorporated in the Local Health Board Standing Orders

Schedule 5.1

Schedule 5.1 – Stakeholder Reference Group

Terms of Reference and Operating Arrangements

1.1 Role

1.1.1 The Stakeholder Reference Group's (SRG) role is to provide independent advice on any aspect of Cardiff and Vale University Local Health Board (LHB) business. This may include:

- Early engagement and involvement in the determination of the UHB overall strategic direction;
- Provision of advice on specific service proposals prior to formal consultation; as well as
- Feedback on the impact of the UHB's operations on the communities it serves.
-

1.1.2 The SRG provides a forum to facilitate full engagement and active debate amongst stakeholders from across the communities served by the LHB, with the aim of reaching and presenting a cohesive and balanced stakeholder perspective to inform the LHB's decision making.

1.1.3 The SRG's role is distinctive from that of Community Health Councils

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(CHCs), who have a statutory role in representing the interests of patients and the public in their areas. The SRG shall represent those stakeholders who have an interest in, and whose own role and activities may be impacted by the decisions of the LHB. Membership may include community partners, provider organisations, special interest and other groups operating within the LHBs area.

1.1.4 It does not cover those stakeholders whose interests are represented within the remit of other Advisory Groups established by the LHB, e.g., the Healthcare Professionals' Forum and Local Partnership Forum.

1.1.5 In addition to the provisions in 1.1.3 above the Board must set out, the relationships and accountabilities with others, such as the Regional Partnership Board.

1.2 Membership

1.2.1 The membership of the SRG, including the approval of nominations to the Group; the appointment of Chair and Vice Chair; definition of member roles, powers and terms and conditions of appointments (including renumeration and reimbursement) will be determined by the Board, taking account of the views of its stakeholders.

1.2.2 There shall be no minimum or maximum requirement in terms of membership size. In determining the number of members, the Board shall take account of the need to ensure the SRG's size is optimal to ensure focused and inclusive activity.

1.2.3 Membership must be drawn from within the area served by LHB, and shall ensure involvement from a range of bodies and groups operating within the communities serviced by the LHB. Where the Board determines it appropriate, the LHB may extend membership to individuals in order to represent a key stakeholder group where there are not already formal bodies or groups established or operating within the area and who may represent the interests of these stakeholders on the SRG.

1.2.4 In determining the overall size and composition of the SRG, the Board must take account of the:

- Demography of the areas served by the LHB;
- Need to encourage and reflect the diversity of the locality, to incorporate different ages, race, religion and beliefs, sexual orientation, gender, including transgender, disability and socio- economic status. Where appropriate, the LHB shall support positive action to increase representation;

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- Balance needed in both the range of difference stakeholders and the geographical areas covered, taking particular care to avoid domination by any particular stakeholder type or geographical area;
- Design and operation of the partnership/stakeholder fora already influencing the work of the LHB at local community levels;
- Need to complement, and not duplicate the work of CHCs; and
- Need to guard against the over involvement of particular stakeholders through their roles across the range of partnership/stakeholder arrangements in place.

1.2.5 The Board shall keep under review the size and composition of the SRG to ensure it continues to reflect an appropriate balance in stakeholder representation.

1.3 Member Responsibilities and Accountability

The Chair

1.3.1 The Chair is responsible for the effective operation of the SRG:

- Chairing Group meetings;
- Establishing and ensuring adherence to the standards of good governance set for the NHS in Wales, ensuring that all Group business is conducted in accordance with its agreed operating arrangements: and
- Developing positive and professional relationships amongst the Group's membership and between the Group and the LHB's Board and its Chair and Chief Executive.

1.3.2 The Chair shall work in close harmony with the Chairs of the LHB's other advisory groups, and, supported by the Board Secretary, shall ensure that key and appropriate issues are discussed by the Group in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.

1.3.3 As Chair of the SRG, they may as an Associate Member of the LHB Board. The Chair is accountable for the conduct of their role as Associate Member on the LHB Board to the Minister, through the LHB Chair. They are also accountable to the LHB Board for the conduct of business in accordance with the governance and operating framework set by the LHB.

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The Vice Chair

1.3.4 The Vice Chair shall deputise for the Chair in their absence for any reason, and will do so until either the existing Chair resumes their duties or a new chair is appointed, and this deputisation includes acting in the role of Associate Member of the LHB Board.

1.3.5 The Vice Chair is accountable, through the SRG Chair to the LHB Board, for their performance as Vice Chair, and to their nominating body or grouping for the way in which they represent their views at the SRG.

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Members

1.3.6 The SRG shall function as a coherent Advisory Body, all members being full and equal members and sharing responsibility for the decisions of the SRG.

1.3.7 All members must:

- Be prepared to engage with and contribute fully to the SRG's activities and in a manner that upholds the standards of good governance – including the values and standards of behaviour – set for the NHS in Wales;
- Comply with their terms and conditions of appointment;
- Equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes; and
- Promote the work of the SRG within the communities it represents.

1.3.8 SRG members are accountable, through the SRG Chair to the LHB Board for their performance as Group members, and to their nominating body or grouping for the way in which they represent the views of their body or grouping at the SRG.

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1.4 Appointment and terms of office

1.4.1 Appointments to the SRG shall be made by the Board, based upon nominations received from stakeholder bodies/groupings. The Board may seek independent expressions of interest to represent a key stakeholder group where it has determined that formal bodies or groups are not already established or operating within the area that may represent the interests of these stakeholders on the SRG.

1.4.2 The nomination and appointment process shall be open and transparent, and in accordance with any specific requirements or directions made by the Welsh Ministers. The appointments process shall be designed in a manner that meets the communication and involvement needs of all stakeholders eligible for appointment;

1.4.3 The Board Secretary, on behalf of the Chair of the LHB, will oversee the process of nomination and appointment to the SRG.

1.4.4 Members shall be appointed for a period specified by the Board, but for no longer than 3 years in any one term. Those members can be reappointed but may not serve a total period of more than 5 years consecutively. The Board may, where it considers it appropriate, make interim or short-term appointments to the SRG to fulfil a particular purpose or need**.**

1.4.5 The ***Chair*** shall be nominated from within the membership of the SRG, by its members, in a manner determined by the Board, subject to any specific requirements or directions made by the Welsh Ministers. The nomination shall be subject to consideration by the LHB Board, who must submit a recommendation on the nomination to the Minister for Health and Social Services. The appointment as Chair shall be made by the Minister, but it shall not be a formal public appointment. The Constitution Regulations provide that the Welsh Ministers may appoint an Associate Member of the Board, and the appointment of the Chair to this role is on the basis of the conditions of appointment for Associate Members set out in the Regulations.

1.4.6 The Chair's term of office shall be for a period of up to two (2) years, with the ability to stand as Chair for an additional one (1) year, in line with that individual's term of office as a member of the SRG. That individual may remain in office for the remainder of their term as a member of the SRG after their term of appointment as Chair has ended**.**

1.4.7 The ***Vice Chair*** shall be nominated from within the membership of the SRG, by its members, in manner determined by the Board, subject to any

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specific requirements or directions made by the Welsh Ministers. The nomination shall be subject to consideration and appointment by the LHB Board. The Constitution Regulations provide that the Welsh Ministers may appoint an Associate Member of the Board. In the SRG Chair's absence, the Vice Chair shall also perform the role of Associate Member on the LHB Board. The appointment of the Vice Chair is therefore also on the basis of the conditions of appointment for Associate Members set out in the Regulations.

1.4.8 The Vice Chair's term of office shall be for a period of up to two (2) years, with the ability to stand as Vice Chair for an additional one (1) year, in line with that individual's term of office as a member of the SRG. That individual may remain in office for the remainder of their term as a member of the SRG after their term of appointment as Vice Chair has ended.

1.4.9 A member's tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements determined for the position. A member must inform the SRG Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office. The SRG Chair will advise the Board in writing of any such cases immediately.

1.4.10 The LHB will require SRG members to confirm in writing their continued eligibility on an annual basis.

1.5. Resignation, suspension and removal of members

1.5.1 A member of the SRG may resign office at any time during the period of appointment by giving notice in writing to the SRG Chair and the Board.

1.5.2 If the Board, having consulted with the SRG Chair and the nominating body or group, considers that:

- It is not in the interests of the health service in the area covered by the SRG that a person should continue to hold office as a member; or
- It is not conducive to the effective operation of the SRG

it shall remove that person from office by giving immediate notice in writing to the person and the relevant nominating body or group.

1.5.3 A nominating body or group may request the removal of a member appointed to the SRG to represent their interests by writing to the Board setting out an explanation and full reasons for removal.

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1.5.4 If an SRG member fails to attend any meeting of the Group for a period of six months or more, the Board may remove that person from office unless they are satisfied that:

i) The absence was due to a reasonable cause; and

(ii) The person will be able to attend such meetings within such period as the Board considers reasonable.

1.5.5 Before making a decision to remove a person from office, the Board may suspend the tenure of office of that person for a limited period (as determined by the Board) to enable it to carry out a proper investigation of the circumstances leading to the consideration of removal. Where the Board suspends any member, that member shall be advised immediately in writing of the reasons for their suspension. Any such member shall not perform any of the functions of membership during a period of suspension.

1.6. Relationship with the Board

1.6.1 The SRG's main link with the Board is through the SRG Chair's membership of the Board as an Associate Member.

1.6.2 The Board may determine that designated Board members or LHB officers shall be in attendance at Advisory Group meetings. The SRG's Chair may also request the attendance of Board members or LHB officers, subject to the agreement of the LHB Chair.

1.6.3 The Board shall determine the arrangements for any joint meetings between the LHB Board and the SRG.

1.6.4 The Board's Chair shall put in place arrangements to meet with the SRG Chair on a regular basis to discuss the SRG's activities and operation.

1.7. Relationship between the SRG and others

1.7.1 The Board must ensure that the SRG's advice represents a balanced, co- ordinated stakeholder perspective from across the local communities served by the LHB. The SRG shall:

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- Ensure effective links and relationships with other advisory groups, local and community partnerships and other key stakeholders who do not form part of the SRG membership;
- Ensure its role, responsibilities and activities are known and understood by others; and

- Take care to avoid unnecessary duplication of activity with other bodies/groups with an interest in the planning and provision of NHS services, e.g., Regional Partnership Boards.

1.8. Working with Community Health Councils

1.8.1 The SRG shall make arrangements to ensure designated CHC members receive the SRG's papers and are invited to attend SRG meetings.

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1.8.2 The SRG shall work together with the CHCs within the area covered by the LHB to engage and involve those within the local communities served whose views may not otherwise be heard.

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Schedule 5.2

Schedule 5.2 – Health Professionals' Forum

Terms of Reference and Operating Arrangements

1.1 Role

1.1.1 The Healthcare Professionals' Forum HPF's role is to provide a balanced, multi-disciplinary view of healthcare professional issues to advise the Board on local strategy and delivery. Its role does not include consideration of professional terms and conditions of service.

1.1.2 The HPF shall facilitate engagement and debate amongst the wide range of clinical interests within the University Health Board (UHB) area of activity, with the aim of reaching and presenting a cohesive and balanced professional perspective to inform the UHB decision making

1.2 Terms of reference and operating arrangements

1.2.1 The Board must set out, the relationships and accountabilities with others, as well as the National Professional Advisory .

1.3 Membership

1.3.1 The membership of the HPF reflects the structure of the seven health Statutory Professional Advisory Committees set up in accordance with Section 190 of the NHS (Wales) Act 2006. Membership of the HPF shall therefore comprise the following eleven (11) members, as a minimum:

Welsh Medical Committee
- Primary and Community Care medical representative
- Mental Health Medical representative
- Specialist and Tertiary Care medical representative

Welsh Nursing and Midwifery Committee
- Community Nursing and Midwifery representative
- Hospital Nursing and Midwifery representative

Welsh Therapies Advisory Committee
- Therapies representative

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Welsh Scientific Advisory Committee
- Scientific representative

Welsh Optometric Committee
- Optometry representative

Welsh Dental Committee
- Dental representative

Welsh Pharmaceutical Committee
- Hospital Pharmacists representative
- Community Pharmacists representative

1.3.2 Where the Board determines it appropriate, the LHB may extend membership to other individuals in order to ensure an appropriate balance in representation amongst healthcare professional groupings and across the range of primary, community and secondary service provision.

1.4 Member Responsibilities and Accountability

The Chair

1.4.1 The Chair is responsible for the effective operation of the HPF:

- Chairing meetings;
- Establishing and ensuring adherence to the standards of good governance set for the NHS in Wales, ensuring that all business is conducted in accordance with its agreed operating arrangements; and
- Developing positive and professional relationships amongst the HPF's membership and between the HPF and the LHB's Board, and in particular its Chair, Chief Executive and clinical Directors.

1.4.2 The Chair shall work in close harmony with the Chairs of the LHB's other advisory groups, and, supported by the Board Secretary, shall ensure that key and appropriate issues are discussed by the HPF in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.

1.4.3 As Chair of the HPF, they will be appointed as an Associate Member of the LHB Board. The Chair is accountable for the conduct of their role as Associate Member on the LHB Board to the Minister, through the LHB Chair. They are also accountable to the LHB Board for the conduct of business in accordance with the governance and operating framework set by the LHB.

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The Vice Chair

1.4.4 The Vice-Chair shall deputise for the Chair in their absence for any reason, and will do so until either the existing chair resumes their duties or a new chair is appointed, and this deputisation includes acting in the role of Associate Member of the LHB Board.

1.4.5 The Vice Chair is accountable through the HPF Chair to the LHB Board for their performance as Vice Chair, and to their nominating body or grouping for the way in which they represent their views at the HPF.

Members

1.4.6 The HPF shall function as a coherent advisory group, all members being full and equal members and sharing responsibility for the decisions of the HPF.

1.4.7 All members must:

- Be prepared to engage with and contribute fully to the HPF's activities and in a manner that upholds the standards of good governance – including the values and standards of behaviour – set for the NHS in Wales;
- Comply with their terms and conditions of appointment;
- Equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes; and
- Promote the work of the HPF within the healthcare professional discipline they represent.

1.4.8 Forum members are accountable through the HPF Chair to the LHB Board for their performance as Group members, and to their nominating body or grouping for the way in which they represent the views of their body or grouping at the HPF.

1.5 Appointment and terms of office

1.5.1 Appointments to the HPF shall be made by the Board, based upon nominations received from the relevant healthcare professional group, and in accordance with any specific requirements or directions made by the Welsh Ministers. Members shall be appointed for a period specified by the Board, but for no longer than 4 years in any one term. Those members can be reappointed but may not serve a total period of more than 8 years consecutively.

1.5.2 The Chair will be nominated from within the membership of the HPF, by its members, in a manner determined by the Board, subject to any specific requirements or directions made by the Welsh Ministers. The nomination will be subject to consideration by the Board, who must

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submit a recommendation on the nomination to the Minister for Health and Social Services. Their appointment as Chair will be made by the Minister, but it will not be a formal public appointment. The Constitution Regulations provide that the Welsh Ministers may appoint an Associate Member of the Board, and the appointment of the Chair to this role is on the basis of the conditions of appointment for Associate Members set out in the Regulations.

1.5.3 The Chair's term of office will be for a period of up to two (2) years, with the ability to stand as Chair for an additional one (1) year, in line with that individual's term of office as a member of the HPF. That individual may remain in office for the remainder of their term as a member of the HPF after their term of appointment as Chair has ended.

1.5.4 The ***Vice Chair*** will be nominated from within the membership of the HPF, by its members, in a manner determined by the Board, subject to the condition that they be appointed from a different healthcare discipline to that of the Chair, along with any specific requirements or directions made by the Welsh Ministers. The nomination shall be subject to consideration and appointment by the Board. The Constitution Regulations provide that the Welsh Ministers may appoint an Associate Member of the Board. In the HPF Chair's absence, the Vice Chair will also perform the role of Associate Member on the LHB Board. The appointment of the Vice Chair is therefore also on the basis of the conditions of appointment for Associate Members set out in the Regulations.

1.5.5 The Vice Chair's term of office will be for a period of up to two (2) years, with the ability to stand as Vice Chair for an additional one (1) year, in line with that individual's term of office as a member of the HPF. That individual may remain in office for the remainder of their term as a member of the HPF after their term of appointment as Vice Chair has ended.

1.5.6 A member's tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements determined for the position. A member must inform the HPF Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office. The HPF Chair will advise the Board in writing of any such cases immediately.

1.5.7 The LHB will require Forum members to confirm in writing their continued eligibility on an annual basis.

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1.6 Resignation, suspension and removal of members

1.6.1 A member of the HPF may resign office at any time during the period of appointment by giving notice in writing to the HPF Chair and the Board.

1.6.2 If the Board, having consulted with the HPF Chair and the nominating body or group, considers that:

- It is not in the interests of the health service in the area covered by the HPF that a person should continue to hold office as a member; or
- It is not conducive to the effective operation of the HPF

it shall remove that person from office by giving immediate notice in writing to the person and the relevant nominating body or group.

1.6.3 A nominating body or group may request the removal of a member appointed to the HPF to represent their interests by writing to the Board setting out an explanation and full reasons for removal.

1.6.4 If a member fails to attend any meeting of the HPF for a period of six months or more, the Board may remove that person from office unless they are satisfied that:

i) The absence was due to a reasonable cause; and
ii) The person will be able to attend such meetings within such period as the Board considers reasonable.

1.6.5 Before making a decision to remove a person from office, the Board may suspend the tenure of office of that person for a limited period (as determined by the Board) to enable it to carry out a proper investigation of the circumstances leading to the consideration of removal. Where the Board suspends any member, that member shall be advised immediately in writing of the reasons for their suspension. Any such member shall not perform any of the functions of membership during a period of suspension.

1.7 Relationship with the Board

1.7.1 The HPF's main link with the Board is through the HPF Chair's membership of the Board as an Associate Member.

1.7.2 The Board may determine that designated Board members or LHB officers shall be in attendance at Advisory Group meetings. The HPF's

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Chair may also request the attendance of Board members or LHB officers, subject to the agreement of the LHB Chair.

1.7.3 The Board shall determine the arrangements for any joint meetings between the LHB Board and the HPF.

1.7.4 The Board's Chair shall put in place arrangements to meet with the HPF Chair on a regular basis to discuss the HPF's activities and operation.

1.8 Rights of Access to the LHB Board for Professional Groups

1.8.1 The LHB Chair, on the advice of the Chief Executive and/or Board Secretary, may recommend that the Board afford direct right of access to any professional group, in the following, exceptional circumstances:

i) Where the HPF recommends that a matter should be presented to the Board by a particular healthcare professional grouping, e.g., due to the specialist nature of the issues concerned; or

ii) Where a healthcare professional group has demonstrated that the HPF has not afforded it due consideration in the determination of its advice to the Board on a particular issue.

1.8.2 The Board may itself determine that it wishes to seek the views of a particular healthcare professional grouping on a specific matter, in accordance with Standing Order 6.5.7.

1.9 Relationship with the National Professional Advisory Group

1.9.1 The HPF Chair (or HPF Vice-Chair) will be a member of the National Professional Advisory Group

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Schedule 5.3

Schedule 5.3 – Local Partnership Forum Advisory Group

Terms of Reference and Operating Arrangements

1..1 Role and Purpose

1.1.1 The LHB Local Partnership Forum (LPF) is the formal mechanism where NHS Wales's employers and trade unions/professional bodies (hereafter referred to as staff organisations) work together to improve health services for the people of Wales. It is the forum where key stakeholders will engage with each other to inform, debate and seek to agree local priorities on workforce and health service issues.

1.1.2 At the earliest opportunity, the Board will engage staff organisations in the key discussions at the LHB Board, LPF and Locality/Divisional level.

1.1.3 All members are full and equal members of the forum and collectively share responsibility for the decisions made.

1.1.4 The LPF will provide the formal mechanism for consultation, negotiation and communication between the staff organisations and management. The TUC principles of partnership will apply. These principles are attached at Appendix 1.

1.1.5 The purpose of the LPF will be to:

- Establish a regular and formal dialogue between the Board's Executive and staff organisations on matters relating to workforce and health service issues.
- Enable employers and staff organisations to put forward issues affecting the workforce.
- Provide opportunities for staff organisations and managers to input into organisation service development plans at an early stage.
- Consider the implications on staff of service reviews and identify and seek to agree new ways of working.
- Consider the implications for staff of NHS reorganisations at a national or local level and to work in partnership to achieve mutually successful implementation.
- Appraise and discuss in partnership the financial performance of the organisation on a regular basis.
- Appraise and discuss in partnership the Board services and activity and its implications.

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- Provide opportunities to identify and seek to agree quality issues, including clinical governance, particularly where such issues have implications for staff.
- Communicate to the partners the key decisions taken by the Board and senior management.
- Consider national developments in NHS Wales Workforce and Organisational Strategy and the implications for the Board including matters of service re-profiling.
- Negotiate on matters subject to local determination.
- Ensure staff organisation representatives are afforded reasonable paid time off to undertake trade union duties
- To develop in partnership appropriate facilities arrangements using A4C Facilities Agreement as a minimum standard.

1.1.6 In addition the LPF can establish LPF sub groups to establish ongoing dialogue, communication and consultation on service and operational management issues specific to Divisions/Directorates/Service areas. Where these sub groups are developed they must report to the LHB LPF.

1.2 General Principles

1.2.1 The LHB and LPF accepts that partnerships help the workforce and management work through challenges and to grow and strengthen their organisations. Relationships are built on trust and confidence and demonstrate a real commitment to work together.

1.2.2 The principles of true partnership working between Trades Union and Management are as follows:

- Staff organisations and management show joint commitment to the success of the organisation with a positive and constructive approach

- they recognise the legitimacy of other partners and their interests and treat all parties with trust and mutual respect

- they demonstrate commitment to security for workers and flexible ways of working

- they share success – rewards must be felt to be fair
- they practice open and transparent communication – sharing information widely with openness, honesty and transparency

- they must bring effective representation of the views and interests of the workforce

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- they must demonstrate a commitment to work with and learn from each other.

All members must:

- be prepared to engage with and contribute fully to the LPF's activities and in a manner that upholds the standards of good governance set for the NHS in Wales

- comply with their terms and conditions of appointment

- equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes, and

- promote the work of the LPF within the professional discipline he/she represents.

1.2.3 A Code of Conduct is attached as **Appendix 2**.

1.3 . Membership

1.3 .1 All members of the LPF are full and equal members and share responsibility for the decisions of the LPF. The LHB shall agree the overall size and composition of the LPF in consultation with those staff organisations the LHB recognises for collective bargaining. The LHB's Trade Union Independent Member will be expected to attend the LPF in an ex-officio capacity. As a minimum, the membership of the LPF shall comprise:

Management Representatives

1.3.2

Chief Executive
Finance Director
General Managers/Divisional Managers (as locally identified)
Director of Workforce and OD
Workforce and OD staff (as locally identified).

1.3.3 Other Executive Directors and others may also be members or may be co-opted dependent upon the agenda.

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Staff Representatives

1.3.4 The Board recognises those staff organisations listed in Appendix 3 for the representation of members who are employed by the organisation.

1.3.5 Staff representatives must be employed by the organisation and accredited by their respective organisations for the purposes of bargaining. If a representative ceases to be employed by the Board or ceases to be a member of a nominating organisation then they will automatically cease to be a member of the LPF. Full time officers of the staff organisations may attend meetings subject to prior notification and agreement.

1.3.6 Members of the LPF who are unable to attend a meeting may send a deputy, providing such deputies are eligible for appointment to the LPF.

1.4 Quorum

1.4.1 Every effort will be made by all parties to maintain a stable membership. There should be 50% attendance of both parties for the meeting to be quorate.

1.4.2 If the meeting is not quorate no decisions can be made but information may be exchanged. Where joint chairs agree extraordinary meeting may be scheduled within 7 calendar days' notice.

1.4.3 Consistent attendance and commitment to participate in discussions is essential. Where a member of the LPF does not attend on 3 consecutive occasions, the Joint Secretaries will write to the member and bring the response to the next meeting for further consideration and possible removal.

1.5 Officers

1.5.1 The Staff Organisation Chair, Vice Chair and Secretary will be elected from the LPF annually. Best practice requires these three officers to come from different staff organisations.

1.6 Chairs

1.6.1 The Management and Staff Organisation Chair will chair the LPF. This will be done on a rotational basis. In the absence of the Chair(s) the Vice Chair(s) will act as Chair. The Chairs shall work in partnership with each other and, as appropriate, with the Chairs of the Board's other advisory groups. Supported by the Board Secretary, Chairs shall ensure that key and appropriate issues are discussed by the LPF in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.

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1.7 Joint Secretaries

1.7.1 Each side of the LPF should appoint/elect its own Joint Secretary. The Management and Staff Organisation Secretary will be responsible for the preparation of the agendas and minutes of the meetings held, and for obtaining the agreement of the Management and Staff Organisation Chairs.

1.7.2 The Director of Workforce and OD will act as Management Secretary and will be responsible for the maintenance of the constitution of the membership, the circulation of agenda and minutes and notification of meetings.

1.8 Sub Committees

1.8.1 When is considered appropriate, the LPF can decide to appoint a subcommittee, to hold detailed discussion on a particular issue(s). Nominated representatives to sub committees will communicate and report regularly to the LPF.

1.9 Management of Meetings

1.91. Meetings will be held bi-monthly but this may be changed to reflect the need of either staff organisations or management.

1.9.2 The business of the meeting shall be restricted to matters pertaining to LPF issues and should include local operational issues. Board wide strategic issues and issues that have LHB/Trust wide implications shall be referred to the Welsh Partnership Forum via the LHB Board.

1.9.3 The minutes shall normally be distributed 10 days after the meeting and no later than 7 days prior to meeting. Items for the agenda and supporting papers should be notified to the Management Secretary as early as possible, and in the event at least two weeks in advance of the meeting.

1.9.4 The LPF has the capacity to co-opt others onto the LPF or its sub groups as deemed necessary by agreement.

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Appendix 1

Six Principles of Partnership Working

- a shared commitment to the success of the organisation
- a focus on the quality of working life
- recognition of the legitimate roles of the employer and the trade union
- a commitment by the employer to employment security
- openness on both sides and a willingness by the employer to share information and discuss the future plans for the organisation
- adding value – a shared understanding that the partnership is delivering measurable improvements for the employer, the union and employees.

Appendix 2

Code of Conduct

A code of conduct for meetings sets ground rules for all participants:-

- Respect the meeting start time and arrive punctually
- Attend the meeting well-prepared, willing to contribute and with a positive attitude
- Listen actively. Allow others to explain or clarify when necessary
- Observe the requirement that only one person speaks at a time
- Avoid 'put downs' of views or points made by colleagues
- Respect a colleague's point of view
- Avoid using negative behaviours e.g. sarcasm, point-scoring, personalisation
- Try not to react negatively to criticism or take as a personal slight
- Put forward criticism in a positive way
- Be mindful that decisions have to be made and it is not possible to accommodate all individual views

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- No ‘side-meetings’ to take place

- Respect the Chair

- Failure to adhere to the Code of Conduct may result in the suspension or removal of the member.

Appendix 3

List of Recognised Trade Unions/Professional Bodies referred to as ‘staff organisations’ within these Standing Orders

British Medical Association (BMA)
Royal College of Nursing (RCN)
Royal College of Midwives (RCN)
UNISON
UNITE
GMB
British Orthoptic Society
Society of Radiographers
British Dental Association
Society of Chiropodists and Podiatrists
Federation of Clinical Scientists
Chartered Society of Physiotherapy (CSP)
British Dietetic Association
British Association of Occupational Therapists (BAOT)

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Schedule 2.1

MODEL STANDING FINANCIAL INSTRUCTIONS FOR LOCAL HEALTH BOARDS

This Schedule forms part of, and shall have effect as if incorporated in the Local Health Board Standing Orders (incorporated as Schedule 2.1 of SOs).

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Foreword

These Model Standing Financial Instructions are issued by Welsh Ministers to Local Health Boards using powers of direction provided in section 12 (3) of the National Health Service (Wales) Act 2006. Local Health Boards in Wales must agree Standing Financial Instructions (SFIs) for the regulation of their financial proceedings and business. Designed to achieve probity, accuracy, economy, efficiency, effectiveness and sustainability in the conduct of business, they translate statutory and Welsh Government financial requirements for the NHS in Wales into day to day operating practice. Together with the adoption of Standing Orders (SOs), a Scheme of decisions reserved to the Board and a scheme of delegations to officers and others, they provide the regulatory framework for the business conduct of the LHB.

These documents form the basis upon which the LHB's governance and accountability framework is developed and, together with the adoption of the LHB's Values and Standards of Behaviour framework, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

All LHB Board members and officers must be made aware of these Standing Financial Instructions and, where appropriate, should be familiar with their detailed content. The Director of Finance will be able to provide further advice and guidance on any aspect of the Standing Financial Instructions. The Board Secretary will be able to provide further advice and guidance on the wider governance arrangements within the LHB. Further information on governance in the NHS in Wales may be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/

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SCHEDULE 1 - REVISED GENERAL CONSENT TO ENTER INDIVIDUAL CONTRACTS

Cardiff and Vale University Local Health Board

1. INTRODUCTION

1.1 General

1.1.1 These Model Standing Financial Instructions are issued by Welsh Ministers to Local Health Boards using powers of direction provided in section 12 (3) of the National Health Service (Wales) Act 2006. Local Health Boards (LHBs) in Wales must agree Standing Financial Instructions (SFIs) for the regulation of their financial proceedings and business. They shall have effect as if incorporated in the Standing Orders (SOs) (incorporated as Schedule 2.1of SOs).

1.1.2 These SFIs detail the financial responsibilities, policies and procedures adopted by Cardiff and Vale University Local Health Board (the LHB). They are designed to ensure that the LHB's financial transactions are carried out in accordance with the law and with Welsh Government policy in order to achieve probity, accuracy, economy, efficiency, effectiveness and sustainability. They should be used in conjunction with the Schedule of decisions reserved to the Board and the Scheme of delegation adopted by the LHB.

1.1.3 These SFIs identify the financial responsibilities which apply to everyone working for the LHB and its constituent organisations. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial control procedure notes. All financial procedures must be approved by the Director of Finance and Audit and Assurance Committee.

1.1.4 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Board Secretary or Director of Finance must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the LHB's SOs.

1.2 Overriding Standing Financial Instructions

1.2.1 Full details of any non-compliance with these SFIs, including an

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explanation of the reasons and circumstances must be reported in the first instance to the Director of Finance and the Board Secretary, who will ask the Audit and Assurance Committee to formally consider the matter and make proposals to the Board on any action to be taken. All Board members and LHB officers have a duty to report any non-compliance to the Director of Finance and Board Secretary as soon as they are aware of any circumstances that has not previously been reported.

1.2.2 **Ultimately, the failure to comply with SFIs and SOs is a disciplinary matter that could result in an individual's dismissal from employment or removal from the Board.**

1.3 Financial provisions and obligations of LHBs

1.3.1 The financial provisions and obligations for LHBs are set out under Sections 174 to 177 of, and Schedule 8 to, the National Health Service (Wales) Act 2006 (c. 42). The Board as a whole and the Chief Executive in particular, in their role as the Accountable Officer for the organisation, must ensure the LHB meets its statutory obligation to perform its functions within the available financial resources.

2. RESPONSIBILITIES AND DELEGATION

2.1 The Board

2.1.1 The Board exercises financial supervision and control by:

a) Formulating and approving the Medium-Term Financial Plan (MTFP) as part of developing and approving the Integrated Medium-Term Plan (IMTP);

b) Requiring the submission and approval of balanced budgets within approved allocations/overall funding

c) Defining and approving essential features in respect of important financial policies, systems and financial controls (including the need to obtain value for money and sustainability); and

d) Defining specific responsibilities placed on Board members and LHB officers, and LHB committees and Advisory Groups as indicated in the 'Scheme of delegation' document.

2.1.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the 'Schedule of matters reserved to the Board' document. The Board,

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subject to any directions that may be made by Welsh Ministers, shall make appropriate arrangements for certain functions to be carried out on its behalf so that the day to day business of the Health Board may be carried out effectively, and in a manner that secures the achievement of the organisations aims and objectives. This will be via powers and authority delegated to committees, sub-committees, joint committees or joint sub-committees that the LHB has established or to an officer of the LHB in accordance with the 'Scheme of delegation' document adopted by the LHB.

2.2 The Chief Executive and Director of Finance

2.2.1 The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

2.2.2 Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accountable Officer, to the Welsh Government, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the LHB's activities; is responsible to the Chair and the Board for ensuring that financial provisions, obligations and targets are met; and has overall responsibility for the LHB's system of internal control.

2.2.3 It is a duty of the Chief Executive to ensure that Board members and LHB officers, and all new appointees are notified of, and put in a position to understand their responsibilities within these SFIs.

2.3 The Director of Finance

2.3.1 The Director of Finance is responsible for:

a) Implementing the LHB's financial policies and for co-coordinating any corrective action necessary to further these policies;

b) Maintaining an effective system of internal financial control including ensuring that detailed financial control procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

c) Ensuring that sufficient records are maintained to show and explain the LHB's transactions, in order to disclose, with reasonable accuracy, the financial position of the LHB at any time; and

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d) Without prejudice to any other functions of the LHB, and Board members and LHB officers, the duties of the Director of Finance include:

(i) the provision of financial advice to other Board members and LHB officers, and LHB Committees and Advisory Groups,

(ii) the design, implementation and supervision of systems of internal financial control, and;

(iii) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the LHB may require for the purpose of carrying out its statutory duties.

2.3.2 The Director of Finance is responsible for ensuring an ongoing training and communication programme is in place to affect these SFIs.

2.4 Board members and LHB officers, and LHB Committees and Advisory Groups

2.4.1 All Board members and LHB officers, and LHB Committees and Advisory Groups, severally and collectively, are responsible for:

a) The security of the property of the LHB;

b) Avoiding loss;

c) Exercising economy, efficiency and sustainability in the use of resources; and

d) Conforming to the requirements of SOs, SFIs, Financial Control Procedures and the Scheme of delegation.

2.4.2 For all Board members and LHB officers, and LHB Committees and Advisory Groups who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board, Committees, Advisory Groups and employees discharge their duties must be to the satisfaction of the Director of Finance.

2.5 Contractors and their employees

2.5.1 Any contractor or employee of a contractor who is empowered by the LHB to commit the LHB to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

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3. AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT

3.1 Audit and Assurance Committee

3.1.1 An independent Audit and Assurance Committee is a central means by which a Board ensures effective internal control arrangements are in place. In addition, the Audit and Assurance Committee provides a form of independent check upon the executive arm of the Board. In accordance with SOs the Board shall formally establish an Audit and Assurance Committee with clearly defined terms of reference. Detailed terms of reference and operating arrangements for the Audit and Assurance Committee are set out in Schedule 3 to the SOs. This committee will follow the guidance set out in the NHS Wales Audit Committee Handbook.

http://www.wales.nhs.uk/sitesplus/documents/1064/NHS%20Wales%20Audit%20Committee%20Handbook%20%28June%202012%29.pdf

3.2 Chief Executive

3.2.1 The Chief Executive is responsible for:

a) Ensuring there are arrangements in place to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;

b) Ensuring that the Internal Audit function meets the Public Sector Internal Audit Standards and provides sufficient independent and objective assurance to the Audit and Assurance Committee and the Accountable Officer;

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/641252/PSAIS_1_April_2017.pdf

c) Deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption;

d) Ensuring that an annual Internal Audit report is prepared for the consideration of the Audit and Assurance Committee and the Board. The report must cover:

- a clear opinion on the effectiveness of internal control in accordance with the requirements of the Public Sector Internal Audit Standards.

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- major internal financial control weaknesses discovered,
- progress on the implementation of Internal Audit recommendations,
- progress against plan over the previous year,
- a strategic audit plan covering the coming three years, and
- a detailed plan for the coming year.

3.2.2 The designated internal and external audit representatives are entitled (subject to provisions in the Data Protection Act 2018 and the UK General Data Protection Legislation without necessarily giving prior notice to require and receive:

a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

b) Access at all reasonable times to any land or property owned or leased by the LHB;

c) Access at all reasonable times to Board members and LHB officers;

d) The production of any cash, stores or other property of the LHB under a Board member or an LHB official's control; and

e) Explanations concerning any matter under investigation.

3.3 Internal Audit

3.3.1 The Accountable Officer Memorandum requires the Chief Executive to have an internal audit function that operates in accordance with the standards and framework set for the provision of Internal Audit in the NHS in Wales. This framework is defined within an Internal Audit Charter that incorporates a definition of internal audit, a code of ethics and Public Sector Internal Audit Standards. Standing Order 10.1 details the relationship between the Head of Internal Audit and the Board. The role of the Audit and Assurance Committee in relation to Internal Audit is set out within its Terms of Reference, incorporated in Schedule 3 of the SOs, and the NHS Wales Audit Committee Handbook.

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3.4 External Audit

3.4.1 Pursuant to the Public Audit (Wales) Act 2004 (c. 23), the Auditor General for Wales (Auditor General) is the external auditor of the LHB. The Auditor General may nominate his representative to represent him within the LHB and to undertake the required audit work. The cost of the audit is paid for by the LHB. The LHB's Audit and Assurance Committee must ensure that a cost-efficient external audit service is delivered. If there are any problems relating to the service provided, this should be raised with the Auditor General's representative and referred on to the Auditor General if the issue cannot be resolved.

3.4.2 The objectives of the external audit fall under three broad headings, to review and report on:

a) Whether the expenditure to which the financial statements relate has been incurred lawfully and in accordance with the authority that governs it;

b) The audited body's financial statements, and on its Annual Governance Statement and remuneration report [1];

c) Whether the audited body has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

3.4.3 The Auditor General's representatives will prepare a risk-based annual audit plan, designed to deliver the Auditor General's objectives, for consideration by the Audit and Assurance Committee. The annual plan will set out details of the work to be carried out, providing sufficient detail for the Audit and Assurance Committee and other recipients to understand the purpose and scope of the defined work and their level of priority. The Audit and Assurance Committee should review the annual plan and the associated fees, although in so doing it needs to recognise the statutory duties of the Auditor General. The annual audit plan should be kept under review to identify any amendment needed to reflect changing priorities and emerging audit needs. The Audit and Assurance Committee should consider material changes to the annual audit plan.

3.4.4 The Auditor General's representative should be invited to attend every Audit and Assurance Committee meeting. The cycle of approving and monitoring the progress of external audit plans and reports, culminating in the opinion on the annual report and accounts, is central to the core

[1] Note: The Healthcare Inspectorate Wales will review and report on the Annual Quality Statement.

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work of the Audit and Assurance Committee.

3.4.5 The Auditor General's representatives will liaise with Internal Audit when developing the external audit plan. The Auditor General's representative will ensure that planned external audit work considers the work of Internal Audit to avoid duplication wherever possible and considers where Internal Audit work can be relied upon for opinion purposes.

3.4.6 The Auditor General and his representatives shall have a right of access to the Chair of the Audit and Assurance Committee at any time.

3.4.7 The Government of Wales Act 2006 (GOWA) provides that the Auditor General has statutory rights of access to all documents and information, as set out in paragraph 3.2.2a of these SFIs, that relate to the exercise of many of his core functions, including his statutory audit of accounts, value for money examinations and improvement studies. The rights of access include access to confidential information; personal information as defined by the Data Protection Act 2018 and the UK General Data Protection Legislation; information subject to legal privilege; personal information and sensitive personal information that may otherwise be subject to protection under the European Convention of Human Rights; information held by third parties; and electronic files and IT systems. Paragraph 17 of Schedule 8 to GOWA operates to provide the Auditor General with a right of access to every document relating to the Trust that appears to him to be necessary for the discharge of any of these functions. Paragraph 17(3) of Schedule 8 also requires any person that the Auditor General thinks has information related to the discharge of his functions to give any assistance, information and explanation that he thinks necessary. It also requires such persons to attend before the Auditor General and to provide any facility that he and his representatives may reasonably require, such as audit accommodation and access to IT facilities. The rights apply not just to the LHB and its officers and staff, but also to, among others, suppliers to the LHB.

3.4.8 The Auditor General's independence in the exercise of his audit functions is protected by statute (section 8 of the Public Audit (Wales) Act 2013), and audit independence is required by professional and ethical standards. Accordingly, the LHB (including its Audit and Assurance Committee) must be careful not to seek to fetter the Auditor General's discretion in the exercise of his functions. While the LHB may offer comments on the plans and outputs of the Auditor General, it must not seek to direct the Auditor General.

3.4.9 The Auditor General will issue a number of reports over the year, some of which are specified in the Auditor General's Code of Audit and

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Inspection Practice and International Standards on Auditing. Other reports will depend on the contents of the audit plan.

The main mandatory reports are:

- Report to those charged with governance (incorporating the report required under ISA 260) that sets out the main issues arising from the audit of the financial statements and use of resources work
- Statutory report and opinion on the financial statements
- Annual audit report.

In addition to these reports, the Auditor General may prepare a report on a matter the Auditor General considers would be in the public interest to bring to the public's attention; or make a referral to the Welsh Ministers if significant breaches occur.

3.4.10 The Auditor General also has statutory powers to undertake Value for Money Examinations and Improvement Studies within the LHB and other public sector bodies. At LHBs he also undertakes a Structured Assessment to help him assess whether there are proper arrangements for securing economy, efficiency and effectiveness in the use of resources. The Auditor General will take account of audit work when planning and undertaking such examinations and studies. The Auditor General and his representatives have the same access rights in relation to these examinations and studies as they do in relation to annual audit work.

3.5 Fraud and Corruption

3.5.1 In line with their responsibilities, the LHB Chief Executive and Director of Finance shall monitor and ensure compliance with Directions issued by the Welsh Ministers on fraud and corruption.

3.5.2 The LHB shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist (LCFS) as specified by Directions to NHS bodies on Counter Fraud Measures 2005 http://www.wales.nhs.uk/sitesplus/documents/1064/WHC%282005%2995%20%28Revised%29%20Directions%20to%20National%20Health%20Service%20bodies%20on%20Counter%20Fraud%20Measures%202005.pdf

3.5.3 The LCFS shall report to the LHB Director of Finance and the LCFS must work with NHS Counter Fraud Authority (NHSCFA) and the NHS Counter Fraud Service Wales (CFSW) Team in accordance with the

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Directions to NHS bodies on Counter Fraud Measures 2005.

3.5.4 The LCFS will provide a written report to the Director of Finance and Audit and Assurance Committee, at least annually, on proactive and reactive counter fraud work within the LHB.

3.5.5 The LHB must participate in the annual National Fraud Initiative (NFI) led by Audit Wales and must provide the necessary data for the mandatory element of the NFI by the due dates. The LHB should participate in appropriate risk measurement or additional dataset matching exercise in order to support the detection of fraud across the whole public sector.

3.6 Security Management

3.6.1 In line with their responsibilities, the LHB Chief Executive will monitor and ensure compliance with Directions issued by the Welsh Ministers on NHS security management.

3.6.2 The Chief Executive has overall responsibility for controlling and coordinating security.

4. FINANCIAL DUTIES

4.1 Legislation and Directions

4.1.1 The Health Board has two statutory financial duties, the basis for which is section 175 of the National Health Service (Wales) Act 2006, as amended by the National Health Service Finance (Wales) Act 2014. Those duties are then set out and retained in the Welsh Health Circular "WHC/2016/054 - Statutory Financial Duties of Local Health Boards and NHS Trusts." They are as follows:

- First Duty - A duty to secure that its expenditure, which is attributable to the performance by it of its functions, does not exceed the aggregate of the funding allotted to it over a period of 3 financial years.
- Second Duty - A duty to prepare a plan to secure compliance with the first duty while improving the health of the people for whom it is responsible, and the provision of health care to such people, and for that plan to be submitted to and approved by the Welsh Ministers.

4.1.2 The details and requirements for the two duties are set out in the Welsh Health Circular "WHC/2016/054 - Statutory Financial Duties of Local Health Boards and NHS Trusts."

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http://www.wales.nhs.uk/sitesplus/documents/863/12b%29%20Statutory%20Duties%20of%20Welsh%20Health%20Boards.pdf

4.2 First Financial Duty – The Breakeven Duty

4.2.1 The Health Board has a statutory duty to secure that its expenditure does not exceed the aggregate of the funding allotted to it over a period of 3 financial years, that is to breakeven over a 3-year rolling period.

4.2.2 Welsh Government will determine revenue and capital allocations prior to the start of each financial year and notify Health Boards.

4.2.3 Health Boards must ensure their boards approve balanced revenue and capital plans in line with their notified allocations before the start of each financial year.

4.2.4 The Director of Finance of the LHB will:

a) Prior to the start of each financial year submit to the Board for approval a report showing the total allocations received, assumed in-year allocations and other adjustments and their proposed distribution to delegated budgets, including any sums to be held in reserve;

b) Ensure that any ring-fenced or non-discretionary allocations are disbursed in accordance with Welsh Ministers' requirements;

c) Periodically review any assumed in-year allocations to ensure that these are reasonable and realistic; and

d) Regularly update the Board on significant changes to the initial allocations and the application of such funds.

4.2.5 The Chief Executive has overall executive responsibility for the LHB's activities and is responsible to the Board for ensuring that it meets its First Financial Duty.

4.3. Second Financial Duty – The Planning Duty

4.3.1 The Health Board has a statutory duty to prepare a plan, the Integrated Medium-Term Plan (IMTP), to secure compliance with the first duty while improving the health of the people for whom it is responsible, and the provision of health care to such people, and for that plan to be submitted to and approved by the Welsh Ministers**.**

4.3.2 The Integrated Medium-Term Plan must reflect longer-term planning

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and delivery objectives and should be continually reviewed based on latest Welsh Government policy and local priority requirements. The Integrated Medium-Term Plan, produced and approved annually, will be 3 year rolling plans. In particular the Integrated Medium-Term Plan must reflect the Welsh Ministers' priorities and commitments as detailed in the NHS Planning Framework published annually by Welsh Government.

https://gov.wales/sites/default/files/publications/2019-09/nhs-wales-planning-framework-2020-23%20.pdf

4.3.3 The NHS Planning Framework directs Local Health Boards to develop, approve and submit an Integrated Medium-Term Plan (IMTP) for approval by Welsh Ministers. The plan must

- describe the context, including population health needs, within which the Health Board will deliver key policy directives from Welsh Government.
- demonstrate how the Health Board are
  - delivering their well-being objectives, including how the five ways of working have been applied
  - contributing to the seven Well-being Goals,
  - establishing preventative approaches across all care and services
- demonstrate how the Health Board will utilise its existing services and resources, and planned service changes, to deliver improvements in population health and clinical services, and at the same time demonstrate improvements to efficiency of services.
- demonstrate how the three-year rolling financial breakeven duty is to be achieved.

4.3.4 An Integrated Medium-Term Plan should be based on a reasonable expectation of future service changes, performance improvements, workforce changes, demographic changes, capital, quality, funding, income, expenditure, cost pressures and savings plans to ensure that the Integrated Medium-Term Plan (including a balanced Medium-Term Financial Plan) is balanced and sustainable and supports the safe and sustainable delivery of patient centred quality services.

4.3.5 The Integrated Medium-Term Plan will be the overarching planning document enveloping component plans and service delivery plans. The Integrated Medium-Term Plan will incorporate the balanced Medium-Term Financial Plan and will incorporate the LHB's response to delivering the

- NHS Planning Framework,
- Quality, governance and risk frameworks and plans and
- Outcomes Framework

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4.3.6 The Integrated Medium-Term Plan will be developed in line with the NHS Planning Framework and include:

- A statement of significant strategies and assumptions on which the plans are based;
- Details of major changes in activity, service delivery, service and performance improvements, workforce, revenue and capital resources required to achieve the plans; and
- Profiled activity, service, quality, workforce and financial schedules.
- Detailed plans to deliver the NHS Planning Framework and quality, governance and risk requirements and outcome measures;

4.3.7 The Chief Executive has overall executive responsibility to develop and submit to the Board, on an annual basis, the rolling 3 year Integrated Medium Term Plan (IMTP).

4.3.8 The Board will:

a) Approve the Integrated Medium-Term Plan prior to the beginning of the financial year of implementation and in accordance with the guidance issued annually by Welsh Government. Following Board approval, the Plan will be submitted to Welsh Government prior to the beginning of the financial year of implementation.

b) Approve a balanced Medium-Term Financial Plan as part of the Integrated Medium-Term Plan, which meets all financial duties, probity and value for money requirements; and

c) Prepare and agree with the Welsh Government a robust and sustainable recovery plan in accordance with Welsh Ministers' guidance where the LHB plan is not in place or in balance.

4.3.9 The Board approved Integrated Medium-Term Plan will be submitted to Welsh Government, for approval by the Minister, in line with the requirements set out in the NHS Planning Framework.

4.3.10 The finalised approved Integrated Medium-Term Plan will form the basis of the Performance Agreement between the LHB and Welsh Government.

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5. FINANCIAL MANAGEMENT AND BUDGETARY CONTROL

5.1. Budget Setting

5.1.1 Prior to the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval and delegation by the Board. Such budgets will:

a) Be in accordance with the aims and objectives set out in the Board approved Integrated Medium-Term Plan, and Medium-Term Financial Plan, and focussed on delivery of improved population health, safe patient centred quality services;

b) Be in line with Revenue, Capital, Commissioning, Activity, Service, Quality, Performance, and Workforce plans contained within the Board approved balanced IMTP;

c) Take account of approved business cases and associated revenue costs and funding;

d) Be produced following discussion with appropriate Directors and budget holders;

e) Be prepared within the limits of available funds;

f) Take account of ring-fenced, specified and non-recurring allocations and funding;

g) Include both financial budgets (£) and workforce establishment budgets (budgeted whole-time equivalents)

h) Be within the scope of activities and authority defined by the National Health Service (Wales) Act 2006, including pooled budget arrangements;

i) Identify available reserves;

j) Take account of the principles of Well-being of Future Generations (Wales) Act 2015 including the seven Well-being Goals and the five ways of working; and

k) Identify potential risks and opportunities.

5.2. Budgetary Delegation

5.2.1 The Chief Executive may delegate, via the Director of Finance, the

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management of a budget to permit the performance of a defined range of activities, including pooled budget arrangements under Regulations made in accordance with section 33 of the National Health Service (Wales) Act 2006 (c. 42). This delegation must be in writing, in the form of a letter of accountability, and be accompanied by a clear definition of:

a) The amount of the budget;
b) The purpose(s) of each budget heading;
c) Individual or committee responsibilities;
d) Arrangements during periods of absence;
e) Authority to exercise virement;
f) Achievement of planned levels of service; and
g) The provision of regular reports.

The budget holder must sign the accountability letter formally delegating the budget.

5.2.2 The Chief Executive, Director of Finance and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

5.2.3 Budgets must only be used for the purposes designated, and any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

5.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Director of Finance.

5.2.5 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled and managed appropriately.

5.2.6 All budget holders will sign up to their allocated budgets at the commencement of the financial year.

5.2.7 The Director of Finance has a responsibility to ensure that appropriate and timely financial information is provided to budget holders and that adequate training is delivered on an on-going basis to assist budget holders managing their budgets successfully.

5.3. Financial Management, Reporting and Budgetary Control

5.3.1 The Director of Finance shall monitor financial performance against budget and plans and report the current and forecast position, and financial risks, on a monthly basis and at every Board meeting. Any

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significant variances should be reported to LHB Board as soon as they come to light and the Board shall be advised on any recommendations and action to be taken in respect of such variances.

