

Health Board Meeting

Thu 27 May 2021, 10:00 - 13:00

Virtually via Microsoft Teams

Agenda

10:00 - 10:00

0 min

1. Preliminary Matters

Information Marcus Longley

1.1. Welcome and Introductions

Information Marcus Longley

1.2. Apologies for Absence

Information Marcus Longley

1.3. Declarations of Interest

Information Marcus Longley

1.4. SHARED LISTENING & LEARNING - STAFF AND PATIENT STORY COVID CHALLENGES AND OPPORTUNITIES

Discussion Gareth Robinson

10:00 - 10:00

0 min

2. CONSENT AGENDA

2.1. FOR APPROVAL

2.1.1. Unconfirmed Minutes from the meeting held on 25 March 2021

Decision Marcus Longley

-  2.1.1a Unconfirmed Minutes Health Board Meeting 25 March 2021 Final UHB 27 May 2021.pdf (13 pages)
-  2.1.1b Cofnodion Heb Eu Cadarnhau o Gyfarfod y Bwrdd Iechyd Unconfirmed Minutes Health Board Meeting 25 March 2021 Final-en-cy-C.pdf (14 pages)

2.1.2. Unconfirmed Minutes from the In Committee meeting held on 25 March 2021

Decision Marcus Longley

-  2.1.2a Unconfirmed IC HB Minutes 25.3.21 for public meeting Final UHB 27 May 2021.pdf (2 pages)
-  2.1.2b Cofnodion y Cyfarfod a Gynhaliwyd yn Breifat Unconfirmed IC HB Minutes 25.3.21.pdf (3 pages)

2.1.3.

Chairs Report and Affixing of the Common Seal

Decision *Marcus Longley*

 2.1.3 Chair's Report UHB May 2021 GG.pdf (6 pages)

2.1.4.

Mental Health Act Committee Annual Report

Decision *Maria Thomas*

 2.1.4a MHAMC Annual Report 2020 2021 Cover Report UHB 27 May 2021.pdf (3 pages)

 2.1.4b Appendix 1 MHAMC Annual Report 2020-2021 UHB 27 May 2021.pdf (8 pages)

2.1.5.

Quality & Safety Committee Annual Report

Decision *Jayne Sadgrove*

 2.1.5a Quality and Safety Committee Annual Report UHB 27 May 2021.pdf (3 pages)

 2.1.5b Appendix 1 Quality Safety Committee Annual Report 2020 2021 UHB 27 May 2021.pdf (11 pages)

2.1.6.

Review of the Model Standing Orders and SFI's

Decision *Cally Hamblyn*

 2.1.6a Amendment to Standing Orders - Revised Model Issued April 2021.pdf (5 pages)

 2.1.6b Appendix 1. Draft May 2021 -GC01 Standing Orders (Main Document).pdf (51 pages)

 2.1.6c Appendix 2. Draft May 2021 - GC01 Standing Orders - Schedule 1.0 - Scheme Reservation and Delegation of Powers V2.pdf (20 pages)

 2.1.6d Appendix 3. Draft May 2021 - GC01 Standing Orders - Schedule 2.0 pdf (1 pages)

 2.1.6e Appendix 4. Draft May 2021 - GC01 Standing Orders - Schedule 5.0 pdf (1 pages)

 2.1.6f Appendix 5. Draft May 2021 - GC01 Standing Orders - Schedule 5.2 pdf (7 pages)

2.1.7.

Budget Setting Arrangements for 2021/2022

Decision *Steve Webster*

 2.1.7 Budget Setting Arrangements for 21-22 UHB 27 May 2021.pdf (12 pages)

2.2.

FOR NOTING

2.2.1.

Action Log

Information *Marcus Longley*

 2.2.1 Action Log UHB 27 May 2021.pdf (5 pages)

2.2.2.

Chief Executives Report

Information *Paul Mears*

 2.2.2 CEO Update Report May 21 UHB 27 May 2021.pdf (6 pages)

2.2.3.

Population Health & Partnerships Committee Highlight Report 7 April 2021

Information *Philip White*

 2.2.3 Highlight Report - PH & P Cmt April 2021 UHB 27 May 2021.pdf (3 pages)

2.2.4.

Audit & Risk Committee Highlight Report 13 April 2021

Information Patsy Roseblade

 2.2.4 Audit Risk Committee Highlight Report UHB 27 May 2021.pdf (4 pages)

2.2.5.

People & Culture Committee Highlight Report 26 April 2021

Information Jayne Sadgrove

 2.2.5 People and Culture Committee Highlight Report UHB 27 May 2021.pdf (3 pages)

2.2.6.

Planning, Performance & Finance Committee Highlight Report 27 April 2021

Information mel jehu

 2.2.6 PPFC 27 April 2021 Highlight Report UHB 27 May 2021.pdf (3 pages)

2.2.7.

Mental Health Act Monitoring Committee Highlight Report 5 May 2021

Information Maria Thomas

 2.2.7 MHAMC Highlight Report 5.5.21 UHB 27 May 2021 v2.pdf (4 pages)

2.2.8.

Quality & Safety Committee Highlight Report 18 May 2021

Information Jayne Sadgrove

 2.2.8 QSC Committee Highlight Report UHB 27 May 2021.pdf (4 pages)

2.2.9.

Remuneration and Terms of Services Committee Highlight Report

Information Marcus Longley

 2.2.9a Remuneration Cmt Highlight Report 22.3.21 UHB 27 May 2021.pdf (2 pages)

 2.2.9b Remuneration Committee Highlight Report 20.4.21 UHB 27 May 2021.pdf (2 pages)

2.2.10.

Joint Committee Reports

Information Cally Hamblyn

 2.2.10a Confirmed minutes EASC 10 Nov 2020 EASC 9 March 2021 UHB 27 May 2021.pdf (12 pages)

 2.2.10b SSPC Assurance Report 18 March 2021 UHB 27 May 2021.pdf (3 pages)

 2.2.10c Joint Committee Briefing UHB 27 May 2021.pdf (3 pages)

2.2.11.

Annual Report for the Research Innovation and Improvement Hub

Information Kelechi Nnoaham

 2.2.11a RIIC Hub Annual Report_270521_cover paper UHB 27 May 2021.pdf (3 pages)

 2.2.11b CTM RIIC HUB ANNUAL REPORT UHB 27 May 2021.pdf (16 pages)

 2.2.11c Appendix 2 RIICHub_Work Programme_21-22forsign off_FINAL UHB 27 May 2021.pdf (5 pages)

2.2.12.

Carers Annual Report

Information Clare Williams

 2.2.12a Carers end of year Progres Report UHB 27 May 2021.pdf (5 pages)

 2.2.12b 2020-21 Cwm Taf Morgannwg UHB End of Year Report v5 060521.pdf (11 pages)

2.2.13.

Strategy Development Update

Information

Paul Mears

 2.2.13 CEO Strategy Update UHB 27 May 2021.pdf (4 pages)

2.2.14.

All Wales Nurse Staffing Act (2016) Nurse Staffing Levels Three Yearly Assurance Report 2018-2021

Information

Greg Dix

 2.2.14a Nurse Staffing Three Yearly Report UHB 27 May 2021.pdf (6 pages)

 2.2.14b Appendix A Annual Assurance Report on compliance on the Nurse Staffing Levels (Wales) Act. (2019-2020) (1).pdf (12 pages)

 2.2.14b Appendix A1 Medical wards 2018-2019.pdf (2 pages)

 2.2.14b Appendix A2 Establishment Surgical Wards 2018-2019.pdf (2 pages)

 2.2.14b Appendix A3 Establishment surgical wards 2019-2020.pdf (3 pages)

 2.2.14b Appendix A4 Establishmets Medical Wards 2019-2020.pdf (5 pages)

 2.2.14b Appendix A5 Establishment medical Wards 2020-2021.pdf (4 pages)

 2.2.14b Appendix A6 Establishment Surgical wards 2020-2021.pdf (3 pages)

 2.2.14c Appendix B - Report Template for CTUHB 2018-2019.pdf (9 pages)

 2.2.14d Appendix C Annual Assurance Report on compliance on the Nurse Staffing Levels (Wales) Act. (2019-2020).pdf (12 pages)

 2.2.14e Appendix D - Annual Assurance report ctm 2020-2021.pdf (16 pages)

 2.2.14f Appendix E All Reasonable steps final Dec 2019.pdf (3 pages)

 2.2.14g Appendix F Final CTMUHB Operating Framework and escalation policy 2020.pdf (38 pages)

2.2.15.

All Wales Nurse Staffing Act (2016) Nurse Staffing Levels Annual Assurance Report 2020-2021

 2.2.15a Nurse Staffing Act Annual Assurance Report UHB 27 May 2021.pdf (6 pages)

 2.2.15b Appendix A - Annual Assurance report ctm 2020-2021- ver 4.pdf (16 pages)

 2.2.15c Appendix B - 25B wards - 2020-2021.pdf (7 pages)

 2.2.15d Appendix C Nurse Staffing Levels (Wales) Act 2016 - Statutory Guidance VERSION 2.pdf (13 pages)

 2.2.15e Appendix D Final CTMUHB Operating Framework and escalation policy 2020.pdf (38 pages)

 2.2.15f Appendix E All Reasonable steps final Dec 2019.pdf (3 pages)

10:00 - 10:00

0 min

3.

MAIN AGENDA

3.1.

Matters Arising not Considered within the Action Log

Discussion

Marcus Longley

10:00 - 10:00

0 min

4.

CO-CREATE WITH STAFF AND PARTNERS A LEARNING AND GROWING CULTURE

4.1.

Healthcare Inspectorate Wales/Audit Wales Joint Review of Quality Governance Summary of Progress Made - May 2021 Follow Up Report

Discussion

Audit Wales and Healthcare Inspectorate Wales

 4.1a AW HIW Joint Follow Up Report May 2021 UHB 27 May 2021.pdf (3 pages)

 4.1b Cwm-Taf-Joint-review-eng UHB 27 May 2021.pdf (32 pages)

4.2.

Neonatal & Maternity Improvement Programme

Discussion *Greg Dix and Nick Lyons*

 4.2 Maternity & Neonates Report UHB 27 May 2021.pdf (5 pages)

4.3.

Continuous Improvement Self Assessment Process in response to Targeted Intervention

Discussion *Paul Mears and Richard Morgan-Evans*

 4.3 TI Update Board Report UHB 27 May 2021.pdf (5 pages)

10:00 - 10:00

0 min

5.

WORK WITH COMMUNITIES AND PARTNERS TO REDUCE INEQUALITY, PROMOTE WELL-BEING AND PREVENT ILL HEALTH

5.1.

Primary Care Update

Discussion *David Miller and Sarah Bradley*

 5.1 Primary Care CBM Board Paper Final 27th May 2021.pdf (13 pages)

5.2.

Public Health Update

Discussion *Kelechi Nnoaham and Angela Jones*

 5.2a Public Health Update UHB 27 May 2021.pdf (3 pages)

 5.2b Cwm Taf Morgannwg University Health Board as a Population Health Organisation_Final200521 UHB 27 May 2021.pdf (18 pages)

5.3.

Covid 19 Vaccination Programme Update - Verbal Update

Discussion *Clare Williams*

5.4.

E-Cigarettes Update - Smoke Free Hospital Premises

Discussion *Kelechi Nnoaham*

 5.4 Update to position statement e-cigs v0.4 UHB 27 May 2021.pdf (5 pages)

5.5.

Vascular Engagement Outcome

Decision *Clare Williams*

 5.5a Vascular Engagement Public Board May 21 UHB 27 May 2021.pdf (6 pages)

 5.5b South East Wales Vascular Network Report on Engagement 2021 Final Report UHB 27 May 2021.pdf (146 pages)

10:00 - 10:00

0 min

6.

PROVIDE HIGH QUALITY, EVIDENCE BASED AND ACCESSIBLE CARE

6.1.

Integrated Performance Dashboard

Discussion *Clare Williams*

 6.1a Integrated Performance Dashboard UHB 27 May 2021.pdf (11 pages)

 6.1b Appendix 1 Assessment Dashboard May 2021 Final UHB 27 May 2021.pdf (14 pages)

6.2.

Integrated Medium Term Plan Update and Feedback - Verbal

Discussion *Clare Williams*

6.3.

Post Covid Service Recovery Position - To Follow

Discussion *Gareth Robinson*

6.4.

Organisational Risk Register

Discussion *Georgina Galletly*

 6.4a Organisational Risk Register HB May 2021 - Cover Paper.pdf (5 pages)

 6.4b Appendix 1 - Current Master Organisational Risk Register - Updated 12.5.2021.pdf (15 pages)

 6.4c Appendix 2- Risk Management Improvement Plan - Updated May 2021.pdf (3 pages)

10:00 - 10:00

0 min

7.

ENSURE SUSTAINABILITY IN ALL THAT WE DO, ECONOMICALLY, ENVIRONMENTALLY AND SOCIALLY

7.1.

Finance Update Month 12 2020/2021 - To Follow

Discussion *Steve Webster*

7.2.

Finance Update Month 1 2021/2022

Discussion *Steve Webster*

 7.2 M1 Finance Report for UHB 27 May 2021.pdf (21 pages)

10:00 - 10:00

0 min

8.

ANY OTHER BUSINESS

Discussion *Marcus Longley*

10:00 - 10:00

0 min

9.

DATE AND TIME OF NEXT MEETING - WEDNESDAY 9 JUNE 12.30PM

Minutes of the Meeting of Cwm Taf Morgannwg University Health Board
(CTMUHB) held on Thursday 25th March 2021 as a Virtual Meeting
Broadcast Live via Microsoft Teams

Members Present:

Marcus Longley	Chair
Paul Mears	Chief Executive
Maria Thomas	Vice Chair
Gareth Robinson	Interim Chief Operating Officer
Hywel Daniel	Executive Director for People
Dilys Jouvenat	Independent Member
Greg Dix	Executive Director of Nursing
Ian Wells	Independent Member
James Hehir	Independent Member
Jayne Sadgrove	Independent Member
Keiron Montague	Independent Member (In part)
Nicola Milligan	Independent Member
Patsy Roseblade	Independent Member
Nicola Milligan	Independent Member
Kelechi Nnoaham	Executive Director of Public Health
Clare Williams	Executive Director of Planning & Performance (Interim)
Steve Webster	Executive Director of Finance
Nick Lyons	Executive Medical Director

In Attendance:

Georgina Galletly	Director of Corporate Governance
Lee Leyshon	Assistant Director of Engagement & Communications
Cally Hamblyn	Assistant Director of Governance & Risk
Cathy Moss	CTMUHB Community Health Council
David Jenkins	Independent Advisor to the Board (Observing)
Sara Utley	Audit Wales
Louise Mann	Assistant Director of Quality & Safety (In part)
Valerie Wilson	Director of Midwifery, Gynaecology & Sexual Health (In part)
Mohamed Elnasharty	Consultant Obstetrician & Gynaecologist (In part)
Victoria Box	Midwife (In part)
Ria Jenkins	Midwife (In part)
Emma Walters	Corporate Governance Manager (Secretariat)

Agenda Item

1 PRELIMINARY MATTERS

1.1 Welcome & Introductions

The Chair welcomed everyone to the meeting, particularly those joining for the first time, those observing and colleagues joining for specific agenda items. The format of the proceedings in its virtual form were also noted by the Chair.

The Chair advised that he was pleased to announce that J Sadgrove had been appointed as Vice Chair of the Health Board and would commence in post on 1 June 2021. The Chair extended his thanks to M K Thomas for the fantastic contribution she had made over many years during her time as Independent Member and Vice Chair of the Health Board.

The Chair advised that he was also delighted to announce that Lisa Curtis-Jones had been appointed as an Associate Member and would commence in post on 1 June 2021. The Chair added that I Wells term of office had been extended for another four years.

1.2 Apologies for Absence

Members noted apologies from Philip White, Independent Member, Mel Jehu, Independent Member and Fiona Jenkins, Interim Executive Director of Therapies & Health Sciences.

1.3 Declarations of Interest

No declarations of interest were received.

1.4 Shared Listening & Learning – Patient Experience Story

L Mann shared the story of a patient who was a survivor of domestic abuse.

Board Members welcomed the story which they had found to be extremely moving and powerful. The Chair extended his thanks to L Mann for the presentation.

Resolution: The Patient Story was NOTED.

1.5 Shared Listening & Learning – Staff Experience Story

V Wilson, Director of Midwifery, Gynaecology & Sexual Health was joined by her colleagues to share a Staff Experience Story which outlined the progress that had been made within Maternity Services following the review undertaken by the Royal College of Obstetricians and Gynaecologists/Royal College of Midwives in December 2019.

Members noted the improvements that had been made particularly in relation to listening to staff and families, incident reporting and shared learning processes. Members welcomed the introduction of the lunch and learn events which had received excellent feedback from staff and noted that the events had helped to improve the service for patients as well as improving the wellbeing of staff.

The Chair extended his thanks to V Wilson and her colleagues for the presentation.

Resolution: The Staff Experience Story was NOTED.

2 CONSENT AGENDA

Members confirmed there were no reports they wished move from the Consent Agenda to the Main Agenda. There were no questions raised by Members on the consent agenda items prior to the meeting.

CONSENT FOR APPROVAL

2.1.1 Unconfirmed Minutes of the Meeting held on the 28th January 2021

Resolution: The minutes were APPROVED as a true and accurate record.

2.1.2 End of Year Reporting Arrangements

Resolution: The arrangements for end-of-year Corporate Governance Reporting were APPROVED.

2.1.3 Chairs Report and Affixing the Common Seal

Resolution:

- The Affixing of the Common Seal was ENDORSED.
- Chairs Action in respect of the Independent Maternity Services Oversight Panel Thematic Report Response and Implementing Smoke Free Premises and Vehicle Regulations 2020 was RATIFIED.

2.1.4 Section 33 Agreements

Resolution: The renewal of the Section 33 Agreement under the National Health Service (Wales) Act 2006 with Bridgend County Borough Council regarding the provision of integrated mental health daytime opportunities was APPROVED.

2.1.5 Amendment to Standing Orders

Resolution: The Amendments to the Standing Orders were APPROVED.

2.1.6 Hosting Agreements for National Imaging Academy Wales

Resolution: The extension to the hosting agreement for the National Imaging Academy for Wales until 31 March 2023 was APPROVED.

2.1.7 Continuous Improvement Self-Assessment Process in Response to Targeted Intervention

Resolution: The revised approach to self-assessment of improvement against the Targeted Intervention Maturity Matrix was APPROVED.

2.1.8 Cwm Taf Morgannwg NHS General Charitable Funds Update as at 28th February 2021

Resolution:

- The proposal to extend the Charities, Churches and Local Authorities (CCLA) contract for the period covering 1 August 2019 – 31 July 2023 was APPROVED;
- The decision of not to distribute excess over 20% of the market value of investments to the individual funds for the time being was ENDORSED;
- The proposal to invest surplus cash of £600k in CCLA Charities Official Investment Fund (COIF) Charities Ethical Investment Fund units was APPROVED;
- The current balances and investment performance of Cwm Taf Morgannwg NHS General Charitable Funds and the rate of the Investment Management Fees charged by CCLA were NOTED.

2.2 FOR NOTING

2.2.1 Committee Action Log

Resolution: The Action Log was NOTED.

2.2.2 Chief Executives Report

Resolution: The Chief Executives report was NOTED.

2.2.3 University Status Triennial Review

Resolution: The Review Report was NOTED and SUPPORTED.

2.2.4 Equality & Monitoring /Strategic Equality Plan Update

Resolution: The Plan and Report were APPROVED for publication.

2.2.5 Civil Contingencies and Business Continuity Report Q4 of 2019/20 and 2020-21

Resolution: The Annual Report was NOTED.

2.2.6 Audit & Risk Committee Highlight Report 8 February 2021

Resolution: The Highlight Report was NOTED.

2.2.7 Planning, Performance & Finance Committee Highlight Report 8 February 2021

Resolution: The Highlight Report was NOTED.

2.2.8 Quality & Safety Highlight Report 16 March 2021

Resolution: The Highlight Report was NOTED.

2.2.9 Remuneration & Terms of Service Committee Highlight Reports 28 January 2021 and 4 March 2021

Resolution: The Highlight Reports were NOTED.

2.2.10 Stakeholder Reference Group Highlight Report 17 February 2021

Resolution: The Highlight Report was NOTED.

2.2.11 Local Partnership Forum Highlight Report

Resolution: The Highlight Report was NOTED.

2.2.12 Digital & Data Committee Highlight Report

Resolution: The Highlight Report was NOTED.

2.2.13 Joint Committee Reports

Resolution: The Reports were NOTED.

3. MAIN AGENDA

3.1 Matters Arising not considered within the Action Log

There were no further matters arising identified.

4. CO-CREATE WITH STAFF AND PARTNERS A LEARNING & GROWING CULTURE

4.1 Neonatal and Maternity Improvement Programme Report

G Dix, N Lyons and V Wilson presented members with the report which provided an update with regard to the Independent Maternity Services Oversight Panel (IMSOP) review and associated improvement relating to Health Board Maternity services and Neonatal services. Members noted that the IMSOP programme of work now formally included Neonatal Services.

Members noted that the report identified the work being undertaken within Neonatal Services to ensure the safety of the current service, to ensure the improvements being made were being embedded within Integrated Locality

Groups and to ensure that engagement was being undertaken with patients and families. Members noted that further work would be required in relation to culture within Neonatal Services. In relation to Maternity Services, a further three recommendations had been formally signed off.

In response to a question raised by N Milligan in relation to the Management Development Programme that the Team had introduced, V Wilson confirmed that work was being undertaken with the Learning & Development Team to ensure consistency was in place.

A question was raised by N Milligan in relation to recommendation 707, and V Wilson advised that this related to the dignity of women experiencing pregnancy loss and added that a wonderful facility had now been put into place for patients. V Wilson added that the scanning machine should be in place imminently.

M K Thomas welcomed the significant improvement in data that was now being presented to the Neonatal & Maternity Improvement Board and extended her thanks to V Wilson and the Team for enabling this to happen.

The Chair extended his thanks to G Dix, N Lyons and V Wilson for presenting the report and recognised the progress that had been made in a number of key areas.

Resolution: The Programme Report was NOTED.

4.2 Annual Board Effectiveness Self-Assessment

G Galletly presented Members with the report and advised that each year the Board is required to undertake an annual assessment of its effectiveness. The report identified that during the year the Health Board had undertaken and/or engaged in a number of assessments that would provide internal and external sources of assurances to support the Board in undertaking its annual effectiveness assessment.

P Roseblade asked a question in relation to the £58m deficit not being referenced within the Structured Assessment Report received in 2020 and G Galletly confirmed that the Health Board would shortly be receiving the Structured Assessment from Audit Wales for the current year (2021) which would reflect the position for the current calendar year.

In relation to a question raised by M Longley regarding the current trajectory, G Galletly advised that all sources of information had indicated that good progress had been made over the last year. Members noted that other sources of assurance would include the scrutiny undertaken by Welsh Government of the current escalation status alongside the outcome of the follow-up review being undertaken by Healthcare Inspectorate Wales/Audit Wales in relation to Quality Governance.

Resolution: The Self-Assessment Maturing Rating of Level 3 was APPROVED.

5. WORK WITH COMMUNITIES AND PARTNERS TO REDUCE INEQUALITY, PROMOTE WELLBEING AND PREVENT ILL HEALTH

5.1 Public Health Update - Covid-19 Pandemic Response

K Nnoaham presented the Board with an update on the pandemic response. Members noted the improvement against the R Rate within Cwm Taf Morgannwg, the recent reduction in positive cases and positivity rates within the Merthyr Tydfil area, the uptake of testing across all three Local Authority areas, the increase in positive cases amongst 30-39 year olds and 10-19 years olds particularly within the Merthyr Tydfil area, the continued improvement being seen in hospital admissions and Covid ITU bed occupancy, with the exception of Prince Charles Hospital where there had been an increase.

The Chair extended his thanks to K Nnoaham for the presentation and added that Tuesday of this week had marked the anniversary of the lockdown that had been introduced in the UK where we all paused to reflect on the appalling human toll the virus has had on our communities.

Resolution: The Covid-19 Pandemic Response update was NOTED.

5.2 Covid-19 Vaccination Update

C Williams presented the report the report which provided Members with an update on progress being made against the Covid-19 Vaccination programme. Members recognised the significant amount of work that had been undertaken to deliver the programme and paid tribute to the staff, members of the community and Local Authority partners for the support they had provided. Members noted that the Health Board was on target to meet the mid-April deadline for delivering the vaccines to over 50's, despite concerns being in place regarding fluctuating supplies and noted that consideration was now being given to vaccinating the harder to reach communities.

J Sadgrove raised a question in relation to the plans for the opening of the Aberfan Community Centre as a mass vaccination centre and C Williams advised that whilst it had been intended to use the facility as a mass vaccination centre, following security checks it was felt that the facility would not be secure enough to hold the vaccine. Members noted that this would not affect the number of vaccines available to residents of the Merthyr Tydfil areas, with transport being provided to residents if they had difficulty in getting to the vaccination centre in Merthyr Tydfil. Members noted that it was also hoped that a number of community pharmacies would be commissioned in April to deliver vaccines in areas with challenging transport links.

In response to a question raised by I Wells as to whether there was data available to show how many people were refusing to have the vaccine, C Williams advised that the current "Did Not Attend" rate was 3%, with a very recent increase being seen which may be linked to concerns raised in relation to the Astra Zeneca vaccine. Members noted that patients had been contacted to

determine why they had decided to not attend for their vaccine and noted that no definitive themes could be identified, however, 30% of patients did state that they did not want the vaccine. K Nnoaham advised that 70% continued to be the prevalent figure in relation to herd immunity.

M K Thomas advised that she was very pleased with the effort that had been made by staff to deliver the programme and questioned whether any lessons could be learnt for other vaccination programmes, for example, flu vaccination. C Williams advised that a strategic decision had been made to ensure the vaccination team were not solely focussed on Covid and added that an Operational Manager was in the process of being recruited who would be responsible for managing the whole vaccination programme. K Nnoaham added that a number of lessons had already been learnt and there was an ambition to extend the knowledge and capacity that had been gained across other vaccination programmes.

The Chair extended his thanks to C Williams for presenting the report and welcomed the progress that had been made.

Resolution: The report was NOTED and the latest Covid-19 Mass Vaccination Plan for Phase 2 was APPROVED.

6. PROVIDE HIGH QUALITY, EVIDENCE BASED AND ACCESSIBLE CARE

6.1. Organisational Risk Register

G Galletly presented the report which provided the Board with an opportunity to review and discuss the latest version of the Organisational Risk Register.

I Wells acknowledged the progress that had been made and welcomed the inclusion of dates when risks would next be reviewed. In response to a question raised by I Wells, G Galletly confirmed that the Risk Owner had been included in the overall Risk Register and added that she would be happy to include this information for Board Members moving forward.

G Galletly confirmed that following helpful feedback received from Board members in relation to the timelines of Risk Register reports being presented to Committees, a review of timings would be undertaken moving forwards.

In relation to a question raised by P Roseblade in relation to a risk relating to the main gates at one of the hospital sites, G Robinson agreed to provide an update on this outside of the meeting.

P Roseblade advised that she would welcome a discussion outside of the meeting on impact of risk and risk values. G Galletly advised that she welcomed the opportunity to discuss this further outside of the meeting and added that any further feedback from Board Members on the Risk Register would be welcomed to inform the ongoing development and improvements.

- Resolution: The report was NOTED and the recommendations in relation to accepting the new risks, de-escalated risks, updated risks and closed risk were APPROVED.
- Action: G Galletly to undertake a review of timelines for presenting future risk register reports to Committee meetings.
- Action: G Robinson to provide an update to P Roseblade outside of the meeting in relation to the risk related to the main gates.
- Action: G Galletly and P Roseblade to meet outside of the meeting to discuss impact of risk and risk values.

6.2 Integrated Performance Dashboard

C Williams presented the report and provided an update against four key areas which included information flows from Welsh Health Specialised Services, the Elective Care Recovery Programme, Unscheduled Care Performance and Cancer Performance.

Members noted that the Elective Care Recovery Programme was a core component of the Health Board's Integrated Medium Term Plan and noted that a discussion was held at the March Quality & Safety Committee on this matter, with a further discussion planned for the May meeting of the Committee.

Members noted that whilst cancer performance remained disappointing, a recovery plan was in the process of being developed by all three Integrated Locality Groups to improve performance.

In relation to a question raised by I Wells in relation to Ophthalmology Follow Up Outpatients not Booked, G Robinson advised that the Bridgend Integrated Locality Group was in the process of undertaking a piece of work to address the position, with consideration being given to outsourcing and extending the role of Community Optometrists. Members noted that this piece of work would also form part of the Elective Care Recovery Programme.

In relation to a question raised by I Wells regarding the current performance of Stroke Quality Improvement at Princess of Wales Hospital and what plans were in place to improve performance, G Robinson advised that F Jenkins, Interim Executive Director for Therapies and Health Sciences was responsible for this area and would be able to provide an update on her return from annual leave.

In response to a question raised by N Milligan in relation to the reduction in performance against the workforce metrics and what plans were in place to address this, H Daniel advised that a discussion had been held with Integrated Locality Groups regarding current performance and it had been agreed that realistic targets would be set against each metric which would be monitored closely at the Integrated Locality Group performance meetings. Members noted that in relation to sickness, whilst the position was starting to normalise, an increase was being seen in stress related sickness. In relation to Personal Development Reviews (PDR), H Daniel advised that the PDR process was in the

process of being redesigned using the new values and behaviours framework and consideration was also being given to improving compliance.

Following a question raised by N Milligan in relation to Neurodevelopmental Service performance which had now reduced to 36% for 26 week waits, G Robinson advised that a proposal had been developed by the Bridgend Integrated Locality Group seeking support to appoint an additional Consultant, which would need to be considered within the planning process for the next year. In response to concerns raised by N Milligan in relation to patients waiting over 80 weeks for an assessment, which was not acceptable, G Robinson agreed to clarify the latest position on this matter outside the meeting. M K Thomas added that a significant amount of work had been undertaken to transform the service, especially at Tier 1, and the team were continuing to consider innovative ways in which the service could be provided.

In response to a question raised by J Sadgrove in relation to emergency ambulance services and the reasons behind the worsening performance regarding the response to red calls, G Robinson advised that the issues related to patient flows and added that it would be difficult to link the poor performance to Welsh Ambulance Services Trust (WAST) response times.

In response to a question raised by the Chair as to whether the links between the Health Board and WAST were sufficient to ensure a co-ordinated approach was in place, P Mears advised that an excellent operational relationship was now in place with WAST, with regular catch up meetings being held at Board level. P Mears added that an Unscheduled Care Programme Board was now in place which WAST were key partners on the group.

Resolution: The report was NOTED.

Action: F Jenkins to provide an update on the current position regarding Stroke Quality Improvement Performance on her return from annual leave.

Action: G Robinson to confirm the current position in relation to Neurodevelopmental performance outside of the meeting, particularly in relation to patients waiting over 80 weeks for an assessment.

7. ENSURE SUSTAINABILITY IN ALL THAT WE DO, ECONOMICALLY, ENVIRONMENTALLY AND SOCIALLY

7.1 Integrated Health and Care Strategy Engagement

C Williams presented the report which provided the Board with an update on progress against the development of the Integrated Health and Care Strategy and the engagement that would need to be undertaken over the next few months with the Board, wider leadership teams and communities.

P Mears advised that a significant amount of work would need to be undertaken to make the Health Board a truly population health focussed organisation and

added that engagement would be a key element to this piece of work, particularly the engagement with our communities.

In response to a comment made by S Webster in relation to ensuring the level of detail regarding expected outputs from this piece of work were identified, P Mears advised that there would be a need to have an overarching ambition in place on the future model of care as well as a more detailed Clinical Strategy which would include detail in relation to service models.

The Chair extended his thanks to C Williams for presenting the report and welcomed the important discussion held on this matter. C Williams advised that the National Clinical Framework had been appended to the report as some of the local work would need to be undertaken in parallel to the national framework.

Resolution: The report was NOTED.

7.2 Integrated Medium Term Plan

C Williams provided the Board with a verbal update and advised that the last year had been a challenging year in which to plan. Members noted that Welsh Government had requested that the Health Board submit a draft plan which would be subject to continued discussion. The draft plan would be submitted to Welsh Government by 31 March 2021 with Board oversight. C Williams advised that as a Health Board there is a requirement to have an approved three year Integrated Medium Term Plan, which was already in place following the plan submitted to Welsh Government last year. Members noted that Welsh Government had acknowledged that the Health Board's previous approved plan would remain extant.

Resolution: The update was NOTED.

7.3 Staff Wellbeing Survey

H Daniel presented the report which provided the Board with a summary of the findings from the Staff Wellbeing Survey undertaken in October 2020.

J Sadgrove welcomed the report which she had found to be helpful and informative and advised that the issues relating to the wellbeing of our staff was on the risk register and is an area of concern for both the Quality & Safety Committee and People & Culture Committee. J Sadgrove advised that the report makes reference to there being a lack of awareness amongst staff of the wellbeing service and suggested that a question on this could be added into the next survey. H Daniel agreed that awareness did need to be raised of what services were in place for staff and added that a dedicated communications resource was in the process of being recruited to address this.

In response to a question raised by J Sadgrove regarding the timing of the next survey, which was proposed to be undertaken during April/May, whether it would be more appropriate to undertake this in June, H Daniel agreed to

consider the timing of the next survey and added that he would be keen to survey staff on a regular basis.

J Sadgrove commented on the “You Said, We Did” poster which she fully supported and made reference to staff stating that they felt under resourced. J Sadgrove added that she could not see a response to this and suggested that this needed to be acknowledged.

In response to a question raised by D Jouvenat in relation to whether evaluation was being undertaken of the effectiveness of some of the services that had been introduced for staff, H Daniel advised that the effectiveness of services was being evaluated and confirmed that if a service was not working steps would be taken to try alternative solutions.

I Wells made reference to the relatively small number of responses that had been received from staff which may impact the data analysis, however, also recognised that the responses provided also contained valuable data which must be acted upon. I Wells also agreed that the timing of the next survey may need to be reconsidered.

N Milligan advised that one of the biggest areas of concern raised by staff is lack of flexibility and added that consideration would need to be given to this moving forward. H Daniel agreed that the Health Board would need to refresh its approach to flexible/agile working.

Resolution: The Report was NOTED.

Action: Timing of the next staff survey to be considered by H Daniel.

Action: Acknowledgement to be given to the statements made by staff in relation to them feeling under resourced and response to be provided in the “You Said, We Did” poster.

7.4 Finance Update – Month 11

S Webster presented the report and advised Members that whilst the overall forecast had remained at breakeven, the planned return of funding to Welsh Government had increased by 5.9m to 26.9m. Members noted that there were some residual risks relating to this, which included the operational spend scheduled for March 2021 and the accrual of annual leave which currently stood at 15.9m. Members noted that there would still be a risk that the Health Board would end up with a surplus, which the Health Board would try to minimise.

In response to a question raised by P Roseblade as to whether Welsh Government had given any indication they would accept the surplus, S Webster advised that the Health Board were hopeful however, a formal response is awaited.

Resolution: The report was NOTED.

8 ANY OTHER BUSINESS

No items were identified.

9 DATE AND TIME OF THE NEXT MEETING

The next meeting would take place at 10.00am on Thursday 27 May 2021.

10 CLOSE OF MEETING

Unconfirmed

Rhif yr Eitem ar yr Agenda:

Cofnodion Cyfarfod Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg
(BIPCTM) a gynhaliwyd ddydd Iau 25 Mawrth 2021 fel Cyfarfod Arlein a
Ddarlledwyd yn Fyw drwy Microsoft Teams

Aelodau'n Bresennol:

Marcus Longley	Cadeirydd
Paul Mears	Y Prif Weithredwr
Maria Thomas	Is-gadeirydd
Gareth Robinson	Prif Swyddog Gweithredu (Dros Dro)
Hywel Daniel	Cyfarwyddwr Gweithredol Pobl
Dilys Jouvenat	Aelod Annibynnol
Greg Dix	Cyfarwyddwr Gweithredol Nyrsio
Ian Wells	Aelod Annibynnol
James Hehir	Aelod Annibynnol
Jayne Sadgrove	Aelod Annibynnol
Keiron Montague	Aelod Annibynnol (Yn rhannol)
Nicola Milligan	Aelod Annibynnol
Patsy Roseblade	Aelod Annibynnol
Nicola Milligan	Aelod Annibynnol
Kelechi Nnoaham	Cyfarwyddwr Gweithredol Iechyd y Cyhoedd
Clare Williams	Cyfarwyddwr Gweithredol Cynllunio a Pherfformiad (Dros Dro)
Steve Webster	Cyfarwyddwr Gweithredol Cyllid
Nick Lyons	Cyfarwyddwr Meddygol Gweithredol

Eraill yn Bresennol

Georgina Galletly	Cyfarwyddwr Llywodraethiant Corfforaethol
Lee Leyshon	Cyfarwyddwr Cynorthwyol Ymgysylltu a Chyfathrebu
Cally Hamblyn	Cyfarwyddwr Cynorthwyol Llywodraethu a Risg
Cathy Moss	Cyngor Iechyd Cymuned BIPCTM
David Jenkins	Cynghorydd Annibynnol i'r Bwrdd (yn Arsylwi)
Sara Utley	Archwilio Cymru
Louise Mann	Cyfarwyddwr Cynorthwyol Ansawdd a Diogelwch (Yn rhannol)
Valerie Wilson	Cyfarwyddwr Bydwreigiaeth, Gynaecoleg ac Iechyd Rhywiol (Yn rhannol)
Mohamed Elnasharty	Obstetregydd a Gynaecolegydd Ymgynghorol (Yn rhannol)
Victoria Box	Bydwraig (Yn rhannol)
Ria Jenkins	Bydwraig (Yn rhannol)
Emma Walters	Rheolwr Llywodraethu Corfforaethol (Ysgrifenyddiaeth)

Eitem ar yr Agenda

1 MATERION RHAGARWEINIOL

1.1 Croeso a Chyflwyniadau

Croesawodd y Cadeirydd bawb i'r cyfarfod, yn enwedig y rhai a oedd yn ymuno am y tro cyntaf, y rhai a oedd yn arsylwi a'r cydweithwyr oedd yn ymuno ar gyfer eitemau penodol ar yr agenda. Nodwyd hefyd fformat y digwyddiad yn ei ffurf rithwir gan y Cadeirydd.

Dywedodd y Cadeirydd ei fod yn falch o gyhoeddi bod J Sadgrove wedi'i benodi'n Is-gadeirydd y Bwrdd Iechyd ac y byddai'n cychwyn yn ei swydd ar 1 Mehefin 2021. Estynnodd y Cadeirydd ei ddiolch i MK Thomas am y cyfraniad gwych a wnaeth dros nifer o flynyddoedd yn ystod ei chyfnod fel Aelod Annibynnol ac Is-gadeirydd y Bwrdd Iechyd.

Dywedodd y Cadeirydd ei fod hefyd yn falch iawn o gyhoeddi bod Lisa Curtis-Jones wedi'i phenodi'n Aelod Cyswllt ac y byddai'n cychwyn yn ei swydd ar 1 Mehefin 2021. Ychwanegodd y Cadeirydd fod tymor swydd I Wells wedi'i ymestyn am bedair blynedd arall.

1.2 Ymddiheuriadau am Absenoldebau

Nododd yr aelodau ymddiheuriadau gan Philip White, Aelod Annibynnol, Mel Jehu, Aelod Annibynnol a Fiona Jenkins, Cyfarwyddwr Gweithredol Dros Dro Therapiau a Gwyddorau Iechyd.

1.3 Datganiadau o fuddiannau

Ni dderbyniwyd unrhyw ddatganiadau o fuddiannau.

1.4 Gwrando a Dysgu ar y Cyd-Stori am Brofiad Claf

Rhannodd L Mann stori claf a oedd wedi goroesi cam-drin domestig.

Croesawodd Aelodau'r Bwrdd y stori yr oeddent yn ei chael yn hynod deimladwy a phwerus. Estynnodd y Cadeirydd ei ddiolch i L Mann am y cyflwyniad.

Penderfyniad:

NODWYD Stori'r Claf.

1.5 Gwrando a Dysgu ar y Cyd - Stori am Brofiad Staff

Ymunodd cydweithwyr V Wilson, Cyfarwyddwr Bydwreigiaeth, Gynaecoleg ac Iechyd Rhywiol â hi i rannu Stori am Brofiad Staff a amlinellodd y

cynnydd a wnaed o fewn y Gwasanaethau Mamolaeth yn dilyn yr adolygiad a gynhaliwyd gan Goleg Brenhinol yr Obstetregwyr a Gynaecolegwyr/Coleg Brenhinol y Bydwragedd ym mis Rhagfyr 2019.

Nododd yr aelodau y gwelliannau a wnaed yn arbennig mewn perthynas â gwrando ar staff a theuluoedd, adrodd am ddigwyddiadau a phrosesau dysgu ar y cyd. Croesawodd yr aelodau gyflwyniad y digwyddiadau cinio a dysgu a oedd wedi derbyn adborth rhagorol gan staff gan nodi bod y digwyddiadau wedi helpu i wella'r gwasanaeth i gleifion ynghyd â gwella llesiant staff.

Estynnodd y Cadeirydd ei ddiolch i V Wilson a'i chydweithwyr am y cyflwyniad.

Penderfyniad: NODWYD y Stori am Brofiad Staff.

2 AGENDA CANIATÂD

Cadarnhaodd yr Aelodau nad oedd unrhyw adroddiadau y dymunent eu symud o'r Agenda Caniatâd i'r Prif Agenda. Ni chododd yr Aelodau unrhyw gwestiynau ar yr eitemau ar yr agenda caniatâd cyn y cyfarfod.

CANIATÂD I GYMERADWYO

2.1.1 Cofnodion y Cyfarfod a gynhaliwyd ar 28 Ionawr 2021 sydd eto i'w Cadarnhau

Penderfyniad: CYMERADWYWYD y cofnodion fel cofnod gwir a chywir.

2.1.2 Trefniadau adrodd diwedd y flwyddyn

Penderfyniad: CYMERADWYWYD y trefniadau ar gyfer Adrodd ar Lywodraethu Corfforaethol diwedd blwyddyn.

2.1.3 Adroddiad y Cadeirydd a Gosod y Sêl Gyffredin

Penderfyniad:

- CYMERADWYWYD Gosod y Sêl Gyffredin.
- CADARNHAWYD Camau'r Cadeirydd mewn perthynas ag Ymateb Adroddiad Thematig y Panel Trosolwg Annibynnol ar Wasanaethau Mamolaeth a Gweithredu Rheoliadau Mangreoedd a Cherbydau Di-fwg 2020.

2.1.4 Cytundebau Adran 33

Penderfyniad: CYMERADWYWYD adnewyddu'r Cytundeb Adran 33 o dan Ddeddf Gwasanaeth Iechyd Gwladol (Cymru) 2006 gyda Chyngor Bwrdeistref Sirol Pen-y-bont ar Ogwr mewn perthynas â darparu cyfleoedd iechyd meddwl integredig yn ystod y dydd.

2.1.5 Diwygiad i'r Rheolau Sefydlog

Penderfyniad: CYMERADWYWYD y Newidiadau i'r Rheolau Sefydlog.

2.1.6 Cytundebau Lletya ar gyfer Academi Ddelweddu Genedlaethol Cymru

Penderfyniad: CYMERADWYWYD yr estyniad i'r cytundeb lletya ar gyfer Academi Ddelweddu Genedlaethol Cymru tan 31 Mawrth 2023.

2.1.7 Proses Hunanasesu Gwelliannau Parhaus mewn Ymateb i Ymyrraeth wedi'i Tharged

Penderfyniad: CYMERADWYWYD y dull diwygiedig o hunanasesu gwelliant yn erbyn y Matrics Aeddfedrwydd Ymyrraeth wedi'i Tharged.

2.1.8 Diweddariad am Gronfa Elusennol Gyffredinol GIG Cwm Taf Morgannwg fel ar 28 Chwefror.

Penderfyniad:

- CYMERADWYWYD y cynnig i ymestyn y contract Elusennau, Eglwysi ac Awdurdodau Lleol (CCLA) ar gyfer y cyfnod o 1 Awst 2019 - 31 Gorffennaf 2023.
- CYMERADWYWYD y penderfyniad i beidio â dosbarthu gormodedd o dros 20% o werth marchnad y buddsoddiadau ar y cronfeydd unigol am y tro.
- CYMERADWYWYD y cynnig i fuddsoddi £600k o arian dros ben mewn unedau Cronfa Buddsoddi Moesegol Elusennau Cronfa Buddsoddi Swyddogol Elusennau (COIF) CCLA;
- NODWYD balansau cyfredol a pherfformiad buddsoddi Cronfa Elusennol Gyffredinol GIG Cwm Taf Morgannwg a chyfradd y Ffioedd Rheoli Buddsoddiadau a godir gan CCLA.

2.2 I'W NODI

2.2.1 Log Gweithredu'r Pwyllgor

Penderfyniad: NODWYD y Cofnod o Gamau Gweithredu.

2.2.2 Adroddiad y Prif Weithredwr

Penderfyniad: NODWYD adroddiad y Prif Weithredwr.

2.2.3 Adolygiad Tair Blynedd o Statws Prifysgol

Penderfyniad: NODWYD a CHEFNOGWYD Adroddiad yr Adolygiad.

2.2.4 Diweddariad am y Cynllun Cydraddoldeb Strategol/Cydraddoldeb a Monitro

Penderfyniad: CYMERADWYWYD y Cynllun a'r Adroddiad i'w cyhoeddi.

2.2.5 Adroddiad o Gynlluniau Sifil Wrth Gefn a Pharhad Busnes ar gyfer Chwarter 4 2019/20 a 2020-21

Penderfyniad: NODWYD yr Adroddiad Blynyddol.

2.2.6 Adroddiad Cryno'r Pwyllgor Archwilio a Risg – 8 Chwefror 2021

Penderfyniad: NODWYD yr Adroddiad Cryno.

2.2.7 Adroddiad Cryno'r Pwyllgor Cynllunio, Perfformiad a Chyllid – 8 Chwefror 2021

Penderfyniad: NODWYD yr Adroddiad Cryno.

2.2.8 Adroddiad Cryno Ansawdd a Diogelwch – 16 Mawrth 2021

Penderfyniad: NODWYD yr Adroddiad Cryno.

2.2.9 Adroddiadau Cryno'r Pwyllgor Taliadau a Thelerau Gwasanaeth – 28 Ionawr 2021 a 4 Mawrth 2021

Penderfyniad: NODWYD yr Adroddiadau Cryno.

2.2.10. Adroddiad Cryno'r **Grŵp** Cyfeirio Rhanddeiliaid – 17 Chwefror 2021

Penderfyniad: NODWYD yr Adroddiad Cryno.

2.2.11 Adroddiad Cryno'r Fforwm Partneriaeth Lleol

Penderfyniad: NODWYD yr Adroddiad Cryno.

2.2.12 Adroddiad Cryno'r Pwyllgor Digidol a Data

Penderfyniad: NODWYD yr Adroddiad Cryno.

2.2.13 Adroddiadau'r Cyd-bwyllgorau

Penderfyniad: NODWYD yr Adroddiadau.

3. PRIF AGENDA

3.1 Materion sy'n Codi heb eu hystyried yn y Cofnodion Gweithredu

Nid oedd unrhyw faterion pellach sy'n codi a nodwyd.

4. CYD-GREU DIWYLLIANT DYSGU A THYFU GYDA STAFF A PHARTNERIAID

4.1 Adroddiad o'r Rhaglen Wella Gwasanaethau Newyddenedigol a Mamolaeth

Cyflwynodd G Dix, N Lyons a V Wilson yr adroddiad i aelodau a roddodd ddiweddariad mewn perthynas ag adolygiad y Panel Trosolwg Annibynnol ar Wasanaethau Mamolaeth (IMSOP) a gwelliant cysylltiedig yn ymwneud â gwasanaethau Mamolaeth y Bwrdd Iechyd a gwasanaethau Newyddenedigol. Nododd yr aelodau fod rhaglen waith IMSOP bellach yn cynnwys Gwasanaethau Newyddenedigol yn ffurfiol.

Nododd yr aelodau fod yr adroddiad yn nodi'r gwaith sy'n cael ei wneud o fewn y Gwasanaethau Newyddenedigol i sicrhau diogelwch y gwasanaeth presennol, er mwyn sicrhau bod y gwelliannau sy'n cael eu gwneud yn cael eu hymgorffori mewn Grwpiau Lleoliad Integredig ac i sicrhau bod gwaith ymgysylltu'n cael ei wneud gyda chleifion a theuluoedd. Nododd yr aelodau y byddai angen gwneud rhagor o waith mewn perthynas â diwylliant o fewn y Gwasanaethau Newyddenedigol. Mewn perthynas â'r Gwasanaethau Mamolaeth, roedd tri argymhelliad arall wedi'u cymeradwyo'n ffurfiol.

Mewn ymateb i gwestiwn a godwyd gan N Milligan mewn perthynas â'r Rhaglen Datblygu Rheolaeth yr oedd y Tîm wedi'i chyflwyno, cadarnhaodd V Wilson fod gwaith yn cael ei wneud gyda'r Tîm Dysgu a Datblygu i sicrhau bod cysondeb ar waith.

Codwyd cwestiwn gan N Milligan mewn perthynas ag argymhelliad 707, a chynghorodd V Wilson fod hyn yn ymwneud ag urddas menywod sy'n colli beichiogrwydd ac ychwanegodd fod cyfleuster gwyb bellach wedi'i roi ar waith i gleifion. Ychwanegodd V Wilson y dylai'r peiriant sganio fod ar waith yn fuan.

Croesawodd MK Thomas y gwelliant sylweddol mewn data a oedd bellach yn cael ei gyflwyno i'r Bwrdd Gwella Newyddenedigol a Mamolaeth ac estynnodd ei diolch i V Wilson a'r Tîm am alluogi hyn i ddigwydd.

Estynnodd y Cadeirydd ei ddiolch i G Dix, N Lyons a V Wilson am gyflwyno'r adroddiad a chydabu'r cynnydd a wnaed mewn nifer o feysydd allweddol.

Penderfyniad: NODWYD Adroddiad y Rhaglen.

4.2 Hunanasesiad Blynnyddol o Effeithiolrwydd y Bwrdd

Cyflwynodd G Galletly yr adroddiad i'r Aelodau a chynghorodd ei bod yn ofynnol i'r Bwrdd gynnal asesiad blynnyddol o'i effeithiolrwydd bob blwyddyn. Nododd yr adroddiad fod y Bwrdd Iechyd yn ystod y flwyddyn wedi cynnal a/neu gymryd rhan mewn nifer o asesiadau a fyddai'n darparu ffynonellau sicrwydd mewnol ac allanol i gefnogi'r Bwrdd i gynnal ei asesiad effeithiolrwydd blynnyddol.

Gofynnodd P Roseblade gwestiwn mewn perthynas â pheidio â chyfeirio at y diffyg o £58m yn yr Adroddiad Asesu Strwythuredig a dderbyniwyd yn 2020 a chadarnhaodd G Galletly y byddai'r Bwrdd Iechyd yn derbyn yr Asesiad Strwythuredig yn fuan gan Archwilio Cymru ar gyfer y flwyddyn gyfredol (2021) a fyddai'n adlewyrchu'r sefyllfa ar gyfer y flwyddyn galendr gyfredol.

Mewn perthynas â chwestiwn a godwyd gan M Longley ynghylch y taflwybr cyfredol, dywedodd G Galletly fod yr holl ffynonellau gwybodaeth wedi nodi bod cynnydd da wedi'i wneud dros y flwyddyn ddiwethaf. Nododd yr aelodau y byddai ffynonellau sicrwydd eraill yn cynnwys gwaith craffu gan Lywodraeth Cymru ar y statws uwchgyfeirio cyfredol ochr yn ochr â chanlyniad yr adolygiad dilynol sy'n cael ei gynnal gan Arolygiaeth Gofal Iechyd Cymru/Archwilio Cymru mewn perthynas â Llywodraethu Ansawdd.

Penderfyniad: CYMERADWYFYD y Sgôr Aeddfedu Hunanasesu o Lefel 3.

5. GWAITH GYDA CHYMUNEDAU A PHARTNERIAID I LEIHAU ANGHYDRADDOLDEB, HYRWYDDO LLESIANT AC ATAL AFIECHYD

5.1 Diweddariad ynghylch Iechyd y Cyhoedd – Ymateb i Bandemig COVID-19

Cyflwynodd K Nnoaham ddiweddariad i'r Bwrdd ar yr ymateb i'r pandemig. Nododd yr aelodau y gwelliant yn erbyn y Gyfradd R o fewn Cwm Taf Morgannwg, y gostyngiad diweddar mewn achosion positif a chyfraddau positifrwydd yn ardal Merthyr Tudful, y nifer sy'n profi ar draws tair ardal yr Awdurdod Lleol, y cynnydd mewn achosion positif ymhlith pobl 30-39 oed. a phlant 10-19 oed yn enwedig yn ardal Merthyr Tudful, y gwelliant parhaus i'w weld mewn derbyniadau i'r ysbyty a deiliadaeth gwelyau Covid Unedau Therapi Dwys, ac eithrio Ysbyty'r Tywysog Charles lle bu cynnydd.

Estynnodd y Cadeirydd ei ddiolch i K Nnoaham am y cyflwyniad ac ychwanegodd fod dydd Mawrth yr wythnos hon wedi nodi blwyddyn ers y cyfnod clo a gyflwynwyd yn y DU lle gwnaethom i gyd oedi i fyfyrion ar y difrod dynol echrydus y mae'r firws wedi'i achosi i'n cymunedau.

Penderfyniad: NODWYD y diweddariad ynghylch yr Ymateb i Bandemig COVID-19.

5.2 Diweddariad ynghylch brechu rhag COVID-19

Cyflwynodd C Williams yr adroddiad a roddodd y wybodaeth ddiweddaraf i'r Aelodau am y cynnydd sy'n cael ei wneud yn erbyn rhaglen frechu Covid-19. Cydnabu'r aelodau'r gwaith sylweddol a wnaed i gyflawni'r rhaglen a thalwyd teyrnged i'r staff, aelodau'r gymuned a phartneriaid yr Awdurdodau Lleol am y gefnogaeth yr oeddent wedi'i darparu. Nododd yr aelodau fod y Bwrdd Iechyd ar y trywydd iawn i gyrraedd y dyddiad cau ganol mis Ebrill ar gyfer

rhoi'r brechlynnau i bobl dros 50 oed, er bod pryderon ynghylch cyflenwadau cyfnewidiol a nodwyd bod ystyriaeth bellach yn cael ei rhoi i frechu'r cymunedau anos eu cyrraedd.

Cododd J Sadgrove gwestiwn mewn perthynas â'r cynlluniau ar gyfer agor Canolfan Gymunedol Aberfan fel canolfan frechu dorfol a chynghorodd C Williams, er y bwriadwyd defnyddio'r cyfleuster fel canolfan frechu dorfol, yn dilyn gwiriadau diogelwch, y teimlwyd na fyddai'r cyfleuster yn ddigon diogel i ddal y brechlyn. Nododd yr aelodau na fyddai hyn yn effeithio ar nifer y brechlynnau sydd ar gael i drigolion ardal Merthyr Tudful, gyda chcludant yn cael ei ddarparu i breswylwyr pe byddent yn cael anhawster cyrraedd y ganolfan frechu ym Merthyr Tudful. Nododd yr aelodau y gobeithid hefyd y byddai nifer o fferyllfeydd cymunedol yn cael eu comisiynu ym mis Ebrill i ddosbarthu brechlynnau mewn ardaloedd sydd â chysylltiadau trafndiaeth heriol.

Mewn ymateb i gwestiwn a godwyd gan I Wells ynghylch a oedd data ar gael i ddangos faint o bobl oedd yn gwrthod cael y brechlyn, dywedodd C Williams mai 3% oedd y gyfradd gyfredol "Heb Fynychu", gyda chynnydd diweddar iawn a allai fod yn gysylltiedig â phryderon a godwyd mewn perthynas â'r brechlyn Astra Zeneca. Nododd yr aelodau y cysylltwyd â chleifion i benderfynu pam eu bod wedi penderfynu peidio â mynychu i gael eu brechlyn a nodwyd na ellid nodi unrhyw themâu diffiniol, fodd bynnag, nododd 30% o gleifion nad oeddent am gael y brechlyn. Dywedodd K Nnoaham mai 70% oedd y ffigur cyffredin mewn perthynas ag imiwnedd torfol o hyd.

Dywedodd MK Thomas ei bod yn falch iawn o'r ymdrech a wnaed gan staff i gyflwyno'r rhaglen a holodd a ellid dysgu unrhyw wersi ar gyfer rhaglenni brechu eraill, er enghraifft, brechu rhag y fflw. Dywedodd C Williams fod penderfyniad strategol wedi'i wneud i sicrhau nad oedd y tîm brechu yn canolbwyntio'n llwyr ar Covid ac ychwanegodd fod Rheolwr Gweithredol yn y broses o gael ei recriwtio a fyddai'n gyfrifol am reoli'r rhaglen frechu gyfan. Ychwanegodd K Nnoaham fod nifer o wersi eisoes wedi'u dysgu ac roedd uchelgais i ehangu'r wybodaeth a'r gallu a enillwyd ar draws rhaglenni brechu eraill.

