Public Board Meeting

Thu 30 November 2023, 09:30 - 14:05

CF61 Community Space, Station Road, Llantwit Major CF61 1ST

Agenda

09:30 - 09:40
10 min

1. Welcome & Introductions

Charles Janczewski

09:40 - 09:40
0 min

2. Apologies for Absence

Charles Janczewski

09:40 - 09:40
0 min

3. Declarations of Interest

Charles Janczewski

09:40 - 09:40
0 min

4. Minutes of the Board Meeting held on 28 September 2023

Charles Janczewski

4. Minutes Public Board 28.09.23 MP CAJ.pdf (23 pages)

09:40 - 09:40
0 min

5. Action Log – 28 September 2023

Charles Janczewski

5. Public_Board_Action Log.pdf (3 pages)

09:40 - 12:15
155 min

6. Items for Review and Assurance

Charles Janczewski

6.1. Patient Story – Lynn's Story: "You would not even know I had Cancer"

10 minutes *Jason Roberts*

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

10 minutes *Charles Janczewski*

6.2 Chairs report November 2023.pdf (8 pages)

6.3. Chief Executive Report

15 minutes *Suzanne Rankin*

6.3 CEO Report to Board - November 2023.pdf (4 pages)

6.4. Board Assurance Framework

10 minutes *Matt Phillips*

6.4 BAF_Cover Report Board.pdf (3 pages)
6.4a Board Assurance Framework1.pdf (70 pages)

6.5. Chairs' reports from Committees of the Board:

10 minutes

i) Digital & Health Intelligence - 03.10.2023

ii) Finance & Performance - 18.10.2023

iii) Quality, Safety & Experience - 25.10.2023

iv) Mental Health Legislation & Mental Capacity Act - 31.10.2023

v) Audit & Assurance - 07.11.2023

6.5.2 Finance & Performance Chairs Report 18.10.2023.pdf (4 pages)
6.5.3 QSE Chairs Report 25.10.2023.pdf (3 pages)

6.6. Integrated Performance Report:

45 minutes *Fiona Kinghorn / Paul Bostock / Rachel Gidman / Jason Roberts / Catherine Phillips*

- Public Health
- Operational Performance
- People & Culture
- Quality, Safety & Experience
- Finance

6.6 C&V Integrated Performance Report Cover.pdf (6 pages)
6.6a C&V Integrated Performance Report November 2023.pdf (30 pages)
6.6b Operational Performance report General Dental Services.pdf (6 pages)
6.6c ANNEX 1 GDS Dental Assurance Review 20 Sept 20203.pdf (1 pages)
6.6d ANNEX 2 Dental Quality Standards.pdf (1 pages)

6.7. Break for Refreshments

10 minutes

6.8. Strategic Planning Update

10 minutes *Abigail Harris*

Please note there are supporting documents for this item which are located in the supporting documents folder.

6.8 Strategic Planning, Commissioning and Partnership Update Nov 23.pdf (5 pages)

6.9. Integrated Annual Plan Quarter 2 Report

15 minutes *Abigail Harris / Ashleigh O'Callaghan*

6.9 Integrated Annual Plan 20232024 Quarter 2 Report.pdf (3 pages)
6.9a Integrated Annual Plan Quarter 2 Report.pdf (30 pages)

6.10. Health Inclusion Team Update

20 minutes *Paul Bostock / Ayla Cosh*

6.10a Health Inclusion Team Update.pdf (13 pages)

12:15 - 14:05
110 min

7. Items for Approval / Ratification

7.1. Business Cases:

7.1.1. Paediatrics Infectious Diseases

10 minutes

- 7.1 Paeds ID case Cover Report.pdf (4 pages)
- 7.1a Paediatric Infectious Disease Rationalised Case August 2023 1.pdf (26 pages)

7.2. Park View Health Centre – Declaration of Surplus and Disposal

5 minutes *Catherine Phillips*

- 7.2 Park View Site - Declare as surplus.pdf (4 pages)

7.3. Barry Gateway Redevelopment – Disposal of Broad Street Clinic and Lease of new Facility

5 minutes *Catherine Phillips*

- 7.3 Barry Town Gateway and Broad St Clinic.pdf (16 pages)

7.4. Break for Lunch

30 minutes

7.5. Adoption of Revised Standing Orders

5 minutes *Matt Phillips*

- 7.5 Standing Orders_Board Report.pdf (3 pages)
- 7.5a Standing Orders_App 1_Schedule of Amendments.pdf (5 pages)
- 7.5b Standing Orders_App 2_Standing Orders.pdf (96 pages)
- 7.5c Standing Orders_App 3_SFI.pdf (86 pages)
- 7.5d Standing Orders_App 4_Delegations.pdf (58 pages)

7.6. Annual Director of Public Health Report

15 minutes *Fiona Kinghorn*

Please note there are supporting documents for this item which are located in the supporting documents folder.

- 7.6 DPH Report Cover.pdf (3 pages)

7.7. Co-production, Engagement and Consultation Framework and Toolkit

15 minutes *Abigail Harris / Sarah Tipping*

- 7.7 Co-production, Engagement and Consultation Framework & Toolkit.pdf (3 pages)

7.8. Stakeholder Reference Group – Chair Nomination

5 minutes *Matt Phillips*

- 7.8 SRG Chair Nomination Cover Report.pdf (2 pages)

7.9. Safeguarding Annual Report

5 minutes *Jason Roberts*

- 7.9 Cover Paper Safeguarding Annual Report 2022 23.pdf (2 pages)
- 7.9a Safeguarding Annual Report 2023.pdf (48 pages)

7.10. Board & Committee Schedule 2024/25

5 minutes *Matt Phillips*

- 7.10 Corporate Meeting Schedule Cover Report.pdf (2 pages)
- 7.10b DRAFT FULL YEAR PLANNER 2024-25 v1.pdf (2 pages)

7.11. Welsh Sexual Assault Services Programme Board

10 minutes *Suzanne Rankin*

Please note there are supporting documents for this item which are located in the supporting documents folder.

7.11 SW SARC Regional Model Implementation Report for HBs ns.pdf (4 pages)

14:05 - 14:05
0 min

8. Items for Noting and Information

8.1. Annual Presentation of Nurse Staffing Levels to the Board

Jason Roberts

8.1 Nurse Staffing Act Cover Report.pdf (3 pages)
8.1a Appendix 1 - Annual Presentation of Nurse Staffing Levels to the Board Nov 23 (1).pdf (8 pages)
8.1b Appendix 2 - Summary of Nurse Staffing Levels (1).pdf (5 pages)

8.2. Corporate Risk Register

Matt Phillips

8.2 Board Report_Corporate Risk Register.pdf (3 pages)
8.2a Corporate Risk Register.pdf (9 pages)
8.2b Assurance Map.pdf (3 pages)

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

Matt Phillips

- WHSSC Joint Committee Briefing - 19.09.2023
- NWSSP Assurance Report - 21.09.2023
- EASC Summary – 19.09.2023
- Local Partnership Forum Report - 12.10.2023

8.3.1 WHSSC Briefing (Public) 19.09.2023.pdf (6 pages)
8.3.2 NWSSP Assurance Report 21.09.2023.pdf (4 pages)
8.3.3a Chair's EASC Summary from 19.09.2023.pdf (9 pages)
8.3.4 LPF Briefing 12.10.2023.pdf (3 pages)

8.4. Committee Minutes:

Matt Phillips

a. Audit & Assurance – 05.09.2023
b. Quality, Safety & Experience – 30.08.2023
c. Quality, Safety & Experience – 26.09.2023
d. Mental Health Legislation & Mental Capactiy Act – 01.08.2023
e. Finance & Performance – 23.08.2023
f. Finance & Performance – 20.09.2023
g. People & Culture – 12.09.2023
h. Digital & Health Intelligence – 15.08.2023

8.4a Public Audit Minutes 05.09.2023.pdf (10 pages)
8.4b Public QSE Minutes 30.08.2023.pdf (6 pages)
8.4c QSE Public Minutes 26.09.2023.pdf (11 pages)
8.4d MHLMCA Minutes 01.08.23.pdf (7 pages)
8.4e Public Finance & Performance Minutes 23.08.23.pdf (5 pages)
8.4f Public Finance & Performance Minutes 20.09.23.pdf (9 pages)
8.4g Public People & Culture Minutes 12.09.23.pdf (12 pages)
8.4h Public DHIC Minutes 15.08.2023.pdf (7 pages)

14:05 - 14:05
0 min

9. Agenda for Private Board Meeting:

i. *Approval of Private Board minutes*
ii. *Financial Update*
iii. *Approval of Private Committee minutes*

14:05 - 14:05
0 min

10. Any Other Business

Charles Janczewski

14:05 - 14:05
0 min

11. Review of the meeting

Charles Janczewski

14:05 - 14:05
0 min

12. Date and time of next meeting:

Charles Janczewski

Thursday 25 January 2024 – Woodland House. Nant Fawr Rooms 1,2 & 3

14:05 - 14:05
0 min

13. Declaration:

Charles Janczewski

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

Unconfirmed Draft Minutes of the Public Board Meeting
Held On 28 September 2023
Woodland House, Maes y Coed Road, Cardiff
9.30am

Chair:		
Charles Janczewski	CJ	University Health Board Chair
Present:		
Paul Bostock	PB	Chief Operating Officer
Abigail Harris	AH	Executive Director of Strategy & Planning
David Edwards	DE	Independent Member – ICT
Rachel Gidman	RG	Executive Director of People & Culture
Akmal Hanuk	AH	Independent Member – Local Community
Meriel Jenney	MJ	Executive Medical Director
Mike Jones	MJ	Independent Member – Trade Union
Fiona Kinghorn	FK	Executive Director of Public Health
Sara Moseley	SM	Independent Member – Third Sector
Ceri Phillips	CP	University Health Board Vice Chair
Suzanne Rankin	SR	Chief Executive Officer
Jason Roberts	JR	Executive Nurse Director
David Thomas	DT	Director of Digital & Health Information
Rhian Thomas	RT	Independent Member – Capital & Estates
Clive Morgan	CM	Assistant Director of Therapies
Matt Phillips	MP	Director of Corporate Governance
Rob Mahoney	RM	Deputy Director of Finance
In attendance:		
Joanne Brandon	JB	Director of Communications, Arts, Health Charity and Engagement
Maisie Provan	MPr	Armed Forces Covenant and Veterans Collaborative Lead
Suzanne Wood	SW	Consultant in Public Health
Observers:		
Members of the public		Present
Members of the public		Livestream
Secretariat		
Caroline Evans	CE	Executive Assistant to the Chair/Vice Chair
Apologies:		
Sam Austin	SA	Deputy Chief Executive – Llamau
Lance Carver	LC	Director of Social Services
Keith Harding	KH	Independent Member – University
Fiona Jenkins	FJ	Executive Director of Therapies and Health Sciences
Catherine Phillips	CP	Executive Director of Finance
John Union	JU	Independent Member – Finance
Susan Elsmore	SE	Independent Member – Local Authority
Richard Skone	RS	Assistant Medical Director

Item No	Agenda Item	Action
UHB 23/09/001	**Welcome & Introductions** The University Health Board Chair (UHB Chair) welcomed all to the Board meeting in English and in Welsh.	
UHB 23/09/002	**Apologies for Absence** Apologies for absences were noted.	
UHB 23/09/003	**Declarations of Interest** No Declarations of Interest were noted	
UHB 23/09/004	**Minutes of the Meeting Held on 27 July 2023** The minutes from the Board meeting held on 27 July 2023 were received **The Board resolved that:** a) The minutes from the Board meeting held on 27 July 2023 were approved as a true and accurate record of the meeting.	
UHB 23/09/005	**Action Log** The Action Log was received. All actions listed on the Action Log were marked as complete with exception of: **UHB 23/05/015** Integrated Performance Report Two further actions would follow in November: **UHB** **23/01/018** Board Champions Query raised by CEO **UHB 23/03/013** QSE Chairs Report – Deep Dive regarding Still Births to consider at QSE. Board meeting was October 22. Action - check date and report back. **The Board resolved that:** a) The Action Log was reviewed and noted.	
UHB 23/09/006	**Patient/Staff Story – Vinnie's Story** The Patient/Staff Story was received. The Executive Director of Public Health introduced the Patient Story and a video was played to the Board. The story related to a gentleman called Vinnie, a heroin addict from a very young age. He was prescribed an injectable drug called Buvidal which was able to significantly	

	support life measures during his treatment for addiction, more so than Methadone and provided greater clarity of thinking, reduced craving and lessoned anxiety. • During Covid, Welsh Government agreed that Buvidal could be prescribed by Cardiff and Vale Community Addictions Unit as well as GP's through the GP Shared Care Scheme and Kaleidoscope through the Rapid Access to Prescribing Service (APB's) for the homeless and for people within the criminal justice services. It is also prescribed in HMP Cardiff. • To date, 932 people within Cardiff and Vale, excluding those in HMP, have been treated with Buvidal and Cardiff and Vale is the first area in the UK to use it in Primary care. Welsh Government have agreed to fund this drug for the 24/25 financial year. • A discussion followed on the Patient Story. • It was agreed that the Chair would send a letter of thanks to Vinnie for his contribution. • Powerful story to share with wider comms and used to resonate with young people with many problems • Huge multi-disciplinary and multi-agency collaboration saving lives and money in the long term. Connection between services for the homeless and criminal justice partners. • Comms met the team at CRI when they were trialling the drug to agree appropriate time to put Comms out. • Some colleagues had met the team at CRI and some of the service users. • Key to the story – wider services are important part of the journey • Within a 24-hour experience with Buvidal, potential withdrawal goes away • Long term evaluation to ensure that this is sustainable as it is the key to saving lives • Recommend to the Board that members visit HMP to understand the work of the team • Consider at the Board development session, to understand this. **The Board resolved that:** a) The Patient Story was noted.	
UHB 23/09/007	**Chair's Report and Chair's Action taken since last meeting** The Chair thanked two colleagues for their services to the Board. • Councillor Susan Elsmore's term of office was coming to an end in October. He thanked her for her hard work over the last seven years representing the Local Authority.	

	• Sam Austin, Associate Member of the Board and Chair of the Stakeholder Reference Group whose term of office had come to an end. He thanked her for her valuable contribution as a third sector individual which had demonstrated the importance of partnership working. • Expressed his gratitude to staff across the organisation for their contributions and wide-ranging work which could never be underestimated. • Highlighted the fantastic work of the Allied Professional Services and drew attention to the "Keeping me well" website, developed and planted in by Cardiff and Vale and now Wales wide. • Keen to share in public at the Board Development Session as really important to demonstrate how the organisation looked after the population. The Chair's Report and Chair's Action taken since the last meeting were received. **The Board resolved that:** a) The report was noted. b) The Chair's Actions undertaken were approved c) The application of the Health Board Seal and completion of the Agreements detailed within the report were approved	
UHB 23/09/008	**Chief Executive Report** The Chief Executives Report was received. The Chief Executive Officer advised the Board that: • Reflected on the approved refreshed Strategy 23/25 launched at the AGM. Important that the strategy was now in order to achieve the ambitions working with the team. • Briefly covered the approach, still in planning process which was a useful vehicle in refreshing the strategic objectives. • Now have the Quarter one report for this financial year • Strategy refreshed based on feedback, further to go on the integration and alignment • Operating model for organisation was an important enabler and provided a process, seeking involvement and engagement • Existing strategic programmes managed by AH's team. Most of it remained relevant and required a little alignment and re-framing. Advice and guidance to be sought at next board development. • Make connection between planning architecture from long term strategic planning to the annual planning. Clear line of sight to see where the Health Board are going to deliver in 24/25 and which will be measured by the Key Performance Indicators (KPI's) and provide assurance that the document will be used and deployed. **The Board resolved that:** a) The strategic overview and key Executive activity to provide assurance described in the report was noted.	

UHB 23/09/009	**Board Assurance Framework** The Director of Corporate Governance (DCG) presented the first Board Assurance Framework (BAF) in his new role and explained that the BAF would be in a new format going forward and would incorporate the new strategy and new strategic objectives. The key points were noted in the report and the Board were requested to review and note the BAF as it was presented. Key points to note: • Workforce risk had decreased certainly since Covid, although had maintained tight control and the systems were providing more transparency. Retention and culture all overlap • Wellbeing BAF had increased due to cost of living putting pressure on staff. Taken to People and Culture Committee to outline that stress and anxiety were the reasons for sickness increase of 26% and 29%. Looking at health and wellbeing implementation plan to ensure mitigations were in place. • Digital risk had increased mainly due to lack of identifiable resources. Working with Finance to identify resource. DHIC meeting scheduled for 3rd October • Chair highlighted importance of reviewing risks on a regular basis A query was raised as to why some of the risks had remained on the register for a while, what the trajectory of movement was against standards and how the risk could be reduced given the current financial situation. It was confirmed that there would be an opportunity to review the risks, which represented all areas of the Health Board, against the new strategy and look at improved ways of presenting the data. It was emphasised that such a large organisation could expect to have risks and although the progress may not be apparent, they were being moved forward as much as possible and progress had been made over the last few months. It was agreed that trying to reduce the level of risk was difficult with the financial restrictions and that some risks were long standing. Often, they were complicated scenarios around infrastructure, work force challenges, equipment upgrade requirements which often required financial input. Efforts were being made to mitigate the risk and the Board were transparent and sharing their honest opinion. Reference was made to the workforce element and how the Health Board would continue to support the International element in the future. It was confirmed that there was a team in place to provide wrap around support upon their arrival in the UK, not just academically but pastoral support with religion and culture and to ensure they were looked after and cared for. It was hoped that this would continue going forward with a planned celebration. The Board Assurance Framework (BAF) was received. **The Board resolved that:** a) The 15 risks to the delivery of Strategic Objectives detailed on the BAF for September 2023 were reviewed and noted.	
UHB 23/09/010	**Chairs' reports from Committees of the Board:**	

	The Chairs' Reports from the Committees of the Board detailed on the agenda were received and the following specific comments were highlighted by Chairs: **Audit & Assurance Committee**: David Edwards as Vice Chair in John Union's absence. Nothing to raise but Board to be aware of Non-Standing Item - Orthopaedic Services, tackling waiting lists. Verbal update on the 5 December **Finance & Performance Committee**: David Edwards in John Union's absence. One written report on 20/9. A lot of focus on the finances. Committee is scrutinising performance. Note that a very apparent effort currently going on with Executive Team around the financial challenge which does provide some assurance. **Quality, Safety & Experience Committee**: Committee met on monthly basis, one written report from August Committee. Informed of change in presentation of data. Now more of a dashboard approach with narrative which was well received. The September meeting focussed on Infection Prevention and Control. Working through quality indicators in a systematic way to get that level of assurance. In August meeting, there was a presentation on Stroke performance where the Health Board scored C against the UK standard. Business case put in place in order for them to achieve an A. Presentation on immunisation and the mortality implications and to maximise the population who don't comply with immunisation requirements. September report from Primary, Community and Intermediate Care (PCIC). A deep dive into Infection, Prevention and Control was carried out throughout the Clinical Boards. There were improvements in most areas with a lot of work being carried out. One of major factors was the quality of the Health Board's estate which was a major obstacle. The waiting list backlog for looked after children assessments was being addressed and the numbers were now coming down. Informed of a problem at the Children's Hospital, Paediatric Intensive Care Unit (PICU). Important work being carried out to try to reduce prevalence of pressure sores in PICU. Very small babies being ventilated for a considerable time and therefore looking at ways to mitigate that risk. **People & Culture Committee**: Sickness rates were coming down including those of the Medicine Clinical Board. Resolved to hear from the Clinical Boards at each meeting. Reference to Health and Safety risks, particularly Capital and Estates risks. Important for this to remain on the Agenda. Highlighted behaviours of staff such as dumping items in UHW tunnels. Had a detrimental effect on morale having to work in such a difficult environment. Deferred Culture as felt they would deal with one bad risk at a time. **Mental Health Legislation & Mental Capacity Act Committee**: Standard items were discussed and highlighted for Board information; Mental capacity Act, Mental Health Act and Mental Health Measures. Important to be aware of the unprecedented number of referrals which was having implications throughout the Clinical Board, especially within CAHMS but also referrals for assessment of adolescent children as well as the actual treatment being initiated. Data issues and Workforce sickness absence of the team had initiated a series of measures to address these issues. Now moving towards compliance within the next few months.	

	The Board resolved that: a) The Committee Chairs' Reports were noted.	
UHB 23/09/011	**Integrated Performance Report:** The Integrated Performance Report was received. **Public Health:** The Executive Director of Public Health (EDPH) advised the Board that • Recently had surveillance testing; to continue with approach • Respiratory infections of some concern including new Covid variant which is still being monitored. Potential for spread and severity is less worrying than initially thought • Likely that we may have a peak in Covid cases which may be quite mild but difficult to predict. No indication that we will have particularly bad winter. Respiratory viruses - no indication that these will be bad either • Had a difficult year last year with streptococcal infections • Have received statistics for Covid Vaccination uptake across wales. Started Winter vaccine programme on 11 September and now complete **Operational Performance** The Chief Operating Officer advised the Board that: **Emergency care** Continuing to deliver against IMT commitment for reduction of Ambulance handover times. Have seen an expected increase to 12 and 24 hour waits. Have seen significant changes to ward moves and space created. Situation has been more difficult than anticipated and it continued into September. Now starting to improve as ward changes and flow embed. Length of stay is biggest challenge. Needs to be next organisational focus. Then start to see improvements in Cancer and stroke too With regard to patients who had been stranded or super stranded, the acute bed base shouldn't have any more than 40% of patients in beds for more than 7 days. And no more than 20% after reaching 21 days. Cardiff and Vale are an outlier against those numbers. This is an opportunity for a 1% improvement on stranded and super stranded which would equate to 13 beds. Achieving the target of being in the top 25% of like sized organisations, that would mean 250 to 300 beds which would be a big improvement to the flow, patient safety and also financially. Taken a while to work out approach across all specialities within UHW and UHL picked 6 or 7 wards and working out a programme and an approach. **Planned care** On track to deliver with no patients waiting more than 3 years for first outpatient appointment and 97% patients starting treatment within 2 years is on track. Working through delivering against 99% by end of March. More work to do within outpatients in reducing waiting times. Standard is to get to 9,000. Introducing Seen on Symptoms (SOS). This would give patients more responsibility how they were followed up and	

	managed as outpatients. Managing their own conditions. Very complex and a big programme of work but would see improvement. Cancer statistics for July were 65.6% and August was similar not the 75% Welsh standard but better than UK standard. Cardiff and Vale are performing better than most other organisations in UK. 25% of patients on cancer waiting list of 2300 (single cancer pathway) are waiting for endoscopy. Insourcing contract now signed off and began at UHL at the weekend. Also have new rooms coming on line in November and December which will give significant boost in capacity Currently have 268 patients waiting over 62 day; not all patients have a cancer diagnosis. Need to deliver 75% performance. Working out how to get there by March 2024. Reasons for this include complexity of patients, some requiring various investigations. **Diagnostics** 8-week standard for routine diagnostics is behind and needs to be reached by June 2024. Endoscopy capacity will help. The Community Diagnostic Hub will be up and running before Christmas which will provide additional mobile imaging capacity to reduce the waiting times for patients for MRI, CT and Ultrasound. **Mental Health** Adults - delivering on both 28-day assessment standard and 28-day treatment standard. Children – no patients were treated within 28 days in August, median wait time is 30 days. Standard was met for Assessment within 28 days and treatment starting within 35 days. The trajectory is to get to 60% by March with a month by month step improvement. Currently no plan to get to 80% of standard. As Vice Chair highlighted some of the issues why treatments have been an issue. Now put more resource into assessments. **Primary care** The urgent Primary Care utilisation remains good with 1000 patients being seen per week in urgent primary care centres. These patients may otherwise have gone to the Emergency Department or would have waited 3 or 4 days, perhaps longer to be seen by their GP **Dental** A forensic review is required to understand what is happening across dental services. Stark situation and cannot give assurance what is happening with the dental locums and waiting lists until this is carried out and a more comprehensive update will be given in due course. **Stroke** Since QSE report, have now received latest Sentinel Node Audit Programme (SNAP), a UK national benchmarking system. Cardiff and Vale achieved a B; a Fantastic achievement. Timely thrombolysis remains the biggest issue. There have been three internal stroke summits, the most recent last week. Now have a clear way forward for stroke services and currently working through how this will be managed. **Hip fracture** The hip fracture summit took place this week. Have gone from bottom 25% to top 25% in UK on time to ward, getting patients to the ward within 4 hours, receiving pain relief and access to theatres. Remain an outlier on length of stay. A discussion then took place:	

In response to queries from Independent Members, the COO explained that there was now a model being worked up on the primary and secondary care teams on managing more patients at home. Less about earlier discharge, more about preventing them from requiring secondary care. Aim to reduce length of stay and redeploy resource. Require 40 beds to fund this model.

Referred to business case. Working up a plan for the winter on how to prevent admissions from nursing homes and residential homes using safer at home model. Subject to Welsh Government funding, hoping next spring to manage 175 patients per week.

Now got a period of consolidation, having seen more improvements than expected. Now need to take stock and plan ahead. Will come back with a more comprehensive update in due course

In response to a question from Llais as to why children and young people presenting with ADHD were having to wait 26 weeks, the COO explained that the Clinical Board were struggling with the unprecedented demand and were currently working with Welsh Government to improve this and also to record more accurate data.

Llais raised concerns around the Dental waiting lists and offered their support in sharing evidence of what the issues were.

Reference was made to the recent Regional Partnership Meeting. The two Local Authorities (LA's) were carrying out work with children and young people around neuro diversity. Nationally there was an increase in young people coming forward and there was a significant overlap with neuro diversity.

Outlined some of the services being set up to support young people such as the Hub where young people can go and talk about their mental health and their feedback used. Good to hear progress and partnerships blossoming with LA's and 3rd sector colleagues.

In response to a question if an analysis had been carried out on what was driving the demand, it was clear that the pandemic had caused lots of issues with mental health but unclear if this was long term. Demand within Paediatric Intensive Care had also significantly increased. Looking at managing post Covid demand and capacity.

Reference was made to two Public Health Reports outlining the many challenges that people faced in the community such as the impact of significant gaps in schooling, as well as poverty, the situation internationally and also social media. Hard to predict how it will change but remain hopeful that it will start to reduce.

The Medical Director referred to a recent summit with mental health colleagues and primary care. Demand had increased for children and young adults but encouraging signs that situation is improving.

Reference was made to The Hangout, established partnership working with the Health Board. Facility was quiet but now seeking an evaluation of how many children would access services as a result of this. Planning to work with schools and looking into having a facility within A&E.

People & Culture

The Executive Director of People & Culture (EDPC) advised the Board that:

- Sickness rates now the lowest since 2020. Not complacent but encouraging. Focus on staff in work and those not in work in need support.

- Values based appraisals data which included new recruits, currently 71.6%, striving for 85%. Figure does not factor in staff absence/maternity leave.

- Working with Nurse Director and nursing colleagues on the Workforce Probability Agenda. Looking at making staff more permanent rather than using temporary staff agency. From 31 August to 18 September, used 2000 less hours of agency staff. Hopefully see the financial benefits. Medical staff working with Medical Director's team, have initiated a new rate card on 18 September.

- Supporting staff with cost of living, 500 staff to date going to the wage stream, good feedback received. Currently looking at fluctuation of turnover with Head of People and Culture and the Clinical Boards. Organisation has grown in size with 2000 more members of staff, partly due to centralisation of Vascular and Major Trauma.

- Reshaping conversations and scrutiny with Clinical Boards, looking into non-traditional way to find the best staff for the different professions HEIW provided supported with this work.

- Staff survey due to be launched on 16th October and closes on 13 November although this may be extended. Highlighted importance of listening to staff. Working with Comms on this. The survey has historically not achieved a great response rate. Asked colleagues to encourage staff to participate and bring support and improvement, more of a networking approach. Last time uptake was less than 30%, now aiming for 60%. Paper copies available as well as electronic. Trade Unions involved and encouraging staff to take part. Comms focussing on engagement work, roadshows, spread and scale academy and improving engagement within organisation.

In response to a question from an Independent Members as to what was being captured within the survey it was confirmed that HEIW lead on this and Cardiff and Vale don't have any level of engagement with the co-design.

Referred to articles in the media regarding sexual harassment. Aware of this and action required.

Quality and Safety

The END advised the Board that he would take the paper as read and noted:

- Seen a slight decrease of concerns from beginning of year. Teams working hard to improve position but still over Welsh Government goal of 75%
- Managing concerns and an early resolution important more
- Duty of candour continues to embed across the organisation with 8049 incidents reported since 1st April. A sign that people are comfortable to report incidents.

	• Patient feedback reaching more patients and relatives and members of public although unable to increase response rate. Piece of work being carried out by team to improve 80% response rate. • Incident reporting a positive picture with 33 overdue incidents, reduced to 26. Since time of writing report, Executive Performance Review and deep dive carried out and now have clear position. • Infection, Prevention and Control (IP&C) - C diff position better, MRSA not in good position. • Quality and Safety this month – would have achieved MRSA had there not been considerable incidents in dialysis units with 57 cases. There has now been a significant improvement. **Finance:** The Deputy Director of Finance (DDF) advised the Board that: • WG had not accepted IMTP due to deficit. To achieve the target, need to deliver £32m savings. • Plan to have £32.8m deficit at month 5 now £42m deficit. • Made up of £4.7m savings yet to deliver. Small operational variance of £3m a lot of which is in mental health due to the current pressures • Slowing variance. Seen pressure earlier in year. • Sustainability board set up. Sought to put some additional momentum into saving £16m to achieving £32m savings. • Starting to see green shoots although not yet reflected in finances but looking to see improvements • Forecast an improvement from month 7. • Under target for public sector payment performance which is on course to achieve capital resource. A discussion followed The operational position had changed. Additional pressure and having to manage £3million. Finance had adjusted contracts. The Sustainability Board met to review finances and add assurance to financial recovery. **The Board resolved that:** a) The contents of the report were noted.	
UHB 23/09/012	**Reinforced Autoclave Aerated Concrete (RAAC) – Structures and Condition within Cardiff and Vale University Health Board Estate** The Reinforced Autoclave Aerated Concrete (RAAC) – Structures and Condition within Cardiff and Vale University Health Board Estate report was received. The Deputy Director of Finance (DDF) advised the Board that: • The Risk ratification approach developed between Shared Services and Specialist Estate Services. NHS Wales Estate is massive and in various states of condition. Physically surveying each part of estate would be impossible. Within the framework capital estates have commissioned a company to risk assess and survey across the estate. These are ongoing physical surveys. • To date, the initial surveys can report and also anticipate very little RACK as they work though the estate. As this is an ongoing process, the position statement is that we are extending out to seek assurances, there have been	

	similar process within primary care estate. Being mindful that some are owned by other contractors and university partners where we use that estate. Similar approach to ensure visitors and employees are safe. Identifies very little risk and where risk has been identified very low. Will keep board informed. A discussion then took place. In response to a question if RAAC would impact on budgets, the DDF stated that he was not aware of that, or of what was happening elsewhere in Wales. It was agreed that there is a degree of public anxiety around this and Welsh Government have published some information around it. It was suggested that Cardiff and Vale need to provide some assurance and the level of risk. Welsh Government statement would be shared via our Comms team. No further questions happy to note position described. **The Board resolved that:** a) The findings of the report were noted and the Board was assured that there were very limited areas where RAAC could possibly be, however it is unlikely. b) The Board was assured that the areas were known and that surveys would be completed to confirm or otherwise.	
UHB 23/09/013	**Vaccination and Tackling Inequities in Uptake** The Chair welcomed Suzanne Wood, Consultant in Public Health to the meeting. The Executive Director of Public Health advised the Board that: Referred to integrated performance report. Advised that there were inequities within childhood vaccination and winter vaccinations. The report detailed examples of statistics with regard to vaccination uptake and the action taken to date and work plan moving forward to try to decrease inequity gaps. The Vaccination and Tackling Inequities in Uptake presentation was received. • Vaccination saves lives. • Moving forward to decrease inequity. • **Childhood Vaccines** From age one routine vaccination to age five, the gap between most and least disadvantaged widened with a 10% difference in uptake. • Socio-economic Status Covid campaign completed. Much slower and lower uptake within most disadvantaged groups. • **Ethnic Groups** Difference of over 45% in terms of uptake within the population. Staff uptake statistics showed 25% uptake within Arab population and 64% within white population • **Vulnerable Groups** Flu uptake was low at 43.5% Covid uptake was 89.7% in 2021 and 59.5 % in Autumn 2022 indicating vaccine fatigue Learning a lot from pandemic	

	Targeted social media in areas of deprivation to get to right groups. Pop up groups in mosques. Gaps have started to close indicating a successful campaign • Children's vaccination – catch up sessions for flu vaccinations in Asda supermarket • Have a vaccine equity strategic plan signed by QSE A discussion then took place. There was a need to co-produce and work with people on the ground, targeting the right communities and using multi languages and appropriate resources and education about the vaccine. Using own staff as enablers into the community Regarding staff, there were vaccination leads and champions within Clinical Boards and vaccinations were being carried out in workplaces. Identified an opportunity to allocate bank staff to assist in vaccination within their own communities such as the Somalian community. The EDPH referred to a recent PCIC engagement staff meeting where they were advised that fewer bank staff were coming forward as vaccinators. Following a question from an IM as to what action was being carried out to address vaccination fatigue, Comms were being sent out using innovative and meaningful messages to families. Suzanne Woods accepted an invitation to visit Llais **The Board resolved that:** a) The Vaccination and Tackling Inequities in Uptake presentation was noted.	
UHB 23/09/014	**Neonatal Care / Letby** The Neonatal Care/Letby report was received. The Chair referred to the August Board Development meeting looking at how to reassure the public that recent events in Countess of Chester Hospital were unlikely to occur in Cardiff and Vale. The paper covered trying to mitigate risk in Neo Natal Unit but also highlighted the Speaking up Safely aspect with staff feeling comfortable and confident to raise concerns. The Executive Director of People and Culture advised the Board that: • Welsh Government cascaded their Speaking up Safely document which reiterated the importance of the Board and the roles as Executives. A Self-assessment required completion with a deadline of the end of October. Since the last Board Development meeting, the Governance and People and Culture Teams had met and two meetings had taken place around timelines and preparing and agreeing the self-assessment prior to it going to Board Development. This involved a significant amount of speaking up that could grow within Cardiff and Vale, being such a large organisation. The Teams were looking at the next steps and tightening up on processes. Executive Nurse Director advised the Board:	

- From a Patient and Quality and Safety point of view, everyone was shocked with the atrocities at Chester Hospital. As a Board, passed on support and condolences to families. Never completely able to mitigate against individuals who were intent on causing harm to people but the priority as an organisation was to mitigate as much as possible.
- To provide assurance, to oversee that if any baby died in the unit, a review would be carried out using the Perinatal Mortality Review Tool (PMRT) into the cause of death and any issues.
- As part of the Ockenden review, have developed a maternity oversight group and Neo natal oversight group which has now merged and aligned the Governance and leadership within maternity
- In the event of a child death, it would form part of the intensive care audit, reported nationally. From a safeguarding point of view, in the event of any child death, this would be also looked into at Executive level.
- It was hoped that the paper would provide assurance to Board Members that there is a robust system in place.
- One month to six weekly, END and EMD meet with safeguarding team to provide Executive oversight.
- END, their Deputy and the EMD recently visited the Neo Natal unit to talk to staff and patients to ensure they felt reassured by the systems. Met with positive response.
- Regarding mortality, there were no reasons to be concerned around behaviours although there were concerns particularly around infection rates which was being investigated
- Public reporting comes out historically, want to make it more current

A discussion then took place:

A question was raised as to why no reference was made to the current Board Champion for Raising Concerns, Mike Jones who was very keen to engage with this.

This overlapped with the action to bring wider Board Champion work back to Board in November 2023

Query was raised as to how does this fitted in with the duty of candour and how as a Board do they understand the other concerns. The END clarified that Duty of Candour was aligned to this.

In response to a question as to how a formal report on mortality would be brought back to Board, it was confirmed that this had already been channelled through QSE as a new structure with a new level of reporting and the Duty of Candour report would be included in this and should be part of the system in place.

The importance of informing patients and families of any issues was highlighted and that this provided assurance on processes. The Board were advised that a significant amount of work was being done around positive culture, reporting and learning.

As per request from Central Government, it was agreed that in the future, no reference would be made to the name of the individual responsible for these tragic deaths.

Llais queried how they would feed this back into Cardiff and Vale

The Board resolved that:

	a) The assurance provided by existing processes to raise concerns, existing mortality governance and professional concerns process were noted. b) The work that was underway to strengthen assurance further was noted.	
UHB 23/09/015	**Strategic Planning Update** The Strategic Planning Update was received. The Executive Director of Strategic Planning advised the Board that: • The Annual plan process was well under way with production for next year. Sessions had taken place with the Clinical Boards in the Senior Leadership Board meeting where they presented key priorities • A high-level draft would be coming to Board in January and the final plan for approval in March • With reference to the Regional planning work, it was noted that the planned Workshop on the 11th October would be re-scheduled. • Opportunity for CEO's Medical Directors, Planning Directors and Chief Operating Officers within three Health Boards to share learning from experiences so far on regional models, ophthalmology, vascular. • Agreed that Cancer regional planning work with Velindre would come under revised planning arrangements. A lot more work in process on cancer and acute oncology, finding a way of driving that forward, **The Board resolved that:** a) The proposed approach to realigning and updating the Health Boards strategic planning framework to deliver the refreshed strategic objectives was noted. b) The approach to Board engagement of the realigned strategic programme framework was supported. c) The proposed updated approach to a high-level but triangulated (finance, performance and delivery) Annual Plan Quarterly Assurance Report was noted. d) The work in progress within the Regional Planning Programme was noted.	
UHB 23/09/016	**Integrated Annual Plan Quarter 1 Report** The Integrated Annual Plan Quarter 1 Report was received. The Executive Director of Strategic Planning advised the Board that: • It looked very different from previous reporting carried out on quarterly basis. Have a responsibility as an organisation to provide assurance and to understand where the challenges were regarding the overall delivery of the plan. • Integrated performance report - submitted to Welsh Government • More focus required in green areas regarding delivery?? **The Board resolved that:** a) The progress achieved in Quarter 1 towards the delivery of the Integrated Annual Plan 2023/2024 was noted.	

UHB 23/09/017	**Shaping our Future Wellbeing - Refreshed Strategy** The Shaping our Future Wellbeing - Refreshed Strategy was received. The Executive Director of Planning advised the Board that: • Refreshed Strategy brought back to board for final process • Good attendance from staff at the formal launch of the strategy • Separate webpage alongside the strategy to update information. A few amendments made • Fed back into individual teams, people can see that this is contributing to the Health Board's vision • Question from member of public regarding the programme for wellbeing • Strategy document proposals sets targets • Reminder to colleagues and the public that the programme "Shaping our Future Wellbeing" requires realignment. Developed in 2019 and submitted to Welsh Government in 2019 around that programme. Described Hubs and Wellbeing Centres. Still the direction of travel, not a scaling down but realism of how it can be worked through and about phasing the work. Agreed to refresh it. Work being carried out in Barry and Vale of Glamorgan. Will be updating the programme • Capital challenge in Wales and managing programme business cases **The Board resolved that:** a) The strategy document, agreeing the strategic objectives as the Health Boards wellbeing objectives, as required under the Wellbeing of Future Generations Act was approved.	
UHB 23/09/018	**Operational Winter Plan** The Operational Winter Plan was received. The Chief Operating Officer advised the Board that: • The report had been channelled through SLB and finance • Started winter planning in August • Recent Winter summit, 50 people attended. Good engagement included Local Partnership Forum (LPF) representatives. Co-produced from LPF, Comms and People and Culture. Similar to last year. • Asking board to support move to winter fund reserve. • Moving to seasonal approach. • Looking to bolster the EU footprint with additional capacity for patients who were required to stay overnight and a Clinical Decision unit within Paediatrics. Aiming for this to be the last year where additional capacity was bought. • Plan to re-open capacity in the winter • Slight issue with length of stay • Have got a bit of additional capacity within Lakeside. Seeing additional benefit of frailty model • Ringfenced short stay beds. • Gap is smaller than last year. Opening additional capacity and using EU footprint. • Speciality Hub. No space to use footprint in EU. • Wellbeing - work around Comms, roadshows, intend to repeat it. Encourage people to attend roadshows, ask Suzanne sessions. Want to communicate that well. Paediatric Intensive Care – plan will bring back at future date.	

	Additional critical care Ask is to approve plan and use money differently. A discussion then took place. A question was asked regarding recurrent funding, it was clarified that this was within the existing budget and not additional money. A query was raised as to whether there was any further capacity or funding available to make flu vaccine more accessible for staff. It was confirmed that more nurses were available this year so in a better position. Still issues with vaccine fatigue. Vaccine Champions on Clinical Boards have triangulated approach to try to increase uptake, although some Clinical Boards Champions struggling to carry out this work. Fortnightly Dashboard goes to QSE. Cardiff and Vale are not a complete outlier, it's an all Wales issue. A suggestion was made to move away from thinking of A&E as the front door and to change the language. The COO confirmed that the winter planning would change from next year and the "Safer at Home" model would be embedded i.e. more patients at home being supported by the District Nurses and community. Referred to the EU footprint and how the plan would increase capacity. Plan for a Clinical Decision Unit. Increasing footprint. Quite confident that this would provide more space within EU although this was not without risk. **The Board resolved that:** a) The UHB Winter Plan 23/24 was noted. b) The revised approach to seasonal planning, including the recurrent allocation of the £1.5m winter reserve was approved.	
UHB 23/09/019	**Tissue and Organ Donation Annual Report at 12.30 as early** The Tissue and Organ Donation Annual Report was received. • Report was clear and generally very positive. • One area that Cardiff and Vale are within or above is access to SNODS. The Chair highlighted the fantastic work of SNODS and CLODS. Very impressive report looking at percentages. Highlighted that the small numbers could easily deflect away from their success. Staff were very pro-active and demonstrated at a national level their commitment and drive and the progress within Wales. In response to a question whether a piece of work was required to raise awareness of Organ and Tissue Donation, it was confirmed that there was a publicity budget available and there were ongoing publicity campaigns. In Wales, Organ and Tissue Donation was now included in the school curriculum. There were some specific issues to address, such as assumption of consent, whereby families had registered but had not shared knowledge with families.	

	There was a shortage of organ donations within certain demographics. Team described the data and how they were supporting these families. A reference was made to understanding ethnicity and the need to encourage more people within the minority groups to donate Director of Comms agreed to share link with DCG on programme called “greatest gift” in which Mike Stephens was the Lead Consultant. Asian Doctors working with Asian Cymru and World Transplant Games. EMD to pass on thanks to the Team from the Board. **The Board resolved that: yes** a) The Tissue and Organ Donation Annual Report was noted.	
UHB 23/09/020	**Equity, Equality, Experience and Patient Safety Framework** The Equity, Equality, Experience and Patient Safety Framework was received. The Executive Director of Public Health advised the Board that: • Ambition and framework set out to overlap between Patient Experience and Patient Safety for sign off at the meeting. An approach was being worked out to address the inequities within some of the outcomes. A discussion then followed. Alignment with language to be checked and agreed milestones. An additional introductory slide possibly required. To ensure that it linked in to the strategy and demonstrated the limitations of the framework in order to achieve the strategic aims. As the framework was introduced, need to measure the progress. Work being carried out on the data. An improvement group had been set up. Developing additional themes within systems. **The Board resolved that: yes** a) The Framework was approved. b) The progression of the work as outlined was supported and championed.	
UHB 23/09/021	**Interventional Radiology Business Report** The Interventional Radiology Business Report was received. This was channelled through SLB and Finance and was fully funded by Welsh Government and therefore not a financial ask. Referred to two intervention radiology suites and issues around corrosion. End of life for machines would be quite sudden. Welsh Government agreed to support replacement. Seeking permission to proceed and approve contract to Phillips. David Edwards confirmed that the Business Case was scrutinised and the committee recommendation received. **The Board resolved that:**	

	a) It was approved that the Contract Award to Philips for the replacement of the 2 existing IR Suites with their proposed Azurion 7 B20-15 units and associated maintenance from years 2 to 7, upon award of the capital kit procurement, Philips would then instruct their construction suppliers to provide costs for the associated works and implementation plan which would be agreed and signed off by the Health Board to prove value for money.	
UHB 23/09/022	**Ombudsman Annual Letter 2022/23** The Ombudsman Annual Letter 2022/23 was received. • Highlighted three areas of concern, those being communication, treatment and waiting lists. • These were consistent across Wales and involved a huge piece of work to support. • From a waiting list point of view, there was an ambitious plan to reduce it over two years. Not complacent, focussed on this every day. • Clinical effectiveness – have a mechanism. Keen to learn from those themes. It was agreed that they had provided a satisfactory report. In the vast majority of cases, they were content although some required an independent investigation. It was noted that the numbers were very low given the high number of interactions which highlighted the professionalism of staff living the values. **The Board resolved that:** a) The contents of the Annual Letter were noted.	
UHB 23/09/023	**Armed Forces Covenant** The Armed Forces Covenant was received. The Chair welcomed Maisy Provan to the meeting. Maisie shared a detailed presentation with the Board Maisie introduced herself as a qualified physiotherapist and trained reservist. Her current role was funded by the Armed Forces Covenant Trust Fund as part of a wider two-year pilot project. The Covenant was formed in 2011, a promise that as a nation, the Armed Forces Community would not be disadvantaged. In 2021 the Armed Forces covenant duty was released which meant that NHS Trusts were required to consider the Armed Forces when planning their health care in terms of waiting lists and service related injuries. • Currently don't have a system to flag and record patients coming in • 28 people in Health Board with an Armed Forces connection • Had a few accreditations with the Health Board, ERS goal, all needing renewal • Defence Medical Welfare Officer recently recruited into post • Started delivering staff training around armed forces awareness • Pride and Veteran Stand - disadvantaged LGBT veterans. • Seeking more accurate representation on ESR. • Building Armed Forces Champions cohort across the Health Board • Armed forces staff leading the way	

	• Working with IT as part of PMS Demographics section. • Recently Signed Armed forced covenant at Cardiff castle. • Gold status employer recognition • Vets Trauma Network – trying to bring into line with England. Helping them with their physical injuries. • Have a Veterans Mental Health Service • Re-signed Armed Forces Covenant • Need to highlight to staff to check with patients if they are currently or previously in the Armed Forces A discussion followed. Both the COO and the EDPC introduced themselves and offered their support. It was apparent that there was tn overlap with people and culture. Following a question around Psychology and Mental Health, Maisy confirmed that there was a dedicated team and a need to bring them together. Currently being evaluated for University of Chester. Providing evidence for a research paper which will drive the need for this work. **The Board resolved that: yes** a) The report highlighting the work being done to support the Armed Forces and Veterans Community was noted. b) The signing of Armed Forces Covenant (undertaken by the Chair on 8th September 2023) was approved.	
UHB 23/09/024	**Naming of "CD1" – Cardiff Edge Business Park** The Naming of "CD1" – Cardiff Edge Business Park was received. The Executive Director of Strategic Planning advised the Board that: A recommendation had been received to name the centre Canolfan Lechyd Genomig Cymru. **The Board resolved that:** a) The following name for the new genomics hub at Cardiff Edge Business Park, following SLB endorsement on the 21st September was approved: ***Canolfan Iechyd Genomig Cymru / Wales Genomic Health Centre***	
UHB 23/09/025	**Committee / Governance Group Minutes:** The Committee / Governance Group Minutes were received. **The Board resolved that:** a) The Committee / Governance Group Minutes were noted	

UHB 23/09/026	**UHW2 Investment Board** The UHW2 Investment Board was received Working through future hospitals programme for UHW and UHL. First submitted in March and asked for amendments. Submitted to Welsh Government October 2021 Gateway review undertaken. Amber red rating predominantly on funding • Welsh Government commissioned clinical review, wanted assurance that the clinical models were sound and achievable. • Received the report. Nuffield trust were brought in to carry out reviews. Had opportunity to comment on accuracy. • Accepted recommendations (8). • Minister's support, unable to share as yet. • Headline – independent review – urgent review of UHW required • Nigel Edwards to return from retirement to present • Can see significant and challenging affordability • Many of critical areas where there were regulation requirements received warning notes that not fit for purpose including Digital capability • Things that impact on continuity of service, issues heating and electricity • UHW being particularly at risk, air handling ventilation, soil stacks (foul drainage) • Although no RACK present, there were high levels of asbestos. • Risk did not address Digital piece • Proposed approach • Implications for services • Areas of vulnerability A discussion followed. Proposed approach: to set out a range of options for infrastructure and investment board to consider a phased approach over longer period of time. To continue to consolidate work Meriel Jenney leading on with Victoria LeGrys and Nav Masani on Nuffield trust recommendations. Observations – keeping infrastructure but able to adapt and be flexible. Pragmatic conversation with Welsh Government required regarding long term redevelopment. Need to take control over situation. Suggestion to enter discussion with Welsh Government with clear view regarding what the timeline was for approving SOFH. Need to have confirmation that Welsh Government colleagues will work to identify a funding solution, digital, infrastructure and new hospital. Willing to commit to a detailed masterplan, a risk-based approach which would include all new build, digital. Unknown what the outcome of the discussion would be and recognise the realism of financial challenge, require help that there would be a funding stream. In response to a question if any costings were available, this was dependant on the timeline and if it could be redeveloped on the scale required. Masterplan required to establish which parts needed refurbishment, this being carried out over time, block by block although would potentially have higher end cost and impact on service delivery.	

	Likely to cost more over time but may be affordable as work carried out in a phased approach. It was acknowledged that this would be difficult given the current high interest rates. Welsh Government wanting Cardiff and Vale to look at areas of prioritisation. **The Board resolved that:** They supported the approach that the Executive Director of Planning had outlined	
UHB 23/09/028	**Corporate Risk Register** The Corporate Risk Register (CRR) was received. The DCG advised the Board that the report was for noting. **The Board resolved that:** a) The Corporate Risk Register and the work in that area which was now progressing was noted.	
UHB 23/09/029	**Chair's Reports from Advisory Groups and Joint Committees:** The Chair's Reports from Advisory Groups and Joint Committees were received. **The Board resolved that:** a) The Chair's Reports from Advisory Groups and Joint Committees were noted.	
UHB 23/09/030	**Model Standing Orders for The Emergency Ambulance Services Committee (EASC)** The Model Standing Orders for The Emergency Ambulance Services Committee (EASC) were received. **The Board resolved that:** a) The H&S Annual Report was noted.	
UHB 23/09/031	**Committee / Governance Group Minutes** The Committee / Governance Group Minutes were received. **The Board resolved that:** a) The Committee / Governance Group Minutes were noted.	
UHB 23/09/032	**Any Other Business** No other business was received.	
	Agenda for Private Board Meeting: ***i.*** *Approval of Private Board minutes* ***ii.*** *South Wales Fire and Rescue Service Prosecution Update* ***iii.*** *Approval of Private Committee minutes*	

	Date & time of next Meeting: Thursday 30 November, CF61 Community Space, Station Road – CF61 1ST	

ACTION LOG

Following Public Board Meeting

28 September 2023

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
Actions Completed					
UHB 23/05/015	**Integrated Performance Report: QSE**	Mortality data assurance to be provided following a deep dive at a QSE Committee meeting	**28.09.2023**	Meriel Jenney	**COMPLETED** **Update on 28 September 2023** *Covered in IPR*
UHB 23/05/014	**Chairs' reports from Committees of the Board – Senior Leadership Board (SLB)**	The EDPC to provide assurance to the Board on WAGESTREAM decisions	**28.09.2023**	Rachel Gidman / Jason Roberts	**COMPLETED** **Update on 28 September 2023** *Covered in IPR*
UHB 23/03/010	**Chair's Report re length of stay**	The Chief Operating Officer to report back to Board with regards to the length of stay data.	**28.09.2023**	Paul Bostock	**COMPLETED** **Update on 28 September 2023** *Covered in IPR*
UHB 23/09/006	**Patient/Staff Story**	Thank you letter from Chair to be sent	**30.11.2023**	Matt Phillips	**COMPLETED** *Letter sent 02.10.23*
UHB 23/09/005	**Action Log**	Check that UHB 23/03/013 was taken to QSE as date preceded last Board.	**30.11.2023**	Jason Roberts/Angela Hughes	**COMPLETED** Checked on 28 September 2023 – while the QSE date preceded Jul Board, the action was from March so the sequencing makes sense

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
UHB 23/09/019	**Tissue and Organ Donation Annual Report**	Share the organ transplantation YouTube links with Board	**30.11.2023**	Suzanne Rankin	**COMPLETED** *Sent via email on 28.09.2023*
UHB 23/09/012	**Reinforced Autoclave Aerated Concrete (RAAC)**	WG Statement on RAAC to be shared via our comms channels.	**30.11.2023**	Joanne Brandon	**COMPLETED** *The WG Statement on RAAC was added to SharePoint News and sent out to all staff via the Weekly Staff Update on 06.10.2023*
UHB 23/09/011	**Integrated Performance Report**	Starting well agenda annual update to RPB to be shared with Board Members once released	**30.11.2023**	Abi Harris	**COMPLETED** *Circulated to Board on 13.10.2023*
Actions in Progress					
UHB 23/09/018	**Operational Winter Plan**	Explore possibility of providing vaccination sessions on weekends and nights	**30.11.2023**	Fiona Kinghorn	**IN PROGRESS** *Fiona Kinghorn provided further information to the Independent Member – Trade Union via email and will provide a verbal update to the Board in November 2023 <u>via Action Log discussion</u>*
UHB 23/09/011	**Integrated Performance Report**	Dental deep dive to be taken to Finance and Performance Committee and then back into Board	**30.11.2023**	Paul Bostock	**Update on 30 November 2023** *On agenda, item 6.6*
UHB 23/01/018	**Board Champions**	Report to be provided at the end of each year to detail the work undertaken by Board Champions.	**26.01.2023**	Rachel Gidman/Matt Phillips	**Update on 26 January 2024**
Actions referred <u>TO</u> Committees of the Board/Board Development					
UHB 23/05/016 **and**	**6 Goals Improvement Programme**	Board Development session to be held on the 6 Goals Improvement Programme and To include Safer at Home update	**29.02.2024**	Paul Bostock/Matt Phillips	**Update on 29 February 2024** *Going to Board Development February 29th 2024*

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
UHB 23/09/011					
Actions referred <u>FROM</u> Committees of the Board/Board Development					

Report Title:	**Chairs Report to Board**				Agenda Item no.	6.2	
Meeting:	**UHB Board**		Public	X	Meeting Date:	**30 November 2023**	
			Private				
Status *(please tick one only):*	Assurance	X	Approval		Information		
Lead Executive Title:	**Chair of the Board**						
Report Author (Title):	**Head of Corporate Governance**						

Main Report
Background and current situation:

1. SITUATION/BACKGROUND

This report aims to provide an update to the Board on relevant matters in my capacity as Chair of the Health Board, where I highlight key areas of activity including Board business and topical areas of interest.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING

2.1 Board Membership

A. The Board will wish to note the resignation of Fiona Kinghorn as Executive Director of Public Health, with effect from 29 December 2023, when Fiona enters the next chapter of her life and takes up retirement. Fiona has held Executive Director of Public Health responsibility in Cardiff and Vale University Health Board since Autumn 2018, and made an enormous contribution during the Covid-19 pandemic, leading on the regional public health response and strategically holding the rein on mass vaccination for the population of Cardiff and Vale of Glamorgan. Fiona will be very much missed. Processes are underway for the recruitment of her successor.

B. Councillor Susan Elsmore our Independent member for Local Authority completed their term of office which ended on 31 October 2023. Recruitment of her successor is underway.

C. The Board will wish to note the resignation of Professor Keith Harding as Independent Member for University, with effect from 30 November 2023

2.2 Board Development Session –26 October 2023

Strategy Planning Delivery and Framework

In October's Board Development meeting we continued our strategy work and potential delivery mechanisms that centered on defined portfolio areas, Senior Responsible Officers (SROs) and programmes of work.

The Board reviewed the self-assessment work that had been undertaken following Welsh Governments introduction of the Speaking up Safely framework which will be spearheaded by Mike Jones, Trade Union Independent Member and Board Champion jointly with Matt Phillips, Director of Corporate Governance as the Executive Lead.

The Board took the time to understand the long-term financial outlook, including the projections on population health and the likely impact that would have on Health organisations in the future, and the financial implications therein. This was also further reflected in the Team Wales event led by Judith

Paget, Director General for Health and Social Services and the NHS Wales Chief Executive in October which I attended.

2.3 Diary Highlights since the last Board Meeting

Patient at Risk Team (P@RT)

As we progress into the winter period, and the challenges that brings to our incredible workforce, it is important to celebrate the fantastic work that continues to be undertaken by our colleagues and teams across all areas of the Health Board. On this occasion I would like to highlight the work undertaken by our Patient at Risk Team (P@RT) who have been doing some excellent work, including the recent launch of the Call 4 Concern patient safety initiative.

Cardiff & Vale Patient at Risk Team is an integrated team of 27 Critical care consultants and 28 experienced nurse practitioners, that provide 24/7 help and support to all adult patients that show acute deterioration in their physical health in University Hospital Landough, University Hospital Wales and Hafarn Y Coed. P@RT was formed in 2021 in response to the Welsh Governments recommendations and the National Outreach Quality Standards. Since then P@RT practitioners have gone on to help, support and advice over 17,000 acutely unwell adult patients and the hundreds of clinical staff that care for them and provide over a thousand hours of formal education.

The core role of P@RT is to optimise the patient's outcome and experience by ensuring clinical deterioration is identified early allowing P@RT to work with medical and nursing teams to confirm appropriate medical managements plans and treatment escalation plans, which may include escalation to high care areas such as ICU, setting treatment limitations or instigating palliation. Over the last 2 years data has shown 97.3 % of the patients seen by P@RT remained on the wards, response times are compliant with the HB recommendations and staff satisfaction surveys have shown outstanding support.

Call 4 Concern Launch

P@RT also provide help and support to all patients discharged from the ICU and are currently piloting a Call 4 Concern (C4C) initiative with these patients. Call 4 Concern gives the patient and/or their advocate another opportunity to be heard. It is a patient safety initiative which provides a safety net to adult inpatients who are concerned they are developing an acute physiological deterioration which they feel has been insufficiently addressed by their medical and nursing team. It provides patients, their relatives/advocates the opportunity to a second opinion from a highly skilled team of nurse practitioners that can assess the patient and determine if their care needs escalating to a more senior doctor or review by the Critical Care team. Using a carefully designed pathway, they can call P@RT for a second opinion if they are concerned their physical health condition is deteriorating despite engagement with their medical and nursing team. This is a project that will spread to all wards after the effects of the pilot has been analysed.

The soft launch began in September and is now being rolled out wider. I am delighted to see such a great initiative launch in Cardiff & Vale demonstrating the organisations commitment to service improvements projects and our ethos to continue to strive to improve patient safety, experience and eventual outcome for those in our care.

My Health Passport Launch – 16 November

I was pleased to attend and support the launch of 'My Health Passport' which is being introduced in the health board to provide staff who have a pre-existing or new health condition, a means to capture any support or adjustments that they feel would benefit them at work. The information within 'My Health Passport' can then be shared by the individual with their line manager, enabling a conversation to generate a better understanding of wellbeing needs in the workplace, and how these can be supported. This is an important initiative developed jointly with our Unison colleagues and ensures our staff feel listened to and that they can be their best every day, which aligns to our Strategic Objectives. It was a pleasure to welcome Jane Hutt MS, Minister for Social Justice and Chief Whip for Welsh Government.to the launch event who was very supportive of this partnership initiative.

In the News – BBC Filming

In my last report, I outlined how we were in discussions for the health board to participate in a new television documentary. I can confirm that we are now progressing with this and a six-part series for BBC Two and BBC One Wales "Hospital and Saving Lives" is currently being filmed. The intention is to showcase our patient journeys from the waiting list through to treatment and demonstrate an authentic portrayal of those decisions and treatment processes made on a daily basis by our great teams across the organisation. On behalf of the Board I would like to extend my thanks to all of those involved with this filming opportunity whilst continuing to deliver high quality service on behalf of the Health Board, for our patients and population. This is a great opportunity to showcase the daily work of our hard-working teams across the organisation.

Business Continuity and Emergency Ambulance Services Committee Feedback

During these challenging times, it is important to recognise the achievements our staff are making on a daily basis to ensure that the best possible care is being provided to our patients in all areas of our work, albeit with the daily pressures they are dealing with. This is particularly prevalent given the recent business continuity incident declared in University Hospital Wales which was a response to a very overcrowded Emergency Unit and a lack of patient flow through, and out, of the hospital.. The incident was stood down on the 9 November and I want to pass on my thanks to the fantastic efforts of our staff and the response from our external partners, which enabled us to reset the emergency care pathway and restore timely flow and ambulance handovers.

I wanted to share on behalf of the board some recent positive feedback we have received from the Emergency Ambulance Services Committee which reviews the performance of the Ambulance service working with health boards in Wales. Their most recent report highlighted that "Cardiff and Vale continued to deliver excellent performance and were meeting their predicted trends as per the Integrated Commissioning Action Plan (ICAP)". This truly demonstrates the commitment and dedication of our staff as we continue to deal with significant challenges within our services. I would

like to express my sincere gratitude to you all for your ethos to do your best, no matter the challenge and continue to strive to deliver the best possible care we can for our patients and communities

3. KEY RISKS/MATTERS FOR ESCELATION TO BOARD/COMMITTEE

3.1 - Fixing the Common Seal/Chair's Action and other signed Documents since the last Board meeting

The **common seal** of the Health Board has been applied to 9 documents since as listed below;

Seal No.	Description of documents sealed	Background Information
1038	Settlement Deed	Deed of Surrender between (1) Cardiff and Vale UHB and (2) Rhiwbina Rugby Club in relation to land at Whitchurch Hospital
1039	Settlement Deed	Deed of Surrender between (1) Cardiff and Vale UHB and (2) AFC Whitchurch
1040	Lease	Grant of Replacement Lease between (1) Cardiff and Vale UHB and (2) AFC Whitchurch in relation to land at Whitchurch Hospital
1041	Settlement Deed	Deed of Surrender between (1) Cardiff and Vale UHB and (2) Whitchurch and Health Cricket Club in relation to land at Whitchurch Hospital
1042	Lease	Grant of Replacement Lease between (1) Cardiff and Vale UHB and (2) Whitchurch and Health Cricket Club in relation to land at Whitchurch Hospital in relation to land at Whitchurch Hospital
1043	Settlement Deed	Deed of Easement for underground service media relating to fibre optic cable at UHW between (1) Cardiff and Vale University Local Health Board & (2) Cardiff University
1044	Contract	Contractor contract UHW Tertiary Tower Electrical Infrastructure upgrade
1045	Settlement Deed	Deed of Release re option to purchase part of Landsdowne Hospital site between (1) Cardiff and Vale University Health Board and and (2) Christopher John Robinson (3) Warren Heywood and (4) John James Collis
1046	Agreement	Supply chain partner for the development of Parkview wellbeing hub

The following **Legal Documents** are reported as having been signed on behalf of the Health Board;

Date Signed	Type of Document	Background Information
20.09.2023	Licence for Utilities Works	Licence for Utilities Works between (1) Cardiff and Vale UHB and (2) Velindre NHS Trust in relation to the Northern Meadows allowed for a 'services corridor'
20.09.2023	Licence for Works	Licence for Works at Whitchurch Hospital to Undertake Football Pitch Works between (1) Cardiff and Vale UHB and (2) Velindre NHS Trust
20.09.2023	Agreement	Tripartite Agreement of Commitment between (1) Cardiff and Vale UHB (2) Velindre NHS Trust and (3) afc Whitchurch in relation to a commitment to undertake works to provide a football pitch for the football club
20.09.2023	Licence	Habitat Licence at Whitchurch Hospital - (1) CVUHB and (2) Velindre INHST
25.09.2023	Licence	Licence to Occupy land at Riverside Health Centre, Canton Court, Cardiff between (1) Cardiff and Vale University Health Board and (2) Grow Cardiff
02.10.2023	Agreement	Letter to Aldi Stores for agreement to extend works Licence from 31.07.23 to 16.02.24 - was due to expire 31.10.23
02.10.2023	Memorandum of Understanding	Memorandum of Terms of Occupation (MOTO) between (1) Cardiff & Vale University Local Health Board and (2) Public Health Wales relating to Mobile Breast Test Wales to be sited at Whitchurch Hospital
02.10.2023	NEC 4 Short Form Contract	NEC 4 Short Contract between (1) Cardiff & Vale UHB and (2) ET&S Construction Ltd Project: - UHL TACU TENDER, Creating a new clinical recovery area
02.10.2023	NEC 3 Short Form Contract	NEC 3 Short Contract between (1) Cardiff & Vale UHB and (2) Lorne Stewart PLC Project: St Marys Chiller Replacement
02.10.2023	NEC 3 Short Form Contract	NEC 3 Short Contract between (1) Cardiff & Vale UHB and (2) Lorne Stewart PLC Project: Reinforcement of Domestic Hot Water Services at UHL
05.10.2023	NEC 4 Short Form Contract	NEC 4 Short Contract between (1) Cardiff & Vale UHB and (2) 2D Building Contractors Ltd Project: Emergency Unit Assessment South at UHW
05.10.2023	NEC 4 Short Form Contract	NEC 4 Short Contract between (1) Cardiff & Vale UHB and (2) 2D Building Contractors Ltd Project: - Emergency Unit Assessment North at UHW

13.09.2023	NEC 3 Short Form Contract	NEC 3 Short Form Contract between (1) Cardiff and Vale University Health Board and (2) Lorne Stewart PLC
12.10.2023	Licence	Licence to occupy relating to Rookwood Hospital between (1) Cardiff and Vale University Local Health Board (2) The Forge Entertainment (Genz) Limited
30.10.2023	Licence	Car parking license between Cardiff & Vale University Health Board and The Police and Crime Commissioner for South Wales
31.10.2023	Deployment Order	Deployment Order – Radiology Informatics System between Cardiff & Vale University Health Board and Philips Electronics UK Ltd

The following **Chairs Actions** have been taken on behalf of the Health Board; The Board is requested to ratify these decisions in accordance with Standing Orders;

Date Received	Chairs Action Details	Approval Status	Date Approved
08.09.2023	1) Deed of Surrender between (1) Cardiff and Vale UHB and (2) Rhiwbina Rugby Club 2) Deed of Surrender between (1) Cardiff and Vale UHB and (2) AFC Whitchurch Grant of Replacement (1) Cardiff and Vale UHB and (2) AFC Whitchurch 3) Deed of Surrender between (1) Cardiff and Vale UHB and (2) Whitchurch and Health Cricket Club 4) Grant of Replacement Lease between (1) Cardiff and Vale UHB and (2) Whitchurch and Health Cricket Club.	Approval to Apply UHB Seal and enter agreements	20.09.2023
08.09.2023	Contractor contract UHW Tertiary Tower Electrical Infrastructure upgrade	Approval to apply seal and enter agreements	28.09.2023
22.09.2023	Deed of Easement for underground service media relating to fibre optic cable at UHW between (1) Cardiff and Vale University Local Health Board & (2) Cardiff University	Approval to apply seal and enter agreements	28.09.2023
05.10.2023	Extension of contract for the provision of two mobile theatres and a recovery area to support the Health Board Ophthalmology Recovery Plan.	Approval to enter into a contract totaling £3,072,546.00 incl. VAT	06.10.2023

09.10.2023	Permission to enter into and apply the UHB Seal to the following; • Access Agreement relating to the laying of electricity apparatus at Whitchurch Hospital, Cardiff between (1) Cardiff and Vale University Health Board and (2) Velindre University National Health Service Trust • Deed of Variation of the transfer of Land at Whitchurch Hospital between (1) Cardiff and Vale University Health Board and (2) Velindre University National Health Service Trust	Approval to enter into and apply the UHB Seal to the listed documents.	11.10.2023

09.10.2023	Permission to enter into and apply the UHB Seal to a Deed of Release regarding an option to purchase part of the former Landsdowne Hospital site between (1) Cardiff and Vale University Health Board and (2) Christopher John Robinson (3) Warren Heywood and (4) John James Collis	Approval to enter into and apply the UHB Seal to the listed document.	11.10.2023
11.10.2023	Additional capacity for the South East Wales Satellite Renal Dialysis contract	Approval to enter into a contract with an increased value of £840,200.00 from the previously agreed £77,092,732.00 (Revised contract value £77,932,932.00) VAT Reclaimable	12.10.2023
16.10.2023	Managed Equipment Service for Ultrasound and associated Decontamination Services	Approve a Contract Award to Canon Medical Systems UK Ltd for a period of 7 Years with a total contract value of £6,147,638.84 with fixed pricing across the contract thus avoiding inflationary costs across the 7 years equating to a total of £1,383,284.10 cost avoidance.	20.10.2023
16.10.2023	Temporary Community Diagnostic Centre (CDC) Solution at UHL	To award Alliance the contract from contract award up to the 31st March 2024 with an extension option of up to nine months at the sole discretion of the Health Board. Due to the capped funding value, the Health Board can only afford the 5 day service, therefore, the primary period has been modelled on this basis from mid November 2023 - Total £686,400.00.	26.10.2023
18.10.2023	POLARIS Trial	This trial will be led by Cardiff and Vale UHB, who will undertake the role as sponsor for this research. Total research cost, 6 year trial £1,229,491.00	21.10.2023
18.10.2023	PIPAC in Cancers of the Colon, Ovaries and Stomach (PICCOS) Trial	This trial will be led by Cardiff and Vale UHB, who will undertake the role as sponsor for this research. Contract value £925,661.36	21.10.2023
19.10.2023	Air Blast Chillers procurement UHW CPU. Construction of external steel	UHW CPU Air Blast Chillers be awarded to BECT Building Contractors Ltd via the Internal	01.11.2023

	platform and installation of new chiller units	Buildings Framework. Contract value £687,310.61	
31.10.2023	Supply chain partner for the development of Parkview wellbeing hub	New contract value. Original fees had to be updated to account for increased scope. Contract value Including VAT £1,846,800.00	01.11.2023
10.11.2023	Uplift to value of electrical framework	Increase the contract value by the maximum allowable amount, £2,700,000.00 including VAT. Previous framework value £4.5mil Proposed new framework value £6.75mil- increase £2.25mil	03.11.2023
10.11.2023	Approval to send off ePMA Business Case for submission to WG.	Approval to submit a Business case relating to the Electronic Prescribing and Medicine Administration (ePMA) Funding of this entire business case is being requested from Welsh Government which totals £9.2m	10.11.2023

Recommendation:

The Committee is requested to:

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

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please place an "X" in the below boxes 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 place an "X" in the below boxes as relevant

Prevention		Long term		Integration		Collaboration	X	Involvement	

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

Main Report

1. EXECUTIVE SUMMARY

As we head into a particularly challenging part of the year, I wish to provide the Board with assurance that we have plans in place to respond to the anticipated winter pressures whilst the important work to support organisational, team and individual resilience continues. In addition, that despite the organisational focus inevitably turning to operational matters we will continue to strive to meet our financial duties in the face of the concurrent climate of financial constraint and finally to give assurance that the essential work of planning for next year and beyond is well underway. All of these matters will be shared individually with the Board for discussion, reflection, advice and ultimately approval by the relevant Executive Directors. My purpose here is to provide assurance that despite the multiplicity of significant tasks and arenas of focus appropriate strategic leadership and focus is being applied to each with the aim of achieving the best outcomes, deconflicting actions and enabling the potential multiplying effect of the interdependencies. In addition, I will refer to a recent Business Continuity Incident for the awareness of the Board however more detail will be provided by the Chief Operating Officer during the course of his operational update.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING

2.1 WINTER PLANNING

Board members will recall that in September the Winter Plan was presented, discussed and noted.

The work to engage colleagues and partners continues which is an important underpinning to success and resilience. Work to mobilise on the key priorities set out within the plan; flexing of capacity to meet demand, stepping up social care, intermediate and primary care, SAFER and "home-first" to facilitate timely and safe discharge and alignment of workforce deployment and phasing of resources and budgets continues putting in place a comprehensive set of arrangements that are agile and responsive, is progressing well. We have also ensured that our partnership working arrangements are continuing to improve and taking the opportunity to meet mutual priorities such as achieving an increase in therapies support to help re-able patients in community beds.

We have also been working on a number of initiatives to strengthen our winter planning in relation to Primary & Intermediate Care & Mental Health with the further embedding of the 111 press 2 service which enables patients to reach the appropriate assistance and advice via the well-established 111 service alongside the Mental Health Matters campaign which aims to support safe and appropriate discharge for older people.

An important element of our plan is supporting the health and well-being of the team and a wide range of resources continue to be promoted and facilitated. In addition, the Winter Respiratory Virus Vaccination Programme to offer both covid and flu vaccines to frontline team members continues to be rigorously promoted, encouraged and uptake monitored. Uptake is improving slowly and the

immunisation team are working hard to ensure a great deal of flexibility is supported in when and where vaccines are offered in order to optimise uptake. I continue to discuss the rates of uptake at all my Senior Leadership Board meetings and have requested that it is a topic for discussion at all team meetings. I will provide the most recent uptake figures verbally at the Board meeting. I encourage all who are eligible to take up the offer of vaccination to protect yourself, your loved ones, colleagues, patients and the public.

As these activities progress and I can assure the Board that close scrutiny is maintained on expenditure and opportunities to maximise efficacy and efficiency, reduce waste and variation and promote high quality, value-based pathways of care are taken. I will share an update with the Board in the New Year on how effective our plans and response have been.

2.2 FINANCIAL POSITION UPDATE

I welcome the statement made by the Finance Minister on the 17 October 2023 announcing a significant increase in funding for NHS Wales and recognise that considerable work has been done across Welsh Government to identify savings to bring forward into NHS Services. In recognition of this work and the impacts upon other Welsh Government departments I am clear that the work of the Senior Leadership Board must be focused on delivery and meeting the new financial requirements we have been set.

The Health Board subsequently received direction setting out an allocation of £63m of additional funding along with an additional savings target being a further 10% of the original planned deficit. This means that the Health Boards planned deficit of £88.4m is now reduced to a planned deficit control total of £16m.

	HCHS 23-24 Formula Share	Planned Deficit	10% Reduction	Adjusted Deficit	Conditionally Recurrent: Covid Legacy	Conditionally Recurrent: Inflationary Uplift	Non Recurrent: Inflationary Uplift	Non Recurrent: Energy	Total Allocations	Control Total
Cardiff & Vale	13.50%	88.4	-8.8	79.6	20.3	25.1	10.1	7.6	63.1	16.0
NHS Wales	100.00%	648.0	-64.8	583.2	150.0	186.1	75.1	49.2	460.4	123.0

We are committed to the achievement of the revised control total which would enable £45.4m of the additional funding to be recurrent, a significant step towards future sustainability. Delivery of the revised £16m deficit control total will test the organisation and risks remain connected to the potential winter pressures as well as some challenges within the existing savings programme. Clearly a robust and agile winter plan, as discussed, is very important alongside continued collaborative working and programme scrutiny across the organisation. Additional opportunities will be explored, risk assessed and implemented accordingly in order to de-risk our chances of success.

A high level of scrutiny across the financial performance is maintained to assure delivery remains in line with the financial plans. Board members will recall the establishment of a Sustainability Programme Board that I Chair which meets fortnightly to scrutinise the financial position, generation of savings opportunities and delivery of agreed plans. This has been operational for six months and I believe is enabling collective leadership and ownership of the sustainability programme together with providing the opportunity to deconflict activities and identify opportunities that can create added value across a number of priorities. It is not all plain sailing and learning is captured along the way, all of which is building leadership capability and embedding high quality ways of working and reinforcing our organisational values.

The Board will continue to receive detailed briefings on progress alongside the routine assurance papers through Finance & Performance Committee.

2.3 PLANNING AHEAD

In my last report I updated the Board on the approach to deploying the refreshed strategy, Shaping our Future Wellbeing to 2035 ("the Strategy"), *Living Well, Caring Well, Working Together*. Additionally, I described the links between the Strategy deployment and the operational planning through a description of the planning architecture and hierarchy.

Work is now underway to cascade this refreshed vision and I began this via my Ask Suzanne session on the 3 November. This was a great opportunity to share with colleagues how we had utilised their considerable engagement and contribution to shape the final version of the Strategy as well as to discuss the strategic objectives and how colleagues can use them to shape their own team and departmental plans. We discussed the importance of strategic alignment and how they have an essential role to play in successful achievement of our shared vision.

As previously discussed, a critical element of the Strategy deployment is the Intermediate Medium-Term Plan (IMTP) and the annual plans that form it. Development of the Annual Plan 2024-2025 is progressing in line with the agreed organisational timeline. A Senior Leadership Board workshop was held on 16 November to bring together the headline plans from the corporate departments and the clinical boards. This will then feed into the submission of the IMTP/annual plan which Welsh Government have confirmed will be due on the 28 March 2024. This is also the date on which the Board will be considering the final plan for submission. We are expecting Welsh Government planning guidance to be received at the end of November or early December and the financial allocation is expected in the last couple of weeks in December. The December Board development session will enable the Board to shape and refine the plan's priorities and actions and take assurance that the annual plan is developing in a strategically aligned way and enabling delivery of the Strategy.

We will continue to strengthen and improve the reporting to Board on delivery of the key areas of the strategic planning work programme and give Board assurance that actions agreed in the Annual Plan are being progressed and managed in accordance with agreed milestones and trajectories.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

On the 6 November 2023 the Health Board declared a Business Continuity Incident in response to a very overcrowded Emergency Unit and long waits for patients to be handed over from ambulances (compared to our usual standards) and low predicted discharge numbers. The purpose of the declaration was to mobilise additional resources and strengthen command and control of a potentially safety critical situation and to ultimately secure the safety of patients and colleagues alike. This is a pro-active step and should be seen in this light. The incident was stood down on the 9 November thanks to the fantastic efforts of the CAV team and the response from our external partners of which we are incredibly proud and grateful. The operational teams were able to reset the emergency care pathway and restore timely flow and ambulance handovers. There will be a formal debrief and lessons learnt in due course of which more detail will be provided by the Chief Operating Officer.

As I stated at the beginning of this report we are heading into a very challenging period. I continue to be proud and humbled everyday by the tremendous commitment, professionalism and expertise exhibited by CAV colleagues. I thank you all and anticipate our collective efforts, robust plans and high-quality management and leadership will support and enable a sustained and resilient response. I'm also grateful for our effective partnership working and relationships and trust that in sum the Board can be assured that all that can be done to secure the organisation's success and well-being is being done.

Recommendation:

The Board are requested to:
NOTE the Strategic Overview and Key Executive Activity to provide assurance described in this report.

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

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

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

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

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

Main Report
Background and current situation:

The Board Assurance Framework (BAF) provides the Board with information on the key Strategic Risks that could impact upon the delivery of the Health Board's Strategy. It comprises:

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

These risks are all detailed within the attached BAF. There are three broad groups in which the risks have been ordered within the BAF these groups are:

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

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

This iteration of the BAF is an initial evolution resulting from the strategy refresh that launched in September and the resulting work on portfolios, SROs, committee responsibilities etc.

The principle change is the introduction of the new strategic objectives into the BAF and the alignment with the strategic risks. This work will continue to shape and change the BAF.

The key changes to the risks on the BAF from the Board Meeting in September 2023 are track changed for clarity. A significant piece of review work has been undertaken by the People and Culture team. Key assessment changes:

Risk 11 Wellbeing has decreased the net risk score.

Assurance is provided by:

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

Recommendation:

The Board are requested to:

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

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

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

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes/~~No~~
The BAF as a document details the risks in relation to the delivery of Strategic Objectives.
Safety: Yes/~~No~~
There is a risk within the BAF on Patient Safety which also details the impact.
Financial: Yes/~~No~~
There is a risk within the BAF on Financial Sustainability which also details the impact.
Workforce: Yes/~~No~~
There is a risk within the BAF on Workforce which also details the impact.
Legal: ~~Yes~~/No
Reputational: Yes/~~No~~
Having a non-approvable IMTP will impact upon the reputation of the Health Board
Socio Economic: Yes/~~No~~

There is a risk on the BAF on Health Inequalities these inequities have significant social and economic costs both to individuals and societies.	
Equality and Health: Yes/~~No~~	
As above	
Decarbonisation: ~~Yes~~/No	
Approval/Scrutiny Route:	
Executive Directors	Individual review undertaken prior to Board with each Executive Lead.

Strategic Objective	Priorities	Portfolio	SRO	Committee	Strat Risks
Putting People First We will be a great place to train, work and live, where we listen to and empower people to live healthy lives. By 2035, colleagues would recommend us a great place to work, our workforce will reflect the diversity of our communities and more people will be living healthier lives.	People will feel valued, developed, supported and engaged. We will have an inclusive culture where the diversity of the Health Board's people will be representative of the Health Board's local populations. Through our integrated population health improvement programme, we will enable and empower people to live healthy lives and reduce their risk of ill health.	Shaping Our Future People and Culture	Director of People and Culture	People and Culture	9. Attract, recruit & retain 10. Sustainable Culture Change 11. Staff Wellbeing
		Shaping our Future Population Health/Equitable Health	Director of Public Health	People and Culture	8. Exacerbation of Health Inequalities 9. Workforce 14. Financial Sustainability 15. Digital Strategy and Road Map
Providing Outstanding Quality We will provide outstanding services which are equitable, timely and safe, where people are treated with kindness and are supported to achieve the outcomes that matter to them. We will have reduced inequities in prevention, improved access to clinical services and clinical outcomes.	Focus on minimising inequity in healthy behaviours, preventative services, access to clinical services, and health outcomes, to reduce current unfair, unjust differences experienced by people in the community Deliver outstanding quality of care every time - from the most complex care for the most critically ill to routine care that prevents and protects against ill health and disease – addressing physical and mental health needs. Achieve the best outcomes for patients in line with what matters most to them, their families and carers. Develop the Health Board's approach to continuous quality to improvement and make the best use of the Health Board's resources.	Shaping our Future Quality Excellence	Medical Director and Director of Nursing	Quality Safety and Experience	1. Patient Safety 2. Maternity 3. Critical Care 4. Cancer 5. Stroke 6. Urgent and Emergency Care 7. Planned Care 9. Workforce 11. Staff Wellbeing 12. Capital Assets 14. Financial Sustainability 15. Digital Strategy and Road Map

Delivering in the Right Places By 2035 we will be using real time integrated data to inform joint decision making and multi-disciplinary team working, giving people access to and ownership of their data to enable them to manage their health and wellbeing. We will be well on our journey to provide care in the right place, in facilities that are fit for purpose, flexible and promote recovery.	To achieve digital maturity enabling the Health Board to connect and communicate, supporting shared decision making in the planning and delivery of health care services. Refresh and deliver the Health Board's programme for creating integrated health and care facilities in our local communities where people can access the information and support they need under one roof. With Cardiff University and NHS partners, develop the Health Board's plans for ensuring hospitals providing acute care are fit for the future. Develop more shared infrastructure with public and private sector partners to get best value for the Health Board's investment.	Shaping our Future Integrated Services	Medical Director	Quality Safety and Experience	2. Maternity 4. Cancer 5. Stroke 7. Planned Care 8. Exacerbation of Health Inequalities 10. Sustainable Culture Change 15. Digital Strategy and Road Map
		Shaping our Digital Future	Director of Digital	Digital Health Intelligence Committee	9. Workforce 15. Digital Strategy and Road Map
		Shaping our Future Estate and Infrastructure	Director of Finance	Finance and Performance Committee	9. Workforce 12. Capital Assets
Acting for the Future We will work to ensure that what we do today does not compromise the wellbeing of our future generations. We will protect the environment and develop and use new technologies, treatments and techniques to provide the best possible health outcomes	Develop and expand the Health Board's research, teaching and innovation portfolios in collaboration with Cardiff University and other partners. Contribute to the development of and adopt cutting-edge and novel treatment, techniques and technologies where they deliver improved patient outcomes and improved value. Maximise the Health Board's contribution to the foundational economy	Shaping Our Future Clinical Care for the Next Generations	Medical Director	Quality Safety and Experience	8. Exacerbation of Health Inequalities 9. Workforce 12. Capital Assets 13. Delivery of IMTP 14. Financial Sustainability 15. Digital Strategy and Road Map

and sustainable health care into the future. By 2030 we will have reduced the Health Board's carbon footprint by 34% and will have increased our research and clinical innovation activities	Deliver the Health Board's carbon emissions targets and fully support active and sustainable travel for staff and visitors to patients. Promote, reward and embed successful waste reduction as part of our quality programme of continuous improvement.	Shaping Our Future Environment for the Next Generations	Director of Planning	Finance and Performance Committee	8. Exacerbation of Health Inequalities 9. Workforce 12. Capital Assets 13. Delivery of IMTP 14. Financial Sustainability 15. Digital Strategy and Road Map
		Sustainable Investment	Director of Finance	Finance and Performance Committee	8. Exacerbation of Health Inequalities 9. Workforce 12. Capital Assets 13. Delivery of IMTP 14. Financial Sustainability

Key Risks

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

Risk	Risk Appetite	Corp Risk Register Ref.	Gross Risk *(no controls)*	Net Risk *(after controls)*	Change from Sep 23	Target Risk *(after actions are complete)*	Context	Executive Lead	Committee
1. Patient Safety	Open	1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 18, 19, 20, 21	**25**	**20**	⇨	**10**	Patient safety should be the first priority above all else for the Cardiff and Vale University Health Board. Safer patient care includes the identification and management of patient-related risks, reporting and analysis of patient safety incidents, concerns, claims and learning from such then implementing solutions to minimise/mitigate the risk of them recurring. The Duty of Candour was formally launched in April 2023 and will further improve communication with patients and opportunities for learning across the Health Board.	Executive Nurse Director/ Executive Medical Director /Executive Director for Therapies and Health Science/ Chief Operating Officer	Quality, Safety and Experience
2. Maternity	Cautious	14, 15, 16	**25**	**15**	⇨	**15**	The recommendations of the Ockenden Review into maternity services in England were published at the end of March 2022. The Ockenden review and its recommendations is very much in the public domain and attracted significant coverage from the media. Becoming compliant with the Ockenden requirements also brings opportunity benefits such as full compliance with the Cwm Taf and other formal reviews recommendations and achieving BAPM compliance in the Neo-Natal Unit.	Executive Nurse Director/ Executive Medical Director/ Chief Operating Officer	Quality, Safety and Experience
3. Critical Care	Cautious	18, 19, 20	**25**	**15**	⇨	**10**	For a sustained period prior to the COVID19 pandemic there were recognised critical care capacity challenges in CAV. The sustainability of Critical Care Services in Cardiff is reported in the 2014 unmet needs study WG, and the 2019 FICM	Executive Nurse Director/ Executive Medical	Quality, Safety and Experience

							external review. Following the COVID19 pandemic these challenges remain and still needs to be addressed. Critical care department capacity is not in a position to deliver a sustainable service to the population it serves. To address this the UHB has approved additional investment for 23/24 to open 3 additional level 3 beds and to establish the Patient at Risk Team (PART) from 7am-7pm/7 days a week to 24/7 by the end of Q3.	Director/ Chief Operating Officer	
4. Cancer	Cautious	7, 9	**20**	**15**		**10**	One of the Health Board's Strategic Objectives is to have sustainable cancer services that deliver the single cancer pathway standard to treat patients with a confirmed diagnosis of cancer within 62 days. To achieve this, the system needs to ensure sufficient capacity is prioritised to meet the predicted weekly demand for cancer patients at the outpatient, diagnostic and treatment stages of the pathway whilst also being sufficiently flexible to respond to peaks and troughs in demand. The recently published Welsh Government Planned Care Plan, the Wales Cancer Network's Quality Statement and the emerging Wales Cancer Network's Improving Cancer Services and Outcomes Action Plan reflect the high priority of cancer services. Despite improvements seen through Q1 23/24, it is not expected that the UHB will reach the WG target of 75%. The weekly cancer delivery group has now implemented a standardised and revised demand and capacity approach across all tumour sites. The likely improvement timescale to reach the standard is now the end of Q2.	Executive Nurse Director/ Executive Medical Director/ Chief Operating Officer	Quality, Safety and Experience
5. Stroke	Cautious		**20**	**15**		**10**	Stroke services within C&V UHB have declined since the COVID pandemic, caused by a reduction in clinical services, but an increase in demand,	Executive Nurse Director/	Quality, Safety and Experience

							most noticeably in patients self-presenting to the Emergency Department. There has been a real drive to improve this service for the patients and improvement has been seen in thrombolysis rates, achieving 15.3% in October 2023 but this is not yet sustainable change hence the continuing focus on this area. ~~>10% since June 22 and now at 10.9%.~~ Challenges include patients self-presenting to ED, dilution of stroke cases within the very busy ED leading to delay in recognition of stroke, scanning and treatment. Despite increased thrombolysis rates, door to needle times are not improving to pre-pandemic performance. There is often no dedicated Stroke medic at the front door meaning Medics are faced with competing given the capacity constraints within the footprint. There has been considerable organisational focus on the stroke pathway and ~~3~~5 internal stroke summits have been held. There is a clear improvement plan in place and we are already seeing some improvements to the time for patients to be admitted to the specialist stroke ward. The next stroke summit ~~to review performance and finalise the proposed changes to the clinical model took place on 30th July.~~is on 20th November The NHS Executive is supporting in the review and updating of the improvement plan following its assessment of the pathways in the UHB and across Wales. Meetings commenced 29.08.23. April to June SSNAP performance saw an improved grading from Grade C to B.	Executive Medical Director/ Chief Operating Officer	
6. Urgent and Emergency Care	Cautious	6, 8, 10	**20**	**15**	→	**10**	One of the Health Board's Strategic Objectives is to have a sustainable unplanned (emergency) care system that provides the right care, in the right place, first time. To achieve this, a whole system approach is required with health and social care working in partnership – both together and also	Executive Nurse Director/ Executive Medical Director/	Quality, Safety and Experience Committee

							with independent and third sector partners. The recently published Welsh Government Six goals for Urgent and Emergency Care span the whole pathway and reflect priorities to provide effective, high quality and sustainable healthcare as close to home as possible, and to improve service access and integration. The impact of the covid pandemic has had many consequences. This includes sustained pressure across the urgent and emergency care system and, whilst underlying actions to progress the plans to achieve the strategy have progressed, covid-19 has impacted on the speed of ongoing action and implementation of plans. The Sustainable Primary and Community Care risk reported in 2021/22 has been incorporated into this newly reported risk for 2022/23. During Q4 the UHB has been able to make considerable improvements in ambulance handover times and are now better than the October 2021 baseline. We have also seen reductions in the numbers of patients spending more than 24 and 12 hours. We have set ambitious trajectories as part of the 23/24 IMTP to further improve on ambulance hand over times and waiting times in the EU dept. Urgent and Emergency performance has continued to improve compared to last year. Q2 has more challenged then expected, largely due to increased length of stay for adult inpatients. Performance for Q3 has been challenging although remains better than the previous year	Chief Operating Officer	

7. Planned Care	Cautious		**16**	**12**		**8**	One of the Health Board's Strategic Objectives is to have sustainable planned care services that deliver the ministerial measures of no-one waiting >52 weeks for a new outpatient appointment by December 2022 and no-one waiting >104 weeks for treatment (all stages) by March 2023. To achieve this, the system needs to ensure sufficient capacity to meet recurrent demand and to increase capacity and activity sufficiently above pre-Covid levels to make inroads into the backlog. The recently published Welsh Government Planned Care Plan reflects the high priority of planned care services. The waiting time standards have since been revised by WG and the ask is now for no patients to wait longer than 52 weeks for their first appointment by 30/6/23, no patients to wait longer than 156 weeks for treatment by 30/9/23 and no patients to wait longer than 104 weeks by 31/12/23. Whilst the UHB is not currently predicting to deliver these standards for 8 specialities, we are expecting to be deliver for 22 others so the vast majority of UHB patients will be treated within these timescales. Therefore, the risk has been reduced. The NHS executive have outlined revised ministerial standards which include no patient waiting for 3 years for an outpatient appointment and working towards 97% of patients receiving treatment in less than 104 weeks by September and 99% of patients by the end of the financial year. Each Clinical Board will be signing off revised trajectories and delivery plans by the 30th June 2023. Each Clinical Board have revised plans for the 23/24 financial year to meet the revised standards above. Welsh Government have responded positively to the plans for the regional funding for planned care and as a result there will be non-recurrent funding	Executive Nurse Director/ Executive Medical Director/ Chief Operating Officer	Quality, Safety and Experience

							to the clinical boards to deliver plans as well as recurrent funding for a protected surgical zone at UHL as well as a community diagnostic hub. These are designed for sustainable increases to capacity and controls for demand respectively At the end of October 2023, the clinical boards remained on track for the delivery of the 97 and 99% standards for December and March respectively. There remain challenges in the delivery of no 156 week waiting patients by the end of December. The focus will be on continual improvement of this number and an aim to clear in financial year		
8. Exacerbation of Health Inequalities	Open		**16**	**12**		**12**	COVID-19 has compounded existing health inequalities in Wales, which have shown little improvement in the last ten years, based on the gap in life expectancy between the most and least deprived fifth of the population. Although the main disparities have been age, sex, deprivation and ethnicity, there is clear evidence of intersectionality, risk factors compounding each other to further disadvantage individuals with protected characteristics (based on the Equality Act 2010). As the granular level data emerges, there is no evidence to suggest that this pattern is not replicated fully at a Cardiff and Vale UHB level.	Executive Director of Public Health	Quality, Safety and Experience Committee
9. Attract, recruit, retain~~Workforce~~ Saunders,Nathan 20/11/2023 15:51:45	Open	4, 6, 11, 16	**25**	**16**		**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	Executive Director of People and Culture	People & Culture Committee

							increase year on year, with a significant increase over the last three years.		
10. Sustainable Culture Change	Open		**16**	**8**		**4**	In line with UHB's Strategy, Shaping Our Future Wellbeing and aligned to the Healthier Wales plan (2018), the case for change is pivotal to transfer our services to ensure we can meet our future challenges and opportunities. Creating a belief which continues to build upon our values and behaviours framework will make a positive cultural change in our health system for our staff and the population of Cardiff and the Vale.	Executive Director of People and Culture	People & Culture Committee
11. Staff Wellbeing	Open	4, 6, 11, 16,	**20**	**16**		**5**	As a result of the global Covid19 pandemic, our employees have been exposed to unprecedented levels of psychological and physical distress both at home and in the workplace. Evidence indicates that, Healthcare workers are at greater risk of developing mental health problems as a result. The impact of this is unlikely to be experienced equally, with people with existing mental health difficulties and people from Black, Asian and minority ethnic communities among those who are likely to be affected disproportionately	Executive Director of People and Culture	People & Culture Committee
12. Capital Assets	Open	1, 2, 3, 4, 17, 19, 20, 23	**25**	**20**		**10**	The UHB delivers services through a number of buildings across Cardiff and the Vale of Glamorgan, from health centres to the Tertiary Centre at UHW. All NHS organisations have statutory responsibilities to manage their assets effectively: an up to date estate strategy is evidence of the management of the estate. The IT SOP sets out priorities for the next five years and Medical Equipment is replaced in a timely manner within the resources available, though backlogs for a proactive replacement programme remain.	Executive Director of Strategic Planning, Executive Director of Therapies and Health Science, Executive Director of Finance	Finance & Performance Committee
13. Delivery of IMTP 23-26	Open	22	**20**	**15**		**10**	The Integrated Medium-Term Plan is the key planning document for the Health Board setting out the milestones and actions we are taking in the next 1 to 3 years in order to progress Shaping Our Future Wellbeing, our ten-year strategy.	Executive Director of Strategic Planning	Finance & Performance Committee

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

Lines of Defence

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

Key:

(1) First Line of Defence – Management level assurance

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

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

Risk Appetite

Key:

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

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

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

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

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

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

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

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

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

Gap in Assurances	Discharging patients is out of the Health Boards control			
Actions		**Lead**	**By when**	**Update**
1. Review of hospital acquired COVID 19 and COVID deaths (wave 1) being undertaken and monitored through Nosocomial C&V Programme Board.		Jason Roberts	30.09.23	Work ongoing. Review has commenced early learning shared with operational colleagues and it is informing the development of the recovery plan Review of deaths continues in line with WG requirements with oversight from Nosocomial National Programme Board
Impact Score: 5	**Likelihood Score: 2**	**Target Risk Score:**		**10 (High)**

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

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

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

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

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

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

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

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

	• T2 new area opened during Pandemic, but with no increase in staffing (loss of 6 beds on Delivery Suite, 14 opened on T2). • Community based care is expanding with the emphasis being placed on 'normal/low risk/need care being provided in community by midwives and MSWs. Reduced antenatal admissions and shorter postnatal stays result in an increase in community care. Midwives are undertaking the New-born and Physical Examination (NIPE) instead of paediatricians, either in hospital or at home. • With the publication of the latest NICE guideline on Antenatal Care that recommends that all women be 'booked' by 12 weeks' gestation, more women are meeting their midwife earlier than previously happened before 10 weeks. This early visit requires midwifery assessment/advice, but the pregnancy may end as a fetal loss, so the total number of postnatal women is less than antenatal. In most maternity services approximately 10% of women are 'booked' and then have no further contact with the midwife. • Constraints accommodating the increased number of Inductions of Labour (IOL) and instrumental deliveries within current footprint. • Good level of incident reporting but insufficient resources to complete investigations, action plans and learning from events actions. • Independent external Birth-rate+ re-assessment has been undertaken. The final report for CaV indicates a midwifery shortfall of 11wte.
Impact	• Closure of Community Home Birth Services and Maternity Led Unit due to lack of staff. • Delays in allocating IO's to investigations, subsequent delays in completing investigations, action plans and LFE • Rise in instrumental deliveries • Delays in IOL and constraints in accommodating elective caesarean sections due to lack of NICU capacity • Congested department and long waits for IOL & ECS • Insufficient consultant cover for labour ward, NCEPOD readmission reviews • Lack of specialist roles; labour ward leads, Foetal surveillance, bereavement, transitional care nursing. • Lack of training in Human factors, CTG, labour ward coordinator leadership. • Poor staff morale and retention due to the sustained pressures in the system • Worsening patient experience and outcomes (see separate risk on patient safety) and run of adverse incidents.
Impact Score: 5	Likelihood Score:5 | Gross Risk Score: **25 (Extreme)**
Current Controls	• Induction of 38 Newly qualified Midwives (NQM) and 43 Newly Qualified Paediatrics nurses from Student Streamlining • Introduction of daily clinical huddles between each days Lead Midwife, Lead obstetrician, lead neonatologist and lead neonatal nurse each day • Rollout of 3 extra consultant sessions for obstetric governance and 1 extra consultant session Neonatology governance to enable allocation of IO's to investigations • RAG rating of position against national report recommendations, presentation of gap analysis to executives and to senior Leadership Board for support of required resources • Continued recruitment actions • Board agreement to fund resource necessary to fully meet Ockenden recommendations • Escalation of concerns to HEIW re single out-turn of midwives and paediatric nurses • Establishment of monthly Ockenden Oversight group led by clinical board • Establishment of MatNeo oversight group led by Executive triumvirate • Team continue to support recruitment and retention, submission of request for oversea recruitment. • Daily SiteRep reporting introduced into maternity and Neonates and DoNM/HoM daily catch up

Current Assurances	• Operational position reported into Management Executive (Daily) (1) • Mechanisms in place to monitor key measures being strengthened into visible dashboard.(1) • Key operational performance indicators and progress against plans reported into the Maternity/Neonatal oversight Group being led by Executive Nurse Director. (1) • Midwifery on call manager linked into Executive evening huddle to clarify daily risks.		
Impact Score: 5	Likelihood Score: 3	Net Risk Score:	**15 (Extreme)**
Gap in Controls	• Confirmation of additional funding resource to fill gaps in assurance mapping • Recruitment strategies to sustain and increase multidisciplinary teams (appendix 1). • Developing an effective, high quality and sustainable model of managing intrapartum care and current constraints • Several incidents out of time • Ability to successfully recruit to additional posts agreed as part of Ockenden.		
Gap in Assurances	• Data and benchmarking information • Resources to meet the national recommendations		

Actions	Lead	By when	Update
1. Ongoing recruitment above establishment, increasing training places	AJ	30.11.23	This action continues to take place.
2. Reviewing current obstetric practice in line with NICE guidance	CR/SZ	30.09.23	This action continues to take place.
3. Senior daily oversight of obstetric /Neonatal capacity and escalation to Executives	AJ	30.11.23	This action continues to take place.
4. Continued maternity / Neonatology oversight meetings with Executive lead	JR/AJ	30.11.23	This action continues to take place.
5. Ongoing review of job planning and consultant establishment	CR/AT	30.09.23	Job planning undertaken further resource required to meet Ockenden recommendations. Supporting revenue case approved by Board 30.3.23
Impact Score: 5 Likelihood Score: 3	Target Risk Score:		**15 (high)**

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

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

Risk **Date added: 01/11/22**	There is a risk that the organisation will not be able to provide effective, high quality and sustainable critical care capacity.		
Cause	• There is a progressively deteriorating problem with access for critically ill patients to ICU in Cardiff as a direct result of capacity. This now means patients who would benefit from ICU admission and care are not able to have this. • Gap of 15 ICU beds in CAV (2014 unmet needs study WG) • Funded increase in tertiary workload has increased the overall demands on critical care services in CAV • Poor infrastructure within the critical care unit – limited access to cubicles • ~~Patient at Risk Team (PART) only operate during daytime hours (7am-7pm)~~Annual increase in demand for critical care services of approx. 4-5%		
Impact	• Adverse impact upon the Emergency Department and theatre flow • Untimely patient access • Inequity of patient access • 15% of referrals not admitted to critical care • Impact other operationally e.g. anaesthesia and theatres • Impact tertiary development e.g. ECMO • Patient outcomes worse • Reputation, Professional & Legal risk • Workforce - Reduced Recruitment & Retention • Poor staff morale and retention due to the sustained pressures in the system • Delayed admission and discharge from critical care leading to poor patient experience and outcomes		
Impact Score: 5	Likelihood Score:5	Gross Risk Score:	**25 (Extreme)**
Current Controls	• Strengthened site-based leadership and management • Strengthened OPAT oversight and support for DTOCs • Workforce plans in place to support recruitment and retention • Registered nursing recruited to establishment • Local escalation plan in place and utilised when appropriate to support operational pressures • PART team provide ~~daytime~~ 24/7 support for patients not admitted to critical care • Ringfenced PACU to protect high-risk elective urgent and cancer surgery • Winter escalation plan in place to support delivery of critical care to the sickest patients during the winter months		

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

Actions	Lead	By when	Update
1. Secure funding and develop implementation plan for further three ICU beds	PB	30/04/23	Complete – beds opened in Nov 23. ~~Board approved in April 2023~~ ~~Recruitment has commenced, beds planned to open on phased basis in 2023/24.~~ ~~On track for first bed to open Sept 2023~~
2. Implementation of 24/7 PART team	PB	31/10/23	~~Plan developed.~~ ~~Board approved in April 23~~ ~~Recruitment commenced, offers have been made to prospective candidates, on track to implement model by October 2023.~~ Complete – went live Oct. 2023
3. Implementation of the UHW site masterplan and critical care infrastructure programme a. Medium term development of additional cubicles and support facilities b. Development of a new unit as part of UHW2 development. c. Transfer of LTiV services to a bespoke facility in UHL	AH / PB	31.03.23	Approval from CMG/SLB to proceed with the Strategic Outline Case for Critical Care expansion and refurbishment. Approval from CMG/SLB to proceed with the Strategic Outline Case for Critical Care expansion and refurbishment. Aim to submit to WG in Q4 23/24. a. Design completed for C3S, further work required on design for C3N. The design will include additional cubicles to meet IP&C demand. (medium term plan to bridge to UHW2). b. Engaged with the Programme Director for UHW2 on future demand for CC to inform planning. c. LTiV/complex care now established on C3L. No current planning to create a bespoke facility in UHL

4. Ongoing development of recruitment and retention strategies		JR / RG	31.03.23	This piece of work continues
5. Winter Plan		PB	30.11.23	Additional planning and mitigation for winter will be required due to the co-location of PACU and CCU to facilitate the estates work needed to bring Cardiothoracic Surgery back to UHW. Potential for reduced flexibility to use PACU beds for escalation / DTOC. Alternative escalation plans being developed.
Impact Score: 5	Likelihood Score: 2	Target Risk Score:		**10 (high)**

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

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

Risk **Date added: 01/11/22**	There is a risk that the organisation will not be able to provide effective, high quality and sustainable cancer services.		
Cause	• The impact of the covid pandemic has resulted in sustained pressure across the planned care system due to the growth in backlog of patients waiting to access treatment. The pressure on capacity in outpatients, diagnostics and treatments to see elective patients in a timely manner has also impacted on those waiting on a cancer pathway. • Referral demand for cancer is now greater than pre-Covid levels and our planned care system has struggled to respond to this increase in demand and carve out sufficient capacity for cancer at outpatients, diagnostics, and treatments stages • There are sustained workforce pressures at a clinical level with challenges around recruitment and retention of staff • Weaknesses in the central cancer team in terms of changes of leadership, structure, vacancies and temporary staffing leading to lack of clarity and consistency		
Impact	• Long waiting times for first contact and diagnostics contributing to lengthening of the overall pathway for cancer patients • Overall PTL has grown 3-fold since pre-Covid • Significant volumes of patients now waiting >62 days and >104 days • Potential for harm e.g. missing the window of opportunity for surgical intervention, delays to starting chemotherapy/radiotherapy • Poor staff morale and retention due to the sustained pressures in the system • Worsening patient experience and outcomes (see separate risk on patient safety)		
Impact Score: 5	Likelihood Score:4	Gross Risk Score:	**20 (Extreme)**
Current Controls	• Strengthened governance and oversight • COO is now Executive Lead for Cancer • Cancer is one of the delivery programmes in the 2023/24Operational Plan • SOP in place to support tracking process • Roles and responsibilities redefined • Training being rolled out to refresh understanding of SCP guidance • Workforce team continue to support recruitment and retention • Ambition clearly stated – first contact by day 10, diagnosis by day 28, treatment by day 62 • Two cancer summits held with senior leadership teams, directorate management teams and tumour site clinical leads • Demand/capacity work commenced		

Current Assurances	• Operational position reported into Cancer Oversight Meeting weekly tracking improvements(1) • Weekly PTL tracking meeting with General Managers/Directorate Managers now in place • Weekly cancer delivery group in place with directors of operations owning accountability for improvements in delivery • Executive Cancer Board meets quarterly(1) • Mechanisms in place to monitor key schemes in Cancer as part of the Operational Delivery Plan (1) • Key operational performance indicators and progress against plans reported into the Finance & Performance Committee (1) • Breach reports produced for every patient treated >62 days (1) • Harm reviews conducted for every patient treated >146 days (1) • Cancer reported as part of the Board Integrated Performance report (1) The UHB will require Q2 in order to recover the current cancer performance standard after stalled progress at the end of Q1. This was largely an impact of increased waiting times for Endoscopy where there is now a clear plan of improvement		
Impact Score: 5	Likelihood Score: 3	Net Risk Score:	**15 (Extreme)**
Gap in Controls	• Continuation of demand/capacity work to inform how much capacity needs to be carved out for cancer • Undertake pathway work to streamline the journey for cancer patients and reduce the downtime between steps on the pathway • Recruitment strategies to sustain and increase multidisciplinary teams (see separate risk on workforce)		
Gap in Assurances	• Whilst a Cancer Oversight Meeting is in place, there is a need to establish a weekly PTL tracking meeting with General Managers/Directorate Managers • Breach reports need to be shared with the Directorates for validation and themes (e.g. risks/issues/constraints) need to be fed through a continuous improvement loop to ensure mitigation/solutions are put in place • The Cancer Strategy needs to be finalised and a workplan developed		

Actions	Lead	By when	Update
1. Continue to develop and iterate the demand/capacity work	MT	30.6.23	Complete. D&C reviewed weekly in cancer oversight meeting
2. Undertake a review of the key tumour site pathways with a view to removing constraints and delays in the patients' journey	MT	30.6.23	Partially complete. Individual pathways reviewed based on D&C analysis.
3. Finalise the Cancer Strategy and develop a workplan	RL/BW	30.06.23	Complete and published. Cancer services developing a workplan.
4. Development of recruitment and retention strategies	RG	31.03.23	See separate BAF risk on workforce
5. Delivery of cancer improvement plan – SCP and backlog – via revised governance structures	MT	Ongoing	Revised aim to meet SCP 75% standard by the end of Q4.~~New~~
6.			
7. Individual patient reviews of all longest waiting patients with Directors of Ops	MT	30.09.23	Complete. Longest waiting patients reviewed weekly for all specialities.~~New~~
Impact Score: 5	Likelihood Score: 2	Target Risk Score:	**10 (High)**

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

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

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

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

Risk **Date added: 01/11/2022**	Poor compliance with SSNAP – currently a C score.
Cause	• An increasingly busy ED (double the number of patients) has seen a high demand upon the Stroke Service. Patients are often self-presenting which may result in an initial delay to be triaged resulting in (i) delays to Stroke calls being put out (ii) delays to patients receiving CT scans within 1-hour (iii) delays in the recognition and subsequent delivery of thrombolysis to patients. • The Stroke Unit at UHW regularly runs at 100% occupancy. Every effort is made to ensure there is a bed available for new stroke admissions. The large volumes of patients in the ED mean there is often a delay in patients being triaged and assessed within 4 hours, making it difficult to get the patients to the acute ward within a timely manner. Patients awaiting admission to the stroke unit in September between them spent almost 70 days in the ED. • Pressures across the system have resulted in ~~mean that~~ Stroke beds ~~are often~~being used for non-Stroke patients. These short-term gains have long term impact on Stroke affecting the ability to admit new stroke patients within 4 hours, which has knock-on impact on specialist MDT assessments, commencement of rehabilitation and supportive discharge planning. Since the ringfencing of stroke beds in February, this situation has greatly improved with a commitment to protecting stroke capacity however the most challenging site pressures still have the potential to impact this ringfenced status. Performance against the 4 hours admit target is now ≥50% and this measure reached 70% in June 2023. • Since additional capacity beds which were collocated with stroke closed in August 22, performance against the 4 hours admit target improved to 20% in September. Support is needed to protect stroke beds for patients on the stroke pathway • Stroke CNS being pulled into ward numbers due to poor staffing levels. The CNS role is now protected and would only be pulled into ward numbers in the most exceptional of circumstances.

Impact	• Delays in patients receiving their CT scans within 1 hour • Delays in patients being recognised as potential Stroke patients • Delays in patients receiving timely treatment such as thrombolysis • Delays in patients being recognised as potential thrombectomy patients • Patients not receiving swallow screening in a timely manner (<4 hours) • Delays in patients being admitted to the acute Stroke ward in a timely manner (<4 hours) • Delays in patients leaving the acute Stroke ward (long lengths of stay, non-stroke patients being admitted due to ambulance waits) • Poor patient outcomes • Lack of available CRT slots or inappropriate CRT slots meaning patients in SRC are unable to be discharged in a timely manner		
Impact Score: 5	Likelihood Score:4	Gross Risk Score:	**20 (Extreme)**
Current Controls	• Awareness raising on the importance of early swallow screen assessment – training plan executed and improvement in performance evident. • ~~Awareness raising on the importance of early swallow screen assessment – investment in training over the summer needs reinforcement with the timing of swallow screen and its urgency.~~ • Taking any golden opportunities, we can – whenever there is capacity on the stroke unit, the stroke team are driving and pushing the ED stroke pathway to achieve the 4 hours admit wherever we can. The stroke team are real champions of the principles of 'Think Thrombolysis, Think Thrombectomy' and are pushing the imaging pathway to reach diagnosis as early as possible and ensure all patients are considered and assessed for urgent treatments which could reduce the disabling impact of the stroke. • Stroke Service Manager in post since July 22; Clinical Director for stroke in post from October 22. Dedicated resource for focused work with ED, radiology and medicine to ensure the optimal stroke pathway is in place and applied for all patients. • Seeking investment for uplift of CNS resource and dedicated stroke medical resource to support the front door for stroke. Clinical model now designed and being worked up through stroke summit meetings to produce full business case. • Wider programme of works is needed to continue momentum of a stroke service improvement programme, particularly given future requirements for regional network service delivery and for UHW to become the regional thrombectomy centre. • Protection of stroke beds from Feb 2023 • Roll out of ROSIER tool at triage from May 2023		
Current Assurances	• Operational position reported into MCB (Monthly) (1) • Mechanisms in place to monitor key schemes in Stroke Operational Group and MCB SMT/IM DPR (1) • Monthly touch point meeting with the Delivery Unit (1) • Improving SSNAP Grading for April to June 23 to Grade B		
Impact Score: 5	Likelihood Score: 3	Net Risk Score:	**15 (Extreme)**
Gap in Controls	Lack of consistent cover to the ground floor by a dedicated Stroke Medic CNS cover not 7/7 ~~Stroke beds not ringfenced~~ SRC capacity ROSIER compliance remains a challenge.		
Gap in Assurances	Competing demand on regional, thrombectomy and clinical board priorities		

Actions	Lead	By when	Update
1. Nursing Uplift Stroke CNS cover to 12 hour shifts 7 days per week. **Benefits** Increased out of hours CNS support to Code Stroke, facilitation of thrombolysis and	NT/JM/LP	31/05/2023	Next Stroke summit on 20.11.23 where staffing will be discussed~~Ongoing - Pilot continuing temporarily with~~

thrombectomy treatment pathways, 4 hours admit target and nurse assessments. **Interdependencies / Risks** Capacity and flow, medical support			~~CNS team supporting 12 hour shifts 7 days per week.~~ ~~Case being made for current pilot to be made permanent with a view to 24/7 CNS cover in the future. Proposal to be tabled at 5th Stroke Summit on 25.9.23~~
2. Medical Extend locum SHO for SRC in backfill of specialist middle grade moving to UHW front door (Mon-Fri 9-5) Collaboration with other specialities (e.g. neurology) to improve stroke junior doctor out of hours cover. May incur cost to medicine. Contribute 4 locum consultant sessions to a new post with ITU for a neuro critical care specialist with 4 stroke sessions Change of future models include hot clinics for TIA patients to support prevention of Stroke as part of the ongoing Stroke improvement plan. **Benefits** Cross speciality working - more sustainable OOH model and offers training opportunities. Reviewing the structure of the out of hours rota will offer further support to the medical on call team. Specialist middle grade and uplift of consultant sessions would support TIA clinic reconfiguration and front door senior decision making. Improved selection of patients for C4 beds, improved management of mimics in ED, acceleration of stroke assessment and diagnostics, improvement in 4 hours admit. This model offers the service an interim solution for winter demands, reducing the urgency of consultant uplift, allowing for planned succession and recruitment. **Interdependencies / Risks** Uplift is needed both in and out of hours. Locum posts are expensive but it is unknown if the workforce is there for external middle grade or consultant recruitment.	TH/NT/SB	31/01/2023	6 Front door sessions continue despite no longer continuing with locum SHO cover at SRC based on balance of risk. 4 vacant stroke sessions now covered in split ITU post from 1.8.23 on 12 month contract. Future clinical model for delivery 24/7 consistent stroke care to be presented at 5th stroke summit on the 20/11~~25/9~~/23. Will require significant investment. An enhanced shared front door model with Neurology ~~will be~~continues to be explored at the stroke summit on the 2~~5~~0/~~9~~11/23. Previous submissions did not meet service requirements so revised model with wider window to be presented.
3. Capacity C4 beds only to admit those patients on the stroke pathway with a protected minimum of 4 beds. Until additional capacity Winter beds open the ask is to cap medical outliers to 4 on the ward at any one time. **Benefits** – median number of admissions per day = 3 in September. 4 beds protected should offer admission capacity for most new stroke patients and we would hope to see the 4 hours admit performance >50%. When necessary to	NT/DP/NW/SB	31/03/2023	Completed - Ringfencing of all C4 stroke beds now in place and embedded. SOP agreed.

relieve pressure across the system medical outliers would be admitted; the cap would attempt to minimise the impact of these admissions on stroke performance. **Interactions/Risks** – Ability to create 4 beds each day once used is uncertain. Exit strategy needed for any medical outliers and stroke mimics. Flow needed across whole stroke pathway; community services to be approached re options to prioritise stroke beds in CRT slot allocation if possible.			
4. Diagnostics Daily imaging 'hot slots' for carotid dopplers/ MRIs/ CTA for stroke patients. **Benefits –** Timely diagnoses and treatment for both stroke patients and stroke mimics. Improved discharge profile to support protection of beds. **Interactions and Risks –** hot slots may not be needed every day (would be booked by 10am and released back to radiology if not needed). Ideally would operate over 7 days.	NT/TH	31/05/2023	Completed - New process of escalating urgent diagnostics in place which is responsive to requests in a timely manner. Hot slots no longer required.
Impact Score: 5	Likelihood Score: 2	Target Risk Score:	**10 (high)**

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

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

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

Current Controls	• Development of Primary Care Support Team to provide proactive support to fragile practices • Plans agreed and implemented for contract resignations and list closures • Rollout of MDT cluster model to further 2 clusters (1 already implemented) • Urgent Primary Care hubs in the Vale – c.4,000 appointments per month • Cardiff CRT and Vale CRT support people to remain at home, avoid hospital admission and be discharged from hospital – but challenges do remain on capacity and timeliness • Implementation of CAV24/7 and NHS Wales 111 • Strengthened site-based leadership and management • Urgent & Emergency Care is one of the five delivery programmes in the 2022/23 Operational Plan. Delivery Group in place. Urgent and Emergency Care System Plan developed, aligned to the National six goals – see actions. • Ambulance handover improvement plan developed and delivered improvements • Workforce team continue to support recruitment and retention • Local Choices Framework governance in place and utilised when appropriate to support operational pressures		
Current Assurances	• Operational position reported into Management Executive (weekly) (1) • Mechanisms in place to monitor key schemes in Urgent & Emergency Care Operational Delivery Plan (1) • Key operational performance indicators and progress against plans reported into the Finance & Performance Committee.. (1) • Urgent and Emergency Care reported as part of the Board Integrated Performance report (1)		
Impact Score: 5	Likelihood Score: 3	Net Risk Score:	**15 (Extreme)**
Gap in Controls	• Actively scale up multidisciplinary cluster models • Recruitment strategies to sustain and increase multidisciplinary teams (see separate risk on workforce)Developing an effective, high quality and sustainable Acute Medicine modelReconfiguring our in-hospital footprint to improve efficiency and patient flow		
Gap in Assurances	N/A		

Actions	Lead	By when	Update
1. Secure funding and develop implementation plan for further MDT cluster rollout and Urgent Primary care Centre in Cardiff	LD	31/7/23	Coverage is planned to increase to 84% before the end of the financial year. A review of future roll out will then be undertaken.~~Focus continues on UPCC, programme being delivered via Six Goals programme, coverage not yet at 100%,~~
2. Develop cohesive Winter Plan that introduces 150 beds or bed equivalents	PB	30/11/22	Complete
3. Develop acute admission protocols	MJ	05/06/23	Complete
4. Continued development of joint Health and Social Care strategies to allow seamless solutions and services for patients with health or social needs	AH / PB	31/03/23	Partnership working continues. Joint action plans in place
5. Introduce integrated care assessment unit as part of the Winter Plan to discharge patients into UHW Lakeside for focused social care intervention whilst maintaining care.	PB	31/10/22 - 31/01/23	Complete

6.	Implementation of the UHW site masterplan, including de-escalation of additional capacity and reconfiguration of the EU	PB	31/07/23	Complete first phase.~~. The first phase of the UHW reorganisation has been completed – closure of speciality hub, provision of assessment wards on A1, ward moves to facilitate. Work has now turned to getting the models embedded and performing.~~
7.	Development of recruitment and retention strategies	RG	31/03/23	See separate BAF risk on workforce
8.	Review trauma pathways across UHW and UHL and agree make-up of both ambulatory, same day urgent and emergency and inpatient services and footprint	PB	30/8/23	Ongoing. Revised aim to complete by 30.09.2023
9.	Develop business case for "safer home" multi-disciplinary team that caters immediately for people in crisis to support locally and timely rather than admit into hospital	PB	30/8/23	Business case for first stage now supported and will go live in Q4~~Business case for Safer at home in development with a revised target date of 31st October.~~
10.	Delivery of redesigned Emergency Department – CDU, Paeds CDU, e-triage	PB		Q4 go-live for adult and paeds CDU and e-triage
11.	Development and approval of the 2023 / 24 Winter Plan	PB	30/09/2023	Winter plan has been supported and is on track ~~New~~
12.	Review of Board round processes as part of bed pressure and length of stay programme	PB	30/09/23	Plan is being discussed through SLB 2/11/23 and a taskforce to educate and develop learning on wards, including the role out of STAMP is underway ~~New~~
Impact Score: 5	Likelihood Score: 2	Target Risk Score:		**10 (high)**

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

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

Risk **Date added: 01/11/22**	There is a risk that the organisation will not be able to provide effective, high quality and sustainable planned care services.		
Cause	• The impact of the covid pandemic has resulted in sustained pressure across the planned care system due to the growth in backlog of patients waiting to access treatment. The pressure on capacity in outpatients, diagnostics and treatments for urgent/emergency care has impacted on those waiting to access the system for planned care. • Referrals for planned care are at pre-Covid levels overall, however there is significant variation between specialities. Whilst our planned care system (outpatients, diagnostics, treatments) is almost back to full capacity, it has been challenging to achieve activity levels significantly above pre-Covid activity. • There are sustained workforce pressures at a clinical level with challenges around recruitment and retention of staff		
Impact	• Significant volumes of patients waiting for new outpatient appointments, diagnostics and treatment • Some patients are tipping over into waits of more than 3 years, some of these are still at the outpatient stage • Potential for harm in terms of clinical deterioration whilst patients are waiting, particularly at the outpatient stage where patients have yet to be seen by a secondary care clinician and priority determined • Poor staff morale and retention due to the sustained pressures in the system • Worsening patient experience and outcomes (see separate risk on patient safety) • Organisational/reputational harm due to political and media interest and scrutiny		
Impact Score: 4	Likelihood Score:4	Gross Risk Score:	**16 (Extreme)**
Current Controls	• Planned Care is one of the delivery programmes in the 2023/24 Operational Plan • Demand/capacity work undertaken to model expected delivery against the ministerial measures • Additional capacity schemes funded through WG planned care monies are in place and delivering e.g., mobile ophthalmology theatres, 2nd gynae treatment room commissioned, spinal unit commissioned, mobile endoscopy unit in place, additional waiting list initiative clinics • Workforce team continue to support recruitment and retention • Suite of reports and dashboard created by the Digital and Healthcare Intelligence team to support Directorate teams and Clinical Board in terms of managing the planned care position		

Current Assurances	• Current position against 52/104weeks monitored via weekly Planned Care Performance meeting (1) • Operational position reported into daily/weekly 'hot' reports(1) • Planned Care Delivery Board in place bi-weeky; suite of metrics reviewed at every meeting (1) • Monthly meeting with the NHS Executive on Planned Care(1) • Mechanisms in place to monitor key Planned Care schemes as part of the Operational Delivery Plan (1) • Key operational performance indicators and progress against plans reported into the Finance & Performance Committee (1) • Planned Care reported as part of the Board Integrated Performance report (1)		
Impact Score: 3	Likelihood Score: 4	Net Risk Score:	**12 (High)**
Gap in Controls	• Availability of planned care funding may mean that choices need to be made in terms of delivery • Further work required to maximise treat in turn • Delivery of solutions required to ensure all specialities can access sufficient capacity to enable a return to pre-Covid levels of activity • Recruitment strategies to sustain and increase multidisciplinary teams (see separate risk on workforce)		
Gap in Assurances	• Whilst a sub-group on supporting patients whilst they are waiting has been established, the group is in its infancy and needs to progress at pace		

Actions	Lead	By when	Update
1. Continue to develop and iterate the demand/capacity work for 23/24 to inform the IMTP	AW/JC	31.1.23	. Complete. Revisions have been made against the new ministerial targets.
2. Development of recruitment and retention strategies	RG	31.03.23	See separate BAF risk on workforce
3. Implemented High Volume Low Complexity (HVLC) lists in UHW to reduce long waiting patients	RT	01.10.23	HVLC lists due to start in Q3.
4. Implement mobile diagnostic solution in UHL (in advance of community diagnostic hub)	SL	01.11.23	Procurement complete, implementation date currently being negotiated planned for the first week in January
5. Develop plan for UHL HVLC lists – to be delivered in 2024/25 (Q1)	RT	01.11.23	Start date of Q1 on track for delivery
6. Weekly patient level tracking with COO's office of the extreme long waiters	MT	01.11.23	In place and continuing
Impact Score: 4 / Likelihood Score: 2	Target Risk Score:		**8 (High)**

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

The COVID-19 pandemic compounded existing health inequalities in Wales, which have shown little improvement in the last ten years, based on the gap in life expectancy between the most and least deprived fifth of the population. Although the main disparities have been age, sex, deprivation and ethnicity, there is clear evidence of intersectionality, risk factors compounding each other to further disadvantage individuals with protected characteristics (based on the Equality Act 2010).