5.3.2 The Director of Finance will devise and maintain systems of financial management, performance reporting and budgetary control. These will include:

a) Regular financial reports, for revenue and capital, to the Board in a form approved by the Board containing sufficient information for the Board to:

- Understand the current and forecast financial position
- Evaluate risks and opportunities
- Use insight to make informed decisions
- Be consistent with other Board reports, and as a minimum the reports will cover:
    - Current and forecast year end position on statutory financial duties
    - Actual income and expenditure to date compared to budget and showing trends and run rates
    - Forecast year end positions
    - A statement of assets and liabilities, including analysis of cash flow and movements in working capital.
    - Explanations of material variances from plan
    - Capital expenditure and projected outturn against plan
    - Investigations and reporting of variances from financial, activity and workforce budgets.
    - Details of corrective actions being taken, as advised by the relevant budget holder and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation;
    - Statement of performance against savings targets
    - Key workforce and other cost drivers
    - Income and expenditure run rates, historic trends, extrapolation and explanations
    - Clear assessment of risks and opportunities
- Provide a rounded and holistic view of financial and wider organisational performance.

b) The issue of regular, timely, accurate and comprehensible advice and financial reports to each delegated budget holder, covering the areas for which they are responsible;

c) An accountability and escalation framework to be established for the organisation to formally address material budget variances

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d) Investigation and reporting of variances from financial, activity and workforce budgets;

e) Monitoring of management action to correct variances;

f) Arrangements for the authorisation of budget transfers and virements.

5.3.3 Each Budget Holder will

- be held to account for managing services within the delegated budget
- investigate causes of expenditure and budget variances using information from activity, workforce and other relevant sources
- develop plans to address adverse budget variances.

5.3.4 Each Budget Holder is responsible for ensuring that:

a) Any likely overspending or reduction of income that cannot be met by virement is not incurred without the prior consent of the Chief Executive subject to the Board's scheme of delegation;

b) The amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised, subject to the rules of virement;

c) No permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and workforce establishment as approved by the Board.

5.3.5 The Chief Executive is responsible for identifying and implementing cost and efficiency improvements and income generation initiatives in accordance with the requirements of the Medium-Term Financial Plans and SFI 9.1.

5.4. Capital Financial Management, Reporting and Budgetary Control

5.4.1 The general rules applying to revenue Financial Management, Reporting and Budgetary Control delegation and reporting shall also apply to capital plans, budgets and expenditure subject to any specific reporting requirements required by the Welsh Ministers.

5.5 Reporting to Welsh Government - Monitoring Returns

5.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring returns are submitted to the Welsh Ministers in accordance with published guidance and timescales.

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Health boards and trusts financial monitoring guidance 2021 to 2022 (WHC 2021/011) | GOV.WALES

5.5.2 All monitoring returns must be supported by a detailed commentary signed by the Director of Finance and Chief Executive. This commentary should also highlight and quantify any significant risks with an assessment of the impact and likelihood of these risks maturing.

5.5.3 All information made available to the Welsh Ministers should also be made available to the Board. There must be consistency between the Medium-Term Financial Plan, budgets, expenditure, forecast position and risks as reported in the monitoring returns and monthly Board reports.

6. ANNUAL ACCOUNTS AND REPORTS

6.1 The Board must approve the LHB's annual accounts prior to submission to the Welsh Ministers and the Auditor General for Wales in accordance with the annual timetable.

6.2 The Chair and Chief Executive have responsibility for signing the accounts on behalf of the LHB. The Chief Executive has responsibility for signing the Annual Governance Statement and the Annual Quality Statement.

6.3 The Director of Finance, on behalf of the LHB, is responsible for ensuring that financial reports and returns are prepared in accordance with the accounting policies, guidance and timetable determined by the Welsh Ministers, as per Welsh Government's Manual for Accounts, and consistent with Financial Reporting Manual (FReM) and International Financial Reporting Standards.

6.4 The LHB's annual accounts must be audited by the Auditor General for Wales. The LHB's audited annual accounts must be adopted by the Board at a public meeting and made available to the public.

6.5 The LHB will publish an annual report, in accordance with guidelines on local accountability, and present it at its Annual General Meeting. The Board Secretary will ensure that the Annual Report is prepared in line with the Welsh Government's Manual for Accounts. The Annual Report will include

- The Accountability Report containing:
  - Corporate Governance Report
  - Remuneration Report and Staff Report
  - Accountability and Audit Report

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- The Performance Report, which must include:
  - An overview
  - A performance Analysis

7. BANKING ARRANGEMENTS

7.1 General

7.1.1 The Director of Finance is responsible for managing the LHB's banking arrangements and for advising the Board on the provision of banking services and operation of accounts. This advice will consider guidance/Directions issued from time to time by the Welsh Ministers. LHBs are required to use the Government Banking Service (GBS) for its banking services.

7.1.2 The Board shall approve the banking arrangements.

7.2 Bank Accounts

7.2.1 The Director of Finance is responsible for:

a) Establishing bank accounts and ensuring that the Government Banking Service is utilised for main Health Board business transactions;

b) Establishing additional commercial accounts only exceptionally and where there is a clear rationale for not utilising the Government Banking Service;

c) Establishing separate bank accounts for the LHB's non-exchequer funds;

d) Ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made;

e) Ensuring accounts are not overdrawn except in exceptional and planned situations.

f) Reporting to the Board all arrangements made with the LHB's bankers for accounts to be overdrawn;

g) Monitoring compliance with Welsh Ministers' guidance on the level of cleared funds.

7.2.2 With the exception of Project Bank Accounts, all bank accounts should be held in the name of the LHB. No officer other than the Director of

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Finance shall open any account in the name of the LHB or for the purposes of furthering LHB activities.

7.2.3 Any Project Bank Account that is required may be held jointly in the name of the LHB and the relevant third-party contractor.

7.3 Banking Procedures

7.3.1 The Director of Finance will prepare detailed instructions on the operation of bank accounts, that ensure there are sound controls over the day-to-day operation of bank accounts, which must include:

a) The conditions under which each bank account is to be operated;

b) Those authorised to sign cheques or other orders drawn on the LHB's accounts.

c) Effective divisions of duty for employees working within the banking and treasury management function to minimise the risk of fraud and error.

d) Authorised signatories are identified with sufficient seniority, and in the case of e banking approvers, together with an appropriate payment approval hierarchy.

e) Procedures are in place for prompt banking of money received.

f) Ensure there are physical security arrangements in place for cheque stationery, e-banking access devices and payment cards.

g) Cheques and payable orders are treated as controlled stationery with management responsibility given to a duly designated employee.

h) Frequent reconciliations are undertaken between cash books, bank statements and the general ledger so that all differences are fully understood and accounted appropriately.

i) Commercial bank accounts should only be used exceptionally where there is a sound rationale and demonstrates value for money. Commercial accounts should be procured through a tendering exercise and the outcome reported to the Audit Committee on behalf of the Board.

7.3.2 The Director of Finance must advise the LHB's bankers in writing of the conditions under which each account will be operated.

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7.3.3 The Director of Finance shall approve security procedures for any payable orders issued without a hand-written signature e.g. automatically printed. All Payable Orders shall be treated as controlled stationery, in the charge of a duly designated officer controlling their issue.

7.4 Review

7.4.1 The Director of Finance will review banking arrangements of the LHB at regular intervals to ensure they reflect best practice, that they are efficient and effective and represent best value for money. The results of the review should be reported to the Audit and Assurance Committee.

8. CASH, CHEQUES, PAYMENT CARDS AND OTHER NEGOTIABLE INSTRUMENTS

8.1 General

8.1.1 The Director of Finance is responsible for:

a) Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

b) Ordering and securely controlling any such stationery, ensuring all cash related stationery treated as controlled stationery with management responsibility given to a duly designated employee;

c) The provision of adequate physical facilities and systems for officers whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

d) Establishing systems and procedures for handling cash and negotiable securities on behalf of the LHB.

e) Ensuring effective control systems are in place for the use of payment cards,

f) Ensuring that there are adequate control systems in place to minimise the risk of cash/card misappropriation.

8.1.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs (informal documents acknowledging debt).

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8.1.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance.

8.1.4 The holders of safe/cash box combinations/keys shall not accept unofficial funds for depositing in their safe/cash box unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the LHB is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the LHB from responsibility for any loss.

8.1.5 The opening of coin operated machines (including telephone, if applicable) and the counting and recording of takings shall be undertaken by two officers together, except as may be authorised in writing by the Director of Finance and the coin box keys shall be held by a nominated officer.

8.1.6 During the absence (for example, on holiday) of the holder of a safe/cash box combination/key, the officer who acts in their place shall be subject to the same controls as the normal holder of the combination/key. There shall be written discharge for the safe and/or cash box contents on the transfer of responsibilities and the discharge document must be retained for inspection.

8.2 Petty Cash

8.2.1 The Director of Finance will issue instructions restricting the use and value of petty cash purchases.

8.2.3 Petty cash use should be minimised and be subject to regular cash balance reviews in order to minimise cash levels held.

8.2.3 Petty cash should be operated under an imprest system and be subject to regular checks to ensure physical and book cash levels are consistent.

9. INCOME, FEES AND CHARGES

9.1 Income Generation and Participation in/Formation of Companies

9.1.1 The LHB shall only generate income for those goods and services that are approved by the Welsh Ministers. Any income generating activities must be complementary to the provision of NHS services and must be in accordance with the Welsh Ministers' policy and powers to raise money as set out in section 169 of the National Health Service (Wales) Act 2006 (c. 42).

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9.1.2 The LHB can only form or participate in a company for income generation, improving health, healthcare care and health services, purposes with the consent and/or direction of Welsh Ministers. The LHB should obtain advice from Welsh Government officials prior to undertaking substantive work on formation or participation in any company.

9.2 Income Systems

9.2.1 The Director of Finance is responsible for designing and maintaining procedures to ensure compliance with systems for the proper recording, invoicing, and collection and coding of all monies due.

9.2.2 The Director of Finance is also responsible for ensuring that systems are in place for the prompt banking of all monies received.

9.3 Fees and Charges

9.3.1 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Welsh Ministers or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

9.3.2 All officers must inform the Director of Finance promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

9.4 Income Due and Debt Recovery

9.4.1 Delegated budget holders and managers are responsible for informing the Director of Finance of any income due that arises from any contracts, service levels agreements, leases, activities such as private patients or other transactions.

9.4.2 Delegated budget holders and managers must inform the Director of Finance when overpayment of salary or expenses have been made, in order that recovery can be made.

9.4.3 The Director of Finance is responsible for recovering income due and for ensuring debt recovery procedures are in place to secure early payment and minimise bad debt risk on all outstanding debts.

9.4.4 Income not received should be dealt with in accordance with losses procedures.

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9.4.5 Overpayments should be detected (or preferably prevented) and recovery initiated.

9.4.6 The Chief Executive and the Director of Finance are responsible for ensuring the Welsh Ministers' guidance on disputed debt arbitration is strictly adhered to.

10. NON-PAY EXPENDITURE

10.1 Scheme of Delegation, Non-Pay Expenditure Limits and Accountability

10.1.1 The Board must agree a Scheme of Delegation in line with that set out in its Standing Orders Scheme of Reservation and Delegation of Powers.

10.1.2 The Chief Executive will approve the level of non-pay expenditure and the operational scheme of delegation and authorisation to budget holders and managers within the parameters set out in the LHB's scheme of delegation.

10.9.1 The Chief Executive will set out in the operational scheme of delegation and authorisation:

- The list of managers who are authorised to place requisitions for the supply of goods, services and works and for the awarding of contracts; and
- The maximum level of each requisition and the system for authorisation above that level.

10.2 The Director of Finance's responsibilities

10.2.1 The Director of Finance will:

a) Advise the Board regarding the NHS Wales national procurement and payment systems thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds would be incorporated in SOs and SFIs;

b) Prepare procedural instructions or guidance within the Scheme of Delegation on non-pay expenditure;

c) Ensure systems are in place for the authorisation of all accounts and claims;

d) Ensure Directors and officers strictly follow NHS Wales system and procedures of verification, recording and payment of all

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amounts payable.

e) Maintain a list of Executive Directors and officers (including specimens of their signatures) authorised to certify invoices.

f) Be responsible for ensuring compliance with the Public Sector Payment policy ensuring that a minimum of 95 percent of creditors are paid within 30 days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed.

g) Ensure that where consultancy advice is being obtained, the procurement of such advice must be in accordance with applicable procurement legislation, guidance issued by the Welsh Ministers and SFIs;

h) Be responsible for Petty Cash system, procedures, authorisation and record keeping, and ensure purchases from petty cash are restricted in value and by type of purchase in accordance with procedures

10.3 Duties of Budget Holders and Managers

10.3.1 Budget holders and managers must ensure that they comply fully with the Scheme of Delegation, guidance and limits specified by the Chief Executive and Director of Finance, and that:

a) All contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of both any commitment being made and NWSSP Procurement Services being engaged;

b) Contracts above specified thresholds are advertised and awarded, through NWSSP Procurement Services, in accordance with EU and HM Treasury rules on public procurement;

c) Contracts above specified thresholds are approved by the Welsh Ministers prior to any commitment being made;

d) Goods have been duly received, examined and are in accordance with specification and order,

e) Work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct,

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f) No requisition/order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to Board members or LHB officers, other than:

(i) Isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars,

(ii) Conventional hospitality, such as lunches in the course of working visits;

This provision needs to be read in conjunction with Standing Order 8.5, 8.6 and 8.7.

g) No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;

h) All goods, services, or works are ordered on official orders

i) Requisitions/orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

j) Goods are not taken on trial or loan in circumstances that could commit the LHB to a future uncompetitive purchase;

10.3.2 The Chief Executive and Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance issued by the Welsh Ministers. The technical audit of these contracts shall be the responsibility of the relevant Director as set out in the LHB's scheme of delegation.

10.4 Departures from SFI's

10.4.1 Departing from the application of Chapters 10 and 11 of these SFI's is only possible in very exceptional circumstances. Health Boards must consult with NWSSP Procurement Services, Director of Finance and Board Secretary prior to any such action undertaken. Any expenditure committed under these departures must receive prior approval in accordance with the Health Board Scheme of Delegation.

10.5 Accounts Payable

10.5.1 NWSSP Finance, shall on behalf of the LHB, maintain and deliver detailed policies, procedures systems and processes for all aspects of accounts payable

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10.6 Prepayments

10.6.1 Prepayment should be exceptional, and should only be considered if a good value for money case can be made for them (i.e. that "need" can be demonstrated). Prepayments are only permitted where either:

- The financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to Net Present Value (NPV) using the National Loans Fund (NLF) rate plus 2%);
- It is the industry norm e.g. courses and conferences;
- In line with requirements of Managing Welsh Public Money
- There is specific Welsh Ministers' approval to do so e.g. voluntary services compact.

10.6.2 In **exceptional** circumstances prepayments can be made subject to:

a) The appropriate Executive Director providing, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the LHB if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments;

b) The Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (considering the Public Contracts Regulations 2015 where the contract is above a stipulated financial threshold); and

c) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

11. PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES

General Information

11.1 Procurement Services

11.1.1 While the Chief Executive is ultimately responsible for procurement the service is delivered by NWSSP Procurement Services.

11.1.2 Procurement staff are employed by NHS Wales Shared Services Partnership (NWSSP) and provide a procurement support function to all health organisations in NHS Wales. Although NWSSP is responsible for the provision of a Procure to Pay service and provision of appropriate professional procurement and commercial advice, ultimate

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responsibility for compliance with legislation and policy guidelines remains with the Health Board. Where the term Procurement staff or department is used in this chapter it should be read as equally applying to those departments where the procurement function is undertaken locally and outside of NWSSP Procurement Department, for example pharmacy and works who undertake procurement on a devolved basis.

11.2 Policies and Procedures

11.2.1 NWSSP Procurement Services shall, on behalf of the LHB, maintain detailed policies and procedures for all aspects of procurement including tendering and contracting processes. The policies and procedures shall comply with these SFIs, Procurement Manual, and the Revised General Consent to enter Individual Contracts. included as **Schedule 1** of these SFIs**.**

11.2.2 The Chief Executive is ultimately responsible for ensuring that the LHB's Executive Directors, Independent Members and officers within the organisation strictly follow procurement, tendering and contracting procedures.

11.2.3 NWSSP Director of Procurement Services is responsible for ensuring that procurement, tendering and contracting policies and procedures

- Are kept up to date;
- Conform to statutory requirements and regulations;
- Adhere to guidance issued by the Welsh Ministers;
- Are consistent with the principles of sustainable development.

11.2.4 All procurement guidance issued by the Welsh Ministers should have the effect as if incorporated in these SFIs.

11.3 Procurement Principles

11.3.1 The term "procurement" embraces the complete process from planning, sourcing to taking delivery of all works, goods and services required by the LHB to perform its functions, and furthermore embrace all building, equipment, consumables and services including health services. Procurement further embraces contract and/or supplier management, including market engagement and industry monitoring.

11.3.2 The main legal and governing principles guiding public procurement and which are incorporated into these SFIs are:

- Transparency: public bodies should ensure that there is openness and clarity on procurement processes and how they are implemented;

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- Non-discrimination: public bodies may not discriminate between suppliers or products on grounds of their origin;
- Equal treatment: suppliers should be treated fairly and without discrimination, including in particular equality of opportunity and access to information;
- Proportionality: requirements and conditions in the procurement should be reasonable in proportion to the object of procurement and measures taken should not go beyond what is necessary;
- Legality: public bodies must conform to European Community and other legal requirements;
- Integrity: there should be no corruption or collusion with suppliers or others;
- Effectiveness and efficiency: public bodies should meet the commercial, regulatory and socio-economic goals of government in a balanced manner appropriate to the procurement requirement;
- Efficiency: procurement processes should be carried out as cost effectively as possible and secure value for money.

11.4 Legislation Governing Public Procurement

11.4.1 There are a range of EU Directives which set out the EU legal framework for public procurement. These EU Directives have been implemented into UK law by statutory regulations which govern public sector procurement, the primary statutory regulations in Wales being 'The Public Contracts Regulations 2015 No. 102.' From 1 January 2021, all aspects of EU law in respect of the EU Directives relating to public procurement, except where expressly stated otherwise by domestic legislation, will continue to govern public sector procurement, although further amendments or developments of EU related procurement law following this will not be incorporated into domestic law. The Welsh Government policy framework and the Wales Procurement Policy Statement (WPPS) also govern this area. One of the key objectives of governing legislation is to ensure public procurement markets are open and that there is free movement of supplies, services and works. Legislation, policy and guidance setting out procedures for awarding all forms of regulated contracts shall have effect as if incorporated in the LHB's SFIs.

11.4.2 The main Regulations (the Public Contracts Regulations (2015 No. 102)) cover the whole field of procurement, including thresholds above which special and demanding procurement protocols and legal requirements apply. All Directors and their staff are responsible for seeing that those Regulations are understood and fully implemented. The protocols set out in the Regulations, and any Procurement Policy Notices, are the model upon which all formal procurement shall be based.

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11.4.3 Procurement advice should be sought in the first instance from Procurement Services. The commissioning of further specialist advice shall be jointly agreed between the LHB and Procurement Services e.g. Engagement of NWSSP Legal and Risk Services prior to 3rd party Legal Service providers.

11.4.4 Other relevant legislation and policy include:

- The Well-being of Future Generations (Wales) Act 2015
- Welsh Language (Wales) Measure 2011
- Modern Slavery Act 2015
- Bribery Act 2010
- Equality Act 2010
- Welsh Government's Code of Practice for Ethical Employment in Supply Chains.
- The Producer Responsibility Obligations (Packaging Waste) Regulations 2007
- Welsh Government 'Towards zero waste: our waste strategy'
- The Welsh Government Policy Framework
- The Wales Procurement Policy Statement (WPPS)

11.5 Procurement Procedures

11.5.1 To ensure that the LHB is fully compliant with UK Procurement Regulations, EU Procurement Directives and Welsh Ministers' guidance and policy, the LHB shall, through NWSSP Procurement Services, ensure that it shall have procedures that set out:

a) Requirements and exceptions to formal competitive tendering requirements;
b) Tendering processes including post tender discussions;
c) Requirements and exceptions to obtaining quotations;
d) Evaluation and scoring methodologies
e) Approval of firms for providing goods and services.

11.5.2 All procurement procedures shall reflect the Welsh Ministers' guidance and the LHB's delegation arrangements and approval processes.

11.6 Procurement Consent

11.6.1 Paragraph 13(3) of Schedule 2 to the National Health Service (Wales) Act 2006 places a requirement on LHBs to obtain the consent of the Welsh Ministers before:

- Acquiring and disposing of property;
- Entering into contracts; and
- Accepting gifts of property (including property to be held on trust, either for the general or any specific purposes of the LHB or for any

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purposes relating to the health service).

The provision allows the Welsh Ministers to give consent, which may be given in general terms covering one or more descriptions of case.

11.6.2 General Consent has been granted to LHBs by the Welsh Ministers for individual contracts up to the value of £1 million in each case with the exception of those contracts specified in SFI 11.6.4 All contracts exceeding this delegated limit, all acquisitions and disposals of land of any limit, and the acceptance of gifts of property, must receive the written approval of the Welsh Ministers before being entered into. In addition, Health Board's must provide a contract summary to Welsh Government for contracts between £500,000 and £1 million prior to the contract being let. This requirement also applies to contracts that are to be let through a mini-competition under a public sector contract framework, such as National Procurement Service, NHS Supply Chain or Crown Commercial Services. The use of suitable Welsh frameworks where access is permissible shall take precedence over frameworks led by Public Sector Bodies outside of Wales. Further detailed guidance is incorporated within the Procurement Procedures.

11.6.3 **Schedule 1** details the requirement and process for LHBs to obtain consent to enter into contracts exceeding £1m and monitoring arrangements for contracts below £1m.

11.6.4 The requirement for consent does not apply to any contracts entered into pursuant to a specific statutory power, and/or Welsh Ministers direction, and therefore does not apply to:

i) Contracts of employment between LHBs and their staff;
ii) Transfers of land or contracts effected by Statutory Instrument following the creation of the LHBs;
iii) Out of Hours contracts; and
iv) All NHS contracts, that is where one health service body contracts with another health service body.

11.6.5 The Revised General Consent does not remove the requirement for LHBs to comply with SOs, SFIs or to obtain any other consents or approvals required by law for the transactions concerned.

Planning

11.7 Sustainable Procurement

11.7.1 To further nurture the Welsh economy, in support of social, environmental and economic regeneration, Health Boards must also be mindful to structure requirements ensuring Welsh companies have the

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opportunity to transparently and fairly compete to deliver services regionally or across Wales where possible. The principles of the Well-being and Future Generations Act (Wales) 2015 (WBFGA 2015) should be adopted at the earliest stage of planning. Procurement solutions must be developed embracing the five ways of working described within the Act and capture how they will deliver against the seven goals set out in the Act.

11.7.2 The WBFGA 2015 requires that bodies listed under the act must operate in a manner that embraces sustainability. The Act requires public bodies in Wales to think about the long-term impact of their decisions, to work better with people, communities and each other, and to prevent persistent problems such as poverty, health inequalities and climate change.

11.7.3 The 7 Wellbeing goals are

- a prosperous Wales
- a resilient Wales
- a healthier Wales
- a more equal Wales
- a Wales of cohesive communities
- a Wales of vibrant culture and thriving Welsh language
- a globally responsible Wales.

These goals have been put in place to improve the social, economic, environmental, and cultural well-being of Wales

11.7.4 Public bodies need to make sure that when making their decisions they consider the impact they could have on people living their lives in Wales in the future. The Act expects them to:

- work together better
- involve people reflecting the diversity of our communities
- look to the long term as well as focusing on now
- take action to try and stop problems getting worse - or even stop them happening in the first place.

11.7.5 The LHB is required to consider the Welsh Government Guidance on Ethical Procurement and the new Code of Practice on ethical employment in supply chains which commits public, private and third sector organisations to a set of actions that tackle illegal and unfair employment practices including blacklisting, modern slavery and living wage.

11.7.6 The LHB shall make use of the tools developed by Value Wales in implementing the principles of the WBFGA 2015. The LHB shall benchmark its performance against the WBFGA 2015. For all contracts over £25,000, the LHB shall take account of social, economic and

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environmental issues when making procurement decisions using the Sustainable Risk Assessment Template (SRA).

11.8 Small and Medium Sized Enterprises (SMEs), Third Sector Organisations (TSOs) and Supported Factories and Businesses (SFBs)

11.8.1 In accordance with Welsh Government commitments policy set out in the current WPPS and subsequent versions of this statement the LHB shall ensure that it provides opportunities for these organisations to quote or tender for its business.

11.9 Planning Procurements

11.9.1 Health Boards must ensure that all staff with delegated budgetary responsibility or who are part of the procurement process for goods, services and works are aware of the legislative and policy frameworks governing public procurement and the requirement of open competition.

11.9.2 Depending on the value of the procurement, a process of planning the procurement must be undertaken with the Procurement Services and appropriate representative from the service and other appropriate stakeholders. The purpose of a planning phase is to determine:

- the likely financial value of the procurement, including whole life cost
- the likely 'route to market' which will consider the legislative and policy framework set out above.
- The availability of funding to be able to award a contract following a successful procurement process.
- That the procurement follows current legislative and policy frameworks including Value Based Procurement

11.9.3 The procurement specification should factor in the 4 principles of prudent healthcare:

- Equal partners through co-production;
- Care for those with the greatest health need first;
- Do only what is needed; and
- Reduce inappropriate variation.

Value based outcome/experience/delivery principles must also be included where appropriate ensuring best value for money, sustainability of services and the future financial position. Value for money is defined as the optimum combination of whole-life cost and quality to meet the requirement.

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11.9.4 Where free of charge services are made available to the Health Board, NWSSP Procurement Services must be consulted to ensure that any competition requirements are not breached, particularly in the case of pilot activity to ensure that the Health Board does not unintentionally commit itself to a single provider or longer-term commitment. Regular reports on free of charge services provided to the Health Board should be submitted by Board Secretary to Audit and Assurance Committee.

11.9.5 Health Boards are required to participate in all-Wales collaborative planning activity where the potential to do so is identified by the procurement professional involved in the planning process. Cross sector collaboration may also be required.

Joint or Collaborative Initiatives

11.9.6 Specialist advice should be obtained from Welsh Government and the opinions of NWSSP Procurement Services and NWSSP Legal and Risk prior to external opinion being sought where there is an undertaking to commence joint or collaborative initiatives which may be deemed as novel or contentious.

11.10 Procurement Process

11.10.1 Where there is a requirement for goods or services, the manager must source those goods or services from the Health Board's approved catalogue. Where a required item is not included within the catalogue, advice must be sought from the Procurement Services on opportunities to source those goods or services through public sector contract framework, such as National Procurement Service, NHS Supply Chain or Crown Commercial Services. The use of suitable Welsh frameworks where access is permissible shall take precedence over frameworks led by Public Sector Bodies outside of Wales.

11.10.2 In the absence of an existing suitable procurement framework to source the required item, a competition must be run in accordance with the table below. Health Boards must ensure the value of their requirement considers cumulative spend across the Health Board for like requirements and opportunity for collaboration with other Health Boards and Trusts:

11.10.3 Agreements awarded are required to deliver best value for money over the whole life of the agreement. Value for money is defined as the optimum combination of whole-life cost and quality to meet the requirement.

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Competition Requirements

11.11 Procurement Thresholds

11.11.1 The following table summarises the minimum thresholds for quotes and competitive tendering arrangements. The total value of the contract, whole life cost, over its entire period is the qualifying sum that should be applied (except in specific circumstances relating to aggregation and contracts of an indeterminate duration) as set out below, and in EU Procurement Directives and UK Procurement Regulations.

Goods/Services/Works **Whole Life Cost Contract value** **(excl. VAT)**	**Minimum competition[1]**	**Form of Contract**
<£5,000	Evidence of value for money has been achieved	Purchase Order
>£5,000 - <£25,000	Evidence of 3 written quotations	Simple Form of Contract/Purchase Order
>£25,000 – Prevailing OJEU threshold	Advertised open call for competition. Minimum of 4 tenders received if available.	Formal contract and Purchase Order
>OJEU threshold	Advertised open call for competition. Minimum of 5 tenders received if available or appropriate to the procurement route.	Formal contract and Purchase Order
Contracts above £1 million	Welsh Government approval required[2]	Formal contract and Purchase Order

[1] subject to the existence of suitable suppliers
[2] in accordance with the requirements set out in SFI 11.6.3.

11.11.2 Advice from the Procurement Services must be sought for all requirements in excess of £5,000.

11.11.3 The deliberate sub-dividing of contracts to fall below a specific threshold is strictly prohibited. Any attempt to avoid these limits may expose the Board to risk of legal challenge and could result in disciplinary action against an individual[s].

11.11.4 Deliberate re-engagement of a supplier, where the value of the individual engagement is less than £5,000, must not be undertaken where the total value of engagements taken as a whole would exceed

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£5,000 and require competition.

11.12 Designing Competitions

11.12.1 The budget holder or manager responsible for the procurement is required to engage with the Procurement team to ensure:

- Required timescales are achievable
- Specifications are drafted which:
  - are fit for inclusion in competition documents;
  - are drafted in a manner encouraging innovation by the market;
  - are capable of being responded to and do not narrow competition;
  - deliver in line with legislative and policy frameworks.
  - include robust performance measures to effectively measure and manage supplier performance; and
  - consider the ability of the market to deliver.

11.12.2 Appropriate performance measures are included in agreements awarded, thus ensuring best value for money decisions taken that return maximum benefit for the organisation and ultimately the improvement of patient outcomes and wider health and social care communities.

11.12.3 Criteria for selecting suppliers and achieving an award recommendation must:

- be appropriately weighted in consideration of quality/price;
- consider cost of change where relevant;
- be transparent and proportionate;
- deliver value for money outcomes;
- fully explore complexity/risk; and
- consider whole life cost.

11.13 Single Quotation Application or Single Tender Application

11.13.1 In exceptional circumstances, there may be a need to secure goods/services/works from a single supplier. This may concern securing requirements from a single supplier, due to a special character of the firm, or a proprietary item or service of a special character. Such circumstances may include:

- Follow-up work where a provider has already undertaken initial work in the same area (and where the initial work was awarded from open competition);
- A technical compatibility issue which needs to be met e.g. specific equipment required, or compliance with a warranty cover clause;
- a need to retain a particular contractor for genuine business

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continuity issues (not just preferences); or

- When joining collaborative agreements where there is no formal agreement in place. Request for such a departure must be supported by written evidence from the Procurement Service confirming local agreements will be replaced by an all Wales competition/National strategy.

11.13.2 Procurement Services must be consulted prior to any such application being submitted for approval. The Director of Finance must approve such applications up to £25,000, the Chief Executive or designated deputy, and Director of Finance, are required to approve applications exceeding £25,000. A register must be kept for monitoring purposes and all single tender actions must be reported to the Audit Committee.

11.13.3 In all applications, through Single Quotation Application or Single Tender Application (SQA or STA) forms, the applicant must demonstrate adequate consideration to the Chief Executive and Director of Finance, as advised by the Head of Procurement, that securing best value for money is a priority. The Head of Procurement will scrutinise and endorse each request to ensure:

- Robust justification is provided;
- A value for money test has been undertaken;
- No bias towards a particular supplier;
- Future competitive processes are not adversely affected;
- No distortion of the market is intended;
- An acceptable level of assurance is available before presentation for approval in line with the Health Board Scheme of Delegation; and
- An “or equivalent” test has been considered proving the request is justified.

11.13.4 Under no circumstances will Procurement Services endorse a retrospective SQA/STA, where the Health Board has already entered into an arrangement directly.

11.13.5 As SQA or STA are only used in exceptional circumstances the Health Board, through the Chief Executive, must report each, including the specifics of the exceptional circumstances and the total financial commitment, in sufficient detail to its Audit and Assurance Committee. The report will include any corrective action/advice provided by the Chief Executive, Director of Finance or NWSSP Director of Procurement Services to prevent recurrence by the Health Board.

11.13.6 The Audit and Assurance Committee may consider further steps to be

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appropriate, such as:

- Instruct a representative of the Health Board to attend Audit and Assurance Committee;
- Escalate to the Board;
- Request an internal Audit Review;
- Request further training or
- Take internal disciplinary action.

11.13.7 No SQA/STA is required where the seeking of competition is not possible, nor would the application of the SQA/STA procedure add value to the process/aid the delivery of a value for money outcome. Procurement Manual details schedule of departures from SQA/STA where competition not possible.

11.13.8 For performance monitoring purposes, the NWSSP Procurement Service will retain a central register of all such activity including SQA/STA's not endorsed by Procurement or any exceptional matters.

11.14 Disposals

11.14.1 Disposal of surplus, obsolete equipment/consumables is also subject to the competition rules.

11.14.2 Obsolete or condemned articles and stores, which may be disposed of in accordance with applicable regulations and law at the prevailing time (e.g. Waste Electrical and Electronic Equipment (WEEE)) and the procedures of the Health Board making use of any agreements covering the disposal of such items.

11.14.3 The Health Board must obtain the best possible market price.

Approval & Award

11.15 Evaluation, Approval and Award

11.15.1 The evaluation of competitions via quotation or tender, must be undertaken by a minimum of 2 evaluators from within the operational service of the Health Board. Evaluation Teams for competitions of greater complexity and value must be multi-disciplinary and reach a consensus recommendation for internal approval.

11.15.2 The internal approval of any recommendation to award a competition must follow the Board's Scheme of Delegation.

11.15.3 The communication of the external notification to the market to award the contract must be managed by the Procurement Service.

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11.15.4 Information throughout the process must be handled and retained as 'commercial in confidence' and not shared outside of staff directly involved in the competition process.

11.15.5 All associated communication throughout the competition process must also be managed by the Procurement Service.

Implementation & Contract Management

11.16 Contract Management

11.16.1 Contract Management is the process which ensures that both parties to a contract fully meet their respective obligations as effectively and efficiently as possible, in order to deliver the business and operational objectives required by the contract and in particular, to achieve value for money. The relevant budget holder, shall oversee and manage each contract on behalf of the LHB so as to ensure that these implicit obligations are met. This contract management will include:

- Retaining accurate records
- Monitoring contract performance measures
- Engaging suppliers to ensure performance delivery
- Implementing contractual sanctions in the event of poor performance in conjunction with advice from Procurement Services; and
- Permitting stage payments as part of a formally agreed implementation/delivery plan which must be supported by written evidence issued by the budget holder.

11.16.2 Contract management on All Wales contracts will be provided by NWSSP Procurement Services.

11.16.3 Advice on best practice on Contract Management is available from NWSSP Procurement Services.

11.17 Extending and Varying Contracts

11.17.1 Extending, modifying or varying the scope of an existing contract is possible, if the provision to do so was included as an option in the original awarded contract, e.g. scope of requirement, further expenditure due to unforeseen circumstances, change in regulatory requirements, etc.

11.17.2 If there is no such provision, the Public Contracts Regulations 2015 define such limitations.

11.17.3 The Public Contracts Regulations 2015 provide further constraints on

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this matter, under which modifications/variations/extensions are capped at 50% of the original award value.

11.17.4 Further approval is not required to extend an agreement beyond the original term/scope where prior approval was granted as part of the procurement process.

11.17.5 If there was no provision to extend, further approvals are required from the Health Board budget holder and the local Head of Procurement. Budget holders must also be mindful of the threshold under which the original contract was awarded. Any increase in the contract value may require a more senior level of approval in line with the Scheme of Delegation.

11.17.6 This ensures an appropriate identification and assessment of potential risks to the Health Boards compliance of approvals being granted within the Scheme of Delegation and assurance that value for money continues to be delivered from public funds.

11.17.7 The budget holder must seek advice from NWSSP Procurement Services in advance of committing further expenditure to ensure the contract is reflective of requirements. The budget holder must assess whether there is sufficient evidence to support the justification and whether the budget is available to support the additional requirements.

Transactional Processes

11.18 Requisitioning

11.18.1 The budget manager in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the LHB. The budget holder will source those goods or services from the approved catalogue. Where a required item is not included within the catalogue, advice must be sought from the Procurement Services on opportunities to source those goods or services through public sector contract framework, such as National Procurement Service, NHS Supply Chain or Crown Commercial Services.

11.18.2 Where a required item is not on catalogue or on framework contract the budget manager shall request the NWSSP Procurement Services to undertake quotation / tendering exercises on their behalf in line with SFI 11.11 thresholds.

11.18.3 All orders for goods and services must be accompanied by an official order number, available from the Procurement Department. In no circumstances must a requisition number be used as an order

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number.

11.19 No Purchase Order, No Pay

11.19.1 The Health Board will ensure compliance with the 'No Purchase Order, No Pay' policy, the All Wales policy which was introduced to ensure that Procure to Pay continues to provide world-class services on a 'Once for Wales' basis.

11.19.2 The policy ensures that a purchase order is raised at the beginning of a purchase in circumstances where a purchase order is required under the policy. This follows industry standard best practice as it provides a commitment as to what is likely to be spent. The supplier must obtain a purchase order number for their invoice in order for it to be processed for payment.

11.20 Official orders

11.20.1 Official Orders, issued following approved requisition and sourcing, must:

a) Be consecutively numbered;
b) State the LHB's terms and conditions of trade.

11.20.2 Official Orders will be issued on behalf of the Health Board by NWSSP Procurement Services.

12. HEALTH CARE AGREEMENTS AND CONTRACTS FOR HEALTH CARE SERVICES

12.1 Health Care Agreements

12.1.1 The Health Board will commission healthcare services for its resident population both internally, from its own LHB provided services, and externally, from other LHBs, Trusts and other providers. The Chief Executive is responsible for ensuring the LHB enters into suitable Health Care Agreements (or Individual Patient Commissioning Agreements, where appropriate) for the provision of health care services from external providers.

12.1.2 All Health Care Agreements should aim to implement the agreed priorities contained within the Integrated Medium-Term Plan and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should consider:

- The standards of service quality expected;
- The relevant quality, governance and risk frameworks and plans;
- The relevant national service framework (if any);

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- The provision of reliable information on quality, volume and cost of service; and
- That the agreements are based on integrated care pathways.

12.1.3 All agreements must be in accordance with the functions conferred on the LHB by the Welsh Ministers.

12.2 Statutory provisions

The National Health Service (Wales) Act 2006 (c. 42) enables Health Boards to commission certain healthcare services. The relevant sections under the Act are as follows:

- Section 7 sets out the definition of an NHS contract, being an arrangement under which one health service body arranges for the provision to it by another of goods or services which it reasonably requires for the purposes of its functions. It also provides a definition of a health service body;
- Section 9 sets out arrangements to be treated as NHS contracts for ophthalmic and pharmaceutical services;
- Section 32 makes provision in relation to services which can be provided to Health Boards by local authorities;
- Section 33 enables the Welsh Ministers to make provision which enables Health Boards and Local Authorities to enter into prescribed arrangements as to the provision of services which are in connection with specified circumstances, if they are likely to lead to an improvement in the way in which each of their functions are exercised;
- Part 4 enables Health Boards to plan for the provision of primary medical services;
- Part 5 enables Health Boards to plan for the provision of primary dental services;
- Part 6 enables Health Boards to plan for the provision of general ophthalmic services;
- Part 7 enables Health Boards to plan for the provision of pharmaceutical services;
- Section 188 enables the Welsh Ministers to make provision which enables Health Boards and the prison service to enter into prescribed arrangements as to the provision of services which are in connection with specified circumstances, if they are likely to lead to an improvement in the way in which each of their functions are exercised;
- Section 194 sets out the Health Boards powers to make payments towards expenditure on community services; and
- Section 195 sets out the conditions for payment where expenditure proposed under section 194 is in connection with services to be provided by a voluntary organisation.

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12.3 Reports to Board on Health Care Agreements (HCAs)

12.3.1 The Chief Executive will need to ensure that regular reports are provided to the Board detailing performance, quality and associated financial implications of all health care agreements with external providers. These reports will be linked to, and consistent with, other Board reports on commissioning and financial performance.

13 GRANT FUNDING

It is a matter for LHBs to determine whether individual activities should be procured, or be eligible to receive grant funding, seeking legal advice as necessary. (Grants are defined as all non-procured payments to external bodies or individuals for activities which are linked to delivering policy objectives and statutory obligations. Payments are made to fund or reimburse expenditure on agreed items or functions in accordance with legally binding conditions.)

13.1 Legal Advice

13.1.1 Before the award of funding is made, legal advice where necessary must be sought to ensure that:

- The award does not breach the LHBs functions or its regularity of expenditure duty (that is, the activities for which the grant is made are within the scope of activities that the LHB has a legal remit to undertake);
- The activities would not be deemed to be normally subject to procurement legislation and policy; and
- A legally binding agreement is made with all delivery organisations.

See attached toolkit for grants v procurement:

Grant v Procurement.doc

13.2 Policies and procedures

13.2.1 The LHB shall maintain detailed policies and procedures for all aspects of grant funding. The policies and procedures shall comply with these SFIs, and where appropriate the Welsh Government's Code of Practice to funding the third sector:

https://gov.wales/sites/default/files/publications/2019-01/third-sector-scheme-2014.pdf

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13.2.2 The Chief Executive is ultimately responsible for ensuring that the LHB's grant procedures:

- Are kept up to date;
- Conform to statutory requirements;
- Adhere to guidance issued by the Welsh Ministers;
- Are consistent with the principles of sustainable development; and
- Are strictly followed by all Executive Directors, Independent Members and staff within the organisation.

13.2.3 The award of grant funding must comply with the policy and principles set out in the Procurement section of these SFIs and ensure that the award meets the requirements of regularity, propriety and value for money.

13.2.4 All grant guidance issued by the Welsh Ministers should have the effect as if incorporated in these SFIs.

13.3 Corporate Principles underpinning Grants Management

13.3.1 While there is a need to make the financial arrangements for awarding funding as simple and streamlined as possible, LHBs should also ensure that taxpayers' money is spent appropriately and that it provides good value for money.

13.3.2 The overarching principles for managing public resources in Wales are set out in Managing Welsh Public Money .The document states that the award of funding should be made in accordance with the law and the requirements of propriety, regularity and value for money.

13.3.3 Regularity requires compliance with appropriate authorities, regulations and legislation. Propriety requires both public authorities and funded bodies to deliver appropriate standards of conduct, behaviour and corporate governance. In addition, the public expects official decisions to be made fairly and impartially with public money spent wisely and appropriately, delivering value for money and ensuring that best use is made of resources.

13.3.4 The **corporate principles** of grants management are:

- The development of grant management processes and procedures that are transparent, accountable, proportionate and consistent;
- The delivery of a high-quality regulatory framework that responds to demands but does not place unnecessary administrative burdens on LHBs or funded bodies;
- A regulatory framework that will take into consideration the need for proportionality, balancing the need for governance with the burden

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of administration, thus striking an appropriate balance between accountability and simplicity;

- An effective grant management process to ensure funded bodies spend the funding efficiently, transparently and for the purpose intended, with a view to maximising the impact and outcome from budgets;
- An appropriate evidence-based approach to underpin the design and development of all new funding programmes to ensure efficient and effective use of public funds, ensuring that the funding programme is the optimal solution and that funding is targeted where it is most needed and where it can have most impact;
- A consistent framework that will reinforce respect and effectiveness of the rules for both administrators and funded bodies; and
- Compliance of the grant funding with State aid requirements in accordance with the State aid rules.

13.4 Grant Procedures

13.4.1 It is vital that money is put to use in a way that delivers the maximum benefit to the people of Wales. Grants funding programmes need to be managed as efficiently and cost effectively as possible to make sure that every penny is spent appropriately and in an accountable manner. When establishing grant funding programmes, LHBs should ensure principles of good practice available from a number of external sources are considered and reflected in grant programmes. Information on grants management is available on the Audit Wales website at:

Grants management mini-guides | Audit Wales

13.4.2 Health Boards must agree a clear purpose for each grant and how it will measure the delivery organisation's success in delivering those purposes. It should also agree appropriate targets with the delivery organisation.

13.4.3 For grant programmes that span a number of financial years, the LHB is responsible for evaluating the programmes to ensure they are fit for purpose, achieving required outcomes and continue to provide value for money.

13.4.4 LHBs are responsible for ensuring that appropriate procedures exist in relation to all the grants and funding for which they are accountable. **They are also responsible for ensuring that any grant provided to an entity that engages in economic activity complies with the State aid rules.**

13.4.5 LHBs are required to undertake due diligence checks on all potential delivery organisations to determine the economic and financial viability

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of any organisation(s) to administer public funds, and the reliability of the organisation(s). These checks are important in order to identify any risks or issues that could expose the LHB to potential financial loss, fraud or reputational damage. A proportionate level of due diligence should be carried out, both prior to the award of any grant funding and throughout the life of the award.

13.4.6 The LHB must enter into legally binding funding agreements with all delivery organisations. When developing funding agreements, the LHB should ensure principles of good practice available from a number of external sources are considered and reflected.

13.4.7 The LHB is responsible for ensuring that all third-party delivery organisations comply with and adhere to the terms and conditions of the Funding Agreement.

14. PAY EXPENDITURE

14.1 Remuneration and Terms of Service Committee

14.1.1 In accordance with SOs the Board shall establish a Remuneration and Terms of Service Committee, with clearly defined terms of reference and operating arrangements that specify which posts fall within its area of responsibility. This Standing Financial Instruction should be read in conjunction with Standing Order 3.4.

14.1.2 The Committee shall report in writing to the Board the basis for its recommendations. The Board shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of Directors and other senior employees, in accordance with the framework set by the Welsh Ministers. Minutes of the Board's meetings should record such decisions.

14.1.3 The Board will, after due consideration and amendment if appropriate approve proposals presented by the Chief Executive for the setting of remuneration and terms of service for those employees and officers not covered by the Committee.

14.1.4 The LHB will remunerate the Chair, Chief Executive, Executive Directors and Independent Members of the Board in accordance with instructions issued by the Welsh Ministers. Welsh Ministers approval will be required in the exceptional event that remuneration needs to be above the maximum of the salary band range, administratively this approval will be exercised by the Director General HSSG.

14.1.5 The Remuneration and Terms of Service Committee will consider

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cases of redundancy and Voluntary Early Release applications. The Remuneration and Terms of Service Committee will consider any novel employment and pay cases, such as compromise agreements and non-disclosure agreements, ensuring Welsh Government advice has been sought and considered.

14.2 Funded Establishment

14.2.1 The workforce plans incorporated within the approved Integrated Medium-Term Plan will form the funded establishment, i.e., the budget for all approved posts. (The financial budgets (£) and workforce establishment budgets (budgeted whole-time equivalents) as per SFI 5.1.1 g)

14.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive or an officer with delegated authority.

14.3 Staff Appointments

14.3.1 Staff must only be engaged by authorised managers, in accordance with the Board's Scheme of Delegation. The engagement must be within the approved budget and funded establishment.

14.3.2 No Board member or LHB official may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration outside the limit of their approved budget and funded establishment unless authorised to do so by the Chief Executive.

14.4 Pay Rates and Terms and Conditions

14.4.1 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for employees in accordance with pay, terms and conditions set out in Ministerial directions on Agenda for Change and Medical and Dental pay, and any staff with pre-existing terms and conditions of service, following a TUPE transfer into employment or ad hoc salaried staff.

14.4.2 The Remuneration Committee will determine pay rates and conditions of services for board members, and other senior employees, in accordance with ministerial instructions.

14.5 Payroll

14.5.1 The Director of People and Culture, has responsibility for securing an

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efficient, well-controlled payroll service from NHS Wales Shared Services Partnership that:

- pays the correct staff with the correct amount,
- all payments are supported by properly authorised documentation.

14.5.2 The Director of People and Culture is responsible for:

a) The control framework and detailed procedures which are in place to:
   - To ensure all payments comply with HMRC, Pensions Agency and other regulation in relation to the deduction and payment of tax, national insurance, pension or other payments,
   - reduce the risk of fraud and error within the payroll function.

b) Specifying timetables for submission of properly authorised time records and other notifications;

c) The final determination of pay and allowances including verification that the rate of pay and relevant conditions of service are in accordance with current agreements;

d) Agreeing the timing and method of payment with the payroll service;

e) Authorising the release of payroll data where in accordance with the provisions of the applicable Data Protection Legislation (the Data Protection Act 2018 and the UK General Data Protection Legislation;

f) Verification and documentation of data;

g) The timetable for receipt and preparation of payroll data and the payment of employees and allowances;

h) Maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

i) Security and confidentiality of payroll information;

j) Checks to be applied to completed payroll before and after payment; and

k) A system to ensure the recovery from those leaving the employment of the LHB of sums of money and property due by them to the LHB.

14.5.3 The Chief Executive is responsible for:

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a) Ensuring that arrangements for a payroll service from NHS Wales Shared Services Partnership (NWSSP) is supported by appropriate Service Level Agreements, terms and conditions, adequate internal controls and internal audit review procedures;

b) Ensuring a sound system of internal control and audit review of any internally provided payroll service; and

c) Maintenance and/or the authorisation of regular and independent reconciliation of pay control accounts.

14.5.4 Appropriately nominated managers have delegated responsibility for:

a) Submitting time records, and other notifications in accordance with agreed timetables;

b) Completing time records and other notifications in accordance with the Service Level Agreements; and

c) Submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Director of People and Culture and/or Chief Executive must be informed immediately. In circumstances where fraud is suspected, this must be reported to the Director of Finance.

14.6 Contracts of Employment

14.6.1 The Director of People and Culture must:

a) Ensure that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and

b) Deal with variations to, or termination of, contracts of employment.

15. CAPITAL PLAN, CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

15.1 Capital Plan

15.1.1 Capital plans, and annual capital programmes, must be approved by the Board before the commencement of a financial year and should be

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in line with the objectives set out in the approved Integrated Medium-Term Plan (IMTP) for the organisation. The actual capital plan and programmes must be delivered within Welsh Government capital finance resource limits.

15.1.2 The Director of Planning (or nominated responsible director) will develop a capital plan, and detailed capital programme, for the organisation that sets out a detailed capital investment plan to support the objectives set out in the IMTP. The capital programme must be affordable and within the capital allocations, as set out in the Welsh Government (WG) Capital Resource Limit for the year, and the LHB must not exceed the allocation resource limit. There must be an approved revenue funding plan in place to support any revenue costs associated with the capital plan. Regular updates must be provided to the Board, and relevant Board Committees, during the financial year.

15.1.3 The Board must approve a three-year Capital Plan, and an annual Capital Programme, as set out in the Integrated Medium-Term Plan and Budgetary Control chapters of these SFI.

15.2 Capital Investment Decisions

15.2.1 Robust business case and capital investment appraisal must be undertaken prior to formal submission to Welsh Government, the level of detail within the appraisal commensurate with the value and risk of the investment. Capital investment decisions should be undertaken in line with Welsh Government requirements and guidance for the development of business cases as set out in:

- NHS Wales Infrastructure Investment Guidance (Welsh Health Circular WHC (2018) 043)
  - https://gov.wales/sites/default/files/publications/2020-03/nhs-wales-infrastructure-investment-guidance.pdf
- Better business cases: investment decision-making framework
  - https://gov.wales/better-business-cases-investment-decision-making-framework

15.2.2 The Director of Finance must provide a professional opinion on the financial elements of the business case. Capital investment decisions will be taken by the organisation in line with the financial thresholds specified by Welsh Government and in the Health Board's Scheme of Delegation.

15.3 Capital Projects

15.3.1 The Chief Executive shall ensure that any capital investment above the Welsh Ministers' delegated limit is not undertaken without approval of the Welsh Ministers and that formal confirmation of capital resources

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has been received.

15.3.2 When capital investment decisions are taken and a Capital Programme is approved the project cannot be initiated until the authority to commit expenditure is formally delegated to a manager, in line with the organisation's Scheme of Delegation. The capital project must then be procured in line with normal procurement procedures or the Designed for Life or other approved procurement framework and in line with Welsh Government requirements and guidance and the applicable procurement legislation. Management control and financial reporting systems must be established to ensure that the project is:

- delivered on time;
- on budget; and
- within contractual obligations.