Estynnodd y Cadeirydd ei ddiolch i C Williams am gyflwyno'r adroddiad a chroesawodd y cynnydd a wnaed.

Penderfyniad: NODWYD yr adroddiad a CHYMERADWYWYD y Cynllun Brechu Torfol Covid-19 diweddaraf ar gyfer Cam 2.

6. DARPARU GOFAL HYGIRCH O ANSAWDD UCHEL AR SAIL TYSTIOLAETH

6.1. Cofrestr Risg y Sefydliad

Cyflwynodd G Galletly yr adroddiad a roddodd gyfle i'r Bwrdd adolygu a thrafod fersiwn ddiweddaraf y Gofrestr Risg Sefydliadol.

Cydnabu I Wells y cynnydd a wnaed a chroesawyd cynnwys dyddiadau pan fyddai risgiau'n cael eu hadolygu nesaf. Mewn ymateb i gwestiwn a godwyd gan I Wells, cadarnhaodd G Galletly fod y Perchennog Risg wedi'i gynnwys yn y Gofrestr Risg gyffredinol ac ychwanegodd y byddai'n hapus i gynnwys y wybodaeth hon ar gyfer Aelodau'r Bwrdd wrth symud ymlaen.

Cadarnhaodd G Galletly, yn dilyn adborth defnyddiol a gafwyd gan aelodau'r Bwrdd mewn perthynas â llinellau amser adroddiadau'r Gofrestr Risg yn cael eu cyflwyno i Bwyllgorau, y byddai adolygiad o'r amseriadau yn cael ei gynnal wrth symud ymlaen.

Mewn perthynas â chwestiwn a godwyd gan P Roseblade mewn perthynas â risg yn ymwneud â'r prif gatiau yn un o'r ysbytai, cytunodd G Robinson i roi'r wybodaeth ddiweddaraf am hyn y tu allan i'r cyfarfod.

Dywedodd P Roseblade y byddai'n croesawu trafodaeth y tu allan i'r cyfarfod ar effaith risg a gwerthoedd risg. Dywedodd G Galletly ei bod yn croesawu'r cyfle i drafod hyn ymhellach y tu allan i'r cyfarfod ac ychwanegodd y byddai unrhyw adborth pellach gan Aelodau'r Bwrdd ar y Gofrestr Risg yn cael ei groesawu i lywio'r datblygiad a'r gwelliannau parhaus.

- Penderfyniad: NODWYD yr adroddiad a CHYMERADWYWYD yr argymhellion mewn perthynas â derbyn y risgiau newydd, risgiau wedi'u dad-ddwysáu, risgiau wedi'u diweddarau a risg gaeedig.
- Cam
Gweithredu: G Gallet i gynnal adolygiad o linellau amser ar gyfer cyflwyno adroddiadau cofrestr risg yn y dyfodol i gyfarfodydd y Pwyllgor.
- Cam
Gweithredu: G Robinson i roi'r wybodaeth ddiweddaraf i P Roseblade y tu allan i'r cyfarfod mewn perthynas â'r risg sy'n gysylltiedig â'r prif gatiau.
- Cam
Gweithredu: G Galletly a P Roseblade i gwrdd y tu allan i'r cyfarfod i drafod effaith gwerthoedd risg a risg.
- 6.2 Y Dangosfwrdd Perfformiad Integredig
- Cyflwynodd C Williams yr adroddiad a rhoddodd ddiweddariad yn erbyn pedwar maes allweddol a oedd yn cynnwys llif gwybodaeth gan Wasanaethau Arbenigol Iechyd Cymru, y Rhaglen Adfer Gofal Dewisol, Perfformiad Gofal Heb ei Drefnu a Pherfformiad Canser.
- Nododd yr aelodau fod y Rhaglen Adfer Gofal Dewisol yn rhan greiddiol o Gynllun Tymor Canolig Integredig y Bwrdd Iechyd a nodwyd bod trafodaeth wedi'i chynnal ym Mhwyllgor Ansawdd a Diogelwch mis Mawrth ar y mater hwn, gyda thrafodaeth bellach wedi'i chynllunio ar gyfer cyfarfod mis Mai y Pwyllgor.

Nododd yr aelodau, er bod perfformiad canser yn parhau i fod yn siomedig, fod cynllun adfer yn y broses o gael ei ddatblygu gan y tri Grŵp Lleoliad Integredig i wella perfformiad.

Mewn perthynas â chwestiwn a godwyd gan I Wells mewn perthynas â Chleifion Allanol ag Apwyntiadau Dilynol Offthalmoleg nad ydynt wedi'u Archebu, dywedodd G Robinson fod Grŵp Lleoliad Integredig Pen-y-bont ar Ogwr yn y broses o wneud darn o waith i fynd i'r afael â'r sefyllfa, gan ystyried rhoi gwaith ar gontract allanol ac ehangu rôl Optometryddion Cymunedol. Nododd yr aelodau y byddai'r darn hwn o waith hefyd yn rhan o'r Rhaglen Adfer Gofal Dewisol.

Mewn perthynas â chwestiwn a godwyd gan I Wells ynghylch perfformiad cyfredol Gwella Ansawdd Strôc yn Ysbyty Tywysoges Cymru a pha gynlluniau oedd ar waith i wella perfformiad, dywedodd G Robinson fod F Jenkins, Cyfarwyddwr Gweithredol Dros Dro Therapiau a Gwyddorau Iechyd yn gyfrifol am y maes hwn ac y byddai'n gallu rhoi diweddariad ar ôl dychwelyd o'i gwyliau blyneddol.

Mewn ymateb i gwestiwn a godwyd gan N Milligan mewn perthynas â'r gostyngiad mewn perfformiad yn erbyn metrigau'r gweithlu a pha gynlluniau oedd ar waith i fynd i'r afael â hyn, dywedodd H Daniel fod trafodaeth wedi'i chynnal gyda Grwpiau Lleoliad Integredig ynghylch perfformiad cyfredol ac y cytunwyd y byddai targedau realistig yn cael eu gosod yn erbyn pob metrig a fyddai'n cael eu monitro'n agos yng nghyfarfodydd perfformiad y Grwpiau Lleoliad Integredig. Nododd yr aelodau, er bod y sefyllfa'n dechrau normaleiddio, fod cynnydd yn cael ei weld mewn salwch sy'n gysylltiedig â straen. Mewn perthynas ag Adolygiadau Datblygiad Personol (PDR), dywedodd H Daniel fod y broses PDR wrthi'n cael ei hailgynllunio gan ddefnyddio'r fframwaith gwerthoedd ac ymddygiadau newydd a bod ystyriaeth hefyd yn cael ei rhoi i wella cydymffurfiaid.

Yn dilyn cwestiwn a godwyd gan N Milligan mewn perthynas â pherfformiad y Gwasanaeth Niwroddatblygiadol a oedd bellach wedi gostwng i 36% ar gyfer arosiadau 26 wythnos, dywedodd G Robinson fod cynnig wedi'i ddatblygu gan Grŵp Lleoliad Integredig Pen-y-bont ar Ogwr yn ceisio cefnogaeth i benodi Ymgynghorydd ychwanegol, a fyddai angen ei ystyried yn y broses gynllunio ar gyfer y flwyddyn nesaf. Mewn ymateb i bryderon a godwyd gan N Milligan mewn perthynas â chleifion yn aros dros 80 wythnos am asesiad, nad oedd yn dderbyniol, cytunodd G Robinson i egluro'r sefyllfa ddiweddaraf mewn perthynas â'r mater hwn y tu allan i'r cyfarfod. Ychwanegodd MK Thomas fod cryn dipyn o waith wedi'i wneud i drawsnewid y gwasanaeth, yn enwedig yn Haen 1, a bod y tîm yn parhau i ystyried ffyrdd arloesol y gellid darparu'r gwasanaeth.

Mewn ymateb i gwestiwn a godwyd gan J Sadgrove mewn perthynas â gwasanaethau ambiwlans brys a'r rhesymau y tu ôl i'r gwaethygiad mewn perfformiad o ran yr ymateb i alwadau coch, dywedodd G Robinson fod y materion yn ymwneud â llif cleifion ac ychwanegodd y byddai'n anodd

cysylltu'r perfformiad gwael ag amseroedd ymateb Ymddiriedolaeth Gwasanaethau Ambiwlans Cymru (WAST).

Mewn ymateb i gwestiwn a godwyd gan y Cadeirydd ynghylch a oedd y cysylltiadau rhwng y Bwrdd Iechyd a WAST yn ddigonol i sicrhau bod dull cydgysylltiedig ar waith, dywedodd P Mears fod perthynas weithredol ragorol bellach ar waith gyda WAST, gyda chyfarfodydd dal i fyny rheolaidd yn cael eu cynnal ar lefel y Bwrdd. Ychwanegodd P Mears fod Bwrdd Rhaglen Gofal Heb ei Drefnu bellach ar waith a bod WAST yn bartneriaid allweddol ar y grŵp.

Penderfyniad: NODWYD yr adroddiad.

Cam
Gweithredu: F Jenkins i roi'r wybodaeth ddiweddaraf am y sefyllfa bresennol o ran Perfformiad Gwella Ansawdd Strôc ar ôl dychwelyd o'i gwyliau blynyddol.

Cam
Gweithredu: G Robinson i gadarnhau'r sefyllfa bresennol mewn perthynas â pherfformiad Niwroddatblygiadol y tu allan i'r cyfarfod, yn enwedig mewn perthynas â chleifion sy'n aros dros 80 wythnos am asesiad.

7. SICRHAU CYNALIADWYEDD ECONOMAIDD, AMGYLCHEDDOL A CHYMDEITHASOL YM MHOPETH A WNAWN

7.1 Gwaith Ymgysylltu'r Strategaeth Iechyd a Gofal Integredig

Cyflwynodd C Williams yr adroddiad a roddodd y wybodaeth ddiweddaraf i'r Bwrdd am y cynnydd yn erbyn datblygu'r Strategaeth Iechyd a Gofal Integredig a'r ymgysylltiad y byddai angen ei wneud dros yr ychydig fisoedd nesaf gyda'r Bwrdd, timau arweinyddiaeth ehangach a chymunedau.

Dywedodd P Mears y byddai angen gwneud cryn dipyn o waith i wneud y Bwrdd Iechyd yn sefydliad sy'n gwirioneddol ganolbwyntio ar iechyd y boblogaeth ac ychwanegodd y byddai ymgysylltu yn elfen allweddol i'r darn hwn o waith, yn enwedig yr ymgysylltiad â'n cymunedau.

Mewn ymateb i sylw a wnaed gan S Webster mewn perthynas â sicrhau lefel y manylder ynghylch allbynnau disgwylidig o'r darn hwn o waith, dywedodd P Mears y byddai angen bod ag uchelgais gyffredinol ar y model gofal yn y dyfodol, yn ogystal â Strategaeth Glinigol fanylach a fyddai'n cynnwys manylion mewn perthynas â modelau gwasanaeth.

Estynnodd y Cadeirydd ei ddiolch i C Williams am gyflwyno'r adroddiad a chroesawodd y drafodaeth bwysig a gynhaliwyd ar y mater hwn. Dywedodd C Williams fod y Fframwaith Clinigol Cenedlaethol wedi'i atodi i'r adroddiad gan y byddai angen gwneud rhywfaint o'r gwaith lleol ochr yn ochr â'r fframwaith cenedlaethol.

Penderfyniad: NODWYD yr adroddiad.

7.2 Cynllun Tymor Canolig Integredig

Rhoddodd C Williams ddiweddariad llafar i'r Bwrdd a dywedodd fod y flwyddyn ddiwethaf wedi bod yn flwyddyn heriol i gynllunio ynddi. Nododd yr aelodau fod Llywodraeth Cymru wedi gofyn i'r Bwrdd Iechyd gyflwyno cynllun drafft a fyddai'n destun trafodaeth barhaus. Byddai'r cynllun drafft yn cael ei gyflwyno i Lywodraeth Cymru erbyn 31 Mawrth 2021 gyda goruchwyliaeth y Bwrdd. Dywedodd C Williams fod gofyniad fel Bwrdd Iechyd i gael Cynllun Tymor Canolig Integredig tair blynedd cymeradwy, a oedd eisoes ar waith yn dilyn y cynllun a gyflwynwyd i Lywodraeth Cymru y llynedd. Nododd yr aelodau fod Llywodraeth Cymru wedi cydnabod y byddai cynllun cymeradwy blaenorol y Bwrdd Iechyd yn parhau i fodoli.

Penderfyniad: NODWYD y diweddariad.

7.3 Arolwg Lles y Staff

Cyflwynodd H Daniel yr adroddiad a roddodd grynodedb i'r Bwrdd o ganfyddiadau'r Arolwg Lles Staff a gynhaliwyd ym mis Hydref 2020.

Croesawodd J Sadgrove yr adroddiad a oedd, yn ei barn hi, yn ddefnyddiol ac yn addysgiadol a chynghorodd fod y materion yn ymwneud â lles ein staff ar y gofrestr risg a'i fod yn destun pryder i'r Pwyllgor Ansawdd a Diogelwch a'r Pwyllgor Pobl a Diwylliant. Dywedodd J Sadgrove fod yr adroddiad yn cyfeirio at ddiffyg ymwybyddiaeth ymhlith staff o'r gwasanaeth lles ac awgrymodd y gallai cwestiwn ar hyn gael ei ychwanegu at yr arolwg nesaf. Cytunodd H Daniel fod angen codi ymwybyddiaeth o'r gwasanaethau oedd ar waith ar gyfer staff ac ychwanegodd fod adnodd cyfathrebu pwrpasol yn y broses o gael ei recriwtio i fynd i'r afael â hyn.

Mewn ymateb i gwestiwn a godwyd gan J Sadgrove ynghylch amseriad yr arolwg nesaf, y cynigiwyd ei gynnal yn ystod Ebrill/Mai, a fyddai'n fwy priodol ymgymryd â hyn ym mis Mehefin, cytunodd H Daniel i ystyried amseriad yr arolwg nesaf ac ychwanegodd y byddai'n awyddus i gynnal arolygiad staff yn rheolaidd.

Gwnaeth J Sadgrove sylwadau ar y poster "You Said, We Did" a gefnogodd yn llawn a chyfeiriodd at staff gan nodi eu bod yn teimlo nad oedd ganddynt ddigon o adnoddau. Ychwanegodd J Sadgrove na allai weld ymateb i hyn ac awgrymodd fod angen cydnabod hyn.

Mewn ymateb i gwestiwn a godwyd gan D Jouvenat mewn perthynas ag a oedd gwerthusiad yn cael ei gynnal o effeithiolrwydd rhai o'r gwasanaethau a gyflwynwyd ar gyfer staff, dywedodd H Daniel fod effeithiolrwydd gwasanaethau yn cael ei werthuso a chadarnhaodd, pe bai gwasanaeth yn gweithio, y byddai camau yn cael eu cymryd i roi cynnig ar atebion amgen.

Cyfeiriodd I Wells at y nifer gymharol fach o ymatebion a gafwyd gan staff a allai effeithio ar y dadansoddiad data, fodd bynnag, cydnabu hefyd fod yr

ymatebion a ddarparwyd hefyd yn cynnwys data gwerthfawr y mae'n rhaid gweithredu arno. Cytunodd I Wells hefyd y gallai fod angen ailystyried amseriad yr arolwg nesaf.

Dywedodd N Milligan mai un o'r meysydd sy'n peri'r pryder mwyaf a godwyd gan staff yw diffyg hyblygrwydd ac ychwanegodd y byddai angen ystyried hyn wrth symud ymlaen. Cytunodd H Daniel y byddai angen i'r Bwrdd Iechyd adnewyddu ei ddull o weithio hyblyg/ystwyth.

Penderfyniad: NODWYD yr adroddiad.

Cam
Gweithredu: Amseriad yr arolwg staff nesaf i'w ystyried gan H Daniel.

Cam
Gweithredu: Cydnabyddiaeth i'w rhoi i'r datganiadau a wnaed gan staff mewn perthynas â theimlo nad oes ganddynt ddigon o adnoddau ac ymateb i'w darparu yn y poster "You Said, We Did".

7.4 Diweddariad Cyllid - Mis 11

Cyflwynodd S Webster yr adroddiad a chynghorodd yr Aelodau, er bod y rhagolwg cyffredinol wedi aros ar sefyllfa o adennill costau, bod yr enillion arfaethedig o ran cyllid i Lywodraeth Cymru wedi cynyddu 5.9m i 26.9m. Nododd yr aelodau fod rhai risgiau gweddilliol yn ymwneud â hyn, a oedd yn cynnwys y gwariant gweithredol a drefnwyd ar gyfer Mawrth 2021 a chroniad gwyliau blynyddol a oedd ar hyn o bryd yn 15.9m. Nododd yr aelodau y byddai risg o hyd y byddai'r Bwrdd Iechyd yn cael ei hun â gwarged, y byddai'r Bwrdd Iechyd yn ceisio ei leihau.

Mewn ymateb i gwestiwn a godwyd gan P Roseblade ynghylch a oedd Llywodraeth Cymru wedi rhoi unrhyw arwydd y byddent yn derbyn y gwarged, dywedodd S Webster fod y Bwrdd Iechyd yn obeithiol, fodd bynnag, rydym yn aros am ymateb ffurfiol.

Penderfyniad: NODWYD yr adroddiad.

8 UNRHYW FATERION ERAILL

Ni nodwyd unrhyw eitemau.

9 DYDDIAD AC AMSER Y CYFARFOD NESAF

Byddai'r cyfarfod nesaf yn cael ei gynnal am 10.00am ddydd Iau 27 Mai 2021.

10 DIWEDD Y CYFARFOD



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Heb eu cadarnhau

Minutes of the In-Committee Meeting of

Cwm Taf Morgannwg University Health Board (CTMUHB) held on
Thursday 25th March 2021 as a Virtual Meeting via Microsoft Teams

Members Present:

Marcus Longley	Chair/ Independent Member
Paul Mears	Chief Executive
Maria Thomas	Vice Chair/ Independent Member
Nick Lyons	Executive Medical Director/ Deputy Chief Executive
Gareth Robinson	Interim Chief Operating Officer
Hywel Daniel	Executive Director for People
Patsy Roseblade	Independent Member
Dilys Jouvenat	Independent Member
Greg Dix	Executive Director of Nursing
Ian Wells	Independent Member
James Hehir	Independent Member
Jayne Sadgrove	Independent Member
Keiron Montague	Independent Member
Kelechi Nnoaham	Executive Director of Public Health
Mel Jehu	Independent Member
Nicola Milligan	Independent Member
Clare Williams	Executive Director of Planning & Performance (Interim)
Steve Webster	Executive Director of Finance

In Attendance:

Georgina Galletly	Director of Corporate Governance/Board Secretary
Cally Hamblin	Assistant Director of Governance & Risk
David Jenkins	Independent Advisor to the Board (Observing)
Sara Utley	Audit Wales
Wendy Penrhyn-Jones	Head of Corporate Governance & Board Business (Secretariat)

PRELIMINARY MATTERS

- 1.1 **Welcome & Introductions**
Marcus Longley welcomed everyone to the meeting in particular Patsy Roseblade as this was her first Board meeting since joining CTMUHB.
- 1.2 **Apologies for Absence**
Members NOTED apologies from Philip White, Independent Member and Fiona Jenkins, Interim Executive Director of Therapies & Health Sciences
- 1.3 **Declarations of Interest**
No declarations of interest were received.

2 MAIN AGENDA

2.1 Proposal for Property Acquisition & Disposal

A report seeking approval of the purchase of the freehold of the above site was RECEIVED.

In discussing the proposed purchase this was supported with the exception of Keiron Montague who felt he could not do so due to detailed plans for the use of the additional capacity not yet being available.

RESOLVED:

- The proposed purchase of the freehold be APPROVED on the basis that detailed plans for the proposed use of the additional accommodation be brought back to the Board in due course for consideration.

2.2 IMTP Scrutiny and Approval

A report seeking approval for the submission to Welsh Government of the draft CTM Annual Plan for 2021/22 was RECEIVED along with a presentation briefing Board Members as to the key issues that were impacting on the draft Annual Plan.

Clare Williams stated that at this stage the Board was being asked to support the submission of the draft annual plan to Welsh Government rather than approval of the content of the plan. Board Members NOTED that the submission was on the basis that CTMUHB would continue to work in parallel with Welsh Government to further develop the plan with a view to the financial impact being aligned with approved funding.

Paul Mears sought Board Member comments on the latest iteration of the draft Accountable Officer letter (appended to the agenda papers) addressed to the Director General/Chief Executive of NHS Wales, Welsh Government. Board Members confirmed that they were content with the letter.

RESOLVED:

- The submission of the draft CTMUHB Annual Plan for 2021/22 be APPROVED.
- The submission of the draft Accountable Officer letter be SUPPORTED.

3. ANY OTHER BUSINESS

There was no further business and the in-committee meeting of the Board was closed.

Cofnodion y Cyfarfod a Gynhaliwyd yn Breifat:

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg (CTMUHB) a gynhaliwyd ddydd Iau 25 Mawrth 2021 fel Cyfarfod Rhithwir drwy Microsoft Teams

Aelodau'n Bresennol:

Marcus Longley	Cadeirydd/Aelod Annibynnol
Paul Mears	Y Prif Weithredwr
Maria Thomas	Is-Gadeirydd/Aelod Annibynnol
Nick Lyons	Cyfarwyddwr Meddygol Gweithredol/Dirprwy Brif Weithredwr
Gareth Robinson	Prif Swyddog Gweithredu (Dros Dro)
Hywel Daniel	Cyfarwyddwr Gweithredol Pobl
Patsy Roseblade	Aelod Annibynnol
Dilys Jouvenat	Aelod Annibynnol
Greg Dix	Cyfarwyddwr Gweithredol Nyrsio
Ian Wells	Aelod Annibynnol
James Hehir	Aelod Annibynnol
Jayne Sadgrove	Aelod Annibynnol
Keiron Montague	Aelod Annibynnol
Kelechi Nnoaham	Cyfarwyddwr Gweithredol Iechyd y Cyhoedd
Mel Jehu	Aelod Annibynnol
Nicola Milligan	Aelod Annibynnol
Clare Williams	Cyfarwyddwr Gweithredol Cynllunio a Pherfformiad (Dros Dro)
Steve Webster	Cyfarwyddwr Gweithredol Cyllid

Eraill yn Bresennol

Georgina Galletly	Cyfarwyddwr Llywodraethiant Corfforaethol/Ysgrifennydd y
Cally Hamblyn	Bwrdd
	Cyfarwyddwr Cynorthwyol Llywodraethu a Risg
David Jenkins	Cynghorydd Annibynnol i'r Bwrdd (yn Arsylwi)
Sara Utley	Archwilio Cymru
Wendy Penrhyn-Jones	Pennaeth Llywodraethu Corfforaethol a Busnes y Bwrdd (Ysgrifenyddiaeth)

MATERION RHAGARWEINIOL

- 1.1 Croeso a Chyflwyniadau
Croesawodd Marcus Longley bawb i'r cyfarfod yn arbennig Patsy Roseblade gan mai hwn oedd ei chyfarfod cyntaf o'r Bwrdd ers ymuno â CTMUHB.
- 1.2 Ymddiheuriadau am Absenoldebau
NODODD yr aelodau ymddiheuriadau gan Philip White, Aelod Annibynnol a Fiona Jenkins, Cyfarwyddwr Gweithredol Dros Dro Therapiau a Gwyddorau Iechyd

- 1.3 Datganiadau o fuddiannau
Ni dderbyniwyd unrhyw ddatganiadau o fuddiannau.

2 PRIF AGENDA

- 2.1 Cynnig ar gyfer Caffael a Gwaredu Eiddo
DERBYNIWYD adroddiad yn gofyn am gymeradwyaeth i brynu rhydd-ddaliad y safle uchod.

Wrth drafod y pryniant arfaethedig, cefnogwyd hyn ac eithrio Keiron Montague a deimlai na allai wneud hynny oherwydd nad oedd cynlluniau manwl ar gyfer defnyddio'r capasiti ychwanegol ar gael eto.

PENDERFYNWYD:

- Y dylai'r bwriad i brynu'r rhydd-ddaliad gael ei GYMERADWYO ar y sail y dylid dod â chynlluniau manwl ar gyfer y defnydd arfaethedig o'r llety ychwanegol yn ôl i'r Bwrdd maes o law i'w hystyried.

- 2.2 Craffu a Chymeradwyo IMTP
DERBYNIWYD adroddiad yn gofyn am gymeradwyaeth i gyflwyno Cynllun Blynnyddol CTM drafft ar gyfer 2021/22 i Lywodraeth Cymru ynghyd â chyflwyniad i Aelodau'r Bwrdd ynghylch y materion allweddol a oedd yn effeithio ar y Cynllun Blynnyddol drafft.

Dywedodd Clare Williams fod gofyn i'r Bwrdd, ar hyn o bryd, gefnogi cyflwyno'r cynllun blynnyddol drafft i Lywodraeth Cymru yn hytrach na chymeradwyo cynnwys y cynllun. NODODD Aelodau'r Bwrdd fod y cyflwyniad ar y sail y byddai CTMUHB yn parhau i weithio ochr yn ochr â Llywodraeth Cymru i ddatblygu'r cynllun ymhellach gyda'r nod o alinio'r effaith ariannol â chyllid a gymeradwywyd.

Gofynnodd Paul Mears am sylwadau Aelodau'r Bwrdd ar y fersiwn ddiweddaraf o lythyr drafft y Swyddog Atebol (wedi'i atodi i bapurau'r agenda) a gyfeiriwyd at Gyfarwyddwr Cyffredinol/Prif Weithredwr GIG Cymru, Llywodraeth Cymru. Cadarnhaodd Aelodau'r Bwrdd eu bod yn fodlon â'r llythyr.

PENDERFYNWYD:

- Y dylid CYMERADWYO y broses o gyflwyno Cynllun Blynnyddol drafft CTMUHB ar gyfer 2021/22.

- Y dylid CEFNOGI y broses o gyflwyno llythyr drafft y Swyddog Atebol.

3. UNRHYW FATERION ERAILL

Nid oedd unrhyw faterion pellach a chaewyd cyfarfod y Bwrdd yn y pwyllgor.

HEB EU CADARNHAU



AGENDA ITEM

2.1.3

CTM BOARD

CHAIR'S REPORT

Date of meeting

27 May 2021

FOI Status

Open/Public

If closed please indicate reason

Not Applicable - Public Report

Prepared by

Director of Corporate Governance

Presented by

Marcus Longley, Health Board Chair/
Independent Member

Approving Executive Sponsor

Director of Corporate Governance

Report purpose

FOR APPROVAL

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)

Committee/Group/Individuals

Date

Outcome

N/A

NOTED

ACRONYMS

None

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. It also outlines where I have been required to affix the Common Seal of the Health Board for which endorsement is sought.

This overarching report highlights for Board Members the key areas of activity and where appropriate any associated risks, some of which are referred to within the business of the Board meeting and also highlights topical areas of interest to the Board.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 Health Board Appointments

Chair – Colleagues will be aware that my term of office finishes at the end of September 2021, and that I have decided not to seek a second term. Welsh Government Public Appointments Branch are leading the process to advertise and recruit a new Chair to commence in October 2021.

Vice Chair – Maria Thomas is officially retiring at the end of May 2021. I am so very grateful for Maria to have continued her role beyond the maximum period and for a smooth transition for the new Vice Chair. I would like to personally thank Maria for the outstanding service she has provided to the Health Board and for being a valuable member of the Board. I would like to wish Maria a very happy retirement and all the very best for the future. I am delighted to inform you that Jayne Sadgrove has been appointed as the new Vice Chair for Cwm Taf Morgannwg UHB and is due to commence post on the 1st June 2021.

Independent Members – The process of recruitment has commenced with Welsh Government for Independent Members whose Term of Office are due to end in the Autumn. The Board will be notified in advance of any new appointments.

Associate Member – Gio Isingrini's Term of Office came to an end in January 2021. Lisa Curtis Jones has been successful in securing the appointment of the Associate Member for Cwm Taf Morgannwg. Lisa is due to commence her role on the 1st June 2021. The Chair would like to



welcome Lisa who is observing today's Board Meeting ahead of her official start date.

Executive Posts

An update on Executive appointments is included in the Chief Executive's Report to the Board.

2.2 Governance and Leadership Support to the Board/Targeted Intervention (Organisation) & Special Measures (Maternity)

Members will be aware that as previously reported, David Jenkins has been providing governance and leadership support to myself and the Board regularly attending and observing the work of the Board and its Committees. David's term came to an end with Cwm Taf Morgannwg on the 30th April 2021 after agreeing with the Minister and Welsh Government that the Board's oversight, challenge and governance has sufficiently improved.

I am very grateful to David for the support he has provided to me as Chair and to the wider Board.

2.3 Board Strategy Development Sessions 22 April 2021 & 29 April 2021.

There were two sessions held in April focussed on the development of the Health Board's overarching Strategy. The first focussed on "Resetting Cwm Taf Ambition" and the second focussed on "Developing our Ambition".

2.4 Diary Commitments/Meetings attended since the last Board Meeting.

- Chairs Peer Group Meeting
- NHS Reset Chairs /Vice Chairs Meeting
- Local Authority Leaders/Chair/CEO Meeting
- Independent Members/Chair/CEO Meeting
- 1:1s Director of Governance
- Board Development Session
- Cwm Taf Public Service Board Meeting
- Committee Chairs Meeting
- 1:1s David Jenkins
- 1:1s Chief Executive
- Quality, Safety & Risk Committee
- Consultant Panel Interviews
- 1:1s Vice Chair

- Remuneration Committee
- Appraisal Meetings with Independent Members
- Executive Director Interviews
- Cwm Taf Morgannwg Staff Q&A session
- Cwm Taf Board TI Self Assessment Meeting
- Meeting with CEO Healthcare Inspectorate Wales
- Meeting with Wales Audit Office

Meetings / discussions with Local Politicians

- AM/MP weekly meetings with Chair/CEO

3 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 COMMON SEAL

The Board is asked to ratify the use of the Common Seal applied since the last Board meeting;

- Agreement between Cwm Taf Morgannwg UHB and the contractor TSF Contracts Ltd of Unit 1a Hepworth Business park, Coedcae Lane, Pontyclun CF72 9FQ – Ward 5 Refurbishment, Royal Glamorgan Hospital.
- Agreement between Cwm Taf Morgannwg UHB and the contractor PJ Saunder Ltd of Unit 9 The Beeches Industrial Estate Talbot Green CF72 9DY - Upgrade to the existing anti-ligature risks in existing mental health units at Prince Charles Hospital, Princess of Wales Hospital, Caswell Angleton and Taith, Glanrhyd Hospital, and Cefyn yr Afon.
- Agreement between Deed of Transfer - Unit 3, Gwaun Elai Campus Ely Valley Road, Llantrisant CTMUHB The Welsh Minister
- Agreement between Cwm Taf Morgannwg and Welsh Ministers and the coal Authority –Deed of Covenant for Unit 3, Gwaun Elai Medi Science Park, Ynys Maerdy.
- Agreement between Cwm Taf Morgannwg and Welsh Ministers - Deed of Variation for property Unit 3, Gwaun Elai Pontyclun.
- Agreement between Cwm Taf Morgannwg UHB and HM Land Registry TR1 - Transfer of whole of registered title(s) – Property known as Unit 3, Gwaun Elai Rhodfa Marics, Ynysmaerdy, Pontyclun. Executed as a deed by The Santhouse Pensioner Trust Company Transferee for entry in the register.
- Agreement between Cwm Taf Morgannwg UHB and Assura Aspire UK Limited - TIR lease relating to Tylorstown Surgery, Ferndale Road, Tylorstown, Ferndale CF43 3HB.

- Agreement between Cwm Taf Morgannwg UHB and Assura Aspire UK Limited - TIR lease relating to Maerdy Surgery, North Terrace, Maerdy, Ferndale CF43 4DD.
- Agreement between Cwm Taf Morgannwg UHB and Assura Aspire UK Limited - TIR lease relating to Ferndale Medical Centre, High Street, Ferndale CF43 4XX.
- Agreement between Cwm Taf Morgannwg UHB, Bridgend County Borough Council, The Police and Crime Commissioner for South Wales, The Chief Constable of South Wales Police and National Probation Service - Bridgend Multi Agency Safeguarding Hub
- Agreement between Cwm Taf Morgannwg UHB and Rhondda Cynon Taff CBC - funding to support the delivery of the additional learning needs transformation programme, including preparing for and managing the implementation of the Additional Learning Needs and Educational Tribunal (Wales) Act 2018.
- Agreement between Cwm Taf Morgannwg UHB and Ace Building Contractors (Wales) Limited - Day surgical unit at Prince Charles Hospital, Merthyr Tydfil.

This requires endorsement by the Board as set out in the recommendations of this report.

3.2 CHAIR'S URGENT ACTION

There are no chair's urgent actions to note during this report period.

5 IMPACT ASSESSMENT

Quality / Safety / Patient Experience implications	Yes (Please see detail below)
	The number one focus of the Board and its business is to ensure good quality and safe patient care across all areas of its activity.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	The 22 Health & Care Standards for NHS Wales are mapped into the 7 Quality Themes but within a Governance Framework.
Equality impact assessment completed	Not required



	No specific impact identified.
Legal implications / impact	Yes (Include further detail below)
	Board endorsement of the Affixing of the Common Seal, is a requirement of the Board's Standing Orders.
Resource (Capital/Revenue £ / Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Well-being Objectives	Work with communities and partners to reduce inequality, promote well-being and prevent ill-health

6 RECOMMENDATION

Members of the Board are asked to:

- NOTE the report.
- ENDORSE the Affixing of the Common Seal to the above listed documents.

		AGENDA ITEM	
		2.1.4	
CTM HEALTH BOARD			
MENTAL HEALTH ACT MONITORING COMMITTEE ANNUAL REPORT 2020/21			
Date of meeting		27/05/2021	
FOI Status		Open/Public	
If closed please indicate reason		Not Applicable - Public Report	
Prepared by		Kathrine Davies, Corporate Governance Manager	
Presented by		M Thomas, Vice Chair & Chair of MHAM Committee	
Approving Executive Sponsor		Executive Director of Primary, Community & Mental Health	
Report purpose		FOR APPROVAL	
Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)			
Committee/Group/Individuals		Date	Outcome
Mental Health Act Monitoring Committee		05/05/2021	Approved
ACRONYMS			
MHAMC	Mental Health Act Monitoring Committee		
CTMUHB	Cwm Taf Morgannwg University Health Board		

1. SITUATION / BACKGROUND

- 1.1 The purpose of this report is to highlight to the Board the activities and performance of the Mental Health Act Monitoring Committee (MHAMC) during the year 2020-2021.
- 1.2 The Chair of the MHAM Committee is required to present an annual report outlining MHAMC's business through the financial year to the Health Board to provide an assurance on the monitoring and scrutiny undertaken of Cwm Taf Morgannwg University Health Board (CTMUHB) performance in relation to the Mental Health Act.
- 1.3 The MHAMC's Annual Report for 2020-2021 is presented at Appendix 1 for approval. The Terms of Reference approved by the Health Board in September 2020 are available upon request and are published on the Health Boards website. A Committee Effectiveness Survey is currently underway and will be analysed with a view to an improvement plan being developed and presented to the Committee at its next meeting in August 2021.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

- 2.1 The purpose of this report is to seek Board approval of the Committee's Annual Report.

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

- 3.1 The publication of the Annual Report demonstrates compliance with Standing Orders, which stipulates that each Advisory Group is required to submit an annual report to the Board through the Chair within three months 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.

4. IMPACT ASSESSMENT

Quality / Safety / Patient Experience implications	There are no specific quality and safety implications related to the activity outlined in this report.
Related Health and Care standard(s)	Governance, Leadership and Accountability

	If more than one Healthcare Standard applies please list below:
Equality impact assessment completed	Not required
Legal implications / impact	Yes (Include further detail below) This report complies with the requirement to submit an annual report to the Board through the Chair within 3 months 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.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Well-being Objectives	Work with communities and partners to reduce inequality, promote well-being and prevent ill-health

5. RECOMMENDATION

The Health Board is asked to:

- APPROVE the MHAMC Annual Report for 2020/21.

Appendix 1

Mental Health Act (MHA) Monitoring Committee

Annual Report 2020-2021

MENTAL HEALTH ACT (MHA) MONITORING COMMITTEE DRAFT ANNUAL REPORT 2019-20

1. FOREWORD

I am pleased to present the draft Annual Report of the Mental Health Act Monitoring Committee. The purpose of this report is to formally report on the work of the Committee for the year ending 31 March 2021 in accordance with the Committee's Terms of Reference.

I would like to express my thanks to all the officers of the Health Board, Local Authorities and South Wales Police who have supported and contributed to the work carried out and for their commitment in meeting important targets and deadlines.

2020-2021 has been very challenging during the ongoing Covid-19 pandemic with the Health Board having to move to different ways of working. I would like to extend my thanks to the Mental Health team for adapting so quickly to new processes such as the implementation of electronic documentation and using Microsoft Teams to facilitate hearings and enable the Health Board to meet the requirements of the MHA and Code of Practice.

The Committee has continued to foster and promote a culture of working in partnership for ongoing improvement. As Chair, I have ensured that the work of the Committee progresses in line with its Terms of Reference and also ensured that crossover work is seamless with the Together for Mental Health Partnership Board which I also chair.

Due to my pending retirement, a new Chair of the Committee has been elected and I am pleased to advise that the new Chair will be Jayne Sadgrove and would like to wish her every success for the future.

Maria K Thomas

Chair, Mental Health Act Monitoring Committee / Vice Chair, CTMUHB.

2. INTRODUCTION

The MHA Monitoring Committee is chaired by the Vice Chair of the Health Board and monitors the Health Board's compliance with the statutory requirements of the MHA. The work of this Committee, including its Terms of Reference, has been reviewed and refreshed during the year being reported (2020/21). The Committee has continued to evolve with changes to report format and agenda content during the year.

The papers for the meeting are routinely published on the organisation's [website](#).

The Committee meets on a quarterly basis and following each meeting produces a highlight report which is then submitted to the next Board meeting to highlight key issues and risks. Broader mental health issues are discussed and taken forward via other established fora such as the Together for Mental Health Partnership Board (which is Chaired also by the Vice Chair of the Health Board).

The purpose of the MHA Monitoring Committee is to ensure that all the requirements of the MHA 1983 (as amended) are met by the Health Board.

The Committee considers:

- how the delegated functions under the MHA are being exercised (for example using the Annual Audit) and in line with the 'Code of Practice' requirements
- the multi-agency training requirements of those exercising the functions (including discussing the training report for assurance)
- the operation of the 1983 Act within the Cwm Taf Morgannwg area
- issues arising from the operation of the hospital managers' power of discharge
- suitable mechanisms for reviewing multi agency protocols / policies relating to the 1983 Act
- trends and patterns of use of the MHA 1983
- cross-agency audit themes and sponsor appropriate cross-agency audits
- lessons learnt from difficulties in practice and the development of areas of good practice.

The Committee is also responsible for developing an annual report for presentation to the Health Board.

3. MEMBERSHIP

The membership of the MHA Monitoring Committee comprises both Independent and an Executive Director Members, enabling the Committee to provide appropriate scrutiny and assurance to the Board independently of the management decision-making processes.

Independent membership during 2020-21 was as follows:

- Maria K Thomas, Vice Chair of the Health Board (Chair of the Committee)
- Mel Jehu, Independent Member
- James Hehir, Independent Member
- Phillip White, Independent Member

During 2020/21 the Executive Director Committee Member was Alan Lawrie, Executive Director of Operations (until December 2020). Alan Lawrie delegated his representation to Julie Denley, Director of Primary, Community and Mental Health.

Gareth Robinson, Interim Chief Operating Officer replaced Alan Lawrie from January 2021 (although due to Covid-19 it was necessary to cancel the meeting due to have taken place in February 2021)

4. MEETINGS

Due to the Coronavirus Pandemic of 2020/21 a number meetings of Board Committees were paused, initially in the Spring of 2020 and then again just before the end of the financial year. The MHA Monitoring Committee therefore met on three occasions during 2020/21 and as a consequence its forward work programme was reviewed to ensure that issues were appropriately prioritised.

The three dates on which it met during 2020/21 were as follows:

- 21 August 2020
- 4 November 2020
- 10 December 2020

Mental Health Act Monitoring Attendance 2020-2021		21 Aug 2020	4 Nov 2020	10 Dec 2020	Total
Maria Thomas (Chair)	Vice Chair, Independent Member	✓	✓	✓	3 / 3
Mel Jehu	Independent Member	✓	✓	✓	3 / 3
James Hehir	Independent Member	✓	✓	✓	3 / 3
Phillip White	Independent Member	✓	✓	✓	3 / 3
Alan Lawrie	Director of Primary, Community & Mental Health (until December 2020)	x	x	x	0 / 3
Julie Denley	Director of Primary, Community & Mental Health Services	✓	✓	✓	3 / 3
Gareth Robinson	Interim Chief Operating Officer (from January 2021)				-
Kishore Kale	Clinical Director	x	✓	x	1 / 3
Phil Lewis	Head of Nursing (Acute Mental Health)	✓	✓	✓	3 / 3
Sam Shore	Senior Nurse	x			1 / 1
Robert Goodwin	Service Group Manager, Mental Health		✓	✓	2 / 2
Fiona Thomas	Localities Manager Mental Health	✓	✓	✓	3 / 3
Jeremy Burgwyn	Head Administrator, Mental Health Team	✓	✓		2 / 2
Peter Thomas	South Wales Police Advisor for Mental Health	✓	✓		2 / 2
Colin Hatherley	South Wales Police Mental Health Officer	x	x		0 / 2
Karen Thomas	Superintendent, South Wales Police	x	✓		2 / 1
Alyson Jones	Representative Merthyr Tydfil County Borough Council	x			0 / 1
Angela Edavene	Representative Merthyr Tydfil County Borough Council		✓		1 / 1
Frances Hall	Representative Rhondda Cynon Taff CBC	x	✓		1 / 1
Alex Beckham	Representative Rhondda Cynon Taff CBC	✓	x		1 / 1

Mental Health Act Monitoring Attendance 2020-2021		21 Aug 2020	4 Nov 2020	10 Dec 2020	Total
Jackie Davies	Representative Bridgend CBC	X	✓		1 / 1
Julie Cude	Head of Nursing CAMHS	✓			1 / 1
Ceri William-Price	Consultant, CAMHS		X	X	0 / 2
Gregory Lloyd	Welsh Ambulance Services Trust	X	✓		1 / 2
Wendy Penrhyn-Jones	Head of Corporate Administration	✓	✓	✓	3 / 3

All of the above meetings were quorate.

The Committee's Terms of Reference were reviewed and approved by the Board in July 2020. A minor further amendment requested by the MHA Monitoring Committee in August 2020 and the terms of reference were reapproved by the Board September 2020 and are available upon request.

5. MAIN AREAS OF MHAM COMMITTEE ACTIVITY

The agenda for each meeting has followed a standard format in five main parts:

- Part 1 - Preliminary Matters
- Part 2 - Items for Approval/Discussion
- Part 3 - Governance, Performance and Assurance
- Part 4 - For Information / Other Matters.

Part 1 - Preliminary Matters

This section of the meeting provides the standard governance approach within all Board Committees within CTMUHB. This includes the action log which captures all areas for attention following the meeting.

Part 2 - Items for Approval / Discussion

This section has included receiving the:

- Committee Annual Report 2019/2020 and self-assessment questionnaire
- Results of the Committee Self-Assessment
- Self-Assessment Action Plan

Part 3 - Governance, Performance and Assurance

This section has included reports throughout the year which included:



- Mental Health Act – Quarterly Activity Statistical Report
- Report from Mental Health Operational Group
- Strategic update from South Wales Police (Section 13,15 & 136)
- including mental health staff in police control centre
- Mental Health Act Breaches Relating to the Mental Health Act
- Risks related to the Monitoring of the Mental Health Act
- Crisis Care Concordat
- South Wales Police Mental Health APP
- Impact of Covid-19 on Patients in relation to the Mental Health Act
- Conclusions from the Section 136 Audit

Part 4 - For Information / Other Matters

There were no items shared with the Committee for information sharing purposes.

The 'Forward Look' plan for the Committee was reviewed at each meeting to ensure its content remained appropriately focused.

The Committee Highlight Report is produced following each meeting and subsequently presented to the next available Board meeting.

Links with Other Committees/Boards

Where appropriate a process is in place for any relevant matters to be referred to other Board Committees for scrutiny and or action.

6. ACTION LOG

In order to monitor progress and any necessary follow-up action, the Committee uses an Action Log that captures all agreed actions and this is reviewed at the beginning of each meeting.

7. GOVERNANCE

The Committee provides an essential element of the overall governance framework for the organisation. The Terms of Reference for the Committee provide a robust commitment to monitor the application of the MHA.

8. ASSURANCE TO THE BOARD

Like many service areas mental health services were impacted by the pandemic and Welsh Government made provision for how the Mental Health Act could be applied and administered should the pandemic have warranted this. The committee was updated as regards these provisions which did not prove necessary and it was assured that patients' needs were met and full compliance with legislation maintained.

The Committee continued to receive updates regarding ongoing audit work and changes put into place to improve the application of the MHA and work to integrate approaches and policies in relation to the Act have again continued in year.

The MHA Monitoring Committee wishes to assure the Board that on the basis of the work completed by the Committee during 2020-2021, there are effective measures in place to scrutinise and monitor the application of the MHA.



AGENDA ITEM

2.1.5

CTM BOARD

QUALITY & SAFETY COMMITTEE ANNUAL REPORT 2020-2021

Date of meeting

27/05/2021

FOI Status

Open/Public

If closed please indicate reason

Not Applicable - Public Report

Prepared by

Emma Walters, Corporate Governance Manager

Presented by

Georgina Galletly, Director of Corporate Governance

Approving Executive Sponsor

Director of Corporate Governance

Report purpose

FOR APPROVAL

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)

Committee/Group/Individuals

Date

Outcome

Quality & Safety Committee

18/05/2021

ENDORSED FOR APPROVAL

ACRONYMS

1. SITUATION / BACKGROUND

- 1.1 Under Standing Order 10.2.3, each Committee of the Board is required to submit an annual report *“setting out its activities during the year and detailing the results of a review of its performance”*.

- 1.2 This annual report from the Quality & Safety Committee details the activities and performance for the Committee for the reporting period 2020-2021.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

- 2.1 The Committee Annual Report at Appendix 1, summarises the key areas of business activity undertaken by the Committee from April 2020 – March 2021 and highlights some of the key issues which the Committee intend to give further consideration to over the next 12 months.

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

- 3.1 Please refer to Appendix 1 for the full detail contained within the report.

4. IMPACT ASSESSMENT

Quality / Safety / Patient Experience implications	There are no specific quality and safety implications related to the activity outlined in this report.
Related Health and Care standard(s)	Governance, Leadership and Accountability If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
Legal implications / impact	Not required
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £ / Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.



Link to Strategic Well-being Objectives	Provide high quality, evidence based, and accessible care

5. RECOMMENDATION

5.1 The Committee are being asked to ENDORSE FOR BOARD APPROVAL the Committee Annual Report.

Quality & Safety Committee

Committee Annual Report 2020-2021

QUALITY & SAFETY COMMITTEE ANNUAL REPORT 2020-2021

1. FOREWORD

I am pleased to be able to commend to you this annual report, which has been prepared for the attention of the Board and reviews the work of the Committee for the financial year 2020-2021.

During the year, I have been greatly supported by Maria Thomas (former Chair of the Committee), James Hehir, Nicola Milligan, Dilys Jouvenat, Paul Griffiths, Keiron Montague and Patsy Roseblade who have contributed their considerable knowledge and wide-ranging experience to the Committee.

I would like to express my sincere thanks to all the officers of the Committee who have supported and contributed to the work carried out and for their commitment in meeting important targets and deadlines. I would particularly like to extend my thanks to colleagues within the Corporate Governance Team for the support they provided me throughout the year. I also wish to record my appreciation for the support and contribution given by the Internal Audit team at the NHS Wales Shared Services Partnership (NWSSP), by Audit Wales, Healthcare Inspectorate Wales and Delivery Unit colleagues.

I would like to extend my thanks to David Jenkins, Independent Advisor to the Board who attended a number of meetings throughout the year, and would like to thank him for the invaluable support provided to the Board during 2020/2021.

Going forward, the Committee intends to continue to pursue a full programme of work covering a wide range of topics and subject areas as part of its long term aim to help further strengthen the governance arrangements of the Health Board.

Jayne Sadgrove
Chair of the Quality & Safety Committee
Cwm Taf Morgannwg University Health Board (CTMUHB)

2. INTRODUCTION

The purpose of the Quality & Safety Committee “the Committee” is to provide assurance to the Board on the provision of workplace health & safety and safe and high quality care to the population we serve, including prevention through public health, primary and secondary care. The Committee embraces the values of the Health Board and the objectives outlined within its Integrated Medium Term Plan (IMTP) which are:

- Work with communities and partners to reduce inequality, promote well-being and prevent ill-health.
- Provide high quality, evidence based and accessible care.
- Ensure sustainability in all that we do, economically, environmentally and socially.
- Co-create with staff and partners a learning and growing culture.

The key function of the Quality & Safety Committee is to provide scrutiny on behalf of the Board on all matters relating to Quality and Safety.

Following the introduction of monthly meetings during 2019/2020, a decision was made to move to holding bi-monthly meetings during 2020/2021.

As part of the actions arising from the maternity service review a significant organisational development programme continued to be rolled-out to deliver sustainable cultural and behavioural changes. The Board has continued to use this opportunity, together with the learning from the 2019 Wales Audit Office (WAO – now Audit Wales) & Healthcare Inspectorate Wales (HIW) national thematic audit on quality governance and the proposed HIW local governance review to further strengthen both internal controls and quality governance arrangements going forward.

3. ROLE, MEMBERSHIP, ATTENDEES AND COMMITTEE ATTENDANCES

3.1 ROLE

The role of the Committee is to advise and assure the Board on whether there are effective Quality & Safety arrangements in place – through the design and operation of the Health Board system of assurance – to support it in its decision taking and in discharging the accountabilities for securing the achievement of the Health Board objectives in accordance with the standards of good governance determined for the NHS in Wales.

The Committee’s Terms of Reference are reviewed annually and are available via the following link: <https://cwmtafmorgannwg.wales/how-we-work/standing-orders/>

3.2 MEMBERSHIP

The membership of the Quality & Safety Committee comprises of six Independent members, enabling the Committee to provide robust scrutiny and assurance to the Board independently of the management decision-making processes.

A summary of the Independent membership during 2020-2021 is outlined in table 1 below:

Table 1 – Composition & Membership of the Quality & Safety Committee Apr 2020-March 2021

Name	Period
Members	
Jayne Sadgrove (Committee Chair) Independent Member	April 2020 – March 2021 Committee Chair from August 2020
Maria K Thomas Vice Chair/Independent Member	Apr 2020 – March 2021 Committee Chair up until July 2020
Keiron Montague Independent Member	Apr 2020 – June 2020
James Hehir Independent Member	Apr 2020 - March 2021
Nicola Milligan Independent Member	Apr 2020 – March 2021
Dilys Jouvenat Independent Member	April 2020 -March 2021
Paul Griffiths Independent Member	July 2020 – December 2020
Patsy Roseblade Independent Member	From March 2021

3.3 ATTENDANCE AT QUALITY & SAFETY COMMITTEE 2020-2021

During the year, the Committee met on six occasions. All meetings were quorate and were well attended as shown in Table 2 below:

Table 2 - Meetings and Member Attendance 2020-2021

In Attendance	12 May 2020	14 July 2020	8 Sept 2020	18 Nov 2020	19 Jan 2021	16 Mar 2021	Total
Independent Members							
• Not required to attend as held as quorate meeting							
Maria K Thomas (Chair of the Committee up to July 2020)	✓	✓	x	✓	✓	✓	5 / 6
Jayne Sadgrove (Chair of the Committee up from August 2020)	✓	✓	✓	✓	✓	✓	6 / 6
Keiron Montague – Independent Member (up until June 2020)	✓						1 / 1
Nicola Milligan – Independent Member	✓	x	✓	✓	✓	✓	5 / 6
Dilys Jouvenat – Independent Member	*	✓	✓	✓	✓	✓	5 / 5
James Hehir – Independent Member	*	✓	x	x	✓	✓	3 / 5
Paul Griffiths – Independent Member (from July 2020 to December 2020)		✓	x	✓			2 / 3
Patsy Roseblade Independent Member (from March 2021)						✓	1 / 1

3.4 ATTENDEES

The Committee's work is informed by reports provided by leads within CTMUHB, Cwm Taf Morgannwg Community Health Council, Healthcare Inspectorate Wales, Audit Wales, Internal Audit and the Delivery Unit. Although not members of the Committee, colleagues from these areas are invited to attend each meeting of the Quality & Safety Committee. Invitations to attend the Committee meeting are also extended, where appropriate and on an 'ad hoc' basis, to specific staff when reports which relate to their specific area of responsibility are being discussed.

4. QUALITY & SAFETY COMMITTEE BUSINESS

The Quality & Safety Committee provides an essential element of the Health Board's overall assurance framework. As a result of the Covid-19 pandemic, all meetings were held virtually via Microsoft Teams during 2020/2021 and a Consent Agenda process was introduced during the year also. Any items included on the consent agenda were considered by Members prior to each meeting, with Members given the opportunity to raise questions prior to the meetings regarding the reports. All reports included on the Main Agenda were discussed during each meeting. The Quality & Safety Committee agenda broadly follows a standard format, comprising of specific sections, the activity of the Committee during 2020 are outlined in Appendix 1 of this report.

Links with Other Committees/Boards

Key risk areas from the Quality & Safety Committee are highlighted at full Board by the Committee Chair via the highlight report.

During the course of 2020-2021, the following items were referred from other Committees:

- Audit Wales Operating Theatre Department Review - Referral from Audit & Risk Committee
- Internal Audit Follow Up Review - Head & Neck Position Statement - Referral from Audit & Risk Committee

During 2020/2021 a new process was introduced for Committee referrals. At each meeting, for any Committee referrals made, the Chair of the Committee or the Corporate Governance Lead will ensure that the the following questions are captured should a referral be made:

- What are you referring?
- Why are you referring?
- What is the outcome you are anticipating from this referral?

5. ACTION LOG

In order to monitor progress and any necessary follow up action, the Committee has developed an Action Log that captures all agreed actions. This has provided an essential element of assurance both to the Committee and from the Committee to the Board.

During 2020/2021, an Annual Cycle of Committee Business was also introduced which has helped to structure the forward work programme for future Committee meetings and helped to identify the key areas of focus for the Committee.

6. GOVERNANCE

The effectiveness of the Committee is monitored through the following key governance activity:

- Annual Review of the Terms of Reference
- Annual Committee Annual Report

- Highlight Reports from the Committee to the Health Board meetings
- Annual Committee Effectiveness Self-Assessment Survey
- Committee Annual Cycle of Business

The Corporate Governance Team maintain a “Committee Effectiveness Tracker” to ensure the above activity is undertaken at the appropriate times during the year.

Committee Annual Self-Assessment

The Committee completed its Annual Self-Assessment for 2019-2020 via Survey Monkey and the analysed results were presented to the March 2021 meeting of the Committee.

7. ASSURANCE TO THE BOARD

The Quality & Safety Committee considers that on the basis of the work completed by the Committee during 2020 - 2021, there are effective measures in place that have delivered its agreed Terms of Reference.

The forward work programme for 2021-2022 and beyond, ensures that the Committee retains scrutiny on key areas of activity, not exclusive to but including the following:

- Patient experience
- Learning lessons and sharing best practice
- Maternity Services oversight and scrutiny
- Quality Governance arrangements
- Compliance with the Nurse Staffing Levels (Wales) Act
- Quality improvement initiatives
- Scrutiny of any Regulatory and Inspectorate Body reports
- Community Health Council visits
- Consideration of the Audit Wales Structured Assessment feedback to consider how best to manage and prioritise the volume of the Committees business.
- Monitoring the activity considered by the Health, Safety & Fire Sub Committee established in August 2019

In addition the Committee Chair will meet with the lead officers and the Chair of the Board to discuss progress of the work of the Committee.

A committee cycle of business was also developed for 2020-21. The cycle of business will identify the reports which will be regularly presented for consideration. The annual cycle is one of the key components in ensuring that the Committee is effectively carrying out its role. It also facilitates the management of agendas and Committee business.

8. LINKS WITH OTHER COMMITTEES

The Quality & Safety Committee will continue to have close links with other Committees of the Board, particularly the Audit & Risk Committee and Health Safety & Fire Sub Committee.

Through either specific meetings or the regular Independent Member meetings there is an opportunity for Committee Chairs to support the work of each of the Committees they Chair, share learning and avoid duplication. All Committee Chairs have access to Committee Highlight Reports to the Board.

DRAFT

APPENDIX 1

1. Preliminary Matters

This included the apologies for absence, welcome and introductions, declarations of interest, receiving and approving the unconfirmed minutes of the last meeting and receiving the action log. This section also included a Patient Story as and when available.