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

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

Risk	There is a risk that the exacerbation of inequalities due to the harms caused by the COVID-19 pandemic and cost of living crisis will reverse progress in our goal to reduce the 12-year life expectancy gap, and improvements to the healthy years lived gap of 22 years.
Date added:	29.07.21
Cause	• Health inequalities arise in three main ways, from ○ structural issues, e.g. income, employment, education and housing ○ unhealthy behaviours ○ inequitable access to, or experience of, services, which can be a result of discrimination due to inaccessible services, public information or healthcare sites that may be relevant/pertinent to their particular needs • Deaths from COVID-19 have been almost double in the most deprived quintile when compared with the least deprived quintile of the population in Wales, and there has been a disproportionate rate of hospitalisation and death in ethnic minority communities • In Wales, socio-economic health inequalities in COVID-19 become more pronounced further along the hospital treatment pathway. Based on data from the first few months of the pandemic we can see that inequalities were not particularly pronounced for confirmed cases (unlike England) but the gradient became bigger for admissions, ICU and deaths. This may be related to the idea of staircase effects whereby health inequalities accumulate across the system and the 'inverse care law' whereby people from deprived areas may not seek help until later when their condition has deteriorated, which may be related to accessibility, health literacy and competing demands on their time. The role of the healthcare organisation in flexing to provide effective treatment according to individual need along that pathway is key • It follows, therefore, that services run by organisations which do not address their own structural issues (nor advocate others to do so), do not support staff and their population to take up healthier, or reduce health-harming, behaviours, and which are not tailored towards reducing inequalities will fail to address the causes of increasing health inequality • The impact of inflation leading to the 'cost of living crisis' currently being experienced in the UK, with rising prices for energy (gas, electricity) and fuel (petrol, diesel) food and other goods and services has a negative impact on health as real disposable incomes fall with this being more marked in lower income

	households. High inflation also risks exacerbating mental health challenges with concerns about debt being a leading cause of anxiety
Impact	• The key population groups with multiple vulnerabilities, compounded or exposed by COVID-19, include: ○ Children and young people ○ Minority ethnic groups, especially Black and Asian populations ○ People living in (or at risk of) deprivation and poverty ○ People in insecure/low income/informal/low-qualification employment, especially women ○ People who are marginalised and socially excluded, such as people who are homeless • Risk factors interact and multiple aspects of disadvantage come together, increasing the disease burden and widening equity gaps. Underlying chronic conditions, as well as unequal living and working conditions, have been found to increase the transmission, rate and severity of disease including COVID-19 • The longer-term, and potentially largest, consequences for widening health inequalities can arise through political and economic pathways. Areas with higher unemployment have greater increase in suicides; and people living in the most deprived areas experience the largest increase in mental illness and self-harm • This is not simply a social injustice issue, health inequalities are also estimated to cost £3-4 billion annually in Wales through higher welfare payments, productivity losses, lost taxes, and additional illness • The total annual cost associated with inequality in hospital service utilisation to the NHS in Wales is estimated to be £322 million, equivalent to 8.7% of the total hospital service expenses, driven largely by higher service use among people living in the more deprived areas compared to those living in the least deprived areas (PowerPoint Presentation (nhs.wales) • This remains an uncertain time with concerns about resurgence of COVID-19 which disproportionately impacts the most vulnerable in society, together with the economic impact of the rapid increase in inflation. This may mean that health inequalities widen if public policy and local interventions do not act to rectify this imbalance swiftly. However, most levers for economic action are at the UK government level. Warmth and food availability will be key issues locally

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

Current Controls	**1. Statutory function** The Socio-economic Duty places a legal responsibility on public bodies in Wales when they are taking strategic decisions to have due regard to the need to reduce the inequalities of outcome resulting from socio-economic disadvantage. Approaching implementation of the Socio-economic Duty effectively will help us maximise our contribution to addressing such inequalities, and also to meet our obligations under the Human Rights Act 1998 and international human rights law. Of note, but more of a reputational risk, if an individual or group whose interests are adversely affected by our strategic decision, in circumstances where that individual or group feels the Duty has not been properly complied with, they would have the right to instigate a judicial review claim against the UHB. **2. Role as an Employer** • In our Equality, Inclusivity and Human Rights Policy, we have an active programme, which sets out the organisational commitment to promoting equality, diversity and human rights in relation to employment, and ensuring staff recruitment is conducted in an equal manner • Our Strategic Equality Plan 'Caring about Inclusion 2020-2024' has a number of key delivery objectives and is premised on the basis of embedding equality, diversity and human rights, and Welsh language, into UHB business processes, for example: Recruitment and Selection Policy, Annual Equality Report, Equality reports to the People & Culture Committee, Reports/Updates to the Centre for Equality and

	Human Rights, Outcome Report to the Welsh Government Equalities Team regarding sensory loss, provision of evidence to the Health and Care Standards self-assessment, Equality and Health Impact Assessments • All our Executives have taken up a leadership role across the nine protected characteristics specified in the Equality Act 2010 - age, disability, gender identity, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation - our CEO is the lead for race • In August 2022 the Chancellor recognised that support is needed even for staff on wages up to £45,000 and included senior nurses in this description to manage increased energy bills. Staff have been signposted to resources to help them to cope with the cost-of-living crisis **3. Refocused Joint strategic and operational planning and delivery** • The refresh of the UHB Strategy Shaping our Future Well-being continues to shine a light on the issue of equity at the strategic level • Each of our strategic programmes within Shaping our Future Well Being Strategy will consider how our work can further tackle inequalities in health • Our Shaping our Future Public Health strategic programme has a focused arena of work aimed at tackling areas of inequalities. We are working closely with the two local authorities and other partners, through our PSBs and RPB partnerships to accelerate action in our local organisations and communities, particularly in relation to healthy weight, immunisation and screening. This includes building on local engagement with our ethnic minority communities during the Covid-19 pandemic. Such focused work is articulated in 'Cardiff and Vale Local Public Health Plan 2023-26' within our UHB three-year plan, and has been strengthened in 2023/24 by the development of a strategic framework for tackling equity, equality, experience and patient safety • Through our PSB and RPB plans we already prioritise areas of work to tackle inequalities and the refreshed needs assessments for both PSBs and RPB will further identify collective actions • The Youth Justice Board is implementing the recommendations of our Public Injecting & Youth Justice Health Needs Assessments in Cardiff • Cardiff PSB and Cardiff and Vale Substance Misuse Area Planning Board are implementing the recommendations of its Needle Exchange programme review to tackle health inequality as part of COVID-19 substance misuse recovery work • Our Suicide and Self-Harm Prevention Strategy has been published • The multi-agency approach to Seldom Heard Voices, which targeted initiatives towards areas of deprivation during the pandemic e.g. walk in vaccine clinics, will continue as we move through recovery. • The Annual Report of the Director of Public Health (2020), published in September 2021, focusses on reducing inequity and sets out a vision for future partnership working that will enable us to recover strongly and more fairly. • The latest Annual Report of the Director of Public Health report on value, (published January 2023) also contains a chapter which focuses on the relationship between a Value-based approach and reducing inequities.
Current Assurances Saunders,Nathan 20/11/2023 15:51:45	We have identified a bellwether set of indicators to help measure inequalities in health in the Cardiff and Vale population through which we will develop further to measure impact of our actions. This formed part of the Annual Report of the Director of Public Health 2020, published September 2021 (1). Examples include: • The gap in healthy life expectancy at birth between the most and least deprived in Cardiff and Vale UHB reduced from 16.6 years in 2017/19 to 14.4 years in 2018/20 for males. In females however, the gap increased from 14.6 years in 2017/19 to 18.0 years in 2018/20. Neither of these estimates yet takes account of the impact of the pandemic. • As of 10 Dec 2022, the gap in coverage of COVID-19 autumn 2022 booster vaccination between those (all ages) living in the least deprived and most deprived

	areas of Cardiff and Vale UHB was 29.8%, with fewer people vaccinated from the most deprived groups. This compares to a gap of 23% across the whole of Wales between those in the least deprived groups compared to those living in the most deprived groups. • Discussions with Public Health Wales have been held to support the development and regular monitoring on health inequities. • A gap analysis of health inequalities data has been undertaken as part of a national exercise which indicates that data collection on date of birth and postcode are good but that this drops considerably for other important variables.		
Impact Score: 4	**Likelihood Score: 3**	**Net Risk Score:**	**12 (High)**
Gap in Controls	• Unidentified and unmet healthcare needs in seldom heard groups • Capacity of partner organisations to deliver on plans and interdependency of work		
Gap in Assurances	• Monitoring data (often managed via external agencies) and establishing trends difficult to determine over shorter timescales		

Actions	Lead	By when	Update
1. Embed a 'Socio-economic Duty' way of thinking into strategic/operational planning, *beyond* complying with our statutory duty	Fiona Kinghorn /Rachel Gidman	2023/24	We plan to strengthen the strategic response to the Socio-economic Duty, ensuring actions are systematically applied. The EHIA process is being reviewed on an All Wales basis with the view of creating a Once for Wales approach. C&VUHB will contribute to the development and implementation. Our UHB will continue to work collaboratively with our stakeholders to shape our services and culture.
2. Within the UHB and through our PSB and RPB partnerships, develop and deliver a suite of focused preventative actions to tackle inequalities in health	Fiona Kinghorn	March 2024	Suite of preventative actions to tackle inequalities developed with PSB and RPB partnerships. The first year of Amplifying Prevention has strengthened collective action being taken by partner agencies to address inequalities, particularly in relation to communication with people who live in C&V and staff. The second year will additionally include a focus on targeted work with communities and settings known to experience inequity. Following publication of the Population Needs Assessment and the two

		April 2024	Wellbeing Needs Assessments, tacking inequalities is recognised as a priority for all local and regional partner organisations. A comprehensive Health Needs Assessment for Inclusion Health has been completed, a Programme Board for Health Inclusion has been established, and a clinical model is being worked through.
		June 2023 Sep 2023 and every 6 months	An equity, equality, experience and patient safety strategic framework went to the SLB in June 2023, and to the Board Development session in June 2023 and has been shared with the Local Partnership Forum. The Framework will go to Board in Sept 23 for formal adoption, then updates will be made to Board on implementation every 6 months.
3. Improve the routine data collection in relation to equality and inequity, both across the UHB and with partner organisations, and develop a broader suite of indicators to monitor progress	Fiona Kinghorn	March 2023 June 2023 January 2024	High level Amplifying prevention indicators developed. More granular indicators and evaluation to be developed in year. The national Gap analysis of health equity data collection was well responded to by C&VUHB teams, and the local survey results are to be discussed at the next C&VUHB Value Based Healthcare and Data Improvement Groups. The insight from these discussions will help lead to the development of a suite of indicators that can help us to monitor health inequity over time at the population level, and support services to consider indicators that relate to specific services.

				There are improvements that need to be made in the routine collection of protected characteristics in order to support the introduction of new indicators, this will need to be addressed by each Clinical Board.
Impact Score: 4	**Likelihood Score: 3**	**Target Risk Score:**		**12 (High)**

9. ~~Workforce~~ Attract, Recruit and Retain – Executive Director of People and Culture (Rachel Gidman)

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

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

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

Risk **Date added:** **6.5.2021**	There is a risk that the ~~organisation~~ Health Board will not be able to attract, recruit and retain ~~people to work in our clinical teams~~ people to deliver high quality care and essential services for the population of Cardiff and the Vale.
Cause	~~• in the NHS~~ ~~The unprecedented events of the last three years have placed significant pressure on our workforce, due to increased demand on services. Demand for staff has been significantly higher than the supply which has meant that our existing teams have been placed under extreme pressure.~~ • The increased demand across the NHS and Social Care has left a shortage in some professions and the sustained pressures have impacted negatively on wellbeing and retention ~~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 have 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).~~. • ~~etention has improved overall but remains high in certain professions/areasTurnover remains higher than pre-pandemic levels but since November 22 it has improved slightly , from 13.66% to 12.81%.~~ ~~• Sickness Absence rates remain high; although the rates appear to be falling to more 'normal' levels. The monthly sickness rate for July 2023 was 6.12% and August2023 was 5.89%, after an all-time high of 8.56% for December 2023.~~ ~~• Significant operational pressures across the whole system sover the last three years has impacted negatively on the health and wellbeing of our staff.~~ ~~• The development of our existing workforce has reduced as a direct result of t significant operational pressures, which is impacting negatively on retention.~~ • Attraction, recruitment and retention is also being affected by the negative image that is portrayed that NHS staff do not receive the right remuneration for the work that they do. The Industrial Action that commenced in December 2022 has not helped the national reputation of the NHS as an employer. • People now think differently about work and what is important to them.
Impact	~~•~~ ~~Negative impact on our people and our teams, as a result we are experiencing:~~ - Higher levels of sickness absence • ~~and~~ Llack of management capacity to support staff appropriately; - Higher levels of turnover; - Low morale and poor staff engagement; - Increased reliance on temporary workforce e.g. bank, agency, locums, etc;

- Reduced capacity to undertake appraisals, identify development needs, and focus on talent management and succession planning.

- Lack of capacity to upskill and develop our current workforce.
- Reduction in uptake of student training places and higher attrition rates, resulting in a reduction of graduates.

- ~~We are starting to see improvements in the above areas; we need to sustain this improvement going forward~~
- Potential n~~N~~egative impact on quality of care & safety. ~~provided to the population.~~
- ~~Inability to meet on-going demands, operational pressures and needs of our workforce~~
- Inability to expand services as required due to lack of staff with the relevant experience, skills, etc.

Impact Score: 5	Likelihood Score: 5	**Gross Risk Score:**	**25 (Extreme)**

Current Controls

- The People and Culture Committee ~~was established in May 2023 to~~ provide more scrutiny and assurance to Board.
- People and Culture Plan in place with a robust governance structure ~~processes to~~ monitoring ~~progress~~delivery against the agreed~~key~~ priorities.~~deliverables~~.
- Monthly Executive Review meetings with Clinical Boards.
- Strategic oversight meetings, e.g. NPG, MWAG, ~~Workforce Sustainability Group.~~
- ~~Heads of People & Culture have been reintroduced into the Clinical Boards to provide additional support with strategic priorities, including delivery of P&C Plan, workforce planning, retention, workforce redesign, sustainability, etc.~~
- ~~Hotspots are identified using our workforce data, plans are coproduced to support with recruitment, retention, staff wellbeing, etc.~~
- ~~The People Resourcing team continue to improve the way we attract and recruit, they will ensure that any recruitment needed for the remodelling of clinical areas is achieved in a timely manner.~~
- ~~The Staff Bank are continuing to focus on increasing the supply of HCSW and RN's on the bank which will support the reduction of agency usage and improve quality. They are also increasing the variety of roles employed by the bank to avoid Agencies which has included Geneticists, pharmacists, Allied Health professions etc.~~
- ~~A Retention Toolkit has been developed and a number of bespoke action plans have been initiated in some of the hotspot areas to ensure problems are addressed urgently.~~
- ~~Starter Survey implemented for all newly appointed novice nurses to identify their experience of working at C&V UHB during their first 3-6 months of employment.~~
- ~~The People Services Team are aligned to Clinical Boards, to provide specialist advice and support aligned to the organisation's priorities, e.g. reducing sickness absence, reducing formal ER cases, effective change management, etc.~~
- ~~Focussed recruitment campaigns to improve the diversity of our workforce and to positively benefit the local community.~~
- ~~Welsh Government Campaign *Train, Work, Live* to attract for Wales – GP, Doctors, Nursing and Therapies.~~
- ~~Medical Workforce Advisory Group (MWAG) progress and monitor employment matters that directly affect our Medical & Dental staff.~~
- ~~Centrally managed Medical and Dental Staff Bank in place to increase the supply of doctors (using temporary workforce), maintain quality and reduce costs. Fill rate is consistently over 95%.~~
- ~~E-Job Planning system in place to ensure Consultants and SAS Doctors have their job plans reviewed and approved annually.~~

Saunders.Nathan 20/11/2023 15:51:45

- ~~Health & Wellbeing strategy monitored through the strategic Health & Wellbeing Group.~~
- ~~Monthly Clinical Board Reviews with a focus on improving our workforce position are now well established.~~
- ~~Monthly Nursing Productivity Group to review nursing workforce metrics and develop appropriate plans to improve performance.~~
- ~~Baseline Workforce Plans have been developed for each Clinical Board initially concentrating on our Nursing workforce, which is the staff group where we have the biggest gap in supply. Workforce Plans are also being developed for our Medical workforce. The aim is to have workforce plans for all our Clinical/Service Boards for all staff groups within the next 12 months.~~
- ~~Modernising the ward skill mix with the introduction of Band 4 Assistant Practitioners will partly address the Registered Nurses vacancies that we have within the UHB. It will enable the RNs to do what only RNs can do by providing them with appropriately trained staff that meet the needs of the patients.~~
- ~~The implementation of Band 4 Assistant Practitioner roles has also enabled a further RN recruitment pipeline for international nurses who can undertake an OSCE to progress to an RN role within potentially 3-6 months.~~

Current Assurances

- Robust monitoring of People and Culture Plan KPI's at the People and Culture Committee and Board. (1)
- ~~Fortnightly monitoring of workforce sustainability priorities through the Sustainability Programme Board.~~
- ~~Monthly monitoring and forecasting of RN, ODP and HCSW vacancies .~~
- Qtrly IMTP/Annual Plan ~~U~~ updates to WG.
- WG JET and IQPD
- Effective partnership working with Trade Union colleagues (WPG, LNC, LPF). (1)
- ~~Workforce Sustainability Group, aligned to Sustainability Programme Board~~

Impact Score: 4	Likelihood Score: 4	**Net Risk Score:**	**16 (Extreme)**

Gap in Controls

Agreed Retention Plan for all staff.
Retention & OD Lead for the UHB
Workforce supply affected by National Shortages.

Gap in Assurances

Actions	Lead	By when	Update
~~Recruitment &~~ Agreed Retention Plan for all staff, aligned to HEIW Toolkit and HEIW Nurse Retention Plan. ~~and Plans approved by UHB~~	Jonathan Pritchard	31/01/24	

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

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

In line with UHB's Strategy, Shaping Our Future Wellbeing and aligned to the Healthier Wales plan (2018), the case for change is pivotal to transfer our services to ensure we can meet our future challenges and opportunities. Creating a ~~belief~~culture 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~~they are overwhelmed with system pressures, change and ongoing demands ~~as a result of the pandemic~~. • Staff ~~not understanding the~~are not feeling involved in, or understanding the part their role plays for the case for cultural 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 / respect and resolution • Transformation of services may not happen due to staff reluctance to drive the change through improvement work. • Patient experience ultimately affected. • UHB credibility as an employee of choice may decrease • Staff experiencing fatigue and burnout making active and positive engagement in change challenging and buy-in difficult to achieve. • Existing inequalities exacerbated • Not realising the opportunities within workforce sustainability		
Impact Score: 4	**Likelihood Score: 4**	**Gross Risk Score:**	**16 (Extreme)**
Current Controls	• The People and Culture Committee provide more scrutiny and assurance to Board. • People and Culture Plan in place with a robust governance structure monitoring delivery against the agreed priorities.. • Monthly Executive Review meetings with Clinical Boards. • Strategic oversight meetings, e.g. NPG, MW Values and behaviours Framework in place • Cardiff and Vale ~~Transformation story and narrative~~UHB refreshed strategy: Shaping Our Future Wellbeing • ~~Leadership Development Programmes, e.g. Acceler8 and CLIMB supporting inclusive, compassionate leadership principles~~ • ~~Management Programmes offering a blended approach to learning and including development around change and transformation~~ • Talent management and succession planning framework ~~cascaded through the UHB~~ • Values based recruitment / appraisal • ~~Staff surveys results and actions taken, including NHS Staff Survey and Medical Engagement Scale~~. • ~~Involvement in All Wales NHS Staff Engagement Working Group~~		

	• ~~Increasing the diversity of the workforce through the Kickstart programme, Apprenticeship Academy, Project SEARCH; development of UHB action plans, e.g. Anti-Racist Action Plan~~ • Strategic Equality Plan • Anti-Racist Action Plan • Workplace Race Equality Standards (2024) • Welsh Language Standards • Patient experience score cards • ~~CEO and Executive Director of People and Culture sponsors for culture and leadership~~ • Raising concerns procedure/Freedom to Speak Up. ~~UHB part of all Wales Group looking at Freedom to Speak Up across NHS Wales~~ • ~~Interviews conducted with senior leaders regarding learnings and feedback from Covid 19 and lessons learnt document completed in September 2020 looking at the whole system. Discovery learning report completed in the Autumn 2020~~ • ~~Strategic Equality Plan and Welsh Language Standards implementation and monitoring via the Equality, Diversity, Inclusion and Welsh Language Team~~ • ~~Executive Team identified as Inclusion Ambassadors, each leading on a Protected Characteristic, and Welsh Language, being cascaded throughout Clinical Boards~~Adoption of consistent, evidence based approach to Culture and Leadership via the NHSE Culture and Leadership Programme		
Current Assurances	Internal Audit on Staff Wellbeing, Culture and Values (Sept 2022) report [3]; Engagement of staff side through the Local partnership Forum (LPF) [1] Matrix of measurement now in place which will be presented in the form of a highlight report to Committee [1]		
Impact Score: 4	**Likelihood Score: 2**	**Net Risk Score:**	**8 (High)**
Gap in Controls	~~Agreed and consistent organisational approach to cultural change~~ ~~Continued high demands impacting on ability to release staff for development / involvement in transformation / development~~ No leadership / management principles as a UHB (currently align with HEIW compassionate leadership principles) No organisational cultural dashboard		
Gap in Assurances	VBA rate continues to be low but is increasing across the UHB Capacity to respond to requests for cultural and transformation work Effective measures of culture / engagement		

Actions	Lead	By when	Update
~~1. Learning from Canterbury Model with a Model Experiential Leadership Programme- Leadership Programmes have been developed:~~ ~~(i) Acceler8~~ ~~(ii) Collabor8~~ ~~(iii) Climb~~ To develop management and leadership development where Compassionate and inclusive leadership principles will be at the core of all the programmes. Saunders,Nathan 20/11/2023 15:51:45	Rachel Gidman	~~November 2023~~March 2024 ~~September~~ November 2023 – March 2024	~~Acceler8 Senior Leadership Programme Cohort 2 ended in May 2023. Evaluation is currently postponed while we await outcomes of internal audit review re Leadership and Management Development.~~ Internal advisory audit report received. Management actions have been submitted and work on developing Leadership and Management Principles in collaborations with key stakeholders will commence December 2023. The Collabor8 Leadership programme, Cohort 1 has closed ~~and an evaluation is under way~~. ~~A second Cohort is planned for Autumn 2023,~~

		December ~~November~~ 2023 – March 2024 ~~September~~November 2023 – ~~December~~March 2024~~3~~ ~~July – November~~ February 2024~~2023~~ ~~July - November 2023~~ March 2024 ~~September – December~~November 2023 – February 2024 ~~July – November~~November 2023 – March 2024~~2023~~	~~which will be followed by a programme review.~~ A review of the programme will take place based upon the audit findings, and the work around leadership and management principles. ~~The review of a CAV Leadership Development Strategy is underway looking to develop the~~The project plan for developing 'leadership principles' ~~and competencies of~~ within CAVUHB is in development based upon the findings of the audit advosory report. Engagement in development will take place between December 2023 and March 2024. ~~A mapping exercise has been concluded and currently awaiting results of internal audit advisory piece which will springboard this piece of work.~~ Education, Culture and OD Team ~~(previously LED) have~~will schedule~~d~~ the management development offer to ~~December 2023~~March 2024. Programmes for April 2024 onwards to be determined ~~and communicated~~ following ~~outcomes of audit advisory piece and NHS Wales Staff Survey findings~~engagement in principles, NHS Wales Survey findings and based upon advisory audit management response. ~~Development of the UHB coaching network continues. An organisational 'call out' for qualified coaches to take place Autumn 2023. A new role has been established within ECOD to support Coaching and Talent Management.~~ECOD team are supporting inexperinced

			coaches to complete qualification and achieve coaching hours required. A review of coaching qualification route is taking place to look at the inclusion of more practical experience, e.g. Agored Cymru.
		~~June - October 2023~~December 2023	~~Working with Worth Consulting and the Head of EDI in order to identify most effective means of supporting mentors~~ECOD department developing 'good practice' guidance and support for mentors. This will be aligned to support retention plans, and in the future, 'reverse mentoring'. This work will link to SEP and Ani-Racist Action Plan. ~~Networks to be engaged with in Autumn 2023 to decide how best to engage with and develop potential mentors.~~
		~~August – December 2023~~January 2024	
		~~July – December~~November 2023	~~Staff turnover has impacted on delivery of Coaching Supervision – this need is being reviewed versus accessing external supervision for UHB coaches.~~ ECOD team working with Worth Consulting to develop in-house practical coaching supervision training for qualified and experienced coaches. Qualification (Level 7) to be reviewed March 2024.
		~~July – October~~November 2023 - January 202~~3~~4	
		~~July~~December 2023	Simplified VBA process continues to be communicated and the 2 hour on-line training runs monthly~~is ongoing~~ to support both managers and staff and is well attended. The training also forms part of the management programmes.
		~~July – December 2023~~	Simplified paperwork has been agreed and is part of

		~~May-June~~November 2023 – March 2024 ~~May 2023~~ November 2023 – January 2024 November – December 2023	communication and training. All CBs have provided an action plan and trajectory for achieving VBA targets and this is discussed at Executive Reviews. The HoPC link closely with ECOD to identify areas requiring additional support. ~~by March 2023 (60%) and June 2023 (85%). VBA training continues to be well attended and compliance is showing an increase. Update paper went to P&C Committee 13th July, recommendation to review again in November 2023.~~ The ALAS Culture and Leadership Programme (CLP) discovery phase has been completed . ~~Analysis and recommendations have been presented and a whole team development session is scheduled for October 2023 to share findings and co-produce actions. This will then move on to the delivery phase.~~ Whole departmental day scheduled for December 14th 2023 where production of actions will be commenced and findings explored. Programme of work to be developed by the ALAS DMT for next 12-18 months with support from P&C Team. ~~There has been an increase in the number of requests to facilitate cultural programmes/OD work within directorates and teams. The CLP approach shared with SLB and P&C Committee in August and September 2023. Executive Team to assess and identify priorities areas.~~ The Culture and Leadership Programme has been approved and adopted as a consistent approach to support cultural work. Culture Summit held in

			August, paper taken to SLB and P&C Committee. P&C team working with COO and Executive Team to identify priority areas. ~~Work in two additional areas already in development.~~ Theatres UHL currently at the end of Phase 2 (Discovery) ~~(Starts 11th September), and CHfW (starts September 2023).~~, ALAS in Phase 3 (Design), other areas identified as priorities in Phase 1 – scoping. Radiology planned for January 2024. OD ~~support for UHB strategic programmes also requested, SOFH, SOFCS etc and~~ challenges to capacity being discussed. Agreement of organisational priorities re OD support and conversations re capacity ongoing. CLP approach will require different levels of support for areas depending on findings and complexity of required intervention. ~~HEIW provided 8 licenses for CAV on the NHSE/I Culture and Leadership Programme Framework to increase capability and understanding of the tool. Course has been completed and the learning incorporated into CAV approach.~~Heads of People and Culture have completed the CLP programme on NHSE/I and are integral to the programme going forward. Training also shared with Trade Union colleagues to build awareness and engagement. People and Culture Team are supporting EU with retention and wellbeing work. Scoping of programme underway. Head of ECOD working with DoN.

			ECOD team developing toolkit to support CLP in CAVUHB. Programme management approach to ensure consistency, measurements and review, and targeted support. ~~Equity and Inclusion Audit has been completed and reasonable assurance obtained. Management response provided and action plan developed to address areas for improvement.~~
~~2.~~1. Equality, Diversity and Inclusion Welsh Language Standard being implemented. Inclusion - Nine protected Characteristics	Rachel Gidman	~~October 2023~~ November 2023 – March 2024 ~~Nov 2023~~Jan 2024 December 2023 ~~July – September 2023~~November 2023 – January 2024 November – March 2024 ~~Sept-Dec 2023~~	Engagement plan for development of the Strategic Equality Objectives in draft. Engagement to commence December 2023, plan to be published April 2024. Equality Strategy Welsh Language Group ~~under review~~reviewed. Draft governance proposal agreed in principle by CEO and Exec Director of P&C. ~~Discussion with~~ Director of Corporate Governance ~~September 2023~~to confirm next steps. ~~To~~Proposal to be presented to P&C Committee ~~Nov~~Jan 202~~3~~4. A robust translation process is in place supported by 2 Welsh Language Translators and an SLA with Bi-lingual Cardiff. ~~Cost effectiveness of SLA currently being reviewed based on costs per word and waiting times. Initial analysis demonstrates savings to be made through increasing in-house translation capacity. Currently under review with support from Finance colleagues.~~ The UHB continues to receive and respond to inquiries from the Welsh language Commissioner's Office,

		~~Sept – Dec 2023~~December 2023 – March 2024 December 2023 – March 2024 ~~Sept 2023 – March 2024~~ November – February 2024 ~~December 2023~~September 2023 December 2023 – March 2024	particularly around reception areas, recruitment and data. The Welsh language team are supporting prioritised Clinical Boards to further understand their responsibilities and are taking a stepped approach to this ~~due to capacity~~and linking in closely with Directors of Ops. ~~. Welsh Language Clinical Consultation Plan published.~~ Priorities identified for 2024/25 to support CB in achieving WL Standard compliance through a pragmatic and achievable way. All 9 protected characteristics including Welsh language are sponsored by an Executive and an independent member. This approach has also been rolled-out across CBs. An 'Inclusion Ambassador' pack has been circulated that support in understanding and learning. Training has been identified for mentors to support Inclusion Ambassadors at executive level. Step two will be identification / nominations for mentors, followed by training. Timing of this to be informed by SEP development and Anti-Racist Action Plan. Existing networks are collaborating to develop the scope and outline of an 'Ally Network'. Work is progressing slowly due to capacity, including capacity of network members and resources available. On pause while a focus is given to network development., ~~initial proposal to be taken to revised Epuity and Inlcusion Group in December 2023. .~~ The Anti-Racist Wales Action Plan for CAVUHB has been

			agreed. Initial priority around data is being implemented with a data campaign and support to complete records on ESR. ~~and the Steering Group is in development to monitor delivery..~~ The ~~draft proposal for a~~ framework ~~looking at~~ for Equality, Health Inequalities and Safety has been ~~presented to SLB and is currently being reviewed based on feedback for presentation to BOard~~agreed. ~~The Equity, Inclusion and Welsh Language Team are working collaboratively with Dysgu Cymraeg as part of Welsh Government's More than just words strategy to develop the organisation's Welsh language capabilities. Mental Health CB and EU have been identified as initial areas of focus.~~ The Equity, Inclusion and Welsh Language Team have secured Welsh Language Training, from courtesy to fluency, at no cost from the National Centre for Learnng Welsh. The team are working with the Directors of Ops to focus in areas including reception / patient facing areas.
Impact Score: 4	**Likelihood Score: 1**	**Target Risk Score:**	**4 (Moderate)**

11. Impact of working in healthcare on~~Covid19 Pandemic on~~ Staff Wellbeing in light of sustained high demand – Executive Director of People and Culture (Rachel Gidman)

~~As a result of the global Covid19 pandemic, o~~Our employees have been exposed to unprecedented levels of ~~psychological and physical distress both at~~ demand, change and uncertainty since the COVID-19 pandemic. ~~home and in the workplace.~~ Evidence indicates that, Healthcare workers are at greater risk of developing mental health problems as a result of a pandemic in the years following such an event. 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 g pandemic and the pressures now emerging in term of continued high levels of demand, staffing shortages and societal issues such as the cost of living crisis. This, together with limited time to reflect and recover, will increase the risk of burnout in staff.		
Date added:	6th May 2021		
~~**Cause – During Pandemic**~~ ~~**Post-Pandemic**~~**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 ~~/ i~~I • Impact upon manager wellbeing of balancing staff and service needs • Conflict between demands of service delivery and staff wellbeing • Exposure to psychological impact of ~~-~~increasingly complex and challenging demands of care ~~/~~ • ~~i~~Inability to deliver care to required standard due to short staffing (moral injury) • Ongoing demands over an extended period of time ~~– addressing waiting lists / financial climate, minimising ability to take leave / rest / recuperate / attend learning and development~~ • Cost of living 'crisis' • Financial climate		
Impact	• Values and behaviours of the UHB will not be displayed due to high pressure environment, and potential for exacerbation of existing poor behaviours • Operating on ~~minimal~~ reduced staff levels in clinical areas due to sickness absence and/or staff shortages • 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) • Increased referrals for higher level psychological support • UHB credibility as an employere of choice may decrease • Potential exacerbation of existing health conditions • Impact on retention (negative) and attraction of staff into healthcare		
Impact Score: 5	**Likelihood Score: 4**	**Gross Risk Score:**	**20 (Extreme)**
Current Controls	• The People and Culture Committee provide more scrutiny and assurance to Board.		

	• People and Culture Plan in place with a robust governance structure monitoring delivery against the agreed priorities.. • Monthly Executive Review meetings with Clinical Boards. • Strategic oversight meetings, e.g. NPG, MW Values and behaviou • ~~Self-referral to wellbeing services~~ • ~~Managerial referrals to occupational health~~ • Provision of in-house People Health and Wellbeing Service enablling self referral (EWS), and manager referral (Occ Health) • E~~xternal support, e.g. Canopi~~ • ~~Wellbeing Q&As and drop ins (ad-hoc and upon request)~~ • EWS and Recovery College workshops (on-line) • ~~Wellbeing Support and training for Line managers~~Stress Risk Assessments • ~~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~~ • ~~Network of Wellbeing champions (training linked with the 'Time to Change Wales Programme')~~ • Health and Wellbeing ~~Strategic~~Steering group • Development of rapid access to Dermatology • Post traumatic pathway service ~~currently under review~~ • Deployment principles to support staff and line managers • Wellbeing and Safety walkabouts ~~to signpost resources~~ • ~~Long Covid Peer Support Group~~ • ~~Employee Wellbeing Support Pathway and Financial Wellbeing Pathway~~ • ~~Implementation of 'Money and Pensions Service (MaPS) training for the wellbeing champions and line managers~~ • ~~Establishment of the Cost of Living and Wellbeing webpages on Sharepoint~~ • ~~Dedicated staff benefits, savings and discount web pages~~ • ~~Provision of MaPS presentations on 'pensions' and 'pensions and menopause'~~ • Clinical Board Executive Reviews • Introduction of Culture and Leadership Programme • NHS Wales Staff Survey 2023 – engagement and communication plan
Current Assurances	• Internal monitoring and KPIs within the OH&EHWS (1) • Wellbeing champions normalising wellbeing discussions (1) • VBA focussing on individual wellbeing and development (1) • Successful retention of the gold (and platinum) Corporate Health Standard awards via the 'Enhanced Status Checks' in March 2023 • ~~HIT Team recommendation plan completed following UHB engagement, priority actions to be focus~~ (1) • Substantive funding identified to maintain on a permanent basis the enhanced EWS service from April 2023 • Development of a new and permanent OD Manager - Wellbeing and Engagement role • Taking Care of Carers Audit and Action Plan to become part of Business as usual (3) • Internal audit on Staff Wellbeing, Culture and Values (September 2022) Report and implementation of Management Actions (3) • Trade unions insight and feedback from employees (2) • Working with HEIW as part of the Financial Wellbeing (FWB) task and finish group to develop a FWB strategy for NHS staff in Wales (2)
Impact Score: 45	**Likelihood Score: 34** | **Net Risk Score:** 1620 **(Extreme)**
Gap in Controls	• Staff shortages / industrial action leading to movement of staff and high demand for cover

	• Transparent and timely Communication especially to staff who ~~are not in their substantive role e.g. redeployed, hybrid working~~do not have digital access • Continued increase in manager referrals to Occupational Health ~~and increased PEHD work to support -recruitment~~ • EWS seeing an increase in staff presenting with more complex issues, including a rise in referrals needing a wellbeing check due to the presentation of high risk in the referral • No Colleague Health and Wellbeing Framework			
Gap in Assurances	• Organisational acceptance and approval of wellbeing as an integral part of staff's working life balanced against demand and flow • Awareness and access of employee wellbeing services, particularly for staff without email / internet access • Clarity of signposting and support for managers and workforce			
Actions		**Lead**	**By when**	**Update**
	1. Commissioning model / whole team approach introduced in People and Culture to ensure managers / teams can request support / advice / guidance and training which is delivered / supported by the most appropriate team / individuals and/or external partners. Includes representation from ECOD, People Services, Wellbeing Services, Equity and Inclusion.	Nicola Bevan and Lisa Franklin	November~~July~~ 2023 – March 2024 November 2023 – March 2024.	~~The OD Manager – Wellbeing and Engagement has moved into the Education, Culture and OD Team to ensure a holistic and integrated approach to staff wellbeing and engagement. This role will work in partnership with the EWS, People Services and Equity and Inclusion to support the creation and delivery of support and development in areas of need. This may not always be in the form of team development, and may involve manager coaching / addressing root problem. This approach will also support the shaping of the strategic wellbeing narrative through co-production and staff/TU involvement.~~ Pilot of commissioning approach underway to ensure 'fit for purpose' when launched. Requests not going through the approach are being supported where applicable, with involvement from all P&C areas when necessary.

		November – January 2024	Review of pilot and engagement with CBs / SLB etc in new year. Continued signposting to cost of living support and development of resources in partnership with TU Partners and MaPS.
		November 2023	H&WB Steering Group to review priorities and work on Financial Wellbeing. Money Matters Week November was supported by Roadshows across sites.
		~~September 2023 – January 2024~~	Financial Wellbeing packs have been circulated to key leads in primary care and community for cascading through the teams.
		~~September 2023 – Jan 2024~~	EWS, ECOD and People Services ~~will work with~~have supported Ops during Autumn / Winter 2023/24 to support a series of roadshows for staff. The Winter Roadshows ~~will include~~include wellbeing advice and signposting, financial wellbeing, NHS Wales Staff Survey updates and general advice and guidance.
			~~A staff Financial Wellbeing pathway has been developed and will form part of the roadshows in Autumn /~~

			~~Winter 2023.~~The staff Financial Wellbeing Pathway has been finalised and is available via sharepoint. This includes a 'one page' version, and a more detailed version with additional details. Dedicated staff financial wellbeing and CoL web pages have been established on sharepoint.
2. ~~Employee Wellbeing Service working with the Occupational Health Service, People Services and ECOD~~The People and Culture Team will ~~to~~ identify insights from workforce data, including themes emerging from EWS, OH, People Svcs, Culture work and Staff Survey, ~~collated~~ to shape strategic and operational response to themes / emerging trends. This will also be informed by working in collaboration with Clinical Boards.	~~Nicola Bevan~~Claire Whiles	~~April 2023 – March 2024~~ ~~July 2023 – Jan 2024~~ November 2023 – March 2024 ~~September 2023~~ December 2023 ~~July – December 2023~~	~~The Health Intervention Impact Report has been utilised to shape the year two priorities and actions within the People and Culture Plan.~~ ~~Development of a Health and Wellbeing Framework continues. A Working Group will be established by the Wellbeing Strategy Group in October 2023 to shape the Framework. This will be presented to WPG in January 2024.~~ The Health and Wellbeing Steering Group has been reviewed and new TORs developed. The group will meet every 2 months to focus on the development of the H&WB Framework, and to steer the organisation in terms of wellbeing priorities.

		November 2023	The group will report to the People and Culture Committee. ~~The Health Charity are supporting colleagues at Whitchurch to fund a water station onsite following completion of a SBAR.~~ Peer support developments – MedTRiM training will be reviewed following limited interaction with the training provider. ~~is partially completed. Meeting with provider re-scheduled for Autumn 2023 to review progress and next steps~~. Sustaining Resilience at Work Pracitioner Training (StRaW) has been undertaken by Children and Women CB supported by P&C Team. ~~An infrastructure that supports the practitioners has been established and is overseen by four StRaW Managers and a StRaW co-ordinator. The StRaW Practitioner Network has been created and monthly network meetings established. An interim review to take place December 2023.~~ ~~Development of~~ 'My Health Passport' to enable employees who believe they may need support or work adjustments due to a disability or long term health condition, will

			be launched on 16th November 2023. T~~his could be in relation to a pre-existing or new health condition. The passport is designed for the employee to share with their line manager to support effective conversations around support and performance. The passport will be soft-launched throughout the organisation in November to coincide with Disability Awareness Month.~~
3. Enhance communication methods across UHB - Social media platform - Regularity and accessibility of information and resources - Improve website navigation and resources	Nicola Bevan	November – March 2024~~July – December 2023~~ January 2024 ~~April 2023 – March 2024~~ ~~October 2023 – March 2024~~ ~~September 2023~~November 2023 – March 2024	A variety of communication models including Twitter accounts, screen savers, ESR messaging are being utilised to share Wellbeing updates across the UHB. A 12-month communication plan has been developed to ensure that wellbeing topics are covered throughout the year P&C Team working with Communications Team to develop a People and Culture communication and Engagement Plan. Draft presented to P&C Committee Nov 2023. The Financial Wellbeing Working group has now been stood down as it has delivered on the main actions. The remaining actions on the 'Action Plan' will be delivered and progress monitored via the

			Strategic Wellbeing group. ~~A financial wellbeing flyer has been developed by the EWS team. Meeting being planned with key members of the comms team to discuss how to strengthen comms to support EWS~~
		~~August 2023 – March 2024~~	
		November 2023 – March 2024	Wagestream was implemented in August 2023. This platform provides financial education and guidance, along with the ability for staff working additional hours as over-time / bank to draw down payment on a weekly basis, supporting staff during the cost of living challenges, and reducing reliance on agency workers. ~~Communication campaign to commence July 2023.~~ As of 30th October, 706 employees have signed up, 29 awaiting enrollment, and 22 have started a savings pot.
		~~September – October 2023~~	
		~~September – December 2023~~	Further engagement work to highlight benefits available.
			~~Communication of engagement and wellbeing surveys continue with P&C team attending CB SMTs. Five attended so far, remaining sessions to be booked in Autumn 2023.~~

Saunders,Nathan
20/11/2023 15:51:45

			~~Communications also being developed to thank staff for participation in surveys / platforms; to communicate key themes and to outline actions being taken / planned. This will form part of the engagement plan for NHS Wales Staff Survey.~~ Engagement and communication plan for NHS Wales Staff Survey commenced August 2023. This includes online messaging, social media, roadshows and videos from CEO. To continue to closing date of 27th November. Analysis of survey will inform actions into 2024/25. P&C Team so support CB understanding and communication.
4. Training and education of management - Integrate wellbeing into all parts of the employment cycle (recruitment, induction, training and ongoing career) - Enhance training and education courses and support for new and existing managers	Claire Whiles	~~July – December 2023~~November 2023 – March 2024 December 2023 – March 2024 ~~September –~~ November 2023 – January 2026~~December 2023~~ November 2023 – March 2024	~~Appointment of~~ OD Manager, Wellbeing and Culture supporting and shaping Leadership and Management development offerings and staff survey engagement ~~to sustained focus on staff wellbeing~~. Work being undertaken to develop CAVUHB ~~re~~ Leadership Principles (see Culture BAF) will also enhance this. ~~Retention toolkit developed to support teams / CBs / managers. To include links and guidance to support at a local level.~~ HEIW supporting a 2 year post to support Retention. The post will

		~~September –~~ ~~November~~November 2023 – March 2024~~2023~~ August 2023	sit within P&C and work in partnership with CBs to form retention plans, utilise toolkit, gather data etc. Post out to advert, interviews November 2023, potential start date, Feb/March 2024. Acceler8 Cohort 2 completed. Current review and evaluation of leadership development to ~~follow audit advisory feedback~~run alongside leadership principles development. ~~Draft commissioning model agreed, to be communicated via WPG, SLB.~~ Financial Wellbeing (FWB) lead working with P&C leads to look at embedding FWB into moments that matter such as staff induction. Meeting held and sign posted to staff induction leads
5. Wellbeing interventions and resources f~~unding bid approved November 2021. Implementation to start December 2021 for completion March 2022~~to be evidence based, targeted, reviewed and evaluated. ~~Wellbeing Strategy group to shape with feedback from Cl Boards.~~ Saunders,Nathan 20/11/2023 15:51:45	Claire Whiles	September 2023 – March 2024	Work on evaluation metrics underway within ECOD, EWS and OH. Current review of reporting and identification of dashboard to provide organisational insights and assurance. This will ensure effective monitoring, evaluation and planning of all wellbeing services and interventions. Work progressing slowly due to ~~inability to fill vacant role~~capacity. Potential opportunity in 2024 to

		~~October~~December 2023 – ~~January~~February 2024 November 2023 – March 2024 ~~July 2023 – March 2024~~November 2023 ~~September – October 2023~~ November 2023 – March 2024 ~~April-June 2023~~	utilise new Occupational Health database to support EWS. Wellbeing Framework draft presented to Strategic Wellbeing Group Feb 2023. ~~Following revised TORs for Strategic~~ Health and Wellbeing Steering Group to develop workplan around delivery of the framework.~~, work will re-commence in October 2023.~~ Schwartz Rounds ~~clinical leads identified. Facilitator Training took place on 18th July 2023.~~ Steering Group established ~~and intial meeting took place September 2023~~and facilitators trained. Project plan ~~in development, first round to take place October 2023, and will be held monthly~~developed and rounds being communicated via many platforms. Pilot round October 2023, rounds to be held monthly at venues identified by Steering Group through collaboration with CBs. Schwartz Round Administrator role – currently no capacity to fill role~~, to review in Autumn 202~~3.Risk re Schwartz Round Administrator role – currently not assigned.

		~~September~~ November2023 – March 2024 July – October 2023	~~Wellbeing Retreat Pilot completed, draft evaluation currently in review – delayed due to capacity.~~ ~~CManagement Response to Internal Audit agreed and returned and presented at Audit Committee.~~ Organisational approach to Cultural Assessment ~~was presented to SLB in August 2023~~approved November 2023. Utilising NHSE tool which is an evidenced based model designed by NHSE, The King's Fund and Professor Michael West. Working with HEIW to implement and embed. Will support development of an inclusive, compassionate and healthy workplace. Cultural Assessment work currently being prioritised by Executive Team to support ~~a range of CBs~~priority areas. This will require collaborative working across P&C Team and CBs, including TU partners. Range of Financial Wellbeing (FWB) resources available to staff via the dedicated FWB webpages with several links to the

			other recognised resources such as: Money Helper, Cardiff Credit Union, Stop Loan Sharks Wales and many more. ~~Schwartz Rounds- Facilitators, administrators and members of a Steering group have been identified. Training for the facilitators has been arranged for 18th July which is a joint session with ABUHB. Training for the administrators and members of the Steering Committee is being arranged with the 'Point of Care Foundation. The intentions is to roll out the rounds from October 2023~~
Impact Score: 5	**Likelihood Score: 1**	**Target Risk Score:**	**5 (Moderate)**

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

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

Risk **Date added:** 12.11.2018	There is a risk that the condition and suitability of the UHB estate, IT infrastructure and Medical Equipment impacts on the delivery of safe, effective and prudent health care for the patients of Cardiff and Vale UHB. The condition of facilities within our main hospitals and some community facilities are impacting on our ability to continue to provide the full range of services, and provide the new treatments WHSSC would like to commission from us. This is as a result of insufficient funding and resource to bring the estate up to the required condition in a timely way.		
Cause	• Significant proportion of the estate is over-crowded, not suitable for the function it performs, or falls below condition B (assessed regularly on an all-Wales basis by NHS Shared Services Partnership). • Investment in replacing facilities and proactively maintaining the estate has not kept up the requirements, with compliance and urgent service pressures being prioritised. • Lack of investment in IT also means that opportunities to provide services in new and efficient ways are not always possible and core infrastructure upgrading is behind schedule. • Insufficient resource to provide a timely replacement programme, or meet needs for small equipment replacement • Lack of timely decisions regarding the development of strategic business cases required to address the significant estates challenges we face.		
Impact	• The health board is not able to always provide services in an optimal way, leading to increased inefficiencies and costs. • Service provision is regularly interrupted by estates issues and failures. • Patient safety and experience is sometimes adversely impacted. • IT infrastructure not upgraded as timely as required increasing operational continuity and increasing cyber security risk • Medical equipment replaced in a risk priority order where possible, insufficient resource for new equipment or timely replacement • Staff facilities needed to support good staff wellbeing are inadequate in many areas.		
Impact Score: 5	**Likelihood Score: 5**	**Gross Risk Score:**	**25 (Extreme)**
Current Controls	• Estates strategic plan in place which sets out how over the next ten years, plans will be implemented to secure estate which is fit for purpose, efficient and is 'future-proofed' as much as possible, recognising that advances in medical treatments and therapies are accelerating. Subject to mid-point review as covered in Board Development session in February 2023. • Statutory compliance estates programme in place – including legionella proactive actions, and time safety management actions. • The strategic plan sets out the key actions required in the short, medium and long term to ensure provision of appropriate estates infrastructure. • The annual capital programme is prioritised based on risk and the services requirements set out in the IMTP/annual plan, with regular oversight of the programme of discretionary and major capital programmes. The 2023/24 Capital Plan will be submitted for Board approval in July 2023.		

	• Medical Equipment prioritisation is managed through the Medical Equipment Group and there is a process in place for rapid decision making if there is a urgent need to replace a piece of equipment. • Business Case performance monitored through Capital Management Group every month and Finance & Performance Committee at each meeting, every month. • The Health Board has submitted to Welsh Government a 10-year capital outlook, which has been prioritised to reflect the most pressing infrastructure and service challenges and risks. • Shaping Our Future Hospitals Programme Business Case was submitted to WG in October '21 and scrutinised at WG Infrastructure Investment Board in December '21. The WG Cabinet has considered Our Future Hospitals PBC alongside the priorities across the whole of Wales. There is support 'in principle' for the Health Board to proceed with the development of the next stage of the business case process – the Strategic Outline Case. • Welsh Government has agreed the Strategic Outline Case scope and a resource request has been submitted to Welsh Government. Welsh Government has commissioned an independent review of the clinical model described in the PBC and we understand that approval to proceed with developing the SOC will be dependent on the findings of this independent review (which is concluding in early September). • In accordance with the prioritised plan the Board approved and submitted to Welsh Government the Tertiary Tower Business Case and the Vascular MTC Theatres Business Case. The latter will improve the overarching theatre provision.
Current Assurances	• The estates and capital team have a number of business cases in development to secure the necessary capital to address the major short/medium term service estates issues. • The statutory compliance areas are monitored every month in the Capital Management Group to ensure that the key areas of risk are prioritised and reporting of estates risks to the Health and Safety Committee is being strengthened(1) • The Executive Director of Strategic Planning and the Director of Capital, Facilities and Estates meet regularly with the Welsh Government Capital Team to review the capital programme and discuss the service risks (3). • Regular reporting on capital programme and risks to Capital Management, Management Executive and Finance & Performance Committee (1) (2) • IT risk register regularly updated and shared with DHCW (2) • Health Care Standard completed annually (3) • Medical equipment risk registers developed and managed by Clinical Boards, reviewed at UHB medical equipment group (1) (2) • Finance & Performance Committee continue to oversee the delivery of the Capital Programme (1) • Timely decision making in relation to the Shaping Our Future Hospitals Strategic Outline Case (3)

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

Gap in Controls	• The current annual discretionary capital funding is not enough to cover all of the priorities identified through the risk assessment and IMTP process for the estate and digital infrastructure and medical equipment replacement services which requires the need to prioritise investment and resource allocation based on assessed level of risk and alignment with strategy and IMTP priorities. • In year requirements further impact and require the annual capital programme to be re-prioritised regularly. • Traceability of Medical Equipment • The Welsh Government current capital position is very compromised due to size of budget compared with estimated need which will impact significantly on the

	Capital Programme of the UHB. Not all business cases in the Welsh Government capital plan will be deliverable and the UHB needs to be mindful of the potential reputational risk of delays between OBC and FBC approvals with supply chain partners.			
Gap in Assurances	• The regular statutory compliance surveys identify remedial works that are required urgently, for which there is no discretionary capital funding identified, requiring the annual plan to be re-prioritised, or the contingency fund to be used. • Medical equipment is also subject to regulatory requirements, and therefore requires re-prioritisation during the year. • Despite the substantial end of year capital, the recurrent position remains unchanged. • Full condition surveys of all buildings have not been carried out so not possible to fully understand the condition of the estate.			
Actions		**Lead**	**By when**	**Update**
1.	The Estates Strategy requires review and refresh and there is a need to ensure that it is future proof. The scoping of this work to understand what is required will take place before Christmas	Catherine Phillips	31.03.24	Mid-term review undertaken and agreed following Board Development in February 2023 to undertake a number of actions overseen by the Health & Safety Committee by the end of 23/24. Refresh of strategy required following sign off of HB strategy with reference to realistic funding available and clarity of funding for UHW2.
2.	The Health Board continues to prioritise the use of the discretionary capital budget to target small priority schemes.	Abigail Harris	31.03.24	This continues with discretionary capital. Prioritised plan is signed off by CMG and SLB and Board.
3.	An acute infrastructure group is overseeing the short – medium term priorities.	Abigail Harris	31.03.24	The group continues to meet to oversee the priorities and development of a number of business cases that have been prioritised to ensure they progress in a timely way to address significant infrastructure risks such as Mortuary and BMT.
Impact Score: 5	**Likelihood Score: 2**	**Target Risk Score:**		**10 (high)**

13. Risk of Delivery of IMTP 23-26 – Executive Director of Strategic Planning (Abigail Harris)

In October 2021 the Welsh Government signalled a return to a three-year planning approach post-pandemic. Due to the extremely challenging financial position the Health Board submitted an annual plan in a three-year context for 2023/24. The final plan which was approved by the Board on 30th March 2023 and submitted to WG. The plan sets out service delivery proposals reflecting the ministerial priorities, the next milestones in the delivery of our strategy and the financial recovery that will be delivered over the next three years. Further work was requested, and additional information was provided to WG in May 2023. Due to the financial deficit facing NHS in Wales (including C&V UHB) further work was required to look at options for reducing the deficit beyond the position set out in the annual plan. These options were considered by Board and submitted in August as required. The plan has not yet been formally accepted by the Minister.

Risk	There is a risk that the Health Board will fail to deliver the commitments set out in the 23/24 Annual Plan both in terms of service and financial commitments. The plan does not achieve overall financial balance in 2023/2024 and it is unlikely to be accepted by the Minister. There are a number of factors in play including the withdrawal of Covid-19 funding and inflationary pressures, for example on energy costs. All Health Boards have been asked to develop further options that would achieve an improvement in the deficits set out in the annual plans.		
Date added:	May 22 (updated for 2023/24 in May 23)		
Cause	Challenging targets have been set for the Health Board in respect of planned care recovery. Detailed and stretching plans have been developed which the Health Board is committed to delivering but, at this stage the Health Board is not able to achieve all planned care targets for 2023/24. The financial recovery plan will also be challenging to delivery, with stretching targets for sustainably improving our overarching financial position. Whilst we are committed to deliver the actions set out in the plan, there may be dependencies of external factors which impact on our delivery – including constraints relating to funding – capital and revenue, workforce and speed with which we can implement the necessary gearing up to increase capacity.		
Impact	A plan that does not fully meet the requirements for an IMTP is categorised as an annual plan set within a three-year context. The failure to have in place a fully compliant plan could result in the Health Board being escalated to the next level of the performance and escalation framework, which could bring with its reputational loss and increased scrutiny by WG. If we are not able to deliver all of the actions set out in our plan, our planned care recovery could take longer to deliver for the populations we serve and quality of care and patient experience could be impacted.		
Impact Score: 5	**Likelihood Score: 4**	**Gross Risk Score:**	**20 (Extreme)**
Current Controls	An Operational Plan Delivery structure has been established to drive the delivery of the Planned Care Plan and the Emergency and Urgent Care Improvement Plan. We have submitted number of proposals against the WG Top Sliced Planned Care Recovery Fund aimed at improving our waiting times position in line with ministerial priorities and funding has now been confirmed which will enable our plans to proceed at pace. The Performance and Escalation Framework for Clinical Boards has been re-introduced to hold CBs to account for delivering their respective service and financial plans. A process is being established to ensure a programme approach to delivery of the actions within the financial recovery plan. Senior management and oversight arrangements are being strengthened, monthly review meetings are held with each clinical board meetings with Clinical Boards and a series of summits have been led by the Chief Operating Officer to focus on focus on delivery 'hotspots' such as stroke. These are leading to improvement plans, and the		

	improved performance is tracked through the Integrated Performance Report that goes to the Finance and Performance Committee and the Board.
Current Assurances	Financial performance is a standing agenda item monthly on Senior Leadership Board with escalation to Management Executives Meeting (1). In addition to this a Sustainability Board has been established to oversee the delivery of the financial plan. The financial position is reviewed by the Finance and Performance Committee which meets monthly and reports into the Board. (1) The Board receives a financial update report from the Executive Director of Finance at each of its meetings. (1) Welsh Government are fully engaged and have been briefed on the Health Board's position. (3) Service delivery performance is tracked through the structures established to oversee planned care recovery and the improvement in emergency and urgent care, with regular reporting into ME and Board on progress. (1) WG also holds monthly Integrated Planning, Quality and Delivery Review meetings with the health board to track progress. (3) Improvement trajectories are being updated quarterly to ensure they remain on track to deliver the agreed targets. (1)

Impact Score: 5	**Likelihood Score: 3**	**Net Risk Score:**	**15 (Extreme)**
Gap in Controls	Detailed delivery plans are not in place for all elements of the financial recovery plan. Detailed delivery plans are not in place in all specialties to achieve Welsh Government 52-week NOP ambition. The Health Board continues to have a high number of medically fit for discharge patients with limited control over actions of partners to assist.		
Gap in Assurances	There is currently no assurance on the plan. Once developed assurance will be provided through reporting to Management Executives, Finance Committee and the Board. The Health Boards position has deteriorated in relation to its financial position.		

Actions	Lead	By when	Update
1. Ensure detailed plan with programme to drive delivery of financial recovery plan	Catherine Phillips	30/06/23	Detailed Plan and supporting information discussed extensively in Board and provided to WG. Additional oversight arrangements being established to ensure delivery including Sustainability Programme Board chaired by the Chief Executive.
2. Provide Q1 progress report – including mitigating actions, to the Board for scrutiny. Development of the Integrated Performance Report provides assurance on Ministerial Priorities	Abigail Harris	30/09/23	This will be presented to Finance & Performance Committee and Board in September 2023

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

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

Across Wales, Health Boards and Trusts set out plans to manage their financial pressures by driving out inefficiencies, while at the same time looking to derive greater value from their resources through innovative ways of working and practicing Prudent and Value Based Healthcare. The deficit plan submitted for 2022/23 was not achieved and has contributed to a worsened financial outlook for 2023/24 which has also been exacerbated by the cessation of Welsh Government Covid-19 funding and unprecedented inflationary pressures which are not funded. For 2023/24 the Health Board has submitted an Annual Plan in a three year context with a realistic yet challenging plan for restore financial sustainability over the medium-term.

Risk **Date added:** 01.04.2022 (updated May 2023)	There is a risk that the organisation will continue to breach its statutory financial duties by being unable to produce a balanced three-year plan.		
Cause	Cessation of Covid-19 funding and unprecedented inflationary pressures, for example on energy costs. The UHB also has to manage its operational budget and deliver planned savings on a sustainable recurrent basis.		
Impact	Breach of statutory duties, escalation. Unable to deliver a balanced year-end financial position. Reputational loss.		
Impact Score: 5	Likelihood Score: 5	**Gross Risk Score:**	**25 (Extreme)**
Current Controls	Additional expenditure is being authorised within the governance structure and the UHB Scheme of Delegation. Financial Plan submitted to Welsh Government 30th March 2023 explaining inability to deliver financial balance over the three-year period 2023-2026. Themed Savings programme managed through fortnightly Sustainability board chaired by CEO.		
Current Assurances	The financial position is reviewed by the Finance & Performance Committee which meets monthly and reports into the Board (1) Financial performance is a standing agenda item monthly on Senior Leadership Board with escalation to Management Executives Meeting (1) Financial performance is monitored by the Management Executive (1). Assurance from internal audit annual review of core financial controls including budgeting and planning. Sustainability Programme Board in place, chaired by the Chief Executive.		
Impact Score: 5	**Likelihood Score: 5**	**Net Risk Score:**	**25 (Extreme)**
Gap in Controls	No gaps currently identified.		
Gap in Assurances	None identified.		

Actions	Lead	By when	Update
1. The organisation has identified 94% of the 2023/24 £32m savings target at the end of October with further opportunities identified to close the gap. Schemes will be further progressed through Q3 to ensure full delivery.	Catherine Phillips	30/09/23	Further schemes to be progressed through Q3 to close the savings gap.

Impact Score: 3	Likelihood Score: 5	**Target Risk Score:**	**15 (Extreme)**

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

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

Risk	There is a risk that the Digital Strategy and Roadmap will not be implemented, due to lack of resources, resulting in a deficit in infrastructure, applications and informatics capability.		
Date added:	04.10.22 updated 12.09.23		
Cause	CAVUHB IT and digital services are known to have been historically underfunded resulting in a significant legacy deficit in infrastructure, applications and informatics capability that has built up over at least a decade (our PMS and the core module that sit on top for UEC, inpatients and outpatients were built c20 years ago). Colleagues need mobile, scalable, agile solutions which are unachievable whilst we are locked into legacy. There are some programmes and plans identified to rectify these issues however they are unachievable with the current resource allocation		
Impact	We have capability in human resources but lack capacity for planning, management and execution of the activities needed to deliver the digital strategy and roadmap. Just to produce the case(s) for change requires capacity we do not have in the current circumstance Delivery on digital maturity would give capability to colleagues that will reduce inefficiency, release clinical time to care, improve safe practice, allow near real time data to be available to support clinical decision making at the point of care by moving from paper and analogue means of capturing and recording information to digital means where data flows seamlessly between settings Recruitment remains a challenge requiring the use of interim agency support in key areas. Existing resources are consumed with tactical short-term fixes given the legacy so we are unable to prioritise those activities that take us forward – we don't have enough people and we don't have enough money to make the changes we want and need to see. There is a risk that the financial savings and improved staff and patient experience expected from the Digital Roadmap plans will not be fully realised, due to the lack of resources, resulting in a deficit in IT infrastructure, applications and informatics capability and consequential adverse impacts.		
Impact Score: 5	**Likelihood Score: 5**	**Gross Risk Score:**	**25 (Extreme)**
Current Controls	• Digital strategy approved by Board in20/21 with roadmap for 21/22/23 • Digital components described in IMTP • Some additional funding secured via the Business Case Advisory Group • IT infrastructure priorities developed and set out for 2022-2025		
Current Assurances	• D & HI have a number of business cases in development which require revenue investment (1) • Risk register articulates the risks of not being able to deliver digital solutions to support delivery of healthcare (1) • Internal audit report highlights the risk in delivering digital strategy citing the investment challenges that will prevent full implementation.		
Impact Score: 5	**Likelihood Score: 4**	**Net Risk Score:**	**20 (Extreme)**
Gap in Controls	• Current annual discretionary funding is insufficient to cover the maintenance upkeep of the core infrastructure.		

Gap in Assurances	• Unable to currently provide assurance that the finance will be provided		
Actions	**Lead**	**By when**	**Update**
1. Final report on the UHB's HIMSS digital maturity to be shared and discussed at DHIC and a summary brought to Board (private meeting) thereafter	DT	31.07.23	
2. Cyber plans reviewed and further updated to reflect Audit recommendations and Cyber Assessment Framework requirements from the WG Cyber Resilience Unit for 23/24.	DT	30.08.23	
3. Cyber awareness raising webinar organised by WG and DHCW for board members held on 03/07/23. Cyber Imp plan to be developed and shared with Board, via DHIC 4. Update on Cyber Implementation plan to be discussed at private meeting of DHIC in October. 5. Board to be appriased of cyber position at private session of Board (Nov 23)	DT DT DT	30.09.23 01.10.23 30.11.23	
Impact Score: 5	**Likelihood Score: 4**	**Target Risk Score:**	**20 (Extreme)**

Key:

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

Report Title:	Finance and Performance Committee Chair's Report				Agenda Item no.	6.5.2	
Meeting:	Board		Public	x	Meeting Date:	30.11.2023	
			Private				
Status *(please tick one only):*	Assurance	x	Approval		Information		
Lead Executive:	Director of Corporate Governance						
Report Author (Title):	Senior Corporate Governance Officer						

Main Report
Background and current situation:

The purpose of this report is to provide the Board with a summary of key issues discussed at the Finance and Performance Committee Meeting held on **18 October 2023.**

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

The Committee noted and discussed the following key points: -

Financial Report – Month 6 - at month 6, the Cardiff and Vale University Health Board (the Health Board) was reporting an overspend of £51.300m which comprised of £5.747m unidentified savings, £1.352m of operational overspend and the planned deficit of £44.200m (six twelfths of the annual planned deficit of £88.4m set out in 2023/24 financial plan).

Operational Position – Month 4 – at month 6, there was a £1.352m operational deficit in delegated and central positions.

It was noted that if schemes were delivered in line with the profile, the reported deficit would peak at month 6 before turning the curve on a trajectory to hit the £88.4m planned deficit.

Savings Programme – Month 4 – it was noted that at month 6, the Health Board had identified £36.046m of green, amber and red savings against the £32m savings target, however £6.707m were classified as red schemes.

It was noted that the month 6 Savings Programme deficit was expected to be recovered, supported by a number of additional actions as the year progressed, enabling the Health Board to deliver its planned deficit position of £88.4m.

The Committee was presented with the current cumulative profile of identified and red schemes up to the savings target of £32m and it was noted that the impact of successfully delivering the agreed £16m additional actions would meet the £32m target in month 10 and allow additional savings of £4.046m to address the operational deficit to deliver a breakeven position.

Welsh Government Strategic Cash Support Request - The Committee was advised that a technical update note had been issued by Welsh Government (WG) on the 8th November 2022 which had confirmed that the cash implications of the Health Boards operational deficit were a separate issue to the annual movement of working balances cash exercise.

It was noted that Health Boards were required to submit an Accountable Officer letter (once requirements were established) in support of a request for Strategic Cash Support.

It was also noted that WG were expected to confirm that application requests should be submitted by close of play Monday 20th November 2023 and the Committee was advised that the Health Board intended to submit a formal request for strategic cash support in line with its forecast deficit

through an Accountable Officer Letter in line with the Welsh Government timetable against the reported forecast deficit of £88.4m.

Operational Performance Report:

The Committee were provided with key updates on:

Urgent & Emergency Care**:** - it was noted that pressures in all areas had started to ease following ward moves and reconfiguration of the University Hospital Wales site and that the focussed work on ambulance handovers through the year had led to significant reductions in the number of patients waiting outside the Emergency Department.

It was noted that August 2023 saw an improvement in Health Board compliance against the Sentinel Stroke National Audit Programme (SSNAP) measures for the Stroke Pathway with the percentage of patients directly admitted to the stroke unit within 4-hours increasing to 65% and remained significantly above the all Wales average.

Planned Care**:** – The Committee was advised that more focus would be required on the 52 week waits as there were still too many patients waiting for a year of more for an outpatient appointment.

The Committee was assured that it was not a Health Board wide issue and that the operational team were working with specific specialties, particularly in Paediatrics and Medicine, to reduce or to maintain their outpatient waits below 52 weeks.

It was noted that an Outpatient Improvement plan would be launched and that the use of See on Symptoms (SOS) and Patient Initiated Follow-up (PIFU) pathways would be an important tool in the management of follow-up services and the Health Board would continue to develop their use across services.

Diagnostics**:** it was noted that the waiting list position for Diagnostics had deteriorated in recent months, with particular challenges in Radiology and Endoscopy however it was hoped that the upcoming development of a Community Diagnostic Hub, and interim use of mobile facilities would address radiological backlogs.

The Committee was advised that in relation to Endoscopy, the service had an improvement plan in place, with additional theatre and insourcing capacity, aligned to a longer-term workforce plan to further address the deterioration in the length of wait.

Dental**:** The Committee was advised that the Health Board were undertaking a deep dive into the provision of General Dental Services within Cardiff and the Vale and it was noted that Dental services were going through a period of reform as WG assessed the impact of contract reforms on the provision of services and access to primary care dentistry.

Mental Health Services**:** The Committee was advised that a Mental Health Community Summit had been held on September 6th 2023 with over 40 participants from Primary Care, Children & Women's and Mental Health Clinical Boards in attendance.

It was noted that the summit included;

- Broad discussion on the pathways of care across the system which resulted in a conversation around requirement of excellent alignment in the need to simplify pathways for patients and utilise primary care more appropriately.
- A review of the current model and pathways undertaken by patients
- A preferred model for Adult services which would streamline the service and would make it clearer which patients see who and when.
- A review of the current pathway for Children, Young People and Family (CYPF)
- Next steps for CYPF and a number of pathways.

Cancer Deep Dive:

The Committee was advised that the report received forewarned that performance would dip and get worse before it could get better.

It was noted that the plan developed with Clinical Boards was to see continuous improvement in the percentage of patients treated within the standard and an aim to exceed 75% by the end of September 2023 in line with the 62-day single cancer pathway.

The Committee was provided with the aims for the service which included:

- 90% of patients to have had their first contact within 14 days.
- 85% of patients to have had their diagnosis by day 28

The Committee was advised that at the end of August 2023, the confirmed cancer performance was 66.4%, and the September 2023 performance, which would be confirmed at the end of October 2023, was likely to see a deterioration as mentioned.

The Committee were provided with the 2 main reasons for the deterioration which included:

- The endoscopy waiting list where 30% of patients on the single cancer pathway were waiting for endoscopy.
- An increase in referrals. It was noted that colorectal and skin referrals had increased exponentially.

Electronic Prescribing and Medicines Administration Business Case: The Business Case was received, reviewed and recommended to Board for approval via a Chairs Action due to the case requiring sign off at the beginning of November 2023.

Paediatrics Infectious Diseases case: The Business Case was received, reviewed and recommended to Board for approval.

Recommendation:

The Board is requested to:

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

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

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

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

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

Saunders,Nathan
20/11/2023 15:51:45

Report Title:	Quality, Safety and Experience Committee – Chair's Report				Agenda Item no.	6.5.2	
Meeting:	Board		Public	x	Meeting Date:	30.11.2023	
			Private				
Status *(please tick one only):*	Assurance	x	Approval	x	Information		
Lead Executive:	Director of Corporate Governance						
Report Author (Title):	Corporate Governance Officer						

Main Report
Background and current situation:

The purpose of this report is to highlight the key issues which were raised and discussed at the Quality, Safety and Experience Committee meeting held on the **25th October 2023.**

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

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

Quality Indicators: – The Committee were presented with the Quality Indicators Report to provide assurance in relation to a number of quality, safety, and patient experience priorities which included, but were not limited to:

- National Reportable Incidents and Never Events;
- Infection Prevention and Control;
- Falls and Pressure Damage;
- Medication Incidents;
- Mortality;
- Clinical Effectiveness;
- COVID Investigations;
- Patient Experience and Concerns Assurance;
- Safe Care.

It was noted that the COVID pandemic had interrupted work undertaken on the falls framework, however within the previous 12 months, the Health Board had refreshed the agenda of the Falls Delivery Group to focus on key areas of the strategy. This type of accessible intervention across Cardiff and the Vale would start to impact on outcomes.

Regarding Patient Experience and Concerns, the Committee was advised that the Health Board had been in discussions with Cedar around the analysis of feedback, and that the Health Board might be slightly ahead in their analysis using Civica in comparison to the national picture.

The Committee was informed that the Health Board had recently established the Patient At Risk Team (P@RT) which had been embedded into the organisation and that they had recently invested to make it a 24/7 service, but further Communications work was needed.

Children & Women's Waiting List Update: - The Committee were provided with an update on the volume of waiting lists within the Children & Women's Clinical Board. It was noted that they had seen a huge increase in demand recently, and they were unsure how long this demand would continue for.

The Committee was advised that the number of Looked After Children (LAC) had increased to 1400, compared to 1280 pre-COVID, but the number was being monitored through monthly Clinical Board meetings, and they had put resource in to reduce it. They were undertaking a whole system review

to see what could be done to relieve health visitors of some of their work, to free up more time to undertake the annual assessments.

The Committee was informed of the ongoing situation within surgery and outpatients waiting lists, and that moving forward they would work through the surgery and outpatient waiting lists from a clinical priority perspective, regardless of specialty. It was noted that overall, waiting lists had reduced, and they hoped that by the end of March 2025, no children would wait over 2 years for surgery. It was noted that conversations were needed with WHSSC around how to fairly allocate the capacity they had, and to be clear on the criteria for accepting patients from other Health Boards.

Maternity Thematic Review: - The Committee were presented with the Maternity Thematic Review which summarised the key themes and findings from a number of recent reports, to demonstrate the actions being taken to make improvements to the organisation. These themes included, but were not limited to:

- Workforce;
- Patient Safety, Quality & Experience;
- Training and Education;
- Leadership and Team Working.

The Committee were informed that they had significant staff shortages, however they had increased their commissioning and had employed 35wtes. The majority of their midwives did retire and return, and the Health Board had explored other roles that retired midwives could come back into to build flexibility within the workforce. In addition, a large piece of work had been undertaken to understand the reasons for leaving the organisation, and they had looked at how to make Cardiff an attractive place to stay and work.

It was noted that the above would be a 2-3-year programme, and while they still had a lot of work left to do, the clinical board were aware of where work was needed. It was agreed that a periodic update would return to the Committee, and a 6-12 monthly summary would be taken to Board.

Specialist Clinical Board Assurance Report – South Wales Trauma Network Verbal Update: - The Committee was provided with a verbal update, and it was noted that a formal review of the Major Trauma Centre (MTC) had been postponed until Q4 in 2023. As a result of demands, they had created capacity potentially at the risk of some other services the Health Board would provide. Additionally, some of the funding excluded from the business case they had to request back (for example, they had insufficient radiology resource and so funds were returned).

It was suggested that the team return to the QSE Committee to provide an update on what the MTC had achieved over the previous three years, and on their future plans.

Policies – Interoperative Cell Salvage Policy and Procedure: - the Committee were provided assurance that the Health Board had been inspected by the Human Tissue Authority (HTA), and that their policies were not highlighted as an issue.

Minutes from Clinical Board QSE Sub-Committees – Clinical, Diagnostics & Therapies Minutes for 14.07.2023 & 22.09.2023: - The Committee noted both sets of Minutes.

Any Other Business: - The Committee was informed that there were no immediate causes of concern around the increased rates of sepsis. The P@RT team had enabled a clear pathway for patients who had deteriorated, and that the Health Board had recently advertised for a Clinical Lead for Sepsis who would lead the Sepsis Group.

The Board is requested to:

a) Note the contents of the Report.

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

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

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

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

Saunders,Nathan
20/11/2023 15:51:45

Report Title:	C&V Integrated Performance Report			Agenda Item no.	6.6
Meeting:	C&V UHB Board Development	Public	X	Meeting Date:	30/11/2023
		Private			
Status *(please tick one only):*	Assurance	x	Approval	Information	
Lead Executive:	Fiona Kinghorn, Jason Roberts, Rachel Gidman, Paul Bostock, Catherine Phillips				
Report Author (Title):	Information Manager				

Main Report
Background and current situation:

Public Health

Percentage of adult smokers who make a quit attempt via smoking cessation services: Q1 data shows a slight decreased in the percentage of Quitters (59%) compared to same Quarter last year (64%).

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

- **Communication and awareness raising** actions using social media, targeted communications to parents via the schools, resources shared with GPs to support vaccine invites and videos targeted towards ethnic minority communities.
- Actions to **improve access**, supporting GP practices to offer catch/up sessions, the use of community venues in areas where uptake is lowest. Call-handler support to offer appointments in a more proactive way.
- **Education and information sessions** in schools where uptake is low, information sessions targeted at parents and **educational resources** for teachers.
- Broader actions as part of the **Amplifying prevention** work include focus groups and actions leveraging the partnerships with local organisations within the community.

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

Percentage uptake of the COVID-19 vaccination for those eligible: The Autumn/Winter COVID-19 booster vaccination has been underway since the 11th of September and, as of the 26th of October, in Cardiff and the Vale and uptake according to PHW is 27.09% which is slightly above the Welsh average of 26.99%. More vaccination appointments have been made available with the opening of the third Mass Vaccination Site in Rookwood and work is underway to boost staffing to maintain their capacity throughout the week.

Percentage uptake of the influenza vaccination amongst adults aged 65 years and over: The Autumn Winter vaccination is underway and due to end in March 2024. The current uptake as of the 31st of October is 57%, slightly above the Welsh average of 56.5%, data is provided mainly by primary care to PHW and will be updated periodically, it is not live data and is affected by some lag.

Operational Performance

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

October has seen an periods of sustained pressure and a deterioration from September across our suite of EU metrics: however, our average ambulance handover delay reduced and our ambulance performance remains in excess of our IMTP commitments and continues to show a considerable improvement from our historic performance. The number of 'majors' EU attendances has fallen and is currently better than our ambition, following the redesign and removal of SDEC patients from the EU flow.

The number of patients waiting 12 and 24 hours in our Emergency Department increased during October. The improvements resulting from the significant number of ward moves and redesign of our EU/AU footprint in July are taking time to fully imbed and will have impacted our performance, we continue to analyse breaches to better understand and improve our flow processes. As we enter the winter months we are already seeing increased pressure throughout our health system, with sustained periods of pressure impacting all areas of urgent and emergency care.

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

September saw further improvement in our compliance against some key SSNAP measures for our Stroke Pathway. The percentage of patients directly admitted to the stroke unit within 4-hours increased to 67.9% and remains significantly above the all Wales average. Our percentage compliance and median time to ward and CT scan remains improved from our performance in 2022 and we continue to work across Clinical Boards to progress the Stroke Service Improvement Plan. Our SSNAP grade has improved to B for the period April-June 2023, this is a significant 8-point improvement from the previous quarter and a reflection of the work undertaken by the teams. We continue to experience challenges in increasing the number of patients thrombolysed and this remains an area of continued focus, working with colleagues from the NHS Executive.

In terms of our compliance with the 62-day single cancer pathway standard, whilst we did not deliver the 75% standard as we had originally intended, our performance in August increased to 66.4% and has remained above 60% since February this year. A separate paper on Cancer was submitted to the Finance and Performance Committee last month. The September position will be available by the time of the meeting. Every quarter the UHB submits a refreshed position on our historic data to capture any treatments from previous months which have been confirmed as cancer since the original submission. The table below shows the rolling 12-month position including the latest data refresh for Q1.

SCP compliance	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
Original submission	40.1%	42.6%	54.8%	57.8%	58.5%	55.1%	61.5%	62.2%	64.2%	61.7%	62.0%	65.6%	66.4%
Compliance following quaterly refresh	50.0%	50.3%	56.9%	60.0%	62.8%	57.5%	62.9%	63.5%	66.0%	64.5%	63.6%		

The numbers of patients waiting on an RTT waiting list has increased this month. We continue to focus on long-waiting cohorts and Cancer pathways with weekly scrutiny against the national standards and ministerial ambitions.

We remain on track to deliver our commitments to eliminate 3-year Outpatient waits, and reduce our 3- and 2-year treatments waits in line with Ministerial ambitions. We are currently over our trajectory to deliver our commitment on 52-week outpatient waits. While we have made progress in reducing the cohort of patients who will breach by March 2024 the number of in month breaches remains above our ambition. Our work to eliminate 3- year outpatient waits and reduce the number of 2-year waits has improved outpatient waiting times, but we continue to see high volumes of 52-week outpatient waits within some of our treatment specialties where we are focusing on reducing long waits across the pathway. We continue to address outpatient waits through activity, validation and pathway redesign to ensure only those who need secondary care intervention are referred. This is not a UHB wide issue and we are working with specialties, particularly in Paediatrics and Medicine, to reduce to or maintain their outpatient waits below 52 weeks.

We have seen a reduction in the number of 100% delayed follow-up outpatient appointments in recent months, however, the number of delays is still higher that our ambition. Clinical Boards have developed action plans to reduce these numbers with specific focus on the longest delays. We continue to validate the waiting lists and work is ongoing to refine our patient management systems to improve data quality of follow-up outpatient lists. The use of See on Symptoms (SOS) and Patient Initiated Follow-up (PIFU) pathways is an important tool in the management of follow-up services and we continue to develop their use across our services.

The waiting list position for Diagnostics has deteriorated in recent months, with particular challenges in Radiology and Endoscopy. It is hoped that the upcoming development of a Community Diagnostic Hub, and interim use of mobile facilities will address radiological backlogs. Endoscopy capacity has been focused on Cancer, Urgent and long waiting surveillance patients. The service have an improvement plan, with additional theatre and insourcing capacity, aligned to a longer term workforce plan to further address the deterioration in the length of wait.

In October the UHB is undertaking a deep dive into the provision of General Dental Services with Cardiff and the Vale. Dental services are going through a period of reform as Welsh Government assess the impact of contract reforms on the provision of services and access to primary care dentistry. A report will be brought to a future Committee meeting for discussion.

Demand for adult and children's Mental Health services remains significantly above pre-Covid levels, including an increased presentation of patients with complex mental health and behavioral needs. Part 1a compliance for adults fell to below 50% in April following an exceptionally high number of referrals in March. However, the teams have managed to recover their waiting list position and June's reported compliance with the 28-day standard returned to 100%, remained high in July at 99.8% and was 100% in August and September. Part 2 compliance remains challenged, an improvement trajectory has been shared with NHS Executive colleagues, with Part 1 service developments supporting improvements to Part 2 compliance.

As previously noted, we have made changes to the Emergency Unit and Assessment Unit areas as described in July's paper. We anticipated that this would impact our EU attendance and 4-hour performance, beginning in July, will full month effect from August's data. This has been evidenced in the Q2 data with reported attendances and 4-hour compliance reduced from May, June and July. Welsh Government have been notified of the changes and our teams are working to ensure these changes will help to better align our reporting with

ongoing national proposals. Cardiff and Vale have been asked to lead an All Wales task and finish group to explore how we capture and report activity from an emergency and urgent perspective nationally. The changes developed will part of the Welsh Emergency Care Data Set (WECDS) development which will replace EDDS. The Health Board are meeting with the Delivery Unit regularly to develop a dataset as an exemplar in Wales. The aim is that this will be adopted across the whole of Wales to ensure we can compare services in an equitable and fair way.

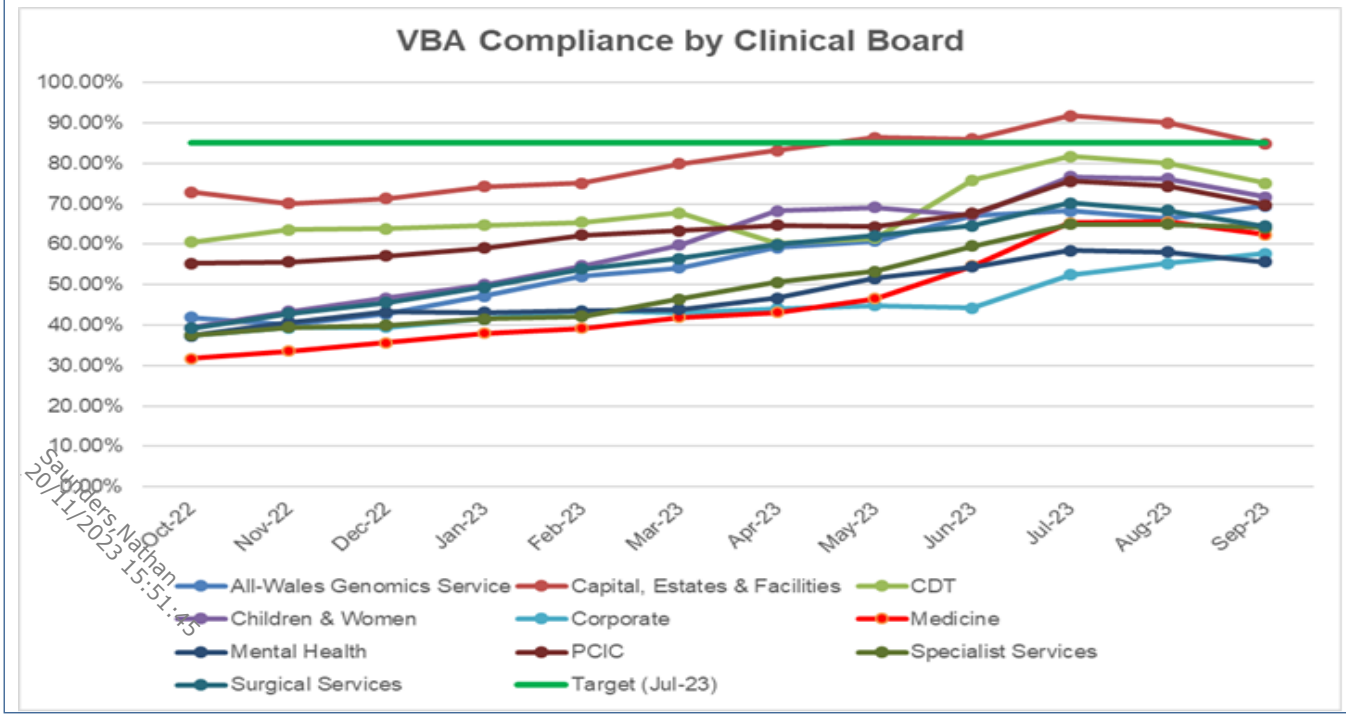
People and Culture

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

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

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

- The turnover rate (the WTE staff leaving the Health Board in the past 12 months represented as a percentage of the average WTE staff in post for the same period) has fallen from a high of 13.66% at Nov-22 to 11.80% at Sep-23. Clinical Boards are working on a range of measures to improve staff retention.
- The compliance with Valued-based Appraisal has fallen for the past 2 months, after having risen steadily from 32.36% in Apr-22 to a high of 71.64% in Jul-23. The rate for Sep-23 was 67.81%. This pattern is reflected in the performance of all of the Clinical Boards with the exception of the All-Wales Genomics Service and the Corporate Executives, which continue to rise. This is shown in the chart below



Quality Safety and Experience

Our commitment lies in putting in place a strong Quality, Safety, and Experience (QSE) structure that emphasises improving assurance and delivering excellence. This project requires a systematic and ongoing strategy. Our provided information showcases how we have integrated factors such as People's experience , efficiency, risk mitigation, and compliance with relevant regulations.

We are putting in place a strict monitoring system to oversee the framework's efficacy. To measure its long-term impact, Quality Indicators (QIs) and Key Performance Indicators (KPIs) have been established. We regularly seek feedback from users and stakeholders, applying data-driven insights to identify areas that require ongoing improvement.

The Quality, Safety, and Experience Committee (QSE) reports these indicators and thoroughly examines them.

Finance

At month 7, the UHB is reporting an overspend of £16.021m . This is comprised of £6.419m unidentified savings/operational overspend and the revised planned deficit of £9.602m (seven twelfths of the revised forecast year end deficit of £16.460m).

The forecast year end position has been amended in October from a planned deficit of £88.4m to a forecast deficit of £16.460m in line with the revised target control total issued by Welsh Government on the 20th October 2023 as follows:

Table: Movement from 2023/24 initial Core Draft Plan to Forecast Outturn at Month 7

	Revised forecast @ Month 7 £m
Planned Deficit @ Month 6	88.400
Less:	
10% Improvement required	(8.840)
Recurrent Covid Legacy U/L Deficit Funding	(20.300)
Recurrent Inflationary Uplift	(25.100)
Non recurrent Inflation Uplift	(10.100)
Energy Funding	(7.600)
Revised Forecast Deficit £m	**16.460**

Additional actions are progressing to recover the month 7 operational & CRP overspend and deliver the 10% improvement required to enable the UHB to deliver the revised £16.460m control target deficit.

Recommendation:
The Board / Committee are requested to: **NOTE the contents of this report**

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

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

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

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

Cardiff and Vale
Integrated Performance Report

November 2023

Report Contents

1. Ministerial Priorities

2. Cardiff and Vale Performance Report

Click on a hyperlink to navigate directly to the section required

Section 1: Ministerial Priorities

Return to Main Menu

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

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

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

Priority	Aim	C&V Commitment	Commitment to meet ministerial ambition?	By When	In Month Performance against C&V commitment	Link in Performance Report
Delayed Transfers of Care	**Reduction in backlog of delayed transfers** Measure: number of delayed transfers of care. Reporting period: monthly	217	Yes	June 2023	191 October	Hyperlink to section
Primary Care Access to Services	**Improved access to GP and Community Services** Measure: >95% achievement of core access to in-hours GMS Services Reporting: monthly	95%	Yes	June 2023	98% September	Hyperlink to section
	Increased access to dental services Measure: 50% of expected new patient target Reporting: monthly	50%	Yes	June 2023	99% September	Hyperlink to section
	Improved use of community pharmacy Measure: >90% of all eligible community pharmacies providing CCPS (June 2023) Reporting: monthly	90%	Yes	June 2023	98% June	Hyperlink to section
	Improved use of optometry services Measure: Reduce number of patients referred from primary care (optometry and General Medical Practitioners) into secondary care Ophthalmology services Reporting: monthly	877	Yes	Dec 2023	860 September	Hyperlink to section
Urgent and Emergency Care	**Implementation of a 24/7 urgent care service, accessible via NHS 111 Wales** Measure: Performance response time in NHS 111 Reporting: TBC	tbc	tbc	June 2023	tbc	Hyperlink to section
	Implementation of Same Day Emergency Care services Measure: Increase in SDEC attendances Reporting: monthly	1233	Yes	June 2023	1835 October	Hyperlink to section
	Honour commitments that have been made to reduce handover waits Measure: Eliminate 4 hour ambulance handover delays Reporting: monthly	0	Yes	June 2023	0 October	Hyperlink to section

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

Section 1: Ministerial Priorities

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

Return to Main Menu

Priority	Aim		C&V Commitment	Commitment to meet ministerial ambition?	By When	In Month Performance against C&V commitment	Link Performance Report
Planned Care, Recovery, Diagnostics and Pathways of Care	**Achieve RTT waiting time targets** Measure 1: 52 week new outpatient target by March 2024 Reporting: monthly		8999	No	Mar 2024	11133 September	Hyperlink to section
	Measure 2: 104 week treatment target by December 2023 Reporting: monthly		3788	Yes	Dec 2023	4054 September	Hyperlink to section
	Set foundations for achieving waiting list targets Measure: Reduce outpatient overdue follow by 25% against 2019/20 levels Reporting: monthly		37623	Yes	Mar 2024	44425 September	Hyperlink to section
	Implement regional diagnostic hubs Measure 1: progress reporting on regional diagnostic hub Reporting: quarterly		Go-Live	Yes	Dec 2023	Q1 24/25	Hyperlink to section
	Measure 2: Achieve 8-week diagnostic Reporting: monthly		0	No	June 2025	12246 September	Hyperlink to section
	Implement straight to test model Measure: progress reporting on straight to test Reporting: quarterly		Go-Live	Yes	Sept 2023	On track	Hyperlink to section
Cancer	**Achieve SCP target** Measure: 75% of patients starting their first definitive cancer treatment within 62 days Reporting: monthly		75%	Yes	June 2023	66.4% August	Hyperlink to section
	Implement the national cancer pathways within the national target Measure: progress reporting on national cancer pathways Reporting: quarterly		Go-Live	Yes	Sept 2023	Planning ongoing	Hyperlink to section
Mental Health and CAMHS	**Achieve waiting time performance for Local Primary Mental Health Support Services and Specialist CAMHS** Reporting (for all): monthly	Measure 1: Part 1a (adults)	80%	Yes	June 2023	100% Sept	Hyperlink to section
		Measure 2: Part 1b (adults)	80%	Yes	June 2023	100% Sept	
		Measure 3: Part 2 (adults)	80%	Yes	June 2023	45.7% Sept	
		Measure 4: Part 1a (children)	80%	Yes	June 2023	87% Sept	
		Measure 5: Part 1b (children)	80%	Yes	June 2023	22% Sept	
		Measure 6: Part 2 (children)	80%	Yes	June 2023	91% Sept	
	Implement 111 press 2 on a 24/7 Measure: progress on implementing NHS 111 press 2 Reporting: quarterly		Go-Live	Yes	Sept' 2023	Delivered	Hyperlink to section

Section 2: Cardiff and Vale Performance Report

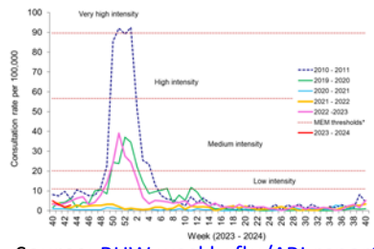
The Performance Report section provides detail of UHB performance across the quadruple aims.

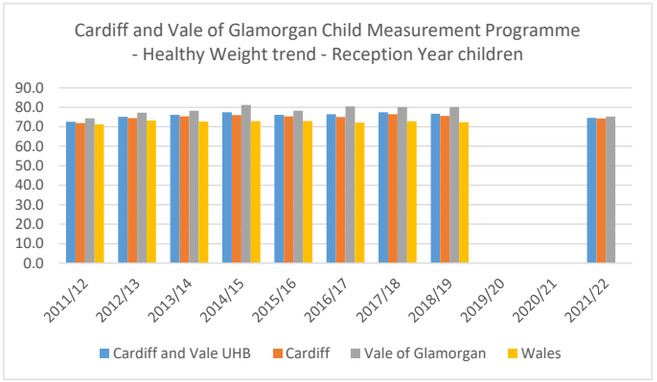
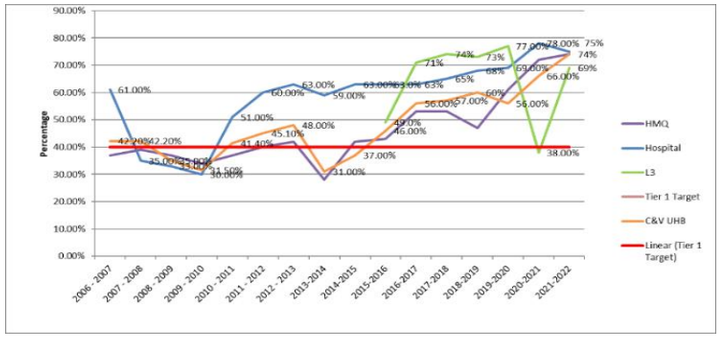
Detail on what is included under each quadruple aim is provided below.

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

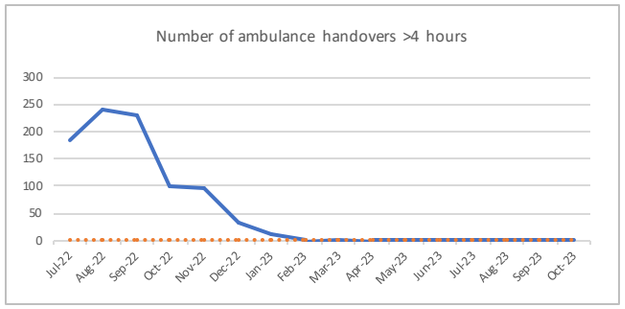
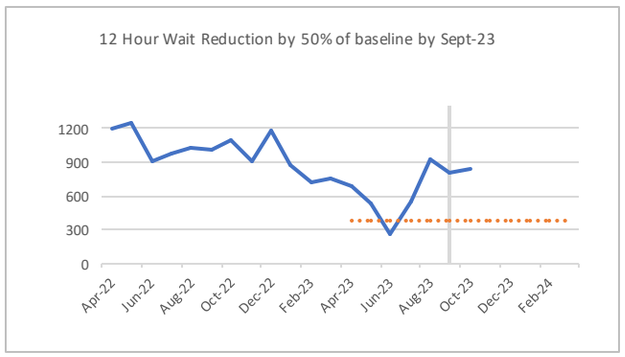
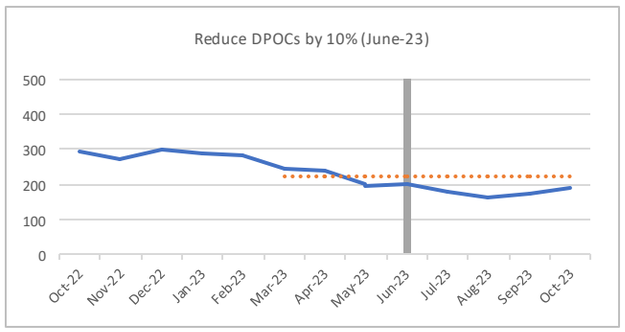
Return to Main Menu

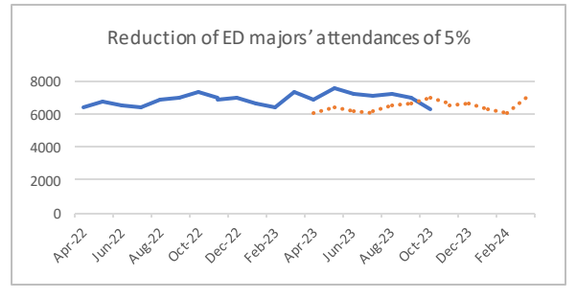
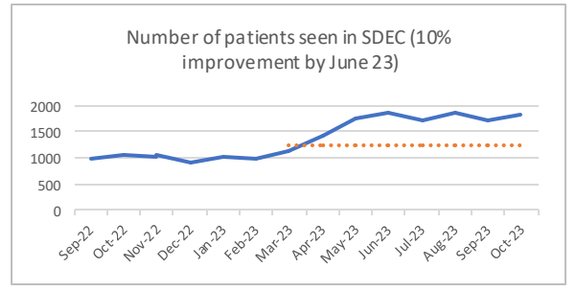
Number	Aim	Contents
Aim 1	People in Wales have improved health and well-being with better prevention and self-management	Public Health
Aim 2	People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement	Urgent and Emergency Care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

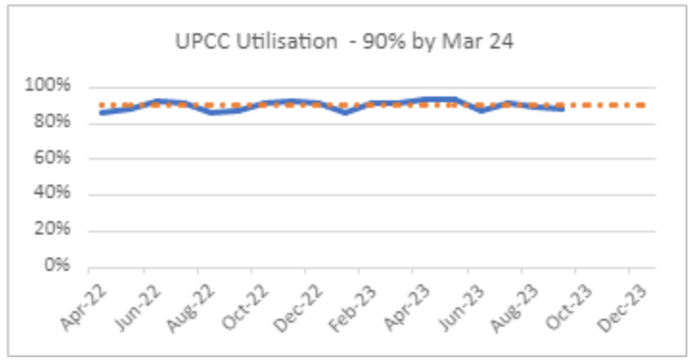
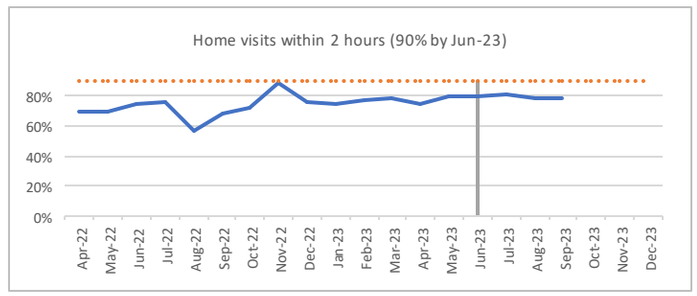
Priority	Performance Summary	Reported Period	Data
Health Protection Acute Respiratory Infections (ARI)	Acute Respiratory Infections (ARI) • Influenza activity remains low, indicating there is not yet widespread circulation • Hospital admissions for Covid-19 have fallen sharply across Wales since mid October. Covid-19 clusters in hospital are low and stable. There has been a gradual increase in LFD/PCR positivity in the last fortnight • Omicron sub-variant EG.5.1 and XBB.1.16 are currently the most common variants across Wales • RSV activity in under 5s has continued to increase and is at a very high level	Week 43	 Source: PHW weekly flu/ARI report
Health Protection Immunisation	Immunisation: • Eligible cohorts have started receiving the Covid-19 Autumn/Winter Booster, with 49,866 doses given in Cardiff and Vale as of the 26th October 2023, and 27.08% uptake to date (cf Wales average 26.99% uptake). • As of the 5th of November UHB COVID-10 Staff vaccination uptake sits at 32.7% and it is at 29.6% for Influenza vaccination. • This is delivered as part of the Staff Winter Respiratory Vaccination campaign which will see the co-administration of Covid-19 and Influenza vaccinations via appointments at Mass Vaccination Centres, occupational health and with opportunistic vaccination through vaccination champions.	Q2 2023/24	Wales COVID-19 vaccination surveillance weekly report.pdf Infant covid 19 vaccination. https://public.tableau.com/app/profile/public.health.wales.health.protection/viz/RapidCOVID-19virology-Public/Vaccination Weekly COVID-19 vaccination report by health board https://www2.nphs.wales.nhs.uk/CommunitySurveillanceDocs.nsf/3dc04669c9e1eaa880257062003b246b/cf7a9a9adcddbb0a8025866b003a51a1/$FILE/Wales%20COVID-19%20vaccination%20surveillance%20weekly%20report.pdf
Health Protection Health Protection System	Health Protection System • Planning for a regional, all hazards Integrated Health Protection Partnership is well established, with expected full implementation by end of year • A Cardiff and Vale Health Protection Plan has been developed in consultation with key partners; the Plan will be finalised in Q3	Q3 2023/24	

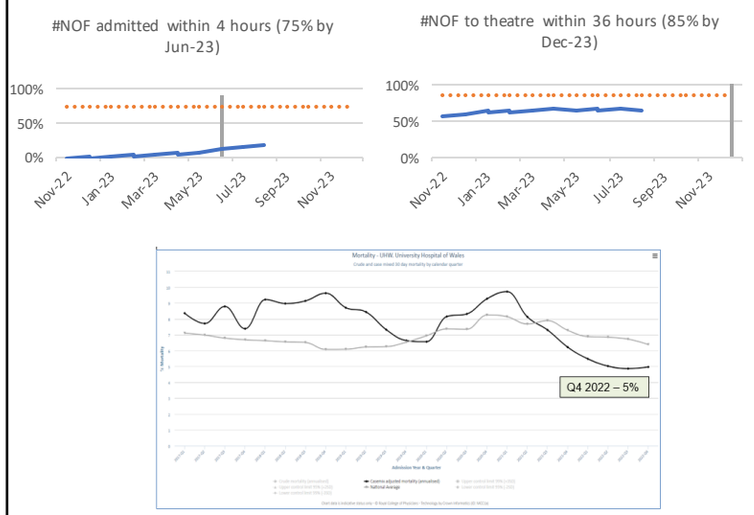
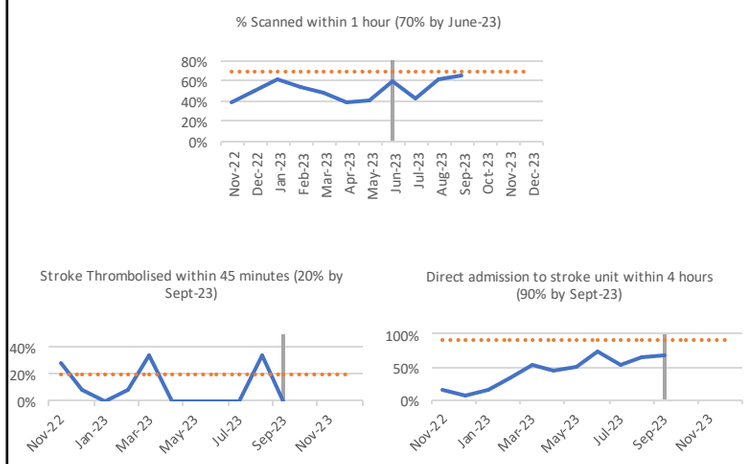
Priority	Performance Summary	Reported Period	Data
Health Improvement Healthy weight	Healthy weight: • 74.6% of reception aged children in Cardiff and the Vale of Glamorgan are categorised as healthy weight (CMP, 2021/22). Cardiff and Vale have the second highest proportion of healthy weight children compared to other Health Board areas based on the latest available data. • 40% of adults in Cardiff and the Vale of Glamorgan are of a healthy weight (NSfW, 2021/22+2022/23)*; 39% are eating five portions of fruit/vegetables a day (NSfW, 2021/22+2022/23)* and 68% are meeting physical activity guidelines of being active for at least 150 minutes per week (NSfW, 2021/22+2022/23)*. • Differences remain between our most and least deprived communities with levels of healthy weight lower, and consumption of fruit and vegetables/physical activity levels also lower in the most deprived areas of Cardiff and Vale.	Q2 2023-2024	
Health Improvement Tobacco	Tobacco • 12% of Cardiff and Vale of Glamorgan smoke), one of the lowest prevalence rates in Wales • In Quarter 1 - 0.6% of smokers set a firm quit date. 59% quit smoking at 4 weeks (HMQ, Pharmacy Level 3 and Hospital Smoking Cessation Service combined) • HMQ community – 70% of Treated Smokers had quit smoking at 4 weeks. • Level 3 Pharmacy –25% of Treated Smokers had quit smoking at 4 weeks. • Hosptial Service - 45% of Treated Smokers had quit smoking at 4 weeks. • Q2 data to be collected and submitted to Welsh Gov – Nov 23.	Quarter 1 2023-2024	

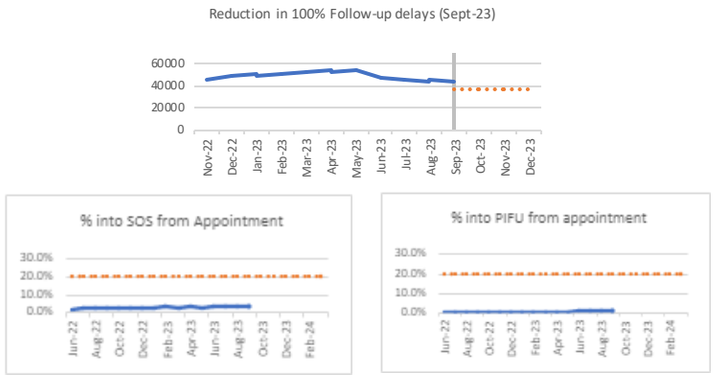
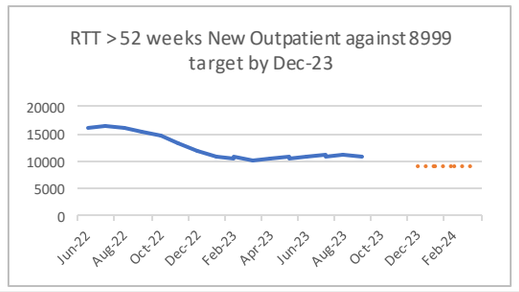
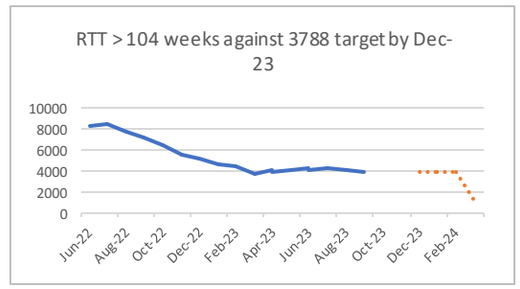
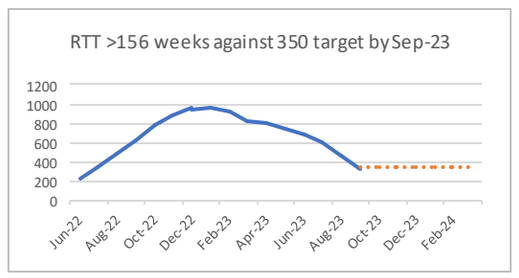
No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
1.	Percentage of adult smokers who make a quit attempt via smoking cessation services	1 Jan 23 to 31 Mar 23	0.8% per quarter	**0.6%**	Q2: 0.50% | Q3: 0.40% | Q4: 0.70% | Q1: 0.60%
2.	Percentage of people who have been referred to health board services who have completed treatment for substance misuse (drugs and alcohol)		Improvement trend	Work in progress with substance misuse	
3.	Percentage of children who are up to date with the scheduled vaccinations by age 5 ('4 in 1' preschool booster, the Hib/MenC booster and the second MMR dose)	1 Apr 23 to 30 Jun 23	95%	**83.7%**	Q1: 83.70% | Q2: 87.20% | Q3: 86.80% | Q4: 84.80%
4.	Percentage of girls receiving the Human Papillomavirus (HPV) vaccination by the age of 15 (Applicable during: 01.04.2023 - 30.06.2023 and 01.01.2024 - 31.03.2024)	1 Jan 23 to 31 Mar 23	90%	**74.4%**	Q1: 74.40% | Q2: 72.60% | Q3: 70.30% | Q4: 71.30%
5.	Percentage uptake of the influenza vaccination amongst adults aged 65 years and over (Applicable during: 01.09.2023 - 31.03.2024)	1 Sept 22 to 31 Mar 23	75%	**57%**	31st Oct: 57.00%
6.	Percentage uptake of the COVID-19 vaccination for those eligible (Applicable during: Spring Booster 01.04.2023 - 30.06.2023) (Autumn Booster 01.09.2023 - 31.03.2024)	1 Sep 23 to 30 Mar 24	75%	**30.96%**	w/e 15/10: 17.55% | we 22/10 | w/e 26/10: 27.09% | w/e 02/11: 30.96%
7.	Percentage of patients offered an index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner assessment appointment	Aug-23	90%	**31.9%**	May-23: 3.40% | Jun-23: 4.70% | Jul-23: 12.30% | Aug-23: 31.90%
8.	Percentage of well babies entering the new-born hearing screening programme who complete screening within 4 weeks	Jun-23	90%	**97.7%**	Mar-23: 96.30% | Apr-23: 95.60% | May-23: 98.00% | Jun-23: 97.70%
9.	Percentage of eligible new-born babies who have a conclusive bloodspot screening result by day 17 of life	Sep-23	95%	**97.6%**	Jun-23: 97.30% | Jul-23: 93.50% | Aug-23: 95.30% | Sep-23: 97.60%

Priority	Performance Summary	Reporting Period	Data
Ambulance Handover Annual Plan Commitments: • Zero 4-hour ambulance delays (June 23) • Reduce average lost minutes to 30 (Sept 23)	• The number of ambulance handovers >4 hours has reduced from 230 in September 2022 to zero since January 2023. We are now giving the same focus to patients waiting 2-hours for an ambulance handover. In June there were two 2-hour holds, a reduction from 206 in March, in July we reported 15, in August 20 and September 27. • Average lost minutes per arrival at UHW remains reduced decreasing to 25 minutes in October from 27 in September. Average lost minutes per arrival for the Health Board was 21. This performance remains better than our annual plan commitment.	Oct-23	
Emergency Department Annual Plan Commitments: • Zero 24-hour ED waits (June 23) • Reduce 12-hour ED waits by 50% (Sept 23)	• In October, 27 patients waited 24-hours in the EU footprint without a stop-clock, a decrease from the 41 patients in August but increased from 11 in September • 12-hour ED waits increased slightly from 803 in September to 835 in October, this is above our IMTP ambition. Work continues to embed the improvements following the significant number of ward moves and EU/AU redesign over the summer, which has impacted our performance for Q2	Oct-23	
Delayed Pathways of Care, LOS and Beds Annual Plan Commitments: • Reduce DPOCs by 10% (June-23) • Reduce >21 day LOS by 5% (June-23) • Re-establish dedicated AOS beds (Sept) Saunders,Nathan 20/11/2023 15:51:45	• Delayed pathways of care remain a national challenge, the October 2023 census reported 191 delayed pathways, an increase from 173 in September but below our commitment of 217 • We are currently tracking the numbers of stranded (7-day LOS) and superstranded (>21-day LOS) patients in our Acute beds. This is a more operationally useful measure than LOS measures which include rehabilitation and integrated care beds. We will be monitoring these going forward against the standards of <40% stranded and < 20% superstranded. At the time of writing our analysis showed 31% and 58% respectively. • Work continues to evaluate the most appropriate and effective approach for the Acute Oncology Service (AOS), including consideration of dedicated beds following a recent pilot. An update and proposal is now planned for the beginning of Q3.	Oct-23	

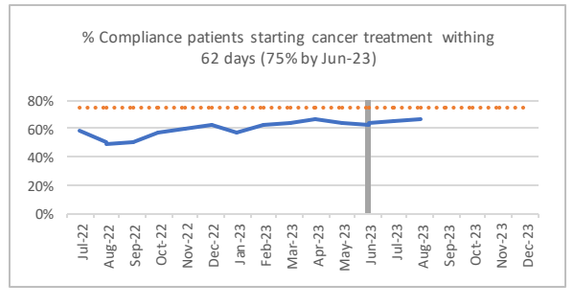
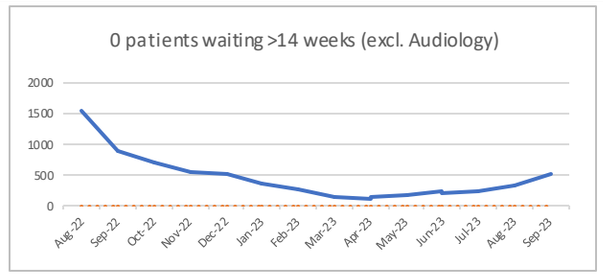
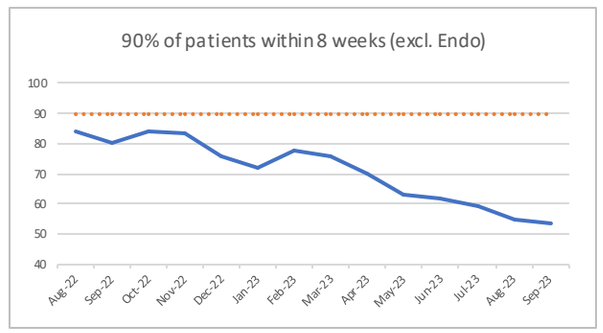
Priority	Performance Summary	Reporting Period	Data
ED Attendances Annual Plan Commitment • Reduction of ED majors' attendances of 5% compared to same period 2022/23 (every quarter)	• In October 2023 we reported 11,653 EU attendances, an decrease from the 12,395 reported in September • The number of EU Majors attendances in October 2023 was 6,216, an decrease from September and below our ambition of 6507.	Oct-23	
Same Day Emergency Care Annual Plan Commitment • 10% increase in the total number of patients managed through SDEC (June 2023) • Reduced number of unplanned re-presentations within 7-days of SDEC attendance (September 2023) • Improve % of take managed in SDEC without requiring admission	• In October 2023 we saw 1,162 patients seen via surgical SDEC and 673 via the medical SDEC. In total 1,835 patients were seen, above our commitment of a 10% increase by the end of Q1. The number of attendances to medical SDEC had been increasing month on month since June 2022, but showed a small reduction from August to September. • A new process for national submissions has been undertaken and we hope to report on the other measures once complete	Oct-23	

Priority	Performance Summary	Reporting Period	Data
Urgent Primary Care Annual Plan Commitments: • 80% appointment utilisation in UPCCs (June 2023), 85% (September 2023), 90% (March 2024) • All clusters to have adequate access to UPCC capacity (September 2023) • NHS 111 - >90% urgent calls logged and returned within 1 hr (December 2023) • Increased redirections from ED to UPCC (March 2024)	• Average utilisation of 88% achieved across Cardiff and Vale for September, a decrease from 91% in July. • Delivery plan in place to develop Urgent Care Centres as part of the 6 Goals Programme, to achieve full and equitable access across Cardiff and Vale – (76% Coverage, increasing to 86% by December) • Calls to CAV247/OOH service - Q1 = 93%, Q2 87% • Work in progress – Pilot commenced to re-direct ED patients to UPCC slots. Work ongoing to expand this to 24/7 and to include Paediatrics. Total referrals for Q1 = 63, Q2 = 122	Sept-23 Q2-Sept 23	
Community Services • Home Visit (P2) f2f in 2 hrs >90% (June 2023)	• The Health Board was 100% compliant in September 2023 against the standard of 100% for 'Emergency' GP OOH patients requiring a home visit within one hour, with 7 of 7 patients receiving their visit with one hour. • For patients that required an 'Emergency' appointment at a primary care center in September the Health Board was 100% compliant, with 8 of 8 patients receiving an appointment within 1 hour • The Health Board was 79% compliant against the commitment of 90% for 'Urgent' GP OOH patients requiring a home visit within 2 hours, with 81 of 102 patients receiving their visit within 2 hours	Sept-23	

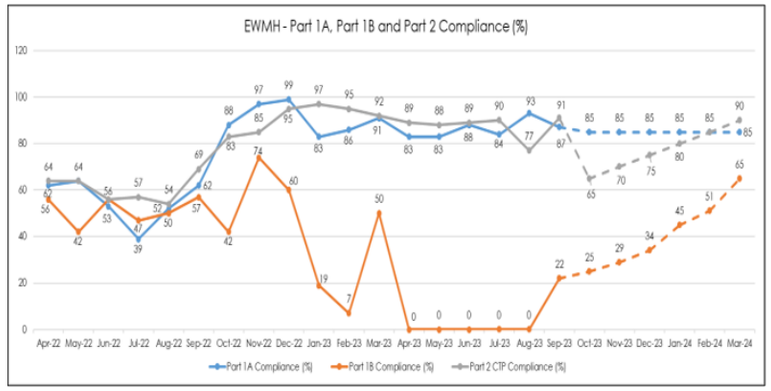
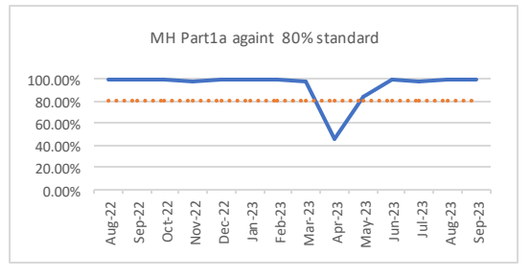
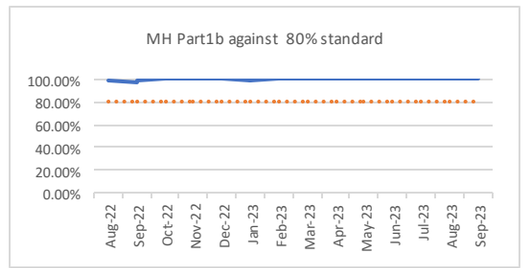
Priority	Performance Summary	Reporting Period	Data
Fracture Neck of Femur IMTP Commitments: • 75% admitted within 4 hours (June-23) • 85% to theatre within 36 hours (December-23)	Performance against the standards within the National Falls and Fragility Fracture Audit Programme (FFFAP) has shown some improvement. In August 2023 the annualised data shows 18.5% of patients were admitted to a specialist ward with a nerve block within 4 hours. In August, 67.5% of patients received surgery within 36 hours, this has been increasing since August 2022 and our performance is above the national average of 57% over the last 12 months. A third summit with key stakeholders was held in June with a follow up at the end of September. We have an ambition for significant increases in our performance moving forwards to make Cardiff and Vale an upper quartile performer when compared to UK peers. In addition to pathway improvements, we are committed to improving outcomes for patients. Data from the National Hip Fracture Database shows that annualised Casemix Adjusted Mortality rates have falls from early 2021 and is now below the national average at 5% for Q4 22/23.	Aug-23	
Stroke IMTP Commitments: • 70% scanned within 1 hour (June-23) • 90% admitted within 4 hours (Sept-23) • 20% thrombolysis rate (Sept-23)	While overall Stroke performance remains below the standards set out in the Acute Stroke Quality Improvement Measures and The Sentinel Stroke National Audit Programme (SSNAP), we have seen recent improvements in compliance with the 4-hour door to Ward standard. In August : • 0% of patients were thrombolysed within 45 minutes of arrival, the All-Wales average was 7.0% • The percentage of CT scans that were started within 1 hour in September was 66.1%, the All-Wales average was 58.8% • The percentage of patients who were admitted directly to a stroke unit within 4 hours was 67.9% in September, the All-Wales average was 32.4% The UHB has held a number of internal Stroke summits and improvements to the stroke pathway are now being implemented including increased Clinical Nurse Specialists during out of hours, additional middle grade medical cover for the Emergency Unit and ringfencing of additional stroke beds to deploy the pull model from EU effectively. The UHB aspires to achieve a rating of grade 'A' for SSNAP. At the most recent SSNAP audit the service we awarded grade 'B', a significant improvement from the previous quarter.	Sept-23	
Intensive Care Unit IMTP Commitments: • Patient at risk team 24/7 (Sept 23) • ITU - 1 additional staffed bed (Sept 23) • ITU - 2 additional staffed beds (March 24)	• The patient at risk team (PART) is due to move from a 12/7 service to a 24/7 service from the 1st October following successful staff recruitment. This change will be pivotal in supporting the wards and ITU with the save management and transfer of patients. • 3 additional ITU Level 3 beds will be resourced over the course of this financial year. The first of those beds is on-track to be resourced from September 2023 following successful recruitment of staff	Sept-23	

Priority	Performance Summary	Reporting Period	Data
Outpatient Follow-up Management Annual Plan Commitment • Follow up outpatients–reduce 100% delayed follow up by 25% on Jan'23 baseline of 50163 (September 2023) • SOS and PIFU –10% of appropriate outpatient appointments (September 2023); 20% (March 2024) • SOS and PIFU –20% of appropriate outpatient appointments	• In total there were 192,040 patients awaiting a follow-up outpatient appointment at the end of September • Of these, there were 44,425 patients who were 100% delayed for their follow-up outpatient appointment, a decrease noted from August • 3.2% of outpatient appointments saw patients moving into a See on Symptoms pathway • 0.6% of outpatient appointments saw patients moving into Patient Initiated Follow-up pathway	Sept-23 Sept-23	
52 Week New Outpatient Annual Plan Commitment • <8999 > 52 weeks (March 2024)	• We have developed a weekly monitoring and assurance process to update on progress against our key long waiting cohorts. A separate paper was submitted to Finance and Performance Committee last month detailing our plan to meet the revised ministerial ambitions and we will update here from October's data. Weekly assurance is provided to the Chair.	Sept-23	
104 Week Treatment Annual Plan Commitment • 3788 patients > 104 week waits for treatment (December 2023) • 1263 patients > 104 week waits for treatment (March 2024)	• We have developed a weekly monitoring and assurance process to update on progress against our key long waiting cohorts. A separate paper was submitted to Finance and Performance Committee last month detailing our plan to meet the revised ministerial ambitions and we will update here from October. Weekly assurance is provided to the Chair. We are on track to meet our December commitment	Sept-23	
156 Week Waits Annual Plan Commitment • <350 patients >156 week wait for treatment (September 2023) • 0 patients >156 week wait for treatment (December 2023)	• We have developed a weekly monitoring and assurance process to update on progress against our key long waiting cohorts. At the end of September there were 330 patients waiting 156 weeks for treatment, lower than our commitment.	Sept-23	

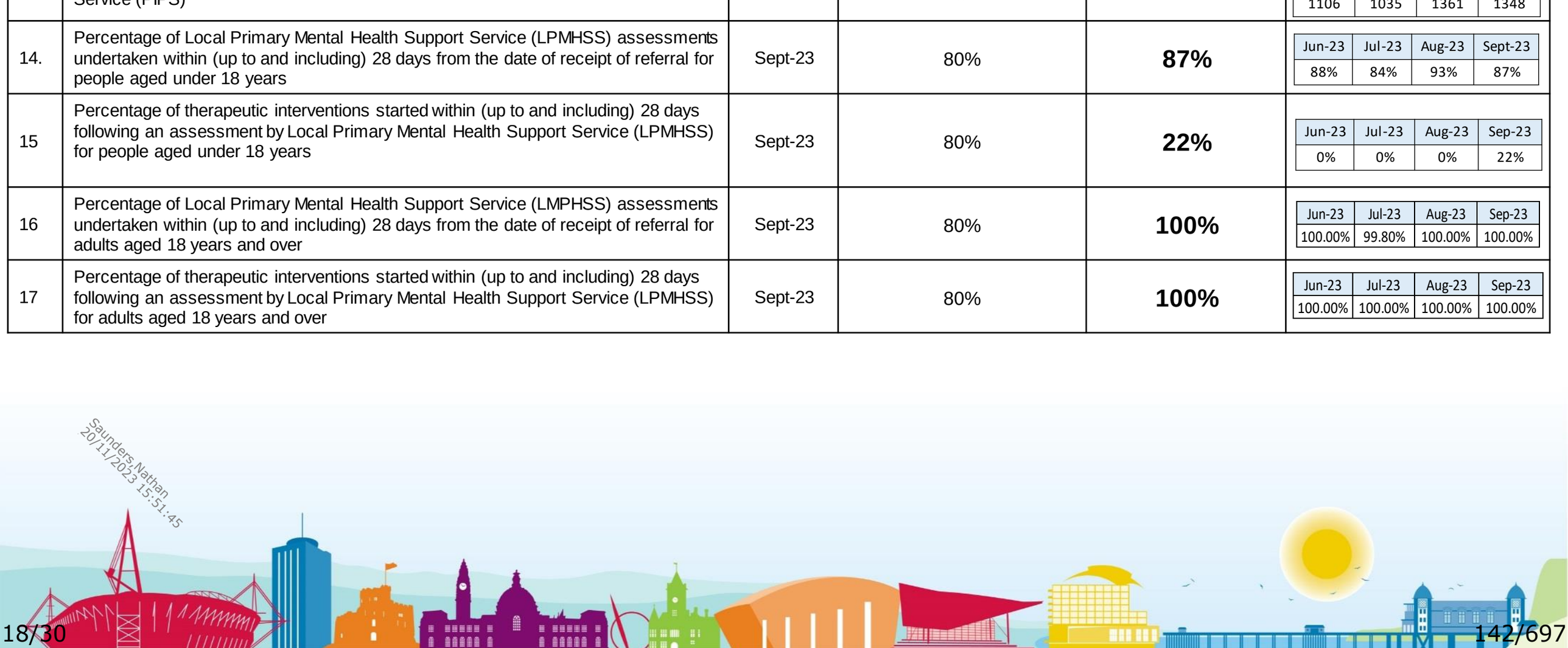
Priority	Performance Summary	Reporting Period	Data
Community Pharmacy Annual Plan Commitment: • >90% of all eligible community pharmacies providing CCPS (June 2023) • 10% increase in pharmacy independent provider access (December 2023)	98% of all eligible community pharmacies providing CCPS • 102 Community Pharmacies currently eligible to provide CCPS • 101/103 Community Pharmacies signed up to deliver CCPS. 3502 PIP consultations undertaken in Q2, increased from 2395 in Q1. There has been an increase to 31% of pharmacies providing PIP services.	Q2-Sept 2023	PIP consultations: Jul-23: 1106; Aug-23: 1035; Sep-23: 1361; Oct-23: 1348
GMS Escalation Annual Plan Commitment: • >95% of practices reporting escalation levels (June 2023) • >95% achievement of core access to in-hours GMS Services (September 2023)	• Average of 88% of Practices reporting escalation levels (Average for Q1 88%) - Number of escalations from practices reducing (of practices reporting of which 8% at Lvl3, 92% >Lvl3) • 98% achievement of core access standards to in hours GMS	Q2-Sept 2023	Escalation reporting: Q1: 88.0%; Q2: 88.0% National Access Standards: Q1: 98.0%; Q2: 98.0%
Dental Annual Plan Commitment: • 50% of expected target for new patients, urgent and historic (June 2023); 90% (March 2024)	• % of Primary Care Dental Services Contract value (GDS) delivered for new patients seen – 99.8% • % of Primary Care Dental Services Contract value (GDS) delivered for new urgent patients seen - 45.1% • % of Primary Care Dental Services Contract value (GDS) delivered for historic patients seen – 43.8%	Q2-Sept 2023	New: Jun-23: 46.1%; Jul-23: 64.1%; Aug-23: 84.2%; Sep-23: 99.8% New Urgent: 22.0%; 29.5%; 37.3%; 45.1% Historic: 16.0%; 27.5%; 36.9%; 43.8%
Optometry Annual Plan Commitment • >90% of eligible practices offering Clinical Community Optometry Services (CCOS) (June 2023); 95% (December 2023)	• Contract reform and implementation still in progress	Q2-Sept 2023	
Respiratory Annual Plan Commitment • 50% of backlog of suspected COPD patients receive spirometry (June 2023); 100% March 2024)	• Community Spirometry service available in both Cardiff and Vale regions. • •1006 patients referred (in total) up to August - 83% have attended appointments, 103 patients remain on waiting list. Estimate 35% of expected demand has been seen in service. Service scope expands from November to include post-bronchodilator spirometry for COPD , FeNO and Reversibility for suspected asthma.	Q2-Sept 2023	

Priority	Performance Summary	Reporting Period	Data
Cancer Annual Plan Commitment • >75% compliance with the 62-day SCP standard (June 2023), 80% (December 2023)	• There continues to be an improvement against the Single Cancer Pathway and the backlog trajectories agreed with the Delivery Unit. August saw 66.4% of patients receiving treatment within 62 days. At the time of writing there are a total of 2421 suspected cancer patient on the SCP. 351 have waited over 62 days, of which 108 have waited over 104 days. There have been a number of actions taken to improve the oversight and operational grip of the process for overseeing patients. Three cancer summits have taken place with the tumour group leads and operational teams to understand the demand, the causes for delay in the 62-day pathway and what actions are required to reduce the delays experienced by our patients.	Aug-23	
• Develop draft UHB strategy to deliver national cancer pathways (June 2023)	• The UHB draft strategy has been developed including working with national cancer pathways	No date	
Therapies Annual Plan Commitment • 0 patients waiting over 14 weeks (excluding audiology) (June 2023)	• Excluding Audiology there were 529 patients waiting over 14-weeks for Therapy in at the end of September. In total there were 1703 patients waiting longer 14 weeks for Therapy, an increase from August.	Sept-23	
Diagnostics Annual Plan Commitment • 90% of patients within 8-weeks (excl. endoscopy) (December 2023) • Endoscopy – urgent <6weeks; SCP<14days; 0 surveillance patients 100% past target date (December 2023) • Regional Diagnostic Centre go-live (December 2023)	• Excluding endoscopy there were 8322 diagnostic patients waiting longer than 8 weeks for a Diagnostic at the end of September. In total there were 12246 patients waiting longer than 8 weeks for a diagnostic test, an increase from August. • 53% of patients seen within 8 weeks in September-23 (excluding Endoscopy), a reduction from July and August. • Planning for the Community Diagnostic Hub is underway following agreement of central funding from WG. Expected go-live is estimated to be Q1 2024/25. Plans are in development to provide additional diagnostic capacity through mobile units in advance of this.	Sept-23 No date	

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

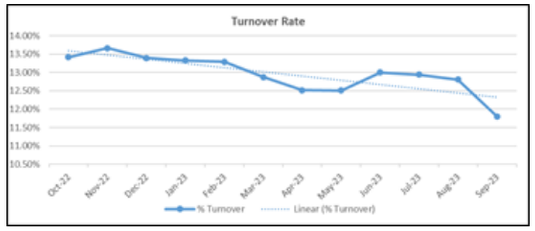
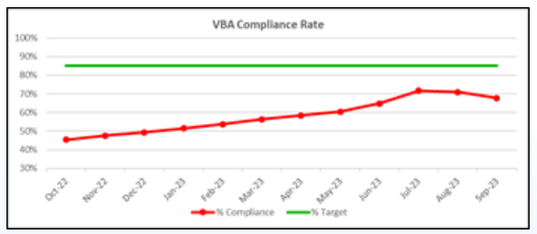
Priority	Performance Summary	Reporting Period	Data
Children's Mental Health Annual Plan Commitments: • >80% Part 1a performance – SCAMHS • Part 1b – 10% improvement (September 2023); further 10% (December 2023); achieve >80% compliance (March 2023) • Reduce SCAMHS Intervention longest wait to no longer than 6 weeks	Part 1a compliance remains above the 80% target at 87% in September. Part 1b performance increased to 22% but remains low due to additional assessment undertaken to meet Part 1a and high referral levels in June 23. The number waiting and longest wait for Part 1b have decreased following increases due to the merge in data reporting for PMH and CAMHS. There have been data quality issues and a through improvement in the capture of data which has further impacted reported performance. In line with the new integrated model and focus on ensuring that children and young people access the most appropriate pathway under the mental health measure, we have redesigned the PARIS record keeping module and associated reporting to accurately capture the children and young people accessing and waiting for interventions for both Part 1b and Part 2 (SCAMHS). It is planned for this to go live in September so we expect to be able to provide accurate reporting from October.	Sept-23	
Adult Mental Health Annual Plan Commitments: • >80% Part 1a performance • >80% Part 1b performance Saunders,Nathan 20/11/2023 15:51:45	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 1434 referrals in September 2023. As highlighted at the previous Board meetings, this demand increase includes an increased presentation of patients with complex mental health and behavioral needs. Significant work has been undertaken to improve access times to adult primary mental health: • Part 1a: in September the percentage of Mental Health assessments undertaken within 28 days was 100% • Part 1b compliance remains at 100%	Sept-23	 

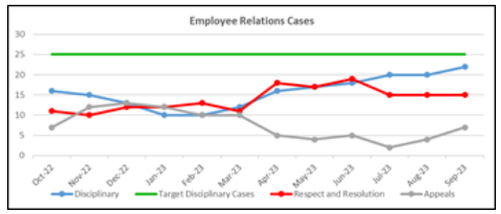
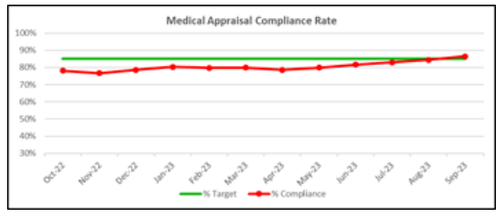
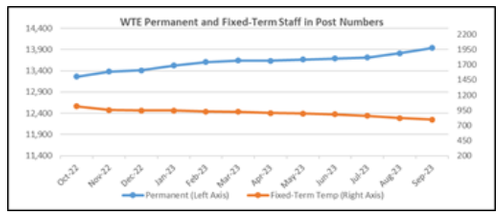
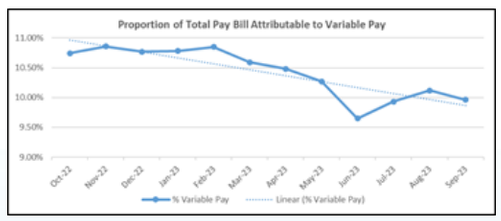
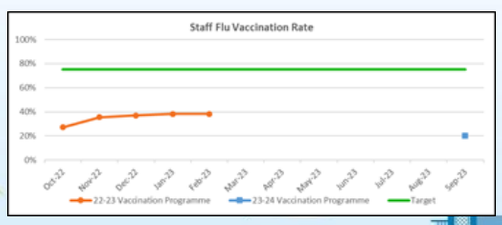
No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
10.	Percentage of GP practices that have achieved all standards set out in the National Access Standards for In-hours	Sept-23	100%	**98%**	Q1: 98.0% / Q2: 98.0%
11.	Percentage of primary care dental services (GDS) contract value delivered (for courses of treatment for new, new urgent and historic patients)	Sept-23	30% (Sept 23) 100% (Mar 24)	**New 99.8%** **New Urgent 45.1%** **Historic 43.8%**	Jun-23: 46.1% / 22.0% / 16.0% Jul-23: 64.1% / 29.5% / 27.5% Aug-23: 84.2% / 37.3% / 36.9% Sep-23: 99.8% / 45.1% / 43.8%
12.	Number of patients referred from primary care (optometry and General Medical Practitioners) into secondary care Ophthalmology services	Sept-23	Reduction by Mar 24	**860**	Jun-23: 958 / Jul-23: 1000 / Aug-23: 953 / Sep-23: 860
13.	Number of consultations delivered through the Pharmacist Independent Prescribing Service (PIPS)	Sept-23	Increase against 22/23	**1361**	Jul-23: 1106 / Aug-23: 1035 / Sep-23: 1361 / Oct-23: 1348
14.	Percentage of Local Primary Mental Health Support Service (LPMHSS) assessments undertaken within (up to and including) 28 days from the date of receipt of referral for people aged under 18 years	Sept-23	80%	**87%**	Jun-23: 88% / Jul-23: 84% / Aug-23: 93% / Sept-23: 87%
15	Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by Local Primary Mental Health Support Service (LPMHSS) for people aged under 18 years	Sept-23	80%	**22%**	Jun-23: 0% / Jul-23: 0% / Aug-23: 0% / Sep-23: 22%
16	Percentage of Local Primary Mental Health Support Service (LMPHSS) assessments undertaken within (up to and including) 28 days from the date of receipt of referral for adults aged 18 years and over	Sept-23	80%	**100%**	Jun-23: 100.00% / Jul-23: 99.80% / Aug-23: 100.00% / Sep-23: 100.00%
17	Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by Local Primary Mental Health Support Service (LPMHSS) for adults aged 18 years and over	Sept-23	80%	**100%**	Jun-23: 100.00% / Jul-23: 100.00% / Aug-23: 100.00% / Sep-23: 100.00%



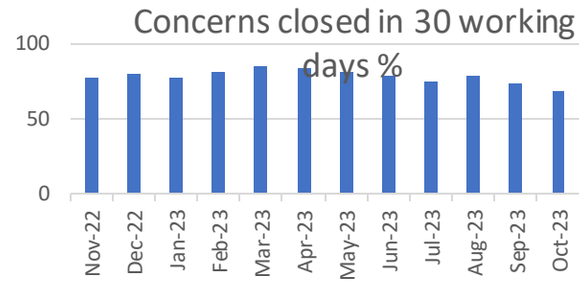
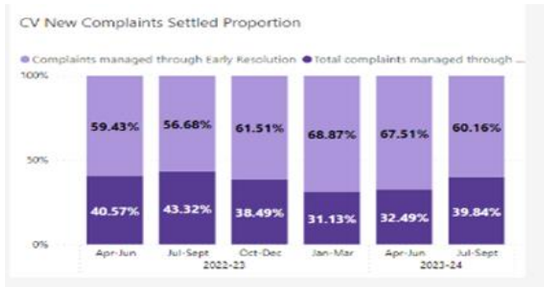
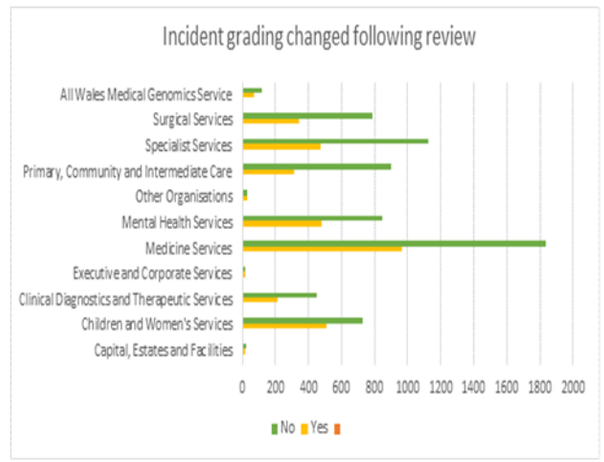
No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
18.	Percentage of emergency responses to red calls arriving within (up to and including) 8 minutes	Oct-23	65%	**53%**	Jul-23: 57% / Aug-23: 51% / Sep-23: 52% / Oct-23: 53%
19.	Median emergency response time to amber calls	Sept-23	12m improvement trend	**01:12:07**	Jun-23: 00:47:06 / Jul-23: 01:02:14 / Aug-23: 01:21:44 / Sep-23: 01:12:07
20.	Median time from arrival at an emergency department to triage by a clinician		12m reduction trend	Work in Progress	WIP – Expected Q3
21.	Median time from arrival at an emergency department to assessment by a senior clinical decision maker		12m reduction trend	Work in Progress	WIP – Expected Q3
22.	Percentage of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge	Sept-23	95%	**70.5%**	Jun-23: 75.3% / Jul-23: 75.6% / Aug-23: 68.8% / Sep-23: 70.5%
23.	Number of patients who spend 12 hours or more in all hospital major and minor emergency care facilities from arrival until admission, transfer, or discharge	Sept-23	0 (Mar 2024)	**803**	Jun-23: 260 / Jul-23: 548 / Aug-23: 924 / Sep-23: 803
24.	Percentage of patients starting their first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)	Aug-23	80% (Mar 2026)	**66.4%**	May-23: 64.4% / Jun-23: 63.6% / Jul-23: 65.6% / Aug-23: 66.4%
25.	Number of patients waiting more than 8 weeks for a specified diagnostic	Sept-23	0 (Mar 2024)	**12246**	Jun-23: 9175 / Jul-23: 10009 / Aug-23: 11415 / Sep-23: 12246
26.	Percentage of children (aged under 18 years) waiting 14 weeks or less for a specified Allied Health Professional	Sept-23	Improvement trend	**80.29%**	Jun-23: 85.00% / Jul-23: 85.23% / Aug-23: 82.79% / Sep-23: 80.29%
27.	Number of patients (all ages) waiting more than 14 weeks for a specified therapy	Sept-23	0 (Mar 2024)	**1703**	Jun-23: 1240 / Jul-23: 1282 / Aug-23: 1373 / Sep-23: 1703

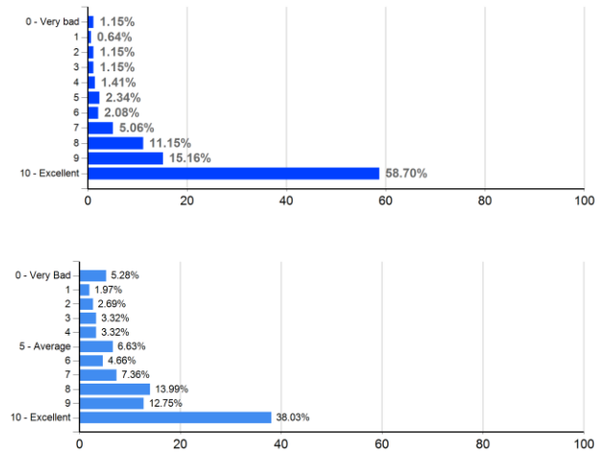
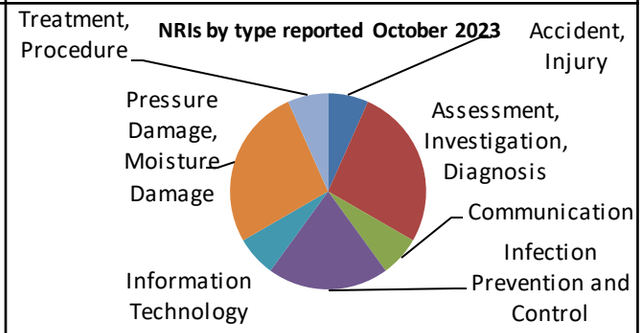
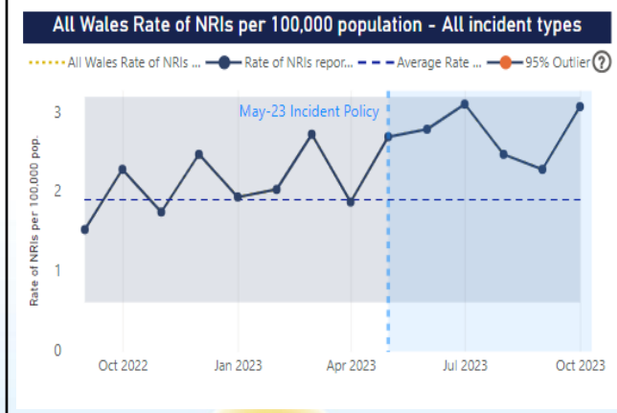
No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
28.	Number of patients waiting more than 52 weeks for a new outpatient appointment	Sept-23	Improvement trajectory towards 0	**11133**	Jun-23: 10789; Jul-23: 11138; Aug-23: 11230; Sep-23: 11133
29.	Number of patients waiting more than 36 weeks for a new outpatient appointment	Sept-23	Improvement trajectory towards 0	**20646**	Jun-23: 19839; Jul-23: 20580; Aug-23: 21018; Sep-23: 20646
30.	Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%	Sept-23	Improvement trajectory towards 0	**44425**	Jun-23: 46981; Jul-23: 45644; Aug-23: 44993; Sep-23: 44425
31	Number of patients waiting more than 104 weeks for referral to treatment	Sept-23	Improvement trajectory towards 0	**4054**	Jun-23: 4133; Jul-23: 4164; Aug-23: 4085; Sep-23: 4054
32.	Number of patients waiting more than 52 weeks for referral to treatment	Sept-23	Improvement trajectory towards 0	**25541**	Jun-23: 24778; Jul-23: 25653; Aug-23: 25463; Sep-23: 25541
33.	Percentage of patients waiting less than 28 days for a first appointment for specialist Child and Adolescent Mental Health Services (sCAMHS) – now EWMHS	Sept-23	80%	**87%**	Jun-23: 88%; Jul-23: 84%; Aug-23: 93%; Sep-23: 87%
34.	Percentage of children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment	Sept-23	80%	**25%**	Jun-23: 26%; Jul-23: 20%; Aug-23: 17%; Sep-23: 25%
35.	Percentage of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health	Sept-23	80%	**63%**	Jun-23: 58%; Jul-23: 60%; Aug-23: 57%; Sep-23: 63%

Priority	Performance Summary	Reported Period	Data
Turnover	The overall trend is downwards since Oct-22; the rates have fallen from 13.66% in Nov-22 (the highest rate of turnover in the past 12 months) to a low of 11.80% in Sep-23 UHB wide. This is a net 1.86% decrease, which equates roughly to 222 WTE fewer leavers. The top 5 reasons recorded for leaving are; 'Voluntary Resignation - Other/Not Known', 'Voluntary Resignation – Relocation', 'Retirement Age', 'Voluntary Resignation – Work Life Balance' and 'Voluntary Resignation – Promotion'.	Sep-2023	
Sickness Absence	Rates remain high; although the rates appear to be the falling towards more 'normal' levels. The monthly sickness rate for Sep-23 was 5.49% after an all-time high of 8.58% for Dec-22. The 12-month cumulative rate has fallen steadily over the past 9 months to 6.53% (by comparison with Sep-22, which was 7.12%).	Sep-2023	
Statutory and Mandatory Training	After month-on-month increases between Oct-22 and Aug-23 the compliance rate has fallen slightly, to 81.24% for Sep-23, 3.76% below the overall target. The compliance for Capital, Estates & Facilities, All-Wales Genomics Services, and Clinical Diagnostics & Therapeutics are all above the 85% target, and Children & Women's, PCIC, Corporate Executives and Specialist Services are above 80% compliance. After reaching 74.87% for Jul-23 the compliance with Fire training has also fallen during Sep-23, to 73.87%. Again, Capital, Estates & Facilities and the All-Wales Genomics Services have exceeded the 85% compliance target, and Clinical Diagnostics & Therapeutics is above 80%.	Sep-2023	 
Values Based Appraisal	After reaching 71.64% in Jul-23 VBA compliance has fallen to 67.81% for Sep-23. Capital, Estates & Facilities (84.80%) are the only Clinical Board to have exceeded the 85% target, between May and August, but their compliance has fallen slightly. All of the Clinical Boards with the exception of Mental Health and the Corporate Executive group remain above the 60% transitory target which was set to be achieved by Mar-23.	Sep-2023	

Priority	Performance Summary	Reported Period	Data
Employee Relations	As can be seen in the graph the number of employee relations cases the People Services team are supporting has risen in the past three months but remains below the UHB Target. Further work is being undertaken to help embed the Just Culture principles within the UHB and a Just Culture Toolkit is being developed. The People Services Team continue to analyse trends of employee relations cases to develop bespoke training packages or additional toolkits/support services where appropriate.	Sep-2023	
Job Plans	90.37% of clinicians have engagement with job planning and have a job plan in the system, however only 50.17% of these plans are fully signed off. Focus continues to be on supporting the approval and sign off process.	Sep-2023	
Medical Appraisals	The rate of compliance with Medical Appraisal has risen during the past 12 months. At Sep-23 the compliance was 86.54%, i.e. above the 85% target.	Sep-2023	
Staff in Post	The overall Health Board Staffing Numbers have increased in the last 12 months by 454.99 WTE, to 14,732.78 WTE. The change in the split between permanent and fixed-term as shown in the graph below is largely due to validation of the ESR data held for staff contract type. Bank usage has been removed from the graph; there is detailed weekly monitoring and analysis of bank, agency and overtime use taking place within the Health Board.	Sep-2023	
Variable Pay (Bank, Agency, Overtime..)	The trend of proportion of the pay bill spend on variable pay (Bank, Agency, overtime etc.) is falling. It has been as high as 10.85% of the total spend on pay, but in Sep-23 was 9.96%. It must however be borne in mind that the total pay bill is increasing.	Sep-2023	
Staff Influenza Vaccination Programme	The 2023-24 winter influenza vaccination programme commenced in Sep-23. So far 20% of staff have received the vaccine, by comparison with a target of 75% vaccination. The 2022-23 programme reached 38.30% of staff by Feb-23.	Sep-2023	

No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
36.	Percentage of sickness absence rate of staff	Sep-23	6%	**5.49%**	Jun-23: 5.86% | Jul-23: 6.18% | Aug-23: 6.18% | Sep-23: 5.49%
37.	Staff turnover measure tbc starters and leavers and/or vacancies?	Sep-23	7%-9%	**11.80%**	Jun-23: 13.00% | Jul-23: 12.94% | Aug-23: 12.81% | Sep-23: 11.80%
38.	Agency spend as a percentage of the total pay bill	Sep-23	12 month reduction trend	**1.54%**	Jun-23: 1.99% | Jul-23: 2.41% | Aug-23: 2.42% | Sep-23: 1.54%
39.	Percentage headcount by organisation who have had a Personal Appraisal and Development Review (PADR)/medical appraisal in the previous 12 months (including doctors and dentists in training)	Sep-23	85%	**69.00%**	Jun-23: 65.86% | Jul-23: 72.37% | Aug-23: 71.82% | Sep-23: 69.00%

Priority	Performance Summary	Reported Period	Data
Concerns 30 day performance	• **Welsh Government target for responding to concerns is 75% within 30 working days** • During September and October 2023, the Health Board received : • 646 Concerns • 71% closed within 30 working days (including Early Resolution) • 48 % closed under Early Resolution (within 2 days including day of receipt) • 155 Enquiries • 94 Compliments We currently have 291 active concerns Top 3 themes and trends 1. Concerns around appointments (waiting times/cancellations) 2. Communication 3. Clinical Treatment and Assessment	September and October 23	 
Duty of Candour	• 16,670 incidents have been reported by staff across the Health Board • Approximately 33% incidents regraded by the Patient Experience team working with the Clinical Boards and feeding back to the incident reporter. • Approximately 65 incidents reviewed per day by the Patient Experience Team • We continue to support DOC awareness sessions across Primary and Secondary care • Since 1st April 2023 we have triggered the DOC on 35 occasions • We have internally audited the process and compliance • We are undertaking a mid year review with colleagues in primary care		

Priority	Performance Summary	Reported Period	Data
Patient Feedback – Civica	• Went live on Friday 28th October 2022 and we are currently surveying up to 800 patients daily via text, 600 chosen randomly from general hospital activity and 200 from the EU. As of the end of October 2023, we have sent 124,540 texts and are seeing a response of 18%. • In September, we sent 13,218 texts and had 2185 completions (17% response). • In October, we sent 13,461 texts and had 2252 completions (17% response). • Of those respondents who were discharged during September/October and answered the rating question, 86% were satisfied with our service. • Currently, our response rate is 18% and whilst it's our understanding that this is higher than many organisations, we will be focussing on improving this over the next year, with an ambitious aim for a minimum return of 25% by end of March 24.	Sep/Oct-23 (Random) Sep/Oct-23 (EU)	
Patient Safety	During October, 2046 patient safety incidents were reported, an increase of more than 3,400 incidents form the previous month. Pressure damage was again the highest reported patient safety incident category, followed by accident injury (falls). Again more than half were reported as low harm. <u>NRI performance October</u> • Number of open NRIs – 63 (67 in Sept) • Number of NRIs submitted - 15 • Number of closures submitted – 20 (10 submitted in September) • Number of overdue NRIs – 29 (27 in September) Figure 2 shows C&V NRI reporting rate per 100,000 population exceeds the national average which shows we have a low threshold for external reporting reflecting openness and transparency. As a tertiary referral centre it also reflects the complex nature of care provided not only to C&V patients but to those receiving specialist treatment within our HB. July and October 2023 were high NRI reporting months, Figure 1 shows a breakdown of what was reported to NHS Exec as an NRI in October 2023 by C&V.		 