15.3.3 Project management controls and financial reporting systems must be established to ensure these objectives are met. Reporting requirements to Welsh Government will be set out in the approval letter provided post Ministerial approval.

15.3.4 Regular updates must be provided to the Board, and relevant Board Committees, during the financial year.

15.4 Capital Procedures and Responsibilities

15.4.1 The Chief Executive:

a) Shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon plans;

b) Is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

c) Shall ensure that any capital investment above the Welsh Ministers' delegated limit is not undertaken without approval of the Welsh Ministers and that confirmation of capital resources has been received;

d) Shall ensure that the three-year Capital Plan, and detailed annual Capital Programme, is approved by the Board, as part of the IMTP, prior to the commencement of the financial year;

e) Shall ensure the availability of resources to finance all revenue consequences of the investment, including capital charges; and

f) Shall ensure that any 3rd party use of NHS estate is properly

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controlled, reimbursed and reported. This will include ensuring that appropriate security, insurance and indemnity arrangements are in place and that there is a written agreement as to each party's responsibilities and liabilities.

15.4.2 For every capital expenditure proposal, the Chief Executive shall ensure:

a) That a business case is produced in line with Welsh Ministers' guidance and where appropriate the 5-case Model;

b) That the Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case and involved appropriate LHB personnel and external agencies in the process.

15.4.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management in accordance with the Welsh Ministers' guidance.

15.4.4 The approval of a capital programme by the Health Board shall not constitute approval for the initiation of expenditure on any scheme.

15.4.5 The Chief Executive shall issue to the manager responsible for any scheme:

a) Specific authority to commit expenditure;

b) Authority to proceed to tender; and

c) Approval to accept a successful tender.

15.4.6 The Chief Executive will issue a scheme of delegation for capital investment management in accordance with the Welsh Ministers' guidance and the LHB's SOs.

15.4.7 The Director of Planning and Director of Finance shall issue detailed procedures governing the project, financial and contractual management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully consider the requirements and delegated limits for capital schemes set out in Welsh Ministers' guidance and approval letters. The procedures will also cover post project benefits realisation to ensure benefits set out in the business case supporting the investment are delivered. The Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

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15.4.8 The Director of Finance shall ensure, for each capital project over £2m, that the Welsh Government Project Bank Accounts policy is applied unless there are compelling reasons not to do so. The Director of Finance should apply to Welsh Government officials for exemption from use of Project Bank Accounts, setting out the compelling reasons.

15.5 Capital Financing with the Private Sector

15.5.1 The LHB must not enter into any new capital financing arrangements with the private sector, including Private Financing Initiatives, Mutual Investment Model and 3rd Party Developments, without the consent of the Welsh Ministers.

15.6 Asset Registers

15.6.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Planning and Director of Finance, concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted periodically.

15.6.2 The LHB shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be in accordance with the Welsh Ministers' guidance and to satisfy the financial disclosure requirements for the Annual Accounts.

15.6.3 Additions to the fixed asset register must be clearly identified to the operational or departmental manager or delegated budget holder and be validated by reference to appropriate documentation to provide evidence of the financial value recorded, including:

a) Properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

b) Stores, requisitions and wages records for own materials and labour including appropriate overheads; and

c) Lease agreements in respect of assets held under a finance lease and included on the LHB's balance sheet.

15.6.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate). Disposal receipts are to be treated in accordance with the Welsh Ministers' guidance and clearly set out in

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the over-arching business case.

15.6.5 The Director of Finance shall apply accounting policies for fixed assets in line with Welsh Government guidance and accounting standards and values recorded in the asset register, including depreciation and revaluations. The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in general ledgers against balances on fixed asset registers.

15.6.6 The value of each asset, and depreciation, shall be considered annually in accordance with valuation guidance and methods specified by the Welsh Ministers. Assets should be considered for early revaluation where there is the likelihood of impairment as a result in a change of valuation or asset life.

15.7 Security of Assets

15.7.1 The overall control of fixed assets is the responsibility of the Chief Executive.

15.7.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance. This procedure shall make provision for:

a) Recording managerial responsibility for each asset;

b) Identification of additions and disposals;

c) Identification of all repairs and maintenance expenses;

d) Physical security of assets;

e) Regular verification of the existence of, condition of, and title to, assets recorded;

f) Identification and reporting of all costs associated with the retention of an asset; and

g) Reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

15.7.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Planning and Director of Finance.

15.7.4 Whilst individual officers have a responsibility for the security of

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property of the LHB, it is the responsibility of Board members and senior LHB officers in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

15.7.5 Any damage to the LHB's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and LHB officers in accordance with the procedure for reporting losses.

15.7.6 Where practical, assets should be marked as LHB property.

16. STORES AND RECEIPT OF GOODS

16.1 General position

16.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

a) Kept to a minimum;
b) Subjected to annual stock take; and
c) Valued at the lower of cost and net realisable value.

16.2 Control of Stores, Stocktaking, condemnations and disposal

16.2.1 Subject to the responsibility of the Director of Finance for the systems of financial control, overall responsibility for the control of stores shall be delegated to a senior officer by the Chief Executive. The day-to-day responsibility may be delegated by them to departmental officers/managers and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Manager; the control of any fuel oil and coal of a designated estates manager.

16.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Manager. Wherever practicable, stocks should be marked as health service property.

16.2.3 The Director of Finance is responsible for developing financial control systems and procedures for the regulation and operation of the stores, to include the accounting arrangements for receipt, issues, and returns of goods to stores, and losses.

16.2.4 Stocktaking arrangements shall be agreed with the Director of Finance

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and there shall be a physical check covering all items in store at least once a year.

16.2.5 Where a complete system of controlled stores is not justified, alternative stores arrangements shall require the approval of the Director of Finance.

16.2.6 The designated officer/manager shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated officer/manager shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI 17, Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

16.3 Goods supplied by an NHS supplies agency

16.3.1 For goods supplied via NHS Wales Shared Services Partnership – Procurement Services (NWSSP-PS) or any other NHS purchasing and supplies agency central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Director of Finance or authorised officer who shall satisfy himself that the goods have been received before accepting the recharge.

17. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

17.1 Disposals and Condemnations

17.1.1 The Director of Finance must prepare detailed procedures for the disposal of assets and goods, including condemnations, and ensure that these are notified to managers.

17.1.2 When it is decided to dispose of an LHB asset and goods, the head of department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

17.1.3 All unserviceable assets and goods shall be:

a) Condemned or otherwise disposed of by an officer, the Condemning Officer, authorised for that purpose by the Director of Finance;

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b) Recorded by the Condemning Officer in a form approved by the Director of Finance which will indicate whether the assets and goods are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second officer authorised for the purpose by the Director of Finance.

17.1.4 The Condemning Officer shall satisfy themselves as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

17.2 Losses and Special Payments

17.2.1 Losses and special payments are items that the Welsh Government would not have contemplated when it agreed funds for NHS Wales or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments, and special notation in the accounts to draw them to the attention of the Welsh Government.

17.2.2 The Director of Finance is responsible for ensuring procedural instructions on the recording of and accounting for losses and special payments are in place; and that all losses or special payments cases are properly managed in accordance with the guidance set out in the Welsh Government's Manual for Accounts.

17.2.3 Any officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and/or the Director of Finance or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Director of Finance and/or the Chief Executive.

17.2.4 Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Director of Finance must inform the Local Counter Fraud Specialist (LCFS) and the CFS Wales Team in accordance with Directions issued by the Welsh Ministers on fraud and corruption.

17.2.5 The Director of Finance or the LCFS must notify the Audit and Assurance Committee, the Auditor General's representative and the fraud liaison officer within the Welsh Government's Health and Social Services Group Finance Directorate of all frauds.

17.2.6 For losses apparently caused by theft, arson, neglect of duty or gross

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carelessness, except if trivial, the Director of Finance must notify:

a) The Audit and Assurance Committee on behalf of the Board, and

b) An Auditor General's representative.

17.2.7 The Director of Finance shall be authorised to take any necessary steps to safeguard the LHB's interests in bankruptcies and company liquidations.

17.2.8 The Director of Finance shall ensure all financial aspects of losses and special payments cases are properly registered and maintained on the centralised Losses and Special Payments Register and that 'case write-off' action is recorded on the system (i.e. case closure date, case status, etc.).

17.2.9 The Audit and Assurance Committee shall approve the writing-off of losses or the making of special payments within delegated limits determined by the Welsh Ministers and as set out by Welsh Government in its Losses and Special Payments guidance as detailed in Schedule 3 of the SOs.

17.2.10 For any loss or special payments, the Director of Finance should consider whether any insurance claim could be made from the Welsh Risk Pool or from other commercial insurance arrangements.

17.2.11 No losses or special payments exceeding delegated limits shall be authorised or made without the prior approval of the Health and Social Services Group Director of Finance.

17.2.12 All novel, contentious and repercussive cases must be referred to the Welsh Government's Health and Social Services Group Finance Directorate, irrespective of the delegated limit.

17.2.13 The Director of Finance shall ensure all losses and special payments are reported to the Audit and Assurance Committee at every meeting.

17.2.14 The LHB must obtain the Health and Social Services Group Director General's approval for special severance payments.

18. DIGITAL, DATA and TECHNOLOGY

18.1 Digital Data and Technology Strategy

18.1.1 The Board shall approve a Digital Data and Technology Strategy which sets out the development needs of the LHB for the medium term based on an appropriate assessment of risk. The Integrated Medium-Term

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Plan shall include costed implementation plans of the strategy. The Board shall also ensure that a Director has responsibility for Digital Data and Technology.

18.1.2 The LHB shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about the LHB that are made publicly available.

18.2 Responsibilities and duties of the responsible Director

18.2.1 The responsible Director for Digital Data and Technology has responsibility for the accuracy, availability and security of the LHB digital systems and data and shall:

a) Devise and implement any necessary procedures to ensure adequate (reasonable) protection and availability of the LHB's digital systems and data, for which they are responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Network and Information Systems Regulations 2018, the UK General Data Protection Legislation and any relevant domestic law considerations via the Data Protection Act 2018;

b) Ensure that, following risk assessment of threats, adequate (reasonable) controls exist over access to systems, data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

c) Ensure that an adequate management (audit) trail is maintained of access to digital systems and data and that such audit reviews as the Director may consider necessary to meet the organisational requirements under the Network and Information System Regulations 2018 are being carried out;

d) Shall ensure that policies, procedures and training arrangements are in place to ensure compliance with information governance law and the Network and Information System Regulations 2018; and

e) Shall ensure comprehensive incident reporting.

18.3 Responsibilities and duties of the Director of Finance

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18.3.1 The Director of Finance shall need to ensure that new financial data and systems, and amendments to current financial data and systems, are developed in a controlled manner and thoroughly tested prior to implementation and business as usual phases. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation and business as usual phases.

18.4 Contracts for data and digital services with other health bodies or outside agencies

18.4.1 The responsible Director for Digital Data and Technology shall ensure that contracts for data and digital services for clinical, management and financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for

- the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage, and
- the availability of the service including the resilience required to maintain continuity of the service.

The contract should also ensure rights of access for audit purposes.

18.4.2 Where another health organisation or any other agency provides a data or digital service for clinical, management and financial applications, the responsible Director for Digital Data and Technology shall, to maintain the confidentiality, integrity and availability of the service provided, periodically seek assurances that adequate controls, based on risk assessment, are in operation.

18.5 Risk assurance

18.5.1 The responsible Director for Digital Data and Technology shall ensure that the risks to the LHB arising from the use of data, information and digital are effectively identified and considered and that appropriate action is taken to mitigate or control risk. This shall include the preparation and testing of appropriate resilience plans, including both a business continuity and disaster recovery plan.

19. PATIENTS' PROPERTY

19.1 LHB Responsibility

19.1.1 The LHB has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of patients that lack capacity, or found in the possession of patients' dead on arrival.

19.1.2 Where the Welsh Ministers' instructions require the opening of

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separate accounts for patient monies, these shall be opened and operated under arrangements agreed by the Director of Finance.

19.1.3 In all cases where property, including cash and valuables, of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates (Small Payments) Act 1965 (c. 32)), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

19.1.4 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

19.1.5 Where patient property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

19.2 Responsibilities of the Chief Executive

19.2.1 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission, that the Health Board will not accept responsibility or liability for patient property brought onto health service premises, unless it is handed in for safe custody and a copy of an official patient property record is retained as a receipt, by:

a) Notices and information booklets;

b) Hospital admission documentation and property records; and

c) The oral advice of administrative and nursing staff responsible for admissions.

19.3 Responsibilities of the Director of Finance

19.3.1 The Director of Finance must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patient property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

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20. FUNDS HELD ON TRUST (CHARITABLE FUNDS)

20.1 Corporate Trustee

20.1.1 Paragraph iii of Section A to the SOs refers to the LHB having specified powers to act as corporate trustee for the management of funds it holds on trust (charitable funds). SFI 20.2 defines the need for compliance with Charities Commission latest guidance and best practice.

20.1.2 The discharge of the LHB's corporate trustee responsibilities for funds held on trust are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

20.1.3 The LHB shall establish a Charitable Funds Committee as set out in Standing Order 3.4 to ensure that each fund held on trust which the LHB is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

20.2 Accountability to Charity Commission and the Welsh Ministers

20.2.1 The trustee responsibilities must be discharged separately and full recognition given to the LHB's dual accountabilities to the Charity Commission for charitable funds and to the Welsh Ministers for exchequer funds.

20.2.2 The Schedule of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Board members and LHB officers must take account of that guidance before taking action.

20.2.3 The LHB shall make appropriate arrangements for the Annual Accounts and audit of Funds held on Trust in accordance with Charity Commission requirements.

20.3 Applicability of Standing Financial Instructions to funds held on Trust

20.3.1 In so far as it is possible to do so, most of the sections of these SFIs will apply to the management of funds held on trust.

20.3.2 The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

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21. RETENTION OF RECORDS

21.1 Responsibilities of the Chief Executive

21.1.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with the Welsh Ministers' guidance, the UK General Data Protection Legislation and any relevant domestic law considerations via the Data Protection Act 2018, and the Freedom of Information Act 2000 (c. 36).

21.1.2 The records held in archives shall be capable of retrieval by authorised persons.

21.1.3 Records held shall only be destroyed in accordance with the applicable data protection laws and at the express instigation of the Chief Executive. Details shall be maintained of records so destroyed.

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Report Title:	**HIA Draft Opinion & Annual Report 21-22**				Agenda Item no.	7.8	
Meeting:	Board		Public	X	Meeting Date:	26/05/22	
			Private				
Status *(please tick one only):*	Assurance	X	Approval		Information		X
Lead Executive:	Director of Corporate Governance						
Report Author (Title):	Head of Internal Audit						

Main Report
Background and current situation:

In accordance with the Public Sector Internal Audit Standards (PSIAS), the Head of Internal Audit (HIA) is required to provide an annual opinion, based upon and limited to the work performed on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.

This is achieved through delivery of an audit plan that has been focused on key strategic and operational risk areas and known improvement opportunities. The 2021/22 plan was formally approved by the Audit and Assurance Committee at its April 21 meeting.

The draft Annual Report sets out the draft HIA Opinion together with the summarised results of the internal audit work performed during the year. The report also includes a summary of audit performance and an assessment of conformance with the Public Sector Internal Audit Standards.

The report also details the outcome of audits undertaken at NWSSP, DHCW, WHSSC and EASC that support the overall opinion for the Health Board.

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

The draft HIA Opinion for 21/22 is that 'The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively'.

From the individual audits completed at the time of producing the draft Annual Report, the following final / draft ratings have been provided:

- 6 Substantial Assurance
- 10 Reasonable Assurance
- 7 Limited Assurance.
- 3 advisory or non-opinion

The Report also includes details of the 12 audits that have been removed or deferred from the plan during 2021/22, as reported to the Audit & Assurance Committee. These audits and the reason for their removal / deferment have been considered when compiling the draft HIA Opinion.

The draft Annual Report includes a number of highlighted areas where reference is made to reports that were in draft and audits that were work in progress (WiP) at the time of writing. These will be updated to reflect the position when the final HIA Opinion and Annual Report are produced and submitted to the Audit & Assurance Committee and Board in June 2022.

Mohamud Salah 05/12/2021 16:56:39

The HIA Opinion will need to be reflected within the Health Board's Annual Governance Statement along with confirmation of action planned to address the issues raised. Particular focus should be placed on the agreed response to the 7 Limited Assurance opinions issued during the year and the significance of the recommendations made.

Recommendation:
The Board are requested to: • **Consider and note** the Draft Head of Internal Audit Opinion and Annual Report for 2021/22.

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

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

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes/~~No~~
The Annual Report provides the Board with a level of assurance around the management of a series of risks covered within the specific audit assignments delivered as part of the Internal Audit Plan. The report also provides information regarding the areas requiring improvement and assigned assurance ratings.
Safety: Yes/No
Financial: Yes/No
Workforce: Yes/No
Legal: Yes/No
Reputational: Yes/No
Socio Economic: Yes/No
Equality and Health: Yes/No

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

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Head of Internal Audit Opinion & Annual Report 2021/2022

May 2022

Cardiff & Vale University Health Board

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Appendix A Conformance with Internal Audit Standards
Appendix B Audit Assurance Ratings

Report status:	Draft
Draft report issued:	26 April 2022
Final report issued:	XX May 2022
Author:	Head of Internal Audit
Executive Clearance:	Director of Corporate Governance
Audit Committee:	XX June 2022

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Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Cardiff and Vale University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Mohamed Ibrahim 05/13/2022 8:16:25

1. EXECUTIVE SUMMARY

1.1 Purpose of this Report

Cardiff and Vale University Health Board's (Health Board) Board is accountable for maintaining a sound system of internal control that supports the achievement of the organisation's objectives and is also responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system. A key element in that flow of assurance is the overall assurance opinion from the Head of Internal Audit.

This report sets out the Head of Internal Audit Opinion together with the summarised results of the internal audit work performed during the year. The report also includes a summary of audit performance and an assessment of conformance with the Public Sector Internal Audit Standards.

As a result of the continued impact of COVID-19 our audit programme has been subject to significant change during the year. In this report we have set out how the programme has changed and the impact of those changes on the Head of Internal Audit opinion.

1.2 Head of Internal Audit Opinion 2021-22

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Chief Executive as Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the system of internal control. The approved Internal Audit plan is focused on risk and therefore the Board will need to integrate these results with other sources of assurance when making a rounded assessment of control for the purposes of the Annual Governance Statement. The overall opinion for 2021/22 is that:

Reasonable assurance		The Board can take **Reasonable Assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.

1.3 Delivery of the Audit Plan

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Due to the considerable impact of COVID-19 on the Health Board, the internal audit plan has needed to be agile and responsive to ensure that key developing risks are covered. As a result of this approach, and with the support of officers and independent members across the Health Board, the plan has been delivered substantially in accordance with the agreed

schedule and changes required during the year, as approved by the Audit and Assurance Committee (the 'Committee'). In addition, regular audit progress reports have been submitted to the Committee. Although changes have been made to the plan during the year, we can confirm that we have undertaken sufficient audit work during the year to be able to give an overall opinion in line with the requirements of the Public Sector Internal Audit Standards.

The Internal Audit Plan for 2021/22 year was initially presented to the Committee in April 2021. Changes to the plan have been made during the course of the year and these changes have been reported to the Committee as part of our regular progress reporting.

There are, as in previous years, audits undertaken at NWSSP, DHCW, WHSSC and EASC that support the overall opinion for NHS Wales health bodies (see section 3).

Our latest External Quality Assessment (EQA), conducted by the Chartered Institute of Internal Auditors (in 2018), and our own annual Quality Assurance and Improvement Programme (QAIP) have both confirmed that our internal audit work continues to 'generally conform' to the requirements of the Public Sector Internal Audit Standards for 2021/22. For this year, as in 2020/21, our QAIP has considered specifically the impact that COVID-19 has had on our audit approach and programmes. We are able to state that our service 'conforms to the IIA's professional standards and to PSIAS.'

1.4 Summary of Audit Assignments

This report summarises the outcomes from our work undertaken in the year. In some cases, audit work from previous years may also be included and where this is the case, details are given. This report also references assurances received through the internal audit of control systems operated by other NHS Wales organisations (again, see section 3).

The audit coverage in the plan agreed with management has been deliberately focused on key strategic and operational risk areas; the outcome of these audit reviews may therefore highlight control weaknesses that impact on the overall assurance opinion.

Overall, we can provide the following assurances to the Board that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively in the areas in the table below.

Where we have given Limited Assurance, management are aware of the specific issues identified and have agreed action plans to improve control in these areas. These planned control improvements should be referenced in the Annual Governance Statement where it is appropriate to do so.

Mohamed.Sara 05/13/2022 07:38:05

In addition, and in part reflecting the impact of COVID-19, we also undertook a number of advisory and non-opinion reviews to support our overall opinion. A summary of the audits undertaken in the year and the results are summarised in table 1 below.

Table 1 – Summary of Audits 2021/22

Substantial Assurance	Reasonable Assurance
• Core Financial Systems • Verification of Community Dialysis Sessions – Specialist Services CB • Health & Safety • Wellbeing Hub at Maelfa • COVID-19 Vaccination Programme - Phase 3 delivery • Welsh Risk Pool Claims	• Legislative, Regulatory & Alerts Compliance • Healthy Eating Standards - Hospital Restaurant & Retail Outlets • Cancellation of Outpatient Clinics Follow-up - Mental Health CB • Theatres Utilisation – Surgery CB • Retention of Staff • Welsh Language Standards • Raising Staff Concerns (Whistle Blowing) • Development of Genomics Partnership Wales • Nurse Rostering: Children's Hospital for Wales – Children & Women's CB • Waste Management (Draft)
Limited Assurance	**Advisory & Non-Opinion**
• Ultrasound Governance – CD&T CB • Clinical Audit • Five Steps to Safer Surgery • IT Service Management (ITIL) • Network and Information Systems (NIS) Directive • Nurse Bank (Temporary Staffing Department) • ChemoCare IT System (Draft)	• Arrangements to support the delivery of Mental Health Services – Mental Health CB • Major Capital Scheme – UHW II • Development of Integrated Audit Plans
No Assurance	**Assurance yet to be determined**
N/A	• Risk Management (WiP) • Recovery of Services and Delivery of the Annual Plan 2021-2022 (WiP) • Performance Reporting (Data Quality) (WiP) • Capital Systems Management (WiP) • Post Contract Audit of DHH Costs (WiP) • Management of Staff Sickness Absence (Planning)

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Please note that our overall opinion has also taken into account both the number and significance of any audits that have been deferred during the course of the year (see section 5.7) and also other information obtained during the year that we deem to be relevant to our work (see section 2.4.2).

2. HEAD OF INTERNAL AUDIT OPINION

2.1 Roles and Responsibilities

The Board is collectively accountable for maintaining a sound system of internal control that supports the achievement of the organisation's objectives and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement is a statement made by the Accountable Officer, on behalf of the Board, setting out:

- how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;
- the purpose of the system of internal control, as evidenced by a description of the risk management and review processes, including compliance with the Health & Care Standards; and
- the conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures, together with assurances that actions are or will be taken where appropriate to address issues arising.

The Health Board's risk management process and system of assurance should bring together all of the evidence required to support the Annual Governance Statement.

In accordance with the Public Sector Internal Audit Standards (PSIAS), the Head of Internal Audit (HIA) is required to provide an annual opinion, based upon and limited to the work performed on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. This is achieved through an audit plan that has been focussed on key strategic and operational risk areas and known improvement opportunities, agreed with executive management and approved by the Audit Committee, which should provide an appropriate level of assurance.

Mohamed Sarar
05/13/2022 6:38:25

The opinion does not imply that Internal Audit has reviewed all risks and assurances relating to the Health Board. The opinion is substantially derived from the conduct of risk-based audit work formulated around a selection of key organisational systems and risks. As such, it is a key component that the Board takes into account but is not intended to provide a comprehensive view.

The Board, through the Audit and Assurance Committee, will need to consider the Head of Internal Audit opinion together with assurances from other sources including reports issued by other review bodies, assurances given by management and other relevant information when forming a rounded picture on governance, risk management and control for completing its Governance Statement.

2.2 Purpose of the Head of Internal Audit Opinion

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Accountable Officer and the Board of Cardiff and Vale University Health Board which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control.

This opinion will in turn assist the Board in the completion of its Annual Governance Statement and may also be taken into account by regulators including Healthcare Inspectorate Wales in assessing compliance with the Health & Care Standards in Wales, and by Audit Wales in the context of both their external audit and performance reviews.

The overall opinion by the Head of Internal Audit on governance, risk management and control results from the risk-based audit programme and contributes to the picture of assurance available to the Board in reviewing effectiveness and supporting our drive for continuous improvement.

2.3 Assurance Rating System for the Head of Internal Audit Opinion

The overall opinion is based primarily on the outcome of the work undertaken during the course of the 2021/22 audit year. We also consider other information available to us such as our overall knowledge of the organisation, the findings of other assurance providers and inspectors, and the work we undertake at other NHS Wales organisations. The Head of Internal Audit considers the outcomes of the audit work undertaken and exercises professional judgement to arrive at the most appropriate opinion for each organisation.

A quality assurance review process has been applied by the Director of Audit & Assurance and the Head of Internal Audit in the annual reporting process to ensure the overall opinion is consistent with the underlying audit evidence.

We take this approach into account when considering our assessment of our compliance with the requirements of PSIAS.

Mohamed Shah
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The assurance rating system based upon the colour-coded barometer and applied to individual audit reports remains unchanged. The descriptive narrative used in these definitions has proven effective in giving an

objective and consistent measure of assurance in the context of assessed risk and associated control in those areas examined.

This same assurance rating system is applied to the overall Head of Internal Audit opinion on governance, risk management and control as to individual assignment audit reviews. The assurance rating system together with definitions is included at **Appendix B**.

The individual conclusions arising from detailed audits undertaken during the year have been summarised by the assurance ratings received. The aggregation of audit results gives a better picture of assurance to the Board and also provides a rational basis for drawing an overall audit opinion. However, please note that for presentational purposes we have shown the results using the eight assurance domains that were used to frame the audit plan at its outset (see section 2.4.2).

2.4 Head of Internal Audit Opinion

2.4.1 Scope of opinion

The scope of my opinion is confined to those areas examined in the risk-based audit plan which has been agreed with senior management and approved by the Audit and Assurance Committee. The Head of Internal Audit assessment should be interpreted in this context when reviewing the effectiveness of the system of internal control and be seen as an internal driver for continuous improvement. The Head of Internal Audit opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control is set out below.

Reasonable Assurance	 - + Yellow	The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.

This opinion will need to be reflected within the Annual Governance Statement along with confirmation of action planned to address the issues raised. Particular focus should be placed on the agreed response to any Limited Assurance opinions issued during the year and the significance of the recommendations made (of which there were seven audits in 2021/22).

2.4.2 Basis for Forming the Opinion

The audit work undertaken during 2021/22 and reported to the Audit and Assurance Committee has been aggregated at Section 5.

The evidence base upon which the overall opinion is formed is as follows:

- An assessment of the range of individual opinions and outputs arising from risk-based audit assignments contained within the Internal

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Audit plan that have been reported to the Audit and Assurance Committee throughout the year. In addition, and where appropriate, work at either draft report stage or in progress but substantially complete has also been considered, and where this is the case then it is identified in the report. This assessment has taken account of the relative materiality of these areas and the results of any follow-up audits in progressing control improvements (see section 2.4.3).

- The results of any audit work related to the Health & Care Standards including, if appropriate, the evidence available by which the Board has arrived at its declaration in respect of the self-assessment for the Governance, Leadership and Accountability module.
- Other assurance reviews which impact on the Head of Internal Audit opinion including audit work performed at other organisations (see Section 3).
- Other knowledge and information that the Head of Internal Audit has obtained during the year including cumulative information and knowledge over time; observation of Board and other key committee meetings; meetings with Executive Directors, senior managers and Independent Members; the results of *ad hoc* work and support provided; liaison with other assurance providers and inspectors; research; and cumulative audit knowledge of the organisation that the Head of Internal Audit considers relevant to the Opinion for this year.

As stated above, these detailed results have been aggregated to build a picture of assurance across the Health Board.

In reaching this opinion we have identified that the majority of reviews during the year concluded positively with robust control arrangements operating in some areas.

From the opinions issued during the year, six were allocated Substantial Assurance, ten were allocated Reasonable Assurance and seven were allocated Limited Assurance. No reports were allocated a 'no assurance' opinion. In addition, three advisory or non-opinion reports were also issued.

At the time of producing the draft Annual Report, six audits are still work in progress with the assurance rating yet to be confirmed. It is anticipated that the majority of the work will be sufficiently progressed so that the ratings can be established before production of the final Annual Report.

In addition, the Head of Internal Audit has considered residual risk exposure across those assignments where limited assurance was reported. Further, the Head of Internal Audit has considered the impact where audit assignments planned this year did not proceed to full audits following preliminary planning work and these were either: removed from the plan; removed from the plan and replaced with another audit; or deferred until a future audit year. The reasons for changes to the audit plan were presented to the Audit and Assurance Committee for consideration and

Mohamed Siddiqui 05/13/2022 16:16:2

approval. Notwithstanding that the opinion is restricted to those areas which were subject to audit review, the Head of Internal Audit has considered the impact of changes made to the plan when forming their overall opinion.

A summary of the findings is shown below. We have reported the findings using the 8 areas of the Health Board's activities that we use to structure both our 3-year strategic and 1-year operational plans.

Corporate Governance, Risk Management and Regulatory Compliance

We have undertaken five reviews in this area.

Legislative, Regulatory & Alerts Compliance – We identified that progress had been made in developing the Health Board's Legislative and Regulatory Tracker, but further work was required to enhance it as an effective assurance tool. An increased focus was also needed on assuring that actions arising from Welsh Health Circulars and Patient Safety Alerts have been fully completed. We issued a **reasonable** assurance opinion.

Welsh Language Standards – The Health Board has identified the actions required to achieve compliance with the Standards and developed an approach to tracking implementation. However, we identified a need for a review of roles and responsibilities in the implementation and delivery of the Standards and a revisit of the associated Policy, resources and risk management arrangements. We issued a **reasonable** assurance opinion.

Health & Safety –The Health Board is developing a Health and Safety Culture Plan 2022-25 which will enable effective implementation of the recommendations from the external review of Health & Safety. We only identified three low priority recommendations, which are best practice in nature and support the improvement journey of Health and Safety arrangements. We issued a **substantial** assurance opinion.

Risk Management *[WiP] -*

A review of the draft Annual Governance Statement highlighted that it was generally consistent with our knowledge of the UHB through the audit work performed in the Internal Audit plan and a review of other organisational documents.

Strategic Planning, Performance Management & Reporting

We have undertaken two reviews in this area.

Recovery of services and Delivery of Annual Plan 2021/22 *[WiP] -*

Performance Reporting *[WiP] -*

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The initial plan was to undertake separate audits of Recovery of Services and Delivery of the Annual Plan, but these were combined into the one audit above to avoid potential overlap of scope.

Financial Governance and Management

We have undertaken three reviews in this area.

Core Financial Systems – We reviewed the Health Board's General Ledger and Accounts Receivable processes and only identified two low priority findings around enhancements to the Financial Control Procedures and ensuring the removal of system access for leavers. We have issued a **substantial** assurance opinion.

Welsh Risk Pool (WRP) Claims - The Health Board has effective processes in place to ensure that the required forms and schedules are appropriately completed for all claims, and these are submitted to the WRP within the stipulated timescales. We have issued a **substantial** assurance opinion

***Post Contract Audit of DHH Costs** [WiP] -*

The audits of the payment systems provided by NWSSP, which we undertake each year to provide assurance to the Health Board all concluded with positive assurance. The four primary care contractor payment systems were given Reasonable or Substantial Assurance, with the audits of Payroll and Accounts Payable both receiving Reasonable Assurance (Payroll is draft).

The planned work on Financial Plan / Reporting was Deferred to the 22/23 Plan, due to Covid related pressures on the Health Board. We note that elements of the Health Board's financial planning and reporting arrangements were covered by Audit Wales as part of their Structured Assessment, which provided the Health Board with a level of assurance.

Quality & Safety

We have undertaken Four reviews in this area.

Healthy Eating Standards - Hospital Restaurant & Retail Outlets – We found that the Health Board's Standards were clearly documented and provide clear guidance for restaurant and retail outlets to follow. The basis of effective governance and audit arrangements were in place but would benefit from further review and enhancement to assist in raising the profile and position of the standards. We issued a **reasonable** assurance opinion.

Clinical Audit – Significant enhancements are required to the Health Board's Clinical Audit structures and governance arrangements. The key areas to be addressed related to the development and introduction of a Clinical Audit Strategy, Policy and Procedures, and the development of resources and systems to effectively monitor all Clinical Audit activity. We issued a **limited** assurance opinion.

Mohamed Hanara 05/13/2022 09:38:25

Five Steps to Safer Surgery – The Health Board has processes in place to ensure that aspects of the five steps are undertaken. However, we identified inconsistencies in the application of the Safer Surgery Checklist and there was also a lack of information available to evidence completion of all steps. The Health Board needs to improve staff engagement with the five steps and also develop the mechanisms for recording, monitoring and reporting compliance levels. We issued a **limited** assurance opinion.

Theatres Utilisation – Surgery CB – We identified that systems and processes were in place to facilitate the use of theatre resource, but further work was needed to ensure the completeness of Theatreman and that theatre utilisation is being maximised. Effective governance arrangements are in place but, as part of the Recovery and Redesign Portfolio there is a need for the arrangements to be agile. The Health Board would also benefit from having a clearly defined Policy and Procedure to direct operating theatre scheduling, cancellation and utilisation. We issued a **reasonable** assurance opinion.

The planned work on the Q&SE Governance arrangements was deferred due to pressures on acute service areas during the pandemic.

The planned work on the ALNET Act was deferred as work is still on-going to embed processes within the Health Board.

Information Governance & Security

We have undertaken three reviews in this area.

IT Service Management (ITIL) - Overall, there were poor controls in place over the IT Service Desk function. We acknowledged that management are planning major improvements by implementing a new call handling system, restructuring the service desk department, and introducing new ways of working based on the ITIL Framework. However, based on the situation at the time of audit we issued a **limited** assurance opinion. The significant matters which required management attention included; the lack of an IL Framework for the delivery of services; the lack of documented guidance for call handlers; Inaccurate call classification and prioritisation of calls; and high levels of 'open' calls with a lack of monitoring.

Network & Information Systems (NIS) Directive – We identified a number of significant matters including; the submitted Cyber Assessment Framework (CAF) was partially complete resulting in an incomplete self-assessed position; No retention of the supporting information provided to the Cyber Resilience Unit as part of the CAF assessment; Improvement actions had not been identified and a plan had not yet been developed; and the Corporate cyber security risk had not been updated to include NIS Regulations. We issued a **limited** assurance opinion.

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ChemoCare IT System [Draft] - There is a framework for control over the ChemoCare system and there were areas of good practice. However, the controls have not been fully enacted. We identified that out-of-date versions of Windows server and SQL Server database are in use and generic accounts exist with system administrator privileges. There is also a lack of formal supplier's performance monitoring mechanism and we noted weaknesses within the Business Continuity Plan, Hosting and Backup arrangements and password policy. We issued a draft **limited** assurance opinion.

The planned work on the IM&T Control & Risk Assessment was Deferred as the last assessment was only finalised in May 22 and the agreed actions are being monitored through the Health Board's tracker.

The Planned work on the Digital Strategy Roadmap was deferred to the 22/23 plan and will be included in the scope of the Digital Strategy audit.

The three reviews undertaken within the Information Governance and Security area all received limited assurance ratings. The deferment of the Digital Strategy audit has also impacted on the level of assurance we are able to provide within this area. The Health Board will need to ensure that going forward there is appropriate investment and development within this area to address the identified issues.

Operational Service and Functional Management

We have undertaken five reviews in this area.

Ultrasound Governance, CD&T CB – We identified significant issues relating to the design and implementation of the revised Medical Ultrasound Risk Management Policy and Procedure. Governance arrangements were found to be lacking and required review to effectively direct and oversee the implementation of the requirements prescribed by the revised policy and procedure. We issued a **limited** assurance opinion

Cancellation of Outpatient Clinics Follow-up, Mental Health CB – We identified that significant work had been undertaken towards implementing the recommendations in the original limited assurance audit report. We were able to verify that the control design had been improved, but the implementation of the controls required a further period to become embedded. We issued a **reasonable** assurance opinion

Verification of Community Dialysis Sessions, Specialist Services CB - Effective governance, reporting and monitoring arrangements were in place for the provision of dialysis sessions. We only identified one key matter which related to the accessibility of key documents that support the monthly verification exercise. We issued a **substantial** assurance opinion.

Mohamed Sarra
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Arrangements to support the delivery of Mental Health Services, Mental Health CB - This was an advisory review to evaluate and support

the Clinical Board to list their services, capturing the means of delivery and any associated risks and challenges. We identified that management within the Clinical Board have a good understanding of the risks and challenges facing mental health services. We identified opportunities which, if taken forward, would enable the Clinical Board to enhance the arrangements to support the delivery of Mental Health Services.

Nurse Rostering: Children's Hospital for Wales, Children & Women's CB) - The Health Board has acknowledged that there is a need to advance the nurse rostering process with the introduction of a new rostering system, HealthRoster. A number of the issues that we have identified through this review have the potential to be resolved through the introduction of the new system. We made recommendations which related to documented approval and dissemination of rosters and the management of rosters, including the documentation and approval of make up shifts, overtime, and shift changes. We issued a **reasonable** assurance opinion.

COVID-19 Vaccination Programme - Phase 3 delivery – We identified that the Health Board had effective planning processes in place to ensure delivery of phase 3 of the vaccination programme and the plan was subject to robust governance and oversight. We issued a **substantial** assurance opinion.

The planned audit of the QS&E Governance Framework within the Medicine CB was deferred because management and staff within the Clinical Board were fully focused on dealing with the pandemic.

The planned separate audit of Primary Care Vaccinations within the PCIC Clinical Board was combined with the wider audit of the Covid 19 Vaccination Programme.

The planned audit of Medical Equipment & Devices was deferred to 22/23 due to pressures on HB.

Workforce Management

We have undertaken four reviews in this area.

Retention of Staff – The Health Board has a People and Culture Plan in place with specific actions and initiatives for retention of staff. However, we noted that the ability to deliver is challenging in the current climate and a review of capacity would be beneficial. We issued a **reasonable** assurance opinion

Welsh Language Standards – The Health Board has developed an approach to track the implementation of actions to achieve compliance with the Welsh Language Standards. However, we identified a need to review roles and responsibilities in the implementation and delivery of the Standards and also revisit policy, resources and risk management arrangements. We issued a **reasonable** assurance opinion

Mohamed Latif
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Raising Staff Concerns (Whistleblowing) - The Health Board's approach to responding to staff concerns through its Freedom to Speak Up (F2SU) process aligns with the All-Wales Procedure for Staff to Raise Concerns. However further work was required around communication of the process, recording of concerns and governance arrangements. We issued a **reasonable** assurance opinion.

Nurse Bank (Temporary Staffing Department) - There was a lack of resilience within the current structure of the Temporary Staffing Department, which impacts the operational effectiveness of the Nurse Bank. We identified issues around recruitment to the Nurse Bank, payment to agencies, and a general lack of engagement with service users. We issued a **limited** assurance opinion.

Management of Staff Sickness Absence *[Planning]*

The planned audit of the Medical & Dental Staff Bank was deferred to 22/23 due to the pressures on the Health Board. This is a relatively new service so the delay will allow further time for processes to bed in.

Capital & Estates Management

We have undertaken six reviews / outputs in this area.

Development of Genomics Partnership Wales - A robust project team structure was operating and there was appropriate engagement with users and stakeholders. An accelerated FBC development approach was agreed at the project, but despite this, targeted FBC dates were not achieved due to slippage in the Welsh Government OBC approval timeline. Contract negotiations, following FBC approval, further delayed the commencement of works on site. The FBC target cost has increased, post approval, by £450k following further design development and market testing. At the time of the audit, the increase was being managed within the £1.2m project contingency. We issued a **reasonable** assurance opinion.

Wellbeing Hub at Maelfa - A robust project team structure was operating with supporting workstreams, continued liaison with external advisers and routine reporting to the Project Team and Delivery Group. The construction programme was being effectively managed, and the project was forecast to be delivered on time. The latest Project Manager's report indicated that a projected underspend of £8,233 was anticipated. The key matters arising related to enhancements to the practices of the supporting workstreams and improved timeliness of contractual payments at the project. We issued a **reasonable** assurance opinion.

Mohamed Salah
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Waste Management [Draft] - We identified a number of issues around the need to review the Waste Management Policy contents/guidance; Further development and embedding of Budget and Risk Management processes; The preparation of a training needs assessment; Enhancement of contractual/payment processes; Further development of waste

minimisation Initiatives to reduce waste and Enhanced monitoring and reporting arrangements. We issued a draft **reasonable** assurance opinion.

***Capital Systems Management** [WiP].*

For the UHW II major capital scheme, we provided an on-going observer role with proactive input, and overview of the progression through the period.

Advice and support were also provided to the Health Board through the year in relation to the future development of integrated audit plans.

The planned audit of Decarbonisation was deferred to the 2022/23 plan reflecting the fact that the Health Board was not requirement to publish its Action Plan until March 2022, and the timing of expenditure of the initial capital allocations provided by Welsh Government.

2.4.3 Approach to Follow Up of Recommendations

As part of our audit work, we consider the progress made in implementing the actions agreed from our previous reports for which we were able to give only Limited Assurance. In addition, where appropriate, we also consider progress made on high priority findings in reports where we were still able to give Reasonable Assurance. We also undertake some testing on the accuracy and effectiveness of the audit recommendation tracker.

In addition, Audit Committees monitor the progress in implementing recommendations (this is wider than just Internal Audit recommendations) through their own recommendation tracker processes. We attend all audit committee meetings and observe the quality and rigour around these processes.

For the second year in a row, due to the impact of COVID-19, we are aware that it has been more difficult than usual for NHS organisations to implement recommendations to the timescales they had originally agreed. In addition, we also recognise that for new recommendations it may be more difficult to be precise on when exactly actions can be implemented by. However, it remains the role of Audit Committees to consider and agree the adequacy of management responses and the dates for implementation, and any subsequent request for revised dates, proposed by Management. Where appropriate, we have adjusted our approach to follow-up work to reflect these challenges.

Going forward, given that it is very likely that the number of outstanding recommendations will have grown during the course of the pandemic, audit committees will need to reflect on how best they will seek to address this position.

We have considered the impact of both our follow-up work and where there have been delays to the implementation of recommendations, on both our ability to give an overall opinion (in compliance with the PSIAS) and the level of overall assurance that we can give.

Mohammad Sirkan 05/13/2022 16:06:25

From the specific follow up audit undertaken in 2021/22, it was identified that progress had been made by management in implementing recommendations from the Mental Health Cancellation of Outpatient Clinics Limited Assurance audit, with an improved rating of substantial assurance given.

The Health Board has continued to develop its recommendation tracking process during 2021/22. Despite the on-going effects of the pandemic, the Corporate Governance team has continued to review all outstanding recommendations with management and the outcomes have been reported to each meeting of the Audit & Assurance Committee.

The Corporate Governance team has also carried out additional work with relevant Executive leads to review and re-assess outstanding recommendations within the tracker from 2018/19. The outcomes of this process have been reported to the Audit and Assurance Committee and reflected within the tracker.

We have worked with the Corporate Governance team through the year to review and provide feedback on the tracker prior to its submission to each meeting of the Committee. We have also undertaken work towards the end of the year to validate the stated position for a sample of recommendations within the tracker. *We were able to confirm the recorded position for the majority of the sampled recommendations and therefore provide the Audit Committee with additional assurance around the accuracy of the tracker.* - *This work is on-going so will need to confirm this wording as it is completed.*

2.4.4 Limitations to the Audit Opinion

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems.

As mentioned above the scope of the audit opinion is restricted to those areas which were the subject of audit review through the performance of the risk-based Internal Audit plan. In accordance with auditing standards, and with the agreement of senior management and the Board, Internal Audit work is deliberately prioritised according to risk and materiality. Accordingly, the Internal Audit work and reported outcomes will bias towards known weaknesses as a driver to improve governance risk management and control. This context is important in understanding the overall opinion and balancing that across the various assurances which feature in the Annual Governance Statement.

Caution should be exercised when making comparisons with prior years. Audit coverage will vary from year to year based upon risk assessment and cyclical coverage on key control systems. In addition, the impact of COVID-19 on this year's (and to an extent last year's) programme makes any comparison even more difficult.

Mohammad Sabir 05/13/2022 10:06:25

2.4.5 Period covered by the Opinion

Internal Audit provides a continuous flow of assurance to the Board and, subject to the key financials and other mandated items being completed in-year, the cut-off point for annual reporting purposes can be set by agreement with management. To enable the Head of Internal Audit opinion to be better aligned with the production of the Annual Governance Statement a pragmatic cut-off point has been applied to Internal Audit work in progress.

By previous agreement with the Health Board, audit work reported to draft stage has been included in the overall assessment, with all other work in progress rolled-forward and reported within the overall opinion for next year.

The majority of audit reviews will relate to the systems and processes in operation during 2021/22 unless otherwise stated and reflect the condition of internal controls pertaining at the point of audit assessment.

Follow-up work will provide an assessment of action taken by management on recommendations made in prior periods and will therefore provide a limited scope update on the current condition of control and a measure of direction of travel.

There are some specific assurance reviews which remain relevant to the reporting of the organisation's Annual Report required to be published after the year end. Where required, any specified assurance work would be aligned with the timeline for production of the Health Board's Annual Report and accordingly will be completed and reported to management and the Audit Committee subsequent to this Head of Internal Audit Opinion. However, the Head of Internal Audit's assessment of arrangements in these areas would be legitimately informed by drawing on the assurance work completed as part of this current year's plan.

2.5 Required Work

Please note that following discussions with Welsh Government we were not mandated to audit any areas in 2021/22.

2.6 Statement of Conformance

The Welsh Government determined that the Public Sector Internal Audit Standards (PSIAS) would apply across the NHS in Wales from 2013/14.

The provision of professional quality Internal Audit is a fundamental aim of our service delivery methodology and compliance with PSIAS is central to our audit approach. Quality is controlled by the Head of Internal Audit on an ongoing basis and monitored by the Director of Audit & Assurance. The work of Internal Audit is also subject to an annual assessment by Audit Wales. In addition, at least once every five years, we are required to have an External Quality Assessment. This was undertaken by the Chartered Institute of Internal Auditors (IIA) in February and March 2018. The IIA

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concluded that NWSSP's Audit & Assurance Services conforms with all 64 fundamental principles and 'it is therefore appropriate for NWSSP Audit & Assurance Services to say in reports and other literature that it conforms to the IIA's professional standards and to PSIAS.'

The NWSSP Audit and Assurance Services can assure the Audit and Assurance Committee that it has conducted its audit at the Health Board in conformance with the Public Sector Internal Audit Standards for 2021/22.

Our conformance statement for 2021/22 is based upon:

- the results of our internal Quality Assurance and Improvement Programme (QAIP) for 2021/22 which will be reported formally in the Summer of 2022; and
- the results of the work completed by Audit Wales.

We have set out, in **Appendix A**, the key requirements of the Public Sector Internal Audit Standards and our assessment of conformance against these requirements. The full results and actions from our QAIP will be included in the 2021/22 QAIP report. There are no significant matters arising that need to be reported in this document.

2.7 Completion of the Annual Governance Statement

While the overall Internal Audit opinion will inform the review of effectiveness for the Annual Governance Statement, the Accountable Officer and the Board need to take into account other assurances and risks when preparing their statement. These sources of assurances will have been identified within the Board's own performance management and assurance framework and will include, but are not limited to:

- direct assurances from management on the operation of internal controls through the upward chain of accountability;
- internally assessed performance against the Health & Care Standards;
- results of internal compliance functions including Local Counter-Fraud, Post Payment Verification, and risk management;
- reported compliance via the Welsh Risk Pool regarding claims standards and other specialty specific standards reviewed during the period; and
- reviews completed by external regulation and inspection bodies including Audit Wales and Healthcare Inspectorate Wales.

Mohammed Sarabi
05/13/2022 10:36:03

3. OTHER WORK RELEVANT TO THE HEALTH BOARD

As our internal audit work covers all NHS Wales organisations there are a number of audits that we undertake each year which, while undertaken

formally as part of a particular health organisation's audit programme, will cover activities relating to other Health bodies. These are set about below, with relevant comments and opinions attached, and relate to work at:

- NHS Wales Shared Services Partnership;
- Digital Health & Care Wales;
- Welsh Health Specialised Services Committee; and
- Emergency Ambulance Services Committee.

NHS Wales Shared Services Partnership (NWSSP)

As part of the internal audit programme at NHS Wales Shared Services Partnership (NWSSP), a hosted body of Velindre University NHS Trust, a number of audits were undertaken which are relevant to the Health Board. These audits of the financial systems operated by NWSSP, processing transactions on behalf of the Health Board, derived the following opinion ratings:

Audit	Opinion	Comments
Accounts Payable	Reasonable	
Payroll	Reasonable (Draft)	
Primary Care Services – Medical (GMS), Pharmaceutical (GPS), Dental (GDS), and Ophthalmic (GOS) Services	Reasonable Substantial Substantial Substantial	

Please note that other audits of NWSSP activities are undertaken as part of the overall NWSSP internal audit programme. The overall Head of Internal Audit Opinion for NWSSP is Reasonable Assurance.

Digital Health & Care Wales (DHCW)

As part of the internal audit programme at DHCW, a Special Health Authority that started operating from 1 April 2021, a number of audits were undertaken which are relevant to the Health Board. These audits derived the following opinion ratings:

Audit	Opinion	Comments
Welsh Radiology Information System	Reasonable	
Data Centre Transition	Substantial	
Data Analytics	Reasonable	
System Development	Reasonable	

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GP System Procurement Project	Substantial	

Please note that other audits of DHCW activities are undertaken as part of the overall DHCW internal audit programme. The overall Head of Internal Audit Opinion for DHCW is Reasonable Assurance.

Welsh Health Specialised Services Committee (WHSSC) and Emergency Ambulance Services Committee (EASC)

The work at both the Welsh Health Specialist Services Committee (WHSSC) and the Emergency Ambulance Services Committee (EASC) is undertaken as part of the Cwm Taf Morgannwg internal audit plan. These audits are listed below and derived the following opinion ratings:

Audit	Opinion	Comments
WHSSC – Risk management (Draft)	Reasonable	
WHSSC – Cancer and blood services	Substantial	
WHSSC – All Wales Positron Emission Tomography (PET) Service	Reasonable	
EASC – Governance arrangements	Reasonable	

While these audits do not form part of the annual plan for the Health Board, they are listed here for completeness as they do impact on the organisation's activities. The Head of Internal Audit has considered if any issues raised in the audits could impact on the content of our annual report and concluded that there are no matters of this nature.

Full details of the NWSSP audits are included in the NWSSP Head of Internal Audit Opinion and Annual Report and are summarised in the Velindre NHS Trust Head of Internal Audit Opinion and Annual Report. DHCW audits are summarised in the DHCW Head of Internal Audit Opinion and Annual Report, and the WHSSC and EASC audits are summarised in the Cwm Taf Morgannwg University Health Board Head of Internal Audit Opinion and Annual Report.