2. Consent Agenda

During 2020 – 2021 the following items were received on the Consent Agenda for Approval/Endorsement:

- Quality & Safety Committee Terms of Reference
- Major Trauma Network Clinical Guidelines
- Cancer Services – Standard Operating Procedure for Harm Reviews
- Annual Quality Statement
- Quality Governance Framework
- Quality & Safety Committee Annual Report 2019/2020
- Once for Wales Concerns Management System
- Health, Safety & Fire Sub Committee Terms of Reference
- Quality & Safety Committee Annual Cycle of Business
- Environmental Policy
- Medicines Management Vaccine Policy
- Handling Persistent & Serial Complaints Policy

During 2020 – 2021 the following items were received on the Consent Agenda for Noting/Information

- Improvement Plan to support the Intervention into CTMUHB Systems and Processes for Reporting, Management and Review of Patient Safety Incidents and Concerns
- Healthcare Inspectorate Wales Review of Mental Health Services at Ward 7, Ysbyty Cwm Cynon;
- Child Protection Medicals
- Equality & Welsh Language Update
- Committee Forward Work Programme
- Corporate Policies Sub Group Update
- Quality Impact Assessment Process
- Safeguarding & Public Protection Annual Report 2019/2020
- Policy Management Improvement Plan (Clinical and Non Clinical Policies)
- NHS Wales Shared Services Partnerships Legal & Risk Services – Impact & Reach Report
- Covid 19 Lessons Learnt Report
- Shared Listening & Learning Forum update
- Staff Incident Reporting Feedback
- Community Health Council (CHC) Briefing - Living with Coronavirus: Health and Care Services During Winter
- Community Health Council Briefing - Maternity Services in Wales: What CHCs have heard during the coronavirus Pandemic and Health Board Response
- Welsh Ambulance Services NHS Trust Patient Experience Highlight Reports
- Leave No-One Behind Report
- Clinical Audit Quarterly Update

- Medical Device Alert MDA 2020/019 Abbott Trifecta Valve Prosthesis
- Vaccination Update

3. Main Agenda

During 2020 – 2021 the following items were received:

- Update on Maternity Services and Neonates;
- COVID-19 Update
- COVID-19 Nursing Workforce Plan to Support Increased Capacity
- Royal College of Anaesthetists & Royal College of Surgeons Invited Service Review on the Intensive Care Service for General Surgery Patients At Princess Of Wales Hospital
- Development of Universal Mortality Reviews in Cwm Taf Morgannwg University Health Board
- A Summary of Avoidable Mortality in Cwm Taf Morgannwg University Health Board
- Cwm Taf Morgannwg University Health Board National Clinical Audit Programme and Covid-19
- Quality Governance Arrangements for non COVID-19 Activities
- Guidance Note Issued by Welsh Government – Discharging Board Committee Responsibilities During COVID-19 Response Phase
- Health, Safety & Fire Report
- Revised Quality Governance Framework
- Ophthalmology Follow Up Outpatients Not Booked Update
- General Follow Up Outpatients Not Booked Update
- National Collaborative Commissioning Unit NHS Wales Quality Assurance Improvement Service Annual Position Statement
- Resetting Cwm Taf Morgannwg Operating Framework
- Organisational Risk Register – Risks Assigned to the Quality & Safety Committee
- Quality Governance – Regulatory Review Recommendations and Progress Updates
- Delivery Unit (DU) Management Review of Patient Safety Incidents and Concerns - Quarterly Update
- Healthcare Inspectorate Wales (HIW) and Wales Audit Office - Joint Review into Quality Governance
- Resetting Cwm Taf Morgannwg Operating Framework – Harm Reviews
- Out of Hours Cwm Taf Morgannwg Peer Review
- Inpatient Mortality Review Update
- Primary Care Covid-19 Mortality Review Update
- MBRRACE Perinatal Mortality Surveillance Report
- Peer Review – Systematic Anticancer Therapies (First Round)
- CTM Response to “First Do No Harm” – The Report of the IMMDS Review the Cumberlege Report
- Management & Review of Organisational Wide - Clinical and Non Clinical Policies
- Ophthalmology Position Statement
- Learning From Improvement Position
- Quarter 3 & Quarter 4 Plan Implications on Potential Harm

- Delivery Unit Review of Ophthalmic Diagnostic & Treatment Centre - Progress Report
- Delivery Unit Review on Cardiology to Cardiac Surgery Follow Up - Progress Report
- Rationale for opening of the Field Hospital and Assurances received by Gold to inform the decision - To include Quality Impact Assessment
- Specialist COVID Mortality Review Oversight Group Draft Terms of Reference
- Improving Serious Incident Management in CTM: Revised Serious Incident Toolkit and Serious Incident Team
- Learning Disability Services Covid Reflections
- Improving Quality & Preventing Reoccurrence within Maternity Services
- Resilience in the Workforce in Maternity Services
- Neonatal Services - An Update of Perinatal Mortality Review
- Delivery Unit Action Plan - Cancer Services
- Update on Covid19 Nursing Workforce Plan to Support Increased Capacity
- Chief Operating Officer Report
- Committee Annual Self-Assessment Questionnaire Response

Integrated Quality & Safety Exception Reports were received from the following areas:

- Bridgend Integrated Locality Group;
- Merthyr & Cynon Integrated Locality Group
- Rhondda Taff Ely Integrated Locality Group;
- Facilities Directorate
- Primary Care Directorate

The following Chairs reports and minutes from the Committee Sub Groups were received by the Committee during 2020 – 2021:

- Infection, Prevention & Control Committee;
- Health, Safety & Fire Sub Committee
- Medicines Management Expenditure Committee

4. Items for Information

During 2020 – 2021 the following items were received:

- Ombudsman Annual Report and Accounts for 2019/2020
- Cwm Taf Morgannwg UHB Ombudsman Report



AGENDA ITEM

2.1.6

CTM BOARD

AMENDMENT TO STANDING ORDERS

Date of meeting	27/05/2021
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	CallyHamblyn, Assistant Director of Governance & Risk
Presented by	Georgina Galletly, Director of Corporate Governance
Approving Executive Sponsor	Director of Corporate Governance
Report purpose	FOR APPROVAL

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	Date	Outcome
	(DD/MM/YYYY)	Choose an item.

ACRONYMS	
EASC	Emergency Ambulance Services Committee
SFIs	Standing Financial Instructions
SO's	Standing Orders
WHSSC	Welsh Health Specialised Services Committee

1. SITUATION / BACKGROUND

1.1 The Cwm Taf Morgannwg University Health Board Standing Orders form the basis upon which the Health Board's governance and accountability framework is developed and, together with the adoption of the Health Boards Standards of Behaviour Policy is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

1.2 All Health Board members and officers must be made aware of these Standing Orders and, where appropriate, should be familiar with their detailed content.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 The SO's and SFI's have recently been reviewed by officials in association with representatives of the Board Secretaries and Directors of Finance Peer Groups and a revised model was issued for implementation in correspondence from the Minister for Health and Social Services received on the 7th April 2021.

2.2 The scope of this report is to outline the changes made in relation to the revised model SO's. Due to timing the revised SFI's and SO's for the Hosted Joint Committees (EASC and WHSSC) will follow at a future meeting.

2.3 Changes have only been made to the sections of the SO's as indicated in 2.4 – 2.8.

2.4 Standing Orders (Main Document) – Appendix 1
Minor amendments as indicated in red have been made to this document.

2.3 Standing Orders – Schedule 1.0 – Scheme of Delegation – Appendix 2
Amendments reflected in red.

2.5 Standing Orders – Schedule 2.0 – Key Guidance, Instructions and other related documents – Appendix 3
Minor change in red relating to the new website link for the e-governance manual.

2.6 Standing Orders – Schedule 2.1 – Standing Financial Instructions
As noted above the model SFI's will follow at a future Audit & Risk Committee.

2.7 Standing Orders – Schedule 3.0 – Board and Committee Terms of Reference and Operating Arrangements
No changes made to the Committee Terms of Reference as part of the revised model.

2.7 Standing Orders – Schedule 4.0 – Joint Committee Arrangements
EASC's and WHSSC's revised model SO's are currently being progressed through their Joint Committee meetings and will be received at a future Audit & Risk Committee and Board Meeting in due course.

2.8 Standing Orders – Schedule 5.0 – Advisory Group Terms of Reference and Operating Arrangements – Appendices 4 and 5
Minor change in red to Schedule 5.0.

Revised terms of reference included for Schedule 5.2:

- Clinical Advisory Group (CAG) – Previously known as the Healthcare Professionals' Forum.

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

3.1 In endorsing approval of the Clinical Advisory Group Terms of Reference and Operating Arrangements the Health Board will be varying the Model Standing Orders as follows:

Name Change:

Change in name from Healthcare Professionals' Forum to Clinical Advisory Group (CAG).

Term of Office:

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 a longer period as determined by the Board. That individual may remain a member of the CAG after their term of appointment as Chair has ended.



Relationships with the National Professional Advisory Group
The CAG Chair (or CAG Vice-Chair) will not necessarily be a member of the National Professional Advisory Group and this is a position approved by the Board as variation to the model Standing Orders. CTMUHB will however, ensure at least one member of the CAG is a member of the National Professional Advisory Group who will act as the formal link between the two Groups.

- 3.2 If approved, the Standing Orders will be uploaded to SharePoint and the Health Board's Internet site.
- 3.3 The Standing Orders will be further strengthened in year as and when required.

4. IMPACT ASSESSMENT

Quality Impact (Quality, Safety, Patient Experience Implications)	Quality Impact Assessment Undertaken
	No - QIA Not Undertaken
	If Yes, Please include outcome:
	If No, Please include Justification: QIA will be undertaken in due course.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality impact assessment completed	Not required
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £ / Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Well-being Objectives (The Strategic objectives of the organisation have been developed in such a way that they can also be considered our well-being objectives)	Provide high quality, evidence based, and accessible care



5. RECOMMENDATION

5.1 The Board is asked to APPROVE:

- The amendments to the Health Board's Standing Orders as outlined in section 2 of this report.
- The variation to SO's in relation to the Clinical Advisory Group as outlined in section 3.1.

Standing Orders

Reservation and Delegation of Powers

For Cwm Taf Morgannwg University Health Board

Adopted from the Model Standing Orders and Standing Financial Instructions issued by Welsh Government in April 2021

Date approved:	May 2021
Approved by:	Health Board
Review date:	Annual
Version:	3
Responsible Director:	Director of Corporate Governance/Board Secretary
Distribution:	Board Members All staff
FOI Status:	Open

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 known as the Standards of Behaviour 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	7
Statutory framework	7
NHS framework	10
Local Health Board Framework	11
Applying Standing Orders.....	11
Variation and amendment of Standing Orders	12
Interpretation	12
The role of the Board Secretary	12
Section B – Standing Orders.....	14
1. THE LOCAL HEALTH BOARD	14
1.1 Membership of the Local Health Board	14
1.2 Joint Directors	16
1.3 Tenure of Board members	16
1.4 The Role of the LHB Board and responsibilities of individual members	17
2. RESERVATION AND DELEGATION OF LHB FUNCTIONS.....	19
2.1 Chair's action on urgent matters	19
2.2 Delegation of Board functions	19
2.3 Delegation to officers	20
3. COMMITTEES	20
3.1 LHB Committees	20
3.2 Joint Committees	21
3.3 Sub-Committees	22
3.4 Committees established by the LHB	22
3.5 Other Committees	23
3.6 Confidentiality.....	23
3.7 Reporting activity to the Board	23
4. NHS WALES SHARED SERVICES PARTNERSHIP.....	24
5. ADVISORY GROUPS	24
5.1 Terms of Reference & Operating Arrangements	24
5.2 Support to the Advisory Groups	24
5.3 Confidentiality	24
5.4 Advice & Feedback.....	25
5.5 Reporting Activity.....	235

5.6 The Stakeholder Reference Group	25
5.7 Relationship with the Board	25
5.8 Relationship between the SRG and others	25
5.9 Working with Community Health Councils.....	26
5.10 The Clinical Advisory Group (CAG)	27
5.11 Terms of Reference and Operating Arrangements.....	27
5.12 Relationship with the Board	27
5.13 Rights of Access to the LHB for Professional Groups.....	27
5.14 Relationship with the National Professional Advisory Group.....	28
5.15 Local Partnership Forum.....	28
5.16 Relationship with the Board and Others.....	28
 6. WORKING IN PARTNERSHIP	 30
6.1 Community Health Councils (CHCs).....	31
 7. MEETINGS	 321
7.1 Putting Citizens first	321
7.2 Annual Plan of Board Business.....	32
7.3 Calling Meetings.....	33
7.4 Preparing for Meetings.....	34
7.5 Conducting Board Meetings.....	35
7.6 Record of Proceedings.....	39
7.7 Confidentiality.....	39
 8. VALUES AND STANDARDS OF BEHAVIOUR.....	 40
8.1 Declaring and recording Board members' interests	40
8.2 Dealing with Members' interests during Board meetings	41
8.3 Dealing with officers' interests.....	42
8.4 Reviewing how Interests are handled	43
8.5 Dealing with offers of gifts , hospitality and sponsorship	43
8.6 Sponsorship	443
8.7 Register of Gifts, Hospitality and Sponsorship.....	44
 9. SIGNING AND SEALING DOCUMENTS	 45
9.1. Register of Sealing	45
9.2 Signature of Documents.....	46
9.3 Custody of Seal.....	465
 10. GAINING ASSURANCE ON THE CONDUCT OF LHB BUSINESS.....	 46
10.1 The role of Internal Audit in providing independent internal assurance	47
10.2 Reviewing the performance of the Board, its Committees & Advisory Groups..	47
10.3 External Assurance.....	48

11. DEMONSTRATING ACCOUNTABILITY.....	48
12. REVIEW OF STANDING ORDERS.....	49
Appendix 1	50
Six Principles of Partnership Working	50
Appendix 2	51
Code of Conduct.....	51
Appendix 3	52
List of Recognised Trade Unions/Professional Bodies ~~referred to as 'staff organisations' within these Standing Orders~~	52

The following Schedules which support the Standing Orders are held separately to this main Standing Orders Document. These are:

- **Schedule 1** **Scheme of ~~Delegation and Reservation of Powers~~
Reservation and Delegation of Powers**
- **Schedule 2** **Key Guidance Instructions and Other Related Documents ~~Documents Including the Standing Financial Instructions~~**
- **Schedule 2.1** **Model Standing Financial Instructions for LHB's**
- **Schedule 3** **Board Committee ~~Terms of Reference~~ Arrangements**
- **Schedule 4** **Joint Committee Arrangements**
- **Schedule 5** **Advisory Group Terms of Reference**

Section A – Introduction

Statutory framework

- i) The Cwm Taf Morgannwg Local 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”. The Establishment Order was amended in 2019 to reflect the Local Health Boards (Area Change) (Wales) (Miscellaneous Amendments) Order 2019 which changed the areas of Cwm Taf University Local Health Board and Abertawe Bro Morgannwg University Local Health Board and also changed their names. The principal local government area of Bridgend transferred from Abertawe Bro Morgannwg University Local Health Board and forms part of the area of Cwm Taf University Local Health Board from 1 April 2019 onwards. Abertawe Bro Morgannwg University Local Health Board was renamed Swansea Bay University Local Health Board and Cwm Taf University Local Health Board was renamed Cwm Taf Morgannwg University Health Board. The Amendments giving effect to these changes were made to the Local Health Boards (Establishment and Dissolution) (Wales) Order 2009 and the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009.
- ii) The principal place of business of the LHB is – Ynysmeurig House, Navigation Park, Abercynon, CF45 4SN
- iii) All business shall be conducted in the name of Cwm Taf Morgannwg University LHB, and all funds received in trust shall be held in the name of the LHB as a corporate Trustee.
- iv) LHBs are corporate bodies and their functions must be carried out in accordance with their statutory powers and duties. Their statutory powers and duties are mainly contained in the **NHS (Wales) Act 2006** 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 Boards suspension.

- vi) Sections 12 and 13 of the NHS (Wales) Act 2006 provide for Welsh Ministers to confer functions on LHBs and to give directions about how they exercise those functions. LHBs must act in accordance with those directions. Most of the LHB's statutory functions are set out in the **Local Health Boards (Directed Functions) (Wales) Regulations 2009 (S.I. 2009/1511)**.
- vii) **The Welsh Health Specialised Services Committee (Wales) Directions 2009 (2009/35)** provide that the seven LHBs in Wales will work jointly to exercise functions relating to the planning and securing of specialised and tertiary services and for the purpose of jointly exercising those functions will establish the Welsh Health Specialised Services Committee ("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.
- viii) **The Emergency Ambulance Services Committee (Wales) Directions 2014 (2014/8)** as amended by the **Emergency Ambulance Services (Wales) Amendment Directions 2016 (2016/8)** provide that the seven LHBs in Wales will work jointly to exercise functions relating to the planning and securing of emergency ambulance services and for the purpose of jointly exercising those functions will establish the Emergency Ambulance Services Committee ("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.
- ix) In addition to directions the Welsh Ministers may from time to time issue guidance which LHBs must take into account when exercising any function. However in some cases the relevant function may be contained in other legislation. In exercising their powers LHBs must be clear about the statutory basis for exercising such powers.
- x) As a statutory body, the LHB has specified powers to contract in its own name and to act as a corporate trustee. The LHB also has statutory powers under sections 194 and 195 of the NHS (Wales) Act 2006 to fund projects jointly planned with local authorities, voluntary organisations and other bodies.
- xi) **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)**.

- xii) Section 72 of the NHS Act 2006 places a duty on NHS bodies to co-operate with each other in exercising their functions. NHS bodies includes the NHS bodies in England such as the NHS Commissioning Board, NHS Trust and NHS Foundation Trusts and, for the purpose of this duty, also includes bodies such as NICE, the Health and Social Care Information Centre and Health Education England.
- xiii) Section 82 of the NHS Act 2006 places a duty on NHS bodies and local authorities to co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales.
- xiv) Further duties and powers placed on health boards in relation to co-operation 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>

- 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 *'Doing Well, Doing Better: Standards for Health Services in Wales'* (formally the Healthcare Standards) Framework, the NHS Risk and Assurance Framework, and the NHS planning and performance management systems.

* The NHS Wales Values and Standards of Behaviour Framework can be accessed via the following link:

<https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/living-public-service-values/values-and-standards-of-behaviour-framework/>

- 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 Cwm Taf Morgannwg University LHB and others. The decisions to approve these policies will be recorded in an appropriate Board minute and, where appropriate, will also be considered to be an integral part of the LHB's SOs and SFIs. Details of the LHB's key policy statements are also included in Schedule 2.
- xxv) LHBs shall ensure that an official is designated to undertake the role of the Board Secretary (the role of which is set out in paragraph xxxiii below).
- xxvi) For the purposes of these SOs, the members of the LHB shall collectively to be known as "the Board" or "Board members"; the officer and non-officer members shall be referred to as Executive Directors and Independent Members respectively; and the Chief Officer and the Chief Finance Officer shall respectively be known as the Chief Executive and the Director of Finance – SOs 1.1.2 refers.

Applying Standing Orders

- xxvii) The SOs of the LHB (together with SFIs and the Values and Standards of Behaviour Framework – the Standards of Behaviour 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 Risk

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 Risk 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 application 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

- 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 Cwm Taf Morgannwg University LHB, including details on how to contact them, are available on the Cwm Taf Morgannwg website (<https://cwmtafmorgannwg.wales/>)

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 Establishment Order was amended in 2019 to reflect the Local Health Boards (Area Change) (Wales) (Miscellaneous Amendments) Order 2019 which changed the areas of Cwm Taf University Local Health Board and Abertawe Bro Morgannwg University Local Health Board and also changed their names. The principal local government area of Bridgend transferred from Abertawe Bro Morgannwg University Local Health Board and forms part of the area of Cwm Taf University Local Health Board from 1 April 2019 onwards. Abertawe Bro Morgannwg University Local Health Board was renamed Swansea Bay University Local Health Board and Cwm Taf University Local Health Board was renamed Cwm Taf Morgannwg University Health Board. The Amendments giving effect to these changes were made to the Local Health Boards (Establishment and Dissolution) (Wales) Order 2009 and the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009. 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 ~~20~~ 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. ~~All such members shall have~~

~~full voting rights. There may also be Associate Members who do not have voting rights. 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

appliCAGle, as specified in Schedule 2 of the Constitution Regulations. Any member must inform the Chair as soon as is reasonably practiCAGle 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

applied 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. The only exception to this position is the Charitable Funds Committee where all Board Members form the Corporate Trustee.

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 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.

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 University 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 University 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 **CAG** 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 Community Health Councils (CHCs), who have a statutory role in representing the interests of patients and the public in their areas. The SRG shall represent those stakeholders who have an interest in, and whose own role and activities may be impacted by the decisions of the LHB. Membership may include community partners, provider organisations, special interest and other groups operating within the LHBs area.
- 5.6.4 It does not cover those stakeholders whose interests are represented within the remit of other Advisory Groups established by the LHB, e.g., the Healthcare Professionals' Forum and Local Partnership Forum.
- 5.6.5 In addition to the provisions above the Board must set out, the relationships and accountabilities with others, such as the Regional Partnership Board.

5.7 Relationship with the Board

- 5.7.1 The SRG's main link with the Board is through the SRG Chair's membership of the Board as an Associate Member.
- 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 Community Health Councils

5.9.1 The SRG shall make arrangements to ensure designated CHC members receive the SRG's papers and are invited to attend SRG meetings.

5.9.2 The SRG shall work together with CHCs within the area covered by the LHB to engage and involve those within the local communities served whose views may not otherwise be heard.

Refer to Schedule 5.1 for detailed Terms of Reference and Operating Arrangements

5.10 THE HEALTHCARE PROFESSIONALS' FORUM (HPF) CLINICAL ADVISORY GROUP (CAG)

Role & Scope

~~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.~~

~~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.~~

5.10.1 The CAG will:

- Act as the clinical voice within CTMUHB.
- Work with and alongside Management Board and Executives and will be the representative voice of all clinical groups across the Health Board advising on clinical services and care.
- Provide a balanced, multi-disciplinary view of healthcare professional issues to advise the Board on local strategy and delivery.
- Facilitate engagement and debate amongst the wide range of clinical interests within CTMUHB's area of activity, with the aim of reaching and presenting a cohesive and balanced healthcare professional perspective to inform the CTMUHB's decision making.

5.10.2 ~~The role of CAG does not include consideration healthcare professional terms and conditions of employment.~~

5.10.3

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 **CAG's** main link with the Board is through the CAG Chair's membership of the Board as an Associate Member.

5.12.2 The Board may determine that designated Board members or CTMUB officers shall be in attendance at Advisory Group meetings. The **CAG's** Chair may also request the attendance of Board members or CTMUHB officers, subject to the agreement of the CAG Chair.

5.12.3 The Board shall determine the arrangements for any joint meetings between the CTMUHB Board and the **CAG**.

5.12.4 The Board's Chair shall put in place arrangements to meet with the **CAG** Chair on a regular basis to discuss the **CAG's** activities and operation.

5.13 Rights of Access to the LHB Board for Professional Groups

5.13.1 CTMUHB Chair, on the advice of the Chief Executive and/or Director of Corporate Governance (Board Secretary), may recommend that the Board afford direct right of access to any professional group, in the following, exceptional circumstances:

- i) Where the **CAG** 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 **CAG** 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 **CAG** Chair (or **CAG** Vice-Chair) will **not necessarily** be a member of the National Professional Advisory Group **and this is a position approved by the Board as variation to the model Standing Orders. CTMUHB will however, ensure at least one member of the CAG is a member of the National Professional Advisory Group who will act as the formal link between the two Groups.**

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 Community Health Councils (CHCs)

6.1.1 The **Community Health Councils (Constitution, Membership and Procedures) (Wales) Regulations 2010** (S.I. 2010/288) (as amended) and the **Community Health Councils (Establishment, Transfer of Functions and Abolition) (Wales) Order 2010** (S.I. 2010/289) place a range of duties on LHBs in relation to the engagement and involvement of CHCs in its operations.

6.1.2 In discharging these duties, the Board shall work constructively with the

CHCs working jointly within the LHB's area by ensuring their involvement in:

- The planning of the provision of its healthcare services;
- The development and consideration of proposals for changes in the way in which those services are provided; and
- The Board's decisions affecting the operation of those healthcare services that it has responsibility for

and formally consulting with those CHCs working jointly within the LHB's area on any proposals for substantial development of the services it is responsible for.

- 6.1.3 The Board shall ensure that each relevant CHC is provided with the information it needs on a timely basis to enable it to effectively discharge its functions.

Relationship with the Board

- 6.1.4 The Board may determine that designated CHC members shall be invited to attend Board meetings.
- 6.1.5 The Board shall make arrangements for regular joint meetings between the CHC members and the Board, to be held not less than once every three calendar months and ensuring attendance of at least one third of the Board's members.
- 6.1.6 The Board's Chair shall put in place arrangements to meet with the relevant CHC Chair(s) on a regular basis to discuss matters of common interest.

7. MEETINGS

7.1 Putting Citizens first

- 7.1.1 The LHB's business will be carried out openly and transparently in a manner that encourages the active engagement of its citizens, community partners and other stakeholders. The LHB, through the planning and conduct of meetings held in public, shall facilitate this in a number of ways, including:

- Active communication of forthcoming business and activities;
- The selection of accessible, suitable venues for meetings **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 CHCs.

7.2 Annual Plan of Board Business

7.2.1 The Board Secretary, on behalf of the Chair, shall produce an Annual Plan of Board business. This plan will include proposals on meeting dates, venues and coverage of business activity during the year, taking account that ordinary meetings of the Board will be held at regular intervals and as a minimum six times a year. The Plan shall also set out any standing items that will appear on every Board agenda.

7.2.2 The plan shall set out the arrangements in place to enable the LHB to meet its obligations to its citizens as outlined in paragraph 6.1.1 whilst also allowing Board members to contribute in either English or Welsh languages, where appropriate.

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)

~~*For the Annual Reporting period 2019-2020 the LHB must hold an AGM in public no later than the 30th November 2020. Thereafter, the LHB must hold an AGM in public no later than the 31 July each year.*~~

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.

~~7.2.6 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) at the LHBs principal sites and 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.

7.2.7 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.,
~~such as the organisation's annual quality statement.~~

7.2.8 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):
- ~~At the LHB's principal sites;~~ 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 CHCs 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 CHC representative(s).

7.5.25 The Board will make decisions based on a simple majority view held by the Board members present. In the event of a split decision, i.e., no majority view being expressed, the Chair shall have a second and casting vote.

7.5.26 In no circumstances may an absent Board member or nominated deputy vote by proxy. Absence is defined as being absent at the time of the vote.

7.6 Record of Proceedings

7.6.1 A record of the proceedings of formal Board meetings (and any other meetings of the board where the Board members determine) shall be drawn up as 'minutes'. These minutes shall include a record of Board member attendance (including the Chair) together with apologies for absence, and shall be submitted for agreement at the next meeting of the Board, where any discussion shall be limited to matters of accuracy. Any agreed amendment to the minutes must be formally recorded.

7.6.2 Agreed minutes shall be circulated in accordance with Board members' wishes, and, where providing a record of a formal Board meeting shall be made available to the public both on the LHB's website and in hard copy or other accessible format on request, in accordance with any legislative requirements, e.g., Data Protection Act 2018, the General Data Protection Regulation 2018, and the LHB's Communication Strategy and Welsh language requirements.

7.7 Confidentiality

7.7.1 All Board members (including Associate Members), together with members of any Committee or Advisory Group established by or on behalf of the Board and LHB officials must respect the confidentiality of all matters considered by the LHB in private session or set out in documents which are not publicly available. Disclosure of any such matters may 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 - Standards of Behaviour 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 framework adopted by the Board is the Standards of Behaviour Policy which 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 - Standards of Behaviour 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 with¹ has any direct or indirect pecuniary interest in any matter being considered by the Board, including a contract or proposed contract, that member must not take part in the consideration or discussion of that matter or vote on any question related to it. The Board may determine that the Board member concerned shall be excluded from that part of the meeting.

8.2.8 The Constitution Regulations define 'direct' and 'indirect' pecuniary interests and these definitions always apply when determining whether a member has an interest. These SOs must be interpreted in accordance with these definitions.

8.2.9 **Members with Professional Interests** - During the conduct of a Board meeting, an individual Board member may establish a clear conflict of interest between their role as 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 and Risk 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 gifts², hospitality and sponsorship

8.5.1 The Values and Standards of Behaviour Framework - Standards of Behaviour 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

¹ In the case of persons who are married to each other or in a civil partnership with each other or who are living together as if married or civil partners, the interest of one person shall, if known to the other, be deemed for the purpose of this Standing Order to be also an interest of the other.

² The term gift refers also to any reward or benefit.

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;
- **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** Standards of Behaviour 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,

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.

- 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 and Risk Committee (or equivalent) at least annually. The Audit and Risk 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 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 sealing's 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 and Risk 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 be achieved by the reports of the respective Joint Committee Chair, and reported back by the Chief Executive. Reference should be made to paragraph 3.2 above regarding the governance arrangements which should be agreed for each of the Joint Committees.

10.0.5 Arrangements for seeking and providing assurance 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 and Risk 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

10.2.2 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.

10.2.3 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.

10.2.4 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, ~~the Senedd Cymru/Welsh Parliament's Public Accounts Committee National Assembly for Wales'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 An equality impact assessment has been undertaken and found that as an administrative document, there is no *direct* impact on the health of the population, the addressing of inequalities in health or the delivery of services. However, it does clearly impact on how Cwm Taf Morgannwg UHB makes its decisions.

12.0.2 These SOs shall be reviewed annually by the Audit and Risk Committee, which shall report any proposed amendments to the Board for consideration. The requirement for review extends to all documents having the effect as if incorporated in SOs, including the appropriate impact assessments.

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 (RCM)
- 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 1

MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS

**This Schedule forms part of, and shall have effect as if incorporated in the
University 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 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 Risk Committee

The Audit and Risk Committee will provide assurance to the Board of the effectiveness of its arrangements for handling reservations and delegations.

Individuals to who powers have been delegated

Individuals will be personally responsible for:

- Equipping themselves to deliver on any matter delegated to them, through the conduct of appropriate training and development activity; and
- Exercising any powers delegated to them in a manner that accords with the LHB's values and standards of behaviour.

Where an individual does not feel that they are equipped to deliver on a matter delegated to them, they must notify the Board Secretary of their concern as soon as possible 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 on the following pages shows only the "top level" of delegation within the CTMUHB. The Scheme is to be used in conjunction with the system of control and other established procedures within the CTMUHB.

SCHEDULE OF MATTERS RESERVED TO THE BOARD¹

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
1.	FULL	GENERAL	The Board may determine any matter for which it has statutory or delegated authority, in accordance with SOs ~~(except for those decisions delegated to the Welsh Health Specialised Services Committee (WHSSC) or Emergency Ambulance Services Committee (EASC)).~~
2.	FULL	GENERAL / OPERATING ARRANGEMENTS	The Board must determine any matter that will be reserved to the whole Board. These are: Approve the introduction or discontinuance of any significant activity or operation. Any activity or operation shall be regarded as significant if the Board determines it so based upon its contribution/impact on the achievement of the CTMUHB's aims, objectives and priorities
3.	FULL	GENERAL	Approve the LHB's Governance Framework
	FULL	OPERATING ARRANGEMENTS	~~Adopt the standards of governance and performance (including the quality and safety of healthcare, and the patient experience) to be met by the CTMUHB, including standards/requirements determined by professional bodies/others, e.g. Royal Colleges~~
4.	FULL	OPERATING ARRANGEMENTS	Approve, vary and amend: - Standing Orders; - 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	~~Approve the CTMUHB's framework for performance management, risk and~~

¹ 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.

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
		ARRANGEMENTS	~~assurance~~ Ratify any urgent decisions taken by the Chair and the Chief Executive in accordance with Standing Order requirements.
	FULL	OPERATING ARRANGEMENTS	~~Approve the CTMUHB's Values and Standards of Behaviour Framework — Standards of Behaviour Policy~~
	FULL	OPERATING ARRANGEMENTS	~~Approve the introduction or discontinuance of any significant activity or operation. Any activity or operation shall be regarded as significant if the Board determines it so based upon its contribution/impact on the achievement of the CTMUHB's aims, objectives and priorities~~
6.	FULL No - Audit & Risk Committee	OPERATING ARRANGEMENTS	~~Ratify in public session any instances of failure to comply with Standing Orders~~ Formal consideration of report of Director of Corporate Governance (Board Secretary) and/or Director of Finance 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.
	FULL	OPERATING ARRANGEMENTS	~~Approve policies for dealing with complaints, claims legal claims and incidents~~
	FULL	OPERATING ARRANGEMENTS	~~Approve individual compensation payments in line with the Standing Financial Instructions in relation to compensation payments.~~
8.	FULL	OPERATING ARRANGEMENTS	Authorise use of the CTMUHB's official seal
9.	FULL	OPERATING ARRANGEMENTS	Approve the LHB's Values and Standards of Behaviour framework – Standards of Behaviour Policy
	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the appointment and dismissal of the Chief Executive
10.	FULL	ORGANISATION	~~Ratify and manage the appraisal and discipline of the Chief Executive.~~

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
		STRUCTURE & STAFFING	~~Approve the appointment, remuneration, appraisal, discipline and dismissal of Executive Directors and any other Board level appointments, e.g. the Director of Corporate Governance / Board Secretary~~ Require, receive and determine action in response to the declaration of Board members' interests, in accordance with advice received, e.g. From Audit & Risk Committee or Board Secretary
	FULL	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 & Risk Committee~~
	FULL	ORGANISATION STRUCTURE & STAFFING	~~Approve, [arrange the] review, and revise the CTMUHB's top level organisation structure and corporate policies (as outlined in the "Policy on Policies" e.g. Standards of Behaviour Policy)~~
	FULL	ORGANISATION STRUCTURE & STAFFING	~~Appoint, [arrange the] review, revise and dismiss Board Committees, including any joint-Committees directly accountable to the Board~~
	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~~
	FULL	ORGANISATION STRUCTURE & STAFFING	~~Appoint, equip, review and (where appropriate) dismiss individuals appointed to represent the Board on outside bodies and groups~~
	FULL	ORGANISATION STRUCTURE & STAFFING	~~Approve the terms of reference and reporting arrangements of all Committees, joint-Committees and groups established by the Board~~
	FULL	ORGANISATION STRUCTURE & STAFFING	~~Approve the arrangements relating to the discharge of the CTMUHB's responsibilities as a Corporate Trustee for funds held on trust~~
11.	FULL	STRATEGY &	Determine the CTMUHB's strategic aims, objectives and priorities

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
		PLANNING	
12.	FULL	STRATEGY & PLANNING	~~Approve the CTMUHB's Integrated Medium Term Plan (IMTP), including the balanced Medium Term Financial Plan~~ 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)
	FULL	STRATEGY & PLANNING	~~Approve the CTMUHB's Risk Management Strategy and 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
	FULL	STRATEGY & PLANNING	~~Approve the CTMUHB's engagement and involvement strategy, including communication~~
14.	FULL	STRATEGY & PLANNING	Agreement of Well-being objectives in accordance with the requirements of the Well-being and Future Generations (Wales) Act 2015
	FULL	STRATEGY & PLANNING	~~Approve the CTMUHB's key strategies and programmes related to:~~ ~~Population Health Needs Assessment and Commissioning Plan~~ ~~The development and delivery of patient centred clinical services for their population~~ ~~Improving quality and patient safety outcomes~~ ~~Workforce and Organisational Development~~ ~~Infrastructure, including IM&T, Estates and Capital (including major capital investment and disposal plans)~~
	FULL	STRATEGY & PLANNING	~~Approve the CTMUHB's budget and financial framework (including overall distribution of the financial allocation and unbudgeted expenditure)~~

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
15.	FULL	STRATEGY & PLANNING	Approval of Well-being Plan prepared and agreed by the Public Service Board
	FULL	STRATEGY & PLANNING	~~Approve new contracts for the CTMUHB to provide, or to secure provision from providers for Personal Medical; Dental; Pharmacy; Optometry services to some or all of the CTMUHB's population services~~
16.	FULL	STRATEGY & PLANNING	Approve the LHB's Integrated Medium Term Plan, including the balanced Medium Term Financial Plan
	FULL	STRATEGY & PLANNING	~~Approve individual contracts (other than NHS contracts) above the limit delegated to the Chief Executive set out in the SFIs~~
17.	FULL	STRATEGY & PLANNING	Approve the LHB's budget and financial framework (including overall distribution of the financial allocation and unbudgeted expenditure)
	FULL	PERFORMANCE & ASSURANCE	~~Approve the CTMUHB's audit and assurance arrangements~~
18.	FULL	OPERATING ARRANGEMENTS	Approve the LHB's framework and strategy for performance management.
	FULL	PERFORMANCE & ASSURANCE	~~Receive reports from the CTMUHB's Executive on progress and performance in the delivery of the CTMUHB's strategic aims, objectives and priorities and approve action required, including improvement plans~~
19.	FULL	STRATEGY & PLANNING	Approve the LHB's framework and strategy for risk and assurance.
	FULL	PERFORMANCE & ASSURANCE	~~Receive assurance reports from the Board's Committees, groups and other internal sources on the CTMUHB's performance and approve action required, including improvement plans~~
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.
	FULL	PERFORMANCE & ASSURANCE	~~Receive reports on the CTMUHB's performance produced by external regulators and inspectors (including, e.g. WAO, HIW, etc.) that raise issue or concerns impacting on the CTMUHB's ability to achieve its aims and objectives and approve~~

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
			~~action required, including improvement plans, taking account of the advice of Board Committees (as appropriate)~~
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)
	FULL	PERFORMANCE & ASSURANCE	~~Receive the annual opinion of the CTMUHB's Chief Internal Auditor and approve action required, including improvement plans~~
22.	FULL	STRATEGY & PLANNING	Approve the LHB's patient, public, staff, partnership and stakeholder engagement and co-production strategies.
	FULL	PERFORMANCE & ASSURANCE	~~Receive the annual management letter from the CTMUHB's external auditor and approve action required, including improvement plans~~
23.	FULL	OPERATING ARRANGEMENTS	Approve the introduction or discontinuance of any significant activity or operation. Any activity or operation shall be regarded as significant if the Board determines it so based upon its contribution/impact on the achievement of the LHB's aims, objectives and priorities
	FULL	PERFORMANCE & ASSURANCE	~~Receive the annual opinion on the CTMUHB's performance against <i>Doing Well, Doing Better: Standards for Health Services in Wales</i> (formally the <i>Healthcare Standards</i>), and approve action required, including improvement plans.~~
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
	FULL	REPORTING	~~Approve the CTMUHB's Reporting Arrangements, including reports on activity and performance locally, to citizens, partners and stakeholders and nationally to the Welsh Government~~

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
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.
	FULL	REPORTING	~~Receive, approve and ensure the publication of key CTMUHB reports, including its Annual Report and annual financial accounts~~
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	Appoint, equip, review and (where appropriate) dismiss individuals appointed to

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
		STRUCTURE & STAFFING	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 & Risk 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

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
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

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
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			
1.	CHAIR		In accordance with statutory and Welsh Government requirements
2.	VICE CHAIR		In accordance with statutory and Welsh Government requirements
3.	CHAMPION / NOMINATED LEAD		In accordance with statutory and Welsh Government requirements

DELEGATION OF POWERS TO COMMITTEES AND OTHERS²

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 following Committees and others:

² As defined in Standing Orders

<https://cwmtafmorgannwg.wales/how-we-work/decision-making-2/>

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.

SCHEME OF DELEGATION TO EXECUTIVE DIRECTORS, OTHER DIRECTORS AND OFFICERS

The CTMUHB's Standing Orders and Standing Financial Instructions specify certain key responsibilities of the Chief Executive, the Director of Finance & Procurement 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 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 Standing Financial Instructions form the basis of the CTMUHB's Scheme of Delegation to Officers.

DELEGATED MATTER	RESPONSIBLE OFFICER(S)	DEPUTY
Agreeing and signing the Integrated Medium Term Plan / Long Term Agreements	Chief Executive	Executive Director of Planning & Performance
Authorisation and monitoring of losses and compensations and ex gratia payments, in accordance with financial limits.	Chief Executive	Executive Director of Finance
Arrangements for the management of land, buildings, and other assets belonging to or leased by the CTMUHB / Capital Schemes	Chief Executive	Executive Director of Finance
Arranging loans.	Executive Director of Finance	Deputy Director of Finance
Achievement of the three financial targets.	Chief Executive	Executive Director of Finance
Admission to Performers Lists and similar lists	Chief Executive / Medical Director	Executive Director of Operations.
Changes to Medical Lists.	Medical Director	Executive Director of Operations.
Controls Assurance/Risk Management.	Director of Corporate Governance / Board Secretary	Assistant Director of Governance & Risk
Data Protection arrangements	Chief Executive	Medical Director/ Director of Corporate Governance / Board Secretary
Debt recovery	Executive Director of	Deputy Director of Finance

DELEGATED MATTER	RESPONSIBLE OFFICER(S)	DEPUTY
	Finance	
Delegation of budgets and approval to spend funds.	Chief Executive	Director of Finance
Development and implementation of Procurement Policy.	Executive Director of Finance	Managing Director of NHS Wales Shared Services Partnership
GMS Cash Limited Cost Rent Schemes.	Executive Director of Finance	Deputy Director of Finance
Health and Safety Arrangements.	Chief Executive	Executive Director For People ~~Executive Director of Therapies and Health Sciences~~
Insurance Arrangements (with approval from the relevant division within NHS Wales department)	Executive Director of Finance	Deputy Director of Finance
Investigate any suspected cases of irregularity not related to fraud and corruption in accordance with government directions.	Chair/Chief Executive	Deputy Chief Executive / Director of Corporate Governance Board Secretary
Single tenders/ issuing tenders and post tender negotiations.	Chief Executive	Executive Director of Finance
Legal Advice.	Executive Nurse Director	Deputy Executive Nurse Director
Putting Things Right – Raising a concern about the NHS in Wales	Executive Nurse Director	Deputy Executive Nurse Director

DELEGATED MATTER	RESPONSIBLE OFFICER(S)	DEPUTY
Obstetric List.	Medical Director	Deputy Medical Director
Operation of detailed financial matters, including bank accounts, and banking procedures.	Executive Director of Finance	Deputy Director of Finance
Workforce	Executive Director of Workforce and OD	Assistant Director of Workforce (and OD)
Manage central reserves and contingencies.	Executive Director of Finance	Deputy Director of Finance
Management of non-exchequer funds.	Chief Executive	Executive Director of Finance
Management and control of stocks other than pharmacy stocks.	Chief Executive	Executive Director of Finance
Management and control of pharmacy stock.	Chief Executive	Head of Medicines Management
Management and control of computer systems and facilities.	Chief Executive	Executive Director of Planning & Performance
Monitor and achievement of management cost targets.	Chief Executive	Executive Director of Finance
Nurse Staffing Levels (Wales) Act to designate a senior registered nurse to calculate nurse staffing levels.	Executive Nurse Director	Deputy Executive Nurse Director
Recording of payments under the losses and compensations regulations.	Executive Director of Finance	Deputy Director of Finance
Special Payments	Chief Executive	Executive Director of Finance
Sealing and signing of documents.	Chair/Chief Executive	Vice Chair / Executive Director of Operations
Work relating to counter fraud and corruption in accordance	Executive Director of	Deputy Director of Finance

DELEGATED MATTER	RESPONSIBLE OFFICER(S)	DEPUTY
with Welsh Government directions	Finance	
Authority to exclude a practitioner (doctors and dentists) in accordance with the procedure for 'Upholding Professional Standards in Wales'.	Medical Director	Deputy Medical Director

This scheme only relates to matters delegated by the Board to the Chief Executive and their Directors, together with certain other specific matters referred to in the Standing Financial Instructions.

Each Director is responsible for delegation within their department. They shall produce a scheme of delegation for matters within their department, which should 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 University Health Board Standing Orders

CTMUHB framework

The CTMUHB'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)
- **Key policy documents (available on the SharePoint site)**

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:

<http://ctCTMUHB-intranet/Pages/Home.aspx>

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 CTMUHB business are also issued electronically, usually under cover of a Welsh Health Circular.

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 – **Clinical Advisory Group (Formerly known as the** Healthcare Professionals Forum)

Schedule 5.3 – Local Partnership Forum

Clinical Advisory Group (CAG)

Terms of Reference and Operating Arrangements

The Clinical Advisory Group is CTMUHB's equivalent to the Health Professions Forum.

1.0 Role & Scope

1.0.1 CAG is essential to CTM as it will:

- Listen to our workforce is an essential component of any successful organisation.
- Basis of CTMs need for a clinical strategy that is clinically driven, and as such need meaningful contributions from clinicians across CTM.
- Provide a structure within CTM that enables the front line clinical team voices to reach management and the Board from a pan-health board perspective
- Report directly to the CTM Board.

1.0.2 Summary of CAG purpose:

- To advise CTM Board on clinical topics and initiatives, and to review items requested by the Board.
- Via a Clinical Sounding Board (CSB), gather, listen and respond to clinicians delivering care.
- Advise the UHB Board on all aspects of Clinical Strategy
- Act as a clinical voice within CTMUHB
- To take the place of the traditional 'Healthcare Professional Forum' and ensure it meets the requirements

1.0.3 The CAG will:

- Act as the clinical voice within CTMUHB.
- Work with and alongside Management Board and Executives and will be the representative voice of all clinical groups across the Health Board advising on clinical services and care.
- Provide a balanced, multi-disciplinary view of healthcare professional issues to advise the Board on local strategy and delivery.
- Facilitate engagement and debate amongst the wide range of clinical interests within CTMUHB's area of activity, with the aim of reaching and presenting a cohesive and balanced healthcare professional perspective to inform the CTMUHB's decision making.

1.0.4 The role of CAG does not include consideration healthcare

professional terms and conditions of employment.

1.1 Terms of reference and operating arrangements

1.1.1 The Board will set out, the relationships and accountabilities of CAG with other groups as required, including the National Professional Advisory Group.

1.1.1.1 National Professional Advisory Group must have a member attending from the CAG. This person will act as the link between these two forums.

1.2 Membership

1.2.1 Summary of membership and chairing of the CAG

- CAG will include a full cross section of clinical professions from across all Integrated Locality Groups.
- This membership will be regularly reviewed to ensure there is a good mix of clinical voices from all professional and geographic areas
- The CAG will be chaired by an appointed clinician with support from a deputy chair.
- Additional support can and will be provided, noting that the forum will be an agile group focussing on discussion and receiving viewpoints

1.2.2 The membership of the CAG will reflect 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 CAG 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

- o Community Pharmacists representative

1.2.3 CAG membership will be extended beyond this eleven set members in order to ensure a broad representation of healthcare professional groups from across specialties and geography of CTM, including primary, community and secondary service provision.

1.2.4 CTMUHB has extended membership of the CAG to reflect representation from Nursing & Midwifery, Allied Health Professions, Medical, Primary Care, and Community from each of the three Integrated Locality Groups.

1.3 Member Responsibilities and Accountability:

1.3.1 Summary of the expectations of CAG members:

- To attend the CAG session each month where possible or give apologies in advance
- To respect other clinician's views when debating and discussing
- To respect and champion the values of the Health Board in the way the meetings are held
- To feel empowered to contribute wherever possible
- To feedback discussion to fellow clinical colleagues

The Chair

1.3.2 The Chair is responsible for the effective operation of the CAG:

- 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 CAG's membership and between the CAG and the CTMUHB's Board, and in particular its Chair, Chief Executive and Clinical Directors.

1.3.3 The Chair shall work in close harmony with the Chairs of the CTMUHB's other advisory groups, and, supported by the Director of Corporate Governance, shall ensure that key and appropriate issues are discussed by the CAG in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.

1.3.4 As Chair of the CAG, they will be appointed as an Associate Member of the CTMUHB Board. The Chair is accountable for the conduct of

their role as Associate Member on the CTMUHB Board to the Minister, through the CTMUHB Chair. They are also accountable to CTMUHB Board for the conduct of business in accordance with the governance and operating framework set by the Health Board.

The Vice Chair

1.3.5 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 deputation includes acting in the role of Associate Member of CTMUHB Board.

1.3.6 The Vice Chair is accountable through the CAG Chair to CTMUHB 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 CAG.

Members

1.3.7 The CAG shall function as a coherent advisory group, all members being full and equal members and sharing responsibility for the decisions of the CAG.

1.3.8 All members must:

- Be prepared to engage with and contribute fully to the CAG'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 CAG within the healthcare professional discipline they represent.

1.3.9 CAG members are accountable through the CAG Chair to CTMUHB 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 CAG.

1.4 Appointment and terms of office

1.4.1 Appointments to the CAG shall be made officially by the Board, ensuring membership is invited from the relevant healthcare professional groups, and in accordance with any specific requirements or directions made by the Welsh Ministers. These will be based upon CAG recommendations.

- 1.4.2 Recommendations of membership will be conducted by CAG to replace members who have had to stand down or reach the end of their term in role.
- 1.4.3 The *Chair* will be identified from within the membership of the CAG, 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.
- 1.4.4 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 a longer period as determined by the Board. That individual may remain a member of the CAG after their term of appointment as Chair has ended.
- 1.4.5 The *Vice Chair* will be identified from within the membership of the CAG, 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 appointment to Vice Chair of CAG 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 CAG's Chair's absence, the Vice Chair will also perform the role of Associate Member on the CTMUHB 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.
- 1.4.6 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 a longer period as determined by the Board. That individual may remain a member of the CAG after their term of appointment as Vice Chair has ended.
- 1.4.7 A member's tenure of appointment will be for a period of up to two (2) years.
- 1.4.8 Any member's tenure will cease in the event that they no longer meet any of the eligibility requirements determined for the position. A member must inform the CAG Chair as soon as is reasonably practical to do so in respect of any issue which may impact on their eligibility

to hold office. The CAG Chair will advise the Board in writing of any such cases immediately.

1.4.9 CTMUHB will ensure membership is in line with this eligibility on an annual basis by way of an annual review of the Terms of Reference.

1.5 Resignation, suspension and removal of members

1.5.1 A member of the CAG may resign office at any time during the period of appointment by giving notice in writing to the CAG Chair and the Board.

1.5.2 If the Board, having consulted with the CAG 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 CAG that a person should continue to hold office as a member; or
- It is not conducive to the effective operation of the CAG

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 Where applicable a nominating body or group may request the removal of a member appointed to the CAG to represent their interests by writing to the Board setting out an explanation and full reasons for removal.

1.5.4 If a member fails to attend any meeting of the CAG 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 the CAG membership, the Board may suspend the membership 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 CAG's main link with the Board is through the CAG Chair's membership of the Board as an Associate Member.
- 1.6.2 The CAG's Chair may also request the attendance of Board members or any other individual to attend a group meeting.
- 1.6.3 The Board shall determine the arrangements for any joint meetings between the CTMUHB Board and the CAG.
- 1.6.4 The Board's Chair shall put in place arrangements to meet with the CAG Chair on a regular basis to discuss the CAG's activities and operation.

1.7 Rights of Access to the LHB Board for Professional Groups

- 1.7.1 CTMUHB Chair, on the advice of the Chief Executive and/or Director of Corporate Governance (Board Secretary), may recommend that the Board afford direct right of access to any professional group, in the following, exceptional circumstances:

- i) Where the CAG 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 CAG has not afforded it due consideration in the determination of its advice to the Board on a particular issue.

- 1.7.2 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.

1.8 Relationship with the National Professional Advisory Group

- 1.8.1 The CAG Chair (or CAG Vice-Chair) will not necessarily be a member of the National Professional Advisory Group and this is a position approved by the Board as variation to the model Standing Orders. CTMUHB will however, ensure at least one member of the CAG is a member of the National Professional Advisory Group who will act as the formal link between the two Groups.



AGENDA ITEM

2.1.7

HEALTH BOARD

BUDGET SETTING ARRANGEMENTS FOR 2021/22

Date of meeting

27/05/2021

FOI Status

Open/Public

If closed please indicate reason

Not Applicable - Public Report

Prepared by

Mark Thomas, Deputy Director of Finance

Presented by

Executive Director of Finance & Procurement

Approving Executive Sponsor

Executive Director of Finance & Procurement

Report purpose

FOR APPROVAL

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)

Committee/Group/Individuals

Date

Outcome

Executive discussion

Ongoing

Choose an item.

Management Board

21/04/21

APPROVED

Planning, Performance and Finance Committee

27/04/21

ENDORSED

ACRONYMS

1. SITUATION / BACKGROUND

The draft financial plan for 2021/2022 was agreed by the Health Board on 26 March 2020 to be submitted to the Welsh Government as part of the overall 2021/2022 plan. The Executive summary is attached at Annex A, and a high level summary is shown in the table below. As the plan currently shows a £19.8m deficit for the year as a whole, it remains a draft plan, and feedback and further discussion with the Welsh Government is needed.

Summary of Core Plan, Covid, & Planned Care Recovery	Q1	Q2	Q3	Q4	Total
	£m	£m	£m	£m	£m
Core plan - assuming even phasing over Q1-4 initially	5.7	5.7	5.7	5.7	22.8
Covid costs net of WG funding	-7.4	-4.0	4.5	3.9	-3.0
Planned care recovery (costs assumed matched by funding)	0.0	0.0	0.0	0.0	0.0
Total	-1.7	1.7	10.2	9.6	19.8
Cumulative total	-1.7	0.0	10.2	19.8	

The purpose of this report is to provide further information on the budget setting principles and assumptions and the proposed allocation of the draft budget to Integrated Locality Groups (ILGs) and other service and corporate directorates for the three separate elements of the financial plan:

- The core plan
- Covid response
- Planned care recovery

The ILG and other budgets then provide clarity on the financial envelopes for local operational, workforce and financial plans to be developed during April and May.

The detailed working papers supporting the budget allocations have been shared with the Finance leads for each area.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 The core plan

A summary of the proposed budget increases, over and above the recurrent budgets, is provided below:

Core plan	Total	Merthyr & Cynon	Rhondda & Taff Ely	Bridgend	Medicines Mgt	Primary care	Other DE	Contracting	Corporates	Non Delegated	Total
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Forecast recurrent deficits	33.9	5.5	5.1	3.0	3.2	0.3	0.3	0.8	0.7	15.0	33.9
WG Income	-29.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-29.4	-29.4
Inflation	14.3	1.1	1.5	1.8	0.6	0.1	0.2	2.6	0.7	5.8	14.3
Investments	10.3	0.0	0.0	0.0	0.0	0.3	0.0	0.0	0.0	10.0	10.3
Unavoidable Recurrent cost pressures and demand growth	15.5	1.0	1.0	1.4	3.6	0.0	0.0	5.0	0.0	3.6	15.5
Non Recurring costs and benefits	-5.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-5.8	-5.8
Savings Targets	-16.1	-3.6	-4.0	-4.0	-2.7	-0.2	-0.3	-0.6	-1.2	0.5	-16.1
TOTAL BUDGET	22.7	4.0	3.5	2.1	4.7	0.4	0.2	7.8	0.2	-0.2	22.7

The key principles and assumptions used to allocate the above budgets are described below.

Forecast recurrent deficits at 31 March 2021- £33.9m

The components of the forecast recurrent deficit at 31 March 2021 are summarised below:

Forecast recurrent deficits at 31 March 21	Merthyr & Cynon	Rhondda & Taff Ely	Bridgend	Medicines Mgt	Primary care	Other DE	Contracting	Corporates	Non Delegated	Total
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Planned recurrent deficit	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	13.4	13.4
Total savings shortfalls- M10 forecasts	3.7	2.7	4.6	1.1	0.3	0.3	0.8	0.4	1.6	15.6
CHC	0.3	0.3	-2.5							-1.9
Other recurrent cost pressures	1.6	2.1	0.8	2.1	0.0	0.0	0.0	0.3	0.0	6.8
Total	5.5	5.1	3.0	3.2	0.3	0.3	0.8	0.7	15.0	33.9
Total excluding CHC - £m	5.3	4.8	5.5							
Total excluding CHC - % of base budget	2.4%	2.4%	2.9%							

The forecast shortfalls against the recurrent savings targets for 2020/2021 have been fully funded as part of the 2021/2022 financial plan. This is in the context of the key cause of these shortfalls being the inevitable focus on the Covid response during the year.

The £4.9m for other recurrent cost pressures reflected in the plan is lower than was put forward by ILG and Directorates, as has been previously discussed, and significant management action is needed to manage these to the funded level.

Ongoing costs of the Covid response or otherwise due to Covid are not included in the recurrent deficit from 2020/2021 within the core plan; they are reflected in the Covid element of the 2021/2022 plan.