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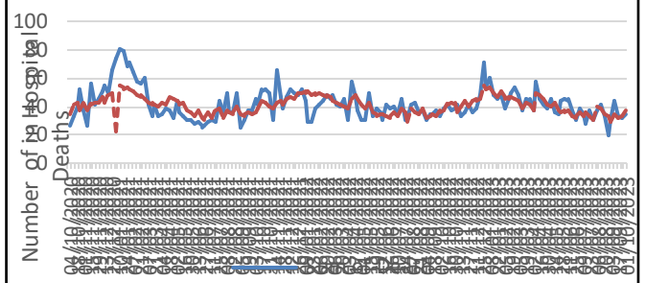
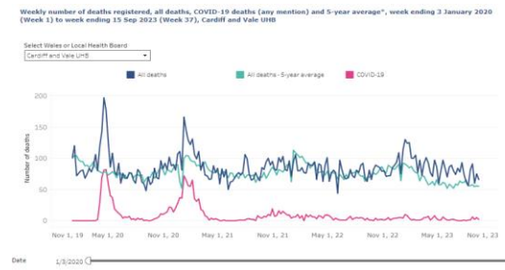
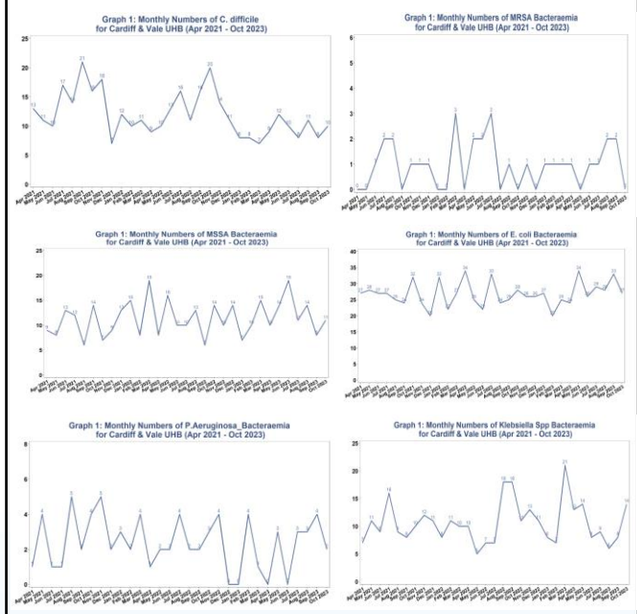
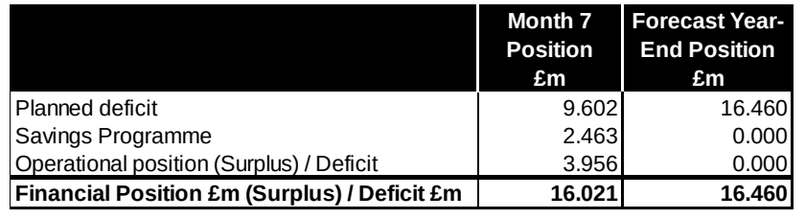
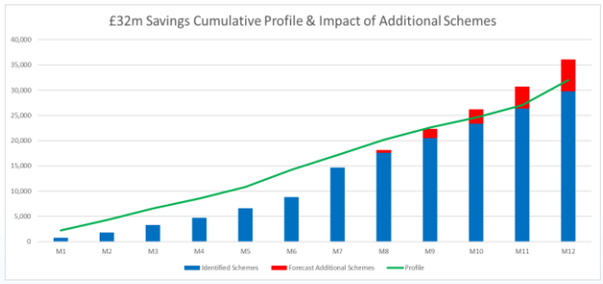
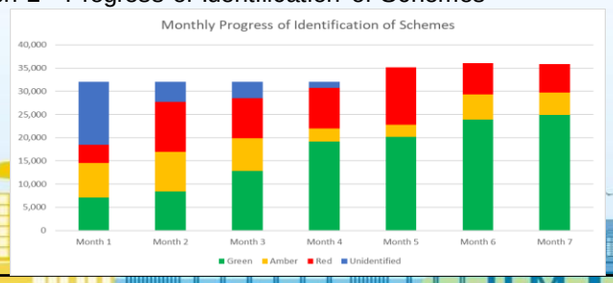
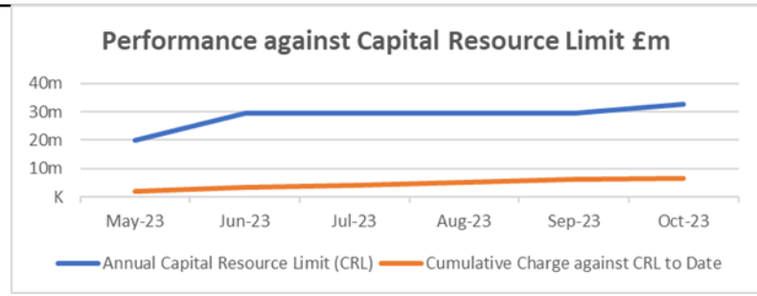
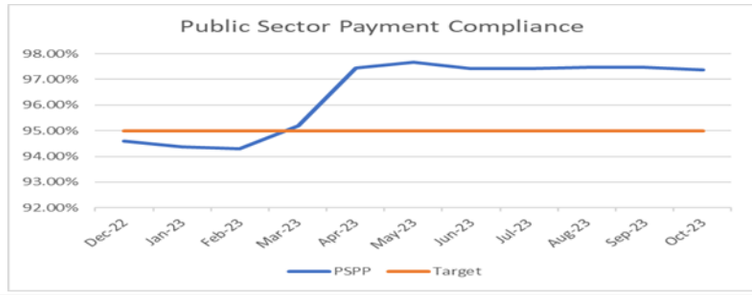
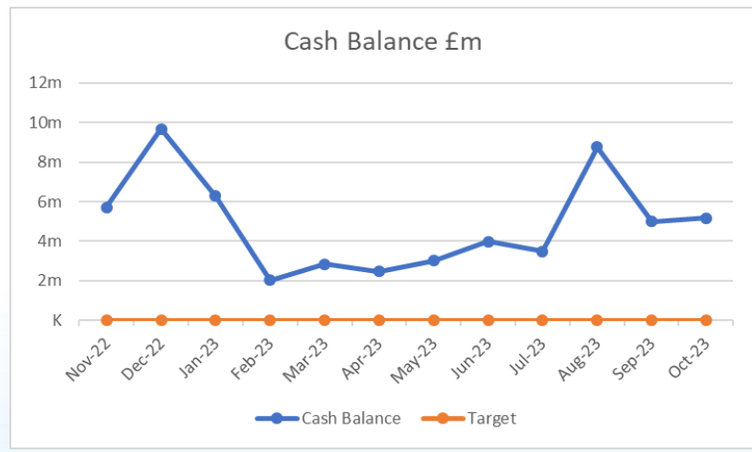
Priority	Performance Summary	Reported Period	Data
Tier 1 Mortality	• The Crude inpatient Mortality chart demonstrates the numbers of inpatient deaths that occur in the Health Board on a weekly basis and compares this measure with the average for the previous 5 years for the same week. The blue line demonstrates the rolling crude inpatient mortality rate compared to the 5-year average for the same reporting week (red line), with the exception of March 2020 and December 2020 to February 2021, the first and second waves of Covid-19.Inpatient crude mortality continues to track the five year average • Crude all-cause mortality, demonstrates the weekly number of deaths registered in Cardiff and the Vale of Glamorgan, regardless of where they occurred. COVID – 19 deaths the pink line, illustrates the number of deaths where COVID-19 features anywhere on the death certificate. There is a correlation between increases above the five-year average and deaths where the patient had Covid on their death certificate during the first two waves of the pandemic. An increase above the five year average has been noted across wales since April 2023 with a similar increase noted in Cardiff and Vale UHB with five year average crude mortality in week 28 being recorded as 76 compared with 63.6 for the previous five year average.	Oct-23 Oct-23	 
Infection Control	• Between April 23 and October 23, there were 68 cases of **C. difficile**. The current rate is **23.05 cases per 100,000 population** which is **28% lower than the equivalent period in 2022/23.** The reduction expectation (RE) rate is 25 cases per 100,000 population, the current CAV rate is **8% below the RE**. CAV is on trajectory to achieve the RE rate while also having the lowest rate across the 6 UHBs. • There were 93 cases of **S. aureus bacteraemia**. The current rate is **31.53 cases per 100,000 population** which is **11% higher than the equivalent period in 2022/23**. The RE rate is 20 cases per 100,000 population, the CAV rate is **58% over the RE**. CAV is not on trajectory to achieve the RE rate and has the 3rd highest rate across the 6 UHBs. • There were 197 cases of **E. coli bacteraemia**. The current rate is **66.78 cases per 100,000 population** which is **3% higher than the equivalent period in 2022/23.** The RE rate is 67 cases per 100,000 population, the CAV rate is **the same as the RE.** CAV is on trajectory to achieve the reduction RE rate and we have the 2nd lowest rate across the 6 UHBs. • There were 72 cases of ***Klebsiella spp* bacteraemia**. The current rate is **24.41 cases per 100,000 population** which is **4% lower than the equivalent period last in 2022/23**. The current maximum number needed to achieve the reduction expectation is 58 cases, thus **CAV is 22% over the RE**. CAV is not on trajectory to achieve the RE number, we have the 3rd highest rate across the 6 UHBs. • There were 15 cases of ***P. aeruginosa* bacteraemia**. The cumulative rate is **5.09 cases per 100,000 population** which is **6% lower than the equivalent period in 2022/23.** The current maximum number to achieve the RE is 18 cases, thus **CAV is 18% under the current RE number**. CAV is on trajectory to achieve the RE number while also having the 3rd lowest rate across the 6 UHBs.	Apr-23 – Sep-23	

Priority	Performance Summary	Reported Period	Data
Deliver 2023/24 Draft Financial Plan	**Financial Plan Approved by Board and submitted to Welsh Government** • Brought forward underlying deficit of £40.3m • Covid Consequential costs of £34.2m & Additional energy costs of £11.5m • 23/24 Demand and cost growth and unavoidable investments of £48.8m • Allocations and inflationary uplifts of £14.4m • A £32m (4%) Savings programme **This resulted in a 2023-24 planning deficit of £88.4m.** The forecast year end position has been amended in line with the revised target control total issued by Welsh Government on the 20th October 2023 as follows: • Planned Deficit @ Month 6 £88.400m • 10% Improvement required £8.840m • Recurrent Covid Legacy Funding £20.300m & Inflationary Uplift £25.100m • Non recurrent Inflation Uplift £10.100m & Energy Funding £7.600m • Revised Financial Forecast Deficit £16.460m At month 7, the UHB is reporting an overspend of £16.021m . This is comprised of £6.419m unidentified savings/operational overspend and the revised planned deficit of £9.602m (seven twelfths of the revised forecast year end deficit of £16.460m).	Oct-23	
Delivery of recurrent £32m savings target	At month 7, the UHB has identified £35.861m of green, amber and red savings against the £32m savings target, however £6.115m are classified as red schemes. The month 7 position includes a Savings Programme adverse variance of £2.463m. The month 7 Savings Programme deficit is expected to be recovered, supported by a number of additional actions as the year progresses, enabling the UHB to deliver its revised planned deficit position of £16.460m. The UHB expects to be able to manage the balance of savings plans required to deliver the forecast deficit of £16.460m with the risk of non-delivery of savings shown in Graph 1 and the progress of reducing the risk via identification of schemes in Graph 2	Oct-23	Graph 1 – Profile of Savings Delivery  Graph 2 - Progress of Identification of Schemes 

Priority	Performance Summary	Reported Period	Data
Remain within capital resource limits	The UHB forecasts to deliver within it's Capital Resource Limit.	Oct-23	
Creditor payments compliance 30 day Non-NHS	The UHB's public sector payment compliance performance is above the target of 95%. Performance for the month to the end of October was **97.48%** and improvements are illustrated in the graph to the right.	Oct-23	
Remain within Cash Limit	The UHB's working capital requirement assumes that Welsh Government will provide support to movements in working capital from the 2022-23 Balance Sheet and for the £88.4m planning deficit in the UHB 2023-24 Financial Plan. Dialogue with Welsh Government around the confirmation and timing of cash support for these areas and anticipated additional allocations is continuing.	Oct-23	
Maintain Positive Cash Balance	The closing cash balance at the end of October 2023, was £5.162m. A detailed monthly cashflow forecast is included in the monthly monitoring return submission to Welsh Government. The UHB's working cash assumption for 2023-24 is based on the following key assumptions :- • Welsh Government support for movements in working capital from the 2022-23 Balance Sheet which is to be assessed as the year progresses. • Additional 1.5% consolidated pay award (£11.5m) for which Resource cover was received from Welsh Government in 2022-23 but has been paid out in 2023-24 and requires cash support. • Approval pf the UHB's formal request for Strategic Cash support for the £16.460m revised 2023/24 forecast deficit. • Timely confirmation of unconfirmed Cash Limit allocations (circa £80m @ month 7 (includes the 2023_24 pay award & Covid allocations)) Discussion is ongoing with Welsh Government to provide cash support for these	Oct-23	

No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
40.	Percentage of episodes clinically coded within one reporting month post episode discharge end date	Apr-23	Improvement trend	70%	Jan-23: 59%; Feb-23: 56%; Mar-23: 44%; Apr-23: 70%
41.	Percentage of all classifications' coding errors corrected by the next monthly reporting submission following		90%	Work in progress	
42.	Percentage of calls ended following WAST telephone assessment (Hear and Treat)		17% or more	Work in progress	
43.	Number of Pathways of Care delayed discharges		12 month reduction trend	Work in progress	
44.	Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan for people aged under 18 years	Jul-23	90%	**90.2%**	Apr-23: 89.40%; May-23: 88.10%; Jun-23: 89.20%; Jul-23: 90.20%
45.	Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan for adults 18 years and over	Jul-23	90%	**46.7%**	Apr-23: 50.30%; May-23: 49.10%; Jun-23: 47.30%; Jul-23: 46.70%
46.	Number of patient experience surveys completed and recorded on CIVICA *(Total partial/full survey completions, including SMS, Bedside and bespoke)*	Sep/Oct-23	Month on month improvement	**4750**	

No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
47.	Cumulative number of laboratory confirmed bacteraemia cases: *Klebsiella* sp and; *Pseudomonas aeruginosa*	Oct-23	*Klebsiella sp* - 58 *P. aeruginosa* – 18	**72** **15**	Not on trajectory to achieve the reduction expectation number On trajectory to achieve the reduction expectation number
48.	Cumulative rate of laboratory confirmed bacteraemia cases per 100,000 population: *E-coli*; *S.aureus* (MRSA and MSSA)	Oct-23	***E. coli*** – 67 cases per 100,000 population ***S. aureus*** – 20 cases per 100,000 population	**66.78 cases per 100,000 population** **31.53 cases per 100,000 population**	On trajectory to achieve the reduction expectation rate Not on trajectory to achieve the reduction expectation rate
49.	Cumulative rate of laboratory confirmed *C.difficile* cases per 100,000 population	Oct-23	25 cases per 100,000 population	**23.05 cases per 100,000 population**	On trajectory to achieve the reduction expectation rate
50.	Percentage of confirmed COVID-19 cases within hospital which had a definite hospital onset of COVID-19	May-23	Reduction against 22/23	Work in progress	Work in progress
51.	Percentage of ophthalmology R1 appointments attended which were within their clinical target date or within 25% beyond their clinical target date	Jul-23	95%	**58.12%**	Apr-23: 58.04%; May-23: 58.12%; Jun-23: 58.66%; Jul-23: 58.83%
52	Number of ambulance handovers over 1 hour	Oct-23	0 (Mar 24)	**1853**	Jul-23: 1473; Aug-23: 1728; Sep-23: 1810; Oct-23: 1853
53.	Number of patient safety incidents that remain open 90 days or more	Oct-23	12-month reduction trend	**4,649**	Work in progress – number of open over 90 days is increasing month on month

Report Title:	General Dental Services Operational Performance Report				Agenda Item no.	6.6b
Meeting:	UHB Board		Public	X	Meeting Date:	30.11.2023
			Private			
Status *(please tick one only):*	Assurance	✔	Approval		Information	
Lead Executive:	Chief Operating Officer					
Report Author (Title):	Assistant Director of Primary Care					

Main Report
Background and current situation:

The PCIC Dental Contracting Team with the support of the Shaping Change Team, and Llais have undertaken a review of the performance and delivery of Contracted General Dental Services to better meet the requirements of the Board and its Committees in understanding performance, access and waiting times for General Dental Services, improving reporting for the Health Board as a whole, both internally and externally.

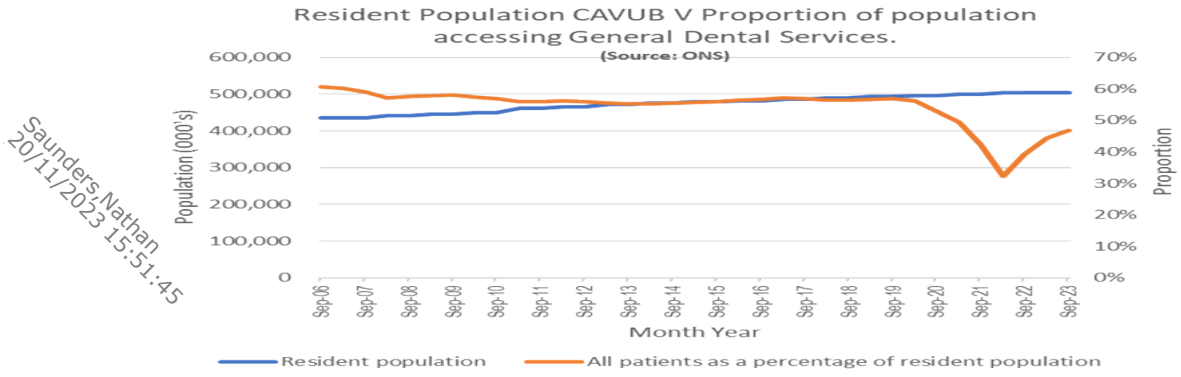
This report provides:

- A background to the General Dental Services contract and available contracting allocation for the population of CAV.
- A summary of the Welsh Government directed contractual performance standards for 2023/24 including performance monitoring and delivery.
- The impact of the financial allocation and contractual standards on access to NHS GDS.
- The quality standards implemented by the PCIC Dental Contracting Team to maximise performance and access in CAV.

Background:
The provision of General Dental Services (GDS) across Wales are commissioned through Welsh Government national contract arrangements delivered by independent contractors (High Street Dentists) providing NHS general dental care and treatment since 2006 using a monitoring framework of Units of Dental Activity (UDA). From 2006, the commissioning of services for dentistry has been the responsibility of Health Boards, who do so via the national directed contract according to the needs of their population via a central dental financial allocation.

Welsh Government statistics demonstrate that 2 years prior to implementation of the national GDS contract in 2006, 55% of the population were seen by an NHS Dentists in Wales with over 25% of the population receiving treatment through private providers, with the remainder choosing not to access dental services or accessing on an ad-hoc/urgent need basis; a small proportion accessing specialist services such as community or hospital dental services. This served as the reference period on which funding allocations were set for Health Board to commission services.

The graph demonstrates the population of Cardiff and Vale, and % of the population accessing NHS dentistry from 2006 – 2023.



As population increased over the following years, central funding from Welsh Government (WG) has not increased proportionately, hence access dropped steadily until 2020 when the pandemic caused a significant drop in access. The graph demonstrates that we are 10% off recovering our pre-pandemic position, but this is impacted by an untested new contract variation which has had implications for access. Dental need has increased during the pandemic, so each patient treated may require considerably more treatment and appointments than they would have done pre-pandemic.

The Welsh Programme for Government, sets out priorities up to 2026 and makes a commitment to reform primary care dentistry and also to increase access to dentists. In March 2022, Welsh Government issued direction to all Health Boards in Wales to restart Dental Contract Reform to March 2024, using an action learning approach previously adopted for the reform programme. The aim of the Welsh Government direction and reform is to continue and adapt alternative measures and take the time to assess the impact through a 'test and modify' approach to ensure change is taking NHS dentistry in the direction needed.

All GDS contractors were either given a choice to either to remain on contract reform programme with a suite of delivery measures, or to remain on Units of Dental Activity (UDAs). The position in CAV is:

- 25.8% (16) will be operating under UDA
- 74.2% (45) will be operating under Dental Reform

Further changes to performance measures from April 2024 are part of current national negotiation processes.

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

There are three key areas to highlight and these include the contractual performance standards (as directed nationally), the additional quality standards (non-directed) that have been introduced by the CAV team and further actions suggested by Llais that could be taken.

1. Contractual Performance Standards (Directed)

The Welsh Government GDS contractual performance standards for 2023/24 are as follows.

For practices operating under **UDA** contractual route the following performance standards apply:

- Practices will be expected to achieve 95% of commissioned contract value

For practices operating under **contract reform route** the following performance standards/principles apply:

- 25% of the contract value will remain as UDAs
- 75% of the contract value will move to reform performance measures:
    - 10% associated with fluoride varnish application measure
    - 25% of the contract value need to be New/Urgent patients, the volume of patients will vary per practice dependant on the contract size
    - 40% historic patients *(Continued care for a minimum number of historic patients that have previously been seen within the previous 4 contractual years)*

Monthly performance monitoring is undertaken by the PCIC Dental Contracting Team. A total of 60/61 contract performance meetings have been undertaken through August and September 2023 with ongoing intensive monitoring undertaken by the team as part of a performance framework for practices flagging as a red overall.

The enclosed report **(Annex 1)** provides the overall GDS contractors' performance which is RAG rated to show the level of performance up to September 2023, against the combined contractual performance standards for 2023/24, as well as action being taken to address any under-performance.

For contract reform practices, there is an overall improvement in performance and projected outturn, therefore an increase in contracts projected to achieve their annual target by end of year 2024. For UDA practices there is a slight deterioration in performance.

Current and projected performance trajectories for practices operating under UDA and dental reform demonstrate an overall improvement in performance compared to 2022/23.

Standard Full Year (UDAs)*	Achieved (Mid October 2023)	Expected Year End Performance
Annual Performance Standard 81,309 UDAs	48.0% 37,928 UDAs (15,608 patients)	95% 77,244 (32,185 patients)

*Based on an average of 2.4 UDAs per patients

Considering the contract values and thresholds of those 45 contracts who have chosen to operate under contract reform in 2023/24 the table below demonstrates total number of patient contacts for each standard (Full year) and % performance to date achieved as at October 2023:

Standard Full Year (Patient contacts)*	Achieved (Mid October 2023)	Expected performance end year
155,032 Historic/Existing Patient contacts	51.6% (79,969 patients)	95% 147,280 patients)
33,523 New Patient contacts/New Urgent Patient Contacts (Combined)	59.3% (19,881 patients)	95% (31,847 patients)

**To note that standards can be off-set and interchangeable as per Welsh Government guidance*

The number of existing patients seen across **all** dental contracts (UDA/contract reform) has increased in 2023/24 when compared to 2022/23:

Month	Existing Patients Seen 2022/23	Existing Patients Seen 2023/24
April	5000	4590
June	35,758	25,371
September	70,345	80,902
October	81,901	94,944
December	104,088	
March	137,480	

Monthly monitoring will continue with year end performance trajectory estimates available from December 2023.

2. Additional Quality Standards (Non-Directed)

Annex 2 summarises additional quality standards that have been introduced by the PCIC Dental Contracting Team. The purpose is to understand the capacity gap in NHS dental provision within CAV and support achievement of contract standards by maximising capacity and access to NHS dental services within the financial allocation.

Centralised Dental Waiting List (CDWL)

The Centralised Dental Waiting List (CDWL) was established in May 2021 to establish the capacity gap in access to NHS Dental Services, an indicator of demand and a pathway for patients to access general dental services in an equitable manner. The CDWL is not a list of patients with a specific oral health need, many of the patients will be healthy and simply want regular check-ups.

CAV is the only Health Board with a fully monitored and managed CDWL with other Health Boards demonstrating similar access issues, but limited ability to measure the size of the problem. The establishment and management of the CDWL in CAV has been positively received by Welsh Government however there are no core standards under which the waiting list is to be managed or RTT measures.

The number of patients on the CDWL is increasing. Original estimates in early 2023 indicated the CDWL would reduce to 11,000. This was based on practices operating under the new contract reform arrangements for 2023/24 with around 900 new patients allocated to practices per month and an average of 580 per month joining. However, the number of patients requesting to be added to the CDWL has increased and is likely to be due to increased public awareness of the list, dental practices directing patients to join the list, as well as an increase in media coverage of dental capacity in Wales causing patients to seek an NHS dentist.

The CDWL has increased from just over 17,000 in May 2023 to 21,800 in September 2023 and the current waiting time is 16 months. Since May 2023, on average 1,500 new patients are added to the centralised waiting list each month with 900 patients being allocated off the list to an NHS Dentist. The list is validated annually (with 5,552 patients removed in April 2023) and further validation will be undertaken in January 2024.

The following table provides an estimate of the funding that would be required from Welsh Government to enable the Health Board to commission the capacity required to provide access to NHS dental services for the current CDWL and 60% and 80% of the population. It is important to note that even with investment, there is a workforce and infrastructure requirement to achieving increased levels of access.

Current CDWL	60% of population	80% of population
£2.78m	£6.75m	£20.26m

Urgent dental access

In April 2023, a new standard was introduced by WG which requires practices to see a set number of new urgent patients. The number is directed as part of the Welsh Government standards and does not take account of demand. The metric does not state the timeframe for patients to be seen.

Within CAV, all patients assessed as having an urgent need are seen within 24 hours. The delivery of this is actively managed by the PCIC Dental Contracting Team. To maximise access, from April 2023, practices were encouraged to participate in a new scheme which supports achievement of the new urgent patient metric. Each week the Heath Board, working closely with CAV 247, allocate new urgent patients to practices. For those practices participating in the new urgent patient scheme, there is an expectation each practice will take a minimum of 50% of their new patient target from the CDWL for 2023-2024. Practices can also request additional patients from this list throughout the year.

Although all patients with an urgent need are seen within 24 hours, there is only approximately 70% of urgent dental capacity utilised on a monthly basis. Therefore, the PCIC Dental Contracting Team has reduced the additional urgent commissioned dental services provided in the out of hours period in order to utilise the urgent dental capacity available through GDS. The team has been raised this

with the Chief Dental Officer for Wales so adjustments to reduce this standard as part of dental contract reform can be considered for 2024.

Performance monitoring

The PCIC Dental Contracting Team is undertaking robust monthly performance monitoring to support access to NHS dental services, this is detailed in **Annex 1**. The monitoring meetings and data identify any performance and target issues that need to be supported and addressed to ensure CAV are maximising access to NHS dental services and utilisation of the dental commissioning allocation.

For dental contract reform practices (August to September) there is an overall improvement and increase in contracts projected to achieve their annual target by end of year. For the UDA contracts, there is a slight deterioration in performance, however action is being taken to improve this. Monitoring includes monthly data analysis with a minimum of quarterly meetings throughout the year with all dental contractors. One contract has been permanently reduced (due to underperformance) and the activity is in the process of being recommissioned to secure access via an alternative provider. Two contracts are under enhanced scrutiny to ensure an action plan is in place and contract values delivered or there will be a permanent reduction in contract value and recommissioning via an alternative provider.

3. Feedback from Llais

In October 2020, the South Glamorgan Community Health Council (CHC) undertook a 'Dental Secret Shopper' exercise to determine the availability of access to NHS dental services in CAV. A comparable exercise was completed 12 months after the initial exercise, to determine if any improvements in access could be measured. The key issues relate to access to an NHS dentist and the time waiting on the centralised waiting list. Llais plan to undertake another survey and this is currently being developed.

Llais have suggested that communication to patients and the public can be improved to ensure transparency on services available, how to access services (particularly urgent care) and what to expect when a patient is placed on the CDWL (including likely waiting times). The PCIC Dental Contracting Team have committed to work in partnership with Llais to review and develop updated patient information for each of these areas with an aim of completing by January 2024.

Recommendation:

The Board is asked to:

- **NOTE** the commissioning arrangements and performance standards for GDS within CAV
- **NOTE** the issue of the required commissioning levels including funding of dental services to meet demand which will need to be raised with Welsh Government
- **NOTE** the year to date position and overall improvement in performance and projected outturn against GDS performance standards for 2023-24
- **NOTE** the increasing CDWL position, action taken to validate the list annually and 100% achievement of placing patients who require urgent dental care within 24 hours while allocation to an NHS dentist
- **NOTE** the additional quality measures and actions taken by the PCIC Dental Contracting Team to support access to GDS
- **NOTE** the actions being taken by the team following feedback from Llais to improve patient communication and awareness of access to dental services in CAV
- **RECOMMEND** a Board development session undertaken by the PCIC Dental Contracting Team to allow for an in-depth discussion and understanding of the contract, constraints and additional actions being taken to support access to NHS Dental services

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

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Finance & Performance	22.11.2023

Saunders,Nathan
20/11/2023 15:51:45

Monthly Performance Monitoring and Assurance Report

Month	**September 2023** (data 20/09/2023)	
Contract Reform contracts	45	
UDA contracts	16	

Projected Outturn 23/24		**August 20th 2023**		**September 20th 2023**		
Overall projected (Contract Reform x 45 all metrics combined)	**Red**	13	28.89%	11	24.4%	↓
	Amber	7	15.56%	8	17.8%	↑
	Green	25	55.56%	26	57.8%	↑

Contract Reform

- August to September, there is an overall improvement in performance and projected outturn, therefore an increase in contracts projected to achieve their annual target by end of year.
- Overall projected to underperform (Red 11/45)-
  - 7/11 are corporates, the team have met Teams with National/Area managers of the companies. Face to face meetings at each individual practice are now in process with oversight and performance management. 1 contract subject to potential 50% reduction on 01/12/2023 and the value of £165k to be recommissioned when agreed.
  - 1/11 is in the process of a 3-month review, a possible reduction (50%). The 20/10/2023 data will be reviewed by team to confirm action.
  - 3/11 have had a face to face meeting with the HB and at present, appear to be overperforming in New Patient metric, which may be used to offset Historic Patient underperformance, ongoing monitoring and management by HB team.
- 8/45 contracts are Amber, are being closely monitored. They are all projected to achieve their New patient target and, in some case, overperform, but are underperforming on Historic Patients. All have received a visit from the team and are aware of their current position and what is required to improve. Ongoing monthly monitoring and management from Health Board Team.

Projected Outturn 23/24		**August 20th 2023**		**September 20th 2023**		
UDA Practices x 16	**Red**	3	18.75%	4	25%	↑
	Amber	2	12.5%	4	25%	↑
	Green	11	68.75%	8	50%	↓

UDA

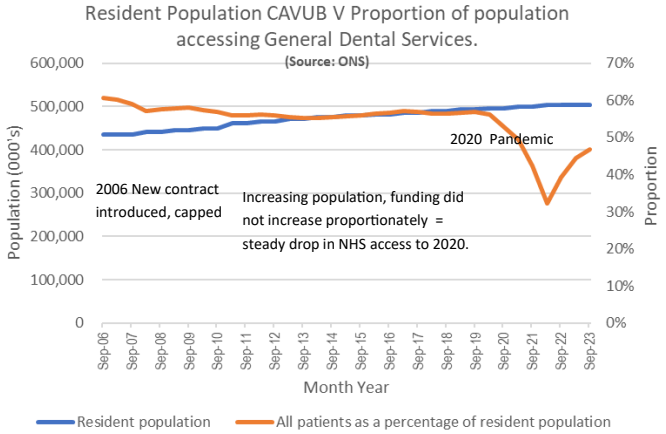
- August to September, there is a slight deterioration in performance however action is being taken to move the position to improve performance to achieve their annual target by end of year via the following actions:
- Overall projected to underperform (Red 4/16)-
  - 1/4 contract will be reduced by 50% from 01/12/2023 (value of £214k and will be recommissioned in Eastern Cardiff) A third visit is planned to monitor ongoing performance of remaining contract value.
  - 2/4 contracts have the same contract owner and a face to face has been held on 22/09/2023, this contract will be closely monitored and reviewed monthly
  - 1/4 contract (value 60k) projected outturn is 80%, a face to face meeting is booked for October.
- 4/16 Amber UDA contracts. All have received a visit from the team and are aware of their current position and what is required to improve with monthly monitoring in place.

Contract Visits 60/61	**60 Complete (98%)** (some contracts have received a second and on one case a 3rd face to face visit)	**1 Due** (booked)	**0 TBC**

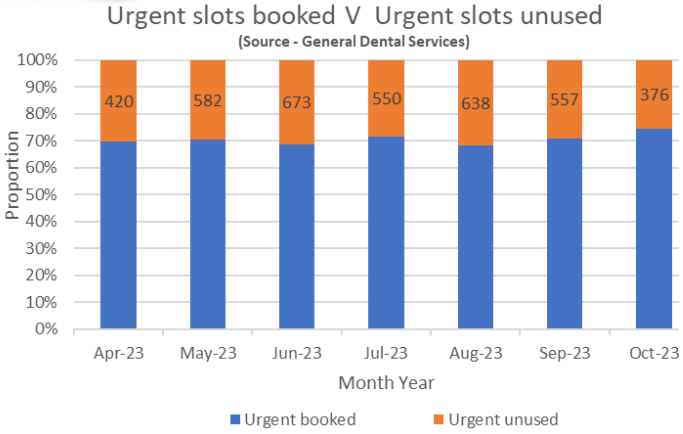
Quality Metrics—General Dental Services

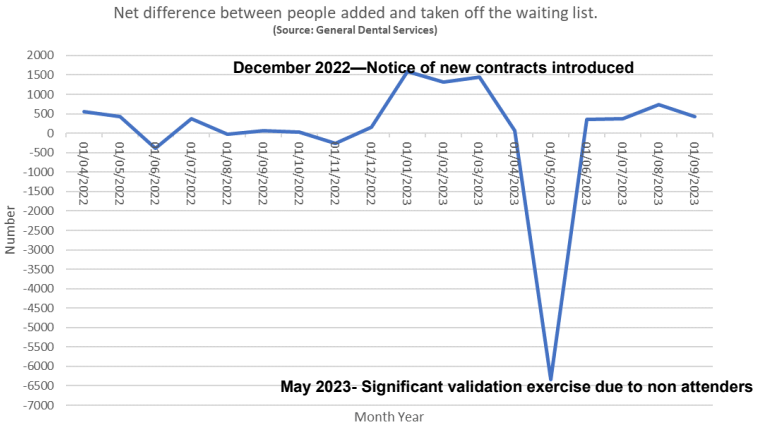
Population and access

The general population of Cardiff and Vale has increased over the years. Citizens accessing dental in CAV UHB has decreased from 60 percent 2006 to 50 percent in 2023. There are a number of culminating factors which influence dental access including contracting arrangements, population increases, increased needs of patients post pandemic, and limited workforce capacity.



Balance between routine and urgent capacity?





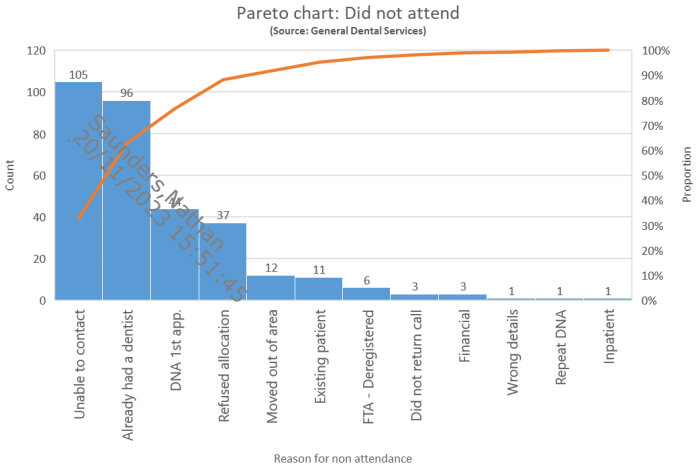
All patients who require access to urgent dental care are seen within 24 hours across University Dental Hospital (UDH), Community (CDS) and General Dental services (GDS). On average there 30 percent unused appointments each month across UDH, CDS and GDS. There should be no need for a patient to suffer with dental pain in C&V due to the ample provision of urgent care.

In April 2023, a new contract variation metric was introduced by WG which requires practices to see a set number of new urgent patients. The number is standard across all health boards, and does not take account of demand. The dental team identified that demand would not reach these numbers, and assisted practices by taking control of the allocation of new urgent patients through CAV 24/7. To benefit from this scheme, practises required to take 50% of their new patient quota from the Centralised Waiting List (CWL), resulting in a much-reduced increase in CWL numbers month on month.

Practices are also encouraged to request additional new patients from the CWL to assist them in fulfilling this WG metric. This prevents practices needing to manage their own new patient waiting lists, and prevents them "recycling" their regular patients, who become "new patients" by definition if they have not attended for four years.

The CWL was devised by the dental team to provide patients with a clear pathway to access NHS dental services, and to prevent them needing to ring around practices and be in "the right place at the right time". One full time member of staff is required to manage the list, and all members of the dental team assist in this. The validation of the waiting list has led to a new process to understand why patents do not attend routine appointments further highlighting how this service is both managed and reported. Early reported data demonstrates the top 3 reasons listed: unable to contact (33%), already had a dentist (30%), and did not attend first appointment (14%).

Reasons for non attendance



Other quality measures considered but not reportable at this point in time include customer feedback post appointment attendance. New centralised service to provide this for all GDS's across the UK.

78 % CAVUHB patients indicated that their dental health was good or very good. Small sample of 410 patient. (Public Health Wales, 2023)

There is a whole raft of performance data collated and reported to support with the management of the GDS at CAVUHB.

Wales view: The CWL is being replicated across Wales by WG as they recognise its benefits and it is popular with dentists, patients and HB administrators.

Report Title:	Strategic Planning Update				Agenda Item no.	6.8	
Meeting:	UHB Board		Public	X	Meeting Date:	30.11.23	
			Private				
Status *(please tick one only):*	Assurance	X	Approval		Information		
Lead Executive:	Executive Director of Strategic Planning						
Report Author (Title):	Executive Director of Strategic Planning						

Main Report
Background and current situation:

This report provides the Board with an update on key areas of strategic planning, commissioning and partnership work programme. Its purpose is to give the Board assurance that actions agreed in our annual work programme or Annual Plan are being progressed and risks around delivery are being managed - it includes progress in relation to the following areas:

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

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

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

1. **Shaping Our Future Wellbeing – 2035:** work is progressing to cascade the refreshed vision and strategy for its delivery across the Health Board and partner organisations. A positive 'Ask Suzanne' session took place with staff and presentations have been made to both Public Service Boards and the Regional Partnership Board. As reported in the last meeting, the October Board development session provided the Board with the opportunity to shape the programmes aligned to the strategic objectives set out in the strategy. Strategy delivery will be overseen by a series of programmes, enabling plans and will be reflected in our annual IMTP. The Board Assurance Framework has been updated to align with the new strategic objectives. Work will continue to ensure we embed the refreshed strategy in the delivery arrangements within the organisation.

2. **Integrated Medium Term/ Annual Planning**

   Annual Plan 23-24: The Quarter 2 annual plan progress report is on the Board agenda as a separate item.

   On 13 September 2023, the Minister for Health and Social Services confirmed the escalation status of Cardiff and Vale University Health Board as being in enhanced monitoring for planning and finance. Officers have provided comments on the draft Enhanced Monitoring framework, which includes information on the planning and strategy support to be provided to the Health Board, and the de-escalation criteria (essentially an approvable plan). The Enhanced Monitoring regime will be reviewed as part of the Integrated Planning and Performance Meetings which take place regularly, with other meetings taking place when necessary.

Annual Plan 2024-25: Development of the plan for 2024-25 is progressing in line with the approach and timeline previous shared with the Board. A Senior Leadership Board workshop was held on 16th November to bring together the headline plans from the corporate departments and the clinical boards. Welsh Government has confirmed that the submission date for the IMTP/annual plan is 28th March 2024, which is the date on which the Board will be considering the final plan for submission. Welsh Government planning guidance is due to be received at the end of November or early December and the financial allocation is expected in the last couple of weeks in December. The December Board development session will enable the Board to shape and refine the plan's priorities and actions.

3. Regional Planning

The SE Wales Regional Planning workshop was postponed in October and is now taking place on 6th December. This is an opportunity for the three health boards, to share individual clinical services plans and agree how we might work towards the development of a regional clinical services plans for services that it would be sensible to plan and deliver collaboratively on the SE Wales footprint in order to improve patient outcomes (including timely and equitable access) and ensure sustainability.

Updates on the three planned care regional planning programmes (diagnostics, ophthalmology and orthopaedics) will be provided at the next Board meeting, along with an update on the development of the plans for the Llantrisant Health Park which Cwm Taf Morgannwg Health Board were leading.

In respect of developing the regional model for stroke services, a well-attended workshop involving people with lived experience of stroke, Llais, third sector partners and clinical teams from both health boards, along with WAST colleagues. The workshop explored the key options for delivering the national stroke standards and the national clinical model for stroke services. The issues relating to each of the options were considered. The output of the workshop was to work up the models in more detail, reflecting the feedback from the ongoing patient survey. In the meantime, Operations colleagues were meeting to discuss how support could be provided to Cwm Taf Morgannwg Health Board through the introduction of a shared out-of-hours rota (which had been in place before Covid 19). This would also provide greater resilience to Cardiff and Vale UHB.

4. Swansea Bay and Cardiff and Vale UHBs Specialist Provider Partnership

Work continues to develop an appropriate structure to govern the partnership as it matures and embeds, in line with previous Board reports. In the last few weeks, the Intervention Radiology Service at Swansea Bay Health Board has experienced significant challenges and temporary support is being provided by Cardiff and Vale and Aneurin Bevan Health Boards. The Chief Operating Officers and Medical Directors were involved in the discussions around shoring up the service in the immediate future. In parallel a multi-health board planning process is being put in place to develop the medium-term sustainable service model for South Wales. The Strategic Planning team is supporting this work.

5. Regional Partnership Board

The Health Board and Regional Partnership Board jointly sponsored a workshop with the King's Fund on 31st October. The purpose was to explore the findings of the two King's Fund reports commissioned in 2021 which looked at opportunities for increasing primary care-based prevention, and to accelerate integration across health and care. The workshop was well attended by colleagues from the RPB, clinical boards and corporate teams, and Llais. A number of 'north stars' were identified – key priorities that would address the recommendations made in the King's Fund reports and give us maximum value in delivering

improved outcomes for the people of Cardiff and Vale of Glamorgan. The output of the workshop will come to the RPB and Board in due course.

The RPB has approved its annual report which provides an overview of the work completed during 2022/2023 – the last year of the first five-year Area Plan. The report highlights the breadth of the work undertaken by the RPB and its impact on our health and care services, and those how use them. The link to the report is here and Board members are encouraged to read it.

https://cavrpb.org/app/uploads/2023/09/RPB_ANNUAL_REPORT_ENG_20234-1.pdf

Work is also progressing in the RPB team to finalise the ten year capital plan which will bring together the primary/community infrastructure plans we have set out in Shaping Our Future in the Community alongside partners plans for community infrastructure, with the principle of integrated services where possible.

6. Commissioning Developments

The implementation programme for the new National Commissioning body has commenced and the new Committee will be called NHS Wales Joint Commissioning Committee (JCC)/ Cyd-bwyllgor Comisiynu GIG Cymru. The NHS Wales Joint Commissioning Committee will be responsible for the commissioning (planning, securing and monitoring) of those services delegated to it by Health Boards and/or as directed by the Welsh Ministers. This will include the current responsibilities of WHSSC, EASC, NCCU and 111 commissioning. Accountability of the JCC Chair is assumed as directly to the Minister for Health and Social Services and to each of the 7 statutory health boards, which is consistent with the current accountability arrangements of EASC and WHSSC. The accountability arrangements between the JCC Chair and Health Boards will require further detail within the Memorandum of Agreement with Health Boards. The Standing Orders, Scheme of Delegation and Terms of References for the JCC will be developed over the coming months for the establishment of the new body from 1st April 2024. An implementation programme has been established and the Programme Initiation Document can be found in the supporting documents for the Board papers.

7. Shaping Our Future Hospital Programme

The Programme has been on pause whilst we await the outcome of the Welsh Government's consideration of the Programme Business Case. At the moment, we do not have the resources to progress the Strategic Outline case – our resource request was submitted to Welsh Government in 2022. In light of the challenging financial outlook, we have been asked to consider shorter term options to ensure the safe delivery of services, addressing the most pressing estates issues. A dedicated Infrastructure Investment Board took place on13th November for Welsh Government Officials to meet with Health Board and Cardiff University colleagues to discuss the options open to us to ensure we have a safe and sustainable provision of service, with the necessary capital and digital infrastructure to do so. A report on the agreed way forward will be brought to the Board for consideration in due course.

Recommendation:

The Board is requested to:

a) Note the progress being made across the Strategic Planning, Commissioning and Partnership portfolio
b) Access the RPB Annual Report and direct any questions or comments to the RPB Director of Integrating Health and Social Care.

c) Agree to received further reports on SE Wales regional planning, including and decisions required by the Board, the King's Fund Action Plan, and the terms of reference and governance arrangements of the new joint commissioning body.

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

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

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

Risk: Yes

There is a risk that if regional models for key services are not agreed and implemented in a timely way, we may need to provide support to other services which become unsustainable, in an unplanned way. Equally a number of our services will become more fragile and vulnerable to sustainability challenges.

Safety: No

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

Financial: Yes

There will be financial implications associated with the regional stroke model and a business case for implementation of the model will be developed and considered through the appropriate process.

Workforce: Yes

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

Legal: Yes

There is a requirement to ensure we have engaged appropriately on any significant changes to the way we have delivered services. Plans for engagement are being developed.

Reputational: No

No specific risks to highlight.

Socio Economic: Yes

All of our plans need to be assessed for socio-economic duty. There is an overlay with the EHIA work which identifies any equality impacts we need to take into consideration. Reducing long waits for treatment has a positive socio-economic impact but we need to ensure that regional solutions which may require longer travelling distances do not negatively impact on any particular groups.

Equality and Health: Yes

EHIAs will be undertaken for the key plans described in this report. Appropriate engagement will need to be undertaken in relation to changes in the way we provide services across the region
Decarbonisation: Yes
No specific issues to highlight but decarbonisation impact will need to be considered as each plan is developed. Decisions on prioritise must consider carbon impact and contribution to decarbonisation.

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

Report Title:	Integrated Annual Plan 2023/2024 Quarter 2 Report				Agenda Item no.	
Meeting:	Board				Meeting Date:	
Status *(please tick one only):*	Assurance	x	Approval		Information	
Lead Executive:	Abigail Harris- Executive Director of Strategic Planning					
Report Author (Title):	Ashleigh O'Callaghan- Head of Strategic Planning					

Main Report
Background and current situation:

The attached report summarises our progress in achieving the milestones we committed to achieve in Quarter 2 as part of our Integrated Annual Plan 20232024.

The report demonstrates that of the milestones set out in our Integrated Annual Plan for Quarter 2 in relation to strategic programmes and operational delivery, 67% have been fully or partially achieved, with high confidence in our ability to get back on track for Quarter 3 in the instances whereby a milestone hasn't been fully achieved as planned.

33% of the milestones were not achieved with low confidence in getting back to the original plan for Quarter 3, and the challenges underpinning these milestones are set out on the summary page within the report itself.

Regarding the financial position, the report summarises that at the end of Q2, the UHB is reporting a £7.1 million deficit against the annual planned deficit of £88.4 million. This remains a challenging position and plans continue to develop to close the current gap providing a trajectory to hit the planned deficit by year end.

The plan also sets out the position regarding delivery of the Quarter 2 deliverables set out within the People and Culture plan for 2023/2024, whereby almost half of the objectives originally set out in the plan have been achieved, alongside a number of significant deliverables in relation to workforce sustainability which were not set out in the original plan.

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

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

The report focuses on whether or not we achieved the key milestones we set out in the plan for Quarter 2 and if not, makes an assessment on our confidence in recovering the original plan.

The report focuses specifically on the progress of our Strategic Programmes and Operational Delivery Priorities, achievement of financial measures and progress in achievement of the milestones set out in the People and Culture plan.

Incorporating feedback following discussion of the Quarter 1 report at Board, the report also provides an overview of the achievement of the ministerial priorities as set out in the NHS Wales Planning Guidance 2023/2024 taken directly from the monthly Integrated Performance Report.

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

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

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

Recommendation:

The Board is requested to:

- **NOTE** the progress achieved in Quarter 2 towards the delivery of our Integrated Annual Plan 2023/2024

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

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

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x

Impact Assessment:

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

Risk: Yes/**No**
Safety: Yes/**No**
Financial: Yes/**No**
Workforce: Yes/**No**
Legal: Yes/**No**
Reputational: Yes/**No**
Socio Economic: Yes/**No**
Equality and Health: Yes/**No**

Decarbonisation: Yes/**No**	
Has consideration been given to the delivery of proposals in accordance with NHS Wales Decarbonisation Plans. If so, please confirm the detail of issues considered and plans made. *(If this has been addressed in the main body of the report, please confirm)*	
Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Integrated Annual Plan

Quarter 2 Report

July-September

How to read this report

This report provides:

- A snapshot of our performance in relation to the **2023/2024 Ministerial Priorities**
  - *This snapshot is taken from our October Integrated Performance Report signed off at Finance and Performance Committee. There is some lagging data that isn't to the end of Q2 due to timing of report submission.*
- An **overview** of achievements in relation to **the milestones we set for Quarter 2** within our Integrated Annual Plan 2023/2024
- A high-level summary of our progress against **our financial measures**
  - *This snapshot is taken from our October Integrated Performance Report signed off at Finance and Performance Committee*
- A high-level summary of our progress against **our people and culture milestones we set for Quarter 2** within our Integrated Annual Plan 2023/2024

More detailed assurance can be found within the Monthly Integrated Performance Report.

Section 1: Minsterial Priorities

The Minister for Health and Social Services has set out 6 priority areas with the NHS Wales Planning Guidance 2023/2024 to help address the immediate pressures and help to build a sustainable health and care service over the next year.

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

Priority	Aim	C&V Commitment	Commitment to meet ministerial ambition?	By When	In Month Performance against C&V commitment
Delayed Transfers of Care	**Reduction in backlog of delayed transfers** Measure: number of delayed transfers of care. Reporting period: monthly	217	Yes	June 2023	173 September
Primary Care Access to Services	**Improved access to GP and Community Services** Measure: >95% achievement of core access to in-hours GMS Services Reporting: monthly	95%	Yes	June 2023	98% June
	Increased access to dental services Measure: 50% of expected new patient target Reporting: monthly	50%	Yes	June 2023	tbc
	Improved use of community pharmacy Measure: >90% of all eligible community pharmacies providing CCPS (June 2023) Reporting: monthly	90%	Yes	June 2023	98% June
	Improved use of optometry services Measure: Reduce number of patients referred from primary care (optometry and General Medical Practitioners) into secondary care Ophthalmology services Reporting: monthly	877	Yes	Dec 2023	840 September
Urgent and Emergency Care	**Implementation of a 24/7 urgent care service, accessible via NHS 111 Wales** Measure: Performance response time in NHS 111 Reporting: TBC	tbc	tbc	June 2023	tbc
	Implementation of Same Day Emergency Care services Measure: Increase in SDEC attendances Reporting: monthly	1233	Yes	June 2023	1704 September
	Honour commitments that have been made to reduce handover waits Measure: Eliminate 4 hour ambulance handover delays Reporting: monthly	0	Yes	June 2023	0 September

Performance Key: Meeting standard / trajectory over target/trajectory

Priority	Aim		C&V Commitment	Commitment to meet ministerial ambition?	By When	In Month Performance against C&V commitment
Planned Care, Recovery, Diagnostics and Pathways of Care	**Achieve RTT waiting time targets** Measure 1: 52 week new outpatient target by March 2024 Reporting: monthly		8999	No	Mar 2024	11133 September
	Measure 2: 104 week treatment target by December 2023 Reporting: monthly		3788	Yes	Dec 2023	4054 September
	Set foundations for achieving waiting list targets Measure: Reduce outpatient overdue follow by 25% against 2019/20 levels Reporting: monthly		37623	Yes	Mar 2024	44425 September
	Implement regional diagnostic hubs Measure 1: progress reporting on regional diagnostic hub Reporting: quarterly		Go-Live	Yes	Dec 2023	Q1 24/25
	Measure 2: Achieve 8-week diagnostic Reporting: monthly		0	No	June 2025	12246 September
	Implement straight to test model Measure: progress reporting on straight to test Reporting: quarterly		Go-Live	Yes	Sept 2023	On track
Cancer	**Achieve SCP target** Measure: 75% of patients starting their first definitive cancer treatment within 62 days Reporting: monthly		75%	Yes	June 2023	66.4% August
	Implement the national cancer pathways within the national target Measure: progress reporting on national cancer pathways Reporting: quarterly		Go-Live	Yes	Sept 2023	Planning ongoing
Mental Health and CAMHS	**Achieve waiting time performance for Local Primary Mental Health Support Services and Specialist CAMHS** Reporting (for all): monthly	Measure 1: Part 1a (adults)	80%	Yes	June 2023	100%August
		Measure 2: Part 1b (adults)	80%	Yes	June 2023	100%August
		Measure 3: Part 2 (adults)	80%	Yes	June 2023	45.7%Aug
		Measure 4: Part 1a (children)	80%	Yes	June 2023	93% August
		Measure 5: Part 1b (children)	80%	Yes	June 2023	0% August
		Measure 6: Part 2 (children)	80%	Yes	June 2023	76.6%Aug
	Implement 111 press 2 on a 24/7 Measure: progress on implementing NHS 111 press 2 Reporting: quarterly		Go-Live	Yes	Sept' 2023	Delivered

Performance Key: Meeting standard / trajectory over target/trajectory

Section 2: Quarterly Milestones

Quarter 2 Summary - Strategic Programmes and Operational Delivery

Quarter 1 Recap

Our plan for Quarter 1 set out **50 specific milestones** aligned to our strategic programmes and operational delivery priorities. Within the Quarter 1 report we set out that of those:

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

Of those 26 objectives that were not achieved in Quarter 1, 4 recovered their planned position during Q2.

Where rolled over plans have not been achieved in Q2, plans to recover over the course of the year have been outlined.

Quarter 2 Progress

Our plan for Quarter 2 set out **48 specific milestones** aligned to our strategic programmes and operational delivery priorities. Of those:

- 22 milestones were fully achieved as planned (46%)
- 10 milestones (21%) were rated as not achieved but had made progress towards achievement and rated high confidence that plans would be recovered by Q3
- 16 milestones (35%) were rated as not achieved with low confidence in original plans being achieved by Q3.

The key challenges underpinning milestones that were not achieved and with low confidence in return to green by Q3 are:

- Lack of clarity on funding for Shaping our Future Hospitals Programme which has limited progress with commencing the Strategic Outline Case (SOC)
- Revised timelines for Clinical Services Plan Development as awaiting outcome of discussions around the SOC
- Revised timelines for development of Full Business Cases for Tranche 1 Shaping our Future Wellbeing Schemes
- Significant number of ward moves and redesign of EU/AU which has impacted performance combined with increased use of medical and surgical SDECs- additional operational pressures expected as we move in to winter
- Planned care- revised ministerial focus and ambition on tackling 2- and 3-year waits has impacted upon achievement of the original ministerial milestones as set out in the plan
- Mental Health- difficulties in recruiting key posts that are required to achieve milestones as set out

All objectives have robust plans to address challenges as set out within the report itself.

46 % milestones fully achieved

21% partially achieved with high confidence in return to green in Q2

33% rated as not achieved with low confidence in returning to green in Q2

Shaping Our Future Population Health / Local Public Health Plan

Quarter 1 - Measures of Success- What did we say we would do?	Delivered (Y/N)	Reasons off track?	Plan To get Back to Green	Rate confidence on ability to get back to green by next quarter?
Identification of patient management system; systematised smoking status recording for all hospital in-patients to access smoking cessation support on admission	N	The Welsh Nursing Care Record (WNCR) has been identified as the patient management system to record smoking status on admission and referral to Smoking Cessation Services. Currently in development stage to draft the correct wording required to capture this	Wording for the relevant smoking status questions needs to be agreed in conjunction with the data definitions work which is being led by DHCW. Once approved, the WNCR will be amended to include the new smoking questions. Likely to be a lengthy process, outside our direct control	Low
Implementation of Level 2 Healthy Travel Charter by C&V UHB to begin	Y	Agreed for C&VUHB to sign up to L2 Charter at SLB October 2023. However, reduced capacity to implement due to wider financial constraints noted		
Quarter 2 - Measures of Success- What did we say we would do?	**Delivered (Y/N)**	**Reasons off track?**	**Plan To get Back to Green**	**Rate confidence on ability to get back to green by next quarter?**
Integrated Health Protection Model for Cardiff and the Vale of Glamorgan implemented	N	Integrated model developed with partners, but not yet fully implemented	Currently developing pathways and procedures to support the integrated model. Good progress. Full implementation expected by end Q4 (subject to detail of funding allocation from Welsh Government).	Low
Agree new health inequities strategic framework	Y			
Engage and work with partners to shape and develop the next phase of Move More, Eat Well	Y	Work has commenced to develop the revised framework for Move More, Eat Well (for 2024 and beyond). This will continue into Q3 and Q4		
Agree the focus for a programmatic preventative approach with primary and community partners, using insights from King's Fund	N	Partnership workshop delayed by a number of factors	Partnership workshop taking place on 31st October 2023	High
Review of falls prevention framework for C&V UHB and early intervention pathways including to Stay Steady clinics	Y			

Shaping Our Future Hospitals (SOFH)

Quarter 1 - Measures of Success- What did we say we would do?	Delivered (Y/N)	Reasons off track?	Plan To get Back to Green	Rate confidence on ability to get back to green by next quarter?
Commence creating SOC content (clinical service plan, digital, health planning and estates strategy refresh); recruit team; procure suppliers and concurrently secure resource to produce digital SOC	N	In the absence of requested funds from WG, the SOC has not started.	Chief Executive held a meeting with WG Capital, Estates and Facilities Officials to discuss SOFH in mid-September. WG have invited CVUHB to an Infrastructure Investment Board (IIB) on 13/11 to answer two questions on how services could be kept running safely if funding for a replacement UHW was not available and secondly, what other options have been considered. The content to be presented to the IIBs being prepared	Low
Quarter 2 - Measures of Success- What did we say we would do?	**Delivered (Y/N)**	**Reasons off track?**	**Plan To get Back to Green**	**Rate confidence on ability to get back to green by next quarter?**
Commence Technical work in response to the clinical services plan	N	In the absence of requested funds from WG, the SOC has not started.	As above	Low

Shaping Our Future Clinical Services

Key area of Focus	Quarter 1 - Measures of Success- What did we say we would do?	Delivered (Y/N)	Reasons off track?	Plan To get Back to Green	Rate confidence on ability to get back to green by next quarter?
Programme governance	Develop Programme Plans, set up governance including programme workstreams, complete frameworks for learning and patient and public involvement	Y			
Key area of Focus	**Quarter 2 - Measures of Success- What did we say we would do?**	**Delivered (Y/N)**	**Reasons off track?**	**Plan To get Back to Green**	**Rate confidence on ability to get back to green by next quarter?**
Baseline assessment	Undertake current baseline assessment of our clinical services, and our future population health need.	N	Underway, delayed whilst annual plans returned to allow for maximum information prior to sending to clinical boards	Assessment templates to be issued by 30/10/23	High
	Hold series of clinical services sessions to develop and test clinical service plan chapters (engagement phase 2)	N	These will now be held in spring/summer 24 as currently awaiting outcome of Plans for UHW2 and discussions with the WG to ensure scope and timeline set within the Clinical Service Plan are accurate	A face-to-face workshop in 2024 to allow for scope and timeline for Clinical Services Plan roadmap to be confirmed by Programme Board	Low

Shaping Our Future Community Services (1/2)

Key area of Focus	Quarter 1 - Measures of Success- What did we say we would do?	Delivered (Y/N)	Reasons off track?	Plan To get Back to Green	Rate confidence on ability to get back to green by next quarter?
Engagement and Planning for delivery of Integrated Community Care Service	Design intermediate care step-up operating model	N	Due to complexity of the service and focussed development of the Safer@Home (community crisis response) service	Continued focussed efforts to finalise new model and deliver new service	High
Engagement and Planning for delivery of Integrated Community Care Service	Alignment of Urgent Primary Care model	Y			
Engagement and Planning for delivery of Integrated Community Care Service	Workforce and recruitment plans	Y			
Developing Capital Infrastructure investment FBCs for Tranche 1 schemes	Health & Wellbeing Centre @ CRI	N	Discussions ongoing with WG to consider submitted OBC and phasing of multiple FBCs	First FBC (Safeguarding and MEP) complete - To be considered by the UHB Board at it is meeting in November, for submission to WG	Low
Developing Capital Infrastructure investment FBCs for Tranche 1 schemes	Wellbeing Hub @ Park View	Y			
Developing Capital Infrastructure investment FBCs for Tranche 1 schemes	Wellbeing Hub @ Eastern Vale	N	Public engagement meeting on 26.06.23 indicated community concerns. Second public drop-in session held 23/10/23. Site options being explored	Review of potential sites proposed by public. Further public engagement sessions required.	Low
Developing Capital Infrastructure investment FBCs for Tranche 1 schemes	SARC @ CRI	N	OBC submitted to WG. Discussions on CRI site ongoing with WG (see H&WC@CRI above)	Continued discussions planned for Q2	Low

Shaping Our Future Community Services (2/2)

Key area of Focus	Quarter 2 - Measures of Success- What did we say we would do?	Delivered (Y/N)	Reasons off track?	Plan To get Back to Green	Rate confidence on ability to get back to green by next quarter?
Engagement and Planning for delivery of Integrated Community Care Service	Detailed 23/24 delivery plans and metrics in place	N	Focus on Safe@Home and financial sustainability review has delayed detailed plans. Regular reporting metrics in place for the programme.	Focus on finalising delivery plans	High
Engagement and Planning for delivery of Integrated Community Care Service	Confirmation of deliverables for Q3	N	Delays in finalising Safe@Home business case to secure funding.	Initial options for phasing being drawn up, with a hope to begin small scale from Q4.	High
Engagement and Planning for delivery of Integrated Community Care Service	Continuing co-production and engagement with partners.	Y			
Engagement and Planning for delivery of Integrated Community Care Service	Alignment to Ministerial mandate for Integrated Community Care Service for Wales when published.	N	More detailed information on 'Further Faster' has not yet been published	Expectation that there will still be a focus on this area, but timeline from WG, and likelihood of funding still unclear.	Low
Engagement and Planning for delivery of Integrated Community Care Service	Alignment to 6 goals and National primary care strategy	Y			

Urgent and Emergency Care (1/2)

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

Key area of Focus	Quarter 1 - Measures of Success- What did we say we would do?	Delivered (Y/N)	Reasons off track?	Plan To get Back to Green	Rate confidence on ability to get back to green by next quarter?
Inpatient Flow, Discharge & Front Door	Reduce 21-day length of stay by 5% from Q1 2022 baseline	N	Continued national difficulties with social care and discharges	Current focus on stranded (7d LOS) and super-stranded (21d LOS) patients. New definition of 'clinically optimised' patients allowing greater focus on discharges. Revised pathways of care within community settings. Continued partnership working around Delayed Pathways of Care.	Low
Alternatives to admission	Reduction of ED majors' attendances of 5% compared to same period 2022/23	N	Continued high demand for Urgent and Emergency Care services across Wales	Delivery of six goals programme incl. alternatives to ED attendance, SDEC and Safer @ Home.	Low
Community and Urgent Primary Care	Home Visit (P2) f2f in 2 hours >90%	N	Workforce availability/shift fill for 2nd GP overnight.	Review of demand and capacity	Low
Priority Services	Stroke - 70% patients scanned within 1 hour	N	June was 59.2%, above the Wales average. CT scan performance impacted by loss of EU scanning availability.	EU Scanner is fixed. Work ongoing to improve the stroke assessment pathway with stroke and EU teams. Specific focus on pathway for self-presenting patients - with NHS Exec input. Review of medical and CNS workforce models.	High
Priority Services	Hip Fractures - 75% patients admitted to ward within 4 hours	N	High numbers of EU attendances. Challenging discharge picture leading to difficulties maintaining flow.	We have seen improvements to the pathway and the median time to ward has reduced significantly. Rapid # neck of femur pathway (three ringfenced beds on trauma ward, new rapid #NOF protocol triggered via switch). Introduce WAST Direct Pathway – working on new go-live date.	Low

Urgent and Emergency Care (2/2)

Key area of Focus	Quarter 2 - Measures of Success- What did we say we would do?	Delivered (Y/N)	Reasons off track?	Plan To get Back to Green	Rate confidence on ability to get back to green by next quarter?
Inpatient Flow, Discharge & Front Door	Reduce ambulance handover average lost minutes to 30	Y			
Inpatient Flow, Discharge & Front Door	Reduce 12-hour ED waits by 50% on Jan '23 baseline	N	Significant number of ward moves, and redesign of EU/AU has impacted performance	12-hour waits have reduced from baseline but remain above our ambition. Embedding improvements following the EU/AU redesign and increased use of medical and surgical SDECs. Additional operational pressures expected as we move into winter.	Low
Inpatient Flow, Discharge & Front Door	Re-establish dedicated AOS beds	N	Work continues to evaluate the most appropriate and effective approach for the Acute Oncology Service (AOS), including consideration of dedicated beds following a recent pilot.	An update and proposal is now planned for the beginning of Q3	Low
Alternatives to admission	Reduction of ED majors' attendances of 5% compared to same period 2022/23	N	EU/AU model changes not reflected in September data	Changes to the EU/AU model and increased use of medical and surgical SDEC facilities	High
Alternatives to admission	Reduced number of unplanned re-presentations within 7-days of SDEC attendance		Not currently measured as part of the nationally submitted dataset		
Community and Urgent Primary Care	85% appointment utilisation in UPCCs	Y			
Community and Urgent Primary Care	All clusters to have adequate access to UPCC capacity	N	Rollout required to Cardiff West and South-West	Roll out to Cardiff West by mid-November. Work ongoing with Cardiff SW.	Low
Priority Services	Stroke – 90% patients admitted to stroke ward within 4 hours	N	Improving month on month. Remains below 90%. Challenges in EU at beginning of pathway. Increase in self-presenting patients.	Action plan working with NHS Executive. Improvement plan for start of stroke pathway - redesign of clinical model, pathway work	Low
Priority Services	Stroke – 20% thrombolysis rate	N	Challenges in EU at beginning of pathway. Increase in self-presenting patients.	Action plan working with NHS Executive. Improvement plan for start of stroke pathway - redesign of clinical model, pathway work. Implemented AI support for thrombolysis pathway to improve identification of stroke from CT scanning	Low
Priority Services	ITU – Patient at Risk Team 24/7 go-live	Y			
Priority Services	ITU – additional 1 staffed bed established	Y			

Planned Care, Cancer and Diagnostics (1/2)

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

Key area of Focus	Quarter 1 - Measures of Success- What did we say we would do?	Delivered (Y/N)	Reasons off track?	Plan To get Back to Green	Rate confidence on ability to get back to green by next quarter?
Service Evaluation- Whole System	Undertake high impact evaluations of first three key specialities	N	Refocus of workstream	Completed in Therapies and Cardiac services. Three key surgical specialties to present their evaluations at Theatres summit in Q2.	High
Cancer	>75% compliance with the 62-day Single Cancer Pathway Standard	N	Focus on reducing backlog of long waiting patients has impacted delivery of standard.	Revised plan by tumour site for key stages of the pathway. Use of NHS Executive Cancer SharePoint resources to underpin revised D&C modelling. Standardised action plan across tumour sites. Weekly performance management by pathway stage – First contact, Diagnosis and Treatment. Continued analysis of breach reports	Low
Planned Care Performance	New Outpatients- 0 patients waiting longer than 52-weeks in all specialties (excluding allergy, urology, rheumatology, general surgery, ophthalmology, orthopaedics and spines)	N	Revised focus from minister on tackling 2- and 3-year waits	Current focus of elective resources to reduce 2- and 3-year OP waits	Low
Planned Care Performance	Total treatment- 0 patients waiting longer than 104 weeks in all specialities (excluding gynae, general surgery, urology, ENT, ophthalmology and spines)	N	Revised ministerial ambitions for 2- and 3-year waits. Industrial action Focus on urgent and Cancer patients	In line with revised ministerial ambitions: Specialties have trajectories for delivery of new ministerial ambition (<3% of patients waiting over 104w by December).	High
Planned Care Performance	Therapies-0 patients waiting over 14 weeks (excluding audiology)	N	Small number of breaches in 3 specialties	Clear long waiters in three specialties over rest of the year.	Low
Primary Care Performance	>95% of practices reporting escalation levels	N	Delayed reporting by 2 practices	Increased to 96% in July	High
Primary Care Performance	>90% of eligible practices offering Clinical Community Optometry Services (CCOS)	N	Contract reform and implementation still in progress	Contract reform and implementation still in progress	Low

Planned Care, Cancer and Diagnostics (2/2)

Key area of Focus	Quarter 2 - Measures of Success- What did we say we would do?	Delivered (Y/N)	Reasons off track?	Plan To get Back to Green	Rate confidence on ability to get back to green by next quarter?
Service Evaluation- Whole System	Undertake high impact evaluations of second three key specialities	Y			
Planned Care Performance	Follow up outpatients – reduce 100% delayed follow up by 25% on Jan '23 baseline	N	The number of 100% delayed patients has reduced by over 5700 patients from the Jan '23 baseline (against the trend of monthly increase through 22/23). Additional system changes to be agreed complimented by additional training.	Administrative and clinical validation. System updates and training to ensure target dates are correct. Focus on the longest waiting cohort.	High
Planned Care Performance	SOS and PIFU – 10% of appropriate outpatient appointments	N	Uptake of the pathways in limited number of specialties - good progress in specialties which have adopted	Clinical engagement at a senior level. Continued rollout with support from outpatient clinical lead	Low
Primary Care Performance	Dental new contract – achieve 50% of expected target for new patients, urgent and historic	N	>98% for new patients, 45.1% new urgent, 43.8% historic. Activity weighted onwards new early in year	Both new urgent and historic now over 50% (October)	High
Primary Care Performance	95% achievement of core access to in-hours GMS Services	Y			
Primary Care Performance	50% of backlog of suspected COPD patients receive spirometry	Y			
Supporting Patients Whilst Waiting	Pathways developed and agreed	Y			

Specialist Services

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

Key area of Focus	Quarter 1 - Measures of Success- What did we say we would do?	Delivered (Y/N)	Reasons off track?	Plan To get Back to Green	Rate confidence on ability to get back to green by next quarter?
Waiting Times for Specialist Services	Cardiac & Thoracic Surgery - new outpatients <16 weeks, maintain <52-week treatment	N	Small number of patients >16w and >52w at end of June	Only 1 thoracic patient breaching the 16 weeks for OPA - appt booked 31st Aug 2023. 4 thoracic patients breaching 52 weeks, 2 who require paediatric support for their surgery and can only be done in UHW - de-listed until we return to UHW. 2 further thoracic patients have requested surgery end of August. 1 complex Cardiac Surgical case that requires family support for both pre-dental work and surgery. Cath Von Oppel is working through the logistics and planning patients care.	High
Key area of Focus	**Quarter 2 - Measures of Success- What did we say we would do?**	**Delivered (Y/N)**	**Reasons off track?**	**Plan To get Back to Green**	**Rate confidence on ability to get back to green by next quarter?**
Waiting Times for Specialist Services	Neurosurgery – maintain <52-week treatment waits	Y			
Palliative Care	Increase % patient satisfaction	Y			
Palliative Care	Reduced admissions for supporting care patients	Y			

Children and Women Services (1/2)

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

Key area of Focus	Quarter 1 - Measures of Success- What did we say we would do?	Delivered (Y/N)	Reasons off track?	Plan To get Back to Green	Rate confidence on ability to get back to green by next quarter?
Child Healthy Weight and Childrens' Vaccinations	82.9% children up to date with vaccinations (at 4 years old)	N	82.4% for Q1 Q1 figure is only 0.5% off track, so not statistically significant. Post-COVID there was a drop in uptake that is still affecting figures and Cardiff & Vale faces challenges of high levels of deprivation and large numbers of ethnic minority communities, both of which are associated with low uptake	Multi-factorial approach, using a com-b (competency, opportunity and motivation to change behaviour) model to address vaccine hesitancy. Delivery impacted by seasonal patterns and fluctuations in vaccinations delivery and uptake. Looking at the last 3 years during the summer months there seems to have always been a drop in uptake compared to the previous quarter. This is likely due to the summer holidays and the fact that the 4-year-old cohort is a moving frame where some children leave the group and others join it due to their age.	Low

Saunders,Nathan
20/11/2023 15:51:45

Children and Women Services (2/2)

Key area of Focus	Quarter 2 - Measures of Success- What did we say we would do?	Delivered (Y/N)	Reasons off track?	Plan To get Back to Green	Rate confidence on ability to get back to green by next quarter?
Neurodevelopment	Reduce longest wait to <138 weeks	N	We were transferred a referral for a patient from out-of-area, the original referral date was honoured.	Appointment already booked for patients waiting >138 weeks. Reviewing all patients waiting >130 weeks with view of booking them into clinic in December. Engaged in the ND Improvement programme and additional monies has been utilised to fund additional posts that are in recruitment. Reviewing options for a "fast track" assessment model similar to that in IAS	High
Emotional Wellbeing & Mental Health (CAMHS & SCAMHS)	Improve performance against Part 1b of MHM by 10%	Y			
Emotional Wellbeing & Mental Health (CAMHS & SCAMHS)	Reduce SCAMHS Intervention longest wait to no longer than 24 weeks	N	Significant impact on capacity in both Psychological Therapies and Psychiatry due to ongoing vacancies.	2.00 WTE posts in Psychological Therapies have been recruited and are commencing in October 2023 which is expected to have a positive impact on the longest waiters. We have also implemented new clinical offers which will support a consistent offer for CYP as well as additional reporting to monitor caseloads.	Low
Children Looked After	Activity for IHAs to be increased by 35 per month	N	Total number of health assessments completed in:- July = 102 August = 110 September = 90 Significant staffing constraints	Increase workforce with paediatricians, nurses and introducing skill mix. Increase the nursing workforce. Introduce Saturday working to the LAC nurses for the children aged 5 years and over. Overtime to be offered to the LAC nurses to help clear the backlog.	Low
Children Looked After	Backlog for over 10s reduced from 245 to <100	Y			
Child Healthy Weight and Childrens' Vaccinations	83.9% children up to date with vaccinations (at 4 years old)		Quarterly data for Q2 not yet available		
Child Healthy Weight and Childrens' Vaccinations	Waiting time for child healthy weight services <14 weeks	Y			

Mental Health (1/2)

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

Key area of Focus	Quarter 1 - Measures of Success- What did we say we would do?	Delivered (Y/N)	Reasons off track?	Plan To get Back to Green	Rate confidence on ability to get back to green by next quarter?
Pathway redesign through co-production, partnerships and integration	Launch of Sanctuary	N	Recruiting to positions currently, and sourcing location from Local Authority	Complete recruitment and identify premises	High
Pathway redesign through co-production, partnerships and integration	Planning and governance for new roles in mental health workforce	N	Recruitment freeze on Peer Lead. Funding for CAPs posts. Waiting on HEIW strategy development.	Recruit peer lead. (All other areas on track)	High
Neuropsychiatry	Commence recruitment following WHSSC approval	N	WHSSC funding decision at Management Group has been paused due to current financial context	Await outcome of funding decision- risk assess impact of not progressing	Low
Safety and Stabilisation	Commencement of Royal College of Psychiatry (RCP) review	N	Awaiting start date	Delays not due to C&V	High
Key area of Focus	**Quarter 2 - Measures of Success- What did we say we would do?**	**Delivered (Y/N)**	**Reasons off track?**	**Plan To get Back to Green**	**Rate confidence on ability to get back to green by next quarter?**
Pathway redesign through co-production, partnerships and integration	Development of business case for Shared Lives.	N	Clinical Lead and Project Manager only allocated 1 month ago	Completion of business case and submission by July 2024	Low
Pathway redesign through co-production, partnerships and integration	Pathway redesign for longest psychological therapy waiting lists	N	Summit held for PTSD pathway but follow up summit required. Primary Care Counselling referrals reducing, and longest waits are being removed from waiting list.	This work is ongoing- our Lived Experience team is working with our Psychological Therapies teams to provide alternative offers for people on waiting lists. There are multiple pathways in the Psychological therapy waits. The longest waits have been removed from the list in recent months. Within the next quarter there will be more work on the pathway redesign towards implementation for the PTSD service in Q2 2024.	High

Mental Health (2/2)

Key area of Focus	Quarter 2 - Measures of Success- What did we say we would do?	Delivered (Y/N)	Reasons off track?	Plan To get Back to Green	Rate confidence on ability to get back to green by next quarter?
Pathway redesign through co-production, partnerships and integration	Recruitment of Intentional Peer Support Lead	N	Held up in Corporate Vacancy Scrutiny Panel, now out to advert	Successful recruitment	High
Pathway redesign through co-production, partnerships and integration	Physician's Associate recruitment	N	No applicants	Workforce support to understand why there were no applicants for mental health PAs	Low
Neuropsychiatry	Develop working models of care.	N	WHSSC decision to delay 2a business case	Recruitment of Speciality Doctor and review of day service provision towards an assessment model required. Developed KPI activity monitoring with WHSSC, to include capture of Liaison activity	Low
Neuropsychiatry	Implement integrated working team	N	WHSSC decision to delay 2a business case	Review of options available to team within current resource	Low
Safety and Stabilisation	Focus group synthesis of evaluation and engagement with national Suicide and Self Harm Strategy group	N	Safety and stabilisation now Business as Usual. Focus group part of ongoing work to implement suicide mitigation training- delay also due to limited digital resource to transfer forms to PARIS	Completion of implementation plan for suicide mitigation training and safety plans only remaining work to complete in plan. It is anticipated that this will now be complete by end of Q4	Low

Section 3: Financial Measures

At the end of Q2 the UHB is reporting a £7.1m deficit against the annual planned deficit of £88.4m. This remains a challenging position and plans continue to develop to close the current gap providing a trajectory to hit the planned deficit by year end.

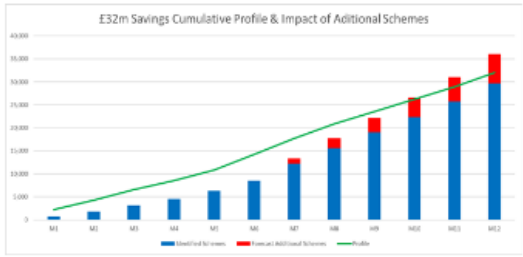
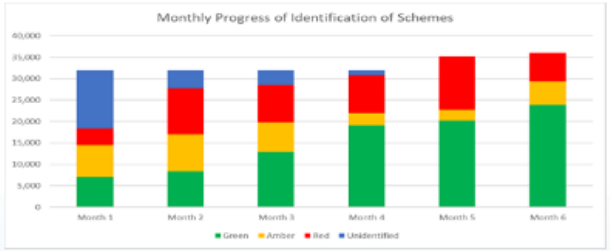
<table>
<tr><th>Priority</th><th>Performance Summary</th><th>Reported Period</th><th>Data</th></tr>
<tr><td>Deliver 2023/24 Draft Financial Plan</td><td>Financial Plan Approved by Board and submitted to Welsh Government

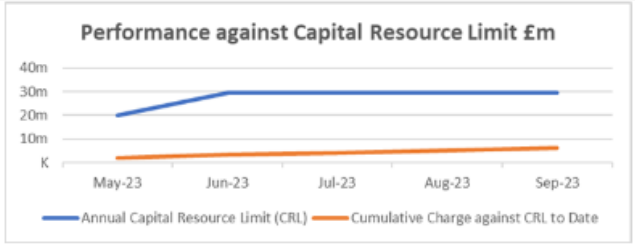
• Brought forward underlying deficit of £40.3m
• Local Covid Consequential costs of £34.2m
• Additional energy costs of £11.5m
• 23/24 Demand and cost growth and unavoidable investments of £48.8m
• Allocations and inflationary uplifts of £14.4m
• A £32m (4%) Savings programme

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

At month 6, the UHB is reporting an overspend of £51.300m. This is comprised of £5.747m unidentified savings, £1.352m of operational overspend and the planned deficit of £44.200m (six twelfths of the annual planned deficit of £88.4m set out in 2023/24 financial plan).</td><td>Sep-23</td><td><table><tr><th></th><th>Forecast Month 6 Position £m</th><th>Forecast Year-End Position £m</th></tr><tr><td>Planned deficit</td><td>44.200</td><td>88.400</td></tr><tr><td>Savings Programme</td><td>5.747</td><td>0.000</td></tr><tr><td>Operational position (Surplus) / Deficit</td><td>1.352</td><td>0.000</td></tr><tr><td>Financial Position £m (Surplus) / Deficit £m</td><td>51.300</td><td>88.400</td></tr></table></td></tr>
<tr><td>Delivery of recurrent £32m savings target</td><td>At month 6, the UHB has identified £36.046m of green, amber and red savings against the £32m savings target, however £6.707m are classified as red schemes. The month 6 position includes a Savings Programme adverse variance of £5.747m.

The month 6 Savings Programme deficit is expected to be recovered, supported by a number of additional actions as the year progresses, enabling the UHB to deliver its planned deficit position of £88.4m.

The UHB expects to be able to manage the balance of savings plans required to deliver the forecast deficit of £88.4m with the risk of non-delivery of savings shown in Graph 1 and the progress of reducing the risk via identification of schemes in Graph 2</td><td>Sep-23</td><td>Graph 1 – Profile of Savings Delivery
 
Graph 2 - Progress of Identification of Schemes
  </td></tr>
</table>

Priority	Performance Summary	Reported Period	Data
Remain within capital resource limits	The UHB forecasts to deliver within it's Capital Resource Limit.	Sep-23	
Creditor payments compliance 30 day Non-NHS	The UHB's public sector payment compliance performance is above the target of 95%. Performance for the month to the end of September was **97.48%** and improvements are illustrated in the graph to the right.	Sep-23	
Remain within Cash Limit	The UHB's working capital requirement assumes that Welsh Government will provide support to movements in working capital from the 2022-23 Balance Sheet and for the £88.4m planning deficit in the UHB 2023-24 Financial Plan. Dialogue with Welsh Government around the confirmation and timing of cash support for these areas and anticipated additional allocations is continuing.	Sep-23	
Maintain Positive Cash Balance	The closing cash balance at the end of September 2023, was £4.998m. A detailed monthly cashflow forecast is included in the monthly monitoring return submission to Welsh Government. The UHB's working cash assumption for 2023-24 is based on the following key assumptions :- • Movements in working capital from the 2022-23 Balance Sheet to be assessed as the year progresses. • Additional 1.5% consolidated pay award (£11.5m) for which Resource cover was received from Welsh Government in 2022-23 but has been paid out in 2023-24 and requires cash support. • Cash support for the £88.4m deficit of the UHB 2023-24 Financial Plan. • Timely confirmation of unconfirmed Cash Limit allocations (circa £74m @ month 6 (includes the 2023_24 pay award & Covid allocations)) Discussion is ongoing with Welsh Government to provide cash support for these four areas.	Sep-23	

Section 4: People and Culture Measures

Quarter 2 Summary - People and Culture Plan

Aim: to deliver an inclusive, engaged, sustainable and responsive workforce

26 specific milestones were set out for delivery in our 2023/2024 People and Culture Plan.

Of those:

- 12 were fully achieved
- 1 as not achieved, but with high confidence that this milestone could be recovered by Q3
- 13 were not achieved and with low confidence that the milestone could be recovered by Q3

The key challenges underpinning milestones that were not achieved and with low confidence in return to green by Q3 are:

- Focus on other priority areas
- Limited team capacity to lead /staff absences
- Completion of objectives taking longer than initially planned/expected

In addition, a number of significant deliverables were achieved in relation to workforce sustainability have been achieved that were not set out in the initial plan.

Key area of focus	Qtr 2 – Measures of Success – What did we say we would do?	Delivered Y/N	Reasons off track?	Plan to get back to Green	Rate confidence on ability to get back to green by next quarter?
Attract and Recruit	Reduce vacancies to 9%	Y			
	Reduce time to shortlist to 7 days	N	Sept 23 report shows an average of 9.1 days to shortlist applications	Provide Clinical Boards with summary recruitment performance data to encourage improvement.	Low
	Reduce R/N vacancies to 5% or below	Y			
Retaining our People	Reduce turnover to a more sustainable position, 12%	Y			
	Implement HealthRoster (new e-rostering system) for Nursing workforce	Y			
	Implement and embed HEIW Retention Plan, self-assessment tool	N	Required consolidating with UHB plan to include all staff groups.	Plan completed, themes identified which will be linked to annual priorities. Recruitment to a Band 8a Retention Lead.	Low
	Implement health and care joint induction	N	Social care has been approached and do not want to explore a joint induction at present but we are progressing joint training with Care Homes.	HEIW funding has been secured for an additional facilitator post for 2023/24 and will be requested for next year so we have the infrastructure in place should the social care position change.	Low
	Deliver and promote a new Speak up Safely Framework	N	Assessment undertaken & submitted to WG on 30/10/23	Plan to launch Framework during Q3. Exec lead is Director of Corporate Governance and P&C team are working closely with him	High

Key area of focus	Qtr 2 – Measures of Success – What did we say we would do?	Delivered Y/N	Reasons off track?	Plan to get back to Green	Rate confidence on ability to get back to green by next quarter?
	Achieve 85% Values Based Appraisal target by Sept 23	N	After reaching 71.64% in Jul 23 VBA compliance has fallen to 67.81% in Sept 23.	Position discussed at CB reviews, plan to reach 85% by Dec 23	Low
	Implement Wagestream for staff rostered through HealthRoster, enabling them to access 60% of salary earned through working additional shifts	Y			
Wellbeing	Integration of the new All Wales Occupational Health database	Y			
	Introduce Schwartz Rounds across the UHB	Y			
	Consistent approach to avoidable employee harm, supported by process review and access to support.	N	Reviewed offer within ABUHB but majority in CAVUHB existing approach.	Support built into process, work being undertaken to identify other areas for enhancement, e.g. toolkit.	Low
	Improve sickness absence levels back to pre-pandemic levels.	Y			
Equality, Inclusion & Welsh Language	Develop and implement Anti-Racist Action Plan	Y		.	
	Develop and implement the workforce actions in LGBTQ+ Action Plan	N	Focus has been on SEP consultation and ARAP implementation.	Plan to revisit in Q4.	Low
	60% of recruitment adverts & job descriptions translated into Welsh	N	Focus has been on timely responses to WL Commissioner and support for targeted areas.	Work underway to identify systems and processes to support achievement of the target through CB engagement.	Low

Key area of focus	Qtr 2 – Measures of Success – What did we say we would do?	Delivered Y/N	Reasons off track?	Plan to get back to Green	Rate confidence on ability to get back to green by next quarter?
	Improve rate of provision of all EDI data to 55%	N	Although a data campaign has started, little movement has been seen. Overall provision at Sep-23 was 29%	Data campaign underway linked to WRES to promote importance.	Low
	Stonewall submission	N	Limited team capacity has led to the prioritisation of legislative requirements. Also, LGBTQ+ network currently without committee.	Currently collating evidence, will review priorities to make submission decision.	Low
Education, Culture and OD	Enhance coaching network capacity	N	Completion of qualifications is taking longer than anticipated, due to competing demands/priorities.	Coaching network continues to grow, cohort 3 of coach trainees underway and utilisation of platform.	Low
	Develop a consistent, evidence-based approach to cultural assessments. Identifying hotspots	Y			
	Achieve 85% compliance for statutory and mandatory training	N	Compliance reduced to 81.24% in Sept 23	Improvement plans discussed at CB reviews, making progress towards achieving the target of 85% however anticipate a 'dip' over the Winter months. Mandatory February planned to address this.	Low
Shaping our Future Workforce	Recruit & train an additional 30 Assistant Practitioners for ward areas (total of 60 in Qtr 1 & 2)	Y			
	Train an additional 25 managers/leaders in workforce planning	N	HoPC with a special interest in SWP left the UHB in Jul 23. We have not been able to recruit into this role due to financial constraints	There is no capacity within the current team to deliver this training	Low
	Provide training for managers and users in the correct use of ESR	N	Training Needs Analysis undertaken, but no offerings yet made for managers. ESR Team staff absences has delayed implementation.	Review workload priorities in order to commence training provision, and look at additional/alternative approaches.	Low
	Establish Workforce Sustainability programme to support the UHB to reduce the over reliance on temporary workforce, including agency. Build a sustainable & affordable workforce.	Y			

Key area of focus	Qtr 2 – Measures of Success – What did we say we would do?	Delivered Y/N	Reasons off track?	Plan to get back to Green	Rate confidence on ability to get back to green by next quarter?
Workforce Sustainability **Additional significant deliverables achieved in Q2 which were not in the plan**	Reduce agency use for R/N	Y			
	Stop HCSW agency on 01/04/2023	Y			
	Reduce admin and management agency, bank and OT usage from 01/08/2023	Y			
	Reduce Medical and Dental WLI usage	Y			
	Introduce Rate Cards for Consultants and Junior Doctors working additional hours- fairness, consistency and equity	Y			

Cardiff and Vale Health Inclusion Service Development Update

November 2023

Dr Ayla Cosh

GP and Clinical Director for Cardiff and Vale Health Inclusion Service

Cardiff and Vale UHB, Wales

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

CAVHIS

The traditional model of primary care in Cardiff and Vale does not address the needs of people with multiple disadvantage this leads to:

Poor health outcomes

- **All-cause mortality is 12 x** higher in men and 8 x higher in women for health excluded groups
- **Average age of death** is 48 for men and 43 for women (homelessness)
- **Mortality 20 x** higher in the first year following prison release
- 2018/19 – **10 people died each week** following prison release (Inquest report 2019)
- Annual number of people dying whilst under probation services in Wales increased exponentially by 194% between 2018/19 and 2020/21 (PHW 2023)

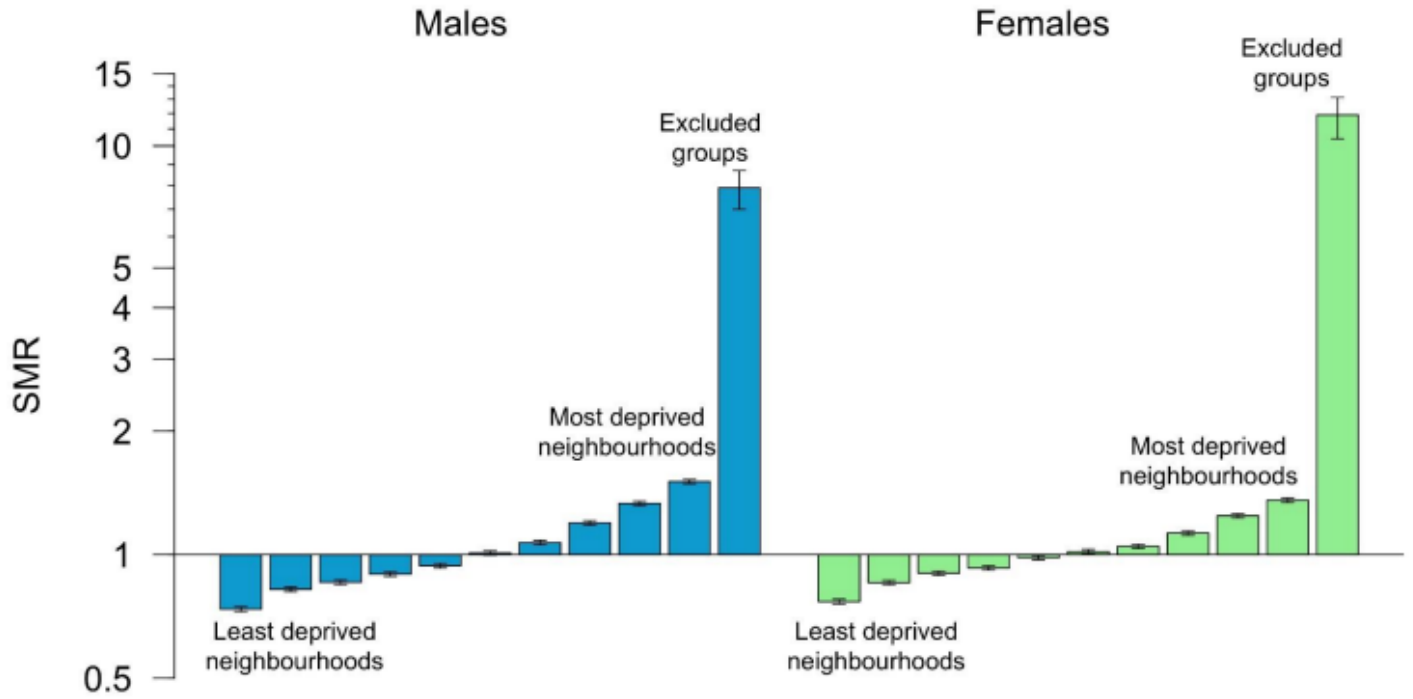
A loss of trust in the system

Long term escalating costs

Over 6 months, emergency department use by people experiencing homelessness in Wales cost £11 million more in healthcare costs than a general comparator group

Standardised mortality ratios by deprivation and exclusion

Standardised mortality ratio (SMR) for the general population in England, 2015, by neighbourhood deprivation, compared to SMR for excluded groups, with 95% confidence intervals.



Notes

1. SMRs for the general population are calculated using ONS mid-year population estimates by IMD decile for 2015 and ONS number of deaths in 2015 by IMD decile. Standardisation is conducted using 5-year age groups. The reference population is the whole population of England in 2015.
2. SMRs for excluded groups are taken from *Aldridge RW, Story A, Hwang SW, et al. Morbidity and mortality in homeless individuals, prisoners, sex workers, and individuals with substance use disorders in high-income countries: a systematic review and meta-analysis. Lancet 2017; 6736: 1–10.* Note that these estimates are made from studies from a number of high-income countries, while the SMRs for the general population are for England only. Also note that the studies that contribute to the SMR estimate for excluded groups use a range of comparison groups.

Health inclusion service model for Cardiff and Vale of Glamorgan TIER 3 SERVICE

Entry to service by the following groups:
Refugees/asylum seekers
High needs Homeless
Sex Workers
Prison leavers
Roma Gypsies/Travellers

Self referral or
Referral from:
Home Office
Emergency Unit
Homeless MDT
Dept of Sexual Health
3rd Sector

CAVHIS

Cardiff and Vale Health Inclusion Service
(Integrated Health and Social Care Service)
'Meeting the health needs of excluded groups with respect, dignity and compassion' **A 'no wrong door' approach**.

Health/Oral Health Needs Assessment
Social needs assessment
Screening
Vaccination
GMS care

Co-Located with dedicated:

Dental Services
GP
Health Visiting
Midwifery
Mental Health Services
TB/ID services
Community Paediatrics
Substance Use services
Podiatry
Optometry
Physiotherapy
Pharmacy
Occupational Therapy
TSW

3rd Sector
DWP
Citizen's advice
Housing
Council
Legal advice

Exit to GMS registration and mainstream services once stable and appropriate

Saunders,Nathan
20/11/2023 15:51:48

Outreach → **High Needs homeless hostels:**
Ty Ephraim
Adam's Court
Hayes Place
Ty Tresilian

Probation services
Sex parlours
Camp sites
Street Medicine

In-reach Pathway program → **Emergency Unit**

UHW Llandough
(Discharge Planning)

Work Completed Since Last Executive Update – Nov 22 (1)

- Establishment of Health Inclusion Program Board with input from Council and third sector at exec level.
- Defined populations according to health outcomes rather than vulnerability and work done on stratification of need
- Decided on Key Service Components – Tiers 1-3
- Service mapping – health/local authority/third sector partners
- Benchmarking visits –Brighton, Glasgow, London
- Attendance at International Conference on Integrated Care ICIC23 to present work to date and learn from other services
- Stakeholder engagement session July 23: good representation from cross sector partners, no surprises with SWOT analysis

Work Completed Since Last Executive Update (2)

- Health Inclusion EU In Reach Liaison Nurses – interim part-time arrangement put in place whilst funding for substantive posts identified. Pathway mapping. Data collection. Engaging EU partners in developing model.
- Sexual Health Outreach nurse appointed
- Adult ID clinic located at CAVHIS
- Paediatric ID Clinic at CAVHIS to start
- Purpose of outreach van
- Outreach engagement worker
- Health Inclusion Dentistry partnership (development of Health Inclusion dentistry model)
- Development of Baseline Data Set

Health Protection Funds used

EU and Day Case Activity Associated with Homeless

- Of the 370 individuals, 349 had a valid NHS number
- The 349 cases were used to link to acute and community patient data stored on the UHB's Business Intelligence System
- 5 yrs data summarised for EU attendances, outpatient appointments, inpatient and day case admissions and community clinic appointments

		NHS Activity for Registered Homeless People with a Valid NHS Number							
		Outpatients			Admissions		Community		
	EU Visits	Attended	DNA	DNA Rate	Inpatient	Daycase	Attended	DNA	DNA Rate
2018/2019	487	278	242	47%	128	7	738	156	17%
2019/2020	567	309	204	40%	123	13	612	169	22%
2020/2021	622	414	259	38%	140	9	592	200	25%
2021/2022	627	511	311	38%	139	8	748	199	21%
2022/2023	741	406	294	42%	140	12	924	194	17%

	5 Years EU Activity	
EU Outcome	Patients	Distribution
Discharged	1837	60.3%
Did Not Wait	593	19.5%
Admitted	454	14.9%
Other	97	3.2%
Redirected	60	2.0%
Died In EU	3	0.1%
Total	**3044**	**100%**

Work Completed (3) – Baseline Data continued:

Year	Patients Attending EU	Total EU Visits	Total Hours Spent in EU	Avg Hours Spent in EU
2018/2019	145	487	4344	9
2019/2020	158	567	4921	9
2020/2021	165	622	4793	8
2021/2022	190	627	7563	12
2022/2023	194	741	11441	15

Inpatient Admissions

	Inpatient Admissions			
Year	Patients	Admissions	Bed Days	ALOS
2018/2019	71	135	748	5.5
2019/2020	61	136	935	15.3
2020/2021	73	149	1437	19.7
2021/2022	79	147	2799	35.4
2022/2023	73	152	1965	26.9

Given the increase in time spent in EU for the most recent two years, individual times were reviewed:

Time Spent in EU	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023
0-4 Hours	230	272	268	200	218
4-8 Hours	106	134	164	173	205
8-12 Hours	51	59	88	89	104
12-24 Hours	57	52	69	88	106
1-2 Days	34	40	29	54	49
2-3 Days	6	5	3	13	28
3-4 Days	2	4		4	13
4-5 Days			1	3	11
5-7 Days	1	1		3	5
9 Days 20 Hours					1
13 Days 20 Hours					1
Grand Total	487	567	622	627	741

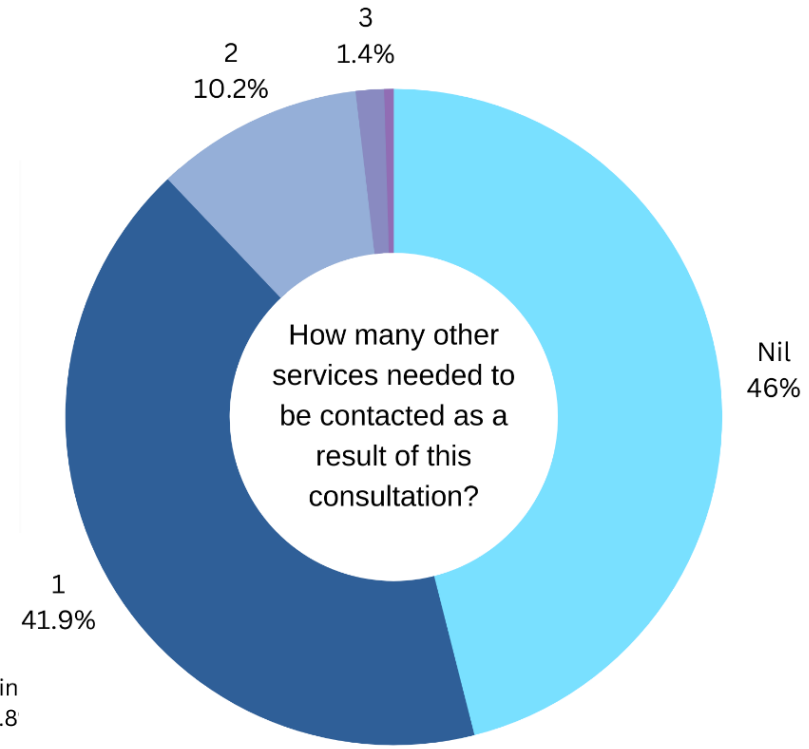
	Admissions for the 5 Years		
Specialty	Admissions	Bed Days	ALOS
GENERAL MEDICINE	232	1197	5.2
TRAUMA & ORTHOPAEDICS	72	433	6.0
ADULT MENTAL ILLNESS	71	2831	39.9
GENERAL SURGERY	51	546	10.7
GASTROENTEROLOGY	46	370	8.0
ALCOHOL & DRUG	37	631	17.1
MIDWIVES	35	101	2.9
THORACIC MEDICINE	30	86	2.9
INTENSIVIST	16	324	20.3
ORAL SURGERY	15	25	1.7

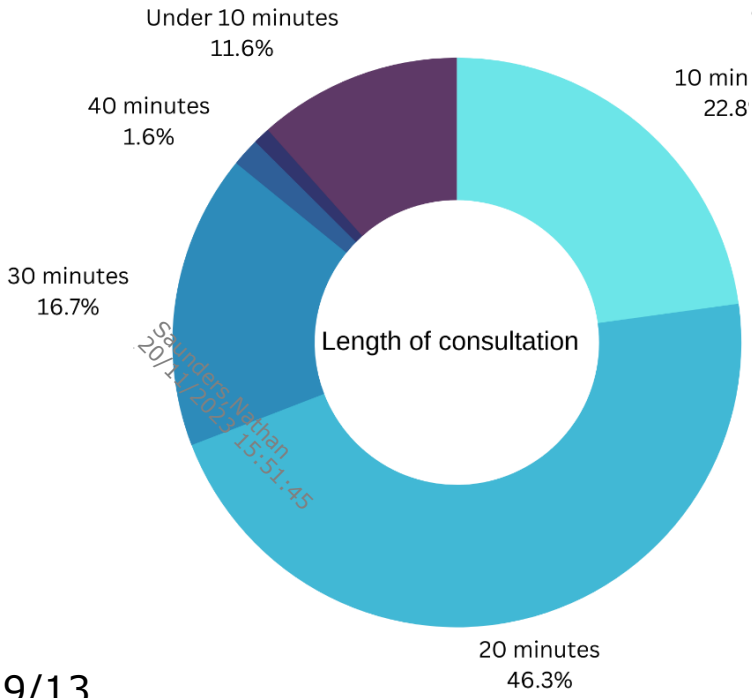
These people are at least 8 times more likely to attend EU than the general population in these age groups.

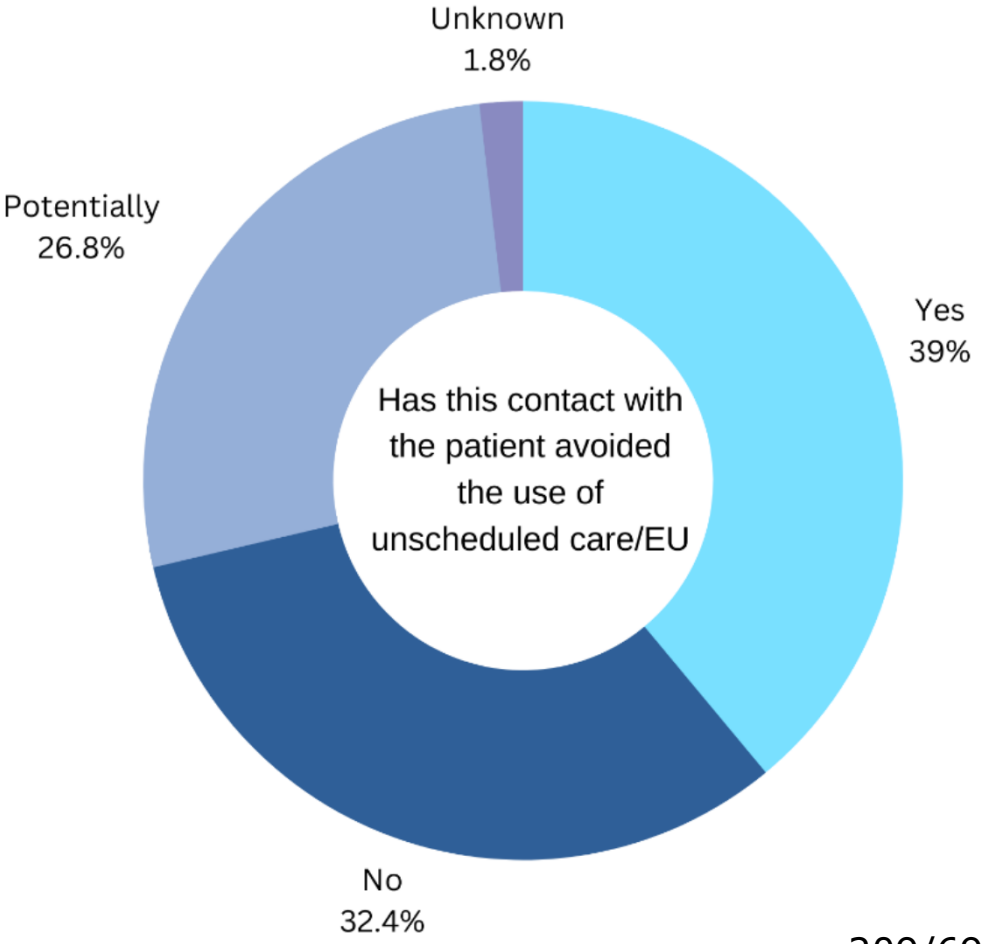
The total homeless population at any point in time is likely to be at least three times the number registered with GAVHIS

GP Homeless Outreach Clinic 6 month data: 311

- Mostly Male
- Mostly bt age 30-39







Work Plan November 2023-March 2024

- Pathway partnership – Faculty of Homelessness and Inclusion Health
- Scoping of Potential Model of Care for VOG
- Probation pilot funding/WAST data
- Sexual health outreach development
- Roma Gypsy and Traveller mapping
- Prove Efficacy and Impact of EU In-Reach Role and GP Out- Reach Model using fixed term funding available until April 2024
- **Service Specification and Business case development specific to Tier 3 service model(March 2024)**
- Model development – engaging partners, stream lining funds/avoiding duplication 'Integration, effectiveness and costs of different models of primary health care provision for people who are homeless: an evaluation study' NIHR Sept 23 – Four models of care over 3 years, outcome – screening/engagement in long term health management https://www.nihr.ac.uk/news/specialist-gp-healthcare-models-shown-to-help-care-for-homeless-more-effectively-than-regular-services/34599?utm_source=NIHR+mailing+list&utm_campaign=894ba1191f-NEWS_RESEARCH_26_8_2021_COPY_01&utm_medium=email&utm_term=0_570d86f9cb-894ba1191f-33084735

Where Do We Want to be in a year from now?
Focus on Outreach/In Reach

- **Fully Established and funded In-Reach/Outreach Teams:**
  - Health Inclusion Liaison Team based in the ED, with ability to support safe turnaround in ED and assist with timely discharges from wards
  - GP Outreach Models, providing opportunities to divert admissions and/or support timely return of individuals back into care of CAVHIS
  - Nurse/GP Outreach into Red Light Areas and Sex Parlour
  - Wider MDT providing additional core skills within CAVHIS relevant to 5 Health Inclusion Groups
  - Robust performance management and IT systems
- **Proven Model of Care to support seamless transition of Prison Leavers into Community-** Probation outreach across 2 sites
- **Provide GMS care for multiply excluded homeless people known to Council Single Persons gateway**

Resulting in:
- **Reduced use of unscheduled care and spending on 'did not waits'**
- **Reduced bed days**
- **Building of trust**
- **Improved Health**
- **Increase in partnership working across health, local authority and third sector**

Where do we want to be 2 years from now? Focus on GMS care

- **Provision of GMS for Tier 3 individuals who will not/cannot engage with core primary care (Roughly 2500 – NOT including RGT)**

- high needs complex homeless (roughly 1000)
- sex workers (200)
- AS under section 98 (roughly 400) asylum seekers under section 95 who are too vulnerable to access traditional care (200)
- ATS (50)
- Those under IOM/Short term sentencing (350)
- Establishment of RGT Outreach

- **Provision of Step Up/Step Down Beds outside of secondary care**

What Do we Need to Deliver the Plan?

- Continued Executive Level Support to ensure Health Inclusion remains a high- level and joint priority for the partnership agenda (RPB/PCC)
- A strategy for integrated commissioning of services specific to health inclusion
- Business Case to be Prioritised to enable year 1 and 2 aspirations to be delivered
- Urgent Need to Identified Accommodation to support expansion of service model
- Enhanced Service for GPs to undertake Tier 2
- Clusters to work on Tier 1 opportunities

Report Title:	**Implementation of Paediatric Infectious Diseases Service – WHSSC Tertiary Paediatric Strategy – Women and Childrens Clinical Board**			Agenda Item no.	7.1
Meeting:	Board	Public	X	Meeting Date:	30.11.2023
		Private			
Status *(please tick one only):*	Assurance		Approval	X	Information
Lead Executive Title:	Executive Medical Director				
Report Author (Title):	Director of Operations – Children & Women's Clinical Board				

Main Report
Background and current situation:

Paediatric Immunology and Paediatric Infectious Diseases (PIID) is classed as a single tertiary sub-speciality made up of the two component parts throughout the UK.

In the contemporary global context PIID specialists provide a key clinical link between Public Health, Microbiology/Virology and all tertiary and secondary paediatric clinical services, typically in the form of a regional managed clinical MDT network.

Tertiary paediatric immunology is a WHSSC commissioned service within Wales. However, there is no commissioned paediatric infectious diseases (ID) service in South Wales.

Children and young people in North Wales have access to the tertiary Infectious Diseases services in Alder Hey hospital in Liverpool, which is an established centre of excellence. This represents inequity of access to this service across Wales and compared with the wider UK, particularly to the detriment of the paediatric population of South Wales.

Importantly, infectious diseases form a top burden of acute morbidity and mortality and health care use in infants and children. The incidence of infection in children is strongly correlated with social deprivation. Many of the children admitted to paediatric intensive care facilities will either have presented with an infection or will have had an infectious complication of another health care problem for example, cancer, immunodeficiency etc.

There has been a profound impact on the immunity of our population to common infections as a consequence of our lock down strategy during the COVID 19 pandemic in 2020 -21. As a consequence of this strategy we have seen a cohort of children with no immunity to common seasonal viruses such as RSV. This 'immune debt' has led to recent outbreaks of severe RSV, invasive group A strep and flu, all of which have resulted in high numbers of children requiring secondary and tertiary paediatric services. We do not know what the longer-term impact of this immune debt will be on the incidence of infections going forwards.