4. DELIVERY OF THE INTERNAL AUDIT PLAN

4.1 Performance against the Audit Plan

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The Internal Audit Plan has been delivered substantially in accordance with the schedule agreed with the Audit and Assurance Committee, subject to changes agreed as the year progressed. Regular audit progress reports have been submitted to the Audit and Assurance Committee during the year. Audits that remain to be reported but are reflected within this Annual

Report will be reported alongside audits from the 2022/23 operational audit plan.

The revised audit plan approved by the Committee in April 2021 contained 44 planned reviews. Changes have been made to the plan with 12 audits deferred/cancelled. All these changes have been reported to and approved by the Audit Committee. As a result of these agreed changes, we have delivered 32 reviews.

The assignment status summary is reported at section 5.

In addition, we may respond to requests for advice and/or assistance across a variety of business areas across the Health Board. This advisory work, undertaken in addition to the assurance plan, is permitted under the standards to assist management in improving governance, risk management and control. This activity is reported during the year within our progress reports to the Audit and Assurance Committee.

4.2 Service Performance Indicators

In order to monitor aspects of the service delivered by Internal Audit, a range of service performance indicators have been developed. The key performance indicators are summarised as follows:

Indicator Reported to Audit and Assurance Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2021/22	G	April 2021	By 30 June	Not agreed	Draft plan	Final plan
Total assignments reported against adjusted plan for 2021/22	G	XX% (XX/XX)	100%	v>20%	10%<v<20 %	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	100%	80%	v>20%	10%<v<20 %	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	R	62%	80%	v>20%	10%<v<20 %	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100%	80%	v>20%	10%<v<20 %	v<10%

5. RISK BASED AUDIT ASSIGNMENTS

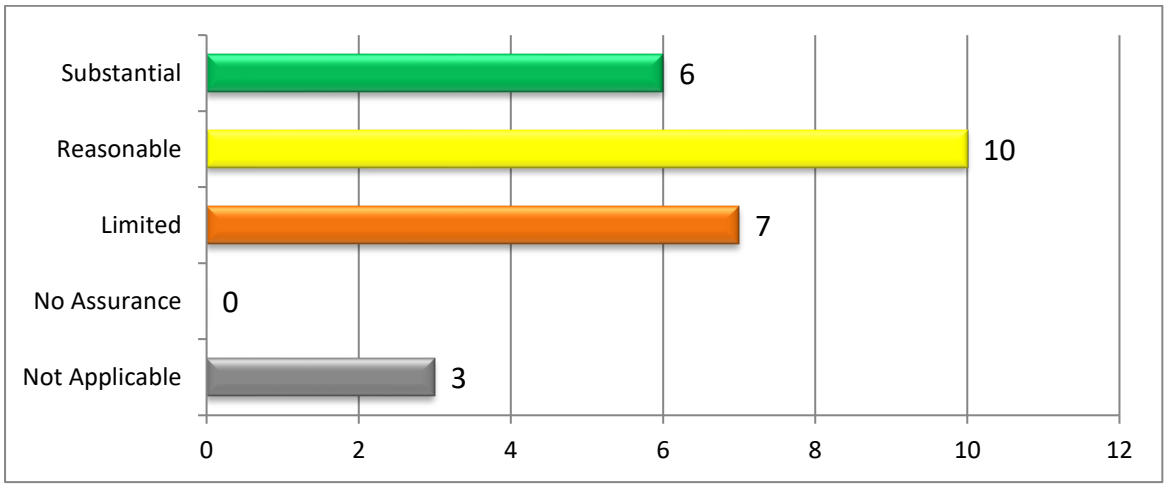
The overall opinion provided in Section 1 and our conclusions on individual assurance domains is limited to the scope and objectives of the reviews we have undertaken, detailed information on which has been provided within the individual audit reports.

Mohamad Sajan
05/13/2022 16:36:

5.1 Overall summary of results

In total 32 *(table currently showing 26 and will need to be updated following completion of work in progress)* audit reviews were reported during the year. Figure 2 below presents the assurance ratings and the number of audits derived for each.

Figure 2 Summary of audit ratings



* Need to add in outcomes for the 6 audits that are still to be completed.

Figure 2 above does not include the audit ratings for the reviews undertaken at NWSSP and DHCW.

The assurance ratings and definitions used for reporting audit assignments are included in **Appendix B**.

In addition to the above, there were several audits which did not proceed following preliminary planning and agreement with management. In some cases, the impact of COVID-19 was the reason for the deferral or cancellation and in other cases, it was recognised that there was action required to address issues and/or risks already known to management and an audit review at that time would not add additional value. These audits are documented in section 5.7.

The following sections provide a summary of the scope and objective for each assignment undertaken within the year along with the assurance rating.

5.2 Substantial Assurance (Green)



Mohamed Surah
05/13/2022 16:56:12

In the following review areas the Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Those few matters that may require attention are compliance or advisory in nature with low

impact on residual risk exposure.

Review Title	Objective
Core Financial Systems	To establish if the Health Board has appropriate processes in place to ensure the effective management of the General Ledger and Accounts Receivable financial systems.
Verification of Community Dialysis Sessions – Specialist Services CB	To evaluate and determine the adequacy of the systems and controls in place within the Nephrology and Transplant Directorate for the verification of community dialysis sessions provided by external suppliers
Health & Safety	To establish if the Health Board has developed appropriate plans to implement the recommendations from the external review of Health & Safety.
Wellbeing Hub at Maelfa	To evaluate the progression and delivery of the project against the key business case objectives and to assess the adequacy of the systems and controls in place to support the successful delivery of the project.
COVID-19 Vaccination Programme - Phase 3 delivery	To evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to the delivery of Phase 3 of the Covid 19 Vaccination Programme
Welsh Risk Pool Claims	To provide assurance that the claims reimbursement process is in compliance with the requirements of the Welsh Risk Pool Standard and claims are accurate.

5.3 Reasonable Assurance (Yellow)



In the following review areas, the Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Some matters require management attention in either control design or operational compliance and these will have low to moderate impact on residual risk exposure until resolved.

Mohamed Salah
05/13/2022 16:36:25

Review Title	Objective
Legislative, Regulatory & Alerts Compliance	To establish if effective processes are in place to ensure that the Health Board complies with legislative / regulatory requirements, alerts, safety notices and other communications
Healthy Eating Standards - Hospital Restaurant & Retail Outlets	To establish if the standards are clearly documented and communicated, with effective governance and audit processes in place.
Cancellation of Outpatient Clinics Follow-up - Mental Health CB	Provide assurance against the implementation of the agreed management actions in response to issues raised in the original Limited Assurance report.
Theatres Utilisation – Surgery CB	To determine if adequate systems and controls are in place to ensure that theatre resources are efficiently and effectively utilised.
Retention of Staff	To establish if the Health Board has effective strategies, policies and plans in place to ensure appropriate retention of staff.
Welsh Language Standards	To evaluate and determine the adequacy of the actions the Health Board has taken to assess the impact and achieve compliance with the Welsh Language Standards.
Raising Staff Concerns (Whistle Blowing)	To evaluate and determine the adequacy of the systems and processes in place for managing staff concerns.
Development of Genomics Partnership Wales	To evaluate the progression and delivery of the project against the key business case objectives and to assess the adequacy of the systems and controls in place to support the successful delivery of the project.
Nurse Rostering: Children's Hospital for Wales – Children & Women's CB	To evaluate and determine the adequacy of the systems and controls in place for the rostering arrangements within the Children's Hospital for Wales, in advance of moving across to HealthRoster.
Waste Management (Draft)	To determine the adequacy of, and operational compliance with, the UHBs systems and procedures, taking account of relevant NHS and other supporting regulatory and procedural requirements.

Mohamed.Sarah 05/13/2022 16:36:25

5.4 Limited Assurance (Amber)



In the following review areas, the Board can take only **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with moderate impact on residual risk exposure until resolved.

Review Title	Objective
Ultrasound Governance – CD&T CB	To evaluate the design, implementation and compliance with ultrasound governance arrangements as outlined within the Health Board's Ultrasound Risk Management Policy and Procedure.
Clinical Audit	To evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to Clinical Audit.
Five Steps to Safer Surgery	To establish if effective arrangements are in place to ensure all stages of the five steps to safer surgery checklist are consistently undertaken.
IT Service Management (ITIL)	To provide assurance that a process is in place for ensuring IT services are provided in an efficient and secure manner and that reflect the needs of the organisation.
Network and Information Systems (NIS) Directive	To establish if the organisation is compliant with the NIS Regulations, has appropriate measures to protect, detect and respond to cyber incidents, and has accurately completed the self-assessment.
Nurse Bank (Temporary Staffing Department)	To review the effectiveness of the process and controls operating within the Health Board's Nurse Bank. Establish the level of efficiency and effectiveness of service provided to the Clinical Boards.
Chemocare IT System (Draft)	To provide assurance that data held within the Chemocare IT System is accurate, secure from unauthorised access and loss, and that the system is used fully.

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5.5 No Assurance (Red)



No reviews were assigned a 'no assurance' opinion.

5.6 Assurance Not Applicable (Grey)



The following reviews were undertaken as part of the audit plan and reported without the standard assurance rating indicator, owing to the nature of the audit approach. The level of assurance given for these reviews are deemed not applicable – these are reviews and other assistance to management, provided as part of the audit plan, to which the assurance definitions are not appropriate but which are relevant to the evidence base upon which the overall opinion is formed.

Review Title	Objective
Arrangements to support the delivery of Mental Health Services – Mental Health CB	to evaluate and support the Clinical Board to list their services, capturing the means of delivery and any associated risks and challenges
Major Capital Scheme – UHW II	To provide an observer role, proactive input, and an overview of the progression through the period.
Development of Integrated Audit Plans	Integrated Audit Plans will be developed for inclusion within the respective business case submissions for relevant major projects/ programmes.

5.7 Deferred Audits

Additionally, the following audits were deferred for the reasons outlined below. We have considered these reviews and the reason for their deferment when compiling the Head of Internal Audit Opinion.

Mohamed Sarah 05/13/2022 10:06:25

Review Title	Reason for Deferral
ALNET Act	The Director of Therapies and Health Sciences requested Deferral to the 22/23 plan as work is

Review Title	Reason for Deferral
	on-going to embed processes within Health Board.
Consultant Job Planning Follow-up	Removed as assurance level increased to Reasonable after the 20/21 follow-up
Clinical Board's QS&E Governance	QS&E Governance arrangements were reviewed by Audit Wales and a new Framework is also being introduced within the Health Board.
Estates Assurance - Decarbonisation	The Health Board is not required to publish its Decarbonisation Action Plans until March 2022, and the timing of expenditure of the initial capital allocations provided by Welsh Government.
IM&T Control & Risk Assessment	The last assessment was only finalised in May 22 and the agreed actions are being monitored through the Health Board's tracker.
Medical & Dental Staff Bank	Relatively new service so delay would allow further time for processes to bed in. The audit of the Nurse Bank provided coverage of temporary staffing arrangements.
Medicine CB – QS&E Governance Framework	The on-going pressures on the Clinical Board through the pandemic meant that they were unable to engage with the audit.
Financial Plan / Reporting	Elements of financial planning / reporting covered by Audit Wales as part of their Structured Assessment, which provided the Health Board with a level of assurance.
Delivery of 21/22 Annual Plan	Combined with audit of Recovery of Non-Covid services due to potential overlap of scope.
Medical Equipment and Devices	The on-going pressures faced by key service areas including the Emergency Unit.
PCIC CB – Primary Care Vaccinations	Combined with the wider audit of the Covid 19 Vaccination Programme - Phase 3 delivery.
Digital Strategy Roadmap	Deferred to 22/23 plan due to pressure on IM&T service and will be included in scope of Digital Strategy audit.

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5.8 Work in Progress

At the time of producing the draft Annual Report, the following audits were still work in progress and the assurance ratings had not been determined. It is anticipated that the majority of this work will be sufficiently progressed so that the ratings can be established before production of the final Annual Report.

Review Title	Objective
Risk Management	To review the on-going development and implementation of the Risk Management Strategy and Procedure.
Recovery of Services and Delivery of the Annual Plan 2021-2022	To review the processes in place for monitoring development and delivery of the Recovery & Redesign portfolio and delivery against the agreed Annual Plan for 21/22.
Performance Reporting (Data Quality)	To evaluate and determine the adequacy of the systems and controls in place in relation to the 'Integrated Performance Report' and the processes in place for its production and reporting.
Capital Systems Management	To determine the adequacy of, and operational compliance with, the Capital systems and procedures, taking account of relevant NHS and other supporting regulatory and procedural requirements.
Management of Staff Sickness Absence	To Review the systems in place for the analysis and reporting of staff sickness absence rates and supporting poor performing areas.
Post Contract Audit of DHH Costs	To carry out a review of the costs related to the Dragons Heart Hospital, as per the Welsh Government recommendation following the independent assurance review undertaken by KPMG.

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6. ACKNOWLEDGEMENT

In closing I would like to acknowledge the time and co-operation given by Directors and staff of the Health Board to support delivery of the Internal Audit assignments undertaken within the 2021/22 plan.

Ian Virgill
Head of Internal Audit
Audit and Assurance Services
NHS Wales Shared Services Partnership
April 2022

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Appendix A

ATTRIBUTE STANDARDS	
1000 Purpose, authority and responsibility	Internal Audit arrangements are derived ultimately from the NHS organisation's Standing orders and Financial Instructions. These arrangements are embodied in the Internal Audit Charter adopted by the Audit Committee on an annual basis.
1100 Independence and objectivity	Appropriate structures and reporting arrangements are in place. Internal Audit does not have any management responsibilities. Internal audit staff are required to declare any conflicts of interests. The Head of Internal Audit has direct access to the Chief Executive and Audit Committee chair.
1200 Proficiency and due professional care	Staff are aware of the Public Sector Internal Audit Standards and code of ethics. Appropriate staff are allocated to assignments based on knowledge and experience. Training and Development exist for all staff. The Head of Internal Audit is professionally qualified.
1300 Quality assurance and improvement programme	Head of Internal Audit undertakes quality reviews of assignments and reports as set out in internal procedures. Internal quality monitoring against standards is performed by the Head of Internal Audit and Director of Audit & Assurance. Audit Wales complete an annual assessment. An EQA was undertaken in 2018.
PERFORMANCE STANDARDS	
2000 Managing the internal audit activity	The Internal Audit activity is managed through the NHS Wales Shared Services Partnership. The audit service delivery plan forms part of the NWSSP integrated medium term plan. A risk based strategic and annual operational plan is developed for the organisation. The operational plan gives detail of specific assignments and sets out overall resource requirement. The audit

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	strategy and annual plan is approved by Audit Committee. Policies and procedures which guide the Internal Audit activity are set out in an Audit Quality Manual. There is structured liaison with Audit Wales, HIW and LCFS.
2100 Nature of work	The risk based plan is developed and assignments performed in a way that allows for evaluation and improvement of governance, risk management and control processes, using a systematic and disciplined approach.
2200 Engagement planning	The Audit Quality Manual guides the planning of audit assignments which include the agreement of an audit brief with management covering scope, objectives, timing and resource allocation.
2300 Performing the engagement	The Audit Quality Manual guides the performance of each audit assignment and report is quality reviewed before issue.
2400 Communicating results	Assignment reports are issued at draft and final stages. The report includes the assignment scope, objectives, conclusions and improvement actions agreed with management. An audit progress report is presented at each meeting of the Audit Committee. An annual report and opinion is produced for the Audit Committee giving assurance on the adequacy and effectiveness of the organisation's framework of governance, risk management and control.
2500 Monitoring progress	An internal follow-up process is maintained by management to monitor progress with implementation of agreed management actions. This is reported to the Audit Committee. In addition audit reports are followed-up by Internal Audit on a selective basis as part of the operational plan.

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2600 Communicating the acceptance of risks	If Internal Audit considers that a level of inappropriate risk is being accepted by management it would be discussed and will be escalated to Board level for resolution.

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Appendix B - Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

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4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ
Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

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Report Title:	Corporate Welsh Language Policy			Agenda Item no.	7.9
Meeting:	Board Meeting	Public	x	Meeting Date:	May 26th 2022
		Private			
Status *(please tick one only):*	Assurance		Approval	x	Information
Lead Executive:	Executive Director for People and Culture				
Report Author (Title):	Welsh Language Officer				

Main Report
Background and current situation:

In 2019, the Welsh Language Commissioner published the Welsh Language Standards which placed a duty on Cardiff and Vale University Health Board to provide an effective Welsh language service. Under Standard 79, the UHB is required to have a policy which facilitates and promotes use of the Welsh language.

The Welsh Language policy aims to enable all services and employees to offer a Welsh language service. The policy demonstrates the UHB's commitment towards ensuring that patients, service users, our workforce, and the public should be able to communicate in Welsh when using our services or in their place of work.

The policy covers a range of services offered by the organisation, including telephonic communications and consultation appointments with clinical staff. It also commits the organisation to increase our recruitment of staff with Welsh language skills and to develop Welsh language skills amongst our existing workforce.

The policy recognises the UHB's duty in ensuring compliance with the Welsh Language Measure (2011) and to progress and support the Welsh Government's Welsh Language in Healthcare Strategic Framework (the More than Just Words Strategy).

By the most recent Welsh Government estimates, Cardiff and the Vale of Glamorgan have almost 125,000 Welsh speakers living in the local area. The number of Welsh speakers using our services increases when considering those who access our specialist services living in the surrounding areas. Furthermore, research demonstrates a positive impact on patient outcomes when the individual being cared for are able to use their preferred language. Improved communication between patients and staff reduces anxieties and concerns raised. Through implementing this policy we will be creating a more inclusive organisation for our Welsh speaking population.

The co-operation of clinical boards and their local Welsh language leads will be essential in ensuring the organisation complies with this policy and the Welsh Language Standards.

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

Unnamed paper 05/13/2022 16:36:25

The Welsh Language Policy is a one which the organisation is required to develop and approve to comply with Welsh Language Standards. The policy has been finalised following consultation with staff.

Recommendation:

The Board is requested to:

a) **Approve** the Welsh Language Policy attached to 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		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	x	Integration		Collaboration		Involvement	x

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes
Failure to comply with the Welsh Language Standards could lead to further sanctions by the Welsh Language Commissioner.
Safety: Yes
Giving patients and service users the opportunity to use Welsh as their preferred language to communicate will improve patient safety. They will find it easier to understand and communicate with our staff.
Financial: Yes
Failure to comply with the Welsh Language Standards could ultimately lead to a £5,000 sanction by the Welsh Language Commissioner.
Workforce: Yes
The policy will help our workforce to use their preferred language of Welsh as part of their working life of the organisation. The policy would also help staff develop their Welsh language skills
Legal: Yes
The policy would assist the organisation to improve their compliance with the Welsh Language Standards Measure (2011)
Reputational: Yes
The policy would help the organisation to improve its reputation as a place that welcomes the use of the Welsh language by the public, patients, and staff.
Socio Economic: Yes
The policy will improve the recruitment of staff with Welsh language skills, which will extend the use of the Welsh language within the organisation. The policy would also improve the opportunity for patients and service users to use their preferred language of Welsh. Ultimately, it would contribute to the development of the language in the Cardiff and Vale area.
Equality and Health: Yes
The policy will support the creation of a more inclusive UHB.
Decarbonisation: No

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

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Equality & Health Impact Assessment for

Corporate Welsh Language Policy

Please read the Guidance Notes in Appendix 1 prior to commencing this Assessment

Please note:

- The completed Equality & Health Impact Assessment (EHIA) must be
  - Included as an appendix with the cover report when the strategy, policy, plan, procedure and/or service change is submitted for approval
  - Published on the UHB intranet and internet pages as part of the consultation (if applicable) and once agreed.
- Formal consultation must be undertaken, as required[1]
- Appendices 1-3 must be deleted prior to submission for approval

Please answer all questions:-

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Workforce and Organisational Development Welsh Language Officer Alun.Williams4@wales.nhs.uk
3.	Objectives of strategy/ policy/ plan/ procedure/ service	The objective for this policy is to ensure that the Cardiff and Vale University Health Board complies with the Welsh Language Standards 2019. Additionally, it seeks contribute to the Welsh Governments' More than Just Words Strategy and the Wellbeing of Future Generations strategy. It broadly seeks:

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[1] http://nww.cardiffandvale.wales.nhs.uk/portal/page?_pageid=253,73860407,253_73860411&_dad=portal&_schema=PORTAL

		• to improve the use of the Welsh Language within the organization and amongst its staff • to improve the healthcare and other services it can offer to patients and service users through the medium of Welsh.
4.	Evidence and background information considered. For example • population data • staff and service users' data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages Population pyramids are available from Public Health Wales Observatory[2] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[3].	**Local population data.** According to the latest Welsh Government figures from StatsWales, a total of 124,900 people in Cardiff and Vale of Glamorgan area can speak Welsh, approximately 23.4% of the population: Annual Population Survey - Ability to speak Welsh by local authority and year (gov.wales) **Welsh Language Skills on ESR** Cardiff and Vale University Health Board employs over 17,000 staff. Cardiff and Vale endeavours to capture information about the current Welsh language skills of our staff by encouraging them to self-assess and record their skills via the NHS Electronic Staff Record (ESR). However, not all staff have access to ESR so the data is currently incomplete. Current data shows that 36% of the staff have registered their language skills. Currently, there are 274 members of staff who've registered their Welsh Language skills as fluent, 185 members of staff with a higher level of Welsh Language skills, 145 with intermediate skills, 215 with foundation and 768 members of staff with basic skills. The organisation will be planning to improve the level of Welsh Language registration on ESR during the coming year. **Welsh Language Standards** In 2019, the Welsh Language Commission provided the set of 121 standards that the organisation was expected to comply to ensure it provided a quality healthcare and public service through the medium of Welsh. (*ranging from telephone services and correspondence to one-to-one meetings with clinical*

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[2] http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf
[3] http://www.cardiffandvaleuhb.wales.nhs.uk/the-challenges-we-face

		consultants): Welsh Language in Healthcare - Cardiff and Vale University Health Board (nhs.wales) **The Welsh Government More than Just Words Strategic Framework** The organisation is also required to implement this strategic framework, introduced by the Welsh Government to increase the level of Welsh language services offered by the organisation. It ensures that patients and service users are pro-actively asked for their language choice through their patient journey and improve the awareness and importance of the Welsh language choice amongst the staff. The strategy also puts importance of improving Welsh Language skills of staff and encourages the recruitment of staff with Welsh Language skills: More than just words: action plan 2019 to 2020 | GOV.WALES **Welsh Language training** The organisation has been working in partnership with the National Centre for Learning Welsh and been offering fully funded courses in developing Welsh language skills. Over 300 members of staff have been taking advantage of the opportunity and registering on the courses. **Patient Experience Research** Extensive research shows that there is a positive impact of offering Welsh medium care. The Mwy na geiriau / More than just words strategy provides patient/staff experience of the impact in providing healthcare in Welsh: Service Provider: *"Throughout my career, I've seen many situations where there has been a lack of availability of Welsh-medium staff which has led to a misinterpretation of patients' needs or even a misdiagnosis because patients are confused, in pain or have lost the ability to understand and speak English"* Service User: *"In Welsh I can talk about experiences and personal things. The flow isn't the same in English. You have to translate, especially when you are*

Mohamed-Sarah
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		talking about something that is so important." Service User*: "I think it is hard to ask for a Welsh language service. You don't want to upset the people who are treating you."* Further information: Mwy na geiriau / More than Just Words Strategic Document.
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	The policy would affect the general public, patients, service users and staff: 1. The public would receive information, notices and messages in the language of their choice of English or Welsh. 2. Patient and service users will be able to receive healthcare treatment and service through the chosen language of either Welsh or English. 3. Staff will have the right in certain areas to use their preferred language of Welsh.

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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 For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65 Mohamed,Sarah 05/13/2022 16:36:25	There will be a positive impact on people under the age of 18 who may find it easier to communicate through the medium of Welsh. This may due to the language they use within their home, school or community and lack confidence to communicate in English. There will be a positive impact for older patient and service users who prefer to use Welsh when discussing their healthcare. This is particularly important for patients with dementia and the ability to speak Welsh would be crucial when talking with nursing and medical staff.	Ensuring that language choice is being asked during patient intake and registered on patient management systems. Ensuring that front line areas are aware of the language choice made by the patient, and ensuring they provide best care as possible in that language.	1. Achieve compliance to the Welsh language standards around patient choice on their preferred language, especially when receiving information or having face to face services. 2. Progress on the More than Just Words strategy of encouraging staff to use Welsh language skills and use them with patients.

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
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	Patients and services users with a disability will be able to use their preferred language of Welsh to improve communication with staff. This will help them to reduce stress and anxiety. Welsh speaking service users with long term illnesses and disabilities who are used to speaking welsh with families, communities and friends will find it easier to discuss their ailments in Welsh. Mental health and wellbeing – for some staff, the opportunity to use the Welsh language in distressing situations such as grievance and disciplinary meetings may enhance wellbeing and reduce anxiety relating to expressing / conveying information and feelings in such meetings.	1. Ensure that they are given a language choice during intake. 2. Front line areas will ensure that they are able to use Welsh in face-to-face areas as much as possible. 3. Provide bilingual patient information. 4. Measures in place for staff to use their preferred language of Welsh in situations as described under the organisational section of the Welsh Language Standards.	1. Achieve compliance to the Welsh language standards around patient choice on their preferred language, especially when receiving information or having face to face services. 2. Progress on the More than Just Words strategy of encouraging staff to use Welsh language skills and use them with patients.

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender	Patients of different genders will be able to use their preferred language choice of Welsh during treatment. This will help to reduce anxiety and stress during distressing situations. They will be able to convey their emotions and information better. Welsh speakers come from diverse range of backgrounds including those who are undergoing reassignment. Many of them will find it easier to discuss their treatment/process with our healthcare staff in their preferred language.	1. Ensure that they are given a language choice during patient intake. 2. Front line areas will ensure that they are able to use Welsh in face-to-face areas as much as possible. 3. Provide bilingual patient information.	1. Achieve compliance to the Welsh language standards around patient choice on their preferred language, especially when receiving information or having face to face services. 2. Progress on the More than Just Words strategy of encouraging staff to use Welsh language skills and use them with patients.
6.4 People who are married or who have a civil partner. Mohamed,Sarah 05/13/2022 16:36:25	Patients who are married or have a civil partnership might use Welsh with their partners throughout their partnership/marriage. Their partners/spouse might prefer to use Welsh regardless of the patients choice, especially when discussing their	1.Ensure that they are given a language choice during intake and/or discussion about their healthcare. 2. Front line areas will ensure that they are able to use Welsh in face-to-face areas as much as possible.	1. Achieve compliance to the Welsh language standards around patient choice on their preferred language, especially when receiving information or having face to face services. 2. Progress on the More than Just Words strategy of encouraging staff to use Welsh language skills

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
	partners'/spouses care.	3. Provide bilingual patient information.	and use them with patients.
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.	Women will be able to use their preferred language of Welsh as part the maternity services they receive by the organisation. It will improve their communication to staff and convey their emotions and feelings in stressful situation. It will also encourage them to use Welsh as part of their maternity period if they want to maintain Welsh as the language of communication between them and the baby.	1. Ensure that they are given a language choice during intake. 2. Front line areas will ensure that they are able to use Welsh in face-to-face areas as much as possible. 3. Provide bilingual patient information.	1. Achieve compliance to the Welsh language standards around patient choice on their preferred language, especially when receiving information or having face to face services. 2.Progress on the More than Just Words strategy of encouraging staff to use Welsh language skills and use them with patients.
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers Mohamed,Sarah 05/13/2022 16:36:25	Patients and service users of different race, nationality colour, culture or ethnic origin will be given a language choice when receiving healthcare treatment. Those who prefer to use Welsh will then be able to communicate easier with our staff when receiving treatment.	1. Ensure that they are given a language choice during intake. 2. Front line areas will ensure that they are able to use Welsh in face-to-face areas as much as possible. 3. Provide bilingual patient information.	1. Achieve compliance to the Welsh language standards around patient choice on their preferred language, especially when receiving information or having face to face services. 2. Progress on the More than Just Words strategy of encouraging staff to use Welsh language skills and use them with patients.

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
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	Welsh speakers might hold their religious faith through the medium of Welsh. Therefore, they might prefer to discuss any faith aspects of their care through the medium of Welsh.	1. Ensure that they are given a language choice during intake. 2. Front line areas will ensure that they are able to use Welsh in face-to-face areas as much as possible. 3. Provide bilingual patient information.	1. Achieve compliance to the Welsh language standards around patient choice on their preferred language, especially when receiving information or having face to face services. 2. Progress on the More than Just Words strategy of encouraging staff to use Welsh language skills and use them with patients.
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)	Welsh speakers come from a diverse range of communities, including from the LBTG community. Many of them prefer to receive healthcare in the preferred language of Welsh	1. Ensure that they are given a language choice during intake. 2. Front line areas will ensure that they are able to use Welsh in face-to-face areas as much as possible. 3. Provide bilingual patient information.	1. Achieve compliance to the Welsh language standards around patient choice on their preferred language, especially when receiving information or having face to face services. 2. Progress on the More than Just Words strategy of encouraging staff to use Welsh language skills and use them with patients.
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	Patients and service users who prefer to use Welsh will be able to use their preferred language of Welsh when receiving healthcare service. This will help them to communicate better with	1. Ensure that they are given a language choice during intake. 2. Front line areas will ensure that they are able to use Welsh in face-to-face areas as	1. Achieve compliance to the Welsh language standards around patient choice on their preferred language, especially when receiving information or having face to face services.

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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
vibrant culture and thriving Welsh language	staff members, leading to better outcomes. It will also lead to reduction in anxiety and stress during distressing moments.	much as possible. 3. Provide bilingual patient information.	2. Progress on the More than Just Words strategy of encouraging staff to use Welsh language skills and use them with patients.
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	Welsh speakers come from a diverse range of communities. Many of them prefer to receive healthcare in the preferred language of Welsh	1. Ensure that they are given a language choice during intake. 2. Front line areas will ensure that they are able to use Welsh in face-to-face areas as much as possible. 3. Provide bilingual patient information.	1. Achieve compliance to the Welsh language standards around patient choice on their preferred language, especially when receiving information or having face to face services. 2.Progress on the More than Just Words strategy of encouraging staff to use Welsh language skills and use them with patients.
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	Our Welsh speaking patients and service users range across the South Wales area, especially for our specialist services. They will be able to continue to use their preferred language of Welsh with this organisation.	1. Ensure that they are given a language choice during intake. 2. Front line areas will ensure that they are able to use Welsh in face-to-face areas as much as possible. 3. Provide bilingual patient information.	1. Achieve compliance to the Welsh language standards around patient choice on their preferred language, especially when receiving information or having face to face services. 2.Progress on the More than Just Words strategy of encouraging staff to use Welsh language skills and use them with patients.

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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
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	None		

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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	**Equity in access : I**mproved access and communications for patients/service users who preferred language is Welsh.	1. Ensure that they are given a language choice during intake. 2. Front line areas will ensure that they are able to use Welsh in face-to-face areas as much as possible. 3. Provide bilingual patient information – including messages through social media and online information.	1. Achieve compliance to the Welsh language standards around patient choice on their preferred language, especially when receiving information or having face to face services. 2.Progress on the More than Just Words strategy of encouraging staff to use Welsh language skills and use them with patients.
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (eg	Improved quality of information for those who prefer to speak Welsh – would lead to more people receive messages on healthier lifestyles.	1. Ensure that they are given a language choice during intake. 2. Front line areas will ensure that they are able to use Welsh in face-to-face areas as much as possible. 3. Provide bilingual patient information – including messages through social media and online information.	1. Achieve compliance to the Welsh language standards around patient choice on their preferred language, especially when receiving information or having face to face services. 2.Progress on the More than Just Words strategy of encouraging staff to use Welsh language skills and use them with patients.

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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
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		These will include how to maintain healthy lifestyles.	
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions Well-being Goal – A prosperous Wales	It would help with staff with welsh speaking skills be able to communicate and bond better with their patients, leading to improve outcomes for both parties.	1. Ensure that they are given a language choice during intake. 2. Front line areas will ensure that they are able to use Welsh in face-to-face areas as much as possible. 3. Provide bilingual patient information – including messages through social media and online information. These will include how to maintain healthy lifestyles.	1. Achieve compliance to the Welsh language standards around patient choice on their preferred language, especially when receiving information or having face to face services. 2.Progress on the More than Just Words strategy of encouraging staff to use Welsh language skills and use them with patients.
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	Clear bilingual information on signs and public information will help patients navigate easier around the hospitals.	Bilingual signs and signpostings	1. Achieve compliance to the Welsh language standards around patient choice on their preferred language, especially when receiving information or having face to face services.

Submitted on 13/03/2024 15:39:53

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
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 preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales			2.Progress on the More than Just Words strategy of encouraging staff to use Welsh language skills and use them with patients.
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	Patients and service users will be able to use their will promote a feeling of belonging and minimise social isolation.	1. Ensure that they are given a language choice during intake. 2. Front line areas will ensure that they are able to use Welsh in face-to-face areas as much as possible. 3. Provide bilingual patient information – including messages through social media and online information. These will include how to maintain healthy lifestyles.	1. Achieve compliance to the Welsh language standards around patient choice on their preferred language, especially when receiving information or having face to face services. 2.Progress on the More than Just Words strategy of encouraging staff to use Welsh language skills and use them with patients.

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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	Being able to use Welsh will help with the Welsh Governments aim of a million Welsh speakers by 2050.	1. Ensure that they are given a language choice during intake. 2. Front line areas will ensure that they are able to use Welsh in face-to-face areas as much as possible. 3. Provide bilingual patient information – including messages through social media and online information. 4. Extend the use of Welsh language lessons for staff. 5. Recruit Welsh speaking staff to the organisation to drive up the use of the language internally.	1. Achieve compliance to the Welsh language standards around patient choice on their preferred language, especially when receiving information or having face to face services. 2. Progress on the More than Just Words strategy of encouraging staff to use Welsh language skills and use them with patients.

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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	Adopting the policy will help patients and services user to have an improve care in their preferred language of Welsh.

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?	1. Achieve compliance to the Welsh language standards around patient choice on language choice, information and face to face services. 2. Progress on the More than Just Words strategy of encouraging staff to use Welsh language skills and use them with patients.	Welsh Language Officer/ Equality Adviser/ Assistant Director for Organisational Development	31/03/2023	1. Achieve compliance to the Welsh language standards around patient choice on their preferred language, especially when receiving information or having face to face services. 2. Progress on the More than Just Words strategy of encouraging staff to use Welsh language skills and use them with patients.

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	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	No			

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	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.4 What are the next steps? Some suggestions:- • Decide whether the strategy, policy, plan, procedure and/or service proposal: o continues unchanged as there are no significant negative impacts o adjusts to account for the negative impacts o continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so) o stops. • Have your strategy, policy, plan, procedure and/or service proposal approved • Publish your report of this impact assessment • Monitor and review	The policy continues unchanged.	Welsh Languag Officer / Equalit Manager	31/03/2023	Work with the Workforce and Organisational Development Directorate to implement the polic

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Appendix 1

Equality & Health Impact Assessment

Developing strategies, policies, plans and services that reflect our Mission of 'Caring for People, Keeping People Well'

Guidance

The University Health Board's (the UHB's) Strategy 'Shaping Our Future Wellbeing' (2015-2025) outlines how we will meet the health and care needs of our population, working with key partner organisations to deliver services that reflect the UHB's values. Our population has varied and diverse needs with some of our communities and population groups requiring additional consideration and support. With this in mind, when developing or reviewing any strategies, policies, plans, procedures or services it will be required that the following issues are explicitly included and addressed from the outset:-

- Equitable access to services
- Service delivery that addresses health inequalities
- Sustainability and how the UHB is meeting the requirements of the Well-being of Future Generations (Wales) Act (2015)[4]

This explicit consideration of the above will apply to strategies (e.g. Shaping Our Future Strategy, Estates Strategy), policies (e.g. catering policies, procurement policies), plans (e.g. Clinical Board operational plans, Diabetes Delivery Plan), procedures (for example Varicella Zoster - chickenpox/shingles - Infection Control Procedure) and services /activity (e.g. developing new clinical services, setting up a weight management service).

Considering and completing the Equality & Health Impact Assessment (EHIA) in parallel with development stages will ensure that all UHB strategies, policies, plans, procedures or services comply with relevant statutory obligations and responsibilities and at the same time takes forward the UHB's Vision, 'a person's chance of leading a healthy life is the same wherever they live and whoever they are'. This process should be proportionate but still provide helpful and robust information to support decision making. Where a more detailed consideration of an issue is required, the EHIA will identify if there is a need for a full impact assessment.

Some key statutory/mandatory requirements that strategies, policies, plans, procedures and services must reflect include:

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[4] http://thewaleswewant.co.uk/about/well-being-future-generations-wales-act-2015

- All Wales Standards for Communication and Information for People with Sensory Loss (2014)[5]
- Equality Act 2010[6]
- Well-being of Future Generations (Wales) Act 2015[7]
- Social Services and Well-being (Wales) Act 2015[8]
- Health Impact Assessment (non statutory but good practice)[9]
- The Human Rights Act 1998[10]
- United Nations Convention on the Rights of the Child 1989[11]
- United Nations Convention on Rights of Persons with Disabilities 2009[12]
- United Nations Principles for Older Persons 1991[13]
- Welsh Health Circular (2015) NHS Wales Infrastructure Investment Guidance[14]
- Welsh Government Health & Care Standards 2015[15]
- Welsh Language (Wales) Measure 2011[16]

This EHIA allows us to meet the requirements of the above as part of an integrated impact assessment method that brings together Equality Impact Assessment (EQIA) and Health Impact Assessment (HIA). A number of statutory /mandatory requirements will need to be included and failure to comply with these requirements, or demonstrate due regard, can expose the UHB to legal challenge or other forms of reproach. This means showing due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation;
- advance equality of opportunity between different groups; and
- foster good relations between different groups.

EQIAs assess whether a proposed policy, procedure, service change or plan will affect people differently on the basis of their 'protected characteristics' (ie their age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion, sex or sexual orientation) and if it will affect their human rights. It also takes account of caring responsibilities and Welsh Language issues.

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[5] http://gov.wales/topics/health/publications/health/guidance/standards/?lang=en
[6] https://www.gov.uk/guidance/equality-act-2010-guidance
[7] http://gov.wales/topics/people-and-communities/people/future-generations-act/?lang=en
[8] http://gov.wales/topics/health/socialcare/act/?lang=en
[9] http://www.wales.nhs.uk/sites3/page.cfm?orgid=522&pid=63782
[10] https://www.equalityhumanrights.com/en/human-rights/human-rights-act
[11] http://www.unicef.org.uk/UNICEFs-Work/UN-Convention
[12] http://www.un.org/disabilities/convention/conventionfull.shtml
[13] http://www.ohchr.org/EN/ProfessionalInterest/Pages/OlderPersons.aspx
[14] http://www.wales.nhs.uk/sites3/Documents/254/WHC-2015-012%20-%20English%20Version.pdf
[15] http://gov.wales/topics/health/publications/health/guidance/care-standards/?lang=en
[16] http://www.legislation.gov.uk/mwa/2011/1/contents/enacted

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They provide a systematic way of ensuring that legal obligations are met and are a practical means of examining new and existing policies and practices to determine what impact they may have on equality for those affected by the outcomes.

HIAs assess the potential impact of any change or amendment to a policy, service, plan, procedure or programme on the health of the population and on the distribution of those effects within the population, particularly within vulnerable groups. HIAs help identify how people may be affected differently on the basis of where they live and potential impacts on health inequalities and health equity. HIA increases understanding of potential health impacts on those living in the most deprived communities, improves service delivery to ensure that those with the greatest health needs receive a larger proportion of attention and highlights gaps and barriers in services.

The **EHIA** brings together both impact assessments in to a single tool and helps to assess the impact of the strategy, policy, plan, procedure and/or service. Using the EHIA from the outset and during development stages will help identify those most affected by the proposed revisions or changes and inform plans for engagement and co-production. Engaging with those most affected and co-producing any changes or revisions will result in a set of recommendations to mitigate negative, and enhance positive impacts. Throughout the assessment, 'health' is not restricted to medical conditions but includes the wide range of influences on people's well-being including, but not limited to, experience of discrimination, access to transport, education, housing quality and employment.

Throughout the development of the strategy, policy, plan, procedure or service, in addition to the questions in the EHIA, you are required to remember our values of *care, trust, respect, personal responsibility, integrity and kindness* and to take the Human Rights Act 1998 into account. All NHS organisations have a duty to act compatibly with and to respect, protect and fulfil the rights set out in the Human Rights Act. Further detail on the Act is available in Appendix 2.

Completion of the EHIA should be an iterative process and commenced as soon as you begin to develop a strategy, policy, plan, procedure and/or service proposal and used again as the work progresses to keep informing you of those most affected and to inform mitigating actions. It should be led by the individual responsible for the strategy, policy, plan, procedure and/or service and be completed with relevant others or as part of a facilitated session. Some useful tips are included in Appendix 3.

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For further information or if you require support to facilitate a session, please contact Susan Toner, Principal Health Promotion Specialist (susan.toner@wales.nh.uk) or Keithley Wilkinson, Equality Manager (Keithley.wilkinson@wales.nhs.uk)

Based on

- Cardiff Council (2013) Statutory Screening Tool Guidance
- NHS Scotland (2011) Health Inequalities Impact Assessment: An approach to fair and effective policy making. Guidance, tools and templates[17]
- Wales Health Impact Assessment Support Unit (2012) Health Impact Assessment: A Practical Guide[18]

[17] http://www.healthscotland.com/uploads/documents/5563-HIIA%20-%20An%20approach%20to%20fair%20and%20effective%20policy%20making.pdf (accessed 4 January 2016)
[18] http://www.wales.nhs.uk/sites3/page.cfm?orgid=522&pid=63782 (accessed on 4 January 2016)

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Appendix 2 – The Human Rights Act 1998[19]

The Act sets out our human rights in a series of 'Articles'. Each Article deals with a different right. These are all taken from the European Convention on Human Rights and are commonly known as 'the Convention Rights':

1. Article 2 Right to life. NHS examples: the protection and promotion of the safety and welfare of patients and staff
2. Article 3 Freedom from torture and inhuman or degrading treatment. NHS examples: issues of dignity and privacy, the protection and promotion of the safety and welfare of patients and staff, the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travelers, issues of patient restraint and control
3. Article 4 Freedom from slavery and forced labour
4. Article 5 Right to liberty and security. NHS examples: issues of patient choice, control, empowerment and independence, issues of patient restraint and control
5. Article 6 Right to a fair trial
6. Article 7 No punishment without law
7. Article 8 Respect for your private and family life, home and correspondence. NHS examples: issues of dignity and privacy, the protection and promotion of the safety and welfare of patients and staff, the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travelers, the right of a patient or employee to enjoy their family and/or private life
8. Article 9 Freedom of thought, belief and religion. NHS examples: the protection and promotion of the safety and welfare of patients and staff, the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travelers
9. Article 10 Freedom of expression. NHS examples: the right to hold and express opinions and to receive and impart information and ideas to others, procedures around whistle-blowing when informing on improper practices of employers where it is a protected disclosure
10. Article 11 Freedom of assembly and association
11. Article 12 Right to marry and start a family
12. Article 14 Protection from discrimination in respect of these rights and freedoms. NHS examples: refusal of medical treatment to an older person solely because of their age, patients presented with health options without the use of an interpreter to meet need, discrimination against UHB staff on the basis of their caring responsibilities at home
13. Protocol 1, Article 1 Right to peaceful enjoyment of your property
14. Protocol 1, Article 2 Right to education
15. Protocol 1, Article 3 Right to participate in free elections
16. Protocol 13, Article 1 Abolition of the death penalty

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[19] https://www.equalityhumanrights.com/en/human-rights/human-rights-act

Appendix 3

Tips

- Be clear about the policy or decision's rationale, objectives, delivery method and stakeholders.
- Work through the Toolkit early in the design and development stages and make use of it as the work progresses to inform you of those most affected and inform mitigating actions
- Allow adequate time to complete the Equality Health Impact Assessment
- Identify what data you already have and what are the gaps.
- Engage with stakeholders and those most affected early. View them as active partners rather than passive recipients of your services.
- Remember to consider the impact of your decisions on your staff as well as the public.
- Record which organisations and protected characteristic groups you engaged with, when you engaged with them and how you did so (for example, workshop, public meeting, written submission).
- Produce a summary table describing the issues affecting each protected group and what the potential mitigations are.
- Report on positive impacts as well as negative ones.
- Remember what the Equality Act says – how can this policy or decision help foster good relations between different groups?
- Do it with other people! Talk to colleagues, bounce ideas, seek views and opinions.

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Welsh Language Corporate Policy

Policy Statement

To ensure the Health Board delivers its aims and responsibility on the Welsh Language Policy, we are committed that patients, service users and the public will be able to use their preferred language of Welsh with us. Staff will also be able to use their preferred language of Welsh when applicable according to the Standards.

Providing first-rate health services to the population of Cardiff and the Vale is the primary function of this organisation, but as is the same for every organisation providing healthcare, there are a range of regulations under which we must operate, and not only those regulations that deal directly with health matters.

Whilst our individual departments may specialise in aspects of clinical care for example, and operate under strict guidance in those specialist areas, corporately the organisation must also comply with matters such as Health and Safety, Equalities or Employment Regulations.

Compliance with the Welsh Language Standards is no different, and non-compliance carries the same organisational risk as does failing to comply with any other duties placed on our University Health Board.

Cardiff and Vale University Health Board supports our patients and services users who require a Welsh language provision when discussing their healthcare. We also recognise the importance for staff to use their preferred language of Welsh when applicable, and developing their Welsh skills.

The Board is committed to providing the best experience to our patients in their preferred language. Evidence from research on patient language choice has shown the positive outcomes for the patients when they are able to use their preferred language, including improved communication between patient and staff and decrease in anxieties and concerns.

We recognise the importance for staff to use their preferred language of Welsh when applicable and developing their Welsh skills. We also recognise the duty the UHB in ensuring that it complies with the Welsh Language Measure (2011) and progress and support on the Welsh Government's Welsh Language in Healthcare Strategic Framework (the More than Just Words Strategy).

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Document Title: Welsh Language Corporate Policy	2th of 16 pages	Approval Date:
Reference Number:		Next Review:
Version Number		Date of Publication:
Approved by :		

(Note: Write the policy statement in the first person and explain exactly what the Health Board is committed to doing.)

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Policy Commitment

The policy will enable each service/team within CAVUHB to provide a bilingual service, and ensure compliance with legislation set out in the Welsh Language Standards, as applied health boards under the Welsh Language Standards (No. 7) Regulations 2018

Supporting Procedures and Written Control Documents

This Policy describe the following with regards to ensuring care through the preferred language of Welsh.

Other supporting documents are:

- Welsh Language Standards Compliance Notice for Cardiff and Vale UHB
- More than Just Words Strategic Framework

Commented [AW(aVU-CM1]: hyperlinks

Scope

This policy applies to all of our staff in all locations including those with honorary contracts and has links to partnership working and third-party contractors.

Equality and Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has been completed and this found there to be a positive.

Policy Approved by	Strategy and Delivery Committee
Group with authority to approve procedures written to explain how this policy will be implemented	Equality Strategy and Welsh Language Standards Group
Accountable Executive or Clinical Board Director	Executive Director for People and Culture

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Document Title: Welsh Language Corporate Policy	3th of 16 pages	Approval Date:
Reference Number:		Next Review:
Version Number		Date of Publication:
Approved by :		

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	Date approved by Board/Committee/Sub Committee dd/mm/yyyy	TBA *[To be inserted by the Gov. Dept]*	*New Policy*
2			

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1. Scope

1.1 Employees

The Strategy will apply to all employees and Bank Workers of CAVUHB.

1.2 Primary Care Contractors

Primary Care Contractors (i.e. General Practitioners, Dentists, Pharmacists and Opticians) are independent, self-employed contactors and are not normally employees of CAVUHB; however, Primary Care Contractors have a requirement to follow the principles and requirements of legislation and policies under the Welsh Language Act 2011 to provide services bilingually. In relation to this Strategy, CAVUHB will provide support, advice and guidance to Primary Care Contractors.

1.3 Others

Contracted third parties (including agency staff), students, volunteers, trainees, work placements, staff from other organisations who work from all sites, individuals contracted directly by CAVUHB will need to comply with the requirements stated within this strategy whilst working on CAVUHB premises.

Assurance will need to be provided to relevant managers by the Welsh Language Team that this group of individuals are adequately trained to a satisfactory standard, depending on role and risk assessment.

2. Legislative and NHS Requirements

2.1 Welsh Language (Wales) Measure 2011

The Measure placed duties on organisations in Wales to deliver services through the medium of Welsh, consider the language when making policies, encourage more Welsh Language use in the workplace, promote the language and keep records of how they are performing their duties.

This was enacted for Health Boards via the Welsh Language Standards (No. 7) Regulations 2018, and those that are relevant to CAVUHB can be found in our Compliance Notice, which is on our Welsh Language in Healthcare web page here.

2.2 The Active Offer

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An Active Offer means that a service is provided in Welsh without someone having to ask for it. It is the responsibility of everyone who provides care services for people and their families across Wales to deliver the Active Offer. This includes health services, social care services and social services.

2.3 The Well-Being of Future Generations (Wales) Act 2015

The Act states that the Welsh Language should be given due consideration as part of setting and delivering well-being objectives reflecting its official status in Wales and the national well-being goal of “a thriving Welsh Language”.

Where specific outcomes are identified as priorities e.g. promoting or protecting the language, or ensuring the adequate bilingual provision of services that meets local need, these should considered in the setting of well-being objectives.

The seven Well-being Goals also includes A Healthier Wales, and the Welsh language forms a part of this aim also, and each of the other. The Welsh Language Commissioner’s 2018 guidance document on Promotion Strategies for example contained an adapted wheel infographic showing how the Welsh language is a part of each of the seven Goals.

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3 Implementation

Reflecting the identified areas within the Welsh Language Standards, CAVUHB will focus on five main areas:

Service Delivery (Standards 1-68).
Policy Making (Standards 69-78).
Operational Standards (Standards 79-114).
Record Keeping (Standards 115-117).
Supplementary Standards (Standards 118-121).

3.1 Written Communication

The public are entitled to communicate with CAVUHB in Welsh and English. Should CAVUHB receive written correspondence in Welsh from a member of the public, CAVUHB will respond in Welsh, unless the correspondent has stated otherwise.

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Should a person contact CAVUHB for the first time, via email, staff will include an email signature requesting the language preference of the person, and use the information received to communicate from that point on in the preferred language of that person.

Letterheads, email signatures and any corporate identity will be bilingula in accordance with the relevant Standards.

3.2 Telephone Communication

Staff answering the telephone on a main line e.g. the telephone line advertised externally, will answer the telephone bilingually at all times.

Should a caller request a Welsh Language Service, staff will make every effort to transfer that call to a Welsh speaking member of staff.

If they are not able to communicate in Welsh, they will inform the caller that they may use a translation service to continue the call (at the out of hours call centre) or continue the call in English if a discussion on a specific subject matter is required.

When CAVUHB advertise telephone numbers, they will advertise the Welsh and English lines available and provide this information as part of its publicity.

For calls made to direct lines at CAVUHB, again, staff will answer the telephone bilingually making a greeting to the caller and follow the same protocol as stated for main telephone lines.

Staff will be encouraged to use their Welsh Language skills, whatever their level or ability, in order to support the caller's language preference.

If staff have a telephone answer machine service, then the message will be bilingual and staff will be informed of the process in order to record a bilingual message using an internal guidance document.

Staff who communicate with a person for the first time will ask whether they wish to use the Welsh Language in future calls/ correspondence. A record of that wish will be kept and used to inform the language of future calls/correspondence with that person.