Recurrent Inflation - £14.3m

Recurrent cost pressure	£m	Allocation
Pay – A4C	4.3	Allocated to Non Delegated initially, pending detailed calculation based on M1 payroll compared to M12 payroll and confirmation of pay award for 21/22.
Pay – Medical	1.4	Allocated to Non Delegated initially, pending detailed calculation based on M1 payroll

		compared to M12 payroll and confirmation of pay award for 21/22.
Pay - Consultant incremental drift including commitment awards	0.3	£100k per ILG to reflect estimated increased costs.
Pay – agency cost inflation	0.5	£150k per ILG to reflect estimated costs
Pay – incremental drift	1.0	Allocated based on recurrent A4C pay budgets.
Community pharmacy – earmarked Welsh Government (WG) allocation	0.5	100% Medicines Management.
Continuing Healthcare (CHC) inflation – 2% estimate	1.2	Allocated based on recurrent CHC budgets.
NHS Funded Nursing Care (NHSFNC) inflation	0.3	100% Bridgend ILG.
Non pay inflation – 2% estimate	2.2	Allocated based on recurrent non pay budgets.
LTA Inflation- core 2.0%	2.6	100% Contracting
Total	14.3	

Investments - £10.3m

Investment area	£m	Rec / NR	Allocation
Locally determined priorities	1.0	Rec	Allocated to Non Delegated initially and will be released based on the actual costs of the commitments already made - Vascular reconfiguration £0.65m (additional Cardiff & Vale (C&V) commissioning cost net of cost reduction in Rhondda Taf Ely (RTE) ILG - initial estimate being refined but the change has been agreed) - Early cancer diagnosis and cancer management development (already approved by Management Board)
Primary care – WG earmarked allocation	0.3	Rec	Allocated to Primary Care.
Health Board Transformation Fund	1.0	NR	Provision of £1m has been made for the transitional costs of moving from current to new better value service models/pathways and workforce models. This transition often involves double running costs for a period, and this is what the resource is set aside for. Its use has not yet been prioritised, and this will be part of

			the more detailed planning and budget setting process over April to June. Allocated to Non Delegated initially and will be released based on the actual costs of the agreed local priorities.
Enablers	1.0	Rec	£1.0m has been included in the plan for further investment in enablers for improvement. Again the exact use of this will be decided in the more detailed planning process over April to June. This will be linked in part to whether WG supports the Health Board's request for Targeted Intervention (TI) funding (as this includes some enabling investment). But the key areas of priority identified are as follows: • CTM improvement (including Value Based Healthcare) • Population health • ICT and informatics • Business partnering support to ILGs in some areas. Allocated to Non Delegated initially and will be released based on the actual costs of the agreed local priorities.
Out of hospital transformation	7.0	NR	Allocated to Non Delegated initially and will be released based on the actual costs of the agreed expenditure plan for 2021/2022. There is a significant concern as currently there is not a plan to manage within the £7.0m funding available.
Total	10.3		

Recurrent cost pressures - £15.5m

Recurrent cost pressure	£m	Allocation
CHC growth(2% provided)	1.2	Allocated between ILGs based on recurrent CHC budgets
Prescribing growth	2.3	100% Medicines Management, with corresponding savings target
NICE growth - internal	1.3	100% Medicines Management
NICE growth – external	1.0	100% Contracting
Nurse Staffing Act	0.9	Allocated to Non Delegated initially and will be released based on the agreed actual costs

Welsh Health Specialised Services Committee (WHSSC) and Emergency Ambulance Services Committee (EASC)	4.0	100% Contracting
Welsh Risk Pool (WRP) – risk sharing	0.4	Budget held centrally
Internal cost and service pressures	2.9	£700k per ILG as a contingency against unavoidable cost increases. The balance of £800k is allocated to Non Delegated initially and will be used to fund agreed recurrent cost pressures across other areas & provide a small level of contingency.
Increased demand for beds	1.5	Budget held centrally and released non-recurrently in 21/22 as part of the £5.8m net non-recurring benefit (see below). Required recurrently from 22/23 for transformation.
Total	15.5	

Non-recurring costs and benefits - £ (5.8)m

Non-recurring costs and benefits	£m	Allocation
Retrospective CHC claims	0.5	Budget held centrally and will be released to fund agreed costs
Other non-recurring costs	0.6	Budget held centrally and will be released to fund agreed costs. This is largely the medical staffing efficiency scheme and prioritised projects/reviews in ILGs to be agreed.
Laboratory Information Network Cymru (LINC)- Programme costs	0.2	Budget held centrally and will be released to fund agreed costs
Radiology Information System – Programme costs	0.1	Budget held centrally and will be released to fund agreed costs
Overseas nursing Invest to Save (I2S) project phase 2 initial investment	0.7	Budget held centrally and will be released to fund agreed costs. The total costs are likely to be in the region of £2m. An Invest to Save grant application is expected to be made for 75% of the costs.
Records digitisation I2S project	1.5	Budget held centrally and will be released to fund agreed costs
Targeted intervention costs	2.5	Budget held centrally and will be released to fund agreed costs. It is important to note that WG have not yet confirmed the level for

		funding for TI in 21/22 in relation to CTM Improvement and so the assumed £2.5m may not all be available.
Release of reserve for increased demand for beds	(4.7)	Negative budget held centrally
Accountancy gains	(6.2)	Negative budget held centrally
Slippage on investments	(1.0)	Negative budget held centrally
Total	(5.8)	

Recurrent savings targets - £16.1m

As noted above all areas have been funded for their forecast recurrent savings shortfalls from 2020/2021.

For 21/22 all areas have been allocated a 2% savings target based on their forecast recurrent budgets at 31 March 2021. The only exception is Primary Care prescribing where the savings target has been set at £2.3m which is equivalent to the budget increase for Primary Care prescribing growth for 21/22.

2.2 Covid response

Given the significant uncertainties around the costs of the Covid response, and the uncertainties in funding after Q1/2, it is proposed to allocate Covid budgets on a quarterly basis.

A summary of the allocation of the proposed non-recurring budget increases for Covid response costs in Q1 (over and above the recurrent budgets) is provided below. The total budgets being allocated are as per the assessments made in the draft financial plan (Appendix 1).

Q1 Covid plan	Total	Merthyr & Cynon	Rhondda & Taff Ely	Bridgend	Medicines Mgt	Primary care	Other DE	Contracting	Corporates	Non Delegated	Total
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
TTP	2.9	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.9
Mass Vaccination	3.2	0.0	0.0	0.0	0.0	3.2	0.0	0.0	0.0	0.0	3.2
Cleaning Standards	0.6	0.2	0.2	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.6
CHC/FNC Support	0.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.9	0.9
PPE	0.6	0.2	0.2	0.2	0.0	0.0	0.1	0.0	0.0	0.1	0.6
Long COVID	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
Field Hospital	1.0	0.0	0.0	0.3	0.0	0.0	0.0	0.0	0.3	0.4	1.0
Primary care prescribing	0.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.9	0.9
Dental income Loss	0.4	0.0	0.0	0.0	0.0	0.4	0.0	0.0	0.0	0.0	0.4
IT	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.0	0.2
Planned care exp're reductions	-1.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-1.5	-1.5
Secondary care reactive costs	2.8	0.7	0.7	0.7	0.0	0.0	0.7	0.0	0.0	0.0	2.8
Secondary care reactive costs- HCSW previously charged to W&OD but now being allocated to ILGs	0.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.7	0.7
Undelivered Savings	4.0	0.9	1.0	1.0	0.7	0.1	0.1	0.1	0.3	-0.1	4.0
Costs to transition back out of Covid operating models	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	1.0
TOTAL BUDGET	17.7	2.0	2.1	2.4	0.7	3.7	0.8	0.1	3.6	2.4	17.8

The key principles and assumptions used to allocate the above non-recurring budgets are as follows. It is important to highlight the distinction between Covid Programme costs (which are effectively pass through costs to WG) and other Covid costs which are a 'real' cost to the Health Board and will need to be managed within our fair shares Covid allocation:

	Qtr 1 £m	Non recurring allocation
Programme costs:		
Test Trace Protect (TTP)	2.9	£2.8m budget allocated to Public Health plus a small allowance for pathology testing at circa £30k/month. Adjusted periodically to reconcile with actual costs/WG funding.
Mass vaccination	3.2	Budget allocated 100% to Primary Care. Adjusted periodically to reconcile with actual costs/WG funding.
Cleaning standards	0.6	Budget allocated to ILGs based on estimated split provided by Facilities. Adjusted periodically to reconcile to actual costs/funding
CHC/FNC support for Care homes	0.9	Budget retained and managed centrally.
Personal Protective Equipment (PPE)	0.6	Q1 allocation based on continuation at M12 levels. Adjusted periodically to reconcile with actual costs/WG funding.
Other Covid Costs :		
Long Covid	0.1	Budget allocated 100% to Merthyr & Cynon (M&C) ILG.
Field Hospital	1.0	Estimated staffing costs for April allocated to BILG (£300k) and estimated running costs for Q1 (£300k) allocated to Estates with balance held in reserve pending clearer view on M2/M3
Primary care prescribing	0.9	Allocated to Non Delegated initially pending clearer view on additional Covid costs.
Dental income loss	0.4	Allocated to Non Delegated initially. Actual net costs above budget due to Covid then funded.
IT	0.2	Budget allocated 100% to ICT.
Planned Care expenditure reductions	(1.5)	Allocated to Non Delegated initially. Will need to be assessed in light of the final planned care recovery plan and the level of planned elective cases compared to pre Covid levels by site.
Secondary Care reactive costs	2.8	Monthly budget is £918k based on 75% of 20/21 run rate. Budget allocated equally between the three ILGs and Facilities.
Secondary care reactive costs- Healthcare Support Worker (HCSW) previously charged to Workforce & Organisational Development (W&OD) but now being allocated to ILGs	0.7	Monthly budget is £225k based on 75% of 20/21 run rate. Allocated to Non Delegated initially and will be released to ILGs in proportion to the actual amounts being recharged to ILGs in M1.
Undelivered savings	4.0	Allocation based on actual savings targets for 21/22.

Costs to transition back out of Covid operating models	1.0	Allocated to Non Delegated initially and will be released by the Chief Operating Officer (COO) & Director of Finance (DoF) based on consideration of ILG proposals
Total	17.7	

2.3 Planned care recovery

It is expected that feedback will be received from the Welsh Government on the Planned Care Recovery Plan, and on the allocation of the initial £100m Welsh Government budget, in the near future. In the meantime, a process for making decisions on initial commitments at risk is underway. These will be funded centrally at risk, based on minimum expectations of allocations from the Welsh Government.

2.4 Other matters

- Accountability letters and budget sign off arrangements

As in previous years, the CEO will be sending accountability letters to each Executive Director, which will include the formal budget sign off arrangements and will also cover finance, performance, quality and workforce.

Director	Areas included in CEO accountability letters
Director of Operations	BG ILG MC ILG RTE ILG Medicines Management Primary care Other areas within Delivery Executive
Director of Finance	Finance Estates
Director of Planning	Planning & Partnerships Performance & Information Contracting & Commissioning ICT
Medical Director	Medical Directorate
Director of Nursing	Patient Care & Safety
Director of Workforce	Workforce and OD
Director of Public Health	Public Health
Director of Corporate services	Corporate Development
Director of Therapies & Health Sciences	Therapies and Health Sciences

In addition to the above, the Director of Operations will also be sending accountability letters to the ILG Directors and other Directors responsible for the areas within his portfolio.

- Anticipated additional Welsh Government allocations

Further Welsh Government funding, in addition to the anticipated funding referred to earlier in this report, has been announced and is expected to be allocated to Health Boards. The process for making these allocations is generally one based on a response to specific Health Board proposals.

This areas of funding announced include the following in particular:-

- Adult mental health
- Child and Adolescent Mental Health Services (CAMHS)
- Urgent care (Contact ahead, Urgent Primary Care, and Ambulatory Urgent Care).

As specific Welsh Government allocations to CTM become clear, they will be devolved as appropriate.

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

There are a number of risks around the 2021/22 budget and finances which have been flagged in the financial plan already agreed. These will be clarified further through feedback from Welsh Government on the draft plan, and through the local planning process over April and May, leading to an update of the plan by the end of June.

The key overarching areas of action needed to develop the plan, both locally in ILG and Directorates, and from an overall plan perspective, are as follows:-

- Service and workforce plans to manage and prioritise cost pressures within the available resources in the plan
- Prioritising the use of the internal funding set aside for transitional service changes and enabling.
- Development of efficiency savings plans to deliver on the agreed savings targets
- Service and workforce plans to manage transformation investment within the available resources in the current year and to plan for sustainability in 2022/2023 once the non-recurring transformation funding comes to an end.
- Tracking of the use of the annual leave carried forward, and balancing the associated costs against a release of the resources held on the balance sheet as the accrued leave reduces.
- Development and refinement of Covid response plans, and agreeing updated mechanisms for reporting on Covid related costs against the budgets set.
- Development and refinement of the Planned Care Recovery plan within additional resources agreed by Welsh Government
- Working with Welsh Government to achieve a balanced plan for Q3/4
- Working through the year to reduce the level of recurrent deficit being taken into 2022/2023 (currently £32.2m in the draft plan).

4. IMPACT ASSESSMENT

Quality / Safety / Patient Experience implications	There are no specific quality and safety implications related to the activity outlined in this report.
Related Health and Care standard(s)	Staff and Resources
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below)
	If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below.
	If no, please provide reasons why an EIA was not considered to be required in the box below.
Legal implications / impact	Not Required
Resource (Capital / Revenue £ / Workforce) implications / Impact	There are no specific legal implications related to the activity outlined in this report.
Link to Strategic Well-being Objectives	Yes (Include further detail below)
	The report discusses the allocation of resources in line with the IMTP and CTM priorities.
	Ensure sustainability in all that we do, economically, environmentally and socially

5. RECOMMENDATION

The Board is asked to:

- APPROVE the proposed budgets and budget-setting arrangements for 2021/2022. It should be noted that these budgets are draft as the overall financial plan remains a draft plan given it is currently a deficit plan.

ACTIONS ARISING FROM PREVIOUS BOARD MEETINGS

	Minute Ref.	Date	Agreed Action	Lead Director	Timescale	Status as at May 2021
1	HB/20/229	26.11.20	Integrated Performance Dashboard Suggested a discussion was held at a future Board meeting in relation to the work being undertaken on Planned Care and the focus being placed on the Elective Strategy for the next 6-12 months	Interim Chief Operating Officer	March 2021 Now July 2021	An update on the Planned Care Programme will be presented to the Quality & Safety Committee at its July meeting. It is intended to present an update to July Board also.
2	HB/20/229	26.11.20	Integrated Performance Dashboard Response to be provided outside of the meeting in relation to the plans that were in place to improve 26 week performance target for Neurodevelopmental Services	Interim Chief Operating Officer	Complete	A briefing has been shared with Independent Members by email outside of the meeting

Agenda Item 2.2.1

3	HB/20/174	30.09.20	Safe, Sustainable and Accessible Emergency Medicine and Minor Injury and Illness Services for the People of Rhondda Taff Ely Formal proposal in relation to Paediatrics Services to be presented to the November meeting Programme of work to be included in future iterations of the report to enable Board members to have assurance that timescales identified were being met	Medical Director	In progress	The work now expanded to include review of safe staffing of neonatal units across the HB as the co-dependencies are significant. Successful recruitment and resolution of some long term issues on middle grade rota management mean that sustainable resolution can be expected in Q1 21/22
4	HB/20/179	30.09.20	Values & Behaviours Update Full implementation plan to be presented to the next People & Culture Committee. Implementation plan to include full expected impact	Director of People	Complete	The action plan has been shared with the Chair of the People & Culture Committee and has been added to the agenda for the April meeting.
5	Agenda Item 4.3	28.01.21	Targeted Intervention – Programme for Continuous Improvement in response to Targeted Intervention Further review to be undertaken of the self-assessment scores, particularly in relation to the discussion held in relation to staff survey results	Director of Corporate Governance	Complete	Report received at the March 2021 meeting.

Agenda Item 2.2.1

6	Agenda Item 6.1	28.01.21	Organisational Risk Register Confirmation to be sought outside of the meeting as to whether telecommunications systems were compatible across the Health Board	Director of Planning & Performance	Complete	The telecommunication systems within Bridgend are currently managed through a Service Level Agreement (SLA) with Swansea Bay. Both systems are relatively new and they are therefore likely to be unified in a retender process in the next 3 years."
7	Agenda Item 6.1	25.03.21	Organisational Risk Register Review of timelines for presenting future risk register reports to Committee meetings to be undertaken	Director of Corporate Governance	Complete	Where timings allow following Management Board sign off of the Risk Register the latest version available will be received by the Board Committees.
8	Agenda Item 6.1	25.03.21	Organisational Risk Register G Robinson to provide an update to P Roseblade outside of the meeting in relation to the risk related to the main gates.	Interim Chief Operating Officer	Complete	Response provided outside of the meeting
9	Agenda Item 6.1	25.03.21	Organisational Risk Register G Galletly and P Roseblade to meet outside of the meeting to discuss impact of risk and risk values.	Director of Corporate Governance	Complete	Meeting held on the 8 th April 2021.

Agenda Item 2.2.1

10	Agenda Item 6.2	25.01.21	Integrated Performance Dashboard F Jenkins to provide an update on the current position regarding Stroke Quality Improvement Performance on her return from annual leave.	Interim Director of Therapies & Health Sciences	Complete	A report was presented to the Population Health and Partnerships Committee on 7 April, which included an update on stroke performance. The Committee asked for the Quality and Safety Committee to give oversight to stroke performance and the action plan for improvement, and for the Population Health & Partnerships Committee to have a further update in 6months.
11	Agenda Item 6.2	25.01.21	Integrated Performance Dashboard G Robinson to confirm the current position in relation to Neurodevelopmental performance outside of the meeting, particularly in relation to patients waiting over 80 weeks for an assessment.	Interim Chief Operating Officer	Complete	A briefing has been shared with Independent Members by email outside of the meeting
12	Agenda Item 7.3	25.01.21	Staff Wellbeing Survey Timing of the next staff survey to be considered	Director of People	Completed	It has been agreed that the next survey will be sent out to staff in July 2021

Agenda Item 2.2.1

13	Agenda Item 7.3	25.01.21	Staff Wellbeing Survey Acknowledgement to be given to the statements made by staff in relation to them feeling under resourced and response to be provided in the You Said, We Did poster.	Director of People	Complete	A review is in the process of being undertaken by the Strategic Lead for Wellbeing and Employee Experience



AGENDA ITEM

2.2.2

CTM BOARD

CHIEF EXECUTIVE'S REPORT

Date of meeting

27 May 2021

FOI Status

Open/Public

If closed please indicate reason

Not Applicable - Public Report

Prepared by

Richard Morgan-Evans, Chief of Staff

Presented by

Paul Mears, Chief Executive Officer

Approving Executive Sponsor

Chief Executive

Report purpose

FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)

Committee / Group / Individuals

Date

Outcome

(Insert Name)

(DD/MM/YYYY)

Choose an item.

ACRONYMS

AW

Audit Wales

COO

Chief Operating Officer

CTM

Cwm Taf Morgannwg

HIW

Healthcare Inspectorate Wales

NWSSP

NHS Wales Shared Services Partnership

WG

Welsh Government

1. SITUATION / BACKGROUND

- 1.1 The purpose of this report is to keep the Board up to date with key issues affecting the Organisation. A number of issues raised within this report feature more prominently within reports of the Executive Directors as part of the Board's business.
- 1.2 This overarching report highlights for Board Members the key areas of activity of the Chief Executive, some of which is further referenced in the detailed reports that follow, and also highlights topical areas of interest to the Board.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 New appointments and recruitment updates

I am pleased to announce that we have been conducting recruitment for key senior posts, including the Director of Digital, Director of Strategy and Transformation and Director of Improvement. This ensures that we begin to complete the Executive Team to help guide the organisation forward with our exciting plans.

We have now appointed Marc Penny as the Director of Improvement. Marc has now begun to form a team made up of various important skillsets which can be used in our ongoing improvement journey. Once we have confirmation of the other two appointments this will be shared with the wider Health Board.

Last month we held interviews for the Chief Operating Officer role and after a careful consideration, we have decided not to recruit to a substantive position at this time. I'd like to personally thank Gareth Robinson for his ongoing hard work as the interim-COO. Gareth will remain in the interim role over the next few months and will continue his valuable work overseeing key operational areas of work including the Unscheduled Care Improvement Programme as well as the Elective Recovery Programme of work.

May I take this opportunity to also welcome Richard Morgan-Evans to the organisation as the Chief of Staff. Richard has come from neighbouring Aneurin Bevan UHB (ABUHB) and will be supporting strategic priority areas for the organisation including overseeing the Targeted Intervention Improvement programme of work.

2.2 Targeted Intervention (TI) Escalation update to Welsh Government (WG) and Board self assessment

Last month the Board held a very useful self-assessment session to gauge our progress across the TI and special measures spectrum. This is updated on in detail within the dedicated paper on the agenda.

We also held a joint meeting with WG to update our current position and forward plans. This update was met positively and we agreed that explicit forward plans would be outlined over the coming weeks before we rejoined as senior teams in August for another escalation session.

2.3 Regional mortuary facility

In response to the COVID-19 pandemic the South Wales Local Resilience Forum commissioned a number of extra facilities within the region as part of its Mass Fatalities Plan. Within that plan a purpose built temporary unit was commissioned for the Merthyr Tydfil region (known as SW02) once the Cardiff facility (SW01) was decommissioned in March 2021. This new store unit was agreed for placement at Prince Charles Hospital and is located next to the Mortuary building at the rear of the hospital.

Whilst SW02 was commissioned by the Local Resilience Forum, Cwm Taf Morgannwg University Health Board are responsible for the safe and effective management of the unit. This ensures there is consistency with the application of relevant Standard Operating Procedures in line with the Human Tissue Act (HTA) standards. SW02 is now part of our HTA Site Licence for Prince Charles Hospital and became operational on 22 March 2021 following successful inspections by the Licence Holder, Designated Individual, Persons Designated and Pathology management team. The dedicated work of our mortuary, estate and facilities team has ensured its commissioning within the agreed timescale and meeting of HTA standards. This temporary unit may be in place for up to 12 months and can be utilised by all Health Boards within the Local Resilience Forum partnership if there are regional issues with capacity. All such usage is managed through a booking system and only within Mortuary office hours to ensure consistent practice and governance control. To date the unit has not been utilised, reflecting a relative return to normal activity across the region. The Local Resilience Forum continue to review and oversee this strategic project.

2.4 Clinical Advisory Group (CAG) establishment

After a lot of discussion and input from a variety of individuals, I am pleased to announce that the Clinical Advisory Group has been formed to include a cross section of clinicians from across our Health Board. This forum will take the place of the Healthcare professionals forum and will ensure we are constantly encouraging a platform by which clinicians from all specialties and localities have chance to discuss proposals and suggest new ideas.

This group will complement the Clinical Sounding Board by taking on board issues raised at that level but will have a confirmed membership.

There was a large interest from clinicians to join this group, which exceeded the total number possible. My thanks go out to all that applied to join the group. The CAG will be chaired by Anna Lewis, Respiratory Consultant based at Royal Glamorgan Hospital (RGH), and will be a valuable mechanism to feed in to the Board. Anna will also attend the Board to provide updates where required as well as to feedback to the CAG.

The CAG will be formally established by approval of the Terms of Reference (ToRs) for the group which are included in the Standing Orders for formal approval by the Board later on in the May 2021 Board agenda. Approval of the ToRs and its Chair, will result in the Chair seeking an Associate Board Member appointment from the Minister.

2.5 Director Portfolios

After helpful discussions and taking account for new and re-organised roles, we have now finalised the Director portfolios. This portfolio update comes at a good time as new officer members begin to join as well as wider Directors. This will be helpful to ensure that the Board is explicitly aware of key responsibilities and that there is wider transparency to avoid any duplication or confusion.

2.6 Elective recovery planning and proposals

With a lot of focus rightly being placed on recovering our elective & routine activity as covid continues to decline, I am delighted to report that thanks to the input of many teams across the Health Board we have been allocated a non-recurrent additional funding of £16.83m this year from WG. This funding will support recovery plans across the organisation including primary and secondary care initiatives and will mean much needed additional activity can take place to clear long

waiting lists. More detail on this will be updated by the interim-Chief Operating Officer as part of the Board agenda.

2.7 Royal College of Surgeons – President virtual visit to CTMUHB

The Health Board had the pleasure of meeting Professor Neil Mortensen, President of the Royal College of Surgeons of England and his team to have the opportunity not only to convey the key issues facing surgery in Wales but also to share learnings and best practice from elsewhere. From the meetings on 28th and 29th April we have received positive feedback from Professor Mortensen on our Consent Plus and Ambulatory emergency assessment unit projects as well as praise for CTMs participation in the cholecystectomy quality improvement collaborative.

I believe collaborative meetings such as this are important to bring mutual benefit to all involved and I'm sure the CTM staff in attendance found it to be a valuable forum.

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

- 3.1 The Board should note the changing context and environment for commissioning and delivering healthcare and wellbeing services, in the context of balancing the need to continue to respond to the COVID-19 pandemic, as well minimizing harm from non-COVID-19 activity, and providing essential and routine services to our communities. This balance will bring a new set of issues to manage and risks to consider.

4. IMPACT ASSESSMENT

Quality / Safety / Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Governance, Leadership and Accountability
	It is anticipated that all elements of quality, safety and patient safety will be impacted positively by the implementation of the "Continuous Improvement in response to TI Programme".
Equality impact assessment completed	No (Include further detail below)



Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £ / Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Well-being Objectives	Provide high quality, evidence based, and accessible care

5. RECOMMENDATION

5.1 The CTM Board is asked to:

- NOTE the report.

HEALTH BOARD

HIGHLIGHT REPORT -
POPULATION HEALTH AND PARTNERSHIPS COMMITTEE

DATE OF MEETING	27 May 2021
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable – Public Report
PREPARED BY	Wendy Penrhyn-Jones, Head of Corporate Governance & Board Business
PRESENTED BY	Keiron Montague, Vice-Chair, Population Health & Partnerships Committee
EXECUTIVE SPONSOR APPROVED	Clare Williams, Director of Planning & Performance (interim); Gareth Robinson, Chief Operating Officer (interim).
REPORT PURPOSE	FOR NOTING
ACRONYMS	
CTMUHB	Cwm Taf Morgannwg University Health Board.

1. PURPOSE

- 1.1 This report had been prepared to provide the Board with details of the key issues considered by the Population Health and Partnerships Committee at its meeting on the 7th April 2021.
- 1.2 Key highlights from the meeting are reported in section 2.
- 1.3 The Board is requested to NOTE the contents of the report and actions being taken.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There are no items to report in this section
ADVISE	At the time of the Committee meeting there were no relevant items on the Organisational Risk Register that had a score of 15 or above requiring them to be assigned to the Committee. Nevertheless it was agreed that there would be further discussions between the Director of Planning & Performance and the Director of Public Health to articulate the level of risk around the population health aspects of the Regional Partnership Board Transformation Programme. This was felt important given that the impact of not delivering the programme of work was high but the likelihood of this happening was more challenging to describe. It was agreed an update would be received at the next meeting. A presentation was received around the successful use of behavioural insight communications methodology which had been commissioned by CTMUHB and its three local authority partners. This sought to positively influence public behaviour in relation to covid-19 issues. A report was received setting out key achievements and work to refocus the Primary Care Strategic Programme, outstanding deliverables and learning following the pandemic. It was agreed that updates would be received on a six-monthly basis. A report was received outlining the new NHS Pharmaceutical Regulations (Wales) requiring the organisation to develop and publish a Pharmaceutical Needs Analysis by October 2021. Members noted that this work was being progressed in line with expected deadlines. A presentation regarding Systems Groups was received providing useful context as to their role. Updates were being planned for each meeting.

	A report was received regarding population health interventions and services within the stroke pathway. Following discussion of the report it was agreed that a referral be made to the Quality & Safety Committee for further scrutiny of the quality improvement measures set out in the report. This was actioned following the meeting. A report was received on the Regional Partnership Board Transformation Fund, the challenges associated with delivery against this and the plans in relation to sustainability going forward. Members noted an evaluation had been commissioned to understand the impact the programme was having on services which would help inform future funding decisions. Updates were noted to be planned for each future meeting. It was agreed the matter needed to be referred to the Planning, Performance & Finance Committee. This was actioned following the meeting and considered by that Committee on 27th April 2021.
ASSURE	– The current version of the Committee's Terms of Reference were received following changes to membership arrangements approved by the Board in January 2021 and subsequently in March 2021. – The Committee Annual Effectiveness Survey Action Plan was approved and it was agreed that it would be helpful to circulate a copy of the Committee Fact Sheet given the Committee had new members. – The Committee Cycle of Business for 2021-2022 was also approved.
INFORM	There are no items to report in this section
APPENDICES	Not Applicable



AGENDA ITEM

2.2.4

HEALTH BOARD MEETING

HIGHLIGHT REPORT FROM THE AUDIT & RISK COMMITTEE

DATE OF MEETING

27/05/2021

PUBLIC OR PRIVATE REPORT

Public

IF PRIVATE PLEASE
INDICATE REASON

Not Applicable - Public Report

PREPARED BY

Emma Walters, Corporate Governance
Manager

PRESENTED BY

Patsy Roseblade, Independent Member

EXECUTIVE SPONSOR
APPROVED

Georgina Galletly, Director of Corporate
Governance

REPORT PURPOSE

FOR NOTING

ACRONYMS

None Identified.

1. PURPOSE

- 1.1 This report had been prepared to provide the Board with details of the key issues considered by the Audit & Risk Committee at its meeting on 13 April 2021.
- 1.2 Key highlights from the meeting are reported in section 2.
- 1.3 The Sub Committee is requested to NOTE the report.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	Nil
ADVISE	• The Post Payment Verification Annual Report was received. The Committee noted that the Covid-19 pandemic had disrupted the activity that had been planned for 2020/2021 and agreed to receive an interim update on progress at a future meeting; • The Procurement and Scheme of Delegation report was received. The Committee approved the Financial Control Procedures subject to changes made to the Capital Monitoring Financial Control Procedure; • The Internal Audit Plan for 2021/2022 was received. The Committee approved the Internal Audit Charter. A further discussion would be held between the Committee Chair and Head of Internal Audit in relation to consistency of internal audit ratings; • The Audit Recommendations Tracker was received. Members made reference to the large number of recommendations which remained open, particularly the ones which fell under the remit of the Director of Operations; • The Organisational Risk Register was received and it was agreed that a discussion would be held outside of the meeting to discuss the risks that had been de-escalated; <u>Part 2 – Hosted Bodies</u> • The Welsh Health Specialised Services Committee (WHSSC) Corporate Risk Assurance Framework and Risk Register was received. Following concern raised by the Committee Chair as to how the actions noted would enable the target rating to be achieved, the WHSSC Director of Finance agreed to undertake a review of all actions and target ratings.
ASSURE	• Internal Audit Reports Received; - o IT Service Management – Limited Assurance - o Estates Directorate Management Arrangements – Reasonable Assurance - o Financial Systems – Reasonable Assurance

	o Prince Charles Hospital Redevelopment Covid 19 Site Safety - Substantial Assurance The Local Counter Fraud Update was received. The Committee noted that an analysis would be undertaken of the number of people visiting the Counter Fraud SharePoint page and noted that discussions would be held with the Director of Finance in relation to nominations for a Counter Fraud Champion following concerns raised by the Committee Chair as to the appropriateness of this role being the Director of Finance, given that Counter Fraud reported to the Director of Finance, which meant that there was no segregation of duty.
INFORM	The following reports were approved by the Committee: - Cwm Taf Morgannwg UHB Forward Plan for Clinical Audit 2020-2021 The following reports were noted by the Committee: - Declarations of Interest Register and Gifts and Hospitality Report; - Losses and Special Payments Report; - Audit Enquiries Letter to those charged with Governance; - Internal Audit Progress Report; - Internal Audit Review – Estates Directorate Compliance; - Internal Audit Review – Welsh Risk Pool Claims Process; - Internal Audit Review – Governance Arrangements during Covid-19 Pandemic Follow Up Advisory Review; - Internal Audit Review – Prince Charles Hospital Redevelopment Governance Audit; - Internal Audit Review – Prince Charles Hospital Redevelopment Financial Management; - Internal Audit Review – Prince Charles Hospital Redevelopment Technical Compliance; - Internal Audit Review – Prince Charles Hospital Development – Agreed Integrated Audit Plan 2021/2022; - Audit Wales Progress Report; - Audit Wales CTMUHB Outturn Fee and Letter; - Financial Control Procedure Medical Variable Pay – Summary of Authorised Breaches – In Committee report <u>Part 2 – Hosted Bodies</u> - WHSSC Internal Audit Recommendations Tracker; - Emergency Ambulance Services Committee (EASC) Risk Register;



	Internal Audit Review – WHSSC Women and Children Directorate.
APPENDICES	NOT APPLICABLE



AGENDA ITEM

2.2.5

CTM BOARD

HIGHLIGHT REPORT FROM THE PEOPLE & CULTURE COMMITTEE

DATE OF MEETING

27/05/2021

PUBLIC OR PRIVATE REPORT

Public

IF PRIVATE PLEASE
INDICATE REASON

Not Applicable - Public Report

PREPARED BY

Wendy Penrhyn-Jones, Head of Corporate
Governance & Board Business

PRESENTED BY

Jayne Sadgrove, Independent Member/
Chair of the People & Culture Committee

EXECUTIVE SPONSOR
APPROVED

Hywel Daniel, Executive Director for People

REPORT PURPOSE

FOR NOTING

ACRONYMS

None Identified.

1. PURPOSE

- 1.1 This report had been prepared to provide the Board with details of the key issues considered by the People & Culture Committee at its meeting on the 26 April 2021.
- 1.2 Key highlights from the meeting are reported in section 2.
- 1.3 The Board is requested to NOTE the report.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There are no matters to escalate to the Board on this occasion.
ADVISE	- An internal audit report providing a review of Medical & Dental rostering (Limited Assurance) was received following a referral from the Audit & Risk Committee. Following discussion of the issues therein, the Committee requested an update for its next meeting setting out the outstanding actions and a realistic timeline for delivery bearing in mind a review by internal audit was planned for quarter three of 2021/22. - An update was received on the next phase of work in rolling out the Values & Behaviours Framework which was acknowledged to be complex piece of organisational development work which would take time to become embedded. Discussions centred on the work of this phase and how this was presented to staff. - The Committee endorsed a radically refreshed approach to leadership development designed to shape a culture and capability of compassionate, collaborative leadership that was linked to the embedding of values & behaviours. - Actions designed to bring about focused improvement of current Statutory & Mandatory Training Compliance which was linked to an organisational metrics report was also received at this meeting.
ASSURE	- The Committee welcomed the following presentations which provided helpful insights into the cultural improvement journey in these areas. The informative presentations also provided Independent Members with the information to seek further assurance when undertaking future site visits and testing the cultural temperature within the organisation. - Cultural Change in: - Maternity - Neonatal - Child & Adolescent Mental Health Services

	• The Committee approved the Committee Annual Business Cycle. It was agreed that a proposal be brought to the next meeting on the frequency of reporting the activity of the Employee Experience Group and Organisational Development Group to the Committee. • The Committee received a report on the Organisational Risk Register for those matters where risks had a score of 15 or more and were assigned the Committee noting actions taken to manage or mitigate those high-level risks. It was noted that the Organisational Risk Register would continue to evolve as it matures and embeds within the organisation. Due to the timing of the report verbal updates to complement the report were provided.
INFORM	• The Committee approved the following documents: – The Special Leave Policy, it was recognised that this policy could be further strengthened to recognise special leave requirements relating to surrogacy and miscarriage. – Recruitment & Retention Payment Protocol. – Consideration of a Shared Parental Leave Policy was deferred in order to allow additional consideration to its content. • A report on International Nurse Recruitment was deferred until the next meeting. • The following items were received for information: – An Internal Audit Report (Reasonable Assurance) regarding Medical Agency Usage – The Internal Audit Plan for 2021/22 illustrating the various audits planned in relation to workforce related issues across the organisation – A summary of the delivery position around recommendations arising from previous internal audit reports
APPENDICES	Not applicable.

CTM BOARD
HIGHLIGHT REPORT – PLANNING, PERFORMANCE & FINANCE COMMITTEE

DATE OF MEETING	27/05/2021

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Kathrine Davies, Corporate Governance Manager
PRESENTED BY	Mel Jehu, Independent Member (Committee Chair)
EXECUTIVE SPONSOR APPROVED	Director of Planning & Performance, Chief Operating Officer, Director of Finance

REPORT PURPOSE	FOR NOTING

ACRONYMS	
IMTP	Integrated Medium Term Plan
ILG	Integrated Locality Groups

1. PURPOSE

1.1 This paper had been prepared to provide the Board with details of the key issues considered by the Planning, Performance & Finance Committee which took place on 27 April 2021.

1.2 Key highlights from the meeting are contained in section 2.

1.3 The Board are requested to NOTE the contents of the report and actions being taken.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	The Month 12 Finance Update was received and the Committee noted that the draft position reported to Welsh Government was a Month 12 deficit of £182k and a small surplus of £30k.
ADVISE	The Committee received presentations on the current position in relation to the Integrated Medium Term Plan (IMTP) and the Planned Care Recovery and noted that governance arrangements would be discussed with regard to the Health Board sign-off of the final Plan to Welsh Government in June 2021.
ASSURE	- A detailed review of the Integrated Performance Dashboard was undertaken noting the assessment summary in relation to the following areas: - Re-Setting Elective Services - Referral to Treatment Times (RTT) - Unscheduled Care - Elective Waiting Lists - Cancer Waiting times - Stroke Services - The Committee endorsed for Board Approval the report on Budget Setting Arrangements for 2021-22. The budget setting principles, assumptions and the proposed allocation of the draft budget to Integrated Locality Groups and other service areas were noted in relation to the financial aspects of core plan, Covid-19 response and planned care recovery. - The Committee received the Organisational Risk Register and reviewed the Planning, Performance & Finance risks, noting the changes identified within the report.



INFORM	The Committee received for information and noting the Accountable Officer Letter Sent to Welsh Government
APPENDICES	NOT APPLICABLE

HEALTH BOARD

HIGHLIGHT REPORT FROM THE MENTAL HEALTH ACT MONITORING COMMITTEE

DATE OF MEETING	27/05/2021
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Kathrine Davies, Corporate Governance Manager
PRESENTED BY	Maria Thomas, Vice Chair & Chair of the Mental Health Act Monitoring Committee
EXECUTIVE SPONSOR APPROVED	Gareth Robinson, Chief Operating Officer (Interim)
REPORT PURPOSE	FOR NOTING
ACRONYMS	
MHA	Mental Health Act
SWP	South Wales Police

1. PURPOSE

- 1.1 This paper had been prepared to provide the Board with details of the key issues considered by the Mental Health Act (MHA) Monitoring Committee at its meeting on the 5 May 2021.
- 1.2 Key highlights from the meeting are reported in section 2.
- 1.3 The Board is requested to NOTE the contents of the report and actions being taken.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	Nil this period.
ADVISE	• The Committee received an update on The Alternative Place of Safety – The Sanctuary and a case study exemplar. The Committee were reminded that a visit to the Sanctuary had originally been intended for 2020 which had needed to be postponed due to the Covid-19 pandemic. It was agreed that this now be rearranged for Independent Members in 2021. • The Committee received a report on the Actions and Learning Arising from Fundamental Breaches of the Mental Health Act Reported Quarter 2 2020-21. • The Committee received a report on Quarterly Mental Health Act (MHA) Activity Report for Adult, Older Persons and Children and Adult Mental Health Services (CAMHS) for Quarter 4 – January – March 2020-21. With regard to the issue of young people being detained on adult mental health wards, assurances were sought on the actions being put into place to mitigate this situation arising. The Committee agreed to receive an update on this important issue at its next meeting. • The Committee received the MHA Breaches and Errors Report for Quarters 3 and 4. The Committee discussed planned training enhancements under Section 5 Doctor's Holding Powers. • The Committee noted a report on Covid-19 Remote MHA Assessments setting out changes to practice in relation to remote Mental Health Assessments. • The Committee received the report on the Risks Relating to the MHA for Quarter 3 and noted that there had been two fundamental breaches of the Act. The Committee expressed disappointment regarding this and noted additional actions were being put into

	place to once again raise awareness on MHA processes with a view to avoiding further breaches. The Committee is due to receive an update at its next meeting. The Committee received a MHA Operational Group update report. The Committee discussed patient flow from the Powys area and assessment arrangements in Prince Charles Hospital. It was agreed that further work would be undertaken to understand the relevant demand and capacity issues. A further update was agreed for the next meeting.
ASSURE	- The Committee approved the Committee Annual Report for 2020-22 and agreed that the Annual Self-Assessment would be undertaken outside the meeting via Survey Monkey for review at the next meeting in July 2021. - The Committee approved the Committee Annual Cycle of Business for 2021-22.
INFORM	- The Committee received and noted the strategic update from South Wales Police (SWP). - The Committee received and noted the report which provided a verbal update on progress in relation to the development of the Regional Crisis Care Concordat Group. - The Committee also noted the verbal update on the SWP Mental Health App pilot. - The Committee noted that this was the final meeting for Maria Thomas who was stepping down from her role as CTMUHB Vice-Chair and therefore the Committee Chair role too. Members paid tribute to the outgoing Chair for her many years of valuable contribution to the improvement of mental health services for the local community. Jayne Sadgrove (who was in attendance at the meeting) was noted to be taking-up the role of CTMUHB Vice-Chair from June 2021 and would therefore assume the role of the Committee Chair at



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

	the next meeting.
APPENDICES	Not Applicable.



AGENDA ITEM

2.2.8

CTMUHB BOARD MEETING

HIGHLIGHT REPORT FROM THE QUALITY & SAFETY COMMITTEE

DATE OF MEETING

27/05/2021

PUBLIC OR PRIVATE REPORT

Public

IF PRIVATE PLEASE
INDICATE REASON

Not Applicable - Public Report

PREPARED BY

Emma Walters, Corporate Governance
Manager

PRESENTED BY

Jayne Sadgrove, Independent Member

EXECUTIVE SPONSOR
APPROVED

Greg Dix, Executive Director of Nursing

REPORT PURPOSE

NOTING

ACRONYMS

None Identified.

1. PURPOSE

- 1.1 This report had been prepared to provide the Board with details of the key issues considered by the Quality & Safety Committee at its meeting on 18 May 2021.
- 1.2 Key highlights from the meeting are reported in section 2.
- 1.3 The Sub Committee is requested to NOTE the report.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	Positive Escalation: • The Committee noted within the Bridgend ILG report that the Child & Adolescent Mental Health Service Clinical Service Group had been awarded funding for Carnegie Clinic and the Princess of Wales Clinic; • The Committee noted within the Merthyr & Cynon ILG report the planned opening at the end of May of Ty Enfis, which would provide dementia care for patients. Members noted that this would be an important development for patients and staff; • The Committee were pleased to note that the RTE ILG Locality Nurse Director and nursing leads from across the ILG and Infection, Prevention & Control Team (IP&C) team had won an award at a national Celebration Event in the category 'project with the biggest potential impact'.
ADVISE	• A patient story was shared with the Committee which described the experiences of a family member who had a relative in hospital during the Covid-19 pandemic. The story highlighted communication failures that had occurred along the patient's pathway which had been deeply upsetting for the family at such a difficult and worrying time. Members valued the story being shared and were keen to learn of the improvements being implemented to prevent reoccurrence. • The Organisational Risk Register was received and Members noted that steps were being taken to ensure the Committee were being presented with the most latest version of the register which was welcomed and endorsed; • An update on the Maternity and Neonatal Improvement Programme was received. Members noted the further progress that had been made and that concerns had been raised by the Independent Maternity Services Oversight Panel in relation to medical input into Serious Incident reviews which they felt needed to be strengthened; • The Chief Operating Officers report was received. Members requested sight of the Planned Care Recovery Programme at a future meeting and noted the increase in attendances at Emergency Departments. Concerns were raised by an Independent Member in relation to availability of adequate Personal Protective Equipment (PPE) for hard of hearing staff. Concerns

	were also raised in relation to delays in ambulance handovers and the ILG's were asked to include their improvement journeys in relation to this activity in future reports; • The Committee received and noted the Integrated Locality Group Quality & Safety Reports together with the Primary Care Quality & Safety report and key matters were brought to the attention of the Committee; • The Quality Dashboard was received. Members requested an update at a future meeting on Medication Errors; • A report on Nosocomial Healthcare Acquired Infections was received. Members noted that a review would need to be undertaken of cases as the Health Board's transmission rate was in excess of 2000 patients and noted that a standardised approach was being taken across Wales; • A Stroke Quality Improvement report was received. Members noted that discussions were being held regarding the provision of stroke services within the Health Board and across Wales. The Committee requested a further update at a future meeting. • Updates were received on the Urgent Care Improvement Programme and Nursing Assurance, the Committee welcomed these reports and requested a further update on progress at a future meeting; •
ASSURE	• The Committee received an update on the latest position regarding the Covid-19 pandemic. Members noted the reduction in cases, low positivity rates and the success of the vaccination programme, with further work required to encourage people to receive their second vaccination. Members noted that whilst not presently an issue for Wales, the Indian variant was being monitored
INFORM	The Committee received the following reports for approval via the consent agenda: • Quality & Safety Committee Annual Report 2020/2021; • Clinical Audit Policy & Strategy. The Committee received the following reports for noting via the consent agenda/main agenda: • Action Log and Forward Work Programme; • Controlled Drugs Local Intelligence Network Annual Report; • Infection Prevention & Control Committee Highlight Report and Annual Report;

	• Welsh Health Specialised Services Committee Quality & Patient Safety Chairs Summary Reports; • Radar Committee Highlight Report; • Research & Development Six Monthly Update; • WAST Patient Safety & Experience Highlight Report February 2021; • Clinical Audit Forward Plan 2020/2021; • Covid-19 Related Mortality Rates in Care Homes; • Human Tissue Authority Compliance Update Report and Annual Report; • Cancer Services Annual Report; • Highlight Report from the Facilities Directorate; • Update report on Suicide Prevention; The Committee received the following reports/updates at the In Committee section of the meeting: • Ty Lidiard Update report; • Homicide Review – verbal update; • Healthcare Inspectorate Wales Routine Quality Checks Tier 1 Activity; • Management of Commissioning Risks.
APPENDICES	NOT APPLICABLE



CTM BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE REMUNERATION &
TERMS OF SERVICE COMMITTEE

DATE OF MEETING

27/05/2021

PUBLIC OR PRIVATE REPORT

Public

IF PRIVATE PLEASE
INDICATE REASON

Not Applicable - Public Report

PREPARED BY

Wendy Penrhyn-Jones

PRESENTED BY

Marcus Longley, Chair

EXECUTIVE SPONSOR
APPROVED

Hywel Daniel, Executive Director People

REPORT PURPOSE

FOR NOTING

ACRONYMS

None Identified.

1. PURPOSE

- 1.1 This report had been prepared to provide the Board with details of the key issues considered by the Remuneration and Terms of Service Committee at its meeting on 22 March 2021.
- 1.2 Key highlights from the meeting are reported in section 2.
- 1.3 The Board is requested to NOTE the report.



2. HIGHLIGHT REPORT

ALERT / ESCALATE	Nil
ADVISE	The Committee received a written report setting out proposals in respect of the remuneration of the Executive Director for People which would also be subject to Welsh Government approval. The Committee received an oral update regarding the recent interviews for the appointment of a Chief Operating Officer which had not resulted in an appointment. The Committee received a report regarding changes to the remit of the Director of Corporate Governance/Board Secretary which will see the officer relinquishing responsibility for Communications & Engagement with a view to them taking over the leadership of the Concerns/Putting Things Right/Redress function. The Committee also noted that Welsh Government proposals were currently subject to comment by NHS Wales Chairs and Chief Executives which sought to ensure core elements of the Board Secretary role were protected in regulation (via Standing Orders). The Committee approved four Voluntary Early Release Scheme applications with a fifth to be subject to Chair's Action outside the Committee once the business case was finalised.
ASSURE	
INFORM	Nil
APPENDICES	NOT APPLICABLE



CTM BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE REMUNERATION &
TERMS OF SERVICE COMMITTEE

DATE OF MEETING

27 May 2021

PUBLIC OR PRIVATE REPORT

Public

IF PRIVATE PLEASE
INDICATE REASON

Not Applicable - Public Report

PREPARED BY

Wendy Penrhyn-Jones, Head of Corporate
Governance & Board Business.

PRESENTED BY

Marcus Longley, Chair/ Independent
Member

EXECUTIVE SPONSOR
APPROVED

Hywel Daniel, Executive Director for People

REPORT PURPOSE

FOR NOTING

ACRONYMS

None Identified.

1. PURPOSE

- 1.1 This report had been prepared to provide the Board with details of the key issues considered by the Remuneration and Terms of Service Committee at its meeting on 20 April 2021.
- 1.2 Key highlights from the meeting are reported in section 2.
- 1.3 The Board is requested to NOTE the report.



2. HIGHLIGHT REPORT

ALERT / ESCALATE	Nil
ADVISE	The Committee received a summary document detailing the revised portfolios which was formally noted by the Committee. An update was also received on the arrangements for the recruitment of a Director of Digital and a Director of Strategy & Transformation. A formal report would be prepared following the appointment process for consideration by the Committee to approve the appointment. The Committee noted support had been received from Cardiff & Vale University Health Board for an extension of the contract between that health board and CTMUHB which related to a shared post – the Director of Therapies and Health Sciences.
ASSURE	Nil
INFORM	Nil
APPENDICES	NOT APPLICABLE



**EMERGENCY AMBULANCE SERVICES
JOINT COMMITTEE MEETING**

**'CONFIRMED' MINUTES OF THE MEETING HELD ON
10 NOVEMBER 2020 AT 09:30HOURS
VIRTUALLY BY MICROSOFT TEAMS**

PRESENT

Members:	
Chris Turner	Independent Chair
Stephen Harrhy	Chief Ambulance Services Commissioner
Judith Paget	Chief Executive, Aneurin Bevan ABUHB
Paul Mears	Chief Executive, Cwm Taf Morgannwg CTMUHB
Carol Shillabeer	Chief Executive, Powys PTHB
In Attendance:	
Steve Ham	Chief Executive Officer, Velindre NHS Trust
Hannah Evans	Director of Transformation, Swansea Bay SBUHB
Gavin Macdonald	Interim Chief Operating Officer, Betsi Cadwaladr UHB
Jason Killens	Chief Executive, Welsh Ambulance Services NHS Trust (WAST)
Stuart Davies	Director of Finance, Welsh Health Specialised Services Committee (WHSSC) and EASC Joint Committees
Ross Whitehead	Assistant Director of Quality and Patient Experience
Ricky Thomas	Head of Informatics, National Collaborative Commissioning Unit (NCCU)
Rachel Marsh	Director of Planning, Strategy and Performance, Welsh Ambulance Services NHS Trust
Shane Mills	Director of Nursing and Quality, National Collaborative Commissioning Unit

Part 1. PRELIMINARY MATTERS		ACTION
EASC 20/86	WELCOME AND INTRODUCTIONS Chris Turner (Chair), welcomed Members to the virtual meeting (using the Microsoft Teams platform) of the Emergency Ambulance Services Committee. Paul Mears was welcomed to his first meeting.	Chair
EASC 20/87	APOLOGIES FOR ABSENCE Apologies for absence were received from Gill Harris, Tracy Myhill, Tracey Cooper and Gwenan Roberts.	Chair
EASC 20/88	DECLARATIONS OF INTERESTS There were no additional interests to those already declared.	Chair

EASC 20/89	MINUTES OF THE MEETING HELD ON 8 SEPTEMBER 2020 The minutes were confirmed as an accurate record of the Joint Committee meeting held on 8 September 2020. Members RESOLVED to: • APPROVE the Minutes of the meeting held on 8 September 2020.	Chair
EASC 20/90	ACTION LOG Members RECEIVED the action log and NOTED specific progress as follows: EASC 20/45 & 20/57 Learning Lessons of working during a pandemic To be received at the next meeting (added to the Forward Look). EASC 20/57 Unscheduled Care Dashboard Stephen Harrhy updated Members by explaining that progress had been made in the work to develop the Unscheduled Care Dashboard. Specification has been developed following work with health boards which would be circulated (added to the Action Log) and external funding had been confirmed. A tender process would soon commence. EASC 20/57 Healthcare Inspectorate Wales (HIW) Report The report has been circulated. EASC 20/60 Governance Update A report would be received at the next meeting (added to the Forward Look). EASC 20/70 CASC as Co-Chair Task and Finish Group Members noted the ongoing work with the Fire and Rescue Services in relation to their work as first responders. Stephen Harrhy agreed to provide an update on the work at the next meeting (added to the Action Log). EASC 20/73 EASC allocation letters for Major Trauma Services and Critical Care Transfer Services Stephen Harrhy confirmed that the allocation letters had been received for Major Trauma and Critical Care Transfer Services from the Welsh Government and discussions had commenced with providers. Information related to potential slippage would be included in the next finance report.	CEO WAST CASC Completed Ctte Sec CASC CASC & Director of Finance

	EASC 20/74 Serious Adverse Incidents (SAIs) In relation to the benchmarking information requested, Jason Killens confirmed that the National Quality Group of UK Ambulance Services are developing a snapshot across all Ambulance Services in the UK which will be shared when received. Members RESOLVED to: NOTE the Action Log.	CEO WAST
EASC 20/91	MATTERS ARISING There were no matters arising.	
EASC 20/92	CHAIR'S REPORT The Chair's report was received. Members RESOLVED to: NOTE the Chair's report.	
Part 2. ITEMS FOR DISCUSSION		ACTION
EASC 20/93	CHIEF AMBULANCE SERVICES COMMISSIONER'S REPORT The Chief Ambulance Services Commissioner's (CASC) report was received. In presenting the report, Stephen Harray highlighted the following key items: - Ministerial Ambulance Availability Taskforce Members noted that letters were in the process of being sent to the Taskforce Members outlining the approach being taken and the plans for the production of the Interim Report which would be submitted to the Minister at the end of the year. The Taskforce would be asked to critique the key documents and reviews which have been completed on ambulance services. The aim will be to update the EAS Joint Committee and its sub groups as often as practicable (Added to the Action Log). - Ambulance Quality Indicators (AQI) Members noted that the AQIs were now being published again following the pause due to the pandemic and they were backdated to cover the whole year. - Emergency Medical Retrieval and Transfer Service (EMRTS) Capital funding was being sought to support the service direction, particularly for 24/7 working and additional vehicle requirements. Some revenue slippage has been utilised to lease vehicles which would then need to be resolved in 2021. No issues were raised by Members concerning this approach.	CASC CASC / Director of Finance

	• Non-Emergency Patient Transport Service (NEPTS) Members noted that the timescales for transfers had been brought forward for Aneurin Bevan, Betsi Cadwaladr and Cwm Taf Morgannwg University Health Boards and Powys Teaching Health Board, with the expectation that all transfers would be completed by mid-2021. Stephen Harrhy thanked the health boards for their support in moving forward the agreed collective approach. • Revising EASC Integrated Medium Term Plan The EASC IMTP was discussed at the EASC Management Group and a summary had been provided to Members to ensure that the revised priorities were supported. WAST explained that they welcomed the new approach and were working closely with the EASC Team on the detail. The key deliverables were clarified in order to lead to a balanced approach. No issues were raised by Members to this approach. • Ministerial Ambulance Availability Taskforce Further progress had been made on arrangements for the Taskforce. An interim report was planned for submission before the end of the year. The report would be shared with Members and would be discussed in detail at the meeting in January 2021 (Added to the Action Log). • Beyond the Call Shane Mills was invited to present the findings of the work commissioned by the Welsh Government through the Mental Health Crisis Care Concordat – National Review of Access to Emergency Services for those experiencing mental health and or welfare concerns, report title 'Beyond the Call'. Members noted the importance of language and how mental health services were described. Mental health was referred to as those with a diagnosed mental health disorder and welfare concerns such as social issues and housing, which has an impact on mental health. The review would be published in November and would be shared widely in the system. Members noted the barriers to access to services which were compounded by mental health, including the stigma attached to it. The review involved all agencies across health and social care and also wider public services such as the police and fire and rescue services. Opportunities were highlighted such as the 111 service as well as a range of other “in hours” and “out of hours” services.	CASC

The Review recommended further work to enhance the 111 service in Wales which has also been supported by the 111 service board. The Review captured the missed opportunities, supported by data, although this was more difficult in social care. The role of the Police within mental health was also captured and this constituted 9-15% of their daily calls. A bespoke data collection was created and 10,000 calls used which were broken down into 17 index areas. The Review was also supported by an expert reference group.

Shane Mills gave an overview of the findings of the data and the inter-connectedness in terms of how and when people accessed services. Members noted the breakdown of information by gender and age, type of caller (self-callers or public), time spent on the phone and the overall time spent. There were 10 recommendations made by the Review which included ensuring real time data and effective multiagency collaboration. Members noted other areas of ongoing work included an access review with MIND and also a conveyance review.

Carol Shillabeer added the key drivers in terms of the work identified by the Police and it was important to work closely with them to develop the Review, which has led to a generally better understanding with the Police. In terms of services across Wales there is variability in provision but work to streamline the model in Wales, and potentially a once for Wales approach, can be progressed.

Members discussed the prevalence of mental health demands during the pandemic and whether a once for Wales approach could be achieved and how to simplify access for people. Jason Killens also shared WAST's findings that having mental health practitioners in the call centres had been very well received during the pandemic. The link between drug and alcohol use was discussed and it was confirmed that a strong relationship had been identified in the Review.

Members were keen to have actions to take forward in each area to ensure that the findings of the review were acted on. Members noted that the Review would be formally presented to the Minister with responsibility for Mental Health services and Mental Health Crisis Care Concordat. The recommendations had been discussed with the 111 service board and further opportunities would be progressed. Mental health practitioners would be available in the WAST control centres over the winter.