Given the rapidly changing landscape of infections affecting children it is going to be essential that south Wales has a paediatric ID service that can work alongside colleagues in microbiology, virology, public health, primary care etc to plan for infection outbreaks in children in the future, enabling our service to be reactive to changes as they occur.

Children and young people's rights to equitable access to clinical care and clinical research are underlined in many strategic documents, notably the UN Convention and Committee on the rights of CYP, UNICEF Sustainable Development Goals (SDG 3), The Rights of CYP Wales art 24 (2011), Turning the Tide by RCPCH (2012, 2018), and A healthier Wales (2019). NIHR INCLUDE calls for an improvement in the inclusion of under-served groups in research. This study regards children as an under-served group, as well as those people from socio-economically disadvantaged groups.

Over the past 10 years, some of the most urgent components of a PIID service have been provided by 2 consultants with dual accreditation in General Paediatrics and Tertiary Paediatric Immunology and Infectious diseases, training and research expertise. The infectious disease work is delivered largely in addition to their core job plans that require them to deliver a tertiary immunology service as well as secondary care general paediatrics. If these Consultants were to retire there will be no service provision for South Wales.

There is an urgent need for sustainable continuation of regional direct clinical services and provision of training for succession planning; consolidation of regional clinical leadership towards Welsh Public Health activity.

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

A Business Case for implementation of a Paediatric Infectious Diseases Service within Cardiff and Vale University Health Board was invited by WHSSC in 2022-23 as part of the 2023-24 annual planning round linked to the 5-year Commissioning Strategy for Specialised Paediatric Services.

This case was originally reviewed and approved by Cardiff and Vale Health Board's Investment Group at the start of 2023/24 and was submitted to WHSSC.

Since submission of this original case to WHSSC, due to the current financial climate and to reduce the level of Health Board investment required in 2023/24, a rationalised version of the original Paediatric Infectious Diseases case was invited and approved by Investment Group in October 2023. This has been discussed and is supported by WHSSC.

The rationalised case proposes a phased approach in implementation, delaying the initial planned implementation of an antimicrobial stewardship programme (AMS) and paediatric out-patient antimicrobial therapy (pOPAT).

This proposal reduces investment FYE from £1.180m to £0.678m (a reduction in investment of £0.482m). Additional in year slippage also recognized in terms of lead in to recruitment.

The Phase 1 investment proposal is for 21 dedicated paediatric consultant ID sessions to be commissioned by WHSSC to enable the delivery of a paediatric infectious diseases service alongside the current paediatric immunology service. The Consultant team would be supported by nursing, junior doctors, and administration and other supporting therapy input as detailed in Table 1:

Table 1: original to rationalised case WTE and £ investment by staff type:

	Original Case			Rationalised Case			Variance		
Resource Requirement/Role	WTE	PYE 23/24 £'000	FYE 24/25 £'000	WTE	PYE 23/24 £'000	FYE 24/25 £'000	WTE	PYE 23/24 £'000	FYE 24/25 £'000
Consultant PIID	2.60	306	371	2.10	150	299	-0.50	-156	-72
Consultant Microbiology	0.60	72	86	0.00	75	0	-0.60	4	-86
Senior Clinical Fellow	1.20	96	128	1.20	0	128	0.00	-96	0
Clinical Nurse Specialist	1.80	81	108	0.80	30	0	-1.00	-51	-108
Advanced Nurse Practitioner	1.00	52	69	0.00	0	51	-1.00	-52	-18
HCSW	0.30	6	8	0.00	0	0	-0.30	-6	-8
Psychology	0.20	8	17	0.20	4	18	0.00	-4	1
Antimicrobial Pharmacist	0.50	23	30	0.00	0	0	-0.50	-23	-30
MDT Team Coordinator	1.00	31	41	0.00	0	0	-1.00	-31	-41
Clinic Coordinator	0.60	13	17	0.60	11	19	0.00	-2	2
Medical Secretary	1.30	32	42	1.00	20	35	-0.30	-12	-7
Staff Set up		11	0		6	0		-5	0
Non Pay		72	92		31	55		-41	-37
Micro/Vir/Mycology		18	23		7	14		-11	-9
PIC Line Service		0	25		0	0		0	-25
Overheads		81	105		35	60		-46	-45
	11.10	900	1,160	5.90	369	678	-5.20	-531	-482

Rationalised Phase 1 paediatric infectious diseases service investment summary:

Annual Revenue Requirement	Current Year (23-24) (£)	Recurrent (24-25) (£)
	369,000	678,000
Capital Requirement (£)	0	

Both AMS and a pOPAT service are a vital component of a paediatric ID services. It is proposed that once this initial service is established a Phase 2 case to establish AMS and pOPAT services is considered by WHSSC in future planning cycles.

The costs included in the case are total costs of implementing a Paediatric Infectious Diseases Service as a provider. The Cardiff and Vale Commissioner share of this investment will be based on 'South Wales population shares'. Currently, this equates to 20.46% of total investment (% share subject to review annually).

Recommendation:

The Committee is requested to:

a) Support this rationalised, phased approach to implementation of a Paediatric Infectious Diseases Service in Cardiff and Vale UHB for South Wales for submission to WHSSC
b) Accept this change in approach will result in a phased implementation of a full Paediatric Infectious Diseases Service for South Wales and will exclude the development of Regional paediatric antibiotic stewardship and a paediatric outpatient parenteral antibiotic service (OPAT) programme which will form the basis of a Phase 2 case at a later date.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please place an "X" in the below boxes 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 place an "X" in the below boxes 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~~

Risk Title	Descriptor	Probability (1-5)	Impact (1-5)	Total risk score (PxI)	M

Base line fragility of overburdened service	Service set up heavily relies on leadership expertise from current 2 senior consultants within 1-5 years of retirement. Sickness/burn-out/unforeseen absence would cause significant set back (years)	5	5	25	Immediate fun for existing con their current jo Immediate app ID consultant p
Clinical outputs	Service set up activity will displace current (unfunded) clinical output, notably consult service until additional staff in post.	3	3	9	Immediate app ID consultant p
24/7 on call for telephone advice	Part of NHSE PIID service specification Cannot be provided with this business case (needs 4WTE PIID)	5	1	5	Regional expec planning) Integration wit for out of hour
Interdependencies/ Infrastructure	p-OPAT requires PIC line service (theatre time is scarce). p-OPAT provision on weekends (local CNS and community nursing availability)	5	1	5	Internal escalat Pre-agree local
Major activity surges and pandemics	Small service with highly variable unpredictable demand (i.e. vulnerable)	4	5	20	Formulate esca support (e.g. fr

Safety: ~~Yes~~/No

Financial: Yes/~~No~~

The Paediatric Infectious diseases service is currently not commissioned within Cardiff and Vale UHB. This will require investment as outlined in the body of this report.

Workforce: Yes/~~No~~

Recruitment and training will be required

Legal: ~~Yes~~/No

Reputational: ~~Yes~~/No

Socio Economic: Yes/~~No~~

Addressed in main body of the report

Equality and Health: Yes/No

Decarbonisation: ~~Yes~~/No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Investment Group	
Senior Leadership Board	
Finance & Performance	18.10.23

Cardiff and Vale University Health Board Business Case

For revenue investment proposals greater than £75,000

All business cases must be submitted in line with the timescales outlined in Annex d

Title	
Clinical /Service Board or Department	Implementation of Paediatric Infectious Diseases Service – WHSSC Tertiary Paediatric Strategy – Women and Childrens Clinical Board

Expected funding source (highlight/delete as appropriate)	Welsh Health Specialised Services
Where a business case is in regards to external funding sources this template **must** be used unless the source of funding requires their own template to be used.	

Approval and scrutiny route	
Has this case been signed off by the Clinical Board / Corporate Departments senior team?	Women and Children Core Board Meeting 13th of January 2023 Revised version agreed August 2023.
Has this case been signed off by the Clinical Board / Corporate Departments finance and workforce business partners?	Cath David / workforce business partner
Clinical Boards: Has the COOs office signed off this document? **Corporate Departments:** Has the relevant Executive sponsor signed of this document?	yes/no

Contents

1. Executive Summary 1

2. Introduction and Background 1
3. Strategic Context - Alignment to UHB strategic direction 2
4. Summary current service provision and case for change 5
4.1 PIID service specification, MDT requirement and UK benchmarking
4.1.2 Antimicrobial stewardship and p-OPAT services - further background
4.2 PIID service - current position in South Wales
4.2.1 Paediatric Immunology service
4.2.2 Paediatric Infectious Diseases service - description of scope
4.2.3 Clinical and laboratory Microbiology/Virology/Mycology service from Public Health Wales
4.2.4 Summary of current position and risks for PID
5. Case of change - The evidence 10
6. Option Appraisal 12
7. The preferred option 12
7.1 Benefits .....
7.1.1 Benefits tracker .....
7.2 Risk .....
7.3 Total cost - resource Implications and Affordability .....
Annex a: Workforce implications .....

Annex b: Non-pay, support service, infrastructure ……
Annex c: Capital requirements ……
Annex d: BCAG submission deadlines ……
Appendix 1

1. Executive Summary

Currently there is no commissioned or funded tertiary Paediatric Infectious Diseases service for South Wales.

Recognising increasing complexity and globalisation, and the importance of emerging new infections and antimicrobial resistance, the provision of a tertiary paediatric infectious diseases service has long been a requirement of a Regional Children's Hospital in England, as detailed in the NHSE 2013/14 service specification for Paediatric Immunology and Infectious Disease (PIID), and by DOH England (2008) and the NHS constitution (2009).

The absence of a resourced regional clinical PIID network, carries significant postcode related inequity of access to care as well as adverse public health outcomes, that this case seeks to address.

Over the past 10 years, some of the most urgent components of a PIID service have been provided by 2 consultants with dual accreditation in General Paediatrics and Tertiary Paediatric Immunology and Infectious diseases, training and research expertise. The infectious disease work is delivered largely in addition to their core job plans that require them to deliver a tertiary immunology service as well as secondary care general paediatrics. With ever increasing demand for infectious disease expertise in the past few years, the situation has reached breaking point with the directorate of Acute Child Health no longer being in a position to deliver tertiary infectious disease expertise in a safe and sustainable way. Both consultants are senior, and unless support and resource are now put in place, they will seek retirement or alternative employment by September 2023.

These consultants provide the Paediatric Immunology service, which is part of the WHSSC funded Immunodeficiency Service for Wales and which is aligned with services in other nations. Their departure would precipitate collapse of this service (loss of 6 of 8 paediatric sessions).

There is an urgent need for sustainable continuation of regional direct clinical services and provision of training for succession planning. Furthermore, this business case includes consolidation of regional clinical leadership towards Welsh Public Health activity, notably prevention, enhanced surveillance, screening, eradication programs and outbreak management.
It is anticipated that the team would work towards the development of a regional paediatric antibiotic stewardship and a paediatric outpatient parenteral antibiotic service (OPAT) program as part of hospital from home strategies and while not part of phase 1 of the service would welcome the opportunity of working with WHSCC over the next three years to develop a further proposal to establish this service across Wales.

The proposal is that 21 dedicated paediatric consultant ID sessions are commissioned to enable the delivery of a paediatric infectious diseases service alongside the current paediatric immunology service. This in total would amount to 2.7 WTE paediatric consultants to deliver both paediatric immunology and paediatric ID services, with 3 further Paediatric Immunology sessions remaining with the adult immunology lead and the immunology laboratory. The Consultant team would be supported by nursing, junior doctors, and administration and other supporting therapy input.

The creation of a sustainable tertiary PID service is an integral part of the WHSSC Paediatric Strategy for tertiary services and as such has an associated source of revenue assumed recurrently within WHSSCs financial plans from 2023 onwards.

Annual Revenue Requirement	Current Year (£)	Recurrent (£)
	369,000	678,000
Capital Requirement (£)	0	

2. Introduction and Background

Paediatric Immunology and Paediatric Infectious Diseases (PIID) is classed as a single tertiary sub-speciality made up of the two component parts throughout the UK.

In the contemporary global context PIID specialists provide a key clinical link between Public Health, Microbiology/Virology and all tertiary and secondary paediatric clinical services, typically in the form of a regional managed clinical MDT network.

Tertiary paediatric immunology is a WHSSC commissioned service within Wales. However, there is no commissioned paediatric infectious diseases (ID) service in South Wales.

Children and young people in North Wales have access to the tertiary Infectious Diseases services in Alder Hey hospital in Liverpool, which is an established centre of excellence. This represents inequity of access to this service across Wales and compared with the wider UK, particularly to the detriment of the paediatric population of South Wales.

Indeed, as early as 2008, the Department of Health in England made the following statements:

"*With the emergence of new infections, new diagnostic tools, new antimicrobial treatments, increasing resistance to antibiotics, increased immunosuppressive treatments, the complexity of modern tertiary care and increased global travel, it has been recognised that* ***paediatric specialist centres should have access to and support from a specialist in PIID***"

In 2013, NHS England produced a detailed service specification for Paediatric Immunology and Infectious Diseases, based on over 15 standards of care. An equivalent set of documents does not exist for PIID within Wales.

"In addition, PIID clinical and academic researchers provide NHS patients with access to the latest new diagnosis/treatments for immune problems, infections and vaccines to prevent new and emerging infections (NHS Constitution (2009) and seek to ensure that patients from every part of England are made aware of research that is of particular relevance to them"

Importantly, infectious diseases form a top burden of acute morbidity and mortality and health care use in infants and children. The incidence of infection in children is strongly correlated with social deprivation. Many of the children admitted to paediatric intensive care facilities will either have presented with an infection or will have had an infectious complication of another health care problem for example, cancer, immunodeficiency etc. Although COVID 19 infection in children rarely resulted in serious respiratory disease as it did in adults, we did see the emergence of a life-threatening inflammatory disorder known as PIMS-TS that affected a small minority of children as a consequence of infection by COVID 19. South Wales saw 71 cases of PIMS-TS between May 2020 and April 2022, which is proportionally very high and due to the high incidence of COVID 19 in our population. In the

later waves, with changes in variants, severe respiratory COVID-19 also emerged in children and young people in South Wales (16 cases). Management of these children, as well as diagnostic work up of a ~20 further suspected PIMS-TS cases for other causes (e.g. systemic JIA or post-COVID recurrent fevers), was coordinated by the paediatric immunology consultants in Cardiff who established a guideline and management pathway alongside paediatric infectious diseases colleagues in England. The vulnerability posed by a lack of a commissioned paediatric ID service was brought into sharp focus by the PIMS-TS outbreak as, without the skill of our immunology colleagues in the management of infectious diseases and consequent inflammatory syndromes, we would not have been able to manage this outbreak within south Wales.

COVID 19 was not the first new infection to affect children in recent years. The HIV pandemic of last century has left an ongoing legacy of children infected by vertical transmission (mother to baby). The paediatric HIV service is currently the only funded paediatric ID service within south Wales, but that provides only 0.4 WTE clinical nurse specialist time and none of the necessary consultant time. Similar services are required for children affected by hepatitis, again spread by vertical transmission, tuberculosis (particularly prevalent in the recent Afghan and Ukrainian refugee population), tropical diseases etc. We also need to be prepared for future outbreaks of infections yet uncharacterised.

There has been a profound impact on the immunity of our population to common infections as a consequence of our lock down strategy during the COVID 19 pandemic in 2020 -21. As a consequence we have seen a cohort of children with no immunity to common seasonal viruses such as RSV. This 'immune debt' has led to recent outbreaks of severe RSV, invasive group A strep and flu, all of which have resulted in high numbers of children requiring secondary and tertiary paediatric services. We do not know what the long term impact of this immune debt will be on the incidence of infections going forwards.

During the winter of 2022-23 there was an unprecedented regional outbreak of cases of myocarditis in very young children infected with enterovirus. This is a common virus that normally causes a self-limiting illness in children, but can sporadically be very serious in young babies. Over a period of a 2 months, 9 babies from south Wales (5) and south west England (4) were diagnosed with rare condition that sadly carries a very high mortality. Indeed, 2 further babies are highly likely to have died from the same condition prior to reaching PCCU (full post mortems awaited).

Our paediatric immunology consultants set up a collaborative MDT with colleagues from Bristol in order to manage these children. They wrote a pathway that included providing a novel antiviral drug to all the children alongside anti-inflammatory therapy. It would have not been possible to manage these very sick children in a coordinated and collaborative way if we had not had the expertise required within south Wales.

Given the rapidly changing landscape of infections affecting children it is going to be essential that south Wales has a paediatric ID service that can work alongside colleagues in microbiology, virology, public health, primary care etc to plan for infection outbreaks in children in the future, enabling our service to be reactive to changes as they occur.

Children and young people (CYP) are our future. Their rights to equitable access to clinical care and clinical research are further underlined in many strategic documents, notably the UN Convention and Committee on the rights of CYP, UNICEF Sustainable Development Goals (SDG 3), The Rights of CYP Wales art 24 (2011), Turning the Tide by RCPCH (2012, 2018), and A healthier Wales (2019). NIHR INCLUDE calls for an improvement in the inclusion of under-

served groups in research. This study regards children as an under-served group, as well as those people from socio-economically disadvantaged groups.

This case describes the component parts that will provide a contemporary Paediatric Infectious Diseases service for South Wales, aligning this with the services provided to children in North Wales and the rest of the UK.

3. Strategic Context – Alignment to UHB strategic direction

Getting things right early in life lays the foundations for lasting population wellbeing, health and resilience. The UK strategy documents for Child Health emphasise prevention and health promotion, and a holistic bio-psychosocial model of care, (Facing the Future, Together for Child Health Standards, Paediatrician of the Future RCPCH 2018-21). The proposed PIID service model supports this approach.

The managed clinical network is aligned with the principles of Shaping our Future Wellbeing, Prudent Health Care, A Healthier Wales, Value in Healthcare, and wider national strategies, in particular the National Clinical Framework for a learning health and care system.

Outcome and Priority	How does this proposal support any of these outcomes
Outcome 1: Home first ❖	The managed clinical PIID service network brings equitable access to expertise as close to home as possible, irrespective of post code. Furthermore, it supports development of All Wales integrated care pathways connecting Public Health, community, primary, secondary, tertiary services. The initial funding of the PID service will enable the development of a further funding proposal to provide a south Wales wide program of paediatric antimicrobial stewardship (PAS) and Outpatient Parenteral Antimicrobial Therapy (p-OPAT) integrated in community-based hospital at home services. Close collaboration with Public Health Wales on outbreaks, emerging diseases, surveillance, screening, transmission prevention and eradication bolsters this also. Reducing hospital admissions and visits also avoids major negative collateral social, educational, employment and financial impact on CYP and families (siblings, parents/carers).
Outcome 2: Outcomes that matter to people ❖	Getting things right first time through early appropriate diagnostics and correct management, improves outcomes, reduces complications, stigma and harm. Experiencing seamless care **(re)builds TRUST** in our system, enhances partnership working and

	improves the experience of CYP, families and professionals alike. Our model represents cross-silo system redesign. It frees up scarce hospital infrastructure and enables continued covid-19 response and post-pandemic recovery. Use of **Value Based Health Care** methodology for ongoing multisource evaluation and system learning will support this further.
Outcome 3: Empower the person ❖	A PIID network leadership empowers professionals in all tiers to function 'at the top of their pay grade'. Our emphasis on self-care empowers families and reduces reliance on services and over-medicalisation. During the **Covid-19 pandemic and emergence of PIMS-TS** strong Paediatric ID leadership for Wales, jointly with the Clinical Research facility, from CHfW, demonstrated this is achievable and there is keen support and momentum from colleagues across South Wales for a collaborative clinical network. Our regional capacity building plan will future proof the PIID service, and reputational benefits will enhance recruitment of high calibre trainees and staff to Wales.
Outcome 4: Waste, harm and variation	A regional PIID service supports prevention and screening programs and effective local clinical care, including recognition and management of rare and serious infections. The proposed network model addresses current postcode related inequity of access within South Wales, between North and South Wales, and between Wales and England/UK. Without funded PIID service for South Wales, acute support and scheduled care will have to be sourced from England (e.g. Bristol, Birmingham Liver Unit, GOSH, King's and St Mary's in London). This is unrealistic and will cause waste and harm and variation from delayed/missed diagnoses and treatment, poor clinical oversight and governance, increased acute out of Wales transfers and excessive travel for families, with associated environmental impact

	and inevitable disengagement of those who need it most. Telemedicine and the wider digital strategy for Wales enable our remote support to patients and professionals (e.g. WCP, Attend Anywhere, TEAMS MDTs, consultant connect, e-advice) and reduce our carbon footprint. Antibiotic stewardship reduces harm, waste, and environmental impact from inappropriate use of antimicrobials.

4. Summary current service provision and case for change

4.1.1 PIID service specification, MDT requirement and UK benchmarking

In the contemporary global context **PIID** specialists provide a **key clinical link** between Public Health, Microbiology/Virology/Mycology and all tertiary and secondary paediatric clinical services, typically in the form of a regional managed clinical MDT network.

In 2013 NHS England produced a detailed service specification for Paediatric Immunology and Infectious Diseases (PIID), based on over 15 standards of care (https//:www.england.nhs.uk/specialised-commissioning-document-library/service-specifications/). Condition specific standards can be provided on request.

The first column of Table 1 lists the key conditions which should be managed by the specialist PIID centre or by a general paediatrician in a local hospital under a network/shared care arrangement with support from the specialist centre. This is based on the NHSE Service Specification (2013), and adjusted to reflect new clinical advances and insights (not exhaustive). Column 2 and 3 will be discussed in section 4.2.

	Conditions requiring Paediatric Immunology and Infectious Disease expertise	Existing funding	Unfunded Paediatric Infectious Diseases expertise
1	Immunodeficiency syndromes - primary and secondary e.g. due to immune suppression or late effects of cancer treatment; clinical management and diagnostic laboratory support. Includes HSCT care pathway with Newcastle BMT unit, all Wales 22Q MDT, Immunology-Genetics MDT	Immunodeficiency Centre for Wales	integral to Immunology service
2	Immunedysregulation MDT clinic for autoinflammation including periodic fevers, complex autoimmunity sndromes	Immunodeficiency Centre for Wales	integral to Immunology service
3	opportunistic infections in immune compromised hosts	Immunodeficiency Centre for Wales	integral to Immunology service
4	common infections in immune-compromised host	Immunodeficiency Centre for Wales	integral to Immunology service
5	recurrent infections - work up for immune deficiency	Immunodeficiency Centre for Wales	integral to Immunology service
6	Kawasaki's syndrome, PIMS-TS and similar		Ad hoc CHfW & regional
7	severe, invasive and complicated infections		Ad hoc CHfW & regional
8	viral hepatitis		regional service lead & delivery - linked with B'ham & Kings liver centres
9	HIV	HIV funding	
10	fever of unknown origin (PUO)		Ad hoc CHfW & regional
11	nosocomial infections, health care associated infections		Ad hoc CHfW & regional
12	multiresistant infections (bacterial, fungal and viral)		Ad hoc CHfW & regional
13	postoperative and post traumatic infections		Ad hoc CHfW & regional
14	complex or multidrug resistant TB and mycobacterial infections		Ad hoc CHfW & regional
15	supporting sec care TB services		regional service lead & delivery
16	complex and unusual neonatal infections		Ad hoc CHfW & regional
17	prevention and treatment of congenital infections (HIV, hepatitis, toxoplasmosis, CMV, syphilis, rubella, herpes simplex, varicella, chlamydia)		Ad hoc CHfW & regional
18	persistent lymphadenopathy - cervical and other		Ad hoc CHfW & regional
19	sexually transmitted infections in CYP		Ad hoc, joint with Adult Integrated Sexual Health Clinics
20	complex vaccine advice for passive and active immunisation		joint immunisation coordinator PHW
21	rare, travel imported and emerging infections and outbreaks, e.g. Lyme, Malaria, Typhoid, MERS, SARS-COV-1, Ebola, Monkey pox, SARS-COV-2, severe hepatitis , neonatal enterovirus mycocarditis outbreak, iGAS		Ad hoc CHfW & regional

Table 1 PIID conditions

The NHSE service specification also summarises the PIID MDT staff and resource requirements as per Table 2.

PIID MDT staff and resource requirements as per NHSE service spec 2013
Consultants (GRID PIID trained
Paediatric Specialist Nursing support (ANP, CNS)
access to clinical Paediatric Micro/Vir/Mycology and laboratory support
Immunology laboratory support
antimicrobial pharmacy support
clinical psychology and play therapy support
access to clinical geneticist
access to safeguarding liaison, social worker and community support workers
access to anaesthetist or PICU based PIC line service

Table 2 PIID MDT requirements

In Table 3 below, we provide benchmarking data for PIID consultants in regional Children's Hospitals in England, which illustrates the stark contrast with the Children's Hospital for Wales.

PID Centre	Consultants	Inpatient Beds	Beds per 1WTE (10PA) PID Consultant
Children's Hospital for Wales (CHFW)	0.8WTE funded sessions and provided by x2 consultants approaching retirement	133 – Including PICU – 7 ITU 4 HDU NICU - 33	133
Evelina	6 consultants 36 PA's (4 IPC PA's)	200 Beds (33 ICU)	56
Bristol	4 consultants 30.75 clinical PA	189 + 47 neonate beds = 236 (20 ICU)	76
St George's	7 consultants 34 PA	160 (15 ICU/step down) 43 NICU/SCBU	47
Alder Hey	5 consultants 33 PA	310 beds (24 ICU)	93
GOSH (no immunology)	5 consultants 36 PA	389 beds? (20 CICU; 15 PICU; 9 NICU)?	105
St Mary's (no immunology)	9 consultants 35 clinical PA's supported by additional PA's from academic working 1:6 on call	130 beds (70 paeds, 15 ICU, 45 NICU)	37
Southampton (consult only)	3 consultants 15 PA	168 (14 ICU, NNU 38)	112
Sheffield (also do immunology)	4 consultants 33.5 PA's	154 beds? From CQC 10 PICU 10 HDU	45

Table 3 Benchmarking of PIID services in England (not all centres have submitted data) Courtesy to CSAC Chair PIID 2021

4.1.2 Antimicrobial stewardship and p-OPAT services – further background

Paediatric Antimicrobial Stewardship (PAS)

The prudent use of antimicrobial agents is essential to maintain the effectiveness of our antimicrobial armoury against increasing global antimicrobial resistance. There is compelling evidence to support the introduction of antimicrobial stewardship programmes in both community and hospital settings, in terms of reduced antibiotic use, improved quality of prescribing and cost-savings (ref British Society for Antimicrobial chemotherapy www.bsac.org.uk).

However, the introduction of paediatric programs lags behind. Furthermore, a recent survey of 17 regional children's hospitals in the UK also highlighted wide variation in program set-up (ref Paediatric antimicrobial stewardship programs in the UK's regional children's hospitals, Vergano et al, Journal of Hospital Infection, June 2020).

This has since prompted the formation of the UK-PAS network, which aims to collaborate with local and international stakeholders, collect and share benchmarking data on antimicrobial use, resistance and clinical outcomes, share information, engage patients and public and contribute to policy through research findings and advocacy. (ref UK Paediatric Antimicrobial Stewardship https//:uk-pas.co.uk)

Paediatric Outpatient Parenteral Antibiotic Therapy (p-OPAT)

OPAT, when governed and delivered well, is an important component of antimicrobial stewardship. Development, delivery and governance of outpatient parenteral (IV) antibiotic therapy (OPAT) programmes enables early discharge of patients to home. This carries significant well-being, resource and environmental benefits. Again, programs and studies have initially focused on adult practice (ref British Society for Antimicrobial Chemotherapy www.bsac.org.uk).

Paediatric programs (p-OPAT) lag behind, but are clearly of vital importance for children and young people themselves. In addition, hospital admissions heavily affect siblings, parents, family life, school attendance, parental work and family finance through additional costs (travel, food) and loss of income. This burden is disproportionately carried by socially deprived populations with unstable low incomes (e.g. zero hours contracts).

As p-OPAT programs are being introduced across the UK, they demonstrate significant positive impact on inpatient services, e.g. in Southampton 130 p-OPAT episodes saved 1683 bed days (ref. The impact of p-OPAT implementation at a Tertiary Children's Hospital in the UK, Patel et al, Paediatric Infectious Disease Journal Dec 2018).

Clinical Governance and p-OPAT staffing

Updated good practice recommendations for outpatient parenteral antimicrobial therapy (OPAT) in adults and children in the UK, were recently published and in addition to the above, highlight the following key points (Ref Updated good practice recommendations for outpatient parenteral antimicrobial therapy (OPAT) in adults and children in the UK, A Chapman et al, JAC Antimicrobial resistance Dec 2020).

Strong clinical governance and clear care bundles are an essential part for both PAS and p-OPAT programs to ensure regular clinical review to:

- reduce overall antibiotic prescribing
- ascertain infection source control
- monitor for clinical and pharmacological complications (including level monitoring)
- initiate prompt IV to oral switch
- make the correct choice of antimicrobial agent balancing effectiveness, ease of administration and development of resistance.

As such programs are being introduced across the UK studies repeatedly demonstrate the importance of a paediatric infectious disease clinician alongside microbiology and specialist pharmacist as key to the success and sustainability of such programmes.

The implementation of a AMS and OPAT programme for South and West Wales will not be part of phase 1 of the PID service but the development of a proposal, working alongside WHSCC, will be a major part of the work undertaken in this first phase, with the aim of having a service in the next 3-5 years.

Telemedicine

This is increasingly used successfully and should be incorporated into programs systematically with appropriate safety netting and plans for escalation.

4.2 PIID service – current position in South Wales

Column 2 and 3 from Table 1 illustrate that only Paediatric Immunology and HIV services (see appendix 1) are currently funded in South Wales.

4.2.1 Paediatric Immunology service

The WHSCC funded Immunodeficiency Centre for Wales provides adult and paediatric immunodeficiency clinical services and diagnostic laboratory support.

The service also includes adult and paediatric PID HSCT clinics, Autoinflammatory clinics, the All Wales 22q11 MDT clinic, a Paediatric Immunology-Genetics MDT and membership of the Syndrome Without A Name (SWAN) MDT clinic. In addition, adult and paediatric immunoglobulin replacement therapy (IgRT) and home therapy is a key component (Table 1 conditions 1-5).

This is a high-profile service with extensive laboratory and research expertise, a strong academic track record and large global collaborative network. The service hosts the TPD for adult immunology training in Wales and has a proved record of trainees passing FRCPath.
The Immunodeficiency Centre for Wales will be seeking Quality in Primary Immunodeficiency Services accreditation in Paediatric Immunology in the near future (https://www.qpids.org.uk). Of note, access to Clinical Infectious Diseases is a requirement of the Immunodeficiency service specification.

The Paediatric Immunology service is provided by 1 Adult trained Immunology consultant (Prof S Jolles, service lead, TPD), and two tertiary-trained PIID consultants (3 sessions each).

Current Paediatric Infectious Disease support to Paediatric Immunology: the PIID consultants are dual trained and thus have the expertise to provide the (unfunded) Paediatric Infectious Disease component of care to Paediatric Immunology patients.

4.2.2 Paediatric Infectious Diseases service – description of scope

Paediatric Infectious Disease specialists also provide an extensive portfolio of services.

- Their clinical workload is heavily biased towards acute consultation to all tertiary and secondary care services (infections can affect all organs) and involves extensive onward liaison with diagnostic services, notably microbiology and imaging.
- The numbers of CYP requiring tertiary beds directly under PIID are small, but carry high complexity and often long lengths of stay.
- Specialist outpatient services, in particular for children with chronic and life-long infections conditions (e.g. blood borne viruses) form a smaller component. Close links with adult counter parts are vital for transition.
- A further large workstream involves provision of paediatric clinical expertise to ensure inclusion of CYP in all Public Health Wales policy, as well as clinical management of outbreaks, emerging diseases, surveillance, screening, mother to child transmission prevention and eradication programs.
- Furthermore, they provide joint clinic leadership with microbiology colleagues in antimicrobial steward ship and o-PAT programs.

The typical service model to provide regional equity of access and resilience is through managed clinical MDT network.

Current position: This is unfunded. It is partially delivered, largely in own time, and on some CAV secondary care funding. There is heavy reliance from clinicians across the region particularly for consults and advice. Nonetheless, there is highly likely a degree of under-diagnosis and under-treatment. Without operational support, we have limited data on activity, incidence and outcome. Welsh specific program targets are likely not met. See *Appendix 1* for available data on HIV, TB case and outbreak management, atypical mycobacteria, Hepatitis B & C, Syphilis, CMV, other congenital infections, PIMS-TS and recent Neonatal Enterovirus Myocarditis outbreaks.

4.2.3 Clinical and laboratory Microbiology/Virology/Mycology service from Public Health Wales

This service currently provides paediatric antimicrobial ward rounds at CHfW to PICU, NICU, Haematology/Oncology and General Paediatrics as well as a 24/7 telephone advice and liaison service. A full PIID services relies on and requires close collaboration with these important clinical and laboratory services.

Current position:

- Excellent working relationships exist between PIID and microbiology clinicians.
- Absence of a funded Paediatric Infectious Disease service means that their clinical support to antimicrobial ward rounds cannot be provided and joint PIID-microbiology consultations and mutual liaison are frequent but ad hoc.
- Of note, supporting a tertiary paediatric infectious diseases service, and particularly a regional PAS and p-OPAT service would require additional clinical Microbiology/Virology/Mycology resource.

4.2.4 Summary of current position and risks for PIID

Paediatric Infectious Diseases

Over the past 10 years the most pressing care has been delivered within CHfW and across the region by two senior highly motivated consultants with required tertiary expertise. This work has been outside their job plans and has not been re-numerated. Many other components have not been delivered or at best ad hoc.

The unsustainability of this situation was brought into sharp focus by the COVID pandemic, where there was a need to assemble and lead the paediatric COVID/PIMS-TS-MDT with all associated clinical and R&D support on a 1 in 2 on call for South Wales (in excess of 600 hrs consultant time across the 2 waves).

With ever increasing demand, this has now reached break point and cannot continue safely. Both consultants are senior, and unless support and resource are now put in place, they will seek retirement or alternative employment by September 2023.

Impact on Paediatric Immunology

Retirement or resignation of one or both PIID consultants also precipitates a crisis in Paediatric Immunology for Wales as they hold the largest cohort (6 sessions), with some incoming support of a General Paediatrician at CHfW (1 session). This is particularly sensitive as the overall service lead of the Immunodeficiency Service for Wales (1 paediatric session) is also approaching retirement. This WHSSC service is already invested in and aligned to strategies in other nations, and without funded Paediatric Infectious Disease component this will be a very difficult and costly recovery.

Risk to patients

There is profound clinical interdependency with delivery of tertiary services delivered at Noah's Ark Children's Hospital, notably Paediatric Intensive Care, Neonatal Intensive Care, and system based medical & surgical paediatric specialties, e.g. haematology-oncology, respiratory, cardiac, rheumatology, gastro-enterology, renal, neurology, neuro-surgery, ENT, trauma and orthopaedics, surgery, and ophthalmology. Close links between PIID and secondary care paediatric units and regional Neonatal units are essential to ensure equitable access to timely diagnosis, appropriate local management, referrals and transfers.

Whilst their expertise is highly valued by clinicians across the region, the current situation highly likely incurs missed prevention opportunities, delayed diagnosis and incorrect treatment, with associated further morbidity. The absence of a managed network means further variation in access to excellence.

Ad hoc working under high time pressure with no designated support or governance structures is inefficient use of consultant time and importantly adds risk to patients.

Imminent collapse of the services will much exacerbate this risk and necessitate immediate recommissioning outside Wales with increased transfers and travel to England, and for many children in reality no service at all.

Risk to regional capacity building – PIID training

An effective clinical PIID network requires expertise building across the region. There are no opportunities within Wales to train in PIID, either at SPIN or GRID level and there are no other paediatricians in Wales who have such qualifications. Ambitious Welsh trainees have to go to England for PIID training and often do not return. When the current PIID consultants leave, there is no back up within Wales, and with this legacy any future competitive recruitment into Wales would be compromised.

The current tertiary PIID consultants are accredited trainers, and have extensive expertise in workforce management also.

Hence the current tertiary PIID consultants have obtained provisional CSAC approval (Aug 22) to offer both SPIN and GRID training, but this is subject to a fully funded PIID service and training post. There is keen interest and some high calibre Welsh Paediatric trainees have registered their interest with CSAC.

Current plan:

- **SPIN (special interest module**) for ST6-8 trainees and PIID network consultants
  Subject to funding Senior Clinical Fellow post – 1.2 WTE trainees due to start date Sept 2023.
- **Tertiary GRID training (Paediatric Infectious Disease focus)**
  Subject to creation of HEIW funded ST6-8 post at UHW. Wales School of Paediatrics supportive, pursuing HEIW funding – earliest possible start September 2024 (subject to HEIW funding)

The prospect of a funded PIID service and training program has already enhanced our reputation and generated high calibre interest not only in training but also in our future consultant PIID posts and CNS and ANP posts. There is yet hope to turn the tide. However, the timelines are tight, and if funding is not confirmed within the coming months, this scheme will collapse and set us back years.

5. Case of change - *The evidence*

Through the implementation of the WHSSC Tertiary Paediatric Strategy this case is an opportunity to capitalise on the extensive clinical, research, teaching and leadership expertise of these senior consultants to build a comprehensive regional Paediatric ID service, and one to which Wales can competitively recruit excellence in due course.

Expertise and skillset of the current senior tertiary PIID consultants at CHfW:

- Strong clinical, teaching and academic track record, and a wide (inter) national peer network
- Accredited PIID trainers, and medical mentors to Clinical Nurse Specialists undertaking MSCs
- Expertise in workforce management and in leading culture change management, cross-silo working and transformation of services, notably the successful creation of Paediatric Integrated Primary Care Cluster clinics in Cardiff and Vale and Community Health Pathways.
- Extensive network of excellent working relationships right across South Wales, and with colleagues in Public Health, providing an invaluable basis for the development of a managed clinical network.

All elements of the proposed package for Paediatric Infectious Diseases are deeply interdependent and required to provide:

1. Equitable access to expert clinical care and research, irrespective of postcode. Key elements

2. Ensured inclusion of CYP in all Public Health Wales policy, as well as clinical management of outbreaks, emerging diseases, surveillance, screening and eradication programs.
3. Regional paediatric antimicrobial stewardship (PAS) and a paediatric Outpatient Parenteral Antimicrobial Therapy (p-OPAT) program as part of hospital at home.
4. Regional PIID capacity, expertise and future sustainability building program
5. Robust clinical and educational governance structures underpinning the PIID service.

Managed clinical network

A network has many benefits beyond equity of access and much strengthens resilience of small services within South Wales. There is keen interest from paediatric units across South Wales in the formation of a managed PIID network and initial discussions are underway. Broadly the architecture will involve funded leadership from the PIID team, with named local lead consultants in each unit. Important ingredients include development of secondary-tertiary care pathways defining referral thresholds and reciprocal clinical remits, and strong business, governance and QI frameworks.

Commitment to mutual learning and teaching is expected and educational opportunities and training will be provided, e.g. PIID SPIN module for consultants. The 'Bringing Networks to Life' resource from RCPCH offers useful guidance, and a scoping exercise of successful networks will be undertaken as part of the formation.

Of note, the PIID service will not be able to offer out of hours cover as this would require 4WTE. This will be mitigated by clear expectation setting across the region, e.g. advance weekend planning. Out of hours care to PIID inpatients at CHfW will be provided through integration with General Paediatrics at CHfW.

The backbone of the service is PIID consultant leadership, but supported by a senior clinical fellow, Clinical Nurse Specialists and administrative staff.

The proposed development of an AMS and OPAT service will require further staff including an advanced nurse practitioner, Clinical Microbiology support, and a Pharmacist.

The table below sets out the predicted job planned Direct Clinical Care (DCC) activity required to support a Paediatric Infectious Diseases service in Cardiff and Vale (21 DCCs).

Table 4 Total PIID consultant Direct Clinical Care sessions (annualised) provided through full investment in this case

Activities	Description	DCC Sessions per annum
Acute services		
Consultant CHfW ward rounds	3 hrs twice weekly. One service consultant, once all	150.40
Acute consult service Mon-Fri 9-18 for CHfW and local units & ad hoc case MDTs and joint clinic reviews & micro-viro-myco lab liaison	2.5 hrs weekdays	173.33
Joint Micro rounds CHfW PICU, NICU, haem onc, Paeds and antimicrobial stewardship	8 hrs per week	111.09
Weekly UHW regional rapid access slots combined with & Paeds ID & Viral Hep clinic	52 clinics per year	78.00
Regional OPAT service joint with Microbiology	Leadership and patient management	168
Scheduled services		

Monthly regional network clinical MDT (with 5 UHBs)	2 hrs MDT (plus admin)	22.40
HIV family clinics (includes transition) at UHW	12 per year	18.00
TB clinics CAV at CRI	12 per year	18.00
TB CNS MDTs and queries	0.5 hrs per week	6.93
TB regional cohort MDT	4 per year (2 sessions per MDT)	8.00
TB outbreak ad hoc outbreak clinics	6 per annum	9.00
TB outbreak leadership & MDTs (including refugees)	12 MDTs (2 hrs per Consultant)	6.40
Paeds ID outreach clinics (SBUHB, HDHD, ABUHB, CTM)	4 per year per site	32.00
Paeds ID UHW team clinical MDT (CNS support) all consultants @ 42 wks py	1 hr per week 52 weeks	33.60
Clinical leadership - outbreaks, emerging diseases	1 session per week 52 weeks	33.60
Fetal Medicine MDT	24 per year (30 min for 1 Consultant)	3.20
Ante natal ID MDT	12 per year (1 hour for 2 Consultants)	12.80
Total DCC sessions		**21.06 Per Week**

As explained previously, Paediatric Infectious Disease services are heavily biased towards acute consultation services and outpatient clinics present a smaller time commitment. However, for further reference Table 5 below summarises the total clinic capacity offered.

Table 5 Paediatric Infectious Disease clinic capacity provided by full investment in this case

Clinic	Frequency	Clinics per annum	Appointments
Weekly UHW regional rapid access slots combined with & Paeds ID & Viral Hep clinic	52 clinics per year	52	312
HIV family clinics (includes transition) at UHW	12 per year	12	72
TB clinics CAV at CRI	12 per year	12	72
TB outbreak ad hoc outbreak clinics	6 per annum	6	36
Paeds ID **outreach clinics** (SBUHB, HDHD, ABUHB, CTM)	4 per year per HB	16	96
Total clinics / clinic appointments		**98**	**588**

6. Option Appraisal

The options available are:

Option 1 Status quo

This will not address the current inequity across Wales. Inaction will mean change. As described above the inability develop a sustainable a Paediatric Infectious Disease service, poses a real risk of losing Welsh Paediatric Infectious Disease expertise altogether and precipitate collapse of Paediatric Immunology services also. Paediatric ID is reliant on two individuals who do not have dedicated time in their job plan and will be retiring within 0-5 years, or, as the current situation is morally and practically untenable, indeed seek alternative employment. This will pose a clinical risk to patients and poor patient experience and

significant reputational damage to Wales. Furthermore, Paediatric Infectious Diseases is by nature an acute specialty with highly unpredictable surges (outbreaks, pandemics) and close ties to Public Health Wales, and does not lend itself to commissioning outside Wales. This is not considered to be an option.

Option 2 Partial or delayed funding
All proposed elements are deeply interdependent as well as time sensitive. Partial or delayed funding is undeliverable and will continue the crisis. In the event of an invited review of a partially funded service, this is likely to fail (RCPCH Invited Reviews Service www.rcpch.ac.uk and Academy of Medical Royal Colleges, aomrc-invited-reviews framework). Collapse of both Paediatric Immunology and Paediatric Infectious disease provision will not be averted.

Option 3 Expansion of service
The proposal is that 21 dedicated paediatric consultant ID sessions are commissioned to enable the delivery of a paediatric infectious diseases service alongside the current paediatric immunology service. This in total would amount to 2.8 WTE paediatric consultants to deliver both paediatric immunology and paediatric ID services, with 2 further Paediatric Immunology sessions remaining with the adult immunology lead and the immunology laboratory. The Consultant team would be supported by nursing, junior doctors, and administration and other supporting therapy input.

As a consequence of having a defined fully commissioned service as above a number of subsidiary benefits across the system are enabled and described in section 7.

7. The Preferred option

Paeds ID is a small service, and any investment in the team below the levels described in this paper will not meet the service specification or sustainability required for the service. Full investment in this case as described in option three is therefore recommended as the only viable option.

7.1 Benefits of investment in a full Paediatric Infectious Diseases Service

Quantifiable benefits	*Non-quantifiable benefits*
Provision of clinical Paediatric Infectious disease services for South Wales in network model 1.Timely and equitable access to the highest quality of care and clinical research close to home irrespective of postcode. *Result:* Increased early diagnosis and correct treatment, and discharge with reduced morbidity from delays and complications 2.Standardised and integrated service through development of care pathways *Result*: Increased quality of referrals, referral avoidance, increased, increased efficiency and reduced wait times 3. Maximal responsiveness to new insights *Result:* rapid implementation of care improvements	1.**Life-long effects of:** • of earlier correct diagnosis and reduced iatrogenic complications on later morbidity. • of reduced hospital stays and visits on social/financial/wellbeing of CYP, siblings, parents/carers and social deprivation scores 2.Down stream effects of **rebuilding TRUST** in seamless care on jobsatisfaction, patient and staff wellbeing. **3. Wider effects of building confidence in self care for childhood infections on** future health care seeking behaviours of CYP in adult life.

4. Expertise framework supporting local development of integrated pathways with primary care, and self-care for families.	4. **Ripple effec**ts on of the above on siblings, family, friends and wider community
Designated regional paediatric programs and care bundles for: • paediatric antibiotic stewardship **(PAS)** • paediatric Parenteral (IV) antibiotic therapy **(p-OPAT)** • **Blood culture taking** • **IV-line care** To support excellent care at home or as close to home as possible (local paediatric units).	**Wider and longer term impact** • on antimicrobial resistance • on microbiome health • on public perception/knowledge of antibiotic use
Provision of CYP/family centred programs for • Outbreaks • Emerging Diseases • Prevention (incl vaccination) • Surveillance • Screening • Eradication	**Wider impact on:** • Community transmission • Longterm physical and mental health (incl stigma) and well being of CYP/families • Educational/professional/social attainment • Longterm social deprivation scores
Regional PIID Capacity Building and succession planning **Existing extensive teaching portfolio** of PIID delivered clinical to PICU, NICUs, tertiary specialisms, micro/viro trainees, maternity services, Public Health, regional Paediatric grand rounds e.a. **Network model** accelerates this across the region as membership will have defined learning & local teaching commitments **Increased local R&D expertise** through participation in clinical trials and studies. **SPIN and GRID PIID training will become available in Wales** (currently trainees go to England and often do not return) **PIID training support of allied professionals**, e.g. PIID CNS, ANP, AM Pharmacist (e.g. MSc mentoring). **Overall much increased resilience** of PIID service (major surges, outbreaks, pandemics, staff absence) and of small local paediatric	**Reputational benefits** • For Children's Hospital and Welsh paediatric units • For HEIW and Welsh School of Paediatrics among UK trainees, senior nursing colleagues and other allied professionals. • To standing of Wales among PIID consultant peers across the UK and internationally **Enhancement of competitive recruitment to Wales** of high calibre ambitious: • tertiary PIID consultants for Children's Hospital for Wales • secondary care consultants with a special interest in PIID to NICUs and paediatric units across South Wales • Paediatric trainees (PIID and all) ***Note:*** Expressions of interest are indeed coming in since inclusion of WHSSC Paediatric Strategy

services in managing common and rare childhood infections.	Longterm impacts of above on regional **clinical and academic excellence, sustainability and succession planning.**
Clinical Goverance PIID Full electronic auditable clinical activity and outcome records of consults, MDTs, referrals, admissions and clinics. Improved quality of enhanced surveillance programs (e.g. respiratory viruses in 0-5 yrs) Robust QI mechanisms ensuring measurable clinical and systems learning (VBHC) Public transparency and involvement of children, young people and families in improvement and shaping of services	**Culture shift** in other paediatric and wider services from using Value Based Health Care methodology within the PIID service Wider impact from **listening to the voices of children and young people**.

7.1.1 Benefits Tracker

The grace and favour nature of the existing service, coded largely through General paediatrics, and absence of a regional model makes coding of existing and an assessment of unmet demand challenging. The benefits of investment of the case will regularly be visited and refined by the Directorate and Clinical Board Team as the service is initiated and matures.

Benefit title	Benefit descriptor including	Expected realisation date	Measure(s) to be used	Baseline position at 22-23	Projected position at Oct 23	Actual position at Oct 23	Projected position at Apr 24	Actual position at Apr 24	Projected position at end 2024/25	Actual position at end 2024/25
Lead and support: **Provision of clinical Paediatric Infectious disease services for South Wales**	Formation and leadership of managed clinical Paediatric Infectious disease MDT network for South Wales Acute Paediatric Infectious Diseases consult service Mon-Fri 9-18 hrs for South Wales Rapid Paediatric Infectious Diseases review service for South Wales at CHfW Support joint ward rounds & MDTs with Microbiology/PICU/NICUs/HaemOnc/Immunology/medical and surgical specialties/secondary (CHfW and South Wales) Paediatric Infectious Diseases clinics at CHfW and outreach clinics 4 UHBs Support and delivery of Paediatric TB services for South Wales Lead clinical paediatric blood borne virus service and deliver clinics for South Wales (HIV, Hep B and C) As integral part of clinical care provision of equitable access to all relevant studies and NIHR portfolio clinical trials for CYP across South Wales		Compliance with NHSE PIID service specification Compliance with disease specific standards of care Equity of access to care within South Wales, and compared with North Wales and UK Alignment with Welsh Digital Strategy and National Clinical Framework for a learning health and care system. Compliance with UN Convention on Rights of the Child (2013) Sustainable development goals Unicef (SDG 3, 2015) Rights of Children and Young persons Wales art 24 (2011) Turning the Tide RCPCH 2018 (excellent care includes equitable access to research and trials) Reduction in LOS for those conditions requiring PIID input Improved equity of access (atlas of variation Increase in activity through improved diagnosis	Unfunded with exceptions of HIV service 6 sessions Microbiology support (SLA with PHW)	Recruitment into Consultant posts and infrastructure complete Workplan to achieve compliance with standards of care drafted		Progress made towards meeting compliance with standards of care, strategic direction. Evidence of reduction in Length of Stay for PIID patient cohort Update Welsh access data to evidence improved equity of service access outside Cardiff and Vale Evidence of increase in activity due to improved diagnosis/access		Service fully embedded Compliance with standards listed Revisit data points from Apr 24 in terms of activity, LOS Efficiency identified	
Provide clinical Paediatric Infectious Diseases expertise to policy and clinical management of: **Outbreaks Emerging Diseases, Surveillance, Screening**	Ensure inclusion of appropriate plans for children and young people and their families/carers in all relevant workstreams Support local implementation and clinical case management via the clinical MDT network Strengthen collaborations with • PHW working parties • Infection Control • Immunisation		Meet WHO, UK and Welsh program specific targets Provide Joint briefings with Public Health Wales, e.g to Welsh Government **Examples** MERS, **SARS-Cov1 &2, PIMS-TS** Monkeypox, **Ebola 1&2 HCID guidance for children and families,** severe hepatitis syndrome, neonatal enterovirus myocarditis, iGAS, refugee	Unfunded					WHO, UK and Welsh targets met. Where not met clear project plan and timescales identified	

and eradication Programs	• UK networks and registers • Maternity services • Health Inclusion Services (refugees and asylum seeker screening) • Sexual Health • Homeless services • Young offenders • Substance misuse/ CAMHS		screening & emergencies (Afghanistan TB, Ukraine Hep C and MDRTB risk). Ongoing screening, prevention and treatment programs (e.g. HIV and Hep B). Paediatric TB outbreaks South Wales (~ 1 yearly); Hep C eradication.							
Lead and support development of **Paediatric Antibiotic Stewardship (PAS) program** **&** **Paediatric Outpatient Parenteral Antimicrobial Therapy (p-OPAT) service** **as part of hospital at home initiative across the 5 UHBs in Wales**	Development of regional designated paediatric programs and care bundles for: • paediatric antibiotic stewardship **(PAS)** • paediatric Parenteral (IV) antibiotic therapy **(p-OPAT)** As essential pre-requisite also bolstering of existing programs for: • **Blood culture taking** • **IV-line care** In collaboration with Paediatric Microbiology, Infection Control, Paediatric Antimicrobial Pharmacists, and with designated CNS/ANP support. Support local implementation, monitoring and access to Clinical Trials participation through managed regional clinical PIID network.		Compliance with UK best practice guidance (BSAC, UK-PAS, Chapman et al) Reduction in antibiotic (IV and oral) prescribing/patient Reduction in antimicrobial prescribing/patient	Unfunded Requires 6 additional Microbiology sessions also (SLA via PHW)			Any outstanding requirement to meet UK best practice identified and workplan in place Review pharmacy data to evidence reduction in antibiotic IV and oral prescribing / patient Review pharmacy data to evidence reduction in antimicrobial prescribing / patient		UK best practice guidance met Further reduction in antibiotic IV, Oral and Antimicrobial prescribing	
Building Paediatric Infectious Diseases expertise, capacity and sustainability for South Wales	To Capitalise on the expertise in leadership, change management, teaching, training and academia, and the extensive (inter)national peer networks of the two current senior consultants in Paediatric Immunology and Infectious Diseases at CHfW to establish a comprehensive sustainable and future proof service for South Wales, prior to their retirement.		1. **Formation of managed clinical MDT network for South Wales** (strong regional momentum, initial discussions underway) • Teaching and peer learning (monthly network MDTs) • Network membership includes defined learning and local teaching commitments (e.g. SPIN module for local lead consultant) 2.**Creation of HEIW funded post for CSAC accredited GRID and SPIN module Training for Wales** • Provisional CSAC approval obtained (Aug 22) subject to funding of full Paeds ID business case.	Unfunded Requires support from Clinical Research Facility at CHfW also.	Recruitment of key posts to support MDT network complete		Clinical MDT network for South Wales implemented Any outstanding support from Clinical Research Facility identified and actioned Discussions with HEIW to secure funding complete PIID training requirements for allied professionals and access published Teaching portfolio plans finalised		MDT embedded HEIW funded post recruited Training programme for allied health professionals delivered R&D trials identified and progress made towards recognised funded recruitment onto trials Continued retention of trained staff	

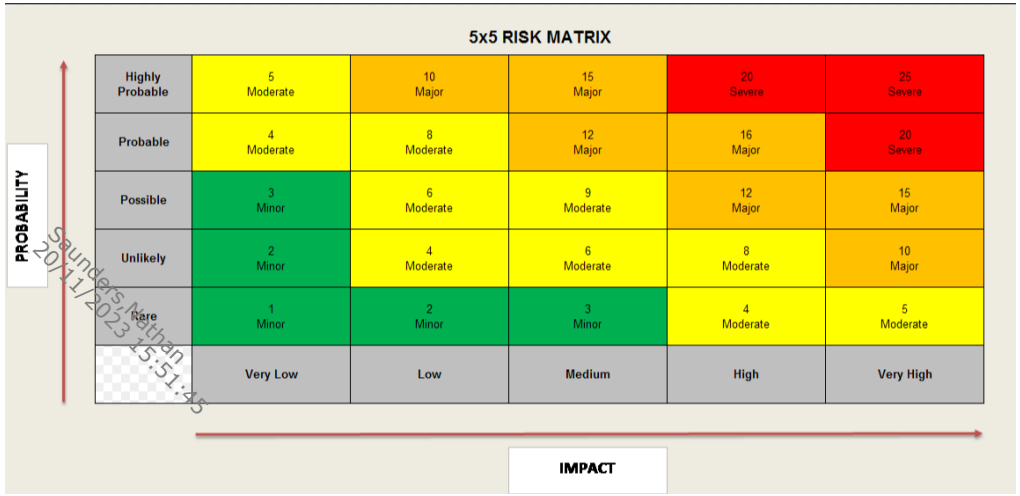
			• School of Paediatrics for Wales supportive; in discussion with HEIW. **PIID training support of allied professionals,** e.g. PIID CNS, ANP, AM Pharmacist (e.g. MSc mentoring). **Extensive PIID delivered South Wales teaching portfolio** e.g. regional Paediatric grand rounds, PICU, NICUs, tertiary specialisms, micro/viro trainees, maternity services, Public Health, e.a. **Building local R&D expertise** through supported participation in Clinical Trials and studies across South Wales **Reputational benefits enhancing recruitment of high calibre trainees, consultants and specialist nurses for Wales.** Management of vacancies and retention				Posts recruited retained and trained			
Clinical Governance Saunders,Nathan 20/11/2023 15:51:45	Underpinning all Paediatric Infectious Disease service elements with robust clinical governance (current governance of unfunded activity is restricted by absence of resource)		Full electronic auditable clinical activity and outcome records of consults, MDTs, referrals, admissions and clinics. Establishment and regular audit of condition specific integrated care pathways Adoption of VBHC methodology for ongoing evaluation of patient/family, patient organisations and staff feedback and systems learning Regular evaluation of regional Paediatric Infectious expertise development and learning Designated clinical and educational governance review meetings, e.g. Incident reviews, morbidity &mortality meetings, quarterly	unfunded	MDT/data coordinator post recruited and trained		Data collected routinely and available for audit /MDT Audit plan in place Clinical Governance review meetings, incident reviews, morbidity and mortality meetings, quarterly clinical network business meetings set up and well attended		Work with Finance colleagues to ensure VBHC methodology embedded and opportunities for efficiencies through value identified Sharing of good practice	

			clinical network business meetings							

Risk

This section must outline the key risks associated with successful implementation (should the case be approved) and plans for mitigating their removel. Where cases are approved this will form a key part of future review meetings with BCAG and provide assurance as to risks are being managed to maximise chnaces of success.

Risk Title	Descriptor	Probability (1-5)	Impact (1-5)	Total risk score (PxI)	Mitigating Action	Owner
Base line fragility of overburdened service	Service set up heavily relies on leadership expertise from current 2 senior consultants within 1-5 years of retirement. Sickness/burn-out/unforeseen absence would cause significant set back (years)	*5*	*5*	*25*	Immediate funding of Paediatric ID sessions for existing consultants, to allow backfill of their current job plans Immediate appointment of locum Paediatric ID consultant pending substantive post	
Clinical outputs	Service set up activity will displace current (unfunded) clinical output, notably consult service until additional staff in post.	*3*	*3*	*9*	Immediate appointment of locum Paediatric ID consultant pending substantive post	
24/7 on call for telephone advice	Part of NHSE PIID service specification Cannot be provided with this business case (needs 4WTE PIID)	*5*	*1*	*5*	Regional expectation setting (pre-weekend planning) Integration with General Paediatrics at CHfW for out of hours inpatient care	
Interdependencies/ Infrastructure	p-OPAT requires PIC line service (theatre time is scarce). p-OPAT provision on weekends (local CNS and community nursing availability)	*5*	*1*	*5*	Internal escalation Pre-agree local escalation plans	
Major activity surges and pandemics	Small service with highly variable unpredictable demand (i.e. vulnerable)	*4*	*5*	*20*	Formulate escalation plan for immediate support (e.g. from within network)	



7.3 Total Cost - Resource Implications and Affordability

This service is currently being provided without funded or remunerated resource.

The phasing of planned implementation recognises a lead into recruitment and the requirement to embed a new service which will develop during the early years. The impact and resulting efficiencies in the existing service will take time to realise and work undertaken to identify the value of these.

The table below describes the financial impact of meeting implementation of a Paediatric Infectious Diseases Services into Cardiff and Vale UHB.

The investment reflects a **£0.678m** recurrent requirement, with **£0.369m** in 2023/24 and a further **£0.309m** in 2024/25.

	Year 1 £'000s	Year 2 £'000s	Year 3 £'000s
TOTAL RECURRENT (not formula driven – complete)	363	678	678
TOTAL NON RECURRENT (not formula driven – complete)	6	0	0
	369	678	678

Assumed start date	2023-24 with slippage on recruitment in year 1
Funding Source Revenue	WHSSC with Cardiff & Vale UHB investment via risk share
Funding Source Capital	N/A

	Resource Requirement/Role	Band	WTE	Per post FYE £'000	PYE 23/24 £'000	FYE 24/25 £'000	Comments
Medical	Consultant PIID	Cons	2.10	143	150	299	Job plans detailed in Table 1
	Senior Clinical Fellow	CF	1.20	70	74	128	out of hours rota 2B
Nursing	Clinical Nurse Specialist	7	0.80	64	30	51	
AHP and Other Clinical	Psychology	8b	0.20	88	4	18	
Admin and Management	Clinic Coordinator	3	0.60	31	11	19	
	Medical Secretary	4	1.00	35	20	35	
Non Pay	Staff Set up				6	0	
	Non Pay				31	55	
	Micro/Vir/Mycology				7	14	Laboratory Non-Pay
	Overheads				35	60	
TOTAL			**5.90**		**369**	**678**	

Appendix 1

1. **HIV case management and transmission prevention in pregnancy**

   As per UK guidelines, this is managed by a multidisciplinary team comprising of an adult HIV specialist, obstetrician, specialist midwife and paediatrician with expertise in the management of HIV (part of PIID).

   Currently 14 children are known to be infected with HIV in South Wales, coming from 4 health boards. Three of them are aged under 10 and the youngest is 3 years old. Care is provided from Cardiff and treatment requires infectious disease expertise.

   Approximately ten women per year are managed by the team in Cardiff. Patients are referred from within Cardiff and Vale but also regularly from Cwm Taf Morgannwg and Aneurin Bevan UHBs.

2. **Tuberculosis**

   This is rare, but potentially fatal in children, and, as many infectious diseases, it is strongly associated with social deprivation. UK guidelines for the management of TB states that every UHB should have a named local paediatrician for TB, who should have access to tertiary paediatric infectious disease advice. This requires PIID expert guidance. In 2019, 100 cases of TB disease were reported in adults with 11 in children under 15 years.

   Paediatric team routinely works closely with adult TB teams offering prompt screening to child contacts of all diagnosed infectious adults. Where clusters of adults are involved in extended families this can mean a coordinated approach to screening up to 20 children sometimes on a repeated basis while the adult outbreak is brought under control.

   In addition, only in the past 5-10 years in South Wales there have been 3 TB incidents involving infected staff members in nursery schools, and 2 incidents in neonatal units (one was in Bristol, involving South-Wales patients). In all of these incidents PIID expertise was required by Public Health Wales to assist in the management of the incidents. This are major undertakings, e.g. the last outbreak alone required counselling and screening tests on 87 children.

   Cardiff is an initial reception centre for asylum seekers, who are offered screening for TB soon after arrival. In this population, language and other cultural issues may pose challenges for TB control. Approximately 20 children per year are diagnosed with latent TB and treated with three months of antimicrobial therapy.

3. **Atypical mycobacterial infections**

   In the past three years 20 children with complicated atypical mycobacterial lymphadenitis, not amenable to surgical treatment have been referred to Cardiff from all the South Wales Health Boards. They require prolonged periods of combination antibiotics and monitoring for up to 18 months.

4. **Viral hepatitis B and C (HBV and HCV)**

   Paediatric HBV and HCV infection is generally asymptomatic but carries a significant life time risk of liver-failure or liver cancer. HBV requires monitoring +/- suppressive treatment, and curative treatment HCV for children >3 years of age has been available since May 2021.

   Around 15 children across South Wales, are currently receiving care for HBV or HCV (8 HBV, 7 HCV) delivered by the PIID consultant with support from quartenary hepatology centres as needed. Both HBV and HCV are highly likely underdiagnosed in children in Wales. The Welsh liver disease implementation group (LDIG) have provided 0.2WTE CNS for 1 year to support cure of the current HCV cohort, and develop a range of case finding

pathways with Maternity services, Health Inclusion Services (asylum seeker screening), Sexual Health, Homeless, Young offenders A/E, Secondary Paediatrics, Substance misuse/ CAMHS
This work is restricted by absence of funded consultant time for leadership and targets will not be met.

5. Paediatric COVID and PIMS-TS

Although COVID 19 is generally a mild illness in children, occasional life-threatening chest disease occurs and needs prompt expert management. More importantly, the emergence of the rare but potentially life-threatening paediatric condition PIMS-TS (paediatric multisystem inflammatory syndrome temporarily associated with COVID 19) has required urgent pathway development and coordination for very unwell children presenting in Wales during the pandemic with this condition (~50 cases 2020-2022).

6. Congenital infections – antenatal screening, counselling and MDT work with Maternity services

Beyond HIV and Hepatitis B, antenatal blood screening and ultrasounds also detect a range of other maternal infections, which have important implications for their babies. Importantly examples include CMV and syphilis, but this list is not exhaustive. Clinical management requires an MDT approach, typically including and adult ID physician, obstetrician, midwife, neonatologist and paediatric ID specialist.

CMV - Cytomegalovirus is the commonest congenital infection and is the most frequent cause of sensorineural hearing loss. It is estimated to occur in 1 in 200 pregnancies and 1 in 1000 births will result in a child with significant sequelae. This means that 300 affected children per year are born across South Wales. Although awareness is increasing and the consultants in Cardiff are working closely with the neonatal network to increase CMV testing many infants go undiagnosed and present later in childhood with deafness and neurodevelopmental problems.

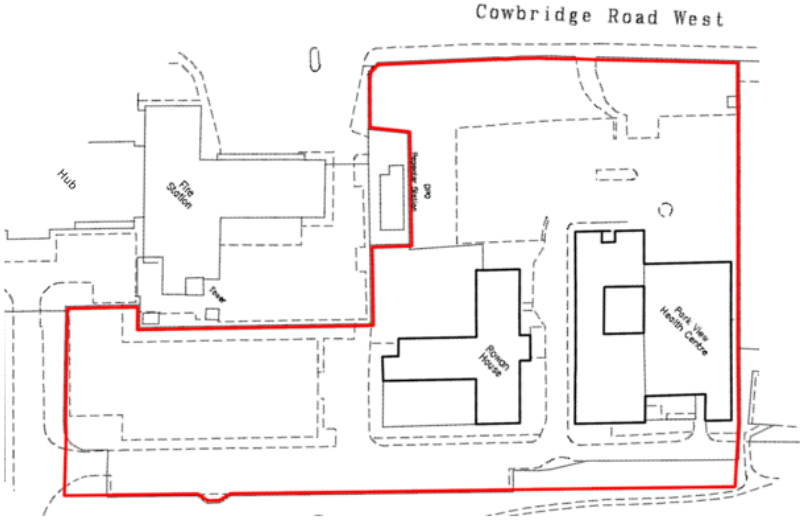
Syphilis - syphilis in pregnancy can have life changing consequences for babies, if not diagnosed and treated promptly and correctly. Syphilis infections amongst adults have tripled in the past ten years with the result of increasing numbers of women and their infants requiring management.
Between 5 and 10 pregnant women with evidence of syphilis infection are referred to the MDT each year, including two recent cases of active early infection putting the baby at very high risk of significant morbidity.

Report Title:	PARK VIEW HEALTH CENTRE Declaration as Surplus and Disposal			Agenda Item no.	7.2
Meeting:	UHB Board	Public	√	Meeting Date:	30 November 2023
		Private			
Status *(please tick one only):*	Assurance		Approval √	Information	
Lead Executive:	Executive Director of Finance				
Report Author (Title):	Director Of Capital, Estates and Facilities				

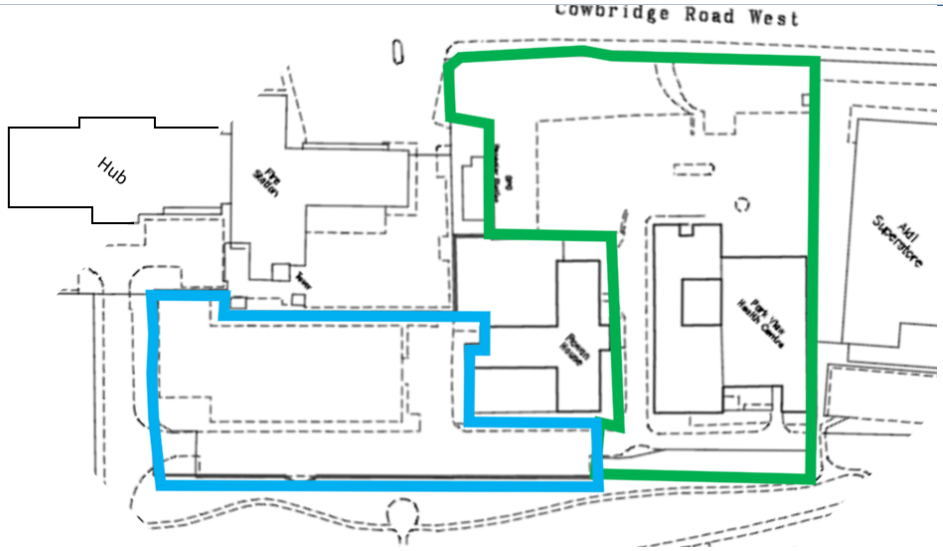
Main Report
Background and current situation:

The purpose of this paper is to update the Board of current position in relation future requirement of the former Park View Health Centre Site and request for approval to declare the land surplus to requirement.

The Park View site as outlined below in red was originally part of the larger Ely Hospital Site. The site housed the former Park View Health Centre whilst Rowan House remains in operation. Following a major flood, the Park View Health Centre was decommissioned and eventually demolished in early 2023. Rowan House continues to remain operational, with Swansea Bay Health Board operating a learning disabilities service.



The wider UHB strategy for the West of Cardiff proposes the development of a Wellbeing Hub @ Ely. This is currently at Full Business Case Stage. The proposed development will form an integrated facility combined with the neighbouring Cardiff Council Hub, utilising part of the Park View site. This is illustrated by the blue outline on the plan below. The UHB have no requirement for the remainder of the site (outlined in green) and this can be made available for disposal.



Working in partnership with South Wales Police, a Memorandum of Understanding, dated 26th June 2023 has been signed, which states that in the event of a declaration as surplus, both parties will work in collaboration to transfer the Park View site from the UHB to South Wales Police under the Welsh Government Land Transfer Protocol.

A joint valuation has been undertaken, which indicated a value of £645k. This valuation is dated 6th November 2019 and will be updated when the disposal progresses. This is likely to be early in the 2024/25 financial year.

A key risk to this process is the existence of an overage on the Park View site dating back to the original disposal of the Ely Hospital site in 2007 as part of the St David's PFI scheme. The agreement for this included an overage agreement to the benefit of Macob Projects Ltd. The agreement, valid for 80 years states that "If the property is used for any other use save for Healthcare, medical services and ancillary services, it will trigger overage". Macob Projects Ltd was dissolved on 14th November 2020. Capital Estates and Facilities, with advice from NWSSP SES, NWSSP L&R and a specialist Property Litigator have investigated this overage agreement with a view to understanding whether it is still valid.

Counsel advice has been received and the UHB have engaged solicitors to apply to the court for a declaration that the overage agreement is no longer enforceable, and an order that the restriction be cancelled or otherwise removed.

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

- There is no requirement to retain any of the area identified for disposal to support the proposed Wellbeing Hub @ Ely. All building and car parking areas have been identified for the development within the approved outline planning permission.

- The disposal of the surplus element of the Park View sites offers the UHB to achieve notable capital receipts, while removing a liability site. Furthermore, the disposal in partnership with South Wales Police offers the opportunity to retain public sector services on the site, sharing adjacencies with the neighbouring Fire Station and proposed Wellbeing Hub@Ely.

- The overage matter can be noted as a risk at this time and could impact the income achieved. CEF will continue to press for this to be resolved.

- The disposal of part of the Park View site does not impact the operation of Rowan House, or the ongoing proposals for the Wellbeing Hub@Ely.

Recommendation:

The Board is asked to:

NOTE: there is no requirement to retain the Park View site marked in green to support the development of the Wellbeing Hub @ Ely

APPROVE: to declare the area identified as surplus to requirement

APPROVE: the disposal of the site via the WG Land Transfer Protocol to South Wales Police for the purpose of the development of a new Police Station for the area

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: Yes/**No**
Workforce: Yes/**No**
Legal: **Yes**/No
NWSSP Specialist Estates and NWSSP Legal and Risk have advised.
Reputational: Yes/**No**
Socio Economic: Yes/**No**
Equality and Health: Yes/**No**
Decarbonisation: Yes/**No**

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
UHB Board	30 November 2023

Finance & Performance Committee	22 November 2023
Senior Leadership Board	2 November 2023
Capital Management Group	18 October 2023

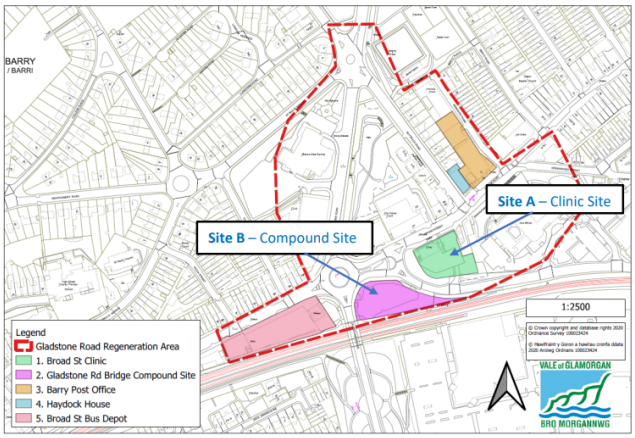
Report Title:	**BARRY GATEWAY DEVELOPMENT – Disposal of Broad Street Clinic and Lease of New Facility**			Agenda Item no.	7.3
Meeting:	**UHB BOARD**	Public	√	Meeting Date:	30 November 2023
		Private			
Status *(please tick one only):*	Assurance		Approval √	Information	
Lead Executive:	**EXECUTIVE DIRECTOR OF FINANCE**				
Report Author (Title):	**DIRECTOR OF CAPITAL, ESTATES AND FACILITIES**				

Main Report

Background and current situation:

The purpose of this report is to request that the UHB Board give approval to enter into an agreement with the Vale of Glamorgan, for the provision of new clinic facilities at Broad Street, Barry, replacing the current existing clinic premises. The existing premises are in need of investment and are not to current Healthcare standards. The report provides the background on how this can be achieved, with no additional capital investment from the UHB, other than the capital receipt gleaned from the sale of the existing building.

Broad Street Clinic is located on Broad Street, Barry; adjacent to the VoG Civic Offices. The clinic houses UHB community services including AAA, CAHMS, Eye Clinic, ISH, Podiatry, SALT and Wound Clinics. No GMS services are present. The 1950s building itself is in poor condition and past its lifespan. Of particular note is the condition of external curtain walling façade and the lack of accessibility to the upper floor. The backlog maintenance for the building has been estimated to be in the region of £270k. This is excess of the building value (which will be discussed later).



The Vale of Glamorgan Council have commenced detailed planning on the Barry Town Centre Gateway Regeneration Project. This project is to facilitate a comprehensive mixed-use redevelopment of several key sites at the western end of the Barry town centre (Holton Road/Broad Street) identified within the area indicatively dashed red above. This will include the provision of a range of new affordable homes, integrated with health facilities and commercial uses. This would help boost the town, improving it as a sustainable place for living, working, and shopping.

The UHB, VoG and Welsh Government are working closely to facilitate the delivery of a project to provide much needed affordable homes and health facilities in an integrated development that contributes to the regeneration of Barry Town Centre. The VoG proposal for the Broad Street Clinic site centres upon the disposal of the UHB site (to VoG) and the construction of a new replacement facility on neighbouring land. The UHB would be required to invest the income from the Broad Street disposal into the overall development. In exchange, VoG would construct and fit out the new building. A long lease would then be granted at a peppercorn rent.

Broad Street Clinic Value and Disposal

Upon inspection of the Broad Street land title, it became evident that a restrictive covenant, to the benefit of VoG, governs the use of the site. The covenant states “the Secretary of State covenants with the Council not to use the property described in the first Schedule hereto other than for purposes connected with the provision of health facilities”. This restricts any permitted use of the site to the delivery of healthcare. This results in an impact upon the value of the land in any future disposals.

As the proposed disposal will be governed by the Welsh Government's Estate Coordination and Land Transfer Protocol (LTP), a UHB/VoG joint valuation report has been commissioned. This report has considered the restrictive covenant as well as providing a value for other site scenarios. These values will need to be updated prior to exchange of contracts to ensure that any inflationary rises are captured.

(i)	Scenario 1	Healthcare use as per covenant	£172,264
(ii)	Scenario 2	Mixed-use redevelopment	£400,000
(iii)	Scenario 3	Public house / drive through retail	£450,000-£500,000

Lease of New Premises

The key point of the proposed venture is that while the value of Broad Street is suppressed by the restrictive covenant, the UHB will be provided with a replacement modern facility at no additional capital cost. This will deliver a new clinic, at nil consideration, that is fit for purpose and will enable the UHB to continue to deliver services for the benefit of the local community.

The VoG consideration for the new lease will be at below market value/nil consideration. The VoG have governance in place for this, under general consents contained in Local Government Act 1972

Discussions have taken place between the VoG and UHB with advice from both NWSSP Specialist Estates Services and NWSSP Legal and Risk. A set of draft Heads of Terms (HoTs) have been agreed in principal. Key points are summarised below and the full HoTs are included in appendix 2. Exchange of contracts is to occur 12 (twelve) weeks after formal agreement of these Heads of Terms in tandem with exchanging contracts for the linked Heads of Terms for the lease of the Clinic (Heads of Terms No.2).

HoTs 1 Clinic Site.	**Proposed Acquisition by the Vale of Glamorgan Council of the Broad Street**
Property:	Broad Street Clinic
Vendor:	Cardiff and Vale University Local Health Board
Purchaser:	The Vale of Glamorgan Council
Purchase Price: (restricted value in favour of the Council). This value will be revised due to the passage of time since the report.	Informed LTP joint valuation report dated 23rd February 2022 £172,264

HoTs 2 located	**Proposed Lease for new Accommodation for relocated Broad St Clinic to be within Site B Redevelopment**
Property: older	Self-contained Ground Floor and First Floor facility, within proposed new affordable persons development. To be located within part of Site B.
Landlord:	The Vale of Glamorgan Council
Tenant:	Cardiff and Vale University Local Health Board
Rent:	Peppercorn
Term:	125 years.
Tenant Break:	After 25 years and yearly thereafter with 6 months written notice.

The above Heads of Terms are subject to lease and the following conditions being met:

(i) The Tenant to obtain Welsh Government Approval;
(ii) The Landlord's Project Board approval;
(iii) The Tenant's Board approval;

(iv) The Landlord securing all funding required to deliver the redevelopment of Site A and Site B (part of The Barry Town Centre Gateway Regeneration Project) including funding from the Welsh Government and any other sources of funding as may be required;
(v) The Tenant will reinvest the Capital receipt (currently valued at £172,264) into the Fit Out. For the avoidance of doubt, the Landlord will not provide any additional funding for the Fit Out.
(vi) The Landlord securing all statutory consents (including but not limited to securing a satisfactory planning permission for the demolition, clearance and full redevelopment of the Property for a residential or mixed use residential and commercial development);

While the new facility will be handed to the UHB complete, there will be a requirement for a fit out of specialist clinical and IT works.

With the proposed term of the lease at a peppercorn rent for 125 years, there will be IFRS 16 implications. Day to day running, energy and business rates will be a UHB responsibility and by the nature of the new facility, higher than the equivalent running costs for Broad Street. As the scheme is designed, estimates will be made available. Once these terms have been approved, the UHB will instruct NWSSP Legal and Risk to draft lease documentation. Each of the final engrossments will require the UHB Seal.

VoG Actions to Date
As the Barry Gateway project is wider VoG led initiative, the VoG are to submit a "Transforming Towns" grant application to the Welsh Government for a grant of £4,220,681 towards an overall project cost of £20,648,942. The anticipated date of this submission is 9th August 2023. It is hoped the Welsh Government will determine the grant application during September 2023.

Subsequent legal contractual discussions are aiming for a March 2024 completion.

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

The current restrictions on value associated with the existing land and building owned by the UHB on Broad Street, Barry.

The recognised partnership working of the UHB, VoG and Welsh Government working closely to facilitate the delivery of the project to provide much needed affordable homes and health facilities, in an integrated development, that contributes to the regeneration of Barry Town Centre.

The recognition that the UHB would be required to invest the income from the Broad Street disposal into the fit out of the new facility. In exchange, VoG would construct the new building. A long lease would then be granted at a peppercorn rent.

The recognition that existing services will transfer to the new building and the acknowledgement that there may be an increase in revenue consequences, as highlighted in the report, associated with energy and business rates.

In order to meet the VoG timescales, approval to proceed is required as soon as possible.

Recommendation:

The UHB Board is asked to:

APPROVE the declaration of Broad Street Clinic as surplus and the subsequent disposal under the Wales Land Transfer Protocol.

APPROVE the income from the sale of Broad Street Clinic will need to be ring fenced to finance the fit out of the new facility.

APPROVE the two Heads of Terms;
Proposed Acquisition by the Vale of Glamorgan Council of the Broad Street Clinic Site.
Proposed Lease for new Accommodation for relocated Broad St Clinic to be located within Site B Redevelopment and the signature thereof.

APPROVE the issuing of the report to Board for affixation of the UHB Seal to the resultant lease documentation.

SUPPORT the transfer of services into the new facility and the likely increase in revenue consequences associated with running costs, against the cost of the existing facility.

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please tick as relevant*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	x
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x
4. Offer services that deliver the population health our citizens are entitled to expect	x	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		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: Yes/**No**	
Safety: Yes/**No**	
Financial: Yes/**No**	IFRS16 implications.
Workforce: Yes/**No**	
Legal: **Yes**/No	NWSSP have advised. NWSSP L&R will continue to advise on lease.
Reputational: Yes/**No**	
Socio Economic: Yes/**No**	
Equality and Health: Yes/**No**	
Decarbonisation: Yes/**No**	

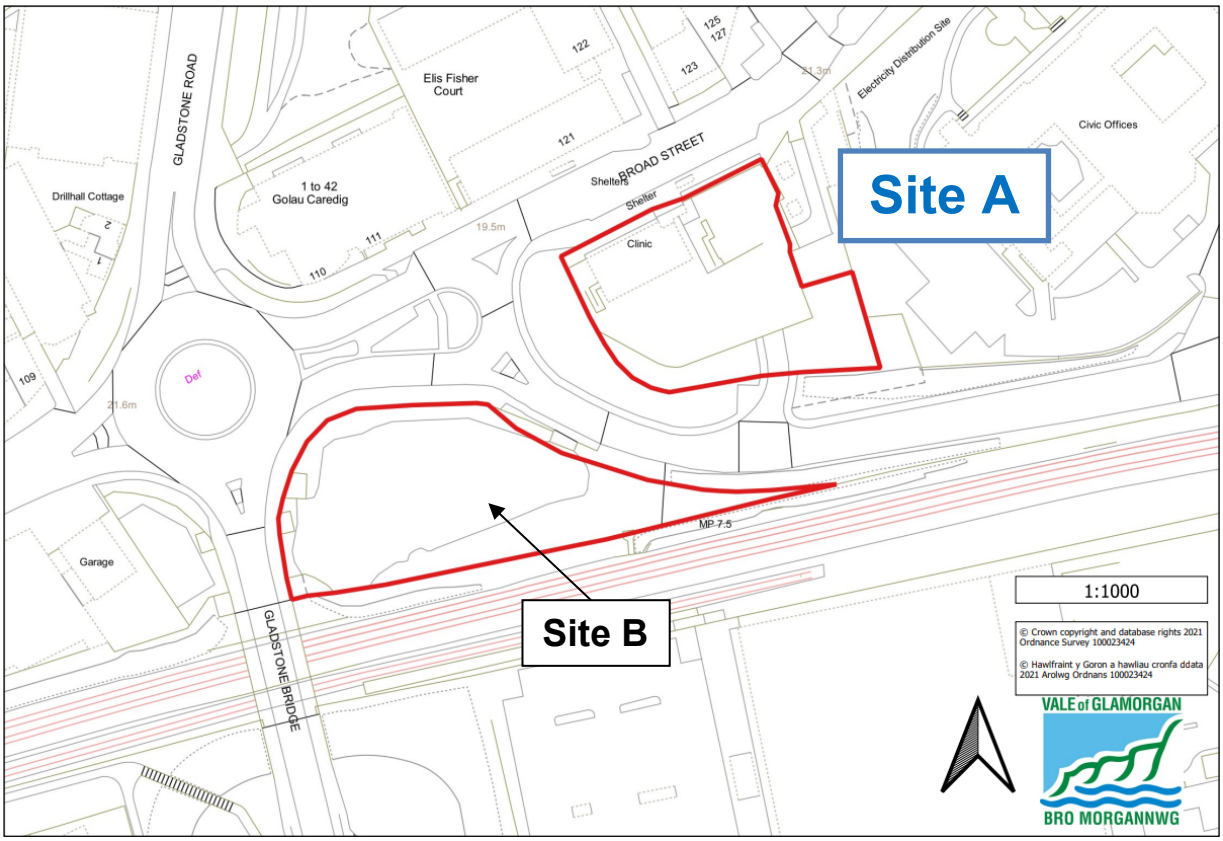
Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
UHB Board	30 November 2023
Finance & Performance Committee	22 November 2023
Senior Leadership Board	02 November 2023
Capital Management Group	16 October 2023

Heads of Terms No.1: **Proposed Acquisition by the Vale of Glamorgan Council of the freehold interest (held by Cardiff and Vale University Local Health Board) of the Broad Street Clinic Site (Site A).**		
1.	**Property Address/Demise**	Broad Street Clinic 130, Broad Street, Barry CF62 7AL Property identified as **Site A** indicatively edged red in **Appendix A** The Property has an area measuring approximately 0.239 ha (0.59 acres).
2.	**Purpose of Sale**	The freehold interest of the Property is to be transferred to The Vale of Glamorgan Council in exchange for the Premium identified below, pursuant to the principles and best practices of the Welsh Government's Estate Coordination and Land Transfer Protocol. The Property will be transferred as is. The Purchaser will demolish, clear, and develop for an affordable residential use (and/or other such use the Purchaser wishes to develop the site subject to statutory consents) as part of the Barry Town Centre Gateway Regeneration Project.
3.	**Vendor:**	Cardiff and Vale University Local Health Board Woodland House, Maes y Coed Road, Heath, Cardiff CF14 4HH Contact: Jonathan Nettleton (Property and Accommodation Manager, Capital Estates and Facilities). Email: jonathan.nettleton@wales.nhs.uk Telephone: 029 2183 6230
4.	**Purchaser:**	The Vale of Glamorgan Council Civic Offices Holton Road Barry CF63 4RU Contact: Lorna Cross (Operational Manager, Property Services) Email: LCross@valeofglamorgan.gov.uk Telephone: 01446 709307
5.	**Tenure:**	Freehold Title: The site is covered by title WA705939.
6.	**Consideration Premium**	The Purchase Price will be the sum of £172,264 *Informed by the Avison Young valuation report dated 23rd February 2022, Purchase Price £172,264 (restricted value in favour of the Council).* This valuation may need to be revised if completion occurs over six months past the date of the report.
7.	**Legal and Surveyor Costs:**	Each party to bear their own costs in accordance with the public sector land transfer protocol. The cost of any updated land valuation to be shared equally.

8.	**Linked Heads of Terms:**	**Linked to Heads of Terms No.2. –** These Heads of Terms are linked to: the proposed Lease of space for the Clinic on the proposed redevelopment of the Compound Site (Site B in Appendix A).
9.	**Timing of Completion**	Upon completion and availability of the new Clinic space.
10.	**Conditions:**	The heads of terms are subject to contract and the following conditions being met: (i) Welsh Government approval. (ii) The Seller's Board approval. (iii) The Purchaser's Project Board approval being obtained. (iv) The Purchaser securing all funding required to deliver the redevelopment of Site A and Site B (part of The Barry Town Centre Gateway Regeneration Project) including funding from the Welsh Government and any other sources of funding as may be required; (v) Operational completion, to the reasonable satisfaction of the Health Board of the new facility. (vi) The Seller investing the capital receipt from the sale of Site A into the redevelopment of Site B (for example toward the cost of fitting out the new accommodation for the proposed relocation of the Clinic). (vii) The Purchaser securing all statutory consents (including but not limited to securing a satisfactory planning permission for the demolition, clearance and full redevelopment of the Property for a residential or mixed use residential and commercial development); (viii) The Purchaser having access to undertake full Site/Ground Condition Surveys and obtaining satisfactory results; (ix) The title being free of any defects, onerous conditions or restrictions that prevent the site being used for the intended purposes by the purchaser.
9.	**Permitted Use**	Affordable residential use (and/or other such use the Purchaser wishes to develop the site subject to statutory consents).
10.	**Sellers Solicitors**	Correspondence Address: NHS Wales Shared Service Partnership 4th Floor Companies House Crown Way Cardiff CF14 3UB Contact: Email: louise.scott-nichols@wales.nhs.uk T: 02920 905027
11.	**Purchasers Solicitors**	Correspondence Address: Legal Services Vale of Glamorgan Council Civic Offices Holton Road Barry

		CF63 4RU Contact Name: Jocelyn Ham. *E-mail:* JHam@valeofglamorgan.gov.uk *Telephone: 01446 709406*
12.	**Timing and Other Matters**	Exchange of contracts is to occur 12 (twelve) weeks after agreement of these Heads of Terms in tandem with exchanging contracts for the linked Heads of Terms for the lease of the Clinic (Heads of Terms No.2). Any environmental liability (including any liability under the Contaminated Land Regime) arising in respect of hazardous or noxious substances in, on, under or emanating from the Property on and between the date of exchange and completion of contracts shall be the sole responsibility of the Purchaser.
13.	**Contract**	These Heads of Terms are subject to contract.

APPENDIX A: Location of Site A



Heads of Terms No.2:

Proposed Lease for new Accommodation (approximately 520 Sq. m) for relocated Broad St Clinic to be located within Site B Redevelopment.

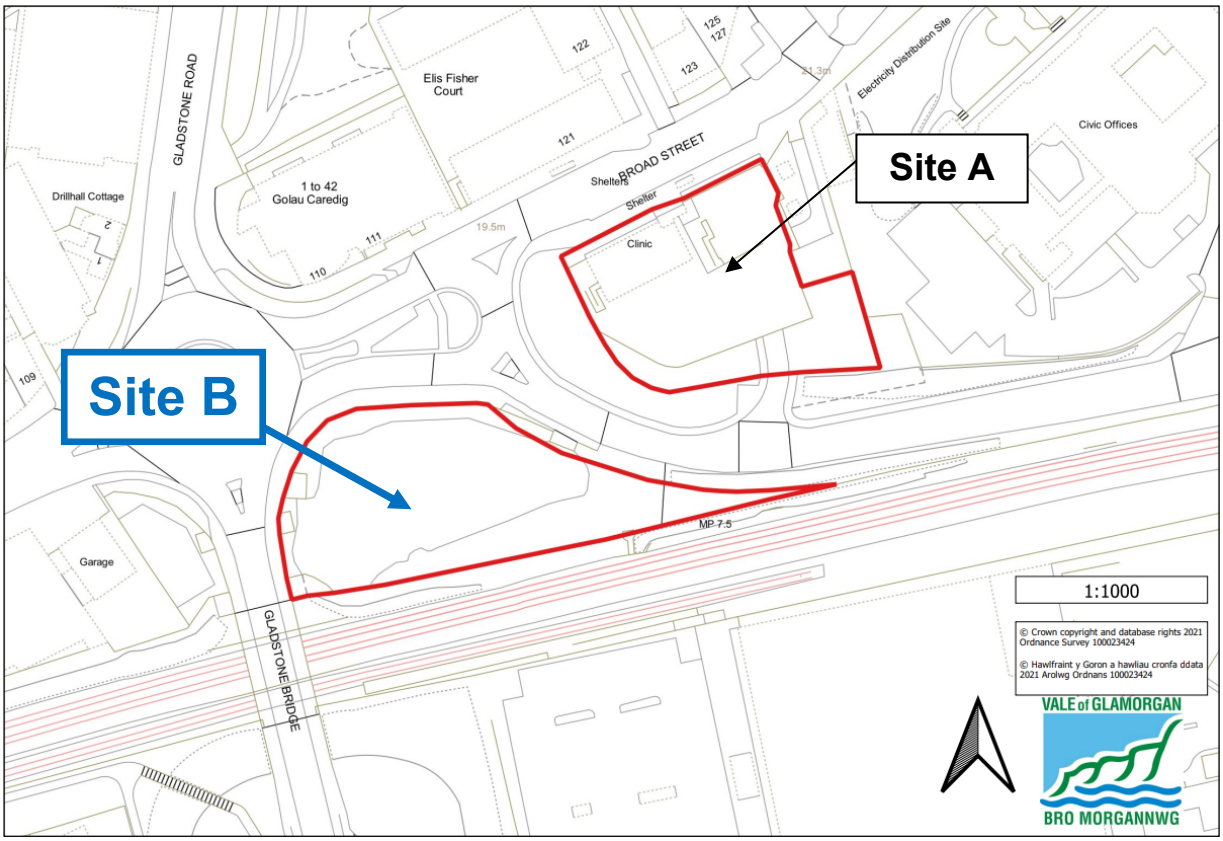
1.	**Property Address/Demise**	Self-contained Ground Floor and First Floor facility, within proposed new affordable older persons residential development, Gladstone Road Bridge Compound Site, Dock View Road, Barry. To be located within part of **Site B** (indicatively edged red in **Appendix 1):** a. approximately **520 Sq. m** of floorspace (indicatively edged dashed blue in **Appendix 2**) within part of the Ground and First Floor of a proposed affordable older persons residential building development; and b. approximately 12 **no. car parking spaces** (indicatively identified in **Appendix 2**).
2.	**Landlord**	The Vale of Glamorgan Council Civic Offices Holton Road Barry CF63 4RU Contact: Lorna Cross (Operational Manager, Property Services) Email: LCross@valeofglamorgan.gov.uk Telephone: 01446 709307
3.	**Tenant**	Cardiff and Vale University Local Health Board Woodland House, Maes y Coed Road, Heath, Cardiff CF14 4HH
4.	**Rent**	Peppercorn rental.
5.	**Type of Lease**	Head Lease
6.	**Landlord's Works (including timing)**	Landlord to facilitate a works contract at its own cost to construct a 5 to 6 storey building development comprising of a mix of affordable older persons homes and a self-contained health clinic on the ground and first floor. The Landlord will facilitate at its own cost, the new mixed-use building development, including 520 Sq. m of clinical space, subject to agreeing an acceptable design specification with the Tenant. The area will be completed by the Landlord only to a level of second fix M&E including data, partitions, sanitaryware, decoration, floor/ceiling finishes, joinery etc. The Landlord will not be responsible for the installation and testing of any clinical equipment. The Tenant will be responsible for all costs associated with the Fit Out and implementing the Fit Out, such as clinical equipment, furniture, and specialist items and IT Server room. An **Internal Specification** is attached as **Appendix 3**. The Landlord will endeavour to complete the works by February 2026.

		(Note – at the time of drafting these Hot's, the Project Programme indicates the works contract would achieve practical completion during February 2025. However, projects can be delayed and hence the Longstop Date is identified 12 months later).
7.	**Tenant's Works (including timing)**	nil
8.	**Lease Length**	125 years
9.	**Lease Start Date**	5 days after PC
10.	**Break Clauses or Renewal Rights**	*The Tenant to be granted an unconditional (save as to the condition as per Tenant's responsibilities) break option after 25 years (and yearly option thereafter)* 6 months written notice prior to break date.
11.	**1954 Act Protection**	Excluded
12.	**Rights**	At all times: • To support and protection from the Building; • for access to and egress from the Property from the Building and common parts; • to park up to 12 private cars or motorbikes belonging to the Tenant, its employees, patients and visitors; • [to use the ambulance bay for dropping off and collecting patients]; • to use and to connect into any Service Media at the Building; • to display the name logo and operations of the Tenant on a sign or noticeboard in the entrance hall of the Building; • use the common parts for purposes in connection with the use and enjoyment of the Property for the Permitted Use; and • to enter such parts of the Building and/or the Landlord's adjoining or neighbouring property in order to carry out Tenant's obligations.
13.	**Rent Reviews**	N/A
14.	**Assignment and Subletting**	None; however, the Tenant will be permitted to share occupation of the Property (whole or part) with a person/organisation providing services that are ancillary to the Permitted Use or for social care or community healthcare services as a bare licensee provided that the Tenant provides the Landlord with notice in writing of the occupant's details in advance and further, that no relationship of landlord and tenant is created.
15.	**Services and Service Charge**	All services to be separately provided i.e. boilers/water/heating etc./separately metered. Tenant to pay the Landlord an agreed service charge (amount and frequency tbd) for the repair and maintenance of the external shell of the Clinic part of the building development, including green wall (subject to agreement for its inclusion within the final scheme design) and the same for the 12 no. parking spaces and external access route/open space within the site. The Tenant will have no liability in connection with any obligations/ costs incurred by the Landlord in complying with any requirements (including but not limited to any requirements in connection with EPC Regulations or the MEES Regulations) to maintain or improve the energy efficiency rating of the Property and/or Building [save where such improvements are required where the energy efficiency rating to the Property and/or Building has been reduced

		by any alterations to the Property undertaken by the Tenant or failure by the Tenant to comply with their repair obligations under the Lease].
16.	**Repairing Obligations**	The Tenant will be responsible for the full internal repair and maintenance (including separate lift) of the demise excluding structural aspects, windows (incl frames) and external shell.
17.	**Alterations**	Any internal non-structural alterations are permitted without landlord's consent. Any external non-structural alterations will require consultation with landlord prior to consent being given (consent not to be unreasonably withheld or delayed). Any structural alterations either internally or externally will require landlord's consent.
18.	**Permitted Use**	A surgery, clinic or healthcare centre for the provision of medical services under the NHS, and where ancillary to that use, any other ancillary primary, community health and social care and community healthcare purposes.
19.	**Insurance**	The Tenant will pay the Landlord a percentage of the cost of insuring the new building under its block policy by way of annual charge (to be collected via the Service Charge). The Tenant will insure its fixtures, fittings and contents of the Property carrying the risk of insurance itself under the All Wales Risk Pool (whilst the Tenant remains a Health Service Body) and indemnify the Council for any actions or claims relating to the use of its leased clinical space and ancillary car parking spaces.
20.	**Dilapidations**	A schedule of condition will be prepared by the Landlord prior to the lease commencement to record the condition of the Property prior to occupation; the schedule is to be agreed by both parties. The Property is to be handed back at the end of the term by the Tenant in no worse condition to that evidenced by the schedule of condition.
21.	**Rates & Utilities**	Tenant is responsible for all NNDR liabilities, utility payments and any other outgoings associated with the use of the Property. Services to be separately metered and separately assessed for NNDR with the Tenant being responsible for both.
22.	**Legal and Surveyor Costs**	Each party to bear their own costs.
23.	**Conditions**	These Heads of Terms are subject to lease and the following conditions being met: I. The Tenant to obtain Welsh Government Approval; II. The Landlord's Project Board approval; III. The Tenant's Board approval; IV. The Landlord securing all funding required to deliver the redevelopment of Site A and Site B (part of The Barry Town Centre Gateway Regeneration Project) including funding from the Welsh Government and any other sources of funding as may be required;

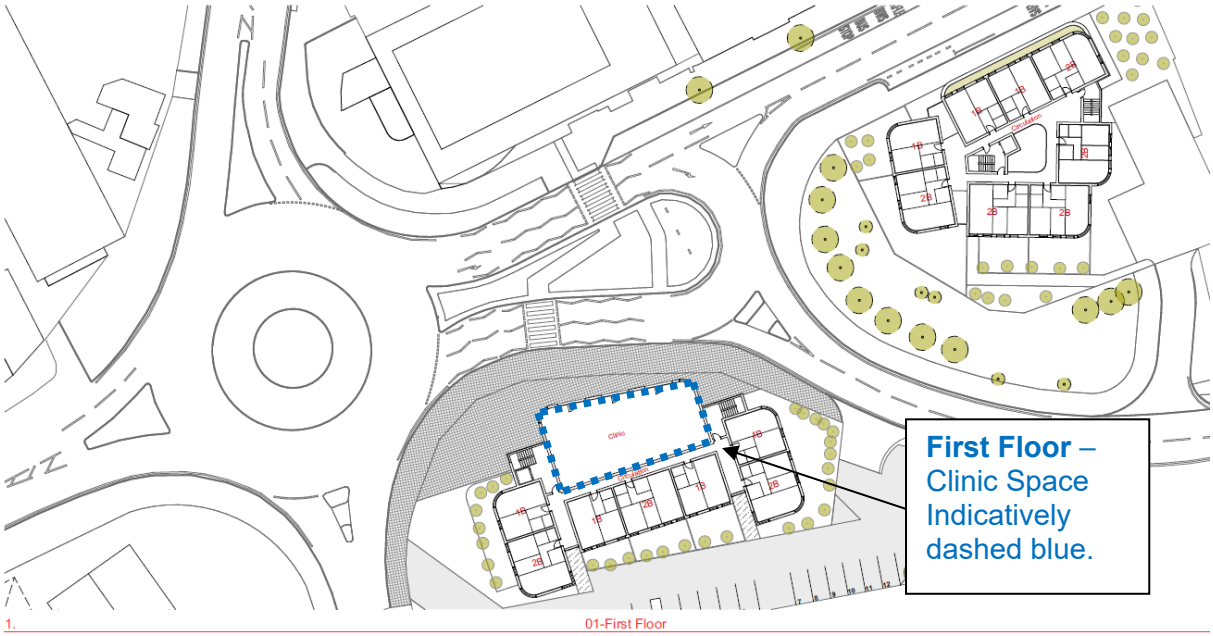
		V. The Tenant will reinvest the Capital receipt (currently valued at £172,264) into the Fit Out. For the avoidance of doubt, the Landlord will not provide any additional funding for the Fit Out. VI. The Landlord securing all statutory consents (including but not limited to securing a satisfactory planning permission for the demolition, clearance and full redevelopment of the Property for a residential or mixed use residential and commercial development);
24.	**General**	The Landlord will provide the Tenant with the following documents on practical completion of the works contract for the main building development: Health & Safety file, Building Manual, Energy efficiency certificate, carbon reduction commitment issues, Environmental good practice issues.
25.	**Landlord's Solicitors**	Correspondence Address: Legal Services Vale of Glamorgan Council Civic Offices Holton Road Barry CF63 4RU Contact Name: Jocelyn Ham. *E-mail: JHam@valeofglamorgan.gov.uk* *Telephone: 01446 709406*
26.	**Tenant's Solicitors**	Contact: NHS Wales Shared Service Partnership 4th Floor Companies House Crown Way Cardiff CF14 3UB T: 02920 905027 Email: louise.scott-nichols@wales.nhs.uk
27.	**Timing and Other Matters**	Exchange of contracts is to occur 12 weeks after agreement of these Heads of Terms, however linking to the exchange date of the Heads of terms for site A.
28.	**Contract**	These Heads of Terms are subject to contract, Landlord's Project Board approval and Tenant's Board approval

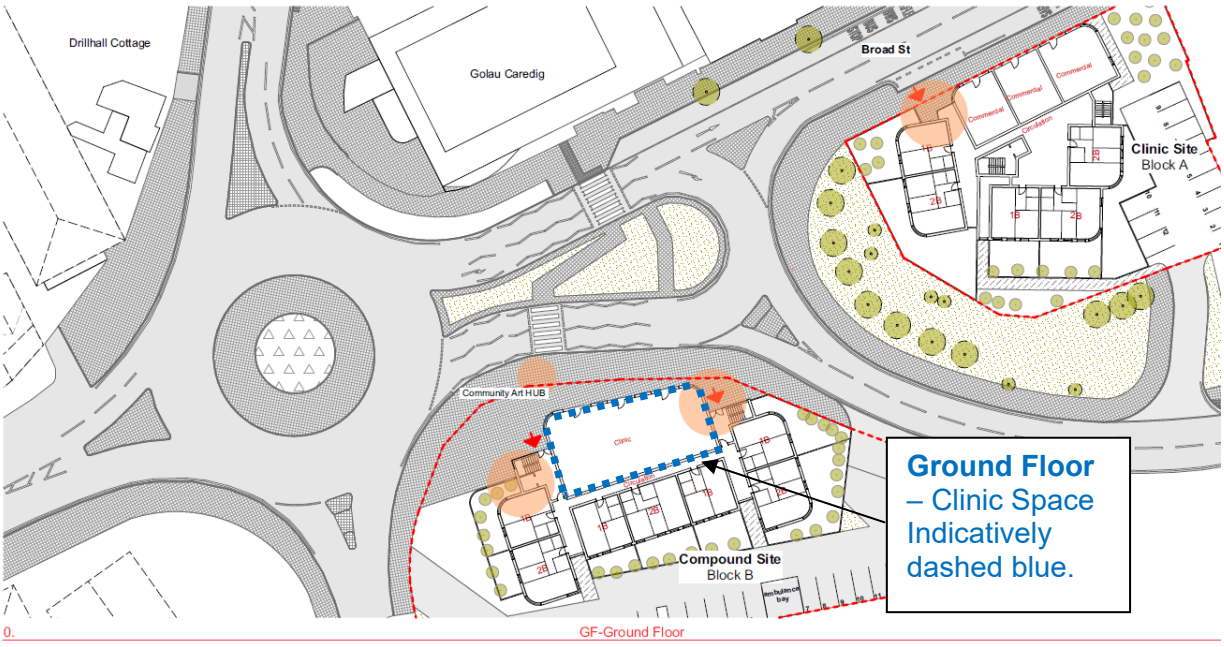
APPENDIX 1: Location of Site B

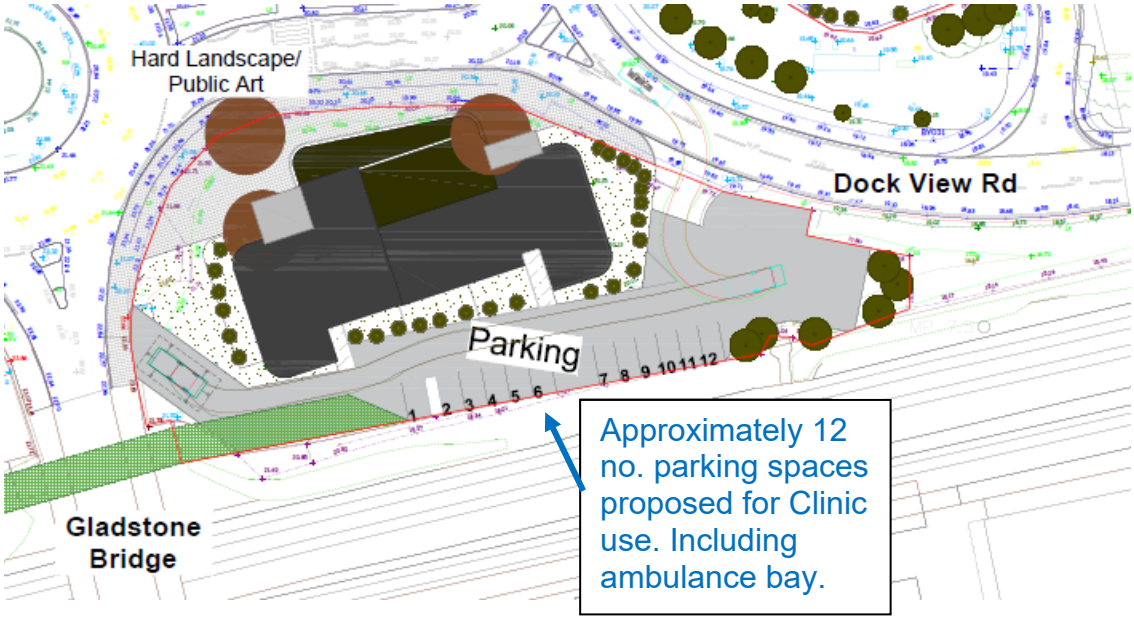


APPENDIX 2:

(a) Approximately 520 Sq.m of Floorspace for Clinic (indicatively edged dashed blue) within part of the Ground Floor and First Floor of a proposed affordable older persons residential building development and
(b) approximately 12 no. car parking spaces (indicatively identified numbered below).







APPENDIX 3

Internal Specification:

Excluded

- Specialised data storage/server room, including specialist ventilation
- Blinds
- Specialised telephony and call systems
- Specialised clinical infrastructure, oxygen lines, etc.
- Specialised Sanitary Ware – hydrotherapy pools, closomat type w/c's, specialist handbasins, etc
- Specialised internal signage, customised art, etc
- Cookers, refrigeration, washing/drying
- Specialised Clinical Waste storage, transportation and removal
- Portable Fire Fighting Equipment
- Security Alarms/CCTV
- IT Server Room

Included

- Mains electricity, water and sewage
- Separate electricity and water meters
- Emergency Lighting
- LED Lighting, PIR sensors - TBA
- Power outlets - TBA
- Extract Ventilation – TBA
- Alarms systems – smoke/heat/fire detection
- Specialised/Secure door entry – main doors and internal doors
- Electric Heating and hot water system, with energy management - TBA
- Sprinkler system - TBA
- Connection for General Data – highspeed broadband connection
- Cabling for dedicated alarms and CCTV
- Connection for General Telephony
- Connection for General Media
- Flooring - TBA
- Internal Joinery – to include room partitions, fixed storage, door sets, window boards, fire doors, skirting, handrails, reception counter - TBA
- Wall Covering / Finishes – including paint, tiling to w/cs, shower rooms, kitchen, treatment rooms - TBA
- Ceiling Coverings / Finishes – TBA
- Sanitary Ware/ Showers – includes staff, patient and visitor - TBA
- Kitchen Cabinetry – RNIB Standards TBA
- Passenger Lift

Report Title:	Adoption of Revised Standing Orders			Agenda Item no.	7.5
Meeting:	Board	Public	x	Meeting Date:	30 November 2023
		Private			
Status *(please tick one only):*	Assurance		Approval	x	Information
Lead Executive:	Director of Corporate Governance				
Report Author (Title):	Director of Corporate Governance				

Main Report
Background and current situation:

Standing Orders 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 Local Health Board.

A review of the Model Standing Orders and Model Standing Financial Instructions (SFI's) has been undertaken by Welsh Government.

The revised documents have been issued by the Minister for Health and Social Services in accordance with her powers of direction contained within sections 12(3) (for Local Health Boards) and 19(1) (for NHS Trusts) and 23(1) (Special Health Authorities) of the National Health Service (Wales) Act 2006.

The Board is required to incorporate and adopt this latest review into its Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions (which form part of the Standing Orders) as appropriate.

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

The key changes reflect the implementation of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 and incorporate updates to the Model SFI's previously issued in letters from the NHS Wales Director of Finance.

A summary of the changes is provided below, with a more detailed overview provided at Appendix One and the full versions are at the appendices.

Section	Page	Amendment
Standing Orders		
Statutory Framework Para xix	10	Addition of the provisions provided by the Health and Social Care (Quality and Engagement) (Wales) Act 2020
NHS Framework Para xxv	11	Addition of Health and Social Care Act 2020
Stakeholder Reference Group Para 5.9	29	Amendment to include working relationship with Llais
Working in Partnership Para 6.1	32	Amendment to reflect engagement and involvement of Llais in the operations of the Health Board.
Annual Plan of Board Business Para: 7.2.5	35	Amendment to allow for AGM to be held no later than 30th September 2023 for 2022/23. This has been extended to the end of October 2023 for ABUHB following approval by the Board in May 2023.
Conducting Board Meetings: para: 7.2.5, 7.2.7 and 7.5.24	35,38, 40	Addition of Llais

Standing Financial Instructions		
External Audit Para:3.4.7	15	Addition of 'LHB'
Fraud and Corruption Para: 3.5.2	16	Addition of 'as amended'
Legislation and Directions Para:4.1.2	18	Addition of WG DoF contact details
Annual Accounts and Reports Para: 6.2	27	Addition of Performance Report, Accountability Report, Statement of Financial Position as documents requiring CEO signing
Procurement Consent Para: 11.6.4	42	Amended to include contracts with WEIS and to ensure consistency with NWSSP
Schedule 1	81	Inclusion of revised letter: General Consent to Enter Individual Contracts

Recommendation:

The Board are requested to:

- **Approve the adoption of the new Standing Orders and Standing Financial Instructions**

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: Yes
These are the rules that govern financial decision making
Workforce: No
Legal: Yes
Reputational: No

Socio Economic: No
Equality and Health: No
Decarbonisation: No

Approval/Scrutiny Route:	
Welsh Government	These are determined and provided by WG

Section	Page	Amendment
Standing Orders		
Statutory Framework Para xix	10	**Additional paragraph:** **The Health and Social Care (Quality and Engagement) (Wales) Act 2020 (2020 asc 1) (**the 2020 Act) makes provision for: • Ensuring NHS bodies and ministers consider how their decisions will secure an improvement in the quality of health services (the Duty of Quality); • Ensuring NHS bodies and primary care services are open and honest with patents, when something may have gone wrong in their care (the Duty of Candour); • The creations of a new Citizens Voice Body for Health and Social Care, Wales (to be known as Llais) to represent the views of and advocate for people across health and social care in respect of complaints about services; and The act has been commenced at various stages with the final provision, relating to the preparation and publication of a code of practice regarding access to premises coming into effect in June 2023. Local Health Boards will need ensure they comply with the provisions of the 2020 Act and the requirements of the statutory guidance. The Duty of Quality statutory guidance 2023 can be found at https://www.gov.wales/duty-quality-healthcare The NHS Duty of Candour statutory guidance 2023 can be found at https://www.gov.wales/duty-candour-statutory-guidance-2023
NHS Framework Para xxv	11	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 Health and Care Quality Standards 2023, the NHS Risk and Assurance Framework, and the NHS planning and performance management systems.
Stakeholder Reference Group Para 5.9	29	**5.0 Working with Llais** 5.0.1 The SRG shall make arrangements to ensure designated Llais members receive the SRG's papers and are invited to attend SRG meetings.

Section	Page	Amendment
		5.0.2 The SRG shall work together with Llais within the area covered by the LHB to engage and involve those within the local communities served whose views may not otherwise be heard.
Working in Partnership Para 6.1	32	**6.0 The Citizen Voice Body for Health and Social Care, Wales (to be known as Llais)** 6.0.1 Part 4 of the **Health and Social Care (Quality and Engagement) (Wales) Act 2020 (2020 asc 1)** (the 2020 Act) places a range of duties on LHBs in relation to the engagement and involvement of Llais in its operations. 6.0.2 The 2020 Act places a statutory duty on the LHB to have regard to any representations made to them by Llais. Statutory Guidance on Representations has been published to guide NHS bodies, local authorities and Llais in how these representations should be made and considered. 6.1.3 The Statutory Guidance on Representations made by the Citizen Voice Body can be found at https://www.gov.wales/sites/default/files/publications/2023-04/statutory-guidance-on-representations-made-by-the-citizen-voice-body.pdf 6.1.4 The 2020 Act also places a statutory duty on the LHB to promote awareness of Llais and make arrangements to engage and co-operate with Llais with the view to supporting each other in the exercise of their relevant functions. Promoting and facilitating engagement between individuals and Llais through access to relevant premises can help strengthen the public's voice and participation in shaping the design and delivery of services. The LHB must have regard to the Code of Practice on Access to Premises and Engagement with Individuals (so far as the code is relevant). 6.1.5 The Code of Practice on Access to Premises and Engagement with Individuals can be found at https://www.gov.wales/code-practice-llais-accessing-premises-and-engaging-people 6.1.6 In discharging these duties, the Board shall work constructively with Llais to ensure both organisations are able to discharge their duties. They will ensure their involvement in: ▪ The planning of the provision of its healthcare services; ▪ The development and consideration of proposals for service change and the way in which those services are provided;

Section	Page	Amendment
		▪ The Board's decisions affecting the operation of those healthcare services that it has responsibility for; and ▪ Engaging, formally consulting and working jointly within the LHB's area on any proposals for substantial development or change of the services it is responsible for, in line with the Guidance on Changes to Health Services in Wales 2023. The Guidance on Changes to Health Services can be found at https://www.gov.wales/guidance-changes-health-services 6.1.7 The Board shall ensure that Llais is provided with the information it needs on a timely basis to enable it to effectively discharge its functions. *Relationship with the Board* 6.1.8 The Board may determine that a designated Llais representative(s) shall be invited to attend Board meetings. The Board shall ensure arrangements are in place for regular meetings between LHB officers and regional representatives of Llais. 6.1.9 The Board's Chair shall put in place arrangements to meet with the Regional Director and relevant representatives of Llais on a regular basis to discuss matters of common interest.
Annual Plan of Board Business Para: 7.2.5	35	The LHB must hold an AGM in public no later than the 31 July each year [Note: no later than 30 September 2023 for year 2022/2023].
Conducting Board Meetings Para: 7.5.7	38	(whether directly or through the activities of bodies such as Llais and the LHB's Advisory Groups representing citizens and other stakeholders)
Conducting Board Meetings Para: 7.5.24	40	Such views will usually be presented to the Board through the Chairs of the LHB's Advisory Groups and the Llais representative(s).

Section	Page	Amendment
Standing Financial Instructions		
External Audit Para:3.4.7	15	Paragraph 17 of Schedule 8 to GOWA operates to provide the Auditor General with a right of access to every document relating to the LHB that appears to him to be necessary for the discharge of any of these functions
Fraud and Corruption Para: 3.5.2	16	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 (as amended).
Legislation and Directions Para:4.1.2	18	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." Full details of the WHC can be obtained by contacting the HSSG Director of Finance at hywel.jones38@gov.wales
Annual Accounts and Reports Para: 6.2	27	The Chief Executive has responsibility for signing the Performance Report, Accountability Report, Statement of Financial Position and the Governance Statement.
Procurement Consent Para: 11.6.4	42	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; iv) All NHS contracts, that is where one health service body contracts with another health service body; v) Contracts entered into by Health Education and Improvement Wales (HEIW) for services which are the consequences of annual commissioning approved by the Minister e.g. annual education and training commissioning also do not require further Ministerial notification or consent. To ensure consistency with guidance issued by NWSSP Procurement Services, further exceptions highlighted below should also be applied: vi) Contracts over £500k - £1 million (for noting) and £1 million + (for approval); a) Wales Public Sector Framework Agreements e.g. Frameworks established by National Procurement Services (NPS) or NWSSP (not exhaustive) – no further approval required to award contracts under these Frameworks through a direct award or mini competition. ii) Third Party Public Sector Framework Agreements e.g. Frameworks established by Crown Commercial Services, NHS Supply Chain (not exhaustive) – no further approval required to award contracts under these

Section	Page	Amendment
		Frameworks through a direct award. Approval will however be required for award of contracts under these Framework Agreements through mini-competition or where the specification of the product/service required is modified from that stated within the Framework Agreement.
Schedule 1	81	Inclusion of revised letter: General Consent to Enter Individual Contracts

Standing Orders

Reservation and Delegation of Powers

Cardiff and Vale University Health Board

Approved: November 2023

Foreword

These Model Standing Orders are issued by Welsh Ministers to Local Health Boards using powers of direction provided in section 12 (3) of the National Health Service (Wales) Act 2006. 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 as may be 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 is developed and, together with the adoption of the LHB's Values and Standards of Behaviour Framework Policy 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 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.

Further information on governance in the NHS in Wales may be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/.

Contents

- Foreword....2
- Section A – Introduction....9
- Statutory Framework....9
- NHS Framework....12
- Local Health Board Framework....13
- Applying Standing Orders....13
- Variation and amendment of Standing Orders....14
- Interpretation....14
- The role of the Board Secretary....15
- Section B – Standing Orders....16
- 1. THE LOCAL HEALTH BOARD....16
- 1. Membership of the Local Health Board....16
- *Officer Members [to be known as Executive Directors]*....16
- *Non Officer Members [to be known as Independent Members]*....17
- *Associate Members*....17
- *Use of the term 'Independent Members'*....17
- 1.2 Joint Directors....17
- 1.3 Tenure of Board members....18
- 1.4 The Role of the LHB Board and responsibilities of individual members....18
- *Role*....18
- *Responsibilities*....19
- 2. RESERVATION AND DELEGATION OF LHB FUNCTIONS....20
- 2. Chair's action on urgent matters....21
- 2. Delegation of Board functions....21
- 2.3 Delegation to officers....21
- 3. COMMITTEES....22
- 3.1 LHB Committees....22
- *Use of the term 'Committee'*....22
- 3.2 Joint Committees....22
- *Joint Committee Standing Orders, terms of reference and operating arrangements*....23
- 3.3 Sub-Committees....23
- 3.4 Committees established by the LHB....24
  - Quality and Safety....24
  - Audit....24

- ▪ Information governance 24
- ▪ Charitable Funds 24
- ▪ Remuneration and Terms of Service 24
- ▪ Mental Health Act requirements. 24
- 3.5 Other Committees 25
- 3.6 Confidentiality 25
- 3.7 Reporting activity to the Board 25

- 4. NHS WALES SHARED SERVICES PARTNERSHIP 25

- 5. ADVISORY GROUPS 26

- 5.1 Terms of reference and operating arrangements 26
- 5.2 Support to the Advisory Groups 27
- 5.3 Confidentiality 27
- 5.4 Advice and feedback 28
- 5.5 Reporting activity 28
- 5.6 THE STAKEHOLDER REFERENCE GROUP (SRG) 28
- *Role* 28
- 5.7 Relationship with the Board 29
- 5.8 Relationship between the SRG and others 29
- 5.9 Working with Llais 29
- 5.10 THE HEALTHCARE PROFESSIONALS' FORUM (HPF) 30
- *Role* 30
- 5.11 Terms of reference and operating arrangements 30
- 5.12 Relationship with the Board 30
- 5.13 Rights of Access to the LHB Board for Professional Groups 30
- 5.14 Relationship with the National Professional Advisory Group 31
- 5.15 THE LOCAL PARTNERSHIP FORUM (LPF) 31
- *Role* 31
- 5.16 Relationship with the Board and others 31

- 6. WORKING IN PARTNERSHIP 32

- 6.1 The Citizen Voice Body for Health and Social Care, Wales (to be known as Llais) 33
- *Relationship with the Board* 34

- 7. MEETINGS 34

- 7.1 Putting Citizens first 34
- 7.2 Annual Plan of Board Business 35
- *Annual General Meeting (AGM)* 35
- 7.3 Calling Meetings 36
- 7.4 Preparing for Meetings 36
- *Setting the agenda* 36
- *Notifying and equipping Board members* 36
- *Notifying the public and others* 37
- 7.5 Conducting Board Meetings 37

- *Admission of the public, the press and other observers* 37
- *Addressing the Board, its Committees and Advisory Groups* 38
- *Chairing Board Meetings* 38
- *Quorum* 39
- *Dealing with motions* 39
- *Voting* 41
- 7.6 Record of Proceedings 41
- 7.7 Confidentiality 42

- 8. VALUES AND STANDARDS OF BEHAVIOUR 42

- 8.1 Declaring and recording Board members' interests 42
- 8.2 Dealing with Members' interests during Board meetings 43
- 8.3 Dealing with officers' interests 45
- 8.4 Reviewing how Interests are handled 45
- 8.5 Dealing with offers of gifts , hospitality and sponsorship 45
- 8.6 Sponsorship 46
- 8.7 Register of Gifts, Hospitality and Sponsorship 46

- 9. SIGNING AND SEALING DOCUMENTS 47

- 9.1. Register of Sealing 48
- 9.2 Signature of Documents 48
- 9.3 Custody of Seal 48

- 10. GAINING ASSURANCE ON THE CONDUCT OF LHB BUSINESS 48

- 10.1 The role of Internal Audit in providing independent internal assurance 49
- 10.2 Reviewing the performance of the Board, its Committees and Advisory Groups 49
- 10.3 External Assurance 50

- 11. DEMONSTRATING ACCOUNTABILITY 50

- 12. REVIEW OF STANDING ORDERS 51

- Schedule 1 52
- MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS .52
- MODEL SCHEME OF RESERVATION 53
- AND DELEGATION OF POWERS 53
- Introduction 53
- DECIDING WHAT TO RETAIN AND WHAT TO DELEGATE: GUIDING PRINCIPLES 54
- HANDLING ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS: WHO DOES WHAT 55
- The Board 55
- The Chief Executive 55
- The Director of Corporate Governance/Board Secretary 55

- The Audit and Assurance Committee 55
- Individuals to who powers have been delegated 56
- SCOPE OF THESE ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS 56
- SCHEDULE OF MATTERS RESERVED TO THE BOARD....57
- DELEGATION OF POWERS TO COMMITTEES AND OTHERS....65
- SCHEME OF DELEGATION TO EXECUTIVE DIRECTORS, OTHER DIRECTORS AND OFFICERS....66

- Schedule 2 73
- KEY GUIDANCE, INSTRUCTIONS AND OTHER RELATED DOCUMENTS73
- LHB framework 73
- NHS Wales framework....73
- Schedule 2.1 74
- MODEL STANDING FINANCIAL INSTRUCTIONS FOR LOCAL HEALTH BOARDS 74

- Schedule 3 75
- BOARD COMMITTEE ARRANGEMENTS 75

- Schedule 4 76
- JOINT COMMITTEE ARRANGEMENTS....76

- Schedule 5 77
- ADVISORY GROUPS 77
- Terms of Reference and Operating Arrangements 77

- Schedule 5.1 78
- Stakeholder Reference Group 78
- Terms of Reference and Operating Arrangements 78

- THE STAKEHOLDER REFERENCE GROUP (SRG)....78
- 1.1 Role 78
- 1.2 Membership....78
- 1.3 Member Responsibilities and Accountability: 79
- *The Chair* 79
- *The Vice Chair*....80
- *Members* 80
- 1.4 Appointment and terms of office....81
- 1.5 Resignation, suspension and removal of members....82
- 1.6 Relationship with the Board 83
- 1.7 Relationship between the SRG and others 83
- 1.8 Working with Llais 83

- Schedule 5.2....84
- Health Professionals' Forum 84
- Terms of Reference and Operating Arrangements 84

- THE HEALTHCARE PROFESSIONALS' FORUM (HPF) 84

- **1.1 Role 84**
- **1.2 Terms of reference and operating arrangements 84**
- **1.3 Membership 84**
- **1.4 Member Responsibilities and Accountability: 85**
- ***The Chair* 85**
- ***The Vice Chair* 85**
- ***Members* 86**
- **1.5 Appointment and terms of office 86**
- **1.6 Resignation, suspension and removal of members 87**
- **1.7 Relationship with the Board 88**
- **1.8 Rights of Access to the LHB Board for Professional Groups 88**
- **1.9 Relationship with the National Professional Advisory Group 89**

- **Schedule 5.3 ..... 90**
- **Local Partnership Forum Advisory Group 90**
- **Terms of Reference and Operating Arrangements 90**
- **1.1 Role and Purpose 90**
- **1.2 General Principles 91**
- **1.3 Membership 92**
- ***Management Representatives* 92**
- ***Staff Representatives* 92**
- **1.4 Quorum 93**
- **1.5 Officers 93**
- **1.6 Chairs 93**
- **1.7 Joint Secretaries 93**
- **1.8 Sub Committees 94**
- **1.9 Management of Meetings 94**
- **Appendix 1 ..... 95**
- **Six Principles of Partnership Working 95**
- **Appendix 2 ..... 96**
- **Code of Conduct 96**
- **Appendix 3 ..... 97**
- **List of Recognised Trade Unions/Professional Bodies referred to as 'staff organisations' within these Standing Orders 97**

Section A – Introduction

Statutory Framework

i) The Cardiff and Vale University Health Board (the LHB) is a statutory body that was established on 1st 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)**, "the Establishment Order".

ii) The principal place of business of the LHB is:

Executive Headquarters
Woodland House
Maes-Y-Coed Road
Cardiff
CF14 4TT

iii) All business shall be conducted in the name of Cardiff and Vale University Health Board, 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** which is the principal legislation relating to the NHS in Wales. Whilst the **NHS Act 2006** applies equivalent legislation to the NHS in England, it also contains some legislation that applies to both England and Wales. 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 Welsh Ministers have 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 LHBs to make SOs for the regulation of its proceedings and business including provision for the Board's suspension. 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).**

vi) **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 ("WHSSC"). Under powers set out in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006, the Welsh Ministers have made the **Welsh Health Specialised Services Committee (Wales) Regulations 2009 (S.I. 2009/3097)**, which make provision for the constitution and membership of the WHSSC including its procedures and administrative arrangements.

vii) **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 ("EASC"). 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 EASC including its procedures and administrative arrangements.

viii) 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 LHBs must be clear about the statutory basis for exercising such powers.

ix) 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.

x) The **National Health Service Bodies and Local Authorities Partnership Arrangements (Wales) Regulations 2000 (S.I. 2000/2993)** have effect as 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).**

xi) 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.

xii) 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.

xiii) Further duties and powers placed on health boards in relation to co-operation and partnership with local authorities and other partners in Wales 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 and 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 (2015/1989),** 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

xiv) **The Health and Social Care (Quality and Engagement) (Wales) Act 2020 (2020 asc 1) (**the 2020 Act) makes provision for:

- Ensuring NHS bodies and ministers consider how their decisions will secure an improvement in the quality of health services (the Duty of Quality);
- Ensuring NHS bodies and primary care services are open and honest with patents, when something may have gone wrong in their care (the Duty of Candour);
- The creations of a new Citizens Voice Body for Health and Social Care, Wales (to be known as Llais) to represent the views of and advocate for people across health and social care in respect of complaints about services; and

The act has been commenced at various stages with the final provision, relating to the preparation and publication of a code of practice regarding access to premises coming into effect in June 2023.