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3.3 Reception Areas

Welsh speaking staff will identify themselves as such by wearing a Welsh lanyard or pin badge. Staff members learning Welsh will also identify themselves, in order to support patients requiring a Welsh language service.

Staff able to communicate in Welsh will support patients requiring a Welsh Language service, and should a Welsh speaking member of staff be unavailable staff will be aware that they can access language support via "Language Line", a translation support service.

Information on "Language Line" is available to staff via an all staff guidance document.

Every reception area will display a sign stating that patients or visitors, their families/carers and staff are welcome to use the Welsh Language at the reception.

3.4 Face-to-Face Meetings Organised by CAVUHB

When inviting more than one person to a meeting, staff will ask every person whether they wish to use Welsh Language to communicate at the meeting. If at least 10% (but less than 100%) of the invited persons inform the meeting organizer that they wish to use Welsh Language, they will arrange for translation services to be provided.

CAVUHB will advertise public events bilingually, and all materials for the event will be available bilingually.

Attendees will be asked prior to public events to identify their language preference and communication needs, and simultaneous translation services will be arranged if required.

The Welsh language will not be treated less favourably than English language communication at public events.

Should CAVUHB fund at least 50% of a public event, it will ensure that the Welsh Language is not treated less favourably than the English Language.

Speakers at the public event will be asked if they wish to present in Welsh, and if so, staff will ensure that this is possible, and translation services for attendees is organised.

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3.5 Clinical Consultations

CAVUHB will publish a plan for each 5 year period setting out the extent to which we are able to carry out clinical consultations in Welsh.

The plan will detail the actions CAVUHB intends to take in order to increase the ability to offer this service and a timetable for its actions.

An assessment of the success of this plan will be published, three years after its development and the assessment will be published.

3.6 Documents, Publications and Forms

All public-facing CAVUHB documents and publications, and all forms that are to be completed by an individual (e.g. a consent form for treatment) or available to one or more individual will be available in Welsh and English.

The Welsh Language will not be treated less favourably in terms of clarity or size, and CAVUHB will not differentiate between the Welsh and English version in relation to any requirements that are relevant to the document or form e.g. a deadline for submitting a form or a time scale for response.

All notices in public areas will be produced bilingually, or where necessary a separate Welsh and English Language version may be created, but in such cases both versions will be displayed with equal prominence and at the same time.

3.7 Websites, Social Media Accounts and Apps

CAVUHB's website will be available in English and Welsh and will be equally accessible to the user in both languages. CAVUHB's website will not treat the Welsh Language less favourably than the English Language.

Corporate Social Media accounts will be available in English and Welsh, and should a question be raised in Welsh, a response will be given in Welsh.

All Apps that CAVUHB publishes will be fully functional in Welsh as well as English (other than clinical apps intended for staff only).

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3.8 Signage

All newly erected signs (as of May 2019) including temporary signs or display notices, will convey the same information in Welsh and English. Welsh Language text on signs and notices will be accurate in terms of meaning and expression and placed above, or to the left, of the English text, as required by the relevant Standard.

3.9 Third Party Contracts and Tendering

When an invitation for a tender is published, CAVUHB will state that tenders may be submitted in Welsh. If such a tender is submitted then it will not be treated less favourably than a tender in the English language e.g. timescales for receiving tenders and for informing tenderers of decisions.

Tenders for third party contracts must include a section informing the bidders of the requirements to comply with the Welsh Language Standards, where that is a relevant consideration in the services to be provided (this could range from signage as part of works at a hospital location to bilingual services in the provision of healthcare services).

3.10 Policy Development

Any new policy formulated, reviewed or revised by CAVUHB will consider the effects that policy has on:

Opportunities for persons to use the Welsh Language and;
Treating the Welsh Language no less favourably than the English Language.

When CAVUHB publishes a consultation document relating to a policy decision, CAVUHB will consider and seek views on a) and b) above and how the policy can be formulated or revised so that it would not have an adverse effect on the use of the Welsh Language. This will be part of the Equality Impact assessment process.

When research is commissioned or undertaken in order to assist the development of a policy decision CAVUHB will ensure that it considers how it would have positive effects on a) and b) above.

The impact assessment will accompany any decision and approval reports to the Board.

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3.11 Recruitment and Staffing

All CAVUHB documents relating to recruitment and staffing matters (health board policies, application forms, workplace guidance etc) will be available in Welsh and in English.

CAVUHB will state on its internal correspondence with staff, that should staff wish to receive any paper correspondence that relates to their employment in Welsh, then CAVUHB will make this available.

E-Mail signature and out of office messages wording for staff is provided as part of a guidance written to support staff in providing a bilingual service.

Staff are encouraged to identify themselves as Welsh speakers or Welsh Learners and given a method of identification, either using a lanyard or a badge, in order to support patients and delegates.

All posts will be assessed for their Welsh language skills requirements and advertised accordingly. Where any post is offered to an individual, CAVUHB will ask whether a Welsh Language contract of employment is required and if that is the individual's preference, then CAVUHB will supply that contract in Welsh.

Using CAVUHB's Bilingual Skills Strategy staff will assess the language requirements of new posts and categorise posts as follows:

Welsh Speaking Essential.
Welsh Speaking Desirable.
Welsh Skills are not necessary.

Where posts are identified as essential or desirable CAVUHB will specify that as part of the advertisement. Posts will be advertised in Welsh and English and a response will be given in Welsh should an application be submitted in Welsh. Applications for posts will be clear that an applicant may conduct their interview in Welsh should they require to do so.

Application forms for posts and subsequent materials, will not be treated less favourably than the English Language versions of those documents.

Staff wishing to make a complaint may do so in Welsh and should a complaint be made in Welsh, a response will be given in Welsh.

CAVUHB documentation setting out the complaints and disciplinary procedures will state that a Welsh speaking member of staff may make a complaint or hold a disciplinary in Welsh. Should a meeting be required with a

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member of staff in relation to a complaint, CAVUHB will make it known that a Welsh speaker has the right to conduct that meeting in Welsh. CAVUHB will provide this by using a simultaneous translator if a Welsh speaking member of staff is not available or specifically skilled to deal with that complaint.

3.12 Training and Development

Staff member's Welsh Language skills are assessed via the competency levels within ESR and these skills can be updated according to staff training and development.

Opportunities for staff to receive Welsh Language training during working hours will be given either via on-line training or dedicated classroom attendance courses.

Staff are provided with opportunities to receive Welsh Language awareness sessions as part of the Corporate Induction programme, which includes Welsh Language awareness and information about the Welsh Language Standards.

This training is also available to primary care contractors and internal staff and can be arranged through the Equality and Welsh Language Team.

3.13 The Intranet

CAVUHB will provide a dedicated Intranet page for staff in order to promote and facilitate the use of the Welsh Language. This will include access to training opportunities, guidance on how to arrange both written and simultaneous translation, and how to obtain resources such as Welsh language software or lanyards and badges to identify staff members as Welsh speakers.

The Home Page of CAVUHB's intranet will be available in Welsh and dedicated pages relating to Workforce and OD provision will also be available in Welsh.

Should a Welsh speaking member of staff require the spell checking and grammar facility, this will be available to download on the Intranet site or via a service point call.

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3.14 Complaints

Any complaint made in Welsh by a patient or member of the public will be dealt with in the exact same way and within the same timescales as any that are made in English.

Any complaint brought against CAVUHB via the Welsh Langauge Commissioner's investigations process will be dealt with within the set timescales, and it will be the responsibility of all relevant officers to provide the necessary information at the time, and act upon any action points after a decision has been made.

3.15 Partnership Working

Wherever possible and feasible, CAVUHB will work with its partners, both locally and regionally, on joint-projects that are designed to deliver on aspects of Welsh-language servcie delivery. These could include staff training sessions, promotional campaigns, guidance documents and other similar issues. Partners would include Public Service Board members such as Cardiff City Council and the Vale of Glamorgan Council alongside partner-organisations in the Welsh Language Forum of both local authority areas.

3.16 Promoting the Welsh Language

The promotion of the Welsh Language will be visual as part of CAVUHB's identity and any service that we provide.

Publicity materials relating to the promotion of the Welsh Language will be made available in Welsh.

Should CAVUHB publicise an English Language service that corresponds to a Welsh Language service we will state on the English Language promotional materials that a Welsh Language Service is available.

CAVUHB will continue to promote events such as Dydd Gwyl Dewi/ St David's Day, Dydd Santes Dwynwen, Shwmae and I Have a Right Day etc.

3.17 Record Keeping

CAVUHB will keep a record of:

The number of complaints we receive in relation to our compliance with the standards.

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The number of employees who have Welsh Language skills and their skills levels.

The number of new and vacant posts where Welsh Language skills are essential, desirable or need to be learnt.

This information will be published as part of the annual report.

3.18 Annual Reporting

CAVUHB will produce and publish an annual report in accordance with standard 120 of the Compliance Notice – Section 44 Welsh Language (Wales) Measure.

4. Reviewing and Monitoring

This policy will be reviewed every 3 years, additional reviews may be required if any changes are made to legislation.

4.1 Managerial Responsibilities

Managers must take overall responsibility for ensuring that this policy is implemented and monitored effectively, they must ensure that all of their employees are aware of their responsibilities.

This policy will be presented to the Equality and Welsh Language Forum and Welsh Language Standards Working Group for consultation and will then follow the recognised approval route to Quality, Safety and Risk Committee, monitoring of compliance and review.

The Director of Workforce and Organisational Development is ultimately responsible for the Welsh Language in the Health Board. All non-compliance will be reported and acted upon in accordance with disciplinary procedures and escalated to the Quality, Safety and Risk Committee and Executive Board.

4.2 Retention/Archiving

The relevant Director will ensure that copies of this policy are archived and stored in line with CAVUHB records management policy, and are made available for reference purposes should any situation arise where they are required.

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4.3 Non-compliance

All employees are expected to comply with this policy, failure to comply with the policy is a serious offence and could result in disciplinary action.

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Pwyllgor Gwasanaethau Ambiwlans Brys
Emergency Ambulance Services Committee

EMERGENCY AMBULANCE SERVICES JOINT COMMITTEE MEETING

'CONFIRMED' MINUTES OF THE MEETING HELD ON 18 JANUARY 2022 AT 11:15HOURS VIRTUALLY BY MICROSOFT TEAMS

PRESENT

Members:	
Chris Turner	Independent Chair
Glyn Jones	Interim Chief Executive, Aneurin Bevan ABUHB
Carol Shillabeer	Chief Executive, Powys Teaching Health Board PtHB
Stuart Walker	Interim Chief Executive, Cardiff and Vale CVUHB
Mark Hackett	Chief Executive, Swansea Bay SBUHB
Steve Moore	Chief Executive, Hywel Dda HDdUHB
Paul Mears	Chief Executive, Cwm Taf Morgannwg CTMUHB
In Attendance:	
Jason Killens	Chief Executive, Welsh Ambulance Services NHS Trust (WAST)
Rachel Marsh	Director of Planning, Strategy and Performance, Welsh Ambulance Services NHS Trust (WAST)
Roshan Robati	Senior Programme Advisor for Unscheduled Care, Betsi Cadwaladr BCUHB
Stuart Davies	Director of Finance, Welsh Health Specialised Services Committee (WHSSC) and EASC Joint Committees
Ross Whitehead	Deputy Chief Ambulance Services Commissioner, EASC Team, National Collaborative Commissioning Unit (NCCU)
Ricky Thomas	Head of Informatics, National Collaborative Commissioning Unit (NCCU)
Matthew Edwards	Head of Commissioning and Performance, EASC Team, National Collaborative Commissioning Unit (NCCU)

Part 1. PRELIMINARY MATTERS		**ACTION**
EASC 22/01	**WELCOME AND INTRODUCTIONS** Chris Turner (Chair), welcomed Members to the virtual meeting (using the Microsoft Teams platform) of the Emergency Ambulance Services Committee and gave an overview of the arrangements for the meeting.	Chair

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	Members were reminded that, following discussion with the Chairs of both EASC and the Welsh Health Specialised Services Committee (WHSSC), it had been agreed to hold a shortened meeting in light of the current severe operational pressures that Health Boards were facing. The Chair explained that an abbreviated agenda had been prepared with the meeting focussed on two main items, these were emergency ambulance capacity and the draft EASC Integrated Medium Term Plan (IMTP). It was stated that the performance report, Chief Ambulance Services Commissioner (CASC) report and the Welsh Ambulance Services NHS Trust (WAST) provider update had also been included for noting and information. Whilst the three items would not be considered during the meeting, the Chair confirmed that members could raise any related matters with the Chair or any member of the EASC Team. In light of operational pressures and the need for a shortened meeting, other routine reports were deferred to the next meeting of the Committee, due to be held on Tuesday 15 March 2022.	
EASC 22/02	**APOLOGIES FOR ABSENCE** Apologies for absence were received from Tracey Cooper, Steve Ham, Stephen Harrhy, Gwenan Roberts and Jo Whitehead.	Chair
EASC 22/03	**DECLARATIONS OF INTERESTS** The Chair reminded those that had not yet responded to the request for Declarations of Interest to respond and suggested that the EASC Team could be contacted if there were any queries.	Chair
EASC 22/04	**MINUTES OF THE MEETING HELD ON 9 NOVEMBER** The minutes were **confirmed** as an accurate record of the Joint Committee meeting held on 9 November 2021. Members **RESOLVED** to: • **APPROVE** the minutes of the meeting held 9 November 2021.	Chair
EASC 22/05	**ACTION LOG** Members **RECEIVED** the action log and **NOTED**:	

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	EASC 21/64 Ambulance Handover Delays It was noted that discussions were ongoing with various sites and options being discussed regarding this matter. **EASC 21/65 Focus on session - Update on Demand & Capacity** It was agreed that a short paper would be prepared to include the assumptions used in the modelling. Members **RESOLVED** to: • **NOTE** the Action Log.	**EASC Team** **EASC Team**
EASC 22/06	**MATTERS ARISING** There were no matters arising.	
EASC 22/07	**CHAIR'S REPORT** The Chair's report was received. It was noted that the Chair had recently met with both Velindre University NHS Trust and Betsi Cadwaladr UHB. Each presentation had been tailored to suit local requirements and priorities and, again, this resulted in positive interactions and welcome feedback. The Chair advised that personal objectives had now been received from the Minister following the end of year appraisal. In addition to the core objectives, three additional targeted objectives had been included to reflect the specific role of the Committee. It was agreed that the inclusion of the specific Six Goals objective indicated the Minister's clear wish to formally extend the Committee's role in the urgent and emergency care arena. The Chair confirmed that the in-year review with the Minister would be held shortly. Members **RESOLVED** to: • **NOTE** the Chair's report	
Part 2. ITEMS FOR DISCUSSION		**ACTION**
EASC 22/08	**EMERGENCY AMBULANCE CAPACITY (2022-23)** Ross Whitehead presented the report relating to emergency ambulance capacity and the continuing challenge in ensuring the delivery of effective and responsive emergency ambulance services.	

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	Members noted that changes in demand and lost capacity through handover, sickness and other areas had resulted in poor responses for patients, failure to achieve response targets and episodes of harm for some patients. The Welsh Ambulance Services NHS Trust (WAST) had recently provided a transition case to the Chief Ambulance Services Commissioner outlining their preferred option for additional capacity next year. This option included the recruitment and training of an additional 294 full time equivalents (FTEs) during 2022-23 to aid in reducing patient harm and system risk and supporting the move towards the strategic ambition previously presented to the Committee. Additional capacity would bolster operational resources and mitigate the impact of lost capacity through handover delays and workforce practices, whilst improvement plans to address these were being implemented. This capacity would predominantly come from recruiting and training additional Emergency Medical Technicians and would be unlikely to draw significantly on candidates that Health Boards would be seeking. Members noted that the case had been considered and agreed by the WAST Board during a closed board session and would be made available to Members on request. It was noted that the EASC Team were currently reviewing the case on behalf of the Committee. Whilst it has not been possible to fully appraise the case in the timescale between its submission and the meeting of the Joint Committee, it was clear from an operational delivery and patient safety perspective that the ambulance service would require additional capacity next year. The case presented as the WAST preferred option which included the £10m revenue during 2022-23 with an ongoing revenue tail of £16m plus an additional £16m capital requirement. It was noted that there were multiple risks associated with delivering the preferred model, particularly from a recruitment perspective, that would result in a significant underspend against this requirement if they materialised.	

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There was currently no identified funding source from the committee or centrally to fund any uplifts in ambulance capacity on a recurrent basis. In addition, the committee does not have responsibility for capital funding for emergency ambulance services, but effective delivery of any additional capacity could require capital funding.

The paper presented aimed to seek the views of the Committee Members on the approach to increasing operational capacity within the emergency ambulance service during the financial year 2022-23, with a view to improving responsiveness of emergency ambulances for the population and supporting the wider health system.

The Chair thanked Ross Whitehead for the report adding that this would stimulate discussion among Members regarding their views around the approach to emergency ambulance capacity for the next financial year. The Chair requested that Members:

- considered the principle of recruiting additional frontline Ambulance staff in 2022-23
- note that the CASC and his team undertake a full assessment of the transitional plan recently received from WAST and provide clear recommendations to the committee via the EASC Management Group
- agree that reference would be made to the transition plan in the EASC IMTP.

It was confirmed that the 294 FTEs would be in addition to the additional resources funded in 2020-21 and 2021-22. It was also noted that during this time there had been a significant increase in activity and a material increase in lost capacity due to the increase in ambulance handover delays. Members were reminded that the modelling undertaken used an average of 6,000 lost handover hours per month; the current average was now 18,000 hours.

Members were advised that the modelling undertaken indicated that in excess of 300 FTEs were required, the 294 FTEs indicated the level that WAST feel that they were able to recruit and train.

It was agreed that this was a significant request and that, whilst this may address the pressure across the system in the short term, there should a robust effort to explore more sustainable opportunities to relieve the pressure across the system in the longer term.

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	Members agreed that this request to increase emergency ambulance capacity reflected an inherently inefficient health and social care system. Equally, it was agreed that this was not just a case for additional resources due to capacity being held outside of our hospitals, but that there were key risks in terms of patient safety and experience. It was suggested that a process of scrutiny and assurance be undertaken. It was agreed that involving Health Board Directors of Finance, Directors of Planning and Chief Operating Officers, working with WAST colleagues, would ensure a robust process involving key stakeholders. The Chair thanked Members for their views and contribution to this important discussion. The EASC Team would coordinate the process, linking in with the EASC Management Group. This would ensure that appropriate EASC governance processes were followed and also that the risks, benefits and assumptions made within the case were fully understood. Members **RESOLVED** to: • **NOTE** the report and agreed actions.	**EASC Team**
EASC 22/09	**DRAFT EASC Integrated Medium Term Plan (IMTP) 2022-25** Ross Whitehead provided an update on the work to develop the EASC IMTP for 2022-25. It was suggested that Members would be familiar with many of the key principles adopted. The plan aimed to reflect and align with key strategic documents, Welsh Government policy, EASC Chair's objectives, plans for transformational change across Health Boards (HB) and Trusts and Commissioning Intentions (2022-23). The key priorities for EASC commissioned services were confirmed as: • **Emergency Medical Services (EMS)** Building upon the engagement undertaken with a wide range of stakeholders in relation to the vision for a modern ambulance service (initially presented, discussed and agreed at the EASC Committee in July 2021). Steps were already being taken on this journey and a case for additional emergency ambulance capacity and additional funding for Year 1 (2022-23) has been submitted.	

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Implementation of a new commissioning framework for EMS that started to reflect the progress made towards the vision for a modern ambulance service, would be a key part of this work around EMS. This new framework would be enacted on 1 April 2022.

- **Non-Emergency Patient Transport Services (NEPTS)**
  Following completion of the transfers of work from HBs, NEPTS would focus on:
  - delivering the best patient transport model for Wales ensuring value and utilisation efficiency
  - strengthening the quality assurance process for providers
  - understanding the current and future needs of HBs and developing and implementing a responsive and adaptive NEPTS service
  - developing a robust forecasting and modelling framework
  - collaborating with the system to reduce system inefficacies.

- **Emergency Medical Retrieval and Transfer Service (EMRTS) including the Adult Critical Care Transfer Service (ACCTS)**
  EASC will continue to work with EMRTS Cymru to:
  - consolidate the implementation of the ACCTS with a clear focus on improving patient outcomes, value, quality and safety
  - explore opportunities for an enhanced Critical Care Practitioner-led response
  - finalise and circulate EMRTS Service Evaluation
  - support the work of the Wales Air Ambulance Charity in the implementation of their new organisational strategy.

In terms of wider system transformational work programmes, the key priorities included within the EASC IMTP were confirmed as:

- **National Transfer and Discharge Service**
  Work will be undertaken to ensure a more effective and efficient approach to transfer and discharge services, ensuring reduced fragmentation and improving patient flow into and out of secondary care facilities.
  Next steps would include:
  - developing the service through collaborative working with partner organisations
  - developing and seeking agreement for the business case.

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- **NHS 111 Wales**
  It was confirmed that:
  - options for commissioning NHS 111 Wales were currently being considered
  - there were many cross-cutting themes
  - there was a need to realise opportunities to simplify the NHS 111 Wales approach and service as we transition to commissioning phase
  - further discussions are required to ensure close alignment between EMS and 111 services.

- **Emerging System Change**
  In response to plans for transformational change, it was confirmed that the EASC would:
  - act as a forum for discussing the plans that are being developed across HBs at the earliest opportunity
  - support the wider urgent and emergency care system, with transport as a key element of the work to improve patient flow within the wider health system
  - work with partners to improve service delivery and performance and to lead the commissioning of new transport models in response to system need.

In terms of the EASC financial plan it was confirmed that:

- Early sight of financial requirements has been provided with a draft financial plan presented at EASC in November
- Draft financial plan was then presented to the deputy directors of finance including timelines and assumptions
- Engagement undertaken with peer groups to ensure inclusion in HB IMTPs
- Final draft of the financial plan to be presented to EASC MG in February and EASC Joint Committee in March.

Members were advised of the timeline for submission of the approved EASC IMTP to Welsh Government in March.

A discussion was then held, key points raised included:

- non-emergency patient transport services - noting the completion of transfers of work from HBs, it was agreed that a position report would now be prepared to capture the issues, risks and opportunities in this area in light of the COVID-19 pandemic and the constraints of social distancing, the reported increase in virtual consultations and the development of alternative pathways

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	• that, as commissioners, the Committee should take action to remove inefficiencies that exist within the system and should embrace the innovation and opportunities that exist including same day emergency care, palliative paramedics • that a comprehensive baseline analysis and scoping exercise would be undertaken as part of the work to develop the case for a national transfer and discharge service in order to remove duplication and to ensure an efficient and effective service. The Chair thanked Ross Whitehead for the presentation and thanked Members for their contribution and suggestions for the EASC IMTP. The EASC Team would now refine the plan in light of the helpful comments received and circulate in line with the timeline presented. Members **RESOLVED** to: • **NOTE** the presentation and agreed actions.	
Part 3. ITEMS FOR NOTING AND DISCUSSION		**ACTION**
EASC 22/10	**KEY REPORTS AND UPDATES** Due to the agreement for a shortened meeting and an abbreviated agenda to reflect the operational pressure being faced across the NHS system, the performance report, CASC report and WAST provider update were included for noting and information. Whilst these three items were not considered during the meeting, the Chair confirmed that members should raise any related matters with the Chair or any member of the EASC Team. It was agreed that the WAST Team would undertake work to develop a system that would capture and report on episodes where the ambulance services was not able to deploy a response vehicle or where the patient decided to find their own transport to hospital. Members **RESOLVED** to: • **NOTE** the performance report, CASC report and WAST provider update	**WAST Team**
Part 4. OTHER MATTERS		**ACTION**
EASC 22/11	**ANY OTHER BUSINESS** There was none.	

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DATE AND TIME OF NEXT MEETING		
EASC 22/12	The next scheduled meeting of the Joint Committee would be held at 09:30 hrs, on Tuesday 15 March 2022 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 ……

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CONFIRMED MINUTES OF THE MEETING OF THE FINANCE COMMITTEE
HELD ON 24th FEBRUARY 2021
VIRTUAL MEETING via TEAMS

Present:

Dr Rhian Thomas	RT	Chair, Independent Member – Capital and Estates
John Union	JU	Independent Member – Finance
Charles Janczewski	CJ	Board Chair
Abigail Harris	AH	Executive Director of Strategic Planning
Caroline Bird	CB	Acting Chief Operating Officer
Catherine Phillips	CP	Executive Director of Finance
Chris Lewis	CL	Deputy Director of Finance
Hywel Pullen	HP	Interim Deputy Director of Finance (Strategy)
Nicola Foreman	NF	Director of Corporate Governance
Marie Davies	MD	Deputy Director of Planning
Robert Mahoney	RM	Interim Deputy Director of Finance (Operational)
Suzanne Rankin	SR	Chief Executive
Stuart Walker	SW	Medical Director

Secretariat:

Paul Emmerson	PE	Senior Finance Manager

Apologies:

David Edwards	DE	Independent Member – Information Communication & Technology
Rachel Gidman	RG	Executive Director of People and Culture
Ruth Walker	RW	Executive Nurse Director

FC 22/02/001	**WELCOME AND INTRODUCTIONS** The Chair welcomed everyone to the meeting.	**ACTION**
FC 22/02/002	**APOLOGIES FOR ABSENCE** Apologies for absence were noted.	
FC 22/02/003	**DECLARATIONS OF INTEREST** The Chair invited members to declare any interests in proceedings on the Agenda. None were declared.	

Mohamed Salim
04/13/2022 16:36:25

FC 22/02/004	**MINUTES OF THE COMMITTEE MEETING HELD ON 26th JANUARY 2022** The minutes of the meeting held on 26th January 2022 were reviewed and confirmed to be an accurate record. **Resolved – that:** The minutes of the meeting held on 26th January 2022 were approved by the Committee as an accurate record.	
FC 22/02/005	**ACTION LOG FOLLOWING THE LAST MEETING** There were no outstanding actions.	
FC 22/02/006	**CHAIRS ACTION SINCE THE LAST MEETING** There had been no Chairs action taken since the last meeting.	
FC 22/02/007	**FINANCIAL PERFORMANCE MONTH 10** The Deputy Director of Finance summarised the key points within the Month 10 Finance Report. At month 10, the UHB reported an underspend of £0.406m against its plan. During the 10 months to the end of January the UHB incurred gross expenditure of £83.823m relating to the management of COVID 19, which was assumed to be offset by Welsh Government COVID 19 funding leaving an operating surplus of £0.406m. The full year gross COVID forecast moved marginally by £0.023m in the month as the result of additional funding being made available for Covid 19 – Support at HMP Cardiff. The Executive Director opinion was outlined as follows: The reported financial position for the 10 months to the end of January was an increase of £0.204m on the surplus reported at month 9. Further progress was required on recurrent saving schemes with a further £4.492m savings to be identified in order to maintain the underlying financial position. This had not improved significantly over the last 2-3 months and was a key financial risk that needs to be managed. Plans to utilise reduced reductions in planned Expenditure were well developed. The key risk faced was the full utilisation of resources made available to support services during the pandemic where workforce is the key constraint. Moving onto the Finance Dashboard it was highlighted that there were two areas flagged as red, being the delivery of the recurrent £12.000m 1.5% target,	

Mohamed Sarah
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	where there was a £4.5m shortfall which in turn adversely impacted on the carried forward underlying deficit. The UHB Chair (CJ), queried the prospects of making progress on the shortfall in recurrent savings in 2022/23 given that the UHB has not yet met its recurrent savings in 2021/22. In reply, the Deputy Director of Finance indicated that the UHB needed to collapse Covid response costs before it could increase its focus on progressing some of the high value opportunities which would then be open to the UHB to pursue. In this context releasing recurrent savings remained a considerable challenge. Table 5 illustrated that the UHB had a operational surplus of £0.406m at Month 10. This was comprised of an in month and a cumulative underspend on income and pay which was broadly offset by overspend on non pay. The Finance Committee Chair (RT) asked if work to manage the £0.660m shortfall on catering income was in progress and in reply the Deputy Director of Finance indicated that income was expected to recover as footfall across sites increased, however the pace of recovery was uncertain. In respect of a further query, it was noted that that some of the costs of both accommodation and catering were fixed when the service was maintained regardless of the level of that service. The pay position at month 10 was an operational underspend of £8.6m and the additional gross COVID 19 pay expenditure was nearly £40m. There was an operational overspend of £9.700m on non-pay budgets which was offset by the reported underspends against pay and income budgets. The forecast gross COVID 19 expenditure for the year was £119m and spending of £84m had been incurred at month 10. This was supported by additional Welsh Government funding. Picking up on Welsh Government funding for Covid 19, the Executive Director of Finance detailed that the total forecast funding for COVID 19 was £140.333m, which matched the forecast gross costs together with the £21.313m of support for the planning deficit. Referring to the profile of Covid Recovery expenditure the Finance Committee Chair (RT) noted that a relatively large proportion of the annual expenditure was forecast to be incurred in the final 2 months of the year. The Interim Chief Operating Officer confirmed that a number of the schemes were back loaded to the end of the year and whilst this represented a challenge the UHB was taking all reasonable steps to use the resource which was available. At month 10, the full year forecast reductions in planned expenditure were £7.4m which was an increase of £0.3m on the month 9 forecast. Plans to utilse this reource were well progressed with an oversight from the UHB's Management Executive. Delegated performance was relatively stable in month, although it was noted that performance varied between Clinical Boards.	

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	The UHB was confident that the £16m savings target would be broadly achieved this year, however, as previously noted further progress needed to be made on recurrent schemes as the forecast year end underlying deficit of £25.3m would increase to £29.7m if the current gap against the recurrent savings target did not improve. Moving on the Committee was informed that the UHB was expecting cash support from Welsh Government in respect of resource limit only allocations from previous years where the associated cash outlay was now materialising. The UHB's public sector payment compliance performance was 93.5% at the end of January which was slightly below the target of 95%. At month 10, the UHB had an approved Capital Resource Limit (CRL) of circa £59.2m and cumulative expenditure of £15.8m was reported against this. Since the report was written, the capital resource limit had increased by a further £4.4m due to a bid to Welsh Government for additional expenditure that the UHB expected to deliver this financial year, mainly around medical and IT equipment. The Committee was advised that of the updated CRL which was £63.4m at the time of the meeting, orders raised to date were 74% of the revised Limit. In conclusin, the Committee was informed that the key risks were; the further progress required to find another £4.4m recurrent schemes in order to maintain the underlying position; the management of risks to achieve a break even position, including the full utilization of resources that were allocated to the UHB; and the management of capital so that a broadly balanced position against the capital resource limit was reached at year end. The UHB Chair (CJ) referred to the non recurrent funding provided to the UHB to support the underlying deficit in 2021/22 and queried whether support had been provided on a recurrent basis to other Health Boards across Wales. In reply, the Deputy Director of Finance indicated that one Health Board had been provided with non recurrent structural funding for a three year period, however, it was thought that a number of other Health Boards were in a similar position to the UHB, with no confirmation of the continuation of Welsh Government support to cover underlying deficits. The UHB Chair (CJ) indicated that further clarification on the likelihood of continuing support for the underlying deficit would be pursued through the Chairs Group with Welsh Government. The independent Member (Finance) asked for clarification on the planning and lead times required for exiting from the Covid expenditure programmes such as testing, tracing and vaccination. In response the Deputy Director of Finance indicated that the UHB was expecting coverage for national programmes such as testing, tracing and vaccination in line with Welsh Government planning guidance. However, withdrawal from local response costs would need to be managed by the UHB and this was a risk and would be a challenge in 2022/23. The Interim Chief Operating Officer added that the	

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	UHB had worked through the detail of actions required to collapse the Covid response costs with Clinical Boards and Corporate teams and confirmed that the bed base was the largest component in determining the additional response cost incurred by the UHB. The UHB Chair (CJ) acknowledged the work of UHB Officers in steering the UHB through what was an exceptional year in respect of the continuing demand of managing the impact of Covid. **Resolved – that:** The Finance Committee **noted** the reported underspend of £0.406m at month 10; The Finance Committee **noted** the gross month 10 financial impact of COVID 19 which was assessed at £83.823m and that this was matched with anticipated income; The Finance Committee **noted** the forecast breakeven which is consistent with the financial plan submitted to Welsh Government on 30th June and assumes additional funding of £140.333m to manage the impact of COVID 19 in 2021/22, including confirmed funding of £21.313m in respect of the 2020/21 recurrent savings shortfall; The Finance Committee **noted** that COVID 19 reductions in planned care expenditure can be used to to mitigate financial risks in the plan and support system resilience; The Finance Committee **noted** that following a request from Welsh Government that the UHB has identified the additional working cash required in 2021/22 to satisfy the cash outlay that is expected to be incurred in respect of resource only funding adjustments confirmed by Welsh Government in previous years. The Finance Committee **noted** the 2021/22 brought forward Underlying Deficit was £25.3m and that the forecast carry forward of £25.3m into 2022/23 is dependent upon delivery of the £12m recurrent savings target which required the identification of a further £4.4m savings schemes. The Finance Committee **noted** the UHB is forecasting a breakeven position at the year end in line with the submitted annual financial plan. In order to achieve this the key risk that needs to be managed is to utilise the resources that have been allocated to the UHB; The Finance Committee **noted** that the UHB is forecasting a broadly balanced position against its capital resource limit at year end and will need to continually monitor the position so that progress can be pro-actively managed to achieve this.	
FC 22/02/008	**FINANCE RISK REGISTER**	

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	The Interim Deputy Director of Finance presented the 2021/22 Finance Risk Register to the Committee. The following risks identified on the 2021/22 Risk Register remained categorized as extreme risks (Red): • Maintaining the underlying deficit of £25.3m on line with the draft annual plan; • Delivery of the recurrent element of the CIP (£12.0m). The Committee was advised that the red rated risks had already been discussed as part of the previous agenda item. **Resolved – that:** The Finance Committee **noted** the risks highlighted within the 2021/22 risk register.	
FC 22/02/009	**FINANCE COMMITTEE – TERMS OF REFERENCE** The Director of Corporate Governance indicated that the Finance Committee Terms of Reference (TOR) were reviewed earlier in the year to capture additional responsibilities in respect of monitoring the capital programme. The Committee advised that further changes were highlighted and referred to the changes in respect of the publication of papers. The Committee was asked to review and consider the changes to the TOR. **Resolved – that:** The Finance Committee **reviewed** the changes to the Terms of Reference as highlighted. The Finance Committee **ratified** the changes to the Terms of Reference. The Finance Committee **recommended** approval of the amended Terms of Reference to the Board at the Board Meeting on 31st March 2022.	
FC 22/02/010	**FINANCE COMMITTEE – ANNUAL WORKPLAN** The 2022/23 Workplan for the Finance Committee was introduced by the Director of Corporate Governance to provide members of the Finance Committee with the opportunity to review the Work Plan for 2022/23 prior to presentation to the Board for approval. **Resolved – that:** The Finance Committee **reviewed** and **ratified** the 2022/23 Work Plan;	

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	The Finance Committee **recommended** approval of the workplan to the Board.	
FC 22/02/011	**FINANCE COMMITTEE – ANNUAL REPORT** A paper summarising how the Finance Committee has met its Terms of Reference during the financial year was introduced by the Director of Corporate Governance. The Finance Committee considered and agreed the report subject to an update to the attendance figures. **Resolved – that:** The Finance Committee **recommended** the report to the Board for **approval** subject to an amendment to reflect updated attendance figures.	
FC 22/02/012	**MONTH 9 FINANCIAL MONITORING RETURNS** These were noted for information.	
FC 22/02/013	**ITEMS TO BRING TO THE ATTENTION OF THE BOARD** There were no items to bring to the attention of the Board.	
FC 22/02/014	**DATE OF THE NEXT MEETING OF THE COMMITTEE** **Wednesday 23rd March 2022 2.00pm; Virtual Meeting via Teams**	

Mohamed.Sarah
05/13/2022 16:36:25

CONFIRMED MINUTES OF THE MEETING OF THE FINANCE COMMITTEE
HELD ON 23rd MARCH 2021
VIRTUAL MEETING via TEAMS

Present:

Dr Rhian Thomas	RT	Chair, Independent Member – Capital and Estates
John Union	JU	Independent Member – Finance
David Edwards	DE	Independent Member – Information Communication & Technology
Charles Janczewski	CJ	Board Chair
Akmal Hanuk	AH	Independent Member – Community
Mike Jones	MJ	Independent Member – Trade Union
Susan Elsmore	SE	Independent Member – Local Authority
Caroline Bird	CB	Interim Chief Operating Officer
Catherine Phillips	CP	Executive Director of Finance
Chris Lewis	CL	Deputy Director of Finance
Hywel Pullen	HP	Interim Deputy Director of Finance (Strategy)
Nicola Foreman	NF	Director of Corporate Governance
Robert Mahoney	RM	Interim Deputy Director of Finance (Operational)

Secretariat:

Paul Emmerson	PE	Senior Finance Manager

Apologies:

Ruth Walker	RW	Executive Nurse Director
Suzanne Rankin	SR	Chief Executive

FC 22/03/001	**WELCOME AND INTRODUCTIONS** The Chair welcomed everyone to the meeting. The Finance Committee Chair (RT) noted that the Deputy Director of Finance was retiring and thanked Chris for his service to the Committee.	**ACTION**
FC 22/03/002	**APOLOGIES FOR ABSENCE** Apologies for absence were noted.	
FC 22/03/003	**DECLARATIONS OF INTEREST**	

Mohamed-Sarah
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	The Chair invited members to declare any interests in proceedings on the Agenda. None were declared.	
FC 22/03/004	**MINUTES OF THE COMMITTEE MEETING HELD ON 16th FEBRUARY 2022** The minutes of the meeting held on 26th February 2022 were reviewed and confirmed to be an accurate record. **Resolved – that:** The minutes of the meeting held on 16th February 2022 were approved by the Committee as an accurate record.	
FC 22/03/005	**ACTION LOG FOLLOWING THE LAST MEETING** There were no outstanding actions.	
FC 22/03/006	**CHAIRS ACTION SINCE THE LAST MEETING** There had been no Chairs action taken since the last meeting.	
FC 22/02/007	**FINANCIAL PERFORMANCE MONTH 11** The Deputy Director of Finance summarised the key points within the Month 11 Finance Report. At month 11, the UHB reported an underspend of £0.287m against its plan. During the 11 months to the end of February the UHB incurred gross expenditure of circa. £95m relating to the management of COVID 19, which was assumed to be offset by Welsh Government COVID 19 funding leaving an operating surplus of £0.287m. The full year gross COVID funding was now £119.375m . Moving onto the Finance Dashboard it was highlighted that there were three areas flagged as red, being the delivery of the recurrent £12.000m 1.5% target which in turn adversely impacted on the carried forward underlying deficit. In addition, the creditor payment compliance had remained marginally below 95% and this was also now flagged as red. The Committee was informed that the UHB still expected to report a breakeven position at year end. Table 5 illustrated that the UHB had a operational surplus of £0.287m at Month 11. The pay position at month 10 was an operational underspend of £9.4m and the additional gross COVID 19 pay expenditure was nearly £45m. There was an operational overspend of £10.5m on non-pay budgets which was offset by the reported underspends against pay and income budgets. The Finance Committee Chair (RT) noted that the operational overspend against pay reported by the Medicine Clinical Board was a recurrent issue and	

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	asked if this was reflected in the assumptions underpinning the 2022/23 plan. In response, the Deputy Director of Finance reflected that the UHB did not generally apply additional budget to areas which were overspending. It was noted that nursing pressures in the Clinical Board had been accentuated by COVID due to the demands on nursing time which in turn had increased demand for nursing cover which included agency. In this context. it was expected that nursing pressures would reduce as the impact of COVID receded. In addition, the Committee was informed that all nursing establishments has been fully funded and signed off by the Executive Director of Nursing and that the UHB was working to increase its nursing capacity through both local and international recruitment. In response to a query from the Independent Member – Local Authority (SE) the Interim Chief Operating Officer confirmed that the UHB continued to monitor presentations with COVID at the Emergency Department as well as bed occupancy due to COVID. The data collected did not presently suggest the same level of demand which had been observed in previous waves. The Committee was informed that a step up in forecast gross COVID 19 expenditure was expected in the final month of the year in part due to the notification in the later part of the year of some of the funding streams. The Committee was advised that the UHB had plans in place to utilise the funding in full. Similarty, plans were in place to utilise the full year forecast reductions in planned expenditure were circa £8m. Picking up on this theme the Finance committee Chair (RT) noted that there were a number of reported areas where expenditure was expected to step up in the final month and asked for further assurance around the process to ensure that this was effectively managed. The UHB Chair (CJ) echoed the request for further assurance and the Executive Director of Finance indicated that the UHB would review the level of detail included in report to provide additional assurance to the Committee. The Deputy Director confirmed that the detailed plans to utilise the full year forecast reductions in planned expenditure had been shared previously with Committee members and that these were progressing with oversight from the UHB's Management Executive. The Executive Director of Finance added that the detailed management of plans to use Covid Recovery funding was administered through the Chief Operating Officer and that the UHB had an established process to manage its capital expenditure through the Capital Management Group which had been meeting on a more regular basis towards year end to ensure that plans were executed to maximise the benefit to the UHB. In reply to a further query from the Finance Committee Chair (RT), the Chief Operating Officer confirmed that the UHB could not rollover recovery funding to the following year and that a separate recovery alloaction had been confirmed for 2022/23. It was confirmed that there was slippage against some recovery of the original schemes and that this had allowed the UHB to invest in other schemes as well as supporting the operational position.	

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	The UHB was confident that the £16m savings target would be broadly achieved this year, however, as previously noted further progress needed to be made on recurrent schemes as the forecast year end underlying deficit of £25.3m would increase if the current gap against the recurrent savings target did not improve. Moving on the Committee was informed that the UHB was expecting a positive cash position at year end. Welsh Government had provided the UHB with additional working cash support of circa £26.5m in year and the UHB needed to review how much of this would need to be drawn down in year. The UHB's public sector payment compliance performance remained marginally below the target of 95%. At month 11, the UHB had an approved Capital Resource Limit (CRL) of circa £67m and cumulative expenditure of circa £24m was reported against this. Since the month end, the capital resource limit had increased by a further £3.2m. To provide further assurance to the Committee that the UHB would broadly balance expenditure against its capital resource limit in year, the Committee was informed that: • There were orders raised of £64m of which £22m were receipted and/or invoiced. • There were further orders to raise of £8m and £50m overall to be receipted/invoiced • Delivery of the Capital Plan is still expected in 2021/22, however over 70% of orders were still to be receipted in the last two weeks of 2021/22. A high percentage of the outstanding medical and IT equipment orders would need to be vested to ensure ownership within 21/22 (£20-30m). The Committee was informed that the UHB's Capital Planning, Procurement and Financial Accounting Teams were working hard to ensure that orders were fulfilled to meet the Capital Plan. The Finance Committee Chair (RT) acknowledged the diligence of the Teams in the management of the UHBs capital plan and the UHB Chair (CJ) endorsed the acknowledgement. The Independent Member (JU) enquired if the UHB retained a list of capital projects which could be implemented at short notice if additional capital resource was offered by Welsh Government and the Deputy Director of Finance confirmed that this was still the case. **Resolved – that:** The Finance Committee **noted** the reported underspend of £0.287m at month 11;	

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	The Finance Committee **noted** the gross month 11 financial impact of COVID 19 which was assessed at £94.957m and that this was matched with anticipated income; The Finance Committee **noted** the forecast breakeven which is consistent with the financial plan submitted to Welsh Government on 30th June and assumes additional funding of £140.688m to manage the impact of COVID 19 in 2021/22, including confirmed funding of £21.313m in respect of the 2020/21 recurrent savings shortfall; The Finance Committee **noted** that COVID 19 reductions in planned care expenditure can be used to to mitigate financial risks in the plan and support system resilience; The Finance Committee **noted** that following confirmation of an additional £26.517m working cash to support Resource Limit only allocations issued in previous years, the UHB is now forecasting a positive year end cash balance. The Finance Committee **noted** the 2021/22 brought forward Underlying Deficit of £25.3m and that the forecast carry forward of £25.3m into 2022/23 is dependent upon delivery of the £12m recurrent savings target which required the identification of a further £4.4m savings schemes. The Finance Committee **noted** the UHB is forecasting a breakeven position at the year end in line with the submitted annual financial plan. In order to achieve this the key risk that needs to be managed is to utilise the resources that have been allocated to the UHB; The Finance Committee **noted** that the UHB is forecasting a broadly balanced position against its capital resource limit at year end and will need to continually monitor the position so that progress can be pro-actively managed to achieve this.	
FC 22/03/008	**FINANCE RISK REGISTER** The Interim Deputy Director of Finance presented the 2021/22 Finance Risk Register to the Committee. The following risks identified on the 2021/22 Risk Register, which were both related to the underachievement against the recurrent savings target remained categorized as extreme risks (Red): • Maintaining the underlying deficit of £25.3m on line with the draft annual plan; • Delivery of the recurrent element of the CIP (£12.0m). The Committee was advised that the red rated risks had already been discussed as part of the previous agenda item. The Committee was informed that the 2022/23 Risk Register would be presented to the next meeting. **Resolved – that:**	

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	The Finance Committee **noted** the risks highlighted within the 2021/22 risk register.	
FC 22/03/009	**MONTH 11 FINANCIAL MONITORING RETURNS** These were noted for information.	
FC 22/03/010	**ITEMS TO BRING TO THE ATTENTION OF THE BOARD** There were no items to bring to the attention of the Board.	
FC 22/03/011	**DATE OF THE NEXT MEETING OF THE COMMITTEE** **Wednesday 26th April 2022 2.00pm; Virtual Meeting via Teams**	

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05/13/2022 16:36:25

Confirmed Minutes of the Public Audit & Assurance Meeting
Held on 8th February 2022 at 09:00
Via MS Teams

Chair:		
John Union	JU	Independent Member for Finance
Present:		
Mike Jones	MJ	Independent Member for Trade Union
Ceri Phillips	CP	UHB Vice Chair
In Attendance:		
Nicola Foreman	NF	Director of Corporate Governance
Rachel Gidman	RG	Executive Director of People & Culture
Catherine Phillips	CP	Executive Director of Finance
Timothy Davies	TD	Risk & Regulation Officer
Ian Virgil	IV	Head of Internal Audit
Wendy Wright	WW	Deputy Head of Internal Audit
Darren Griffiths	DG	Audit Wales
Claire Whiles	CW	Assistant Director of Organisational Development
Nigel Price	NP	Local Counter Fraud Specialist
Observers:		
Nathan Saunders	NS	Senior Corporate Governance Officer
Secretariat:		
Sarah Mohamed	SM	Corporate Governance Officer
Apologies:		
David Edwards	DE	Independent Member for ICT and Committee Vice Chair
Charles Janczewski	CJ	UHB Chair
Aaron Fowler	AF	Head of Risk & Regulation
Anthony Veale	AV	Audit Wales
Mark Jones	MJ	Audit Wales

Item No	Agenda Item	Action
AAC 22/02/08/001	**Welcome and Introductions** The Committee Chair (CC) welcomed everyone to the meeting.	
AAC 22/02/08/002	**Apologies for Absence** **The Committee resolved that:** a) Apologies were noted.	
AAC 22/02/08/003	**Declarations of Interest** **The Committee resolved that:** a) No Declarations of Interest were noted.	

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AAC 22/02/08/004	**Minutes of the Committee meeting held on 9th November 2021** Darren Griffiths (DG) noted that there were amendments to be made regarding page 2 and page 3. The Director of Corporate Governance (DCG) stated that the changes had been received and would be incorporated. **The Committee resolved that:** a) Subject to the above amendments being made to the draft minutes of the meeting held on the 9th November 2021, the draft minutes were held as a true and accurate record of the meeting.	
AAC 22/02/08/005	**Action log following meeting held on 9th November 2021** The Executive Director of Finance (EDF) confirmed that AAC 21/11/09/010 on the Action Log had been completed. **The Committee resolved that:** a) The Action Log was discussed and noted.	
AAC 22/02/08/006	**Any other urgent business:** To agree any additional items of urgent business that may need to be considered during the meeting The Committee resolved that: a) No other urgent business was noted.	
	Items for Review and Assurance	
AAC 22/02/08/007	**Internal Audit Progress Reports** Ian Virgil (IV) presented the Internal Audit Progress Report (the Report) and highlighted the following – • Eight audits were scheduled to be finalised for the February meeting but had not been completed to meet that deadline. • Two of the audits had reached draft report stage. • The IT service management system draft report was with Management for review and comments. • Section 3 of the Report confirmed that the outcome from the four audits had been finalised. • The graph on section 4 of the Report highlighted 34 reviews in the plan. The current progress was that 10 audits had been finalised to date and a further 2 were	

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	at the draft stage. A further 11 were a “work in progress” and 9 were in the planning stages. • Page 4 of the Report detailed that following the Management Executive meeting in November, it was agreed that 4 audits would be deferred from the plan due to ongoing pressures in the Health Board. • Two audits would also be combined into one audit due to the overlap. • With the adjustments made and the 34 audits remaining, there was enough coverage across the Health Board to be able to give a formal opinion to the Health Board for the year. • Under section 5 of the Report good progress had been made in developing the plan for 22/23. Meetings had taken place with the Executives and a draft plan would be created to go back to the Management Executive meeting and then submitted to the April Audit Committee meeting for formal approval. The Committee Chair (CC) queried whether the 9 reports in the planning stage and 2 in other stages could be completed within the timescale. IV responded that although the formal audit year ran from April to March, the audits would continue through May to be submitted to the June Committee. IV commented that he was confident that the reports could be completed within time. Wendy Wright (WW) presented the following reports and highlighted the following: 1. The Core Financial Systems Final Report - The General Ledger and Accounts Receivable had been looked at. - They made two low priority recommendations. Firstly, regarding the best practice point and secondly regarding the timeliness in actioning leavers in the Oracle system. - In comparison to the previous audit completed it was noted that the position had improved. 2. Theatre Utilisation (Surgery Clinical Board) - The audit was undertaken on behalf of the Surgery Clinical Boards and objectives focused on governance arrangements, policy and procedures. - One high priority recommendation was made which related to policy and procedure. - Two recommendations were made in relation to the Theatreman System.	

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	- The third medium priority recommendation related to opportunities to maximise Theatre resource. - The report provided reasonable assurance. 3. Retention of Staff Report - The objectives focused on strategies, plans, policies and initiatives to support staff retention. In addition to the Leavers process and data collected for staff turnover. - 5 medium priority recommendations were made. - It was found that the People and Culture Plan was fundamental for taking that area forward. - A recommendation was also made regarding the Nurse Retention Action Plan. - In terms of looking ahead, the People and Culture Plan was strong on determining what evaluation arrangements had been put in place to determine if the plan and objectives had been affected. - Any retention initiatives taken forward should have evaluation mechanisms in place. - The Leavers' Checklist was a helpful guidance document for managers and should become more formalised within the Health Board procedure. - The report provided reasonable assurance. 4. Welsh Language Standards - Provided medium priority across the six recommendations that had been raised. - The first recommendation related to having greater cascade of actions around Clinical Boards and departments. - Another point raised was in relation to rolling out Welsh Language champions across the Health Board. - Given the lapse of time that had passed since the Welsh Language Standards had come into being, there was opportunity to give greater consideration to the resource arrangement and governance arrangement around the Standards. - The last point was in relation to the publication of Welsh Language Policy which was under review. The Chair queried the number of reds for response times on Appendix B. The Chair queried if that was due to the pressures the teams had faced. IV responded that delays had been due to pressures within the organisation.	