	Members noted that further work to clarify the next steps and the governance routes would take place and further information would be shared at the NHS Wales CEO group. Shane Mills was warmly thanked for the helpful presentation and he agreed to share the final version of the document with Members (Added to the Action Log). • Commissioning Intentions Members noted a more streamlined approach would be taken and this had been discussed at the EASC Management Group. The approach would take account of the emerging context and a further iteration would be taken to the EASC Management Group for further development before being presented at the next EASC meeting (Added to the Forward Look). The Chair thanked Stephen Harrhy for his report and Members RESOLVED to: • NOTE the Chief Ambulance Services Commissioner's report	Carol Shillabeer Ctte Sec CASC
EASC 20/94	WELSH AMBULANCE SERVICES NHS TRUST (WAST) PROVIDER REPORT The update report from the Welsh Ambulance Services NHS Trust (WAST) was received. Members noted: • Covid Pandemic Abstractions had risen, slightly less than the peak of the first wave and had triggered the tactical approach to production. This included using staff from 3 Fire and Rescue Services on a regular basis to support production for the front line. Jason Killens offered to bring forward the lessons learned from the first wave to the next meeting (added to the Action Log). • Health and Safety Executive (HSE) Members noted the update which related to the wearing of personal protective equipment (PPE). As a result policies had been updated and the dialogue with the HSE had been helpful with a number of meetings held. Progress was being made and the approach by WAST had been appropriately adjusted. • Clinical Indicators / Clinical Outcomes Jason Killens gave an overview of the work related to the electronic case card (moving away from the digital pen). A supplier has been identified and capital funding secured for implementation towards the end of next year. This would enable a greater understanding related to outcomes and over time this will allow informed adjustments to the service.	CEO WAST

Members noted that there was a training requirement, some could be undertaken on line and some would also need to be face to face. Some modifications and testing would be also required. The issues of interoperability with emergency department systems was also raised and Members were assured that this was a function of the system. This would happen in a phased way and linking to the Welsh Clinical Portal and other different systems across NHS Wales in due course.	
• Non-Emergency Patient Transport Services (NEPTS) In keeping with the requirement for social distancing this was having an impact on the service because vehicles were restricted in the number of patients they could accommodate. This issue was being discussed at the NEPTS Delivery Assurance Group. • Emergency Medical Services Demand and Capacity Review Members were reminded that the staff growth had been planned for a further 136WTE this year and good progress had been made with the expectation that this target would be met by the end of year. This was having a positive impact in the unit hours of production (UHP) which was very encouraging.	NEPTS DAG
Members asked: In terms of production hours and the impact of the investment in line with the Demand and Capacity Review Members asked regarding the forecasting and the impact over the winter months. Members noted that 100% of the rosters equated to 119,000-120,000 hours. The figures in October were similar to earlier in the year due to various reasons. The forecasting into the winter used various scenarios including normal winter demand and high levels of Covid. The aim would be to get to 107% of roster fills (113% would be the maximum fill due to vehicle availability).	
In terms of the urgent care system and the inter-operability opportunities, Members noted that the unscheduled care dashboard work was currently at the tender process stage and further information would be available in due course (Added to the Action Log).	CASC
Members RESOLVED to: • NOTE the WAST provider report.	

EASC 20/95	FOCUS ON – SYSTEM PRESSURES Stephen Harray introduced the session and provided some context in relation to the purpose of the session. A presentation had been shared with Members which concentrated on the commissioner perspective on planning and securing sufficient ambulance services for the population of Wales within the context of severe system pressures. In terms of the WAST Demand Management Plan (WAST DMP) at level 5 or 6 Members noted that this would mean that WAST would not be able to send a resource to any caller. This was felt to be an extreme position and that every opportunity should be taken to try and avoid such occurrences. The aim of the session was to: • Ensure ambulance availability - actions to take over handover delays and WAST actions to maximise resources available • Understand the impact of escalation across the system as a whole – on both health boards and WAST. • How health boards and WAST work together and the regional solution • Align escalation plans with Covid learning • Capacity for alternatives for demand management • Find the tolerances • Identify actions to take. Members agreed to this approach. Ross Whitehead gave the presentation, again highlighting the commissioner perspective to plan and secure sufficient ambulance services for Wales. On a few occasions recently, the WAST DMP had been triggered and these system pressures challenged the ability of the Committee to meet with its statutory obligation. Members noted that WAST had undertaken modelling forecasts in line with the expectations of the Welsh Government in relation to the impact of the pandemic and many forecasts indicated that WAST would not reach the 65% performance target for red calls. An overview of incident demand, attended scene, attended hospital and lost hours was provided. Members noted the specific impact of the pandemic on service provision as well as the data and the actions already taken in terms of recruitment, establishing the Operational Delivery Unit, the doubling of handover delays since August and the WAST DMP level 6 triggered on more than one occasion.	

	Members noted the modelling and scenario plans for worst case, most likely in high covid levels and most likely in low covid levels. In terms of the collective position and the actions required to deliver the statutory requirements this winter, Members noted the key areas of efficiencies, investment and additionality opportunities for the operational delivery unit and handover delays. The modelling that had been undertaken had assumed 90% of the handover delays experienced in 2019. Members discussed the ongoing system pressures, and in particular for health boards, with regard to handover delays at emergency departments. Stephen Harrhy also confirmed that the work undertaken by Improvement Cymru would also inform the process going forward. Members supported the requirements to maximise the availability of ambulances this winter, the need to have a focus on reducing harm and improving quality and patient outcomes and the need to act in a proactive way starting from a Health Board footprint but to engage collectively on a regional basis where this was needed by exception. Members committed particularly to the following actions: Ambulance Resource – Central funding has been provided to support WAST to staff rosters up to the fleet maximum of 113%. Funding for this would come centrally from the winter protection fund and WAST should maximise available resource with immediate effect. Stephen Harrhy agreed to circulate a report on securing additional NEPTS capacity as part of the Q3 and Q4 winter protection plan (Added to the Action Log). Resource Efficiency – Members agreed that WAST should effectively target this additional resource to times of the day, dates and regions where there was currently a mismatch between demand and capacity. Safe cohorting of patients / patient offload Department (POD) staffing and operating model – Members recognised the role that the safe cohorting of patients would have this winter in enabling the timely release of ambulances and Stephen Harrhy agreed to work with WAST and the relevant health boards to find a solution to staffing and agreeing the operating model for these areas for this winter (Added to the Action Log).	CASC CASC

	Operational Delivery Unit (ODU) – Members recognised the role of the ODU in supporting system level information flow and recognised it needed to develop further to support the system. Members agreed that Health Boards should proactively maximise their own capacity prior to requiring regional support. Stephen Harrhy agreed to continue to work with the Chief Operating Officers (COOs) on this to agree scope and responsibilities and to develop the operating model for the ODU (Added to the Action Log). Information – Members recognised the opportunities that were currently available for sharing information between WAST and Health Boards and the additional opportunities that an expanded unscheduled care dashboard and ‘signals for noise’ present us with. Jason Killens agreed to review and enhance the data provided regularly to Health Boards with a focus on a range of the Ambulance Quality Indicators (AQIs) (Added to the Action Log), Stephen Harrhy agreed to work with the NHS Wales Informatics Service (NWIS) to provide an immediate Business Intelligence based solution and to move forward the on-going procurement of a dashboard and supporting data infrastructure to have a single view in health boards and WAST (Added to Action Log). Handover Levels – Members discussed the importance of minimising patient handover lost hours and the requirement to maintain levels below 150 hours per day as any level above this would be challenging from a resource availability perspective (Added to the Action Log). Members also discussed the importance of turning vehicles around quickly and adopting a ‘no tolerance’ approach to delays over 1 hour. Escalation – Members agreed that a standardised approach to escalation (and the level within organisations) with a focus on proactive actions, quality improvement and harm reduction would be necessary and helpful for providing clarity on responsibilities and actions at all levels of escalation, both at Health Board level and in WAST. Stephen Harrhy agreed to take this work forward and would circulate a draft proactive proposal to Members (Added to the Action Log). Post Production Lost Hours – Members agreed that quick progress was required on the understanding and reduction of post-production lost hours particularly those associated with rest breaks. Members discussed the need to provide WAST with support and cover for this, recognising that it would be a challenging ask.	Health Boards CASC CEO WAST CASC Health Boards and WAST CASC

	Jason Killens agreed to respond to Stephen Harrhy on this issue and clarify his thoughts on potential ways forward (and learn from other services and reviews) which would be shared with all Members (added to the Action Log). Members RESOLVED to: NOTE the presentation and action the areas agreed above.	CASC & CEO WAST
Part 3. ITEMS FOR APPROVAL OR ENDORSEMENT		ACTION
EASC 20/96	FINANCE REPORT The EASC Finance Report was received. Members noted the stable position. Further work would be undertaken to include critical care and for the Emergency Medical Retrieval and Transfer Service. Work continued to monitor the additional funding provided for additional staff in WAST, out of hospital care and winter planning. Members RESOLVED to: APPROVE and NOTE the report.	Director of Finance
EASC 20/97	EASC SUB GROUP MINUTES Members received the confirmed minutes of the EASC Sub Groups as follows: - EASC Management Group - 27 Aug 2020 - NEPTS Delivery Assurance Group – 18 Aug and 29 Sept 2020 - EMRTS Delivery Assurance Group – 16 June 2020. Members RESOLVED to: - APPROVE the confirmed minutes as above.	CASC
EASC 20/98	EASC GOVERNANCE INCLUDING THE RISK REGISTER The EASC Governance report was received. In presenting the report Stephen Harrhy explained that two risks had been escalated on the risk register namely the performance in the red and amber categories. Members RESOLVED to: - APPROVE the risk register - NOTE the governance report and the requirement for the effectiveness survey.	CASC

EASC 20/99	FORWARD PLAN OF BUSINESS The forward plan of business was received. Members noted that further work was required on the Emergency Medical Service (EMS) Framework. Further work would take place outside of the meeting to suggest the next Focus on topic. Following discussion, Members RESOLVED to: • APPROVE the Forward Plan.	Chair
Part 4. OTHER MATTERS		ACTION
EASC 20/100	ANY OTHER BUSINESS One further item of business was raised at the meeting. Jason Killens suggested that the NEPTS Delivery Assurance Group could discuss discharge planning across the winter. Ross Whitehead suggested as time was a major factor in this matter as well as access to providers and offered to write to WAST with some proposals which was agreed by Members.	CASC

DATE AND TIME OF NEXT MEETING		
EASC 20/101	A meeting of the Joint Committee would be held at 09:30 hrs, on Tuesday 9 March 2021 at the Welsh Health Specialised Services Committee (WHSSC), Unit G1, The Willowford, Main Ave, Treforest Industrial Estate, Pontypridd CF37 5YL but likely to be held virtually on the Microsoft Teams platform.	Committee Secretary

Signed
Christopher Turner (Chair)

Date

ASSURANCE REPORT

NHS WALES SHARED SERVICES PARTNERSHIP COMMITTEE

Reporting Committee	Shared Service Partnership Committee
Chaired by	Mrs Margaret Foster, Chair
Lead Executive	Mr Neil Frow, Managing Director, NWSSP
Author and contact details.	Peter Stephenson, Head of Finance and Business Development
Date of meeting	18 March 2021
Summary of key matters including achievements and progress considered by the Committee and any related decisions made.	
Managing Director's Report – the main issues noted were: - Welsh Risk Pool - the 2020/21 £121m DEL forecast includes significant additional risk since December due to the current national lockdown. Cases which would have otherwise continued to settlement are being delayed into the next financial year. The potential risk to the outturn has been quantified at £6m and mitigating steps are being taken to see what other appropriate action can be taken to reduce any changes to the forecast outturn. The risk-sharing agreement has been frozen as at the end of January at the agreed figure of £13.779m and this has been communicated to Directors of Finance. - SSPC Membership - The Minister is currently updating the regulations to enable both Health Education and Improvement Wales, and Digital Health & Care Wales, to become full voting members of the Shared Services Partnership Committee. As part of this process, Welsh Government have taken the opportunity to review the Shared Services element of the Velindre NHS Trust Establishment Order to ensure that it appropriately covers all the services provided and offered by NWSSP. Their findings were that the Order remains appropriate, and in accord with the definition of what NWSSP were established to do. - TRAMS - Committee Members were written to at the start of February to confirm their APPROVAL to support the TRAMS proposal and specifically to fund a small and non-recurring revenue gap in years 3 and 4 of the project through a first call on NWSSP savings. Positive confirmation of support was received from all NHS organisations on this proposal, including a number who have committed to use their share of any NWSSP savings even though they do not directly benefit from the TRAMS business case. Feedback is currently awaited from the Minister's Office with regard to endorsement of the Programme Business Case following the positive Capital Infrastructure Investment Board meeting on the 28th January.	

Items Requiring SSPC Approval

Annual Plan – Since presenting the Plan to the January SSPC, the Director of Planning, Performance, and Informatics has met individually with Committee members to discuss the indicative plan and confirm key priorities for 2021-22. The Touchpoint meeting with the Welsh Government Planning team on 2 March was followed by a further meeting with the Finance Delivery Unit on 8 March. Both were extremely positive. The key aspects of the plan, and the associated financial implications and requirements, were presented to the Committee. The plan is ambitious but proportionate and financially balanced. The plan seeks to:

1. Support the NHS in reducing the four harms of COVID19, including the vaccination campaign.
2. Continue to deliver the basics well, with a strong focus on end user experience.
3. Review processes and tailor services to customer priorities as they restart areas such as planned care.
4. Implement a number of 'Once for Wales' solutions that deliver service improvement and transformation.
5. Apply learning from the pandemic and embed new efficient and sustainable ways of working across the organisation.
6. Put the voice, health, and wellbeing of our staff at the heart of our plans.

The Plan was supported by Committee members in particular highlighting the potential impact and support NWSSP could have with regard to the foundational economy and the decarbonisation agenda. The Committee APPROVED the plan.

Laundry Services - Sufficient progress has been made with three out of the five existing laundries to allow the TUPE transfer process to conclude on 1st April. A number of appointments have been made to strengthen the management structures within NWSSP to oversee the transfer and subsequent operation of the laundry service going forward as well as ensuring the next phase of the laundry development is taken forward in a timely manner. The financial positions have largely been agreed with ABUHB, BCUHB and Swansea Bay for the three laundries transferring on 1 April. The transfer will mean customers who currently have their laundry service provided by one of these laundries will continue to receive the same service "as is" with no anticipated change in delivery arrangements or cost attributed to that service at the present moment. A draft Service Level Agreement has been documented for the provision of this service which was APPROVED by the Committee and which will be reviewed after the end of the first quarter of operation together with the development of additional KPIs.

Temporary Medicines Unit - The Committee APPROVED the extension of the associated TMU SLA and Technical Agreements, up to March 2023.

Scan4Safety- The Scan4Safety Business Case was presented by the NWSSP Director of Procurement and the Programme Manager. This had previously been reviewed by the Committee in January. In addition, it had been taken to DoFs in February and was going back to DoFs on 19th March. The benefits of the initiative were reiterated and were fully supported by the Committee. The Committee APPROVED the Full Business Case for submission to Welsh Government subject

to endorsement of the revised funding arrangements by DOFs on 19th March 2021.

NHS Wales Mediation Network – The Committee were asked to consider a request to fund the costs associated with the development of a new Mediation Network for NHS Wales. The development of the Network is seen to be an integral part of the wider work to address concerns relating to bullying and harassment arising from Staff Survey feedback, setting a framework for improved working relationships and encouraging respect and early resolution of grievances and dignity at work matters. The Committee APPROVED the request to fund the 2021/22 costs (approx. £60k) from a call on savings within NWSSP.

Digital Workforce Systems Scheduling – The Committee received a proposal relating to the adoption of a Once for Wales e-scheduling system contract for District Nursing and other Community-based staff at its January 2021 meeting. The required approach was endorsed in the January meeting and the Committee were now being asked to NOTE the award of a two-year contract for this system with effect from 31 March 2021.

Finance, Workforce and Governance Updates

Project Management Office Update – The Committee reviewed and noted the programme and projects monthly summary report, which highlighted the team's current progress and position on the schemes being managed.

Finance and Workforce Report - As at the end of M10 the year-end forecast remains at a break-even position. The final ESR recharges for 2020/21 have now been confirmed to UHBs/Trusts and the recharge invoices raised in February following the previously noted risk in respect of this. The previously communicated risk associated with the CTES SIP Fund has been reduced and £0.368m of funds will be returned to UHBs/Trusts in 2020/21.

Corporate Risk Register – there is now one red risk on the register, relating to the replacement of the NHAIS system which is due to go live on 1 July. Two former red risks, relating to the implications of BREXIT and the replacement of the Ophthalmology Payments system have now been reduced to an amber rating.

Finance Monitoring Reports – the Committee were provided with the monitoring returns for Months 9, 10 and 11 for information.

Matters requiring Board/Committee level consideration and/or approval

- The Board is asked to NOTE the work of the SSPC and ensure where appropriate that Officers support the related work streams.

Matters referred to other Committees

N/A

Date of next meeting	20 May 2021

WELSH HEALTH SPECIALISED SERVICES COMMITTEE JOINT COMMITTEE MEETING – MAY 2021

The Welsh Health Specialised Services Committee held its latest public meeting on 11 May 2021. This briefing sets out the key areas of consideration and aims to ensure everyone is kept up to date with what is happening in Welsh Health Specialised Services.

The papers for the meeting are available at:

<https://whssc.nhs.wales/joint-committee/committee-meetings-and-papers/2021-2022-meeting-papers/>

Minutes of Previous Meetings

The minutes of the meeting of 9 March 2021 were taken as read and approved.

Action log & matters arising

Members noted there were no outstanding actions or matters arising.

Chair's Report

The Chair's Report referred members to the forthcoming early retirement of Kevin Smith, Committee Secretary, on 31 May, and his return part time for around five weeks from 7 June, and the appointment of his successor, Jacqueline Evans, from 1 June 2021.

The Report also referred members to the Chair's Actions taken to approve the appointment of Professor Ian Wells as an Independent Member of the Joint Committee with effect from 1 May 2021 for an initial term of two years.

In addition, the Chair reported that Emrys Elias had tendered his resignation with effect from 31 May 2021 and that a nomination had been received for a successor, whose appointment would be dealt with later in the week by Chair's Action.

Members (1) noted the contents of the report; (2) ratified the appointment of Jacqueline Evans as Committee Secretary with effect from 1 June 2021; and (3) ratify the Chair's Action appointing Prof Ian Wells.

Managing Director's Report

The Managing Director's report, including updates on:

- Opening of the interim Mother & Baby Unit at Tonna Hospital;
- The south Wales Thoracic Surgery Strategic Outline Case (SOC);
- The PET Programme Business Case;
- The status of the audit of the 2020-21 Accounts;
- De-escalation the SBUHB TAVI service from level 3 to level 2;
- Removal of the CVUHB Paediatric Intensive Care service from escalation; and
- Removal of the SBUHB Soft Tissue Sarcoma service from escalation,

was taken as read.

It was agreed that SBUHB would circulate the Thoracic Surgery SOC to members.

South Wales Major Trauma Network (SWMTN) Update

Members received a presentation on the work of the SWTN from its opening in September 2020 to March 2021, which included a summary of the Delivery Assurance Group report. Members noted the content of the presentation and discussed elements of it in detail.

A further update will be provided to the Joint Committee meeting in six months' time.

Neonatal Transport Service for South and Mid Wales

Members received a paper that proposed a project structure and governance assurance framework as requested following Joint Committee's decision regarding the establishment of an Operational Delivery Network Transport Service for mid, west and south Wales in April 2021. It was noted that the proposed structure borrowed many features from the SWMTN model, which was regarded as exemplary.

Members noted (1) the proposed project management process and associated timeline; and (2) the draft commissioner assurance process, recognising that this would be subject to further discussion in the 'In Committee' section of the meeting and with the programme team.

Revised Risk Management Strategy

Members received a paper that presented the revised Risk Management Strategy (RMS) for WHSSC for approval and shared the latest version of the Corporate Risk Register for information.

Members (1) approved the revised Risk Management Strategy; (2) noted the latest version of the Corporate Risk Register; and (3) noted that further work is on-going to develop risk reporting in line with the RMS.

Activity Reports for Months 11 and 12 2020-21

Members received papers that highlighted the scale of the decrease in activity levels during the COVID-19 period, and whether there are any signs of recovery in specialised services activity. These activity decreases are shown in the context of the potential risk re patient harms and of the loss of value from nationally agreed financial block contract arrangements.

The Month 12 report been restructured from previous format to deal with specialties/areas on an all-Wales basis and would be developed further based on feedback received.

Members noted the information presented in the reports.

Financial Performance Report – Month 12 2020-21

Members received a paper the purpose of which was to provide the final outturn for the financial year. The financial position at was an under spend of £12.03m after making prudent provisions.

The under spend relates mainly to months 1-12 under spend on the pass through elements of NHS Wales provider SLA's, NHS England anticipated underperformance against agreed block contracts where provider activity is forecast at >20% below agreed baseline and Q1 – Q4 2020-21 development slippage. Owing to uncertainty regarding the pace of activity, recovery and timing of information flows from NHS England providers, WHSSC has adopted a prudent approach to providing for expenditure reductions that may arise from under-performance.

Members noted the content of the report.

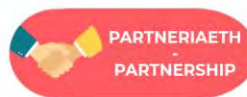
Other reports

Members also took as read the update reports from the following joint Sub-committees and Advisory Groups:

- Management Group;
- All Wales Individual Patient Funding Request Panel;
- Quality & Patient Safety Committee; and
- Integrated Governance Committee

Standing Orders (SOs) and Standing Financial Instructions (SFIs)

The Committee Secretary reported that revised Model SOs and SFIs had recently been received from Welsh Government and that work was underway to review the WHSSC SOs and SFIs to propose any necessary changes. It was agreed that these would be the subject of a Chair's Action.





AGENDA ITEM

2.2.11

CTM BOARD

CWM TAF MORGANNWG REGIONAL PARTNERSHIP BOARD:
RESEARCH, INNOVATION AND IMPROVEMENT HUB – ANNUAL
REPORT 2020/2021

Date of meeting	27/05/2021

FOI Status	Open/Public

If closed please indicate reason	Not Applicable - Public Report

Prepared by	Dr Tom Powell, RIIC Hub Lead Charlotte Evans, RIIC Hub Project Manager

Presented by	Prof Kelechi Nnoaham

Approving Executive Sponsor	Executive Director of Public Health

Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		

Committee/Group/Individuals	Date	Outcome

Regional Partnership Board Meeting	(13/05/2021)	Approved.

1. SITUATION/BACKGROUND

- 1.1 The purposed of this paper is to inform the Board of the activity and impact of the Cwm Taf Morgannwg (CTM) Regional Partnerships Board (RPB) Research, Innovation and Improvement (RIIC) Hub in its first year of operation.
- 1.2 As part of the Welsh Government Transformation Programme Fund to improve quality and value, a nationally coordinated network of hubs was created to bring together research, innovation and improvement activity within each Regional Partnership Board (RPB) footprint.

- 1.3 Anchored within the Partnership Board and engaging equally with its partner organisations the hub is positioned in the centre to act as a focal point for RII knowledge generation and capture. It helps to:
- IDENTIFY examples of innovation and good practice from across the region.
 - PRIORITISE and coordinate RII activity base on RPB priorities.
 - ENGAGE with and support key leaders and stakeholders to accelerate the implementation and adoption of innovative approaches.
- 1.4 The RIIC hub is hosted within CTMUHB, with Prof Kelechi Nnoaham as Executive lead.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING

- 2.1 The annual report is attached at Appendix 1 for noting. There are no key risks or matters for escalation as a result of this paper.
Future Sustainability of the RIIC Hib
- 2.2 The refreshed RIIC work programme (Appendix 2) sets out a continuation of the work to date and builds on the new areas of priority particularly around wellbeing and mental health.
- 2.3 The RIIC hub team have provided a dynamic and adaptive resource to support a number of activities outside of its current work programme, primarily driven by Covid but the future work plan acknowledges that this capacity exists.
- 2.4 The sustainability of the RIIC hub team is inherently measured in the outcomes of the work it delivers and evidences, and the future function and ongoing support of the RIIC hub will be driven through this.
- 2.5 Originally the RII hub funding matched the Welsh Government (WG) Transformation funding timescale and was due to end in March 2021, however this has now been similarly extended until March 2022.
- 2.6 Welsh Government have requested that a sustainability plan is provided by the end of Q2 21/22 (September 2021) by CTMRPB.

3. IMPACT ASSESSMENT

Quality / Safety / Patient Experience implications	There are no specific quality and safety implications related to the activity outlined in this report.
Related Health and Care standard(s)	Choose an item. N/A
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.



Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Well-being Objectives	Work with communities and partners to reduce inequality, promote well-being and prevent ill-health

4. RECOMMENDATION

4.1 That the CTMUHB Board NOTE the annual report and support the development of a future RIIC hub sustainability plan.

CTM RIIC HUB ANNUAL REPORT 2020/21

**Cwm Taf Morgannwg
Research Improvement
and Innovation Hub**

1st Annual Report





TABLE OF CONTENTS

I. INTRODUCTION	
<i>Foreword</i>	3
<i>Introduction to the RIIC Hub</i>	4
<i>impact of the RIIC Hub</i>	5
II. PROJECTS	
<i>Wellbeing</i>	8
<i>Education</i>	9
<i>Housing</i>	10
<i>Mapping</i>	11
III. ENGAGEMENT & COMMUNICATION	12
IV. COVID RESPONSE	13
<i>Response work</i>	
V. LOOKING TO THE FUTURE	
<i>A Plan for the Future</i>	14

ENDORSED BY THE CWM TAF
MORGANNWG REGIONAL
PARTNERSHIP BOARD

By your side.

FOREWORD



Prof. Kelechi Nnoaham
Director of Public Health
Cwm Taf Morgannwg
University Health Board



The year 2020 was one of almost unique challenge and like no other. It drove a level of partnership working across local government, the NHS, the voluntary and community sectors, and beyond. It was a rising challenge working to meet, quickly, efficiently, and creatively.

In 2021 the vaccination programme is well underway and there is hope of a gradual return to normal interaction, but with new variants of the virus posing an ongoing threat.

The development of the vaccine was an exemplar of research ingenuity, but we can also see many other areas where this type of activity makes an impact.

We continue to look to research and innovation activity in all areas to identify, promote and embed continual improvement in the services that we deliver across all organisations within the Regional Partnership Board to guide and improve population health across Cwm Taf Morgannwg.

The ambition for the RIIC hub is for it to act as a focal point, bringing together examples and the supporting evidence base of work and initiatives currently underway across our Health and Care Partnership. This annual report sets out some of the key examples of the RIIC hub in its first year of operation and the impact it has had.

Chris Davies
Independent Councillor and
Regional Partnership
Board Chair



To deliver the best health and wellbeing outcomes for our residents across CTM, it's vital we take positive action together to improve existing practice, and create successful models that will make a difference to people's lives.

As a team that sits at the heart of the CTM research, innovation and improvement eco-system, I am pleased to see the RIIC hub using their knowledge, skills and connections to support fantastic projects that will benefit our residents.

As we enter a new phase of the pandemic, it is more important than ever to hold ourselves to account and question what more we can do together to deliver the best health and social care for the people of Bridgend, Merthyr Tydfil and RCT.

The RIIC hub plays a crucial role in supporting the CTM Regional Partnership Board to reflect on and improve existing health and social care projects, while identifying good practice that we can be inspired by.

It's these relationships that will help us understand what services and support local people need so we can make positive and sustainable transformations in health and social care.

I'm really looking forward to the next year, and seeing what more this team can do for us as a region.

Impact

Collaboration

38 organisations across **10** sectors

Engagement

13,851 tweet impressions
118 followers in 3 months
6 promotional films

COVID Response

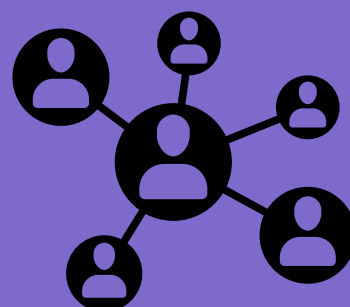
4,578 teaching staff tested
208 schools

Projects

20 projects supported
10 themes covered

Workshops

12 workshops
154 participants





INTRODUCTION TO THE RIIC HUB

Dr Tom Powell, RIIC Hub Lead

Tom.Powell2@wales.nhs.uk



Even before the impact of COVID-19 was felt in Wales, it has been well recognised that delivering Prosperity for All would involve implementing different ways of working for both the public sector, private industry and our local population.

The need to better co-ordinate research, innovation and improvement (RII) was a key action outlined with A Healthier Wales. As part of the Welsh Government Transformation Programme Fund to improve quality and value, a nationally co-ordinated network of hubs was created to bring together research, innovation and improvement activity within each Regional Partnership Board (RPB) footprint.

The Cwm Taf Morgannwg Regional Partnership Board's Research, Improvement, Innovation and Coordination (RIIC) hub was established in spring 2020. It was tasked with identifying and steering opportunities for regional research, innovation and improvement activity and collaborative partnerships.

Our ambition is to act as a focal point for RII knowledge generation and capture that will help to:

- IDENTIFY examples of innovation and good practice from across the region.
- PRIORITISE and co-ordinate RII activity base on RPB priorities.
- ENGAGE with and support key leaders and stakeholders to accelerate the implementation and adoption of innovative approaches.

Despite only being in place for just over 12 months the RIIC hub team have made an number of key impacts which are detailed in this, our first annual report. We've delivered on commitments from our work plan across a number of work streams and acted as a point of contact for new opportunities that support RPB priority themes. In addition like many colleagues across Cwm Taf Morgannwg we have undertaken a number of activities in response to the COVID-19 pandemic.

In our second year of operation we will continue to explore and work with all our partners in the Regional Partnership Board and I would encourage you to get in touch with the team either through our new website, on social media or email.



www.ctmregionalpartnershipboard.co.uk



@RIICHub_CTM



KEY PROJECTS SUPPORTED BY THE RIIC HUB



2020-2021





WELLBEING

Coordinated by Joanne Sullivan, Local Authority Engagement Officer
Joanne.Sullivan3@wales.nhs.uk



Well-Being at Ysbyty'r Seren

Ysbyty'r Seren is Cwm Taf Morgannwg UHB's field hospital which was established in response to the COVID-19 pandemic. It is a temporary Field Hospital and rehabilitation facility for patients recovering from COVID-19. Bed capacity is 217, with area space to expand to 400 if required.

The pandemic brought a change of work focus for the RIIC hub and we responded to a request from the Medical Lead Dr Liza Thomas-Emrus to support and coordinate an innovative model of social prescribing at Ysbyty'r Seren from June 2020 – March 2021.

The RIIC hub led the new service and coordinated the Tim Gwen (Smile) Team, supported by the CTMUHB Arts and Health Coordinator. Tim Gwen expanded to 20 Wellbeing Practitioners, involving a range of services from Mental Health Matters, Age Connects Morgannwg, CTMUHB Chaplaincy, Artists, Musicians, Creative Writers and physical therapists, all providing a hands on service that supports the mental, physical, emotional and spiritual needs of patients in a holistic wellbeing service.

Positive feedback from patients include:

"I feel happy and content when I come in the wellbeing room"

"I can't explain how much better I felt after having my nails painted and my hair cut. I've never been pampered like that before."

"Without people like Mental Health Matters, I wouldn't be mentally well and if I'm not mentally well, how can I be physically well enough to go home"



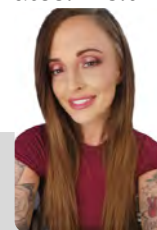
"Implementing social prescribing at Ysbyty'r Seren has been instrumental in the success of the care model delivered. It has resulted in improved staff morale with pride in the patient-centred care given and also improved patient outcomes."

Dr Liza Thomas-Emrus
Ysbyty'r Seren, Temporary Hospital Medical Lead



EDUCATION

Coordinated by Alexandra Skwarnecki-Cokeley, Local Authority Engagement Officer
Alexandra.Skwarnecki-Cokeley@wales.nhs.uk



Health, Education and Industry in Merthyr Tydfil

Working with Merthyr Tydfil Council, an innovative opportunity was identified by the RIIC Hub to link local schools, to drive awareness of science technology and the arts in partnership with organisations across South Wales.

The aim was to challenge children of KS2 ages to think outside of the box and provide access to technology and activities through local businesses, allowing them to create and use ideas of their own whilst providing them with opportunities to look into the future of their community, well-being and career path. In addition we wanted to create sustainable opportunities for schools to access in the future.

The RIIC hub identified a number of opportunities from multiple providers and worked with education colleagues with local businesses within the public sector, charities and third sector for volunteers to provide their expertise to the children. Following an online event, school children were able to vote and select which projects they wanted to work with.

The project will run for 2021 and with the support of the RIIC hub and Merthyr Tydfil Council, will be evaluated to determine its future. We hope to see the initiative continue and roll out across all three local authority areas after 2022.

Collaborators included:

Techniquiest – Food – Farmers – Superheroes

The CTMUHB Arts team- Therapeutic well-being

Cardiff University Pharmabees

Get Fit Wales / Local Activity Providers

Merthyr College & Esports Wales

Switch Off Campaign



"The project has allowed us to explore new ways how best to engage with young people to support their physical and mental wellbeing. We hope to build upon the findings of our project to strengthen the work undertaken within the Merthyr Tydfil Borough"

Scott Tandy, Newydd Housing Association



HOUSING

Coordinated by Elizabeth Thomas, Local Authority Engagement Officer
Elizabeth.Thomas252ccb@wales.nhs.uk



Innovation Housing Cohort

The Circular Economy Innovation Communities (CEIC) Programme, aims to support the public sector to develop new service solutions that enhance productivity and deliver Circular Economy (CE) benefits. CEIC is a fully funded 10 month programme for the public and third sector, by WEFO (Welsh European Funding Office).

As part of the 2020/21 RIIC Workplan which included supporting innovation in Housing, the RIIC Hub helped coordinate and link colleagues from RPB organisations to create a cohort interested in Housing and community regeneration.

A programme of workshops were held by the RIIC hub, with over 40 attendees from over 20 organisations across Cwm Taf Morgannwg. This resulted in a co-produced cohort topic of around 'Decarbonisation of Social Housing'.

The CEIC team will take participants in the programme through every day challenges in their organisation through a circular economy lens: how can we implement solutions that are resource-efficient, resilient and low-carbon by design? Already there has been advanced discussion around creating an 'innovative community' and RIIC hub jointly badging this with Community Housing Cymru (CHC).

"...as the innovation lead at CHC, I see this as a great opportunity for the sector and I'm keen not to reinvent the wheel. The housing association reps who successfully take part in this programme will form part of our sector's innovation community, sharing the learning even further with our help and support."

Edwina O'Hart, Assistant Director of Member Services and Innovations Lead, CHC

LOOKING FOR A NEW CHALLENGE?

**Do you work in the public or third sector,
and have an interest in housing or
community regeneration?**

**The fully funded Circular Economy
Innovation Communities programme
may be for you.**



Circular Economy
Innovation Communities



Cymdeithasau Ewrop
European Social Fund





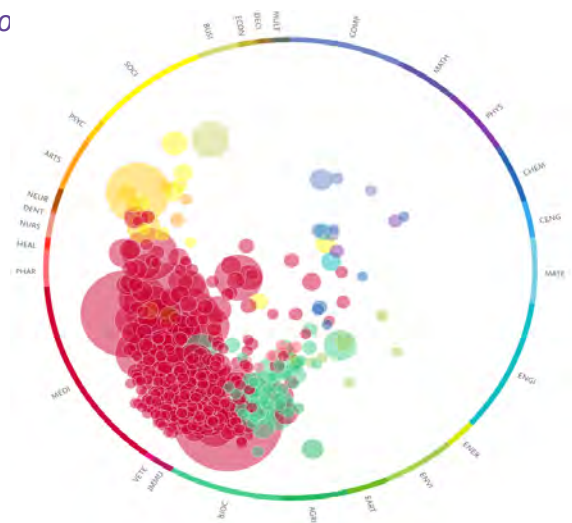
The aim of the mapping exercise was to provide an overview of the Health and Social Care Research, Innovation and Improvement landscape across the Cwm Taf Morgannwg region, along with presenting findings and potential future opportunities for regional stakeholders to explore further.

Working with colleagues at Swansea University and the Accelerate programme this has identified current and recent examples of RII activities across the Cwm Taf Morgannwg region, spanning Primary and Community Care, Secondary Care, Social Care, Academic and Third Sector settings. Examples of such activity include; new models of service provision, innovative approaches to workforce re-design, both basic and applied health and social care research, new approaches to integrated working and sharing of best practice and the design and implementation of new products, processes and services, amongst others.

The mapping exercise will inform the evolving strategy of the Cwm Taf Morgannwg RIIIC hub and wider partners in the region, whilst also providing a common resource to identify good practice and promote its wider adoption, reduce replication and develop a culture of recording and reporting activity across Cwm Taf Morgannwg.

"Working alongside the Cwm Taf Morgannwg RIIHC to map all Health and Social Care related Research, Innovation and Improvement (RII) activity in the region has detailed a high complex and diverse regional RII landscape. This possesses both significant potential and opportunity to drive positive transformation across Health and Care services in Cwm Taf Morgannwg, and in turn, support improved health, wellbeing and prosperity of its regional population. It is hoped that insight and understanding drawn from the findings of this research study will be used to inform the future strategic direction of the CTM RIIHC by providing an evidence base from which priorities can be established, regional strategies derived, and collaborative partnerships initiated as part of a wider movement to drive positive change."

Dr Tom Howson, Innovation Technologist

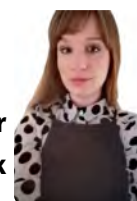




COMMUNICATION & ENGAGEMENT

Rebecca Goodhand, Communications & Engagement Manager

Rebecca.Goodhand@wales.nhs.uk



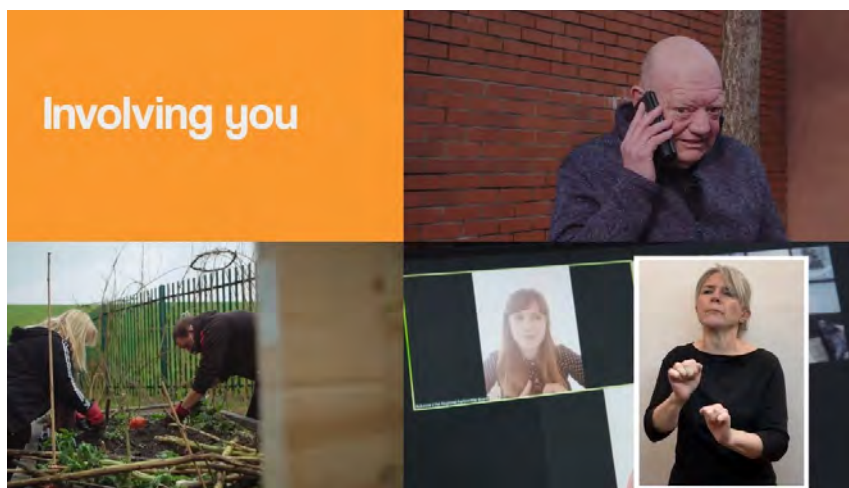
The Research, Innovation and Improvement Co-ordination Hub's core role is to identify and support regional RII activity, and steer collaborative regional partnerships, it is also imperative we have an effective mechanism to deliver, manage and report on this activity. It's important our key stakeholders and audiences understand our purpose and value and ensure partner and citizen voices are heard and championed.

In order to establish a clear identify and platform for information sharing, active participation and storytelling, the RIIC hub have supported with the creation of the new CTM Regional Partnership Board website & brand. We have a built out online profile which will support in building the profile of the RIIC hub and drive better engagement among key stakeholders and priority groups across CTM, identified by the RPB.

We held 8 workshops with over 90 participants from 21 organisations. As a result of the conversations from the workshops, citizen led research has now also been commissioned to identify barriers, opportunities and engagement so we can drive forward better co-production and engagement, ensuring citizens are empowered, informed and heard. This will inform the next phase of our communication and engagement activity, which will feed into the CTM RPB's 2022 Population Needs Assessment.

We have established a working group with our Communications and Engagement RPB leads across Wales, which will now meet monthly to share best practice, tools and advice. In addition, we have secured a pool of 'content reviewers' who represent partners across the CTMUHB, local authorities and third sector who will review, test and challenge content and engagement activity for us, to ensure we are engaging and communicating in the most effective way.

We are looking at establishing a core CTM Regional Partnership Board communications group made up of key comms and engagement contacts from across the region. This will help foster better partnership working, information sharing and engagement.





COVID-19

Pandemic Response

The RIIC hub was established in Spring 2020 and like many colleagues across Cwm Taf Morgannwg was required to pivot into supporting different Covid focused work streams across the RPB. Working with colleagues in partner organisations projects supported included:

- TechForce19.
- CERi the Artificial Intelligence Chatbot.
- COVID NHS staff booking call Centre.
- Rapid COVID Testing,.
- Antibody Testing for NHS staff and School staff.
- Test Trace Protect Programme management
- NHS Voices of COVID study.

During this time the RIIC hub built key relationships with partners, developed project management skills and successfully embedded ourselves into the Cwm Taf Morgannwg footprint.

Antibody Testing

Local Authority Teaching Staff

- The RIIC hub were asked to set up and run the COVID-19 Antibody testing for Local Authority Teaching staff.
- Over 8 weeks approximately 5000 staff were successfully tested.
- Co-opted a number of 4th year medical students to act as phlebotomists and other UHB/LA colleagues.
- We also supported the wider COVID Antibody testing of UHB staff.





Looking to the Future

The refreshed RIIC hub work programme for 21/22 sets out a continuation of the work to date and builds on the new areas of priority particularly around wellbeing and mental health. The RIIC hub team have provided a dynamic and adaptive resource to support a number of activities outside of its current work programme, primarily driven by COVID, but our future work plan acknowledges that this capacity exists.

As we move forward it's important that the RIIC hub continues to develop its scope and portfolio in partnership with colleagues and organisations across the RPB. This will be based on what drives value, enables system leaders to use resources that deliver the best outcomes for the population of Cwm Taf Morgannwg.

Emerging Themes:

ASPIRE

What new innovative new ways of working will persist post COVID? How will we position the RIIC hub to become a integral 'asset' of choice for the RPB?

ACCELERATE & SCALE

The pandemic has significantly accelerated the pace at which our organisations have brought new ways of working / ideas to fruition, due to the pressure to deliver a response. How can we identify this type of activity to ensure this pace is not lost and keep the boldness and ambition to realise a higher return on innovative practices, whilst mitigating risk and helping to shape future policies.

EXTEND & MOBILISE

New partnerships have been created that extend reach, impact and sustainability. We need to instill an agile RIIC hub (both in terms of culture and a working model) that helps to deliver meaningful impact across Cwm Taf Morgannwg and Wales.

The COVID pandemic has demonstrated that speed and agility are important drivers for success and to deliver impact, as is the ability to keep driving forward despite the obstacles that a crisis can impose.

The RIIC hub has demonstrated this ability across key work areas and the future sustainability of the team will be recognised in the outcomes of the work it delivers and evidences.

BAVO

Bridgend Association of Voluntary Organisations
Cynwladfaas Gwyddolddas Gwethreddol Pen-y-bont ar Ogwr



VOLUNTARY ACTION
MERTHYR TYDFIL
GWEITHREDU GWIRFODDOL
MERTHYR TUDFUL



Rhondda Cynon Taf

Cyngor Bwrdeistref Sirol



Cwm Taf Morgannwg

Bwrdd | Regional
Partneriaeth | Partnership
Rhanbarthol | Board



Cyngor Bwrdeistref Sirol

MERTHYR TUDFUL

MERTHYR TYDFIL

County Borough Council



RHONDDA CYNON TAF

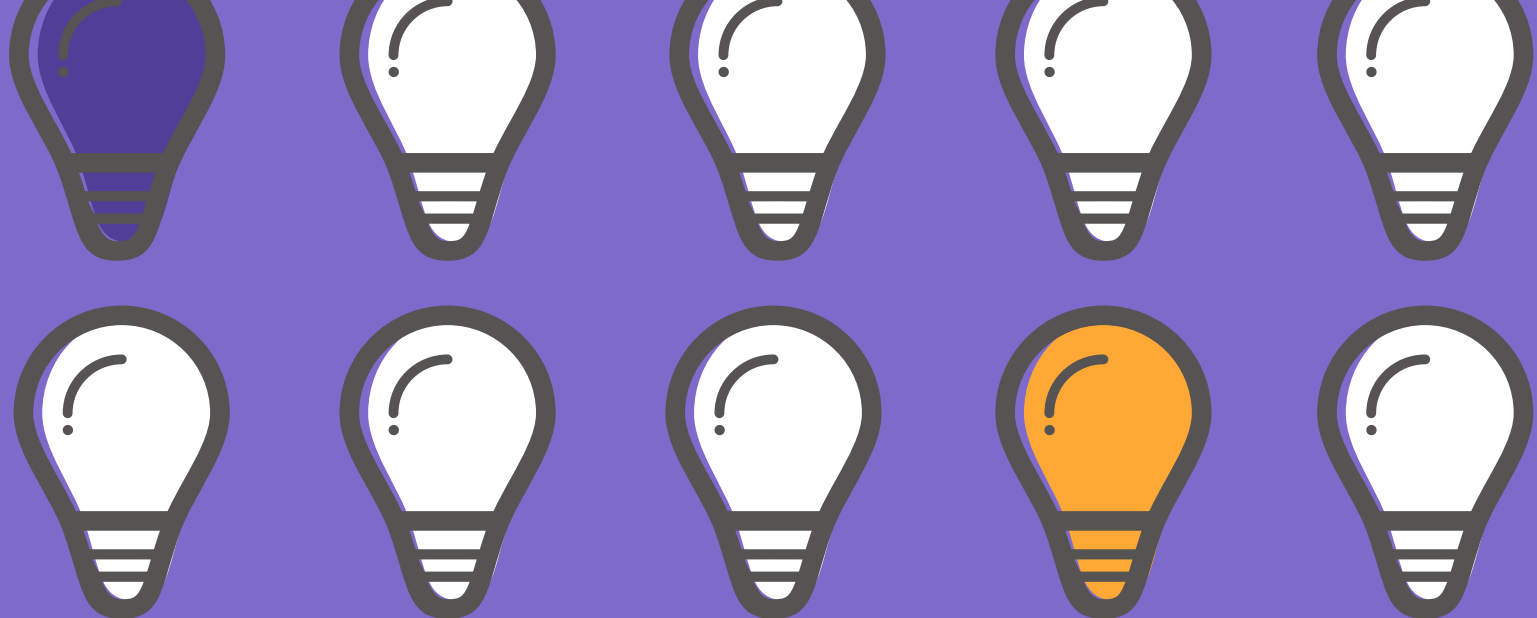


Llywodraeth Cymru
Welsh Government



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

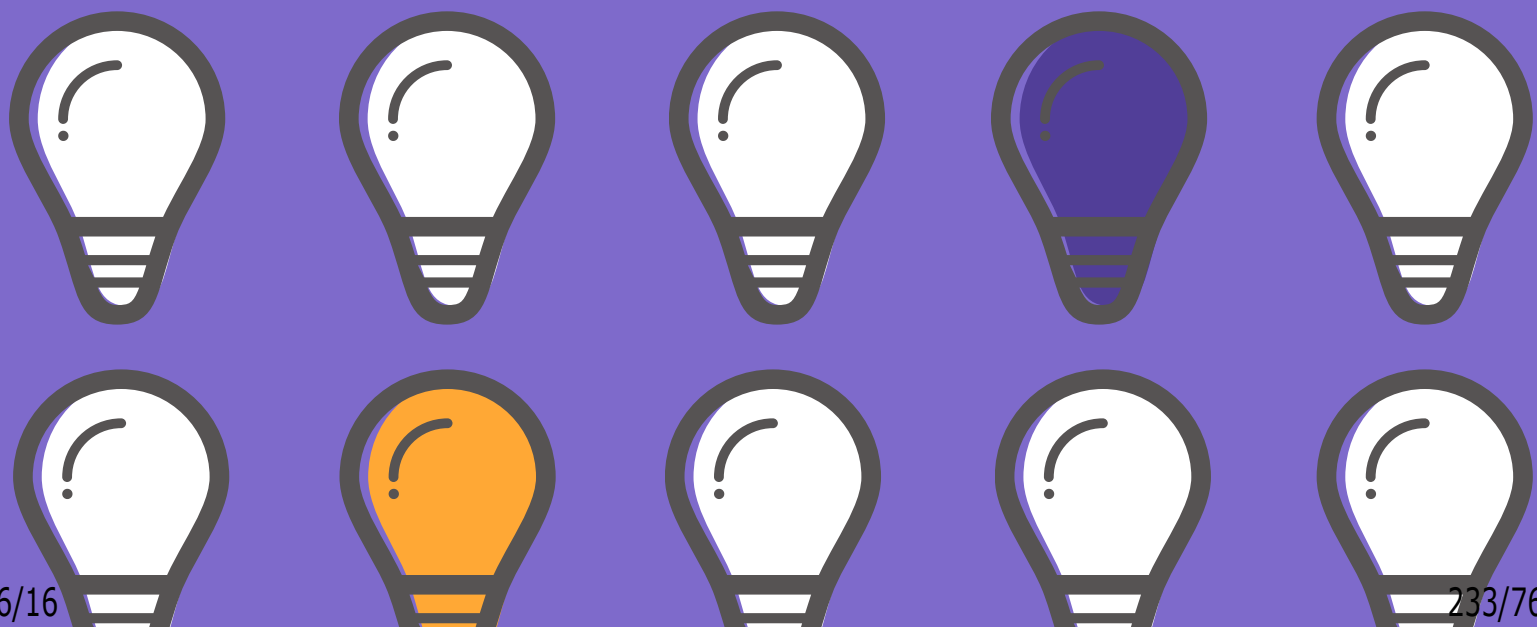


@RIICHub_CTM



**ENDORSED BY THE CWM TAF
MORGANNWG REGIONAL
PARTNERSHIP BOARD**

By your side.



Research, Innovation and Improvement Coordination (RIIC) Hub Work Programme 2020-21



Author: Dr Tom Powell

BACKGROUND/INTRODUCTION

As part of the Welsh Government Transformation Programme Fund to improve quality and value, a **nationally co-ordinated network of hubs** was created to bring together research, innovation and improvement activity within each Regional Partnership Board (RPB) footprint.

The need to better co-ordinate research, innovation and improvement (RII) was a key action outlined with **A Healthier Wales** and these hubs will be identify and steer opportunities for regional research, innovation and improvement activity and collaborative partnerships. This will accelerate the shift toward **higher quality and better value services**, including new models of seamless health and social care.

Each RIIC Hub will deliver:

- Better co-ordination and alignment of a cluttered landscape
- Evidence about integration, new way of working and quality led approaches to RII.
- Strengthened RII infrastructure to promote better quality and higher value RII.

Each Hub will do this through:

- Providing a comprehensive and current overview of all RII activity across the RPB area
- Ensuring that leaders, partners and stakeholders are informed and engaged
- Working with other regional hubs as a national network, with an emphasis on driving the adoption and spread of activity

The Hubs will to **connect to and complement existing networks and activity** and should have a clear understanding of how they will support and strengthen established networks and serve as a catalyst to increase the impact of RII activity through better co-ordination and prioritisation.

Particular importance will be given to improving outcomes for service users by **identifying and promoting high-value RII activity**, and work with other regional hubs as a national network, with an emphasis on importing and exporting good practice, sharing learning and experience, driving the adoption and spread of activity which will benefit service providers, users, and the public

Ambition for the Cwm Taf Morgannwg RI&IC hub

Anchored within the Partnership Board and **engaging equally with its partner organisations** the hub will be positioned in the centre to act as a focal point for RII knowledge generation and capture.

It will help to:

- **IDENTIFY** examples of innovation and good practice from across the region.
- **PRIORITISE** and coordinate RII activity base on RPB priorities.
- **ENGAGE** with and support key leaders and stakeholders to accelerate the implementation and adoption of innovative approaches.

Key Achievements to date

Delivered a number of commitments from the previous 2019-20 work plan across a number of work streams. Acted as a point of contact for new opportunities that support priority themes and identified a number of opportunities for CTMRPB to lead for Wales.

- With Swansea University produced the first detailed mapping of RII activity across Cwm Taf Morgannwg.
- Supported the development of a standalone RPB website and engagement tool.
- With Cardiff Met and Swansea Universities as part of the Circular Economies Innovation programme, set up a Housing Innovation Cohort, the first in Wales.
- Education engagement with Merthyr Tydfil BC. Primary school student led evaluation of potential education opportunities to support Key stage 2 & 3 curriculum.

Response to Covid 19 Pandemic

As the RIIC hub team was established in Spring 2020 it was immediately require to pivot into supporting different work streams across the RPB.

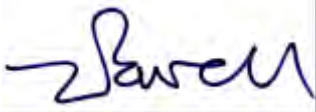
- Teaching Staff Covid Antibody Testing; The RIIC hub team in 11 days set up a multiagency Covid Antibody Testing team that tested over 5000 teaching staff in over the summer of 2020.
- Brought 3rd sector partners into Ysbyty Seren Field Hospital to support Covid Rehabilitation.
- Supported the 'Protect' TTP work stream providing project management and communication support.
- Supported Value Base Healthcare colleagues in the development and deployment of the CERi Chatbot to provide Covid Advice
- Worked with USW to develop a new point of care test for Covid based on LAMP methodology securing over £150 in WG funding.
- With Manchester University, acting as the Welsh partner on the UK wide 'Voices of Covid' research project.

Extension of the RIIC hub into year 3

- Originally the RII hub funding matched the Transformation funding timescale and was due to end in March 2021, however this has now been similarly extended until March 2022
- The refreshed work programme sets out a continuation of the work to date and builds on the new areas of priority particularly around wellbeing and mental health.
- The RIIC hub team have provided a dynamic and adaptive resource to support a number of activities outside of its current work programme, primarily driven by Covid but the future work plan acknowledges that this capacity exists
- The sustainability of the RIIC hub team is inherently measured in the outcomes of the work it delivers and evidences, and the future function and ongoing support of the RIIC hub will be driven through this.

Work package Theme Aims	WG Government Year 3 Priority Areas	Hub Activity	Outcome & Timescale
1. RII OVERVIEW <i>Provide a comprehensive and current overview of all research, innovation and improvement activity across the RPB area</i>	1. An updated current overview of R,I&I activity	1.1 Develop a robust process to gather and share examples of RI&I activity	Initial report produced Jan 2021
		1.2 Build on existing mapping capacity to address gaps in initial work specifically around RII in commercial sector e.g local health tech firms	Sep 2021
	2. Use analysis of the RI&I activity to align regional and national priorities	1.3 Connect and link to evaluating experts to develop capacity so that activities with the greatest potential impact and/or scalability can be championed and promoted.	Working with HEI partners. March 2021
	3. Implementation of lessons learnt over the past 12 – 18 months	1.4 Benchmarking projects/ innovations/ improvement across the RPB signposting access to expertise to robustly evidence impact and outcomes.	As above.
2. ENGAGEMENT <i>Ensure that leaders, partners and stakeholders are informed of, and engaged in, all RI&I activity.</i>	4. Working together as a national RIIC Hub network	2.1 Publicise and promote examples of current good RII activity both internally and externally engages other national organisations.	RPB Website live Spring 2021
		2.2 Raising the profile of high impact initiatives and expertise through networking events across the RPB and Wales.	Case Studies and reports of activity Spring 2021
		2.3 Events, publications, and an annual report presented to the Regional Partnership Board and Health Board;	Annual Report 20/21 - March 2021 Annual Report 21/22 - March 2022
		2.4 Work with other RIIC hubs as a national network, sharing knowledge, driving spread, benefitting providers and users of services	Ongoing.
3. RPB PRIORITIES AND GROUPS <i>Ensure that key RPB priorities are supported</i>	5. Demonstrating how the Hubs are adding value that evidences sustainability.	3.1 Engage with housing expertise within Local Authority Partners and Housing associations to explore 1) housing-related RI&I activity can impact on health & wellbeing and 2) Learning Disabilities service provision	Ongoing

		3.3 Engage with colleagues across the RPB to prioritise and develop key outcomes around wellbeing and mental health alongside key RPB priorities.	
4. REACTIVE CAPACITY TO SUPPORT AD HOC WORK		4.1 Provide a dynamic capacity to support innovative opportunities as they arise.	As required.