Local Health Boards will need ensure they comply with the provisions of the 2020 Act and the requirements of the statutory guidance.

The Duty of Quality statutory guidance 2023 can be found at https://www.gov.wales/duty-quality-healthcare

The NHS Duty of Candour statutory guidance 2023 can be found at https://www.gov.wales/duty-candour-statutory-guidance-2023

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 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 Health and Care Quality Standards 2023, 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/

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.

Local Health Board 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) LHBs will from time to time agree and approve policy statements which apply to the LHB's Board members and/or all or specific groups of staff employed by Cardiff and Vale University Health Board 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 Policy), 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 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.

The role of the Board Secretary (Director of Corporate Governance)

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 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 Health Board, including details on how to contact them, are available at https://cavuhb.nhs.wales/about-us/governance-and-assurance/corporate-governance-team/

Section B – Standing Orders

1. THE LOCAL HEALTH BOARD

1.0.1 The 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, 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 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 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

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 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 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 may 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:

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 may 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

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.

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 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 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 taken into account when making decisions in respect of Shared Services activities.

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.

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 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 Llais, 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.

5.7.2 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.

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 Llais

5.9.1 The SRG shall make arrangements to ensure designated Llais members receive the SRG's papers and are invited to attend SRG meetings.

5.9.2 The SRG shall work together with Llais 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 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 be in attendance at 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)

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 be in attendance at 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 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 Regional Partnership and Public Service Boards – of Board members and LHB officers with delegated authority to represent 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 The Citizen Voice Body for Health and Social Care, Wales (to be known as Llais)

6.1.1 Part 4 of the **Health and Social Care (Quality and Engagement) (Wales) Act 2020 (2020 asc 1)** (the 2020 Act) places a range of duties on LHBs in relation to the engagement and involvement of Llais in its operations.

6.1.2 The 2020 Act places a statutory duty on the LHB to have regard to any representations made to them by Llais. Statutory Guidance on Representations has been published to guide NHS bodies, local authorities and Llais in how these representations should be made and considered.

6.1.3 The Statutory Guidance on Representations made by the Citizen Voice Body can be found at https://www.gov.wales/sites/default/files/publications/2023-04/statutory-guidance-on-representations-made-by-the-citizen-voice-body.pdf

6.1.4 The 2020 Act also places a statutory duty on the LHB to promote awareness of Llais and make arrangements to engage and co-operate with Llais with the view to supporting each other in the exercise of their relevant functions. Promoting and facilitating engagement between individuals and Llais through access to relevant premises can help strengthen the public's voice and participation in shaping the design and delivery of services. The LHB must have regard to the Code of Practice on Access to Premises and Engagement with Individuals (so far as the code is relevant).

6.1.5 The Code of Practice on Access to Premises and Engagement with Individuals can be found at

https://www.gov.wales/code-practice-llais-accessing-premises-and-engaging-people

6.1.6 In discharging these duties, the Board shall work constructively with Llais to ensure both organisations are able to discharge their duties. They will ensure their involvement in:

- The planning of the provision of its healthcare services;
- The development and consideration of proposals for service change and the way in which those services are provided;
- The Board's decisions affecting the operation of those healthcare

services that it has responsibility for; and

- Engaging, formally consulting and working jointly within the LHB's area on any proposals for substantial development or change of the services it is responsible for, in line with the Guidance on Changes to Health Services in Wales 2023.

  The Guidance on Changes to Health Services can be found at https://www.gov.wales/guidance-changes-health-services

6.1.7 The Board shall ensure that Llais is provided with the information it needs on a timely basis to enable it to effectively discharge its functions.

Relationship with the Board

6.1.8 The Board may determine that a designated Llais representative(s) shall be invited to attend Board meetings.

The Board shall ensure arrangements are in place for regular meetings between LHB officers and regional representatives of Llais.

6.1.9 The Board's Chair shall put in place arrangements to meet with the Regional Director and relevant representatives of Llais 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 when these are not held via electronic means;
- The availability of papers in English and Welsh languages and in accessible formats, such as Braille, large print, easy read (where requested or required) and in electronic formats;
- Requesting that attendees notify the 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 Llais.

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.

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 plan will be published on the organisations 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.

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 calendar 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 calendar 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.

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 Llais and the LHB's Advisory Groups representing citizens and other 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).

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.

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 Llais 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 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 Policy**,** 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 Values and Standards of Behaviour Framework Policy 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 Policy**,** and their statutory duties under the Constitution Regulations. Board members must notify the Chair and Board Secretary 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's website.

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 are 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.

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

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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.

interest between their role as a 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], hospitality and sponsorship

8.5.1 The Values and Standards of Behaviour Framework Policy approved 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.

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 take into account:

- **Relationship:** Contacts which are made for the purpose of information gathering are generally less likely to cause problems than those which could result in a contractual relationship, in which case accepting a gift or hospitality could cause embarrassment or be seen as giving rise to an obligation;

[2] The term gift refers also to any reward or benefit.

- **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 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.

8.6.2 All sponsorship must be approved prior to acceptance in accordance with the Values and Standards of Behaviour Framework Policy and relevant procedures. A record of all sponsorship accepted or declined will also be maintained.

8.7 Register of Gifts, Hospitality and Sponsorship

8.7.1 The Board Secretary, on behalf of the Chair, will maintain a register of Gifts, Hospitality and Sponsorship to record offers of gifts, hospitality and 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 and 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 and sponsorship are kept under active review, taking appropriate action where necessary.

8.7.3 When determining what should be included in the Register with regard 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 and 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 and sponsorship.

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 has determined it shall be sealed, or if a transaction to which the document

[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.

relates has been approved by 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 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).

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 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 in 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.

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 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 an 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 shall be presented to the Board for consideration and action, as appropriate. The fact that an assessment has been carried out shall be noted in the SOs.]*

12.0.2 These SOs shall be reviewed annually by the Audit Committee [or equivalent], 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

This Schedule forms part of, and shall have effect as if incorporated in the Local Health Board Standing Orders

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 and Safety Committee;

ii) A sub-Committee, e.g., a locality based Quality and Safety 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.

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.***

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 Director of Corporate Governance/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.

The Audit and Assurance Committee

The Audit 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 Director of Corporate Governance of their concern as soon as possible in so that an appropriate and timely decision may be made on the matter.

In the absence of an officer to whom powers have been delegated, those powers will 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.

SCHEDULE OF MATTERS RESERVED TO THE BOARD[4]

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
1	FULL	GENERAL	Board may determine any matter for which it has statutory or delegated authority in accordance with SOs (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.
3	FULL	GENERAL	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.
5	FULL	OPERATING ARRANGEMENTS	Ratify any urgent decisions taken by the Chair and the Chief Executive in accordance with Standing Order requirements

[4] Any decision to reserve a matter, and the manner in which that retained responsibility is carried out will be in accordance with any regulatory and/or Welsh Government requirements.

6	NO – Audit 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 policy
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 ▪ 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 & PLANNING	Approve the LHB's patient, public, staff, partnership and stakeholder engagement and co-production strategies.
23	FULL	OPERATING	Approve the introduction or discontinuance of any significant activity or operation. Any

		ARRANGEMENTS	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 Committee	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.
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 where Chapter 6 specifies appropriate to delegate to a committee, Chief Executive or Officers	OPERATING ARRANGEMENTS	Approve individual cases for the write off of losses or making of 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 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			
50	CHAIR	Committees	Determine the allocation of Committee duties to each Independent Member (IM) and invite IMs as required to assume the Chair and Vice Chair duties within those Committees

DELEGATION OF POWERS TO COMMITTEES AND OTHERS[5]

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

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 Committees through the Terms of Reference that can be found here - https://cavuhb.nhs.wales/about-us/governance-and-assurance/committees-and-advisory-groups/

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 LHB's Scheme of Delegation to Committees.

[5] As defined in Standing Orders

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.

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

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

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

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			

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.

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.

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.
- 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.

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 Director of Corporate Governance or here - 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 electronically, usually under cover of a Welsh Health Circular.

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

Available https://cavuhb.nhs.wales/about-us/governance-and-assurance/policies-procedures-and-guidelines/

Schedule 3

BOARD COMMITTEE ARRANGEMENTS

This Schedule forms part of, and shall have effect as if incorporated in the Local Health Board Standing Orders

All committees and their terms of reference can be found here - https://cavuhb.nhs.wales/about-us/governance-and-assurance/committees-and-advisory-groups/

Schedule 4

JOINT 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 will be available as separate documentation and will be published on the respective Internet sites for the following schedules:

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/

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 – Stakeholder Reference Group
Schedule 5.2 – Health Professionals Forum
Schedule 5.3 – Local Partnership Forum

Schedule 5.1

Stakeholder Reference Group

Terms of Reference and Operating Arrangements

THE STAKEHOLDER REFERENCE GROUP (SRG)

1.1 Role

1.1.1 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.

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 Llais, 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 appointment (including remuneration 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;
- 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 Llais; 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.

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.

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.

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 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 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.

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:

- 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 Llais

1.8.1 The SRG shall make arrangements to ensure designated Llais members receive the SRG's papers and are invited to attend SRG meetings.

1.8.2 The SRG shall work together with Llais within the area covered by the LHB to engage and involve those within the local communities served whose views may not otherwise be heard.

Schedule 5.2

Health Professionals' Forum

Terms of Reference and Operating Arrangements

THE HEALTHCARE PROFESSIONALS' FORUM (HPF)

1.1 Role

1.1.1 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.

1.1.2 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 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 Group.

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
- 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.

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 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.

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 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.

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 with 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.

- 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 staff organisations 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 employment security for workers and flexible ways of working
- They share success – rewards must be felt to be fair
- They practice open and transparent communication – sharing information widely with openness, honesty and transparency

- They must bring effective representation of the views and interests of the workforce
- They must demonstrate a commitment to work with and learn from each other

All members must:

- be prepared to engage with and contribute fully to the 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 they represent.

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 NHS organisation shall agree the overall size and composition of the LPF in consultation with those staff organisations the LHB recognises for collective bargaining. The Trade Union member of the LHB Board 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 Management will normally consist of the following members of management representatives:

- 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.

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.

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

1.9.1 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 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.

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
- 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 LPF 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)

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).

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/

Contents

Foreword

1. INTRODUCTION
1.1 General
1.2 Overriding Standing Financial Instructions
1.3 Financial provisions and obligations of LHBs

2. RESPONSIBILITIES AND DELEGATION
2.1 The Board
2.2 The Chief Executive and Director of Finance
2.3 The Director of Finance
2.4 Board members and LHB officers, and LHB Committees and Advisory Groups
2.5 Contractors and their employees

3. AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT
3.1 Audit Committee
3.2 Chief Executive
3.3 Internal Audit
3.4 External Audit
3.5 Fraud and Corruption
3.6 Security Management

4. FINANCIAL DUTIES
4.1 Legislation and Directions
4.2 First Financial Duty – The Breakeven Duty
4.3 Second Financial Duty – The Planning Duty

5 FINANCIAL MANAGEMENT AND BUDGETARY CONTROL
5.1 Budget Setting
5.2 Budgetary Delegation
5.3 Financial Management, Reporting and Budgetary
5.4 Capital Financial Management, Reporting and Budgetary Control

5.5 Reporting to Welsh Government - Monitoring Returns

6. ANNUAL ACCOUNTS AND REPORTS

7. BANKING ARRANGEMENTS
7.1 General
7.2 Bank Accounts
7.3 Banking Procedures
7.4 Review

8. CASH, CHEQUES, PAYMENT CARDS AND OTHER NEGOTIABLE INSTRUMENTS
8.1 General
8.2 Petty Cash

9. INCOME, FEES AND CHARGES
9.1 Income Generation
9.2 Income Systems
9.3 Fees and Charges
9.4 Income Due and Debt Recovery

10. NON-PAY EXPENDITURE
10.1 Scheme of Delegation, Non Pay Expenditure Limits and Accountability
10.2 The Director of Finance's responsibilities
10.3 Duties of Budget Holders and Managers
10.4 Departures from SFI's
10.5 Accounts Payable
10.6 Prepayments

11. PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES
11.1 Procurement Services
11.2 Policies and Procedures
11.3 Procurement Principles
11.4 Procurement Regulations and Legislation Governing Public Procurement
11.5 Procurement Procedures
11.6 Procurement Consent
11.7 Sustainable Procurement

11.8 Small and Medium Sized Enterprises (SMEs), Third Sector Organisations (TSOs) and Supported Factories and Businesses (SFBs)
11.9 Planning Procurements
11.10 Procurement Process
11.11 Procurement Thresholds
11.12 Designing Competitions
11.13 Single Quotation Application or Single Tender Application
11.14 Disposals
11.15 Evaluation, Approval and Award
11.16 Contract Management
11.17 Extending and Varying Contracts
11.18 Requisitioning
11.19 No Purchase Order, No Pay
11.20 Official orders

12. HEALTH CARE AGREEMENTS AND CONTRACTS FOR HEALTH CARE SERVICES
12.1 Health Care Agreements
12.2 Statutory provisions
12.3 Reports to Board on Health Care Agreements (HCAs)

13. GRANT FUNDING,
13.1 Legal Advice
13.2 Policies and procedures
13.3 Corporate Principles underpinning Grants Management
13.4 Grant Procedures

14. PAY EXPENDITURE
141 Remuneration and Terms of Service Committee
14.2 Funded Establishment
14.3 Staff Appointments
14.4 Pay Rates and Terms and Conditions
14.5 Payroll
14.6 Contracts of Employment

15. CAPITAL PLAN, CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS
15.1 Capital Plan
15.2 Capital Investment Decisions

15.3 Capital Projects
15.4 Capital Procedures and Responsibilities
15.5 Capital Financing with the Private Sector
15.6 Asset Registers
15.7 Security of Assets

16. STORES AND RECEIPT OF GOODS
16.1 General position
16.2 Control of Stores, Stocktaking, condemnations and disposal
16.3 Goods supplied by an NHS supplies agency

17. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS
17.1 Disposals and Condemnations
17.2 Losses and Special Payments

18. DIGITAL, DATA and TECHNOLOGY
18.1 Digital Data and Technology Strategy
18.2 Responsibilities and duties of the responsible Director
18.3 Responsibilities and duties of the Director of Finance
18.4 Contracts for data and digital services with other health bodies or outside agencies
18.5 Risk assurance

19. PATIENTS' PROPERTY
19.1 LHB Responsibility
19.2 Responsibilities of the Chief Executive
19.3 Responsibilities of the Director of Finance

20. FUNDS HELD ON TRUST (CHARITABLE FUNDS)
20.1 Corporate Trustee
20.2 Accountability to Charity Commission and the Welsh Ministers
20.3 Applicability of Standing Financial Instructions to funds held on Trust

21. RETENTION OF RECORDS
21.1 Responsibilities of the Chief Executive

Schedule 1

Cardiff and Vale University 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 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 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 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 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, 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

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 effect 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.

3. AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT

3.1 Audit Committee

3.1.1 An independent Audit Committee is a central means by which a Board ensures effective internal control arrangements are in place. In addition, the Audit 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 Committee with clearly defined terms of reference. Detailed terms of reference and operating arrangements for the Audit 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.

nwssp.nhs.wales/a-wp/governance-e-manual/governance-e-manual-documents/useful-documents/nhs-wales-audit-committee-handbook-june-2012/

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 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 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.

- 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 a 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 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.

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 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 Committee. The annual plan will set out details of the work to be carried out, providing sufficient detail for the Audit Committee and other recipients to understand the purpose and scope of the defined work and their level of priority. The Audit 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 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 Committee meeting. The cycle of approving and monitoring the progress of external audit plans and reports, culminating in the opinion

[1] Note: The Healthcare Inspectorate Wales will review and report on the Annual Quality Statement.

on the annual report and accounts, is central to the core work of the Audit 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 takes into account 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 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 LHB 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 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 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 (as amended).

https://nwssp.nhs.wales/a-wp/governance-e-manual/knowing-who-does-what-why/supporting-good-governance/nhs-counter-fraud-service-wales/

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 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 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." Full details of the WHC can be obtained by contacting the HSSG Director of Finance at

hywel.jones38@gov.wales

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 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.

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

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.

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

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 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

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.

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 Performance Report, Accountability Report, Statement of Financial Position and the Governance 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

- 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 take into account 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 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.

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 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).

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).

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.

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 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,

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

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 (taking into account 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 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;
- 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.

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 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.

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;
iv) All NHS contracts, that is where one health service body contracts with another health service body;
v) Contracts entered into by Health Education and Improvement Wales (HEIW) for services which are the consequences of annual

commissioning approved by the Minister e.g. annual education and training commissioning also do not require further Ministerial notification or consent.

To ensure consistency with guidance issued by NWSSP Procurement Services, further exceptions highlighted below should also be applied:

vi) Contracts over £500k - £1 million (for noting) and £1 million + (for approval);
   i) Wales Public Sector Framework Agreements e.g. Frameworks established by National Procurement Services (NPS) or NWSSP (not exhaustive) – no further approval required to award contracts under these Frameworks through a direct award or mini competition.

   ii) Third Party Public Sector Framework Agreements e.g. Frameworks established by Crown Commercial Services, NHS Supply Chain (not exhaustive) – no further approval required to award contracts under these Frameworks through a direct award. Approval will however be required for award of contracts under these Framework Agreements through mini-competition or where the specification of the product/service required is modified from that stated within the Framework Agreement.

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 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 take into account 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 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.

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 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.

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 £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 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 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 Committee may consider further steps to be appropriate, such as:

- Instruct a representative of the Health Board to attend Audit 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.

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 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 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 take into account:

- The standards of service quality expected;
- The relevant quality, governance and risk frameworks and plans;
- The relevant national service framework (if any);
- 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 make arrangements for the provision of primary medical services;
- Part 5 enables Health Boards to make arrangements for the provision of primary dental services;
- Part 6 enables Health Boards to make arrangements for the provision of general ophthalmic services;
- Part 7 enables Health Boards to make arrangements 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.

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

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 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

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.

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 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 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 Workforce and Organisational Development, has responsibility for securing an 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 Workforce and Organisational Development 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:

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 Workforce and Organisational Development 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 Workforce and Organisational Development 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 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/nhs-wales-infrastructure-investment-guidance
- 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 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 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 take into account 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.

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 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 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 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 a 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;

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 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 carelessness, except if trivial, the Director of Finance must notify:

a) The Audit 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 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 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 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

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 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.

20. FUNDS HELD ON TRUST (CHARITABLE FUNDS)

20.1 Corporate Trustee

20.1.1 Section A of 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.

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.

Schedule 1

REVISED GENERAL CONSENT TO ENTER INDIVIDUAL CONTRACTS

Y Grŵp Iechyd a Gwasanaethau Cymdeithasol
Health & Social Services Group

Llywodraeth Cymru
Welsh Government

Directors of Finance
Deputy Directors of Finance
Local Health Boards, NHS Trusts Wales, HEIW and DHCW

Our Ref: SE&IG/

Date: 31 March, 2022

Dear All,

This letter supercedes the consent guidance issued in our joint letter on 30 November 2020.

RE: PROCESSES FOR LOCAL HEALTH BOARDS AND NHS TRUSTS CONTRACTS, AND INTERESTS IN PROPERTY EXCEEDING £0.5M

Paragraph 13(3) of Schedule 2 to the National Health Service (Wales) Act 2006 places a requirement on Local Health Boards (LHBs) to obtain the consent of Welsh Ministers before:
- Acquiring and disposing of property;
- Entering into contracts; and
- Accepting gifts of property (including property to be held on trust).

Acquiring and disposing of property

WHC (2018) 043 NHS Wales Infrastructure Investment Guidance issued 22 October 2018 sets out at section 10.1:

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LHBs and HEIW

Contract approvals over £1m for individual schemes will be sought as part of the normal business case submission process where funding from the NHS Capital Programme is required. For schemes funded via discretionary allocations, a request for approval will need to be submitted to Chief Executive NHS Wales, copying in the Deputy Director of Capital, Estates & Facilities Division.

Detailed arrangements in respect of approval process linked to the acquisition and disposal of leases, where consent does not form part of the business case process will be included in a Welsh Health Circular WHC(2015)031. Organisations should ensure that the monitoring arrangements and the requisite forms and returns are included as part of their own assurance arrangements.

NHS Trusts

Whilst formal Ministerial consent is not required for Trusts as detailed above, general consent arrangements are still applicable in terms of relevant transactions. Detailed requirements in terms of appropriate notifications were sent in the Welsh Health Circular referenced above.

Guidance on disposals is contained in Section 11

WHC (2015) 031 issued 22 June 2015 clarified the approval process linked to the acquisition or disposal of a lease, where approval does not form part of a business case process. A lease being a property right requires the consent of the Welsh Ministers in accordance with paragraph 13(2) (a). The WHC set out for NHS Trusts and LHBs a notification and consent process mirroring the contract processes noted below.

Entering into contracts

Guidance was issued to NHS Wales bodies on 27th January 2017 in a letter to Directors of Finance issued jointly by the Deputy Directors of Finance and Capital Estates and Facilities. This letter now updates that guidance to reconfirm to all NHS Wales bodies that the authorisation and consideration of notified contracts and applications for the acquisitions or disposals of a lease or any interest in property are delegated to the Director General, Health and Social Services Group.

The Director General may, as with any other matter relating to the operation of the NHS in Wales, brief the Minister for Health and Social Services on any arrangement of particular policy note, or with a novel, contentious or innovative nature.

Accordingly any issues relevant to the exercise of the Minister for Health and Social Service's consent will, as a matter of course, be drawn to his attention.

The process which NHS Wales bodies entering into contracts must follow is:

- All NHS contracts (unless exempt) >£1m in total to be notified to the Director General HSSG prior to tendering for the contract;

- All eligible LHB and HEIW contracts >£1m in total to be submitted to the Director General HSSG for consent prior to award;
- All eligible NHS Trust contracts >£1m in total to be submitted to the Director General HSSG for notification prior to award; and
- All eligible NHS contracts >£0.5m in total to be submitted to the Director General HSSG for notification prior to award.

The requirement for consent does not apply to any contracts 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 LHBs;
(iii) Out of Hours contracts; and
(iv) All NHS contracts; that is where one health services body contracts with another health service body.

Contracts entered into by HEIW for services which are the consequences of annual commissioning approved by the Minister e.g. annual education and training commissioning do not require further Ministerial notification or consent.

For non- capital contracts requiring DG approval, the request for approval or notification should be sent to Rob Eveleigh in the Financial Control and Governance team : Robert.Eveleigh@gov.wales

Kind regards,

SR Elliot I.K.Gunney

Steve Elliot & Ian Gunney
Cyfarwyddwr Cyllid dros dro - Interim Director of Finance
Dirprwy Gyfarwyddwr, Cyfalaf Ystadau a Cyfleusterau - Deputy Director Capital Estates & Facilities
Finance Directorate / Cyfarwyddiaeth Cyllid
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Y Grŵp Iechyd a Gwasanaethau Cymdeithasol
Health & Social Services Group

Llywodraeth Cymru
Welsh Government

7 November 2022

Chief Executives of Local Health Boards and NHS Trusts

Dear All

ADDENDUM TO STANDING FINANCIAL INSTRUCTIONS

PROCEDURES FOR CONSENT FOR LOCAL HEALTH BOARDS TO ENTER INTO CONTRACTS EXCEEDING £1 MILLION

Some confusion has arisen in relation to the procedures for the consent to enter contracts over £ 1 million. The latest version of the Standing Financial Instructions issued in April 2021 state in paragraph 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 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 entered 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.

Paragraph 11.6.4 states that the exceptions mentioned above are as follows :

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;

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ii) Transfers of land or contracts effected by Statutory Instrument Model Standing Orders, Reservation and Delegation of Powers for LHBs Schedule 2.1: Standing Financial Instructions Status: Update – March 2021;
iii) Out of Hours contracts;
iv) All NHS contracts, that is where one health service body contracts with another health service body.

To ensure consistency with guidance issued to NWSSP Procurement Services, further exceptions highlighted below should be applied;

v) Contracts over £ 500k - £1 million (for noting) and £ 1 million + (for approval);

i) Wales Public Sector Framework Agreements e.g. Frameworks established by National Procurement Services (NPS) or NWSSSP (not exhaustive) - no further approval required to award contracts under these Frameworks through a direct award or mini competition.

ii) Third Party Public Sector Framework Agreements e.g. Frameworks established by Crown Commercial Services, NHS Supply Chain (not exhaustive) – no further approval required to award contracts under these Frameworks through a direct award. Approval will however be required for award of contracts under these Framework Agreements through mini-competition or where the specification of the product/service required is modified from that stated within the Framework Agreement.

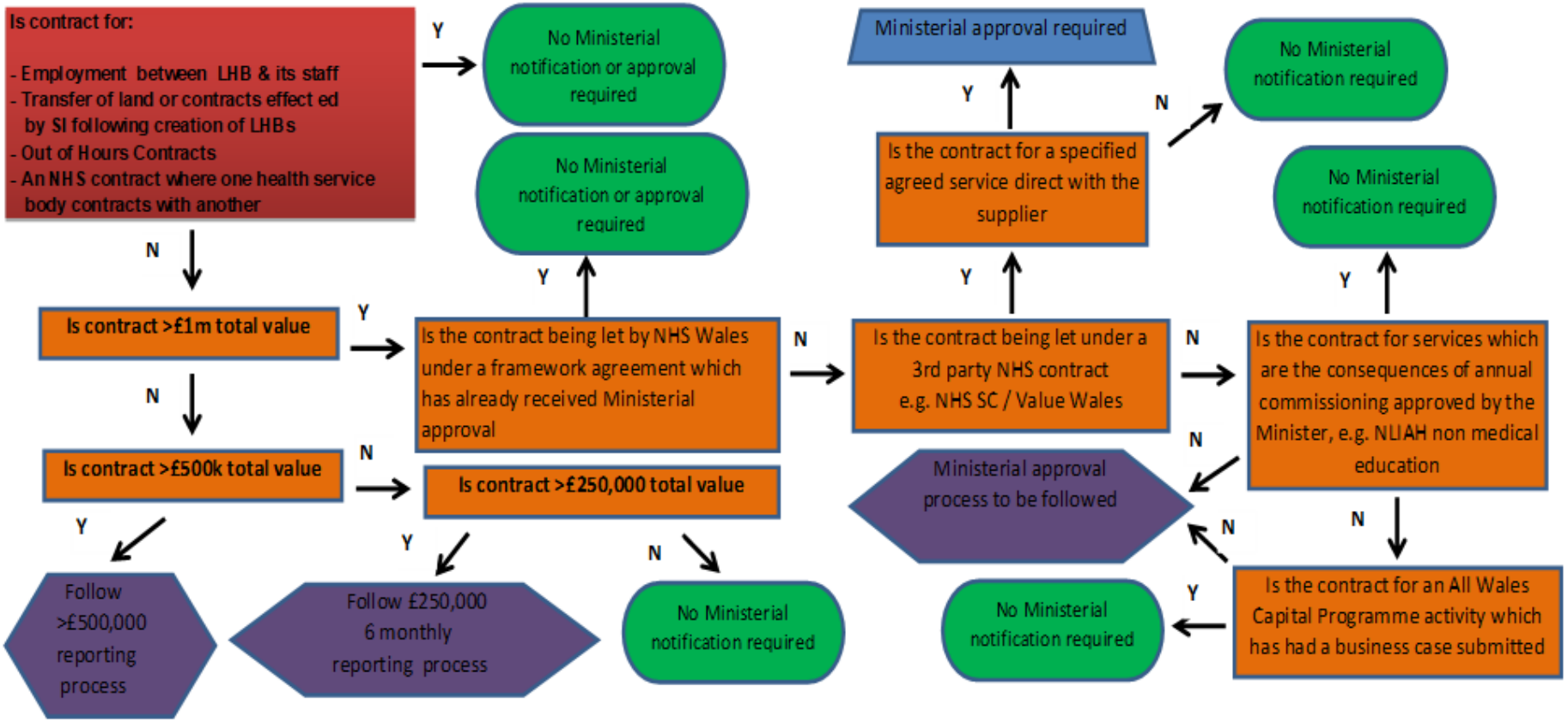
All Health Boards in Wales and Special Health Authorities bodies should apply these exceptions from the date of this letter.

The revision introduced in point v) above will be included formally in the next version of the Standing Financial Instructions.

Yours sincerely

Steve Elliot

Cyfarwyddwr Cyllid dros dro | Interim Director of Finance



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

SCHEME OF DELEGATION AND EARNED AUTONOMY FRAMEWORK

Reference No:	UHB 217	**Version No:**	1.8	**Previous Trust / LHB Ref No:**	N/A

Documents to read alongside this document	UHB Standing Orders, Reservation and Delegation of Powers UHB Standing Financial Instructions More detailed subject specific policies, procedures and guidelines

Classification of document:	Corporate
Area for Circulation:	UHB Wide
Author/Reviewee	Director of Corporate Governance
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Approved by:	UHB Board
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Date Published:	30 November 2023

*This is next formal date of review but due to the nature of the document a review before this date is likely.

Disclaimer

When using this document please ensure that the version you are using is the most up to date either by checking on the UHB database for any new versions. If the review date has passed please contact the author.

Version Control

Version Number	Date of Review Approved	Date Published	Summary of Amendments
1	25/03/2014	25/03/2014	New Document. Detailed scheme of delegation and earned autonomy framework to underpin Schedule 1 of UHB Standing Orders, Reservation and Delegation of Powers
1.1	18/08/2014	Not published	Amendments to reflect comments made regarding content of Version 1, revised authorisations for Clinical Boards at Levels 2 and 3 and some categories extended.
1.2	08/04/2015	22/04/2015	Section 8 - Executive lead for Senior Information Risk Officer changed from the Deputy Chief Executive to the Board Secretary
1.3	05/05/2015	20/05/2015	Review date extended to 30 September 2015
1.4	26/01/2017	27/02/2017	Amendment to section 5 Disciplinary Investigations and Dismissal of staff
1.5	05/12/2017	20/12/2017	Finance and Procurement - amend delegated limits for Head of Compliance & Discretionary Capital, Head of Capital Planning and Director of Therapies and Health Sciences. (AC17/078)
1.6	27/02/2018	18/05/2018	Finance and Procurement - amend to include off payroll working AC17/097)
1.7	30/09/2021	01/10/2021	Updated due to change of responsibilities from Executive Director of Strategic Planning to Executive Finance Director and other changes to Executive responsibilities plus clarifying and consistency in job titles
1.8	30/11/23	30/11/23	Reviewed alongside new release of standing orders and standing financial instructions

Contents

Section 1	Quality, Safety and Experience
Section 2	Service
Section 3	Commissioning and Provision of Services

Section 4	Finance and Procurement
Section 5	Workforce and Organisational Development
Section 6	Corporate
Section 7	Higher Degree of Delegation and Earned Autonomy at Level 2 and 3
Section 8	Executive Responsibilities

Note: Whilst this Scheme of Delegation captures a wide range of subject areas it is not exhaustive. Reference should also be made to policies, procedures, other written control documents and individual role profiles.

References to a post or designation shall be deemed to include a reference to the employee for the time being performing those functions where the post or designation name is altered or the functions are reallocated (for example, the post title of Executive Director of Workforce and OD has changed to Executive Director of People and Culture)

If further clarification is required please contact the Director of Corporate Governance or Head of Corporate Governance.

Quality, Safety and Experience

Area	Delegated Matter	Delegated to	Comment
Legislative Requirements where individuals are named as licence holders or designated individuals			**Note:** This section concentrates on legislation relating to patient safety and quality. It is not intended to be exhaustive. Where appropriate further information will be added to the Scheme of Delegation or will be maintained by Clinical Boards/Corporate Directorates.
Human Tissue Act 2004	Licence Holder	Executive Medical Director	Premises must be licensed to carry out post mortem examinations; to remove tissue/organs from a body and to store bodies or tissues/organs removed from bodies. Each Designated Individual has specific personal responsibilties detailed in legislation
	Designated Individuals	Clinical Board Director/Head of Department	
	Approval of agreements with Third Party for the collection of umbilical cord blood	Executive Medical Director	
Medicines Act 1968	Medicines and Healthcare Products Regulatory Agency (MHRA) Licenced activities	Chief Executive	
	Maintenance of standards to ensure ongoing compliance with licencing requirements	Clinical Board Director	
Medical Act 1983	Maintaining standards to ensure UHB retains Approved Practice Setting status	Executive Medical Director	
The Blood Safety and Quality Regulations 2005	Authorisation Holder	Chief Executive	
	Responsible Person (Blood)	Named Consultant Haematologist	This is the person who has been designated pursuant to regulation 6. A record of Responsible Persons will be maintained by the Governance Directorate.
	Approval of Blood and Component Products Policy	Quality, Safety and Experience Committee	

	Review of policies and approval of procedures and ensuring that arrangements in place.	Transfusion Group	
Concerns/Complaints Management	Set direction, policies and procedures	Executive Nurse Director	Policies approved by Quality, Safety and Experience Committee
	Recording, receipt and initial acknowledgement of concern/complaint	Assistant Director of Patient Experience supported by Concerns Department	Note: Any written concern received by any department/individual other that the Chief Executive must be forwarded to the Chief Executive's office immediately.
	Grading of concern/complaint	Executive Nurse Director or Assistant Direct of Patient Experience	
	Identification of Investigating Officer	Head of Operations and Delivery (Dental), Assistant Director of Therapies/Professional Lead for QSE (CD&T), all other Clinical Boards = Clinical Board Nurse (all Grades of Concern) or Assistant Directors of Corporate Departments	
	Investigation of complaint	Investigating Officer	
	Maintaining regular contact with the complainant with regard to the processing of the concern.	Concerns Department	
	Maintaining regular contact with the complainant with regard to the matters raised in the concern.	Investigating Officer	
	Preparing final draft response (all Grades of Concern)	Investigating Officer	Note: Refer to level of autonomy for Clinical Boards at Levels 2 and 3

	Sign off of final draft	Head of Operations and Delivery (Dental), Assistant Director of Therapies/Professional Lead for QSE (CD&T), all other Clinical Boards = Clinical Board Nurse (all Grades of Concern) or Assistant Directors of Corporate Departments	
	Checking of final draft prior to submission to Chief Executive	Identified Executive Director	

	Sending final response to complainant	Chief Executive	
Incident Reporting and Investigation	Set direction, policy and procedures	Executive Nurse Director	Policies approved by Quality, Safety and Experience Committee
	a) Completion of Incident Form	Staff member involved in incident or in immediate area	
	b) Initial Investigation of Incident	Manager of staff member/person in charge of area	
	c) Reporting of Serious Adverse Incident to Welsh Government	Executive Nurse Director	
	d) Arranging serious incident (SI) meeting	Assistant Director of Patient Safety or Head of Operations and Delivery (Dental), Assistant Director of Therapies/Professional Lead for QSE (CD&T), all other Clinical Boards = Clinical Board Nurse	
	e) Investigation of Serious Incidents	Head of Operations and Delivery (Dental), Assistant Director of Therapies/Professional Lead for QSE (CD&T), all other Clinical Boards = Clinical Board Nurse or Executive Directors to appoint Investigating Officer	
	f) Preparation of final report	Investigating Officer	

	g) Agreement of final report prior to submission to the Executive Nurse Director	Clinical Board Director or Executive Director	
	h) Sign off of final report and closure of investigation.	Executive Nurse Director	
	i) Reporting of incidents in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations	Head of Health and Safety	
	j) Reporting of breaches under the Ionising Radiation (Medical Exposure) Regulations to Health Inspectorate Wales (HIW)	Assistant Director of Patient Safety	
	k) Reporting of Data Protection Breaches to Information Commissioners Office (ICO)	Executive Medical Director	
	Management of UHB notifications to ICO or received as a result of complaint to the ICO		

	- requests and response management	Head of Information Governance	
	- Local management and provision of information	Clinical Board Directors of Operations or Assistant Director of Corporate Directorates	
	- Approval of response	Medical Director	

	l) Reporting of Incidents to the Police	Unless incident reported at time (see below) Executive Nurse Director	
	Where a criminal offence is suspected	Person in charge of area	
	Criminal offence of a violent/harmful nature	Person in charge of area	
	other	Person in charge of area	
	Where a fraud is suspected	See financial section	
	Maintaining Datix Risk Management and Incident Reporting system including upload into National Reporting and Learning System (NRLS)	Assistant Director of Patient Safety and Head of Health and Safety	
HM Coroner	Maintaining relationship and ensuring appropriate response to requests for information.	Executive Nurse Director supported by Assistant Director of Patient Safety	
	Development and implementation of plans following the receipt of "Prevention of Future Death Reports" from HM Coroner	Clinical Board Directors of Operations and Clinical Board Directors of Nursing or Assistant Directors of Corporate Departments	
	Preparation of response to "Prevention of Future Death Reports" from HM Coroner	Clinical Board Directors of Operations and Clinical Board Directors of Nursing or Assistant Directors of Corporate Departments	
	Sign off of Clinical Board response to "Prevention of Future Death Reports" from HM Coroner prior to submission to Executive Nurse Director	Clinical Board Director or Executive Director	
	Sign off of response to "Prevention of Future Death Reports" from HM Coroner	Executive Nurse Director	
	Sending response to HM Coroner	Chief Executive	

Welsh Risk Pool Assessment	Executive Lead	Executive Nurse Director	
	Co-ordination of assessment	Assistant Director of Patient Safety	

	Performance against the Welsh Risk Pool Standards and contributing to assessment process.	Clinical Board Directors of Operations and Clinical Board Directors of Nursing or Assistant Directors of Corporate Departments	
Standards for Health Services in Wales	Executive Lead	Executive Nurse Director	
	Standards for Health Services in Wales - assessment and compliance with provisions of standards	Clinical Board Directors of Operations and Clinical Board Directors of Nursing or Assistant Directors of Corporate Departments	
Patients Safety Alerts	Executive Lead	Executive Nurse Director	
	Maintaining record of Alerts and monitoring compliance	Assistant Director of Patient Safety	
	Responding to requirements and providing information regarding ability to meet requirements	Clinical Board Directors of Operations and Clinical Board Directors of Nursing or Assistant Directors of Corporate Departments	

National Institute of Clinical Excellence (NICE)	Executive Lead	Executive Medical Director	

	Maintaining record of publications and recording compliance	Assistant Director of Patient Safety	
	Responding to requirements and providing information regarding ability to meet requirements	Clinical Board Directors of Operations and Clinical Board Directors of Nursing or Assistant Directors of Corporate Departments	As above re delegation straight to QSE Lead
National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Executive Lead	Executive Medical Director	
	Performing the role of the NCEPOD Ambassador and collation and provision of information to contribute to NCEPOD audit findings	Assistant Medical Director - Clinical Effectiveness and Patient Safety	
	Maintaining record of publications and recording compliance	Assistant Medical Director - Clinical Effectiveness and Patient Safety	
	Responding to requirements and providing information regarding ability to meet requirements	Clinical Board Directors or Executive Directors	
Approval of compensation for staff and patients personal effects, clinical negligence and personal injury claims			Refer to Finance and Procurement section
Clinical Audit	Executive Lead	Executive Medical Director	
	Co-ordination and participation in national audits	Assistant Director of Patient Safety	
	Development of UHB wide Clinical Audit Plan	Assistant Director of Patient Safety	
	Approval of UHB wide Clinical Audit Plan	Quality, Safety and Experience Committee	
	Development and implementation of Clinical Board Audit Plans	Clinical Board Directors	
	Approval of Clinical Board Audit Plans	Clinical Board Quality, Safety and Experience sub-Committees	

Infection Prevention and Control	Set direction, policy and procedures	Executive Nurse Director	Policies approved by Quality, Safety and Experience Committee
	Implementation of procedures and good practice	All staff	
	Co-ordination of management of outbreaks	Executive Nurse Director	
Professional Standards and Regulation - Nursing	Development of Strategic Framework	Executive Nurse Director	
	Implementation of Strategic Framework	Deputy Director of Nursing and Clinical Board Nurse/Clinical Board Lead	
	Referral to Nursing and Midwifery Council (NMC)	Executive Nurse Director*	
	Monitoring of registration (NMC regulatory compliance)	Deputy Director of Nursing and Clinical Board Nurse/Clinical Board Lead	
Professional Standards and Regulation - Medical and Dental	Development of Strategic Framework	Executive Medical Director	
	Implementation of Strategic Framework	Clinical Board Directors and Executive Directors	
	Referral to General Medical Council (GMC)/General Dental Council (GDC)	Executive Medical Director*	
	Monitoring of registration (GMC/GDC regulatory compliance)	Clinical Board Directors and Executive Directors	
Professional Standards and Regulation - Therapies and Health Sciences	Development of Strategic Framework	Executive Director of Therapies and Health Sciences	
	Implementation of Strategic Framework	Clinical Board Directors and Executive Directors	

	Referral to appropriate Professional Body	Executive Director of Therapies and Health Sciences*	
	Monitoring of registration	Clinical Board Directors or Executive Directors	

Safeguarding - Adult Protection	Set direction, policy and procedures	Executive Nurse Director	Policies internal to UHB approved by Quality, Safety and Experience Committee
	Implementation of policy and procedures	Assistant Nurse Director/Clinical Board Leads	
	Investigation in accordance with Protection of Vulnerable Adults (POVA) requirements	Clinical Board Nurse/Designated Lead Managers (DLMs)	
Safeguarding - Child Protection	Set direction, policy and procedures	Executive Nurse Director	Policies internal to UHB approved by Quality, Safety and Experience Committee
	Implementation of policy and procedures	Executive Nurse Director	
	Safeguarding Supervision	Executive Nurse Director	
Safeguarding - Deprivation of Liberty	Supervising Authority	Executive Nurse Director	
	Managing Authority	Executive Nurse Director	

Service Freedoms

Area	Delegated Matter	Delegated to	Comment
Management of Capacity	Management of capacity	Clinical Directors and Assistant Director of Corporate Departments	
	Variation of operating and clinic sessions within existing resources - Outpatients - Theatres - Other	Clinical Board Directors following appropriate consultation with all affected areas.	
	Changes to Bed Allocations leading to relocation of services or permanent reduction in bed capacity		
	Permanent Change	Chief Operating Officer	Need to ensure appropriate engagement with Community Health Council in association with Executive Director of Strategic Planning
	Temporary Change	Chief Operating Officer	Need to ensure appropriate engagement with Community Health Council in association with Executive Director of Strategic Planning
	Changes to Bed Allocations where there is no relocation of services or permanent reduction in bed capacity		
	Permanent Change	Chief Operating Officer	Need to ensure appropriate engagement with Community Health Council in association with Executive Director of Strategic Planning
	Temporary Change	Chief Operating Officer	Need to ensure appropriate engagement with Community Health Council in association with Executive Director of Strategic Planning

Plans for service change UHB217 Version 1.7 Approved :25 Nov 2021	Material service change which impacts across more than one Clinical Board or has capital implications	Executive Director of Strategic Planning and Chief Operating Officer	Refer to "Guidance for Engagement and Consultation on Changes to Health Services"
	Material service changes to be identified in line with Integrated Medium Term Plan on an annual basis leading to requirement to potentially engage	Executive Director of Strategic Planning to confirm following discussion with Clinical Board	
	Community Health Council Any	To be approved by Executive Director of	

Plans for service change	Material service change which impacts across more than one Clinical Board or has capital implications	Executive Director of Strategic Planning and Chief Operating Officer	Refer to "Guidance for I and Consultation on Ch Services"
	Material service changes to be identified in line with Integrated Medium Term Plan on an annual basis leading to requirement to potentially engage	Executive Director of Strategic Planning to confirm following discussion with Clinical Board	
	Community Health Council Any substantial service change to be identified in line with Integrated Medium Term Plan on an annual basis leading to requirement to enter into formal public	To be approved by Executive Director of Strategic Planning and endorsed by the Board	
Local Delivery Plans	consultation Maintaining an up-to-date register of National Delivery Plans, ensuring that the UHBs response to these plans are managed within the required timeframe.	Assistant Director of Strategic Planning	
	Overall co-ordination, development and implementation of the Local Delivery Plans	Chief Operating Officer in collaboration with Clinical Board Directors	
	Delegated responsibility to oversee the development of the Local Delivery Plans.	Executive Director of Therapies and Health Sciences	To be managed as part performance managem arrangements
Drugs and Medication	See Finance Section		See Finance and Procu Medicines Managemen Procurement
Extended Role Activities	See Workforce Section		

Commissioning and Provision of Services To and From Other Organisations

Area	Delegated Matter	Delegated to	Comment
Commissioning including primary care but excluding Continuing Healthcare and Funded Nursing Care	Approval to commission **new** healthcare services from NHS, private, third sector or independent organisations	Executive Director of Strategic Planning	This relates to the commissioning of a new service. Any changes which will have a significant impact on provider strategy must be agreed with the Chief Operating Officer and other relevant Executives prior to agreement. Any additional funding requirements must be agreed with the Director of Finance prior to approval. May be subject to tendering in line with UHB procurement procedures including significant contract variations
	Approval to commission healthcare services from new organisations - NHS, third sector, primary care, private or independent sector	Executive Director of Strategic Planning	This relates to commissioning from an organisation not currently commissioned by the NHS. Any changes which will have a significant impact on provider strategy must be agreed with the Chief Operating Officer and other relevant Executives prior to agreement. Any additional funding requirements must be agreed with the Director of Finance prior to approval. May be subject to tendering in line with UHB procurement procedures including significant contract variations.
	Agreement to provide services and payments in accordance with Medicines Management Incentive Scheme	Clinical Board Director - Primary, Community and Intermediate Care	
	Maintaining a register of commissioning contracts	Executive Director of Strategic Planning delegated to Clinical Board Director	

	Ensuring every commissioning contract has a lead manager responsible for ensuring that contract delivers activity, quality and finance	Executive Director of Strategic Planning delegated to Clinical Board Director	
	Agreement of annual contract with existing providers and within existing budgets - NHS, third sector, independent or private	Nominated lead manager (within existing budget)	
	Agreement of contract variations	Nominated lead manager (within existing budget)	
	Signing contracts of value < £75,000 and contract variations > £25,000	Nominated lead manager	
	Signing contracts of value < £125,000 and contract variations > £25,000	Director of Finance on recommendation of nominated lead manager	
	Signing contracts of value < £500,000 and contract variations > £125,000	Chief Executive on recommendation of nominated lead manager	
	Signing of contracts of value >£500,000 and contract variations > £500,000	Chair and Chief Executive on authority of Board	
	Agreement of changes to contracts where this would place a cost pressure on the organisation which cannot be funded within existing budgets	Director of Finance (subject to business case/Integrated Medium Term Plan process)	
	Agreement of changes to contracts where this would place a cost pressure on the organisation which would have a significant impact on the delivery of outcomes	Executive Director of Strategic Planning	
	Ensuring there is a comissioning and contracting framework in place which sets out expectations around what will be included in documentation and approach to management including meetings	Executive Director of Strategic Planning	Finance and procurement elements to be signed off by Director of Finance, quality and safety to be signed off by Executive Nurse Director
	Ensuring that contracts have appropriate documentation in place including key performance metrics relating to activity, targets, quality and finance and that regular performance monitoring meetings take place	Nominated lead manager	
	Ensuring that there are regular meetings in place to monitor performance against commissioning contracts, that recovery plans are agreed where there are performance or finance issues and that matters of concern are escalated appropiately	Nominated lead manager	

	Ensuring every commissioning contract has a lead finance manager responsible for monitoring financial activity and supporting the lead manager to manage the contract	Executive Director of Finance	
	Authorisation of invoices against contracts (within budget) excluding NHS Long Term Agreements (LTAs)	Nominated lead manager (within delegated authority)	
	Authorisation of invoices against NHS LTAs	Head of Finance (Financial Management and Strategy)	

Commissioning - Continuing Healthcare and Funded Nursing Care	All above sections apply to this area - these are supplementary delegated powers		
	Approving new care packages	Continuing Healthcare (CHC) panel	In line with UHB procedure and panel decisions
	<£75k	Chair of CHC panel	
	<£125k	Executive Director of Finance	
	<£500k	Chief Executive	
	Authorising emergency care packages or changes to care packages outside panel	Director of Operations PCIC or Mental Health	
	Authorising of invoices against agreed packages of care outside panel	Director of Operations PCIC or Mental Health	
	Authorising CHC retrospective claims including Powys and UHB claims		
	<£75k	Director of Operations PCIC and Assistant Director of Finance PCIC	
	<£125k	Executive Director of Finance	
	<£500k	Chief Executive	

Providing staff to or seconding staff from other organisations (e.g staff with academic commitments, seconding staff to partner agencies)	Value <£75k or extension of existing contract for any value	Directors of Operations or relevant Executive Director	
	Value > £75k or change in contract >£75k	Director of Finance	
	Ensuring there is a named contract lead for this	Heads of Operations and Delivery or relevant Executive Director	
	Ensuring there is an appropriate agreement in place, supported by clear specification of what is to be delivered, monitoring arrangements, financial arrangements and exit arrangements	Named contract lead	
Pooled budget arrangements	Approval to enter into pooled budget arrangements under section 33 of the NHS (Wales) Act 2006	Executive Director of Finance on recommendation of Executive Director of Strategic Planning	

Provision of services by UHB to other organisations excluding Welsh Health Specialist Services Committee (WHSSC) and provision of staffing	Approval to provide **new** healthcare services to new and existing organisations	Chief Operating Officer on advice of relevant Clinical Board Director	Signed off by Executive Director of Strategic Planning where there is a potential impact on commissioning strategy and Executive Director of Strategic Planning where there is a potential impact on the UHB long-term strategy Note: Clinical Boards at Level 3 have autonomy to provide services without deferring to Chief Operating Officer.
	Maintaining a register of provider contracts	Executive Director of Finance	
	Ensuring every provider contract has a lead manager responsible for ensuring that contract delivers activity, quality and finance	Executive Director of Finance	
	Agreement of annual contract	Nominated lead manager (within existing budget)	
	Agreement of contract variations	Nominated lead manager (within existing budget)	
	Signing contracts of value < £75,000 and contract variations > £25,000	Nominated lead manager	
	Signing contracts of value < £125,000 and contract variations > £75,000	Executive Director of Finance on recommendation of nominated lead manager	
	Signing contracts of value < £500,000 and contract variations > £125,000	Chief Executive on recommendation of nominated lead manager	
	Agreement of changes to contracts where this would place a cost pressure on the organisation which cannot be funded within existing budgets	Executive Director of Finance (subject to business case/Integrated Medium Term Plan process)	
	Ensuring that services are provided to the appropriate standard and within the contract requirements	Nominated lead manager	Other Clinical Board Directors which provide support services or activity to this contract are responsible for supporting the nominated lead manager in this by delivering their requirements
	Ensuring that contracts have appropriate documentation in place including key performance metrics relating to activity, targets, quality and finance and that regular performance monitoring meetings take place	Nominated lead manager	

	Ensuring every commissioning contract has a lead finance manager responsible for monitoring financial activity and supporting the lead manager to manage the contract	Executive Director of Finance	
	Ensuring invoices are raised for contracts excluding NHS LTAs	Nominated lead manager (within delegated authority)	
	Ensuring invoices are raised for NHS LTAs	Head of Finance (Financial Management and Strategy)	
Arbitration or legal dispute	Decision to go to arbitration or take legal action in relation to any commissioning or provider contract	Chief Executive (or Executive Director of Finance in his/her absence)	
WHSSC as provider	Approval of business cases to go to WHSSC for extension of provision of services or new services	Executive Director of Finance on recommendation of relevant Cllinical Board Director	Must be agreed with any other Clinical Board Directors whose service it will impact on and with the Chief Operating Officer > £0.5m. Cases over £0.5m recurring to be signed off via Management Executive to ensure alignment with UHB commissioning strategy.
	Approving and signing the annual contract with WHSSC	Executive Director of Finance	

	Responding to correspondence from WHSSC	Any Executive Director, Clinical Board Director or Director of Operations	Copied to Director of Finance or Head of Finance (Specialist Services)
	Agreeing contract variations with WHSSC	Executive Finance Director or Head of Finance (Specialist Services)	Based on business cases and recommendation of relevant Clinical Board Director
	Providing activity and financial contract monitoring information to WHSSC	Head of Finance (Specialist Services)	
	Providing quality contract monitoring information to WHSSC	Executive Nurse Director	
	Lead for regular contract monitoring meetings with WHSSC	Executive Director of Finance, Executive Nurse Director, Clinical Board Director, and Clinical Board Director of Operations, Head of Finance for Specialist Services and Women and Children Clinical Boards	Others as appropriate
	Ensuring that the services provided to WHSSC are in line with LTA i.e. activity, finance, safety and quality. Ensuring that appropriate quality of information is provided to enable contract monitoring	Clinical Board Directors, delegated to Clinical Directors and Directorate Managers	
	Ensuring that any issues which require escalation around WHSSC contracts are escalated with appropriate proposals around mitigations	All members of staff	
WHSSC as commissioner	Attending Joint Committee meetings	Chief Executive	
	Attending WHSSC Management Group	Executive Director Strategic Planning and Assistant Director - Corporate Finance	
	Input to WHSSC commissioning decisions and agreement to WHSSC policies	Executive Director of Strategic Planning (and Executive Director of Finance if these involve additional financial commitment)	Appropriate advice to be sought from Medical Director, Chief Operating Officer, other Executives and relevant Clinical Board Directors to gain a UHB view prior to input and/or agreement.
	Dissemination of WHSSC commissioning policies throughout the organisation	Executive Director of Strategic Planning	In accordance with UHB Policies, Procedures and Written Control Documents Policy

	Approving and signing the annual contract with WHSSC as commissioner	Chief Executive	
	Agreeing contract variations with WHSSC	Executive Director of Finance	

Financial Freedoms

Every cost centre must have a single approved budget holder. They are accountable for ensuring that budgets do not overspend and that expenditure is committed within the UHB
Budget holders and their delegated approval levels are approved via the relevant documentation which is provided by the Finance Department with records held in the Finance
Budget holders can nominate authorised signatories for individual cost centres who can commit expenditure on the budget within agreed delegation levels.
Individual members of staff can place orders, but these will be authorised either by a budgetholder or authorised signatory prior to expenditure being committed
Where no budget holder has been nominated for an individual cost centre, the default budgetholder for that cost centre is the Clinical Board Director or the relevant Executive Director
When budget holders are on leave they can appoint a formal deputy whilst they are on leave to manage their budgets. This needs to be confirmed to the budget holder's manager in

Area	Delegated Matter	Delegated to	Comment
Policies and procedures	Approve Standing Financial Instructions and Standing Orders	Board	
	Approve subsidiary financial procedures	Executive Director of Finance or Audit Committee where significant risk to the organisation or a control issue	
	Ensuring that budget holders have appropriate skills/knowledge to manage their budgets	Line manager of budget holder	Director of Finance has ultimate responsibility under SFIs for this
	Manage expenditure within budget	Budget manager	
	Work within financial policies and procedures	All employees	
Management of budgets (Excluding Capital Schemes)	Approval of annual budgets - Corporate Departments and Clinical Boards	Board	
	Approval of annual detailed budgets for Corporate Departments within budget signed off by Board	Relevant Executive Director	
	Approval of annual detailed budgets for Clinical Boards within budget signed off by Board	Chief Operating Officer and Executive Director of Finance	
	Delegation of budgets to budget holders including ensuring the appropriate documentation is completed and returned to the Finance Department	Executive Director or Clinical Board Director	
	Approval of additional budget signatories to budgets including ensuring the appropriate documentation is completed and returned to the Finance Department	Budget holder	
	Authorisation of expenditure above or outside budget	Chief Executive	Reported to Audit Committee

Budget virements	Within Clinical Board or Corporate Department	Clinical Board Director or relevant Executive Director or Head of Delivery	
	Across Clinical Boards	Chief Operating Officer and Executive Director of Finance	
	Across Corporate Departments	Relevant Executive Directors if agreed, or Chief Executive and Executive Director of Finance	
	Across Corporate Departments and Clinical Boards	Relevant Executive Directors if agreed, or Chief Executive and Executive Director of Finance	
	Notification of budget virements to Finance Department to ensure the budget is updated	Person authorising the virement	
Authority to procure revenue goods and services of excluding medicines, medical gases and contracts for healthcare	< £10k	Budgetholder (limit set by Clinical Board or relevant Executive Director)	
	<£75k	Clinical Board Director, Directors of Operations, Assistant Directors and other Senior Officers (limit set by Clinical Board Director or relevant Executive Director)	
	<£125k	Executive Director	
	<£500k	Chief Executive	
	<£1m	Board	
	> £1m (Total cost over the period of the contract)	Welsh Government	

Authority to procure medicines and medical gases	< £10k	Chief Pharmacist or Principal Pharmacist	A detailed scheme of delegation is in place for medicines procurement
	> £10k - £50k	Chief Pharmacist or Principal Pharmacist	These relate to the size of an order for a group of medicines, not to an individual medicine
	> £50k - £100k	Clinical Board Director - Clinical Diagnostics and Therapeutics	
	>£100k - £250k	Chief Operating Officer	
	> £250k - £500k	Executive Director of Finance	
	Stock for use at ward level including controlled drugs	Ward sister/charge nurse	
	Approval of business case to add/remove medicine to Formulary including NICE and AWMSG recommended drugs	Medical Director via Medicines Management Group	
	Approval to provide medicine (restricted or not normally available) to individual (exceptional) patient	Relevant Clinical Board Director(s)	Subject to IPFR framework and policies

UHB217

Off-payroll working (as per procurement process guidance)	Completion of service specification and check on employment status which is to be forwarded to the Head of Procurement	Clinical Board Director / Clinical Board Director of Operations / Executive Director (support provided by Finance and Workforce)	
	Procurement process undertaken ensuring suppliers are aware of the employment status.	Assistant Director of Procurement	
	Clinical Board Director / Clinical Board Director of Operations / Executive Director to be notified of the contract award including reaffirming the employment status of the engagement.	Assistant Director of Procurement	
	If status is deemed to be employed, completion of IR35 offpayroll enrolment	Clinical Board Director / Clinical Board Director of Operations / Executive Director	

Management of stock	Responsibilty to ensure that stock levels are appropriately managed and rotated	Directors of Operations and Delivery	
	Agree consignment levels and hold consignment Registers for all stores areas	Assistant Director of Procurement	
	Completion of returns requesting write off of stock	Budget Holder	
	Approval of write off of stock	Reported to Losses and Special Payments Panel and approved by Audit Committee	
	Responsibility for the security of stock for their area including consignment stock	Directors of Operations - can be devolved to named individuals	
Cash including banking and patients' monies	Management of cash and bank accounts	Executive Director of Finance	
	Approval of petty cash <£20	Budget holders	
	Approval of petty cash £20-£100	Assistant Finance Director - Corporate and Strategy	
	Reimbursement of patients' monies held on trust (non-Mental Health)	Cashiers make payment on evidence of information provided within Cash and Valuables Book and official "system" receipt	Refer to Patients' Property Policy
	Reimbursement of patient monies (Mental Health)		
	Where patient has capacity	Cashiers make payment on authorisation of patient and Ward Manager/Deputy Ward Manager.	Note Cashiers check that the patient has available funds in their account

	Where patient is shown to lack capacity with regard to making this particular decision	Cashiers make payment on authorisation Ward Manager/Deputy Ward Manager witnessed by another member of staff. Another member of staff collects the money from Cashiers with the patient.	As above. Need to ensure that adequate checks in place to ensure compliance with Mental Capacity Act
Capital schemes	Approval of business cases for submission to Welsh Government		
	>£1m	Board	This is outside of current delegation limits but at submission stage there is no commitment to provide/recieve funding. Where the UHB is required to contribute funding the usual limits will apply.
	<£1m	Chief Executive on advice of Management Executive	As above
	Approval of business cases for submission for in-year funding e.g. Health Technologies fund	Management Executive	As above
	Set budgets for capital schemes as part of the annual budget setting arrangements	Board	Based on prioritised recommendations from the Management Executive
	Agree budget holders for each capital scheme and ensure appropriate documentation is completed and sent to the Finance Department	Executive Director of Finance	
	Nominate an Executive Director for each capital scheme with a value of > £200k	Executive Director of Finance	
	Ensure overall UHB capital programme is delivered within budget and financial policies	Assistant Director of Strateci Planning	
	Ensure individual capital scheme is delivered within budget and within financial policies	Nominated capital budget holder	
	Budget virements within capital schemes without exceeding approved budget and purpose for which budget originally approved	Nominated capital budget holder, with confirmation from Director of Planning for schemes over £200k	

	Budget virements across discretionary capital schemes and within discretionary capital budget available including use of contingency		

	<£500k	Executive Director Strategic Planning, Executive Director of Finance and Chief Operating Officer via Major Capital Group	Note this is above the usual limit for an individual director due to the relative low value within the total capital allocation.
	<£1m	Chief Executive following recommendation from Major Capital Group	As above
	>£1m	Board	The Welsh Government will be informed as part of financial monitoring
	Approval to sign contracts for capital expenditure -		
	<£5k	Head of Compliance & Discretionary Capital and Head of Capital Planning	
	<£25k	Director Capital, Estates and Facilities	
	<£125k	Executive Directors of Finance	
	<£500k	Chief Executive	
	>£500k	Board	
	Approval of staged payments in line with contract for capital expenditure		
	<£75k	Director of Capital, Estates and Facilities	
	<£250k	Executive Director of Finance	
	<£500k	Chief Executive	
	>£500k	Board	
	Approval of capital expenditure or staged payments for capital expenditure outside budget	Chief Executive, notified to Board	

	Appointment of architects, quantity surveyors, consultant engineer and other professional advisors with EU Regulations	Director of Capital, Estates and Facilities Executive Director of Finance for all other projects	In line with procurement procedures and within budget available
	Day to day liaison with Welsh Government over capital matters (estates, IM&T and medical equipment)	Director of Capital, Estates and Facilities	
	Approval of additional revenue costs associated with capital expenditure prior to commencement of financial year	Executive Director of Finance following consultation with Management Executive Team	Note: This will also take account of IMTP processes and timescales. CBs are not authorised to agree to fund a revenue cost pressure from within their existing resources.
	Approval of additional revenue costs associated with capital expenditure in year	Chief Executive	
			All figures include VAT

Decision to commence with the procurement process with regard to clinical equipment to ensure where appropriate standardisation	Equipment >£5k	Clinical Board Director to ensure agreement as appropriate via Clinical Equipment Group	Note - for Point of Care Testing Equipment ensure that procurement meets the provisions of the Point of Care Testing Policy
	Equipment <£5k	Clinical Director to ensure agreement as appropriate via Medical Equipment Management Group	As above

Quotation, tendering and contracting procedures for goods and services excluding primary care, continuing health care and funded nursing care and services commissioned from other health boards	No requirement to obtain quotes for single items up to £1,000 or for items to be purchased using a nationally negotiated contract, but there is always a responsibility to ensure best value	Budget holder	One quote is required
	Obtaining **2 written quotations** for expenditure between £1,000 and £5,000	Assistant Director of Procurement and Directors of Operations	Note: up to £5,000 the minimum competition is at the discretion of the Director of Finance Single tender actions shall be permitted under certain limited circumstances. The Chief Executive has delegated authority to the Director of Finance to approve. (see below) All single tender actions will be reported to the Audit Committee.
	Obtaining a minumum of **3 quotations** for goods/services from £5,000 to £25,000	Assistant Director of Procurement and Directors of Operations	

	Obtaining a minimum of **4 written competitive tenders** for goods and services from £25,000-£113k (OJEU Threshold) - Local tender	Assistant Director of Procurement and Directors of Operations	This needs to be completed on the EBravo system. All quotations should be managed in this way. Procurement Services currently using the electronic system
	Authority to commence with Single Tender Actions	Executive Director of Finance	See above
	Approval to go out to contract above EU OJEU limit and upto £1million	Assistant Director of Procurement and Directors of Operations	Note: 5 written competitive tenders required.
	Approval to go out to tender for contracts above £1million	WAG approval required	

	Approval and signing of contracts < £125 (excluding management consultancy)	Executive Director of Finance	
	Approval and signing of management consultancy contracts < £125 (excluding capital projects professional advice)	Chief Executive	
	Approval and signing of contracts £125k - £500k	Chief Executive	
	Approval of contracts > £500k	Board	
	Signing of contracts >£500k following approval by the Board	Chief Executive	
	Approval of contracts > £1million	Welsh Government	
	Signing of contracts >£1m following approval by the Welsh Government	Chief Executive	
	Opening Quotations	E-Bravo System - Procurement	
	Opening Quotations	Capital and Estates	At present Capital and Estates manually process quotations. This will be moved over to E-Bravo asap
	Opening Tenders (Capital and Estates)	Finance Department	This is a temporary arrangement - previously managed by Governance Department
	Opening Tenders (Procurement)	E-Bravo System - Procurement	This needs to completed on the ebravo system. All tenders should be managed in this way. Procurement Services currently using the electronic system

	Maintenance of Register of Tenders	Assistant Director of Procurement	This needs to completed on the EBravo system. All tenders should be managed in this way. Procurement Services currently using the electronic system
	Adding products to catalogues	Assistant Director of Procurement	
	Inclusion of Supplies within OLR catalogue	Divisional Manager or Clinical Director in conjunction with Supplies Manager or Deputy	

	All OLR catalogue requisitions up to £20,000	OLR Designated Officer within Divisions	
	All OLR catalogue requisitions over £20,000	OLR Designated Officer with countersignature of Divisional Manager	
	Orders exceeding 3 years	Executive Director of Finance or Chief Executive	
	All contracts for goods and services and subsequent variations to contracts	Executive Director of Finance or Chief Executive with appropriate Clinical Board Director/Executive Director	
Information Management &Technology (IM&T)	All purchases of hardware and software must be undertaken in line with agreed IT policies, Procedures and contractual arrangements.		For advice please contact the IT Department
	No purchase or installation may be made of IT software whether new or upgrades to existing systems other than via the IT department		
	Purchases of routine desktop hardware should be procured via UHB contracts. Purchasing of servers should always be via IT		
Licences and leases for property	Preparation of all tenancy agreements/licences for all staff subject to UHB Policy on accommodation for staff	Director of Capital, Estates and Facilities	
	Signature of all tenancy agreements/licences for staff (as above)	Executive Director of Finance	
	Approval of rent based on professional assessment	Executive Director of Finance	
	Granting and termination and variation of leases or licences with annual rent less than £100k	Director of Capital, Estates and Facilities	Includes letting of UHB premises to third parties and UHB taking on additional premises
	Granting and termination of leases with annual rent greater than £100k	Board	
	Entering into PFI contract	Board	
Condemning and disposal of assets	Maintain losses and special payments register	Executive Director of Finance	Reported to Audit Committee

	Items with original value obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively		
	with current/estimated purchase price <£499	Budget Manager	
	with current purchase new price >£500	Clinical Board Director or relevant Executive Director	
	with current purchase new price > £5000	Executive Director of Finance	
	Disposal of mechanical and engineering plant (subject to estimated income exceeding £1,000 per sale)	Executive Director of Finance	
	Disposal of property or land	Board	
Fraud	Reporting a suspected criminal offence relating to business eg fraud, theft etc to the police (see separate section re criminal offences relating to the provision of healthcare or employment)	Executive Director of Finance in association with the Local Counter Fraud Specialist	Refer to Counter Fraud and Corruption Policy
	Responsibility to notify Counter Fraud in confidence in case of suspected fraud	All staff	
	Liaison with the Local Counter Fraud Specialist and Counter Fraud and Security Management Services where there are cases of fraud or corruption or anomalies which indicate fraud or corruption	Executive Director of Finance	Reported to Audit Committee
Losses and compensation	Authorise fruitless payments (including abandoned capital schemes)	Audit Committee (upon recommendations from the Losses and Special Payments Panel)	
	<£250k	Chief Executive on advice from the Executive Director of Finance	
	>£250k	Welsh Government	
	Authorise payment for clinical negligence and personal injury claims where legal advice has been obtained and guidance applied (negotiated settlements)	Audit Committee (upon recommendations from the Losses and Special Payments Panel)	
	<£1m (including plaintiffs' costs)	Executive Nurse Director	

	>£1m	Welsh Government	
	Other clinical negligence and personal injury claims where legal advice has not been obtained	Audit Committee (upon recommendations from the Losses and Special Payments Panel)	
	<£25k	Assistant Director of Nursing	
	£25k-£50k	Executive Nurse Director	

	>£50k	Welsh Government	
	Authority to write off losses and authorise special payments for bad debts and claims abandoned - private patients, overseas visitors and others.		
	<£50k	Audit Committee (upon recommendations from the Losses and Special Payments Panel)	
	>£50k	Welsh Government	
	Authority to write off damage to buildings, fittings, furniture and equipment, loss of equipment and property in stores and in use due to culpable causes (e.g. fraud, theft, arson) or other.		
	<£50k	Audit Committee (upon recommendations from the Losses and Special Payments Panel)	
	>£50k	Welsh Government	
	Authorise compensation payments made under legal obligation (excluding Clinical Negligence and Personal Injury)	Chief Executive	
	Authorise extra contractual payments to contractors.		
	<£50k	Executive Director of Finance	
	>£50k	Welsh Government	

	Authorise ex-gratia payments to patients and staff for the loss of personal effects		
	<£1k	Small Claims Panel	
	<£10k	Executive Nurse Director	
	<£50k	Chief Executive	
	>£50k	Welsh Government	
	Authority to write off Losses of cash due to theft, fraud, overpayment of salaries, wages, fees and allowances		
	<£50k	Audit Committee (upon recommendations from the Losses and Special Payments Panel)	
	>£50k	Welsh Government	
Setting of fees and charges	Private patient, overseas visitors, income generation and other related services	Director of Finance	In line with Welsh Government policy

Sponsorship	Sponsorship to attend courses and conferences	Executive Director or Clinical Board Director. Individual is responsible for ensuring this is notified on the gifts and hospitality register	Refer to Standards of Behaviour Framework Policy incorporating Declarations of Interest, Gifts, Hospitality and Sponsorship
	Sponsorship of UHB events e.g. Nursing Conference	Executive Director or Clinical Board Director up to £500. Director of Finance above £500.	
Fundraising	Approval of fundraising using UHB premises or facilities or staff time within working hours	Executive Director of Finance on recommendation from Clinical Board Director	Need to be clear of difference between UHB and charitable funds
Advertising	Approval of paid for contracts for advertising UHB or its services other than those set out below	Director of Finance	Anything else we routinely advertise?

	Advertising relating to sale of properties	Director of Capital, Estates and Facilities	
	Advertising relating to recruitment	Executive Director of People and Culture	
	Advertising relating to public health initiatives	Director of Public Health	
	Public advertisements relating to UHB governance eg advertising AGM or Board meetings	Director of Corporate Governance	
	Advertising relating to income generation schemes within a Clinical Board up to £5,000	Clinical Board Director	
Intellectual Property	Agreement to register intellectual property	Executive Director of Finance	
Submission of funding bids excluding Research and Development (R&D)	Agreement to submit proposals for accessing capital or revenue funding from Welsh Government or any other funding body (excluding R&D but including Invest to Save, Health Technologies Fund etc)	Executive Director of Finance on recommendation of person drawing up the bid	Major bids may need to go via HSMB or Management Executive
Charitable Funds	Agreeing a budget holder for each individual fund	Execytuve Director of Finance	Note, authorised signatories are not allowed for charitable funds
	Approval of use of charitable funds < 25k	Budget holders	
	Approval of use of charitable funds > 25k	Charitable Funds Committee	
	Approval of new staff expenditure	Charitable Funds Committee	
	Approval of use of charitable funds > 125k	Trustee	
	Investment of charitable funds	Executive Director of Finance	

Commercial R & D	Approval and execution (by signature), on behalf of the UHB, of the contract between the UHB and commercial Sponsor for the UHB's delivery of a clinical trial/investigation on behalf of the Sponsor.	Executive Medical Director	Principal investigators (normally a consultant) initiate R&D authorised commercial clinical trials in association with external funding and external trial management.
	Approval and execution (by signature) of service level agreements between the UHB and other NHS organisations and/or third parties for support services required for commercial trials	Executive Medical Director	UHB provides support to other NHS Institutions (principally Velindre NHS trust) for the delivery of commercial trials and vice versa (e.g. radiology), other suppliers to the UHB include Spire and Cardiff University (CU).
	Allocation of Commercial R & D Income	Executive Director of Finance at direction of Executive Medical Director	Income allocated to Clinical Boards, Directorates, Principal Investigator (PI) accounts, support departments and third parties including Higher Education Institutes (HEIs) (principally CU) in line with process agreed with R & D Office (ISR-RD-005 FAQS re RD Funding - V1 FINAL 180713).
	Responsibility for delivering R&D activity in line with funded budgets and maintaining audit trail of expenditure to demonstrate that it is expended on R&D	Clinical Board Director via R&D Lead	Accountable to Medical Director
	Approval of expenditure to support Commercial R & D	Authorised by the relevant Clinical Board/Directorate Manager	Subject to UHB Standing Orders and SFIs
	Approval of use of Principal Investigator Balances	Authorised by the relevant Clinical Board/Directorate Manager & Clinical Board/Directorate R & D Lead	Subject to UHB Standing Orders and SFIs & agreed protocol (ISR-RD-005 FAQS re RD Funding - V1 FINAL 180713).
	Closure of 'Time Barred' (18 month post study closure date) Principal Investigator Balances	Executive Director of Finance	Subject to process agreed with R & D Office & T&F Finance Group (ISR-RD005 FAQS re RD Funding - V1 FINAL 180713).

	Allocation of budgets from Research Legacy Fund to Clinical Boards	Executive Director of Finance	Subject to process agreed with R & D Office & T&F Finance Group (Use of surplus funds generated from commercial trial activity)
	Approval of use of Central Research Legacy Fund	R&D Director	
	Approval of use of Research Legacy Funds devolved to Clinical Boards	Expenditure authorised by the relevant Clinical Board/Directorate Manager & Clinical Board/Directorate R & D Lead	The Clinical Board/Directorate Research & Development Leads Group review reports detailing the deployment of the Research Legacy Fund
Non-Commercial Funded R & D	Approval of UHB led R & D Grant applications	Executive Director of Finance on recommendation from R&D Office	PI to complete with advice and input from Finance Department. Signatures can be required at very short notice. Grant applications can vary from £1k to > £2m
	Approval of R & D Grant applications led by other organisations where UHB commitment is <£75k	R&D Director	
	Approval of R & D Grant applications led by other organisations where UHB commitment is £75k-£125k	Medical Director	
	Approval of R & D Grant applications led by other organisations where UHB commitment is £125k-£500k	Chief Executive	
	Acceptance of UHB R & D Grants	Director of Finance on recommendation from R&D Office	Terms and Conditions can vary.
	Agreement to support costs in Grant applications led by external organizations.	Director of R & D (delegated to R&D Manager in absence of R&D Director)	For example, the UHB may be asked to confirm that NHS support costs included within Cardiff University grant applications are reasonable and will be supported from core NISCHR funding.
	Agreement of annual contract with National Institute for Social Care and Health Research (NISCHR)	Executive Medical Director and Executive Director of Finance	
	Day to day liaison with NISCHR including submission of bids/proposals/contract changes <£75k	R&D Director	

	Approval of NISCHR bids/proposals/contract changes >£75k	Executive Medical Director and Executive Director of Finance	

	Allocation of NISCHR R & D Income	Executive Director of Finance	Determined by Financial Strategy & Plan
	Allocation of Budget associated with NISCHR R & D Income	Executive Director of Finance with agreement of Executive Medical Director	The Budget allocation to Clinical Boards & Directorates is informed by the NISCHR Funding formula, R&D Strategy and recommendation from the R&D Director
	Approval of application to NISCHR for Excess Treatment Cost Funding	R&D Director	PI to complete with advice and input from Finance Department. R&D Director to approve in accordance with NISCHR requirements
	Authorization of Expenditure associated with NISCHR & other externally funded R & D Projects	Expenditure Authorised by the relevant Clinical Board/Directorate Manager & Clinical Board/Directorate R & D Lead	
	Non Commercial Site Agreements where financial transactions are <£75k	R&D Director	
	Non Commercial Site Agreements where financial transactions are £75k-£125k	Executive Medical Director	
	Non Commercial Site Agreements where financial transactions are £125k-£500k	Chief Executive	
	Service Level Agreements where there are financial transactions <£75k	R&D Director	UHB provides support to other NHS organizations for the conductance of trials.
	Service Level Agreements where there are financial transactions >£75k-£125k	Executive Medical Director	

	Service Level Agreements where there are financial transactions £125k-£500k	Chief Executive	
Inter Clinical Board trading arrangements	Agreeing inter Clinical Board trading arrangements which involve recharging other Clinical Boards for services	Executive Director of Finance based on proposal to go to HSMB	

Business cases for new investment	Sign off of business cases for new investment	Chief Executive and Executive Director of Finance	Should normally be via annual budget setting process
Welsh Risk Pool	Approve UHB input into Welsh Risk Pool policies and procedures and financial risk sharing arrangements	Executive Director of Finance and Executive Nurse Director	Note: Further attention required as risk pooling arrangements change

Workforce and Organisational Development Freedoms

Area	Delegated Matter	Delegated to	Comment
Appointment of staff	Appointment of staff within funded establishment (all staff groups excl Consultant Medical and Dental)	Clinical Board Directors , Corporate Directors and Assistant Directors.	Delegation applies when Clinical Board/Corporate Directorate is in financial balance otherwise special interim arrangements may apply, for example approval via vacancy clearing panel.
	Engagement/Recruitment of Consultant Medical/Dental Staff - New, Replacement and Retire and Return	Chief Operating Officer/Executive Medical Director and Executive Director of Finance	
	Engagement of staff outside funded establishment leading to increase in revenue cost but within budget.	Chief Executive	
Pay and conditions	Approval of additional increments to staff within budget and All Wales Terms and Conditions on recruitment.	Heads of Workforce and Organisational Development	
	Approval of revised job resulting in change in grade in line with agreed policy and All Wales Terms and Conditions	Heads of Workforce and Organisational Development	
	Staff re-grading in line with agreed policy and All Wales Terms and Conditions	Assistant Director of Workforce	
	Agreement to recommend to the Welsh Government payments in accordance with Recruitment and Retention Payments Protocol	Director of People and Culture	Recommendation will be made by the Director of Workforce and Organisational Development following the completion of the appropriate steps within the protocol.
	Agreement of variations affecting pay and hours of work for existing employees in line with agreed policy and All Wales Terms and Conditions	Directorate/Locality Managers or Heads of Departments for Corporate Departments	

	Authority to complete standing data forms affecting pay, new starters, variations and leavers	Line Managers	

	Authority to authorise travel, subsistence expenses and exam fees (within 3 months of incurring expenditure)	Line Managers	
	Authority to authorise travel, subsistence expenses and exam fees (after 3 months of incurring expenditure)	Heads of Finance	
	Authorisation of non travel related expenses incurred by staff	Line Managers	
Approval of relocation costs	Chief Executive and Directors	Reserved for Remuneration and Terms of Service Committee	
	Medical and Dental Staff	Executive Medical Director	
	All other staff groups	Executive Directors	
Approval of lease cars	Chief Executive and Directors	Reserved for Remuneration and Terms of Service Committee	
	Other staff	Executive Director	Refer to Lease Car Policy
Approval of mobile phones	Chief Executive	UHB Chair	
	Directors	Chief Executive	
	Other staff	Line Manager based on needs of role	Refer to Management, Issue and Use of UHB Mobile Phone Policy and

Short term engagement of additional staffing resources	Approval of Overtime/Bank	Line Managers	
	Authorisation Of Temporary/Locum Medical and Dental Staff - on contract (MEDACS)	Clinical Board Director or Executive Directors for Corporate Departments*	Refer to arrangements for engaging staff via MEDACS. Executive Directors to retain authority for "corporate departments" e.g. Infection, Prevention and Control and Public Health.
	Authorisation Of Temporary/Locum Medical and Dental Staff - off contract	Clinical Board Director or Executive Directors for Corporate Departments	

	Approval of other Agency staff where agency on GPS Contract - Nursing	Clinical Board Nurses or Assistant Directors for Corporate Departments	
	Approval of other Agency Staff - Nursing utilising Thornbury	Executive Nurse Director	
	Approval of other Agency Staff - Therapies and Health Sciences	Directors of Operations	New section capturing Health Scientists.
Providing staff to or seconding staff from other organisations (e.g staff with academic commitments, seconding staff to partner agencies)	See Commissioning and Provision of Services section		
Approval of Leave	Setting framework for numbers of staff on leave at any one time to maintain service delivery.	Line Managers	
	Annual leave approval	Line Managers	May be formally delegated by Line Manager to supervisor/team leader
	Annual leave - approval of carry forward in exceptional circumstances (up to a maximum of 5 days)	Clinical Board Directors, Clinical Board Nurses or Directors of Operations /Assistant Directors for Corporate Departments	This should also only be in exceptional circumstances

	Annual leave - approval of carry forward of leave accrued during periods of approved absence e.g. sickness/maternity leave in accordance with policy and statutory provisions	In accordance with policy	Refer to appropriate policy. Seek further advice from Heads of Workforce and OD/Assistant Director of HR if necessary.
	Approval of Special Leave (to include compassionate, carers and leave with pay)	Line Managers	Refer to Special Leave Policy
	Approval of Leave without pay	Directorate Managers/ Head of Department for Corporate Departments	Refer to Special Leave Policy
	Medical and Dental Staff Leave of Absence (Paid and Unpaid)	Clinical Board Director*	Executive Director for "corporate departments" e.g. Public Health and Infection, Prevention and Control
	Approval of Time off in Lieu	Line Managers	
	Approval of maternity and paternity leave in line with Policy	Line Managers	
	Sick Leave - return to work on phased basis to assist recovery in accordance with policy.	Line Managers	

	Extension of sick leave on full or ½ pay - Directors	Reserved for Board	
	Extension of sick leave on full or ½ pay - Other Staff	Chief Operating Officor/Executive Directors for Corporate Departments	
	Approval of study leave <£2k	Heads of Department	
	Approval of study leave >£2k (Requires amendment to Scheme of Delegation)	Clinical Board Directors or Executive Directors	
Approval of voluntary early release (VERS), redundancy and early retirement		THIS HAS NOT BEEN DELEGATED - RESERVED FOR REMUNERATION AND TERMS OF SERVICE COMMITTEE	

Disciplinary Investigations and Dismissal of Staff	Dismissal of staff - **in accordance with policy relevant to staff group.** Where the policy applicable to the case in question does not confer delegated power (for instance where Welsh Health Circular 90 (22) applies), the UHB may delegate its functions to a sub Committee of the Board, comprising 3 Board Members, none of the Members of the Sub Committee will have had previous involvement with the case.	Appropriate officer with advice of Heads of Workforce and Organisational Development or Sub Committee of the Board as the case may be.	Refer to appropriate policy.
Recognition of Staff Representatives		Director of People and Culture	**Note** There should be discussion and agreement with line managers before individuals are put forward for accreditation.
Extended Role Activities	Approval of nurses and other professionals to undertake duties/procedures which can be properly described as beyond the normal scope of practice.	Appropriate executive lead in association with the Executive Medical Director	
Approval of Consultant Medical and Dental Job Plans	All staff excluding Clinical Directors	Clinical Directors	
	Clinical Directors	Clinical Board Directors	

Corporate

Area	Delegated Matter	Delegated to	Comment
Attestation of sealing in accordance with Standing Orders	(a) custody	Director of Corporate Governance	
	(b) register of sealings	Director of Corporate Governance	
Declarations of Interest and Gifts, Hospitality and Sponsorship of individual employees	Set direction, policies and procedures	Director of Corporate Governance	Policies approved by the Board on the recommendation of the Audit Committee Note: Policy subject to review
	Maintaining the Register of Interests and the Register of Gifts, Hospitality and Sponsorship	Head of Risk and Regulation	
	Responsibility for declaring a relevant interest or the receipt of a gift, hospitality or sponsorship	All employees	Refer to Standards of Behaviour Framework including Declarations of Interest, Gifts, Hospitality and Sponsorship Policy
	Approval of the receipt of any gift, hospitality or sponsorship requires recording under the policy	Clinical Board Directors or Executive Directors	Gifts above £25 should not be accepted but if a gift is offered and it is not possible to decline it must be declared. Only gifts of low value can be accepted from commercial organisations e.g. pens, diaries. Hospitality only acceptable under very limited circumstances. Tickets to sporting events must not be accepted. Refer to above policy for full details.
	Corporate sponsorship - see Finance section	Executive Director of Finance	
Contractor's Responsibilities	Ensuring contractors and their employees are aware of any requirement to comply with Standing Orders and Standing Financial Instructions	Executive Director for area to which contract relates or Designated Capital Scheme Manager	Also refer to Finance and Commissioning sections.

Indemnity/Insurance Policies	Making arrangements to ensure that appropriate insurance/indemnity is in place - UHB wide	Director of Corporate Governance	

	Making arrangements to ensure that appropriate insurance/indemnity is in place - Clinical Board Specific	Directors of Operations Assistant Directors for Corporate Departments	Note: There are strict rules regarding the UHBs ability to purchase commercial insurance. Advice should be sought from the Governance Department
Risk Management	Set direction, policies and procedures	Director of Corporate Governance	Policies approved by the Audit Committee
	Management and maintenance of the Corporate Risk Register and Assurance Framework	Head of Risk and Regulation	Refer to Risk Register and Risk Assessment Procedure
	Management and maintenance of the Clinical Board Risk Registers	Directors of OperationsAssistant Directors for Corporate Departments	Refer to Risk Register and Risk Assessment Procedure
	Management and maintenance of Directorate Risk Registers	Directorate Managers or Heads of Department for Corporate Departments	Refer to Risk Register and Risk Assessment Procedure
Relationships with Press	Non-Emergency General Enquiries	Director of Communications, Manager on call or Executive Director	
	Within Hours		
	Outside Hours		
Documents for Legal Proceedings	Approve and sign documents necessary either in legal proceedings or resolution of the Board	Refer to Standing Orders and other sections regarding specific categories of documents.	

Legal advice	Engagement of UHB Solicitors and contract management	Director of Corporate Governance	
	Authority to seek legal advice - all issues	Director of Corporate Governance	
	Authority to seek advice on specific legal issues - clinical issues excluding mental health act legislation	Director of Corporate Governance	
	Advice regarding interpretation of Mental Health Act Legislation	Mental Health Act Manager for urgent items. Otherwise via Director of Corporate Governance	

	Advice regarding interpretation of Mental Capacity Legislation/Deprivation of Liberty	Mental Capacity Manager for urgent items. Otherwise via Corporate Governance	
	Advice regarding human resources legislation	Assistant Director of Workfoce	
	Advice regarding property matters (relating to capital works and disposal of property	Director of Capital, Estates and Facilities	
	Advice regarding clinical negligence and personal injury claims	Claims Managers	
Information Governance and Data Protection	Set direction, policies and procedures	Director of Digital Health Intelligence	Policies approved by Digital Health Intelligence Committee
	Information risk policy and statement of internal control in respect of information governance	Director of Digital Health Intelligence	As above
	Operational procedures within the Clinical Boards and Corporate Directorates and ensuring compliance with legal requirements, guidance and best practice.	Directors of Operations or Assistant Directors of Corporate Directorates	
	Provision of advice and support to Clinical Boards and Corporate Directorates	Head of Information Governance	

	Corporate training programme - development and maintenance	Head of Information Governance	
	Clinical Board and Corporate Directorates training programmes - local development and implementation	Directors of Operations or Assistant Directors of Corporate Directorates	
	Responding to the Records Management NHS Code of Practice - Subject Access Requests - General Enquiries	Head of Health Records	
	Responding to Data Protection Act - Subject Access Requests - specific to data protection queries and best practice	Director of Digital Health Intelligence	
	Data Protection Breaches - refer to Quality and Patient Experience section re incidents		
Caldicott Standards	Caldicott Standards and Action Plan	Executive Medical Director	

Freedom of Information Act Compliance	Set direction, policies and procedures	Director of Digital Health Intelligence	Policies approved by Digital Health Intelligence Committee
	Acknowledgement of request and liaison with requester	Director of Digital Health Intelligence	
	Ensure framework in place and arrangements for providing information to facilitate provision information to requester	Directors of Operations or Assistant Directors of Corporate Departments	
	Approval of response prior to sending to requester	Clinical Board Director or Executive Directors	
	Approval of response where it found that information is not held or will be refused under an appropriate exemption	Head of Information Governance	
	Sending final response to requester	Director of Digital Health Intelligence	

	Management of and response to any complaints received under the Freedom of Information Act	Director of Digital Health Intelligence	
Information Sharing Protocols (ISPs)	Set direction, policies and procedures in accordance with Welsh Accord for Sharing Personal Information	Director of Digital Health Intelligence	
	Operational procedures within the Clinical Boards and Corporate Directorates and ensuring compliance with legal requirements, guidance and best practice.	Directors of Operations or Assistant Directors of Corporate Directorates	
	Provision of advice and support and overall co-ordination	Head of Information Governance	
	Development of ISPs	Heads of Operations and Delivery or Assistant Directors of Corporate Departments	
	Approval and sign off of ISPs	Director of Digital Health Intelligence	
	Archiving of ISPs in corporate library	Head of Information Governance	
	Corporate training programme - development and maintenance	Head of Information Governance	
	Clinical Board and Corporate Directorates training programmes - local development and implementation	Directors of Operations or Assistant Directors of Corporate Directorates	
Data Quality	Set direction , policies and procedures	Director of Finance	

	Ensuring data input into systems is of appropriate quality, accuracy and timeliness and in accordance with UHB policies and procedures	All Employees	
	Ensuring data definitions are clear and in line with Welsh Government requirements	Assistant Director - Performance and Information	
	Ensuring that there is a nominated lead for all external data submission	Clinical Board Director, Clinical Director or Assistant Director responsible for data submission	
	Ensuring the accuracy and timeliness of data submissions and that any issues highlighted as appropriate	Nominated Lead for external data submission	

Higher Degree of Delegation and Earned Autonomy at Level 2 and 3

Note: The matters delegated within the wider Scheme of Delegation are delegated at Level 1 - the matters below are additional freedoms delegated to those Clinical Boards assessed as operating at Levels 2 and 3. **Quality, Safety and Experience**

Area	Delegated Matter	Level 2	Level 3	Comment
Concerns/Complaints Management	Sign off of final draft prior to sending to complainant			See Comments in main QSE Section re Concerns Management
	Grade 1	Clinical Boards to manage complete process after initial grading of concern. Copy of response to complainant to be sent to Concerns Department following signature	As Level 2	This level of authorisation is dependent on performance and Executive Nurse Director will formally advise each CB when they can proceed to this level of autonomy.
	Grade 2		Clinical Boards to manage complete process after initial grading of concern. Copy of response to complainant to be sent to Concerns Department following signature	
	Some Grade 3 concerns		Clinical Boards to manage complete process after initial grading and on advice of Concerns Department. Copy of response to complainant to be sent to Concerns Department following signature	

Workforce and Organisational Development

Area	Delegated Matter	Level 2	Level 3	Comment
Appointment of staff	Appointment of staff within funded establishment (all staff groups excl Consultant Medical and Dental)	Clinical Directors and Community Directors	Clinical Directors and Community Directors	Delegation applies when Clinical Board/Corporate Directorate is in financial balance otherwise special interim arrangements may apply, for example approval via vacancy clearing panel.
Pay and conditions	Staff re-grading in line in line with agreed policy and All Wales Terms and Conditions	Assistant Director of Workforce	Assistant Director of Workforce	
Short term engagement of additional staffing resources	Authorisation Of Temporary/Locum Medical and Dental Staff - on contract (MEDACS)	Clinical Board Director	Clinical Board Director	Refer to arrangements for engaging staff via MEDACS. Executive Directors to retain authority for "corporate departments" e.g. Infection, Prevention and Control and Public Health.

Approval of Leave	Medical and Dental Staff Leave of Absence (Paid and Unpaid)	Clinical Board Director	Clinical Board Director	

Commissioning and Provision of Services To and From Other Organisations

Area	Delegated Matter	Level 2	Level 3	Comment
Provision of services by UHB to other organisations excluding Welsh Health Specialist Services Committee (WHSSC) and provision of staffing	Approval to provide **new** healthcare services to new and existing organisations		Clinical Board Director	

Executive Director Responsibilities Delegated Matter	Corresponding Legislation if applicable	Responsible Officer
Freedom of Information - ensuring appropriate UHB response	Freedom of Information Act 2000	Director of Digital Health Intelligence
Information Governance	Data Protection Act 1998	Director of Digital Health Intelligence
Information Governance	Common Law duty of Confidentiality	Director of Digital Health Intelligence
Information Governance	Access to Health Records Act 1990	Medical Director
Mental Health	Mental Health Act 2007	Chief Operating Officer
Mental Health	Mental Health Measure	Chief Operating Officer
Human Rights	Human Rights Act 1998	Executive Director of People and Culture
Equality	Equality Act 2010	Executive Director of People and Culture
Equality	Socio-economic Duty - Equality Act 2010 (Authorities subject to a duty regarding Socio-economic Inequalities) (Wales) Regulations 2021	Executive Director of Public Health

Equality	Race Relations Act	Executive Director of People and Culture	
Equality	Welsh Language Act	Executive Director of People and Culture	
Public Interest/Whistleblowing	Public Interest Disclosure Act / Whistleblowing	Executive Director of People and Culture	
Health and Safety - Staff , Students, Contractors and Visit	Health and Safety at Work Act and Regulations	Executive Director of People and Culture	
Health and Safety - Patients	Health and Safety at Work Act and Regulations	Executive Nurse Director	
Health and Safety	Control of Substances Hazardous to Health Regulations	Executive Director of People and Culture	
Fire Safety	Fire Safety legislation	Executive Director of People and Culture	
Environmental	Environmental Protection Act	Executive Director of People and Culture	
Health and Safety	Violence and Aggression legislation	Executive Director of People and Culture	
Protection of Children	Children Act 1989, 2004	Executive Nurse Director	
Protection of Children	Protection of Children Act 1999	Executive Nurse Director	
Protection of Adults and Vulnerable Groups	Care Standards Act	Executive Nurse Director	
Protection of Vulnerable Groups	Protecting Vulnerable Groups Act 2006	Executive Nurse Director	
Protection of Vulnerable Groups	Sexual Offences Act 2003	Executive Nurse Director	
Protection of Adults	Mental Capacity Act 2005	Executive Nurse Director	
Protection of Adults and Vulnerable Groups	Deprivation of Liberty Safeguards	Executive Nurse Director	
Concerns	NHS Redress Measure	Executive Nurse Director	
Calculating nurse staffing levels for designated acute medical and surgical inpatient wards	Nurse Staffing Levels (Wales) Act 2016	Executive Nurse Director	
Food Hygiene	Food Act (Food Hygiene Regulations)	Executive Director of Finance	
Clinical Standards	Royal College Standards	Medical Director	
Standards	Standards for Health Services in Wales	Executive Nurse Director	UHB217

Decontamination		Executive Director of Therapies and Health Sciences
Nutrition		Executive Director of Therapies and Health Science
Health and Safety	Ionising Radiation (Medical exposure) Regulations	Executive Director of Therapies and Health Science
Medicines Management	Medicines legislation (European, UK and Welsh)	Executive Medical Director
Clinical Standards	National Institute for Clinical Excellence Directives	Executive Medical Director
Clinical Standards and Patient Safety	National Patient Safety Agency Directives	Executive Nurse Director
Patient Safety	Blood safety and quality regulations	Executive Medical Director
Patient Safety	Human Tissues Act 2004	Executive Medical Director
Patient Safety	Clinical trials directives and regulations	Executive Medical Director
Patient Safety	Organ Donation	Executive Medical Director
Employment/staff relations	Employment legislation	Executive Director of People and Culture
Patient Safety	Medical Device Directives and Regulations	Director of Therapies and Health Sciences
Employment/staff relations	European Working Times Directive	Executive Director of People and Culture
NHS Provision	NHS Wales (2006) Act	Executive Director of Strategic Planning
Commissioning	EU Directive on cross border healthcare	Executive Director of Strategic Planning
Public Safety	Civil Contingencies Act 2004	Executive Director of Strategic Planning
Protection of Adults and Vulnerable Groups	Carers Strategy Measure	Executive Nurse Director
Public Health	Smoke Free Premises etc Regulations	Executive Director of Public Health
Public Health	Health Promoting Hospital Vending Directions	Executive Director of Public Health
Finance	NHS Wales Statutory Financial Duties	Executive Director of Finance
Charities	Charities Act	Executive Director of Finance
Finance and probity	Procurement Legislation	Executive Director of Finance
Information Governance	Computer Misuse Act 1990	Director of Digital Health Intelligence
Continuing Health Care	-	Chief Operating Officer
Funded Nursing Care	-	Chief Operating Officer
Primary Care Contractor management and performance	-	Chief Operating Officer
Admission to Performers List	-	Executive Medical Director
Removal of violent patients from GMS services	Health and Safety at Work Act and Regulations	Chief Operating Officer
Accreditation of enhanced services	-	Chief Operating Officer supported by Executive Medical Director
Dental QAS returns	-	Chief Operating Officer

Primary Care Out of Hours Arrangements		Chief Operating Officer
Representation in Statutory Partnerships	-	Executive Director of Strategic Planning
Unified Assessment		Chief Operating Officer
Care Homes Sector		Chief Operating Officer
Performance Management Arrangements	-	Executive Director of Finance
Receipt and Opening of Quotations	Procurement Legislation	Executive Director of Finance UHB217
Cancer Network		Executive Medical Director
Cardiac Network		Chief Operating Officer
Access Targets/Referral to Treatment Times		Chief Operating Officer
Unscheduled Care		Chief Operating Officer
LTA/HCAs		Executive Director of Finance
Land, buildings and assets		Executive Director of Finance
Facilities and Estates Management		Executive Director of Finance
Sustainable Development		Executive Director of Strategic Planning
WHSCC Relationship - Commissioning		Executive Director of Strategic Planning
WHSCC Relationship - Provider		Executive Director of Finance
Primary Care Estates Investments and Approvals		Executive Director of Strategic Planning
Co-ordination of delivery plans (delivery through COO)		Executive Director of Strategic Planning
Clinical Strategy		Executive Director of Strategic Planning
Information Management and Technology (IM&T)		Director of Digital Health Intelligence
Barring and Disclosure		Executive Director of People and Culture
Procurement, Issuing Tenders and Post Tender Negotiations		Executive Director of Finance

External Communications including Media		Chief Executive
Patient Group Directives		Executive Medical Director
Individual Patient Commissioning		Executive Director of Strategic Planning
Caldicott Guardian		Medical Director
Public Health		Executive Director of Public Health
Commissioning		Executive Director of Strategic Planning
Professional Nursing and Midwifery Workforce Standards Education Regulation		Executive Nurse Director
Professional Medical and Dental Workforce Standards Education Regulation Revalidation		Executive Medical Director
Professional Therapies and Health Sciences Workforce Standards Education Regulation		Executive Director of Therapies and Health Sciences

UHB217

Workforce - excluding above Standards Education Regulation		Executive Director of People and Culture
Patient Experience		Executive Nurse Director
Royal College Guidelines - Implementation and Standards		Executive Medical Director
National Institute for Clinical Excellence (NICE)		Medical Director
Research and Development		Medical Director

Delivery of Clinical Services		Chief Operating Officer
Continuous Service Improvement (Clinical Services)		Chief Operating Officer
Continuous Service Improvement (Corporate Functions)		Executive Directors
Clinical Coding		Director of Digital Health Intelligence
Information		Director of Digital Health Intelligence
Data Quality		Director of Digital Health Intelligence
Corporate Governance		Director of Corporate Governance
Risk Management		Director of Corporate Governance
Intellectual Property Rights and Commercialisation		Executive Director of Finance
Information Governance - Senior Information Risk Owner (SIRO)		Director of Digital Health Intelligence
Professional Public health standards Education; revalidation and regulation		Executive Director of Public Health (discharged through Public Health)
Area Planning Board - Substance Misuse		Executive Director of Public Health
Relationships with Public Services Boards		Executive Director of Strategic Planning

UHB217

Report Title:	Annual Report of the Director of Public Health 2022 (published 2023): *Recall of the wild: reconnecting with and restoring nature for biodiversity and health*			Agenda Item no.	7.6
Meeting:	Board	Public	X	Meeting Date:	30/11/2023
		Private			
Status *(please tick one only):*	Assurance		Approval	X	Information
Lead Executive Title:	Executive Director of Public Health				
Report Author (Title):	Specialty Registrar in Public Health				

Main Report
Background and current situation:

Background
This year's Annual Director of Public Health Report is focused on biodiversity and health, with an emphasis on the importance of reconnecting with and restoring nature.

'Biodiversity' is a term used to describe the huge variety of life on Earth, referring to every living thing and different habitats. High biodiversity is vital for our health and well-being, with strong evidence of the benefits and value nature can offer, but during the course of human history it has been in decline globally and locally.

Under the Well-being of Future Generations (Wales) Act and the Environment (Wales) Act, Cardiff and Vale UHB has a responsibility to produce plans, with monitoring against them, for the maintenance and enhancement of green spaces and biodiversity for both current and future generations.

This report sets out recommendations for individuals, public bodies and other organisations to take action to restore biodiversity levels and improve the health of both us and the wider environment.

The nature emergency
A nature emergency was declared by the Senedd and both Cardiff and Vale of Glamorgan local authorities in 2021. Since 1970, 69% of global biodiversity has been lost, with 1 in 6 species in Wales at risk of extinction. The main drivers of biodiversity loss are: human land-use, climate change, pollution, invasive non-native species and species overexploitation. There is now evidence that a 6th mass extinction event is underway, caused by humans. The nature emergency isn't a future problem, it is happening right now, and has been for many decades.

Nature and health
Nature can help with a number of the health challenges currently experienced in Cardiff and the Vale of Glamorgan.

Benefits to health are achieved through pathways including reduced sedentary behaviour, cleaner air, boosting immune systems, provision of healthy and affordable food, improvements in mental well-being, encouragement of social interaction and physical activity, climate change mitigation, and pharmaceutical opportunities. However, there are inequities in Cardiff and the Vale of Glamorgan in access to nature and green spaces, with those in the most disadvantaged areas having the least access at the moment, but the potential for the greatest gains.

Reconnecting with nature
'Nature connectedness' is a term that refers to our connection with nature and whether we feel a part of it, with stronger nature connectedness leading to improved wellbeing and stronger pro-nature conservation behaviours. However, the UK has low levels of nature connectedness relative to other European countries, with the potential health benefits being missed.

To achieve reconnection with nature in Cardiff and the Vale of Glamorgan we need to: ensure there is **nature nearby**; **spend time with nature**; and **notice nature**. Things that can help with this include nature prescribing and 'forest bathing' (spending time in woods), both of which have strong evidence linking them to improved health. There are Local Nature Partnerships in both Cardiff and the Vale of Glamorgan, which can provide support and signposting to local activities for people to get involved with.

Restoring nature
There are a number of agreements, laws and plans at the international, national and local level, along with a multitude of guidelines, resources and specialist groups, to support organisations and individuals with restoring nature. Section 6 of the Environment (Wales) Act 2016 is of particular importance to public organisations in Cardiff and the Vale of Glamorgan, placing a duty on them to maintain and enhance biodiversity and report progress against doing so.

To restore nature we need to: **understand** the status of, value of and threats to biodiversity; **protect** current biodiversity by preventing and mitigating further harm and loss; and **create** more biodiverse environments by enhancing degraded areas and creating new habitats. Actions to achieve this can be taken at multiple levels, including at international, governmental, organisational, community and individual levels. The report provide advice, suggestions and links to resources for doing this.

Recommendations
The report sets out 20 recommendations across individuals, public bodies and organisations in Cardiff and the Vale of Glamorgan that can help the population reconnect with and restore nature, in order to improve the health and well-being of our residents, including nine for Cardiff and Vale UHB itself. The report will be shared with partners via the PSBs and RPB. It is proposed the recommendations for the Health Board should be reviewed for incorporation within the Acting for the Future programme in the revised Shaping Our Future Well-being Strategy.

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

Biodiversity loss is having detrimental effects on the health of the population of Cardiff and the Vale of Glamorgan, impacting both physical health and mental wellbeing. As advocated for by the World Health Organisation and United Nations Convention on Biodiversity, and called for by the Environment (Wales) Act 2016 and Wellbeing of Future Generations (Wales) Act, the aim of this report is to advocate for the need to increase biodiversity and improve the health of our environment and population.

The report, which is located in the supporting documents folder of the meeting, sets out 20 recommendations aimed across individuals, public bodies and organisations in Cardiff and the Vale of Glamorgan, covering the themes of reconnecting with and restoring nature for biodiversity and health. This includes nine recommendations for Cardiff and Vale UHB itself.

Recommendation:

The Committee is requested to:

a. Approve the report.
b. Support the recommendations, including the plan to review recommendations specific to the UHB for inclusion in the Acting for the Future strategic programme.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please place an "X" in the below boxes 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 place an "X" in the below boxes 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
Implementation of the recommendations in this plan will reduce the risk of adverse health amongst our population. It will also address the risk of the Health Board not meeting statutory responsibilities under the Environment (Wales) Act 2016 and the Wellbeing of Future Generations (Wales) Act.
Safety: Yes
The safety of our population would be improved against environmental risks such as extreme weather events, as nature solutions can help in adaptation to a changing climate.
Financial: Yes
Many of the recommendations are cost-neutral and will have indirect cost savings through improvements in employee health; where implementation of recommendations requires a cost these would be taken through normal governance mechanisms for review.
Workforce: Yes
Implementation of the report recommendations by the Health Board will improve employee health and well-being.
Legal: Yes
Implementing the report actions will address the Health Board meeting statutory responsibilities under the Environment (Wales) Act 2016 and the Wellbeing of Future Generations (Wales) Act.
Reputational: Yes
Implementation of these recommendations by the Health Board will assist with meeting the requirements of the Section 6 Duty of the Environment (Wales) Act 2016.
Socio Economic: Yes
Those most economically disadvantaged have the least access to accessible, natural green space and the associated health benefits. Implementing the recommendations of this report will help address these.
Equality and Health: Yes
A number of the actions in this plan involve addressing health inequalities amongst high-risk populations to improve access to testing and treatment for hepatitis.
Decarbonisation: Yes
A number of the actions in the recommendations involve increasing tree cover and green spaces, which will help reduce carbon levels.

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

Report Title:	Co-production, Engagement and Consultation Framework and Toolkit			Agenda Item no.	7.7
Meeting:	Board	Public	X	Meeting Date:	30th November 2023
		Private			
Status *(please tick one only):*	Assurance		Approval	X	Information
Lead Executive Title:	Abigail Harris – Executive Director of Strategic Planning				
Report Author (Title):	Sarah Tipping – Head of Strategic Partnerships and Engagement				

Main Report
Background and current situation:

Following the implementation of the Health and Social Care (Quality and Engagement) (Wales) Act and establishment of Citizen Advice Body (Llais) in April 2023 it was highlighted that the organisation would benefit from a consistent approach to its co-production, engagement and consultation work. Therefore, a framework and toolkit has been developed for colleagues to use across the organisation.

The framework sets out the values and principles which we should strive to follow in this area of work, the toolkit is a practical document which will help guide colleagues through the process of planning and delivering their activity.

As part of the development of the framework and toolkit we have shared it with a range of partners for comment, including:

- All Wales Leads for Communications and Engagement
- The Consultation Institute
- Llais
- Executive Directors including CEO
- Operations Delivery Group
- Stakeholder Reference Group
- Patient Experience Team
- Communications and Engagement Team
- Equity and Inclusion Team
- Governance Team
- Planning Team
- Regional Partnership Board Communications and Engagement Lead
- Co-production Leads

The Framework has taken into consideration the latest Welsh Government Guidance on engagement and consultation.

Once approved, a training package will be developed, based off the framework and toolkit, to further support colleagues in their approach to co-production, engagement and consultation.

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

The Co-production, Engagement and Consultation Framework will help the Health Board will help facilitate a more systematic approach to the involved of people as we continue to develop our services. This means that those who use our services now and into the future can help us shape our services as they continue to evolve, and we introduce changes. Health services do no remain static – they change in response to new technologies, advances in approaches, changes in demand and changes circumstances that can impact service sustainability.

When first developing Shaping Our Future Wellbeing in 2013 we set out the importance of work with people – our patients, our communities, our staff and key stakeholders – in order for us to make the best decisions about how to change and improve our services over time. This principle remains central to our refreshed strategy Shaping Our Future Wellbeing to 2035. 'Working together' is one of the underlying principles, and the need to work effectively and constructively with people who use our services, have lived experience, or could use our services in the future is a theme which runs through each of the four strategic objectives: putting people first, delivering outstanding quality, delivering in the right places and acting for the future. The strategy describes how we will work to deliver our vision, strategic objectives and key priorities, highlighting the importance of a participatory approach:

To deliver our strategy we will work in a way that is participatory. This means enabling and empowering people to be involved in shaping our plans and taking an active role in their care and health as equal partners. Co-production will be at the heart of how we improve our services and we will act on regular and timely feedback from those who use and deliver our services.

This Framework and the supporting toolkit and training package will help us work in a participatory way, enabling and empowering people to help us shape services going forward. The Framework should be read in conjunction with our Equality Diversity and Inclusion Plan – both documents signal the importance of Equality Health Impact Assessments to help us understand how our proposals for change impact on difference groups, and those groups that are heard less.

Recommendation:

The Committee is requested to:

a) Approve the framework and toolkit for use across the organisation.
b) Support the development of a supporting training package.
c) Review the success of the framework and toolkit in 12 months.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please place an "X" in the below boxes 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	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 place an "X" in the below boxes as relevant

Prevention		Long term		Integration		Collaboration	X	Involvement	X

Impact Assessment:

Please state yes or no for each category. ***If yes please provide further details.***

Risk: Yes

There is a risk if we do not undertake effective engagement in the development of our strategic plans and proposals for significant service change.

Safety: No
N/A
Financial: Yes
There will be costs associated with large scale engagement and consultation. Funding will need to be identified as there is no central budget to support engagement and consultation activities.
Workforce: No
Legal: Yes
There is a legal duty to engage with people about significant service changes and guidance has recently been updated by Welsh Government.
Reputational: Yes
Should the Health Board fail to undertake effective engagement, its reputation could be damaged by any negative publicity or legal challenge.
Socio Economic: Yes
There is a need to ensure we consider the socio-economic duty explicitly when we are consider our strategy and strategic and operational plans.
Equality and Health: Yes
Equality Health Impact Assessments (EHIA) are a key part of the Co-production, Engagement and Consultation Framework: EHIA toolkit - Cardiff and Vale University Health Board (nhs.wales)
Decarbonisation: Yes
Decarbonisation impact needs to be considered as part of the assessment any changes we are proposing to the way we deliver services.

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

Report Title:	Stakeholder Reference Group Chair			Agenda Item no.	7.8
Meeting:	Board	Public	X	Meeting Date:	30 November 2023
		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 Stakeholder Reference Group's (SRG) role is to provide independent advice on any aspect of Cardiff and Vale University Local Health Board (LHB) business.

Membership is drawn from within the area served by CAVUHB involving a range of bodies and groups operating within our communities.

The Chair acts as the link between the SRG's activities and the Board. They may also be an associate member of the Board. The maximum term as Chair is 3 years.

Following the completion of the term of office of the previous Chair, Sam Austin, a new Chair needs to be appointed.

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

The Chair is nominated from within the membership of the SRG. All members are asked for expressions of interest, they are then asked to set out to the rest of the SRG their background and suitability for the role. The SRG then decide, through a vote on their nomination. This will take place at their meeting on 28 November 2023.

This nomination must then be considered by the Board who must then submit their recommendation on the nomination to the Minister for Health and Social Services, who will make the appointment.

At the time of writing and publication, the SRG's nomination is not known and so the detail will be provided verbally in the Board meeting for a decision on whether to recommend the individual to the Minister.

Recommendation:

The Board is requested to:

- **Note** the verbal update from the Director of Corporate Governance on who has been nominated by the SRG to assume the role as Chair
- **Support** the nomination and **recommend** the individual to the Minister

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
Safety: Yes
Financial: No
Workforce: Yes
Legal: No
Reputational: Yes
Socio Economic: Yes
Equality and Health: Yes
Decarbonisation: No

Approval/Scrutiny Route:	
SRG	SRG will vote on the matter and provide a nomination to Board

Saunders.Nathan
20/11/2023 15:51:45

Report Title:	Cardiff and Vale University Health Board, Safeguarding Annual Report 2022/2023			Agenda Item no.	7.9
Meeting:	Board	Public	x	Meeting Date:	30.11.2023
		Private			
Status *(please tick one only):*	Assurance		Approval	x	Information
Lead Executive:	Jason Roberts, Executive Nurse Director.				
Report Author (Title):	Linda Hughes-Jones, Head of Safeguarding, Cardiff and Vale University Health Board (UHB)				

Main Report
Background and current situation:

The enclosed Safeguarding Annual Report enables the Board to have a vision of the safeguarding function undertaken within the UHB. This encapsulates examples such as safeguarding mandatory training, collaborative working with partner agencies and the current themes of safeguarding concerns impacting on people within the UHB region.
The report highlights the breadth and depth of the safeguarding workstream, the UHB commitment required to maintain and sustain an ever-increasing risk to the safety and well-being of people accessing health care and those employed within the UHB.
Throughout the past year the UHB has worked tirelessly towards the prevention, early detection and intervention of cases involving potential abuse and neglect.

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

The achievements made by the UHB Corporate Safeguarding Team, the ongoing themes and forecast for the following year.
The report demonstrates the increased safeguarding demand across the region on a multi-agency basis. An increase in abuse and neglect of children and adults at risk is evident and demonstrated through the number of referrals submitted to Local Authorities (LA).
The mandatory safeguarding training commitment including safeguarding children, adults at risk and the Violence Against Women, Domestic Abuse and Sexual Violence, National Training Framework validates the number of employees that require the Group 2 training which is fully delivered by the corporate safeguarding team. This training package is required for all public facing staff and is updated every two years.
Professional Allegations/ Concerns has a direct impact on UHB employees, there has been a noticeable increase in the number of employees disclosing domestic abuse and accessing services from the UHB Health Independent Domestic Violence Advisor (IDVA).
Recognition and acknowledgement of the Clinical Boards involvement in safeguarding processes with support from the corporate safeguarding team. There are 50 Health Lead Practitioners (HLPs) actively participating in adult at risk cases across the UHB, supported by the Executive Team, Directors of Nursing, People's Services and the Safeguarding Team to ensure the prevention of abuse and neglect, safety of people and staff, open transparency and Candor to mitigate any risk whilst in our care or employment.

Recommendation:

The Committee is requested to: Read the report and give authority for the report to be shared with the Cardiff and Vale of Glamorgan, Regional Safeguarding Board and partner agencies.

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	
5.	Have an unplanned (emergency) care system that provides the right care, in the right place, first time	x	10.	Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	x

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

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

Approval/Scrutiny Route:	
Committee/Group/Exec	Date: November 2023

Saunders,Nathan
20/11/2023 15:51:45

GIG CYMRU NHS WALES

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

Safeguarding

Children and Adults at Risk

Annual Report 2022/2023

Contents

1. Introduction 02
2. Training 08
3. Safeguarding Activity 12
4. Audit, Survey, Professional Presentations and Publications 18
5. Safeguarding Supervision 22
6. Expert Advice 24
7. Safeguarding Team Achievements 42
8. Forecast for 2021-2022 43
9. Summary 46

Safeguarding
Children and Adults at Risk

Introduction

This report provides a comprehensive overview of the efforts and achievements made by the Cardiff and Vale University Health Board (UHB) in protecting and promoting well-being of children and adults at risk within the community and when they may receive acute care. It highlights the progress made, challenges faced and outlines strategies for the future.

Safeguarding people from abuse and neglect is a paramount responsibility that requires vigilance and dedication from all stakeholders involved. Throughout the past year the UHB has worked tirelessly towards the prevention, early detection and intervention of cases involving potential abuse and neglect. The UHB works within the legislative guidance, policies and procedures to support people within the region by implementing and developing initiatives to recognise indicators of abuse and neglect.

The 2022/23 UHB Safeguarding Report portrayed a forecast for the coming year that considered the work to be undertaken by the integrated corporate Safeguarding Team. Areas highlighted formed part of the work plan for the team to ensure that progress has been made and projected development is maintained. The forecast areas are shown, to demonstrate advancement made:

Action	Outcome
Introduce a new multi-agency approach to reviews through the Single Unified Safeguarding Review (SUSR)	Completed Green
All Clinical Boards recognises that improved mandatory training compliance is required post COVID-19 - measures to be introduced to improve the current situation	Completed Green
IDVA RE pilot in ED for children aged 13-16 years old addressing potential relationship difficulties	Completed Green
Introduce a new regional multi-agency approach to reviews through the Single Unified Safeguarding Review (SUSR)	Completed Green
Introduction of the Home Office driven Offensive Weapons Homicide Reviews as a pilot in South Wales region	Completed Green
Update PREVENT slides on safeguarding training pack	Completed Green
MARF teaching for staff in Children's Hospital of Wales	Completed Green
Update Level 2 training package for Volunteers	Completed Green
Raise awareness of multi-agency learning following the publication of The Child Safeguarding Practice Review Panel "Child Protection in England" National Review of the death of two children and a local child death case	Completed Green
Update of ED Casualty Card to include Human Trafficking and FGM	Completed Green
Ensure Domestic Abuse ED markers are in place following discussion at MARAC/ Daily Discussions	Completed Green
Update of the UHB Professional Allegations/ Concerns process	Completed Green
Report the data of health workload within Cardiff MASH	Completed Green
Raise awareness and consider survey with HVs to evaluate knowledge and use of PRUDiC process and Overlay	Completed Green
Participate in a PhD study around facilitating safeguarding group supervision	Ongoing Amber
Update UHB Domestic Abuse policies and procedures	Ongoing Amber
Consider a new logo for the UHB Safeguarding Team designed by the Youth Board	Ongoing Amber
Provide the Executive Team with a monthly Informatics Dashboard on Safeguarding activity across the UHB	Ongoing Amber
Audit of assault cases referred to Violence Prevention Team in Paediatric Emergency Department	Ongoing Amber
Improve the safeguarding dashboard recording of Deliberate Self-Harm and Suicide in Young People	Ongoing Amber
Safeguarding recovery plan for school nurses to consider the impact of lockdown on children during COVID-19 and service provision available	Ongoing Amber
Report the data of health workload within Cardiff Multi-Agency Safeguarding Hub (MASH)	Ongoing Amber

Action	Outcome
Expansion of the Routine Enquiry for Child/ Adult Sexual Abuse within the Midwifery Service, in addition consider evaluation of the pilot in collaboration with Centre of Excellence for child Sexual Abuse	Ongoing Amber
Prioritising a targeted increase in mandatory safeguarding training, to achieve a UHB level of 75%	Ongoing Amber
Introduce a standardised proforma to be completed by GPs, Practice Nurses and DoSH when sexual concerns are indicated	Ongoing Amber
Pilot in Paediatric Emergency Department with Action for Children to consider engagement with children and young people in the community to minimise school related violence	Ongoing Amber
Introduce a standardised proforma to be completed by GPs, Practice Nurses and the Department of Sexual Health (DOSH) when sexual concerns are indicated	Ongoing Amber
Introduce Safeguarding Documentation to be used by GP practices across the Cardiff and Vale region. Collaborative work with Children's Services	Ongoing Amber
Demonstrate partnership working to engage with communities in relation to anxieties around Female Genital Mutilation (FGM) reporting	Ongoing Amber
Report evaluation of HV preceptorship training	Deferred Red
Undertake an annual internal UHB Pressure Damage audit across all Clinical Boards	Deferred Red
Audit of young people placed on Acute Adult Mental Health wards	Deferred Red
Audit of safeguarding cases discussed in supervision	Deferred Red
Audit of the use of the safeguarding chronology documentation in acute paediatrics	Deferred Red
Audit the effectiveness of the multi-agency contextual safeguarding pathway within health	Deferred Red
Consider a new logo for the UHB Safeguarding Team, designed by the Youth Board	Deferred Red
Resume UHB Safeguarding Team Newsletter	Deferred Red
Survey of Mental Health staff in relation to safeguarding support from UHB team	Deferred Red

The work undertaken and completed in green is significantly less than previous years' achievements. This is a reflection, of the increased demand of safeguarding work across the region on a multi-agency basis. The corporate safeguarding team has experienced an increase in all forms of abuse and neglect through submitted referrals for children an adults at risk. There has also been an observation that individual cases are more complex, drawing on a number of service areas and organisations to work together to ensure that a safe plan is in place to provide reasonable assurance of safe care and support for individuals. This is recognised through the Regional Safeguarding Board (RSB) partners.

Forecast Population Growth within the Cardiff and Vale University Health Board (UHB) Region

To continue to improve and develop, the UHB Safeguarding Team will consider the growing population of the region to guarantee that the local Public Health

plan for 2020-23 is respected and provides a benchmark for safeguarding service delivery. The current report states that the population of Cardiff is growing at nearly 1% per year, or around 37,000 over the next 10 years. The population of Cardiff and Vale is nearly 500,000 at present with a forecast of 400,000 in Cardiff alone by 2028. The average age of people in the region is increasing and expected to increase for those over 85 years by 20% over the next five years in the Vale and nearly 50% over 10 years. The region is recognised as one of the most ethnically diverse populations in Wales, with one in five people from a Black, Asian and Minority Ethnic background. These statistics, as well as health inequalities identified in specific neighbourhoods across Cardiff and the Vale of Glamorgan, impact on safeguarding and well-being of individuals and families, resulting in targeting services to meet demand.

The emergence of COVID-19 expedited identified cases of substance misuse, emotional and mental health well-being and unhealthy relationships. Social isolation and loneliness had been identified prior to COVID-19 measures as affecting a quarter of vulnerable people within the region. Isolation restrictions during this period may be the result of increased cases reported, requiring a multi-agency safeguarding response.

Cardiff and Vale Corporate Nursing Safeguarding Team Structure

To promote the safeguarding agenda the corporate team consists of:

- Head of Safeguarding
- Named Doctor for Safeguarding Children
- Senior Nurse Safeguarding
- Seven Safeguarding Nurse Advisors
- Safeguarding Nurse Advisor (Flying Start)
- Safeguarding Nurse Advisor (Midwifery Services)
- Safeguarding Trainer/Nurse Advisor
- Specialist Safeguarding Liaison Nurse
- Four Health Independent Domestic Violence Advocate (IDVA) two posts are in fixed term funding positions
- Violence Prevention Team, one Band 6 nurse and one Band 6 advocate fixed term funding positions
- Administration Team

In addition, the Corporate Safeguarding Team has expanded to incorporate

- The Mental Capacity Act/Deprivation of Liberty Safeguards team: Full-time Senior Nurse, two full-time MCA practitioners and Administration support
- Consent Lead, Part-time Nurse

The safeguarding governance structure sits within the portfolio of the Executive Nurse Director and the Deputy Executive Nurse Director. A bi-monthly Safeguarding Steering Group meeting is held within the UHB and is attended by representatives from each Clinical Board (CB). The CBs consist of Mental Health, Specialist Services, Children and Women, Medicine, Surgery, Primary Community and Intermediate Care (PCIC) and Clinical Diagnostics & Therapeutics. The Designated Nurse for the region represents the Public Health Wales Safeguarding Service. More recently South Wales Police and Spire Healthcare nurses have been represented at the meeting; Cardiff and Vale Local Authorities are invited and have receipt of minutes. This reflects the ethos of safeguarding being everybody's business and provides assurance to the UHB Board that the safeguarding agenda is being progressed in line with legislative duties and best practice.

The Safeguarding Team locations are: the Noah's Ark Children's Hospital at the University Hospital of Wales, Cardiff Multi Agency Safeguarding Hub (MASH) and the main office for advice and queries based at Woodland House, Heath, Cardiff. The Cardiff MASH was launched in July 2015, hosted by South Wales Police at Cardiff Bay Police Station. Agencies located within the MASH include Cardiff Local Authority (LA) Children and Adult services, South Wales Police, Cardiff Local Authority Education, Health and Probation services. The purpose of the MASH is to ensure that safeguarding of children, adults at risk and domestic abuse has a timely, appropriate multi-agency response and approach. By co-locating agencies to share information immediately that a concern is raised, safeguarding measures are considered and put into place immediately or within 24 hours. Two safeguarding nurse advisors work within the MASH, sharing appropriate health information to ensure the safety of children and adults at risk across the UHB locality.

The Safeguarding Team continues to work to provide assurance to the Executive Board that the UHB is discharging its duties in line with Health Care Standards (2.7 Safeguarding). The current corporate assessment for the UHB is: Leading the Way. This is unchanged from the previous year and demonstrates the collective progression made by all Clinical Boards (CBs) during the year.

Significant Legislation that Informs the Wales Safeguarding Agenda

The implementation of the Social Services and Well-being Act (Wales) 2014 (SS&W-bA) and the Violence against Women, Domestic Abuse and Sexual Violence Act (Wales) 2015 (VAWDASV) has determined much of the safeguarding work undertaken across Wales. Ensuring that both Acts are implemented within the organisation has been a priority due to the duty to report and investigate, provide awareness raising training, supporting all staff to undertake their duty, recognise their responsibility and encourage partnership working with other statutory agencies. The Welsh Government (WG), National Training Framework five-year plan for Groups 1, 2, 3 and 6 has been submitted and reflects the UHB's commitment to deliver the raising awareness training across the organisation in line with WG expectation. The UHB has worked with Public Health Wales Safeguarding Service to produce a training package aimed at Group 2 training following agreement by WG for Health organisations to deliver a single agency package. This has been implemented within the UHB from September 2019. Delivering the training for Group 2 in accordance with WG recommended staff groups is a challenge for the safeguarding team as it is estimated that a figure of approximately 11,000 staff will require this additional training. Group 3 multi-agency VAWDASV training is expected to commence in 2023.

In addition to the Acts, there has been the introduction of Home Office Mandatory Reporting of Female Genital Mutilation (FGM) in October 2015 and Home Office Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews (2016) under section 9(3) of the Domestic Violence, Crime and Victims Act (2004). The Well-being of Future Generations (Wales) Act 2015 requires the development of Public Service Boards (PSBs) in each Local Authority area; the Boards are in place within the region. PSBs are responsible for assessing the well-being of the local population, the Board agree for a Domestic Homicide Review (DHR) to be commissioned. The DHR responsibility is likely to be transferred to the RSB in the coming year.

The Wales Safeguarding Procedures (2019) incorporating Children and Adults at Risk has been implemented since October 2019. The procedures replace the previous All Wales Child Protection Procedures (2008) and reinforce the instructions within the Social Services and Well-being Act (2015) Wales.

Additional recent significant legislation includes: Domestic Abuse Act (2021), The Duty of Candour Procedure (Wales) Regulations 2023, Department of Health and Social Care NHS PREVENT training and competencies framework (September 2022).

Meeting the demands of the growing activity surrounding the depth and breadth of safeguarding is a constant challenge for the Executive and Deputy Nurse Directors and the corporate Safeguarding Team. Ensuring that the UHB is compliant with the legislation is a priority area; however, maintaining the ethos of the UHB's values and behaviours must be considered when work is undertaken with individuals, families and UHB staff.

Effective safeguarding relies on good working partnerships with other agencies utilising an open and transparent approach. This is reflected by the corporate Safeguarding Team working within the UHB; in addition to the work undertaken with GPs, Local Authority, Police, Education, Probation and Third Sector agencies. Since the introduction of the Cardiff MASH the safeguarding referral process across the UHB has been restructured and is transferred to the appropriate LA by the Safeguarding Team electronically via secure e-mail. Safeguarding referrals continue to be more complex resulting in additional staff time in support and supervision of cases, involving more strategy discussions/meetings, multi-agency investigations and often legal advice. Team members report an increase in violence related referrals through MASH and patients presenting at Emergency Department (ED).

The 2022/23 Safeguarding Report will consider the workstream from April 2022 to March 2023,

demonstrating and evaluating the breadth of the safeguarding agenda and the progression made across the UHB. A summary of the collective safeguarding work undertaken with the Cardiff and Vale Regional Safeguarding Board (RSB), the VAWDASV Regional Strategy and Public Health Wales, NHS National Safeguarding Service validates the enormity of the safeguarding agenda across the region and Wales.

It is appropriate to mention at this point that the UHB, like every other establishment worldwide, has been gripped by the pandemic of COVID-19 since the early part of 2020. Planning and implementing the UHB response to the operational difficulties of ensuring the appropriate resources and provisions being in place when inevitably the pandemic struck the region, understandably took priority over other routine work. This included training, meetings such as UHB Safeguarding Steering Group and multi-agency meetings not directly associated with COVID-19 planning being affected. Arrangements were made to either temporarily discontinue or shorten time spent at meetings.

The initial United Kingdom lockdown commenced on the 23 March 2020, a change that affected us all on a personal and professional basis. Adaptions in the way in which the UHB approached safeguarding commenced immediately. This involved home working facilities to allow the safeguarding team to rotate between home and office base, providing additional support to clinical staff by completing safeguarding reports for children and adults as required, completing adult at risk case management on behalf of Health Lead Practitioners (HLP). The pandemic did not affect the operational resources available for day to day safeguarding; however, attendance at the Emergency Department (ED) dropped by 50%, outpatient clinics and attendances were cancelled, other than in areas such as Midwifery. The impact on services became evident almost immediately. Domestic abuse disclosures in ED increased, likely to be due to no visitors or people accompanying patients allowed in the department. This provided staff with the ability to ask routine enquiry questions without the patient feeling coerced or intimidated by another person. Data shown in the report must be viewed with these circumstances in mind. The impact remains evident in all services across the UHB with recovery and transformation slowly progressing.