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	The Committee resolved that: a) The Internal Audit Progress Report, which included the findings and conclusions from the finalised individual audit reports, was considered. b) The removal of the four identified audits from the Internal Audit Plan for 2021/22 was approved. c) The proposal to combine the two audits on Recovery of Services and Delivery of the 21/22 Plan was approved.	
AAC 22/02/08/008	**Audit Wales Update** Darren Griffiths (DG) presented the Audit Wales Update report and highlighted the following: • Two pieces of work had been completed. That was, (1) the Phase 2 Structured Assessment which had looked at the Corporate Governance and Financial Management Arrangements of the Health Board, and (2) the follow up of the 2017 Review of Radiology Services. • Audit Wales were in the process of drafting the report on the review of the Health Board's Quality Governance Arrangements. There had been a slight delay due to staffing constraints in the team. However, the emerging findings and conclusions had been presented to colleagues on the Executive Team and Members of the Quality, Safety and Experience Committee. • A national report on joint working between Emergency Services had been published. The key messages were summarised in Appendix 1 of the Update. **The Committee resolved that:** a) The Audit Wales Update was noted and discussed.	
AAC 22/02/08/009	**Audit Wales Report: Taking Care of the Carers? – Management Response** DG stated the report had been shared with the Committee at the last meeting. However, due to publication of timescales it had not been possible for the Health Board to put together a response. The management response had now been received. The response was very detailed and thorough. The Health Board could take a great deal of assurance regarding the actions the Health Board was taking in that important area.	

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	The Assistant Director of Organisational Development (ADOD) presented the report and highlighted the following: • The Audit Wales Taking Care of Carers? publication was produced in October 2021. • The audit had enabled the Health Board to provide assurance on the 6 recommendations resulting from the report. • The People and Culture Plan provided additional alignment and pathway for supporting staff in every step of their career journey. • The monitoring and reporting element within the People and Culture Plan would also provide assurance to the Audit Committee. The Independent Member for Trade Union (IMU) highlighted that the focus on staff wellbeing was a very high priority. DG commented that a lot of the actions were listed as "ongoing". For the purpose of tracking the recommendations, it was noted that the Committee might want to consider when to take the recommendations off the Tracker when they feel the appropriate action had been undertaken. The Director of Corporate Governance (DCG) responded that she would agree timescales with the EDPC and ADOD offline to confirm sensible dates. **The Committee resolved that:** a) The management response and actions identified, including reporting requirements and utilisation of the Board Checklist, were supported.	
AAC 22/02/08/010	**Radiology Services - Update on Progress** DG presented the Radiology Services Report and highlighted the following: • An initial review of Radiology Services was completed in 2017. • The review looked at the Health Board's progress against the recommendations made in 2017. • Overall, the Health Board had improved in the way it planned and delivered Radiology Services through strong management of the Service. • Good progress had also been made to address the majority of 2017 recommendations. • No new recommendations were made. However, the recommendation relating to increasing the appraisal	

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	rates of non-clinical staff should be reinstated on the Audit Tracker due to the limited progress to date. The Chair queried why limited action had been taken in relation to the recommendation to increasing the appraisal rates of non-clinical staff, which could cause concern. DG responded that the Service had been grappling with this issue for some time. There was evidence that management has started to address the recommendation, but because the response rate had not increased it was considered important for the recommendation to remain on the Tracker because non-Clinical staff were just as important as Clinical staff. The EDPC commented that it was an area that was low already and the Covid-19 pandemic had made it worse. Appraisals were very low at 30%. The EDPC would request the Head of Workforce in each Clinical Board to focus upon that area. DG highlighted the risk in relation to Diagnostic Services caused by the pent-up demand for services during the pandemic. It was important to draw that risk to the attention of the Committee and Health Board so that the risk could be considered as part of recovery planning. The Chair queried if that would be looked at again in the future. DG responded that it was the second time that Service Area had been reviewed and Audit Wales wanted to make sure their work covered other service areas over the years. However, Audit Wales would keep an eye on the outstanding recommendation as part of their own arrangements for tracking progress. **The Committee resolved that:** a) The Radiology Services Update on Progress was discussed and noted.	
AAC 22/02/08/011	**Structured Assessment (Phase 2) Report and Management Response** DG updated the Committee on the following: • The Phase 2 report had reviewed the Corporate Governance and Financial Management arrangements of the Health Board. • Overall, it was a positive report.	

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	• Audit Wales had found that the Health Board had effective Committee and Board arrangements in place which were underpinned by maturing assurance systems. • Opportunities to strengthen transparency remained. • There were clear plans in place to support the recovery of services but arrangements for monitoring and reporting overall plan delivery should be strengthened. • The Health Board had maintained a robust oversight of its finances. However, the pandemic continues to pose a risk to the Health Board to remain even. • Two recommendations were raised. That was (1) to enhance public transparency of Board business, and (2) to strengthen arrangements for monitoring and reporting on the overall delivery of the Annual Plan and future IMTPs. Both recommendations had been accepted by the Health Board. The DGC commented that the recommendations related mostly to the timeliness of the information on the Health Board's website and making sure there was publication of Board and Committee papers and recordings of those meetings. These areas had now been built into standard operating procedures and should happen automatically. The only one outstanding was making sure that the public and other interested parties were being signposted to future Board and Committee meetings via social media. **The Committee resolved that:** a) The Structured Assessment (Phase 2) Report and Management Response was noted.	
AAC 22/02/08/012	**Risk Management System** The DCG highlighted the following: • An Audit was completed in March 2021. • The report highlighted the 5 recommendations that were picked up by Internal Audit at the time. • The recommendations have been implemented. • An internal audit was due out at the end of the year. • The Appendix set out the plans in terms of training and development to ensure officers understood what the risk appetite was. • The next step was to make decisions in line with the risk appetite. **The Committee resolved that:**	

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	a) The update on the Health Board's Risk Management Systems and ongoing developments in that area was noted.	
AAC 22/02/08/013	**Review of Standing Orders** It was noted that the Standing Orders were up to date and in line with the Model Standing Orders issued by WG. **The Committee resolved that:** a) The update, as set out in the body of the report, with regards to the Health Board's Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions, was noted.	
AAC 22/02/08/014	**Refreshed Governance Arrangements for Covid 19** The DCG highlighted the following: • During the first wave of Covid 19 some Committees of the Board were "stood down". • Committees were not stood down during the current wave, although the Chair had requested that Committee agendas were more refined. • Executives were stood down from all Committees except for those where they were the Executive Lead. • The Covid 19 Governance Group had met twice. The Chair of the Board had considered whether that Group should continue to meet given that Covid was slowing down. • The arrangements would stay in place until they were stood down. The Vice Chair commented that the diagram did not include the Mental Health committee. The DCG responded that Mental Health sat under the site leadership for UHL and would make sure to include it. **The Committee resolved that:** a) The governance arrangements and update as at 21st December 2021(Appendix 1) was noted. b) The Board Governance Group Terms of Reference (Appendix 2) was noted. c) The Systems Resilience Template (Appendix 3) covering the key areas of Quality and Safety, Workforce, Governance, Operations, Governance and Public Health was noted.	

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	d) The current Governance Structure in place (Appendix 4) was noted.	
AAC 22/02/08/015	**Audit Wales Report - Committee Governance Arrangements at WHSSC** The DCG stated that the Committee had previously seen the report by Audit Wales which had made recommendations for WHSSC and WG. The report included in the Committee meeting papers had been prepared by WHSCC and gave their response to the recommendations and updates on where they were. **The Committee resolved that:** a) The progress made against WHSSC management responses to the Audit Wales recommendations outlined in the WHSSC Committee Governance Arrangements report, was noted. b) The progress made against the Welsh Government responses to the Audit Wales recommendations outlined in the WHSSC Committee Governance Arrangements report, was noted.	
	Items for Approval / Ratification	
AAC 22/02/08/016	**Declarations of Interest and Gifts and Hospitality Tracking Report** The Regulation and Risk Officer (RRO) presented the report and highlighted the following: • In November 2021 there was an agreement to modify the process for Declarations of Interest to ensure it was not a single Declaration of Interest rather than an annual requirement. The view was that the previous arrangement was too confusing. • From November 2021 the communication plan had focused upon ensuring that staff should submit a Declaration of Interest once during their employment. • Declaration of Interests could now be completed on ESR which was more user-friendly. • Corporate communications had now suggested that a trial “power hour” was tested. Members from the Risk and Regulation team, along with the ESR and the corporate Communications team would be available at a certain time to provide assistance on the process. • The current Register covered the period from 1st of April 2020 – 1st April 2022. • 1418 Declarations of Interest, gifts and hospitality forms had been recorded on the Register.	

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	• The Register reflected current employees. • 70% of band 8a and above staff had now received active and correct Declaration forms. • 94% of Declarations were green i.e. no cause of concern • 2.6% were a medium risk conflict. • 0.03% were a high conflict risk. • Due to the success of recent advertising campaigns, it had been agreed that the Communications team would initiate a communication plan throughout 2022. That would be delivered through the Staff Connect app, Staff Weekly update, screen savers and the power hour. **The Committee resolved that:** a) The ongoing work being undertaken within Standards of Behaviour was noted. b) The Declarations of Interest, Gifts, Hospitality & Sponsorship Register was noted.	
AAC 22/02/08/017	**Regulatory Compliance Tracking Report** The RRO presented the report and highlighted the following: • The purpose of the report was to provide Members with assurance of the implementation of recommendations made by external Regulatory Bodies. • An internal audit into the Corporate Governance Regulatory Compliance Tracker was undertaken in July and August 2021. • As a result of the audit undertaken, the Health Board was given a reasonable assurance rating. • There was one recommendation from the audit that remains on the internal Tracker. That related to the management of Welsh Health Circulars. • Patient safety solutions were monitored and managed by the Patient Safety and Organisational Learning Manager who maintained a tracker of PSNs received. • The Regulatory Tracker attached to the report was up to date as at 21st January 2022. • The team's assessment of the review/ongoing review of the Tracker should reduce the risk that key regulatory requirements are missed. **The Committee resolved that:** a) The approach taken by the Risk and Regulation team to the tracking and reporting of compliance with regulatory inspections and recommendations, was approved.	

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	b) The assurance provided by the Regulatory Tracker and the confirmation of progress made against recommendations, was approved. c) The continuing development of the Legislative and Regulatory Compliance Tracker was noted.	
AAC 22/02/08/018	**Audit Wales Tracking Report** The RRO presented the report and highlighted the following: • Appendix 1 showed a summary of the external audits undertaken in previous years. • 15 external audits were noted on the Tracker and brought forward from the last Committee meeting. • Since the last meeting, 4 recommendations had been completed and 11 were partially complete. • A review of all outstanding recommendations had been undertaken with Executives Leads. • The report would be presented at each Audit Committee meeting to provide Regulatory updates. The reports had also been discussed at ME meetings. The Chair commented that the two overdue items remained on the Tracker until completed. The RRO responded that it was to do with the complexity and did not reflect a lack of focus by the lead officers. **The Committee resolved to:** a) the progress which had been made in relation to the completion of the Audit Wales recommendations, was noted and assurance was received. b) The continuing development of the Audit Wales Recommendation Tracker was noted.	
AAC 22/02/08/019	**Internal Audit Tracking Report** The RRO presented the report and highlighted the following: • The Tracker attached to the report demonstrated that progress had been made against the recommendations made in years 2019-2020, 2020-2021, 2021-2022. • Overall the outstanding recommendations had reduced from 86 to 85. That could be contributed to the removal of entries. Since that date a further 16 entries had been added to the Tracker. • A review of the outstanding recommendations had been undertaken since the last Audit Committee	

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	meeting and each Executive Lead had been sent the recommendation which fell within their remit. • Assurance was provided by the fact the Tracker was in place and actively managed. IV commented that Audit Wales had the chance to check what was on the draft version of the Tracker. It had been a helpful way to engage in the process and they were planning to carry that on with the team. **The Committee resolved that:** a) The tracking report for tracking audit recommendations made by Internal Audit was noted. b) The progress which had been made since the previous Audit and Assurance Committee Meeting in November 2021 was noted. c) The approach taken towards the management and monitoring of Internal Audit Recommendations was noted.	
AAC 22/02/08/020	**Timetable for the Production of the 2021-2022 Annual Report** The DCG presented the report and highlighted the following: • The report highlighted the timetable for the year. • The Health Board was working with Audit Wales and Internal Audit on the end of year arrangements. The remuneration of staff was the part which was audited. • The Appendix set out the key dates. The final submission to WG was on 15th of June 2022 and a Special Audit Committee meeting and a Board meeting had been scheduled for 14 June 2022. The Chair queried if the proposed timetable followed last year's timetable. The DCG responded that the dates did not change and generally the timetable was the same. IV queried part 1 in the April section of the report. There was a deadline there for Internal Audit to receive and comment on the Sustainability element. That was removed and it would not feed into a formal report from Internal Audit. The DCG responded that they were aware that there was not a formal requirement for it. Last year it was agreed that, as a Board, the sustainable element was still needed. **The Committee resolved that:**	

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	a) The proposed timetable and approach, as set out in the report, for the Annual report 2022-22 prior to the same being presented to full Board for formal approval, was ratified.	
AAC 22/02/08/021	**Audit Wales Annual Audit Report** The DCG stated the report provided a summary of the work completed in 2021. The individual pieces had been brought to the Audit Committee meetings previously. **The Committee resolved that:** a) The Audit Wales Annual Audit Report was noted	
AAC 22/02/08/022	**Committee Annual Work Plan - 2022/23** The DCG stated that the workplan was there to ensure that the Health Board was delivering its Terms of Reference. They were broadly the same as in previous years. The Forward Plan sat alongside the Annual Work Plan and captured anything that was not covered on the Annual Work Plan. The Committee's Annual Work Plan would be submitted to the Board for formal approval at the end of March 2022. DG commented that the Audit Wales Annual Audit Plan would be presented at the next meeting. **The Committee resolved that:** a) The Work Plan 2022/23 was reviewed. b) The Work Plan 2022/23 was ratified. c) Approval to the Board on 31st March 2022 was recommended.	
AAC 22/02/08/023	**Committee Terms of Reference - 2022/23** The DCG stated that since the Terms of Reference were reviewed annually and there were no significant changes. DG commented that he was conscious Audit Wales had not had an opportunity to meet with Members of the Audit Committee without Officers being present. The Chair responded that they previously met with Internal Audit virtually and were happy to meet with Audit Wales in the same way. The DCG commented that a meeting would be organised. **The Committee resolved that:**	**NF**

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	a) The changes to the Terms of Reference for the Audit and Assurance Committee were reviewed. b) The changes to the Terms of Reference for the Audit and Assurance Committee were ratified. c) The changes to the Terms of Reference were recommended to the Board for approval on 31st March 2022.	
AAC 22/02/08/024	**Committee Annual Report – 20221/2022** The DCG stated that the report was a backwards look at the work of the Committee within the last 12 months. It was presented to give assurance to the Committee and to make sure the Committee was doing what it was supposed to do in line with its Terms of Reference. It was noted that the draft report enclosed required updating to reflect the attendance and matters discussed in the Committee meeting that day before submission to the Board in March 2022. **The Committee resolved that:** a) The draft Annual Report 2021/22 of the Audit and Assurance Committee was reviewed. b) The draft Annual Report was recommended to the Board for approval.	
	Items for Information and Noting	
AAC 22/02/08/025	**Response to Audit Wales Decarbonisation Baseline Review** The DCG stated that the EDSP wanted the Committee to have sight of that review. The Committee resolved that: a) The Response to Audit Wales Decarbonisation Baseline Review (including the survey) was noted.	
AAC 22/02/08/026	**Internal Audit reports for information:** i. Core Financial Systems Final Report (Substantial Assurance) ii. Theatre Utilisation Final Report (Reasonable Assurance) iii. Retention of Staff Final Report (Reasonable Assurance) iv. Welsh Language Standards (Reasonable Assurance) Nothing further was added.	
	Review and Final Closure	

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AAC 22/02/08/027	**Items to be deferred to Board / Committee** Nothing further was added.	
AAC 22/02/08/028	To note the date, time and venue of the next Committee meeting: **Tuesday 5th April 2022 at 9.00am**	

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Confirmed Minutes of the Public Audit & Assurance Committee
Held On 5 April 2022 at 9am
Via MS Teams

Chair:		
John Union	JU	Independent Member for Finance
Present:		
Mike Jones	MJ	Independent Member for Trade Union
Ceri Phillips	CP	UHB Vice Chair
In Attendance:		
Nicola Foreman	NF	Director of Corporate Governance
Rachel Gidman	RG	Executive Director of People & Culture
Catherine Phillips	CP	Executive Director of Finance
Ian Virgil	IV	Head of Internal Audit
Wendy Wright	WW	Deputy Head of Internal Audit
Darren Griffiths	DG	Audit Wales
Mark Jones	MJ	Audit Wales
Aaron Fowler	AF	Head of Risk & Regulation
Nigel Price	NP	Local Counter Fraud Specialist
Gareth Lavington	GL	Lead Local Counter Fraud Specialist
Russel Kent	RK	Head of Digital Operations
David Thomas	DT	Director of Digital & Health Intelligence
Marcia Donovan	MD	Head of Corporate Governance
Robert Mahoney	RM	Interim Deputy Director of Finance
Observers:		
Amy Marshall	AM	Audit Wales Graduate Trainee
Secretariat		
Sarah Mohamed	SM	Corporate Governance Officer
Apologies:		
David Edwards	DE	Independent Member for ICT and Committee Vice Chair

Item No	Agenda Item	Action
AAC 5/4/22 001	**Welcome & Introduction** The Committee Chair (CC) welcomed everyone to the meeting.	
AAC 5/4/22 002	**Apologies for Absence** **The Committee resolved that:** a) Apologies were noted.	
AAC 5/4/22 003	**Declarations of Interest** **The Committee resolved that:** a) No Declarations of Interest were noted.	

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AAC 5/4/22 004	**Minutes of the Meeting Held on 8th February 2022** **The Committee resolved that:** a) The draft minutes of the meeting held on the 8th February 2022 were a true and accurate record of the meeting.	
AAC 5/4/22 005	**Action Log - Following Meeting Held on 8th February 2022** - AAC 22/02/08/023 – would be scheduled for July 2022 **The Committee resolved that:** a) The Action Log was discussed and noted.	**Action Log**
AAC 5/4/22 006	**Any Other Urgent Business** **The Committee resolved that:** a) No other urgent business was noted.	
	Items for Review and Assurance	
AAC 5/4/22 007	**Internal Audit Progress Reports** Ian Virgil (IV) presented the IT Service Management Final Report and highlighted the following: • The purpose of the audit was to establish whether the IT service provided by the Health Board was in a sufficient and secure manner which reflected the needs of the organisation. • It was considered against best practice for IT service management as set out in the Information Technology Infrastructure Library (ITIL). • Internal Audit were only able to provide 'limited' assurance. • It was identified that poor controls in relation to the IT service desk function were in place. • It was acknowledged that there were plans to implement a new call handling system, to restructure the service desk department and to introduce new ways of working. • At the time of the audit, eight key matters were identified, four of which were high priority. • Management had provided their agreed actions in response to the audit in Appendix A. The Director of Digital & Health Intelligence (DDHI) advised the Committee on the following: • The audit was completed at a point in time when the Digital Team was supporting the organisation during the pandemic. • The Digital Team had agreed with the recommendations made. • The target date did not reflect the urgency merited by the Health Board.	

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- Four high priority recommendations were made which included the following:

1. Service design

a) To undertake a restructure of the service desk provision which should be based on the ITIL Framework.

- The current limited IT support resources would be restructured to provide a skeleton framework of an ITIL service desk structure.
- A business case was currently under review to increase staffing within the service desk, to allow for separation of key tasks and provide a single point of knowledge.

b) Implementation of the new call handling system should incorporate the facility for users to raise calls via an on-line portal.

- The new service desk implementation would provide a digital front door which would include incident and problem management as well as service requests, change and asset management.
- There would also be a user portal on all user devices.
- The new service desk tool went live internally in March 2022. It would be going live to the entire organisation by 30 April 2022.

c) Existing and new staff should be encouraged to attain ITIL Accreditation.

- Staff ITIL training had started in January 2022.
- 10 members of the IT support/service desk team had successfully passed the ITIL v4 Foundation course and exams to gain their accreditation.
- An additional 6x team members had attended the Advanced ITIL CDS course.

The UHB Vice Chair (VC) queried whether the current HEAT system had been replaced by the Ivanti Service Management (ISM), with a target implementation date of the 30th October 2021 as stated in Appendix A of the report.

The DDHI responded that it had not yet been implemented due to the ongoing pandemic and how busy the team were in supporting the recovery process. The Windows 10 programme had been completed. A pragmatic decision had been made to roll it forward to the new calendar year. It went live internally in March 2022 and it should be fully live in April 2022.

The VC queried if the new system would meet the needs of the organisation.

The DDHI responded that it would and that it would be completely ITIL and industry standard aligned.

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	The CC queried if the target date was September 2022. The DDHI responded that there were components that would be completed in April 2022 but the entire item would be completed by September 2022. 2. Lack of documented guidance a) Procedures and guidelines should be developed for the Service Desk. These should clarify how to deal with incoming calls, the information to collect, the approval process for proposed resolution actions and the routing of those calls. - The Health Board had employed the services of a dedicated Ivanti ITSM Implementation Expert. - As part of the deployment standard operating procedure documents had been created. - A standalone and dedicated automation server had been set up and the same would provide workflow with approval steps which would provide automation for numerous tasks. b) As part of those procedures a set of pre-defined calls should be developed for the most common / simple calls and incidents to enable those to be resolved on first contact. - The ISM implementation also contained an FAQ and Staff Help portal which would continue to be developed and expanded as part of the product use. - A full set of FAQs would be issued by the end of April 2022. - There would also be an icon on people's helpdesk which they could click. 3. Call Classification and prioritisation a) Procedures and guidance on the classification and prioritisation of calls should be drawn up and issued with training provided as appropriate. Staff should be instructed to ensure that calls and incidents were classified and prioritised correctly in accordance with the guidance. – Automated for call category, call type and priority fields had been implemented as standard. – Exceptions could be made, although it would require additional approval within the Service Desk management structure. – That had been populated to ensure prioritisation of calls correctly. b) The planned replacement for the HEAT system should not allow free text in the call category, call type and priority fields.	

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	– Free Text fields for call category, call type and priority fields had been removed. c) The call category, type and priority fields should be mandatory to complete with call handlers selecting the appropriate entry from a drop-down menu. – Call category, call type and priority fields were now all mandatory when creating incidents and service requests. 4. Call status monitoring a) A formal process to ensure call activity was maintained should be established, and completed calls should be closed appropriately. - A new single digital portal for staff to create, view and close incidents and service desks had been created. - Accurate ISM and call metrics would be available. - Calls and requests for staff would automatically be closed after multiple requests had been ignored. - Cases which had not been progressed within a timely fashion would be reported automatically and flagged. - Staff would also have clear visibility of their case progression via the portal. - The audit found many open calls and this system would help to manage this effectively. The VC queried whether the closing of the call was determined by the requestor or the person dealing with the request. The DDHI responded that the closing of calls would be done in agreement with the user. The call would be closed after the third attempt of trying to reach the user. The VC queried if there would be a follow up to ensure the new systems had been implemented and the extent to which the new systems were shown to be successful. IV responded that a follow up of the limited assurance reports had been built into the Committee's Internal Audit Plan for next year. They would communicate with the DDHI and his team to establish an appropriate date to avoid conducing a follow up too soon. The VC stated that given the language in the report it warranted a more immediate action. The DDHI responded that the majority of actions would be completed by 1st May 2022. Although, the structure of the team would not have been completed, that should not prevent making use of the system in its entirety. It was agreed that the DDHI would provide an update at the Committee's July meeting.	**DDHI**

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	Ian Virgil (IV) presented the Internal Audit Progress Report (the Report) and highlighted the following – • Seven audits had been delayed and not finalised in time for this meeting. Those would be brought to the next Committee meeting. • The Capital Scheme Genomics audit and the Estates Assurance Waste Management audit had been issued in draft with a reasonable assurance rating. • Four audits had been finalised since the last Committee. • The Advisory Report for Arrangements to Support the Delivery of Mental Health Services provided suggested areas for the Health Board to take forward, as opposed to formal recommendations. The management response to the report had just been received. That would be included in the next Committee meeting papers. • There were 34 reviews in the 2021/22 Internal Audit Plan, of which (i) 16 had been finalised and 2 were in the draft stage (ii) 12 were a "work in progress", and (iii) 2 were in the planning stage ready to be formally agreed. • The delivery of the 2021/22 Plan had been impacted due to the Covid pressures placed on the Health Board. A total of 10 audits had previously been identified for removal/ deferral from the Plan following discussions with management and the Executive Team. Those had been previously approved by the Committee. • A further two audits had also been proposed for removal / deferral. (i) The PCIC CB – Primary Care Vaccinations audit was proposed for removal from the 21/22 plan. - Elements of the planned scope had been picked up as part of the wider audit of the Covid 19 Vaccination Programme - Phase 3 delivery. To avoid duplication, it was agreed that it would be efficient to include it as part of one audit. (ii) The Digital Strategy Roadmap. - The audit had been agreed for deferral to the 22/23 plan by the DDHI, due to current pressures on the IT team and the availability of key management. The roadmap would be included in the scope of the 22/23 Digital Strategy audit. • The remaining 32 audits gave sufficient assurance for Internal Audit to give an opinion on the Health Board for the year. • The draft 2022/23 plan was subsequently produced and was included separately on the Committee agenda for formal review and approval. The VC queried whether there would be any consequences of delaying the reports, given the high significance of digitisation within the Health Board.	**Internal Audit** **Internal Audit**

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	IV responded that there would be concern if work was not scheduled early in the plan for 2022/23 to look at the wider strategy of Digital. Wendy Wright (WW) presented the following reports and highlighted the following: 1. Verification of Dialysis Sessions - It was a planned audit taken at the request of the Specialist Services Clinical Services Board. - The outcome was substantial assurance. - The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to raising staff concerns. - Although the review highlighted work in that area, three medium priority recommendations were made which included; (i) providing timely and continued communication around the freedom to speak up campaign, (ii) enhancement to the staff concerns held and (iii) how the governance arrangements required alignment. - A further two low priority recommendations were made. 2. Raising Staff Concerns - The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place within the Health Board. - The review highlighted the progress in the area. - Three low priority recommendations were made which included; (i) providing timely communication around the freedom to speak up campaign, (ii) enhancement to the concerns staff held and (iii) the governance arrangements required an all Wales alignment for staff to raise concerns. - A further two low priority recommendations were made. The Executive Director of Finance (EDF) stated that there was an issue about people raising concerns regarding counter fraud. The organisation should consider undertaking a focused piece of work with regards to how staff could raise concerns across the organisation. The Executive Director of People and Culture (EDPC) commented that following conversation with staff, the awareness was not apparent and it was time to increase the education and awareness around counter fraud. The VC stated that all staff should be made aware of the processes and the degree to which they would be listened to. The Independent Member for Trade Union (IMTU) queried if mandatory training would help raise awareness. The EDPC responded that mandatory training was low at the moment. There should to be different options for different people.	**EDF/EDPC**

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	3. Arrangements to Support the Delivery of Mental Health Services • The review was requested by the Mental Health Clinical Board. • The Advisory Review Report highlighted opportunities and contained no recommendations. • It also included a data collection tool for the Clinical Board to take forward. • The Report highlighted that the Clinical Board had a good understanding of the risks and challenges but there should be a focus on what the solutions were. • Further engagement was planned with the Clinical Board to relay the outcome more widely. The VC stated that it was a key piece of work and would help to manage the demand in a more informed way. **The Committee resolved that:** a) The Internal Audit Progress Report, including the findings and conclusions from the finalised individual audit reports, was considered. b) The proposed adjustments to the Internal Audit Plan for 2021/22 were approved.	
AAC 5/4/22 008	**Audit Wales Update** Darren Griffiths (DG) presented the Audit Wales Update report and highlighted the following: • Under Exhibit 3, the scope of the 2021 Local Work had now been agreed. • That included a review of the Estates which followed the recommendations made in 2017. The brief had been issued and signed by the relevant Executive Director and the field work was now under way. • In March 2022, the Auditor General had published a consultation inviting views to inform the future Audit work programme for 2022-23. The closing date for responding to the consultation was 8 April 2022. However, the consultation would be kept open to be able to capture as many responses as possible. **The Committee resolved that:** a) The Audit Wales Update was noted.	
AAC 5/4/22 009	**Review changes to Standing Financial Instructions (SFI) and Accounting Policies** The Director of Corporate Governance (DCG) presented the report and highlighted the following:	

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	• It was good governance and practice to review Standing Orders and SFIs on an annual basis. • The all Wales SFIs and Standing Orders were adopted last year and there had been no changes since then. • The Standing Orders were brought to the last Committee meeting. **The Committee resolved that:** a) The update, as set out in the body of the report, with regards to the Health Board's Standing Financial Instructions was noted.	
AAC 5/4/22 010	**Review System of Assurance** The DCG presented the report and highlighted the following: • It was a quick update on where the Health Board was against the overall system of assurance. • A strategy was brought to the Committee previously, which was then approved by the Board in September 2021. • The purpose of the strategy was to have an overall assurance map across the whole Health Board which would look at areas where there was good or poor assurance. • That would direct regulators in areas where the Health Board had gaps in its assurance. • It was a large piece of work which whilst it was ongoing, it had been delayed due to Covid 19 pressures. • The plan was to present a high- level assurance map to the Board by May 2022. **The Committee resolved that:** a) The proposed development of the Systems of Assurance and the progress made towards a higher level of maturity, were noted.	**DCG**
AAC 5/4/22 011	**Review Draft UHB Annual Report** The DCG stated the Annual Report was made up of 3 parts namely (i) the Performance Report (ii) the Accountability Report and (iii) the Financial Statement. The DCG added that the Accountability Report and Financial Report would be audited. A consistency check would be completed on the Performance Report. The Head of Corporate Governance (HCG) presented the Draft Annual Report and highlighted the following: • The draft Annual Report was a "work in progress" and there were a number of gaps in the current draft. • Some of the information required would not be available until the end of the financial year. There was also some	

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	information to be inserted following last week's Board meeting. • There were gaps in the Accountability Report and the relevant Lead Executives had been chased. • The Committee effectiveness surveys were due to go out that day. It would take another three weeks until the results could be analysed and inserted into the Annual Report. • The draft accounts must be submitted to Welsh Government and Audit Wales by 29 April 2022. • At the end of April 2022, the draft Annual Governance Statement must to be submitted to Internal Audit for their review and comments • On 6 May 2022, the draft Performance Report, the draft Accountability Report and the draft Remuneration Report would go to Welsh Government and Audit Wales. • The Audit Workshop on 12 May 2022, would allow Committee Members to further review the draft document at that stage. • A Special Audit Committee meeting and Special Board meeting were scheduled on 14 June 2022 to sign off the draft Annual Report in readiness for formal submission to Audit Wales and Welsh Government on 15 June 2022. **The Committee resolved that:** a) The progress made in relation to the drafting of the 2021-22 Annual Report was noted; and b) There were no comments with regard to the content of the draft report, attached as Appendix 2.	
AAC 5/4/22 012	**Self-assessment of effectiveness – Verbal** The DCG advised the Committee that self-effectiveness surveys were due to be issued that day and would involve all of the Committees undertaking a self-effectiveness review. The survey response audience had been broadened to improve the response rate and to help improve Committees of the Board. It was noted that the outcome of the survey would firstly be provided to the Audit Committee and then to the relevant Committees. A review against the Code of Governance and the Board Effectiveness Review would be completed for the next Audit Committee meeting. **The Committee resolved that:** a) The Self-assessment of effectiveness verbal update was noted.	**DCG**
AAC 5/4/22 013	**(i) Procurement Compliance Report** The EDF presented the Procurement Compliance Report and highlighted the following:	

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	• The report covered non-compliance and breaches. • There had been extensions to contracts and services due to the Covid pressures. • Those would need to be finalised as the Health Board's Covid response had become more stable. **(ii) Procurement Audit Influenceable Spend Report** The EDF advised the Committee that the report was one of the activities that had come from the breaches and a result of the work completed with regards to Capital governance in the last nine months. The Assistant Director of Procurement Services and Executive Procurement Lead (ADPS) highlighted the following: • The report was a consequence of the work completed in relation to the Capital Governance report phase 1/phase 2 in 2021. • One of the matters that would be looked at was the expenditure that sat outside Procurement influence in that period. • The 2020/21 influenced expenditure of 73.8% had increased significantly to 87.5% for 2021/22, due to the Capital construction expenditure moving to Procurement 's governance management, and the increased influence within medical and surgical consumables expenditure. • Within the currently influenced expenditure of £247,414,470, £102,355,374 manual invoice contracts were identified. • It had been proposed that the expenditure was looked at and popped onto an Oracle catalogue. That should deliver rich data as it would not run through as an Oracle payment but as a contract line. That should give visibility of whether the contracts had been exceeded and if there was additional savings that could be improved. • Examples of the £102,355,374 include CHC placements, laboratory external tests and continence products. • Within the £138,575,257 not influenced amount, a number of expenditure items would remain out of scope for Procurement influence due to the nature of the transactions, e.g., utilities, rates, personal injury, statutory audit fees and clinical negligence. • Removing those out-of-scope items left a figure of £115,310,152.07 which represented the opportunity for increasing Procurement influence for non-pay expenditure. A list of the top 20 categories were included in the report. • A request has been made for Procurement to undertake a "deep dive" analysis on the potential opportunities to increase Procurement influence within non-pay expenditure and return to the Audit Committee in September 2022 with a further update.	**EDF/ADPS**

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	The IMU queried if anything more could be done to reduce the influence on Primary Care. The ADPS responded that all Third Sector spend was managed by Procurement. The contracts had been tendered for a number of years and there was assurance that those contracts were well managed. The Primary Care spend was not services that could be influenced but the Procurement team could look at this. **The Committee resolved that:** a) The contents of the Procurement Compliance report were noted and agreed. b) The contents of the Non Pay Influencable Spend report were approved and agreed.	**ADPS**
AAC 5/4/22 014	**Losses and Special Payments Panel Report** The Interim Deputy Director of Finance (IDDF) presented the Losses and Special Payments Panel Report and highlighted the following: • The Health Board had established a Losses and Special Payments Panel. • That Panel met twice yearly and was tasked with considering the circumstances around all such cases and to make appropriate recommendations to the Committee. • Service improvements were investigated on a case by case basis to see if there were emerging themes that could be improved. • The losses were also presented in the Annual Accounts and would be presented for full disclosure. The CC queried why the clinical negligence amounts in the report were different to what the Panel were asked to consider. The IDDF responded that the £10.946 clinical negligence amount and the £0.167m for personal injury represented the value of cases finalised and presented for approval of final loss. The table in the report represented the impact of new claims made in the 6-month period of review offset by anticipated income that would eventually be recovered from the Welsh Risk Pool. The £0.658m value was therefore the net I&E impact of new claims in the 6-month period. **The Committee resolved that:** a) The write offs outlined in the report were approved.	
	Items for Approval / Ratification	
AAC 5/4/22 015	**Declarations of Interest and Gifts and Hospitality Tracking Report** The Head of Risk & Regulation (HRR) presented the report and highlighted the following:	

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	• There had been a significant increase in the amount of declarations. • A further 130 declarations had been received since completion of the report. • The analysis of declarations of interest received suggested reasonable success from the recent advertising campaign. There had been an above average increase in the quantity of declarations made, as well as increased use of ESR rather than the more administratively heavy use of hardcopy forms and email returns. • The team would continue to work with the Communications team and hold another "power hour" later in the year. • The team were also working with the Board Members to ensure that their end of year declarations were submitted for end of year reporting purposes. **The Committee resolved that:** a) The ongoing work being undertaken within Standards of Behaviour was noted. b) The Declarations of Interest, Gifts, Hospitality & Sponsorship Register was approved.	
AAC 5/4/22 016	**Regulatory Compliance Tracking Report** The HRR advised the Committee on the following: • The report contained a breakdown of the external regulatory and outstanding recommendations. • A report was shared last Monday in the Management Executive meeting to provide oversight of the Welsh Health Circulars that were outstanding. • Following the meeting, the most recent Welsh Health Circular was shared across the Health Board by email. • An update on Patient Safety Notices (PSN) was shared at the last QSE Committee meeting and would be reported twice a year. • As of 7 March 2022, there were 18 active PSN, 12 of which were overdue. Those were being managed by the Patient Safety Experience team. • 7 recommendations were removed from the Regulatory Tracker as they were complete. A further 2 would be removed that day as they have also been completed. • The team continued to work with the recommendation owners. **The Committee resolved that:** a) The assurance provided by the Regulatory Tracker and the confirmation of progress made against recommendations were approved. b) The continuing development of the Legislative and Regulatory Compliance Tracker was noted.	

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AAC 5/4/22 017	**Audit Wales Recommendation Report** The HRR advised the Committee on the following: • There were 20 entries currently reported. • 9 were added following February's Audit meeting. • All 20 entries were partially complete and 4 were over 6 months overdue. The team would focus on those entries to ensure that they did not stagnate without being progressed. **The Committee resolved that:** a) It noted, and was assured by, the progress which had been made in relation to the completion of Audit Wales recommendations. b) The continuing development of the Audit Wales Recommendation Tracker was noted.	
AAC 5/4/22 018	**Internal Audit Tracking Report** The HRR advised the Committee on the following: • The Tracker currently recorded 84 entries. • 18 recommendations had been removed and an additional 7 extra reports would be added to the Tracker at the next Committee meeting. • An additional 4 reports would be added to the Tracker following the meeting. • Following discussions with Internal Audit, there was an action plan to move stagnant entries forward. Each Executive Lead had been sent the recommendations, made by Internal Audit, which fell into their respective remits of work. • There was also an action plan on how to record advisory recommendations. IV acknowledged the work that had gone into the Tracker. Internal Audit would continue to meet with HRR before the Audit Committee meetings to review the draft Tracker. IV also added that WW was currently undertaking work to validate a number of recommendations that were recorded as complete over the last year in order to give further assurance to the Committee with regards to the accuracy of the information on the Tracker. That would be reported at the next Committee meeting. **The Committee resolved that:** a) The tracking report for tracking audit recommendations made by Internal Audit were noted. b) It noted, and was assured by, the progress which had been made since the previous Audit and Assurance Committee Meeting in February 2022.	**Internal Audit**

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AAC 5/4/22 019	**Internal Audit Annual Plan 22/23** IV presented the Internal Audit Annual Plan 22/23 and highlighted the following: • The Plan detailed the audits to be undertaken in 2022/23. • Section 2 of the report set out that the Plan was being developed in accordance with the Public Sector Internal Audit standards. There was also a risk-based approach to developing the Plan. • Page 5 of the report covered the key elements of the Plan. • Section 2 set out the plan to audit key risk areas within the Health Board. • Section 4 would include any work requested on an all Wales basis by Directors of Finance or Board Secretaries. • Internal Audit met with all the Executives in the Health Board to identify potential audits with risk areas within their individual portfolios. An initial Plan was drafted and discussed with the UHB Chair. • The Plan would be under review in case of changes to risks or priorities within the Health Board and to ensure it gave appropriate assurance. The VC queried whether the previous audits that were postponed were included in the Plan IV responded that the majority of them were still in the Plan following discussions with the relevant Executive Directors. The EDPC stated that the Staff Sickness audit was delayed by the team and requested that it went ahead in May as it was urgently needed. IV responded that the Staff Sickness audit was going to be delivered as part of the 2021/22 plan. **The Committee resolved that:** a) The Internal Audit Plan for 2022/23 was approved. b) The Internal Audit Charter for 2022/23 was approved.	
AAC 5/4/22 020	**Audit Wales Annual Plan** Mark Jones (MJ) advised the Committee on the following: • Under the NHS Finance (Wales) Act 2014, Health Boards ceased to have annual resource limits with effect from 1 April 2014. • Instead, they had 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 had exceeded its rolling three-year revenue limit in the past five years. • For 2021-22 and the three years to 31 March 2022, the Health Board had forecast to operate within its revenue and	

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	capital resource limits, subject to anticipated 2021-22 COVID-19 funding of £21.3 million from the Welsh Government. • Covid risks and fraud risks were also included in the Plan. • Exhibit 3 set out the audit fees. The fees had increased by 3.7%. The fee rates had increased for the first time since 2008. • Exhibit 4 set out the Audit team. The Audit Director for Financial Audit had been absent and would not be doing this year's audit. Richard Harris would cover him for this set of accounts. • There were two potential conflict of interests. The new Counter Fraud Manager and MJ were cousins. His wife also worked for the Health Board as a Consultant. DG advised the Committee on the following: • In Anthony Veal's absence, David Thomas would be acting as the Engagement Director for the Health Board. • There were four aspects to the performance audit work. • The Structured Assessment work would be reshaped and refocused this year. Over the last two years there had been a focus on Covid. There would now be a focus on pre-pandemic arrangements. • There was a plan to undertake a piece of work around workforce risks and workforce planning arrangements at each NHS body. Individual reports would be provided to the Health Board. • A locally focused piece of work would also be undertaken. The scope of that had yet to be determined with the Executives. **The Committee resolved that:** a) The Audit Wales Annual Plan Update was noted.	
AAC 5/4/22 021	**Audit Enquiries to those charged with governance and management** The EDF advised the Committee on the following: • A letter had been received from Audit Wales which had detailed audit enquiries to those charged with governance. • A proposed response had been prepared and shared with the relevant colleagues. • Subject to Committee approval, it would be sent as the formal response as part of the audit process. **The Committee resolved that:** a) The response provided to the audit enquiries to those charged with governance and management was endorsed.	
	Items for Information and Noting	

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AAC 5/4/22 022	**Internal Audit reports for information:** 1. Verification of Dialysis Sessions Final Report (Substantial Assurance) 2. Raising Staff Concerns Final Report (Reasonable Assurance) 3. IT Service Management Final Report (Limited Assurance) Arrangements to Support the Delivery of Mental Health Services (Advisory)	
	Agenda for Private Audit and Assurance Committee	
AAC 5/4/22 023	i. Counter Fraud progress report ii. Workforce and Organisational Development Compliance Report	
	Any Other Business	
AAC 5/4/22 024	Items to be deferred to Board / Committee	
	Date & time of next Meeting Thursday 12 May 2022 at 9am via MS Teams	

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Confirmed Minutes of the Quality, Safety & Experience Committee
Held on 22 February 2022 at 09.00am
Via MS Teams

Chair:		
Susan Elsmore	SE	Independent Member – Local Authorities / Chair of the Committee
Present:		
Gary Baxter	GB	Independent Member – University
Akmal Hanuk	AH	Independent Member – Community
Mike Jones	MJ	Independent Member – Trade Union
In Attendance		
Stephen Allen	SA	Chief Officer Community Health Council
Mike Bond	MD	Director of Operations - Surgery
David Scott-Coombes	DSC	Surgical Clinical Board Director
Nicola Foreman	NF	Director of Corporate Governance
Angela Hughes	AH	Assistant Director of Patient Experience
Charles Janczewski	CJ	Chair of the UHB
Fiona Jenkins	FJ	Executive Director of Therapies & Health Sciences
Meriel Jenney	MJ	Executive Medical Director
Fiona Kinghorn	FK	Executive Director of Public Health
Ruth Walker	RW	Executive Nurse Director
Clare Wade	CW	Director of Nursing - Surgical
Observing		
Caitlin Thomas	CT	Graduate Trainee Manager
Secretariat		
Nathan Saunders	NS	Senior Corporate Governance Officer
Apologies		
David Edwards	DE	Independent Member - ICT
Ceri Phillips	CP	Vice Chair of the UHB
John Union	JU	Independent Member - Finance

QSE 22/02/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the meeting in English & Welsh.	**Action**
QSE 22/02/002	**Apologies for Absence** Apologies for absence were noted.	
QSE 22/02/003	**Declarations of Interest** No Declarations of Interest were noted.	
QSE 22/02/004	**Minutes of the Special Committee meeting (October) and Minutes of the Committee meeting held on 14 December 2022** The minutes of the Special meeting held on 26 October 2021 and the minutes of the meeting held on 14 December 2022 were received and confirmed as true and accurate records of those meetings.	

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	The Committee resolved that: a) The minutes of the Special meeting held on 26 October 2021 and the minutes of the meeting held on 14 December 2022 were approved as true and accurate records of those meetings.	
QSE 22/02/005	**Action Log following the Meeting held on 14 December 2022** The Action Log was received and all ongoing actions discussed. **The Committee resolved that:** a) The Action Log from the meeting held on 14 December 2022 was noted.	
QSE 22/02/006	**Chair's Action taken since last meeting** The CC advised the Committee that the approval of Gene Therapy Medicinal Products & Gene Therapy Investigational Medicines Products Policy, Procedure and EHIA had been approved offline in December 2021.	
QSE 22/02/007	**Surgical Clinical Board Assurance Report** The Director of Operations – Surgery (DOS) advised the Committee that the report provided details of the arrangements, progress and outcomes within the Surgery Clinical Board in relation to the Quality, Safety and Patient Experience agenda during 2021 and noted that it would also highlight the actions and progress of the Surgery Clinical Board during the COVID pandemic. The Surgical Clinical Board Director (SCBD) presented the Designing Emergency Surgery Care for the Future to the Committee. The Committee were advised that:- - the current service consisted of Emergency patients coming into the system through various streams and particularly through Primary Care into the Surgical Assessment Unit (SAU) and through the Emergency Department. - The current SAU was not fit for purpose and was too small and situated in a poor environment. • The proposal to address issue with the SAU included (i) creation of a Surgical Emergency Care Unit that provided same day care to patients and (ii) referral of Patients to Same Day Emergency Care (SDEC). • The new SDEC would extend to ENT, Ophthalmology and Maxillofacial patients and would include physical space as well as a virtual ward. - Phase one of the new SDEC was open and that it was hoped the whole unit would be open in June/July 2022.	

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- Digital technology would be required for the SDEC and a number of tools had already been identified and some were already in place.

- Since April 2014 there had been a gradual increase in Emergency Trauma seen across the Health Board as well as the rest of the UK and that alternative ways of working had been introduced during the Covid-19 pandemic, such as hot clinics, and the use of digital technology which had resulted in decreased admissions.

- The future patient journey would now place more patients to a Surgical Triage Coordinator which would result in less patients being in the ED assessment area and that the rest of the patients would go through to the SDEC or directly to an acute surgical unit.

- Regarding Phase 2 – Acute Surgical Ward, (i) the short stay acute surgical ward would be moved from B2 North ward (University Hospital Wales) into the current SAU footprint, (ii) there would be further development of patient pathways to support early discharge for hospital inpatients and (iii) timely access to diagnostics and treatment.

- The model of care fitted with the direction that was dictated by national policy and that the Clinical Board had developed a MDT/professional workforce fully engaged in change with views to upskill staff.

- A new footprint which was “environment compliant” had been created to ensure delivery of safe care and to provide the best experience possible for staff and patients.

The CC noted that the emphasis on the safety and centrality given to patient care.

The Independent Member – Trade Union (IMTU) asked if there was enough staff given the current pressures and if there was confidence that more staff could be provided should they be required.

The Director of Nursing Surgical (DNS) responded that the Clinical Board had proactively recruited throughout the Covid-19 pandemic and that a lot of the recruitment had come from overseas which had supported some of the recovery plans as well as the SDEC.

The Independent Member – University (IMU) asked if there were any examples of other SDEC models that had worked and also how and when outcomes could be measured.

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The DOS responded that throughout the process of creating the SDEC they had engaged with NHS England who had a number of SDECS up and running. He added that the Clinical Board had also signed up to NHS

	Improvements and noted that the SDEC worked very well in other areas of the UK. In response to the second question from the IMU, the DOS noted that attendances were being measured as well as occupied beds to see if admissions had reduced. He added that a dashboard would be created with a number of key measures that would be reported. The Executive Nurse Director (END) advised the Committee that the work being carried out by the Surgical Clinical Board had significantly reflected a Health Inspectorate Wales (HIW) report regarding the Emergency Unit and noted that the SDEC should provide an improved position. The Independent Member – Community (IMC) asked if there was any new area within digital technology that had been identified that would help move at the speed the Clinical Board were aspiring to achieve. The DOS responded that the digital tools mentioned earlier would help move the model forward and noted that help had been received from the Welsh Government (WG) as well as the Health Board with Consultant Connect. He added that bespoke reports had also been developed “in house” with the Health Board’s IT team and noted that other Clinical Boards had done the same. The Chief Officer of the Community Health Council (COCHC) advised the Committee that the new NHS 111 Wales telephone system was coming in which would replace CAV24/7 and noted that he was concerned about the Emergency Unit because patients were sitting on chairs for a long time. He noted that it would be helpful to know what the maximum length of stay would be on the recliner chairs identified within the SDEC and what mechanisms were in place to ensure patients were not there for too long. The SCBD responded that the floorplan presented to the Committee was the assessment and immediate treatment phase and that there was also a ward area which served a different purpose. He added that the purpose of reclining chairs was not just to make it nicer for patients but that it could be used for patients to have intravenous medications. It was noted that the trollies would be for patients who would have an intervention to theatres and that patients staying longer would be going to the dedicated ward areas. He concluded that the Clinical Board wanted patients to be “processed” as quickly as possible but once they had gone from treated to recovery they would move to the ward area.	

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	The COCHC noted that virtual wards/virtual technology had been identified and highlighted that there could be an issue with those who were digitally excluded. The DNS responded that they were already trialling a virtual ward in ENT and that there was a clear set of criteria for the patients and that only patients who fit that certain criteria would be managed by the virtual ward and noted that the patient would know who their point of contact was for 24/7 care. The COCH asked if the SDEC would change the way that patients accessed the service moving forward. The DOS responded that the SDEC was an internal model and extension of the Emergency Unit. The DNS responded that patients would not be admitted to chairs or recliners and that they would only be used for treatment and quick turnaround patients. The CC asked what the term “hot clinic” meant. The SCBD responded that it was an outpatient appointment for a clinical consultation the following day which meant that the patient’s need was tailored appropriately. The DOS reiterated that the whole point and principle around the SDEC was to ensure a patient did not require admission to a hospital bed. The Surgical Clinical Board Assurance Report was received and the Executive Medical Director (EMD) assured the Committee that the Surgical Clinical Board took Quality and Safety very seriously. **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 approved.	
QSE 22/02/008 Mohamed,Sarah 05/13/2022 16:36:25	**Presentation providing an update on:** • **Healthcare Standards** • **Duty of Candour** • **National Quality Framework** • **Annual Quality Statement** The END advised the Committee that the report would provide members with an update on where matters stood after a number of policy changes. The Assistant Director of Patient Experience (ADPE) presented the Committee with information regarding the new Health and Social Care (Quality and Engagement) Wales Act 2020 and noted four principal areas which included: • Duty of Quality	

- Duty of Candour
- Establishment of a new Citizens' Voice Body
- Requirement for NHS Trusts to have Vice Chairs.

It was noted that the Act was passed in March 2020 and received Royal Assent in June 2020 and that the intention was to bring the Act into force in April 2023.

The ADPE advised the Committee of what would be required to implement the Act, which included:

- Statutory guidance.
- Regulations that would set the Duty of Candour procedure.
- Regulations to amend the Putting Things Right (PTR) to ensure they would fit with the Duty of Candour.

The ADPE advised the Committee that the implementation of the Duty of Candour required workshops, e-learning packages, a public awareness campaign and easy to read information leaflets which would be developed with a communication engagement programme taking place across Wales.

In relation to the Duty of Quality, the Committee was informed that the said Duty would seek to achieve a system wide approach to quality in the Health Service to secure improvement and shift the focus away from simply quality assurance.

Regarding the new Citizens' Voice Body, the Committee was informed that it would replace the Community Health Council with a new, independent, national body that would exercise functions across health and social services.