Signature:	
Name:	Dr Tom Powell
Title:	RIIC Hub Lead
Organisation:	Cwm Taf Morgannwg University Health Board
Date:	12 th March 2021

Executive Sign Off:

Signature:	
Name:	Professor Kelechi Nnoaham

Title:	Exec Director of Public Health, Lead for Research and Innovation
Organisation:	Cwm Taf Morgannwg University Health Board
Date:	22.03.21

RPB Chair Endorsed:

Signature:	
Name:	Rachel Rowlands
Title:	Chair of RPB
Organisation:	Age Connect Morgannwg
Date:	20 th March 2021



AGENDA ITEM

2.2.12

CTM BOARD

CWM TAF MORGANNWG CARERS END OF YEAR PROGRESS REPORT
2020/21

Date of meeting	27/05/2021

FOI Status	Open/Public

If closed please indicate reason	Not Applicable - Public Report

Prepared by	Rhian Webber, Strategic Planning and Commissioning Manager, Older Years System Group

Presented by	Greg Dix, Executive Director of Nursing

Approving Executive Sponsor	Executive Director of Nursing

Report purpose	FOR APPROVAL

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)

Committee/Group/Individuals	Date	Outcome
CTM Carers Partnership Group	(04/05/2021)	ENDORSED FOR APPROVAL
Management Board	19/05/2021	ENDORSED FOR BOARD APPROVAL

ACRONYMS

CBC	County Borough Council
CTM	Cwm Taf Morgannwg
CTMUHB	Cwm Taf Morgannwg University Health Board

IMTP	Integrated Medium Term Plan
WG	Welsh Government

1. SITUATION / BACKGROUND

- 1.1 In 2019, a Cwm Taf Morgannwg (CTM) Carers Partnership Group was established with member and senior officer representatives from across Bridgend County Borough Council (CBC), Rhondda Cynon Taff CBC, Merthyr Tydfil CBC, Cwm Taf Morgannwg University Health Board (CTMUHB) and the Third Sector. The CTM Carers Partnership enables the Local Authorities and the Health Board to work together to promote the wellbeing of carers and develop services to address the support needs of carers in the local population, as required under the Social Services and Wellbeing Act (Wales) 2014, which came into force in April 2016.
- 1.2 In 2019/20 the CTM Carers Partnership developed a Carers Statement of Intent which has five aims:
- Aim 1: Identifying Carers of all ages and recognising their contributions
 - Aim 2: Providing up to date, relevant and timely information, advice & assistance to Carers of all ages
 - Aim 3: Providing support, services & training to meet the needs of Carers of all ages
 - Aim 4: Giving Carers of all ages a voice, with more choice & control over their lives
 - Aim 5: Working together to make the most of our resources for the benefit of Carers of all ages.
- 1.3 The following three National Priorities for Carers in 2020/21 were identified:
1. Supporting life alongside caring – all Carers must have reasonable breaks from their caring role to enable them to maintain their capacity to care, and to have a life beyond caring;
 2. Identifying and recognising Carers – fundamental to the success of delivering improved outcomes for Carers is the need to improve Carer's recognition of their role and to ensure they can access the necessary support;
 3. Providing information, advice and assistance – it is important that Carers receive the appropriate information and advice where and when they need it.

- 1.4 In March 2021, Welsh Government (WG) launched the new Strategy for Unpaid Carers which represents their renewed commitment to improving the recognition of and support to unpaid carers in Wales. It set out WG's revised national priorities for unpaid carers, including the addition of a new priority on education and employment. It also noted WG's priority areas for action which will be followed by a more detailed delivery plan in autumn 2021.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

- 2.1 The responsibilities of the CTM Carers Partnership includes the commissioning of services for carers using the WG Carers Grant which is allocated to Health Boards across Wales on an annual basis (the value of which for CTM Region in 2020/21 was £161,000.00). Health Boards across Wales are required to submit an end of year progress report to WG outlining the activities that have been undertaken to address the needs of Carers through the WG priorities and meeting the aims outlined in the funding requirements.

- 2.2 Appendix 1 contains the draft CTM Carers End of Year progress report 2022/21 (individual organisational monitoring reports are available, if required, from Rhian Webber, Strategic Planning and Commissioning Manager, Older Years System Group, Planning and Partnerships). The CTM Carers End of Year Progress Report reflects eligible activity that WG had set in the terms of the grant:

- 1) Supporting Carers in General Practice
Working with your partners, through the primary care clusters, to implement a scheme that supports health professionals working in primary care and community care to develop their Carer awareness and understanding of how to identify Carers, the issues that Carers face and ways of working to better support Carers;
- 2) Discharge from Hospital Planning
Taking steps to support and engage Carers in the patient's discharge planning, for example better information, advice and assistance provided to all Carers when the person they care for is discharged from hospital.

- 2.3 The development of services for Carers is a key element of the CTMUHB IMTP 2020-2023 and the Annual Plan 2020/21. The Carers End of Year Progress Report shows that despite challenges from the Covid Pandemic, we have continued to drive forward and implement projects. Some organisations have had to adapt their working practice due to the restrictions of the pandemic, for example, the mode of delivery of support groups changed to virtual meetings. The

CTM Carers Partnership Group has continued to meet and key leads for Carers across the region have also held regular meetings. Working with partners, the Partnership Group has continued to provide relevant, timely information for Carers and staff delivered virtually through the Carer Champion Network which includes GP surgeries and community pharmacies. There has been the continued development of a pilot project, working closely with partners in the third sector, to support Carers of all ages within a hospital (acute and community) setting particularly around discharge planning. This project has been extensively promoted virtually and has responded to the increased mental health and financial impact upon Carers.

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

- 3.1 In 2021/22, we are ensuring reset and recovery of Carers Services in CTM. Lockdown for Carers has added pressure to their roles and this may increase demand on services as restrictions ease. For example, one organisation saw an increase in their referrals of 400 families in just one day. The CTM Carers Partnership Group is aware of this and the Partnership will work with them in supporting organisations across the CTM region.
- 3.2 CTMUHB will continue to work with partners to deliver national priorities to further improve the support available to Carers by focusing on issues that matter to them. This includes supporting carers to have a life beyond caring; identifying, recognising and supporting carers so that they can continue to care; and providing information and advice when they need it.

4. IMPACT ASSESSMENT

Quality / Safety / Patient Experience implications	Yes (Please see detail below)
	Quality, safety and patient experience is a major theme underpinning the development of innovative, integrated service solutions (for example in mental health, older people's, children's services or Carers services.)
Related Health and Care standard(s)	Governance, Leadership and Accountability
	This Statement of Intent has been developed by CTMUHB, BCBC, MTCBC and RCTCBC in response to WG funding that



	was awarded to Health Boards in 2019-20.
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below. The EIA is from the previous Cwm Taf Carers Strategy and does not reflect the new CTM working. This will be updated in due course.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £ / Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Well-being Objectives	Work with communities and partners to reduce inequality, promote well-being and prevent ill-health

5. RECOMMENDATION

- 5.1 To APPROVE the Carers End of Year Progress Report 2020/21, attached as Appendix 1, for submission to Welsh Government, following approval by the CTM UHB Board at its meeting in May.



Cwm Taf Morgannwg Carers End of Year Progress Report 2020 – 2021

Eligible activity includes:

- 1) **Supporting Carers in general practice** - working with your partners, through the primary care clusters, to implement a scheme that supports health professionals working in primary care and community care to develop their carer awareness and understanding of how to identify carers, the issues that carers face and ways of working to better support carers; and
- 2) **Discharge from hospital planning** - taking steps to support and engage carers in the patient's discharge planning, for example better information, advice and assistance (IAA) provided to all carers when the person they care for is discharged from hospital.

1) Supporting carers in general practice

What action/ activity have you undertaken to work with partners to support health professionals working in primary care and community care to develop their carer awareness and understanding of:

- how to identify carers,
- the issues that carers face and,
- ways of working to better support carers.

Action taken

Due to the Coronavirus pandemic, 2020/21 has been challenging for all. In order for services to continue to meet the need of Carers across the Cwm Taf Morgannwg (CTM) region, organisations have had to adapt their working practices. Bridgend County Borough Council (Bridgend CBC), Merthyr Tydfil County Borough Council (MTCBC), Rhondda Cynon Taf (RCT) County Borough Council (RCTCBC) and Cwm Taf Morgannwg University Health Board (CTMUHB) have continued to work collaboratively in improving support, information and recognition of Carers, whilst making best use of a wide range of knowledge, expertise and support services.

Services for Carers in CTM are provided by a range of organisations in the statutory and Third Sector. As well as accessing general services, like GP Surgeries, there are also specific services to support Carers, including young Carers and young adult Carers. These include:

- In RCT, a Carers Support project run by the Local Authority.
- Services commissioned from the Third Sector including Action for Children, Barnardos and Age Connects Morgannwg.
- A network of Carers Champions in settings across the health sector.
- In Merthyr, services to support Carers were commissioned from third sector organisations and MTCBC have appointed a Carers Coordinator.
- Across Bridgend, Carers Trust South East Wales provide Information and Advice to Carers.
- A Carers Hospital Discharge project across the CTM Region.

In CTM to enable GP surgeries to identify Carers, we ensure each surgery has a Carers Champion, a Carers noticeboard that is updated regularly and dissemination of relevant and timely Carer related information to enable swift signposting of Carers to Carers services in their area.

The transitional funding to support Carers provided by Welsh Government (WG) since 2016/17 to support the implementation of the Social Services and Well Being (Wales) Act 2014 (which came into force April 2016, is very welcome in maintaining the momentum of the Carer related work achieved to date.

The Cwm Taf Morgannwg (CTM) Carers Partnership Group works to prevent any negative impact on Carers services and support. The CTM Carers Partnership Group ensures the continued development and raising awareness of Carers throughout the region, meeting the increased responsibilities for partners under the Social Services Well Being Act.

CTM continues to have representation at the COLIN (Carers Officer Learning and Improvement Network) meetings with representatives from Local Authorities and CTMUHB attending.

Throughout 2020/21 CTMUHB, Bridgend CBC, MTCBC and RCTCBC have sustained the success of the previous year and continued to work collaboratively in improving support, information and recognition of Carers. This CTM End of Year Report highlights the key areas of work and provides examples of the progress made.

Following discussion with colleagues from Bridgend CBC, MTCBC, RCTCBC, Bridgend Association Voluntary Organisation (BAVO), Interlink Rhondda Cynon Taf, Voluntary Action Merthyr Tydfil (VAMT), the CTM Regional Planning Board (RPB) and CTMUHB – recommendations were made to the CTM Carers Partnership Group and then approved by the RPB's Transformation Leadership Group in the allocation of the 2020/21 Welsh Government's Carers Grant.

£135,634.00 of the WG Carers funding was allocated to the Third Sector through an application process.. Organisations were able to bid up to £50,000 of projects to engage with Carers of all ages. The successful projects are listed below:

Name of organisation	Project Name	Outline of project/Areas included	Projects End of Year Reports Received
CTMUHB	Carers Co-ordinator	The Carers Co-ordinator will work across the region with GP practices, hospitals etc. and engage with Local Authorities and Third Sector organisation assisting them to identify Carers in the community.	
Citizens Advice Merthyr Tydfil (CAMT)	CAB4Carers	CAMT will deliver a bespoke service focussing on Carers: - Hospital Discharge - Ongoing support in the community This will be delivered across the region.	
Action for Children RCT Young Carers Project	School Delivery Works	Action for Children will work in schools throughout RCT to raise awareness of young Carers and share their stories. This funding is to add additional hours to the current provision.	Action for Children are in the process of developing a report.
CASE (Care & Support Each Other)	CASE YACS	CASE have proposed a calendar with a series of Learning and skills events that reflect the theme of culture, education, physical and mental wellbeing alongside resilience in RCT.	
ASD Rainbows	Rainbows families	This project will employ a Family Outreach Worker to work across CTM. They will carry out	

		community work with families offering the individualised support needed to enable families to access community activities/support. They will also run a parent and child group for a year.	
MTCBC	Barnardos	MTCBC with Barnardos supports opportunities for Young Carers to socialise with other Young Carers outside of school and offers opportunities to be active and go on holidays without the people they care for.	
Taf Memory Assessment Service, CTMUHB	Support Projects	This funding will be distributed between a number of projects that will assist Carers and also individuals living with Dementia. Accessing professional and peer support for not only their own health and wellbeing, but also in giving them the tools to be able to help maintain the health and wellbeing of the individuals they are caring for. This will be in the Taf area.	Taf Memory Service are in the process of submitting a report.

The remaining £25,366.00 of WG Carers Grant was allocated through the CTM Carers Partnership Group and agreement by the RPB Transformation Leadership Group. These projects are set out below:

Carers Trust South East Wales (CTSEW)	Carers Emergency Fund	This emergency grant was allocated across Cwm Taf Morgannwg. Merthyr: Received a total of 9 applications from Merthyr (3 applications were from people aged 19-24, 6 applications were from people aged 25-64). Rhondda Cynon Taf: Received a total of 72 applications from RCT (4 applications were from people aged 0-18, 12 applications were from people aged 19-24, 54 applications were from people aged 25-64, 2 applications were from people aged 65+). Bridgend: Received a total of 140 applications from Bridgend (3 applications were from people aged 0-18, 10 applications were from people aged 19-24, 127 applications were from people aged 25-64, 0 applications were from people aged 65+).	
CTSEW	Counselling	Additional counselling hours were bought to their current service provision.	CTSEW are in the process of submitting a report.
RCTCBC	Counselling	Additional counselling hours were bought to their current service provision.	
MTCBC	Meaningful care matters	12 week programme supporting unpaid Carers of dementia	

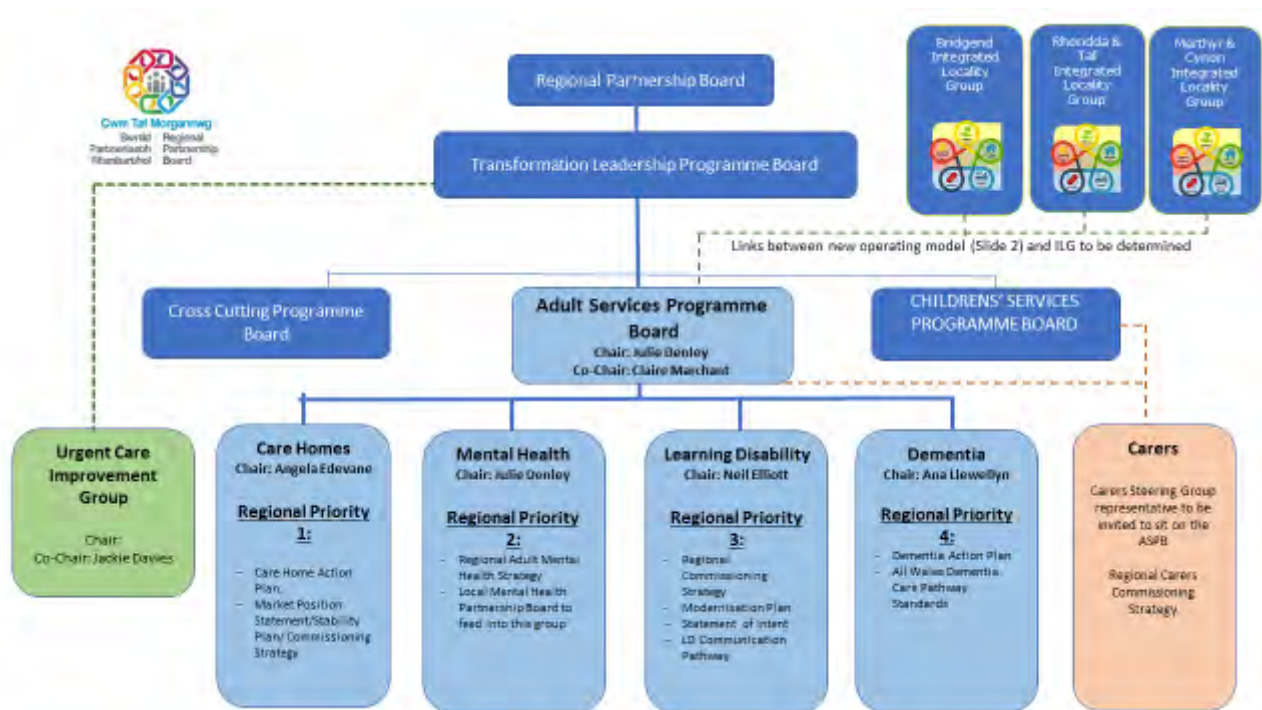
Please explain:

How you have **worked with partners** to implement and deliver improved support for carers?

The Cwm Taf Morgannwg Carers Partnership Group

The CTM Carers Partnership Group was established in 2019 and oversees the CTM Carers Statement of Intent. The governance of the partnership has been reviewed by the CTM RPB. The CTM Carers

Partnership will report to the Adults Services Programme Board that sits underneath the RPB's Transformation Leadership Programme Board.



The CTM Carers Partnership Group has met during 2020-21. Currently membership consists of: Bridgend CBC, Merthyr Tydfil CBC, RCT CBC, VAMT, BAVO, Interlink, Citizen Advice Bureau RCT, Merthyr and Valleys MIND, a Carer representative and CTMUHB.

Statement of Intent for Carers

Following the end of the Cwm Taf Carers Strategy on the 30th March 2019, CTMUHB, in partnership with BCBC, RCTCBC and MTCBC produced a Statement of Intent for Carers.

The CTM Carers Partnership Group await guidance from WG on their proposed Action Plan and the Ministerial Advisory Group as to whether there will be a requirement to produce a regional Carers Strategy or a regional Action Plan to implement WG proposals.

Young Carers Cookery Classes

Following on from a pilot project in 2019-20, working with Barnardos Merthyr Tydfil, Public Health Wales and the CTMUHB Carers Co-ordinator, Barnardos were able to continue delivering cookery books and food produce for young Carers throughout the pandemic.

It is reported that young Carers miss on average 48 days of school a year. By engaging them and giving them life skills this will boost their confidence, give them a sense of inclusion and hopefully inspire them to continue learning. During lockdown these skills proved invaluable as young Carers were able to produce healthy, well balanced meals for their family.

Going forward this opportunity will also be provided for young carers in Rhondda Cynon Taf and Bridgend.

Activity resources were also distributed to the young Carers. CTMUHB also identified technology which enabled young Carers to engage with family, friends and education during lockdown which Barnardos has kept as a future resource.

CCTM Carers A-Z Guide

Throughout the pandemic, CTMUHB has sustained the delivery of A-Z Carer Guides across our region. This resource is available online or hard copies and has proven to be a valuable resource for organisations and Carers living in the CTM region. Copies have been sent to GP practices and outpatient departments on all Acute General Hospital sites.

Partner organisations across the region have also received a supply, including the Community Co-ordinators who are based across the RCT and Merthyr Tydfil region. Age Connects Morgannwg distributed these across the Bridgend region.

Merthyr Tydfil County Borough Council

CTMUB has supported MTCBC in shortlisting and interviewing to reappoint to their Carers Co-ordinator post. The successful applicant commenced in April 2020.

Rhondda Cynon Taf County Borough Council

Carer Conversations: A pilot programme was introduced across social care in RCTCBC in January 2020 to improve the experience and offer of Carer assessments to unpaid Carers. The pilot included new staff guidance co-produced with Carers. This pilot was audited in November 2020 with some very encouraging results and feedback from staff and carers. As a result this is now being rolled out as a permanent approach to carer assessments. Additional funding was obtained to increase the Carers Counselling Service due to increased demand for psychological support.

Carer Friendly Employer: RCTCBC are scoping the possibility of achieving the Carer Friendly Employer accreditation offered by Carers Trust. This will involve a cross-departmental working group to propose a standalone Carers Policy and improve support for unpaid carers within the workforce.

Cares Support Project: The RCT Carers Support Project has continued to support unpaid carers online during the pandemic with a varied programme of online events and activities. The new Carers Hub in Pontypridd was finalised during the year thanks to a capital Integrated Care Fund grant and will become the new home for the Carers Support Project, the Young Adult Carer Service and the Young Carer Support Service during 21/22. This will provide an all-age co-located carer support service in the county. The Happy @ Home grant scheme proved extremely popular, receiving 200 applications from unpaid carers of up to £300 to support wellbeing at home.

Young Adult Carers (YACs): YACs in RCT continue to be supported by a specific support worker. Their programme of events was also moved online due to the pandemic and supported many to maintain emotional wellbeing and work on their resilience during the pandemic with many learning-based events like mindfulness, stress management, anxiety and depression awareness and wellness events. Some social activities have also been successful, such as Bake Off, quiz nights and a YAC Festival. A recognition film is currently in production, celebrating the contribution and achievements of Young Carers and Young Adult Carers during the pandemic.

Young carers and sibling carers

RCTCBC launched the Young Carer Card in March 2021. It offers young carers an easy way to start a conversation about their role and we have also been able to attach discounts in local shops to the card.

Chromebooks, received from WG, were supplied to 25 young carers and YACs aged up to 20.

The young carer support service is provided by Action for Children. Online groups were held throughout the pandemic with one-to-one support available for the most vulnerable young carers. A grant scheme was held for young carers, allowing applications of up to £50 to support them and their families during

the pandemic. Smaller face-to-face groups were held throughout the year as and when restrictions allowed.

Sibling carers received activity packs and were offered the chance to attend a 10-week emotional wellbeing course online. They also benefited from a grant scheme similar to the young carers.

Bridgend County Borough Council

Bridgend CBC have continued to work in partnership with Carers Trust South East Wales and maintain connections with CTMUHB and partners across our region.

How you have **measured success** using qualitative and quantitative data, (including the number of General Practices registered/compliant)

Annual Action Plans

The CTM Carers Action Plan is not a fixed and final plan, but a framework which sets out work to be taken forward over 2020/21. The Action plan is developed with detailed key actions, lead responsibilities, timescales, resource implications and performance measures, which will focus on the outcomes we (the partners) want to achieve.

During 2020-21, due to the impact of the pandemic on the working process, we were not able to update the action plan. It is our intention to update this action plan in the coming months with a view to developing an action plan for 2021-22.

Outcomes we want to achieve and monitoring progress

The success of this Action Plan and the benefits it delivers will be reviewed regularly. It will be a partnership plan and a variety of staff within a wide range of sectors will be responsible for working in collaboration to implement it effectively.

An annual report on progress of the action plan will be reported to the CTM Transformation Leadership Programme Board, as well as the individual organisations i.e. the three Local Authorities, CTMUHB and WG.

Feedback from carers who have accessed and used these services.

We received this case study from the Citizen Advice Bureau Merthyr Tydfil's Carers Hospital Discharge Project called "CAB4Carers":

Mr X approached the CAB4Carers adviser for help with benefits as they share the caring responsibilities for his disabled son with his partner. Mr X called the CAB4Carers adviser for advice on his son's benefits as he is the appointee for all his son's financial matters due to his health issues. His son's claim to Disability Living Allowance was coming to an end and he was asked to make a claim for Personal Independence Payment (PIP) but was unsure how to do this. His partner was claiming Carers Allowance and was concerned that this would have an effect on his PIP claim.

CAB4 Carers gave advice and helped complete the relevant forms on PIP and what he needed to do next. He was also advised on any issues that could arise in regards to the Carers Allowance claim.

After many weeks Mr X was happy to hear that his son did not need to attend an assessment due to the clear complexities of his condition. He was even happier to hear that the supporting information and form enabled the Department of Work and Pensions to make a decision straight away. The DWP awarded the enhanced rate for both components of PIP for 10 years. This is equal to £77,000 over 10

years. Mr X said he was over the moon and that we had relieved so much stress and anxiety for him and his family.

Specific questions to be addressed:

What awareness raising has been undertaken with practice staff (all professions) on the needs of carers, including young carers?

Cwm Taf Morgannwg Carers Co-ordinator

In CCTMUHB, there is a Carers Co-ordinator who:

- Attends public (currently virtual) events such as the Health & Wellbeing Month.
- Produces promotional materials and merchandise.
- Attends Senior Nurse meetings to discuss the role of a Carer.
- Organises the annual Carers conference
- Attends Nurse Induction sessions for all new nurses joining CTMUHB.

The CTM Carers Co-ordinator has continued to send Carers Champions based in the GP practices information to inform them of any relevant and timely Carers information.

Carers Conference

Due to the Coronavirus pandemic there was no Carers conference in 2020. This is an event we hope to achieve in 2021/22.

Awareness Sessions

During the pandemic CTMUHB and partners have continued to make progress in raising the awareness of Carers of all ages. This has been done through social media and press releases.

Cwm Taf Morgannwg Intranet/internet page

CTMUHB have a designated Carers page in the intranet for internal staff to access the latest information, advice and support. We recognise an organisation of our multitude have a high number of Carers and promote the CTMUHB Staff Carers Policy.

CTMUHB also played an integral part in raising awareness of the Covid Vaccine for Carers across our region through information on webpages, social media and fielding telephone calls from Carers.

GP Support Officers (GPSO)

In Merthyr Tydfil Primary Care Cluster they have GP Support Officers (GPSO's) who engage, signpost, offer advice and work with patients to influence cultural and behavioural change for service users within a Primary Care setting. They advise/assess service users and address social issues and offer support. They promote independence and enable service users to take responsibility for their own health and wellbeing. GPSO's support the reduction of attendance within general practice for non-medical intervention and will make referrals to Merthyr Tydfil CBC and the Third Sector.

GPSO's, during consultations, have often identified Carers who have not identified themselves as a Carers (they are a family member that feel it is their duty to look after their relatives). This cohort of service users were not claiming carers allowance or receiving any support from any groups, such as Alzheimer's or Stroke Society.

GPSO's have been able to support these Carers by identifying what is causing stress and putting some extra support and ensuring the correct financial assistance are put in place. They also ensure links with the relevant agencies and particularly ensuring the required adaptations are made at home.

How many General Practices / health centres have implemented Investors in Carers, something similar, or are planning to implement this accredited scheme?

AGORED Cymru

The CTM Carers Co-ordinator encourages GP practices to enrol on the Carer Awareness AGORED Cymru training course. The course is a tool which GP practices can access to develop their awareness of Carers and how they can be supported within the community.

During the pandemic, and for the safety of staff and visitors the Carers Co-ordinator was unable to visit GP practices and continue training. Discussions have already taken place in how best this can be undertaken and we would expect this training to continue in the near future.

Regular updates are posted on social media and internally to inform Carers what is available to them, there is also a designated Carers page in the internet which provides information for staff who are Carers. This also promotes and encourages Carer champions to be identified throughout clinical settings, we currently have 61 Carer Champions registered who are sent regular bulletins on carer events and information which they can promote in their area of work.

The CTM Carers Co-ordinator will continue to reinvigorate and recruit Carers Champions in 2021/22.

How and what specific support are General Practice staff providing to carers?

GP Leaflets

The Carers Co-ordinator has designed and distributed Carer booklets to GP Practices which has a registration form enabling a Carer to complete and hand to their Carer Champion. This has encouraged Carers to self-identify and engage with their GP surgery. These are available to all GP surgeries across the region.

Carer Notice Boards

Each surgery signed up to the Agored training is given a Carers Notice Board that is updated by the Carers Champion monthly. There is also a Carers Champion poster to notify patients who their Carers Champion is. Relevant information has continued to be disseminated throughout the pandemic.

Carers Champion Badges

Each Carers Champion wears a badge so they are easily recognisable to patients.

Primary Care Communications Lead

The Carers Co-ordinator has liaised with key personal in Primary Care to promote good practice by using case studies of the Carer related work being undertaken in GP surgeries across CTM.

What are the tangible outcomes for carers?

All of the positive outcomes as previously mentioned throughout the report.

What signposting arrangements are in place within the General Practice to enable carers to access other support where needed e.g. third sector helplines, websites or local carers services?

Welsh Government reporting template 1.0 - £1m LHB funding

Each GP surgery has a designated Carer Champion who has been issued with a Carers notice board. This is regularly updated by the Carer Champion with information on what events or services are being held in their locality. They also have posters displaying who their Carer Champion is for their surgery.

The CTMUHB Carer's Co-ordinator also sends timely and relevant information they may find beneficial. If there is a specific request that Carer Champions may not know where to signpost, they are able to contact the CTMUHB Carer Co-ordinator for advice. There are also community coordinators in each GP surgery which Carer Champions are able to signpost Carers for further information and advice. GP surgeries also use their television monitors to inform patients of Carer services.

2) Discharge from hospital planning

What action/ activity have you undertaken to support and engage carers in the patient's discharge planning? For example: better information, advice and assistance (IAA) provided to all carers when the person they care for is discharged from hospital.

Action taken

Carers Hospital Discharge Project

During the pandemic resources were utilised to support the pressures faced by the NHS. The CTMUHB Carers Co-ordinator has built strong working relationships within the acute general hospitals offering advice, support and information to Carers who could be staff members and signposting to support organisations. Links with Carer Champions were upheld informing them of any Carer related announcements.

Building on the success of the Carers Hospital Project run by Citizen Advice Merthyr Tydfil (CAB) in 2019-20, plans were put in place to further our engagement on hospital wards. Meeting with the Head of Nursing at Prince Charles Hospital, it was agreed CAB would have weekly access to two hospital wards. This would enable Carers to be identified on admission and identify barriers that would threaten a timely discharge.

The pandemic has for now halted this project but we continue to work with CAB in readiness to resume once safe to do so.

Please explain:

How you have **worked with partners** to implement and deliver improved support for carers

By increasing our engagement network we have been able to establish good working partnerships with more departments within Local Authorities and other third sector organisations.

For young Carers we are working in partnership with Barnardos and Public Health Wales to deliver an accredited cookery class. By building up a trusted relationship with the young Carers we will be better equipped to identify what matters them and how we can collectively support them further.

On Carers Rights Day we raised awareness of Carers of all ages on our social media platforms. This was in place of the information stands in each of our general hospitals with third sector organisations that would have normally been held. These information stalls enable our partners to promote their services to Carers.

How you have **measured success** using qualitative and quantitative data, (including the number of General Practices registered/compliant)

Throughout Merthyr Tydfil, Rhondda Cynon Taf and Bridgend there is a total of 80 General Practitioners. All were sent letters inviting them to nominate a Carer champion and the opportunity to undertake the AGORED training. We had an initial response from 18 requesting more information. From these, 10 practices enrolled staff to undertake the training, in total 13 staff (with some practices putting two through training). To date we have successfully certificated 8 learners (2019-20) and the remainder are continuing with the AGORED course. No members of staff completed the training course in 2020-21 but have continued the course so will complete in the coming months. We use an in-house spreadsheet that is regularly updated to track the learner's progress. In addition we send letters to all 80 General Practitioners on a regular basis to try to engage them further and increase nominations for this course.

Feedback from learners indicates the learning has given them the confidence to approach a "What matters" conversation with Carers and they feel more confident identifying Carers. Largely due to the training course they are able to signpost Carers for additional support and advice.

Feedback from carers who have accessed and used these services.

We received this case study from the Citizen Advice Bureau Merthyr Tydfil's Carers Hospital Discharge Project called "CAB4Carers":

Mr X called the CAB4Carers adviser for advice in regards to his benefit situation. He is a carer for his daughter who has complex needs and until recently, was working part time. This created severe anxiety for Mr X as he was worried about how this would affect his life and caring responsibilities for his daughter. Unsure what to do next, he was already claiming Child Tax Credit and Working Tax Credit and knew that the Working Tax Credit would come to an end as he was no longer working. Mr X sought advice to see if there was anything he could claim.

The CAB4Carers adviser assessed Mr X's financial and personal situation. It was established that he could make a claim to Universal Credit. He received specialist advice in regards to the claim and how much he could expect to receive. He was also advised on Council Tax Reduction and Carers Allowance. He would now be able to claim over £1,250 of Universal Credit per month. This equates to over £15,000 of secured income a year. Mr X was so grateful - he said with our help, he is now better able to care for his daughter.

Specific questions to be addressed:

Have hospital procedures regarding patient discharge been adapted, or introduced, to improve staff awareness of, and input from carers?

CTM Stay Well @ Home team are investigating how they can adapt their policies so they can assist not only the service user but also the Carer. It is hoped that clinical staff can take an holistic approach, where Carers are involved, in supporting the service user to go home. There are 4 members of the Stay Well @ Home staff currently undertaking the AGORED training.

Normally, the CTMUHB Carers Co-ordinator delivers Carer Aware training to graduate nurses on a regular basis but this was not possible over 2020-21 due to the pandemic. There is an online Carer Aware e-learning package which all staff are encouraged to complete. Although this is not mandatory it is something we hope to make mandatory in the future.

How are carers being proactively involved in the hospital discharge/discharge plans for the patient?

If Carers are identified by clinical staff, they can be referred to our hospital discharge project. This will give the Carer the opportunity to raise any concerns they have regarding the service user being discharged.

It may be they require additional support or home adaptations. If identified these issues could be addressed before discharge, therefore giving the Carer more confidence to continue with their caring role at home and possibly reduce the need for re-admission.

We continue to make the links with other projects being run from the hospital setting, such as Care & Repair and Age Connects Morgannwg.

Are carers being pro-actively signposted to third sector support or local authority social services for information, support, or to obtain a carers needs assessment (as appropriate), as part of the patient's discharge process?

Further to the information on page 3, to date CAB4Carers hospital discharge service have signposted to 178 Carers to services provided by either Local Authority or Third Sector. In total, the CAB4Carers project have dealt directly with 315 Carer related queries.



AGENDA ITEM

2.2.13

CTM BOARD

STRATEGY DEVELOPMENT UPDATE

Date of meeting

27/05/2021

FOI Status

Open/Public

If closed please indicate reason

Not Applicable - Public Report

Prepared by

Richard Morgan-Evans, Chief of Staff

Presented by

Paul Mears, Chief Executive

Approving Executive Sponsor

Chief Executive

Report purpose

FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)

Committee/Group/Individuals

Date

Outcome

(Insert Name)

(DD/MM/YYYY)

Choose an item.

1. SITUATION / BACKGROUND

The challenges of the past year have given Cwm Taf Morgannwg (CTM) a strong rationale to reflect on the future direction of the Health Board, learning lessons from the past as well as ensuring we involve our staff in deciding the best course of action to take.

After two thought provoking and inspiring strategy days held in April, which involved the full board as well as key clinical and non-clinical leaders, it has provided the 'kick start' in our ambition to begin to develop key clinical strategies. Hearing from experienced internal and external speakers

provided chance not only to reflect but to pose potential plans for the future.

There is a need to be able to clearly articulate the overarching strategy and vision for the Health Board as well as to define specific and more detailed clinical plans. We can then use this work to engage and involve our communities from an early stage before beginning to deliver against agreed pathways and milestones.

Being able to do this in an efficient way will support the organisation as it begins to resume elective routine activity as well as meet the increasing non-covid unscheduled care demand being experienced by primary and secondary care.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

The development of an overarching vision for the Health Board that sets the foundation for the strategy is important as we continue to drive improvements for the benefit of our population.

The overarching vision to guide us will be completed and communicated by the Health Board, however there is a requirement to seek support in light of the key challenges and opportunities specific to the organisation. We need to ensure we involve our clinical services to help define and co-develop future pathways, taking account of technological development and local population needs.

A collaborative approach will ensure a multitude of opinions and expertise is considered. To best achieve this we want to engage with an external partner to help facilitate and challenge thinking as well as to bring wide experience and relevant research.

The Health Board will be seeking to conduct a number of workshop sessions to develop specific areas of our clinical organisation. This will include formulating a strategy development group before running a series of sessions to understand the priority service areas. These will include clinical areas of interest such as:

- Elective care
- Urgent and Emergency Care
- Long term chronic conditions

These workshop sessions will have system-wide input – primary and community care, medical and non-medical professionals, patient and carer representatives.

Recent facilitated work conducted by Cardiff & Vale UHB in support of the development of their Programme Business Case underpinning 'UHW2' provided positive feedback that utilising a workshop series approach will attract wide clinical and non-clinical input and ensure the accepted norms are being challenged by external specialists.

The output of this work will provide a valuable foundation to develop our clinical services and put us in a position to begin to articulate not only the immediate vision and principles for change but also where the Health Board is going over the next 5 years and beyond this. This work is important as it will act as a framework to guide future service redesign work and business case creation.

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

The Board will be kept appraised as to the progress and outcome of the proposed strategy work. At relevant points, specific updates will be shared to ensure a wide input and understanding. There is nothing further to escalate to the Board at this time.

4. IMPACT ASSESSMENT

Quality / Safety / Patient Experience implications	There are no specific quality and safety implications related to the activity outlined in this report.
Related Health and Care standard(s)	Effective Care
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below)
	If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below.
	If no, please provide reasons why an EIA was not considered to be required in the box below.
Legal implications / impact	
	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications /	
	Yes (Include further detail below)

Impact	There will be a requirement for temporary funding to support an external partner providing professional services to the Health Board.
Link to Strategic Well-being Objectives	Provide high quality, evidence based, and accessible care

5. RECOMMENDATION

It is requested that the Board NOTES the ambition to move forward with developing our clinical strategy in a structured and inclusive way. The approach outlined in this paper will ensure a wide level of involvement as well as ensuring that as a Health Board we challenge ourselves, learning lessons from external sources and taking account of technological developments.



AGENDA ITEM

2.2.14

CTM BOARD

THREE-YEARLY ASSURANCE REPORT ON COMPLIANCE WITH THE
NURSE STAFFING LEVELS (WALES) ACT
2018-2021

Date of meeting	27 May 2021
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Ben Durham, Lead Nurse for Professional Practice and Quality Assurance
Presented by	Greg Dix, Executive Director of Nursing
Approving Executive Sponsor	Executive Director of Nursing
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	Date	Outcome
(Insert Name)	(DD/MM/YYYY)	Choose an item.

ACRONYMS	
NSLWA	Nurse Staffing Levels Wales Act
ILG	Integrated Locality Group

1. SITUATION / BACKGROUND

The Nurse Staffing Levels (Wales) Act (NSLWA) 2016 became law in March 2016 with the final sections of the Act coming into effect in April 2018.

Section 25E requires Health Boards/Trusts to report their compliance in maintaining the nurse staffing level for each adult acute medical and surgical ward. The Health Board (HB) must submit a three-yearly report to Welsh Government. To facilitate this, a process of submitting an annual assurance report, using a nationally agreed template, to each Health Board has been agreed through the All Wales Nurse Staffing programme.

The aim of this report is to provide an overview of the Health Board's level of compliance with the agreed nurse staffing levels; the impact upon the quality of care where the nurse staffing level was not maintained and the actions taken in response to this position. The report is a caveated report and forms the basis of the statutory three year report to Welsh Government required by the NSLWA and covers the time period from 1st April 2018 – 5th April 2021. The report is the culmination of the progress made within Cwm Taf Morgannwg University Health Board (CTMUHB) in the last 3 years since the NSLWA came into law.

During this reporting period the COVID-19 pandemic has created many challenges within CTMUHB, the Welsh Government position associated with the Nurse Staffing Levels (Wales) Act 2016 during these exceptional circumstances was to postpone the annual report to Board, due May 2020 to September 2020. In addition there has been further disruption to some of the All Wales Nursing Staffing Programme work streams. Most notable was the extension to the Act's second duty to Paediatric inpatient wards which was postponed until October 2021. Also during the reporting period, the bi-annual acuity audit for January 2021 was cancelled due to the ongoing COVID-19 pandemic.

The Board is asked to formally receive and note the information contained within the 3 annual reports 2018/2019, 2019/2020 and 2020/2021 Nurse Staffing levels (Wales) Annual Assurance Report (Appendix B,C,D) which has been produced using the prescribed NHS Wales reporting template.

The Board is asked to formally receive and note the information contained within this Caveated Three-Yearly Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act (Appendix A) which has been produced using the prescribed NHS Wales reporting template.

The Act has five sections:

- Section 25A of the Act relates to the overarching responsibility placed upon each Health Board, requiring Health Boards and Trusts to ensure they have robust workforce plans, recruitment strategies, structures and processes in place to ensure appropriate nurse staffing levels across their organisations. This duty came into effect in April 2017.



- Section 25B requires Health Boards/ Trusts to calculate and take reasonable steps to maintain the nurse staffing level in all adult acute medical and surgical wards. Health Boards/Trusts are also required to inform patients of the nurse staffing level.
- Section 25C requires Health Boards/Trusts to use a specific method to calculate the nurse staffing level in all adult acute medical and surgical wards. These duties came into effect in April 2018.
- Section 25D of the Act required that Welsh Government devised statutory guidance to support the Act and this was launched on the 2 November 2017. An operational handbook was subsequently developed to assist Health Boards and Trusts interpret and implement the requirements of the Act and this was issued at the end of March 2018.
- Section 25E requires Health Boards/Trusts to report their compliance in maintaining the nurse staffing level for each adult acute medical and surgical ward and the Health Board must submit a three-yearly report to Welsh Government, along with an Annual Report to Board outlining compliance with the nurse staffing levels, the impact upon the quality of care where the nurse staffing level was not maintained and the actions required in response to this.

The Board's responsibilities under the Act are to:

- Identify a designated person (or a description of a person)
- Determine which ward areas where Section 25B applies
- Receive and agree written reports from the 'designated person' on the nurse staffing level that has been calculated for each adult acute medical and surgical inpatient ward
- Ensure that operational systems are in place to record and review every occasion when the number of nurses deployed varies from the planned roster
- Agree the operating framework which will specify the systems and processes to ensure that all reasonable steps are taken to maintain the nurse staffing level on both a long term and a shift-by-shift basis; and specify the arrangements for informing patients of the nurse staffing.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

Three-Yearly Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act: (Appendix A) sets out the progress made within CTMUHB during 2018/2021 (1th April 2018 - 5th April 2021) in relation to meeting the various statutory requirements of the NSLWA. For ease of providing assurance, the report is divided into the following sections:

- Section 25A, which addresses the Health Boards/Trusts overarching responsibility to ensure appropriate nurse staffing levels in any area where nursing services are provided or commissioned, in addition to the detailed requirements relating to adult medical and surgical wards (pages 1-8 of the report).
- Section 25B, which address the Health Board responsibility for the those wards under this section, this section also includes the 3 annual reports against the

compliance with the Nurse Staffing Levels (Wales) Act and how COVID-19 pandemic has effected wards under section 25B (page 8-13)

- The process and methodology used to inform the triangulated approach to calculate the nurse staffing level on section 25B wards; and the use made of the principles underpinning this approach to provide the foundation for the work being undertaken to ensure appropriate nurse staffing levels are calculated for all areas where nursing services are provided (page 14-15).
- The extent to which the nurse staffing levels in Section 25B wards have been maintained (pages 16-19 of the report).
- The robustness of the systems and processes in place for maintaining the nurse staffing level (pages 20-21 of the report).
- The impact on care quality as a result of not maintaining the nurse staffing levels (pages 22 of the report)
- The actions taken when nurse staffing levels have not been maintained, both in relation to specific incidents and when considering the more strategic challenges in maintaining the calculated staffing levels (page 23-25 of the report).
- Report conclusion (page 25-26 of the report)

Health Boards are required to submit a Three-Yearly Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act. The Board is asked to formally receive and note the information contained within the Three-Yearly Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act (Appendix A) which has been produced using the prescribed NHS Wales reporting template. During the first year of the 2016 Act, the former HB (Cwm Taf) did not become compliant until April 2019. The Princess of Wales Hospital was part of Abertawe Bro Morgannwg Heath Board and due to boundary reconfiguration did not combine with CT UHB until 1st April 2019.

The Covid-19 pandemic has had an effect within all of the various workstreams that are responsible for introducing the NSLA, both at HB level and nationally. Between June 2020 and 30 September 2020 within CTMUHB there have been multiple changes to 22 of the 29 wards at various points in response to COVID-19. The January 2021 bi-annual acuity audit was cancelled, however since November 2020 the Heads of Nursing for the 3 District General Hospitals (DGHs) agreed to provide weekly reports charting any changes to wards within the acute sites. During this height of the 2nd wave of the COVID-19 pandemic, 21 section B wards had been repurposed into Red, Amber and Green as defined by Welsh Government (2020) COVID-19 – 16 point plan.

The extension to the 2016 Act second duty for Paediatric inpatient wards was postponed until October 2021, but work continued and a position paper has been submitted to the Board informing them that under the current clinical model for paediatric inpatient wards within CTM, there will be requirement to fund 43.87 wte Registered Nurse (RN) and 9.81 wte Healthcare Support Workers (HCSW) to be compliant within the 2016 Act.

Changes to note

On the 1st April 2019 Cwm Taf UHB became Cwm Taf Morgannwg University Health Board. Although Cwm Taf UHB only became compliant with the Act in January 2019, the Princess of Wales Hospital (PoWH) had been compliant with the Act since August 2017 and their data was collated as part of the then Abertawe Bro Morgannwg HB therefore there is some missing data in the first year of the CTMUHB NSLA.

Due to Covid-19 some of the wards within Section 25B of the Act, required their staffing establishments to be temporarily revised as wards were repurposed in response to COVID-19. Some wards have been repurposed to provide dedicated additional Covid-19 positive, critical care beds and high care respiratory beds. Due to these changes, some wards that were initially sitting within Section 25B of the Act currently sit outside Section 25B. These changes are described in more detail within the Annual Presentation of Nurse Staffing Levels to the Board (Appendix B, C and D)

All wards that remain under Section 25B of the Act within CTMUHB are displayed via hyperlinks in the 3 yearly assurance report (Appendix A). Also to note that although the January 2021 bi-annual acuity was cancelled the WG expects HB to provide evidence that there has been consideration into how wards under section 25B have had their staffing levels reviewed.

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

The Board is asked to note, in particular, under this section there is a requirement to report if there has been an impact on care quality due to not maintaining the nurse staffing levels. The incidents which need to be reported under the Act yearly are the number of serious incidents/complaints where failure to maintain the nurse staffing level was considered to have been a factor for the following patient harm incidents:

- Hospital acquired pressure damage (grade 3, 4 and unstageable).
- Falls resulting in serious harm or death (i.e. level 4 and 5 incidents).
- Medication related never events.

In addition, from 2019/20, we are also required to consider whether a failure to maintain nurse staffing levels played any part in any/all complaints received about nursing care.

Table 1 within Appendix A sets out the number of serious incidents/complaints that occurred on 25B wards from 1st April 2018 to 5th April 2021. There is also a requirement to report where failure to maintain the nurse staffing level was considered to have been a contributory factor. During this reporting period, there have been 4 identified incidents/complaints directly reported where failure to meet the nurse staffing level has been recorded. However none of these met the threshold to be reported to Welsh Government.

Detail is provided in the final section of the annual assurance report (Appendix A) in relation to the key actions taken in response to specific incidents / nursing care concerns when nurse staffing levels were not maintained as well as the broader, more strategic actions being taken to ensure that both the numbers and the skill set of the nursing workforce is appropriate to provide sensitive and individualised care to all CTMUHB patients.

It is envisaged that wards within Section 25B will continue to be repurposed in response to resetting post COVID-19 and it is recognised that this will continue to present challenges in relation to the workforce required in order to deliver care within these repurposed wards.

4. IMPACT ASSESSMENT

Quality / Safety / Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Staff and Resources
	Safe Care
Equality impact assessment completed	Yes
Legal implications / impact	Yes (Include further detail below)
Resource (Capital/Revenue £ / Workforce) implications / Impact	Yes (Include further detail below)
Link to Strategic Well-being Objectives	Provide high quality, evidence based, and accessible care

5. RECOMMENDATION

The Board is asked to:

- NOTE the position of the Health Board against its responsibilities within the NSLWA with regard to the annual assurance report, recognising that a presentation of the key findings within this report was presented to a board development session on 29 April 2021
- NOTE the conclusions and recommendations have been reported on pages 24-26 of the annual assurance report (Appendix A).

Appendix A	Annual Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act
Health board	Cwm Taf Morgannwg UHB
Date annual assurance report with compliance with the Nurse Staffing Levels (Wales) Act is presented to Board	September 2020 (Deferred from May 2020)
Reporting period	The reporting period is 6th April 2019 -5th April 2020.
Requirements of Section 25A Section 25A refers to the Health Boards/Trusts overarching responsibility to ensure appropriate nurse staffing levels <u>in any area where nursing services are provided or commissioned, not only adult medical and surgical wards.</u>	In addition to the above general principles, there are some specific issues to note in relation to the progress made within the Health Board over the past 12 months and which relate to the individual work streams of the All Wales Nurse Staffing programme: Paediatric In-patient Work stream: In December 2019, the Health Minister announced plans to extend the Nurse Staffing Levels (Wales) Act 2016 to include paediatric inpatient wards. Within CTM UHB a Paediatric In-patient sub-group has been in place since June 19 and a detailed Implementation Plan has been developed. Regular update reports to Management Board have been provided with the aim of ensuring Organisational readiness at the time of commencement of the extension to the Act to paediatric inpatient wards. A letter received by the Chief Nursing Officer (CNO), dated 24th March 2020, provided Nurse Directors with clarity and assurances around the CNO's expectations around the covid-19 pandemic and in relation to the extension of the Act to include paediatric inpatient wards, the CNO confirmed that: Thus far, the provisional schedule for this work has been as follows: • June to August 2020: 3 month public consultation on the draft regulations and amended statutory guidance; • November 2020: regulations laid before the Senedd; • December 2020: Senedd debate and presumptive passing of regulations; • April 2021: Coming-into-force date of regulations on paediatric inpatient wards.

- The timetable of those processes is now clearly compromised. In terms of the legislative steps, the capacity to undertake the drafting requirements is still available within Welsh Government.
- We intend to reschedule the plenary debate to February 2021, allowing the consultation to take place later in 2020, several months after the projected peak of COVID19 activity.
- April 2021 now appears to be entirely unfeasible as a coming-into-force date. Given the current timescales, it is a fair assumption that Health Boards will require approximately 12 months of preparation time under normal circumstances before the regulations could come into force. In the context of this work stream, I consider *normal circumstances* to be suspended.
- However a final decision on a coming-into-force date won't need to be made until the regulations are laid before the Senedd in early 2021.
- The second planned data capture around compliance with the interim paediatrics principles is due this coming May has been postponed until November, pending any further developments.

District Nursing Work stream:

During 2020/21, CTMUHB has provided 6 monthly progress reports on compliance with the Chief Nursing Officer (CNO) and Nurse Directors' interim nurse staffing principles for district nursing. The fifth collection exercise against the district nurse principles that was undertaken in January 20 demonstrates that CTMUHB is making good progress against the principles. The follow up letter to the Health Board from the CNO highlighted the following:

- CTMUHB's performance against the core principles remains very strong with full compliance against principles 2 and 3.
- Principle 4 and 5 are over 90% (it is not expected to achieve 100% return on these principles due to staff turnover).
- For principle 7, CTMUHB are reporting an average of 24.21% uplift across the Organisation, which is a very strong position to build upon. The exercise highlighted that the variation continues between the 'old Cwm Taf' and the Bridgend teams and it would be good to see the gap close between them in time.

	• Principle 8 regarding improving administration support has seen progress overtime, and it is hoped to see this improvement continue going forward. Under section 25A Staffing levels for all inpatient wards across the Health Board have been calculated to ensure that they can provide the level of care required for the patients within that area. During March and April 2020 this has been a dynamic process which was reviewed twice weekly via the Bronze meetings within each Locality Group and decision making logs have been used to document decisions made at each meeting. Staffing levels have been agreed and if required adjusted to meet clinical model and patient acuity. The Executive Nurse Director has determined that a review of nurse staffing levels across all clinical areas across all settings where nursing care is either provided and or commissioned in line with the requirement in Section 25A provides assurance that the principles behind the Act are considered. Since February 2020 staffing levels are reviewed, calculated by Locality Group Nurse Directors and reported via Nursing and Midwifery Workforce meetings. During March 2020 any areas that provide nursing care or commissioned areas that have been repurposed due to COVID-19 have been by have been calculated accordingly and reported via CTM UHB Executive Management Board meetings.
Actions taken in relation to calculating the nurse staffing level on section 25B wards during the reporting period. • Adult acute <u>medical</u> inpatient wards • Adult acute <u>surgical</u> inpatient wards	The nurse staffing levels for 29 adult medical and surgical wards where section 25B applies were presented to the Board in November 2019. Due to the impact of COVID-19 in March and in response to the guidance issued by the Chief Nursing Officer and in acknowledgement of the need for Health Boards/Trusts to agree a 'Once for Wales approach' the Nurse Directors agreed to postpone presenting their Annual Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act, which was due to be presented to their Board in May, until September 2020 Between March 20 and 05/04/2020, 14 of the 29 Section 25B wards presented to the Board in November 2019 were repurposed due to covid-19.

The CNO letter, dated 24th March 2020, provided clarity and assurances around the adult medical and surgical ward workstream and confirmed that “*adult medical and surgical wards that have been repurposed as novel wards to deal with the Covid19 pandemic would be considered an exception under the definition of an adult medical ward, therefore would not be subject to the prescribed triangulated calculation methodology*”. However as some wards were not repurposed for COVID-19 until the final month of this reporting period Appendix B provides a summary of the required establishment for wards where S.25B was applicable for the majority of the reporting period and any repurposed wards due to COVID-19 have been highlighted in Appendix B.

The Health Board has implemented new ways of working and models of care in order to respond and meet the extreme and unprecedented pressures that the Organisation experienced at the end of this reporting period in March/April 2020. This required an extremely flexible approach to the deployment of the nursing workforce across the Health Board site and some wards were repurposed more than once to accommodate the clinical demands.

Appendix A provides the detailed nurse staffing level for the 29 wards where Section 25B applies, together with the rationale and outcome of the review processes undertaken during 2019/20, both as part of the bi-annual calculation cycle and, where it has been deemed necessary, outside of that cycle.

Following the acuity audit undertaken in June 2019 as part of the bi annual recalculation process, wards that are under Section 25B were reviewed in order to ensure the calculation of the nurse staffing levels using the prescribed methodology. Following this, there were no changes required to the staffing levels on these wards.

In November 2019 Ward 7 in Prince Charles Hospital changed speciality and therefore its clinical model. The ward, which was a busy acute adult surgical ward became an adult medical ward focusing on rehabilitation for patients with low acuity. Due to this change this ward was removed section 25B of the Act. During the end of this reporting period March 2020 some wards under

	Section 25B were repurposed due to COVID-19. At each point of the recalculation using the triangulated approach was undertaken and the all Wales workforce planning tool was used to Record the triangulated approach to the nurse staffing level review each time. Within CTMUHB, following the acuity audit undertaken in January 2020 as part of the bi annual recalculation process, wards that are under Section 25B were reviewed in order to ensure the calculation of the nurse staffing levels using the prescribed methodology. Following this process no changes were made to the existing, agreed establishments. However, since this, many of these wards have been required to temporarily revise their establishments due to COVID 19. In March 2020 The Chief Nursing Officer emphasises the needs for Health Boards/Trusts to ensure that they keep a record of the actions taken during the COVID-19 pandemic. Processes for collating this information and actions taken should be reflected within the pending Board paper and in the paper due to be presented to the Board in September 2020, as this information will required within the three yearly report to Welsh Government.
Using the triangulated approach to calculate the nurse staffing level on section 25B wards	The triangulated methodology prescribed in the NSLWA as the required approach to calculating the nurse staffing levels for each ward has become embedded during 2019/20 as a routine, 6-monthly cycle that is undertaken with the nursing teams responsible for each ward within Section 25B. The nursing team's access the data they are required to take account of within this methodology is obtained via the IT performance reporting system 'Qlik Sense' The system provides information relating to patient flow, patient acuity and care quality metrics in a single report that is readily accessible to Ward Managers, Heads of Nursing and ILG Nurse Directors. The monitoring of nurse sensitive indicators are monitored by the Locality Group Nurse Directors via Quality & Safety governance reviews and reporting mechanisms.

Informing patients

The statutory guidance (Appendix C) states that “*LHBs and Trusts must make arrangements to inform patients of the nurse staffing level*” (paragraph 20). The CTMUHB Internal Audit Department conducted a review of the Health Board’s compliance with the NSLWA during 2019/20 and reported that the Board could be reasonably assured in relation to its compliance with the NSLWA.

The Internal Audit report recommended further actions related to the statutory requirements to inform patients of the nurse staffing levels by ensuring that the most up to date information is displayed on wards in relation to the staffing levels agreed by Board, this included ensuring the staffing numbers were in line with agreed workforce planning Template.

Following this report and to ensure full compliance, further actions have been taken during 2019/20 to ensure that a robust system is in place to ensure that the approved template to display the Nurse Staffing Level for each ward is refreshed and reissued as soon as the Board has been formally notified, by the Executive Director of Nursing, of the nurse staffing level that has been agreed for each Section 25B ward. These templates have been updated during COVID-19 March/April 20 as and when a ward has been repurposed.

	Section 25E (2a) Extent to which the nurse staffing levels are maintained
The extent to which the nurse staffing levels have been maintained	When the second duty of the Nurse Staffing Levels (Wales) Act 2016 (the Act) came into force in April 2018, there was no consistent solution to extracting all of the data explicitly required under section 25E, and Health Boards were using a variety of e-rostering and reporting systems. During the reporting period 2019/20, all health Boards/Trusts in Wales have been working as part of the All Wales Nurse Staffing Programme to develop a consistent approach to capturing quantitative data on a daily basis (in lieu of a single ICT solution) to enable each organisation to demonstrate the extent to which the nurse staffing levels across the health board have been maintained in areas which are covered by Section 25B/C of the Act. For the 2019/20 annual report, this Health Board, together with all other Health Boards/Trusts in Wales is providing narrative to describe the extent to which the nurse staffing levels have been maintained in order to meet its statutory reporting requirement under Section 25E of the Act. For the 2020/21 reporting period, it is anticipated that this section of the annual report will contain quantitative data for part of the year at least. This data, once available for every Health Board in Wales, will be presented by all Health Boards in a consistent manner. The anticipated solution from July 2020 is for enhancements to the existing Health and Care Monitoring System to enable to collection of 'planned roster compliance' data on a daily basis It is the responsibility of the Sister/Charge Nurse to ensure effective roster management and deployment of the nursing staff within the required establishment of their wards. It is the responsibility of the Senior Nurse to sign off the planned roster to authorise and confirm that it reflects an appropriate deployment of the nurse staffing resource that sits within the establishment for each ward. The monthly Nursing and Midwifery Workforce group continues to be the forum for strategic action to improve this position. Key performance indicators for this work stream are focused on

	effective rostering, efficiency of the temporary staffing office, recruitment activities and the retention of staff including staff well-being. In June 2019, the Health Board commenced its Registered Nurse overseas nurse recruitment campaign to bring 216 wte nurses from India into the three acute hospital sites by September 2020. By March 2020 86 nurses had landed due to COVID-19 the monthly landings has been placed on hold, however the recruitment for the remaining 130 nurses is due to recommence on September 2020 with 30 nurses scheduled to arrive per month. There are also 61 wte RNS coming into post in September 2020 from Student Streamlining. Towards the end of this reporting period and as response to COVID-19 a “call to arms” bank recruitment initiative was undertaken in March 2020 and has yielded additional Registered nurses and over 300 Health Care Support Workers (HCSW) were employed into the Health Board.
Process for maintaining the nurse staffing level	There are well embedded processes within the nursing structures on each of the acute sites for reviewing staffing levels operationally on a daily basis and for making operational, risk-based decisions about the deployment of staff via the bed/staffing meetings. During 2019/20, nursing teams have introduced the use of the patient acuity data being captured on a daily basis for all Section 25B wards across the Health Board to inform these operational decisions relating to staff deployment. Each Directorate continues to monitor the staffing situation daily and ensure that clinical areas manage the risk where there are any staffing deficits.