Cardiff and Vale University Health Board like other Health Boards across Wales and partner agency organisations are progressing ahead with opening up services in all areas post the pandemic. However, the emerging cost of living crisis, staff recruitment and retention in all areas of social care is detrimental and derailing proposed plans to fully improve services.

Training

The safeguarding team are responsible for developing, planning and delivering a range of training events throughout the year. The aim of safeguarding training is to ensure all staff have the skills, knowledge and understanding to inform the ways in which they engage with people at risk of abuse, harm or neglect. Training will ensure that all staff know how to respond to concerns in line with local and national requirements in a confident and competent manner.

Training is developed to reflect guidance from training competencies as identified in the National Intercollegiate Documents:

- Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff Fourth edition: January 2019, and
- Adult Safeguarding: Roles and Competencies for Health Care Staff First edition: August 2018

Online Safeguarding training at Level 1 and Level 2 is available through Electronic Staff Records (ESR) and forms part of staff mandatory training requirements.

The safeguarding team deliver classroom-based training sessions and TEAMS training at Level 2, Level 3 training is classroom based. These sessions run regularly throughout the year and are advertised in the UHB training prospectus and are booked through the Education, Culture and Organisational Development (ECOD) office. Additionally, the safeguarding team deliver a number of bespoke training sessions with identified staff groups. During this time period staff training across the UHB was considerably reduced in line with COVID guidance and significant reduction in staff resources in clinical areas for a period of time. This is reflected in the data.

Data collated demonstrates a reduction in staff completing training in all areas. This will need to be a priority for the coming year in line with UHB corporate guidance to ensure that compliance is focused. Safeguarding training provides service users and staff with a level of protection against harm through the knowledge gained and the understanding of correct processes to follow.

Online Safeguarding Training Data

Training data for safeguarding training completed/attended up to and including 31 March 2022.

Safeguarding Level 1 training (online)

Number and percentage of staff compliant with Safeguarding Children training at **31 March 2023**

Level of training	Headcount (UHB Total)	Number trained	% trained
Safeguarding Children Level 1*	16806	13012	77.42%
Safeguarding Adults Level 1 * Online training only	16806	13225	78.69%
VAWDASV (Domestic Abuse) Group 1 Online Training Only	16806	11990	71.34%

NOTE:
All staff working in Health Services are required to complete **Level 1** safeguarding training, this package is delivered online via ESR. Relevant staff can also access **Level 2** training material via ESR.

Safeguarding Children and Safeguarding Adults (3 Year refresher) available online and face to face classroom sessions

Number and percentage of staff compliant with Safeguarding Adults training as at **31 March 2023**

Level of training	Headcount (UHB Total)	Number trained	% trained
Safeguarding Children Level 1	All Employees approximately 16,806	13012	Mandatory Training for all employees 77.42%
Safeguarding Adults Level 1	All Employees approximately 16,806	13225	Mandatory Training for all employees 78.69%
Safeguarding Children Level 2	Only specified staff groups require this level of training -see notes section below	5328	Only specific staff groups require this level of training - see notes section below 68.58%
Safeguarding Adults Level 2	Only specified staff groups require this level of training -see notes section below	5361	Only specified staff groups require this level of training - see notes section below 71.75%
VAWDASV Group 2	Only specified staff groups require this level of training -see notes section below	411	This training is organised and delivered exclusively by the safeguarding team. Figures shown are a running total of staff trained to date
VAWDASV Group 3 Multi-Agency training (Champions)	Only specified staff groups require this level of training -see notes section below	13	This training is delivered through a multi-agency trainer team

NOTE:
Level 2 safeguarding training and Group 2 VAWDASV training, is relevant for the following staff to attend/complete ie, all practitioners who have regular contact with patients, their families or carers, or members of the public.

ECOD are in the process of including the VAWDASV Group 2 training to the UHB Mandatory field.

Please Note:
More detailed safeguarding training compliance data is available for each Clinical Board through Education, Culture and Organisational Development (ECOD) and Electronic Staff Records (ESR).

Classroom Based Training Data

Throughout the year, the Safeguarding Team would usually provide a number of classroom- based training sessions and study days which are open for all relevant staff groups. Feedback from staff evidences that training through virtual means inhibits fully active two-way engagement and interaction between the audience and trainer. It is fair to say that technical issues affect some elements of the training flowing freely.

Source: VAWDASV pre/post feedback forms 2021.

Level 2 safeguarding children training session is relevant for the following staff to attend:

Non-clinical and clinical staff who, in their role, have contact (however small) with children, young people and/or parents/carers or adults who may pose a risk to children (Source: Inter Collegiate Document Safeguarding Children, January 2019)

***Level 2 safeguarding adults training is relevant for the following staff to attend all practitioners who have regular contact with patients, their families or carers, or the public. (Source: ICD Adult Safeguarding, August 2018)*

Level 3 Training Sessions

Event	Audience/ Subject delivered	Number of attendees
Child Sexual Exploitation	Level 3	Not held during this time period
Current Themes in Safeguarding Children	Level 3, 2 sessions	91
VAWDASV multi-agency training, train the trainer	Group 3	4 from the Corporate Safeguarding Team
Parental Mental Health and the Impact on Children	Level 3	13
Legal Aspects of Safeguarding	Level 3	Not held during this time period
Safeguarding Adults at Risk Study Day	Level 3, 2 sessions	25
Current Themes in Safeguarding Adults	Level 3	18

Bespoke Training		
Health Visitor Preceptorship Induction	Induction	30
Violence Prevention Team Awareness Training	Level 2	32
District Nurses Bespoke Session	Level 2	32
Dental Training	Qualified Staff and Students	113

Safeguarding Training Meetings Attended

To ensure a robust evidence-based training programme is delivered within Cardiff and Vale UHB, key members of the Safeguarding Team would usually attend local and National Training meetings:

UHB Safeguarding Steering Group Meeting

The meeting is held bi-monthly, the safeguarding training monitoring is a standard agenda item. A UHB Safeguarding Training Strategy has been commenced for the coming year, this will be signed off by the meeting members when completed.

UHB Mandatory Training Steering Group Meeting

The Safeguarding Team attends this meeting to inform the mandatory training agenda and has been involved in work to promote safeguarding children, safeguarding adults training and VAWDASV training.

Cardiff and Vale Regional Safeguarding Board (RSB) training sub-group meeting

This training sub-group reports to the RSB Board and has previously completed a safeguarding training mapping exercise to consider the different levels and types of safeguarding training partner agencies currently deliver. Recent work has focused on the implementation and embedding training for the Wales Safeguarding Procedures.

Safeguarding Training Network Meeting

This training sub-group meeting meets bi-monthly, reports to the NHS Wales Safeguarding Network Service meeting.

National Training Programme – Violence Against Women Domestic Abuse and Sexual Violence (VAWDASV) Regional Training Group

The aim of this multi-agency regional training group is to share best practice and discuss current training compliance for VAWDASV training. The meeting is also driven by the five-year regional VAWDASV training programme, which includes the development and delivery of VAWDASV training for Groups 2, 3 and 6.

During this time period some meetings were stood down.

Safeguarding Activity

All referrals for safeguarding children, adults at risk and domestic abuse are sent electronically by practitioners to a central UHB safeguarding referral e-mail address; the referrals are not screened and are sent directly to Cardiff MASH, Vale of Glamorgan Local Authority teams and Police as appropriate, on the same day as they are received. The referral pathway and referral forms are available on the UHB Safeguarding Children and Adult web pages. This process is unique to Cardiff and Vale UHB and allows the safeguarding team to collate the activity across the UHB to target service areas that may require additional training, supervision or advice.

Table 1: Safeguarding Children Activity: Referrals from Clinical Boards

Clinical Board 2022/23	04	05	06	07	08	09	10	11	12	01	02	03
Medicine	149	153	137	136	163	183	167	134	114	124	138	146
Surgery	1	1	0	3	5	1	3	4	1	0	2	6
Specialist	1	0	2	2	4	4	1	7	9	3	0	6
Mental Health	38	39	36	39	40	28	40	37	33	30	24	38
Children and Women	124	162	170	190	163	134	155	162	133	150	175	190
PCIC	21	20	17	26	21	22	26	23	16	19	29	22
CD&T	2	1	1	1	4	1	2	5	9	4	3	2
Corporate	51	59	62	65	73	55	56	67	51	61	37	65
WAST	2	6	7	1	3	7	7	1	3	2	2	2
Outside Agency/ Unknown	1	5	1	1	1	3	4	1	1	10	3	2
Total	**390**	**446**	**433**	**464**	**477**	**438**	**461**	**441**	**370**	**403**	**413**	**479**

Table 2: Represents the Clinical Board Areas that have submitted Referrals

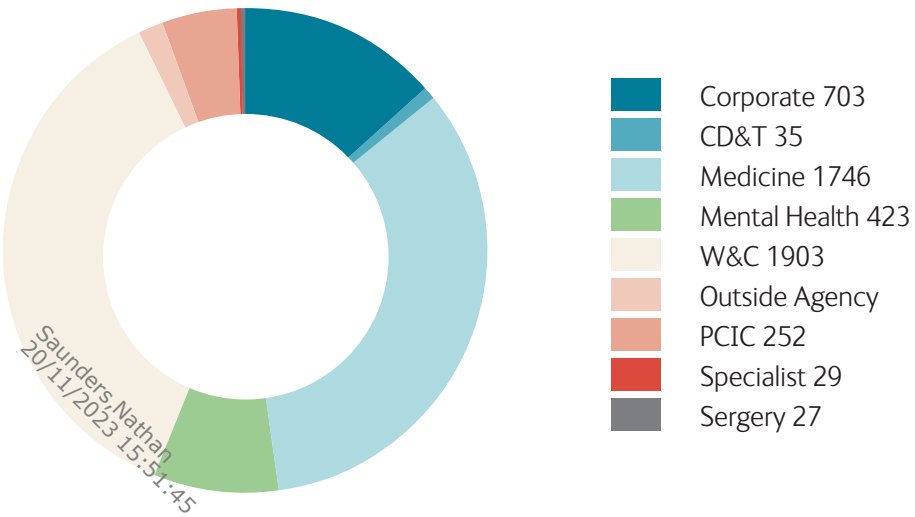
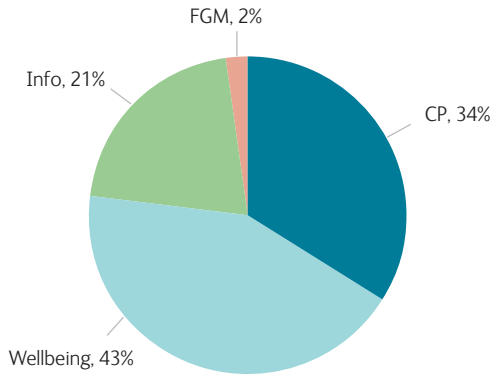


Table 3: Type of Safeguarding Referrals



Identifying that a large proportion of referrals to Children's Services distinguish the concern raised, has improved within the UHB through training and supervision. The implementation of the Early Help Hub in Cardiff during 2019 identifies referrals that are to be progressed to MASH and those that will be signposted to other services for additional support.

Table 4: Age of Children Referred

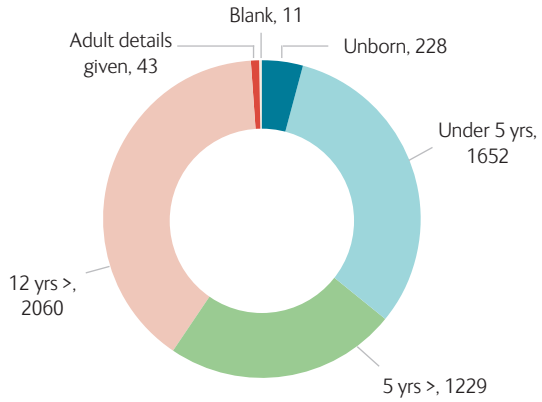


Table 5a: Categories of Abuse

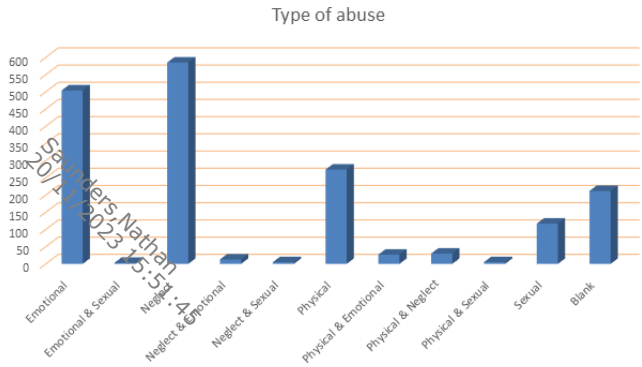


Table 5a and 5b recognises the known categories of concern acknowledged on the referral form by the UHB referrer. Once the referral has been reviewed and assessed by Children's Services the category may change.

Table 5b: Reason for Referral Identified on MARF

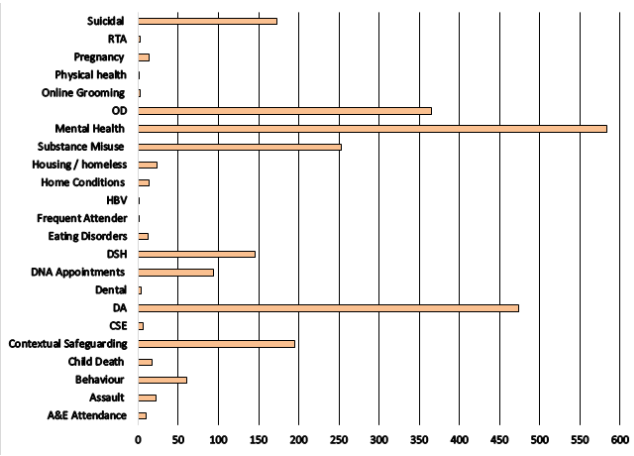


Table 6: Age of Children Referred

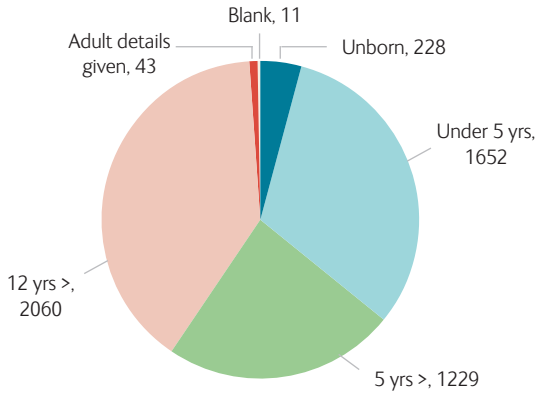


Table 7: Total of Child Protection Medicals Undertaken

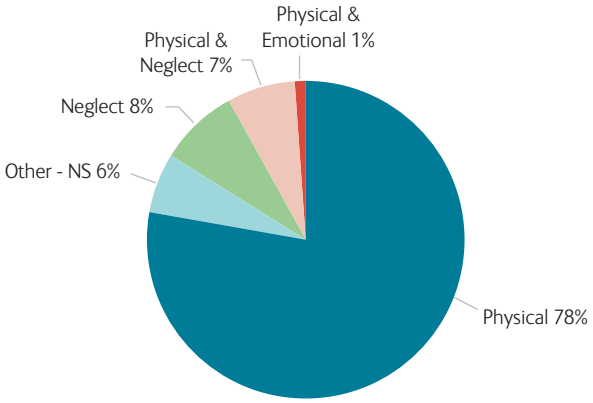


Table 7 represents figures for Child Protection medicals that are undertaken by the Community Paediatricians based at St David's Children's Centre during normal working hours. The table below illustrates the reason for the medical and total percentage. In total there were 284 medicals undertaken. Physical assault represents the greatest category with 220 cases reported, 24 neglect cases, child sexual abuse accounted for 0 cases, 19 physical & neglect, there were 3 physical and emotional cases and 18 cases whereby they were reported as "other not stated".

Safeguarding Adult at Risk Activity

Activity is collated on a monthly basis across the UHB and presented to the Safeguarding Steering Group as a Run Rate Report. The report exhibits activity from 1 April 2022 to 31 March 2023 across all CBs.

Table 8: Adult Safeguarding Activity: Referrals from Clinical Boards

Clinical Board 2022/23	04	05	06	07	08	09	10	11	12	01	02	03
Medicine	7	10	12	13	14	10	9	24	10	10	9	10
Surgery	0	2	1	1	2	5	0	0	2	0	1	4
Specialists	1	2	0	2	2	2	1	1	1	4	0	0
Mental Health	7	17	11	12	16	8	8	12	5	15	6	15
Children and Women	0	0	0	0	0	0	0	0	0	0	0	0
PCIC	1	0	3	2	2	0	1	2	0	0	1	0
Corporate	0	0	0	0	0	0	0	0	0	0	0	0
CD&T	0	0	0	0	0	0	0	0	1	0	0	0
Total	16	31	27	30	36	25	19	39	19	29	17	29

A total of 318 referrals were made by health professionals to the local authority during this period, in comparison 289 referrals were made during the same period in the previous year. This is an increase of 29 referrals in this reporting period.

This safeguarding adult data is collated by the number of health-led referrals across the UHB. Each CB has a Health Lead Practitioner (HLP) that take responsibility to lead on the Adult at Risk process for their own area; HLPs are usually Lead Nurses, Senior Nurses or Advanced Nurse Practitioners. HLPs are given additional bespoke safeguarding adult at risk training by the Head of Safeguarding or Senior Nurse to undertake this role. An electronic shared drive has been established to enhance the process allowing HLPs in each clinical area to be aware of cases in their CB to ensure that cases are maintained and progressed should the named HLP be on annual leave or sick leave. There are 46 active HLPs across the UHB. The process has evolved since the implementation of the SS&W-b Act (2014) and since the launch of Cardiff MASH. This may not be a true reflection of all referrals made, it has been noted that health staff based in integrated community teams are sometimes making referrals directly to the Local Authority and bypassing the UHB Safeguarding Team. This is complicated due to the fact that health staff are working from LA computers and facilities, plus their email address is Local Authority. Measures to ensure that this practice is discontinued are being introduced to ensure that health staff are following the UHB referral process.

Table 9: Captures the number of health-led referrals made by each Clinical Board for this period

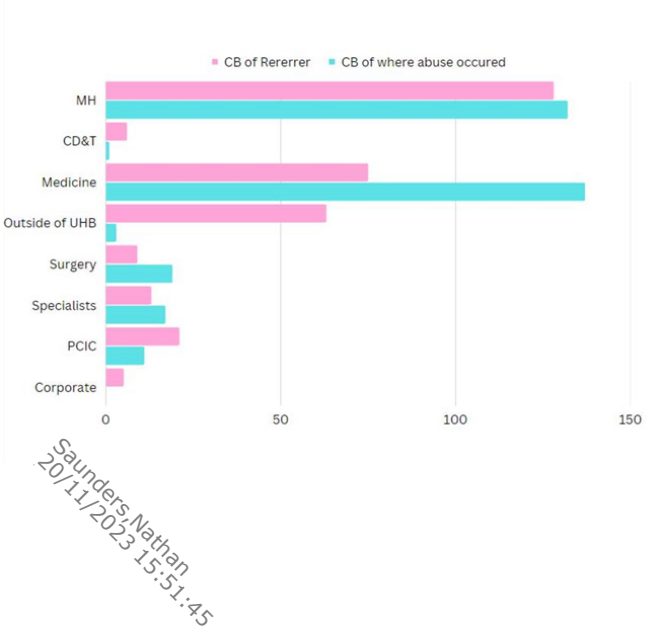
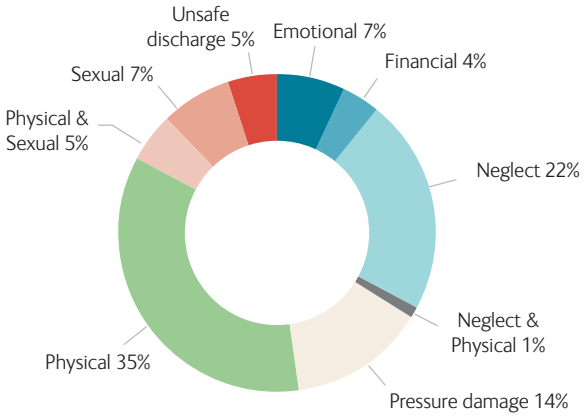


Table 10: Categories of Abuse Described on AS1 Referral Form

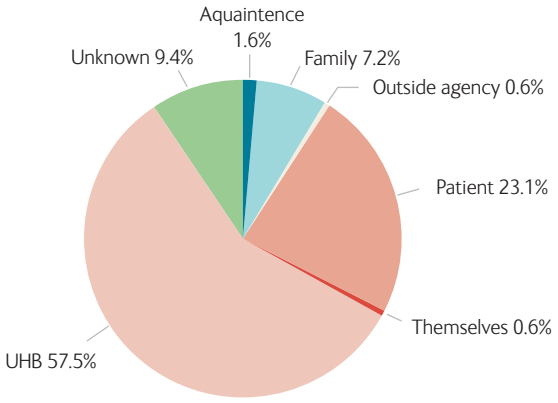


Categories of abuse are easier to capture on the current Adult at Risk referral form as opposed to the Children's referral form, as there are tick boxes for practitioners to choose. Highlighted in table 3 are the areas considered by practitioners to be the reason for submitting the referral to the LA. The most commonly used category is physical abuse and neglect, possibly reflecting perceived poor care within a clinical area in the UHB. AS1s submitted raising concerns of sexual assault account for 7% of those submitted. Concerns are mainly raised by patients reporting another patient; however, there are also reports alleged by patients against staff. All cases of suspected sexual assault are taken seriously by the UHB and will always be reported to police and LA either as an AS1, if consent is obtained by the reporter, or as a Professional Concern if the allegation is against a staff member. Patients (family members are contacted if the patient is deemed to lack capacity) and staff are always asked if they want to report to police, they would be supported to raise the concern if this is required.

Adult cases often prove to be complex, determining the main issue at the point of disclosure or reporting is often difficult for referrers; this is often not established until further fact finding is undertaken. This may be in the shape of a criminal or non-criminal investigation. The HLP will lead on the case if the situation involves a clinical area within the UHB. Cases, where individual

staff members are deemed as the alleged perpetrator of abuse, are managed by the Head of Safeguarding/Senior Nurse since February 2020 to ensure that a consistent approach is in place that aligns with the UHB and RSB Professional Allegation/Concern process. The HLP is central to gathering fact finding statements and keeping in touch with the staff member during this process. The UHB acknowledges that any allegation involving a member of staff will raise anxiety and often results in the employee taking sick leave. The UHB works closely with People's Services department (previously known as Human Resources HR) and the line management team to ensure that a proportional risk assessment is in place to support and protect staff members from further accusations whilst this process is in place.

Table 11: Alleged Perpetrator



Often practitioners from the UHB or from an outside agency will not have the information to determine who the alleged perpetrator is, this is evidenced in Table 4, as no person responsible has been identified on the referral. 165 of the cases cites the Hospital or Hospital staff exclusively as being responsible for the abuse. 74 of the cases are alleged abuse from another patient, more often these are cases in Mental Health clinical areas.

Pressure Damage

A health-led pressure damage six-month pilot study was introduced in December 2018 following agreement by the RSB. This involved the UHB referring pressure damage of grade 3/4 to the LA following completion of an All Wales Risk Assessment tool determining that the pressure damage is deemed to be avoidable. The pilot study was undertaken in the Medicine and PCIC CBs. The pilot study was presented at the RSB meeting in January 2020, recommendations were agreed and the improved referral pathway implemented in the UHB from February 2020. This has resulted in only avoidable health acquired pressure damage of grade 3/4 or unstageable damage reported to LA. This has decreased the number of pressure damage referrals to LA. This is in alignment with recent Welsh Government, Serious Incident Reporting and in compliance with the Social Services and Well-being (Wales) Act (2014). In addition, both Medicine and Primary Care (PCIC) CBs have introduced scrutiny panels that consider pressure damage reporting on a weekly basis. This provides a multi-agency assurance of transparency and appropriate referral submission. There were 72 cases of pressure damage referrals during 2021/22; during this reporting timeframe there has been 44 referrals made.

Table 12: Identifies the age groups of referrals

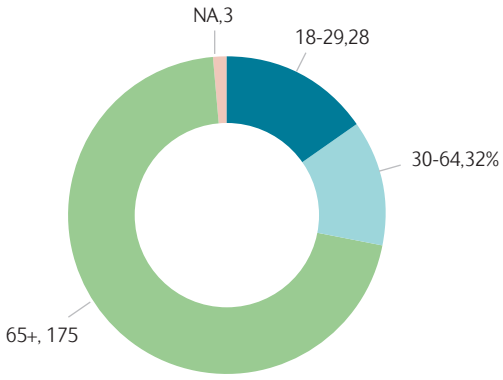
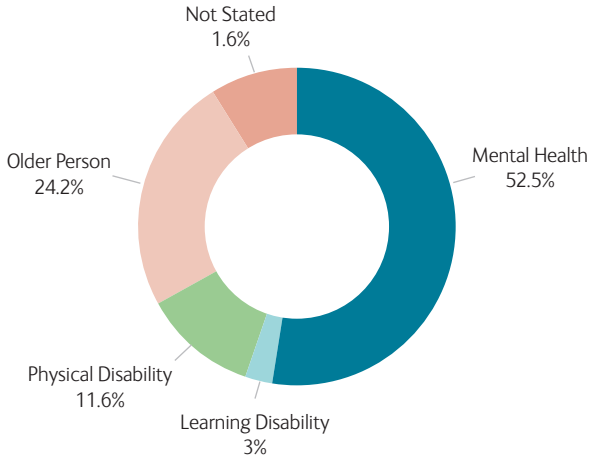


Table 13: Client Groups with perceived Vulnerabilities:



Professional Allegations/Concern Strategy Meetings

The UHB Professional Allegation/Concern guidance updated in 2021 has formalised the approach to address concerns of employees' behaviour in or outside of work. The process is in alignment to the Wales Safeguarding Procedures (2019). UHB employee line management, Police, UHB Safeguarding, UHB People's Service and LA are invited to each meeting to share information and ensure that the UHB is open and transparent in the approach. Concerns include arrest and police investigation around domestic abuse, sexual assault, physical assault etc, outside the workplace. Some cases will proceed through the disciplinary process following closure by police and/or the Court process.

Number of Professional Meetings

Period 2022-2023

Professional allegation/ concern identified in: 179 cases, in addition **100** domestic/self-harm abuse cases were discussed with managers whereby a member of staff has been identified as a "high risk" Domestic Abuse victim or issues around Mental Health. This is a remarkable increase in support sought by Clinical Board areas from the previous year (48 cases of domestic abuse raised by survivors and/or self-harm issues). This is likely to be due to a number of issues: Domestic Abuse awareness, Routine Enquiry for all attendees at Emergency Department - this process also includes staff. Improved communication with police, UHB Concern Team, regular meetings with Clinical Boards chaired by the Deputy Executive Nurse Director and UHB People's Services will also factor in the progress made in identifying additional support for staff.

Issues raised with UHB employees relate to allegations made against them by family members, patients or a criminal investigation by police. All employees are notified of the concern raised as appropriate and an immediate risk assessment is completed by the line manager and the People Service Manager (Human Resources) representative to ensure that safeguarding measures are in place. This certifies the protection and support of the member of staff if further allegations are made and gives the UHB assurance that appropriate and proportional measures are in place to protect the public accessing care and services from the UHB. The Head of Safeguarding and the Senior Nurse will provide advice and support to the line manager to achieve a manageable response ensuring that the employee is directed to the well-being service, Occupational Health or General Practitioner (GP) as required.

In the case of commissioned service providers (independent practitioners – GPs, dentists, optometrists, pharmacists), they will be contacted by the Community Director for Quality and Safety/Deputy Clinical Board Director of PCIC, by the Dental Practice Adviser, or Primary Care Optometric Adviser. If the allegation relates to a member of staff as perpetrator, advice will be given to the employer and proportionate measures will be put in place. The circumstances are more complicated regarding Optometric Practices and Pharmacies as many of the practitioners are employed by major multiple organisations (eg Boots, Well, Specsavers) as they are guided by their corporate requirements in addition to Health Board expectations.

There has been an increase in reporting nationally of survivors disclosing domestic abuse during lockdown and easing of restrictive measures. Admissions of people and children <18 years of age presenting with mental health or emotional well-being concerns has also increased. This is corroborated in a recent draft report from the Public Health Wales, Violence Prevention Team analysing data.

Audit, Survey, Professional Presentations and Publications

Public Health Wales Safeguarding Maturity Matrix (SMM)

The purpose of collating the information is to assess quality improvement, compare compliance against agreed standards and to demonstrate the learning from incidents and reviews. Organisations completed self-assessments along with improvement plans that were submitted to the National Safeguarding Service to assemble a National picture and to report the findings. The aim being to provide assurance, share practice and drive improvements. Cardiff and Vale University Health Board (C&V UHB) fully participate, drawing on information from across all Clinical Boards to inform the UHB self-assessment and provide a true reflection of the current situation. Overall, the UHB acknowledges that there are always improvements to be made in an ever-evolving field such as safeguarding. Implementing the recommendations is monitored with CBs and reported through the UHB Safeguarding Steering Group. The peer review report demonstrates that C&V UHB is operating in line with other organisations across Wales.

All Wales Domestic Abuse Routine Enquiry for Midwives and Health Visitors

Routine Enquiry (RE) questions asked by Midwives and Health Visitors (HV) relating to domestic abuse has been maintained; this involves specific questions asked twice to women accessing services in Midwifery and once to women accessing services in Health Visiting. The results for 2022-23 are:

Routine Enquiry Asked:	Asked Once	Asked Twice
Midwifery Service	97%	90%
Health Visiting Service	93%	Not recorded

In total 10% of the number (504) of birth notes were manually checked in Midwifery to calculate the data.

In addition, 265 positive domestic abuse disclosures were made by women in this period. All survivors were signposted appropriately for expert support and counselling. 121 pregnant women were discussed in MARAC or the high- risk daily discussions during this time period.

The Health Visiting percentage has improved dramatically during this period, this has been achieved through improved reporting mechanisms being implemented. Often HV are unable to ask the RE questions at the birth visit as it is deemed to be unsafe if the partner is in attendance.

Paediatric Emergency Department (PED) Safeguarding Meeting

The Paediatric Emergency Department (PED) Safeguarding Meeting is held weekly and involves multi-disciplinary practitioners. The meeting identifies and highlights cases where additional referral or information is required.

The PED experienced an increase in attendance during this time period to 33,873 compared to 31,00 during the previous 12 months. A total of 2,682 PARIS notifications were completed by the PED team representing just under 7.9% of all PED attendances during this period.

This is demonstrated by the increase of frequent attendances reported to Health Visitor (HV) and School Nurse (SN) via documentation on PARIS (community electronic health record); 504 notifications made. Frequent attendances at PED is an ongoing challenge to the department as it is not designed to provide care for recurrent problems and exposes the child to hospital acquired infections. The demand placed on the department leads to prolonged waiting times to be seen by a professional. This often results in families leaving the department without being seen after the

triage process. 31 PARIS notifications for families who "self-discharged" were sent to HV or SN for information purposes and possible follow up. A new "Did not Wait" pathway has been developed by PED to safeguard children as there is the potential that the number of children not seen is much greater. The introduction of the 'Did Not Wait' pathway in 2022 assists clinicians and nursing staff to decide if additional actions are required to ensure patient welfare.

Children and young people presenting to ED with mental health concerns continue to represent a high proportion of attendances evidenced by the number of referrals made from PED last year for behavioural concerns, overdose or other methods of self-harm. A total of 644 PARIS referrals were made to Children's Services, Health Visitors and School nurses (208 OD/Self harm, 412 Behavioural concerns and 24 alcohol/substance intoxication). Concerns about parental behaviours or anxiety contributed a further 108 referrals.

The weekly safeguarding meeting remains a feature within the PED governance and Safeguarding Steering Group agenda. A total of 49 meetings were held during this time period. The following table summarises the activity of the meeting:

Injuries <12 months old	521 (489 in previous year)
Fractures <2 years old	64 (95 in previous year)
Thermal Injuries	296 (333 in previous year)
Major Trauma Centre Cases	126 (116 in previous year)
Health Visitor/ School Nurse Referrals generated from this meeting	187 HV and 33 School Nurse 63 MARFS for information sharing
Total Cases Discussed	**1007 (1033 in previous year)**

The safeguarding meeting provides a means of assurance that vulnerable children and young people are identified within the PED and referred to other agencies or disciplines appropriately. The annual audit demonstrates PED completes 60% of necessary PARIS notifications after the initial ED attendance with the outstanding referrals completed retrospectively at the meeting. Not all injuries in the under 1year old population necessarily require Health visitor notification if the mechanism of injury is in-keeping with developmental stage. This is the function of the Safeguarding meeting to review such cases. This suggests improvements can be made, particularly with regards to fractures in infants under 2 years of age (44%) as referenced and recommended by a Child Practice Review in 2018.

PED submitted 17 Multi Agency Referral Forms (MARF), (33 submitted in previous year) for concerns of maltreatment of child/young person under 16 years of age. A further 520 MARF (748 submitted in previous year) were submitted for information sharing with Children's Services. Indications for the notification include assessment of a 'Child Looked After' or for families consenting for additional support.

In addition to the work undertaken in respect of children residing within the Cardiff and Vale of Glamorgan region, the UHB is a South Wales Major Trauma Centre (MTC). All children and young people presenting at ED are retrospectively reviewed as a governance requirement. Difficulties experienced are around accessing pre-existing information for the children and young people from out of area, this is usually undertaken for children within the UHB region by accessing PARIS electronic records information. A MARF is routinely submitted to the child's Local Authority (LA) as a prompt to alert Cardiff and Vale UHB Safeguarding Team of any relevant historical concerns. An internal audit demonstrates that 60% of Major Trauma Centre referrals were made, further scrutiny of current practice is required to ensure that the clinical team are aware of the process.

A total of 119 notifications for assault were documented on PARIS during this period, however, it is recognised that not all children or young people are referred to the Violence Prevention Team (VPT). An audit undertaken by a third-year medical student highlighted that 148 cases of assault were identified between 1 January to 31 – December; 88% of the cases were referred to the UHB Violence Prevention Team and 87% to School Nurses. Three of the patients were admitted due to the severity of the injuries during this period, four patients reattended following a second incident, all were referred for additional support. 95% of patients were shown to have engaged with the VPT, however, engagement with the school nursing service or education is unknown. This has emphasised the need to extend the project to explore actions by education authorities following notifications of assault. It is acknowledged that although the notification rates are high there continues to be a potential for missed opportunities to offer support to victims of community violence. To improve outcomes this vulnerable cohort for children and young people will be included in the weekly safeguarding meeting.

A health team consisting of: General Paediatrician, Paediatric Consultants ED and Professor within Dental have been monitoring responses to children injured in community violence. Children and families have been signposted to services and provided with information on bullying. Improvements to the child's experience following attendance at ED has been demonstrated; however, further exploration is required to effectively share information with police and schools to map areas of concern. The information is currently shared with the School Nursing Service, however, greater links with education is required. A pilot initiative with Action for Children looking at ways of engaging young people and minimising community and school related violence has been delayed; however, this will be explored during this coming year.

Adolescent Safeguarding Meeting

This meeting commenced in September 2018, following a pilot scheme in Cardiff and Vale UHB which gathered the opinions of over 300 children and highlighted

that 16 and 17-year olds were seen in the adult ED and not paediatrics. This identified gaps and areas for development. The findings dictated that the aim of the initiative was to 'Improve the Safeguarding processes in the Adult ED and introduce a holistic assessment tool for 16 and 17-year olds. The meeting is held on a fortnightly basis. Attendees are a Consultant and Lead Nurse from ED, Violence Prevention Unit, Safeguarding Team, Department of Sexual Health (DOSH), Children's Rights Advocate/Children's Charter & Youth Board, CAMHS and Child Looked after Team (CLA).

The following are areas which require improvement and additional staff training:

- Only the physical symptoms identified and treated
- Not seen as children
- Safeguarding documentation missing
- Referrals to social services not completed
- Warning signs not noticed (CSE, DA)
- No School noted
- No School Nurse referral
- No signposting
- Missing an opportunity for an intervention

This approach aims to empower staff working particularly in health services, but also partner organisations, to recognise the role they have in promoting healthy lifestyles, supporting behaviour change and contributing to reducing the risk of chronic disease.

A casualty card which incorporates the HEADSS (Home, Education, Activities, Drugs/alcohol, Sexuality and Suicide) and SERAF (Sexual Exploitation Risk Assessment Framework) indicators is used. Questions around these areas are asked when red flag attendances occur.

This table identifies the safeguarding cases:

Total number of adolescent attendances in the period March 2021-April 2022	2861
Number of cases discussed at safeguarding meeting	660
Attendance average with safeguarding needs	23%
Average number of actions required following meeting	12 actions per meeting
Average retrospective referrals	37%

Retrospective Referrals:	
Violence Prevention Team	29
CAMHS Referrals	6
DOSH	2
Child Looked After (CLA) Notifications	9
School Nurse Notifications	17
Safeguarding Referrals	196
Emotional Well-Being Team	7
Drug and Alcohol Services	9
Total Retrospective Referrals	246

Indications highlighted are an increase in overdose since the pandemic. The EU department are planning to update the current casualty card which will be used with children >12 years of age. The updated card will also incorporate a red flag alert for children suspected of being trafficked or at risk of Female Genital Mutilation (FGM).

Safeguarding Supervision

The Public Health Wales All Wales Safeguarding Best Practice Supervision Guidance (2018) states that:

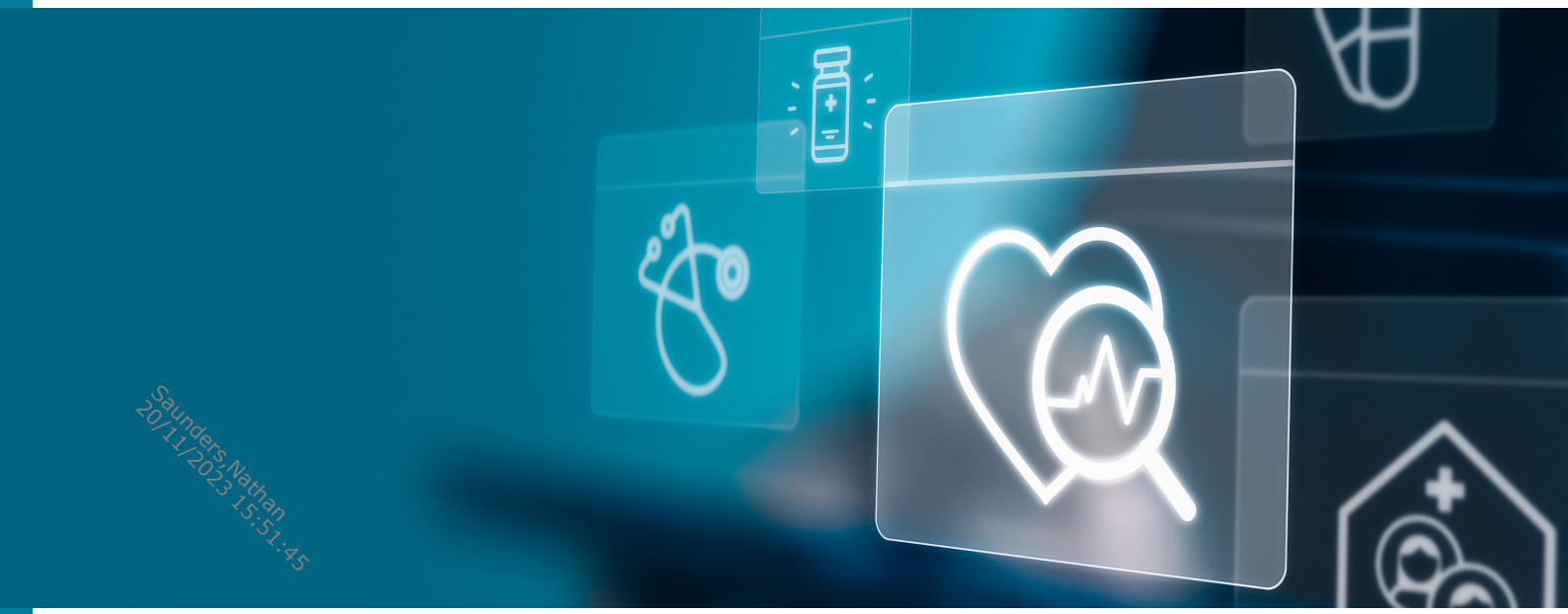
"The aim is to provide guidance on the implementation and utilisation of supervision and support within the context of safeguarding. It sees safeguarding supervision as a priority to which staff are actively supported to have the time to attend"

This approach has been adopted with safeguarding children and adults at risk within the UHB.

The Safeguarding Team successfully introduced a new way of providing group safeguarding supervision with the HV service in 2015 by working with the Executive Team and service managers. This was the first pilot in Wales around safeguarding supervision of HVs and raised much interest from other Health Boards across Wales. The aim of the pilot is to ensure a safe supervision pathway exists that reduces the allocated time required of the Safeguarding Team to provide supervision to the HV service on a 1:1 basis.

The pilot idea advanced and progressed through the UHB's Leading Innovation in Patient Safety (LIPS) headed by the Head of Safeguarding and joined by two team managers from the HV service. The pilot pathway commenced in October 2015 and was overseen by a lecturer in Cardiff University to provide an independent view, accreditation to the pathway and to undertake group forums with the HVs involved. Practitioners report to their supervisor that the learning element of the session is interesting and effective and that transitional skills are adopted through peer discussion around complex cases. The HV supervision groups are working well. 1:1 safeguarding supervision is also available for newly qualified HVs, long term sickness returns or, by request. Safeguarding Nurse Advisors (SNA) have undertaken additional training with Public Health Wales to prepare for the role of facilitator in group supervision. The C&V UHB Pathway has been discussed with other Health Boards through the NHS Network meeting and has been presented as a poster presentation at the Chief Nursing Officer Conference in May 2018 by Cardiff University. Work in this area continues with Cardiff University, a PhD Study has been presented and findings evaluated.

Group Safeguarding Supervision is provided to Midwives, Health Visitors (HV), School Nurses, Cardiff and Vale Health Inclusion Service (C&VHIS) Nurses, Department of Sexual Health (DOSH), Multi-disciplinary staff in Special Schools and Community Therapists and more recently Child and Adolescent Mental Health Service (CAMHS). Safeguarding supervision is provided to other groups such as doctors and acute nurses as required. The aim of supervision is to support staff, facilitate learning and promote best practice.



Adult safeguarding supervision is provided by the Senior Nurse for Safeguarding to the HLPs as required and through arranged sessions within each Clinical Board and/or through Development Day sessions. The supervision is ideally provided on a three-monthly basis in group supervision sessions using the same agenda as the children's safeguarding supervision. However, during this period there has been a lapse due to the pressures on staffing due to COVID. All open adult at risk safeguarding cases are reported to the Executive Nurse Director and Deputy on a monthly basis and discussed at Nurse Director Professional Performance Reviews. Cases involving staff are reported through the bi-monthly Executive Quality and Safety meetings.

"Signs of Safety" training has been introduced in Cardiff Children's Services since 2016-17. The training has been shared with the Safeguarding Team and rolled out to some areas within the Health Visitor and School Nurse service to enhance cohesive partnership working with partner agencies and families. The Signs of Safety approach is used in supervision sessions.

Peer Review

Within Cardiff and Vale UHB, medical staff peer review is held on a monthly basis. It is made available to all doctors involved in child protection work in order that doctors undertaking in this difficult area of work are well supported and have the opportunity to receive peer review and clinical supervision in order to feel confident and competent. Pragmatically, the peer review process encourages paediatricians to meet the expected standards and prevents practitioners working in isolation.

Peer reviews are held for suspected cases of physical abuse at St David's hospital; additionally, a separate peer review is held at the Sexual Assault Referral Centre (SARC) for cases of suspected sexual abuse.

The meeting is chaired by the Named Doctor for safeguarding children or the Medical Lead for Sexual Assault Referral Centre (SARC).

Attendance is consistently good. All child protection cases from the previous month are presented to ensure the management of the case meets the expected standard of practice. The process involves review of the medical report, photo documentation and the multi-agency working. It is an opportunity for professional development and learning within an appropriate environment and allows staff to debrief following difficult cases.

Expert Advice

Partnership Working

The implementation of the SS&WB (Wales) (2014) Act and VAWDASV (Wales) (2015) has encouraged partnership working across strategic partner organisations and third sector agencies. Ensuring that compliance, knowledge and awareness raising is understood within each agency has required joined up thinking through shared training and guidance from the Cardiff and Vale Regional Safeguarding Children and Adult Board.

Cardiff and Vale UHB (C&V UHB) has close strategic and operational links with both the Regional Safeguarding Children and Adult Board. There is representation at the amalgamated RSB.

The meeting is attended by the Executive or Deputy Executive Nurse Director, Named Doctor for Safeguarding Children or the Head of Safeguarding. Minutes for the meeting are shared with Clinical Boards through the UHB Safeguarding Steering Group meeting. Sub- groups of the main Board include Practice Improvement & Development, Case Review Group, Children and Adult Quality Assurance, Communication and Engagement, Monitoring Group, Policy & Procedures, FGM are attended by the safeguarding team who participate fully in the work involved with each group.

Meeting the demand of the workflow within Cardiff Multi-Agency Safeguarding Hub (MASH) is a daily challenge for the two Safeguarding Nurse Advisors (SNA) representing the UHB in the MASH. It is true to say that all agencies within the MASH report an increase in the number of referrals and calls made to the MASH in each consecutive year. Two SNAs from the safeguarding team rotate on a daily basis into the MASH working area. Day to day work consists of attending daily discussions for up to six to ten domestic abuse cases requiring immediate safety planning action, this is in addition to the cases discussed at the fortnightly Cardiff Multi-Agency referral Assessment Conference (MARAC) which a SNA attends. Attending child and adult at risk strategy meetings, which are called immediately a concern is reported and ensuring that all documentation is recorded appropriately on PARIS to make certain that community practitioners meeting with families are alert to the concerns raised, is a feature of the daily work in MASH. An increase of cases discussed has been apparent during this period with up to 10 child strategy meetings per day, 10 high risk daily discussions per day as well as up to three adult strategy meetings held.

The Cardiff MASH demonstrates valued multi-agency working, it has evidenced respect and an understanding of roles amongst the different organisations and broken-down barriers to working in partnership.

Partnership working is evident in the RSCB/RSAB training and audit sub groups; agencies are brought together to consider available training resources and to undertake specific audits from Child Practice Reviews (CPR) or Adult Practice Reviews (APR) and develop action plans.

The UHB works in partnership with the Regional Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) group; to ensure compliance with the training programme in line with the Welsh Government, National Training Framework. The work involves sharing training figures for Mandatory Group 1 training and Group 2. There is the expectation that Group 3 training will be rolled out in the coming year.

The UHB is represented at all Public Health Wales, National Safeguarding Service meetings by the Deputy Executive Nurse Director, Named Doctor for Safeguarding Children and/or the Head of Safeguarding. The meetings bring together Health Boards and Trusts from across Wales, the aim is to maintain standards and to share learning. There are subgroups covering VAWDASV, Training and Child Looked After (CLA). There is representation from the safeguarding team in all meetings, the CLA team attend the sub group for their service.

Female Genital Mutilation (FGM)

FGM is a term used for a range of procedures which involve partial or total removal of the external female genitalia for non-medical reasons. FGM has been illegal

in the UK since September 1985 however in 2015 a number of amendments were made to the more recent 2003 Female Genital Mutilation Act through the Serious Crime Act 2015. It is now illegal in the UK to excise, infibulate or otherwise mutilate the whole or any part of a girl or woman's labia majora, labia minora or clitoris (section 1 of the 2003 Act). For a person to aid, abet, counsel or procure a girl or woman to carry out FGM on her own genitalia (section 2). To assist a non-UK person to mutilate girl or woman's genitalia outside the UK (section 3). To fail to protect a girl from risk of genital mutilation while they have responsibility for her (section 3A) and for a UK national or resident to commit or allow any of the above offences to be committed outside the UK. The Serious Crimes Act 2015 placed a mandatory reporting duty on all health professionals to report "known" cases of FGM in under 18-year olds to the police, this duty has been instigated since 31 October 2015.

The All Wales Clinical Pathway for FGM was created and completed by a task and finish group in October 2015 and ratified in July 2016.Work has been on-going within Public Health Wales to update the pathway and a new version was released in March 2022 and is now in use within the UHB. Specific mandatory training for midwives has been in place since 2014, with approximately 300 midwives receiving the training each year. Additional sessions were introduced to other health professionals through bespoke sessions, an introduction in Level 3 Safeguarding Current Themes and the Level 2 VAWDASV safeguarding training. A continued drive to raise awareness across the UHB has been maintained by the safeguarding team. Midwifery training has been facilitated by the FGM Lead Midwife with additional training across the UHB delivered by members of the safeguarding team. Online FGM training is also available, endorsed by the Home Office; this is accessible to all UHB staff.

Welsh Government requested quarterly updates from all Health Boards across Wales identifying FGM from October 2016 this also included statistics related to number of referrals made to Children's Services where mothers of female children are identified as having experienced FGM. The data collection has since been commissioned to the Violence Prevention Unit and continues to be provided. The reason for referring children to Children's Services ensures that professionals are aware of an increased risk that the female children may experience FGM in the future.

Quarter during 2022- 2023	Number of women identified	Child protection referral Made	Mandatory reporting
Q1	22	17	1
Q2	29	18	1
Q3	14	6	1
Q4	10	4	1

The referral process for suspected or at-risk cases of FGM has been reviewed within the UHB, an example child protection referral is available on the UHB's safeguarding SharePoint (CAVweb), and an FGM Risk Assessment (RA) tool has been added to the Multi Agency Referral Form (MARF) this has been agreed with police and local authority. An increase in recognition has been apparent as a result of the FGM working party training, staff have presented at a South Wales Police (SWP) Conference, BAWSO conferences and the Chief Nursing Officer Conference. A Leading Innovation in Patient Safety (LIPS) project in September 2018 brought Health, SWP and the National FGM centre together considering the referral pathway and outcome within the Cardiff and Vale region. Neither of the LAs were able to attend the LIPS study days although consultation from them was sought. These pathways remain in use.

An FGM service model, the Women's Well-being clinic continues across the UHB, the clinic opened in May 2018 following funding secured from the Police for the psychosexual element and from the Iolanthe award. The Women's well-being clinic consists of a service held weekly (1 all day session) within CAVHIS (Cardiff and Vale Health Inclusion Service in Cardiff Royal Infirmary), which is centrally placed for easy access and provides support to victims or those at risk of FGM. The first year saw a total of 147 women referred to the Women's Wellbeing clinic, with 102 young people/women being reviewed in this time. The majority of referrals are from UHW maternity. There are varying reasons for referral including gynaecological and psychological issues with the predominant reason being pregnancy. One family attended clinic to seek refuge due to risk of FGM. Country of origin has been collated with the majority of women reviewed being from the Sudanese community. Self-referrals at the clinic are accepted. The Clinic has completed its fifth year and numbers remained steady. Funding has once again been sourced for a psychosexual service and is due to start shortly. The Women's Well-being clinic has demonstrated a need for this service within the community and is evidenced by the numbers of women that have been reviewed, future plans include: to continue with the clinic including engaging with the local communities to promote the services within the clinic. Training for community de-infibulation is also being explored as service development.

Procedural Response to Unexpected Death in Childhood (PRUDiC)

The process was first introduced across Wales in 2010 with the aim to *"ensure that the multi-agency response to unexpected child deaths is safe, consistent and sensitive to those concerned and that there is uniformity across Wales".*

The National Safeguarding Service in Public Health Wales revised the document in 2023. The procedure sets a minimum standard for a response to unexpected deaths in infancy and childhood. It describes the process of communication, collaborative action and information sharing following the unexpected death of a child. The updated procedures refer to children aged 16 and 17 years old and remind all practitioners that the PRUDiC procedures apply in this age group.

The process within the UHB is established; the Head of Safeguarding liaises with police to arrange a multi-agency meeting within 48 working hours of the child's death, the meeting is chaired by police, and attendance includes representatives from Children's Services, Education when appropriate, Welsh Ambulance Service Trust, appropriate representation from health professionals involved with the child. The purpose of the meeting is to ensure that there are no suspicious circumstances surrounding the child's death and to make certain that a robust bereavement package is in place for the family.

C&V UHB are fortunate to have a Bereavement Nurse that liaises directly with the family and supports them through this extremely difficult time by discussing with them any pathology information, arrangements for visiting the child in the morgue and registering the death. Referrals are made to charitable organisations to support the family long term and a memory box is created. The table below identifies the number of child deaths of children residing in the Cardiff and Vale of Glamorgan locality.

Number of Child Deaths

Period 2022-2023

16 Cases, 7 Cases are for children usually residing out of C&V UHB region. The Major Trauma Centre is likely to be the reason for an increase in the figures. Of the C&V UHB Cases, 2 cases relate to Young People Suicide

Child and Adult Practice Reviews (CPR and APR)

Guidance for Child and Adult Practice Reviews were updated and came into force from 6 April 2016 following the implementation of the SS&WB (Wales) Act 2014. The guidance is addressed at the Safeguarding Children and Adult Board meetings involving all partner agencies. The purpose of the review is to promote a positive culture of multi-agency child and adult protection learning and reviewing in local areas when there are serious incidents resulting from abuse or neglect, there is a system of multi-agency concise and extended practice reviews. The criteria for child practice reviews are laid down in the Safeguarding Boards

(Function and Procedures) (Wales) Regulations 2015. The outcome is expected to generate new learning to support continuous improvement in inter-agency protection practice.

The process involves agencies, staff and families reflecting and learning from what has happened to improve practice with the focus on accountability and not culpability. This will potentially develop more competent and confident practice, better understanding of knowledge base and perspective of different professional's role and responsibility.

The Head of Safeguarding and Named Doctor for Safeguarding Children participate in the Regional Safeguarding Board sub-group for Child and Adult Practice Reviews when consideration is given to new referrals and the commissioning of a new review. SNAs participate as panel members to individual reviews and complete a health chronology of each health contact to inform the timeline of events that will notify the reviewers preparing the report once collation of each agency's information has been submitted. There has also been representation from the team as a reviewer and Chair for Child Practice Reviews.

Recommendations and learning from the reviews will be identified in action plans or from the learning event. Organising a multi-agency approach for the learning event allows professionals to consider the case in detail, reflect on their own practice and to take learning back to each organisation to prevent the same situation happening again. One Child Practice Review was published in this reporting period. Five CPRs on-going, one Multi-Agency Professional Forum (MAPF) commenced, three Internal Management Reviews (IMR) undertaken. There are no outstanding Adult Practice Reviews in this period.

Child Practice Review	Adult Practice Review	Multi-Agency Professional Forum (MAPF)
5 reviews on-going 2 reviews paused	3 reviews on-going 1 paused	1 Child MAPF ongoing 4 Adult MAPF ongoing 1 Adult MAPF paused

Domestic Homicide Review (DHR)

Completed DHR	Ongoing Awaiting Publication
9	1 (DHR 10 – Pilot SUSR)

DHRs were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004). The provision came in to force on 13 April 2011. The Home Office Multi-Agency Statutory Guidance for The Conduct of Domestic Homicide Reviews has been updated in 2016. Domestic violence includes physical violence, psychological, sexual, financial and emotional abuse involving partners, ex-partners, other relatives or household members. In 2009/10, domestic violence accounted for 14% of all violent incidents and affects both men and women. A domestic violence incident which results in the death of the victim is often not a first attack and is likely to have been preceded by psychological and emotional abuse. It is likely that many people within agencies may have known of these attacks and circumstances. This can sometimes make serious injury and homicide preventable with early intervention.

A DHR means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect. Similarly, to CPR and APR, the DHR will consider what lessons can be learnt by professionals and organisations to safeguard victims, what change can be identified, update policies and procedures, make every attempt to prevent domestic homicide by improving services to individuals and their children through improved inter-agency working.

The DHRs are commissioned through Partnership Boards in Cardiff and the Vale of Glamorgan localities. Referrals are received from South Wales Police and consideration is given at the Partnership Boards to undertake a DHR. The UHB Executives are formally notified of the commissioning of the DHR; the Head of Safeguarding attends a multi-agency meeting to agree the Terms of Reference for cases.

As with CPR and APR, safeguarding nurses are identified within the team to collate information from each health contact and develop a timeline to inform the DHR report. Representatives from the safeguarding team attend all DHR meetings and participate in the development of the report. There has been nine DHRs undertaken in Cardiff since 2015 and one case in the Vale of Glamorgan. This process is likely to transfer to the RSB in 2021-22 and called a Single Unified Safeguarding Review (SUSR).

Domestic Abuse

The implementation of the Violence against Women, Domestic Abuse and Sexual Assault (Wales) Act 2015 has seen a change in the referrals, training and width and breadth of the domestic abuse agenda within the UHB as indeed across Wales. More recently the Domestic Abuse Act 2021 has contributed further to this agenda.

The Regional Multi-Agency Domestic Abuse Strategy for Cardiff and Vale of Glamorgan continues to incorporate a plan to address service need and training actions across the locality of Cardiff and Vale of Glamorgan council area. Welsh Government (WG) has provided guidance for all organisations to consider a five-year plan to meet the National Training Framework expectations to raise awareness with all employees within each organisation. Different levels of training are identified with compliance within each organisation expected to be at 100%. No additional resources have been identified by Welsh Government to achieve this target.

The UHB has provided WG with a forecast of the number of staffs completing training over the next five years. During the period April 2022 to March 2023 the Health IDVA (Health Independent Domestic Violence Advisor) has continued to raise awareness of domestic abuse and raise the profile of the IDVA role within the UHB. In line with the Violence against Women, Domestic Abuse and Sexual Violence (VAWDASV) (Wales) Act 2015 the Health IDVA has continued to deliver VAWDASV, Group 1 training which is mandatory for all staff. In addition, The UHB Safeguarding Team also continues to deliver group 2 training in line with the Welsh Government National Training Framework. There is a requirement within the VAWDASV Act that all professionals working with the public in any capacity must undertake this additional training. A broad estimate of 11,000 staff within the UHB will be expected to complete this training, 411 staff were trained within the UHB during this period. There are also plans for Group 3 VAWDASV Training to commence in 2023/2024. The Health IDVA has also continued to provide ad hoc awareness raising sessions to departments as and when required including within the Emergency Department.

The first Health Independent Domestic Violence Advisor post commenced in October 2016 with a role to deliver advocacy support within Cardiff and Vale University Health Board to clients who have experienced domestic abuse in Cardiff and the Vale of Glamorgan. The UHB is fortunate enough to now have two permanent Health IDVA positions. Within the reporting period the Safeguarding Team has also secured additional external fixed term funding for an additional Health IDVA post. It is very positive that the UHB has recognised the requirement for extra funding in this area. The benefits of a specific health based IDVA has been recognised by other health boards and Health IDVAs are now in post within Aneurin Bevan, Swansea Bay, Hywel Dda and Cwm Taf University Health Boards.

As an organisation we continue to support the White Ribbon Campaign. Several ambassadors and champions within the UHB have completed online training within their roles and departments to promote awareness and support for patients experiencing these types of abuse.

In addition to providing training and raising awareness the Health IDVA continues to provide support to survivors of domestic abuse. During the period April 2022 to March 2023, 628 Ask and Act (A&A) referrals were received. This has shown a continued high volume of referrals with an average of 52 per month which is in line with the average of 53 per month in 2021-2022. Following these referrals, safety planning has been completed with 285 clients either by telephone call or face to face, with an additional 63 of these referrals already engaged with community domestic abuse services. Of the 628 referrals received 227 have been assessed as high risk of domestic abuse by the Health IDVA service or police. In cases where assessments have been completed, individualised safety plans have been developed with support including: markers and security measures on properties, assistance to report to the police, support at Court, Clare's Law Disclosure requests, signpost referrals for counselling and referrals to specialist support services. Furthermore, 12 clients have been supported to access refuge directly from hospital. In addition, the Health IDVA has made 93 referrals to MARAC.

Following the introduction of Domestic Abuse Routine Enquiry in the Emergency Department in 2020 in response to the COVID-19 Pandemic, Routine Enquiry has remained part of practice within ED.

Table 8: Adult Safeguarding Activity: Referrals from Clinical Boards

Month	Total number of Ask and Act referrals	Positive Ask and Act referrals	Ask and Act referrals from other departments within UHB	Ask and Act referrals with disclosures from ED	Ask and Act referrals with non-disclosures from ED
Apr-22	**549**	48	21	27	501
May-22	**285**	55	27	28	230
Jun-22	**244**	56	20	36	188
Jul-22	**220**	41	19	22	179
Aug-22	**218**	44	21	23	174
Sep-22	**431**	55	18	37	376
Oct-22	**482**	52	23	29	378
Nov-22	**302**	58	25	33	244
Dec-22	**150**	45	13	32	105
Jan-23	**278**	55	19	36	223
Feb-23	**239**	53	25	28	186
Mar-23	**199**	59	18	41	140

Within the reporting period the Safeguarding Team has also secured funding for 40 personal alarms and 20 mobile phones for the clients that we support. We have also secured funding for 3 additional lone worker devices for staff experiencing domestic abuse. By providing these safety devices as part of our safety planning we are supporting survivors to feel safer within their own homes and safer continuing with their day to day routines. This supports survivors to maintain their quality of life and independence.

Domestic abuse and other forms of violence can impact negatively on an employee's health and wellbeing and staff morale. In addition, in England and Wales domestic abuse has economic costs of £14 billion arising from lost output due to time off work and reduced productivity (The Home Office, 2019). The Health IDVA supports staff members experiencing domestic abuse and within the reporting period has received 47 referrals for staff members. The Health IDVA has supported the staff members by completing regular risk assessments and working in a client led way to develop safety plans for them at home and in work. This includes working closely with managers, the UHB Health and Safety Team and UHB Security.

Police and Crime Commissioner Funded Project for: Young Person Independent Domestic Violence Adviser. The first in Wales.

The Police and Crime Commissioner has provided funding to Cardiff and Vale University Health Board (C&VUHB) to commence an exciting project for the first health, hospital based Young Person Independent Domestic Violence Advisor (YP IDVA) service, which commenced in November 2022. C&VUHB identified the need for skilled domestic abuse practitioners within the UHB that are able to respond to any disclosure of Domestic Violence or situations around possible unhealth relationships from young people accessing Hospital Services.

Whilst the legal definition of domestic abuse covers those aged 16 and above, we recognise that children under 16 years are disclosing abusive behaviours within intimate and familial relationships and support is currently limited in this area.

The project aim is to support young people presenting at Emergency Department in the first instance between the ages of 11 -17 years old who have:

- Experience of Domestic / Relationship Violence (Intimate / Familial)
- Victim of Sexual Violence
- Indicators of Sexual Exploitation

The Domestic Abuse Act (2021) reinforces and recognises that children who see, hear or experience domestic abuse, are victims in their own right.

The aim of the role is to deliver specialist advocacy and high-quality support, to those highest at risk of domestic abuse, relationship abuse and sexual violence, helping young people to be safe from harm and develop their understanding of healthy relationships.
The role is the first of its kind within Wales and funding has been secured for 3 years.

Some important aspects of the role include:

1. Information and Communication – Timely and accurate information and age appropriate communication is key to meeting young people's needs.
2. The Child's Voice – Victims want to be listened to and their views and needs taken seriously.
3. Support – The support for victims should always be of a consistently high quality and accessible to all.
4. Specialist Support – Recognition that many victims need access to specialised support.
5. Accountability – Victims should be confident that they will receive the services to which they are entitled.

Statistics collated from November 2022 – April 2023:

- 34 Referrals (Young People aged 11 – 17 years)

Referrals are generated directly from Emergency Department (ED) attendance at UHW. The service will expand to cover the children's wards during the coming year. Staff have secured training places for the YP IDVA SafeLives course which will further enhance specialised knowledge.

It is imperative that the Health based YP IDVA service continues to embed itself within the UHB and continues to grow and develop. Routine Enquiry will continue to be promoted within the ED. Furthermore, awareness of Ask and Act (for 16-17-year olds), the completion of the Health YP IDVA referral form (for 11-15-year olds) and the Health YP IDVA role will continue to be promoted across the UHB. This will be achieved through regular training to staff members.

Violence Prevention Team (VPT)

This multi-agency project launched in October 2019 in Cardiff, hosted by the Wales Violence Prevention Unit (VPU) and funded by the Home Office. Cardiff and Vale University Health Board (UHB) were invited to be part of the unit as the Emergency Department (ED) is situated in the University Hospital of Wales (UHW), which is one of the biggest and busiest in the United Kingdom. Every year thousands of people find themselves within an ED as the victim of serious violence (National Violence Surveillance Network 2019). The Violence Prevention Team (VPT) consisting of two staff members, a seconded qualified nurse and an advocate embedded alongside clinicians and trauma practitioners within the ED at UHW. This is the first model of its kind in the UK. Together the VPU comprises of members from South Wales Police, the Police and Crime Commission, Public Health Wales, Her Majesty's Prison and Probation Service, Home Office Immigration and Third Sector support services. Together they take a Public Health approach to prevent all forms of violence across Wales.

The health team based within the ED meet with patients of any age attending with Violence with Injury (VWI). Initially the project concentrated on knife related injuries, however this expanded to include all violence which incorporates Domestic Abuse. The health team approach the patient to provide support, advice and guidance as soon as it is appropriate. The focus is on building a rapport, providing personalised, holistic and integrated support, enabling patients to make informed decisions. The aim is to enable empowerment to improve the patient's well-being and then encourage patients to make informed, long-term positive plans to break away from cycles of violence. With the patients consent the team will refer to external agencies, for continued support in the community, if required following hospital discharge.

The programme objectives are:

- Assessment of all VWI and identifying appropriate pathways of support.
- A reduction in violence.
- A reduction in repeat attendances to the Emergency Department as a result of violence.
- Enabling clinical staff within Emergency Departments in being more equipped to support vulnerable people.
- Increasing incident reporting to the Police
- Improved safeguarding mechanisms for those at risk
- Improving safeguarding procedures for adolescent patients.
- Data collection

Violence Prevention Team Training

The VPT training is developed and delivered by its members in a variety of methods, including classroom-based presentations, drop-in sessions, 1:1 on the spot teaching, and recorded/online sessions. ED teaching sessions are arranged by the Emergency Unit Practice Educator often during the departments study days. All levels of staff within the department have received some form of training, including reception staff, doctors and nurses since October 2019.

It has become apparent, that due to staff rotation and turnover of staff within the department, education sessions need to be consistent and regular. The team are also visible in ED to answer staff questions and encourage engagement.

ED staff education entails:

- Raising awareness of the service and its provisions
- Identifying the VPT referral pathway
- Use of referral forms and processes
- Reporting of all knife related admissions
- Encouraging paediatric referrals
- Encouraging all safeguarding measures are met.

The team has also conducted educational sessions on the Level 3 UHB Safeguarding study days. Including the Current Safeguarding Themes full day training, since November 2019, reaching a variety of different UHB staff members.

Raising awareness has been a key part of the VPT, and contributes to the quality of service that the team provide. Within the UHB the team has liaised with other specialities, such as Major Trauma, Poisons, Drug and Alcohol Liaison Nurses and Psychiatry. The VPT have provided training and support to specialist nurses and health care assistants working in the Major Trauma Centre (MCT), and have developed a clear, robust referral mechanism between the MTC and the VPT. The VPT have recently developed a training package for the Radiology Led Discharge Team to support them in their new role within the ED.

The VPT have developed a number of service links externally to the UHB with both statutory and third sector agencies. Since the beginning of this project, work with third sector agencies have assisted, developed and enhanced the service now being provided to ED patients. Work streams have been formed allowing the team to make seamless referrals into these services; continuing support for patients from hospital and into the community. To develop external links, the VPT has presented at the Serious Youth Violence in South Wales Seminar outlining their role to a wider range of professionals and developing new operational networks. The VPT have also joined the National Violence Reduction Network, which is a bi-monthly meeting of violence reduction specialist sharing knowledge, practice and learning.

The VPT have recently been mentioned in an international publication – Slazburg Global Seminar – Global innovations on youth violence, safety and justice. Highlighting the work of the VPT and its benefits in supporting young people in Wales

COVID-19 measures and restrictions have disrupted the team's training programme, however face to face training sessions are now being resumed.

Training and Networking: April 2021 to March 2022

UHB Training Sessions	
ED Dr introduction	3 sessions (23 people in person + 8 online)
Student Nurse induction	3 individual sessions
1-1 opportunistic teaching	Not recorded (however occurs daily)
Emergency Dept drop in Session	21 Persons in person
Level 3 Current Themes	Level 3 Current Themes
External Training	
Faculty of Nursing Conference	1 Session (28+ Recorded for members)
4 Nations National Conference	1 Session (50+ Recorded for delegates)
Serious Youth Violence Champions – South Wales Police	25 online

Patient Outcomes: April 2021 to March 2022

Knife Related Injuries	117 patients	81 engaged	52 accepted ongoing support after discharge
Violence Related Injuries	697 patients	602 engaged	302 accepted ongoing support after discharge
Self-Harm/Punch Injuries	102 patients	67 engaged	25 accepted ongoing support after discharge
Retrospective MARFS or AS1 submitted	337 patients		

Evaluation

The Violence Prevention Team will work together with Public Health Wales in 2021 to evaluate the programme and services provided. The primary objectives of the evaluation are:

1. To understand the role of the NHS Violence Prevention Team (VPT) in supporting victims of violence-related injury;
2. To assess the efficacy of the VPT in addressing the needs of patients and preventing future violence related injuries;
3. To assess the effectiveness of the implementation and delivery of the VPT within the ED, and identify any developments to further enhance the role of the team;
4. To explore the value of the VPT, and consider sustainability of the model, potential for scale up, and roll-out of the intervention to other health settings in Wales.

Due to the positive outcome from the VPT evaluation, additional funding has now been provided by the Home Office to expand the VPT and develop a similar provision in Morriston Hospital A&E. The C&V VPT are working to support this team and assist them in their development.

CONTEST

Contest is the UK Government's counter-terrorism strategy. It's based on 4 themes:

- Prevent: to stop people becoming terrorists or supporting terrorism
- Pursue: to stop terrorist attacks happening
- Protect: to strengthen our protection against a terrorist attack
- Prepare: to minimise the impact of a terrorist attack

PREVENT is designed to tackle the problem of terrorism at its roots.

The aim of Prevent is to stop people from becoming terrorists or supporting terrorism. Prevent work also extends to supporting the rehabilitation and disengagement of those already involved in terrorism.

The objectives of Prevent are:

- tackling the ideological causes of terrorism
- intervening early to support people susceptible to radicalisation
- enabling people who have already engaged in terrorism to disengage and rehabilitate

The UHB Safeguarding Team, working directly with the Head of Emergency Preparedness Resilience & Response (EPRR) have developed a UHB referral pathway for UHB employees to follow when they have a concern that a service user or a member of staff maybe at risk of radicalisation.

Training in this area is disseminated to UHB employees via a workshop designed to help make staff aware of their contribution in preventing vulnerable people from being exploited for terrorist purposes.

The Safeguarding Team play a key role in this agenda, working closely with Clinical Boards and the UHB EPRR Team. The UHB are expected to report the number of staff attending the workshop to Welsh Government on a quarterly basis.

A small working group from the safeguarding team, the EPRR team and a practice educator from Emergency Department have an on-going annual work plan to ensure that the Prevent Awareness training is delivered to key groups working with members of the public and/or families in the community.

The UHB are working in collaboration with partner agencies to comply with the Department of Health and Social Care NHS PREVENT training framework (September 2022). The Strategic planning team will be introducing a training programme for champions across each Clinical Board and Corporate teams to share awareness and knowledge across the UHB.

Contextual Safeguarding

The contextual safeguarding agenda continues to evolve within adult and child safeguarding practices. Contextual safeguarding seeks to identify and safeguard young people against abuse not just within the home but within the wider environment, this is termed extra-familial abuse (Firmin 2017). Contextual safeguarding seeks to identify how professionals can safeguard children on a wider scale within the community. The way in which individuals can be safeguarded is to disrupt the environment where the abuse is occurring. Contextual safeguarding is important as family members have little influence over these contexts, the only way to access these contexts is through interagency working. Examples of contextual safeguarding are as follows:

- Criminal exploitation/county lines/sexual exploitation
- Peer on peer abuse
- Radicalisation
- Modern Slavery
- Trafficking
- Online abuse

Within the UHB this means increased multiagency partnership working to share information and establish innovative actions to safeguard individuals or a group of individuals within the community. High risk panel meetings within Cardiff driven by Children's Services, have been established to help address contextual safeguarding, these meetings take place once weekly. Young people aged under 18 years are referred into the high-risk panel meeting that are identified as being at imminent or high risk of serious harm. The high-risk panel identifies risks outside of the family home within the community. The safeguarding team have been involved in attending high risk panel meetings to share information and jointly agree a risk management plan with agencies such as children's services, youth offending services, adult services, police, children's services legal team and education. These meetings are complex and at times a group of young people at risk are discussed where there can be numerous risk factors present.

Child Sexual Exploitation continues to be a priority for Welsh Government, Regional Safeguarding Children Board (RSCB) and the National Safeguarding team in Public Health Wales. A National action plan has been introduced to ensure that all statutory agencies and Third Sectors consider how to Prepare, Prevent, Protect and Pursuit (police) will be driven through each organisation. The RSCB endorsed a CSE Strategic Group to consider the prevalence of CSE across Cardiff and the Vale of Glamorgan by undertaking a mapping study and each agency identifying the training that is delivered and sharing the resources available. This challenges the effectiveness of the activity undertaken by the Board to safeguard and promote the welfare of the children who are at risk of, or being harmed by, child sexual exploitation across the region. This is particularly pertinent as a Child Practice Review Multi-Agency Professional Forum presented a CSE case in 2016 whereby a number of children were exploited by the same perpetrator. This group has now been replaced by an Exploitation Thematic Group which is in the process of developing an Exploitation Strategy with the purpose *"to develop a robust multi-agency response to prevent and address exploitation, developing effective services to support victims of exploitation and improve the identification of victims of exploitation across Cardiff and the Vale of Glamorgan"*.

Within the UHB an increase in the workload associated with CSE has continued during 2022-23 following the introduction of additional staff in Children's Services and police to tackle the growing problem in Cardiff. This has led to regular weekly CSE, multi-agency safeguarding meetings (MASM) strategy meetings for individual children suspected to be at risk of CSE. Previously health professionals involved or working with the age group, such as school nurse, Department of Sexual Health (DOSH) or Children Looked After nurses, Sexual Assault Referral Centre (SARC) nurses and Paediatric Emergency Department nurses would attend these meetings. Following a scoping exercise conducted by C&V UHB safeguarding team from October 2022 to December 2022 it was established that a safeguarding nurse advisor would attend CSE multi - agency strategy meetings as health board representatives due to the complexity of the cases and the necessary expertise SNAs have in terms of multiagency working and resources which are available within health. This in turn will continue to reduce the risk to the most vulnerable young people in our locality.. This also proved beneficial due to the team being involved within the wider contextual safeguarding meetings and ensuring

systematic documentation of the meeting outcomes and actions on PARIS (patient electronic records) in order for Health board staff working directly with the young person to be fully informed of the outcomes. As with all strategy meetings held through the Wales Safeguarding Procedures (2019), a plan is implemented to support the child and an attempt made to prevent the child from risk of harm through abuse or neglect. In an attempt to reduce the risk associated with this type of abuse, alert flags in Emergency Department at University Hospital of Wales are placed on identified children and young people, considered to be at risk.

National Referral Mechanism (NRM)

The National Referral Mechanism (NRM) is the framework for identifying victims of human trafficking and modern slavery. Cardiff and Vale UHB Safeguarding team are part of a pilot programme which began in June 2021 with 10 sites across the UK however, between February and April 2023 the sites have increased to 20 pilot sites. The outcome of NRM referrals for children currently residing within Cardiff are no longer decided by the Home Office this has been devolved to a localised multi-agency decision, core panel members are Police, Children's Services and Health. The Single Competent Authority - Home Office will review decisions as part of the pilot, it operates a two- stage decision making process, decisions are made within 45 days to determine whether a child is a victim of Human Trafficking and/or Modern Slavery.

The Reasonable Grounds (RG) threshold is met when it is believed that an individual is a victim of slavery or human trafficking. The RG threshold is lower than the Conclusive Grounds threshold, which is decided on the balance of probabilities. Therefore, at the RG stage panel members need not be satisfied, on the balance of probabilities, that a potential victim is a victim of modern slavery when concluding a positive RG decision. The panel members must agree with the statement that there are: "reasonable grounds to believe that a person is a victim of modern slavery (human trafficking or slavery, servitude, or forced or compulsory labour)".

The conclusive grounds decision is a higher threshold than reasonable grounds decisions. NRM panel meetings take place weekly and Safeguarding Nurse Advisors (SNAs) attends these meetings. SNAs have attended additional Home Office training to enable effective decision making. Attendance at these meetings has increased multi-agency working and increased awareness of concerns within the community, prior to this health would not have information on NRM referrals submitted for children by first responders within Cardiff and would not routinely be aware of the outcomes of the referral. SNA participating as a panel member has increased knowledge and expertise that is shared throughout the UHB via safeguarding documentation in records and updating training to increase awareness to professionals.

Modern Day Slavery

Modern slavery is a serious crime in which people are treated as commodities and exploited for criminal gain. The true extent of modern slavery in the UK is unknown. Modern slavery, in particular Human Trafficking, is an international problem. Modern slavery includes human trafficking, slavery, servitude and forced and compulsory labour. Exploitation takes a number of forms, including sexual exploitation, forced manual labour and domestic servitude; victims come from all walks of life. The Modern Slavery Act 2015 outlines frontline staff responsibility to identify potential victims of modern slavery and human trafficking, refer potential victims and ensure that victims have access to services to which they are entitled. UHB employees are identifying victims and are following the Multi-Agency Response Pathway for suspected cases. Human Trafficking Multi-Agency Risk Assessment Conferences (HT MARAC) are held in Cardiff on a monthly basis, the Safeguarding Team represent the UHB at the meeting. Training for Modern Slavery is incorporated in to the Level 3 Current Themes (adult) Study Days provided by the Safeguarding Team. The training is available for UHB and GP employees. The process has been disrupted during COVID-19 and will require a recovery plan in the coming year.

There is a newly developed Safeguarding Adolescents from Exploitation (SAFE) model in place within Cardiff introduced by the Local Authority Children's Services. This model has established additional multiagency meetings to share information and discuss strategies to obtain a multiagency response to contextual safeguarding risks.

High Risk Panel Meetings have been established as part of the SAFE model, Cardiff and Vale UHB Safeguarding team have been representing health at these meetings the meetings take place weekly. The purpose of the panel meetings is to discuss children/young people that are considered at immediate risk of harm in relation to contextual safeguarding, these involve complex criminal exploitation and child sexual exploitation cases. The meetings aim to establish if a young person is at high risk of exploitation and to maintain oversight of the case. Involved agencies jointly agree a risk management plan and have a collective responsibility. Agencies will look at a form of disruption for the individual or group of young people that are being exploited. Many of the young people discussed, have difficulties with engagement, are frequently deemed as missing. This often requires ongoing strategies to try and locate and engage with the young person. We have approximately three to four high risk panel meetings taking place weekly.

SAFE Locality Operational Groups is a further multiagency meeting that has been developed as part of the SAFE model. A pilot for this group has been taking place within North Cardiff. The health Violence Prevention Team (VPT) represent health at these meetings. The group involves a wide range of professionals within the area – head teachers from local schools, local police in the area for example - PCSOs, children's services managers in the area, Media Academy Cymru, Neighbourhood Housing, Early Help, PA Service. The purpose of the operational group is to focus on areas of concern within Cardiff and share information amongst agencies. Information and local intelligence relating to contexts/locations where harm is being seen within the area is shared with partner agencies and information on peer networks. The group will discuss strategies to disrupt the context/environment that the abuse is taking place.

County Lines

County Lines is a national issue that poses a significant threat to communities and exploits the most vulnerable members of society. Vulnerable local residents will be exploited, coerced and forced to participate. Their properties are targeted and occupied (cuckooing); vulnerable people including children are groomed, intimidated and/or threatened into transporting and hosting drug related activity. The emerging themes for children and adults at risk with this activity is exploitation and abuse in all its forms, human trafficking and any associated criminal action.

Information and training have been shared by South Wales Police (SWP) to raise awareness of the growing issue identified as County Lines. Resources have been provided to partner agencies, to cascade training within their own organisations to frontline staff who are likely to see people presenting with injuries or sickness associated with the culture and crime surrounding County Lines.

The nature of any person presenting at C&V UHB is likely to be a child under the age of 18 years old or an adult deemed to be vulnerable. The threat linked to County Lines is not only a drug problem but is exacerbated by how the criminality is carried out. SWP are reporting an increase in knife crime connected to the gang culture.

Bespoke training from the safeguarding team has been provided to specific areas within the UHB most likely to come into contact with county lines activity - these areas include ED, Maternity Unit, Mental Health, GPs, DOSH, HVs and school nurses. This has informed and reinforced existing reporting arrangements to ensure raised awareness and cascading of information to all UHB staff to be alert to this emerging phenomenon. The safeguarding team are working with police and social services to provide assurance that the effects of county lines activity is addressed by health services.

Deprivation of Liberty Safeguards (DoLS)

The Cardiff and Vale UHB DoLS team operate the supervisory responsibility on behalf of Cardiff and Vale UHB, Vale of Glamorgan Council and Cardiff Council through a Partnership Management Board consisting of senior representatives of each supervisory body.
The DoLS team provide advice to Care Homes, hospital wards and Health and Social Care staff across the sector in relation to Mental Capacity Act (MCA) and DoLS.

There has been an increase in requests for assessments since March 2014 when a Supreme Court Judgement clarified DoLS. This is evidenced in the table below, during 2013-2014 pre- judgement there were 55 requests made:

Period	Number of health requests made	Number of assessments completed	Number of assessments withdrawn (no longer required)
2022/3	1247	378	725

A high proportion of DoLS requests are withdrawn within health due to a number of reasons including; the patient regaining capacity so authorisation is no longer required, the patient may be discharged before the assessment process is complete or sadly, due to the patient's death. Additional funds have been put towards DoLS assessments for the last year to increase assessment capacity and to try and improve timescale for assessment.

Historically, the DoLS coordinator was a Band 7 nurse employed by the UHB and supervised/ professionally managed by the Head of Safeguarding. Following the retirement of the DoLS Co-ordinator in January 2023 it has been agreed that the Vale Local Authority will be responsible for this post going forward, as the hosting organisation.

DoLS/MCA training is to be delivered by the UHB's MCA team going forward. The training is incorporated into existing safeguarding training however, bespoke sessions are also provided to individual wards, dietician's and physiotherapists as requested.

Liberty Protection Safeguards

On 5 April 2023, it was confirmed that the UK Government had announced their intention to step away from the introduction of the Liberty Protection Safeguards (the LPS) and the implementation of the Mental Capacity (Amendment) Act 2019 (the 2019 Act). UK Government confirmed that the necessary legislation to implement the LPS would not be brought forward within this Parliament. Welsh Government voiced their deep disappointment with this decision not to proceed with implementation at this time; outlining that the right to liberty is one of our most fundamental human rights.

Despite this, the Welsh Government have committed to continue to provide funding comparable to 2022/3 levels, to ensure that there is a continued momentum to raise the profile of the Mental Capacity Act, provide increased training and to manage the current DoLS system, to ensure that Wales is in a better position to transition to the LPS.

Mental Capacity Act

A significant amount of work has been put into to developing a Mental Capacity Team within the UHB to provide increased support for staff and to further protect the vulnerable individuals that we care for. The team provides expert advice and guidance for clinicians relating to all aspects of the Mental Capacity Act (2005).

Mandatory training is delivered on a monthly basis and rotated between UHW, UHL and Teams. Bespoke sessions for clinical areas are also available on request.

Due to the increased funding made available from Welsh Government in relation to the LPS, we have been fortunate to be able to supplement this with a full day's Zoom course focused upon assessing mental capacity and best interests decision making provided by an external training provider; with 491 staff having attended this training during 2022/3.

In addition, 10 staff have been funded to undertake an MSc module provided by Swansea University entitled 'Assessing Decision Making Capacity'. The aim of this module is to provide high level knowledge and expertise in carrying out complex mental capacity assessments. Staff who have completed this course are expected to act as mental capacity champions within their clinical area, provide support to staff, highlight issues of concern and act as a link with the MCA Team.

Awareness of the MCA and its principles has also been raised through the development of posters and leaflets for staff. In 2023/4 the team is due to expand following the recruitment of 2.0 Band 7, Mental Capacity Specialist Practitioners, to provide more direct, hands-on support and guidance to staff.

Sexual Assault Referral Centre (SARC), Ynys Saff

Sexual Assault Referral Centre (SARC), Ynys Saff Cardiff and Vale UHB hosts Ynys Saff, the multi-agency Sexual Assault Referral Centre (SARC), in Cardiff Royal Infirmary. The service delivers a comprehensive quality service for victims of sexual assault for adults and children in Cardiff and the Vale of Glamorgan; it also offers a provision for children across South and Mid Wales region who are victims of an acute assault. Ynys Saff sits within the governance framework of the Children and Women Clinical Board. The UHB Safeguarding Team support the service in relation to safeguarding activity with the Safeguarding ISVA/IDVA linking in with SARC ISVAs and making the appropriate referrals to SARC to ensure a wrap- around service for the client.

Referral Data

01/04/2019 – 31/03/2020 – 660 referrals
01/04/2020 – 31/03/2021 – 470 referrals (COVID data)
01/04/2021– 31/03/2022 – 742 referrals

The service continues to provide interview facilities for the police. The Independent Sexual Violence Advocate (ISVA) and Child and Young Person Violence Advocate (CYPSVA) service has continued to develop, with support being offered either remotely, or in person as required.

Children's counselling has continued over the phone and in person. Increased funding from Welsh Government has allowed a reduction in the waiting list for counselling from 2 years previously to 8 weeks for phone counselling and 16 weeks for face to face. There will be no further funding from Welsh Government so it is anticipated this will increase waiting time.

Adult counselling has been via the telephone, "Attend Anywhere" or face to face. The introduction of a new process has seen a significant decrease in the waiting list times and number of clients waiting to be seen. Current waiting time is around 8 weeks for both telephone and face to face whereas previously waiting time was up to 12 months and longer.

Ynys Saff continue to work closely with the Department of Sexual Health, ensuring all options are offered to client to meet their health needs. These pathways are being audited and reviewed regularly. Further work to strengthen links with regional sexual health services will continue as the regional service develops further.

ISO accreditation

Work has been completed to create and update forensic suites to allow forensic medical examinations in line with ISO accreditation. The ISO accreditation work continues at pace, with hope to meet all standards required by October 2023.

Regional SARC developments and Welsh Sexual assault services (WSAS)

Progress continues to implement the Welsh sexual assault services regional plans, with acute forensic cases that would have previously been seen in Merthyr SARC, now being seen in Ynys Saff. Work has been completed to ensure facilities meet ISO standards. Ynys Saff were also provided with funds from the Cardiff and Vale charity to provide wall art in the new areas.

The Outline Business case for the wider CRI development has been submitted to Welsh Government and we are currently waiting for feedback whether the project will be moving forward.

The acute forensic cases from Risca SARC will be transferring to Ynys Saff later in the year once adequate staffing measures are in place. The wrap around care, with respect to ISVA support, Counselling, and sexual health follow up, will continue to be provided by the locality teams as per the hub and spoke model.

Ynys Saff SARC continues to host the interim Paediatric regional service for children across the whole of the South and Mid Wales region. During this period 57 children under the age of 14 years were seen for sexual assault medicals within Ynys Saff. This remains a vast under representation number of children who are experiencing sexual assault, and work is continuing to work with multiagency teams to increase disclosures and ensure clear pathways are in place to ensure all medical needs are met. The interim model offers five afternoon

clinics (Monday to Friday) with provision for:

- Acute service for children and young people up until their 14th birthday who may have experienced rape or sexual abuse
- Historic cases requiring a medial assessment of children residing in Cardiff and Vale UHB, and Cwm Taf Morgannwg UHB (comprising Bridgend, Merthyr Tydfil, Rhondda Cynon Taff)

Regular peer review is held within Ynys Saff for Cardiff Paediatricians. Out-of-hours cover for the regional SARC service continues to be covered by the Cardiff and Vale community paediatric safeguarding rota however regional workforce planning meetings are due to commence in the near future to establish a regional out of hours SARC service with a degree of urgency. Although workforce planning remains a challenge with respect to both the second planned Swansea hub, and the out of hours rota there is a commitment from the regional board to support this.

Training and Development

HEIW are funding the RCPCH/FFLM Paediatric sexual offences medicine course in Cardiff for Welsh medical staff in April 2023 which will increase the workforce with up to date training. The Welsh sexual assault services team are also providing a range of lunch and learn sessions to increase knowledge and confidence around a wide range of topics linked to sexual assault. A Welsh sexual assault services conference will be running in June 2023.

Children Looked After Team

Children Looked After represent one of the most vulnerable groups of children in modern society. It is well evidenced that these children and young people have adverse health outcomes owing to their early life adversity. Cardiff and Vale UHB have both corporate parenting responsibilities as well as statutory obligations to perform health assessments aimed at identifying unmet health needs, improving health outcomes and reducing health inequalities.

A small but dedicated team of staff are employed to fulfil these requirements. Within 5 working days, the UHB should receive notification from the Local Authority that a child has become looked after. The initial health assessment must be completed within 28 days of the child entering care with review assessments required annually for children over the age of 5 years, and 6-monthly for children under 5 years of age.

An audit looking at the delays in completing the statutory health assessment was completed in 2021. This highlighted significant delays in both the notifications being received (26% compliant) and the health assessment being completed (2.4% compliant). This data was shared with the Clinical Board and a staged approach to recruitment of nurse specialists for looked after children was agreed. 2.8 WTE nurses were appointed in March 2023 as an immediate action and further recruitment stages are to be reviewed over the next few months. Following the appointment of the additional nurses the working model adapted to one where all children over the age of 5 years are assessed by the specialist nursing team, whereas it had been those over the age of 10 previously. However, vacancies remain within the medical team for looked after children, adoption and fostering.

There has been a consistent increase in children in care in Cardiff and the Vale of Glamorgan rising from 840 in 2017, to 1,275 in March 2022 and 1,469 in March 2023. Of these 180 children were under adoption regulations and 402 are placed outside of the Cardiff and Vale area. It is clear that whilst the numbers are increasing, the complexity of the cases and difficulties faced by these young people are also rising.

Historically, as a city of sanctuary, Cardiff and Vale UHB have always received unaccompanied asylum-seeking children who fall under the remit of Children Looked After being cared for by the Local Authority. The introduction of the National Transfer Scheme across Wales has resulted in Cardiff and Vale UHB receiving 69 unaccompanied asylum-seeking children. No additional resources have been received to meet this increased demand.

In addition to the health needs of the children and young people, the paediatricians are responsible for reviewing the health needs of all adults applying for positions as foster carers, kinship carers and adopters and attending adoption and fostering panels.

Learning Disability

Learning from three Serious Incident reviews in 2015 and a Safeguarding an Adult at Risk case in 2016 highlighted the need for service improvements required for Learning Disability (LD) patients within the UHB. Progress has been made to improve the quality of care provided to patients with LD. This has been achieved through the "1000 Lives" care bundle launch and implementation development of a "flagging" system of immediate alerting across acute areas, modification of NEWS escalation of deteriorating condition response, risk assessment of immediate need and reasonable adjustments required to care. 250 resource files giving staff advice on implementing the care bundle has been obtained and distributed across Adult, Mental Health and Children and Women service areas. In addition, a daily Business Intelligence System (BIS) report gives notification of all in-patients with LD allowing prompt review of this vulnerable group. There is also a weekly report of mortality within LD patients, allowing level 2 mortality reviews to be chased for learning. Easy read qualitative feedback questionnaires are automatically sent out to patients with LD and also to family and carers after an admission or an outpatient appointment in order to enable learning has been introduced.

The launch in November 2018 of UHB LD Champion Roles, identified staff from all wards and departments to take the lead and raise awareness within their clinical area. Over 150 staff have been trained to date, training is provided on a six-monthly basis (COVID-19 permitted). This will enhance dissemination of available resources and share good practice across the breadth of C&V UHB. An additional Level 3 Safeguarding Themes (Adults) training session incorporates information for practitioners, this event was launched in November 2019. We have worked with Hijinks Drama Company to produce 4 film clip learning from real life situations which challenge staff to appropriately care for patients, with LD. The UHB continues to work in partnership with Swansea Bay Health Board for LD services that are commissioned in community settings. In addition, we now have two UHB Acute Liaison Nurses since June 2020. The posts support all areas with training and advice when individuals with LD are admitted to hospital. The post was identified as a priority within the joint LD commissioning strategy developed for the region. The priorities also include the progression of LD primary care liaison targeted at raising awareness and training on management of individuals and to improve the uptake of an annual health check. An action plan to progress work in this area is in place, both Cardiff and Vale of Glamorgan Local Authorities as well as the UHB are committed to this workstream.

Updates include:

- The Paul Ridd Foundation E-Learning has now been agreed as being mandatory for all public facing staff. This applies to staff directly employed by CAVUHB, and will be incorporated going forward in SLA and contractual arrangements also for all staff providing services on behalf of the Health Board.
- Work continues to ensure that a Learning Disability Champion is accessible to all staff across all patient facing areas and services.

Cardiff and Vale UHB Youth Board

The Youth Board was introduced in 2018 following a recruitment process within the Children and Women CB. This aligned with the launch of the UHB Children's Charter, which was developed from the participation via focus groups of approximately 200 children and young people from Cardiff and Vale of Glamorgan. The focus groups included participants from a wide range of backgrounds, educational levels, ethnicities, genders and sexualities. A representative from the safeguarding team attends appropriate meetings to offer safeguarding advice as appropriate. Safeguarding training has been delivered to the Youth Board to raise awareness of safeguarding matters, how to recognise a concern and to report appropriately. They have created an animation for use in Safeguarding training, which informs learners about the UNCRC (United Nations Convention on the Rights of the Child), from the perspective of a child.

The Youth Board assisted with the questions for the safeguarding audit of "Risk Assessment of Young People Admitted to Adult Wards" to ensure the language was suitable for children and offered the opportunity for honest feedback. They continue to offer meaningful contributions to UHB decisions, ensuring a Children's Rights approach is a constant consideration. Youth Board members complete online mandatory safeguarding training as part of the volunteer service agreement.

In addition, the Youth Board are consulted in relation to numerous interventions such as:

Public Health:
Healthy Weight Healthy Wales (multiple meetings)
Energy drinks consultation
Teenage Immunisations (multiple meetings)
Smoking strategy

Emotional Well-being:
Reviewing CAMHS documentation and letters home
Input into new CAMHS pathways
Design of, development of and then population of new UHB website
Writing of and voicing or starring in 'help' videos for other young people
Input into 'Empower', including naming and logo
Advising on the decoration in Paediatric Emergency Department

Interviewing:
For our new CEO
For our director of nursing
Many CAMHS nurse roles
Many clinical psychologists' roles
Community Connectors (new social prescribing roles)
Included as panel members for the commissioning of a new service for young people
Child Friendly Cities/UNICEF
Feedback consultation / Video content

Comms:
Support with UHB TikTok account
Videos for TikTok on 'back to school advice'
Six-month update interview with Suzanne Rankin (Chief Executive)
Celebration of South Asian month

Advice for specific clinical areas:
Advising on decorating styles for the Paediatric are within the Emergency Department at UHW

Safeguarding Team Achievements

- Launch of Group 3 multi-agency VAWDASV training
- Two Group 3 Trainers identified within the safeguarding team and completed Train the Trainer
- Safeguarding Nurse Advisor participation in the Home Office NRM process for Cardiff
- Annual twice a year safeguarding education for District Nurses delivered as a full day session
- Successful 6- month secondment of the Regional Safeguarding Board Business Manager to the UHB as a Consent Lead
- Implementation and awareness training across the UHB in relation to Children (Abolition of Defence of Reasonable Punishment) (Wales) Act 2020
- Completed a Safeguarding Training Strategy
- Assisted with the safeguarding aspect for GP pathways
- Completed 3 posters for the Public Health Wales Conference. Emergency Department also submitted a poster
- Participating in a stakeholder's scrutiny of the Joint Inspection of Child Protection Arrangements (JICPA)
- Introduction of a UHB Medical Workforce online safeguarding training for UHB staff visiting as observers and those with honorary contracts

Audit's and Additional Work Undertaken or Commenced within Clinical Areas:

- Audit of police PPNs and AS1 referrals to Local Authority teams as part of the Regional Safeguarding Board Quality Assurance work completed by UHB Safeguarding Nurse Advisor
- Mental Health for Older People Lead Nurse completed a questionnaire to staff to evaluate their perception on safeguarding issues
- Digitalised format of MARF on ED Workstation completed by Senior Nurse in ED
- Introduction of Vale of Glamorgan Children's Services Strategy Meetings undertaken by UHB Safeguarding Nurse Advisors
- Adaptions and some changes to safeguarding supervision provided to service areas by safeguarding nurse advisors

Safeguarding Audit's undertaken by 3rd/ 4th Cardiff University Medical Students:

Project: Evaluation of Community Assaults in Young People in South Wales

- **Regional Safeguarding Board Safeguarding Nominations 2022-2023:**

- E Gerrard & S Mathew: **Category 4: Excellent contribution to safeguarding practice**
- Kate Roberts / Wendy Simmonds: **Category 5: Significant wider community safeguarding**
- IDVAS: **Category 4: Excellent Contribution to Safeguarding Practice**

Forecast 2023-2024

Continuing with the achievements made, sustaining and maintaining the safeguarding agenda workload is challenging for the UHB safeguarding team. This is an area that continues to evolve with emerging themes such the overarching Contextual Exploitation. Ensuring that the UHB staff are prepared and aware of their professional duty to report, through providing specific training has been considered and discussed with all appropriate clinical areas. Additional training resources from within the team will be required through 2023-24 and onwards to provide Group 2 Domestic Abuse Training across the UHB, in line with WG expectation. The safeguarding team has proved that it is an innovative team that demonstrates the ability to adapt to contemporary situations. Ensuring that staff resources are available to cover three sites is often demanding, particularly considering the amount of work generated within Cardiff MASH, the multi-agency commitments to the RSB and Public Health Wales Safeguarding Service workplan. The team will strive to resume the energy demonstrated to address the safeguarding agenda and ensure that staff and the public are safeguarded appropriately by the UHB. However, the UHB may need to consider if additional resources are required to bolster the safeguarding team to achieve the ambitious actions for the coming year. Further work during 2023-2024 will include:

Action	Service Delivery
Demonstrate partnership working to engage with communities in relation to anxieties around Female Genital Mutilation (FGM) reporting	Corporate Safeguarding Team & Regional Multi-Agency Partners
Report evaluation of HV preceptorship training	Corporate Safeguarding Team & UHB Health Visiting Service
Develop a UHB leaflet explaining the PRUDiC process and the overlay aspect	Corporate Safeguarding Team, South Wales Police and Children & Women Clinical Board
Undertake an annual internal UHB Pressure Damage audit across all Clinical Boards	Corporate Safeguarding Team & Clinical Boards
Audit of young people placed on Acute Adult Mental Health wards	Corporate Safeguarding Team & Children & Women/ Mental Health Clinical Board
Audit of safeguarding cases discussed in supervision	Corporate Safeguarding Team & Service Groups
Audit of the use of the safeguarding chronology documentation in acute paediatrics	Corporate Safeguarding Team & Paediatricians
Audit the effectiveness of the multi-agency contextual safeguarding pathway within health	Corporate Safeguarding Team
Consider a new logo for the UHB Safeguarding Team, designed by the Youth Board	Corporate Safeguarding Team & UHB Youth Board
Resume UHB Safeguarding Team Newsletter	Corporate Safeguarding Team
Report evaluation of HV preceptorship training	Corporate Safeguarding Team: Training
Launch of Multi-Agency Hub in ED: Cynnwys	Corporate Safeguarding Team & Medicine Clinical Board
Launch a Child Criminal Exploitation Toolkit	Violence Prevention Team & Cardiff University

Action	Service Delivery
Complete a Business Case for additional UHB Safeguarding Nurse Advisors	Corporate Nursing
Consider the UHB position to employing additional IDVAs within the UHB	Corporate Nursing
Complete a safeguarding template proforma for children under 5 years transferred in to area	Corporate Safeguarding Team
Violence Prevention Team to develop training aimed at Year 5 Medical Students raising awareness of Domestic Abuse/ Violence/ Human Trafficking and Honour Based Violence	Corporate Safeguarding Team
Work in partnership with the UHB Patient Experience Team to implement the Duty of Candour in line with Health & Social Care (Quality & Engagement) (Wales) Act 2020	Corporate Safeguarding Team
Update the Safeguarding Training Strategy	Corporate Safeguarding Team
Evaluation of safeguarding training feedback from participants	Corporate Safeguarding Team
Develop a standard letter to patients explaining the adult safeguarding outcome following a referral	Corporate Safeguarding Team & All Clinical Boards
Develop a UHB standard template for an internal safeguarding adult protection plan	Corporate Safeguarding Team & all Clinical Boards
Implement a survey with staff involved in a professional concern process	Corporate Safeguarding Team, Corporate Management and People's Services Team
Standardise People's Services Incident Fact Finding Form for Professional Concerns	People's Services, Corporate Safeguarding Team and all Clinical Boards
Undertake and implement Offensive Weapons Homicide Training in line with Home Office Guidance	Corporate Safeguarding Team
PREVENT champion to be nominated from the safeguarding team	UHB Strategic Planning Team & Corporate Safeguarding Team
Launch of Group 2 Mandatory Domestic Abuse Ask & Act Training within the UHB	Corporate Safeguarding Team
Launch of UHB Group 3 Train the Trainer Domestic Abuse training	Corporate Safeguarding Team
Safeguarding overview and alignment with Mental Health for the Multi Agency Public Protection Arrangement (MAPPA)	Mental Health Clinical Board & Corporate Safeguarding Team
Development of Medical Workforce online safeguarding training for UHB staff observers and honorary contracts	Corporate Safeguarding Team
Consider alignment of the UHB Level 2 Safeguarding Adults training with Cardiff Local Authority	Corporate Safeguarding Team
Audit of 16 year olds attending ED and stating attendance at higher education at college or six form college	Corporate Safeguarding Team

Action	Service Delivery
Implement attendance at Vale Local Authority Children's Services Strategy Meetings	Corporate Safeguarding Team
Implement attendance at Vale Children's Services Exploitation	Corporate Safeguarding Team
Implement and embed the updated multi-agency PRUDiC Procedure	Corporate Safeguarding Team
Consider a review of the Safeguarding Training delivered within the UHB by the Corporate Safeguarding Team	Corporate Safeguarding Team
Develop and introduce a Professional Abuse Questionnaire for UHB employees involved in this process	Corporate Safeguarding Team, People's Services, Equality Lead
Develop and introduce a questionnaire for UHB employees that have received services from the Health IDVAs	Corporate Safeguarding Team, People's Services, Equality Lead
Develop a pathway for Executives to be informed when safeguarding become aware that a Registered Sexual Offender is admitted as a patient or visiting others	Corporate Safeguarding Team
Commence work with each Clinical Board (CB) to complete a Self -Assessment based on the Safeguarding Maturity Matrix, to demonstrate where each CB consider their safeguarding remit, knowledge and participation to be	Executive and Corporate Safeguarding Team, all Clinical Boards.
Develop and evaluate a questionnaire for staff and service users of the Health Violence Prevention Team	Corporate Safeguarding Team
Participate in the Department of Health and Social Care NHS PREVENT training framework for the UHB	Corporate Safeguarding Team, Strategic Planning Team
UHB Safeguarding Team to attend multi-agency Chanel Panel (PREVENT) meetings as representatives for health. This has previously been attended by the UHB Strategic Planning Team.	Corporate Safeguarding Team
Raise awareness across the UHB of the action and reporting required to address emerging themes of "Sexual Assaults in a hospital setting" raised by a published report by Women's Rights Network April 2023	Executive and Corporate Safeguarding Team, Directors of Nursing, Medical Director's, People's Services

Summary

Since April 2014, the National and indeed International safeguarding landscape has broadened. We have seen the introduction of two significant Acts of law in Wales which has impacted on the safeguarding work stream across the UHB requiring significant changes in process, additional training and supervision as well as relocation of existing resources. Further legislation from the Home Office has also defined the need to raise awareness of Domestic Homicide and FGM. The Modern Slavery Act (2015) is another area whereby the safeguarding team need to work with partner agencies to raise staff and public awareness.

During the time period of this report the NHS has experienced significant issues in recruitment and retention of staff across all areas. The use of agency and bank staff has been widespread across clinical areas. This has identified learning around staff mandatory training and increased professional concerns due to care provided to patients. This has been addressed appropriately at the time however it is fair to say that the increase in advice and management of safeguarding cases has impacted on the UHB Safeguarding Team. The team workplan reflects how we are able to map targeted training and supervision of staff. Through staff surveys and audit of the team service delivery we aim to provide a good quality safeguarding service within the UHB. However, the UHB will need to consider how the corporate safeguarding team are able to achieve the growing demands of an increasing workload and the ability to achieve effective results given the forecast of areas that are needing to be addressed.

The Cardiff and Vale University Health Board Safeguarding Team will strive to continue to meet all of the demands set by the UHB and Welsh Government to ensure the safety and safeguarding of children and adults at risk that become known to us. This will only be achieved by continuing to work collaboratively with our strategic partners and internally within the UHB through the Executive Teams and Clinical Boards; ensuring that communication and decision making is embedded in open, honest and transparent practice.

Acknowledgement is given to all UHB professionals who contributed to this report, thank you.

Report Title:	**Corporate Meeting Schedule 2024/2025**			Agenda Item no.	7.10
Meeting:	Public Board	Public	X	Meeting Date:	30.11.2023
		Private			
Status *(please tick one only):*	Assurance		Approval X	Information	
Lead Executive:	**Director of Corporate Governance**				
Report Author (Title):	**Senior Corporate Governance Officer**				

Main Report
Background and current situation:

Each year the Corporate Meeting Schedule is developed to plan out the Board and Committee meeting dates for the following year. This exercise has been completed in relation to 2024/25 and, accordingly, the draft Corporate Meeting Schedule for the year 2024/2025 is being presented to Board for formal approval.

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

The proposed Corporate Meeting Schedule for 2024/2025 is attached at Appendix 1 of this report. The purpose of the said schedule is to ensure that key reporting requirements are met, such as the end of year reporting/ sign off of annual accounts, and also to provide the appropriate timescales to enable the Corporate Governance team to publish Board and Committee papers in order to comply with the Health Board's internal rules, including its Standing Orders.

It is crucial that the dates set out in the Corporate Meeting Schedule are adhered to. Accordingly, if Committee Chairs or Executive Leads are unable to attend agenda settings, arrangements should be made for the relevant Vice Chairs and/or Executive Deputies to represent them in their absence. This should ensure smooth running of the process and provide report authors with the appropriate length of time to prepare reports in advance of the report submission deadlines.

Where there is a requirement to set up an additional "special" meeting, this will be facilitated by the Corporate Governance Team and the Corporate Meeting Schedule will be updated to reflect the same.

Recommendation:

The Board is requested to:

a) **Note** and **approve** the draft Corporate Meeting Schedule for 2024/25, a copy of which is attached as Appendix 1.

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

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

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

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

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: 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:
Management Exec	20.11.2023

Saunders,Nathan
20/11/2023 15:51:45

CORPORATE MEETING SCHEDULE 2024 - 25												
Dates	**Senior Leadership Board / Sustainability Programme Board**	**Audit**	**Board / Development Board**	**Board of Trustee**	**Charitable Funds**	**Digital & Health Intelligence**	**Finance & Performance**	**Health & Safety**	**Mental Health Capacity Legislation**	**Quality, Safety & Experience**	**People & Culture**	**Stakeholder Reference Group**
Apr-24												
Agenda Setting		19 February 2024		27 March 2024			20 March 2024	26 February 2024	18 March 2024	05 March 2024		
Deadline for Papers	28 March 2024	18 March 2024		19 April 2024			02 April 2024	25 March 2024	15 April 2024	08 April 2024		
Date of Meeting	**04 April 2024**	**02 April 2024**	**25 April 2024**	**09 May 2024**			**17 April 2024**	**09 April 2024**	**30 April 2024**	**23 April 2024**		
Agenda Setting												
Deadline for Papers	11 April 2024											
Date of Meeting	**18 April 2024**											
May-24												
Agenda Setting		25 March 2024	17 April 2024			15 April 2024	17 April 2024			**23 April 2024**	01 April 2024	
Deadline for Papers	25 April 2024	22 April 2024	10 May 2024			13 May 2024	07 May 2024			06 May 2024	29 April 2024	
Date of Meeting	**02 May 2024**	**07 May 2024**	**30 May 2024**			**28 May 2024**	**22 May 2024**			**21 May 2024**	**14 May 2024**	
Special Meeting		***07 MAY *WORKSHOP****										
Agenda Setting												
Deadline for Papers	09 May 2024											
Date of Meeting	**16 May 2024**											
Jun-24												
Agenda Setting					29 April 2024		22 May 2024			21 May 2024		
Deadline for Papers	30 May 2024		07 June 2024		27 May 2024		04 June 2024			10 June 2024		
Date of Meeting	**06 June 2024**		**27 June 2024**		**11 June 2024**		**19 June 2024**			**25 June 2024**		
Agenda Setting												
Deadline for Papers	13 June 2024											
Date of Meeting	**20 June 2024**											
Jul-24												
Agenda Setting		20 May 2024	12 June 2024				19 June 2024	17 June 2024		25 June 2024	28 May 2024	
Deadline for Papers	27 June 2024	17 June 2024	05 July 2024				02 July 2024	15 July 2024		08 July 2024	24 June 2024	
Date of Meeting	**04 July 2024**	**02 July 2024**	**25 July 2024**				**17 July 2024**	**30 July 2024**		**23 July 2024**	**09 July 2024**	
Special Meeting		**23/07/2024 ACCOUNTS**	**23/07/2024 ACCOUNTS**									
Agenda Setting												
Deadline for Papers	11 July 2024											
Date of Meeting	**18 July 2024**											
Aug-24												
Agenda Setting						01 July 2024	17 July 2024		24 June 2024	23 July 2024		
Deadline for Papers	25 July 2024		09 August 2024			29 July 2024	06 August 2024		22 July 2024	12 August 2024		
Date of Meeting	**01 August 2024**		**29 August 2024**			**13 August 2024**	**21 August 2024**		**06 August 2024**	**27 August 2024**		
Agenda Setting												
Deadline for Papers	08 August 2024											
Date of Meeting	**15 August 2024**											
Sep-24												
Agenda Setting		22 July 2024	14 August 2024		05 August 2024		21 August 2024			27 August 2024	29 July 2024	
Deadline for Papers	29 August 2024	19 August 2024	06 September 2024		02 September 2024		03 September 2024			09 September 2024	26 August 2024	
Date of Meeting	**05 September 2024**	**03 September 2024**	**26 September 2024**		**17 September 2024**		**18 September 2024**			**24 September 2024**	**10 September 2024**	
Agenda Setting												
Deadline for Papers	12 September 2024											
Date of Meeting	**19 September 2024**											
Oct-24												
Agenda Setting				31 July 2024			18 September 2024	02 September 2024	16 September 2024	24 September 2024		
Deadline for Papers	26 September 2024		04 October 2024	23 August 2024			08 October 2024	30 September 2024	14 October 2024	07 October 2024		
Date of Meeting	**03 October 2024**		**24 October 2024**	**12 September 2024**			**23 October 2024**	**15 October 2024**	**29 October 2024**	**22 October 2024**		
Special Meeting												
Agenda Setting												
Deadline for Papers	10 October 2024											
Date of Meeting	**17 October 2024**											
Nov-24												
Agenda Setting		23 September 2024	16 October 2024			30 September 2024	23 October 2024			22 October 2024	07 October 2024	
Deadline for Papers	31 October 2024	21 October 2024	08 November 2024			28 October 2024	05 November 2024			11 November 2024	04 November 2024	
Date of Meeting	**07 November 2024**	**05 November 2024**	**28 November 2024**			**12 November 2024**	**20 November 2024**			**26 November 2024**	**19 November 2024**	
Agenda Setting												
Deadline for Papers	14 November 2024											
Date of Meeting	**21 November 2024**											
Dec-24												
Agenda Setting					28 October 2024		20 November 2024			26 November 2024		
Deadline for Papers	28 November 2024		22 November 2024		25 November 2024		26 November 2024			02 December 2024		
Date of Meeting	**05 December 2024**		**12 December 2024**		**10 December 2024**		**11 December 2024**			17 December 2024		
Agenda Setting												
Deadline for Papers	12 December 2024											
Date of Meeting	**19 December 2024**											
Jan-25												
Agenda Setting			18 December 2024	11 December 2024			11 December 2024	02 December 2024	16 December 2024	17 December 2024	12 December 2024	
Deadline for Papers	03 January 2025		10 January 2025	03 January 2025			07 January 2025	30 December 2024	13 January 2025	03 January 2025	09 January 2025	

Date of Meeting	09 January 2025		30 January 2025	23 January 2025			22 January 2025	14 January 2025	28 January 2025	21 January 2025	24 January 2025	
Agenda Setting												
Deadline for Papers	16 January 2025											
Date of Meeting	**23 January 2025**											
Feb-25												
Agenda Setting		04 January 2025				06 January 2025	22 January 2025			21 January 2025		
Deadline for Papers	30 January 2025	20 January 2025	07 February 2025			27 January 2025	04 February 2025			10 February 2025		
Date of Meeting	**06 February 2025**	**04 February 2025**	**27 February 2025**			**11 February 2025**	**19 February 2025**			**25 February 2025**		
Agenda Setting												
Deadline for Papers	13 February 2025											
Date of Meeting	**20 February 2025**											
Mar-25												
Agenda Setting			12 February 2025		03 February 2025		19 February 2025			25 February 2025	27 January 2025	
Deadline for Papers	27 February 2025		07 March 2025		03 March 2025		04 March 2025			10 March 2025	24 February 2025	
Date of Meeting	**06 March 2025**		**27 March 2025**		**18 March 2025**		**19 March 2025**			**25 March 2025**	**11 March 2025**	
Agenda Setting												
Deadline for Papers	13 March 2025											
Date of Meeting	**20 March 2025**											

= Quarterly SLB/SPB

Development Board Dates

Report Title:	**South Wales Sexual Assault Referral Centres (SARC) Regional Model Implementation Report**			Agenda Item no.	7.11
Meeting:	UHB Board	Public	X	Meeting Date:	30.11.2023
		Private			
Status *(please tick one only):*	Assurance		Approval	X	Information
Lead Executive Title:	Stephen Harrhy, Chair Welsh Sexual Assault Services Programme/ Director National Commissioning Collaborative Unit				
Report Author (Title):	Joanna Williams, Programme Director Welsh Sexual Assault Services Programme				

Main Report
Background and current situation:

The purpose of this report is to provide an update on the implementation of the South Wales Sexual Assault Referral Centres (SARC) Regionalisation Programme following the Business Case approval in 2019.
Also, to request that Health Boards approve that the WHSSC Joint Committee undertake the reporting function for the programme and to request approval for an in-year funding uplift and the continuation of funding for Phase 2 of the Regionalisation Programme at the current level

The WHSSC Joint Committee received a report on 19 September 2023, see Appendices 1a-d (which can be located in the supporting documents folder), and considered and supported:

- the updated South Wales Sexual Assault Referral Centres (SARC) Regionalisation Programme model,
- that the WHSSC Joint Committee will fulfil the CEO reporting function for the programme from 1 April 2023,
- an in-year funding uplift of £347k and a recurrent full year funding of up to £506k by 2025/26 for phase 1 of the implementation of the SARC Regionalisation Programme; and
- a continuation of funding for Phase 2 at the current level.

Accountability for the delivery of the programme remains with the seven HBs it is now being presented for approval.

Background:

SARC services perform a vital role for victims of rape and sexual abuse, they provide acute medical examinations, therapeutic support, and gathering of forensic evidence and independent advocacy that supports victims through their journey of recovery.

Following a review conducted by Welsh Government (WG) in 2013, the current model for SARC services was recognised as being inadequate for delivering the standards of medical care and therapeutic support needed to empower survivors of serious sexual abuse to both go through the criminal justice system and to recover from their trauma. This was the basis on which the South Wales SARC Regionalisation Programme was established in 2013 with the new Health Led Collaborative Model being agreed in 2019. This agreement included a financial model which would see a 50/50 split between Health and Police for the funding for SARC services.

In 2020, the programme governance was paused due to the COVID-19 pandemic, which delayed the implementation of the operational model. During this time, the significance of ISO accreditation requirements became apparent with the risk that evidence gathered from victims from unaccredited SARCs will potentially be inadmissible in court after October 2023. This could jeopardise victims'

chances of a successful legal outcome. This specifically relates to the Phase 1 (Acute) Forensic and Medical examination.

Assessment:

The full details and financial modelling are contained in the attached Governance Briefing Paper at Appendix 2 which can be located in the supporting documents folder.

Note that any changes to the service model and funding requirements will need to be considered by the individual commissioning organisations through their internal governance structures.

Recommendation:

The Committee is requested to:

a) Note this report
b) Note that the WHSSC Joint Committee received a report on 19 September 2023 regarding the updated South Wales Sexual Assault Referral Centres (SARC) Regionalisation Programme model, and considered and approved a number of recommendations, however as accountability for the delivery of the programme remains with each HB they are now required to consider and approve the recommendations though their formal Board meetings
c) Approve the updated South Wales Sexual Assault Referral Centres (SARC) Regionalisation Programme model
d) Approve that the WHSSC Joint Committee undertake the reporting function for the programme from 1 April 2023
e) Approve an in-year funding uplift of £347k and a recurrent full year funding of up to £506k by 2025/26 for phase 1 of the implementation of the SARC Regionalisation Programme; and
f) Approve the continuation of funding for Phase 2 at the current level.

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please place an "X" in the below boxes as relevant

1. Reduce health inequalities	X	6. Have a planned care system where demand and capacity are in balance	X
2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	X
4. Offer services that deliver the population health our citizens are entitled to expect	X	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
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 place an "X" in the below boxes as relevant

Prevention		Long term		Integration	X	Collaboration	X	Involvement	X

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

Risk: Yes/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:

Governance and Assurance	
Link to Strategic Objectives	
Strategic Objective(s)	Governance and Assurance Choose an item. Choose an item.
Link to Integrated Commissioning Plan	-
Health and Care Standards	Safe Care Effective Care Governance, Leadership and Accountability
Principles of Prudent Healthcare	Reduce inappropriate variation Choose an item.
NHS Delivery Framework Quadruple Aim	People in Wales have improved health and well-being with better prevention and self-management The health and social care workforce is motivated and sustainable People in Wales have better quality and accessible health and social care services, enabled by digital and supported by engagement Choose an item.
Organisational Implications	
Quality, Safety & Patient Experience	-
Finance/Resource Implications	As identified in the report
Population Health	-
Legal Implications (including equality &	Any changes to the service model or funding requirements will need to be considered by the individual commissioning

diversity, socio economic duty etc)	organisations through their internal governance structures.
Long Term Implications (incl WBFG Act 2015)	-
Report History (Meeting/Date/ Summary of Outcome	19 September 2023 – WHSSC Joint Committee
Appendices (located in the supporting documents folder)	Appendices 1a-d – WHSSC Joint Committee Report – 19 September 2023 SARC Chair's Letter Appendix 2 - SARC South Wales Regional Model Implementation Governance Report

Report Title:	Annual Presentation of Nurse Staffing Levels to the Board			*Agenda Item no.*	*8.1*
Meeting:	Board	Public	X	Meeting Date:	30.11.2023
		Private			
Status *(please tick one only):*	Assurance		Approval		Information
Lead Executive Title:	Executive Nurse Director				
Report Author (Title):	Nurse Staffing Levels Lead				

Main Report
Background and current situation:

The Nurse Staffing Levels (Wales) Act 2016 (the 2016 Act) became law in March 2016. The Act requires health service bodies to make provision for appropriate nurse staffing levels, and ensure that they are providing sufficient nurses to allow the nurses' time to care for patients sensitively.

Section 25A of the Act relates to the Health Boards overarching responsibility which came into effect in April 2017, requiring Health Boards to ensure they had robust workforce plans, recruitment strategies, structures and processes in place to ensure appropriate nurse staffing levels across their organisations. The process of determining the staffing levels of 25B wards across the Health Board is well established. In addition, the Executive Nurse Director requests all clinical areas outside of 25B&C to undertake a review of their staffing levels in line with this timetable to provide assurance of compliance with section 25A.

Section 25 B&C identifies wards where there is a duty to calculate nurse staffing levels using a prescribed methodology and maintain nurse staffing levels.

Section 25E refers to the reporting requirement of the 2016 Act. It is a requirement that the Board receives an annual presentation of the Nurse Staffing Levels which have been calculated for all Section 25B wards. This is contained within this report: Annual Presentation of Nurse Staffing Levels to Board.

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

- All 25B wards meet the requirements of the 2016 Act to include supernumerary Ward Sister/ Charge Nurse and the 26.9% uplift is contained within the financial envelope set out for the Clinical Boards.
- Significant re-structuring and change has occurred across Cardiff and Vale UHB and has resulted in changes to the nurse staffing levels in some areas and those areas to be reported as 25B Wards.
- The operational use of SafeCare has provided an opportunity to review nurse staffing levels across all clinical boards, with the re-introduction and re-modelled Nurse Staffing Meetings.
- Internal creation of a SafeCare dashboard allows Cardiff and Vale UHB to respond to trends and changes quickly, in relation to patient acuity, nurse staffing levels and professional judgment of nursing teams.
- Efforts of nursing teams to reduce the use of temporary staffing whilst ensuring safe effective care is delivered to patients is ongoing and being closely monitored. Continued recruitment and retention strategies of both registered and unregistered staff is in place.

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

This report; The Annual Presentation of Nurse Staffing Levels provides the board with:

- An overview of the number of wards included in Section 25B and the nurse staffing levels required (Appendix 2).

- An update on the progress and challenges during the reporting cycle 1st October 2022 -30th September 2023 in relation to nurse staffing (Appendix 1).
- Assurance that the Designated Person has discharged their duty in calculating the number of nurses required in 25B wards ensuring the prescribed methodology has been used. Furthermore, that calculation and monitoring of Nurse Staffing Levels occurs for 25A areas during the biannual recalculation cycle.

Recommendation:

The Committee is requested to:

a) Formally receive and note the information contained within the Annual Presentation of Nurse Staffing Levels. It has been produced using a newly adapted All-Wales reporting template as outlined below.
b) Receive the report as assurance that the statutory requirements relating to section 25B of the Nurse Staffing Levels (Wales) Act 2016 has been fulfilled.
c) Note that the funded nurse staffing establishments detailed in Appendix 2 of 25B wards has been undertaken as part of bi-annual recalculations and furthermore the changes to the areas recorded as 25 wards.
d) Note the reasonable attempts to monitor and maintain nurse staffing levels at a time of significant organisational change.

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please place an "X" in the below boxes as relevant

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

Five Ways of Working (Sustainable Development Principles) considered
Please place an "X" in the below boxes as relevant

Prevention	X	Long term	X	Integration	X	Collaboration	X	Involvement	X

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

Risk: Yes/No
n/a
Safety: Yes/No
n/a
Financial: Yes/No
n/a
Workforce: Yes/No
n/a
Legal: Yes/No
n/a
Reputational: Yes/No

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

Appendix 1

Annual Presentation of Nurse Staffing Levels to the Board	
Health Board	Cardiff and Vale UHB
Date of annual presentation of Nurse Staffing Levels to Board	30th November 2023
Period Covered	01st October 2022 to 30th September 2023
Number of section 25B wards during the period of this report **• Adult acute medical inpatient wards** **• Adult acute surgical inpatient wards** **• Paediatric inpatient wards**	Section 25B of The Nurse Staffing Levels (Wales) Act 2016 (the 2016 Act) places a duty for LHBs and Trusts in Wales to calculate and take all reasonable steps to maintain nurse staffing levels and inform patients of the level. Section 25B currently applies to adult acute medical inpatient wards, adult acute surgical inpatient wards and, paediatric inpatient wards. Wards that fall within Specialist Clinical Board within Cardiff and Vale UHB have been previously included within the surgical inpatient wards. Given the new All-Wales template in use (Appendix 2) and the guidance, specialist clinical board ward areas have been separated out to be included as either medical or surgical wards as appropriate, this is recorded within Appendix 2. The statutory guidance contains a list of excluded areas that do not fall within the definitions of wards to which section 25B pertains. These excluded areas include assessment units, intensive care units and rehabilitation units amongst others and these are therefore not included within Appendix 2. Despite this, in Cardiff and Vale UHB the designated person; the Executive Nurse Director reviews the nurse staffing levels in all 25A areas biannually following the methodology used wards to which section 25B pertains. Within this reporting cycle there has been significant re-organisation of wards at the University Hospital of Wales. This has required additional out of cycle re-calculations of the nurse staffing levels and Appendix 2 summarises change to any establishments. Caution should therefore be applied in interpreting and comparing previous data relating to total establishment provided and further details for this is recorded below. • There have been significant organisational changes within the Emergency and Acute Medicine Directorate. Ward A1 South (formerly A1 Link), previously recorded as an acute medical ward

(25B ward) has now been incorporated within the Assessment Unit (AU) footprint. This 59 bedded unit is excluded as a 25B ward based on the Nurse Staffing Levels (Wales) Act 2016: statutory guidance (2021) definitions. SafeCare is in use across the AU footprint with patient acuity being assessed and recorded twice daily using the Welsh Levels of Care tool. Benchmarking has taken place by the Lead Nurse with other assessment units to ensure that staffing levels are appropriate for the assessment unit. The establishment for this area has been signed off by the designated person.

- A2 Medical Decision Unit also falls within the Emergency and Acute Medicine Directorate. This area was previously recorded as a 25B ward; given the short stay model of care, with an increase in the admission and discharges the clinical board feels that this does not meet the definition of an acute medical ward. Given the changes, SafeCare will be used to closely monitor nurse staffing levels and patient acuity.
- Other areas across the Health Board such as the Integrated Assessment Care Unit Wards A and B are not recorded as a 25B ward due to the rehabilitation model of care delivered. However due to the evolving needs of patients and increasing acuity this could be deemed as meeting the requirements of a 25B ward. These areas and other relevant areas will be closely monitored, using SafeCare data and the professional judgement of the directorate to review whether they should be included as 25B ward in the future.
- As a result of these ongoing reviews an **additional area** has been included in appendix 2 as a 25B area, the Stroke Rehabilitation Unit. On the Stroke Rehabilitation Unit whilst this area provides acute rehabilitation, this area also provides acute care and therefore meets the definition from the 2016 Act: Statutory Guidance of an adult acute medical inpatient ward.

Adult acute <u>medical</u> inpatient wards	Adult acute <u>surgical</u> inpatient wards	Paediatric inpatient wards
20	18	2

	Adult acute medical inpatient wards		Adult acute surgical inpatient wards		Paediatric inpatient wards	
	RN	**HCSW**	**RN**	**HCSW**	**RN**	**HCSW**
Required establishment (WTE) calculated (September 2023)	397.67	362.24	431.42	281.28	106.25	25.02
WTE of required establishment funded (September 2023)	397.67	362.24	431.42	281.28	106.25	25.02
WTE Supernumerary band 7 sister/charge nurse at end of reporting period (funded but excluded from planned roster)	20 WTE		18 WTE		2 WTE	
Using the triangulated approach to calculate the Nurse staffing level on section 25B wards	The process for calculating the nurse staffing levels are well established in Cardiff and Vale UHB. Using the prescribed method in Section 25C of the 2016 Act a triangulated approach is used, captured on the All-Wales recording template. The recording templates are agreed and signed off through the nursing structure from Ward Sister to Executive Nurse Director. The nurse staffing levels are calculated using: **Professional Judgement:** The Ward Sister/ Charge Nurse and Lead and Senior Nurses in conjunction with the Clinical Board Nurse Director use their knowledge of the clinical area to inform the levels of nurse staffing and provide professional judgement. Compliance data with mandatory training, vacancy and sickness rates, temporary staffing usage, bed occupancy and student feedback are all used in supporting this aspect. This information is presented to the designated person as part of the bi-annual establishment reviews and further professional judgement and discussions takes place. **Patient acuity**: In Cardiff and Vale UHB, using the Welsh Levels of Care acuity tool, patients are assigned an acuity score twice in a 24-hour period. Using the digital platform SafeCare; live operational decisions are made in relation to nurse staffing and patient acuity. Furthermore, this has provided a significantly improved opportunity to capture data. The UHB no longer relies on bi-annual audits to inform patient acuity as a power-bi dashboard is available with monthly updates; trends are therefore closely monitored and responded to. This provides much greater insight into patient acuity in each area					

and is used when calculating the nurse staffing levels. SafeCare is used in all 25B areas and many other additional areas, including assessment units and the critical care unit enabling and supporting operational decision making across the organisation.

The infographic above is a live example from one of the ward areas in Cardiff and Vale UHB. It contains information relating to SafeCare Compliance, the acuity levels, the nurse staffing levels and the professional judgment recorded by the nurse in charge. Across the organisation Ward Managers through to Directors of Nurses and the Executive team have access to this dashboard which is updated monthly.