It was noted that the Citizens' Voice Body would have powers to make reports and recommendations to organisations, such as Health Boards, NHS Trusts and Local Authorities, and to provide complaints advice and assistance to citizens should they had a complaint about NHS services and certain social services.

The Committee was advised that most NHS Trusts had implemented the requirement to have Vice Chairs already.

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The ADPE advised the Committee that the Health and Care Standards were introduced in 2015 to bring together and update the Doing Well, Doing Better: Standards for Health Services in Wales (2010) and the Fundamentals of Care Standards (2003).

It was noted that the Health and Care Standards formed the cornerstone of the overall quality assurance system within the NHS in Wales and that, alongside the Framework for Assuring Service User Experience (2013),

	the Standards had helped to ensure that people had positive first and lasting impressions, that they had received care in safe, supportive and healing environments, and that they had understood and were involved in their care. The CC advised the Committee that the information provided on the Healthcare Standards, Duty of Candour and National Quality Framework would benefit discussion at a Board Development Session. The Chair of the UHB asked what the review of the Healthcare Standards would entail and if it would be a "revamp" of the current Standards. The END responded that a revamp of the Standards was not expected and that something new was expected. The IMU asked if the new Duty of Candour had changed anything that the Health Board was not doing already. The END responded that the driver was to be open and transparent that the Health Board was already doing everything that was required. **The QSE Committee resolved that:** a) The Healthcare Standards, Duty of Candour, National Quality Framework and Annual Quality Statement was noted.	**RW/NF**
QSE 22/02/009	**Quality Indicators Report** The Quality Indicators Report was received. The END advised the Committee that there were 3 areas to note which included: • "Never Events" – It was noted that there were currently two Never Events under investigation and the development of a Human Factors Framework and Training Strategy would be an important element of the revised QSE Framework for the next five years. The END noted that feedback at a national level regarding learning was being received around Never Events. • Falls – It was noted that there had been a significant increase in falls at the Lakeside Wing (LSW). The END advised the Committee that was challenging to observe all patients at all times and noted that a more detailed look would be required at a future meeting. • PPE – It was noted that the Quality and Safety team were measuring and monitoring incidents to feed into the PPE Cell and that the team were not overly concerned. **The QSE Committee resolved that:**	**RW**

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	a) The contents of the Quality Indicators report and the actions being taken forward to address areas for improvement were noted.	
QSE 22/02/010	**Exception Reports** The Exception Reports were received. The END advised the Committee of the current pressures which included:- - The -concerns around the ED and the need for patients to be seen and treated through that department more quickly. - The "front door" was challenged by the "back door" and it was recognised that patients were staying in hospital for longer which was a system wide challenge. The END advised the Committee that excellent work was being done with the Local Authority and noted that staffing within that was challenging. She concluded that overall, the aim was to try to improve the flow, increase discharges and increase staffing. The EMD added that she was working closely with doctors and the Communications team to ask the teams to work differently and move patients through the system more quickly and noted that the Chief Executive of the Health Board was leading the work with her team. The END advised the Committee that she was holding sessions called "Ask Ruth" around staffing and professional conduct which enabled direct conversations with staff. The COCHC noted the comment made by the EMD regarding moving patients through the system more quickly and highlighted that there was a risk that the "whole person" was not being seen, just the current need. The EMD responded that due to current pressures the risk to patients in the Community was so high that they had to be focused to address the current need and get the patients back home as quickly as possible. The END concluded that the level of commitment shown by staff during those exceptional pressures was fantastic and a huge credit to the Health Board. The CC agreed and asked for thanks on behalf of the Committee to all Health Board staff to be noted. The Chair of the UHB re-emphasised the comments made by the END, EMD and the CC. **The QSE Committee resolved that:** a) The verbal update regarding Exception Reports was noted.	

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QSE 22/02/011	**HIW Activity Overview & Primary Care Update** The HIW Activity Overview & Primary Care Update was received. The END advised the Committee that an unannounced inspection at Hafan Y Coed, had been undertaken in the previous week to the meeting. She added that whilst the initial outcomes had been positive there were some areas that could be improved and highlighted that once the final report was received, those would be actioned. It was noted that the report had highlighted that the staff were a credit to the Health Board and that staff intentions were very good. The IMU highlighted the National Review of Patient Flow (Stroke Pathway) within the report and asked if a national review would delay the local review and planning being undertaken by the Health Board. The END responded that the answer was unknown, but noted that the Health Board had its own plan and lots of discussions were being had regionally to flush out some of the issues. The EMD responded that Stroke remained very high on the agenda and noted that a sustainable solution would be required given that the Health Board was currently helping out a neighbouring Health Board due to pressures being seen there. The IMTU noted that it was wonderful to hear compliments to staff across all the areas and asked if the feedback was being fed back to those staff and teams which would boost morale. The END responded that the Communications team was feeding back a lot of positive comments and noted that once the formal HIW report had been received, the positive feedback would be provided to the staff at Hafan Y Coed. **The QSE Committee resolved that:** a) The level of HIW activity across a broad range of services was noted. b) The appropriate processes in place to address and monitor the recommendations were agreed.	
QSE 22/02/012	**Board Assurance Framework – Patient Safety** The Board Assurance Framework – Patient Safety was received. The Committee noted that Patient Safety was one of the top three risks, alongside Capital and Workforce. The CC noted that the risks were high level and asked if the Committee felt assured that the controls were in place and working.	

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	The IMU responded that he was assured and asked the Director of Corporate Governance (DCG) to confirm that since the last review were there any further additional risks or mitigations that had been put in place. The DCG responded that she met with the Executive Leads prior to every Board meeting and noted that main Corporate Risks, including the Patient Safety Risk, had not changed since the last Board meeting. **The QSE Committee resolved that:** a) The risks in relation to Patient Safety was reviewed to enable the Committee to provide further assurance to the Board when the Board Assurance Framework was reviewed in its entirety.	
QSE 22/02/013	**Patient Experience Overview** The Patient Experience Overview was received. The ADPE advised the Committee that the report provided an overview of the Patient Experience Team's roles and regulatory function and added that more detailed reports regarding Complaints, Claims and redress themes and trends would be provided to the Committee at later dates in line with the QSE Work Plan. **The QSE Committee resolved that:** a) The increase in concerns numbers and the increased workload from the Welsh Risk Pool were noted.	
QSE 22/02/014	**QSE Committee Annual Work Plan** The QSE Committee Annual Work Plan was received. The DCG advised the Committee that the Work Plan was reviewed annually by the Committee prior to presentation to the Board to ensure that all areas within its Terms of Reference were covered within the Work Plan. It was noted that input from the END, Executive Medical Director (EMD) and other members of the Quality and Safety team had been provided. It was noted that the Q&S Framework was still being established and noted that there were some items on the Work Plan that highlighted future establishment. The CC asked if there were any timescales for the Committees that were currently unestablished. The END responded that the business case had quite a significant financial bill attached and that it had been take to the Executives where some support had been provided. **The QSE Committee resolved that:** a) The Quality, Safety and Experience Committee Work Plan 2022/23 was reviewed.	

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	b) The Committee Work Plan for 2022/23 was ratified c) The Committee Work Plan was recommended for approval to the Board on 31st March 2022.	
QSE 22/02/015	**QSE Committee Terms of Reference** The QSE Committee Terms of Reference were received. The DCG advised the Committee that the Terms of Reference were reviewed annually by the Committee prior to presentation to the Board for approval. **The QSE Committee resolved that:** a) The Quality, Safety and Experience Terms of Reference 2022/23 were reviewed. b) The Committee Terms of Reference for 2022/23 were ratified c) The Committee Terms of Reference were recommended for approval to the Board on 31st March 2022.	
QSE 22/02/016	**QSE Committee Annual Report** The QSE Committee Annual Report was received. The DCG advised the Committee that the Committee Annual Report was reviewed annually by the Committee prior to presentation to the Board for approval. **The QSE Committee resolved that:** a) The draft Annual Report 2021/22 of the Quality, Safety & Experience Committee was reviewed. b) The Committee Annual Report was recommended for approval to the Board on 31st March 2022.	
QSE 22/02/017	**Minutes from Clinical Board QSE Sub Committees: Exceptional Items to be raised by Assistant Director Patient Safety & Quality:** The Minutes from the Clinical Board QSE Sub-Committees were received: a) Children & Women's Clinical Board Minutes b) Specialist Clinical Board Minutes c) CD&T Clinical Board Minutes d) Mental Health Clinical Board Minutes e) Medicine Clinical Board Minutes f) PCIC Minutes g) Surgical Clinical Board Minutes h) Clinical Effectiveness Committee **The Committee resolved that:** a) The Minutes from the Clinical Board QSE Sub-Committees be noted.	
QSE 22/02/018	**Corporate Risk Register**	

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	The DCG advised the Committee that there was nothing further to add to the report received by the Committee. **The Committee resolved that:** a) The Corporate Risk Register risk entries linked to the Quality, Safety and Experience Committee and the Risk Management development work which was now progressing with Clinical Boards and Corporate Directorates, was noted.	
QSE 22/02/019	**Items to bring to the attention of the Board / Committee** The END advised the Committee that the Board should be made aware of the updates received regarding the Healthcare Standards, Duty of Candour and the National Quality Framework, and a discussion around current pressures and the quality of care.	**RW**
QSE 22/02/020	**Agenda for Private QSE Meeting** *i) Minutes of the Private Committee Meeting held on – 14th December 2021* *ii) Action Log – Following the Meeting held on 14th December 2021* *iii) Pandemic Update & Any Urgent / Emerging Themes – Verbal* *iv) Cardiac Surgery Report – Verbal Update* *v) DNAR Orders at St David's Hospital*	
QSE 22/02/021	**Any Other Business** The CC advised the Committee that there had been a high number of Do Not Attempt Resuscitation (DNAR) forms at St. David's Hospital and asked if it could be looked into. The END responded that an update would be provided in the Private session of the QSE meeting and that any relevant discussion would be brought to the Public session at a future date, if appropriate.	
QSE 22/02/022	**Review of the Meeting** The CC advised the Committee that a lot of time had been spent on the Clinical Board Assurance report but noted that it had been required.	
QSE 22/02/023	**Date & Time of Next Meeting:** Tuesday 22 February 2022 at 9am	

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Confirmed Minutes of the Mental Health Legislation and Mental Capacity Act Committee
Held On 09th February 2022 10.00-12.00
Via MS Teams

Chair:		
Ceri Phillips	CP	UHB Vice Chair and Committee Chair
Present		
In Attendance:		
Nicola Foreman	NF	Director of Corporate Governance
Ruth Walker	RW	Executive Nurse Director
Caroline Bird	CB	Interim Chief Operating Officer
Daniel Crossland	DC	Deputy Director of Operations - Mental Health
David Seward	DS	Interim Mental Health Act Manager
Rose Whittle	RW	Directorate Manager – Child Health
Catherine Wood	CW	Director of Operations – Children & Women's
Robert Kidd	RK	Consultant Clinical & Forensic Psychologist
Observers:		
Hannah Stevenson	HS	Graduate Management Trainee
Secretariat		
Nikki Regan	NR	Corporate Governance Officer
Apologies:		
Sara Moseley	SM	Independent Member – Third Sector
Akmal Hunak	AH	Independent Member - Community

Item No	Agenda Item	Action
MHCLC 09/02/001	**Welcome & Introductions** The Chair welcomed everyone to the Committee and acknowledged that the Committee meeting was not quorate. The Director of Corporate Governance advised that the meeting could still go ahead and that any decisions which the Committee was required to approve today, should be ratified by Board in March. **The Committee Resolved that:** a) The Committee meeting went ahead and any formal decisions that the Committee was due to make would be referred to full Board for ratification.	**NF**
MHCLC 09/02/002	**Apologies for Absence** **The Committee Resolved that:** a) The apologies were noted.	
MHCLC 09/02/003	**Declarations of Interest**	

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	The Committee Resolved that: a) No declarations of Interest were given.	
MHCLC 09/02/004	**Unconfirmed Minutes of the Meeting held on 19 October 2021** **The Committee Resolved that:** a) The minutes of the meeting held on 19th October 2021 were agreed as a true record.	
MHCLC 09/02/005	**Action Log from the meeting held on 19 October 2021** The Director of Corporate Governance (DCG) noted the action 20/10/14 was on-going. **The Committee Resolved that:** a) The Action Log was noted.	
MHCLC 09/02/006	**Chair's Action taken since last meeting** **The Committee Resolved that:** a) No Chair's Actions were taken since the last meeting.	
MHCLC 09/02/007	**Any Other Urgent Business Agreed with the Chair** **The Committee Resolved that:** a) No other urgent business was agreed with the Chair.	
MHCLC 09/02/008	**Mental Capacity Act & DoLs Monitoring Report – Update** The Committee received a report on The Liberty Protection Standards (LPS) The Executive Nurse Director (END) updated on the following: - - The Liberty Protection Standards (LPS) was delayed, with consultation on the LPS Code of Practice and Welsh Regulations expected in the Spring. - The Project Manager would align with the work. - There should be further funding confirmed and staff resource model will be clear following publication of the LPS Code of Practice and Welsh Regulations. - Training will be an important component of LPS and a training programme would be planned together with how best to deliver the same to front-line staff. The Consultant Clinical & Forensic Psychologist (CCFP) queried that it was unclear if the Health Board did the monitoring of Section 49 reports. He queried what the mechanism was to look into the reports and whether the Health Board should bring in a mechanism to look at the Section 49 reports.	

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	The END noted that Committee members should have some training to enable them to have a further understanding of the LPS. The Chair noted that when the LPS was released, no one had known the full extent and that may be why it had been delayed. Clarity was needed for training requirements. The delay could be due to potential demands and excessive pressures. The END noted areas of concern were identified when the DOLs portfolio was an agenda inherited by the END. As a Health Board, there was a need to better understand the legislation and to educate the work force The END commented that a new Mental Capacity Act Manager has recently been appointed and would need time to settle into the role. **The Committee resolved that**: a) The contents of the report and the current compliance with MCA and DoLs indicators (noting that these were incomplete due to the recent recruitment to the MCA Manager role), were noted.	
MHCLC 09/02/009	**Mental Health Act Monitoring Exception Report** The Interim Mental Health Act Manager (IMHA) highlighted the main points of the Mental Health Act Monitoring Exception Report, which included: – - A patient had been held without authority for 28 days but that had only been highlighted in October. - The patient was detained in University Hospital Llandough (UHL) before being moved to Mental Health Services for Older People (MHSOP). - Papers had been left on a ward at UHL and the papers could not be formally accepted. - To ensure that such an incident would not happen again, all AMHP's would complete a receipt so the MHA Office know who to chase for detention papers. The IMHA explained that Welsh Government (WG) had not authorised the digital forms. The digital forms were used in England, but COVID had delayed the digitalisation. It was explained that the patient was told they were held without authority and could seek legal advice. The IMHA noted that the Section135 numbers had risen, which may have been due to patients not allowing access to the assessing team.	

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	The CCFP noted that the process to apply for a warrant had become more streamlined and had helped being able to obtain a Section135. The IMHA explained MS Teams had been trialled for hearings to take place and had a positive impact. A meeting had been planned with the Tribunal manager and they were looking to roll out, as standard, the approach for all hearings to be via MS Teams. An issue had arisen where observers had been refused attendance at hearings and were told it was not within their scope to attend. The Chair noted that discussions with HEIW on the issue were required given that HEIW were to provide the training for that. The Deputy Director of Operations - Mental Health (DDOMH) raised the "social circumstances report". Nursing colleagues were asked to submit these, and he had thought that it had presented a quality, support & training issue. The END said she would raise with Chief Nursing Officer (CNO) and HEIW so they are aware of the challenge around the social circumstances report which were to be submitted by nurses. The IMHA noted that a relative had applied for a patient to be sectioned under Section 2 which was rare. The DCG suggested to take this to the Board as the meeting was not quorate and to reflect in the chairs report. **The Committee resolved that:** a) the approach taken by the Mental Health Clinical Board to ensure compliance with the MHA as set out in the body of the report, was supported.	**RW**
MHCLC 09/02/010	**Update on the Reform of the Mental Health Act – Verbal Update** **The Committee resolved that:** a) No further update was given on the reform of the Mental Health Act.	
MHCLC 09/02/011	**Mental Health Measure Monitoring Reporting including Care and Treatment Plans Update Report** The DDOMH presented the agenda item and highlighted the following: – - There were consistently high numbers.	

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- On graph 2, a steady turn around could be seen.
- There were challenges in December 2021 due to staff leave / sickness.
- His team were anticipating lower activity on the Quarter reports.
- Adult performance was at 100%.
- There had been an improvement with Older People.
- Areas of improvement were highlighted for CAMHS.
- Self-referral was highlighted and the compliance figures were good, albeit there were digital issues. New automated reports had now been set up.

The Chair noted the issues but given the pressures it was positive. He congratulated the teams for what had been achieved. He acknowledged that the effects of the pandemic were now being seen in Mental Health services.

The Director of Operations – Children & Women's (DOCW) added her thanks to the Directorate Manager – Child Health (DMCH) and the DDOMH for their generosity of time. She drew the Committee's attention to the approach of the 2 Clinical Boards and how they intended to progress the agenda, collaborative working and the transition of patients. A workshop had been held with the 2 Clinical Boards to discuss the issues and how to ease the transition between the 2 services.

The Interim Chief Operating Officer (ICOO) was pleased to see the reduction in waiting lists, but commented that they should look at how the headline performance was presented. Increased staff absence had caused issues. She added that all Mental Health teams had shown dedication and commitment and she thanked those teams.

The Chair noted that colleagues should be aware of what the Health Board was asked to measure and ensure that the narrative was provided in order to give the complete picture.

The CCFP reminded the Committee that other Health Boards had chosen to report the data in a different way.

The DDOMH noted that the 31 days for assessment had reflected the January figures.

The END echoed the difficult target. She commented that it could change quickly, and that it would only take to be out by one day to cause issues.

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The Committee Resolved that:

a) The proposed approach taken by the Mental Health Clinical Board to ensure compliance with the Mental Health (Wales) Measure 2010 as set out in the body of the report, was supported.

MHCLC 09/02/012	**HIW MHA Inspection Reports** The DDOMH highlighted the following in relation to the agenda item: – - HIW's report covered 41 visits to different healthcare providers, which included a visit to Hazel Ward. - The majority of inspections were done virtually. Some key items were: – - New groups which related to PPE provision. - Digital exclusion which affected some patients (re visiting). There were 3 items raised in relation to assessment and risk: – - Visiting – there was more frustration due to people wanting direct contact with relatives. - Seclusion facilities – the Health Board did not have a seclusion facility. There were some developments regarding a seclusion facility on site. - There were some quality and safety concerns regarding the independent providers. - Some of the items raised had been closed since the report. The END commented that the issues should be taken to the Quality, Safety and Experience Committee (the QSE Committee). The END suggested that HIW attend the Committee. The DGC explained that the HIW report cut across a number of services. This Committee was the appropriate committee to see the report, and the QSE Committee could have had the oversight. The quality governance impact should be picked up. Such reports should all be sent to the Chief Executive's office and be sent out to all from there. END commented that there was a problem with Primary Care. That was because it was slightly "siloed" but she hoped to put it back on the right track. The Chair noted to add the HIW report for next Committee. **The Committee Resolved that:** a) The content of the HIW Mental Health Hospitals, Learning Disability Hospitals and Mental Health Act Monitoring Annual report 2020-2021 was noted.	**NF** **CP/DC**
MHCLC 09/02/013	**Sub-Committee Meeting Minutes:** The Committee received copies of the Sub-Committees' meeting minutes.	

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	The CCFP noted the following: – - Discharging with Section 117 aftercare had been an issue. - There was a discussion around a potential issue with South Wales Police regarding "when the clock starts". - The SW Police representative should be notified following the legal advice to see if a position of understanding could be made. - It was important to note it had been discussed at length. - A potential shortage of Section 12 doctors was expected. - More young people were in the Health Board's facilities. - In terms of the Committee, it was strictly looking at the legislation and quality and safety relating to the same. - There was change in the Mental Health Clinical Board to ensure the structures were replicated and further work in that arena was being undertaken. **The Committee Resolved that:** a) The Hospital Managers Power of Discharge Minutes from 4 January 2022, were noted and; b) The Mental Health Legislation and Governance Group Minutes from 6 January 2022, were noted.	
MHCLC 09/02/014	**Corporate Risk Register** The DCG explained the following: – - The Corporate Risk Register detailed the Corporate Risks which were relevant to the Committee. - The full Corporate Risk Register went to the Board. - The Register had been recently updated and showed those risks which scored 20 and above. - That was to ensure focus on the highest-level risks. - For this Committee there was one risk – Health & Well Being to Minor inpatients. - The risk was likely to be de-escalated. The DCG explained the issue may be due to staffing. She would liaise with Aaron Fowler, especially when there is more than one young person on the admissions ward. The DCG advised that the risk should be kept on the Register. It was noted that at the recent workshop there had been an extensive discussion regarding young people. They could not be ignored but may have been admitted to a medical ward and not a Mental Health (MH) ward. It was questioned how young people could be appropriately cared for and the need to ensure they were safe.	**NF**

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	The END acknowledged the challenge. There were not enough staff who could care for those children. Currently the team was caring for 2 high risk children, as there is no suitable alternative. The END was liaising with local colleagues regarding that issue. The Chair noted that there had been examples where children had been placed in a safe location, but their safety had been compromised. The END acknowledged the incident in Ty Lydiard, where the investigation had focused upon a child who had been placed in an area of safety. The child required considerable help and that had impacted upon another children's care. It was important to recognise that a place of safety was not always right if the care was not right. **The Committee Resolved that:** a) The Corporate Risk Register risk entry linked to the Mental Health Capacity and Legislation Committee and the work which was now progressing was noted.	
MHCLC 09/02/015	**Committee Terms of Reference** The DCG explained that the Committee's Terms of Reference (ToR) were due to go to Board in March for formal approval, but it was important for the Committee to review the same beforehand. The DCG explained the changes which were highlighted in the ToR. **The Committee resolved that:** **a)** The changes to the Terms of Reference for the MHLMCAC were reviewed; and **b)** The changes to the Terms of Reference for the MHLMCAC were to be presented to the Board on 31 March 2022 for formal approval.	
MHCLC 09/02/016	**Committee Work Plan 2022/23** The DCG explained the Work Plan reflected the ToR to ensure that the Committee delivered against the ToR. **The Committee resolved that:** **a)** The Work Plan 2022/23 was reviewed; **b)** The Work Plan 2022/23 was to be presented to the Board for approval at the Board Meeting on 31st March 2022.	
MHCLC 09/02/017	**Committee Annual Report 2021/22**	

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	The DCG explained that the Annual Report fed in to the end of year annual arrangements and into the full Board Annual Report which would be reviewed by WG & Audit Wales. **The Committee Resolved that:** a) The draft Annual Report 2021/22 for the Mental Health Capacity Legislation Committee was reviewed and; b) The draft Annual Report was to be presented to the Board for formal approval on 31 March 2022.	
MHCLC 09/02/018	**Policies/Procedures for approval:** The following Policies and Procedures were presented to the Committee for approval: - - Section 5(2) Doctor's Holding Power Procedure - Section 5(4) Nurse's Holding Power Procedure The DCG noted the need to ensure that the Board approved those Policies and Procedures and that an amendment was required given that Sunni was no longer the Mental Health Act manager. **The Committee Resolved that:** a) The following policies and procedures and associated actions as set out under (i) to (iv) below were to be approved, via the Chair's Report, at the Board meeting on 31 March 2022, namely: **(i)** The Section 5(2) Doctors Holding Power Policy and Procedure; **(ii)** the full publication of the Section 5(2) Doctors Holding Power Policy and procedure in accordance with the UHB Publication Scheme; **(iii)** the Section 5(4) Nurses' Holding Power Policy and Procedure; and *(iv)* the full publication of the Section 5(4) Nurses' Holding Power Policy and procedure in accordance with the UHB Publication Scheme	**CP**
MHCLC 09/02/019	**AOB** The Chair noted the vigil for Dr Gary Jenkins and wanted to convey his best wishes to Dr Jenkins' family, friends and colleagues.	
MHCLC 09/02/020	**Review of the Meeting**	
	To note the date, time and venue of the next meeting: April 26 2022 at 10am	

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	Via MS Teams	

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Confirmed Minutes of the Public Health and Safety Committee Minutes
Held On 25 January 2022 at 09.00am
Via MS Teams

Chair:		
Mike Jones	MJ	Independent Member – Trade Union / Committee Chair
Present:		
Akmal Hanuk	AH	Independent Member – Local Community
Michael Imperato	MI	Independent Member – Legal
Ceri Phillips	CP	UHB Vice Chair
In attendance:		
Nicola Foreman	NF	Director of Corporate Governance
Rachel Gidman	RG	Executive Director of People & Culture
Fiona Kinghorn	FK	Executive Director of Public Health
Robert Warren	RW	Head of Health and Safety
Geoff Walsh	GW	Director of Estates, Capital and Facilities
Janice Aspinall	JA	Safety Representative RCN
Rachael Daniel	RD	Health and Safety Advisor
Jonathan Strachan-Taylor	JS	Safety Representative GMB
Observers:		
Marcia Donovan	MD	Head of Corporate Governance
Secretariat		
Sarah Mohamed	SM	Corporate Governance Officer
Apologies:		

Item No	Agenda Item	Action
HS 25/01/001	**Welcome & Introduction** The Committee Chair (CC) welcomed everyone to the meeting.	
HS 25/01/002	**Apologies for Absence** Apologies for absence were noted.	
HS 25/01/003	**Declarations of Interest** No Declarations of Interest were noted.	
HS 25/01/004	**Minutes of the Meeting held on 12 October 2021** The minutes of the Committee Meeting held on 12 October 2021 were received.	

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	The Committee resolved that: a) The minutes of the meeting held on 12 October 2021 were approved as a true and accurate record.	
HS 25/01/005	**Action Log following the Meeting held on 12 October 2021** The Action Log was received. **The Committee resolved that:** a) The Action Log was noted.	
HS 25/01/006	**Chair's Action taken since last meeting** No Chair's Actions were noted.	
	Items for Review and Assurance	
HS 25/01/007	**Health & Safety Overview** The Head of Health & Safety (HHS) presented the Health and Safety (H&S) Overview and highlighted the following: H&S department • It was noted that since the last meeting the Fire Safety team had been brought across to the Health and Safety department. They were working closely with the training department to organise training courses for staff. Health and Safety Culture Strategy • It was noted that a department workshop took place on 20 October 2021. The department formulated a 3-year Health and Safety Culture Strategy. Work had started on the actions and it would be brought to the next meeting. It had introduced forward thinking and provided a proactive approach to H&S. There were three main themes which included the following: - Achieving training and competence excellence. That would drive compliance and reduce the number of risks. - Achieving H&S risk and incident management excellence. - Achieving communication excellence.	RW

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	It was noted that a stakeholder management system had been created. The H&S team planned to ensure that it was consistently applied throughout the Health Board. It was noted that H&S were currently not audited and that was something that would be completed. It was noted that achieving Fire Safety excellence was also a priority. Since the Fire Safety team had moved across to the H&S department, there was something that could be done to drive the improvement. Management system • It was noted that a management system would be introduced. The H&S department were already using the system. It would help the Clinical Boards manage their H&S. It would also be useful for identifying gaps. Environmental, waste management and change management folders were going to be added. H&S statistics • It was noted that the Health Board had plateaued. Time was lost with every Loss Time Incident (LTI). There were a high number of days also missed by staff due to incidents. December training compliance • It was noted that the face to face Fire Safety training rates had improved significantly and would be carried out into 2022. Compliance within training had been low and the H&S department were working with housekeeping. An improvement would be seen in training compliance which would lead to a decrease in incidents. There was also a project in place to verify trainer's competence within the H&S team. Current work. • The Health Board was organising the Obligatory Response to Violence (ORV) again. • The new Datix system would be coming into force on 1st March 2022. The H&S team were involved in implementing that. Staff COVID-19 RIDDOR reporting • It was noted that the department continued to investigate staff COVID transmissions. It was	

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	likely that an outbreak in the RCN Representative office would be reported. The Independent Member - Local Community (IMLC) stated that he was pleased to hear the progress made. The IMLC queried what plans were in place to meet the KPIs and how could clear communication be implemented. The HHS responded that the dashboard was rolled out every month and was found to be very useful. They were also planning to the use the Intranet more efficiently. They were also planning to have monthly H&S drop in sessions. A H&S advisor was also assigned to each Clinical Board. That would be shared in the next meeting. The Independent Member Legal (IML) queried what was the holistic “buy in” of the stakeholders amongst the staff. The HHS responded that a H&S culture change was needed to protect colleagues. That could be done through a behavioural safety programme. That was not in the H&S Culture Strategy but it was at the forefront. The Safety Representative RCN (SR) stated that she was working hard with the HHI and wider team to change the H&S culture amongst staff. The Executive Director of People & Culture (EDPC) stated that actors would be brought in to do training and provide a different impact. That would be shared with the Committee and Clinical Board once finalised. **Lone worker report** The Lone Worker Report was received. It was noted that the report had been submitted. The current contract with Peoples Safe was due to expire in July 2022. It was noted that Procurement had been contacted. The HHS would like to continue working with People Safe, although he noted that the new contract would be subject to Procurement advice and/or procurement rules. There were 700 active devices and if the supplier was changed that could require more training hours and potential hidden costs. The UHB Vice Chair (VC) commented that he did a Patient Safety walk with the EDPC around one of the facilities. They came across a situation where a colleague was working in a flat above a retail outlet. The	

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	access was one way and if someone went up to the flat the worker would need to escape using the same set of stairs as the intruder. Although the Device was useful, it may not be the only risk factor. The HHS responded that issue came down to individual risk assessment. It would mean having a discussion with managers and staff themselves. The Device was only one part of the risk assessment completed for the Lone Worker groups. The EDPC stated it would be useful to know who were the 700 people using the Lone Worker Device, and if alternatives were required for some people. The Health and Safety Advisor (HAS) stated that the Lone Worker Device was a last port of call. A risk assessment was completed first and then the Lone Worker Device was then added. The Device was meant for the high-risk community staff. **The Health & Safety Committee resolved that:** a) The Health and Safety Overview, which included the Lone Worker Device Report, was noted.	
HS 25/01/008	**Priority Improvement Plan Update (Verbal)** The HHS advised that the Priority Improvement Plan formed part of the H&S Culture Strategy. A more detailed review would be completed in the next few months. **The Health & Safety Committee resolved that:** a) The Priority Improvement Plan Verbal Update was noted.	RW
HS 25/01/009	**Fire Enforcement Report** The Fire Enforcement Report was received. The HHS stated that more information on the Fire Notices would be added to the report. The EDPC requested that the report was put against her name as the Lead Executive. **The Health & Safety Committee resolved that:** a) The on-going efforts to meet the requirements of the 3 key fire safety requirements were noted.	

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HS 25/01/010	**Environmental Health Inspector Report (Verbal)** The Director of Estates, Capital and Facilities (DECF) stated there had been no Environmental Health Inspection visits by the relevant authorities since the last meeting.	
HS 25/01/011	**Fire Enforcement Notices** The Fire Enforcement Notices Paper was received. The HHS advised the Committee on the following – • On 21 April 2021 the Health Board had received a Fire Enforcement Notice. The Notice could not be satisfied and was raised with the compliance team. The Fire and Rescue Service (the Fire Service) sent a letter of caution against one of the Executives. The letter was responded to last Thursday and they had acknowledged receipt. The Health Board was awaiting their response. • There was a deliberate fire in Hafan Y Coed. Another Fire Enforcement Notice had been issued. The Enforcement Notice was closed down following the Fire Service visit to the facility. • On Sunday night there was another deliberate fire in Hafan Y Coed. The Fire Service visited yesterday but they did not issue a Fire Enforcement Notice. They were satisfied with the work being carried out. The H&S team were still reviewing it and working closely with Mental Health. It was highly likely that an ignitor was passed through the garden fence. The staff at Hafan Y Coed had staggered the smoking breaks to ensure that patients in adjacent garden wards could not speak to each other. There were also plans for garden fences to be boarded off. The IMC queried if there was a smoking policy in Hafan Y Coed and what areas could be improved upon. The HHS responded that there were designated areas for smoking. There were lighters in the gardens that did not require a flame, although they did get damaged. The protocol was that the nurses would go downstairs and help the patients light their cigarettes. There were also metal bins in place and regular sweeps in the garden. Overall there were protocols in place to allow patients to smoke in a safe place. The VC commented that some of the staff had put themselves in risk to prevent the incident from	

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	escalating. The VC queried if there were any policies or recommendations on how staff should act in that type of situation. The HHS responded that would come out of the Fire Safety training. The HHS commended the staff and stated that they did act in the right manner. The EDPC stated that there was one action regarding the fences to be completed. The HHS stated that there was a Fire Safety visit on the 8 October 2021 to A4 in UHW. An Enforcement Notice was received regarding physical controls. A lot of the actions had been completed. A rolling ward improvement programme was put in place. The Fire Service was invited back on 8 February to discuss that and the Health Board was able to demonstrate that it was looking after the electrical gear switch. The DECF stated that his team were looking to take out the wards and address the issues in the quieter summer periods. The Fire Service had accepted that approach. **The Health & Safety Committee resolved that:** a) The content of the Fire Enforcement Notices Paper was noted.	
HS 25/01/012	**Enforcement Agencies Report** The Enforcement Agencies Report was received. The HSA advised the Committee on the following – • Since the last meeting, one new issue had been raised with the Health and Safety Executive (HSE). It concerned a TUG being used on the site and there were issues with a hard hat being placed over the mechanisms of the TUG. Once realised, it was taken out of service straight away. • Other concerns included vials of blood not disposed of correctly, loose wires were evident and that there was a lack of First Aid kit and eye wash station in the training area. • Despite the vague description from the HSE it was deduced that the other concerns were in relation to the waste area. • An explanation was provided regarding the TUG maintenance and inspection regime. The other concerns and issues were also addressed in the response which was satisfactorily closed out by the HSE on 1st December 2021.	

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	• A Pre-Inquest Review into two staff COVID deaths, that was originally scheduled for early December, was adjourned and rescheduled for March 16th 2022. • An inquest into a staff COVID death was conducted on the 6th December and the verdict concluded that it was not a work-related transmission. That matched the Health Board's determination. **The Health & Safety Committee resolved that:** a) The content of the Enforcement Agencies Report was noted.	
HS 25/01/013	**Risk Register for Health and Safety (Verbal)** The HHS stated that the Risk Register would need to be updated. A meeting would take place with the Head of Risk and Regulation to drive that forward. The Director of Corporate Governance (DCG) commented that it would be useful to see it in the Committee meetings so that the Committee could view the Register. The HHS stated it would be brought to the next meeting. **The Health & Safety Committee resolved that:** a) The Risk Register for Health and Safety Update was noted.	RW
	Items for Approval/Ratification	
HS 25/01/014	**Pedestrian Safety Strategy** The DECF presented the Pedestrian Safety Strategy Paper and updated the Committee on the following - • Traffic for pedestrians across the Health Board sites had improved over the last few years. A review had been undertaken and a company had looked at access around the sites. They came up with a number of actions. • It was noted that there was still a lot of work to be done in terms of pedestrian safety. More people were being encouraged to cycle and take public transport such as "park and ride". The VC queried how changes to the Highway Code would affect the said Strategy.	

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	The DECF responded that they were working with the Local Authority. There were discussions about bringing the safe cycle route onto sites. There was a need to reflect on changes made in the last couple of years and people's behaviours as they were not in the same place as when the Strategy was introduced. The IMC stated that relationships with Cardiff University should be looked into. A project could be engaged with the Town Planning department at Cardiff University. The DECF responded that a discussion would take place. The IML queried what the timelines of the report were. The DECF responded that the Strategy required funding along with many other obligations. The Discretionary Programme funding, out of which the Strategy was being funded, had been reduced by 25%. The Chair queried if concerns regarding finances could be raised in the Chair's Report to the Board. The DCG agreed that the Chair could escalate his concerns regarding funding via his Chair's Report to Board. The DECF stated that they were starting work on the first cycle hub in UHW. The hub included lockers and showers for cyclists. The hub was one of three such hubs that were in the pipeline. **The Health & Safety Committee resolved that:** a) The content of the Pedestrian Safety Strategy Report was noted.	DCG
HS 25/01/015	**Committee Annual Work Plan and Terms of Reference** The DCG stated that the Committee's Annual Work Plan and Terms of Reference required a review every 12 months and that the Board would approve the same in March. There were very few changes to be made and the changes made were highlighted in red. The Work Plan reflected the Terms of Reference to provide assurance to the Committee that it delivered against the Terms of Reference. **The Health & Safety Committee resolved that:** a) The changes to the Terms of Reference 2022-23 and associated Health and Safety Committee	

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	Work Plan 2022-23 for the Health and Safety Committee, were ratified; and b) The changes be recommended to the Board for Approval.	
HS 25/01/016	**Committee Annual Report** The DCG commented that the report provided a backward look into the work of the Committee. It was not fully completed yet as it would need to include the details from today's meeting. The report would go to Board for approval at the end of March. **The Health & Safety Committee resolved that:** a) The draft Annual Report 2021/22 of the Health and Safety Committee was reviewed; and b) The Annual Report was recommended to the Board for approval.	
	Items for Noting and Information	
HS 25/01/017	**Sub Committee Minutes:** i. Operational Health and Safety Group – 14 September 2021 **The Health & Safety Committee resolved that:** a) The Operational Health and Safety Group minutes were noted.	
HS 25/01/018	**Items to bring to the attention of the Board/Committee** **The Health & Safety Committee resolved that:** a) There was nothing to bring to the attention of the Board.	
HS 25/01/019	**Review of the Meeting** The Chair stated that the past two meetings had finished by 11am. The Chair queried if the timing of the next Committee meeting could be reduced. The DCG responded that timings for individual agenda items could be considered which would help with the overall efficiency of the meeting. **The Health & Safety Committee resolved that:** a) Timings would be added to the agenda.	DCG

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HS 25/01/020	**Any Other Business** Any Other Business was not discussed.	
	Date & time of next Meeting 19 April 2022 at 09:00am via MS Teams	

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MINUTES OF CARDIFF AND VALE STAKEHOLDER REFERENCE GROUP MEETING HELD ON TUESDAY 25 JANUARY 2022 CONDUCTED VIA MICROSOFT TEAMS

Present:	
Sam Austin	Llamau (Chair)
Frank Beamish	Volunteer
Jason Evans	South Wales Fire and Rescue
Iona Gordon	Cardiff Council
Shayne Hembrow	Wales and West Housing Association
Duncan Innes	Cardiff Third Sector Council
Zoe King	Diverse Cymru
Paula Martyn	Independent Care Sector
Linda Pritchard	Glamorgan Voluntary Services
Geoffrey Simpson	One Voice Wales
Siva Sivapalan	Third Sector, Older Persons
Lauren Spillane	Carers Trust
In Attendance:	
Marie Davies	Deputy Director of Strategy & Planning, UHB
Angela Hughes	Assistant Director of Patient Experience, UHB
Anne Wei	Strategic Partnership & Planning Manager, UHB
Apologies:	
Lani Tucker	Glamorgan Voluntary Services
Secretariat:	Gareth Lloyd, UHB

SRG 221/01 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting.

SRG 22/02 APOLOGIES FOR ABSENCE

Although not members of the SRG, apologies were received from Nikki Foreman and Abigail Harris.

SRG 22/03 DECLARATIONS OF INTEREST

There were no declarations of interest.

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SRG 22/04 MINUTES AND MATTERS ARISING FROM STAKEHOLDER REFERENCE GROUP MEETING HELD ON 23 NOVEMBER 2021

The SRG **RECEIVED** and **APPROVED** the minutes of the SRG meeting held on 23 November 2021.

SRG 22/05 UPDATE ON THE OPERATIONAL PRESSURES WITHIN THE UHB

Marie Davies provided the SRG with a brief overview of the operational pressures within the UHB during the past two months.

The UHB had faced a particularly challenging period due to the Omicron variant which had resulted in a significant increase in C-19 prevalence amongst the population. The difficulties created by increasing hospital emergency attendance rates had been compounded by hugely challenging workforce issues. Some areas of the UHB had experienced staff absence rates of up to 20% due to a combination of vacancies, sickness and staff self-isolating . For the past 2-3 weeks the UHB had therefore deployed the Local Choices Framework based on the Welsh Government framework of actions within which local NHS organisations can make decisions about how best to continue to provide essential care under current pressures. This had meant that some elective activity e.g. in Orthopaedics, had been cancelled with staff being redeployed to other areas to help cope with staff shortages to manage emergency admissions. This had been an extremely difficult decision to take and these arrangements would continue for a further three weeks.

Capacity within hospitals was limited due to a combination of workforce issues, the need to close beds as a result of C-19 outbreaks and an increase in the length of stay amongst the over 65 age group . The ability to discharge patients from hospital has been hampered by the lack of domiciliary care and social care services. Twice weekly operational meetings involving senior staff are being held to make bed management plans and patients have been moved around within hospitals to cohort them in order to release space for admissions.

Marie Davies reported that it was anticipated that the UHB's financial settlement for 2022/23 would be significantly less than had been hoped for but there would be a better settlement for Education and Social Care compared to previous years. This would present the UHB with a further ongoing challenge.

The SRG raised as number of questions and made several observations

- The SRG noted how exhausted NHS colleagues must be and thanked them for their continued commitment during the most difficult of times.

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- It would be helpful to receive an update on progress with the integration of health and social care. The SRG was informed that senior nurse leads liaise with senior social services colleagues daily. There is, however, a fundamental shortage of domiciliary care and social care capacity. There are regular meetings between the Executives of the UHB and the two Local Authorities and a joint UHB/local authority Integrated Health and Social Care team is now well established and headed by Cath Doman. Cath Doman is also Programme Lead for the @ Home Shaping Our Future In Our Community Programme. Many of the elements of the Programme are beginning to gain some traction. One such example is the establishment of multi-agency/multi-disciplinary teams for complex discharges in two of the Cardiff GP Clusters. The aim of these teams is to ensure packages are in place to prevent admission to hospital and facilitate discharge. The intention is to establish similar teams in each of the six GP Clusters in Cardiff. The UHB is also working with the local authorities on the creation of a joint workforce with common terms and conditions. It was agreed that Cath Doman be invited to return to the SRG following her attendance in March 2021, to present on progress with the @ Home Shaping Our Future In Our Community Programme.

Action: Anne Wei/Gareth Lloyd

- Is there capacity in residential care homes to enable patients who are ready to be discharged from an acute hospital to be placed there temporarily before returning to their homes? The SRG was informed that this capacity was being monitored but was limited by closures due to C-19 and workforce shortages. Consideration has been given to commissioning capacity in the private sector e.g. hotels, but the risks associated meant that this was not deemed appropriate at this time.
- Will the financial settlement necessitate a re-prioritisation of the UHB's activities? Marie Davies explained that the UHB was developing a comprehensive suite of recovery plans based on different scenarios. The UHB's plans would be reviewed and risk assessed in light of the financial settlement, the need to continue to respond to C-19 and the recently released Ministerial priorities. Prioritisation would be inevitable.
- The SRG enquired about progress with the mass vaccination programme and whether there had been a problem with uptake of the vaccination amongst UHB staff. The SRG was informed that the UHB was currently vaccinating the 5-11 year old age group. There were still pockets of the population amongst whom the uptake was disappointing. The UHB was keen to ensure that accessibility was not a reason for this poor uptake. It had introduced a number of pop-up vaccination sessions but in so doing had to be cognisant of the

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potential security risk posed by 'anti-vaxers'. Over 80% of UHB staff were vaccinated. The UHB had identified staff groups where the vaccination uptake had been relatively poor and was working with these groups to understand the reasons for their reluctance.

- The SRG enquired about the impact of season flu. It was informed that at present there was not much flu circulating within the UHB's population. There were, however, early indications that prevalence was increasing in Europe especially in France and it would inevitably cross over to the UK. Unfortunately, the current flu vaccine was not a particularly good match for the strain in circulation. It was unlikely to prevent infection but would reduce the symptoms.

SRG 22/06 NEXT MEETING OF SRG

Microsoft Teams meeting, 1.30pm-4pm, Tuesday 22 March 2022, dependent on the operational pressures within the UHB at that time.

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LOCAL PARTNERSHIP FORUM MEETING

Thursday 17 February 2022 at 10am, via Teams

Present	
Rachel Gidman	Executive Director of People and Culture (Chair)
Dawn Ward	Chair of Staff Representatives – BAOT/UNISON
Suzanne Rankin	Chief Executive
Abigail Harris	Exec Director of Strategic Planning
Mike Jones	Independent Member – Trade Union
Lianne Morse	Assistant Director of Workforce
Claire Whiles	Assistant Director of OD
Peter Welsh	General Manager, UHL and Barry Hospital
Steve Gauci	UNISON
Jason Roberts	Deputy Executive Director of Nursing (for Ruth Walker)
Caroline Bird	Interim COO
Jonathan Strachan-Taylor	GMB
Rhian Wright	RCN
Nicola Foreman	Director of Governance
Pauline Williams	RCN
Katrina Griffiths	Head of People Services
Judith Hernandez del Pino	Operational Delivery Director
Mat Thomas	UNISON
Peter Hewin	BAOT / UNISON
Janice Aspinall	RCN
Joanne Brandon	Director of Communications
Fiona Kinghorn	Executive Director of Public Health
Andrew Crook	Head of Workforce Governance
Bill Salter	UNISON
In attendance	
Katherine Davies	RCN
David Howells	BMA
Apologies	
Ruth Walker	Executive Director of Nursing
Lorna McCourt	UNISON
Marianne Bray	RCM
Joe Monks	UNISON
Ceri Dolan	RCN
Zoe Morgan	CSP
Julie Davies	UNISON
Secretariat	
Rachel Pressley	Workforce Governance Manager

LPF 22/001 WELCOME AND APOLOGIES

Rachel Gidman welcomed everyone to the meeting and apologies for absence were noted.

Suzanne Rankin was attending her first LPF meeting since she joined the organisation as Chief Executive. RG welcomed her and Dawn Ward introduced TU members of the Forum to her.

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LPF 22/002 DECLARATIONS OF INTEREST

There were no declarations of interest in respect of agenda items

LPF 22/003 MINUTES OF THE PREVIOUS MEETINGS

The minutes of the meetings held on 1 December 2021 were agreed to be an accurate record of the meeting.

LPF 22/004 ACTION LOG

The Action Log was noted.

The following matters arising were raised:

LPF 21/078 (implementation of the smoke-free premises and vehicles regulations): a smoking enforcement team has implemented on a temporary basis. The infrastructure for issuing FPNs has not been put into place so their role is advisory/educational. Discussions re funding for 2022/23 are currently taking place.

LPF 21/081 (workforce resourcing): Peter Hewin asked for an update on the cross cutting job descriptions for Health and Social Care which had been alluded to in previous meetings, and whether it was appropriate for TUs to be involved in discussions at this point. RG advised that this had been discussed during the Covid crisis but had not been progressed at that point, though integration was part of the People and Culture Plan. She agreed that TUs should be involved right at the start of these discussions. Lianne Morse added that monthly meetings with the Local Authorities are taking place but she felt that any changes to terms and conditions would be a long term piece of work, and advised that the initial focus is on integrated roles.

LPF 21/086 *(review of the meeting):* it was agreed that future agendas could be set out as per the main themes of the terms of reference (i.e. items for consideration, communication, consultation/negotiation and appraisal)

Action: Rachel Pressley

LPF 22/005 CHIEF EXECUTIVES REPORT

SR introduced herself and the reasons for moving to Cardiff and Vale, including the alignment of her personal values with our strategy *Shaping Our Future Wellbeing*. She set out her developing priorities and provided a brief summary on each of them:

- Team resilience and wellbeing
- Digital infrastructure
- Urgent emergency care pathway, including the need for this to be the main focus of the organisation for a short period of time to enable improvements for patient and team safety
- Our approach as we move from the pandemic response and restrictions lift
- The underlying financial position
- Refreshing our strategy in the context of the post pandemic world, making our priorities crisper and clearer and grouping them for everyone to understand and see where they sit

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- Embedding our values - raising their prominence, incorporating them into the common language of the organisation and ensuring our activities fit

DW stated that we want to move in Wales from medicalisation to a social approach. She was interested to hear SRs views on this. SR agreed that health and wellbeing is over-medicalised and that a conversation with lots of stakeholders, including community groups, is needed. We need to ensure that the person seeing a medic will really benefit from their expertise. It was noted that Forum members have lots of thoughts and ideas on this topic and that there was a need for a longer conversation at some point.

LPF 22/006 INTEGRATED MEDIUM TERM PLAN

Abigail Harris advised the Forum that a draft IMTP would be presented to the Board the following week. The main issues at present include not having the workforce needed to deliver the full range of services that we want to provide and keeping some of the good practices picked up during the pandemic, but in a sustainable way. The People and Culture Plan will be central to how this is achieved.

The covid pandemic remains an unknown factor. For the purpose of the Plan a 'central scenario', where covid still exists but with a strong focus on recovery, has been adopted.

Key points to note include:

- We need to be the best we can in terms of efficiency in how we deliver services, this includes digitalisation, prehabilitation etc
- Strategic programmes are in place to drive the strategy in terms of hospitals, communities, public health etc and the document has been positioned in this way
- Capitol allocation will be very tight over the next three years and it will be necessary to prioritise
- The next three year period takes us to the end of the current strategy – discussions are taking place about how to refresh it over the next few months. The next iteration of the IMTP will include the refresh and the Regional Partnership Board Plan. It will be necessary to do things differently to be sustainable.
- Many of the running costs accumulated over the last few years (e.g. IP&C, bed base) are not included in the financial allocation for 2022/23. Board will consider if we need a normal cost improvement programme but will also need to take account of recovery and an accelerated transformation programme to ensure that only people who need hospital care come to our hospitals.

DW noted that in the past there had been good partnership engagement with the IMTPs. She recognised the current challenges and pace but asked for early involvement in some of these conversations. AH acknowledged that places of dialogue and influence are very important and agreed that engagement at Clinical Board level was needed. As the IMTP itself can only be a maximum of 50 pages it doesn't capture everything we do and a lot of the detail should be in the Clinical Board plans. RG indicated that the re-set of Clinical Board Local Partnership Forums should support this.

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Mat Thomas asked how we will get the messages out to the people who need our services and if there was a plan for this. He said that difficulties obtaining GP appointments didn't help the situation, especially as not everyone liked phone calls or digital appointments. AH agreed that

there is still a requirement for ongoing conversation and that it needs to recognise that it will not be a one size fits all model. She advised that one of the lessons from Canterbury was to not wait until everything was perfect, but to start and tweak as feedback was received. CAV 24/7 is a good example of this. Joanne Brandon acknowledged that there is a need for more work around sharing these key messages, especially with those not digitally enabled. She said that lots of lessons had been learned through the vaccine programme re connecting with the community but she would be happy to speak to anyone who had ideas about communicating with hard to reach groups.

LPF 22/007 OPERATIONAL UPDATE

Caroline Bird delivered a presentation on the current operational postion and the application of the Local Choices Framework.

The in-hospital position is no longer about the covid wave. There is whole system pressure but the real issue is around occupency and discharges. We have an extended footprint and staffing have been stretched to meet this. The primary focus now needs to be reviewing this and what we can do to change it, and how we can improve the wellbeing of our staff.

The Local Choices Framework was issued by Welsh Governamant to allow Health Boards to reduce or suspend services to support pressures elsewhere in the system. Within Cardiff and Vale this has been used to deploy staff over the past 6 weeks. CB thanked staff for their flexibility and gave assurances that work was taking place to identify what could be done differently to improve the situation for both patients and staff.