Monitoring and reporting of the daily staffing levels has been undertaken informally across the Health Board since April 2019. However from January 2020 in line with decisions made at all Wales level, the Health Board is to commence formally recording the nursing staffing levels on each of the wards per day and the mitigating actions taken in order to maintain the nurse staffing levels on ward areas.

The Nursing Staffing Levels (Wales) Act (2016) Operating Framework and Escalation Policy for CTMUHB (Appendix D) was produced in March 2020. The purpose of this Operating Framework is to support the calculation and maintenance of nursing staffing levels in Adult Acute Medical and Surgical Wards and the actions that are taken to review, record and escalate where nurse staffing levels are not maintained.

Within the Acute Hospitals staffing levels are reviewed three times a day and if required staff are deployed accordingly using All Reasonable Steps (Appendix E) together with professional judgement to draw on information at a local and national level to inform their decision as to the appropriate staffing levels required.

The All Wales Directors of Nursing have agreed, and through the All Wales Nurse Staffing programme group have issued, further clarification on what constitutes the 'All Reasonable Steps' which are statutorily required to be taken in order to maintain the nurse staffing levels at the calculated levels. This document has been in place within CTMUHB since November 2019.

Table 1		Section 25E (2b) Impact on care due to not maintaining the nurse staffing levels			
		The below data relates to care that patients received between 6th April 2019- 5th April 2020.			
Patient harm incidents (i.e. nurse-sensitive Serious Incidents /Complaints)	1) Total number of closed serious incidents/complaints during <u>last</u> reporting period (March 18 - April 19)	2) Total number of closed serious incidents/complaints during <u>current</u> reporting period. (April 19 - March 20)	3) Total number of serious incidents/complaints not closed and to be reported on/during the <u>next</u> reporting period	4) Increase/decrease) in the number of closed serious incidents/complaints between reporting periods	5) Number of serious incidents/complaints where failure to maintain the nurse staffing level was considered to have been a factor
Hospital acquired pressure damage (grade 3, 4 and unstageable).	27	27	0	No change	0
Falls resulting in serious harm or death (i.e. level 4 and 5 incidents).	24	37	27	Increase	0
Medication related never events.	0	3	1	Increase	0
Complaints about nursing care	9	21	3	Increase	0

Section 25E (2c) Actions taken if the nurse staffing level is not maintained	
Actions taken when the nurse staffing level was not maintained	For this reporting period there have not been any of the incidents where not maintaining the planned nurse staffing level was deemed to have contributed to the incidents. It should be noted however, that as yet, it is not possible to draw any cause/effect conclusions about any trends from the small numbers of serious incidents provided in this report, this will require several further data sets to be available. Anecdotal feedback from discussion with the Ward Managers does, at times reference that an incident occurred whilst there was a deviation from the planned roster, however it has not been recorded as a direct result of insufficient staffing levels. All of the incidents and complaints included in this report have been reviewed by the Acute Hospital's Head of Nursing via their internal weekly scrutiny meetings to assess if the nurse staffing levels were maintained at the relevant time, and if not, whether failure to maintain the nurse staffing level contributed to any harm suffered by the patient but also to determine whether there are any other lessons to be learnt from the incidents that can be shared. There are a range of both short and long term actions being taken by the Health Board in an attempt to improve the extent to which a sufficient workforce is available to work within the Registered Nurse and Health Care Support Worker posts on both Section 25B wards and across the wider nursing services. These include: • The schemes being led by the Workforce and Organisational Development teams and Corporate Nursing to develop and implement innovative approaches to recruitment of Registered Nurses as well as new Health Care Support Workers. • Continue to progress the overseas Registered Nurse campaign including the uplift of Practice Development Nurses to support this programme. • Establishing educational partnerships arrangements with the University of South Wales and Swansea University in relation to the creation of new courses to support the extension of the Nurse Staffing Levels (Wales) Act 2016 to include paediatric inpatient wards, the district nursing principles and mental health workstreams. • Creation of career pathways including exploring opportunity for Band 4 nursing roles to support CTMUHB Integrated Health & Care Strategy

Conclusion & Recommendations

In summary, 2019/20 has been a year of significant progress in relation to fully meeting the requirements of the Nurse Staffing Levels (Wales) Act 2016:

- The successful appointment of 216 wte Registered Nurses overseas nurses with 86 landed by March 2020 with a 100% successful pass rate with their OSCE exam.
- The recruitment of substantial numbers of Health Care Support Workers via the 'call to arms' initiative in March 2020 into the permanent roles and enabling an increased workforce onto the staff bank.
- Significant improvement in the availability of information to nurse leaders to support and inform their clinical decision making including the creating of The Nursing Staffing Levels (Wales) Act (2016) Operating Framework and Escalation Policy and All Reasonable Steps.
- Improvements to the information provision to our patients and the public in relation to nurse staffing levels in our hospitals
- Further refinement of the governance systems and processes in place in relation to the NSLWA and the newly created ILGs.
- Preparation for extension of the Act into Paediatric and District Nursing.

The work programme associated with the NSLWA in 2020/21 will prioritise:

- Extension of the Act to Paediatric in-patients in 2021
- District Nursing Principles and work schedules
- Roll out of the new HCMS module to capture staffing levels and patient acuity per day.

Medical wards – 2018-2019

Health board/trust:	Name: Cwm Taf Morgannwg UHB	
Period reviewed:	Start Date: 6th April 2018	End Date: 5 th April 2019
Number of wards where section 25B applies:	Medical: 14	Surgical: 16

Medical Wards CT

Ward	RN Establishment	HCSW Establishment
RGH Ward 12	20.9	19.9
RGH Ward 14	20.9	19.9
RGH Ward 19	20.9	19.9
RGH Ward 20	20.9	19.9
PCH Ward 2	21.4	14.2
PCH Ward 9	20.9	14.2
PCH Ward 10	22.9	25.6
PCH Ward 11	20.9	14.2
PCH Ward 12	23.7	17.1

Wards excluded

RGH Ward 15 – orthopaedic rehab ward

RGH AMU – Medical Admissions ward

Medical wards PoWH

Ward	Type of Ward	Number of Beds	Establishment		Additional information	NSA complaint
			RN	HCSW		
	MEDICAL WARDS					
2	Acute Stroke	24	20.07	13.62	Includes 2 high care bays	YES
4	Cardiology	31	28.24	13.62	Includes 2 high care cardiac monitored bays	YES
5	Respiratory	23	23.79	10.9*	Includes 2 high care bays one comprising of six beds with NIV This ward has a co-ordinator Monday to Friday 08.30-16.30 (included in wte)	NO Additional funding of 2.72wte HCSW required to bring wte up to *13.62
6	Gastroenterology and Endocrinology	27	22.28	13.62	3 of the 27 are gastro day unit (11.5hrs 5 days a week)	YES
20	Acute medicine (Elderly)	22	20.07	13.62	Ward layout challenging to observe patients	YES

Surgical wards CTM 2018-2019

Health board/trust:	Name: Cwm Taf Morgannwg UHB	
Period reviewed:	Start Date: 6th April 2018	End Date: 5 th April 2019
Number of wards where section 25B applies:	Medical: 14	Surgical: 16

Surgical Wards

Ward	RN Establishment	HCSW Establishment
RGH Ward 1	12.37	8.53
RGH Ward 2	20.90	17.06
RGH Ward 3	20.90	17.06
RGH Ward 7	15.21	11.37
RGH Ward 8	22.90	15.81
RGH Ward 9	15.21	8.53
PCH Ward 3	18.06	14.21
PCH Ward 4	20.90	14.21
PCH Ward 6	20.90	14.21
PCH Ward 7	20.90	14.21
PCH Ward 8	20.90	14.21

Wards excluded

RGH Ward 5 – short stay ward

PCH Ward 5 – short stay ward

Ward	SURGICAL WARDS	Number of beds	RN est	HCSW est	Additional information	NSA compliant
7	Surgical	28	20.07	13.62		YES
8	Surgical	28	21.07	13.62	This ward has a co-ordinator Monday to Friday 08.30-16.30 (included in wte)	YES
9	Elective orthopaedic	28	20.07	10.90*	This ward also accepts "screened" trauma patients	YES However due to the mix of elective and trauma patients Additional funding of 2.72wte HCSW required to bring wte up to *13.62 Gap is currently covered by temporary staffing
10	Trauma orthopaedic	29	20.07	13.62		YES However due to dependency and acuity of patients Additional funding of 2.72wte HCSW required to bring wte up to *16.36
11	Gynae and medical outlier ward	18	17.46	9.83	Due to medical patient case mix this is staffed as a medical ward This ward also has Early Pregnancy Clinic running	NO Additional funding of 0.22 wte HCSW required. Professional nursing opinion based on acuity and dependency of patients is that ward requires an uplift of 1.79wte HCSW

Wards excluded

- Private Patients Unit
- Short Stay Unit

Appendix B: Summary of Required Establishment

Health board/trust:	Name: Cwm Taf Morgannwg UHB	
Period reviewed:	Start Date: 6th April 2019	End Date: 5th April 2020
Number of wards where section 25B applies:	Medical: 15	Surgical: 15

Surgical wards Princess of Wales Hospital

Ward	Required Establishment at the start of the reporting period (as at April 6 th 2019)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (as of April 5 th 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
PoW Ward 7	20.07	13.62	Yes	36.65	16.96	Yes	Yes	No		Yes	Yes	Due to COVID. Ward 7&8 were repurposed to create a 43 bedded high care respiratory unit (CPAP/NIV)
PoW Ward 8	21.07	13.62	Yes	36.65	16.96	Yes	Yes	No		Yes	Yes	Due to COVID. Ward 7&8 were repurposed to create a 43 bedded high care respiratory unit (CPAP/NIV)
PoW Ward 9	20.07	13.62	Yes	0	0	No	Yes	No		Yes	Yes	Ward closed as part of repurposing of wards due to COVID
PoW Ward 10	20.07	16.34	Yes	0	0	No	Yes	No		Yes	Yes	Ward was repurposed to creation additional Critical Care capacity in preparation for COVID demand.
PoW Ward 11	17.46	11.62	Yes	13.74	6.38	Yes	Yes	No		Yes	Yes	Repurposed during COVID to increase bed capacity if required.

												Nursing workforce reduced due to limited surgical demand

Surgical Wards Prince Charles Hospital

Ward	Required Establishment at the start of the reporting period (as at April 6 th 2019)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (as of April 5 th 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
PCH Ward 3	18.06	14.21	Yes	40.8	90.96	Yes	Yes	No		Yes	Yes	Repurposed during COVID to create COVID respiratory high care CPAP ward
PCH Ward 4	20.9	14.21	Yes	91.96	45.48	Yes	Yes	No		Yes	Yes	Repurposed during COVID to create an additional critical care due to high demand.
PCH Ward 6	20.9	14.21	Yes	20.9	14.21	Yes	Yes	No		No	No	
PCH Ward 8	20.9	14.21	Yes	20.9	14.21	Yes	Yes	No		No	No	

Surgical Wards Royal Glamorgan Hospital

Ward	Required Establishment at the start of the reporting period (as at April 6 th 2019)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (as of April 5 th 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
RGH Ward 1	12.37	8.53	Yes	12.37	8.53	Yes	Yes	No		No	No	
RGH Ward 2	20.9	16.07	Yes	20.09	16.07	Yes	Yes	No		No	No	
RGH Ward 3	20.9	17.22	Yes	20.9	17.22	Yes	Yes	No		No	No	
RGH Ward 7	15.21	11.37	Yes	20.9	17.22	Yes	Yes	No		Yes	Yes	Repurposed for COVID medicine
RGH Ward 8	20.9	17.22	Yes	0	0	No	Yes	No		Yes	Yes	Closed as part of repurposing of wards for COVID
RGH Ward 9	15.21	8.53	Yes	15.21	8.53	Yes	Yes	No		Yes	No	

Appendix B: Summary of Required Establishment

Health board/trust:	Name: Cwm Taf Morgannwg UHB	
Period reviewed:	Start Date: 6th April 2019	End Date: 5th April 2020
Number of wards where section 25B applies:	Medical: 15	Surgical: 15

To be completed for EVERY wards where section 25B applies

***Supernumerary i.e. 1 WTE supernumerary ward sister/charge nurse included in the establishment**

Medical Wards Princess of Wales Hospital

Ward	Required Establishment at the start of the reporting period (as at April 6 th 2019)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (as of April 5 th 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
PoW Ward 2	20.07	13.62	Yes	24.83	24.04	Yes	Yes	No		Yes	Yes	Repurposed to a COVID medical ward. Resulting in Ward 2 & Ward 4 combining to create 37 COVID beds
PoW Ward 4	28.24	13.62	Yes	24.83	24.04	Yes	Yes	No		Yes	Yes	Repurposed to a COVID medical ward. Resulting in Ward 2 & Ward 4 combining to create 37 COVID beds
PoW	23.79	13.62	Yes	14.83	6.74	Yes	Yes	No		Yes	Yes	Repurposed to create a non-

Ward 5												AGP respiratory COVID ward. Reduced workforce as reduced bed capacity.
PoW Ward 6	22.28	13.62	Yes	16.89	11.13	Yes	Yes	No		Yes	Yes	Part of repurposing of wards during COVID. Reduced bed capacity as 'gastro day unit' not being utilised.
PoW Ward 20	20.07	13.62	Yes	20.07	13.62	Yes	Yes	No		No	No	

Ward	Required Establishment at the start of the reporting period (as at April 6 th 2019)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (as of April 5 th 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
PCH Ward 2	20.9	14.21	Yes	20.9	14.21	Yes	Yes	No		No	No	
PCH Ward 7	15.22	17.06	Yes	20.9	14.21	Yes	Yes	Yes	In November 2019. Ward 7 became a Rehabilitation medical ward therefore it was removed from Section 25B	Yes	Yes	Remained outside of S.25B but during COVID was repurposed to a palliative and rehabilitation post COVID ward.
PCH Ward 9	20.9	14.21	Yes	20.9	19.9	Yes	Yes	No		No	No	
PCH Ward 10	20.9	17.06	Yes	20.9	17.06	Yes	Yes	No		No	No	
PCH Ward 11	20.9	14.21	Yes	20.9	14.21	Yes	Yes	No		No	No	
PCH Ward 12	23.74	17.06	Yes	23.74	17.06	Yes	Yes	No		No	No	

Medical Wards Prince Charles Hospital

Ward	Required Establishment at the start of the reporting period (as at April 6 th 2019)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (as of April 5 th 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
RGH Ward 12	20.9	19.9	Yes	20.9	19.9	Yes	Yes	No		No	No	
Ward 14	20.9	19.9	Yes	20.9	19.9	Yes	Yes	No		No	No	
Ward 19	20.9	19.9	Yes	20.9	19.9	Yes	Yes	No		No	No	
Ward 20	20.9	19.9	Yes	20.9	19.9	Yes	Yes	No		No	No	

Medical Wards Royal Glamorgan Hospital

Appendix: Summary of Required Establishment

Health board/trust:	Name: Cwm Taf Morgannwg UHB	
Period reviewed:	Start Date: 6 th April 2020	End Date: 5 th April 2021
Number of wards where section 25B applies:	Medical: 17	Surgical: 11
	PCH – 2,7,9,10,11,12 PoWH- 4, 5, 6, 7, 8,11 RGH – 12,14,15,19,20	PCH – 5, 6, 8 PoWH- 18,19, 20, BC RGH – 2, 9,10,11

Prince Charles Hospital - Medical Wards

Ward	Required Establishment at the start of the reporting period (as at April 6 th 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (as of April 5 th 2021)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made July 2020			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
Ward 2	20.9	14.21	Yes	20.9	14.21	Yes	Yes	No		No	No	Note – ward has redefined within Covid RAG system several times during this report
Ward 3	40.8	90.96	Yes	23.74	17.06	Yes	No	No	Repurposed during COVID to create a COVID respiratory High care CPAP/NIV ward	No	No	Still defined as a mixed acute medical/ COVID high care respiratory area
Ward 4	91.96	45.48	Yes	NA	NA		No	No	Repurposed to ITU – sits outside section 25B			
Ward 7	20.9	14.21	Yes	20.9	14.21	Yes	No	No	At the beginning of the reporting period, the ward was Rehabilitation medical ward	No	No	Repurposed as COVID-19 palliative and Rehab post COVID ward, repurposed again on the 20/10/20 to Red pathway, then changed to Amber on 3/2/21 and ward closed on 23/2/21
Ward 9	20.9	14.21	Yes	20.9	14.21	Yes	Yes	No		No	No	Ward repurposed to Amber pathway, repurposed on the 28/1/21 to Medical ward Gastro – ward moved from ward 8
Ward 10	20.9	17.06	Yes	20.9	17.06	Yes	Yes	No		No	No	Ward repurposed to Red pathway on 8/12/20 and Amber 20/1/21
Ward 11	20.9	14.21	Yes	20.9	14.21	Yes	Yes	No		No	No	Ward repurposed to Amber pathway 15/12/20
Ward 12	23.74	17.06	Yes	23.74	17.06	Yes	Yes	No		No	No	Ward is an (contacts) amber pathway 18.12.21.

Princess of Wales Hospital - Medical wards

Ward	Required Establishment at the start of the reporting period (as at April 6 th 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (as of April 5 th 2021)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made July 2020			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
Ward 2	24.83	24.04	Yes				No	No	Previously was repurposed in April 2020 to COVID medical ward combined with Ward 4 to create a 37 bedded area	No	No	Repurposed to a Acute Medical Unit – Removed from section 25B
Ward 4	28.24	13.62	Yes	28.24	13.62	Yes	Yes	No	Returned from being a combined ward with ward 2	No	No	Ward 2 stroke moved from Ward 4 to ward 5 on 7/7/20. Ward 4 to return to it originally function
Ward 5	14.83	6.74	Yes	20.07	13.62	Yes	Yes	No	Ward from respiratory AGO COVID ward to surgical ward in Sep 2020.	No	No	Ward repurposed to stroke and rehab ward and Amber pathway (ward 2- 21/2/21 establishment as ward 2 meets this requirement as they had 22 beds) CLEAN/cold admissions
Ward 6	16.89	11.39	Yes	20.7	13.62	Yes	Yes	No	Repurposed During 1 st wave of COVID – beds reduced as 'gastro day unit' not being unitised- Ward repurposed in September 2020 to a T&O, with surgical patients	No	No	Ward 6 moved to ward 8 in 9/2020 with the same establishment requirements. Ward returned to medical Gastro ward with it original staffing levels
Ward 7	35.65	16.96	Yes	20.07	13.62	Yes	Yes	No	During the 1 st Wave of COVID -19 ward 7 and * were repurposed to create a high care Respiratory Unit (CPAP and NIV) Ward 7 was repurposed in September 2020 to a Stroke Ward. Ward 8 Was repurposed to a Gastro ward	No	No	Ward 20 has relocated to ward 6 on the 7/7/2020, Repurposed to a Covid-19 Amber pathway, then relocated with the whole team to Ward 7 in Feb 2021

Ward 8	36.65	16.96	Yes	20.07	13.62	Yes	Yes	No	Ward 8 moved to ward 19 week of 15/2/21	Yes	Yes	Ward 19 –Will become Acute Frailty (the Ward 19 team will move to this ward – again establishment is correct from this team for this ward) clean/cold admissions has been relocated to in January 2021, Care of elderly, ward 8 Covid Amber Pathway
Ward 9	20.07	13.62	Yes	24.52	13.62	Yes	Yes	No	In April 2020 the ward was closed as part of repurposing of wards due to COVID. Repurposed to receive Respiratory high care patients (NIV/Optiflow/CPAP) - Sits outside Section 25B wards	No	No	Previously the accepted T&O patients, ward and Staff all moved to ward 19 (Sep 2020)
Ward 11	16.46	11.61	Yes	16.34	10.9	Yes	Yes	No	Ward 11 – Mixed Surgical/medical ward moved to ward 5 in Sep 2020, then was moved again to Ward 20 in Feb 2021	Yes	Yes	Repurposed to make a Covid recovered and clean respiratory AGP Sep 2020
Ward 20	20.07	13.62	Yes	20.07	13.62	Yes	Yes	No	Ward 2 moved to ward 20 in October 2020 then moved to ward 5 on 21/2/21	No	No	Ward 7 team has been relocated to ward 5 then to ward 19 moved on 25/1/21 then moved to ward 20 in 21/2/21- Surgical Admission

Royal Glamorgan Hospital – Medical wards

Ward	Required Establishment at the start of the reporting period (as at April 6 th 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (as of April 5 th 2021)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made July 2020			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
Ward 4			Choose an item.	20.9	19.9	Yes	No	No	Ward 4 was not a section 25B in April 2020	Yes	No	Ward 14 and their staff were relocated to this ward but moved back to ward 20 on the 11/1/21. On the 1/3/21 Ward returned to AMU – outside section 25B
Ward 12	20.9	19.9	Yes	20.9	19.9	Yes	Yes	No		No	No	
Ward 14	20.9	19.9	Yes	20.9	19.9	Yes	Yes	No	Ward was repurposed to create a mixed surgical/Medical ward- Staffing level remained the same.	No	No	Ward 14 and their staff have been relocated several times during the this reporting period (Ward 4 and Ward 20), but have returned to Ward 14 on 1/3/21
Ward 15			Choose an item.	20.9	19.9	Yes	No	No		Yes	Yes	Repurposed from elderly Rehabilitation to Red COVID admission area during COVID October 2020
Ward 19	20.9	19.9	Yes	20.9	19.9	Yes	Yes	No		No	No	
Ward 20	20.9	19.9	Yes	20.9	19.9	Yes	No	Yes		No	No	Ward closed 25/11/20 Ward 20 moved to ward 11/1/21 and ward 4 (14) moved to ward 20.

Appendix: Summary of Required Establishment

Health board/trust:	Name: Cwm Taf Morgannwg UHB	
Period reviewed:	Start Date: 6 th April 2020	End Date: 5 th April 2021
Number of wards where section 25B applies:	Medical: 17	Surgical: 11
	PCH – 2,7,9,10,11,12 PoWH- 4, 5, 6, 7, 8,11 RGH – 12,14,15,19,20	PCH – 5, 6, 8 PoWH- 18,19, 20, BC RGH – 2, 9,10,11

Prince Charles Hospital - Surgical Wards

Ward	Required Establishment at the start of the reporting period (as at April 6 th 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (as of April 5 th 2021)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made July 2020			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
Ward 5	20.9	14.21	Yes	20.9	14.21	Yes	Yes	No		No	No	
Ward 6	20.9	14.21	Yes	20.9	14.21	Yes	Yes	No		No	No	
Ward 8	20.9	14.21	Yes	20.9	14.21	Yes	Yes	No		No	No	At the start of the report the ward was defined as medical ward, repurposed from Red to Amber pathway. On the 28/1/21 repurposed to T&O ward moved from ward 9

Princess of Wales Hospital – Surgical Ward

Ward	Required Establishment at the start of the reporting period (as at April 6 th 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (as of April 5 th 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made July 2020			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
Ward 10	20.07	13.62	Yes	NA	NA				Ward was repurposed to create additional Critical care capacity for COVID			
Ward 11	13.62	6.38	Yes	13.62	11.9	Yes	Yes	No	Repurposed/reduced capacity and therefore Staffing levels were temporary were reduced during COVID- ward moved to 7.	Yes	Yes	Repurposed COVID recovery and clean Respiratory AGP October 2020
Ward 18	20.07	13.62	Yes	20.07	13.62	Yes	Yes	No		No	No	Previous the ward and staff were on Ward 10 - Ward 18 was repurposed as T&O ward 23/9/2020
Ward 19				20.07	13.62	Yes	Yes	No	Ward 9 (T&O) and the staff were moved in 23/9/2020 Repurposed to make a Surgical ward and T&O	No	No	
Bridgend Clinic				11.9	2.72	Yes	Yes	No	Repurposed from a Private patient ward to a general Surgical / Gynae ward	No	No	

Royal Glamorgan Hospital – Surgical Wards

Ward	Required Establishment at the start of the reporting period (as at April 6 th 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (as of April 5 th 2021)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
Ward 1	12.37	8.53	Yes	17.19	11.37	Yes	Yes	Yes	Ward increased its capacity to 28 beds to accept COVID admission. Ward closed for Refurbishments	No	No	Ward Reopened 23/11/20- repurposed to a COVID ward awaiting results
Ward 2	20.9	19.9	Yes	17.91	11.37	Yes	Yes	No	Ward was a mixed Surgical/medical ward	No	No	Ward repurposed to a COVID ward awaiting results 26/2/21
Ward 3	20.9	19.9	Yes	N/A	N/A	Yes	Yes	No	Ward repurposed to Acute Medical Unit- sits outside Section 25 B wards			
Ward 5	20.9	17.06	Yes	N/A	N/A	Yes	Yes	No	Ward closed 23/11/20			
Ward 6	NA	NA	NA	20.9	17.06	Yes	Yes	No	Ward was AMU (not in Section 25B) Ward 2 moved 20/11/20	No	No	Ward 6 was on ward 5 from 23/10/2020 until it was repurposed to COVID Red
Ward 7	20.9	19.9	Yes	N/A	N/A	Yes	Yes	No	Ward closed 25/4/20 and reopened for ITU use- sits outside section 25B wards			
Ward 8	20.9	19.9	Yes	20.9	19.9	Yes	Yes	Yes	Ward closed on 23/3/20 as part of COVOD repurposing plans	No	No	Ward has moved and been repurposed several times moved to Ward 2 in Oct 2020, ward closed on 23/11/20 and the ward was moved to Ward 6, then moved to Ward 8 10/1/21
Ward 9	15.21	8.53	Yes	20.9	14.2	Yes	Yes	No		Yes	Yes	Temporary increased Capacity during COVID October 2020
Ward 11				17.06	14.21	Yes	Yes	No	Ward 11 was previously maternity ward	Yes	Yes	Surgical planned elective

Appendix B: Health board/trust reporting template

Health boards/trusts are advised to use this template when submitting their annual report to Board. Health boards/trust may include additional information as part of their report as determined by the organisation.

Health board/trust reporting template	
Health board	Cwm Taf Morgannwg University Health Board. Report for previous Cwm Taf University Health Board Prince Charles Hospital (PCH) and Royal Glamorgan Hospital (RGH) wards.
Reporting period	January 2019 - March 2019
Requirements of Section 25A	A triangulated approach is used to calculate nurse staffing levels, utilising three sources of information to determine the required nurse staffing level. In this situation the information triangulated is both qualitative and quantitative in nature. The triangulated approach must include: • Patient acuity - using the evidence-based workforce planning tool (Welsh Levels of Care) to determine the nurse staffing level that will meet all reasonable requirements of care. The aging population of the UK contributes to a higher level of acuity seen within our wards. The higher the acuity of patients the more at risk they are of developing pressure ulcers and falling – both of which are reported to Welsh Government as quality indicators. The increased level of acuity on wards requires a greater number of nursing staff to safely manage the clinical area, sensitively care for the patients and provide one to one nursing care or increased levels of observation to maintain safety. Increasing numbers of patients require total care – from feeding and drinking, through to high level emergency specialised support with responses to the rapidly deteriorating patient. • Professional judgement – the Head of Nursing in conjunction with each ward sister working within an adult acute medical or surgical ward and senior nursing



team using their knowledge of the clinical area plus the evidence from the acuity data to make an informed decision.

- **Quality indicators** - Part of the triangulated approach involves considering those quality indicators that are particularly sensitive to care provided by a nurse. To reduce the burden of measurement, quality indicators that have an established data source should be used and the Act advises the designated person to consider the following quality indicators as these have been shown to have an association with low staffing levels:
 - **Patient falls** - any fall that a patient has experienced whilst on the ward
 - **Pressure ulcers** - total number of hospital acquired pressure ulcers judged to have developed or shown to have deteriorated while a patient on the ward; and
 - **Medication errors** - any error in the preparation, administration or omission of medication by nursing staff (this includes medication related never events).

Cwm Taf University Health Board can demonstrate the robust input professionals have had in documenting the information collected which informed the decision on the calculation template for each adult acute medical and surgical ward. This process is :

- The Registered Nurse participates in continuous acuity data collection. Each patient's acuity score is recorded on the Patient Status Board.
- The Ward Sister/Charge Nurse manages and monitors the accuracy and reliability of the data, and considers the data required for triangulation.
- The Senior Nurse signs off the acuity data as accurate and ensures the appropriate level of triangulation of data. The Senior Nurse also recommends the nurse staffing level needed to provide safe and sensitive care.
- The Head of Nursing (supported by the Assistant Director of Nursing) is responsible for ensuring the process described above is followed and makes the final recommendation of the staffing levels to the Executive Director of Nursing.



- This whole process is supported by senior colleagues from Workforce and OD and Finance.
- The Executive Director of Nursing (as Designated Person), along with the Director of Finance and Chief Operating Officer consider the evidence provided and determines the nurse staffing levels required for the organisation (under Section 25C) and presents this information and evidence to Board.

Financial Year 2018/2019

Date annual report on the nurse staffing level submitted to the Board

January 2019

Number of adult acute medical inpatient wards where section 25B applies

Medical Wards

Ward	RN Establishment	HCSW Establishment
RGH Ward 12	20.9	19.9
RGH Ward 14	20.9	19.9
RGH Ward 19	20.9	19.9
RGH Ward 20	20.9	19.9
PCH Ward 2	21.4	14.2
PCH Ward 9	20.9	14.2
PCH Ward 10	22.9	25.6
PCH Ward 11	20.9	14.2
PCH Ward 12	23.7	17.1

Wards excluded

RGH Ward 15 – orthopaedic rehab ward

RGH AMU – Medical Admissions ward

**Number of adult acute surgical inpatient wards where section 25B applies****Surgical Wards**

Ward	RN Establishment	HCSW Establishment
RGH Ward 1	12.37	8.53
RGH Ward 2	20.90	17.06
RGH Ward 3	20.90	17.06
RGH Ward 7	15.21	11.37
RGH Ward 8	22.90	15.81
RGH Ward 9	15.21	8.53
PCH Ward 3	18.06	14.21
PCH Ward 4	20.90	14.21
PCH Ward 6	20.90	14.21
PCH Ward 7	20.90	14.21
PCH Ward 8	20.90	14.21

Wards excluded

RGH Ward 5 – short stay ward

PCH Ward 5 – short stay ward

Number of occasions where nurse staffing level was recalculated in addition to the bi-annual calculation

A recalculation has been undertaken to confirm the nurse staffing levels for PCH Ward 10. The recalculation was necessary as this is a complex ward including Hyper Acute, Acute and Rehab stroke beds. The intention to undertake the recalculation was reported to Exec Board in November 2018. The recalculation focussed particularly on confirming the number of therapy Healthcare Support Workers required.



Prior to the recalculation the recommended safe staffing levels were as per the above table, 22.9 RNs (including 2 stroke specialist nurses) and 25.6 HCSWs (including 8.53 dedicated to therapy support).

Following the review the number of RNs required remain unchanged, but the number of HCSWs has been revised to 19.9. This change has been implemented with effect from March 2019. This review was undertaken with the full involvement of the Ward Sister, Senior Nurse and Head of Nursing.

It is further intended to review the establishments on PCH ward 7 which has recently and temporarily been re-designated as a discharge ward, this review will be undertaken through April 2019.

The process and methodology used to inform the triangulated approach

As outlined in the Nurse Staffing Act Operational Guidance (appendix 5) the record of triangulated approach to review nurse staffing levels is used.

This includes the Ward Sister holding Supernumerary Status and an uplift of 26.9% on the nurse staffing calculation.

Informing patients

- The University Health Board is informing patients of the nurse staffing levels, and date of agreement, on information boards at the entrance to wards. The All Wales Template is being used and this complies with Welsh Language requirements.
- Frequently Asked Questions information leaflets are also available.

Section 25E (2a) Extent to which the nurse staffing levels are maintained



Process for maintaining the nurse staffing level

At time of writing this report the total vacancy factor is PCH Registered Nurses 38.59 WTE and HCSW, no vacancies. RGH Registered Nurses is 59.35 WTE and HCSW 16.19 WTE.

All reasonable steps are being taken to maintain the approved staffing levels:

- Active recruitment in a timely manner;
- Working with our University of South Wales Colleagues to promote our sites to student nurses;
- Supporting overseas MSc students;
- Supportive monitoring and management of nurses who are absent from work, including implementation of the new All Wales Managing Attendance Policy and well-being at work strategies;
- Working with on-contract nursing agencies to block-book;
- Supportive approach to flexible working and flexible roster patterns; and
- Monthly Workforce reviews.

In addition the operational steps taken are outlined below.

Process for monitoring the nurse staffing level

- The nurse staffing levels are recorded and reviewed three times a day at the safety huddles led by the Head of Nursing and attended by the Senior Nurses and Bed Management Team. Where there is a variation in staffing from the agreed Nurse Staffing Act Levels, approved by Board in January 2019, the reason for this is recorded. If there is a deficit of nurse staffing, the reasonable steps taken to address the staffing level by the Senior Nurse and HoN is also recorded. This could include moving staff from other areas but this would only be done following risk assessment of all areas. The information is stored on an excel spreadsheet and it is this information that is used to inform our response to Section 25E (2b), impact on care of not maintaining the nurse staffing levels.
- Staff are supported to escalate concerns and use the datix reporting process.



- The Assistant Director of Nursing is currently working with the Heads of Nursing to develop a specific risk assessment tool to ensure any decision making on the movement of staff is robust and transparent. We would expect to implement this tool following ratification at our Nursing Workforce and Staffing Act meeting on the 17th April 2019.

Section 25E (2b) Impact on care of not maintaining the nurse staffing levels

Patient harm incidents (i.e. nurse-sensitive Serious Incidents /Complaints)	Total number of closed serious incidents/complaints during last reporting period	Total number of closed serious incidents/complaints during current reporting period.	Increase (decrease) in number of closed serious incidents/complaints between reporting periods	Number of serious incidents/complaints where failure to maintain the nurse staffing level was considered to have been a factor
☐ Hospital acquired pressure damage (grade 3, 4 and unstageable).	2 incidents 0 complaints	3 incidents 0 complaints	Increase by 1	This was not considered to be a factor in these cases.
☐ Falls resulting in serious harm or death (i.e. level 4 and 5 incidents).	0 incidents 0 complaints	0 incidents 0 complaints	N/A	N/A
☐ Medication related never events.	0 incidents	0 incidents	N/A	N/A
☐ Complaints about nursing	N/A	N/A	N.A	N/A



care resulting in
patient harm (*)

(*)This information is
not required for
period 2018/19

Section 25E (2c) Actions taken if the nurse staffing level is not maintained

Actions taken

The Safety Huddles led by the Heads of Nursing ensure that all reasonable steps and mitigating actions have been taken, these include:

- Access and availability of temporary staff, bank and agency;
- Block booking of agency staff;
- Moving staff from other areas – this is risk assessed on a shift by shift basis and a new tool to monitor this practice is in development;
- Ensuring the e-roster has been scrutinised and signed off by the Senior Nurse;
- The Ward Sister or Senior Nurse working within the numbers; and
- Deep dives are undertaken to ensure patient care pathways are being monitored.

Through this period, it has not been an option to consider the closure of beds given the winter pressures escalation level and risk to patient care and safety at the “front door”.

Next steps

- The UHB is introducing an implementation plan for all three acute sites where the Act currently applies. This includes the development of an Escalation Plan. There will be ongoing review of this plan on a monthly basis through the Nursing Workforce and Staffing Act Meeting.
- There is continuous data capture at PCH and RGH – this needs to be in place in POW.
- The UHB needs to ensure the robustness and transparency of the Senior Nurse review of all relevant clinical incidents and concerns by reviewing the staffing levels, and the likely impact of the nurse staffing level on the incident / concern.



- This agenda is challenging with the current number of nurse vacancies.

Appendix C	Annual Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act
Health board	Cwm Taf Morgannwg UHB
Date annual assurance report with compliance with the Nurse Staffing Levels (Wales) Act is presented to Board	September 2020 (Deferred from May 2020)
Reporting period	The reporting period is 6th April 2019 -5th April 2020.
Requirements of Section 25A Section 25A refers to the Health Boards/Trusts overarching responsibility to ensure appropriate nurse staffing levels <u>in any area where nursing services are provided or commissioned, not only adult medical and surgical wards.</u>	In addition to the above general principles, there are some specific issues to note in relation to the progress made within the Health Board over the past 12 months and which relate to the individual work streams of the All Wales Nurse Staffing programme: Paediatric In-patient Work stream: In December 2019, the Health Minister announced plans to extend the Nurse Staffing Levels (Wales) Act 2016 to include paediatric inpatient wards. Within CTM UHB a Paediatric In-patient sub-group has been in place since June 19 and a detailed Implementation Plan has been developed. Regular update reports to Management Board have been provided with the aim of ensuring Organisational readiness at the time of commencement of the extension to the Act to paediatric inpatient wards. A letter received by the Chief Nursing Officer (CNO), dated 24th March 2020, provided Nurse Directors with clarity and assurances around the CNO's expectations around the covid-19 pandemic and in relation to the extension of the Act to include paediatric inpatient wards, the CNO confirmed that: Thus far, the provisional schedule for this work has been as follows: • June to August 2020: 3 month public consultation on the draft regulations and amended statutory guidance; • November 2020: regulations laid before the Senedd; • December 2020: Senedd debate and presumptive passing of regulations; • April 2021: Coming-into-force date of regulations on paediatric inpatient wards.

- The timetable of those processes is now clearly compromised. In terms of the legislative steps, the capacity to undertake the drafting requirements is still available within Welsh Government.
- We intend to reschedule the plenary debate to February 2021, allowing the consultation to take place later in 2020, several months after the projected peak of COVID19 activity.
- April 2021 now appears to be entirely unfeasible as a coming-into-force date. Given the current timescales, it is a fair assumption that Health Boards will require approximately 12 months of preparation time under normal circumstances before the regulations could come into force. In the context of this work stream, I consider *normal circumstances* to be suspended.
- However a final decision on a coming-into-force date won't need to be made until the regulations are laid before the Senedd in early 2021.
- The second planned data capture around compliance with the interim paediatrics principles is due this coming May has been postponed until November, pending any further developments.

District Nursing Work stream:

During 2020/21, CTMUHB has provided 6 monthly progress reports on compliance with the Chief Nursing Officer (CNO) and Nurse Directors' interim nurse staffing principles for district nursing. The fifth collection exercise against the district nurse principles that was undertaken in January 20 demonstrates that CTMUHB is making good progress against the principles. The follow up letter to the Health Board from the CNO highlighted the following:

- CTMUHB's performance against the core principles remains very strong with full compliance against principles 2 and 3.
- Principle 4 and 5 are over 90% (it is not expected to achieve 100% return on these principles due to staff turnover).
- For principle 7, CTMUHB are reporting an average of 24.21% uplift across the Organisation, which is a very strong position to build upon. The exercise highlighted that the variation continues between the 'old Cwm Taf' and the Bridgend teams and it would be good to see the gap close between them in time.

	• Principle 8 regarding improving administration support has seen progress overtime, and it is hoped to see this improvement continue going forward. Under section 25A Staffing levels for all inpatient wards across the Health Board have been calculated to ensure that they can provide the level of care required for the patients within that area. During March and April 2020 this has been a dynamic process which was reviewed twice weekly via the Bronze meetings within each Locality Group and decision making logs have been used to document decisions made at each meeting. Staffing levels have been agreed and if required adjusted to meet clinical model and patient acuity. The Executive Nurse Director has determined that a review of nurse staffing levels across all clinical areas across all settings where nursing care is either provided and or commissioned in line with the requirement in Section 25A provides assurance that the principles behind the Act are considered. Since February 2020 staffing levels are reviewed, calculated by Locality Group Nurse Directors and reported via Nursing and Midwifery Workforce meetings. During March 2020 any areas that provide nursing care or commissioned areas that have been repurposed due to COVID-19 have been by have been calculated accordingly and reported via CTM UHB Executive Management Board meetings.
Actions taken in relation to calculating the nurse staffing level on section 25B wards during the reporting period. • Adult acute <u>medical</u> inpatient wards • Adult acute <u>surgical</u> inpatient wards	The nurse staffing levels for 29 adult medical and surgical wards where section 25B applies were presented to the Board in November 2019. Due to the impact of COVID-19 in March and in response to the guidance issued by the Chief Nursing Officer and in acknowledgement of the need for Health Boards/Trusts to agree a 'Once for Wales approach' the Nurse Directors agreed to postpone presenting their Annual Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act, which was due to be presented to their Board in May, until September 2020 Between March 20 and 05/04/2020, 14 of the 29 Section 25B wards presented to the Board in November 2019 were repurposed due to covid-19.

The CNO letter, dated 24th March 2020, provided clarity and assurances around the adult medical and surgical ward workstream and confirmed that “*adult medical and surgical wards that have been repurposed as novel wards to deal with the Covid19 pandemic would be considered an exception under the definition of an adult medical ward, therefore would not be subject to the prescribed triangulated calculation methodology*”. However as some wards were not repurposed for COVID-19 until the final month of this reporting period Appendix B provides a summary of the required establishment for wards where S.25B was applicable for the majority of the reporting period and any repurposed wards due to COVID-19 have been highlighted in Appendix B.

The Health Board has implemented new ways of working and models of care in order to respond and meet the extreme and unprecedented pressures that the Organisation experienced at the end of this reporting period in March/April 2020. This required an extremely flexible approach to the deployment of the nursing workforce across the Health Board site and some wards were repurposed more than once to accommodate the clinical demands.

Appendix A provides the detailed nurse staffing level for the 29 wards where Section 25B applies, together with the rationale and outcome of the review processes undertaken during 2019/20, both as part of the bi-annual calculation cycle and, where it has been deemed necessary, outside of that cycle.

Following the acuity audit undertaken in June 2019 as part of the bi annual recalculation process, wards that are under Section 25B were reviewed in order to ensure the calculation of the nurse staffing levels using the prescribed methodology. Following this, there were no changes required to the staffing levels on these wards.

In November 2019 Ward 7 in Prince Charles Hospital changed speciality and therefore its clinical model. The ward, which was a busy acute adult surgical ward became an adult medical ward focusing on rehabilitation for patients with low acuity. Due to this change this ward was removed section 25B of the Act. During the end of this reporting period March 2020 some wards under

	Section 25B were repurposed due to COVID-19. At each point of the recalculation using the triangulated approach was undertaken and the all Wales workforce planning tool was used to Record the triangulated approach to the nurse staffing level review each time. Within CTMUHB, following the acuity audit undertaken in January 2020 as part of the bi annual recalculation process, wards that are under Section 25B were reviewed in order to ensure the calculation of the nurse staffing levels using the prescribed methodology. Following this process no changes were made to the existing, agreed establishments. However, since this, many of these wards have been required to temporarily revise their establishments due to COVID 19. In March 2020 The Chief Nursing Officer emphasises the needs for Health Boards/Trusts to ensure that they keep a record of the actions taken during the COVID-19 pandemic. Processes for collating this information and actions taken should be reflected within the pending Board paper and in the paper due to be presented to the Board in September 2020, as this information will required within the three yearly report to Welsh Government.
Using the triangulated approach to calculate the nurse staffing level on section 25B wards	The triangulated methodology prescribed in the NSLWA as the required approach to calculating the nurse staffing levels for each ward has become embedded during 2019/20 as a routine, 6-monthly cycle that is undertaken with the nursing teams responsible for each ward within Section 25B. The nursing team's access the data they are required to take account of within this methodology is obtained via the IT performance reporting system 'Qlik Sense' The system provides information relating to patient flow, patient acuity and care quality metrics in a single report that is readily accessible to Ward Managers, Heads of Nursing and ILG Nurse Directors. The monitoring of nurse sensitive indicators are monitored by the Locality Group Nurse Directors via Quality & Safety governance reviews and reporting mechanisms.

Informing patients	The statutory guidance (Appendix C) states that “<i>LHBs and Trusts must make arrangements to inform patients of the nurse staffing level</i>” (paragraph 20). The CTMUHB Internal Audit Department conducted a review of the Health Board’s compliance with the NSLWA during 2019/20 and reported that the Board could be reasonably assured in relation to its compliance with the NSLWA. The Internal Audit report recommended further actions related to the statutory requirements to inform patients of the nurse staffing levels by ensuring that the most up to date information is displayed on wards in relation to the staffing levels agreed by Board, this included ensuring the staffing numbers were in line with agreed workforce planning Template. Following this report and to ensure full compliance, further actions have been taken during 2019/20 to ensure that a robust system is in place to ensure that the approved template to display the Nurse Staffing Level for each ward is refreshed and reissued as soon as the Board has been formally notified, by the Executive Director of Nursing, of the nurse staffing level that has been agreed for each Section 25B ward. These templates have been updated during COVID-19 March/April 20 as and when a ward has been repurposed.

	Section 25E (2a) Extent to which the nurse staffing levels are maintained
The extent to which the nurse staffing levels have been maintained	When the second duty of the Nurse Staffing Levels (Wales) Act 2016 (the Act) came into force in April 2018, there was no consistent solution to extracting all of the data explicitly required under section 25E, and Health Boards were using a variety of e-rostering and reporting systems. During the reporting period 2019/20, all health Boards/Trusts in Wales have been working as part of the All Wales Nurse Staffing Programme to develop a consistent approach to capturing quantitative data on a daily basis (in lieu of a single ICT solution) to enable each organisation to demonstrate the extent to which the nurse staffing levels across the health board have been maintained in areas which are covered by Section 25B/C of the Act. For the 2019/20 annual report, this Health Board, together with all other Health Boards/Trusts in Wales is providing narrative to describe the extent to which the nurse staffing levels have been maintained in order to meet its statutory reporting requirement under Section 25E of the Act. For the 2020/21 reporting period, it is anticipated that this section of the annual report will contain quantitative data for part of the year at least. This data, once available for every Health Board in Wales, will be presented by all Health Boards in a consistent manner. The anticipated solution from July 2020 is for enhancements to the existing Health and Care Monitoring System to enable to collection of 'planned roster compliance' data on a daily basis It is the responsibility of the Sister/Charge Nurse to ensure effective roster management and deployment of the nursing staff within the required establishment of their wards. It is the responsibility of the Senior Nurse to sign off the planned roster to authorise and confirm that it reflects an appropriate deployment of the nurse staffing resource that sits within the establishment for each ward. The monthly Nursing and Midwifery Workforce group continues to be the forum for strategic action to improve this position. Key performance indicators for this work stream are focused on

	effective rostering, efficiency of the temporary staffing office, recruitment activities and the retention of staff including staff well-being. In June 2019, the Health Board commenced its Registered Nurse overseas nurse recruitment campaign to bring 216 wte nurses from India into the three acute hospital sites by September 2020. By March 2020 86 nurses had landed due to COVID-19 the monthly landings has been placed on hold, however the recruitment for the remaining 130 nurses is due to recommence on September 2020 with 30 nurses scheduled to arrive per month. There are also 61 wte RNS coming into post in September 2020 from Student Streamlining. Towards the end of this reporting period and as response to COVID-19 a “call to arms” bank recruitment initiative was undertaken in March 2020 and has yielded additional Registered nurses and over 300 Health Care Support Workers (HCSW) were employed into the Health Board.
Process for maintaining the nurse staffing level	There are well embedded processes within the nursing structures on each of the acute sites for reviewing staffing levels operationally on a daily basis and for making operational, risk-based decisions about the deployment of staff via the bed/staffing meetings. During 2019/20, nursing teams have introduced the use of the patient acuity data being captured on a daily basis for all Section 25B wards across the Health Board to inform these operational decisions relating to staff deployment. Each Directorate continues to monitor the staffing situation daily and ensure that clinical areas manage the risk where there are any staffing deficits.

Monitoring and reporting of the daily staffing levels has been undertaken informally across the Health Board since April 2019. However from January 2020 in line with decisions made at all Wales level, the Health Board is to commence formally recording the nursing staffing levels on each of the wards per day and the mitigating actions taken in order to maintain the nurse staffing levels on ward areas.

The Nursing Staffing Levels (Wales) Act (2016) Operating Framework and Escalation Policy for CTMUHB (Appendix D) was produced in March 2020. The purpose of this Operating Framework is to support the calculation and maintenance of nursing staffing levels in Adult Acute Medical and Surgical Wards and the actions that are taken to review, record and escalate where nurse staffing levels are not maintained.

Within the Acute Hospitals staffing levels are reviewed three times a day and if required staff are deployed accordingly using All Reasonable Steps (Appendix E) together with professional judgement to draw on information at a local and national level to inform their decision as to the appropriate staffing levels required.

The All Wales Directors of Nursing have agreed, and through the All Wales Nurse Staffing programme group have issued, further clarification on what constitutes the 'All Reasonable Steps' which are statutorily required to be taken in order to maintain the nurse staffing levels at the calculated levels. This document has been in place within CTMUHB since November 2019.

Table 1		Section 25E (2b) Impact on care due to not maintaining the nurse staffing levels			
		The below data relates to care that patients received between 6th April 2019- 5th April 2020.			
Patient harm incidents (i.e. nurse-sensitive Serious Incidents /Complaints)	1) Total number of closed serious incidents/complaints during <u>last</u> reporting period (March 18 - April 19)	2) Total number of closed serious incidents/complaints during <u>current</u> reporting period. (April 19 - March 20)	3) Total number of serious incidents/complaints not closed and to be reported on/during the <u>next</u> reporting period	4) Increase/decrease) in the number of closed serious incidents/complaints between reporting periods	5) Number of serious incidents/complaints where failure to maintain the nurse staffing level was considered to have been a factor
Hospital acquired pressure damage (grade 3, 4 and unstageable).	27	27	0	No change	0
Falls resulting in serious harm or death (i.e. level 4 and 5 incidents).	24	37	27	Increase	0
Medication related never events.	0	3	1	Increase	0
Complaints about nursing care	9	21	3	Increase	0

Section 25E (2c) Actions taken if the nurse staffing level is not maintained	
Actions taken when the nurse staffing level was not maintained	For this reporting period there have not been any of the incidents where not maintaining the planned nurse staffing level was deemed to have contributed to the incidents. It should be noted however, that as yet, it is not possible to draw any cause/effect conclusions about any trends from the small numbers of serious incidents provided in this report, this will require several further data sets to be available. Anecdotal feedback from discussion with the Ward Managers does, at times reference that an incident occurred whilst there was a deviation from the planned roster, however it has not been recorded as a direct result of insufficient staffing levels. All of the incidents and complaints included in this report have been reviewed by the Acute Hospital's Head of Nursing via their internal weekly scrutiny meetings to assess if the nurse staffing levels were maintained at the relevant time, and if not, whether failure to maintain the nurse staffing level contributed to any harm suffered by the patient but also to determine whether there are any other lessons to be learnt from the incidents that can be shared. There are a range of both short and long term actions being taken by the Health Board in an attempt to improve the extent to which a sufficient workforce is available to work within the Registered Nurse and Health Care Support Worker posts on both Section 25B wards and across the wider nursing services. These include: • The schemes being led by the Workforce and Organisational Development teams and Corporate Nursing to develop and implement innovative approaches to recruitment of Registered Nurses as well as new Health Care Support Workers. • Continue to progress the overseas Registered Nurse campaign including the uplift of Practice Development Nurses to support this programme. • Establishing educational partnerships arrangements with the University of South Wales and Swansea University in relation to the creation of new courses to support the extension of the Nurse Staffing Levels (Wales) Act 2016 to include paediatric inpatient wards, the district nursing principles and mental health workstreams. • Creation of career pathways including exploring opportunity for Band 4 nursing roles to support CTMUHB Integrated Health & Care Strategy

Conclusion & Recommendations

In summary, 2019/20 has been a year of significant progress in relation to fully meeting the requirements of the Nurse Staffing Levels (Wales) Act 2016:

- The successful appointment of 216 wte Registered Nurses overseas nurses with 86 landed by March 2020 with a 100% successful pass rate with their OSCE exam.
- The recruitment of substantial numbers of Health Care Support Workers via the 'call to arms' initiative in March 2020 into the permanent roles and enabling an increased workforce onto the staff bank.
- Significant improvement in the availability of information to nurse leaders to support and inform their clinical decision making including the creating of The Nursing Staffing Levels (Wales) Act (2016) Operating Framework and Escalation Policy and All Reasonable Steps.
- Improvements to the information provision to our patients and the public in relation to nurse staffing levels in our hospitals
- Further refinement of the governance systems and processes in place in relation to the NSLWA and the newly created ILGs.
- Preparation for extension of the Act into Paediatric and District Nursing.

The work programme associated with the NSLWA in 2020/21 will prioritise:

- Extension of the Act to Paediatric in-patients in 2021
- District Nursing Principles and work schedules
- Roll out of the new HCMS module to capture staffing levels and patient acuity per day.

Annual Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act 2016	
Health board	Cwm Taf Morgannwg University Health Board
Date annual assurance report with compliance with the Nurse Staffing Levels (Wales) Act is presented to Board	Date this report presented to Board 27th May 2021
Reporting period	The reporting period is 6 th April 2020 -5 th April 2021
Requirements of Section 25A Section 25A refers to the Health Boards/Trusts overarching responsibility to ensure appropriate nurse staffing levels <u>in any area where nursing services are provided or commissioned, not only adult</u>	Section 25A of the 2016 Act relates to the overarching responsibility placed upon each Health Board, requiring Health Boards and Trust to ensure they have robust workforce plans, recruitment strategies, structures and processes in place to ensure appropriate nurse staffing level across their organisation. The 2016 Act came into effect in April 2017. This annual assurance report set out the progress made within Cwm Taf Morgannwg University Health Board (CTMUHB) during 2020-2021 in relation to meeting the various statutory requirements of the 2016 Act. Due to the ongoing COVID-19 pandemic there has been disruption to some of the All Wales Nurse Staffing Programme work streams. The Chief Nursing Officer letter of 24th March 2020 specifically referenced the disruption that the Covid pandemic would cause to the ongoing work to extend the Act's second duty to paediatric inpatient wards. In October 2020 Welsh Government advised that the coming into force date for the extension has been postponed provisionally until October 2021. The Nurse Staffing Programme Team and the paediatric work stream have devised a suite of supportive mechanisms to prepare Health Boards for the extension of the second duty of the Act. Following a consultation process during the Autumn of 2020, the Statutory Guidance has been revised to include paediatric inpatient wards. CTMUHB has representation on each of the work stream groups within the All Wales Nurse Staffing Programme and is actively contributing to the development of evidence based workforce planning tools in

<u>medical and surgical wards.</u>	preparation for further extension of the 2016 Act to other areas in the future. During 2020-2021 a new Integrated Locality Group (ILG) structure within CTMUHB has been fully implemented and these ILGs have responsibilities to ensure that there are processes in place to ensure appropriate staffing levels within all wards that fall under Section 25A of the 2016 Act. The Executive Nurse Director has determined that a review of nurse staffing level across all clinical areas across all settings when nursing care is either provided and or commissioned in line with the requirement in Section 25A wards provides assurance that the principles behind the 2016 Act are considered. Since February 2020 staffing levels are reviewed, calculated by Locality Groups Nurse Directors and this is reported via Nursing and Midwifery workforce meetings. Between March 2020 and March 2021 any area that provides nursing care or commissioned areas that have been repurposed due to COVID-19 has been calculated accordingly and reported via CTMUHB Executive Management Board meetings. In addition there has been workforce efficiency meetings where the Locality Groups discuss and plan to ensure that the required workforce is fulfilled to meet the statutory guidance of 2016 Act, this includes trajectories in relation to retirement, estimated turnover and student streamlining into the CTM UHB. Under section 25A, staffing levels for all inpatient wards across the Health Board have been calculated to ensure that they can provide the level of care required for the patients within that area. During this reporting year 2020-2021, this has been a dynamic process which was reviewed twice weekly via the Bronze meetings within each Locality Group and decision making logs have been used to document decisions made at each meeting. Staffing levels have been agreed and if required adjusted to meet clinical model and patient acuity.
Progress to support for suite of workstreams under the All Wales Nurse Staffing Programme	The Chief Nursing Officer letter of 24th March 2020 specifically referenced the disruption that the Covid pandemic would cause to the ongoing work to extend the Act's second duty to paediatric inpatient wards. In October 2020 Welsh Government advised that the coming into force date for the extension has been postponed provisionally until October 2021. The Nurse Staffing Programme Team and the paediatric work stream have devised a suite of supportive mechanisms to prepare Health Boards for the extension of the second duty of the Act. Following a consultation process during the Autumn of 2020, the Statutory Guidance has been revised to include paediatric inpatients. Paediatric in-patient work stream: Within CTMUHB a Paediatric in-patient sub-group has been in place since June 2019 and a detailed implementation plan has been developed. Regular update reports to Management Board have been provided with the aim of ensuring organisational readiness for the extension of the 2016 Act in October 2021. Thus far, the schedule for this work has been as follow:

Paediatric Welsh Levels of Care - Whilst in draft currently, this continues to be tested by paediatric nurses across Wales. Quality improvement methodology is being used to support health boards in scoring patients twice daily.