Quality indicators – As part of the establishment review process and the bi-annual calculation the Ward Sister/ Charge Nurse through to the designated person considers circumstances where patient well-being is sensitive to the care provided by a nurse.

	Using the quality indicators, data is reviewed on: • **Acute Medical/ Surgical Inpatient Wards:** patient falls, pressure ulcers and medication errors. • **Paediatric Inpatient Wards:** Pressure ulcers, Medication errors and Infiltration/ extravasion injuries Furthermore, consideration is given to complaints made about care provided to patients by nurses. Prior to triangulation an uplift of 26.9% is applied to support staff absences from the ward (26.9% was agreed in 2011 as the evidence-based uplift factor for use in Wales by Nurse Directors). Ward Sisters and Charge Nurses are supernumerary to the planned roster and the signed off establishment. There is one example captured in Appendix 2 where the supernumerary status of the ward sister was not being protected due to an increase in the number of beds and the acuity of patients. During this cycle this has been uplifted to ensure there is 1 WTE supernumerary ward sister. As a result of the current workforce challenges and short notice unavailability of staff there are occasions where the Ward Sisters and Charge Nurses work as part of the roster. This only occurs on a short notice basis and where other mitigating actions have been considered. The redeployment of Ward Sisters and Charge Nurses does not occur as part of roster planning and systems are in place to monitor the number of occasions where this redeployment has occurred. Furthermore, as part of the All-Wales Standard Operating Procedure in the use of SafeCare a Red Flag can be raised when the Ward Sister/ Charge Nurse is not supernumerary to the planned roster.
Finance and workforce implications Saunders.Nathan 20/11/2023 15:51:45	During the bi-annual calculations the designated person, The Executive Nurse Director, the Executive Director of Finance, Executive Director of People and Culture and Chief Operating Officer has met with each of the clinical board triumphant. The required establishment using the triangulated approach is discussed and it is ensured that the signed off establishment is funded. All funding requirements have been met within the Clinical Boards allocated budget for all areas of 25B wards.

	Mental Health Mental Health does not fall under 25B of the 2016 Act and remains a 25A area. It has been acknowledged in previous board reports the difficulty in aligning mental health areas to the financial envelope and this has been managed through redeployment of staff and underspends in other areas. Across Cardiff and Vale UHB the Executive Nurse Director, the Chief Operating Officer, Director of Finance and the Clinical Board are keen to progress this work. Work is underway to re-review the nursing establishments in Mental Health and ensure they are appropriate based on the professional judgment of the designated person in collaboration with the clinical board. Work will then progress to ensure this is supported within the financial envelope. The Welsh Levels of Care principles have been produced for Mental Health. These principles have not been embedded across Wales as an extension to the 2016 Act has currently been paused by the Chief Nursing Officer for Wales, whilst the impact of the 2016 Act is reviewed. Temporary Staffing The challenging financial pressures across the Health Board has been well documented. In previous reports it has been documented the significant reliance on temporary staffing to cope with the effects of pandemic and subsequent workforce challenges. Significant work is being undertaken across nursing to reduce the reliance on temporary staffing. In particular agency is no longer used for Health Care Support Workers and work is progressing to reduce agency usage for registered nurses. To enable this a number of work streams are ongoing (e.g. recruitment and retention strategies) and this is overseen by a Director of Nursing for Workforce and is also closely monitored at the Nursing Productivity Group chaired by the Executive Nurse Director. The process for managing nurse staffing and ensuring that all reasonable steps are maintained is well established in Cardiff and Vale UHB. Since the introduction of SafeCare, this has provided an opportunity to reassess how nurse staffing is reviewed and a number of enhanced steps occurs. These include:

	• Review of nurse staffing levels through the Clinical Boards. • Any unmitigated risk is escalated to the twice daily staffing meeting, chaired by a Director of Nursing. This provides oversight across the clinical boards with red flags being reviewed in SafeCare. Decisions are then documented with SafeCare. • Registered Nurses and Health Care Support Workers are re-deployed when necessary. • Senior Nurse on site out of hours (Monday- Sunday until 20:30) to support staffing decisions.
Conclusion & Recommendations	
	Cardiff and Vale UHB continues to experience significant challenges in maintaining nurse staffing levels. There are well-established processes for the bi- annual recalculations to ensure the reporting requirements of the 2016 Act are met. Furthermore, across the organisation there are established processes in place to review changing acuity and nurse staffing levels. **Highlights of the report includes:** • All 25B wards meet the requirements of the 2016 Act to include supernumerary Ward Sister/ Charge Nurses and 26.9% uplift are contained within the financial envelope set out for the Clinical Boards. • Significant re-structuring and change has occurred across the health board and has resulted in changes to the nurse staffing levels in some areas and those areas to be reported as 25B wards. • Internal creation of a SafeCare dashboard allows Cardiff and Vale UHB to respond to trends and changes quickly. • Efforts of nursing teams to reduce the use of temporary staffing whilst ensuring safe effective care is delivered to patients is an ongoing challenge and a number of metrics are being closely monitored. Continued recruitment and retention strategies of both registered and unregistered staff is in place and overseen by a Director of Nursing. **The Board is asked to:** • Receive the report as assurance that the statutory requirements relating to section 25B of the Nurse Staffing Levels (Wales) Act 2016 have been fulfilled.

	• Note that the funded nurse staffing establishments detailed in Appendix 2 of 25B wards have been undertaken as part of bi-annual recalculations and furthermore the changes to the wards recorded as 25B areas.

Appendix: Annual Presentation of the Nurse Staffing Level to the Board report

Health board/trust:	Cardiff and Vale UHB
Period of the report	1st October 2022- 30th September 2023
Adult Acute Surgical Inpatient Wards	18

The number of staff per shift needs to be entered. The information should reflect the information on the informing patient template.

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report.

Adult Acute Surgical Inpatient Wards

		Reported to the Board in November 2022					Calculated during spring 2023 cycle						Calculated during autumn 2023 cycle						Biannual calculation cycle reviews, and any changes made & rationale during the spring 2023 & autumn 2023 calculation cycles			Any reviews outside of biannual calculation, if yes, provide rationale for any changes made			
Site	Name of Ward	SHIFT	Planned roster as stated within the annual presentation to the Board report (in November 2022)		Required Establishment as stated within the annual presentation to the Board report (in November 2022) including uplift		TOTAL WTE Band 7 supernumerary ward sister/Charge nurse	SHIFT	Planned roster calculated by the designated person during the spring 2023 cycle		Required Establishment as calculated by the designated persons during the spring 2023 cycle including uplift		TOTAL WTE Band 7 supernumerary ward sister/Charge nurse	Date designated person calculated the nurse staffing level	SHIFT	Planned roster calculated by the designated person during the autumn 2023 cycle		Required Establishment as calculated by the designated persons during the autumn 2023 cycle including uplift		TOTAL WTE Band 7 supernumerary ward sister/Charge nurse	Date designated person calculated the nurse staffing level	Completed (Yes/No)	Changed	Rationale	Completed (Yes/No)	Date	Changed	Rationale
			RN (band 5	HCSW (bands	TOTAL WTE RN	TOTAL WTE			RN (band 5	HCSW (bands	TOTAL WTE RN	TOTAL WTE				RN (band 5	HCSW (bands	TOTAL WTE RN	TOTAL WTE									
	West 6 (Cardiothoracics Specialist Clinical Board)	E	4	2	19.9	8.53	0.2	E	4	2	19.9	8.53	1	13/04/2023	E	5	2	21.91	8.53	1	11/01/2023	Y	Y	Uplift in Band 6 establishment. Bethan Ward establishment decreased as ward often closed and used as extra capcity. Previously supernumerary ward sister during C5 establishment and split over two wards.	N	NA	NA	NA
		L	4	2				L	4	2					L	5	2											
		LD						LD							LD														
		TW						TW							TW														
		N	3	1				N	3	1					N	3	1											
UHW	PolyTrauma Unit (Specialist Clinical Board)	E	5	4	24.2	19.9	1	E	5	4	24.2	19.9	1	13/04/2023	E	5	4	24.2	19.9	1	11/01/2023	Y	Y	Uplift in co-ordination role on late shift in Spring cycle.	N	NA	NA	NA
		L	4	4				L	5	4					L	5	4											
		LD						LD							LD														
		TW						TW							TW														
		N	4	3				N	4	3					N	4	3											
UHW	B5 (Specialist Clinical Board)	E	7	4	28.89	18.32	1	E	7	4	28.89	18.32	1	13/04/2023	E	7	4	28.89	18.32	1	10/12/2023	Y	N	NA	N	NA	NA	NA
		L	6	4				L	6	4					L	6	4											
		LD						LD							LD														
		TW						TW							TW														
		N	4	2				N	4	2					N	4	2											
UHW	T5 (Specialist Clinical Board)	E	6	3	29.7	13.64	1	E	6	3	29.7	13.64	1	13/04/2023	E	6	3	29.7	13.64	1	10/12/2023	Y	N	NA	N	NA	NA	NA
		L	6	3				L	5	3					L	5	3											
		LD						LD							LD														
		TW						TW							TW														
		N	5	2				N	5	1					N	5	1											
UHW	T4 (Specialist Clinical Board)	E	7	2	37.37	8.53	1	E	7	2	37.37	8.53	1	13/04/2023	E	7	2	37.37	8.53	1	10/12/2023	Y	N	NA	N	NA	NA	NA
		L	7	2				L	7	2					L	7	2											
		LD						LD							LD														
		TW						TW							TW														
		N	7	1				N	7	1					N	7	1											
UHW	B4 Neuro (Specialist Clinical Board)	E	8	5	35.35	25.18	1	E	8	5	35.35	25.81	1	13/04/2023	E	8	5	35.35	25.18	1	10/12/2023	Y	N	NA	N	NA	NA	NA
		L	8	5				L	8	5					L	8	5											
		LD						LD							LD														
		TW						TW							TW														
		N	5	4				N	5	4					N	5	4											
UHL	CAVOC	E	5	3	21.93	16.24	1	E	7	4	25.99	19.09	1	13/04/2023	E	7	4	25.99	19.09	1	10/12/2023	Y	Y	Increase in beds from 27 to 35 beds and increase in establishment in spring cycle.	N	NA	NA	NA
		L	5	3				L	7	4					L	7	4											
		LD						LD							LD														
		TW						TW							TW														
		N	3	3				N	3	3					N	3	3											
UHL	West 1	E	4	4	19.9	19.9	1	E	4	4	19.9	19.9	1	13/04/2023	E	4	4	19.9	19.9	1	10/12/2023	Y	N	NA	N	NA	NA	NA
		L	4	4				L	4	4					L	4	4											
		LD						LD							LD														
		TW						TW							TW														
		N	3	3				N	3	3					N	3	3											
UHL	West 3	E	3	3	14.2	12.8	1	E	3	3	14.2	12.8	1	13/04/2023	E	2	3	11.4	14.2	1	10/12/2023	Y	Y	Reduction in bed base from 20 to 16 beds. Uplift in HCSW to support patient care.	N	NA	NA	NA
		L	3	2				L	3	2					L	2	3											
		LD						LD							LD														
		TW						TW							TW														
		N	2	2				N	2	2					N	2	2											
UHL	West 5	E	3	4	14.21	17.07	1	E	3	4	14.21	17.07	1	13/04/2023	E	3	4	14.21	17.07	1	10/12/2023	Y	N	NA	N	NA	NA	NA
		L	3	4				L	3	4					L	3	4											
		LD						LD							LD														
		TW						TW							TW														
		N	2	2				N	2	2					N	2	2											
UHW	A5N	E	4	3	18.32	14.2	1	E	4	3	18.32	14.2	1	13/04/2023	E	4	3	18.3	14.21	1	10/12/2023	Y	N	Previous A6N establishment. No change to ward layout.	N	NA	NA	NA
		L	4	3				L	4	3					L	4	3											
		LD						LD							LD														
		TW						TW							TW														
		N	3	2				N	3	2					N	3	2											
UHW	A5S	E	3	2	14.21	11.37	1	E	3	2	14.21	11.37	1	13/04/2023	E	3	2	14.21	11.37	1	10/12/2023	Y	N	Previous A6S establishment. No change to ward layout.	N	NA	NA	NA
		L	3	2				L	3	2					L	3	2											
		LD						LD							LD														
		TW						TW							TW														
		N	2	2				N	2	2					N	2	2											
UHW	A6 South	E	5	3	21.17	14.21	1	E	5	3	21.17	14.21	1	13/04/2023	E	4	2	16.26	11.37	1	10/12/2023	Y	Y	Previously located on Duthie Ward. Reduction in beds 24 to 19.	N	NA	NA	NA
		L	4	3				L	4	3					L	4	2											
		LD						LD							LD														
		TW						TW							TW														
		N	3	2				N	3	2					N	2	2											
		E	8	4				E	8	4					E	8	4											

UHW	B2 Vascular	L	8	4	33.3	19.9	1	L	8	4	33.3	19.9	1	13/04/2023	L	8	4	33.3	19.9	1	10/12/2023	Y	N	NA	N	NA	NA	NA
		LD						LD							LD												
		TW						TW							TW												
		N	4	3				N	4	3					N	4	3										
UHW	A6 North	E	5	2	19.09	11.37	1	E	4	2	16.24	11.37	1	13/04/2023	E	4	2	16.24	11.37	1	10/12/2023	Y	Y	Reduction of 1 x RN on day shift following changes to ward agreed in spring 2023 sign off. Previously Acute surgical ward.	N	NA	NA	NA
		L	5	2				L	4	2					L	4	2										
		LD						LD							LD												
		TW						TW							TW												
		N	2	2				N	2	2					N	2	2										
UHW	C6	E	7	4	30.46	17.06	1	E	7	4	30.46	17.06	1	13/04/2023	E	7	4	30.46	17.06	1	10/12/2023	Y	N	Previous A2 establishment	N	NA	NA	NA
		L	7	4				L	7	4					L	7	4										
		LD						LD							LD												
		TW						TW							TW												
		N	4	2				N	4	2					N	4	2										
UHW	B6	E	7	4	30.46	17.06	1	E	7	4	30.46	17.06	1	13/04/2023	E	7	4	30.46	19.09	1	10/12/2023	Y	Y	Uplift in HCSW overnight to support patient care.	N	NA	NA	NA
		L	7	4				L	7	4					L	7	4										
		LD						LD							LD												
		TW						TW							TW												
		N	4	2				N	4	2					N	4	3										
UHW	C1	E		1	22.07	12.64	1	E	2	1	22.88	12.55	1	14/04/2023	E	2	1	23.27	12.55	1	10/12/2023	Y	Y	Increase from 21 to 23 beds	N	NA	NA	NA
		L	2					L							L												
		LD	4	3				LD	4	3					LD	4	3										
		TW						TW							TW												
		N	3	1				N	3	1					N	3	1										

Appendix 2: Annual Presentation of the Nurse Staffing Level to the Board report. A summary of Nurse Staffing Levels for wards where Section 25B applies.

Health board/trust:	Cardiff and Vale UHB
Period of the report	01st October 2022 to 30th September 2023
Adult Acute Medical inpatient wards	20

The number of staff per shift needs to be entered. The information should reflect the information on the informing patient template.

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to

Adult Acute Medical inpatient wards

Site	Name of Ward	Reported to the Board in November 2022						Calculated during spring 2023 cycle							Calculated during autumn 2023 cycle							Biannual calculation cycle reviews, and any changes made & rationale during the spring 2023 & autumn 2023 calculation cycles			Any reviews outside of biannual calculation, if yes, provide rationale for any changes made			
		SHIFT	Planned roster as stated within the annual presentation to the Board report (in November		Required Establishment as stated within the annual presentation to the Board report (in		TOTAL WTE Band 7 supernumerary ward sister/Charge nurse	SHIFT	Planned roster calculated by the designated person during the spring 2023 cycle		Required Establishment as calculated by the designated persons during the spring 2023		TOTAL WTE Band 7 supernumerary ward sister/Charge nurse	Date designated person calculated the nurse staffing level	SHIFT	Planned roster calculated by the designated person during the autumn 2023 cycle		Required Establishment as calculated by the designated persons during the autumn		TOTAL WTE Band 7 supernumerary ward sister/Charge nurse	Date designated person calculated the nurse staffing level	Completed (Yes/No)	Changed	Rationale	Completed (Yes/No)	Date	Changed	Rationale
			RN (band 5 &6)	HCSW (bands 2,3 &4)	TOTAL WTE RN (bands 5	TOTAL WTE HCSW (bands			RN (band 5 &6)	HCSW (bands 2,3 &4)	TOTAL WTE RN (bands 5	TOTAL WTE HCSW (bands				RN (band 5 &6)	HCSW (bands 2,3 &4)	TOTAL WTE RN (bands 5	TOTAL WTE HCSW (bands									
UHW	B7	E	7	4	36.96	17.06	1	E	6	5	34.12	19.9	1	13/04/2023	E	6	5	34.1	19.9	1	10/05/2023	Y	Y	No change to overall establishment. Uplift in HCSW WTE (Spring establishment review); introduction of Band 4 Assistant Practitioner role.	N	NA	N	NA
		L	7	4				L	6	5					L	6	5											
		LD						LD							LD													
		TW						TW							TW													
		N	6	2				N	6	2					N	6	2											
UHW	C7	E	7	6	26.04	23.86	1	E	7	6	26.04	23.86	1	13/04/2023	E	7	6	26.8	22.74	1	10/05/2023	Y	Y	Previous C6 establishment, ward environment remains similar layout. Diet assistant within the HCSW establishment agreed in Nov 2022. Reduction in Band 3 and small increase in band 5.	N	NA	N	NA
		L	6	5				L	6	5					L	6	5											
		LD						LD							LD													
		TW						TW							TW													
		N	3	3				N	3	3					N	3	3											
UHW	C4	E	3	4	18.06	17.06	1	E	3	4	18.06	17.06	1	13/04/2023	E	3	4	17.06	17.06	1	10/05/2023	Y	N	No change to establishment during cycle, recording error on previous template in spring 2023. Establishment confirmed with ward team as no change.	N	NA	N	NA
		L	3	4				L	3	4					L	3	4											
		LD						LD							LD													
		TW						TW							TW													
		N	3	2				N	3	2					N	3	2											
UHW	Heulwen South	E	3	2	14.21	11.37	Supervisory ward sister/ charge nurse included in establishment for other half of ward.	E	2	2	11.37	11.37	1	13/04/2023	E			Part of ward closed	Part of ward closed	NA	NA	Y	Y	Reduction in establishment completed in May following closure of part of the ward. Patients cared for on Heulwen North, south side not open.	N	NA	N	NA
		L	3	2				L	2	2					L													
		LD						LD							LD													
		TW						TW							TW													
		N	2	2				N	2	2					N													
UHW	Heulwen North	E	2	3	11.37	14.21	1	E			Part of Ward Closed	Part of Ward closed	NA	NA	E	2	2	11.37	11.37	1	10/05/2023	Y	Y	Part of ward closed and now only Heulwen North open. 14 bedded unit hence reduction in establishment.	Y	15/06/2023	Y	NA
		L	2	3				L							L	2	2											
		LD						LD							LD													
		TW						TW							TW													
		N	2	3				N							N	2	2											
UHW	Lakeside Wing Ward 1	E	5	7	20.91	28.43	1	E	3	9	14.21	35.11	1	13/04/2023	E	3	10	14.21	35.11	1	10/05/2023	Y	Y	Introduction of Band 4 Assistant practitioner in spring establishment 2023 review. Change in HCSW day and night. Diet Assistants included within the establishments as providing appropirate care, sensitive to the needs of patients.	N	NA	N	NA
		L	4	7				L	3	8					L	3	9											
		LD						LD							LD													
		TW						TW							TW													
		N	3	3				N	2	4					N	2	3											
UHW	Lakeside Wing Ward 2	E	2	6	11.37	23.02	1	E	2	6	11.37	23.02	1	13/04/2023	E	2	6	11.37	22.73	1	10/05/2023	Y	Y	Introduction of Band 4 assistant practitioners agreed in spring 2023 establishment review. Diet Assistants included within the establishment. Small reduction in Band 3 establishment in current template.	N	NA	N	NA
		L	2	6				L	2	6					L	2	6											
		LD						LD							LD													
		TW						TW							TW													
		N	2	2				N	2	2					N	2	2											
UHW	A7	E	6	4	28.43	19.44	1	E	6	4	28.43	19.9	1	13/04/2023	E	6	4	28.43	19.9	1	10/05/2023	Y	N	NA	N	NA	N	NA
		L	6	4				L	6	4					L	6	4											
		LD						LD							LD													
		TW						TW							TW													
		N	4	3				N	4	3					N	4	3											
UHL	CFU	E	2	1	11.1	2.78	1	E	2	1	11.1	2.78	1	13/04/2023	E	2	1	11.1	2.78	1	10/05/2023	Y	N	NA	N	NA	N	NA
		L	2	1				L	2	1					L	2	1											
		LD						LD							LD													
		TW						TW							TW													
		N	2	0				N	2	0					N	2	0											
																	0											
UHL	East 2	E	4	4	19.9	17.06	1	E	4	4	19.9	17.06	1	13/04/2023	E	4	4	19.9	17.06	1	10/05/2023	Y	N	NA	N	NA	N	NA
		L	4	4				L	4	4					L	4	4											
		LD						LD							LD													
		TW						TW							TW													
		N	3	2				N	3	2					N	3	2											
UHL	East 4	E	4	4	19.9	17.06	1	E	4	4	19.9	17.06	1	13/04/2023	E	4	4	19.9	17.06	1	10/05/2023	Y	N	NA	N	NA	N	NA
		L	4	4				L	4	4					L	4	4											
		LD						LD							LD													
		TW						TW							TW													
		N	3	2				N	3	2					N	3	2											
UHL	East 6	E	4	4	19.9	17.06	1	E	4	4	19.9	17.06	1	13/04/2023	E	4	4	19.9	17.06	1	10/05/2023	Y	N	NA	N	NA	N	NA
		L	4	4				L	4	4					L	4	4											
		LD						LD							LD													
		TW						TW							TW													
		N	3	2				N	3	2					N	3	2											
UHL	East 7	E	4	4	19.9	17.06	1	E	4	4	19.9	17.06	1	13/04/2023	E	3	5	17.06	19.9	1	10/05/2023	Y	Y	Introduction of the band 4 assistant practitioner role and hence change to establishment. Band 4 assistant practitioner's included in total HCSW WTE as is required in template.	N	NA	N	NA
		L	4	4				L	4	4					L	3	5											
		LD						LD							LD													
		TW						TW							TW													
		N	3	2				N	3	2					N	3	2											
UHL	East 8	E	4	4	19.9	17.06	1	E	4	4	19.9	17.06	1	13/04/2023	E	4	4	19.9	17.06	1	10/05/2023	Y	N	NA	N	NA	N	NA
		L	4	4				L	4	4					L	4	4											
		LD						LD							LD													
		TW						TW							TW													
		N	3	2				N	3	2					N	3	2											

UHL	West 2	E	4	4	19.9	19.9	1	E	4	4	19.9	19.9	1	13/04/2023	E	4	4	19.9	19.9	1	10/05/2023	Y	N	NA	N	NA	N	NA
		L	4	4				L	4	4					L	4	4											
		LD						LD							LD													
		TW						TW							TW													
		N	3	3				N	3	3					N	3	3											
UHL	Stroke Rehabilitation Centre	E	5	6	20.44	27.78	1	E	4	7	17.6	30.62	1	13/04/2023	E	4	7	17.6	30.62	1	10/05/2023	Y	Y	Introduction of the band 4 assistant practitioner role and hence change to establishment. Band 4 Assistant practitioner's included in total HCSW WTE as is required in template.	N	NA	N	NA
		L	4	6				L	4	6					L	3	7											
		LD						LD							LD													
		TW						TW							TW													
		N	3	4				N	3	4					N	3	4											
UHW	B2 Link	E	7	4	25.58	21.71	1	E	3	5	14.21	17.01	1	10/05/2023	E	3	5	14.21	19.86	1	10/05/2023	Y	Y	Old C7 establishment- 37 bedded unit, moved to B2 link, reduction to 19 beds and hence reduction in establishment. Uplift in HCSW during Autumn cycle following triagulation and using professional judgment. Diet Assistants included within the establishment.	Y	15/06/2023	Y	Ward move
		L	6	4				L	3	3					L	3	3											
		LD						LD							LD													
		TW						TW							TW													
		N	3	3				N	2	2					N	2	3											
UHW	B1 (Specialist Clinical Board)	E	7	3	29.74	13.4	0.2 (1 WTE Band 7 recorded)	E	7	3	29.66	13.4	0.2 (1 WTE Band 7 recorded)	13/04/2023	E	7	3	30.46	13.4	1	11/01/2023	Y	Y	Uplift in Supernumerary status of the ward sister. Previously recorded as supernumary ward sister as 1.0 WTE Band 7 available on the ward however this role has been required to co-ordinate and oversee additional 4 beds.	N	NA	N	NA
		L	7	3				L	7	3					L	7	3											
		LD						LD							LD													
		TW						TW							TW													
		N	4	2				N	4	2					N	4	2											
UHW	Teenage Cancer Trust (Specialist Clinical Board)	E	3	1	17.22	5.69	1	E	3	1	17.22	5.69	1	13/04/2023	E	3	1	17.22	5.69	1	10/12/2023	Y	N	NA	N	NA	N	NA
		L	3	1				L	3	1					L	3	1											
		LD						LD							LD													
		TW						TW							TW													
		N	2	1				N	2	1					N	2	1											
UHW	B4 Haem (Specialist Clinical Board)	E	7	4	36.6	21.67	1	E	7	4	36.6	21.67	1	13/04/2023	E	7	4	36.6	21.67	1	10/12/2023	Y	N	During the establishment review it was agreed with the Clinical Board and the EDON no change to the establishment required in this area in both Spring and Auntum 2023. (There is a calculation error on the template Spring and Autumn and the CB is aware to submit a new establishment template).	N	NA	N	NA
		L	7	4				L	7	4					L	7	4											
		LD						LD							LD													
		TW						TW							TW													
		N	5	3				N	5	3					N	5	3											
UHW	C4 Neuro (Specialist Clinical Board)	E	3	2	17.5	20.41	1	E	3	2	17.5	20.41	1	13/04/2023	E	2	2	10.58	11.37	1	15/11/2023	Y	Y	The day unit establishment was previously contained within the C4N inpatient beds. These have now been seperated out and hence reduction in establishment.	N	NA	N	NA
		L	3	2				L	3	2					L	2	2											
		LD						LD							LD													
		TW						TW							TW													
		N	2	2				N	2	2					N	2	2											

Appendix: Annual Presentation of the Nurse Staffing Level to the Board report

Health board/trust:	Cardiff and Vale UHB
Period of the report	01st October 2022 to 30th September 2023
Paediatric Inpatient Wards	2

The number of staff per shift needs to be entered. The information should reflect the information on the informing patient template.

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report.

Paediatric Inpatient Wards

		Reported to the Board in November 2022						Calculated during spring 2023 cycle						Calculated during autumn 2023 cycle							Biannual calculation cycle reviews, and any changes made & rationale during the spring 2023 & autumn 2023 calculation cycles			Any reviews outside of biannual calculation, if yes, provide rationale for any changes made			
Site	**Name of Ward**	**SHIFT**	**Planned roster as stated within the annual presentation to the Board report (in November 2022)**		**Required Establishment as stated within the annual presentation to the Board report (in November 2022)**		**TOTAL WTE Band 7 supernumerary ward sister/Charge nurse**	**SHIFT**	**Planned roster calculated by the designated person during the spring 2023**		**Required Establishment as calculated by the designated persons during the spring 2023**		**TOTAL WTE Band 7 supernumerary ward sister/Charge nurse**	**Date designated person calculated the nurse staffing level**	**SHIFT**	**Planned roster calculated by the designated person during the autumn**		**Required Establishment as calculated by the designated persons during the autumn**		**TOTAL WTE Band 7 supernumerary ward sister/Charge nurse**	**Date designated person calculated the nurse staffing level**	**Completed (Yes/No)**	**Changed**	**Rationale**	**Completed (Yes/No)**	**Date**	**Changed**	**Rationale**
			RN (band 5 &6)	**HCSW (bands 2,3 &4)**	**TOTAL WTE RN (bands 5 &6)**	**TOTAL WTE HCSW (bands**			**RN (band 5 &6)**	**HCSW (bands 2,3 &4)**	**TOTAL WTE RN**	**TOTAL WTE HCSW**				**RN (band 5 &6)**	**HCSW (bands 2,3 &4)**	**TOTAL WTE RN**	**TOTAL WTE HCSW**									
UHW	Gwdihiw	E			52.23	13.65	1	E			53.05	13.65	1	14/4/2023	E			55.08	13.65	1	10/12/2023	Y	Y	Increase in RN to support elective stream.	N	NA	N	NA
		L						L							L													
		LD	11	3				LD	12	3					LD	13	3											
		TW						TW							TW													
		N	8	2				N	8	2					N	8	2											
UHW	Island	E			51.17	10.56	1	E			51.17	11.37	1	14/4/2023	E			51.17	11.37	1	10/12/2023	Y	Y	Increase in HCSW to support complex care on the ward. Agreed during spring cycle.	N	NA	N	NA
		L						L							L													
		LD	9	2				LD	9	2					LD	9	2											
		TW						TW							TW													
		N	9	1				N	9	2					N	9	2											

Report Title:	Corporate Risk Register				Agenda Item no.	8.2	
Meeting:	Board Meeting		Public	x	Meeting Date:	30 November 2023	
			Private				
Status *(please tick one only):*	Assurance	x	Approval		Information		x
Lead Executive:	Director of Corporate Governance						
Report Author (Title):	Director of Cororate Governance						

Main Report
Background and current situation:

The Corporate Risk Register ("the Register") has been developed to provide the Board with an overview of the key operational risks from the Clinical Boards and Corporate Directorates.

The Register includes 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 assurance map is a check against those corporate risks that seeks to set out the 3 lines of defence in oepration and from which risk and assurance of that risk is tested/derived.

Appendices:

1. Corporate Risk Register
2. Assurance Map

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

The Risk and Regulation Team ("the Team") continue to work alongside Clinical Boards and Corporate Directorates to ensure that risks are clearly defined and appropriately scored in line with the Health Board's Risk Management and Board Assurance Framework Strategy and associated procedures.

The Team's predominant focus of support to Clinical Boards/Corporate Directorates has been to provide advice and guidance to risk leads/risk owners in their assessment and management of complex risks, and the refinement of their internal risk management processes. In addition, the Team continue to support requests from senior risk managers to deliver risk assessment and risk management training to their teams and newly appointed risk managers. The Board should note that Clinical Board risks are also monitored and scrutinised at Monthly Clinical Board Review Meetings. Clinical risk is addressed through the clinical safety and excellence group governance framework.

Operating within the three 'Lines of Defence', the team have continued to provide risk register 'check and challenge' feedback reports to Clinical Boards/Corporate Directorates detailing recommendations for the improvement of their risk registers and, where relevant, the rationale for not placing candidate risks onto the Register. The team have maintained the assurance of this process by adopting a 'whole team' peer review approach prior to providing feedback to risk leads.

Risks are discussed and assessed through various mechanisms within Clinical Directorates and Boards and within corporate areas. They are amalgamated in the most appropriate way into grouped risks (were necessary) in the register at Appendix one. The register as presented is a collection of those outputs and so new additions should be treated as draft submissions – a clearing/moderation process will form part of the ongoing build work around corporate risks.

The risks presented in the register can be viewed through a lens of cause and effect. There is an identifiable pattern from a cause perspective that predominantly falls into estate and infrastructure risks with a proportion that also fall under the umbrella of workforce.

The majority of additions (highlighted in yellow) in this iteration of the register have been captured by Capital, Estates and Facilities accordingly.

More work is required, led by DCG, to establish a coherent structure of risk moderation and engagement across the HB. Work is ongoing to work with CBs and other areas to refine the risk register in parallel to CB reviews etc.

ASSURANCE is provided by:

- Ongoing discussions with Clinical Boards and the Corporate Directorates regarding the scoring of risk.
- The presence of risk registers in CB and Corporate planning functions eg Capital and Investment decisions.
- The Risk and Regulation Team's 'check and challenge' of Clinical Board/Corporate Directorate candidate risks.
- The programme of education and training that is being implemented by the Risk and Regulation team to ensure that the Health Board's Risk Management policy is engrained and followed within Clinical Boards and Corporate Directorates.
- Increasing routine dialogue on risk issues between Clinical Board/Corporate Directorate Risk Leads and the Team.
- The Reasonable Assurance rating provided by Internal Audit for the Health Board's Risk Management processes.
- Mapping of risk across departments and directorates and aligning it to the evolving strategy and planning work.

Recommendation:

The Board are requested to:

Note the Corporate Risk Register and the work in this area which is now progressing.

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

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

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

Prevention	x	Long term		Integration		Collaboration	x	Involvement	x

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes
The management and maintenance of the Health Board's Corporate Risk Register contributes to the Health Board's Risk Management processed and procedures.
Safety: No
Financial: No
Workforce: No
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation: No
Approval/Scrutiny Route:

CORPORATE RISK REGISTER JULY 2023

Clinical Board/Corporate Directorate	Risk Reference	Date risk added	Date New Risk/s Added November 2022	Risk	Initial Risk Rating: Consequence	Initial Risk Rating: Likelihood	Initial Risk Rating: Total	Controls	Current Risk rating: Consequence	Current Risk rating: Likelihood	Current Risk rating: Total	Actions	Target Risk rating: Consequence	Target Risk rating: Likelihood	Target Risk rating: Total	Date of next review	Assurance Committee	Link to BAF
Capital Estates and Facilities	1	Mar-21	M-34-36 & Estates-30	**Obsolete Medical Gas and Air Delivery Equipment and Plant** **Risk/Issue**: Helipad Main Medical Air Plant supplied and installed by another with no medical gas certification. Plant components are bespoke items which are not specified for medical gas systems. Plant is non-compliant to the HTM02-01 MGPS Part A: Design, Installation, Validation & Verification Medical Compressed Air Systems Ambulatory Care Medical Air Plant supplied and installed by another with no medical gas certification (As above) Plant is non-compliant to the HTM02-01 MGPS Part A: Design, Installation, Validation & Verification Medical Compressed Air Systems **Impact**: Quality of Air supplied & Not compliant **Risk / Issue:** UHW & UHL Medical Gas Pressure reducing sets out of manufacturers recommended operational service dates. Medical Gas safety PRV, equipment and Gauges unable to test and carry out inspection or change. Obsolete equipment and currently out of compliance with overdue unspection. **Impact:** Equipment failure leading to Loss of Service and interruption of supply. This would adversely impact on patients	5	5	25	Regular maintenance being carried out Door inspected weekly as part of a PPM by estates staff	5	4	20	Bid to WG for funding under EFAB schemehas been improved for implimentation 2024/2025 UHL set has been replaced, the second set is due for completion under current upgrade scheme and is due for completion March 2023. There are approximately 15 sets at UHW. Funding has been approved for 6 sets which are due to be completed this financial year. Funding for the remaining sets is being sourced. plan in place to incorporate the difficulties in changing obsolete and live working safety valves and obsolete PRV /GAUGES whilst maintaining the med gas supplies	5	1	5	Aug-23	Finance and Delivery Quality, Safety and Experience	Patient Safety Capital Assets
	2	Mar-21	M27	**Risk/Issue**: UHW Tunnels corroded Main 4inch O2 Pipeline due to building leakage **Impac**t: Equipment Failure leading to Loss of Service and Interruption of oxygen supply to whole of UHL - impacting on patients.	5	4	20	Covr pipework to prevent further ongoing decay	5	4	20	Bid to WG for funding under EFAB scheme has been approved for implementation 2023/2024	5	1	5	Aug-23	Finance and Delivery Quality, Safety and Experience	Patient Safety Capital Assets
	3	Mar-21	8.11.2023 M28, Estates 43, 44a, 44b, 45	**Risk/Issue**: 1. UHL Main Boiler F&E TANKS are badly corroded and require renewing 2. There is not fuel line back-up for the main boilers, if there is a gas shortage or a gas leak that may cause a result of no gas. 3. No 1 & 3 boilers - Obsolete parts for the control panel for the two main boilers. Which now is more likely not to be able to source a replacement part, which cannot be repaired. 4. No 3 boiler -(in Conjunction with RR E44 Steam Boilers 1 & 3 - obsolescence of parts- Control issues / failures with Boilers 1 & 3) Also crack in brick work external and internal **Impact**: 1. Corrosion causing tanks to leak and loss of Heating throughout Hospital. 2. We have no alternative back up of supply to keep the boilers running 3. This would cause the boilers to fail and cause the loss of central heating, hot water and steam supply. 4. UHL does not have the temporary boiler, increasing risk of failure	5	4	20	1. The cleaning of the tank is not carried out as cleaning tanks may result in leakage 2. To source a contractor to supply gas lorry to feed a temporary gas supply to the main boilers. 3. To look to source the availbility of new or second hand parts for the Deep Sea Controller. 4. Look to source New control system required for boiler 1 and 3. ET&S construction is arranging for a structural engineer to attend site.	5	4	20	Bid has been put into WG for funding of replacement tank under EFAB programme. If funding approved funding available 1st April 2023. 2. To get a quotation to install new pipeline for the oil fuel line back up for the 3 main boilers. 3. To get a quotation to install two new control panels for the two main boilers. Parts now obsolete and none available anywhere. NEW burner and control required	5	1	5	Aug-23	Finance and Delivery Quality, Safety and Experience	Patient Safety Capital Assets
	4	Jun-21	8.11.2023 M29, M30, M31, M46, M49, M50	**Risk/Issue:** Ventilation verification of critical systems has identified UHW ITU A3N, UHW ITU B3N North, UHW Cardiac ITU C3, maternity delivery suites, Link does not comply with HTM's for Ventilation. **Impact:** Adverse impact on the safety of staff working in these areas, faiulre to comply with HTM regulations. Potential AHU failure leading to loss of main recovery	5	4	20	System is subject to statutory testing and inspection in line with legislation and HTM regulations. Regular maintenance.	5	4	20	Acute Site Master Planning schemes are looking to resolve most issues around the HTM in particular the ventilation. This is however a medium term plan and requires significant funding. C3South & C3 North are currently going through the design stage Prepare plans to renew the AHU	5	1	5	Aug-23	Finance and Delivery Quality, Safety and Experience	Workforce Patient Safety Capital Assets Staff Wellbeing
	5			**Risk/Issue** Energy Cost pressures. Energy Markets are very unstable which is resulting in dramatic tariff increases for the remainder of 21/22 and for the entire 22/23 financial year. Estimated cost pressures are £2.1 million for 21/22 and £4.6 million for 22/23 (total estimated expenditure is therefore £15 million). **Impact**:Estimated cost pressures are £2.1 million for 21/22 and £4.6 million for 22/23 (total estimated expenditure is therefore £15 million) plus a risk of supply interruption during transfer to new supplier.	4	5	20	Energy spend monitored and reported to Finance department monthly and is further supported by monthly meetings.	4	5	20	None	4	4	16	Aug-23	Finance and Delivery	Financial Sustainability
	6	5/07/2023	S3	**Issue:** BMS Controls Failure of IT to provide connectivity from new systems to BMS **Risk / potential impact:** unable to monitor new systems remotely resulting in the potential for not knowing when systems are failing or need adjusting	4	5	20	All systems are under a regular PPM program and can be analysed by taking a tablet to the system and plugging in directly to the system.	4	5	20	Press IT to provide the necessary links to be able to resume remote monitoring	4	1	4	Aug-23	Finance and Delivery Quality, Safety and Experience	Capital Assets Patient Safety Digital Strategy and Road Map
	7	5/07/2023	8.11.2023 S19, S19b, S26	**Issues**: **Ventilation Smoke/Fire Dampers.** Insufficient asset identification and lack of regular inspections and / or maintenance resulting in defects leading to temporary or permanent failure. **Fire Doors.** Insufficient asset identification and lack of regular inspections and / or maintenance resulting in defects leading to temporary or permanent failure. Fire doors identified as requiring replacing due to condition of doors not meeting fire requirements **Risk/Potential Impact**: Potential for loss of service. Disruption to patient care. Danger of fire spread.	5	4	20	Assets are currently on long term contract arrangement with a single supplier for all UHB sites. Dampers 40% of dampers are not being serviced due to access issues. These range from no access hatche through to exisiting services prevent void access. Ventilation Dental: The current drainage replacement programme involves clearing asbestos from the whole ceiling void on of a wing, one floor at a time. This will allow access to these areas. All assets not currently known. Many fire doors are being inspected regularly however not clear if all are being inspected within regulation timeframe or in some cases at all.	5	4	20	Carry out remedial work to provide access where possible. Note not all dampers will have access available after this process. Continue with schemes to make area accessible. Collation of assets, production of fire door drawings to indentify correct fire doors. Inpliment programme via in house Estates team to carry out inspections. Final taget to achieve >95% compliance at any one time. Quotation required for replacement doors in line with fire legislation requirements -Fire doors have been reclassified around the C&V estate, New PPM to reflect this	5	3	15	Aug-23	Finance and Performance Quality, Safety and Experience	Capital Assets Patient Safety
	8	9/09/2023	S13	**Risk issue**: during maintenance and testing works for operation POET (power outage emergency test) an issue was encountered in electrical sub station 2A where the automatic changeover system to start the low voltage generator is not functioning. Maintenance and re-testing has been carried out on numerous times however has not resolved the issue. The equipment cannot be directly replaced due to the age of the panels and equipment is now obsolete. In the event of an unplanned power outage the changeover system will not work and will require manual switching by Estates staff. Sub 2A provides power for a number of essential areas incluidng Main Operating Theatres, Dy theatresand recovery, SDEC, Mortuary, Cath labs A B and C, sections of the LGF tunnels and other essential plant.	5	4	20	On call Estates Staff are aware of the issue and will attend as a priority in the event of a power loss	5	4	20	Bid to WG for funding under EFAB scheme or BJC funding for 2024	5	1	5	Oct-23	Finance and Performance Quality, Safety and Experience	Capital Assets Patient Safety Urgent and Emergency Care
	9		8.11.2023 E14	**Risk/Issue:** Lifts urgently require replacement. A phased approach has been adopted with the following lifts to be reviewed: Maternity Lifts 8 & 9 All to be considered. With no Authorising Engineer assigned to Lifts, we are unable to appoint Lift AP's and carry out Audits on Lift condition & management systems etc Impact: Failure of lifts restricts public and staff movement around site.	4	5	20	Maintained on a best endeavours philosophy until scheme to replace these lifts is conducted. Reliant on training that has been provided at Eastwood Park. Lift engineer to manage the lift system.	4	5	20	Put a replacement plan in place for lifts To research and obtain quotes for service of a Lift AE.	4	1	4		Finance and Performance Quality, Safety and Experience	Capital Assets Patient Safety
	10		8.11.2023 M17, M18, Estates 111	**Risk/Issue:** UHW HSDU / Main Theatres / Main CIAT Chiller Plant. Chiller Plant pipework severely corroded. Chiller HSDU is 22 years old and failing with new spare parts now unavailble Main theatres plant circuits constantly breaking down. Chillers will require to be renewed in the near future **Impact:** Failure leading to loss of cooling to department.	5	4	20	Regular maintenance being carried out. Actions currently being progressed.	5	4	20	prepare plans to renew the Chiller	5	1	5		Finance and Performance	Capital Assets Patient Safety Staff Wellbeing

CORPORATE RISK REGISTER JULY 2023

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	11		M31, M32	**Risk/Issue:** Main walk in Drugs fridge in UHW Pharmacy stores LGF, is old and requires renewing due to being unreliable and parts difficult to obtain. SPS walk in Drugs fridge in UHW Pharmacy stores GF is old and requires renewing due to being unreliable and parts difficult to obtain. **Impact:** Loss of refrigerated drugs causing interuption to service	5	4	20	Regular maintenance being carried out	5	4	20	Renewal of Fridge and componenets with run and standby equipment required	5	1	5		Finance and Performance	Capital Assets Patient Safety
	12		8.11.2023 M31	**Risk/Issue:** Biochestry Lab at UHW over heating due to increased equipment and failure of exisitng cooling systems. **Impact:** Potential closure of Lab and service loss.	4	5	20	Temporary Cooling installed to keep Lab to correct temperature.	4	5	20	prepare plans to renew air conditioning units and/or install new AHU.	5	1	5		Finance and Performance	Capital Assets Patient Safety
	13		8.11.2023 Estates 93	**Risk/Issue:** Auto Changeover system - On loss of power to LV sub A1 panel, ACB failed to take secondary supply system (SPS generator backup) ACB failed to take load on 3 separate attempts of testing – on all occasions ACB fired through Gaps in control – Unable to test generators on-load (monthly test) as per HTM 06-01 requirement Failure to provide on distribution strategies standby generators resilience of N+1 automatically Switch Panelboard in Sub 2A - Air Circuit breaker (ACB) make/model common to both panels A1 & A2	4	5	20	None specified	4	5	20	None specified	4	1	4		Finance and Performance	Capital Assets Patient Safety
	14		8.11.2023 Estates 112	**Risk/Issue**: Both DSS4 Maternity HV substation double doors and LV switchroom single door are made fro slatted wooden doors and rotten, damaged and not secure for the location of the HV/LV substations.	5	4	20	Monitor condition until planned replacement	5	4	20	Replace both sets of doors to metal/steel type with securefixing and locks, with CLIQ key system.	5	1	4		Finance and Performance	Capital Assets Patient Safety
	15		8.11.2023 Estates 116	**Risk/Issue: Both DSS4 Maternity HV substation double doors and LV switchroom single door are made fro slatted wooden doors and rotten, damaged and not secure for the location of the HV/LV substations.**	4	5	20	controlled access to area, base supports appear to be in good condition	4	5	20		4	1	4		Finance and Performance	Capital Assets
	16		8.11.2023 Estates 122, 84, 810	**Risk/Issue:** Roofing sheets, rusted through S.W corner of A block, to A Block Link - Several holes and sheeting could be affected by inclement weather Plant room roofs at UHW are showing signs of degragation and failure. Roofs are metal profile on steel girders. On A block plant room there is obvious signs of Corrosion with daylight showing clearly on the far right side. Lift rooms roofs leaking causing down time on lifts - Risk / roofs sheets corroding causing collapse of roof - Impact / loose sheets have the potential to fall putting pedestrian and vehicle traffic at risk UHL Staff Restaurant Major Roof Leaks into servery and dining area. Possible Food Standards Agency (EHO) Food Hygiene rating could be affected/contaminated food	5	4	20	Contractor attended site to look at temporary repair, before further damage can be caused by inclement weather (Flooding below and roof sheet deterioration) Early signs of corrosion, roof is reasonably stable at present roof is to be continually monitored to check for further signs of structural loss Temporary repairs/additional cover sheets installed	5	4	20	Put in a plan to formally monitor roof in A block and carry out full structural survey of all roofs including lift plant room roofs Consideration to replace roof covering and roof lights ASAP	5	2	10		Finance and Performance	Capital Assets Staff Wellbeing
	17		8.11.2023 Estates 124	**Risk/Issue:** Main piped oxygen from estates VIE tank runs underground, no ducting and a large tree growing directly above the ground/pipework route. Major rosk if tree roots cause unseen damage to pipework which would disrupt oxygen supply to hospital.	5	4	20	We have emergency manifold system for any emergency scenario, but not for longivity to maintain oxeygn demand for hospital. This concern has also be raised by the MGPS Authorising Engineer as a potential point of failure.	5	4	20	Investment and plan to replace and redirect the main oxygen pipework run into the hospital.	5	1	5		Finance and Performance	Capital Assets Patient Safety
	18		8.11.2023 19	Risk/Issue UHW CHP Plant current O and M contract with Clarke Energy will expire in December 2023	5	4	20	Current O and M contract is in place until December 2023. Internal discussions are being held to develop propsed solutions.	5	4	20	Discussions are in progress with Clarke Energy regarding future options and the provision of an O and M temporary bridging contract until 31/3/23. There will be no warranty/breakdown provisions with this agreement. Risk rating has been upgraded.	5	2	10		Finance and Performance	Capital Assets
	19			There is a risk of patient harm due to the progression of conditions from benign to malignant disease due to increased waiting times for surveilance and planned recall endoscopy procedures. Context: Significant reduction in endoscopy activity throughout COVID period (as per national guidance), to support local redeployment of workforce to staff COVID areas and due to IP&C measures leading to reduced turnaround time between Aerosol Generating Procedures (AGPs). Previous series of SI's related to surveillance backlog Impact: Unnecessary cancer treatments; increased number of GP expedites; non-compliance with national (WG/JAG) waiting timeliness standards	5	5	25	Clinical validation of surveillance waiting list completed until the end of 2021 Corporate risk stratification cube available in BIS to pull through surveillance patients based upon individual risk vs chronological waiting times. NEP also provided documentation for risk stratification Some high risk surveillance patients started to be listed for procedures	5	4	20	DMT to utilise BIS risk surveillance cube to prioritise patients & reduce potential harm Admin team to send patient risk letters for delayed surveillance cases to manage patient risk DMT to consider use of FIT stool test as per BSG to manage risk of overdue lower GI surveillance UPDATE 29.12.21: Clinical validation continues risk assessing patients using a clinical tool recommended by the BSG 27.04.2022 Update; Ongoing insourcing @ UHL. Mobile Theatre in commissioning phase and predicted to be operational Qtr 1 of 2022. TNE pilot complete and pending evaluation. Surveillance validation ongoing but no further recovery funding agreed to date. Update 08.02.2023; Limited capacity to schedule surveillance procedures is ongoing and this remains a significant risk	5	2	10	Aug-23	Finance and Delivery Quality, Safety and Experience	Patient Safety Cancer Planned Care
	20			Due to workforce and capacity constraints across Gastroenterology & Endoscopy the ability to deliver a robust Gastroenterology service to meet competing demands of the speciality and service i.e. emergency/acute gastroenterology; Endoscopy activity to meet cancer diagnostic/therapeutics/surveillance as well as planned care within speciality components of gastroenterology , there is a risk of patient harm due to delayed diagnosis and treatments of cancer and benign diseases; a risk of not fulfilling commissioned activity and income generation and an inability to fulfill training needs for trainees in line with HEIW junior doctor training; Impact; patient risk of harm due to long waits; poor patient experience; patient concerns; staff burnout; reputational risk; potential to lose trainee posts further impacting on workforce; potential to lose commissioned services	5	5	25	Locum cover for the Medical Workforce gaps and progressing active recruitment Overseas Nurse recruitment and reactive recruitment efforts for Registered Nurses Work with NEP on recruitment strategy #BeVital Weekend insourcing to increase capacity Mobile Endoscopy Unit enabled an increase in activity equivalent to 4 rooms Business Case and Endoscopy expansion Implementation of FIT stool testing as part of patient risk stratification/management	5	4	20	7.02.23 - HR to support the Agenda for Change process to adopt the all Wales Clinical Endoscopist JD to be able to assimilate staff across	5	2	10	Aug-23	People and Culture Committee Quality, Safety and Experience	Patient Safety Cancer Workforce Planned Care

CORPORATE RISK REGISTER JULY 2023

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Medicine	21			There is a risk of patient harm due to inpatients at UHL suffering from a new stroke event not receiving timely assessment for Thrombolysis. There are multiple pathways for inpatients, dependent on location and time of day, which can cause delays to accessing treatment which could result in adverse outcomes.	5	5	25	Emergency medical team available at all times although these may not be stroke specific Stroke CNS available in hours to be able to respond immediately at UHW site	5	4	20	Redesign of inpatient thrombolysis pathways. Implementation and promotion of inpatient thrombolysis pathways. Review of workforce to support all stroke patients.	5	2	10	Oct-23	Quality, Safety & Experience Finance and Delivery	Patient Safety Workforce Urgent and Emergency Care
	22			**Context:** Intestinal failure/HPN (Home Parenteral Nutrition) is a WHSSC funded south/mid Wales service for patients unable to maintain their nutrition through alternative routes. There is a single Consultant providing clinical leadership but with no succession plan. Due to advances in surgical techniques and critical care there are increased numbers of patients requiring HPN which is commonly needed longer term (increase in patients numbers form 80 in 2015 to 130 in 2019). The funding model has been based upon an inpatient bed day model which does not capture all service components. The service has no current capacity with delays in inpatient transfer and outpatient assessment. There was widespread patient concern and media reporting when there was previous impact on the HPN nutrition chain. An SBAR and case has been submitted to WHSSC **Risk:** Delays in offering nutrition to patients in whom there is no alternative with complications creates a nubmer of risks including death and increased length of hospitalisation for shorter term bridging treatments. There is also currently a single consultant with a HPN interest creating significant service vulnerability and gaps in patient care during any times of leave. This is against national nutritional society recommendations which creates a risk of reputational harm and regulatory breaches. **Impact:** Potential harm including death; multiple concerns and media coverage; not meeting national guidelines	5	5	25	Position regularly reviewed by nutrition service (crosses CB's) and constraints appropriately escalated. UHB agreed to cover some additional sessions at risk, pending approval of WHSSC business case for additional staff.	5	4	20	Ongoing support and escalation via OPAT. Overseas nurses coming on board October 2022 to support staffing shortfalls. Focused work on staff exit questionairres and engagement with established staff to protect establishment.	5	2	10	Oct-23	Quality, Safety & Experience Finance and Delivery	Patient Safety Workforce
Women and Children	23	01/05/2023		**Issue** - Inadequate midwifery and medical staffing on obstetric assessment unit. **Risk/Impact** - risk of harm to patients due to the inability to implement a robust evidenced based obstetric triage system and patient review.	5	5	25	1. 3 MW allocated on shift when possible, 2.Telephone Triage MW 4 days out of 7 when no AL , 3.Senior obstetric staff allocated to delivery suite, theatres/T2, Antenatal Clinic, Ante/Postnatal wards provide support to OAU when requested by junior staff	5	5	25	BSOTS audit	5	3	15	Oct-23	Quality	Patient Safety Capital Assets
	24			**Issue** - Ongoing Lift Failure - 7, 8 & 9 **Risk/Impact** - Serious harm to women and babies from risk of entrapment or potential delays in emergency treatment due to lifts failing on demand	5	5	25	Lift refurbishment completed at the end of 2020. Failure occurred in December 2020 resulting in damage to doors requiring a 3-month repair time. Current maintenance contract in place however, this hasn't proved to be adequate mitigation. Maintenance contract to be moved to OTIS from Thyssen to overcome the high level of new equipment failures.	5	4	20	Maintenance contract has moved to OTIS from Thyssen. Review a system to best instigate a method for calling lifts for high risk patients which would have to be controlled by the Estates function. Conduct a 24-hour walk-through survey of lift operations to determine any specific times when certain tasks are more likely to be undertaken such as waste management or housekeeping (Action: Estates team) Continue to be escalated to Clinical Board.The contractor has been instructed and they are mobilising (ordering equipment etc) with a view to start on site in March (providing lift 7 is sorted) The installation will take 3 months for lifts 8 install. 1 month settle period for lift to bed in.The 3 month install of lift 9. Initial risk rating increased in view of recent incident where all lifts were out of action. Estates now send SLT lift report daily. Lift 73 was back in action but is now out of action again.	5	2	10	Oct-23	Finance and Delivery Quality, Safety and Experience	Patient Safety Maternity Capital Assets
	25		7.11.2023	**Issue** - Fetal medicine capacity shortfall and breech of ASW 5 day referral standard. **Risk/Impact** - due to fetal medicine capacity shortfall and breech of ASW 5 day referral standard, there is a risk of harm to compromised foetuses and reduced options for termination of pregnancy if delayed beyond 21+6 weeks. Delayed termination beyond 24 weeks means patients have to register the baby as a stillbirth and since criteria for termination is stricter after 24+0 weeks some women mayt be denied that option after 24+0 weeks which they could have had if seen earlier ie potential for wrongful life litigation.	5	4	20	Fetal medicine lead is keeping accurate data regarding breach figures, along with demand and capacity data. Clinics are being overbooked to absorb urgent referrals and active triage to allow joint shared care with local delivery where possible.	4	4	20	The fetal medicine service is actively triaging on a daily basis and managing patients locally where possible and declining to accept referrals when safe to do so. A locum consultant with appropriate experience is providing 2 clinic sessions a week. Extra additional clinics are being put on where possible and will continue to be explored, however this is not always possible due to consultant availability and there still not being enough sessions available to meet the demand on the service. The fetal medicine service will continue to try manage the risk by vigilant triaging to pick off the highest risk cases and trying to manage joint care with local units when possible. Additional clincial space (current antenatal phlebotomy room) is being prepared to reduce crowding in clinics and improve efficiency. 2 Fetal Medicine Consultant posts have been approved for appointment in 2023. For obs lead and CD discussion around job planning fetal medicine consultants to fetal medicine. One substantive fetal medicine consultant appointed March 2023, was previously in the locum post. Business case has been submitted to WHSCC - awaiting response.	5	3	15	Monthly	Quaity, Safety and Experience	Patient Safety Exacerbation of Health Inequalities Maternity Planned Care
	26	02/2023		**Issue** - Obstetric Staffing Level Challenges **Risk/Impact** - Risk of serious adverse outcomes (stillbirth, neonatal death and/or maternal morbidity) due to delayed or moved antenatal appointments due to inadequate senior obstetric staffing levels. Additionally the quality of care women receive may be lower due to not having senior reviews.	5	4	20	1.The ANC lead consultant and ANC manager aim to maximise efficiency and safety of clinic appointments system by weekly review of clinic workload – often staffing shortages only apparent a few days before a clinic. 2.The directorate fund extra paid sessions at short notice to help ANC capacity – the staff doing these extra sessions are mainly the existing consultants at the expense of SPA time and this long term contributes to stress, and reduces consultant capacity to contribute to many other activities including RCA writing etc.	5	4	20	1.The Clinical board must support directorate to allow funding of either more consultant sessions for ANC to facilitate cross covering, or appoint associate specialists to provide continuity and fill the rota gaps: business case devloped and has been approved in Jan 2023 for additional workforce investment. 2.Clinical board must support directorate to fund appropriate experienced administrative staff to ensure clinics are appropriately booked and organised to minimise cancellations and errors. Recruitment taking place to boost administrative support.	5	1	5	Oct-23	Finance and Delivery Quality, Safety and Experience	Patient Safety
	27	01/12/2022	7.11.2023	**Issue** - Paper Based Clinic Records - PAS Service **Risk/Impact** - A)Treatment delay and thus need for more invasive treatment. Increased risk of complications (admission for haemorrhage, additional surgery, infection and additional psychological trauma). B)Poor service data quality, underreporting of clinical workload, loss of funding, prolonged or insufficient clinical governance projects C)Treatment delay, vital info previously gathered unavailable at the point of care – risk of clinical errors, failing to promptly diagnose complications D)Confidentiality at risk when paper files get lost in transit. E)Risk of legal challenges and implications due to non-compliance with statutory abortion framework. Particular legal risk: non-reporting of abortion treatment	4	5	20	1 close collaboration with Emergency Gynae team for managing complications 2. hand-checking of records entered 3. referral to BPAS in case of delay into second trimester 4. e-mails and phone calls from either end to ensure receipt of paper files across sites (not working after 4 pm) 5. overtime paid to admin staff to catch up with HSA4 report	4	5	20	1. A)Emergency team has little or no access to clinical notes B) hand-checking of clinical data rarely possible and of doubtful efficacy 2.BPAS treatment is at a cost and further grief to women who have to undergo a second assessment 3. A)Notes are very frequently lost during transit, much time wasted searching and re-creating notes B) delay of reporting is down to 6 months – still very far away from statutory two weeks. Business case now approved, arranging implementation date with IT. IT currently building software but not ready yet.	42	8		Monthly	Quality, Safety and Experience	Patient Safety

CORPORATE RISK REGISTER JULY 2023

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Children ar	28	04/2021		**Issue** - Inadequate Emergency Gynaecology Facilities **Risk/Impact** - There is a risk of harm and poor patient experience as a result of lack of available provision for emergency gynaecology care resulting in delays and patients waiting to be seen in the corridor due to lack of designated area and staff to review and triage patients	4	5	**20**	Ongoing review of additional workforce to support	4	5	**20**	Regular review of all controls and assurances	4	2	**8**	Oct-23	Finance and Delivery Quality, Safety and Experience	Patient Safety

CORPORATE RISK REGISTER JULY 2023

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	29	08/01/1900		**Issue** - UK wide shortage of Paediatric & Neonatal Intensive Care Capacity **Risk/Impact** - There is a risk that C&YP who are admitted or waiting to be admitted to the ChfW will suffer harm due to the increased demand for PCCU and NICU bed. If children require care in either critical care areas and we are at maximum capacity for the number of nurses we have, then we have to review children that can be moved out of each area, which depends on ward capacity also. In addition to this we review children that can go to local DDH's. We often cancel elective admission to critial care which can lead to more complex surgery later and longer hospital admision times.	5	5	**25**	1. Daily huddles and deployment of nursing resource based on risk. 2. Staff moved wherever possible throughout the day to respond to changing circumstances and level of risk. 3.Bank and Agency requested on every shift, own staff offered enhanced overtime. 4. Daily medical ward round, to assess patients needs for ongoing impatient care. 5.Senior nurse engagement with external agencies, to expedite DTOC. 6.Education and support of practice educators for staff moved to the critical care areas.	5	4	**20**	1.Increased numbers of suitably trained staff in critical care areas. 2. Increased numbers of staff on wards to allow rotations to critical care areas 3. Better flow through critical care with timely discharges back to DGH's. 4.Childrens hospital discharge co-ordinator.	5	2	**10**	Oct-23	Quality, Safety and Experience	Patient Safety Maternity
	30	1.02.2023		**Issue** - Publication of UK Maternity & Neonatal Services Report (Ockenden) detailing standards and requirements **Risk/Impact** - There are risks clinically, experientially and reputationally associated as a result of the current non-compliance against the Ockenden Report recommendations across Maternity and Neonatal Services. This includes: Insufficient Staffing resulting in an inability to learn from adverse events and specifically undertaking learning from adverse events within a timely manner to ensure any learning is embedded into practice and to mitigate/avoid reoccurance of any themes identified	4	5	**20**	Patient safety investigatory monthly meetings review our root cause analysis investigation and identify any learning and actions. Online datix system for reporting incidences. New system in place AMaT to monitor actions. Regular Maternity/Neonates Oversight Group chaired by Executive Nurse Director	4	5	**20**	Regular review of all controls and assurances	4	2	**8**	Monthly	People and Culture Quality, Safety and Experience	Patient Safety Workforce
	31	1.10.2023	7.11.2023	**Issue -** Waiting times for C&YP awaiting ND Assessment **Risk/Impact** - There is a risk of harm and poor patient experience as a result of current waiting times for CYP awaiting ND Assessment. Waiting times are currently significantly high and also the increase in referrals, currently significantly exceeds capacity.	4	5	**20**	1. Review of top 10 long waiters every week. 2. Additional WG funding in place to increase capacity 3. Review of current service model	4	5	**20**	1. Weekly DMT meetings to continue. 2. Continued monthly team meeting 3. Review triage 4. Review pathways 5. Review expedite criteria 6. Ensure representation at WG national meetings 7. Consider as part of empower multi agency meeting	4	1	**4**	Monthly	Finance and Performance Quality, Safety and Experience	Patient Safety Planned Care
	32	08/01/1900		**Issue** - UK wide challenges in recruitment, retention and wellbeing of staff (predominantly Nursing & Midwifery) **Risk/Impact** - There is a risk of morbidity & mortality to patients as a result of insufficient medical and nursing/midwifery staffing levels. This has been made significantly worse by post COVID-19 pandemic and the need to staff additional capacity services. Also, only one outtake of newly qualified nurses and midwives per year, and limited recruitment pool in paediatrics	4	4	**16**	Ongoing communications between Directorates & Clinical Board Regular Directorate Staff Planning Meetings to review/address gaps Regular review of rotas Request use of Bank & Agency, Overtime, Locums where necessary Staff Movement where possible/required based on level of risk/mitigation	4	5	**20**	Regular review of all controls and assurances across Directorates for area specific related risks/mitigations	4	2	**8**	Monthly	People and Culture Quality, Safety and Experience	Patient Safety Workforce
	33			**Estates Risks** The fabric of the estate is suboptimal to delivery of modern, safe and sustainable healthcare. Significant aggregated risks across the Clinical Board Directorate risk registers including: 1. Mortuary - failure to meet HBN20 with potential for improvement notice or closure from the regulator (HTA) 2. Radiopharmacy - failure to meet the requirements of the regulator (MHRA) with potential for improvement notices or closure from the regulator - regional impact on delivery of diagnostic services 3. Stem Cell Processing Unit - inadequate accommodation, compressor failures, failure of supply of liquid nitrogen from the external tank, impact - failure to deliver liquid nitrogen to the cryogenic freezer holding patient stem cells for transplantation. 4. Health Records - inadequate storage capacity across departments including therapies and Laboratories, security of the Health record, potential for data loss, health and safety risks, difficulties in tracking of medical records 5. Clinical Engineering - inadequate accommodation for the equipment library, Fieldway, and mechanical engineering UHW, no space to clean returned equipment 6. Insufficient accommodation for a number of clinical board services including - Occupational Therapy, Speech and language Therapy, Pharmacy, POCT, physio, Cedar 7. Repeated examples of water or sewage ingressing into clinical and non-clinical areas, leading to inability to deliver services 8. UHL Main Occupational Therapy Department and Physiotherapy dept in UHL and old hydro area- Fabric of building is deteriorating , room unusable , leaks throughout the area .Patient records damaged as a result . Poor condition of portacabins. Area condemned due to risk of roof collapse - toilet, cleaners room, fire exit, accessable via main office. situation to be escalated on the estates risk register now. 9. Variable closure of UHL hydrotherapy due to imbalances in chemistry and pool temp to the spinal and neuro rehab patients which impacts on their rehabilitation . Unable to utilise the aditional benefits of aqua therapy 10. The viability and sustainability of an ageing facility in PSU at UHL,	5	5	**25**	Capital planning programme Discretionary capital programme Escalation routes to Estates Business Continuity Plans Managed service contracts Maintenance service agreements Medical equipment governance framework	5	4	**20**	Further work with Capital and Estates to develop prioritised timetabled plans to address known risks. Continue to seek funding through WG for replacement equipment and HTF funds to substitute old technologies Engage with TRaMS project for proposed regional solution to Radiopharmacy, progressing following recent MHRA inspection and ceasing production. Engage with Capital Planning with regards to Mortuary refurbishment project, Outline business case developed and submitted to WG, approved Oct 23. Put in place recommendations from internal audit of medical records storage and security,	5	2	**10**	Dec-23	Finance and Delivery Quality, Safety and Experience	Capital Estates Patient Safety
	34			**Equipment Risks - ageing equipment across the clinical board including:** •**N**VA 1 and NVA 2 simultaneous breakdown, affecting both emergency and elective patients, increasing frequency and severity of breakdown affecting both rooms. •**A**ir handing and chiller units - not in place, subject to regular breakdowns, impact on temperature sensitive services such as Blood Transfusion/drugs, impact on temperature sensitive equipment such as blood analysers, CT scanners leading to loss of service . •**A**geing Nitrogen generators if breakdown unable to get parts impacting on ability to deliver fully operational service •**A**ir tube for lab specimens sitting under contract for maintenance with CD&T, regular breakdowns and damage resulting in inability to use the system to deliver specimens in a timely manner •**P**harmacy isolator failure, impacting ability to make 700 doses per week of pre-filled syringes, potential increase risk of error on wards where several dilutions would be necessary or increase cost associated with purchasing from special manufacturer. •**R**adiopharmacy, risk of failure of 20 year old production cabinets, failure would result in partial or complete cessation of services to CAV UHB and customers in S.E Wales region •**A**utoclaves in Pharmacy. There is a risk that the autoclaves may fail or fail to sterilize effectively. They are used on a weekly/thrice weekly basis to undertake terminal sterilization. The impact to staff should the pressure valve fail would be catastrophic. A failure to sterilise effectively and if undetected through other assurance means would cause a fatal impact on the patient. The inability to use the sterilizers would have an impact to business and availability of product to customers and patients. •**P**harmacy - uses the Tempulog system for continuous temperature monitoring of all refrigerators, freezers and critical ambient areas to assure the appropriate storage conditions for medicines are in accordance with regulatory requirements. Current stock levels of refrigerated medicines are estimated at £950k with £500k being held in one cold room alone. This carries significant risk in the event of a single point of failure. Consequently, there is no longer a maintenance service for the system in the event of break down or replacement parts. It also means that compliance with regulations set out by the MHRA to maintain our MS Specials license at Llandough Aseptic Unit for the manufacture of sterile aseptic products is at risk if medicines particularly high risk sterile injections cannot be guaranteed to have been stored at the correct temperature with resulting patient safety risks. Fluorimeter in biochem needs replacment	5	5	**25**	Capital planning programme Discretionary capital programme Escalation routes to Estates Business Continuity Plans Managed service contracts Maintenance service agreements Medical equipment governance framework	5	4	**20**	1. Capital replacement bid to be submitted for air handling and chiller units 2. Medical devices bid approved for replacement nitrogen generators, a/w installation 3. Replacement process for NVA 1 and 2 4. Engage with TrAMS project for proposed regional solution to radiopharmacy and sterile production units 5. Procurement for new temperature monitoring solution, supplier identified for Pharmacy. Lab medicine to review if same supplier could meet needs for labs 6. Capital bid submitted for Fluorimeter	5	2	**10**	Dec-23	Finance and Delivery Quality, Safety and Experience	Capital Estates Patient Safety

CORPORATE RISK REGISTER JULY 2023

Clinical Board/Corporate Directorate	Risk Reference	Date risk added	Date New Risk/s Added November 2022	Risk	Initial Risk Rating			Controls	Current Risk rating			Actions	Target Risk rating			Date of next review	Assurance Committee	Link to BAF
					Consequence	Likelihood	Total		Consequence	Likelihood	Total		Consequence	Likelihood	Total			
CD&T	35	14.11.2019		**Regulatory Compliance and Accreditation** Non compliance with regulatory and accreditation requirements leading to: - impact on service delivery and patient safety (potential for cease and desist of service) - reputational risk - financial risk e.g. loss of income, fine for breach of statutory duty - inability to maintain suitable systems, practices and facilities to ensure on-going compliance - increasing requirements from regulators which cannot be met - mismatch in capacity/demand on QMS which leads to failure to deliver activities - patient/staff harm as a result of poor safety governance, e.g. ultrasound, MR safety, decontamination, POCT - Health and Safety at Work incidents - patient concerns, claims and redress - failure to comply with GDPR and Information Governance	5	5	25	Governance through QSE and Regulatory Compliance Group with Clinical Board oversight of regulated and accredited services. Incident management, including Root Cause Analysis Concerns management Audit of practice/standards Risk register Service Improvement initiatives Clinical Board Data Integrity Policy and Assessment Standardised QMS approach between directorates Dedicated quality resource in key Directorates	5	4	20	Lack of a single QMS database to enable oversight of compliance (WG procured QMS I-Passport in evaluation phase) Absence of some regulatory roles (e.g. MR Safety Expert, Head of Ionising Radiation) Corporate Medical Records Operational Group not longer standing	5	2	10	Dec-23	Quality Safety and Experience Committee	Patient Safety
	36	1.09.2023		Temporay air handling unit installed in biochemistry lab in UHW to mitigate the longer term issue of replaceing whole air conditioning system does not provide adequate air cooling, there is no even distribution of cool air, the laboratory is not maintained at a consistent temperature. The temporary ducts are brining in significant amounts of dust into the lab, with potential to affect semsitive immunoassays, with potential to p[roduce erroneous results. The high air flow from the ducts can affect the track in the centrifuges. The temporary air handling unit has failed leading to high temperatures affecting staff morale and inability to provide certain tests as business continuity plans were instigated involving the switch off of certain analysers to reduce overall temperature. Mobile air conditioning units are alos in use to try and maintain cooler temperatures but come with risk in electrical load and the ducting becoming hot.	4	5	20	1. Two closed windows replaced with ones that open 2. Mobile air conditioning units rented and installed 3. Oestradiol and Gentamicin have been referred and the Architect turned off 4. In event of total failure all work has business continuity plans 5. Some parameters specifically susceptible to high temperaturescan have re-run rules applied on main automated system to mitigate some potential erroneous results 6. working on short term plan to ensure the air conditioing system is being serviced/ maintained with regular diagnostic reports so prevenatable actions can be taken. 7. Portable units ordered 8. Filters being fitted to ducting to reduce dust and debris	4	5	20	PIE submitted in June to replace air conditioning system. A contigency back up should be included. Update contigency documents to include manufacturers recommendations for running conditions and when to remove equipment from service Complete non-conformities/ recommendations from reagent storage unit	4	2	8	Oct-23	Quality Safety and Experience	Capital Estates Capital Assets Workforce Staff Wellbeing
	37	Sep - 21		**Critical Care - Nursing Workforce** There is a risk that patients will not be admitted to the Critical Care Department in a timely and safe manner due to insufficient Critical Care Nursing Capacity resulting in patient safety risks including serious harm and death, staff burnout and a failure to adhere to national standards and guidelines. This risk is currently exacerbated by the consequences of the Covid19 pandemic due to staff absences due Covid19 infection, sheilding & self-isolation requirements, and the significant associated impacts upon staff wellbeing.	5	5	25	Block booking of temporary staffing is ongoing; Recruitment strategies in place (ongoing recruitment events); Increased our educational team from 2.64 WTE to 5.04 WTE to support the junior workforce; Relying on the availability of an additional clinical area to admit patients; Working collaboratively with patient access to identify beds in a timely manner for Level 1 patients (not currently effective) Robust implementation of the CC escalation plan; Implement the smaller pod-focused initiative.	5	4	20	Develop a strategy to attract prospective employees to work in C&V CC; Develop further cross- Health Board working; Develop a staff feedback opportunity to generate ideas to support Point 1. Gain support from HR and Recruitment to have an open CC recruitment advert; Implement the Leadership Programme developed for senior staff Identify a more robust process for discharging patients within the 4 hour target; Robust implementation of the CC escalation plan; Develop a staff feedback opportunity to generate ideas to support Point 2. Initiate Workforce Task & Finish Group	5	2	10	Aug-23	Quality, Safety and Experience and People and Culture	Patient Safety Staff Wellbeing Workforce Critical Care
	38	08/2022		**Critical Care - Bed Capacity** Lack of physical Emergency Critical Care beds at UHW to admit current and predicted Critical Care Demand to 2030. Delays in Emergency admission to Critical Care present a risk of avoidable deaths and impaired functional outcomes. Emergency Critical Care has 35 Level 3 commissioned beds. Due to its specialist nature, the majority of Critical Care work undertaken at Cardiff and Vale cannot be undertaken anywhere else in Wales.	5	5	25	Currently the directorate are occupying the use of a surge ICU area (C 3 Link) to provide 10 additional physical beds. Capital Planning are in the design process for refurbishment and expansion of Critical Care.	5	4	20	Undertake Design work to produce an outline cost for refurbishment and expansion of Critical Care beds, overseen by Program Board.Seek funding for expansion and refurbishment. Clarify commissioning arrangements	5	2	10	Aug-23	Quality, Safety and Experience Finance and Delivery	Patient Safety Critical Care

CORPORATE RISK REGISTER JULY 2023

Clinical Board/Corporate Directorate	Risk Reference	Date risk added	Date New Risk/s Added November 2022	Risk	Initial Risk Rating			Controls	Current Risk rating			Actions	Target Risk rating			Date of next review	Assurance Committee	Link to BAF
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Specialist Services Clinical Board	39			**Critical Care - Estates** There is a risk of patient and staff harm due to aging and obsolete estates and equipment coupled with reduced capacity within the Critical Care Directorate. Aggragated Risk following risk of harm in the following areas: - HCID Level 2 and 3 (Reduced Capacity) - Sub-standard Heating, Ventilation and Air Circulation - Isolation Facilities - LTV unit - Substandard Infrastructure and plumbing leading to flooding - Obsolete Pendants System providing medical gasses.	4	5	**20**	Prioritisation of clinical need, use of neighbouring facilities and acquiing temporary mobile structures.	4	5	**20**	Business cases to be developed to secure renovation and replacement funding.	4	2	**8**	Aug-23	Finance and Delivery	Capital Assets Patient Safety Critical Care

CORPORATE RISK REGISTER JULY 2023

Clinical Board/Corporate Directorate	Risk Reference	Date risk added	Date New Risk/s Added November 2022	Risk	Initial Risk Rating: Consequence	Initial Risk Rating: Likelihood	Initial Risk Rating: Total	Controls	Current Risk rating: Consequence	Current Risk rating: Likelihood	Current Risk rating: Total	Actions	Target Risk rating: Consequence	Target Risk rating: Likelihood	Target Risk rating: Total	Date of next review	Assurance Committee	Link to BAF
	40	Jan - 2010		**Haematology and Immunology - Clinical Environment** There is an inadequate clinical environment for the care of Haematology Patients (including Bone Marrow Transplant). This creates a risk of cross infection for patients particularly vulnerable to infection. There is a potential impact on patient morbidity and mortality, quality of service and reputation. Despite the controls and assurances currently applied, it is extremely likely that the clinical environment will not meet the minimum required standard at the next JACIE accreditation assessment and the ensuing consequences of this cannot currently be prevented.	5	5	**25**	Risk specific policies, protocols, and guidelines. Cleaning schedules. Installation of air pressure gauges outside BMT cubicles to measure positive air pressures. Patients admitted to ward C4 North (amber) for triage prior to admission to B4 (green). HCAI monitored monthly. Positive air pressure gauges outside the BMT cubicles are monitored daily to ensure appropriate air pressures are maintained. Air pressure system validated by Estates Dept. High C4C scores consistently achieved. A number of options for the relocation of the service have been explored over the past 10 years but have not been successfully adopted. The directorate and Clinical Board are currently working with Estates and Operational Colleagues as part of the Health Board's Acute Sites Master Plan work to develop plans for relocation to the current Outpatient site at UHW.	5	4	**20**	New dedicated Haematology facility required. Escalated to Clinical Board, estates and WHSSC. Bid for Lakeside Wing is to be submitted for consideration.	5	1	**5**	Aug-23	Quality, Safety and Experience and Finance and Delivery	Patient Safety Capital Assets
	41	14/06/2021		**Neurosciences** There is a risk of patient harm due to Epilepsy Telemetry Service facilities for patients with intractable epilepsy being used by another clinical service (Medical Clinical Board post COVID).	5	5	**20**	Discussion ongoing between Clinical Boards to allow service to be accessed. A partial service has been restored - 1 bed on C4 South.	5	4	**20**	Neurosciences has requested to relocate stroke into C4S, returning C4 N to Stroke (medicine) which will reduce staffing contraints on running an isolated service	5	1	**5**	Aug-23	Quality, Safety and Experience and Finance and Delivery	Patient Safety Capital Assets
Finance	42	Apr-22		Risk: The submitted IMTP has a planned deficit of £88.4m for 2023/24 and the Health Board does not have a plan to achieve its revenue statutory breakeven duty without reliance on WG financial support. There is a risk of failure to have a three year IMTP approved by the Welsh Ministers due to an inability to achieve its revenue statutory break even duty.	5	4	**20**	Governance reporting and monitoring arrangements through operational teams, Finance Committee and Board	5	4	**20**	Development of plan to address the deficit in line with WG expectations in 2023/24 and continue to plan to break even in FY25 and FY26.	5	2	**10**	Aug-23	Finance and Delivery	Financial Sustainability Delivery of IMTP 22-25
	43	April 22		Risk: Due to a planned deficit of £88.4m for 2023/24 there is a risk of failure to achieve an Approved Three year Financial plan (IMTP) with potential for additional escalation and intervention arrangements following Enhanced Monitoring arrangements being imposed by Welsh Government.	5	4	**20**	Governance reporting and monitoring arrangements through operational teams, Finance Committee and Board Work continues to address the recurrent deficit in the UHB's financial position.	5	4	**20**	Developing a plan to address the £88.4m deficit is underway.	5	2	**10**	Aug-23	Finance and Delivery	Financial Sustainability Delivery of IMTP 22-25
Digital Health	44	06/08/2011		Cyber Security - Due to prevailing national and international Cyber Security threats there is a risk that the Health Board's IT infrastructure could be compromised resulting in prolonged service interuption and potential impacts on the safety of patients due to an inability to access electronically stored data.	5	5	**25**	The UHB has in place a number of Cyber security precautions. These include the following: - The implementation of additional VLAN's and/or firewalls/ACL's - Segmenting and an increased level of device patching. - The use of Monitoring and Vulnerability Softare - Health Board wide Mandatory Cyber Security Training and Phishing Campaigns.	5	4	**20**	The requirements to address the resourcing of Cyber Security Management have been acknowledged in an approved but unfunded UHB Business Case. (May 2022: Successful business case bid made to BCAG to ensure appointment of dedicated Cyber resources. Roles are currently being advertised and recruited to. Continued efforts need to be made to improve compliance with the Health Board's Cyber Security Mandatory Training and to increase awareness of and engagement with the Health Board's Phishing Campaigns. Compliance with/completion of Cyber Resilience Unit Recommendations. September 2022 : Two of the 4 roles have been appointed to. The remaining posts are in the recruitment process. Jan 2023 - We have successfully appointed a Cyber Security Manager and we anticipate a start date mid February. One of their main priorities will be to implement the improvement action plan May 2023 update - Cyber Security Manager post to be re-advertised. Second phishing simulation email sent to all staff in March 2023. New malware incident SOP developed. June '23: Update being submitted to private meeting of DHIC on 15.08.23, including performance matrix agreed at the last DHIC meeting in May 2023	5	3	**15**	Aug-23	Digital Health Intelligence	Capital Assets Digital Strategy and Road Map
PCIC	45	05/07/2023		**Domiciliary medication administration/support** **Risk:** Sufficency of domiciliary medication administration/support arrangements. **Source of uncertainty/cause:** Currently Cardiff and Vale LA policy is that support with medication/administration support packages are only commissioned or provided by domiciliary care workers utilising a Monitored dosage system (MDS). Community Pharmacies are not required under their contract to supply MDS for this purpose and there are less pharmacies now willing to provide this service for individuals who do not require it as part of reasonable adjustment arrangement to support them independently managing their own medication. **Consequence:** 1. Inability or significant delay in being able to discharge patients with medication support needs with increased risks associated with extended hospitalisation in terms of deconditioning and independence. 2. Impact on staffing resources across the system trying to source Community PHarmcy willing to provide MDS's for patients requiring support. 3. Increased pressure on Community Pharmacies willing to support MDS provision	4	5	**20**	1. Relying on good will of community pharmacies to provide medication in MDS/MAR 2. Secondary care and primary care teams working together to negotiate provision of MDS for individual patients if discharge is looking to be delayed 3. Local Authority have produced a Regional medication policy to allow administration and commissioning of medicines by care workers out of original packs with a Medicines Administration Record (MAR) chart	4	**5**	**20**	Agree funding route for National Community pharmacy MAR service and investment for staff to deliver the other aspects of the LA policy - business case and options appraisal not supported by UHB Commissioning of Community pharmacy MAR service from Cardiff and Vale community pharmacies once funding source identified Care workers need to be trained to administer medication from original packs with a MAR chart	4	2	**8**	Aug-23	Quality Safety and Experience	Patient Safety

CORPORATE RISK REGISTER JULY 2023

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	46	01/09/2023		There is a risk that the Healthcare Dept at HMP Cardiff is unable to meet the needs of patients due to a high number of vacancies in the nursing team. This particularly affects the administration of medication, the assessment of new arrivals and the ongoing triage and care of unwell patients.	5	5	25	Senior management colleagues are working clinically. Clinicians are being drawn from the in-house mental health, substance misuse and pharmacy teams to support the administration of medication. Efforts to recruit to vacant posts are ongoing. A recruitment event was recently held. Agency nurses have been utilised. Pharmacy Technicians have been recruited to dispense medication. Overtime payments are offered to staff. Regular support is being provided by PPDNs to train and support new staff. Working with the Governor and prison service to manage prison daily regime to support reduced capacity within health care.	5	4	20	Continue efforts to recruit nursing staff. Explore further skill mix options to diversify workforce. Some GP advice prvided by CAV247 to prison health care staff when absence/limited GP cover.	5	3	15	Oct-23	Quality Safety and Experience	Patient Safety
Strategic Service Planning	47	05/07/2023		Business Continuity The business continuity planning with in the HB is at risk due to •**D**ut dated plans, no central repository for plans, •**N**o central register of plans •**D**epartments writing plans in isolation •**E**PRR long term sickness, •**P**lans being reliant on backup generator power to maintain services in a power failure when large parts of UHW is not covered This is likely to lead to services not being maintained during and following an incident, increased risk to patient and staff safety, reputation, etc.	5	5	25	There are existing plans in place	5	4	20	EPRR team will continue to support BC Ops have a Single point of contact	5	3	15	Aug-23	EPRR Strategic Oversight Group	Workforce
Mental Health	48	17/08/2023	To be removed	Inability to comply with europrean working time directive. Investment required to change working arrangements to facilitate meal breaks and comly with UHB meal break policy and EWTD. Also not compliant as shift patterns for bank workers on occasion to meet service needs do not have an 11 hour gap between shifts. Without these staff there would be significant shortfalls in registered (and skilled) staffing and rotas.Establishments fall below the 50:50 Registered:unregistered skill mix with inpatient areas not meeting this standard.	5	4	20	There is rolling recruitment of trained and untrained staff. The CB maintains the Accelerated Development Programme for newly qualified staff demonstrating potential for leadership. Job advert progressing to vacancy scrutiny panel.	5	2	10	There is rolling recruitment of trained and untrained staff. The CB maintains the Accelerated Development Programme for newly qualified staff demonstrating potential for leadership. Job advert progressing to vacancy scrutiny panel.	5	1	5	Aug-23	Qyality Safety and Experience	Patient Safety
	49	17/08/2023		Due to Severe High Risk Eating disorders getting timely access to inpatient beds for refeeding or medical stabilisation there is a risk of patient safety	4	5	20	SHED sesrvice working with this group and escalating concerns	4	5	20	Escalated to COO	4	2	8	Oct-23	Quality Safety and Experience	Patient Safety
	50		8.11.2023	Pendine, Pentwyn, Gabalfa, Park Road, CAU, Hamadryad - damp issues, water leakage from roofs, poor facilities such as meeting rooms and limited office space. Lack of panic alarms, uncontrolled access to clinic rooms due to lack of internal lockable doorways - poor wireless signal. Fire Officer has recommended CAU shuts due to estates and fire risks. Alternative accomodation will be required.	5	4	20	Workplace inspections. Currently allocating internal funding for minor refurbs to manage the problems in the short term.	5	4	20	Escalated to COO	5	2	10	Oct-23	Quality Safety and Experience	Patient Safety
Surgery	51	01/03/2023		Due to staffing and operational pressures within the Children's hospital, Paediatric scoliosis theatre lists are being cancelled repeatedly. This is due to requiring PACU service, which is currently not available in Childrens hospital, and limited HDU provision due to emergency admissions taking priority.	4	5	20	implementation of new process in both HDU and the ward. This will require medical input, training of nursing staff, and recruitment of nursing staff. Ring fencing of capacity is essential. All day list for scoli now agreed	4	5	20	implementation of blue sky model in both HDU and the ward. This will require medical input, training of nursing staff, and recruitment of nursing staff. Ring fencing of capacity is essential	4	2	8	Oct-23	Quality Safety and Experience	Patient Safety
	52	19/07/2023		The core function of the Resuscitation Service is unable to fulfilled at all times. The recommended standards are not being met in terms of staffing. The Quality Standards for Resuscitation Services across the UK state that there should be 1 Resuscitation Practitioner (RP) for every 750 clinical members of staff within the Health Board. Training and attendance at 2222 calls is currently being compromised. The current situation places all members of the resuscitation service under a great deal of pressure as their workload is increased significantly. Training is annual and cyclical across all levels of need from basic life support through to all of the advanced courses; Training is prioritised as per guidelines. The footprint of the resuscitation service is UHB wide, encompassing community also, RP's have to visit all sites, and we are very limited with the amount of time we give to the community. The main sites are so huge the demand and priority stays there. We are currenlty full for training for the remainder of this year. Despite varations in the way that training is delivered eg cascade training.	5	5	25	Robust SOPS/Procedures and Policies are in place for the Resuscitation Service but we are uaable to mitigate or meet the demand requested, partiularly in terms of training. There is an urgent need to appoint 'One whole-time equivalent Resuscitation Officer/Practitioner as per Quality Standards for every 750 members of clinical staff.	5	4	20	The Quality Standards document has been RAG rated. There is an urgent need to appoint 'One whole-time equivalent Resuscitation Officer/Practitioner as per Quality Standard for every 750 members of clinical staff. This also must include appointment of deisgnated Paeadiatric Resuscitation Practitioners Depending on geographical distribution of the organisation, more than one Resuscitation Officer/Practitioner may be required to fulfil this requirement for adequate and additional responsibilities relating to resuscitation.' 50% of a RP time should be spent training; the remainder of the time should include other responsibilities such as audit, governance commitments, DNACPR, clinical responsibilities, planning, finance etc. The organisation must also appont a board member/exec lead who has responsibility for Resuscitation Services.	5	1	5	Oct-23	Quality Safety and Experience	Patient Safety
	53	01/09/2023		Service requirement for Centralisation of OG will require a 24/7 rota for provision of care for major UGI patients in South Wales. The impact will be a reduction of workforce for provision of GS on call for the UGI half of the rota.	5	5	25	Interim arangements in place which are monitored on a regular basis	5	4	20	Workforce plans need across the network with appropriate investment/pathways and resource	5	2	10	Oct-23	Quality Safety and Experience	Patient Safety
	54	01/09/2023		Failure of ventilation air handling unit (AHU) unit within Terminal Sterilisation Unit at UHW compromising ability to maintain aseptic conditions. The AHU has been deemed end of life, and is in need of replacement. Due to the age of the AHU, it is no longer working as it should. It does not meet air change requirements for class 8 clean room conditions. There are regular breakdowns which are costly, and disruptive to the service HSDU provide to the UHB. If the AHU were to fail completely, this would result in HSDU having to move processing offsite until the AHU was replaced.	4	5	20	1) System alarmed to warn of issues as they arise. 2) Planned preventative maintenance programme in place. 3) Environmental monitoring undertaken to ensure that air quality is being maintained.	4	5	20	Clarify escalation and awareness	5	2	10	Oct-23	Finance and Delivery	Patient Safety Capital Assets
	55	24.10.2023	7.11.2023	Patients Lost to Follow Up (LTFU): There are 6109 ophthalmology patients that require follow up, 4222 of these do not have a date to come in (figures transient but correct at time of writing RA). Review of a random sample has indicated that the cause of this is not limited to capacity and demand but also a result of patients that should also have been discharged safely, incorrectly being listed for follow up they do not require. Depending on their condition and pathway, categories of these patients that do require a follow up they have not received will be at risk of irreversible, permeant loss of vision. Patients LTFU is a theme of patient concerns raised in Ophthalmology and Datix submissions. Review of these and the patients is ongoing to determine whether any are nationally reportable incidents.	5	5	25	1. List of patients affected generted to use as a traackr and broken down into speciality pathay (condition) for validation. 2. List reviewed with CD for clinical oversight to stratify risk and prioritise accordingly. List also to be crossed checked for any eye casualty attendance. 3. Valitadation of lists in progress. 4. Scaper tool to eview discharge notes Mandate patient outcome recording	5	4	20	1. As per controls and assurances. 2. Vaidation of all patients on list and follow up arranged as per prioritisation. 3. Weekly review tracker to be compiled and monitor trajectory. 4. Review clinical outcome form usage with clinicians	5	2	10	Oct-23	Finance and Delivery Committee	Patient Safety Capital Assets

	CRR Reference as at 8.11.23	Corporate Risks as at 8.11.2023	Current Risk Score as of 8.11.23	First Line of Defence Management Controls: Operational Processes and Management Reviews	First Line of Defence Management Controls: Management information and data	First Line of Defence Management Controls: Other - Self assessment	Second Line of Defence Oversight functions, e.g. Compliance and quality sub-groups and risk management: Compliance / Quality	Second Line of Defence Oversight functions, e.g. Compliance and quality sub-groups and risk management: Health and Safety / Estates	Second Line of Defence Oversight functions, e.g. Compliance and quality sub-groups and risk management: Risk Management	Third Line of Defence Internal Audit, External Audit and other regulators and independent assurance providers: Regulatory Body	Third Line of Defence Internal Audit, External Audit and other regulators and independent assurance providers: Internal Audit/NWSSP Estates	Third Line of Defence Internal Audit, External Audit and other regulators and independent assurance providers: External Audit (Audit Wales)	Reviewed Assurance Level
CEF	CRR1	Risk of patient harm do to obsolete Medical Gas and air delivery equipment and plant.	5x4=20	x	x		x	x	x	x	x		
CEF	CRR2	Risk of patient harm due to corrosion of Main 02 pipeline in UHW which may impact equipment failure leading to loss of service and interruption of oxygen supply.	5x4=20	x	x	x	x	x	x	x	x		
CEF	CRR3	Risk of loss of heating throughout UHL due to main boiler F&E tanks which are badly corroded.	5x4=20	x	x	x	x	x	x		x		
CEF	CRR4	Risk of safety to staff due to ventilation verification of critical systems identified across UHW site which does not comply with HTMs for ventilation.	4x5=20	x	x	x	x	x	x	x	x		
CEF	CRR5	Risk of overspend in financial plans due to unstable energy markets resulting in significant tariff increases.	4x5=20	x	x		x	x	x		x		
CEF	CRR6	Risk of Service Interuption and patient harm due to an inability to remotely connect into the Building Management System	5x4=20	x	x		x	x	x		x		
CEF	CRR7	Risk of patient harm, reputational damage, regulatory penalty and service interruption due to limited asset identification and inspection or maintenance of Health Board Ventillation, Smoke/Fire Dampners and Fire Doors	5x4=20	x	x	x	x	x	x		x		
CEF	CRR8	Risk of Power Outage as autormatic changeover system to start low voltage generator is not functioning	5x4=20	x	x	x	x	x	x				
CEF	CRR9	Risk of lifts failing as urgently need replacing and no authorised engineer assigned to lifts. Impacting public and patient staff movement	4x5=20	x			x		x				
CEF	CRR10	**Risk/Issue:** UHW HSDU / Main Theatres / Main CIAT Chiller Plant. Chiller Plant pipework severely corroded. Chiller HSDU is 22 years old and failing with new spare parts now unavailble Main theatres plant circuits constantly breaking down. Chillers will require to be renewed in the near future **Impact:** Failure leading to loss of cooling to department.	5x4=20	x			x						
CEF	CRR11	**Risk/Issue:** Main walk in Drugs fridge in UHW Pharmacy stores LGF, is old and requires renewing due to being unreliable and parts difficult to obtain. SPS walk in Drugs fridge in UHW Pharmacy stores GF is old and requires renewing due to being unreliable and parts difficult to obtain. **Impact:** Loss of refrigerated drugs causing interuption to service	5x4=20	x	x	x	x						
CEF	CRR12	Risk/Issue: Biochestry Lab at UHW over heating due to increased equipment and failure of exisitng cooling systems. Impact: Potential closure of Lab and service loss.	5x4=20	x			x						
CEF	CRR13	Risk/Issue: Auto Changeover system - On loss of power to LV sub A1 panel, ACB failed to take secondary supply system (SPS generator backup) ACB failed to take load on 3 separate attempts of testing – on all occasions ACB fired through Gaps in control – Unable to test generators on-load (monthly test) as per HTM 06-01 requirement Failure to provide on distribution strategies standby generators resilience of N+1 automatically Switch Panelboard in Sub 2A - Air Circuit breaker (ACB) make/model common to both panels A1 & A2	4x5=20	x			x		x				
CEF	CRR14	Risk/Issue: Both DSS4 Maternity HV substation double doors and LV switchroom single door are made fro slatted wooden doors and rotten, damaged and not secure for the location of the HV/LV substations.	4x5=20	x			x						
CEF	CRR15	Risk/Issue: Both DSS4 Maternity HV substation double doors and LV switchroom single door are made fro slatted wooden doors and rotten, damaged and not secure for the location of the HV/LV substations.	4x5=20	x									

CEF	CRR16	**Risk/Issue:** Roofing sheets, rusted through S.W corner of A block, to A Block Link - Several holes and sheeting could be affected by inclement weather Plant room roofs at UHW are showing signs of degragation and failure. Roofs are metal profile on steel girders. On A block plant room there is obvious signs of Corrosion with daylight showing clearly on the far right side. Lift rooms roofs leaking causing down time on lifts - Risk / roofs sheets corroding causing collapse of roof - Impact / loose sheets have the potential to fall putting pedestrian and vehicle traffic at risk UHL Staff Restaurant Major Roof Leaks into servery and dining area. Possible Food Standards Agency (EHO) Food Hygiene rating could be affected/contaminated food	5x4=20	x			x	x	x				
CEF	CRR17	**Risk/Issue:** Main piped oxygen from estates VIE tank runs underground, no ducting and a large tree growing directly above the ground/pipework route. Major rosk if tree roots cause unseen damage to pipework which would disrupt oxygen supply to hospital.	5x4=20	x				x	x				
CEF	CRR18	Risk/Issue UHW CHP Plant current O and M contract with Clarke Energy will expire in December 2023	5x4=20	x									
Med	CRR19	There is a risk of patient harm due to the progression of conditions from benign to malignant disease due to increased waiting times for surveilance and planned recall endoscopy procedures.	5x4=20	x	x	x	x		x				
Med	CRR20	Risk of patient harm due to workforce and capacity constraints across Gastroenterology & Endoscopy.	5x4=20	x	x		x	x	x				
Med	CRR21	Risk of patient harm due to delays receiving timely assessment for Thrombolysis	5x4=20	x	x	x	x		x	x			
Med	CRR22	Risk of patient harm due to delays providing Home Parenteral Nutrition services and treatment	5x4=20	x	x		x		x				
C&W	CRR23	Risk of patient harm due to inadequate midwifery and medical staffing issues on obstetric assessment unit	5x5=25	x	x		x		x				
C&W	CRR24	Risk of harm to mothers and babies due to delayed lift replacement works and inadequate repairs within the Maternity Services lifts.	5x4=20	x	x		x	x	x	x	x		
C&W	CRR25	**Issue** - Fetal medicine capacity shortfall and breech of ASW 5 day referral standard. **Risk/Impact** - due to fetal medicine capacity shortfall and breech of ASW 5 day referral standard, there is a risk of harm to compromised foetuses and reduced options for termination of pregnancy if delayed beyond 21+6 weeks. Delayed termination beyond 24 weeks means patients have to register the baby as a stillbirth and since criteria for termination is stricter after 24+0 weeks some women mayt be denied that option after 24+0 weeks which they could have had if seen earlier ie potential for wrongful life litigation.											
C&W	CRR26	**Issue** - Obstetric Staffing Level Challenges **Risk/Impact** - Risk of serious adverse outcomes (stillbirth, neonatal death and/or maternal morbidity) due to delayed or moved antenatal appointments due to inadequate senior obstetric staffing levels. Additionally the quality of care women receive may be lower due to not having senior reviews.	5x4=20	x	x		x	x	x	x	x		
C&W	CRR27	**Issue** - Paper Based Clinic Records - PAS Service **Risk/Impact** - A) Treatment delay and thus need for more invasive treatment. Increased risk of complications (admission for haemorrhage, additional surgery, infection and additional psychological trauma). B) Poor service data quality, underreporting of clinical workload, loss of funding, prolonged or insufficient clinical governance projects C) Treatment delay, vital info previously gathered unavailable at the point of care – risk of clinical errors, failing to promptly diagnose complications D) Confidentiality at risk when paper files get lost in transit. E) Risk of legal challenges and implications due to non-compliance with statutory abortion framework. Particular legal risk: non-reporting of abortion treatment	x	x	x		x						
C&W	CRR28	There is a risk of harm and poor patient experience as a result of lack of available provision for emergency gynaecology care resulting in delays.	4x5=20	x	x	x	x	x	x				
C&W	CRR29	There is a risk of patient harm to C&YP due to the increased demand fo PCCU and NICU beds.	5x4=20	x	x	x	x	x	x				
C&W	CRR30	There are risks clinically, experientially and reputationally associated as a result of the current non-compliance against the Ockenden Report recommendations across Maternity and Neonatal Services	4x5=20	x	x		x		x				
C&W	CRR31	**Issue -** Waiting times for C&YP awaiting ND Assessment **Risk/Impact** - There is a risk of harm and poor patient experience as a result of current waiting times for CYP awaiting ND Assessment. Waiting times are currently significantly high and also the increase in referrals, currently significantly exceeds capacity.	4x5=20	x	x								

C&W	CRR32	There is the risk of poor patient experience / outcomes in maternity due to staffing levels within Maternity services	5x4=20	x	x	x	x		x	x			
CD&T	CRR33	There is a risk to the delivery of modern, safe and sustainable healthcare due to suboptimal estate across the CD&T Clinical Board.	5x4=20	x	x	x	x	x	x	x		x	
CD&T	CRR34	There is a risk to the delivery of modern, safe and sustainable healthcare due ageing equipment across CD&T Clinical Board.	5x4=20	x	x	x	x	x	x	x		x	
CD&T	CRR35	Risk of regulatory penalty and reputational damage due to potential non-compliance with regulatory accreditation requirements	5x4=20	x	x	x	x	x	x	x		x	
CD&T	CRR36	Risk of air conditioning not providing adequate air cooling, which has failed, in the biochemistry lab and is unable to maintain a consistent temperature and has the potential to produce erroneous results.	5x4=20	x	x	x	x	x	x	x		x	
Spec Serv	CRR37	Risk to patient safety causing serious incidents due to patients not being admitted to Critical Care Department in a timely manner due to insufficient nursing workforce.	5x4=20	x	x	x	x	x	x	x		x	
Spec Serv	CRR38	Risk to patient safety causing serious incidents due to patients not being admitted to Critical Care Department in a timely manner due to insufficient bed capacity.	4x5=20	x	x	x	x	x	x	x		x	
Spec Serv	CRR39	Risk that patients will not receive care in a suitable environment due to a number of shortcomings in Critical Care facilities.	5x4=20	x	x	x	x	x	x	x		x	
Spec Serv	CRR40	Risks to harm to haematology patients (including bone marrow transplant) due to cross infection hazards created by an inadequate clinical environment.	5x4=20	x	x	x	x	x	x	x		x	
Spec Serv	CRR41	Risk of patient harm due to reduced access to Epilepsy Telemetry Services	5x4=20	x	x	x	x		x	x	x		
Fin	CRR42	Risk failure to achieve revenue statutory duty breakeven duty and achieve an approved three year IMTP	5x4=20	x	x	x	x		x		x	x	
Fin	CRR43	Risk of failure to achieve an approved Three Year IMTP due to a planned defecit of £88.4 million	5x4=20	x	x	x	x		x		x	x	
Dig H	CRR44	Due to national and international Cyber Security threatre, there is a risk that the Health Board's IT infrastructure could be compromised.	5x4=20	x	x	x	x		x	x	x	x	
PCIC	CRR45	Risk of patient harm due to a potential inability to support patients with Monitored Dosage Systems in their own homes	4x5=20	x	x		x		x				
PCIC	CRR46	There is a risk that the Healthcare Dept at HMP Cardiff is unable to meet the needs of patients due to a high number of vacancies in the nursing team.	5x4=20	x	x		x		x				
Strategic SP	CRR47	Risk of Service Interuption due uncomprehensive and inconsistent Business Continuity procedures and processes across the Health Board	4x5=20	x	x		x		x				
Mental Health	CRR48	inability to comply with european working time directive	4x5=20	x	x		x						
Mental Health	CRR49	Risk of patient harm to do severe high risk eating disorders getting timely access to inpatient beds	5x4=20	x	x		x		x				
Mental Health	CRR50	RFA Issued in regard to estates and fire risk. Recommended CAU shut down.	5x4=20	x	x		x	x	x				
Surgery	CR51	Risk of patient harm due to cancellation of Paediatric Scoliosis lists caused by staffing and operational pressures	5x4=20	x	x		x		x				
Surgery	CRR52	Risk of serious patient harm due to the core function of the Resuscitation service unable to be fulfilled at all times.	5x4=20	x	x		x		x				
Surgery	CRR53	Risk that centralisation of OG will require 24 hour cover for provision of care. This will impact on a reduction of workforce for other services.	5x4=20	x	x		x		x				
Surgery	CRR54	Risk of patient harm, due to limited maintenance of Health Board Ventillation	4x5=20	x	x		x		x				
Surgery	CRR55	Patients lost to follow up. Depending on their condition and pathway, categories of these patients that do require a follow up they have not received will be at risk of irreversible, permeant loss of vision.	5x5=25	x	x								

Assurance Key	
Assurance on one line of defence, limited or no third line of defence, assurance over 3 years old.	Low
Assurance across two lines of defence, positive assurance on third line of defence, assurance within last three years.	Medium
Assurance across all three lines of defence, positive assurance on the third line of defence, assurance within last three years.	High

Third Line of Defence - External Audit Rating Key	
Limited	Low
Reasonable	Medium
Substantial	High

WELSH HEALTH SPECIALISED SERVICES COMMITTEE (WHSSC)
JOINT COMMITTEE MEETING BRIEFING – 19 SEPTEMBER 2023

The Welsh Health Specialised Services Committee held its latest public meeting on 19 September 2023. This briefing sets out the key areas of consideration and aims to ensure everyone is kept up to date with what is happening within the Welsh Health Specialised Services.

The papers for the meeting can be accessed using the link below:
2023/2024 Joint Committee - Welsh Health Specialised Services Committee (nhs.wales)

1. Minutes of Previous Meetings
The minutes of the meetings held on the 18 July 2023 & 1 August 2023 were **approved** as a true and accurate record of the meeting.

2. Action log & matters arising
Members **noted** the progress on the actions outlined on the action log.

3. Genomics Update
Members received a presentation on how the All Wales Medical Genomics Service (AWMGS) is leading the way in many areas of genomics (Rare Disease, Cancer, Pharmacogenomics, and Mental Health) covering prevention, diagnosis and targeted treatments where was clinically needed and cost effective.

Members noted the Genomics Delivery Plan for Wales 2022-2025, how genomics was transforming cancer diagnostics and drug prescriptions; and how the AWMGS was delivering equitable genomic testing for improved outcomes in cancer and rare disease enabling precision medicine and reducing adverse drug reactions.

Members **noted** the presentation.

4. Chair's Report
Members received the Chair's Report and **noted**:

- **Appointment of a Vice Chair -** To ensure effective business continuity for WHSSC and the Joint Committee it was proposed that Chantal Patel, Independent Member (IM), WHSSC is appointed to the unremunerated role of Vice Chair for the Joint Committee, in accordance with the WHSSC Standing Orders (SOs),
- **Establishment of WHSSC/EASC Vacancy Control Panel –** Following receipt of a letter to WHSSC on behalf of the CEOs,

WHSSC and EASC have established a joint Vacancy Control Panel, aligned with that of CTMUHB but responsive to the needs of both functions,

- **Chair of the Individual Patient Funding Request (IPFR) Panel** Further to the Extraordinary Joint Committee meeting held on 1 August 2023, which supported the request to take forward the urgent recruitment of the WHSSC Individual Patient Funding Request (IPFR) panel Chair and approved the proposed remuneration package, the post has now been advertised following earlier delays. The aim is to appoint a substantive IPFR Chair by the end of October 2023. **Interim arrangements have been put in place to cover October;** and
- Key meetings attended.

Members (1) **Noted** the report, (2) **Noted** the update on the recruitment of the Chair of the Independent Patient Funding Request (IPFR) Panel; (3) **Noted** the establishment of the WHSSC/EASC Vacancy Control Panel and (4) **Approved** the appointment of Chantal Patel as Vice Chair of the WHSSC Joint Committee.

5. Managing Director's Report

Members received the Managing Director's Report and **noted** the following updates:

- **Progress on South Wales Neonatal ODN** - Funding for the South Wales Neonatal Transport Operational Delivery Network (ODN) was agreed at the 14 March 2023 Joint Committee meeting and funding has been released. However, the recruitment process has not yet taken place and therefore in line with our approach for other, as yet uncommitted investments, we have suspended implementation for this financial year. We will review the need and/or different options for delivering the scheme in 2024-2025. This scheme will now be considered within our process for prioritisation of all uncommitted expenditure and we have requested further information from Swansea Bay UHB (SBUHB), the provider Health Board (HB) to inform this evaluation,
- **Fertility Update - WHSSC Policy development: - CP37 Pre-implantation Genetic Testing-Monogenic Disorders, Commissioning Policy - CP38, Specialist Fertility Services: Assisted Reproductive Medicine, Commissioning Policy -** The WHSSC team met with Llais on 31 August 2023 to discuss the next steps regarding the policy development. WHSSC informed Llais that because of the uncertainty surrounding the budget impact of any policy changes, the current financial challenges for the NHS in Wales meant that policy development has been halted. Colleagues in Llais understood the financial challenge and the difficult choices faced by WHSSC and HBs. A further update meeting is planned for late September 2023; and
- **South Wales Spinal Network (SWSN) -** Following discussion at the NHS Wales Health Collaborative Executive Group (CEG), the

Cardiff and Vale UHB (CVUHB) and SBUHB Regional and Specialised Services Provider Planning Partnership (RSSPPP) set up a project to develop a new service model, to clarify the regional model for South East and South West Wales respectively, as well as the supra-regional model for South Wales, West Wales and South Powys. The project was launched in October 2020, with the aim of developing recommendations for delivering a safe, effective and sustainable model for spinal surgery in South and West Wales.

The final report was presented to the NHS Wales Health CEG on the 6 April 2021. The recommendation was accepted by the CEG, and the responsibility for commissioning the ODN was delegated to the Welsh Health Specialised Services Committee (WHSSC).

Members (1) **Noted** the report; and (2) **Noted** that the South Wales Spinal Network (SWSN) will go live on 25 September 2023.

6. Development of the Integrated Commissioning Plan (ICP) 2024/25

Members received a report offering assurance regarding the development of the 2024/2025 Integrated Commissioning Plan (ICP) and the approach to its development within wider NHS Wales situational context.

Members (1) **Noted** the report (2) Received assurance on the planning process to date which is in line with timeline received by the Joint Committee in May 2023; and (3) **Noted** the approach being taken to respond to the NHS Wales situational context, including an enhanced risk assessment.

7. South Wales Sexual Assault Referral Centres (SARC) Regional Model Implementation Briefing Paper

Members received a report providing an update on the implementation of the South Wales Sexual Assault Referral Centres (SARC) Regionalisation Programme following the Business Case approval in 2019, which proposed that the WHSSC Joint Committee fulfil the CEO reporting function at the request of the NHS Wales Chief Executives; and which requested that the Joint Committee give final approval for Phase 1 implementation of the Programme.

Members (1) **Noted** the report, (2) **Approved** the updated South Wales Sexual Assault Referral Centres (SARC) Regionalisation Programme model, prior to a report being issued to the seven HBs for final approval, (3) **Considered** and **approved** that the WHSSC Joint Committee will fulfil the CEO reporting function for the programme with immediate effect, prior to a report being issued to the seven HBs for final approval, (4) **Recommended to HBs for approval of** an in year funding uplift of £347k and a recurrent full year funding of up to £506k by 2025/26 for phase 1 of the implementation of the SARC Regionalisation Programme, prior to a report being issued to the seven HB's for final approval; and (5)

Recommended to HBs for approval of a continuation of funding for Phase 2 at the current level prior to a report being issued to the seven HBs for final approval.

A separate note will follow to HBs clarifying the financial arrangements for Phase 1.

8. Welsh Government National Commissioning Review Update
Members received a verbal update on progress with the Welsh Government national commissioning programme commissioned by the Minister for Health & Social Services.

Members noted that the National Commissioning Review Implementation Board meeting was taking place immediately after the WHSSC Joint Committee meeting.

Members **noted** the verbal update.

9. Single Commissioner for Secure Mental Health Service Project Initiation Document (PID)
Members received a report presenting the Project Initiation Document (PID) for the Single Commissioner Model for Secure Mental Health Services.

Members (1) **Noted** the report; and (2) **Supported** the recommendation to initiate the project to develop a Single Commissioner Model for Secure Mental Health Services.

10. Revision to Financial Delegated Limits
Members received a report requesting changes to the financial limits for Individual Patient Funding Request (IPFR) approvals.

Members (1) **Noted** the report, and (2) **Approved** the requested changes to the financial limits for Individual Patient Funding Request (IPFR) approvals.

11. WHSSC Model Standing Orders – Governance and Accountability Framework
Members received a report providing an update on the WHSSC Model Standing Orders and Governance and Accountability Framework.

Members (1) **Noted** the report, (2) **Approved** the proposed changes to the WHSSC Standing Orders (SOs), prior to being issued to the seven HB's for approval and inclusion as schedule 4.1 within their respective HB SOs, (3) **Approved** the proposed changes to the WHSSC Standing Financial Instructions (SFIs) prior to being issued to the seven HBs for approval and inclusion as schedule 4.1 Annex 2.1 within their respective HB SOs; and (4) **Noted** that there are no changes to the Memorandum of Agreement (MoA).

12. WHSSC Performance Report Month

Members received a report providing a summary of the performance of WHSSC's commissioned services. Further detail including splits by resident Health Board (HB) was provided in an accompanying Power BI Dashboard report.

Members **noted** the report.

13. Financial Performance Report – Month 4 2023-2024

Members received the financial performance report setting out the financial position for WHSSC for month 4 2023-2024. The financial position was reported against the 2023-2024 baselines following approval of the 2023-2026 WHSSC Integrated Commissioning Plan (ICP) by the Joint Committee in February 2023.

The year to date financial position reported at Month 4 for WHSSC was a forecast overspend of £2.164m against the ICP financial plan and a forecast year-end underspend of £4.202m.

Members **noted** the contents of the report including the year to date financial position and forecast year-end position.

14. South Wales Neonatal Transport Delivery Assurance Group Report (April 2023 - June 2023)

Members received a report providing a summary of the South Wales Neonatal Transport Delivery Assurance Group (DAG) quarterly report for 1 April 2023 – 30 June 2023.

Members (1) **Noted** the highlights of the Q1 Neonatal Transport DAG report, (2) **Noted** that the full report was being shared In-Committee due to potential patient identifiable data; and (3) **Received** assurance that the Neonatal Transport service delivery and outcomes were being scrutinised by the Delivery Assurance Group (DAG).

15. South Wales Trauma Network Delivery Assurance Group Report (Q1)

Members received a report providing a summary of the Quarter 1 2023/24 Delivery Assurance Group (DAG) report of the South Wales Major Trauma Network (SWTN).

Members **noted** the full South Wales Major Trauma Network (SWTN) DAG Report and highlights contained in the cover report.

16. Specialised Paediatric Services Strategy – Implementation Board Highlight Report

Members received a report providing a progress update on the implementation of the Specialised Paediatric Services Strategy.

Members **noted** the report and the progress made.

17. All Wales PET Programme Progress Report
Members received a report providing an update on the progress made by the All Wales Positron Emission Tomography (PET) Programme.

Members **noted** the progress made by the All Wales Positron Emission Tomography (PET) Programme and its associate projects and workstreams.

18. Corporate Governance Matters
Members received a report providing an update on corporate governance matters that had arisen since the previous meeting.

Members **noted** the report.

19. Other reports
Members also **noted** update reports from the following joint Sub-committees:

- Audit and Risk Committee (ARC),
- Management Group (MG),
- All Wales Individual Patient Funding Request (IPFR) Panel,
- Integrated Governance Committee (IGC); and
- Quality & Patient Safety Committee (QPSC);

20. Any Other Business

- **Cheshire & Wirral Mother and Baby Unit (MBU) –** Members noted that a contractor had been identified and a start on site was expected before Christmas. Recruitment to the posts was expected to start in April 2024 with view to new unit being operational by 1 October 2024; and
- **WHSSC Annual Report –** members noted that the WHSSC Annual Report would be circulated via email for approval and brought back to the November meeting for ratification.

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	21 September 2023

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

Matters Arising

- ***Duty of Quality Update –*** The Medical Director gave a verbal update on progress with the implementation of the Duty of Quality. Good progress has been made but challenges remain in making the Duty fit to non-patient facing services and we are meeting shortly with both DHCW and HEIW to share thoughts on how best to approach this. Reference was also made to two major projects (Laundry and TrAMS) that have quality improvements at their core but being unable to make significant progress due to lack of capital.
- ***Recruitment Modernisation Update –*** A presentation was given by the Deputy Director of Employment Services and the Head of Recruitment on progress in addressing recruitment challenges across NHS Wales. Measures have been implemented that have significantly streamlined the process and members commented favourably on the reduction in the time taken to successfully recruit new members of staff.

Chair's Report

The Chair noted attendance at recent meetings with the Minister largely focused on the financial situation across NHS Wales.

The Committee **NOTED** the update.

Managing Director Update

The Managing Director presented his report, which included the following updates on key issues:

- The establishment of a Value and Sustainability Group within NWSSP to drive an organisation wide approach to strengthen cross divisional working, to co-ordinate and deliver actions to demonstrate value for money as well

as continue to innovate and improve quality and consistency for NHS Wales. The Value and Sustainability Group mirrors the national approach and will closely monitor progress in achieving planned savings.

- The negotiations with the landlord on the Mamhilad site for provision of alternative accommodation for the Patient Medical Record service are nearing completion following the discovery of significant Reinforced Autoclaved Aerated Concrete issues in Brecon House. The costs of moving are however substantial with the need to shift 140,000 boxes of records and we are working on how to undertake this in the most cost-effective way.
- The move from the Regional Office in Companies House to Cathays Park has paused as a number of issues have recently arisen in respect of Cathays Park which have caused us to investigate what other options may be available.

The Committee **NOTED** the update.

Items for Approval

Energy April 26 V30 Basket Strategy - The Welsh Energy Group have considered NHS Wales' participation in a longer-term basket strategy for an initial 12-month supply period commencing 1st April 2026. The paper outlined the recommended approach for NHS Wales to confirm participation in the Long-Term Variable (V30) basket strategy for supply of energy for the period. The Committee **APPROVED** participation in the April26 V30 basket strategy.

Laundry Reconfiguration - The paper presented the option of reducing the Laundry Production Units currently utilised in the All-Wales Laundry service from five to four units through the decommissioning of the West Wales unit in Carmarthen and the formation of a storage and distribution hub. The Committee **APPROVED** the proposed decommissioning of the Carmarthen Laundry Production Unit, the creation of a Southwest distribution hub and the subsequent redistribution of volumes across South West and South East Wales.

Changes to the Welsh Risk Pool Risk Sharing Agreement – these had been discussed and agreed at the Welsh Risk Pool Committee on the previous day. The paper set out the Risk Share charges for 2023/24 arising from excess expenditure above the Welsh Government annual allocation for Clinical Negligence and Personal Injury claims. Following the receipt of the 2022/23 annual accounts, the proportions have been reassessed for 2023/24 based on agreed criteria and this has led to some organisations being asked to contribute more, while others will see a reduction in their contributions. The Committee **APPROVED** the updated Risk Share charges to NHS Wales for 2023/24.

Items for Noting

Transforming Access to Medicine (TrAMS)

The original plans for TrAMS have been significantly curtailed by the restrictions on available capital. Accommodation for the service within Southeast Wales is being urgently sought and there are a number of possible options. The existing

Pharmacy Service Technical Units are reaching end-of-life and the need to source alternative accommodation as soon as possible was stressed by a number of members.

The Committee **NOTED** the verbal update.

Finance, Performance, People, Programme and Governance Updates

Finance – The Month 5 financial position is a year-to-date overachievement of non-recurring savings of £0.999m. We continue to forecast a break-even financial position for 2023/24 dependent upon a number of income assumptions relating to pay award funding, energy costs for laundries, continued demand and the costs to support increased transactional activity, IP5 running costs and transitional funding for TRAMS. We are anticipating an element of savings achieved to date will be required to support the transitional and removal costs relating to the transfer of significant volumes of medical records to new premises. Our additional savings submission to Welsh Government on 11th August identified we can make a £1.6m distribution this financial year, in addition to identifying NWSSP supported initiatives that will result in cash releasing savings direct to NHS Wales Organisations and Welsh Government. Following the decision to transfer our utility supplies to the CCS Framework, this gave rise to the opportunity to sell back some small quantities of energy that we had secured the right to forward purchase at lower than current market rates for 2024/25 and 2025/26. The Wales Energy Group (which comprises each Director of Finance or their designated representative) agreed that these tranches of energy will be sold back to British Gas with a net £2.520m one-off windfall gain to NHS Wales to be accounted for in the 2023/24 financial year.

People & OD Update – Sickness absence remains low and statutory and mandatory performance is good. PADR rates are below target and the position has slightly worsened over recent months.

Performance – The in-month July performance was generally good with 37 KPIs achieving the target against the total of 41 KPIs. However, 4 KPIs did not achieve target and are considered Red/Amber. Two of these relate to Recruitment, one to customer satisfaction with the Digital Workforce Team, and one relating to Procurement Savings.

Project Management Office Update – Three projects are currently rated as red, these are the Brecon House relocation where there are issues with the current building being unsafe and the cost of relocation of records, Primary Care Contract reform, and the TrAMS project and particularly the affordability of the proposed solution as part of the wider capital programme.

Corporate Risk Register – There are currently eight red risks on the Corporate Risk Register. These cover energy costs, staffing shortages, the Legal & Risk Case Management System, Brecon House, TrAMs, the impact on the Single Lead Employer Team of proposed Junior Doctors Industrial action, the limitations

imposed by the overall financial climate and the reputational issues for NWSSP relating to the situation at BCUHB. The Committee **NOTED** the above Reports.
Papers for Information
The following items were provided for information only: • Welsh Infected Blood Support Service Annual Report 2022/23; • PPE Stock Report; • Audit Committee Assurance Report; and • Finance Monitoring Returns (Months 4 and 5).
AOB
N/a
Matters requiring Board/Committee level consideration and/or approval
• The Board is asked to **NOTE** the work of the Shared Services Partnership Committee.
Matters referred to other Committees
N/A

Date of next meeting	Thursday 23rd November 2023 10am – 12pm

Pwyllgor Gwasanaethau Ambiwlans Brys
Emergency Ambulance Services Committee

Reporting Committee	**Emergency Ambulance Services Committee**
Chaired by	Chris Turner
Lead Executive Directors	Health Board Chief Executives
Author and contact details.	Gwenan.roberts@wales.nhs.uk
Date of last meeting	19 September 2023

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

An electronic link to the papers considered by the EAS Joint Committee is provided via the following link:
https://easc.nhs.wales/the-committee/meetings-and-papers/september-2023/
The minutes of the EASC meeting held on 18 July 2023 were approved.

PERFORMANCE REPORT

The Performance Report was received which included the Ambulance Service Indicators and the EASC Action Plan. In presenting the report, Stephen Harrhy highlighted a number of key areas.

Members noted that:

- 999 call volumes were approximately 12% lower than the same period last year although more patients were attending Emergency Departments
- 10.3% reduction in incidents in July 2023 compared to July 2022
- Hear and Treat rates were 2.3% (460 incidents) higher in July 2023 compared to July 2022
- Despite the issues above the volume of incidents (patients) transported to a Tier 1 site (Major ED) had increased, 20% higher in July 2023 compared to July 2022 and the delivery of red performance remained challenging and not where it needed to be
- In specific health board areas:
  - Swansea Bay (SBUHB), impacts included increasing pressures of handover delays for 4hour and 10hour delays now implementing the Continuous Flow Model to improve patient care
  - Hywel Dda (HDUHB), issue of the reinforced autoclaved aerated concrete (RAAC) on capacity and the impact on services for the population of West Wales.
  - Cwm Taf Morgannwg (CTMUHB), variation remained from site to site and day to day but overall improvements seen
  - Cardiff and Vale (CVUHB), continued to deliver excellent performance and were meeting their predicted trends as per the Integrated Commissioning Action Plan (ICAP)
  - Aneurin Bevan (ABUHB), remained to have variable performance but some signs of improvement seen
  - Betsi Cadwaladr (BCUHB), stabilisation underway although variation between hospital sites and ongoing learning.

The ICAP plans for SBUHB and HDUHB appeared to be focusing on the right areas but these remained challenging areas

Members noted:

- The mixed view in terms of the impact of handover delays which was leading to improvements to Amber patients. However, this would need to translate into impacting on improving red performance.
- Ongoing work with WAST (by the EASC Team) to plan the trajectory of improvements required which would be shared with Members (Action Log) and Welsh Government officials; the ICAP process would monitor the impact
- Need to better understand utilisation and what a good level would be for all resources to be at the right level
- Amber, median, 65th, 95th and the longest Amber waits remained lower than 2022
- Ambulance handover times were stabilizing on a number of metrics, including total lost hours, % handed over in 15 min and handovers over 4 hours.

Members raised and noted:

- Their support for the approach in relation to the current position and the level of red response performance which was very concerning and remained at a deteriorating position despite local efforts
- That the unseasonal weather had also impacted adversely on the performance
- That actions had been agreed in the ICAPs but the resulting improvement was not always being seen in terms of impacting positively on handover delays
- In some areas, the tolerance remained that 4hour waits were acceptable as a large number of patients were breaching the 4hour target on a daily basis.
- The variability of the WAST ambulance unit hour production (UHP)
- The impact of 'overtime bans' (which were outside of the those identified within the Integrated Medium-Term Plan)
- The importance of getting back to the basics of delivering a responsive ambulance service and the ultimate aim to return to no handovers over 15 mins in line with the statutory targets.

In response, Jason Killens explained that an overtime ban was not in place, although the WAST financial plan had aimed to target areas to control spend. Additional resources had been provided to aid WAST management in a difficult and unanticipated period of demand.

Members noted:

- A deliberate choice had been made to develop the Cymru High Acuity Response Units (CHARU) and this had led to a marginally better performance. The quality of services received by patients had improved including an improvement in the rates of return of spontaneous circulation (ROSC) used as one indicator of patient outcomes
- The current WAST planning model for resources and geographical location was based on up to 6,000 lost hours; the current rate at 18,000+ was impacting adversely on ambulance performance
- Returning to a more traditional (dual crewed ambulance) would not improve performance and it would be more costly and would not be efficient or effective for patients
- WAST answering around 100 calls every day of red calls (which was a small number) and reiterated the need to focus attention on a relatively small number of calls.

- That the impact of the CHARU service had not led to improving performance and it was asked whether this had been the right action for the service. However, although the performance percentages had not increased the quality of the service had improved for patients.

Members welcomed the additional work to target frequent callers and asked how the additional 100WTE staff funding had translated into improvements in health board areas and its impact. Further information was requested about capacity and constraints for the next provider report (Action Log).

Members noted:

- The difficulties in recruiting staff in areas across Wales
- Potential issue looming if no improvements in handover delays and the likelihood of difficult conversations where change was not seen
- Improvements expected in performance in line with reducing handover delays
- Increased sickness levels at WAST in August and not yet clear if this was a blip or recurring trend
- Ongoing work in providing different crews to attend incidents where different needs identified (not one size fits all)
- Improvement event planned with WAST in October and further work to do in supporting non-conveyance and alternatives to conveyance to EDs
- The need to have the alternate blended approaches and help to manage variation and note the risk management approach by WAST
- The importance of maintaining the ICAP process and holding each other to account; and the cross-reference to the national work such as the Six Goals for Urgent and Emergency Care Programme.

QUALITY AND SAFETY REPORT

The Quality and Safety Report was received.

In presenting the report, Stephen Harrhy highlighted the presentation of the revised quality report in light of the requirements of the Duty of Candour and Duty of Quality.

Noted:

- The importance of the quality of services being paramount
- National Reportable Incidents (NRIs) key themes continued to be community response and calls categorisation
- Coroner requests have remained higher than pre pandemic levels; was 244 then and 450 in the last year; growing concerns for patient care
- High numbers of patients receiving 'no send' although not as high as previously but had remained at around 900
- 195 people presented at Emergency Departments who were categorised at Category 1 – immediately life threatening which was concerning; could have benefited from earlier treatment interventions by skilled well trained WAST staff
- Actions to be taken in relation to the Ambulance Service Indicators (ASIs) and work underway to review in line with the Duty of Quality and therefore provide evidence how compliance is assured through the commissioning lens
- Importance of patient story for the next meeting.

EASC COMMISSIONING UPDATE

The EASC Commissioning Update Report was received.

- EASC Commissioning Frameworks - in line with the Commissioning Cycle and the discussion at the previous meeting work had commenced to review the Non-Emergency Patient Transport Service (NEPTS) Commissioning Framework, this included the development of a long-term strategy for the service. Further updates would be provided at future meetings.
- An update on Integrated Commissioning Action Plans (ICAP)
  - the on-going commitment from health boards and WAST to the process
  - an outline of the work undertaken by health boards was provided in an appendix which included the impact of the ongoing work
  - further work plans included the validation of data relating to immediate release requests and the further development of remote clinical triage and signposting opportunities.
- EASC Integrated Medium Term Plan (IMTP) – Formal approval by Welsh Government was awaited. Members noted the IMTP Tracker which reflected the progress made against the agreed performance ambitions. The IMTP Tracker would be updated monthly and updates would be provided at future meetings.
- EASC Commissioning Intentions 2023-24 – Members noted that the Quarter 2 update would be presented the EASC Management Group in October.

Members noted that WAST had not committed to achieving the ambition set within the EASC IMTP that sickness levels should be maintained below 5.5% (WASTs internal target was noted at 6% at the end of the year). It was also noted that the trajectories within the IMTP were multi-factorial, some actions for WAST, some for health boards and some joint actions across WAST and health boards.