MT asked what was preventing us from discharging patients. CB explained that there are about 300 patients are medically fit for discharge but this is prevented by 3 things:

- about 50% have to remain in hospital due to social care challenges (capacity due to outbreaks, workforce challenges and domicilary care)
- a smaller element are from other Health Boards and are waiting for repatriation
- CB believes that we have stretched our footprint so much that we have become inefficient and have lost continuity of care by spreading staff so thinly

DW reported that the TU representatives have heard that staff are unhappy and asked when deployment in this way will end, or is it the new norm and the start of a flexible workforce for the future. She asked that if this is the case that staff representatives are involved in this conversation early on. CB advised that the first step needs to be reducing the size of the footprint and allowing staff to return to their usual areas of work. After this has happened, space and servcies need to be redesigned because it is clear that we cannot continue to do things the way we have previously.

It was agreed that CB would bring an update on the Recovery and Redesign Plan to the next meeting.
Action: Caroline Bird

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LPF 22/008 INTEGRATED PERFORMANCE REPORT

The Local Partnership Forum received the Integrated Performance Report and the following points were noted:

- MT asked how many of the 195 international nurses recruited are now on the 'shop floor' and what the retention rate is like? He also asked if the Board had now approved recruitment of a further 200 international nurses. Lianne Morse advised that 231 international nurses have now taken up employment and achieved NMC registration. She was not aware of any who had left. The quality of the nurses is excellent and Board has approved further recruitment on an all-Wales basis. JR added that pastoral care is provided, including accommodation, and that the existing international nurse community support with this as well.
- MT expressed a hope that an exciting job description was being developed for the Band 3 roles, noting that many of the job descriptions developed are not interesting or motivating. Jason Roberts agreed. He noted that population needs are changing and so is the population in wards. The Nurse Staffing Act is in place, but moving forward we will need a different workforce and skills mix. A Band 3/4 Forum is in place and is working through the job descriptions. JR noted that this is the first time Cardiff and Vale have looked at a Band 4 role and what this looks like.
- Pauline Williams noted that recovery monies had been made available to provide additional security in the Emergency Unit but that this was coming to an end. She asked what the longer term view on staff safety was. JR stated that staff safety is a priority. The principle is to reduce the footprint and therefore the temperature in EU, but in the short term incidents will be monitored and extra security will be used. Judith Hernandez del Pino supported this, reiterating that reducing waiting time will reduce incidents and that the safety of staff remained a top priority.
- Rhian Wright noted that of the 61 nationally reported incidents, 50% occurred in December. She asked if they were still continuing at that level. JR advised that the biggest issues are pressure relief and falls, and that the high percentage was reflective of the situation faced in December. He acknowledged that increased bed capacity had led to increased footprint which had had an impact on staffing and serious incidents. He hoped that renewed enthusiasm for working smartly would lead to a reduction in incidents, but said that he was also mindful of the pressure damage to elderly patients spending long periods in chairs in EU.
- RW also asked if the retirement group had been set up yet and requested an invitation for staff side to attend. RG advised that the focus groups have not started yet but indicated that they would be inter-professional and that staff representatives would be involved.
- DW noted the unintended consequences of additional beds in terms of stretched staffing. She appreciated the challenges faced and the need to put patient safety first, but emphasised that staff wellbeing is also crucial. DW referred to a paper from the Kings Fund on compassionate leadership and the useful resources it contained and asked for this paper to be shared with the Forum

  Action: Rachel Pressley

  SR stated that solutions have to be done together and that our values are central to this. If we aren't *all* living the values it won't be a good experience and people will leave. She noted that compassionate leadership alone is not enough, as it is a shared challenge and we need collaborative leadership to address it.
- Janice Aspinall asked what the UHB plan was around reducing social distancing to 1m. JR advised that the IP&C guidance from Welsh Government remains at 2m for health care settings. However, we do have the option to risk assess and reduce to 1m in areas to enable more patient care. He advised that the IP&C Cell is looking at this and has devised a

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checklist to support managers to risk assess via a hierarchy of control, but that in general the current plan is to maintain to 2m rule in bed/ward areas where the risk is higher. Fiona Kinghorn added that the transition plans haven't been released yet, but we can expect lots of changes, especially in office areas.

LPF 22/009 CHANGES TO AFC TERMS AND CONDITIONS

The Local Partnership Forum received and noted the report on Changes to AFC Terms and Conditions.

The extra days Annual Leave is now on ESR. Staff are encouraged to take AL when they can, however, this year there is the option to carry over up to 10 days and sell up to 10 days. RW reported that some managers have turned down requests to do this. RG asked if this could be picked up outside the meeting with the relevant Assistant Head of Workforce and OD who can provide the appropriate guidance and support.

LPF 22/010 EMPLOYEE HEALTH AND WELLBEING

Claire Whiles delivered a presentation on Employee Health and Wellbeing. She noted that a physically and psychologically safe and healthy workforce is essential for excellent healthcare. There were issues before the pandemic and work has been done before and during it, including work by the Health Charity. As we move to recovery we need to determine the best way to support our staff to reflect and move on, acknowledging that a longer term approach is needed as this will not happen overnight.

Research has been undertaken and feedback obtained from trade union colleagues, surveys, 14,000 voices and other sources.

Research told us that staff wanted: improvements to the working environment; compassionate leadership; EWB services; peer support; more regular feedback; and a holistic approach to wellbeing. Our response is underpinned in the People and Culture Plan – not just in theme 2 (Engaged, healthy and motivated workforce) but also how we recruit, retain, offer learning and development, our systems, and ways of working. Examples of progress to date include:

- Winning Temp – a weekly engagement survey to be piloted with nursing staff
- Schwartz Rounds – being trialled in small areas first
- Staff rooms, water bottles and hydration stations (n.b. with tremendous support from the estates department)
- A more visible EWB team and HIT team – targeted interventions including EU and Mental Health Clinical Board
- Additional OH support which has reduced waiting times
- Leadership and development programmes.

CW reminded the Forum this this is part of the bigger picture and that staff health and wellbeing should be included in all of our strategies, and underpinned by our values and behaviours.

The Forum discussed the presentation and the following points were noted:

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- Steve Gauci noted that the impact of covid is still not fully understood, in particular, long covid can lead to disability and brain fog which can effect capability. This has links with compassionate leadership. CW agreed, and noted that work around the Equality, Diversity and Inclusion (EDI) agenda also needs to be embedded
- Mike Jones noted the important work carried out behind the scenes by the Health Charity and asked if they could be added to the slides
- MT asked for the tunnels and lower ground areas to be considered when determining where hydration stations should be placed
- MT also asked for a robust commitment to get Managing Attendance at Work and Respect and Resolution training back on track. LM agreed to develop a training plan.
  Action: Lianne Morse
- JR commented that the wellbeing agenda including elements of emotional intelligence and compassionate leadership, things which make a real difference. He thanked those involved for the work done.
- FK noted that this forms part of the People and Culture Plan and how we roll out our strategy. She asked that the community staff and corporate teams are remembered as well as hospital staff.
- Katherine Davies stated that it is important to get the message across that compassionate leadership is not weak leadership or being a pushover.

LPF 22/011 ANY OTHER BUSINESS

DW noted that previously there had been an aspiration to set up an LPF for corporate areas and Chris Lewis had agreed to chair this. However, CL is now leaving the organisation and another volunteer will need to be found. She asked the UHB LPF to encourage the Clinical Board LPFs to restart.

LPF 22/012 FUTURE MEETING ARRANGEMENTS

The next meeting will be held on Wednesday 13 April 2022 at 10 am with a staff representatives pre-meeting at 9am. The meeting will be held remotely.

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Report Title:	**Draft Annual Report 2021/22**				Agenda Item no.	**8.2**	
Meeting:	**Board**		Public	x	Meeting Date:	**26 May 2022**	
			Private				
Status *(please tick one only):*	Assurance		Approval		Information		x
Lead Executive:	**Director of Corporate Governance**						
Report Author (Title):	**Head of Corporate Governance**						

Main Report
Background and current situation:

Background

Board Members may recall that the Health Board is required to publish, as a single document, a three part Annual Report and Accounts which includes: -

a. The **Performance Report** which must include:

- An Overview
- A Performance analysis.

b. The **Accountability Report** – to demonstrate how the Health Board has met key accountability requirements to the Welsh Government, and must include:

- The **Corporate Governance Report** – this explains the composition and organisation of the Health Board's governance structures and how they support the achievement of the Health Board's objectives.

- The **Renumeration and Staff Report** – this contains information about the renumeration of senior management, fair pay ratios, sickness absence rates etc.

- The **Parliamentary Accountability and Audit Report** – this contains a range of disclosures relating to the regularity of expenditure, fees and charges, compliance with the cost allocation and charging requirements set out in HM Treasury guidance, material remote contingent liabilities, long term expenditure trends and the audit certificate and report.

c. The **Financial Statements** – this includes Audited Annual Accounts 2021-22.

In recognition of the continuing challenges faced by NHS Wales during 2021-22 due to responding to COVID–19, HM Treasury has reviewed the financial reporting requirements for 2021-22. In order to ease the burden on preparers of government annual reports and accounts ("ARAs"), minimum reporting requirements as per the Financial Reporting Manual (FReM) are in place for a limited time and only relate to non-audited elements of ARAs.

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For 2021-22:-

- There will be no requirement to prepare a separate Annual Quality Statement, or to prepare a separate Annual Putting Things Right report. Information on dealing with

concerns should be contained in the Performance Report, unless a separate report has already been developed.

- Entities apply the FReM are permitted to omit the performance analysis section of the Performance Report. Where content is common between the Performance Overview and the Annual Governance Statement, it will not be necessary to duplicate the information.

- The Sustainability Report is not mandatory for inclusion in the Annual Report. However, the Health Board should make a statement in its Annual Report indicating where and when the metrics will be available, and when available, these should be published on the Health Board's website.

The structure adopted is the one described in the FReM. NHS bodies may omit headings or sections where they consider that these are not relevant, but all of the content outlined in the manual should be included.

The purpose of this report is to present the draft Performance Report and Accountability Report 2021-2022 for approval.

Current position

The draft Annual Report provides useful information to our public and staff, holds us accountable for what we do and both celebrates our achievements and acknowledges our challenges and what we intend to do about them. At the time of writing this report, the draft Performance Report and Accountability Report 2021-2022 are due to be considered by the Audit Committee on 12 May 2022 for review and endorsement. The updated document is presented in the ***supporting documents*** for information.

In line with the timescales set out in Chapter 3 of the Financial Reporting Manual guidance, the draft Performance Report Overview, Accountability Report (including the Governance Statement) and the draft Renumeration Report were submitted to Welsh Government (HSSG Finance) and Audit Wales on 6 May 2022.

The timetable for developing the Annual Report in readiness for submission to Welsh Government as a single unified document by 15 June 2022 is outlined in Table 1 below.

Board Members should note that there have been a couple of amendments to the draft timetable, primarily to reflect that the AGM will be brought forward to 19 July 2022 (at the UHB Chair's request), and the associated publication date of the AGM papers (now scheduled for 8 July).
It is noted that the Chapter 3 of the Financial Reporting Manual (FReM) guidance requires the Health Board to notify the public of the date, time and place of the AGM at least 10 calendar days prior to the AGM meeting and to display the agenda bilingually (in English and Welsh) as a minimum. Whilst not ideal, it is unlikely that the final fully illustrated Welsh version of the Annual Report will be ready for publication before 14 July (because it is scheduled to be with the Medical Illustration team until 14 July). Hence the proposal is to publish the fully illustrated English version of the Annual Report plus the Welsh translated copy of the Annual Report (which will not include the graphic illustration work). It is anticipated that a copy of the fully illustrated Welsh version of the Annual Report will be available for publication on 15 July (ie before the AGM on 19 July 2022).

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Table 1 – Proposed Timetable for Creating the Annual Report 2021-2022

Date	Task
11 April	Draft report to Management Executive
29 April	Internal Audit to receive draft Annual Governance Statement.

29 April	Draft Accounts to be submitted to HSSG Finance and Audit Wales
6 May	Draft Performance Report Overview, Accountability Report (including the Governance Statement), and the draft Renumeration Report to be submitted to HSSG Finance and Audit Wales
6 May	Send the document to the Medical Illustration Team for graphic design work
12 May	Audit Committee Workshop – endorse sign off by Board of draft Performance Report
12 May	Send any updates from Audit Committee to the Medical Illustration Team for graphic design work
13 June	Comments back from Welsh Government to be incorporated for approval of the final draft Annual Report by Audit Committee.
14 June	**Special Audit Committee meeting** – recommend Board approval of the final draft Annual Report
14 June	**Special Board meeting** – to approve the final draft Annual Report
15 June	Final Annual Report and Accounts to be submitted to Welsh Government HSSG Finance and Audit Wales
15 June	Send the final Annual Report to Cardiff Council's Welsh Translation Unit (15 June to 1 July to be translated)
19 June	WG to issue Debtor and Creditor Matrix Income and Expenditure Matrix
4 July	Send Welsh version to Medical Illustration Team to design Welsh version
8 July	Publish Annual General Meeting papers (including the bilingual version of the Annual Report)
14 July	Fully illustrated Welsh version of the Annual Report available
15 July	Publication of the fully illustrated Welsh version of the Annual Report
19 July	Present bilingual Annual Report 2021-2022 to the AGM
19 July	Publish on website, email to key stakeholders etc

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

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- the Draft Accounts were submitted to the Welsh Government Finance team and Audit Wales on the 29 April 2022, and any feedback received will be incorporated into the final document.

- At the time of writing this report the Draft Performance Report, Accountability Report (including the Annual Governance Statement), and Draft Remuneration Report have been submitted to the Welsh Government Finance team and Audit Wales on the 6 May 2022. Any feedback received from the Welsh Government Finance team and Audit Wales will be incorporated into the final document.
- The final Annual Report and Accounts 2021-2022 will be submitted to the Audit and Assurance Committee (for recommendation for Board approval), and to the Board on the 14 June 2022 for final approval.

Recommendation:

The Board is requested to:

a) **NOTE** the minimum reporting requirements outlined in Chapter 3 of the Financial Reporting Manual (FReM) guidance for collating an Annual Report for 2021-2022 as a consequence of the COVID-19 pandemic;

b) **NOTE** and **DISCUSS** the draft Performance Report and Accountability Report; and

c) **NOTE** the latest version of the draft Performance Report and the draft Accountability 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

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Legal: No
Reputational: No
Socio Economic: No
Equality and Health: Yes – an EHIA is to be carried out prior to publication of the final Annual Report.
Decarbonisation: No

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

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Report Title:	**Naming of the Wellbeing Hub at Maelfa**			Agenda Item no.	8.3
Meeting:	**Cardiff and Vale UHB Board Meeting**	Public	X	Meeting Date:	26 May 2022
		Private			
Status *(please tick one only):*	Assurance		Approval ✓	Information	
Lead Executive:	**Abi Harris, Executive Director of Strategic Planning**				
Report Author (Title):	**Service Planning Lead, Strategic and Service Planning Team**				

Main Report
Background and current situation:

The new-build Wellbeing Hub@Maelfa is nearing completion and planned to become operational mid July 2022. As part of the finalisation of the build, the name of the facility needs to be confirmed e.g. for signage and postal address, to comply with the UHB's policy on Naming of Cardiff and Vale Facilities (Reference Number: UHB 270)

Since January 2017 the Wellbeing Hub on the Maelfa development has consistently used the working title "Wellbeing Hub@Maelfa" in the business of the project team and project board (Shaping Our Future Wellbeing Delivery Group). The capital investment business cases for both the project and the programme of which it is part, have also consistently used the working title through to approval by Welsh Government.

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

The title "Wellbeing Hub@Maelfa" meets all of the policy commitments with the possible exception of the recommendation to avoid compound names i.e.

> *Names must have clarity and simplicity, aiding orientation and movement around the facility. Compound names (A name composed of two or more parts) should be avoided. The name must be translated into Welsh.*

However, there are numerous examples of compound names across the UHB's estate.

The Welsh translation is of the title is "Hyb Llesiant@Maelfa".

Throughout multiple community engagement events during the project's development the same title has been used. There have been no concerns raised with the title when engaging with the community. However, the working title has not been formally tested.

It should be noted that there are two other Wellbeing Hubs in development with similar working titles i.e. Wellbeing Hub@Penarth and Wellbeing Hub@Park View. Whilst a decision on the Wellbeing Hub@Maelfa will set a precedent, the working titles of each of those facilities will be brought subsequently to the committee for decisions.

The name has the full agreement of the project team. The policy requires the consideration of the name by the project team, project board, Executive Director, Management Executives team, Strategy and Delivery Group and the Board

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The proposed name is consistent with the UHB Facility Naming Policy.

The development of the wellbeing hub on the Maelfa development forms part of the Shaping Our Future Wellbeing: In Our Community Programme. The SOFW:IOC Delivery Group, which acts as the Board for the programme and its constituent projects, has considered the proposed name and recommend its approval.

The Management Executive Team, is due to meet on 16 May 2022. In relation to this matter, the said Committee will be asked to consider the proposed name and recommend its approval, considered the proposed name and recommend its approval.

The Strategy and Delivery Committee is due to meet on 17 May 2022 and, in relation to this matter will be asked to consider the proposed name and recommend its approval to the Board.

Recommendation:

The Board is requested to:

- Subject to the Strategy and Delivery Committee agreeing to recommend the proposed name to the Board for approval, **APPROVE** the proposed name of "Wellbeing Hub@Maelfa" in respect of the wellbeing hub on the Maelfa development.

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: No

Safety: No

Financial: No

Workforce: No

Legal: No

Reputational: Yes

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Working title has been used consistently for 5 years and is now seeking approval to formalise title
Socio Economic: No
Equality and Health: No
Decarbonisation: No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Management Exec	16 May 2022
Strategy and Delivery Committee	17 May 2022

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CORPORATE RISK REGISTER SUMMARY MAY 2022

Risk Ref	Risk (for more detail see individual risk entries)	Clinical Board / Corporate Directorate	Link to BAF	Initial Risk Score	Risk Score March 22	Risk Score May 22	Trend	Target Risk Score
1	Risk of patient and staff harm due to potential failure of anaesthetic gas scavenging system in UHW theatre GF	Estates	Patient Safety Capital Estates	5x4=20	5x4=20	5x4=20	→	5x1=5
2	Risk of patient harm due to obsolete Oxygen and Nitrous Oxude medical gas manifolds at various UHB sites	Estates	Patient Safety Capital Estates	5x4=20	5x4=20	5x4=20	→	5x1=5
3	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 Estates	5x4=20	5x4=20	5x4=20	→	5x1=5
4	Risk of loss of heating throughout UHL due to serious corrosion of Main Boiler F&E Tanks	Estates	Capital Estates Patient Safety	5x4=20	5x4=20	5x4=20	→	5x1=5
5	Risk to staff safety and regulatory compliance due to non-compliance with HTMs for ventilation - multiple locations UHW	Estates	Workforce, Capital Estates Staff Wellbeing, Patient Safety	5x4=20	5x4=20	5x4=20	→	5x1=5
6	Risk to estimated expenditure in financial plans due to significant increases in energy tarrifs	Estates	Financial Sustainability	4x5=20		4x5=20	→	4x4=16
7	Risk of patient harm and breaches of Welsh Government waiting time guidance due to delays admitting patients from WAST	Medicine	Patient Safety	5x5=25	5x4=20	5x4=20	→	5x2=10
8	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	5x5=25	5x4=20	5x4=20	→	5x2=10
9	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	5x5=25	5x4=20	5x4=20	→	5x2=10
10	Risk to the health and wellbeing of minor inpatients following admission to adult mental health services	Mental Health	Patient Safety	5x5=25	5x4=20	5x4=20	→	5x2=10
11	Risk to patient safety causing serious incidents due to patients not being admitted to Critical Care Department in a timely manner due to insufficient nursing workforce	Specialist Services	Patient Safety Planned Care Capacity	5x5=25	5x4=20	5x4=20	→	5x2=10
12	Risk 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 Planned Care Capacity	5x4=20	5x4=20	5x4=20	→	5x2=10
13	Risk that patients will not receive care in a suitable environment due to a number of shortcomings in Critical Care facilities.	Specialist Services	Patient Safety Capital Assets	5x4=20	5x4=20	5x4=20	→	4x3=12
14	Risks of harm to haematology patients (including bone marrow transplant) due to cross infection hazards created by an inadequate clinical environment.	Specialist Services	Patient Safety	5x5=25	5x4=20	5x4=20	→	5x1=5
17	Risk of failing to achieve a revenue statutory duty breakeven position.	Finance	Financial Sustainability	5x4=20		5x4=20	→	5x2=10
18	Risk to planned care capacity due to loss of agility in operational decision making if e-rostering capability lost through failure to renew contract in June 22.	WOD	Workforce Planned Care Capacity	5x4=20	5x4=20	5x4=20	→	5x2=10
15	Risk that the Health Board will not achieve the underlying defecit in the draft 21/22 plan of £25.3m.	Finance	Financial Sustainability	5x4=20	5x4=20	5x3=15	↓	5x2=10
16	Risk that the Health Board will fail to deliver 2% CIP £16m (1.5% recurrent).	Finance	Financial Sustainability	5x4=20	5x4=20	5x3=15	↓	5x2=10

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Report Title:	Corporate Risk Register				Agenda Item no.	8.4	
Meeting:	Board Meeting		Public	x	Meeting Date:	26/05/2022	
			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 – Risk and Regulation Officer						

Main Report
Background and current situation:

The Corporate Risk Register has been developed to provide the Board with an overview of the key operational risks from the Clinical Boards and Corporate Directorates.

The Corporate Risk Register includes those extreme risks which are rated 20 (out of 25) and above 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 Corporate Risk Register.

The Corporate Risk Register Summary is attached at Appendix A. The Board are asked to note that the Corporate Risk Register Board Summary lists risks in order of highest to lowest risk scores, whilst retaining reference numbers from the detailed Corporate Risk 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.

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.

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 Corporate Risk 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.

There are currently 18 Risks on the Corporate Risk Register. Two of these risks (Risk 6 and 17) are new and there are fourteen risks (1, 2, 3, 4, 5, 7,8,9,10,11,12,13,14,18) that are unchanged and will continue to be recorded on the Register beyond May's Board meeting. Two risks from the Finance Corporate Directorate currently on the Corporate Risk Register (15,16) have been re-defined and re-scored on the Directorate Risk Register; these changes reduce the current risk scores to 15 and if these scores remain unchanged the risks will be removed from the register before the July 2022 Board meeting. The Board are asked to note that risks 2 and 5 on the Corporate Risk Register are amalgamations of separate risks on the Capital Estates and Facilities Risk Register. The

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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.

It is notable that, following development of their internal risk management procedures, the Health and Safety Corporate Directorate were in a position to submit a reliable risk register for review.

Candidate risks were accepted from Capital Estates and Facilities, Finance, Organisational Development Corporate Directorates, and Medicine, Specialist Services, and Mental Health Clinical Boards. The Health and Safety Directorate, and Children and Women, CD&T, Surgery and PCIC Clinical Boards either reported no extreme risks or had extreme risks with scores below 20.

No risk registers were returned by the Strategic Planning and Digital Health Corporate Directorates.

As forecast in the Corporate Risk Register report to Board in March 2022 a re-scheduled meeting has now taken place between the Director of Corporate Governance, the Head of Risk and Regulation and the Site Based Leadership Teams from University Hospital Wales and University Hospital Llandough to determine if there is a requirement to aggregate and record operational and strategic risks identified from this new leadership approach. The meeting concluded that the dynamic and tactical natures of the decisions made in this new leadership approach, combined with the fact that the human, physical and financial resources operated in these hospitals remain under the operational control of Corporate Directorates/Clinical Boards, does not require the recording of operational and strategic risks by the Site Based Leadership Teams.

The present position is therefore as follows:

March 2022	March 2022
• 16 risks rated 20 (extreme risk) • 1 risk rated 15 (extreme risk) which if unchanged will be removed from the Corporate Risk Register.	• 16 risks rated 20 (extreme risk), two of which are new entries. • 2 risks re-defined and re-rated 15 (extreme risk) which if unchanged will be removed from the Corporate Risk Register

Trend Analysis. Staff shortages, often exacerbated by COVID-19 effects, 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 planned care capacity. Whilst some progress has been made in the last quarter with the future availability of estates and facilities, there are still risks reported due to a deterioration in estates and facilities which creates a variety of risk scenarios with potential to adversely impact on workforce health and safety or planned care capacity. A new risk related to an unprecedented increase in energy costs has also emerged.

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, 5, 8, 9, 10,11,12,13,14.
Capital - Estates	1,2,3,4,5,
Planned Care Capacity	11,12,18.
Workforce	5, 8,18.
Financial Sustainability	6,17.
Staff Wellbeing	5.

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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.

Recommendation:

The Board is requested to:

a) 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: No
Safety: No
Financial: No
Workforce: No

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

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Quality Safety and Improvement Committee	12/04/2022
Strategy and Delivery Committee	17/05/2022
Mental Health Capacity and Legislation Committee	26/07/2022

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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	15 March 2022

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: March 2022 - Emergency Ambulance Services Committee (nhs.wales) Chris Turner (Chair), welcomed Members to the virtual meeting (using the Microsoft Teams platform) of the Emergency Ambulance Services Committee.

Suzanne Rankin, CEO for Cardiff and Vale and Hayley Thomas, Deputy CEO from Powys were welcomed to her first meeting. Nick Wood, Deputy Chief Executive NHS Wales at Welsh Government was also welcomed to the meeting.

The minutes of the EASC meetings which took place on 18 January 2022 were approved.

The Chair also took opportunity to reaffirm the role of the EAS Committee in terms of its role within the EASC Directions to plan and secure sufficient ambulance services in Wales in line with Welsh Government and NHS Planning Frameworks.

In terms of context for many of the discussions to take place at the meeting, the Chair reminded Members of the agreed deliverables. In particular, the previous agreed commitment to reducing handover delays – no handover delays over 4 hours and reduce the average time of lost hours by 25% from October 2021 level. It was noted that the current position needed to be significantly improved. In addition, Members noted the phasing out of the military support to the Welsh Ambulance Services NHS Trust (WAST) at the end of March and the likely impact on performance.

PERFORMANCE REPORT

Received as the first standing agenda item at each meeting of the EASC Joint Committee as agreed with the Minister for Health and Social Care.

Members noted that the Ambulance Quality Indicators would be published monthly from April 2022 providing an opportunity to discuss more recent information. The following areas were highlighted:

- the continued challenges around 999 call wait times
- the growing gap between the number of calls answered and the number of incidents generated
- slightly less incidents in January and February
- mitigating action taken including investment in staff and technology
- significant challenges in achieving red 65th percentile

- growth in red demand – at 53% response and median 7mins and 30secs; joint work with Welsh Government and Digital Health and Care Wales looking at linked data sets related to patient outcomes and would report findings at a future meeting
- amber responsiveness 95th percentile continued to grow with significant waits seen; Amber median 1hour 30mins (ongoing impact on patient journey)
- More media stories and political interest being seen
- in light of previous commitments to reduce ambulance handover delays, increases over recent months were noted, with the trend continuing into March (currently 700 hours per day)
- with reducing staffing capacity, WAST forecasting the impact and the level of the Clinical Safety Plan to ensure response at red and amber 1.

Nick Wood asked regarding the EASC perspective and the need for a joint response from WAST and health boards in relation to the safety of the service and meeting community expectations; the impact of the significant drift in lost hours, the deterioration in response rates, the increasing numbers of concerns and increasing numbers of serious adverse incidents. Members were asked if they were confident that their actions would mitigate against the identified risks and would lead to improvements in performance and reduce patient safety incidents.

Members felt this was a fair challenge although there were expectations that the actions identified in the health board plans would lead to improvements in reducing lost hours and a consequence improvement in working towards meeting the performance targets. The Chief Ambulance Services Commissioner (CASC) agreed that the Committee was not in a position to provide the level of assurance needed due to the position with handover delays. The Joint Committee had not been complacent and Members were aware that the planning assumptions had assumed a maximum of 5,000 handover hours in one month. Once these levels had been overtaken a number of mitigating actions had been put in place which included the WAST Clinical Safety Plan. At 20,000 lost hours per month Members were aware that ambulances would not be sent for Amber 2 patients.

Suggested solutions were proposed including to:
- provide temporary additional front-line ambulance capacity into WAST to support the system over the coming months to mitigate the removal of the support from the military and until the required improvements are in place to handover delays and impacting across the system
- continue to work with health boards to understand the variation across the system identified within the action plans submitted and to identify and share best practice
- ensure that the handover improvement plans deliver the required gains, to be monitored by the governance arrangements including the Commissioning Framework
- constantly challenge the current culture where handover delays are tolerated.

It was proposed that the following actions were put in place as the key elements of the system-wide handover improvement plan to address the patient safety concerns, particularly with the withdrawal of support from the military in April:
- maximise temporary additional front-line ambulance capacity during the coming period including overtime and WAST to operate at a higher state of emergency alert to maximise front-line resource
- use of the agreed whole system escalation process and the actions taken

- re-focus on 'red release' to allow WAST to respond appropriately and promptly (had been slippage)
- health board resources in place such as same day emergency care, urgent primary care centres, flow centres or communication hub etc and identify two or three deliverables as part of this Handover Improvement Plan. This would include managing or challenging slippage and monitoring the impact on the patient experience and recognised the need to move at pace.

The Chair thanked Members for the helpful discussion and emphasised the requirement for all Committee Members to respond urgently to the current position related to handover delays and to work with WAST to mitigate the impact of the loss of military resource at the end of March. The suggestions set out by the CASC were accepted and the Chair articulated the hope to see an improved position at the next meeting.

Following discussion, Members **RESOLVED** to:
- **NOTE** the content of the report and additional actions that would be taken to improve performance delivery to be included in the EASC Action Plan.
- **AGREE** to include the units of hours produced to the next iteration of the Performance Report.

PROVIDER ISSUES

Jason Killens, Chief Executive at the Welsh Ambulance Services NHS Trust (WAST) gave an overview of key matters including:
- phased withdrawal of the military support of approximately 250 staff (reduction in capacity of approximately 15% of production) by 31 March 2022
- approximately 100 members of staff were currently in operational training and would become operational in quarter 1, the capacity of the Clinical Service Desk would be doubled early in quarter 1 and this would allow the volume of calls closed via the 'consult and close' process to lift from 10-12% to approximately 15%
- the additional offer to roll on some winter schemes including cohorting and third-party support should the required support and funding be available (non core activities)
- red performance remained below target although an improving picture since December. A deep dive has been undertaken into red performance which was currently being finalised and would be presented to the EASC Management Group
- There were 503 long patient waits in January, this was a reduction compared to December, but rates were still very high with patients waiting excessively long times for services (some waiting more than 24 hours)
- the daily average handover position for the 10 services in England was shared, with WAST performance the worst, particularly in terms of the comparative fleet size
- electronic patient case card – this would be live in all health board areas by the end of March 2022, with many suggestions for improvements for phase 2 of the work
- the detailed briefing issued last week regarding roster changes had been extremely helpful in addressing the significant local, regional and national political interest. It was important for all to portray the positive story, (70 FTE additional staff) information would be circulated more widely to illustrate local level impacts including that 34.5 additional emergency ambulances would be operational across Wales as a result of this work. This would impact in Quarter 3 2022-23

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- high sickness levels and the work being undertaken to achieve the trajectory to return to pre-pandemic levels of 6.5%. It was acknowledged that current levels were far too high and that there would be a plan to reduce these in the next few months.

The CASC emphasised the current focus in terms of:
- Being clear what could be delivered on a quarter by quarter basis
- Encourage health boards to include gaps within plans to identify key requirements
- Commissioning Framework to include detail in terms of what was required.

The Chair invited the CASC to outline other requirements for WAST which included:
- reducing sickness and setting the required improvement trajectory
- agreeing timescales for reducing post-production lost hours and managing the inefficiency in the system
- ensuring all roster changes would be in place by end of November 2022
- reducing the variation within the service by adopting good operational practice on a day by day basis.

The Chair asked Members to actively support the roster review changes and recommended the use of the detailed briefing which had recently been shared. This was cited as an example of good practice which could be replicated for other areas of work.

WELSH AMBULANCE SERVICES NHS TRUST DRAFT INTEGRATED MEDIUM-TERM PLAN (WAST IMTP) UPDATE

The WAST IMTP report was received. In presenting the report, Rachel Marsh highlighted the executive summary and key elements of the Plan including progress made in terms of:
- Progress to recruit the additional 127 full time equivalent (FTE) staff as agreed following the Emergency Medical Services Demand and Capacity Review
- doubling the capacity of the Clinical Support Desk
- introducing mental health practitioners to the organisation
- completing the roll-out of NHS Wales 111 with the programme team
- completing the transfers of Non-Emergency Patient Transport Services (NEPTS) from health boards.

Opportunities for joint working with academic institutions were noted and further discussions would be held outside of the meeting to consider opportunities across the system including joint appointments. The ongoing dialogue had continued between WAST and Health Education and Improvement Wales (HEIW) was noted along with WASTs ambitions to pursue University Trust status.

The CASC highlighted the consistency between the WAST IMTP, the agreed Commissioning Intentions (CIs) and Welsh Government targets.

Members **RESOLVED** to:
- **SUPPORT** the WAST IMTP, noting the risks and financial information to be worked through and mitigated,
- The Chair and the CASC to subsequently endorse the final plan in line with the discussions at the meeting following WAST Board approval and prior to submission to the Welsh Government by the 31 March 2022.

Stephanie Carter 04/03/2022 13:34:25

EASC INTEGRATED MEDIUM TERM PLAN

The EASC IMTP was received. In presenting the report, Ross Whitehead highlighted that the EASC IMTP was consistent with principles presented at the Joint Committee meeting in January 2022 and had been presented at the recent EASC Management Group for endorsement.

The plan focused on Commissioning Intentions (CIs) along with other priority areas for 2022-23 and the three-year planning cycle included the appetite for the commissioning of 111 Services and the development of a National Transfer and Discharge Service reflecting the regionalisation and reconfiguration of services.

The CASC highlighted to Members the key inefficiencies in the system which included:

- Handover delays - It was suggested that the required system improvements that would reduce ambulance handover delays sufficiently would not be in place for some time and that it would be sensible to retain front line ambulance resource for the start of the 2022-23 financial year to manage the clinical risk and patient safety concerns that exist, until wider system improvements could be made.
- WAST financial plan included a £1.8m cost reduction plan to impact on front line costs which would reduce overtime and hold vacancies - it was suggested that this £1.8m be waived due to the current issues related to handover hours and the loss of the military personnel on a 'non-recurrent basis'. The proposal for the temporary resource recognised both the need for action across the system but also the length of time that it was anticipated that required improvements would take place.

Nick Wood asked the CASC to confirm the detail in the financial year 2022-23 which related to the assumptions of a non-recurrent bid to the Welsh Government 6 Goals for Urgent and Emergency Care funding (£25m). Stephen Harrhy confirmed that the assumption within the financial plan was a minimum of £750k but possibly would require some additionality in terms of coverage for the ECNS scheme. Nick Wood noted this and explained that this was under discussion by the Welsh Government Policy Lead officials who were considering the allocation. Stephen Harrhy explained that this had been the approach suggested by health boards to apply for specific urgent and emergency care funding from the £25m which was reflected in the plan. Nick Wood thanked Stephen Harrhy for the clarification.

Members questioned the level of the CIP (1% would have been 2% if the £1.8m was included) and the CASC explained the WAST had also been asked not to make assumptions regarding their Transition Plan within the IMTP as this had not been widely supported at the scrutiny session. The option related to the WAST CIP which included the £1.8 million from front line staff remained contentious but the CASC suggested that the increasing concerns related to patient safety and the likelihood of harm within the current system this was an option to try and get to a balanced financial plan for WAST. Members confirmed that the financial envelope had been agreed by the Directors of Finance but questioned whether the CIP needed to be made from savings around front line staff, i.e. were there other options. Members explained that much higher levels of CIP had been agreed within health boards and felt that WAST should not be subject to different efficiency measures.

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Members were keen that the CIP was revisited to be in line with health boards across Wales. The CASC responded and suggested that if additional funding, albeit on a temporary basis, was not provided to WAST the performance would deteriorate further and this would increase risks in terms of patient safety and experience. Stephen Harrhy suggested that if handover delays were reduced to 15,000 hours by April (which seemed unlikely) there remained a need for temporary funding for WAST. Furthermore, the CASC explained that without the temporary funding information would need to be provided to explain exactly what services could be offered by WAST.

Members suggested that they required more financial detail to discuss within health boards which would need to be balanced against other priority areas. Members felt they would need more granularity in relation to the ambulance services to balance for the wider health of local populations in decisions made by health boards.

Stephen Harrhy agreed to write to Members to explain clearly how the options and opportunities on a Health Board by Health Board basis. This information could be presented in different ways including having a 2% CIP and a non-recurrent allocation of £1.8m. The implications of all options would be clarified although the CASC felt it was essential that WAST have additional funding due to the level of inefficiency within the system at present. Members agreed to the need for additional non-recurrent funding to ensure additional front-line ambulance capacity however more detail would need to be provided, as requested.

Members **RESOLVED** to:

- **NOTE** the process of engagement undertaken in the development of the EASC Integrated Medium Term Plan
- **APPROVE** the EASC Integrated Medium Term Plan (2022-25) for submission to Welsh Government
- Receive information on a health board by health board basis in terms of the WAST CIP and additional temporary funding

CHIEF AMBULANCE SERVICES COMMISSIONER'S (CASC) REPORT

Stephen Harrhy presented the report and highlighted the following:

- Non Emergency Patient Transport Services (NEPTS)

Members noted that detailed work was now being undertaken on NEPTS and the impact of health boards reset and reconfiguration on different elements of NEPTS activity, for example reduced outpatient journeys and an increase in demand for transfers and discharge. A 'Focus on' session will be held at the next EASC meeting exploring this on a health board by health board basis.

- EASC Action Plan

It was reported that the Minister had requested that the EASC Action Plan be updated to incorporate the expected impact of the actions being taken across the system. The latest version had been appended to the CASC report, this would now be updated.

- System Wide Escalation

Members noted that a conversation had been held at the recent NHS Wales Leadership regarding the final version of the System Escalation Plan. Members noted that the final version would be endorsed at the next meeting of the Leadership Board and implemented in April 2022.

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Members **RESOLVED** to: **NOTE** the report

EMERGENCY MEDICAL SERVICES (EMS) COMMISSIONING FRAMEWORK

The EMS Commissioning Framework report was received. Ross Whitehead presented the report and noted previous discussions at EASC Management Group and the recent scrutiny panel on the WAST Transition Plan held with health board representatives.

Members noted that it had become clear from these recent discussions that health boards expected clarity on the commissioning of core ambulance service provision, separately from the transformation elements. This approach would provide health boards with the required clarity on how framework resources were being utilised to deliver the priorities of the Committee and would allow the development of different and transformational service offers within each health board areas to address the needs of their populations. Members were also reminded that the framework was a live document that would be refreshed every 6 months, responding to developments within the service.

Following discussion Members **RESOLVED** to:

- **APPROVE** the development of a framework that distinguishes between core service provision and transformational services
- **APPROVE** the extension of the interim arrangements until the May Committee meeting.

FOCUS ON SESSION – HEALTHCARE INSPECTORATE WALES (HIW) - REVIEW OF PATIENT SAFETY, PRIVACY, DIGNITY AND EXPERIENCE WHILST WAITING IN AMBULANCES DURING DELAYED HANDOVER

The HIW review was received. Ross Whitehead presented the session and Members noted that many elements of this 'Focus On' agenda item had already been discussed earlier in the meeting.

Members noted that the HIW report focusing on ambulance handover delays had already been considered at many health board sub committees. Twenty recommendations had been made which required a system wide response and it was confirmed that the action plan had been accepted by HIW. The EASC Management Group (EASC MG) agreed to establish a task and finish group to deliver the recommendations. Draft terms of reference had been circulated to EASC MG members with dates of the first two meetings and a request for clinical and operational representatives from each health board. It was agreed that regular updates on this work would be provided at future meetings of the Committee and the EASC Team would work closely with HIW on this matter. The first meeting would take place in early April and had been planned for 6 months in the first instance.

Members **RESOLVED** to:

- **RECEIVE** the HIW Review and responses to the recommendations
- **NOTE** the establishment of a task and finish group to focus on delivery of the recommendations via the EASC Management Group.

FINANCE REPORT

The EASC Finance Report was received. Stuart Davies presented the report and highlighted no significant changes and forecast end of year position of a £383k underspend. No significant movements were anticipated.

Members **RESOLVED** to: **NOTE** the report.

Mohammed Sadiq (Redacted) 23/03/2022 07:34:28

EASC SUB GROUPS

The confirmed minutes from the following EASC sub-groups were received and **APPROVED**:

- EASC Management Group – 21 Oct 2021
- NEPTS Delivery Assurance Group – 12 Oct 2021
- NEPTS Delivery Assurance Group – 30 Nov 2021

EASC GOVERNANCE INCLUDING THE RISK REGISTER

The report on EASC Governance was received.

Members **RESOLVED** to:

- **APPROVE** the risk register including 2 new risks and the three red risks which were also being reported to the CTMUHB Audit and Risk Committee
- **APPROVE** the Model Standing Financial Instructions
- **APPROVE** the final information for the model Standing Orders namely the Delegation of Powers and Scheme of Delegation
- **NOTE** and **APPROVE** the Draft Annual Business plan
- **NOTE** the updates relating to red performance and the additional new risks
- **NOTE** the progress with the actions to complete the EASC Standing Orders and the aim to complete all actions by the next meeting
- **NOTE** the Internal Audit on EASC Governance and the plans to track the recommendations.

Key risks and issues/matters of concern and any mitigating actions

- Red and amber performance
- Handover delays
- Withdrawal of support from the military to WAST
- Continuing impact of the Covid 19 Pandemic

Matters requiring Board level consideration and/or approval

- Standing Orders and Standing Financial Instructions would be forwarded as soon as documentation finalised

Forward Work Programme

Considered and agreed by the Committee.

Committee minutes submitted	Yes	✓	No	
Date of next meeting	**10 May 2022**			

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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	24 March 2022

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

Recruitment Modernisation Programme

The Director of People and Organisational Development and the Deputy Director of Employment Services gave a detailed presentation of the work being undertaken in Recruitment to support the significant increase in activity since the start of the pandemic. Looking back to when NWSSP was first established in 2011, significant progress has been made in streamlining the recruitment process, demonstrated by a reduction in the average time-to-hire from 132 to 71 days. New services have been taken on and the Welsh Language functionality has been enhanced. Last summer, further initiatives were progressed relating to the Workforce Directors' Responsiveness Programme including enhancements to TRAC, development of the applicant web page, and maintaining virtual pre-employment checks.

During late summer 2021, the service was faced with unprecedented and unplanned levels of recruitment across NHS Wales due to the Covid response, resulting in the usual high level of compliance with KPI targets not being sustained. This led to the need to review the way in which recruitment is undertaken in Wales and where applicable modernise the service further through changes to processes, technology, and education.

The Deputy Director provided details of specific initiatives under each of the headings of process, technology, and education. One key technological initiative is investment in pre-employment check software that enables identification documents to be held in ESR and viewed via the ESR app. This has been promoted by the Home Office, however the technology is not currently available, but it will be fundamental to virtual pre-employment checks continuing after the current proposed Home Office end-date of September 2022. Due to the short notice provided by the Home Office over this software, funding to purchase it still needs to be confirmed.

Mohammad Sarmad (01/13/2022 16:08:25)

The Modernisation Action Plan is to be taken to the All-Wales Workforce and OD peer group meeting in early April, with a formal update to the May Committee.

The Committee **NOTED** the presentation.

Chair's Report

The Chair updated the Committee on the activities that she had been involved with since the January meeting. This included chairing her first Welsh Risk Pool Committee which had been very informative; attending the Hywel Dda Sustainability Committee; and also attending the NHS Wales Chairs' meeting which allowed her to keep updated on the latest developments and issues. Going forward there will be a number of attendances at board meetings, starting with Digital Health Care Wales and then Health Education and Improvement Wales. The Chair is keen that these are not used solely for NWSSP to update on performance, but to elicit a two-way exchange of ideas and information.

Managing Director Update

The Managing Director presented his report, which included the following updates on key issues:

- The IMTP has now been formally submitted to Welsh Government for their consideration;
- As part of a UK-wide response to the war in Ukraine, Welsh Government asked NWSSP to identify any surplus equipment and consumables that could be donated to Ukraine. Review of current stocks identified items to the value of £524k that could be donated as they are surplus to current requirements (PPE, ventilators, and medical consumables). Thus far, over £131k of surplus items has already been sent to Ukraine from NWSSP;
- The purchase of Matrix House in Swansea was completed by the end of March. The building is currently 75% occupied by NHS Wales, with Public Health Wales and the Welsh Ambulance Service NHS Trust as tenants in addition to NWSSP. Acquisition of this asset will lead to a reduction in future revenue costs to NHS Wales and the opportunity to create a wider public sector hub at some point; and
- The Minister for Health and Social Care visited our Imperial Park 5 Warehouse on 17th March, providing an opportunity to demonstrate to her the extensive range of services that now operate from this facility.

Items Requiring SSPC Approval/Endorsement

Lease Car Salary Sacrifice

In July 2021, the Committee agreed to reduce the CO2 emissions for Salary Sacrifice vehicles through the NHS Fleet scheme. Whilst the intentions of this decision were well founded, the implementation of the first phase from 120g/km to 100g/km has generated the following issues:

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- Those staff who do not have driveways and therefore home charging facilities, are either unable to participate in the scheme or have a very limited choice of cars;
- Only certain EV and hybrid cars meet the lower CO2 limits – therefore a large number of small fuel-efficient cars e.g. 1 litre VW Polo, Ford Ka etc are no longer available to staff. This is particularly problematic to those staff who live in the more rural areas

In view of the above it is evident that some staff are opting not to apply for salary sacrifice cars but instead are continuing to use their private cars, commonly referred to as the 'grey fleet'. These cars are generally older and emit more pollution than the vehicles that were previously available on the lease car salary sacrifice scheme.

In view of this, it was proposed to reinstate the 120g/km cap for petrol and hybrid vehicles from 1st April 2022 but not to allow diesel vehicles to be ordered. The impact of this will be to increase the range of vehicles available, remove new diesel vehicles from the Scheme and provide greater access to those staff who do not possess home charging facilities.

It was also noted that NWSSP do not administer this Service to all Health Boards and Trusts, and it was agreed that the provision of the administration of service to an all-Wales service should be explored

The Committee **APPROVED** the proposed:

- Adjustment in the CO2 emissions;
- Removal of the ability to order new diesel cars on the scheme

Items For Noting

Energy Update

The Committee received a paper relating to the current situation with energy prices. Due to the nature of the markets and high expenditure, the Energy Price Risk Management Group (EPRMG) was formed in 2005 to manage exposure to risk across the NHS Wales energy contracts. The overarching aim of the group is to minimise the impact of energy price rises through proactive management and forward buying.

There have been very significant increases in gas and electricity prices during the year, particularly during recent weeks following the outbreak of the Ukraine war. The EPRMG strategy of purchasing ahead has meant that NHS Wales has benefitted substantially and avoided most of the price increases for gas and electric supply. Whilst this strategy has protected NHS Wales from the huge increase in market prices for 2021/22 it is likely that there will be very significant hikes in energy costs in 2022/23 because of the current contracts coming to an end.

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The recent increase in energy costs is very unwelcome, but is unavoidable given the current war in Ukraine, the sanctions applied to Russia and the removal of Russian Gas and Oil from supplying the global market. However, the EPMRG will attempt to manage the energy costs for NHS Wales as best as we can over the year ahead.

The Committee **NOTED** the paper.

Finance, Performance, People, Programme and Governance Updates

Finance – The Director of Finance & Corporate Services reported that NWSSP was on track to meet each of its revenue financial targets for 2021/22 and the projected outturn on the Welsh Risk Pool was in line with the Integrated Medium-Term Plan. Additional capital funding had been received in quarters three and four, but plans were in place to ensure the funding was fully utilised by the end of the financial year.

Performance – Most KPIs are on track except for those relating to Recruitment Services which was the subject of the deep dive earlier in the agenda. The move towards qualitative output focused measures continues within NWSSP.

People & OD Update – Sickness absence rates remain at very low levels with an absence rate of 2.93% for the last quarter. Performance and Development Reviews and Statutory and Mandatory training results continue to improve although there is still room for further improvement. Headcount is increasing due mainly to the additional staff recruited as part of the Single Lead Employer Scheme. The ESR database has been modified such that most of the facilities it provides can be accessed and delivered in Welsh

Corporate Risk Register – there are two red risks. The first relates to the pressures currently being noted within the Employment Services Directorate, and particularly in Recruitment and Payroll Services, which was the subject of the earlier deep dive. The second refers to the energy price increases which again was the subject of an earlier agenda item.

Papers for Information

The following items were provided for information only:

- PMO Highlight Report
- Audit Committee Highlight Report
- Quality and Safety Assurance Report
- 2022/23 Forward Plan
- Finance Monitoring Returns (Months 10 and 11)

AOB

N/a

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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	19 May 2022

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05/13/2022 16:36:25

Report Title:	Local Partnership Forum Report			Agenda Item no.	8.5.4
Meeting:	UHB Board	Public	x	Meeting Date:	26.05.22
		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 and Culture				

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 20 April 2022 can be summarised as follows:

The Executive Director of People and Culture provided an update report on behalf of the Chief Executive, key points included:

- Staff were thanked for their efforts in light of the continuous pressure across the whole system. Mrs Gidman noted that they were being courageous and escalating concerns rather than accepting them as the norm
- The operational position remains challenging, predominantly because of staff attendance being impacted by the high Covid levels
- The end of year finance position was being accounted for, all the indications were that it would be in line with the UHB's forecast, which has been that the UHB will breakeven (third year in a row) and make full use of the capital funding provided to it. The financial outlook going into 2022/23 is challenging, as we deal with the ongoing challenges and legacy of the pandemic. The draft IMTP submitted at the end of March has a £20.8m deficit.
- The CNO, Sue Tranka, has provided clarity and direction for nursing through her 5 Priorities for the profession
- HSMB received a presentation on the virtual ward, which is about allowing patients to receive the care they need at home through a multidisciplinary approach
- Phase one of Same Day Emergency Care (SDEC) assessment unit is now open to patients - The new assessment unit at UHW has been created to allow rapid access to surgical treatment through ambulatory care.
- The All-Wales Dementia Charter was launched on 6 April which aims to enable hospitals to create the right environment for people with dementia, their families and carers in Wales. It will focus on improvement and offer a short, accessible and visible statement of principles that contribute to a dementia-friendly hospital.
- Cardiff and Vale of Glamorgan Population Needs Assessment 2022-27 has been published by the Cardiff and Vale Regional Partnership Board

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The Deputy Director of Planning advised the Forum that a draft IMTP had been presented to the Board and submitted to Welsh Government. While it was acknowledged as robust in many areas, there was a financial deficit. Opportunities to address this were being worked up and a revised and final plan would be submitted at the end of quarter one.

The Interim COO delivered a presentation on the recovery delivery commitments for 2022/23, highlighting key points for each of the 5 programmes.

The Local Partnership Forum received a copy of the Integrated Performance Report which had previously been considered by Board.

The Local Partnership Forum received the annual report from the Clinical Board Partnership Forums. The purpose of these Forums is to establish ongoing dialogue, communication and consultation on service and operational management issues specific to the Clinical Board areas. The intention is to develop a standardised set of Terms of Reference for all Clinical Board LPFs in the near future.

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 20 April 2022.

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	

Wyn Morris Jones 6/13/2022 07:12:25

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	

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