The CASC also suggested that the approach towards developing the legacy statement for the IMTP would continue as in previous years despite the work to create a new Joint Committee for national commissioning. The plan going forward would be clear for WAST and would dovetail into the new arrangements.

UPDATE ON PROGRESS RELATED TO THE EMERGENCY MEDICAL RETRIEVAL AND TRANSFER SERVICE (EMRTS CYMRU) SERVICE REVIEW

The update report on the EMRTS Service Review was received. Lee Leyshon presented the report and gave an overview of work to date in the phased approach.

Noted:

- Previous information shared at the 'Focus on' session
- In 2nd Phase and seeking public and stakeholder comments on the work started afresh following the EASC decision on 8 November 2022
- The approach adopted was previously outlined at EASC
- Emerging themes identified in Phase 1
- External supplier stakeholder and representative sample feedback
- Remit of the external supplier and highlighted key areas received
- Note that the work of the CASC and External Supplier (Picker Institute) was independent of each other to capture as much public feedback as possible

- Themes identified to date to be part of the core engagement materials for Phase 2
- Data modelling planned in addition to the issues raised in Phase 1 and detail for the approach taken.
- Phase 1 listened to comments and Phase 2 would present the independent review but would also continue to listen to stakeholders and the public in order to arrive at a recommendation for presentation to EASC
- Phase 2 in person / face to face meetings taking place between 12 Oct to 20 Oct and the timetable developed
- Window to respond for the public allowing 4 weeks until 5 November 2023
- Focused listening opportunity for the Commissioner – based on the learning from Phase 1
- Plan to arrive at a recommendation and potentially a preferred option by the Chief Ambulance Services Commissioner to present to EASC
- Concerns remain highest for the members of the public who live closest to the affected bases.

Members thanked the CASC and the EASC Team for the work undertaken to date and noted:

- the 4week public engagement window – 9 October to 5 November 2023 (subsequently increased to 12 November)
- Llais and the interface to check that they are content with the continuing approach
- The rapid opportunity to work through the modelling work and early heads up for HBs to be alongside for any events and be fully apprised of the work to date.

Members also noted

- A meeting took place with Llais in July which generally accepted the extent and the nature of Phase 1. The initial advice from the then Community Health Councils had been to undertake formal engagement for 6-8 weeks followed by a break and then a further 2 weeks and this timescale had been extended based on the public response and the need for sufficient time to consider the complex work involved.
- Ongoing dialogue across NHS Wales and with key stakeholders
- Information would be shared with Members before it was made public
- At the time, some areas of modelling were still outstanding.

The CASC thanked Members and welcomed that all HBs were supportive of the approach taken to date but particularly of Powys and BCU health boards.

The Chair explained that he had deliberately not engaged in the process to maintain an impartial approach for the Joint Committee. The important matter for the work was to provide an improved EMRTS service across Wales utilising the highly specialist critical care service.

WELSH AMBULANCE SERVICES NHS TRUST REPORTS

The Welsh Ambulance Services NHS Trust (WAST) Provider Report was received. In presenting the report, Jason Killens highlighted:

- the work undertaken by WAST to maximise opportunities to improve response to red calls

- Sickness trajectory had been on a downward trend except for August which was being analysed further to identify key reasons
- As part of the Demand and Capacity work and the Roster Review utilising the Cymru High Acuity Resource Units (CHARUs) to improve outcomes, Members noted that WAST was starting to see a month on month improvement particularly in the return of spontaneous circulation (ROSC) as an important outcome measure for patients and last month was the highest ever recorded. Initially only half of the CHARU was 'funded' but WAST had assessed the available resources to get the best response, mindful of the quality and performance issues. Members noted that this was an overall improvement in quality outcomes for patients
- The revised overtime profile and the capacity for the coming winter
- Although not contained within the report, as provider of the 111 service Members noted the ongoing work with the 'new' software provider SALUS and that the contract would soon be terminated by the Programme. Jason Killens raised the question of who would own the re-procurement required for the new call handling system and this would be raised at a future meeting as this was time sensitive (Action Log).

Members noted (in relation to 111)
- the impact on 999 call handling (or call taking) and the need for EASC to be aware
- Resilience would be an issue, although WAST did not feel this would be a significant matter in the first instance
- The opportunity emerging to bring 111 and 999 together particularly in the clinical advice area
- The importance of agreeing the approach and where the 111 work would be best dealt with until the new Joint Committee was in operation
- The importance of the provider procuring the right software to support service delivery
- WAST would want to procure the right software/system as part of the provision of the service but this had not yet been finalised by the programme.

CHIEF AMBULANCE SERVICES COMMISSIONER'S UPDATE REPORT

The Chief Ambulance Services Commissioner's Update Report was received. In presenting the report, Stephen Harrhy highlighted key areas which included:
- Meetings with Welsh Ambulance Services NHS Trust (WAST)
- Meeting with Health Boards
- Review of remote clinical support
- Six Goals for Urgent and Emergency Care Programme
- Connected Support Cymru (previously known as Night Sitting Service)
- Transfer, Discharge and Repatriations
- Review of National Commissioning
- Data linking.

Members noted:
- The report by Healthcare Inspectorate Wales (HIW) on system flow and the impact on WAST and on the EASC Team who would be leading the work to respond
- The continuous flow model and the ongoing work with three health boards to implement; Aneurin Bevan, Betsi Cadwaladr and Swansea Bay University Health Boards

- That the Escalation Policy had been approved by the NHS Leadership Board a while ago and it would need to be updated to get the right balance for the ask between urgent and emergency care, cancer and scheduled care
- New normal to be described to update to the current position
- The link to Goal 5 in the Six Goals for Urgent and Emergency Care Programme and bring together
- Visits to health boards undertaken with a focus on local matters and performance within a more bespoke session
- Regular meetings with WAST; the Review of the Clinical Support Desk which would be presented at a future meeting (Action Log)
- The Six Goals for Urgent and Emergency Care Programme in particular Goal 4 – work with ED colleagues and out of ED; 'what does a good ED look like?' and frailty at the front door
- In relation to Connected Support Cymru, how to better use IT and remote IT; noted that some patients presented when the service they needed was not available and the work on how to support the patient until the service they needed was available; an evaluation report had just been finalised and would be circulated to Members (Action Log)
- Transfer, discharge and repatriation – a holding response had been sent to the Deputy Chief Medical Officer (DCMO) and work was continuing by the EASC Team to plan how to progress and identify the potential resource implementation
- Data linking; consultant paramedic would be identifying better links to the data within the Emergency Communication Nurse System (ECNS) and an update would be provided
- Fire Service – potential for fire services to respond to some red calls and act as the first responder, analysis undertaken (to be shared – Action Log) utilisation of fire services at 15% could link to work with volunteers. Fire Service staff are already trained and have access to defibrillators which could improve red response by 5% (approx.) this could have a big impact in rural areas and could also support non-injury falls.

Members highlighted
- Opportunities within the report;
- Additional information and create an eco-structure of out of hospital services and build a system from the start to cross cover and increase system resilience
- Describing inverting the triangle and what could be done within commissioning intentions
- Opportunity to discuss further what the WAST offer could be in terms of rapid response, remote clinical assessment and 24/7 urgent response to help keep patients at home – consider for a 'focus on' session (Action Log).

EASC FINANCIAL PERFORMANCE REPORT MONTH 4 2023/24

The EASC Financial Performance Report at month 4 in 2023/24 was received. James Leaves presented the report and Members noted no variances within the plan. Discussion had taken place earlier in the meeting in relation to the 100wte staff. All additional funding was being utilised to support the additional overtime costs.

SUMMARY OF THE EASC MANAGEMENT GROUP MEETING HELD IN AUGUST 2023

The meeting had been cancelled due to the number of apologies and the meeting would not have been quorate.

EASC SUB-GROUPS CONFIRMED MINUTES

Approved:

- Non-Emergency Patient Transport Services Delivery Assurance Group notes 1 June 2023

EASC GOVERNANCE

The report on EASC Governance was received which included the:

- EASC Risk Register
- EASC Assurance Framework
- EASC Key Organisational Contacts
- Welsh Language Commissioner – Final Report and Decision Notice
- Letter to host in relation to the statutory Duty of Quality and Candour.

Noted that:

- The Risk Register had five red risks in total, three scoring the highest level at 25.
- The EASC Assurance Framework had been updated in line with the changes above to the risk register, the framework utilised the host body's risk management approach and assurance framework.
- The updated Model Standing Orders were received, Members noted the changes in line with the Health and Social Care (Quality and Engagement) (Wales) Act 2020 which included working with 'Llais Cymru', previously known as Community Health Councils. Once approved the Standing Orders would form part of the schedule for Health Boards.
- Work remained ongoing in relation to the investigation by the Welsh Language Commissioner, supported by the host Cwm Taf University Health Board. The work involved changes to the website software and involved Digital Health and Care Wales. Further updates would be provided at future meetings
- The latest EASC Key Organisational Contacts report was presented and Members asked to review their organisational representatives at EASC and its sub groups
- There were no governance concerns to raise in relation to the Annual Reports prepared by the Emergency Medical Retrieval and Transfer Service (EMRTS) Delivery Assurance Group or the Non-Emergency Patient Transport Services (NEPTS) Delivery Assurance Group.
- The short summary (for assurance) of the latest Audit and Risk Committee meeting which took place on 16 August 2023

FORWARD LOOK AND ANNUAL BUSINESS PLAN

The Forward Look and Annual Business Plan was received and approved.

Key risks and issues/matters of concern and any mitigating actions

- Red and amber performance

• Handover delays (and the development of handover improvement plans in HBs with trajectories) and the impact on services provided to HB local communities and to WAST • The ongoing formal engagement process for the EMRTS Service Review, the closure of Phase 2 and the potential recommendation to the December meeting of EASC.
Matters requiring Board level consideration
• To acknowledge the significant risks for patients in relation to handover delays and the need for health boards to implement the local handover improvement plans and identified trajectories) for every emergency department against the 25% reduction on the minutes lost per arrival and no handover delays over 4 hours – especially in relation to the quality of services patients receive
Forward Work Programme and Annual Business Plan
Considered and agreed by the Committee.

Committee minutes submitted	Yes		No	✓
Date of next meeting	**21 November 2023**			

Report Title:	Local Partnership Forum Report				Agenda Item no.	8.3.4	
Meeting:	UHB Board	Public	x		Meeting Date:	30 November 2023	
		Private					
Status *(please tick one only):*	Assurance		Approval		Information		x
Lead Executive:	Executive Director of People and Culture						
Report Author (Title):	Head of People Assurance and Experience						

Main Report
Background and current situation:

The UHB has statutory duty to "take account of representations made by persons who represent the interests of the community it serves". This is achieved in part by three Advisory Groups to the Board and the Local Partnership Forum (LPF) is one of these.

LPF is co-chaired by the Chair of Staff Representatives and the Executive Director of People and Culture. Members include Staff Representatives (including the Independent Member for Trade Unions) and the Executive Team and Chief Executive. The Forum usually meets 6 times a year.

LPF is the formal mechanism for the Health Board and Trade Union/Professional Organisation Representatives to work together to improve health services. Its purpose, as set out in the Terms of Reference, fall into four overarching themes: communicate, consider, consult and negotiate, and appraise.

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

Key items discussed at the meeting held on 12 October 2023 can be summarised as follows:

The Chief Operating Officer provided an update report to the Forum on behalf of the Chief Executive. Key points included:

- Staff were thanked for their ongoing efforts under continued operational pressures, and for the high levels of engagement at the AGM
- Reshaping the workforce to ensure we are fit for purpose for the future. Staff representatives re-iterated that they would like to be involved in these discussions. This is one of the 7 themes of the People and Culture Plan
- The financial position

Staff representatives noted that there were tensions between some of the non-pay offers in the 2023 pay deal and the financial pressures that health boards are operating under. It was felt that although the initiatives in the pay deal are widely agreed to be cost saving in the long run, they did not necessarily lead to short term wins. It was suggested was that we need to be looking at those locally as a Health Board as well as at the All Wales level and the staff representatives requested a discussion about this at the next meeting

The Chief Operating Officer gave a presentation on the Winter Plan. The importance of compassionate leadership to ensure the wellbeing and engagement of our workforce was noted.

The Head of Strategic Planning attended to give a presentation on the IMTP/Annual Planning process. It was noted that it is an integrated and tactical plan, and that this year the UHB had to submit an Annual Plan due to its financial deficit. The Forum noted that the value of the plan is achieved through the process - through conversations around our ambitions, connecting with clinical boards, the testing of the plans and making decisions- rather than the document itself. Staff representatives sought the opportunity to get involved at a Clinical Board level.

Dr Sian Griffiths (SG), Consultant in Public Health Medicine, provided a presentation on Amplifying Prevention. Key points included: background to the work; Move More Eat Well; childhood immunisation; bowel screening; and communication and engagement. The leadership role of the UHB was considered and Dr Griffiths asked the Forum to think about how we can contribute to amplifying prevention further, using the employment cycle eg promote childhood vaccination when people are going on maternity leave.

The Local Partnership Forum received a copy of the Integrated Performance Report which had previously been considered by Board.

Recommendation:

The Board is requested to:

- NOTE the contents of this report

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

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

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes/No No
Safety: Yes/No Yes
Patient Safety, Quality and Experience is included in the Integrated Performance Report
Financial: Yes/No Yes
The financial situation is included in the Integrated Performance Report and was also referred to in the CEO Update
Workforce: Yes/No Yes
Key WOD KPIs and workforce actions are included in the Integrated Performance Report

Legal: Yes/No No
Reputational: Yes/No No
Socio Economic: Yes/No No
Equality and Health: Yes/No No
Decarbonisation: Yes/No No

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

Saunders,Nathan
20/11/2023 15:51:45

Confirmed Minutes of the Public Audit & Assurance Committee Meeting
Held On 5th September 2023 at 9:00am
Via MS Teams

Chair:		
John Union	JU	Independent Member for Finance and Committee Chair (CC)
Present:		
Mike Jones	MJ	Independent Member for Trade Union
Ceri Phillips	CP	UHB Vice Chair
Rhian Thomas	RT	Independent Member for Capital and Estates (IM-CE)
Charles Janczewski	CJ	UHB Chair
In Attendance:		
Lucy Jugessur	WW	Interim Deputy Head of Internal Audit (IDHIA)
Gareth Lavington	GL	Lead Local Counter Fraud Specialist (LLCFS)
Catherine Phillips	CP	Executive Director of Finance (EDF)
Matt Phillips	MP	Director of Corporate Governance (DCG)
Matt Temby	MT	Managing Director of Planned Care (MDPC)
Ian Virgil	IV	Head of Internal Audit (HIA)
Urvisha Perez	UP	Audit Wales
Lianne Morse	LM	Deputy Director of People & Culture (DDPC)
Andrew Partridge	AP	Corporate Archivist and Records Management Manager (CARMM)
Rob Mahoney	RM	Deputy Director of Finance – Operational (DDF-O)
Observers:		
Secretariat:		
Sarah Mohamed	SM	Corporate Governance Officer
Apologies:		
Rachel Gidman	RG	Executive Director of People and Culture

Item No	Agenda Item	Action
AAC 5/9/23/001	**Welcome & Introduction** The Committee Chair (CC) welcomed everyone to the meeting.	
AAC 5/9/23/002	**Apologies for Absence** Apologies for absence were received. **The Committee resolved that:** a) Apologies were noted.	
AAC 5/9/23/003	**Declarations of Interest** **The Committee resolved that:** a) No Declarations of Interest were noted.	
AAC 5/9/23/004	**Minutes of the Meeting Held on 4th July 2023 and 25th July 2023** The Minutes of the Meeting Held on the 4th July 2023 and 25th July 2023 were received.	

	4th July 2023 Public Minutes - Last action on Page 2 should read the Charitable Funds Audit would go to the CFC. 2th July 2023 Special Minutes - True and accurate record. **The Committee resolved that:** a) The draft minutes of the meetings held on 4th July 2023 and 25th July 2023, were held to be a true and accurate record of the meeting.	
AAC 5/9/23/005	**Action Log – Following Meeting held on 11th May 2023** The Action Log was received. **The Committee resolved that:** a) The Action Log was discussed and noted.	
AAC 5/9/23/006	**Any Other Urgent Business** **The Committee resolved that:** a) No other urgent business was noted.	
	Items for Review and Assurance	
AAC 5/9/23/007	**Internal Audit Progress Report** The Head of Internal Audit (HIA) presented the Internal Audit Progress Report and highlighted the following: - 6 out of the 7 audits which were to be presented had not met the deadline due to various delays in the process of formulating the reports; - However, they were making good progress in delivering the plan; - If these reports were not brought regularly through the Committee as planned, it may create a potential backlog to delivery; - An update report would be brought to the Committee in November. The UHB Chair noted concern around the lack of management response, and asked whether the original timescales were reasonable, whether they were resource short, or if the work had not been planned efficiently. The HIA responded that the delays in the reporting process were mostly due to staff being on annual leave over the summer. Action: 1. For Internal Audit/Director of Corporate Governance to follow up and understand why management responses to the reports had been delayed. The CC asked if the Estates Internal Audit would be carried out for every Health Board across Wales. The HIA confirmed that this was correct, and explained that this had also contributed to the delay in the reporting process in the attempt to get a consistent message across NHS Wales. The UHB Chair commented that 'Limited' would be the only likely outcome for Estates across all of the Welsh Health Boards, and he explained that they had	

strict limitations on their capital spend and their ability to deliver high-quality facilities. The UHB Chair highlighted the major backlog in terms of maintenance, and he hoped this would be reflected in the report.

The UHB Vice Chair asked whether the issue around RAAC concrete would need attention.

The HIA responded that this had been highlighted as a potential area of risk across Wales during planning discussions held in January. He confirmed that it would likely feature in the following year's audit reviews.

The EDF added that the Specialist Estates team, on behalf of Welsh Government (WG), were undertaking a review across all of Wales. She provided assurance that CAVUHB were not in a bad position, and that they would not be looking to Internal Audit to do any work at this stage.

The HIA stated that the Recommendation Tracking Audit report had been finalised, and clarified that the assurance rating should read 'Substantial'.

The HIA explained that the graph highlighted the current progress with the delivery of the 2023/24 Internal Audit Plan, and summarised the following:

- One audit had been finalised, and the other four had reached the draft report stage;
- A further 8 audits were in progress, and 13 were at the planning stage and were ready to start work over the next few months;
- Full details of the current year's audit plan were included in Appendix A of the report.

The HIA stated that there had been several changes to the 2023/24 Plan since the previous Committee in July, and highlighted that:

- An advisory piece of work had been requested by the Chief Executive and the UHB Chair around GP Site Evaluation Process. This work was nearly finished, and an update could be provided in the private session;
- Two items were identified for removal and deferral – the ISO Accreditation within ALAC, and the Medicine CB Acute Model / Same Day Emergency Care respectively.

Regarding the Recommendations Tracker Audit, the IDHIA highlighted that:

- The audit was issued with substantial assurance, as substantial work had been undertaken regarding managing the recommendations;
- The Medium finding related to the lack of supporting narrative to close Internal and External Audit recommendations;
- There were two Low findings.

The UHB Chair highlighted in the report that there were discrepancies in the outcomes of completed audit reviews for recommendation, and the IDHIA explained that this was an error and that they should read 'substantial'.

The CC and UHB Chair praised the work undertaken to get to a 'substantial' rating.

The CC commented that they needed further assurance on the draft report on Consultant Job Plans which had a 'Limited' assurance rating, however that this would be discussed in the November A&A Committee.

	The HIA responded that the Surgery Clinical Board had challenged the report, and that they were awaiting sign off from the Clinical Board following discussions. **The Committee resolved that:** 1. The Internal Audit Progress Report, including the findings and conclusions from the finalised individual audit report, was considered; 2. The proposed adjustments to the 2023/24 plan were approved.	
AAC 5/9/23/008	**CD&T Clinical Board Update** This item was deferred to the November Committee.	
AAC 5/9/23/009	**Audit Wales Update** Urvisha Perez (UP) presented the Audit Wales Update and highlighted the following: - <u>Financial Audit Work</u> – • 2023/23 Accountability Report and Financial Statements – complete • Audit of Accounts Report Addendum – in progress • 2022/23 Charitable Funds Accounts – planned to start in November 2023 - <u>Performance Audit Update</u> – • Part One of the Unscheduled Care Review and the Review of Workforce Planning Arrangements – both reports were being drafted • Primary Care Services Follow-up Review – in the latter stages of fieldwork • Structured Assessment for 2023 – fieldwork was underway, and interviews would be held throughout September • This year's structured assessment included an examination of the Health Board's wellbeing objectives • Part Two of the Unscheduled Care Review would start shortly • The Deep Dive into Digital, the Planned Care Review, and local work (Follow-up of 2019 Clinical Coding) were in the planning stages. The UHB Chair asked whether UP had received full cooperation from colleagues in the structured assessment interviews. UP confirmed that the interviews were going well. **The Committee resolved that:** a) The Audit Wales Update was noted.	
AAC 5/9/23/010	**Audit Wales Orthopaedic Report and Management Response** UP introduced the report, and highlighted the following: - The local Health Board specific report on tackling the Orthopaedic waiting list backlog had been discussed in the July Audit Committee; - The National report on the Orthopaedic services across Wales was included in the meeting papers; - A completed management response had not been ready for the July Committee;	

- The All Wales summary report made two recommendations for WG, and three for Health Boards. Additionally, the Health Board's local report included suggested Board Member questions.

The MDPC highlighted the three main themes, and summarised that:

- Progress to date on Getting It Right First Time included –
    - Reconfiguration of some elements within the Orthopaedics service post-pandemic was needed to implement all of the GIRFT recommendations - this was now complete.
    - The one outstanding reconfiguration element was the PACU provision at UHL, as the cardiothoracic move back to UHW had been delayed until April 2024. However, a plan had been funded through the Planned Care Response to provide an enhanced recovery area to give PACU provision for Ortho patients in UHL.
    - The GIRFT recommendations formed part of a standard governance process which sat within the individual Directorate for Orthopaedics;
- Progress to date on the Musculoskeletal Service included –
    - A lot of work was required to ensure a standardised approach to physiotherapy and other therapy representations within the sub-sets of Orthopaedics
    - Work was ongoing to develop their health pathways.
    - They needed to finalise putting the MSK Steering Group in place, and it would form a sub-set of the Planned Care Board within the governance structure;
- Progress to date on Patient Outcomes included –
    - A lot of work was being done in the region - their Multi-Disciplinary Teams were in place, the Orthopaedic Infection Lead was in post, work was underway in terms of the Keeping Patients Well workstream (which was being managed through the Planned Care Board), and they had a regular validation process in place post-pandemic.

The IM-CE noted that most of the Health Board's complaints centred around communication, and she asked how well C&V were managing their communication with the patients on the waiting lists.

The MDPC responded that within Orthopaedics they had good systems in place, for example the Keeping Me Well piece and the validation of waiting lists, and that they were continually making improvements.

The IM-CE asked whether they had the resources to support the communication piece.

The MDPC responded that he was confident that within Orthopaedics, that they had sufficient resources to allow for effective communication. However, he stated that he did not know the situation for other waiting lists.

The MDPC added that the following Finance & Performance Committee would include a Deep Dive into the Orthopaedics Waiting List.

The Committee resolved that:

a) The Audit Wales Orthopaedic Report and Management Response was noted.

AAC 5/9/23/011	**Declarations of Interest, Gifts and Hospitality Report** The CARMM introduced the report and highlighted the following: - The previous year, a decision was made to move the Declarations of Interest, Gifts and Hospitality onto ESR – since then, they had seen an increased number of employees responding; - At the time of the report, they had received 4267 declarations, and as at 01.09.2023, the number had increased by 175; - This was due to the targeted emails sent to Bands 8-9 who were perceived to be decision-makers – they saw a 50-60% return rate on Declarations, and the percentage of those who had not responded previously had reduced from 21% to 12%; - There was still work to do on other bandings – 63% of Bands 7s had not made a Declaration, and this would continue as a work in progress. The IM-TU highlighted a lack of access or opportunity to log onto ESR via computers at work, and he asked what the plan was around tackling this. The CARMM responded that Comms had been sent out, and that staff who accessed their payslips via ESR would be able to submit a Declaration. He highlighted that it would be important to communicate to staff that the process took a matter of seconds. The CC and the IM-TU commented that many staff within the lower bands did not access their payslips via ESR, and so it would be beneficial to have an alternative format to submit Declarations. The CC asked what other Health Boards were doing to tackle the barriers to lower bands submitting Declarations. The CARMM explained that they had focused on the higher bands due to them being deemed as decision-makers which would impact the care of a patient. The UHB Chair asked whether the submission of a Declaration was a requirement through their governance standing orders for all staff, or whether they should just target their efforts on specific staff. The DCG added that there was no standing order or financial instruction requirement, however broader policies were involved. He added that he would look into how to tackle this effectively. The DDPC offered the support of the ESR team, and added that there was an access and understanding/education issue amongst staff. The CARMM presented a table to the Committee which illustrated all of the Declarations made by staff to date. **The Committee resolved that:** a) The ongoing work being undertaken within Standards of Behaviour was noted; b) The proposals to improve Declaration of Interest reporting across the Health Board was noted.	
AAC 5/9/23/012	**Single Tender Actions** The EDF presented the report, and summarised the following:	

	- The table on Breach activity year-on-year was highlighted, and that the breaches were commensurate with the work undertaken on the Improvement Plan; - They would continue to have breaches whilst they work through what was eligible for procurement onto the Procurement system – Claire Salisbury would provide an update at the following Committee on progress with their Improvement Programme; - The number of STA/SQA's by Department had started to reduce; - They hoped that they had reached the peak of their non-compliant activity, and that activity would settle at a new lower level. The CC asked what "the service did not engage with Procurement" meant, when given as a reason for non-compliance. The EDF responded that there were a variety of reasons as to why a service did not engage. She explained that their Improvement Programme would identify learning and issues around the procurement process, it would ensure that they used the catalogues available, and that they bought at scale. The IM-CE asked how straightforward the process was for a service to engage with Procurement. The EDF responded that she did not think that resource constraints were the issue, and that the system and process usually worked really well. The UHB Vice Chair asked for assurance about the carbon footprint sustainability issue within procurement. The EDF responded that foundation economy and decarbonisation formed part of the decision-making process routinely pulled into Procurement. She highlighted that Claire Salisbury, who was their Head of Procurement and National Lead, also worked on these areas on behalf of Shared Services and WG. She added that where there were opportunities to source products and work with companies more locally, they would do so if it made sense financially. The UHB Chair asked if they used their scheme of delegation appropriately. The EDF suggested that more training and education needed to be done around the procurement process. She highlighted that the reason behind the large number of STA/SQA's for Clinical, Diagnostics and Therapies was that they did not always consider the maintenance and consumables within the purchase of big equipment – however, they had started Whole-Life Procurement which should reduce the number of STA's over time. **The Committee resolved that:** 1. The contents of the Report was noted; 2. The contents of the Report was approved/agreed.	
AAC 5/9/23/013 	**Counter Fraud Progress Report** The LLCFS introduced the report for the period of 17.06.2023 to 18.08.2023, and summarised the following: - Work continued on Promotion and Awareness and Educational Activity – • Their first Corporate induction event would take place in October • The webinar events continued	

	• The E-Learning package went live in April – up until the end of July, 15 staff from C&V had completed the module, largely due to the fact that this training was not mandatory. They continued to explore how this could be improved; - There had been a high level of referrals received – • 25 total referrals were received during this period, of which 15 were promoted to a formal investigation. • They continued to receive a high volume of salary-overpayments that fit within the criteria of those reported to counter-fraud • It was positive that people were aware of the Counter-Fraud team - Work continued on the National Fraud Initiative, and they had not yet found any matches of concern to the organisation; - 3 Fraud Risk Assessments related to the dishonest retention of salary overpayments, working elsewhere (remote/agile working), and a specific incident which related to a post-investigation on an automated medicine cabinet in a GP OOH. Detail for these incidents would be provided in the Private Committee session. Regarding salary overpayments, the CC asked whether non-fraud recovery meant that a full repayment had been made to the Health Board. The LLCFS responded that this was relatively new and that it was protocol from the Counter-Fraud Authority (CFA). He noted that if an employee agreed to repay the monies it would be treated as a civil recovery/non-fraud recovery, which still had to be reported to the CFA. The CC asked for a piece of work to be undertaken to identify the number of salary-overpayment incidents which occur, which could be presented to the Public Audit & Assurance Committee. <u>Action:</u> 1. To provide information on how many salary overpayments had come through to the Counter Fraud team (GL) The DDF-O highlighted that this was a sub-set of the overpayments, and that the vast majority of overpayments were administrative errors and were recovered through normal processes. **The Committee resolved that:** a) The Counter Fraud Progress Report was noted.	
AAC 5/9/23/014	**Overpayment of Health Board Salaries** The DDPC introduced the report, and highlighted the following: - They worked closely with finance colleagues, and they had established that approx. 80% of the overpayments were recovered over an agreed period of time - The focus of the team was on prevention - They had sent out communications on a regular basis to managers to remind them of their requirements in filling out termination forms, staff changes, and recording staff sickness. - They had spoken with Clinical Boards to ensure individuals had the right support - Shared Services had recently launched a live dashboard to track month-on-month where overpayments were happening, and what the cost was. They wished to track the improved progress throughout the year.	

	- The DDPC anticipated that within the next month they could bring data into the Private A&A Committee. The UHB Chair commented that figures were needed in the report to provide assurance to the Board that they were managing the situation. The DDF-O responded that they had only recently started to receive data from the dashboard, and that more time was needed to decipher a trend. He added that broadly the trend was around £1.8m of overpayments, of which they recovered around 85-90% of that. The EDF suggested that they needed to monitor the recovery of the old historic overpayments, as well as to monitor the new. The UHB Chair noted caution around data protection and the sharing of names of staff within the dashboard. However, he suggested that they could create a separate version of the dashboard for the public session. The DDF-O confirmed that the dashboard did share individual's information, and so it would have to be shared in a future Private Committee session. **The Committee resolved that:** a) The contents of the Overpayment of Salary Update report was noted.	
	Items for Approval / Ratification	
AAC 5/9/23/015	No items for approval or ratification.	
	Items for Information and Noting	
AAC 5/9/23/016	**Internal Audit reports for information:** The CC highlighted the two papers for noting: i) Internal Audit Reports for Information ii) Recommendation Tracking – Substantial Assurance **The Committee resolved that:** a) The final Internal Audit reports were noted.	
AAC 5/9/23/017	**National Fraud Initiative Self-Appraisal Checklist 2020-21 report** UP explained that the checklist had been completed and that the paper was just for information. **The Committee resolved that:** a) The National Fraud Initiative Self-Appraisal Checklist 2020-21 report was noted.	
AAC 5/9/23/018	**Agenda for Private Audit and Assurance Committee** *i. Counter-Fraud Progress Update (Confidential – ongoing investigations)*	
AAC 5/9/23/019	**Any Other Business** No Other Business was discussed.	
	Review and Final Closure	

AAC 5/9/23/020	**Items to be deferred to Board / Committee** No items were deferred to Board / Committees.	
AAC 5/9/23/021	**Date and time of next committee meeting** Tuesday 7th November at 2pm via MS Teams	

Confirmed Minutes of the Quality, Safety & Experience Committee

Held on 30.08.2023

Via MS Teams

Chair:		
Ceri Phillips	CP	Committee Chair
Present:		
Akmal Hanuk	AH	Independent Member – Community
Keith Harding	IM	Independent Member – University
Mike Jones	MJ	Independent Member – Third Sector
In Attendance		
Claire Beynon	CB	Deputy Director of Public Health
Mike Bond	MB	Director of Operations for Six Goals and Financial Improvement
Fiona Jenkins	FJ	Executive Director of Therapies and Health Sciences
Meriel Jenney	MJ	Executive Medical Director
Dino Motti	DM	Consultant in Public Health Medicine
Matt Phillips	MP	Director of Corporate Governance
Aled Roberts	AR	Assistant Medical Director, Clinical Effectiveness & Safety
Jason Roberts	JR	Executive Nurse Director
Alexandra Scott	AS	Assistant Director of Quality and Patient Safety
Suzanne Wood	SW	Principal Public Health Practitioner
Observers		
Rebecca Aylward	RA	Deputy Director of Nursing
Richard Skone	RS	Deputy Medical Director
Secretariat		
Nathan Saunders	NS	Senior Corporate Governance Officer
Apologies		
Paul Bostock	PB	Chief Operating Officer
Vicki Burrell	VB	Senior Service Improvement Programme Manager
Angela Hughes	AH	Assistant Director of Patient Experience
Rhian Thomas	RT	Independent Member – Capital & Estates

QSE 23/08/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the meeting in English & Welsh	**Action**
QSE 23/08/002	**Apologies for Absence** Apologies for absence were noted.	
QSE 23/08/003	**Declarations of Interest** No declarations of interest were raised.	
QSE 23/08/004	**Minutes of the Committee meeting held on 18.07.2023** The minutes of the Committee meeting held on 18.07.2023 were received. **The Committee resolved that:** a) The minutes of the meeting held on 9 May 2023 were approved as a true and accurate record of the meeting.	
QSE 23/08/005	**Action Log following the Meeting held on 18.07.2023** The Action Log following the Meeting held on 9 May 2023 was received. **The Committee resolved that:**	

	a) The Action Log from the meeting held on 9 May 2023 was noted.	
QSE 23/08/006	**Chair's Actions** No Chair's Actions were raised.	
QSE 23/08/007	**Quality Indicators Report:** The Quality Indicators Report was received. It was noted that the format of the reporting mechanism had changed and a slideshow was presented to the Committee. The Executive Medical Director (EMD) advised the Committee that reports had previously provided a large amount of narrative and not much data and so the change in format was to ensure better information was being received by the Committee. The Committee were provided with data and detailed information from a number of Quality Indicators which included: • National Reportable Incidents and Never Events • Infection Prevention and Control • Falls and Pressure Damage • Medication Incidents • Patient Safety Solutions • Mortality Data • Clinical Effectiveness • Covid Investigations • Patient Experience Data • Patient Experience - Ombudsman Referrals • Patient Experience - CIVICA • Safe Care Data • Proposed Timely Care Indicators • Proposed Equitable Care Indicators The CC advised the Assistant Director of Quality and Patient Safety (ADQPS) that benchmarking would be a useful visual tool to help provide further assurance to the Committee when receiving future Quality Indicator reports as well as providing an emphasis on the actions required for each area. The EMD thanked the ADPQS for pulling all of the work together and noted that it would be important to provide in future Quality Indicator Reports the: • Data for each quality indicator • The "Why" for each quality indicator • The actions coming out from each indicator • The target or trend that the Health Board would aim for to provide and drive improvement. **The QSE Committee resolved that:** a) The Quality Indicators Report and plans for further development were noted.	**AS**
QSE 23/08/008	**Stroke / Stroke Performance** The Stroke / Stroke Performance was received. The Committee was provided with information on the current operational performance of the stroke service as measured against the UK Stroke Sentinel Audit Programme (SSNAP) and were presented with areas where the service had improved as well as areas where there were still gaps in service provision. The Director of Operations for Six Goals and Financial Improvement (DOSGFI) who was providing cover for the Chief Operating Officer (COO) advised the Committee that the latest quarterly SSNAP performance data scored the overall Health Board stroke service as a C.	

The DOSGFI presented the Committee with a number of actions to improve the stroke service which included:

- 3 Internal Stroke summits had taken place which provided organisational support and focus on stroke patients' pathways and multidisciplinary meetings which brought together medical, nursing and therapy clinicians with operational and senior leaders.
- A Stroke Improvement Programme which was launched in January 2023 and overseen by a dedicated resource which consisted of a Stroke Service Manager and Clinical Director who would report to the Medicine Clinical Board and Executive Management Team.
- Collaborative, cross-clinical board workstreams which included a revision of the stroke imaging pathway and emergency stroke assessment pathway in the Emergency Department (ED).
- A workforce review through redesign of the optimal clinical model
- Implementation of digital solutions to support the emergency stroke assessment pathway and imaging interpretation.

The DOSGFI presented the Committee with the challenges faced by the stroke service which included:

- Delivery of thrombolysis treatment – treatment rates and timely administration
- The provision of senior specialist staff to ensure the optimal patient pathway could be delivered consistently
- Consistent scanning within 60 minutes
- Mortality was just within expected range.

He concluded by presenting the Committee with the next steps which included:

- Delivery of a SSNAP score of "A" which would be supported by the production of an investment business case for a 2024/25 consideration.
- A Clinical Model which had been agreed in principle that would enable 85% of suspected stroke patients to be seen by a consultant
- Consultant cover from 8am to 10pm, 7 days a week in the ED (stroke and neurology coalition).
- A middle grade doctor available 24 hours a day, 7 days a week in the ED
- A stroke Clinical Nurse Specialist (CNS) support 24 hours a day, 7 days a week in the ED, in a phased approach.
- Consultant led clinics for Transient Ischemic Attack (TIA) and established stroke symptoms in the Medical Same day emergency care (MSDEC)
- Junior Doctor and Stroke CNS support to the MSDEC.

The Executive Director of Therapies and Health Sciences (EDTHS) noted that pre-Covid, the stroke service had nearly received a SSNAP score of "A" and noted disappointment of the current "C" score.

She added that when observing national tables, England performed better in stroke than Wales and so regionalised care would be required.

The Independent Member – University (IMU) asked that patient involvement and outcomes be presented in any future data around stroke presented to the Committee.

	The DOSGFI concluded that in order for the Health Board to receive a rating of A, an investment in resource would be required. The CC noted that the data presented was for October until December 2022 and asked if up to date information was available. The DOSGFI responded that it was a monthly report and noted that the SSNAP report was audited and validated which took a while to compile. He added that there was an indication that the Health Board's SSNAP score for January – March 2023 was also a C and that the data for April and June 2023 was being reviewed. It was noted that an update would be received by the Committee more frequently and the CC advised the Committee that they would not rest until the Health Board had a score of A. **The QSE Committee resolved that:** a) The current stroke performance position, the improvements made and the next steps regarding the new clinical model were noted.	**PB**
QSE 23/08/009	**Policies** The following policies and procedures were received: 1. Laser Risk Management Policy and Procedure (UHB 324) 2. Consent to Examination or Treatment Policy (UHB 100) The Assistant Medical Director, Clinical Effectiveness & Safety (AMDCES) advised the Committee that there were some typing errors in the Consent to Examination or Treatment Policy which would require amendment. **The Committee resolved that:** a) The Laser Risk Management Policy and Procedure (UHB 324) was approved b) The Consent to Examination or Treatment Policy (UHB 100) was approved pending the typing error amendments.	**NS**
QSE 23/08/010	**Cardiff and Vale of Glamorgan Childhood Immunisation Action Plan** The Cardiff and Vale of Glamorgan Childhood Immunisation Action Plan was received. The Principal Public Health Practitioner (PPHP) advised the Committee that vaccination was a life-saving intervention, which prevented disease and outbreaks in communities. She added that uptake for vaccination was inequitable both locally and nationally and that the three 'C's' behind vaccine hesitancy needed to be addressed throughout the development of interventions designed to increase uptake which included: • Complacency – the low perception of risk • Convenience – the availability and accessibility of vaccines; health literacy; language barriers and cultural context • Confidence – trust in vaccine safety and effectiveness and in policy makers and programmes It was noted that The Cardiff and Vale of Glamorgan Immunisation Action Plan aimed to continue to work to improve uptake and reduce health inequities for vaccination in childhood, building upon previous improvement actions and insights work, which included 5 key themes: • A data-informed approach • A behavioural sciences approach • Stakeholder engagement • Communication • Evaluation and continuous improvement	

	The Independent Member – Community (IMC) noted their support for the Cardiff and Vale of Glamorgan Vaccine Equity Strategic Plan and asked if there was anything he could do to help support a reduction in inequities for vaccine uptake in the local communities. The Consultant in Public Health Medicine responded that he would arrange a meeting with the IMC outside of the meeting to discuss further. **The Committee resolved that:** a) The progress to date was noted. b) The Childhood Immunisation Plan was endorsed and supported.	
QSE 23/08/011	**Cardiff and Vale of Glamorgan Vaccine Equity Strategic Plan** The Cardiff and Vale of Glamorgan Vaccine Equity Strategic Plan was received. The PPHP advised the Committee that the Cardiff and Vale of Glamorgan Vaccine Equity Strategic Plan was an important agenda that the Health Board needed to be on board with. She added that the action plan outlined requirements to improve the uptake in vaccination and noted that in order to redress inequities, the Cardiff and Vale of Glamorgan Vaccine Equity Strategic Plan sets out five strategic themes which included: • A data informed approach • A behavioural insight approach • Stakeholder engagement • Communication • Evaluation and continuous improvement It was noted that those 5 themes framed a ten-point action plan for 2023/24 to deliver equity in the communities which would require a multi-agency response, and build on the successful programme delivered during the COVID-19 pandemic. **The Committee resolved that:** a) The content of the Vaccine Equity Strategic Plan was noted b) The Vaccine Equity Strategic Plan was approved and supported	
QSE 23/08/012	**Welsh Risk Pool Final Assessment Report** The Welsh Risk Pool Final Assessment Report was received. The Executive Nurse Director (END) advised the Committee that the report provided the findings for the health body following a review conducted by an independent assessment team from the Welsh Risk Pool. He added that the Health Board had received substantial assurance in 5 areas which included: • Management of Concerns (Complaints & Enquiries) • Redress Case Management • Claims Case Management • Learning from Events • WRP Reimbursement Process **The Committee resolved that:** a) The content of the report and the improvement plan was noted.	
QSE 23/08/013	**Introduction to the Public Health Wales Safeguarding Service, Self-Assessment Safeguarding Maturity Matrix (SMM) for Health Boards and Trusts.** The Introduction to the Public Health Wales Safeguarding Service, Self-Assessment Safeguarding Maturity Matrix (SMM) for Health Boards and Trusts was received. The END advised the Committee that it was received by the Committee annually and was for information to show that the Health Board were on target for the self-assessment.	

	The Committee resolved that: a) The Introduction to the Public Health Wales Safeguarding Service, Self-Assessment Safeguarding Maturity Matrix (SMM) for Health Boards and Trusts was noted.	
QSE 23/08/014	**Minutes from Clinical Board QSE Sub Committees:** The Minutes from Clinical Board QSE Sub Committees were received. **The Committee resolved that:** a) The Minutes from the Clinical Board QSE Sub-Committees were noted.	
QSE 23/08/015	**Items to bring to the attention of the Board / Committee:** No items were raised.	
QSE 23/08/016	**Agenda for Private QSE Meeting** *i) Private Minutes -* *ii) Any Urgent / Emerging Themes – Verbal (Confidential Discussion)*	
QSE 23/08/017	**Any Other Business** No other business was raised.	
	Date & Time of Next Meeting: Tuesday, 26 September 2023 via MS Teams	

Confirmed Minutes of the Quality, Safety & Experience Committee

Held on 26.09.2023

Via MS Teams

Chair:		
Ceri Phillips	CP	Committee Chair
Present:		
Akmal Hanuk	AH	Independent Member – Community
Rhian Thomas	RT	Independent Member – Capital & Estates
Mike Jones	MJ	Independent Member – Third Sector
In Attendance		
Vicki Burrell	VB	Senior Service Improvement Programme Manager
Emma Cooke	EC	Deputy Director of Therapies and Health Sciences
Gavin Forbes	GF	Consultant Microbiologist
Angela Hughes	AH	Assistant Director of Patient Experience
Andy Jones	AJ	Director of Nursing – Children & Women's Clinical Board
Helen Kemp	HK	Deputy Clinical Board Director - PCIC
Fiona Kinghorn	FK	Executive Director of Public Health
Anna Mogie	AM	Deputy Director of Nursing - PCIC
Dino Motti	DM	Consultant in Public Health Medicine
Matt Phillips	MP	Director of Corporate Governance
Aled Roberts	AR	Assistant Medical Director, Clinical Effectiveness & Safety
Jason Roberts	JR	Executive Nurse Director
Alexandra Scott	AS	Assistant Director of Quality and Patient Safety
Richard Skone	RS	Deputy Medical Director
Yvonne Hyde	YH	Head of Nursing, Infection Prevention & Control
Clare Wade	CW	Director of Operations for Patient Flow
Observers		
Matthew McCarthy	MM	Interim Head of Safety, Quality and Organisational Learning
Secretariat		
Nathan Saunders	NS	Senior Corporate Governance Officer
Apologies		
Keith Harding	IM	Independent Member – University
Fiona Jenkins	FJ	Executive Director of Therapies and Health Sciences
Meriel Jenney	MJ	Executive Medical Director
Suzanne Rankin	SR	Chief Executive Officer

QSE 23/09/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the meeting in English & Welsh	**ACTION**
QSE 23/09/002	**Apologies for Absence** Apologies for absence were noted.	
QSE 23/09/003	**Declarations of Interest** No declarations of interest were raised.	
QSE 23/09/004	**Minutes of the Committee meeting held on 30.08.23** The minutes of the Committee meeting held on 30.08.23 were received.	

	The Committee resolved that: a) The minutes of the meeting held on 30 August 2023 were approved as a true and accurate record of the meeting.	
QSE 23/09/005	**Action Log following the Meeting held on 30.08.2023** The Action Log following the Meeting held on 30.08.2023 was received. **The Committee resolved that:** a) The Action Log from the meeting held on 30.08.2023 was noted.	
QSE 23/09/006	**Chair's Actions** No Chair's Actions were raised.	
QSE 23/09/007	**PCIC Assurance Report** The PCIC Assurance Report was received. The Deputy Director of Nursing – PCIC (DDNP) advised the Committee that she would take the report as read and noted that she and Deputy Clinical Board Director - PCIC (DCBDP) would raise key points for the Committee which included: • Duty of Candour – it was noted that the Health and Social Care (Quality and Engagement) (Wales) Act 2020 came into effect in April 2023 and had imposed several new duties on all Clinical Boards, including PCIC around the Duty of Candour (DoC) aspects and it was noted that PCIC had not been required to proceed with any DoC declarations to date. • The Medical Examiner Service (MES) – it was noted that with the DoC and the mortality review process, PCIC had been working with independent contractors to make sure that the required support was available in both processes and the Committee were made aware that the PCIC governance team had been working with the lead medical examiner and lead medical examiner officer around the implementation of the mortality review process. • Safe Care: - it was noted that PCIC had no open Nationally Reportable Incidents (NRIs) with 3 being closed over the past 6 months with learning identified from those. - PCIC had reported 1 Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) incident to HIW. The incident was investigated which had identified no harm and a full report would be submitted in October 2023 to meet the regulatory requirements. - It was noted that PCIC were good at scrutinising investigations around Pressure Damage with weekly scrutiny panels held in localities where positive feedback was received by care home staff. • Community Pharmacy – it was noted that PCIC had a very close relationship with the community pharmacy service and collaborated well around incident reporting, complaints and responses from an independent contractor perspective. • Infection prevention and control (IP&C) – it was noted that PCIC had identified that support for independent contractors was required on advice around IP&C requirements and noted that work was ongoing with those contractors.	

	• Key Risks for PCIC – it was noted that a number of risks had been identified within PCIC such as the change to medication policy and impact on supporting patients and prison staffing and it was highlighted that action plans had been formed to mitigate the risks with a number of controls put in place. • Developments – it was noted that a PCIC academy had been established and that the expectation of the Academy would be to effectively consider and coordinate training and education for a broad range of professionals working within primary and community services as set out in the Primary Care Model. The DCBDP concluded that a large amount of strategic work was being undertaken by PCIC around the performance list and engagement with other Health Board colleagues around improvements and various strategic programmes. The Independent Member – Capital & Estates (IMCE) asked if it was felt that the Cardiff and Vale population had sufficient access to local pharmacy services. The DCBDP responded that it was their understanding that there was a population needs assessment undertaken which would be referred to around pharmacy access and noted that there was a Primary Care Panel which would reference that. She added that awareness of impact was identified for when electronic prescribing would start within pharmacies and noted that it had been identified as a risk for PCIC. The IMCE noted that the mobile dental units available for the Cardiff and Vale population were not fit for purpose and asked for further context on those. The DDNP responded that the answer would be sought offline from dental colleagues and provided to the IMCE via email which was undertaken the following day upon completion of the meeting. The Executive Director of Public Health (EDPC) noted that staffing around the prison service was a regularly reported risk and asked for further assurance around that. The DDNP responded that a skill-mix review had been undertaken and questions had been asked around recruitment of staff with new roles being introduced to the service. She added that a lot of work was ongoing around recruitment and collaborative work with prison staff and the overall prison regime to ensure that PCIC could meet the core critical service needs. The CC noted that continued pressures in the prison service had been identified within the report received by the Committee and noted that lessons learned were subject to action plans monitored via QS&E meetings held by PCIC. He asked that those action plans be received by the Committee at future meetings. **The Committee resolved that:** a) The current position and also the actions taken since the previous report to strengthen assurance and manage risks within PCIC Clinical Board were noted.	**NS**
QSE 23/09/008	**Quality Indicators Report – Deep Dive: Infection Prevention & Control (IP&C).** The Quality Indicators Report Deep Dive was received. The Head of Nursing, Infection Prevention & Control (HNIPC) advised the Committee that she would take the report as read and noted key elements to highlight to the Committee which included:	

- Staffing – it was noted that extra staff had been provided to the IP&C team over the past 4 years which had allowed them to continue supporting Clinical Boards and the Corporate Team and it was noted that the team was appointing a Band 8a Senior Nurse in IP&C which would free up the Head of Nursing for IP&C to undertake a more strategic role both within the health board and on an all-Wales level.

- Key Outbreaks – it was noted that the IP&C team continued to support Clinical Boards with incident and outbreak management with outbreaks/incidents of infection including:

  - MRSA outbreak in Neonatal Intensive Care
  - MDR Klebsiella pneumoniae in West 8 UHL where a meeting was held in August 2023 to close the W8 MDR Klebsiella outbreak after nearly 4 years,
  - SSI (Surgical Site infection) in Trauma & Orthopaedics,
  - MSSA in Renal
  - COVID19/Influenza/norovirus outbreaks in multiple clinical areas.

- The Welsh Health Circular 2023/031 – it was noted that the Antimicrobial Resistance & Healthcare Associated Infection Improvement Goals for 2023-24 was received by the Health Board in August 2023 which described the current Health Board position with regards to the reportable bacteraemia's outline.

- Improvement Goals – the HNIPC advised the Committee that a number of improvement goals were identified and highlighted goal 7, 8 and 9:

  - Improvement Goal 7, a reduction in the annual incidence of P. aeruginosa and Klebsiella spp. bacteraemia by 10% against 2017-18 figures. It was noted that there had been 9 cases of Pseudomonas bacteraemia to the end of August 2023, a rate of 4.27 cases per 100,000 and that the Health Board was currently on the trajectory to achieve the reduction expectation of 6.38 cases per 100,000 population and to have the third lowest rate in Wales.

  - Improvement Goal 8, a reduction in the annual incidence of C. difficile disease to 25 cases per 100,000 or below where it was noted that the Health Board would achieve that goal and that there had been 49 C'difficile toxin positive cases in the Health Board from April 1st to the end of August 2023, 10 cases less than the equivalent period in 2022/23.

  - Improvement Goal 9, a reduction in the annual incidence of Staphylococcus aureus bacteraemia to 20 cases per 100,000 or below, with zero tolerance of preventable MRSA blood stream infections and a continued drive to reduce cases. It was noted that there had been 5 cases of MRSA in the Health Board from April 1st to the end of August 2023 and MRSA bacteraemia cases had reduced by 2 compared to the equivalent period in 2022/23.

The HNIPC advised the Committee of other key areas identified within the report which included the work done alongside non-clinical teams (Capital, Estates, and Facilities and procurement) and noted that current ongoing work with procurement included:

- Reviewing the cleaning products used to clean clinical areas which had the potential to make an annual saving for the Health Board of almost £29,000 whilst maintaining high standards of cleaning.

- Effective decontamination of Ultrasound probes.

- Working with pharmacy to source appropriate pre-operative skin cleansing solutions due to a national shortage of what was currently in use

	• Collaborative working between IP&C, Surgery Practice Educators and Procurement to promote the "RCN Gloves off Campaign". She concluded that Since April 2023 there had been over 500 audits undertaken by the IP&C nurses which was the most ever undertaken by the team and noted that a clinical quality dashboard was in development to triangulate the staffing, capacity, acute / dependency and IPC data which would give greater intelligence and understanding of the impact of those variables in relation to healthcare associated infection. The Executive Nurse Director (END) advised the Committee that the link of IP&C to the Tendable system enabled staff to do more audits than ever before which was a positive outcome. **The QSE Committee resolved that:** a) The assurance provided by the actions underway to support scrutiny and oversight of bacteremias and to embed improvements in practice was noted.	
QSE 23/09/009	**Looked After Children – Assessment Backlogs** The Looked After Children – Assessment Backlogs was received. The END advised the Committee that a report was received by the Committee approximately 6 months ago which noted that an update would be received approximately 6 months later which was the reason for the update. The Director of Nursing – Children & Women's Clinical Board (DNCW) advised the Committee that Looked After Children (LAC) remained a key area for the Children & Women's Clinical Board as it was clear that LAC had adverse outcomes and so the continued assessment of their needs was vital. It was noted that the paper received by the Committee previously had described the scope of the problem and since March 2023 the Clinical Board, in response to the problem had looked at additional actions to implement to enable the team to meet the statutory health assessments. The DNCW added that there had been a consistent increase in children in care in Cardiff and the Vale of Glamorgan and that there were currently 1,666 children on the database in September 2023 with 399 children who were looked after out of area which left the Health Board with a considerable number of children living across Cardiff and Vale that the CLA team had statutory obligations around the new initial health assessment, and review health assessment. Actions taken were identified which included: • An additional 2.90 Whole Time Equivalent (WTE) nurses had been appointed to increase the nursing workforce to 7.10wte. • Nurses were now undertaking all initial and review health assessments for children over where prior to March 2023 medical staff were undertaking all health assessments for children under 10. It was noted that the above actions demonstrated the increase in Heath Assessments undertaken and the reduction in the backlog of Health Assessments and that whilst there had been a significant improvement in the numbers waiting, meeting the regulations continued to be a challenge.	

	The DNCW advised the Committee that workforce was still the biggest challenge and noted that the demand still exceeded the Clinical Board's capacity. He added that that there were a number of options outlined within the report to bridge the gaps identified and it was noted that the Clinical Board were working through those options to find the best action to take which would hopefully enable the Clinical Board to continue to report a level of improvement to the Committee. The Independent Member – Capital & Estates (IMCE) noted that it was important for the Committee to remain sighted on LAC and asked what relationship was held between the Health Board and the Local Authority (LA) around the LAC context and if there were any issues. The DNCW responded that there were no significant issues held between the Health Board and the LA and noted that some of the solutions to help with LAC could be digital solutions to work across multiple platforms and progression was required on those digital solutions to ensure that the referral process could be smoother. The Independent Member – Community (IMC) asked if the Digital & Health Intelligence Committee could be sighted on the digital restraints as it was important work to progress. The END agreed and asked that the Committee receive a further LAC update in 6 months' time. **The QSE Committee resolved that:** a) The content of the paper and the actions taken to mitigate the risks associated child health assessments was noted.	**JR**
QSE 23/09/010	**Covid Investigation Programme Update** The Covid Investigation Programme Update was received. The Assistant Director of Quality and Patient Safety (ADQPS) reminded the Committee that 18 months ago, a statutory requirement to investigate all potential and confirmed Healthcare acquired cases of Covid-19 was established in Wales with funding allocated to the Health Board to do that which ran until March 2024. She noted that the charts outlined within the report received by the Committee showed that the Covid Investigation programme was exceeding the trajectory with more investigations completed than required at the current time and if the Health Board continue on that trajectory, it would complete the programme early. It was noted that despite the positive trajectory, there were still risks identified with the programme including staffing because a number of the Covid investigation team were on fixed term contracts until March 2023 and so were in the process of looking for new roles. The ADQPS advised the Committee that to date, there were 511 investigations remaining, down from the starting figure of just over 3500 and that of those 511, 49 were completed but were subject to further scrutiny through either the Covid panels or the Covid Scrutiny Clinic to quality assure the investigation. She added that areas of good practice and learning continued to be collated and noted that learning fitted under four broad overarching themes: • Infection, Prevention and Control, • Operational, • Patient/Family Experience • Estates and Environment.	

	It was noted that the development of AMAT (Audit Management & Tracking) software was currently underway to strengthen the sharing of learning whilst ensuring the programme's legacy. The Independent Member – Trade Union (IMTU) asked if the Health Board were in a position to put a contingence in place should the staffing situation worsen. The ADQPS responded that the Health Board had a number of staff working on the bank within the Covid Investigation team and so those could be drawn upon if required. The IMTU asked what the consequences would be if the Health Board were unable to complete the programme. The ADQPS responded that if the programme was not completed in the provided timeframe, it would pose a financial risk to the Health Board as it was duty bound to investigate. She added that assurance could be taken from the good progress mad so far and the fact that the Health Board was ahead. The ADQPS concluded that the biggest risk with the Covid Investigation programme was that a number of cases had been referred to legal and risk and so there was a potential that those cases would not have been resolved by the March 2024 deadline. **The Committee resolved that:** a) The assurance provided by the progress against the framework was noted	
QSE 23/09/011	**Transition to NRFit for Neuraxial Procedures** The Transition to NRFit for Neuraxial Procedures report was received. The ADQPS advised the Committee that medications could be given by a number of routes, including oral, intravenous and neuraxial. It was noted that neuraxial included spinal – into the cerebral spinal fluid, and epidural – into the extradural space and that there was ongoing requirement for the Health Board to plan switching from luer equipment to Neuraxial equipment with an aim to reduce accidental “wrong-route” errors. The Interim Head of Safety, Quality and Organisational Learning (IHSQOL) advised the Committee that the Health Board were 3 weeks away from the switchover and noted that the Health Board were now in a position to purchase enough neuraxial equipment to undertake all of the neuraxial procedures. He added that there was a very well-established task and finish group leading the work who had involved all relevant specialties in the planning for implementation including delivery of training and testing compatibility of the equipment with certain drugs including chemotherapy and that risks had been identified and mitigation put in place to minimise those risks. The Committee was advised of a number of areas that had been planned around the transition to NRFit for neuraxial procedures which included: • Changeover days - it was noted that changeover days were planned to avoid school holidays, winter pressures and rotation of junior medical staff and it was agreed by the local neuraxial task and finish group that the changeover should be implemented rapidly to minimise the period of time during which the Luer	

compatible neuraxial devices remained in circulation after the introduction of NRFit equivalents.

- Stock – it was noted that in order to ensure the safe transition to NRFit, an initial central order of NRFit equipment and consumables had been placed by procurement and that the initial central order had been designed to give approximately 6 weeks usage for theatre and maternity areas, and a minimum of 4 weeks usage for other areas.

- Education and training – it were noted that a comprehensive SharePoint site had been developed with training material and resources, which included educational videos for anaesthesia and all other specialities and that local “NRFit Champions” had been trained in key clinical areas who provided training to theatre staff as part of safety and quality sessions.

The IHSQOL identified the key risks which included:

- Clinical areas missed from changeover – it was noted that a considerable number of different neuraxial procedures were performed within the Health Board by a wide range of clinical teams across many locations and so there was a risk that areas, particularly small areas, with low volumes of neuraxial procedures, would not be aware of the need to change to NRFit compliant equipment.

It was noted that the risk was managed by:

- Ensuring wide engagement with the Task & Finish Group from across clinical specialties.
- Using information from procurement systems to identify areas which currently used Luer neuraxial equipment.
- Engagement with Clinical Boards/Directorates and presenting at relevant meetings.

- Procedure delays due to incompatible equipment- it was noted that there was a risk that if an area was not fully transitioned to NRFit, it could cause delays in procedures.

It was noted that the risk was managed by a number of actions which included:

- Close working with clinical staff and those responsible for ordering stock in clinical areas to ensure that sufficient equipment would be ordered and delivered ahead of changeover.
- Education of staff to check that all the necessary equipment was available and NRFit compatible before starting a procedure.
- A changeover plan that minimised the time that Luer and NRFit neuraxial equipment was in circulation concurrently.

- Insufficient equipment received prior to changeover – it was noted that it was vital that sufficient quantities of NRFit equipment could be received into Health Board stores for delivery to clinical areas.

It was noted that the risk was managed by:

- Early provision of the initial central order (Mid-August 2023) to procurement to allow time for orders to be placed with suppliers and received into stores.
- A planned second order prior to changeover to add additional required items that had been identified since the initial order was placed.

	- Working with supplier representatives to receive early notification of any supply issues and resolving any issues. **The Committee resolved that:** a) The changeover to NRFit for neuraxial procedures on 15th/16th October 2023, subject to sufficient NRFit equipment being received in Health Board stores by 26th September was approved.	
QSE 23/09/012	**Paediatric Intensive Care Unit (PICU) Pressure Damage Update** The PICU Pressure Damage update was received. The END advised the Committee that the Welsh Health Specialised Services Committee (WHSSC) had identified concerns within the PICU which enabled a piece of work to be undertaken by the Health Board and a report was received via the private session of the Committee in May 2023 with an aim to update the Committee in the public session in September 2023. The DNCW advised the Committee that he would take the paper as read and noted that pressure damage remained a concern for the Clinical Board. He added that a retrospective review of pressure damage within the Acute Child Health Directorate was undertaken and identified 44 patient safety incidents relating to pressure damage reported between 1st March 2022 and 15th March 2023, with 24 children affected. It was noted that: • 11 cases related to incidents of moisture associated skin damage associated with incontinence or nappy rash. • 15 incidents related to medical devices including ventilator masks. The Committee was advised that analysis of the incidents evidenced good risk assessment and Tissue Viability Service and Medical Photography involvement for the most complex cases. It was noted that there were however, improvements required in the oversight and management of pressure damage related patient safety incidents and that immediate training was provided to senior and lead nurses to support appropriate management of incidents reporting and management. The DNCW noted that in response to the review, the Acute Child Health Directorate would implement a monthly Pressure Damage Scrutiny Panel to provide senior oversight of all incidents with involvement from the Tissue Viability Service, with the aim to identify areas of learning and improvement and to reduce pressure damage incidence. He added that A new skin integrity pathway was developed to ensure appropriate action was taken to prevent device related tissue damage within the vulnerable patient cohort and complex service area and that the pathway would commence within four hours of admission to PICU and would be reviewed daily. The Committee was advised that In June 2023 the Acute Child Health Directorate launched the use of the Paediatric Purpose-T pressure ulcer risk assessment tool which was being rolled out across Wales and supported proactive identification of risks of developing pressure damage and mitigating actions. The CC thanked the DNCW for the update and noted that the hard work identified within the report demonstrated the improvements and commitment of the Clinical Board.	

	The END added that the paper had also been received by WHSSC for their assurance. **The 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 Children & Women Clinical Board was noted.	
QSE 23/09/013	**Policies:** The Medicines Code 2023 (UHB 389) was received. The Staff Winter Respiratory Vaccination Policy and Procedure (UHB 494) was received. **The Committee resolved that:** a) The Medicines Code 2023 (UHB 389) was reviewed and approved. b) The Staff Winter Respiratory Vaccination Policy and Procedure (UHB 494) was reviewed and approved.	
QSE 23/09/014	**Bi-Annual National Clinical Audit** The Bi-Annual National Clinical Audit was received. **The Committee resolved that:** a) The assurance provided by the national audit results and oversight of the improvements was noted.	
QSE 23/09/015	**NG Tube Patient Safety Notice** The NG Tube Patient Safety Notice was received. **The Committee resolved that:** a) The reporting of compliance with Patient Safety Alert 008 – 'Nasogastric tube misplacement: continuing risk of death and severe harm' was noted.	
QSE 23/09/016	**Radiation Protection Group – Chairs Report** The Radiation Protection Group – Chairs Report was received. **The Committee resolved that:** a) The summary of the key issues from the meeting were noted.	
QSE 23/09/017	**Minutes from Clinical Board QSE Sub Committees:** The Minutes from Clinical Board QSE Sub Committees were received. **The Committee resolved that:** a) The Minutes from the Clinical Board QSE Sub-Committees were noted.	
QSE 23/09/018	**Items to bring to the attention of the Board / Committee:** No items were raised.	
QSE 23/09/019	**Agenda for Private QSE Meeting**	

	i) Private Minutes - *ii) Any Urgent / Emerging Themes – Verbal (Confidential Discussion)*	
QSE 23/09/020	**Any Other Business** No other business was raised.	
	Date & Time of Next Meeting: October – tbc - via MS Teams	

Minutes of the Mental Health Legislation and Mental Capacity Act Committee
Held on 1 August 2023
Via MS Teams

Chair:		
Ceri Phillips	CP	Committee Chair / University Health Board Vice Chair
Present:		
Sara Moseley	SM	Committee Vice Chair / Independent Member – Third Sector
Rhian Thomas	RT	Independent Member – Capital & Estates
In Attendance:		
Rebecca Aylward	RA	Deputy Executive Director of Nursing
Daniel Crossland	DC	Director of Operations - Mental Health
Becci Ingram	BI	General Manager Children, Young People & Family Health Services (CYPFS)
Robert Kidd	RK	Interim Clinical Director Psychology & Psychological Therapies
James Quance	JQ	Interim Director of Corporate Governance
Jason Roberts	JR	Executive Nurse Director
David Seward	DS	Mental Health Act Manager
Elizabeth Singer	ES	Deputy Chair of the Powers of Discharge sub-Committee
Observers:		
Urvisha Perez	UP	Audit Wales
Secretariat:		
Nathan Saunders	NS	Senior Corporate Governance Officer
Apologies:		
Paul Bostock	PB	Chief Operating Officer
Jeff Champney-Smith	JCS	Chair, Powers of Discharge sub-Committee
Susan Elsmore	SE	Independent Member - Council
Neil Jones	NJ	Clinical Board Director – Mental Health
Jason Roberts	JR	Executive Nurse Director

Item No	Agenda Item	Action
MHLMCA 23/08/001	**Welcome & Introductions** The Committee Chair (CC) welcome everybody to the meeting in English and in Welsh.	
MHLMCA 23/08/002	**Apologies for Absence** Apologies for Absence were noted	
MHLMCA 23/08/003	**Declarations of Interest** No Declarations of Interest were noted.	
MHLMCA 23/08/004	**Minutes of the Meeting held on 2 May 2023** The Minutes of the Meeting held on 2 May 2023 were received. **The Committee Resolved that:** a) The minutes of the meeting held on 2 May 2023 were agreed as a true and accurate record.	
MHLMCA 23/08/005	**Action Log from the meeting held on 2 May 2023** The Action Log was received and discussed.	

	The Committee Resolved that: a) The Action Log was noted.	
MHLMCA 23/08/006	**Chair's Action taken since last meeting** **The Committee Resolved that:** a) No Chair's Actions were taken since the last meeting.	
MHLMCA 23/08/007	**Any Other Urgent Business Agreed with the Chair** **The Committee Resolved that:** a) No other urgent business was agreed with the Chair.	
MHLMCA 23/08/008	**Mental Capacity Act Monitoring Report and DoLS monitoring including: Workforce Requirements** The Mental Capacity Act Monitoring Report and Deprivation of Liberty Safeguards (DoLS) monitoring including Workforce Requirements was received. The Deputy Executive Director of Nursing (DEND) advised the Committee that she would take the paper as read and that the report provided a general overview of the Mental Capacity Act and DoLS compliance as well as the workforce requirements to progress Deprivation of Liberty, which had been supported by Welsh Government (WG) funding until March 2024. Key points from the report were raised which included: • Independent Mental Capacity Advocate (IMCA) Referrals which were noted to have decreased however, there had been some data reporting issues with the software used and the end-user leaving the Mental Health team. • Mental Capacity Training where good progress had been made, although low attendance rates on the day were observed, which was likely due to ongoing clinical pressures and staffing issues. • Additional training provision - Mental capacity and best interests training (Edge Training), which continued to be well received by staff, had been extended until September 2023. • Additional training provision - DoLS in Practice Training (Edge Training), which had been commissioned to help raise awareness around what amounted to a deprivation of liberty, in order to ensure that the Health Board was effectively safeguarding vulnerable patients and that staff were completing DoLS referrals where appropriate. • Deprivation of Liberty referrals where it was noted that there was a stable but increased number of applications. • The current workforce requirements to progress Deprivation of Liberty, which had been supported by WG funding until March 2024, with indications that this funding would continue into 2025 would cost a total of £266,000. • Consent to Examination and Treatment, where it was noted that the appointed part-time Consent Lead had recently taken up post and would begin to work with colleagues across the Health Board to raise awareness of the Consent to Examination and Treatment E-learning package and to encourage staff to utilise it as much as possible. The CC asked if there had been a momentum shift between planning for Liberty Protection Safeguards (LPS) and the continuation of DoLS. The DEND responded that there had not been a shift in momentum because the energy and momentum had shifted to the DoLS element and noted that it was reassuring to hear that WG would match fund to progress with DoLS until 2025.	

	The Independent Member – Third Sector (IMTS) asked if there was a condensed version the DoLS training that Committee members could view to help understand it. The DEND responded that there was and noted that it would be very helpful for the Committee to be sighted on the training, whilst noting that the whole training package, which lasted a full day, would not be useful for Committee members to attend. The Independent Member – Capital & Estates (IMCE) noted that the MSc module of the Assessing decision making capacity training had been popular with staff and asked if the impact that the learning programme had could be contextualised. The DEND responded that it was a really valuable module because it took individuals into the complex decision making required around mental capacity and noted that once the module was completed it meant that that person was an expert in that area, which was really valuable to the individual and the Health Board. She added that the funding was being supported by the money from WG and so the Health Board would not be able to sustain people going on that module but noted that the team were trying to get as many people through as possible. **The Committee resolved that**: a) The contents of the report and the current compliance and actions with Mental Capacity Act and Deprivation of Liberty indicators were noted.	
MHLMCA 23/08/009	**Hospital Managers Power of Discharge Sub Committee Annual Report** The Hospital Managers Power of Discharge Sub Committee Annual Report was received. The Deputy Chair of the Powers of Discharge sub-Committee advised the Committee that she would take the report as read and noted that it gave the Power of Discharge Sub Committee an opportunity to bring to the attention of clinical staff issues that are highlighted during the hearing. The Annual Report provides a review of these issues. She added that the number of queries the Power of Discharge Sub Committee have around legislation and compliance was very low which would indicate a much better handle on the issues. **The Committee resolved that**: a) The Hospital Managers Power of Discharge Sub Committee Annual Report was noted.	
MHLMCA 23/08/010	**Mental Health Act Monitoring Exception Report** The Mental Health Act Monitoring Exception Report was received. The Mental Health Act Manager (MHAM) advised the Committee of the data for a number of areas within the Mental Health Act which included: • Fundamentally defective applications where it was noted that during the quarter there was one fundamentally defective application and details were provided. Section 136 Accident & Emergency, where it was noted that there may be instances when treatment under a 136 was related to the mental disorder, but the patient was not fit for a mental health act assessment within the 24/36-hour period causing the 136 to lapse; for example, a patient could take an overdose which required admittance to A&E and so the “clock” would start at A&E. The MHAM added that in all instances where the 136 had lapsed due to the patient not being fit for a mental health act assessment, a DATIX would be completed. • Overall section 136 where it was noted that 80.4% of individuals assessed had not been admitted into hospital, 59.2% had been discharged to community services and 21.2% were discharged with no follow up appointment.	

	The MHAM added that the number of those under 18 assessed under section 136 had increased from 2 in the previous quarter to 12 in the current quarter, which had pushed up the overall 136 sections above the team's upper control limit. The IMTS noted that it was concerning to see the increase in 136 sections and noted that the Committee held the risk, while in terms of compliance there was something about how the Police needed to somehow share the risk with the Health Board. The Interim Clinical Director Psychology & Psychological Therapies (ICDPPT) advised the Committee that although the number of 136 sections had increased, the Health Board had not, importantly, breached its legal function under the Act. The Director of Operations - Mental Health (DOMH) added that there had been some issues around the Police triage and noted that the team had met with the Deputy Chief Constable to discuss issues and to provide information for links into the right care with the right person. He added that the Health Board had met with the other Health Boards in South Wales, South Wales Police and the Crisis Care Concordant and concluded that the Health Board had good communication between each team on the issues raised. • Mental Health Review Tribunal for Wales (MHRT) where it was noted that the MHRT had recently been in touch with the Health Board regarding the parking issues they had experienced when coming to Hafan Y Coed for face to face hearings and a response had been provided to the MHRT. • Development Sessions where it was noted that The Mental Health Act (MHS) office continued to run awareness sessions including a monthly MHA training day which was available to all staff within the Health Board, a monthly consent to treatment workshop and a quarterly rights and forensic workshop. **The Committee resolved that:** a) The approach taken by the Mental Health Clinical Board to ensure compliance with the appropriate Mental Health legislation, as set out in the report was noted.	
MHLMCA 23/08/011	**HIW MHA Inspection Reports** The Health Inspectorate Wales (HIW) MHA Inspection Reports were received. The DOMH advised the Committee that since the previous report, 4 reports had been published for East12 ward and East16 ward at the University Hospital Llandough (UHL) and Ash Ward and Pine Ward at Hafan Y Coed. He added that the reports could be accessed online which outlined issues raised and actions to be taken as well as the positive feedback received around team working. The IMCE noted that it stated within the report that half of the staff members who completed the HIW online questionnaire disagreed that patient experience feedback was collected and that the organisation acted on concerns raised by patients. She asked how the leads were bringing the staff, as well as patients along with them to provide the improvements outlined within the report. The DOMH responded that a large amount of work had been undertaken subsequent to the report as well as leading up to it which included:	

	• QR codes had been added to all ward so that staff and patients could access questionnaires and be able to upload images if required. • Investment in broad support of teams and the implementation of 2 Schwartz rounds facilitators and a Schwartz rounds coordinator who would report into Health Board Committees. • Use of third sector partners to work alongside patients on the ward to undertake surveys. The CC asked the DOMH to convey the thanks of the Committee to all of the various teams within Mental Health. **The Committee Resolved that:** a) The HIW MHA Inspection Reports were noted.	
MHLMCA 23/08/012	**Public Service Ombudsman Wales Reports** The Public Service Ombudsman Wales Reports were received. The CC advised the Committee the covering report outlined the detail well. He added that out of the 20 cases detailed, 5 required attention which was indicative of the high performance of the various teams. The IMTS noted that 3 of the 4 themes identified were around access to various services and treatments and asked if there was any learning from that, as well as what communication was being provided to patients. The ICDPPT responded that he would look at the psychology directorate Quality & Safety meetings to look at the issues identified around access and would work with the DOMH and the Executive Nurse Director (END) to address that. **The Committee Resolved that:** a) The contents of the PSOW-Public Service Ombudsman for Wales Mental Health Clinical Board report were noted.	
MHLMCA 23/08/013	**Mental Health Measure Monitoring Reporting including Care and Treatment Plans Update Report.** The Mental Health Measure Monitoring Reporting including Care and Treatment Plans Update Report was received. The DDOMH advised the Committee that the report was separated into 4 parts and he would take the report as read. **Part 1A – target: 28-day referral to assessment compliance target of 80% (Adult):** It was noted that Q1 in 2023-24 showed a dip in activity which was one of the first periods of decline since the Covid-19 pandemic, which was largely due to highest number of referrals received in March 2023. The DOMH noted that the Clinical Board had anticipated a return to 100% compliance in July 2023 but it had been met June 2023. **Part 1A – target: 28-day referral to assessment compliance target of 80% (Children & Young People)**	

The General Manager Children, Young People & Family Health Services (GMCYPFHS) advised the Committee that the same had been observed for Children & Young people with the highest number of referrals received in March 2023, but noted that levels had returned to normal with a compliance rate of above 80%

Part 1B – 28-day assessment to intervention compliance target of 80% (Adult); remained 100% compliant.

Part 1B – 28-day assessment to intervention compliance target of 80% (Children & Young People)

The GMCYPFHS advised the Committee that there were ongoing issues with the achievement of the Part 1B target, largely as a result of the volume of assessments which had been undertaken through the previous waiting list initiative where the focus had been on the external waiting list.

She added that there had also been an additional impact as a result of the significant increase in referrals for assessment in March 2023, with increased numbers requiring follow on intervention.

It was noted that a number of actions were being undertaken to improve the compliance rate which included but were not limited to:

- Working with PARIS and the clinical team to address data capture, recording and reporting quality
- Active sickness monitoring and wellbeing support to the team
- Ongoing capacity and demand monitoring
- Recruitment to vacant posts
- Active work on clinical pathways to ensure a clear model that allowed for clear capacity and demand planning
- Active monitoring of caseloads and support of the process of letting go through peer group
- Launch of an anxiety group in May 2023 which had provided an alternative intervention offer for a number of children and young people

Part 2 – Care and Treatment Planning (CTP) - Over 18.

The DOMH advised the Committee that compliance had proved challenging and that engagement with the Delivery Unit (DU) was ongoing.

Part 2 – Care and Treatment Planning (Children & Young People)

The GMCYPFHS noted that the same challenges had been observed in Children & Young People services in terms of engagement from patients within the process which was currently at 89%.

She added that actions to improve compliance against the target included:

- Staff training
- Development of improved data capture and reporting mechanisms through PARIS
- Engagement with Youth Board re: ensuring a child and young person friendly approach to the Care and Treatment Planning process.

Part 3 - Right to request an assessment by self –referral.

The DOMH advised the Committee that compliance had improved in May 2023 and allocation rates had increased.

Part 4 – Advocacy – standard to have access to an IMHA within 5 working days; remained 100% compliant.

	The CC noted that the overall context was one of extreme pressure and noted the comparison with Aneurin Bevan University Health Board. **The Committee Resolved that:** a) The contents of the report were noted.	
MHLMCA 23/08/014	**Corporate Risk Register** The Corporate Risk Register (CRR) was received. The DCG advised the Committee that the report was for noting and that there was one extreme risk still being reported on the corporate risk register, which fell within the remit of the Committee with regards to discharge of patients from Mental Health services. The ICDPPT noted that there were operational pressures across South Wales with regard to appropriate beds for Young People and asked where the risk was located within the Health Board. The DOMH responded that Children in Adult placements was represented in the Mental Health Clinical Board Corporate Risk Register and noted the level of mitigation to put in place was one of the biggest issues in relation to risk. **The Committee Resolved that:** a) The Corporate Risk Register update was noted.	
MHLMCA 23/08/015	**Sub-Committee Meeting Minutes:** The Committee received copies of the Sub-Committees' meeting minutes: • Mental Health Act Hospital Managers Power of Discharge Sub Committee – 11th July 2023. • Mental Health Legislation and Governance Group (MHLGG) – 13th July 2023. **The Committee Resolved that:** a) The Sub-Committee Meeting Minutes were noted.	
MHLMCA 23/08/016	**Any Other Business** No further business was raised.	
	To note the date, time and venue of the next meeting: 31st October 2023 Via MS Teams	

Confirmed Minutes of the Public Finance and Performance Committee Meeting
Held on 23rd August 2023 at 2 pm
Via MS Teams

Chair:		
Michael Imperato	MI	Independent Member – Legal
Present:		
John Union	JU	Independent Member – Finance
David Edwards	DE	Independent Member - ICT
Keith Harding	KH	Independent Member – University
In Attendance:		
Catherine Phillips	CP	Executive Director of Finance
Andrew Gough	AG	Deputy Director of Finance (Strategy)
Paul Bostock	PB	Chief Operating Officer
Matt Philips	MP	Director of Corporate Governance
Rebecca Aylward	RA	Deputy Executive Nurse Director
Abigail Harris	AH	Executive Director of Strategic Planning
Charles Janczewski	CJ	UHB Chair
Observers:		
Secretariat:		
Sarah Mohamed	SM	Corporate Governance Officer
Apologies:		
Robert Mahoney	RM	Deputy Director of Finance (Operational)
Jason Roberts	JR	Executive Nurse Director
Ceri Phillips	CP	UHB Vice Chair
Suzanne Rankin	SR	Chief Executive Officer

Item No	Agenda Item	Action
FPC 23/08/001	**Welcome & Introduction** The Committee Chair (CC) welcomed everyone to the meeting.	
FPC 23/08/002	**Apologies for Absence** Apologies for Absence were noted. **The Finance and Performance Committee resolved that:** a) Apologies for Absence were noted.	
FPC 23/08/003	**Declarations of Interest** No Declarations of Interest were noted.	
FPC 23/08/004	**Minutes of the Finance and Performance Meeting held on 19 July 2023** The minutes of the meeting held on 19 July 2023 were received.	

	The Finance Committee resolved that: a) The minutes of the Finance and Performance Committee meeting held on 19 July 2023, were held as a true and accurate record of the meeting.	
FPC 23/08/005	**Action Log following the Finance and Performance Committee meeting on 19 July 2023** The Action Log was received. **The Finance and Performance Committee resolved that:** a) The Action Log for the Finance and Performance Committee was noted.	
FPC 23/08/006	**Chairs Action since previous meeting** There had been no Chair's Actions taken since the last meeting.	
	Items for Review and Assurance	
FPC 23/08/007	**Financial Report – Month 4** The Deputy Director of Finance for Strategy (DDFS) presented the Financial Report – month 4 and highlighted the following: • At month 4, the Cardiff and Vale University Health Board (the Health Board) was reporting an overspend of £34.354m. • This comprised of £4.055m unidentified savings, £0.832m of operational overspend and the planned deficit of £29.467m (four twelfths of the annual planned deficit of £88.4m set out in 2023/24 financial plan). <u>Operational Position</u> • The operational surplus deteriorated in month from a £0.170m deficit at month 3 to a £0.832m cumulative operational deficit at month 4. • The key driver of the operational deficit was the WHSCC joint committee decision to return to extant contracts for 2023-24. • This has had a £3m net impact on the Health Boards contract income position. The UHB Chair queried when would the WHSCC mitigations be expected to take place. The DDFS responded that a list of further actions had been agreed totalling £16m to address the savings shortfall and the operational pressures being experienced. The Executive Director of Finance (EDF) responded that here was a table in the papers which showed the deficit and mitigations were now needed to be built in.	

	The DDFS advised that the Health Board were also experiencing pressure within the Mental Health Clinical Board. This would be picked up in a deep dive later on in the meeting. The Health Board were also experiencing pressures in estates and facilities. <u>Savings Programme</u> The month 4 position included a Savings Programme variance of £4.055m relating to a four month share of red and unidentified schemes. The Committee was advised that the Health Board expects to be able to manage the balance of savings plans required to deliver the forecast deficit of £88.4m with the risk of non-delivery of savings shown in Graph 1 and the progress of reducing the risk via identification of schemes in Graph 2. The DDFS advised that even if all the red schemes were progressed to amber and green, there would still be a shortfall against the £32m target. It was noted that further schemes had been identified totalling £16m to date to de-risk the financial plan. The additional schemes were currently being implemented and progress on delivery would be monitored by a dashboard on a weekly basis through escalation meetings. Each of the schemes would be led by the executive and theme leads. It was agreed that a detailed savings tracker would be brought to next month's committee meeting. <u>Table 3 - Key Performance Indicator Dashboard at July 2023</u> It was noted that the Health Board expects to remain within its Capital Resource Limit which was £29.597m at month 4. The Health Board also continues to achieve the NHS creditor payment compliance of 97.42%. It was noted that there was also a positive cash balance of £3.498m. The UHB Chair queried what was being done to make sure income generation, procurement and Aroma café were not drifting from their proposed savings. The DDSFS responded that there were a number of saving schemes which were not delivering to the value forecasted at the start of the year. They were taking stock of the maximum that could be delivered from the schemes by 31 March and the additional schemes would back fill any gaps. The UHB Chair requested that assurance was given to the Committee that the Health Board could catch up and make good the gaps. **The Finance and Performance Committee resolved that at Month** a) The reported year to date overspend of £34.353m and the forecast deficit of £88.400m was noted.	**AG**

	b) The financial impact of forecast COVID 19 costs which was assessed at £44.664m was noted. c) The month 4 operational overspend against plan of £0.832m was noted. d) The progress against the savings target, with £30.764m (96%) of schemes identified at Month 4 against the £32m target was noted.	
FPC 23/08/008	**Operational Performance Report** The Chief Operating Officer (COO) presented the Operational Performance Report and highlighted the following: • The biggest issue at the moment was the length of stay which was affecting the ability to flow patients through the hospital. • There had been good progress in cancer. • 76% of stroke patients had gotten to the ward within 4 hours in June. The focus being put into the stroke pathways was starting to have an impact. • There was good progress being made in hip fractures. • Mental Health services were still under pressure on all levels. There was a summit planned for September, together with Primary Care, CAHMS and Adult Mental Health. The UHB Chair queried how robust the data was on measuring dental performance and requested that this was shared at the next meeting. The UHB Chair also requested an update on the CAHMS trajectory. **The Finance and Performance Committee resolved:** a) The year to date position against key organisational performance indicators for 2023-24 and the update against the Operational Plan programmes was noted.	**PB**
FPC 23/08/009	**Planned Care Update** The COO presented slides on Planned Care and highlighted the following: • On the 25th of July, Cardiff and Vale Health Board received a letter in respect of the allocation of the £50m planned care fund and the expected deliverables associated with the allocation. • The Health Board were on track to deliver the Ministerial ambitions. • To ensure delivery of the additional schemes as well as the challenging milestones, the governance within planned care had been revised and strengthened to include dedicated project and programme groups linked to the allocations and deliverables. • Each Clinical Board had developed additional activity plans on a non-recurrent basis to target improvements against the 104 week and 156 week which in turn had been developed as an overall trajectory for delivery to December and March. **The Finance and Performance Committee resolved that:**	

	a) The contents of the report and the additional detail within the presentation on the requirement, governance and plan of delivery were noted.	
FPC 23/08/010	**Mental Health Financial Position Deep Dive** The COO presented slides on the Mental Health Financial Position and highlighted the following: • The Mental Health Clinical Board was under a significant amount of pressure and extra support was being provided to them. • The biggest increase in expenses was the psychiatric intensive care unit which included a £1.1 m forecast overspend. • There are also vacancies within the workforce. • There are also regional and national capacity constraints. The UHB Chair requested a benchmarking exercise to be completed since the Health Board were a massive outlier. **The Finance and Performance Committee resolved that:** a) The Mental Health Financial Position Deep Dive was noted.	**PB**
	Items for Approval/Ratification	
FPC 23/08/011	*No items*	
	Items for Information and Noting	
FPC 23/08/012	**Monthly Monitoring Returns** The Month 4 Monitoring Return was received. **The Finance and Performance Committee resolved that:** a) The extract from the UHB's draft Monthly Financial Monitoring Return for Month 4 was noted.	
FPC 23/08/013	**Any Other Business** No Other Business was discussed.	
	Review and Final Closure	
FPC 23/08/014	**Items to be referred to Board / Committee** No Items to be referred to Board / Committee.	
	Date & time of next Meeting Wednesday 20th September 2023 at 2pm via MS Teams	

Confirmed Minutes of the Public Finance and Performance Committee Meeting
Held on 20 September 2023 at 2pm
Via MS Teams

Chair:		
John Union	JU	Independent Member – Finance (IM-F)
Present:		
David Edwards	DE	Independent Member – Information Communication & Technology (IM-ICT)
In Attendance:		
Paul Bostock	PB	Chief Operating Officer (COO)
Catherine Phillips	CP	Executive Director of Finance (EDF)
Matt Phillips	MP	Director of Corporate Governance (DCG)
Charles Janczewski	CJ	UHB Chair
Abigail Harris	AH	Executive Director of Strategic Planning (EDSP)
Ceri Phillips	CP	UHB Vice Chair
Andrew Gough	AG	Deputy Director of Finance – Strategy (DDFS)
Rob Mahoney	RM	Deputy Director of Finance – Operational (DDFO)
Angela Hughes	AH	Assistant Director of Patient Experience (ADPE)
Calum Shaw	CS	Environmental Sustainability Improvement Manager (ESIM)
Matt Temby	MT	Managing Director Planned Care (MDPC)
Secretariat:		
Rachel Chilcott	RC	Corporate Governance Officer
Apologies:		
Suzanne Rankin	SR	Chief Executive (CE)
Keith Harding	KH	Independent Member – University (IM-U)
Jason Roberts	JR	Executive Nursing Director (END)

Item No	Agenda Item	Action
FPC 23/09/001	**Welcome & Introduction** The Committee Chair (CC) welcomed everyone to the meeting.	
FPC 23/09/002	**Apologies for Absence** Apologies for Absence were noted. **The Finance and Performance Committee resolved that:** a) Apologies for Absence were noted.	
FPC 23/09/003	**Declarations of Interest** No Declarations of Interest were noted.	
FPC 23/09/004	**Minutes of the Finance and Performance Meeting held on 23 August 2023** The minutes of the meeting held on 23 August 2023 were received. **The Finance Committee resolved that:** a) The minutes of the Finance and Performance Committee meeting held on 23 August 2023, were held as a true and accurate record of the meeting.	

FPC 23/09/005	**Action Log following the Finance and Performance Committee meeting on 19 July 2023** The Action Log was received. **The Finance and Performance Committee resolved that:** a) The Action Log for the Finance and Performance Committee was noted.	
FPC 23/09/006	**Chairs Action since previous meeting** There had been no Chair's Actions taken since the last meeting.	
	Items for Review and Assurance	
FPC 23/09/007	**Financial Report – Month 5** The Deputy Director of Finance for Strategy (DDFS) presented the Financial Report – month 5 and highlighted the following: - They had an overspend of £42.827m; - This comprised of £4.667m unidentified savings, £1.327m of operational overspend, and the planned deficit of £36.833m (five twelfths of the annual planned deficit of £88.4m set out in the 2023/24 financial plan); - The Financial Plan approved by Board and submitted to Welsh Government (WG) was not accepted, but it was noted by WG. The components of the plan had resulted in a planned deficit of £88.4m; - They were on a trajectory currently above the £88.4m. The UHB Chair noted concern around the £5.994m gap, and highlighted that no clear timeframe had been identified. <u>Table 3 – Finance – Key Performance Indicator Dashboard at August 2023</u> It was highlighted that: - The KPIs were on red in terms of the planned deficit by the end of the financial year; - They anticipated they would remain within the capital resource limits; - Regarding the delivery of the recurrent £32m savings target – while the number of schemes identified had increased, the recurrence of some schemes was in doubt; - Their creditor compliance payments were at 97.47% at the end of August; - The UHB's working capital requirement would be discussed with WG in around November, following the finalisation of the draft plan at Q1; - They had a positive cash balance at present. The EDF suggested that it would be useful to incorporate the recurrent position into the savings section of the paper. <u>Financial Performance of Clinical Boards</u> The reasons for the change in the deficit were highlighted: - Clinical Boards were still dealing with the COVID footprint and pressures within Mental Health. However, some progress had been made within Mental Health; - WHSSC had decided not to follow the national Director of Finance Agreement around how the LTA performance would be treated, which had a £3m impact on the Health Board.	

COVID Expenditure

- They continued to receive financial support from WG for Health Protection, PPE, Long-COVID, Nosocomial, and Anti-Viral activities;
- They had forecasted £13m funding from WG, of which they relied on the full total due to uncertainty around the increased uptake of COVID around the UK, and the request from WG to use these monies for other initiatives (e.g. vaccination);
- Last year the Health Board had received more support from WG, and so it had been incorporated into the UHB's savings plans that they would continue to spend £34.2m on COVID local response measures. However, they had assessed that they would be at least £3m lower than the £34.2m, which would contribute to their savings programme.

The IM-F asked if there were any risks in this not being delivered. The DFFS provided reassurance that they were in a reasonably robust place to bank that.

Risks

The DFFS outlined the following risks:

- They could not get the three-year approved plan from WG due to their deficit position;
- They would breach their revenue funding limit;
- They were confident they could stay within their capital resource limits, despite the fairly limited capital resource allocation. This would be reviewed towards the year end;
- The big risk would be not delivering the 2023/24 savings programme, as the £88.4m target was contingent on the Health Board delivering a minimum of £32m savings;
- How their performance would operate within the one-year LTA framework. They had forecasted how the DoFs LTA agreement would work, and they had 5% leeway this year.

Savings Programme

It was highlighted that:

- In month 5 there had been an improvement in the number of green, amber and red savings against the £32m savings target;
- WG had asked organisations to identify 10%, 20% and 30% savings beyond their forecast plans – CAVUHB had identified a risk of non-achieved CRPs just to hit the £88.4m;
- They had to find another £16m of savings to safely achieve the £32m - this has had some momentum;
- £13.7m remained as red schemes, and they would need to focus on moving these schemes into green and amber.

The UHB Chair asked what progress was being made against other initiatives totalling the £16m, and explained that the Committee would need to be assured by seeing evidence of achievement in the form of a report.

The DFFS responded that actions had been taken, and that they were soon due to the progress materialised in the financial positions.

The UHB Vice Chair queried if CAVUHB were being unrealistic in achieving their savings targets compared to other Health Boards. The DFFS responded that there

	were risks, but that there was a genuine culture of commitment from the organisation. The IM-ICT asked if the Board had considered measures/precautions that they might have to take towards the end of the financial year if they did not hit the £88m. The EDF responded that their current plan was their best and focus was needed on delivering this. The COO added that the only other plan would be to stand down Planned Care, however it would require difficult conversations. The DDFS talked through the graphs in the report which illustrated the progress made on the savings schemes throughout the year. Regarding the Total Variance Forecast, they forecasted that if the planned schemes delivered, the reported deficit would peak at month 6 before turning the curve on a trajectory to hit the £88.4m planned deficit. <u>Cash Flow Forecast</u> The DFFS summarised that: - They would assess the movements in working capital later in the year; - They accounted for £11.5m in expenditure terms the previous year, which had been paid out in cash this year. At present, they would need approx. £100m from WG. The IM-F asked if there was a timeframe. The DFFS responded that this usually would be drawn down in the last month, but that they would firm this with WG in around November/December. The EDF explained that they were expecting to receive the cash, but that it was not without risk. She suggested bringing this back to the Finance Committee in the next few months for further clarity. <u>Public Sector Payment Compliance</u> – the DDFS confirmed that they were consistently above the target. <u>Capital</u> It was highlighted that: - Next month they would bring back a more detailed list of the capital schemes in the process with bids; - They have expended 17% of the capital resource limit to date – this would accelerate as the year went on; - They had £11m of discretionary capital and the balance of £18m for approved projects by WG - they were in line to spend within the resource limit. **The Finance and Performance Committee resolved that at Month 5:** a) The reported year to date overspends of £42.827m and the forecast deficit of £88.4m was noted; b) The financial impact of forecast COVID-19 costs which is assessed at £44.264m was noted; c) The month 5 operational overspend against the plan of £1.327m was noted; d) The progress against the savings target, with £36.481m (114%) of schemes identified at month 5 against the £32m target was noted.	
FPC 23/09/008	**Orthopaedics Waiting List Deep Dive**	

	It was highlighted that: - The graphs indicated that since April 2022, they had seen a change in their position. However, they had not gone as far as they would have liked, and teams were working towards moving this in the right direction of the ministerial ambitions (97% reduction in waiting lists by December 2023, and 99% reduction by March 2024); - New patient activity was at 100% of their pre-COVID activity levels; - Follow-up activity was at 67% due to elective inpatient activities only being at 57% of pre-COVID levels The COO added that the Major Trauma Centre (MTC) arrived in the middle of the pandemic which took some of their theatre capacity (particularly spinal capacity). The MDPC provided reassurance that the job planning exercise undertaken by the entire Orthopaedics Department was robust. The MDPC continued: - They had a high degree of confidence that the Orthopaedic component of the 97% organisational target would be met in December. The March target of 99% still needed further discussion on how to prioritise activity; - They had a process for reallocating theatre capacity, predominantly for spinal surgery. This was a decision being taken amongst Clinical Boards; - On a monthly basis, the Directorate Management team looked at the GIRFT and Audit Wales recommendations to track the actions which had been implemented. The MDPC provided a summary of the Rehabilitation Programme, which supported people at every stage on the MSK Osteoarthritis Knee (OAK) pathway and Orthopaedic surgical pathway: - There were a number of checkpoints along the pathway, including a number of community-based activities; - This work was linked to Keepingmewell.com strategy; - Living Well was the banner under which the teams work to give patients the best opportunity through education and access to community based-activities. They were undertaking a lot of evaluations under the Living Well programme, with CEDAR support; - Within the Living Well programme, there was a specific Prepare Well programme for Orthopaedics, with resources dedicated to the waiting list. They had undertaken a review which showed that they had 1104 patients on the orthopaedic waiting list go right the way through the programme, and there was a social return on investments (for every £1 spent gives them £2.86 on return). The COO stated that whilst the overall waiting list size for the Health Board was increasing, the Ortho waiting list was reducing. The UHB Vice Chair noted that more work could be done on social investments, e.g. how prehab has improved returns to work. He asked whether this work could be rolled out to other areas in the Health Board. The MDPC responded that this was already underway, and that the Optimisation Delivery Group were looking at how this work could be spread across other pathways within the organisation. He added that WG were adopting CAVUHB's charter on a national basis.	

	The MDPC highlighted confidence in the Orthopaedics validation of waiting lists due to a regular process and cycle of validation. He stated that he was undertaking investigations into the validation process in other pathways. **The Finance Committee noted that:** a) The current position of the Orthopaedic waiting list and the work both to reduce the waits and support patients was noted.	
FPC 23/09/009	**Interventional Radiology** The MDPC summarised that: - Within two interventional rooms in UHW, there was found to be significant corrosion on the machines. It was established that from March 2024, they would not have continued support from the suppliers in the maintenance of the machines; - Teams had undertaken work with WG who afforded the Health Board £7.2m specifically for this programme to go through the procurement process of replacing both machines; - There was a programme including meteorological testing to understand why the corrosion had happened – early indications suggested that it was a combination of humidity and cleaning processes, which had since been adjusted. They would ensure revised air handling and cleaning processes were in place in the future; - They had a full programme team to ensure they procured the right equipment going forward and that the right processes were in place. The Committee was requested to support the business case to proceed with the implementation of exchanging the machines, which would then go to Board for approval. **The Finance Committee noted that:** a) The Committee supported the proposal to replace the Biplane Interventional Neuroradiology Equipment.	
FPC 23/09/010	**Regional Integration Funds** The EDSP summarised that: - The report demonstrated how the funding had been allocated across all of the projects, and provided assurance that there was a mechanism in place to track the detail in terms of the £19m spend; - The Regional Partnership Board (RPB) had committed expenditure which would have given them an overspend this financial year – conversations had been had with the two statutory partners in the Local Authorities, where it was asked as an absolute minimum for there to be no overspend against it; - There was an expectation of the RPB to identify a contribution to the Finance Recovery Plan of £0.5m – to achieve this saving, £1m was required to be identified from the programme. They were nowhere near this in terms of current spend, and the implications of this needed to be understood; - For every area of investment, they had a good system of tracking outcomes – some schemes were not delivering the value of money expected, and so it would form part of the upcoming conversations; The IM-F asked how confident they were that they would not overspend. The EDSP responded that they were very confident that there would not be an overspend, however they were less confident that they would be able to identify	

	savings from their current programme of work in line with what has been identified in the current financial recovery plan as things currently stand. Difficult conversations around initiatives would be required. **The Finance Committee noted:** a) The information on the Q1 report; and b) The partner-wide financial review of the RIF.	
FPC 23/09/011	**Decarbonisation Update** The ESIM shared a presentation with the Committee which summarised the three papers for the Decarbonisation Update. The EDSP commented that: - Conversations had been ongoing to bring work from the decarbonisation and financial agendas closer together (e.g. around Procurement); - Shared Services were looking at whether things could be sourced more locally, and were analysing company's manufacturing processes. However, it was acknowledged that it would be hard to use emissions as criteria when there was a lack of competition. **The Finance Committee noted that**: a) The Committee noted the three reports.	
FPC 23/09/012	**Operational Performance Report** The COO presented the Operational Performance Report and highlighted the following: - Urgent care – they had expected difficulties due to changes being made to their real estate in mid-July. They had started to see an improvement - ambulance handover performances and 4hr performances were better than anticipated, however 12hr trolley waits continued to be of concern. They hoped to soon see the benefits of the moves; - Planned Care – they were on track to deliver the 104-week plan by December. They had around 350 patients waiting over 3 years, and they were in the process of producing an ambitious trajectory to clear this. Diagnostic waits had increased, but the Regional Diagnostic Hub had been approved and they were waiting for a mobile solution as an interim solution to be implemented by the end of Q3/4, which would supply significant additional capacity for diagnostics; - Cancer – performance was steady at 65%. The backlog had increased, partly due to endoscopy delays. Therefore, they should soon start to see a reduction in the time for endoscopy on the cancer pathways. - Risks – risks included the potential strike action, and the published rate card for consultants pay which had resulted in some specialties stating that they were not prepared to do additional work; - CAMHS –performance for treatment was poor (0 patients were treated within 28 days) due to a large amount of capacity being moved into assessment to clear the backlog. They had a plan to achieve 65% of CAMHS patients starting their treatment within 28 days by the end of March. Assurance was provided that assessments had started within 28 days, and that the median wait for treatment was 35 days; - Dental Activity - they had around 50% of new patients being seen, they had a plan to get to 90% by the end of March. The UHB Chair asked for some assurance around the volatility of the cancer pathway. The COO responded that there would always be a bit of movement, but	

	that he understood the reasons behind the numbers. He did not accept that there were validation issues. **The Finance and Performance Committee resolved:** **a)** The Committee noted the year to date position against key organisational performance indicators for 2023-24 and the update against the Operational Plan programmes.	
FPC 23/09/013	**Winter Plan** The COO summarised that: - The plan worked in the currency of beds; - They hoped to use more of the money recurrently, and for a more programmed approach to Business As Usual (BAU) in the winter; - They needed to get to a position where they close capacity in the summer, and reopen in the winter; - Whilst there was a bit more physical capacity than the previous year, initiatives and programmes around efficiencies had started to be embedded which had helped to close the bed gap from around 150 to 90 beds; - Length of stay was not where it should be - the general rule of thumb should be that no more than 20% of the bed base should be occupied by patients waiting over 21 days (CAVUHB was around 32%), and no more than 40% of the bed base should be occupied by patients waiting over 7 days (CAVUHB was around 56%); - They had an opportunity to use money more recurrently with the space they created in the Emergency Units by moving out the assessment units, to put in place a Clinical Decision Unit. There were also plans with the Health Inclusion Service (CAVHIS), which would be brought to Board in November for an update; - If only 80% of the plan was delivered, then they should still be in a reasonably good position. The IM-F clarified that the £1.5m was in budget for this year. The EDF asked if they did not shut down the extra winter acute beds in the summer, whether this would stretch the £1.5m. The COO responded that the risk would lie with himself and the Ops team to deliver the plan, and that they needed to bring a more detailed benefits plan to the Investment Group to secure the investment. The COO noted that he had informed the EU that if they did not see the benefits of some of the programmes, some of the schemes could be reversed. **Action** – CP to take the benefits realisation piece through the Investment Group to decide as part of the Annual Plan. **The Finance and Performance Committee resolved that:** a) The Committee noted the UHB Winter Plan 23/24; b) The Committee recommended a revised approach to seasonal planning, including the recurrent allocation of the £1.5m winter reserve, to be taken to Board.	
	Items for Approval/Ratification	
FPC 23/09/014	**Interventional Radiology Case** This item was discussed during the Items for Review and Assurance section of the meeting, with the Item No: **FPC - 23/09/009**	

	The Finance and Performance Committee resolved that: a) The Committee noted the extract from the UHBs Monthly Financial Monitoring Return.	
	Items for Information and Noting	
FPC 23/09/015	**Monthly Monitoring Returns – Month 5** The Month 5 Monitoring Returns were received. **The Finance and Performance Committee resolved that:** a) The Committee noted the extract from the UHBs Monthly Financial Monitoring Return.	
FPC 23/09/016	**Any Other Business** No Other Business was discussed.	
	Review and Final Closure	
FPC 23/09/017	**Items to be referred to Board / Committee** **Action** – The UHB Chair asked if more time could be spent at Board on this item.	
	Date & time of next Meeting Wednesday 18th October 2023 at 2pm via MS Teams	

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

Confirmed Minutes of the Public People and Culture Committee
Held On 12th September 2023
Via MS Teams

Chair:		
Sara Moseley	SM	Independent Member for Third Sector/Committee Chair
Present:		
Rhian Thomas	RT	Independent Member for Capital & Estates
Susan Elsmore	SE	Independent Member for Local Authority
Akmal Hanuk	AH	Independent Member for Community (IM-C)
In Attendance:		
Matt Phillips	MP	Director of Corporate Governance
Fiona Kinghorn	FK	Executive Director of Public Health
Lianne Morse	LM	Deputy Director of People & Culture
David Thomas	DT	Director of Digital and Health Intelligence
Adam Wright	AW	Head of Service Planning
Richard Skone	RS	Deputy Executive Medical Director
Robert Warren	RW	Head of Health and Safety
Fiona Jenkins	FJ	Executive Director of Therapies
Joanne Brandon	JB	Director of Communications
Suzanne Rankin	SR	Chief Executive Officer
Jason Roberts	JR	Executive Nursing Director
Tara Rees	TR	Specialist Nurse Hepatology
Louise Platt	LP	Director of Operations - Medicine
Jane Murphy	JM	Director of Nursing - Medicine
Alun Tomkinson	AT	
Claire Whiles	CW	Assistant Director of Organisational Development, Wellbeing and Culture.
Marie Davies	MD	Assistant Director of Strategic Planning
Geoff Walsh	GW	Director of Capital Estates and Facilities (DCEF)
Donna Davies	DD	Head of People and Culture
Secretariat		
Nathan Saunders	NS	Senior Corporate Governance Officer
Rachel Chilcott	RC	Corporate Governance Officer
Apologies:		
Paul Bostock	PB	Chief Operating Officer
Rachel Gidman	RG	Executive Director of People & Culture
Mike Jones	MJ	Independent Member for Trade Union

Item No	Agenda Item	Action
P&C 11/9/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the meeting.	
P&C 11/9/002	**Apologies for Absence** Apologies for absence were noted.	
P&C 11/9/003	**Declarations of Interest**	

	No Declarations of Interest were noted.	
P&C 11/9/004	**Minutes from meeting on 16th May 2023** The Minutes were received. 3 changes were identified which included: • The Executive Director of Public Health commented that on page 5 of the minutes, the sentence needed to be changed to "the population was becoming more ethnically diverse". • It was confirmed that it was the HEIW that was developing the observatory, not the HSWPH (page 5). • There was an action around benchmarking on page 5 for the Key Performance Indicators (KPIs) which should be captured – around developing the benchmarking in a way that created an equivalent. **The Committee resolved that:** a) The draft minutes of the meeting held on 16th May 2023, were held to be a true and accurate record of the meeting, subject to the amendments.	
P&C 11/9/005	**Action Log following 16th May 2023 Meeting** The Action Log was received. **The Committee resolved that:** a) The Action Log was discussed and noted.	
P&C 11/9/006	**Chair's Actions** There were no Chair's Actions.	
	Items for Review & Assurance	
P&C 11/9/007	**Staff Story (RCN Nurse of the Year Award)** The RCN Nurse of the Year 2022 Advanced and Clinical Practice Staff Story was presented to the Committee. The EDPH explained the connection between this work and the viral hepatitis and Move More Eat Well Plan, and that these connections with fatty liver disease was not often made. She highlighted that they all had a role in role modelling and encouraging teams to take actions. She added that regarding alcohol, Public Health undertook a lot of training within the community and were undertaking an Internal	

	Audit to investigate if they were doing things right in the Emergency Unit. From a people and culture perspective, the Independent Member – Community (IMC) asked what were the constraints in promoting this kind of innovation and positivity. The Specialist Nurse Hepatology (SNH) responded that from a service delivery point of view, they strove towards preventing hospital bed stays. She acknowledged that staff retention was harder on wards with the current staff shortages, but highlighted that it was important to praise and listen to staff. She added that investment in staff would incentivise them to stay, and that there were a lot of resources in-house which could provide further opportunities for staff. The EDTHS asked the SNH what her next steps were to maximise the award she had received. The SNH explained that because her patient groups were very underrepresented, she would continue to shine a light on liver disease as the three main causes of liver disease were preventable. The Committee Chair highlighted that plans around Value Based Appraisals (VBAs) could feed into this work and was a good example to encourage uptake amongst staff. She added that training and development would make sense financially. **Action** – the END and DEMD to think about how this work would link in with attracting, retaining and developing their professional workforce. **The Committee resolved that:** a) The Staff Story was received.	
P&C 11/9/008	**Health and Safety Update** <u>Health and Safety Sub-Committee Chairs Report</u> The HHS highlighted that: - There had been a general increase in training compliance almost month on month; - There was a slight drop off in training compliance for Module D in the Violence & Aggression Module, potentially due to Mental Health having trouble with ESR; - Smoking continued to be an issue – there was to be an extended push on holding people to account on-site; - There had been a small fire which had been escalated and dealt with very quickly;	

- Serious Incident review – the DCEF's team undertook a review which related to a waste bin falling off the back of a delivery lorry and struck an employee. Actions were taken and operational processes were implemented to mitigate the risk.

The Committee Chair asked how to ensure visibility around the Capital, Estates & Facilities Risk Register from an assurance point of view.

The DCEF responded that:

- This work was presented to the Health & Safety Committee regularly;
- A few years ago, due to the amount of risks Estates had, they were asked to only report those risks that were rated 20+. As a result, those in the 15-18 bracket had come into fruition over the previous months;
- A lot of risks related to entire systems and large infrastructures, and so they were beginning to review and risk assess each component part;
- They had experienced significantly more major breakdowns in the previous 12-18 months;
- There was not money to invest and remove risks from the risk register, and therefore the risk would only increase – this was becoming a serious issue for the Health Board;
- They had received funding for some of the key issues this year, both from EFAB schemes from WG and from the Capital Management Group.

The CC asked the DCEF if the Health Board were concerned about RAAC.

The DCEF responded that they had undertaken surveys over the previous 9-12 months, and a report would be received by the Board in September 2023. He stated that the Health Board did not have any significant issues with RAAC.

<u>Health and Safety Risks</u>

The IM-LA asked how much staff behaviours were responsible for the risks not being attended to.

The DCEF stated that staff behaviours had contributed significantly. He explained that his waste team had been asked to clean out the tunnels, which was outside of their normal job duties. The DCEF added that there was no excuse for wastage in tunnels, as the Health Board offered a waste collection service.

The HHS noted that they were managing the risks, but that it was not sustainable. He added that they had the Tunnel Safety Group back up and running, and they had started to co-opt clinical staff.

	Action – the HHS to bring an update back to the meeting on why people were not using the waste collection service. <u>Capital, Estates and Facilities – Estates Risk Register</u> The IM-LA asked what their position was around escalating the 15-20 rated risks. The DCEF responded that he and the HHS would review all of their risks and then discuss with the DCG on how this would be presented to Board. The IM-CE asked whether the release of the £6m funding would help with those risks in the 15-20 risk category, and if the release of this funding reflected a greater awareness or urgency from WG. The DCEF responded that the EFAB scheme had tried to address some of the infrastructure issues, as there had been no ringfenced money from WG. However, this money would only scratch the surface. He added that there did not always seem to be appropriate planning with WG to resolve these issues. The IM-C asked whether this Committee could escalate these issues to Board, who could then raise it with WG. The DCEF explained that the Health Board were doing the most they could with the current resources they had, and that the issues had been recognised at Board and M.E. level. He stated that WG were aware of the problems, as the Chief Executive, Chair and the University had recently written to Judith Paget. The CEO added that Welsh Government WG were very aware of the challenges faced by the Health Board and the Board should be extremely concerned following a detailed report received at its Board Development session in August 2023. It was noted that a partnership letter had been sent to WG from the Health Board and signed by herself, the Chair and the Vice Chancellor of the University which outlined the risks identified by Capital, Estates & Facilities (CEF) in relation to the estate infrastructure. A limited response was received from WG which outlined that they were aware of those risks. The CEO concluded that the estate infrastructure was a significant risk for the Health Board which required continued and substantial investment. The CC concluded that the Board would need to be sighted on the range of risks received by the Committee.	**RW**

	The Committee resolved that: a) The content of the Health and Safety Sub-Committee Chairs Report was noted. b) It was noted that the highest risk Health and Safety issues across the Health Board would feed into the People and Culture meeting. c) The work undertaken by the CEF Service Board to identify, manage and mitigate where possible the risks associated with the estate infrastructure was noted d) The progress made to address a number of the most severe and disruptive risks whilst recognising the good work undertaken within a limited funding envelop was noted.	
P&C 11/9/009	**Board Assurance Framework Report** The Board Assurance Framework Report was received. **The Committee resolved that:** a) The risks in relation to Sustainable Culture Change were received. b) Comments would be provided to the Executive Director to be addressed prior to Board consideration on 28 September 2023.	
P&C 11/9/010	**Introducing a consistent, evidence-based approach to Cultural Assessments at Cardiff and Vale UHB.** The item was removed from the agenda and deferred to the next Committee meeting. **The Committee resolved that:** a) The item was deferred to the next Committee meeting.	
P&C 11/9/011	**Key Workforce Performance Indicators** The Key Workforce Performance Indicators were received. The Deputy Director of People & Culture (DDPC) advised the Board that the position had improved which was a position described month on month. She added that hard work and focus undertaken by the Clinical Boards had led to those improvements.	

	It was noted that the sickness absence rate for July 2023 was identified at 4.97% but the DDPC advised the Committee that the true number was 6.12%. The DDPC presented the Workforce Sustainability Programme to the Committee which outlined 5 key points which included: • The Cardiff and Vale People and Culture Plan described the need to build a sustainable and affordable workforce. • The plan had been accelerated to support financial sustainability whilst also ensuring quality & safety was not negatively impacted. • A cost reduction programme had been implemented which included £8m from the original plan of schemes identified, £15m additional high value schemes and the additional 10% WG target. • A scheme of delegation had been introduced for the escalation and approval of agency, overtime and bank for all staff groups. • There was an enhanced scrutiny of vacancy approval at Clinical Board and Corporate levels with front line replacement posts below a band 7, not being impacted. A list of current schemes identified were presented to the Committee and included a number of areas such as: • Nursing - Healthcare Support Worker agency had ceased • Capital and Estates - Agency work had ceased • Administration and Management - Overtime and bank had ceased • Medical and Dental - inappropriate use of WLI payments were ceased. - Agency and bank usage had been decreased. The EDPH asked for the staff flu vaccination uptake to be included in the next set of KPIs. **The Committee resolved that:** a) The contents of the report were noted.	**LM**
P&C 11/9/012	**Clinical Board Spotlight**	

	The Medicine Clinical Board Spotlight was received. The Director of Operations – Medicine (DOM) advised the Committee that the Medicine Clinical Board (MCB) had been asked to talk through how it could triangulate data provided by the People & Culture team to look at what required focus. She added that 2 areas where identified for discussion which included: • Sickness • Values Based Appraisals It was noted that in December 2022, the MCB Senior Management Team (SMT) had identified that sickness levels were too high and so actions were taken to help reduce sickness such as: • Implementation of a monthly Sickness Panel where the SMT would meet with lead nurses and general managers to allow them to talk through individual members of staff where specific and guided support was required as well as discussion around short term sickness data. • Commissioning of Audit Work for community hospitals. • Training for staff The Committee was presented with long-term and short-term sickness data for the MCB which showed a reducing trajectory which was pleasing to note. Data for each directorate was presented which also showed reducing trajectories in each area: • Emergency and Acute Medicine • Integrated Medicine • Specialised Medicine The Director of Nursing – Medicine (DONM) presented the Committee with the costs that sickness had created for the MCB for the year 2021-2022 which totalled £405,561 compared to 2022-2023 where the total had decreased to £176,439. In relation to Values Based Appraisals (VBA), the Committee were presented with the data around how many had been completed in 2023 and an upwards trajectory was observed culminating in 66.27% being obtained in July 2023. The CC thanked the DONM and DOM and asked that the thanks of the Committee be fed back to the MCB.	

	The CEO asked that the data be presented to other Clinical Boards to help inspire them with the upwards trajectories shown by the MCB. The Executive Nurse Director (END) advised the Committee that there was a risk within the MCB when ward sisters were being asked to step away from the operational side of running the wards to step into the clinical nursing elements and noted that a conversation was required with the Directors of Nursing around supervisory time. The CC added that it was a crucial action to follow up on. **The Committee resolved that:** a) The Medicine Clinical Board Spotlight was noted.	
P&C 11/9/013	**Staff Communications Plan** The Staff Communications Plan was received. The Director of Communications (DC) provided the Committee with verbal update on the staff communications plan which included areas such as: • Shaping Our Future Wellbeing • Financial Stability • Winter Wellbeing Plans • Recruitment and Retention Roadshows • Staff Benefits aligned to the cost of living work across the whole Organisation. The DC added that there was an alignment of strategic communication activity across the Health Board which linked in with reactive and operational communications. The DC presented the Committee with a number of channels used to provide communication to staff which included: • SharePoint • E-mails • Screensavers • CAVConnect • Ask Suzanne Meetings **Action -** The CC asked that the analytics and business intelligence side of the data around staff engagement could be received by the Committee at a future meeting **The Committee resolved to:** a) The verbal update was noted.	**JB**

P&C 11/9/014	**All Wales Staff Survey** The All Wales Staff Survey was received. The Assistant Director of Organisational Development, Wellbeing and Culture (ADODWC) advised the Committee of updates to the All Wales Staff Survey which included: • HEIW had scoped and designed the survey • A thorough communication and engagement plan had been devised • Site visits would be undertaken when the Staff Survey went live It was noted that the Health Board response rates had declined since 2016, as had the overall engagement score and so a target of 30% had been set by HEIW. The ADODWC advised the Committee that a working group had been established to effectively manage engagement and communication of the Staff Survey within the Health Board and noted that the group would compose and position information about the survey to colleagues across the Health Board whilst emphasising the importance of completion. **The Committee resolved to:** a) The actions being taken were noted. b) The communication and engagement of the NHS Wales Staff Survey within CAVUHB was supported and Members of the People and Culture Committee were asked to commit to championing and encouraging engagement at a local level and to lead the communication of results and development of local action plans following receipt of the analysis in December 2023.	
	Items for Approval / Ratification	
P&C 11/9/015	**Welsh Language Annual Report** The Welsh Language Annual Report was received. The ADODWC advised the Committee that standard 120 of the Welsh Language Standards required the Health Board to publish an annual report to provide an overview of organisational activity around the Welsh language, including compliance with the Standards.	

	She added that a number of areas had been identified within the report for the Committee to receive which included: • Governance and structure • Activities under the 'Meddwl Cymraeg / Think Welsh' Campaign • Provision of bilingual information for patients and the public • Compliance with the Service Delivery Standards • Recruitment of Welsh language skills • Translation services • Concerns raised • Welsh language skill profile of staff It was noted that there had been excellent progress made over the past year in raising the profile of the Welsh language throughout the Health Board. However, it was noted that improvements were needed, as data indicated: • A low number of staff were recruited to the organisation with Welsh language skills identified as essential. • A low number of staff were registering their Welsh Language skills through Electronic Staff Records. The ADODWC advised the Committee that the Health Board was establishing a task and finish group to improve process around recruiting people with Welsh language skills and were running a campaign to increase the registration of Welsh language skills. The CEO advised the Committee that a number of Welsh Language Enforcement notices had been received by the Welsh Commissioner which held a large risk to the Health Board and so work would be required to mitigate the risk. **The Committee resolved to:** a) The report for publication on the Health Board's website was approved.	
P&C 11/9/016	**Policies for Approval** 2 Policies were received for approval: i) Waiting List Initiative Procedure Medical and Dental Staff ii) Industrial Action (All Wales) Guidelines **The Committee resolved that:** a) The Waiting List Initiative Procedure Medical and Dental Staff was approved. b) The Industrial Action (All Wales) Guidelines were approved.	

	Items for Information & Noting	
P&C 11/9/017	**Corporate Risk Register** The Corporate Risk Register was received. **The Committee resolved that:** a) The Corporate Risk Register risk entries linked to the People and Culture Committee and the Risk Management development work which was now progressing with Clinical Boards and Corporate Directorates was noted.	
P&C 11/9/018	**Equality Impact Assessments: More than a Tick Box Exercise Management Response** The Equality Impact Assessments: More than a Tick Box Exercise Management Response were received. The EDPH commented that some time ago, the Health Board adapted its approach to change the title of the assessments from "Equality Impact Assessments" to "Equality *and* Health Impact Assessments". She added that it was a key part of the national framework. **The Committee resolved that:** a) The Equality Impact Assessments: More than a Tick Box Exercise Management Response was noted.	
P&C 11/9/019	**Any Other Business**	
	The CEO noted that the potential for further Industrial Action was always a risk and so plans and discussion should be brought back for future conversation.	**RG**
	Private Agenda Items	
	i) Private Minutes from the previous meeting – 11 July 2023 *ii) Fire Prosecution Update – Verbal (exempt from publication due to confidential nature of legal case)*	
P&C 11/9/020	**Review & Final Closure**	
P&C 11/9/021	Items to be deferred to Board/Committees	
	Date & time of the next meeting: Tuesday 14 November 2023 at 9am via MS Teams	

Confirmed Minutes of the Public Digital & Health Intelligence Committee Meeting
Held On 15 August 2023 at 9 am
Via MS Teams

Chair:		
David Edwards	DE	Independent Member - Digital
Present:		
Akmal Hanuk	AH	Independent Member – Community
Michael Imperato	MI	Independent Member - Legal
In Attendance:		
Matt Phillips	MP	Director of Corporate Governance
Angela Parratt	AP	Director of Digital Transformation
Thomas Bott	TB	Digital Implementation Officer
David Thomas	DT	Director of Digital & Health Intelligence
James Webb	JW	Information Governance Manager
Bruce Johnson	BH	IT Project Manager
Suzanne Rankin	SR	Chief Executive Officer
Mark Cahalane	MC	Head of Digital Services Management
Observers:		
Adam Partlow	AP	Rehabilitation Engineering
Secretariat		
Sarah Mohamed	SM	Corporate Governance Officer
Apologies:		
Keith Harding	KH	Independent Member - University

Item No	Agenda Item	Action
DHIC 15/08/001	**Welcome & Introduction** The Committee Chair (CC) welcomed everyone to the Public meeting and confirmed the meeting was quorate.	
DHIC 15/08/002	**Apologies for Absence** Apologies for absences were noted. **The Committee resolved that:** a) The apologies were noted.	
DHIC 15/08/003	**Declarations of Interest** **The Committee resolved that:** a) No Declaration of Interest were noted.	
DHIC 15/08/004	**Minutes of the Meeting Held 30 May 2023** **The Committee Resolved that:**	

	a) The Minutes of the Meeting held on the 30 May 2023 were confirmed as a true and accurate record.	
DHIC 15/08/005	**Action Log – Following the Meeting held on 30 May 2023** The Action Log was received. **The Committee Resolved that:** a) The Action Log was discussed and noted.	
DHIC 15/08/006	**Chair's Action taken since the Committee Meeting held on 30 May 2023** **The Committee Resolved that:** a) There were no Chair's Action.	
	Items for Review and Assurance	
DHIC 15/08/007	**Digital Transformation Progress Report** The Digital Transformation Progress Report was presented and the following was highlighted: <u>2023/24 IMTP</u> • The emphasis was on national Welsh Government (WG) programmes with the exception of common demographics store. • As reported to DHIC in May 2023, the common demographics store would need to come from within existing resources unless an investment case was successful. However, day to day and operation requests prohibited this at the moment. • The main constraint in the pace of delivery was limited resource availability, which was diverted to meeting organisational priorities and operational needs. • Mitigations were established recently which included the following: - Setting up a Digital Advisory Board - Setting up a Project Management Office - Having the Digital Front Door. <u>Shaping our Future Digital Services</u>	

	• The teams have now held over 60 gathering intelligence conversations with colleagues in other organisations undergoing similar programmes to Shaping our Future Hospitals and Shaping our Future Clinical Services as well as the National Hospital Programme in England. • A workshop took place with a mixture of clinical, nursing, AHP, clinical scientist, innovation and operational colleagues. • The National Hospitals Programme in England and Leeds Teaching Hospitals NHS Trust who had undergone a similar journey in regards to new hospital build, transforming clinical and digital services attended on the day. <u>New Digital & Health Intelligence Structure</u> • A presentation on the Digital Services Management Structure was presented to the Committee. • For an extensive period, there was a gap between digital delivery and the customer base. • The Digital Service Management department embedded digital co-ordinators into clinical boards to help reduce the gap. **The Committee Resolved that:** a) The progress report was reviewed. b) The proposed Governance model was commented on.	
DHIC 15/08/008	**Joint IMT & IG Corporate Risk Register** The Joint IIMT and IG Corporate Risk Register Paper was presented and the following was highlighted: • There were 14 risks identified in the directorates risk register. • The highest risk was cyber security. This would be discussed in the private session. • The remaining risks were scored between 7 and 12. • Two risks were moved from amber to yellow. This included non-compliance with data protection legislation and governance framework. • The DDHI proposed that the effective resource utilisation risk was reduced due to the Digital Advisory Board being set up to support where resources could be spent.	

	The Committee Resolved that: a) Progress and updates to the Risk Register report were reviewed and noted.	
DHIC 15/08/009	**IG Data & Compliance (Sis, Data Protection, GDPR, FOI, SARs, Staffing & Mandatory Training)** The IG Data & Compliance Report was presented and the following was highlighted: • Between May 2023 and June 2023, the Information Governance Department had reviewed a total of 112 information governance related incidents reported via Datix. • Of these breaches reviewed, two breaches met the threshold to be reported to the Information Commissioner's Office (ICO). • A third breach had been reported to the ICO since that period. • Details of the breaches would be outlined in the private meeting of this committee. • In response to the breach in Ireland by a FOI disclosure, the team had reviewed all disclosure logs since 2020. • The average number of FOIs received during the last 12 months had increased marginally to 53 requests per month and the average compliance had slightly dropped to 84%. • There had been a steady drop in compliance in health records requests since February 2023. The total number of monthly requests remained high. The average compliance over the last rolling 12 months was 63%. • A total of 17 subject access requests submitted for non-health records were received from April 2023 to May 2023. 16 requests (94%) were complied with, within the legislated timeframe. • Since January 2022, the Health Board had sent out a total of 750 letters to staff who had been identified by the National Intelligent Integrated Audit Solution (NIIAS), based on a process approved by Management Executive. • The Health Boards Information Governance training compliance was currently 74%. This represented a further 2% increase in overall completeness since figures were last provided to the Committee. The CEO advised that human errors did happen especially under pressure. However, the same importance needed to be given as drug rounds as this hugely impacted patient safety.	

	The Committee Resolved that: a) A series of updates relating to significant Information Governance issues was received and noted.	
DHIC 15/08/010	**Digital Services Key Performance Indicators** The Digital Services Key Performance Indicators Report was presented and the following was highlighted: • The Digital and Health Intelligence team were looking to report on KPIs for activity in the following workstreams: - Service Requests – Requests for information or advice and assistance, as well as general requests. - Incidents – Notifications of failures of systems or equipment. - Change Requests – Requests for an adjustment to an existing specialist system, primarily used for PARIS and other clinical systems. • A gateway was required. However, this was managed by DHCW. Discussions were taking place to develop a SOP to open that gateway. • The administrative portal was presented to the Committee. It was noted that the team were looking to provide an online reporting service for management colleagues using Power-BI. Appendix 1 showed the Workflow reporting for Digital & Health Intelligence through Ivanti. The latest live data pulled from the Ivanti system was presented to the Committee. The CC requested an update on how the KPI statistics were starting to make a difference to the Health Board. **The Committee Resolved that:** a) The progress made since the last update on the Ivanti service desk tool in relation to KPIs was reviewed and noted.	**RK**
DHIC 15/08/011	**Framework Policies, Procedures & Controls** The Framework Policies, Procedures & Controls Paper was presented and the following was highlighted: • A number of policies and procedure documents were out of date and needed to be reviewed and updated.	

	• Since the last meeting in May 2023, the following procedures and policy documents had been reviewed which included - Records Management Policy (UHB 142) - Records Management Procedure (UHB 326) - Information Governance Transportation of Case Notes and Personal Identifiable Information (PII) Procedure (UHB 262). **The Committee Resolved that:** a) The progress made in updating the priority policy and procedure documents was noted.	
	Items for Approval / Ratification	
DHIC 15/08/012	**Policies** *i. Records Management Policy (UHB 142)* *ii. Records Management Procedure (UHB 326)* **The Committee Resolved that:** a) The records management policy and supporting procedure document were approved.	
	Items for Noting and Information	
DHIC 15/08/013	**Minutes: Digital Directors Peer Group** The following Minutes were received by the Committee: **The Committee Resolved that:** a) The Minutes of the Digital Directors Peer Group of the meetings held on 6 June 2023 and 4 July 2023 were received and noted.	
DHIC 15/08/014	**Agenda for Private Digital & Health Intelligence Meeting**	
	(i) Minutes from the Private DHIC Meeting held on 30 May 2023 *(ii)* Digital Budget and Investment and Digital Strategy Case for Investment (confidential paper) *(iii) Caldicott Guardian Requirements (Confidential paper – contains personal data)* *(iv) Cyber Report including: Performance Measures (confidential paper)*	
DHIC 15/08/015	**Any Other Business** No Other Business was discussed.	

DHIC 15/08/016	**Items to bring to the attention of the Board / Committee** No Items were brought to the attention of the Board / Committee.	
	Date & Time of next Meeting: Tuesday 3rd October 2023 at 9am via MS Teams	