Quality Indicators - Four nurse sensitive quality indicators have been proposed. This will consider how the patient acuity, quality indicators and professional judgement will enable triangulation to calculate nurse staffing levels for health board

Paediatric Principles - Nine interim principles for nurse staffing on paediatric wards have been developed as a framework to support health boards in calculating nurse staffing levels while the evidence base for the triangulated methodology is being developed. The UHB is working to comply with the following nine principles and it is noted that all Health Boards will be required to submit a return against them biannually.

A Board paper has been submitted informing the Board of the staffing requirement within every paediatric acute inpatient ward. The current paediatric clinical model for CTM UHB requires an additional 43 wte Registered Nurses (RNs) and 9.8 wte Health Care Support Workers (HCSW) in order to meet the requirement of the 2nd extension of the 2016 Act. It is estimated there will be a cost of £2.1m to meet this requirement.

District Nurse Staffing Principles

During 2020 CTMUHB has provided a 6 monthly progress report on compliance against the District Nurse Staffing principles to the Chief Nursing Officer (CNO). The sixth collection exercise against the District Nurse Staffing principles that was undertaken in September 2020 demonstrates that CTMUHB is continuing to make progress against the principles.

In January 2021 The CNO for Wales issued a formal letter that stated that given the current outlook of rising Covid19 infection rates and increasing strain on nursing services, she decided to cancel the biannual interim District Nurse staffing principles compliance return scheduled for March 2021.

Formal feedback was received on the 16th November 2020 and there was a message that continue steady progress is being made.

Since the last submission CTMUHB District Nursing service has been working closely to align the service of former Cwm Taff and Bridgend. Funding has been applied for to recruit additional DN team leaders and

	Administrative posts to support the Malinko implementation. Bridgend is reorganising to align existing post to meet the District Nurse Staffing principles. CTMUHB's performance against the core principles remains very strong with full compliance against principles 2, 3 and 8. Principle 4 and 5 are over 90% (it is not expected to achieve 100% return on these principles due to staff turnover). Principle 6, at the last return 93.1 % of the DN teams were compliant. For principle 7, CTMUHB are reporting an average of 29.1% uplift across the Organisation, which exceeds the principal of 26.9%, however there still exist differences within the various teams in CTM UHB. Mental Health and Health Visiting The All Wales Nurse Staffing Group has agreed that these work streams will require refocussing and revisiting the work undertaken to date in order to produce the next steps. Within Mental Health the All Wales programme lead the COVID-19 pandemic has had a significant impact, with planned workshops being cancelled. There has been progress in the Health Visiting work stream with the agreement on the acuity tool and how this will be piloted across Wales.
Actions taken in relation to calculating the nurse staffing level on section 25B wards during the reporting period. • Adult acute <u>medical</u> in patient wards • Adult acute	For clarity when discussing section 25B wards of the (2016) Act, these are all acute medical and surgical inpatient wards within HB and will be referred to Section 25 B wards or 25B wards of the Act. A bi-annual acuity audit is undertaken in January and June. The annual Nurse staffing level presentation was reported to CTMUHB Board on the 30th September 2020. The Board would normally receive the annual assurance report in June 2020, but it was disrupted by the COVID-19 pandemic. The Chief Nursing Officer for Wales issued a formal letter on the 24 March 2020 to provide Health Boards and Trusts with clarity and assurances around how COVID-19 pressures would disrupt the business as usual processes of the Nurse Staffing Levels (Wales) Act 2016 (NSLWA). Welsh Government left it to the discretion of each Health Board to decide whether to proceed or cease work on the bi-annual recalculation of adult medical and surgical wards. In accordance with the 'Once for Wales' approach Nurse Directors agreed that their organisations would defer the bi-annual audit and subsequent calculations of nurse staffing level until July 2020. In April 2020 guidance and templates were issued to Health Boards/Trusts to enable organisations to evidence the approach taken to determine the staffing levels that are required on their inpatient wards where

surgical
inpatient
wards

the required staffing level has been affected during the COVID-19 pandemic. The organisation presented a paper to Board in May 2020 to provide assurance on how nurse staffing levels were being/to be calculated and maintained during this period.

In October 2020 The CNO issued a follow up formal letter providing further clarity, reflecting the changes organisations had been required to make to patient pathways/ designation of wards across their acute sites, on the definition of wards for inclusion/exclusion under Section 25B of the Act, and the expectations upon Health Boards in relation to calculating the nurse staffing levels in such wards

The Health Board has implemented new ways of working and model of care in order to respond and meet the extreme and unprecedented pressure that the UHB has experienced in the reporting period due to the COVID-19 pandemic. This has required an extremely flexible approach to the deployment of the nursing workforce across the Health Board sites and many wards have been repurposed more than once to accommodate the clinical demands to meet the rise in demand for patients who require in-patient care due to COVID-19.

The attached All Wales template (Appendix A) provides a summary of the staffing levels that have been calculated for each adult ward prior to and during the Covid 19 pandemic. The template outlines the wards that remain under section 25B of the Act, wards that have been repurposed and the rationale during January and July 2020, as part of the bi-annual calculation cycle and where it has been deemed necessary, outside of that cycle. Following the acuity audit undertaken in July 2020 as part of the bi-annual recalculation process, wards that are under Section 25B were reviewed in order to ensure the calculation of the nurse staffing levels using prescribed methodology. Following the review there have been changes in staffing levels required on these wards. These establishments have been authorised by the ILG Directors of Nursing. Each ward has been subjected to the triangulated approach and the workforce planning tool to produce a ward template.

The January 2020 bi-annual acuity audit was conducted within CTMUHB, no changes were made to existing and funded establishments following this. At the beginning of the reporting period CTMUHB had 29, section 25B wards. In the Annual Report to Board in September 2020 (deferred May 2020), it was highlighted that due to COVID-19 some of the wards within Section 25B of the Act, required their staffing establishments to be temporarily revised as wards were repurposed in response to COVID-19. Some wards have been repurposed to provide dedicated additional COVID-19 positive, critical care beds and high care respiratory beds. Due to these changes, the wards listed below that were initially sitting within Section 25B of the Act currently no longer classed as Section 25B wards.

The report highlighted 22 of the 29 wards that are classed as 25B wards had seen some changes to their function and or had been reorganised/changed location within the hospital. At the time of this report 8 wards had been repurposed and defined as purely COVID-19 wards.

The bi-annual calculation audit was conducted in July 2020 (postponed from June), no section 25B wards required a recalculation of the staffing levels. The only changes following this process were the inclusion and exclusion of wards within Section 25B due to COVID repurposing

Appendix A provides the detailed nurse staffing levels for wards to which section 25B pertains to, from the initial reporting period to ending of the period for 2020-2021, there have been several wards that have either repurposed and been included into 25B wards or have been temporary removed due to the ward being repurposed for critical care or high care (non-invasive ventilation (NIV) capacity. This was clarified by the Chef Nursing Officer letter dated the 15th October 2020.

In July, wards that were added to 25B section within CTMUHB:

- Ward 7 (PCH) was repurposed from a ward focussing mainly on rehabilitation to a Covid acute medical ward
- At Princess of Wales Hospital (PoWh) the following wards were added; Bridgend clinic was repurposed from Private ward to a general surgical and Gynaecology ward. Ward 18 was repurposed to a trauma and orthopaedic ward staff having moved from Ward 10 that had been closed.

Wards that no longer sat within as Section 25B and therefore there was no requirement to undertake to the bi-annual calculation:

- Ward 7 at the Royal Glamorgan Hospital and ward 4 at Prince Charles Hospital continues to operate as an additional Critical Care area
- Ward 3 at Prince Charles hospital has changed from a surgical T&O ward to a high care respiratory ward for COVID-19 positive patients
- Ward 1 in the Royal Glamorgan hospital increased its bed capacity from 16 to 28 beds and there was requirement for an additional 8.33 WTE Registered Nurses and 8.53 WTE health care support workers.

It then was closed with plans to reopen once it has been refurbished to accommodate cubicles within the ward area.

Other changes

- In Royal Glamorgan Hospital (RGH) Ward 4 was repurposed and ward 14 moved into the ward area

Therefore in July 2020 CTMUHB had 31 wards within section 25B of the 2016 Act. The COVID-19 Pandemic has required hospital and consequently wards within section 25B of the 2016 Act to organise, reorganise and at times reorganise again to ensure safe patient care, this includes the repurposing of wards Red, Amber and Green wards as defined by the Welsh Government (2020) COVID-19 – 16 Point Plan to limit, minimise and mitigate the risks associated with transmission in a healthcare setting. In total 21 wards have been, at one time included in the COVID-19 RAG rating. Within this, wards have either been physically moved, swapped or closed, however the bed capacity on each open ward has remained constant, it is noted and for reporting purposes no formal staffing re-calculation has been required outside the biannual calculation.

Since November 2020 following engagement with the Heads of Nursing for the 3 acute hospitals, a process has been developed to ensure a weekly nursing workforce review where any changes to nursing establishments due to repurposing of wards will be reported via the Lead Nurse for Professional Standards to ensure the NSLWA workforce planning templates are updated accordingly.

On 18/12/20 the Executive Nurse Directors and the CNO discussed whether to proceed with the January bi-annual audit given the significant and increasing operational pressures all Heath Boards/Trusts were experiencing. It was decided that the January audit will be cancelled and we will proceed with the audit in June 2021 as planned. Therefore professional judgement and local protocol will be used to assess any changes within section 25B wards

As the COVID-19 pandemic has started to recede within the CTM locality, the 25B wards within the three District General hospital sites has seen a reduction in number of COVID-19 defined wards and therefore it is anticipated that at there will gradual return to 'normal business' and this will be reflected at next bi-annual recalculation in June 2021.

Using the triangulated approach to calculate the nurse staffing level on section 25B wards	The triangulated methodology prescribed in the Nurse Staffing Level (Wales) Act (NSLWA) as the required approach to calculating the nurse staffing levels for each ward has become embedded for the period 2020-2021 as a routine, 6-monthly cycle that is undertaken with the nursing teams responsible for each ward within Section 25B. However as previously discussed the January 2021 cycle has not taken place due the ongoing COVID-19 pandemic. The nursing teams access the data they are required to take account of within this methodology is obtained via the IT performance reporting system 'Qlik Sense' The system provides information relating to patient flow, patient acuity and care quality metrics in a single report that is readily accessible to Ward Managers, Heads of Nursing and ILG Nurse Directors. The monitoring of nurse sensitive indicators are monitored by the Locality Group Nurse Directors via Quality & Safety governance reviews and reporting mechanisms. From a Once for Wales approach there will be the development of a national system to record and review the nurse staffing levels and collate the data required to inform the reporting requirements. An agreement to implement 'Allocate' Nationally (CTM already use this system) and further discussions with Allocate to inform adaptations to the Safecare system and the Implementation of a national system to aid reporting of incidents & complaints.
Informing patients	The Statutory Guidance (Appendix C) states that "LHBs and Trusts must make arrangements to inform patients of the nurse staffing level" (paragraph 20). The statutory requirements to inform patients of the nurse staffing levels by ensuring that the most up to date information is displayed on wards in relation to the staffing levels agreed by Board, this included ensuring the staffing numbers were in line with agreed workforce planning Template. Following the July 2020 bi-annual calculation audit, using the approved calculation templates each 25B ward has been refreshed and the informing patient templates have been reissued. During the 2nd wave of the COVID-19 pandemic no ward calculation templates or informing patient templates have been reissued if the staffing levels remained the same, due to the sheer number of changes seen during the 2nd Wave of the COVID-19 pandemic and where the change has been attributed to repurposing within COVID-19 RAG ratings for example the ward changing from a red ward to an amber ward. This approach had been discussed and approved by the Executive Nurse Director.

Section 25E (2a) Extent to which the nurse staffing levels are maintained
 As the nurse staffing level is defined under the NSLWA as comprising both the planned roster *and* the required establishment, this section should provide assurance of the extent to which the planned roster has been maintained *and* how the required establishments for Section 25B wards have been achieved/maintained over the reporting period.

The extent to which the nurse staffing levels have been maintained	Period covered	Required establishment (WTE) of S25B wards at the beginning of the annual reporting period. (April)?? Need to include Nov 19		Required establishment (WTE) of S25B wards calculated during first cycle (May 2020 deferred Sept 2020)		WTE of required establishment of S25B wards funded following first (May) calculation cycle		Required establishment (WTE) of S25B wards calculated during second cycle (Nov 2020) July bi-annual review.		WTE of required establishment of S25B wards funded following second (Nov) calculation cycle	
		RN:	HCSW:	RN:	HCSW:	RN:	HCSW:	RN:	HCSW:	RN:	HCSW:
	April 2020-March 2021	607.86	476.65	469.7	346.6	469.7	346.6	630.75	450.51	630.75	450.51
Accompanying narrative: During the last reporting period there has been a number of wards under section 25B that have changed (for more details of individual wards and their calculated nurse staffing levels, refer to Appendix A), this can be seen by the differing required establishment for the 25B wards during this period. Briefly in March 2020, prior to the beginning of this annual reporting period the 25B wards within CTM UHB were relatively stable in regards to their required staffing establishment, however as a consequence of the COVID-19 pandemic and the need to repurpose wards to meet the demand wards to which section 25B applies have been affected. During the bi-annual calculation in May 2020 there were three wards that were repurposed into high care respiratory or ITU, 2 wards were closed and staff were redeployed elsewhere, 2 wards were repurposed into rehabilitation wards making a total of 7 wards being removed from section 25B whilst only one was added. Whilst at the second bi-annual calculation in November 2020 there appears to be an additional staffing establishment requirement, this is primarily due to wards either been repurposed and/or reopened and then being											

	included into the section 25B of the 2016 Act. These actions were taken to support capacity within the CTM UHB hospitals in relation to the going COVID-19 pandemic. At this time CTM UHB had 31 wards that were deemed to sit within 25B of the 2016 Act, where the required establishment for RN and HCSW had roughly returned to the requirement prior to the 1st cycle (April 2020). The ILGs Nurse Directors manage financial budgets and have realigned their budgets to meet the ongoing staffing requirements for section 25B wards.
Extent to which the nurse staffing levels are maintained within Section 25B wards	When the second duty of the Nurse Staffing Levels (Wales) Act 2016 (the Act) came into force in April 2018, there was no consistent solution to extracting all of the data explicitly required under section 25E, and health boards were using a variety of e-rostering and reporting systems. During the reporting period 2019/20, all health boards/trusts in Wales worked as part of the All Wales Nurse Staffing Programme to develop a consistent approach to capturing quantitative data on a daily basis (in lieu of a single ICT solution) to enable each organisation to demonstrate the extent to which the nurse staffing levels across the health board. For the 2018/9 and 2019/20 annual reports, this Health Board, together with all other health boards/trusts in Wales provided narrative to describe the extent to which the nurse staffing levels have been maintained in order to meet its statutory reporting requirement under Section 25E of the Act. During the reporting period 2020/21 all health boards/trusts in Wales have begun to implement and use the NWIS delivered enhancements to the NHS Wales Health and Care Monitoring System (HCMS). In light of this development, made available to Health Boards/Trusts across Wales on 1st July 2020, organisations have had access to a consistent approach to capturing quantitative data on a daily basis to enable each organisation to demonstrate the extent to which the nurse staffing levels across the health board have been maintained in areas which are covered by Section 25B/C of the Act: The limited quantitative data that this approach has provided for 2020/21 for this Health Board is presented and discussed below. As highlighted above since July 2020 CTMUHB has had access to capturing quantitative data on a daily basis using the existing Health Care Monitoring system, this has enabled the capture compliance against the planned rosters on a daily basis. Within this module there is a secondary data field to record when there has been a shortfall against the planned roster. The COVID-19 pandemic has had a profound effect within the three DGHs and how they have needed to respond to maintain patient safety and their staff that work within the wards. To assist in process of maintaining the extent to which staffing levels are maintained since November 2020 the Head of Nursing for the 3 principal hospital sites have provided weekly staffing profiles for all their section 25B/C of the 2016 Act.

Since Health Care Monitoring System (HCMS) system has become live in July 2020, daily patient acuity and staffing levels have been recorded daily. The aggregated percentage where staffing levels were maintained and remained compliant within the 2016 Act for the HB section 25B wards was 79.73%. There was a small variant between the 3 DGHs of 6% the lowest DGH having a compliance of 76.45 % and the highest hospital site recording a compliance rate of 82.16%.

Where the staffing levels were not met against the planned roster (21% of the time), the data obtained has demonstrated that professional judgement was made as to the extent that this impacted on the ward and patient care. Of that 21%, the data recorded that 20% of the time, where staffing levels were not met but were deemed safe, whilst 79 % of the time the shift was deemed to be unsafe within the HB section 25B wards. On these occasions, it would be routine practice for the escalation process within the Nursing staffing Levels Wales Act Operating Framework & Escalation Policy (Appendix D) to be followed and escalated via the ILG Nurse Directors and/or Silver meetings during COVID 19.

Mitigating factors and caveats within this data could be:

1. The figures were obtained during COVID-19 pandemic and the hospital wards were extremely busy and as a consequence the data was not captured daily as per protocol.
2. Due to the sheer internal ward moves within each HB site, the tracking of data for each of the wards within section 25B is not 100% accurate

Looking forward, NHS Wales is committed to utilising a national informatics system that can be used as a central repository for collating data to evidence the extent to which the nurse staffing levels have been maintained and to provide assurance that All Reasonable Steps (Appendix E) have been taken to maintain the nurse staffing levels required. It is anticipated that during the next reporting period (2021-2024) a once for Wales informatics system will be developed and will support Health Boards/Trusts in meeting the reporting requirements of the Act and the Once for Wales approach will ensure consistency. Discussions continue on a national basis to identify the national system and the Nurse Staffing Programme team is working with providers to ensure the system is able to support NHS Wales in collating the data required to inform the reporting requirements

**Process for
maintaining the
nurse staffing
level**

In June 2019, the Health Board commenced its Registered Nurse overseas nurse recruitment campaign to bring 215 wte nurses from India into the three acute hospital sites. This programme is now drawing to its conclusion with 213 nurses to date having successfully passed their OSCE and become NMC registrants with the remaining 2 awaiting to resist their OSCE test. In addition 61 wte RNs came into post in September 2020 from Student Streamlining.

Currently the Health Board is continuing to progress the appointment of over 400 Health Care Support Workers (HCSW) into the Health Board in response to the ongoing challenges of COVID-19. This is supported by a Workforce & OD training and educational framework.

Additional Registered Nurse education and training has been provided in readiness of ward nurses being deployed into additional critical care areas. This is part of the wider UHB COVID-19 Nursing Workforce Strategy.

The Nursing Staffing Levels (Wales) Act (2016) Operating Framework and Escalation Policy for CTMUHB supports the calculation and maintenance of nursing staffing levels in Adult Acute Medical and Surgical Wards and the actions that are taken to review, record and escalate where nurse staffing levels are not maintained.

Within the Acute Hospitals staffing levels are reviewed three times a day and if required staff are deployed accordingly using All Reasonable Steps together with professional judgement to draw on information at a local and national level to inform their decision as to the appropriate staffing levels required. The All Wales Directors of Nursing have agreed, and through the All Wales Nurse Staffing programme group have issued, further clarification on what constitutes the 'All Reasonable Steps' which are statutorily required to be taken in order to maintain the nurse staffing levels at the calculated levels. This document has been in place within CTMUHB since November 2019.

There are well embedded processes within the nursing structures on each of the acute sites for reviewing staffing levels operationally on a daily basis and for making operational, risk-based decisions about the deployment of staff via the bed/staffing meetings.

Since January 2020, in line with decisions made at all Wales level, the Health Board has commenced, formally recording the nursing staffing levels on each of the wards per day and the mitigating actions taken in order to maintain the nurse staffing levels on ward areas.

Section 25E (2b) Impact on care due to not maintaining the nurse staffing levels

Patients harmed with reference to quality indicators and complaints (*) which are classified as serious incidents and reported centrally NOTE: (*) complaints refers to those complaints made under complaints regulations (Putting Things Right (PTR))	1) Total number of closed serious incidents/complaints during <u>last</u> reporting period April 2019 – March 2020	2) Total number of closed serious incidents/complaints during <u>current</u> reporting period (April 2020-March 2021)	3) Total number of serious incidents/complaints not closed and to be reported on/during the <u>next</u> reporting period (April 2021-March 2022)	4) Increase/decrease) in the number of closed serious incidents/complaints between reporting periods (**)	5) Number of serious incidents/complaints where failure to maintain the nurse staffing level was considered to have been a factor
Hospital acquired pressure damage (grade 3, 4 and unstageable).	74 incidents received, 67 closed (7 still open) 2 Serious Incidents reported to WG, both closed	46 incidents received 22 closed 24 still open 0 Serious Incidents reported to WG	31 incidents (0 Welsh Government)	38% decrease in received 100% decrease WG	1 incident (0 Welsh Government)
Falls resulting in serious harm or death (i.e. level 4 and 5 incidents).	10 incidents received 5 closed (5 still open) 6 SI's reported to WG, 6 closed	4 incidents received 1 closed 3 still open, 2 SI's reported WG, 2 closed	8 incidents (0 Welsh Government)	60% decrease in received 67% decrease WG	1 (0 Welsh Government)
Medication related never events.	1 Medication Never Event received (1 closed)	0	0	100% decrease in received	N/A
Complaints about nursing care	8 received (8 closed)	3 received 3 closed	0	62.5% decrease in received	N/A

NOTE ():** In relation to the data presented in Column 4 above, direct comparison between the numbers of closed SI's/Complaints reported during 2019/20 and the number reported in 2020/21 should not be made due to the significant changes in the number/size/patient pathway etc of wards classified under Section 25B during 2020/21 as a result of operational changes made during the Covid-19 pandemic period.

Section 25E (2c) Actions taken if the nurse staffing level is not maintained

**Actions
taken
when the
nurse
staffing
level was
not
maintain
ed**

This reporting period has been a challenging year due to COVID-19 pandemic, for section 25B wards it has been at times difficult to update the relevant and corresponding reporting systems due to sheer number of internal moves made during this period.

For this reporting period there has been 2 incidents where not maintaining the planned nurse staffing level was deemed to have contributed to the incidents, 1 hospital acquired pressure damage and 1 fall. It should be noted however, that both of these incidents did not meet the threshold to be reported to the Welsh Government. Both incidents have been reviewed via the respective ILG's internal quality and safety, safeguarding processes and deemed that they were unavoidable although it was noted that staffing could have been a contributing factor.

Although there has been a reduction across all incidents between the reporting periods, it has been noted that comparison between reporting periods of 2019-2020 and 2020-2021 cannot be made due to the operational changes made during the COVID-19 pandemic. Therefore comparison for the next reporting period will also be difficult to access trends and or improvements.

All of the incidents and complaints included in this report have been reviewed by the Acute Hospital's Head of Nursing via their internal weekly scrutiny meetings to assess if the nurse staffing levels were maintained at the relevant time, and if not, whether failure to maintain the nurse staffing level contributed to any harm suffered by the patient but also to determine whether there are any other lessons to be learnt from the incidents that can be shared.

There are a range of both short and long term actions being taken by the Health Board in an attempt to improve the extent to which a sufficient workforce is available to work within the Registered Nurse and Health Care Support Worker posts on both Section 25B wards and across the wider nursing services. These include:

- The schemes being led by the Workforce and Organisational Development teams and Central Nursing to develop and implement innovative approaches to recruitment of Registered Nurses as well as new Health Care Support Workers.
- Continue to plan and provide a registered nurse workforce which includes a further business case for Phase 2 of the overseas RN recruitment which will provide a further 150 nurses into CTMUHB including the uplift of Practice Development Nurses to support this programme.

- Establishing educational partnerships arrangements with the University of South Wales and Swansea University in relation to the creation of new courses to support the extension of the Nurse Staffing Levels (Wales) Act 2016 to include paediatric inpatient wards, the district nursing principles and mental health work streams.
- Contributing to student streamlining for Adults, Paediatrics, Mental Health and District Nursing
- CTMUHB staff representatives on the Health Education and Improvement Wales (HEIW) programmes
- Creation of career pathways including exploring opportunity for Band 4 nursing roles to support CTMUHB Integrated Health & Care Strategy

Conclusion & Recommendations

In summary 2020-2021 has been a challenging year due to the COVID-19 pandemic within the Health Board and its communities

- Meeting the staffing levels for the 25B wards has been difficult due to higher levels of sickness and staff requiring to shield at home
- The repurposing of wards including retraining of staff to meet the clinical demands during the COVID-19 pandemic and the temporary re-deployment of staff to support the additional demands including high care respiratory wards, ITU and the temporary Field Hospital

However despite these challenges there continues to be successes and achievements within this reporting period

- The ability of the Health Board and its staff to adapt at short notice when needing to repurpose wards to meet the clinical needs of our population during the COVID-19 pandemic and the temporary re-deployment of staff to support additional areas including high care respiratory wards, ITU and the temporary Field Hospital
- The HB has continued to land overseas nurse from aboard (primarily from India) with an evolving governance framework that involved a robust isolation, educational and wellbeing process
- Virtual OSCE training continued, the adoption of the temporary NMC registered for the overseas nurses still in training. The continued success of 1st time pass rate for the nurses who undertook their OSCEs' tests.

- 411 student nurses/midwives these being 2nd or 3rd year Student nurses/midwife were employed as HCSW during the COVID-19 pandemic
- 400 HCSW recruited to the Call to Arms to support the hospital sites and are now supporting the mass vaccination programme
- The improvement in the availability of information to nurse leaders to support and inform their clinical decision making including the Nurse staff Level (Wales) Act (2016) Operating Framework and Escalation policy and All Reasonable Steps.
- Improvement with the information provision to our patients and public including the redesigned nurse staffing levels Informing Patient Templates within our hospitals
- ILGs governance system and processes in relation to NSLWA
- The continued preparation and preparedness for the extension to the 2016 Act in Paediatric and District Nursing

The Work programme associated with the NSLWA in 2020-2021 needs to include:

- Readiness for the Extension of Act for Paediatric in patient wards and the recruitment into 43 wte nurse vacancies to deliver this.
- The resetting and the realignment in the following work streams; District nursing, Mental Health and Health visiting. Within the HB these working groups for these work streams have now recommenced
- Enhanced information and increased intelligence for Safe Care, Concerns and incidents datix module for quality assurance processes in the Adult work stream.
- Accuracy and robust data collection in the use of the national HCMS
- Work internally to reset the 25B wards within HB



Nursing Staffing Levels (Wales) Act (2016)

All Reasonable Steps

All Reasonable steps

Reasonable steps which should be taken at each of the following levels - national, strategic corporate (Local Health Board/ NHS Trust) and operational – to maintain the nurse staffing levels are considered to be:

National steps

- The sharing and benchmarking of corporate data.
- Leading of regular reviews of workforce and education commissioning requirements.
- Leading national initiatives to aid staff recruitment and retention.

Strategic corporate steps

- Workforce planning for a continued supply of required staff assessed using the Welsh Planning System.
- Active recruitment in a timely manner at local, regional, national, and international level.
- Retention strategies that include consideration of the NHS Wales Staff Survey results;
- Well-being at work strategies that support nurses in delivering their roles.
- Ensure strategic requirements of the Act embedded into the organisations IMTP/annual planning process.
- Robust workforce planning at ward/service level which are reviewed at least annually through IMTP education commissioning processes.
- Workforce policies and procedures which support effective staff management (eg: flexible working for staff).
- Robust organisational risk management framework.
- Effective risk assessment processes and systems are in place and utilised as required.

Operational steps

- Use of temporary staff from a nursing bank appropriate to the skill mix set out in the planned roster.
- Use of temporary staff from a nursing agency appropriate to the skill mix set out in the planned roster (once bank staff have been considered).
- Temporary use of staff from other areas within the organisation.
- The temporary closure of beds.

- Consideration of changes to the patient pathway (which should be clinically appropriate).
- Effective resource management, utilisation and deployment of staff e.g. appropriate allocation of annual leave and study leave, staff working overtime (within WTE), additional hours or use of hours owed.
- Use of a robust electronic rostering tool and strong governance systems to monitor and review the rosters and ensure effective utilisation of the nursing workforce (e.g. review the staffing roster on a day to day basis, explore with staff member rescheduling annual leave and/or change of shift, postponing staff training/ study leave).
- Ward sister/charge nurse to work within the planned roster.
- Regular review of the acuity of the patients on the ward, including the identification and risk management of patients requiring 'enhanced patient support' in line with local policy and professional judgement.
- "On Boarding". This is the term used when, in very unusual and exceptional circumstances, a patient is required to be placed on the ward and no bed is available. This practice has been extensively discussed within WG and NHS Wales and it is acknowledged that this is not best practice. In the rare event that this is deemed necessary, in line with NHS Wales escalation processes all Health Boards should have in place a clear escalation protocol that includes the circumstances in which this may be considered and the process for implementation. This should also include the requirement that any instance is immediately escalated/reported through the incident management systems within the Organisation and to the Chief Operating Officer and the Executive Nurse Director in hours and out of hours the Executive Director on call to be notified. On the rare occasion that on-boarding occurs this must be time limited and all HB's must have a de-escalation process in place. Should this rare situation occur, at the time of the audit, then the acuity of any such patient should be recorded on HCMS and the escalation / incident reporting situation must be followed.
- Appropriate and timely use of the escalation policy relating to nurse staffing and reporting and management of risk.
- Should this rare situation occur, at the time of the audit, then the acuity of any such patient should be recorded on HCMS and the escalation / incident reporting situation must be followed.

 Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board	Version Number: 2 Next Review date: 01/03/2023
Nursing Staffing Levels (Wales) Act (2016) Operating Framework and Escalation Policy	
Introduction The purpose of this Operating Framework is to support the calculation and maintenance of nursing staffing levels in Adult medical and surgical wards, and the actions that are taken to review and record every occasion when the number of nurses deployed varies from the planned roster. To provide open transparent information on nursing staffing levels within Acute Adult Medical and Surgical Wards.	
Objectives There are a number of objectives, including: Supporting the assessment of patients' care needs with processes which ensure that the nurse staffing levels reflect the care needs of patients at all times. To support the calculation and maintenance of the nurse staffing level, To provide guidance to nursing staff and managers to safely manage risk to patients safety and staff well-being when not able to maintain the nurse staffing level and ensure that this is reported and recorded monitored and all reasonable steps required are undertaken. To provide the mechanism through which open and transparent information on the nurse staffing level on each adult acute medical and surgical ward within the Health Board will be shared.	
Operational Date 01/03/2020	Expiry Date Formal – three years Informal – one year
Scope This Framework is relevant to all managers, registered nurses and health care support workers working within the Adult Acute Medical and Surgical Wards unless otherwise stated.	
Equality Impact Assessment	An Equality Impact Assessment has been undertaken (Appendix 3)
Distribution	Executive Directors Clinical Directors Associate Directors Nursing Medical Directors Heads of Nursing Directorate Managers University Health Board intranet site
To be read by	Executive Board Members Senior Managers on Call Directorate Managers

	Clinical Site Mangers Heads of Nursing Senior Nurses Ward Sisters/Charge Nurses Registered and Non-registered nurses
Documents to read alongside this Policy	Risk Management Policy Incident Reporting Policy Business continuity policy Flexible Working Policy
Approved by	Cwm Taf Morgannwg Executive Board
Accountable Executive / Lead Director (responsible for formal review every three years)	Executive Director of Nursing
Author / Management Lead (carries out informal review annually)	Sharon O'Brien, Assistant Director of Nursing & People's Experience
Freedom of Information Status	Open
If the review date of this policy has passed, please ensure that the version you are using is the most up to date either by contacting the document author or the Corporate Services Department. To avoid use of out of date policies please do not print and then store hard copy of this document. Out of date policies cannot be relied upon.	

		Page
1	Purpose	4
2	Policy Statement	4
3	Scope	5
4	Aim	5
5	Definition of Terms	6
6	Glossary of Terms	9
7	Legislative and NHS Requirements 7.1 Equality Impact Assessment 7.2 Privacy Impact Assessment	10
8	Calculating the Nurse Staffing Level 8.1 Section 25B:Adult Inpatient Medical & Surgical Wards 8.2 Nurse Staffing Level – Key principles 8.3 Informing Patients	10 10 12
9	Maintaining the Nurse Staffing Level 9.1 Systems and Processes for Reviewing	13 13
10	Duties and Responsibilities of Staff 10.1 Strategic duties & responsibilities 10.2 Acute Services Operational Teams (Site/Directorate)	14 14 17
11	Escalation Procedure	22
12	Training	25
13	Monitoring, Reporting and auditing	25
14	Retention / Archiving	26
15	Non Conformance	26
16	References	26
17	Appendices • Appendix 1 All Reasonable Steps • Appendix 2 Escalation Procedure for Staffing Shortfalls • Appendix 3 Equality Impact Assessment • Appendix 4 Privacy Impact Assessment	27

1.0 PURPOSE

The purpose of this Operating Framework is to support the calculation and maintenance of nursing staffing levels in Adult Acute Medical and Surgical Wards and the actions that are taken to review, record and escalate where nurse staffing levels are not maintained.

The purpose of this policy is to provide information and standards which will underpin

- The Health Board's overarching responsibility to provide sufficient nurses in all Adult Acute Medical and Surgical Wards
- The calculation of the nurse staffing levels in adult medical and surgical wards
- The "All Reasonable Steps" required to be taken to maintain nurse staffing levels; and
- The escalation process where staffing levels are not maintained.

It is intended that this policy works in conjunction with existing policies and other written control documents issued by the Health Board.

2.0 POLICY STATEMENT

The safety of our patients and the quality of the care we provide are more important than anything else for Cwm Taf Morgannwg CTM) Health Board. Nursing and health care staff, play a critical role in delivering safe, high quality care to patients and service users. The University Health Board (UHB) puts patients at the heart of all that it does. There is strong evidence that having the right number of nursing staff delivering care in the right place impacts positively on both clinical outcomes and patient experience (Francis 2013, Keogh 2013, and Berwick 2013). Addressing these issues ensures we prioritise the safety and experience of our patients and staff. Clearly safe staffing is not just about staffing ratios, but ensuring that we have the right staff, with the right skills, in the right place at the right time.

The Nurse Staffing Level (Wales) Act 2016 became law in Wales in March 2016. The Act requires health service bodies to make provision for an appropriate nurse staffing level, and to ensure that they are providing sufficient nurses to allow the nurses time to care for patients sensitively. This requirement extends to anywhere where the Health Board is securing the provision of nursing services, including care homes

The Act consists of 5 sections;

- 25A refers to the health boards'/NHS trusts' overarching responsibility to have regard to providing sufficient nurses in all settings.
- 25B & 25C require health boards/NHS trusts' to calculate and take "all Reasonable Steps" to maintain the nurse staffing level in all adult acute medical and surgical wards.
- 25D relates to the statutory guidance released by Welsh Government

- 25E requires health boards/NHS trusts to report their compliance in maintaining the nurse staffing level for each adult acute medical and surgical ward.

The National (UK) understanding of acute services professional nurse staffing standards are also made explicit within the NICE publication 'Safe staffing for nursing in adult inpatient wards in acute hospitals' (2014).

3.0 SCOPE

This Operating Framework is relevant to all healthcare professionals involved in the calculating and maintaining the nurse staffing levels, including the nursing management structure.

This Operating Framework applies to all Acute Services adult areas, including in particular, all wards where Section 25B of the Nurse Staffing Levels (Wales) Act applies.

This Operating Framework is to support the calculation and maintenance of nursing staffing levels in Adult medical and surgical wards, and the actions that are taken to review and record every occasion when the number of nurses deployed varies from the planned roster.

The Framework will provide guidance to nursing staff and managers to safely manage risk to patient's safety and staff well-being when not able to maintain the nurse staffing level and ensure that this is reported and recorded monitored and all reasonable steps undertaken.

Section 25B currently applies to adult acute medical inpatient wards and adult acute surgical inpatient wards.

The following care settings are also included in the scope of this policy:

- Acute medical and surgical admission/assessment units;
- Intensive care units;
- High dependency units;
- Coronary care units;
- Day care units or wards;
- Theatres; and
- Rehabilitation wards.

4.0 AIM

The aim of the Framework is to ensure that nursing staffing levels are in line with the requirements of the Nurse Staffing Level (Wales) Act 2016. The aims of this policy will be achieved by:

- Supporting the assessment of patients' care needs with processes which ensure that the nurse staffing levels reflect the care needs of patients at all times.
- To support the calculation and maintenance of the nurse staffing level,
- To provide guidance to nursing staff and managers to safely manage risk to patients safety and staff well-being when not able to maintain the nurse staffing level and ensure that this is reviewed, recorded, monitored and appropriate actions are taken
- To provide the mechanism through which open and transparent information on the nurse staffing level on each adult acute medical and surgical ward within the Health Board will be shared.

5.0 DEFINITION OF TERMS

Adult acute medical inpatient ward	An area where patients aged 18 or over receive active treatment for an acute injury or illness requiring either planned or urgent medical intervention, provided by or under the supervision of a consultant physician. Patients are deemed to be receiving active treatment if they are undergoing interventions prescribed by the consultant and/or their team, and/or advanced practitioners for their acute injury or illness. It is acknowledge that patients between 16-18 years of age are sometimes admitted to our adult acute medical inpatient wards, however, the primary function of these wards is for patients aged 18 or over.
Adult acute surgical inpatient ward	An area where patients aged 18 or over receive active treatment for an acute injury or illness requiring either planned or urgent surgical intervention provided by or under the supervision of a consultant surgeon. Patients are deemed to be receiving active treatment if they are undergoing interventions prescribed by the consultant and/or their team, and/or advanced practitioners for their acute injury or illness. It is acknowledge that patients between 16-18 years of age are sometimes admitted to our adult acute surgical inpatient wards, however, the primary function of these ward is for patients aged 18 or over.
Designated Person	A person designated by the health board/trust who is responsible for calculating nurse staffing levels on behalf of the CEO/Board. The designated person should be registered with the Nursing and Midwifery Council (NMC) and be of sufficient seniority within the health

board/trust, such as the Executive Director of Nursing for the Board.

Enhanced Patient Support	Enhanced Patient Support (EPS) is a framework through which clinical services assess the need for, and monitor the implementation of, heightened levels of observation and support for inpatients with particular care needs. Some inpatients require closer observation, often with the primary aim of reducing risk and protecting the inpatient and /or others (e.g. they have increased confusion or are at risk of falling and sustaining injury). This activity is often referred to as “specialling” or ‘one to one’ care; it is, however, important to recognise that ‘specialling’ is only one method of enhancing the level of patient support
Nurse	This means a registered nurse who has a live registration on sub parts 1 or 2 of the NMC register.
Nurse staffing level	The Nurse staffing level is the total number of Nurses (i.e. registered nurses) AND those staff undertaking nursing duties under the supervision of or delegated to by a registered nurse (e.g. HCSW). The nurse staffing level refers to the planned roster AND the establishment required to meet the planned roster.
Patient acuity	Acuity can be defined as the measurement of the intensity of nursing care required by a patient. For the purpose of this work we use the term ‘acuity’ as an umbrella term which encompasses other terms such as dependency, intensity and complexity to describe the amount of care that a patient requires based on their health needs. The term ‘Acuity’ has 2 main attributes: 1. Severity, which indicates the physical and psychological status of the patient; and 2. Intensity, which indicates the nursing needs, complexity of care and the corresponding workload required by a patient, or group of patients.
Planned roster	Refers to the number and skill mix of staff required to enable nurses to provide care to meet all reasonable care requirements. The Nurse Staffing levels (Wales) Act statutory guidance states that ‘Supernumerary persons such as students and ward sisters/charge

	nurses/managers should not be included in the planned roster’.
Professional judgement	An informed opinion on the factors that influence clinical decision making in relation to patient safety: Factors that need to be considered as part of professional judgement are listed within the Statutory guidance. The statutory guidance requires that the professional judgement of the Designated Person as well as the registered nurses working within the ward are taken account of when calculating the nurse staffing levels.
Quality indicators	Health boards are required to consider quality indicators which are a robust measure of those factors considered to demonstrate the outcomes for patients and staff that are impacted upon by nurse staffing levels. Some indicators are more sensitive to nursing than others. There are 3 nurse-sensitive indicators that it is required to consider within the Act/statutory guidance: • Patient falls - the designated person should consider any fall that a patient has experienced; • Pressure ulcers - the designated person should consider any pressure ulcers a patient has developed and/or shown deterioration whilst receiving inpatient care; and • Medication administration errors - the designated person should consider any error in the preparation, administration or omission of medication by nursing staff. In addition to these three indicators, the designated person may consider any other indicator that is sensitive to the nurse staffing level they deem appropriate for the ward where the calculation is taking place.
Reasonable requirements	The patients’ nursing needs/ activities of daily living as assessed by the ward nursing team. This means taking into consideration the holistic needs of the patient, including social, psychological, spiritual and physical requirements. The ward sister is responsible for ensuring that these needs are assessed and classified using the Welsh Levels of Care descriptors (see below for further information).
Reasonable steps	A series of national, strategic and operational steps that need to be undertaken when aiming to maintain the nurse staffing level.

Required establishment The total number of staff required to provide sufficient resource to deploy a planned roster that will meet the expected workload to provide care to meet the patients' nursing needs for the area.

This includes a resource of 26.9% to cover all staff absences and other functions that reduce their time to care for patients. Supernumerary persons such as students and ward sisters/charge nurses/managers should not be included in the planned roster.

Triangulation/triangular approach This refers to the method used when calculating the nurse staffing level. Triangulation is a technique that facilitates validation of information from the following three sources of data through a process of cross verification:

- patient acuity;
- professional judgement; and
- Quality indicators.

Welsh Levels of Care Data from each of these three sources is taken into account when calculating the nurse staffing level. A tool developed within NHS Wales that has been validated for use by establishing an evidence base of its applicability in Welsh clinical settings, and determined by the Chief Nursing Officer as being suitable for use.

<http://fundamentalsofcare.dev.wales.nhs.uk/nurse-staffing/doclib/Welsh%20Levels%20of%20Care%20Edition%201.pdf>

6.0 GLOSSARY OF TERMS

EPS	Enhanced Patient Support
HCSW	Health Care Support Worker
AfPP	Association of Perioperative Practice
BADS	British Association of Day Surgery
GPICs	Guidelines for the Provision of Intensive Care Services
JAG	Joint Advisory Group
IMTP	Integrated Medium Term Plan
NICE	National Institute of Clinical Excellence
RN	Registered Nurse
BCI	Business Continuity Incident
TOIL	Time owing in Lieu
WTE	Whole Time Equivalent

7.0 LEGISLATIVE AND NHS REQUIREMENTS

7.1 Equality Impact Assessment (EIA)

Following assessment (Appendix 2) this policy is not felt to be discriminatory or detrimental in any way with regard to the following equality standards:

Gender; Race; Disability; Age; Sexual Orientation; Religion or Belief; Welsh Language or Human Rights.

7.2 Privacy Impact Assessment (PIA)

A privacy impact assessment has been undertaken (appendix 3).

8.0 CALCULATING THE NURSE STAFFING LEVEL

Section 25A

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. 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.

Calculating the nursing staffing levels will include giving consideration to any national recommendations/ standards or best practice recommendations that exists around the service e.g.

- British Cardiovascular Society standards for Acute Cardiac Care Units.
- Association for Perioperative Practice (AfPP) Staffing for Patients in the Perioperative Setting 2014.
- British Association of Day Surgery (BADs), Team Work & Staffing in Day Surgery.
- Guidelines for the Provision of Intensive Care Services (GPICs).
- Joint Advisory Group (JAG) guidelines for Endoscopy.
- Hyper Acute Stroke Units/Acute Stroke Units

[https://www.strokeaudit.org/SupportFiles/Documents/Guidelines/2016-National-Clinical-Guideline-for-Stroke-5t-\(1\).aspx](https://www.strokeaudit.org/SupportFiles/Documents/Guidelines/2016-National-Clinical-Guideline-for-Stroke-5t-(1).aspx).

8.1 Section 25B & 25C: Adult Acute medical and surgical wards

Section 25B&C of the Act relates to adult acute medical and surgical wards where there is a duty to calculate nurse staffing levels using a prescribed methodology and take all reasonable steps to maintain nurse staffing levels.

In every adult acute medical and surgical ward the method of calculation is a 'triangulated' approach which brings together three sources of information to determine the required nurse staffing level. In this situation the information triangulated is both qualitative and quantitative in nature. The triangulation process should include:

- Professional judgement including:
 - o The qualifications, competencies, skills and experience of the nurses providing care to patients.
 - o The effect of temporary staff on the nurse staffing level.
 - o The effect of a nurse's considerations of a patient's cultural needs.
 - o Conditions of a multi-professional team dynamic.
 - o The potential impact on nursing care of a ward's physical condition and layout.
 - o The turnover of patients receiving care and the overall bed occupancy.
 - o Care provided to patients by other staff or health professionals, such as health care support workers.
 - o Any requirements set by a regulator to support students and learners
 - o The extent to which nurses providing care are required to undertake administrative functions.
 - o The complexity of the patients' needs in addition to their medical or surgical nursing needs, such as patients with learning disabilities.
 - o Delivering the active offer of providing a service in Welsh without someone having to ask for it.
- Patient acuity - The Senior Sister/Charge Nurse is responsible for ensuring that the social, psychological, spiritual and physical care needs are assessed and classified using the Welsh Levels of Care descriptors. The calculation of the nurse staffing level will meet all these "reasonable requirements" of care; and
- Quality indicators – Consider "circumstances where patient well-being is particularly sensitive to care provided by a nurse as part of the triangulated method each time the nurse staffing level is calculated" in accordance with the Nurse Staffing Levels (Wales) Act statutory guidance. (e.g. medication administration errors, patient falls, and pressure ulcers).

In addition to these three indicators, the "designated person" may consider any other indicator that is sensitive to the nurse staffing level they deem appropriate for the ward where the calculation is taking place.

The nurse staffing levels will be calculated every 6 months as a minimum and more frequently if the use of the ward changes which alters the nurse staffing level, or if it is deemed necessary.

All the information collected must be reviewed and validated separately before being brought together through a triangulated methodology in order to arrive at an informed decision on the nurse staffing level for each ward.

The planned roster should be informed by the registered nurses within the ward as well as the nursing management structure where the nurse staffing level applies i.e. Head of Nursing and Senior Nurse Manager

The Executive Director of Nursing of Nursing, Midwifery & Patient Safety (as the “designated person”) must be provided with the rationale behind the calculation; must confirm the calculation based on the prioritisation that has been given to the information; and must make a recommendation to the Board regarding the nurse staffing level for each adult acute medical and surgical ward.

The evidence and rationale used to determine the nurse staffing level must be recorded. The nurse staffing level will be the planned roster and the required establishment. The nurse staffing level should be funded from the Health Board’s revenue allocation, taking into account the actual salary points of staff employed.

8.2 Nurse Staffing Level - key principles:

Determining the nurse staffing level for a ward is complex and assessing the individual needs of patients is vital when considering decisions about the nurse staffing levels. Nurse staffing levels will be calculated using a triangulated methodology that uses professional judgement to analyse and advice on the planned roster required to deliver quality patient care outcomes for the acuity and numbers of patients that are cared for within that ward.

Some key principles that are inherent within the required establishments calculated for all wards will include the following principles which are recognised in the literature as reasonable principles to work to, based on the evidence available, when calculating nurse staffing levels for adult acute medical and surgical inpatient wards.

The requirement of using the triangulated methodology to agree the planned roster for each ward included under Section 25B of the Act individually, is deemed to be a more sensitive methodology to calculating the required establishment for a ward than the use of the blunt instrument of specifying the ‘nurse per bed’ ratio.

For wards included under Section 25B of the Act, supernumerary persons such as students and ward sisters/managers should not be included in the planned roster.

8.3 Informing Patients

The Act requires that patients must be informed of the nurse staffing level for each adult acute medical and surgical ward and must be informed of the date the nurse staffing level was agreed by the Board. This should be easily visible to anyone attending the ward. A ‘frequently asked question’ leaflet must be available

on the wards where section 25B applies which include information on how patients/family/carers can raise a concern about the nurse staffing level.

9.0 MAINTAINING THE NURSE STAFFING LEVEL

The Health Board is required, as laid out in the statutory guidance, to ensure that “all reasonable steps” are taken to maintain the nurse staffing level in all Adult Acute Medical and Surgical Wards.

In practice, this will require that a range of actions are taken at a strategic level in the medium to long term, and operationally in the immediate and short term.

It is the responsibility of the Sister/Charge Nurse to ensure effective roster management and deployment of the nursing staff within the required establishment of their wards: It is the responsibility of the Senior Nurse to sign off the planned roster to authorise and confirm that it reflects an appropriate deployment of the nurse staffing resource that sits within the establishment for each ward.

9.1 Systems and Processes for Reviewing

The Health Board is required to put into place systems that allow them to review and record every occasion when the number of nurses deployed varies from the planned roster.

This will include making a record of the rationale that underpins a decision to appropriately vary the planned roster in response to patient acuity /dependency across the hospital system.

All reasonable steps taken to maintain the nurse staffing level as per the planned roster will be recorded and reviewed through the nursing management structure and reported/escalated to the designated person in line with the level of risk the situation demands.

The actions that would be seen to be ‘all reasonable steps’ at a strategic level include:

- Workforce planning for a continued supply of required staff.
- Active recruitment in a timely manner at local, regional, national and international level.
- Retention strategies that includes consideration of the NHS Wales Staff Survey.
- Well-being at work strategies that support nurses in delivering their roles.

The actions that would be recognised as ‘All Reasonable Steps’ in maintaining the nurse staffing level in the immediate to short term, at an operational level, include:

- Use of temporary staff from a nursing bank appropriate to the skill mix set out in the planned roster
- Use of temporary staff from a nursing agency appropriate to the skill mix set out in the planned roster (once bank staff have been considered)
- Temporary use of staff from other areas within the organisation. (When considering using staff from other areas within the organisation individuals should consider and take due regard of the duty placed upon the organisation in section 25A to have sufficient nurses to allow the nurses time to care sensitively for patients wherever nursing services are provided. In addition, decisions about moving staff should take into consideration the staff member's competency and skills).
- Considering the temporary closure of beds.

10.0 DUTIES AND RESPONSIBILITIES OF STAFF

The responsibility for meeting the requirements of the Act spans from the ward/ service to the Board.

10.1 Strategic duties & responsibilities

Chief Executive Officer of the Health Board

The Chief Executive Officer is ultimately responsible for ensuring the Health Board complies with the Nurse Staffing Levels (Wales) Act 2016.

Executive Board

When exercising their responsibilities, the Board should consider and have due regard of the duty on them (under section 25A of the Act) to have sufficient nurses to allow the nurses time to provide sensitive care wherever nursing services are provided.

Specific members of the Board - the Directors of Nursing, Workforce & Organisational Development, Finance and Operations - are required to provide evidence and professional opinion to the Board to assist with its decision making in relation to maintaining the nurse staffing level in adult acute medical and surgical in-patient wards.

The Board are required to:

- Designate a person (or a description of a person) to be responsible for calculating the nurse staffing level in settings where Section 25B of the Act applies;
- Determine which ward areas meet the definitions of the adult acute medical and surgical inpatient wards;
- Receive and agree written reports from the "designated person" on the nurse staffing level for each adult acute medical and surgical inpatient ward at a public board on an annual basis and at any other time when the "designated person" deems this to be required;

- Ensure that systems are place to record and review every occasion when the number of nurses deployed varies from the planned roster; and
- Agree the operating framework which will:
 - o Ensure there are systems and processes in place and specify the decisions in relation to maintaining nurse staffing levels.
 - o Specify the actions to be taken, and by whom, to ensure that all “reasonable steps” are taken to maintain the Nurse Staffing Level on both a long term and a shift by shift basis.
 - o Specify the arrangements for informing patients of the nurse staffing level on each ward along with the date this was agreed by the Board. The information should be set out in an easily accessible format and must comply with requirements under the Welsh Language standards

The Executive Director of Nursing

The Executive Director of Nursing of Nursing, Midwifery & Patient Safety:

- The “designated person” within the UHB who is authorised, on behalf of the Chief Executive Officer, to calculate the nurse staffing level for each adult acute medical and surgical inpatient ward. The ‘designated person’ will calculate the number of registered nurses appropriate to provide patient centred care that meets all “reasonable requirements” in adult acute medical and surgical inpatient wards and must undertake and record the rationale for the calculation.
- Will undertake the nurse staffing level calculation for the adult acute medical and surgical inpatient wards every 6 months or more frequently if there is a change in the use/service which is likely to alter the nurse staffing level, or if they deem it necessary.
- Must formally present the nurse staffing level for each adult acute medical and surgical ward to the Board on an annual basis. In addition, written updates will be provided to the Board if the nurse staffing level on any ward has been changed for any reason.

In addition the Executive Director of Nursing of Nursing, Midwifery & Patient Safety will:

- Advise members of the Board on professional nursing standards including those relating to Nurse Staffing Levels.
- Will undertake the nurse staffing level calculation in all areas where Section 25A applies
- Report to the Board the impact that not maintaining the nurse staffing levels has had on the care provided to patients by nurses and the actions taken in response to not maintaining nurse staffing levels.

Director of Workforce and OD

The Director of Workforce and OD is required to ensure:

- An effective system of workforce planning, based on the Welsh Planning System, is in place in order to deliver a continuous supply of the required numbers of staff;
- That there are systems to ensure active and timely staff recruitment (at both a local, regional national and international level);
- That there are effective staff well-being and retention strategies in place that take account of the NHS Wales Staff Survey;
- That, working in collaboration with the Executive Director of Nursing of Nursing, Midwifery & Patient Safety, there is a strategic recruitment plan in place for nurse staffing across the acute sector, and
- That there is a robust process in place for the management of recruitment into nurse staffing vacancies that is in line with agreed vacancy management plan for the area.
- Ensure strategic requirements of the Act embedded into the organisations IMTP/annual planning process;
- Robust workforce planning at ward/service level which are reviewed at least annually through IMTP /education commissioning processes;

Director of Operations:

The Director of Operations is responsible for ensuring that there are operational processes in place that enable:

- The use of appropriately skilled, temporary (bank or agency) nursing;
- The temporary redeployment of staff between areas;
- The temporary closure of beds ; and
- Consideration of changes to the patient pathway as means through which to maintain nurse staffing levels where required. These processes should be reflected in the Board's escalation policy and business continuity plans.

Director of Finance:

The Director of Finance is responsible for:

- Ensuring that the funding of the agreed nurse staffing level is from the health board's revenue allocation and that it takes into account the actual salary points of staff employed on the wards where section 25B applies.

Assistant Director of Nursing & People's Experience

The Assistant Director of Nursing with responsibility for workforce will:

- Provide leadership and direction for the development and implementation of consistent systems to enable operational compliance with the requirements of the Nurse Staffing Levels (Wales) Act.
- Ensure that support and training in the use of the various nurse staffing levels calculation and maintenance tools and systems (including risk assessment tools), is made available to operational teams in a timely manner

- Manage the processes for undertaking the six monthly re-calculation/review of the nurse staffing levels for all wards that fall under Section 25B of the Act in a timely manner.
- Provide Annual Reports to Board as per AWNSA Board reporting schedule.

10.2 Acute Services Operational Teams (Site/Directorate)

ILG Nurse Directors

- Provide professional guidance to Heads of Nursing in relation to the professional judgement to be applied to the data/criteria which must be used to inform the calculation of the Nurse Staffing Levels for wards included under Section 25B of the Act.
- Contribute to the 6 monthly, detailed discussions that are required when calculating the nursing staff levels for the wards where Section 25B applies and initiate /recommend a review when there is a change in service/use of any clinical ward /area which is likely to change the nurse staffing levels.
- Contribute to the processes to be implemented for calculating the nursing staff levels for the situations where 25A applies.
- Be responsible for monitoring and providing assurance that the professional standards in relation to the nurse staffing level at operational level are being maintained; and that the agreed systems and processes are being applied across all acute hospital sites.
- Be responsible for ensuring that the systems in place to review and record the occasions when the number of nurses deployed varies from the planned roster, are fully complied with at all times across all sites.
- Ensure that effective risk assessment processes and systems are in place and utilised as required.

Head of Nursing

- Provide professional leadership and guidance to their operational nursing teams in the calculation of the Nurse Staffing Levels based upon the requirements set out in section 25B & 25C of the Act.
- Contribute to calculating the nursing staff levels for the situations where 25B applies every six months at minimum, and when there is a change in service/use which is likely to change the nurse staffing levels; and on an annual basis for all other areas.
- Contribute to calculating the nursing staff levels for the situations where 25A applies
- Review the patient acuity and quality indicator data and provide information that enables the Executive Director of Nursing to exercise professional judgement when calculating the nurse staffing levels.
- Ensure that when the planned roster varies in response to the clinical situation, the ward sister/charge nurse and senior nurse are

continuously assessing the situation and keep the “designated person” appraised.

- Ensure that the systems in place to review, record and report every occasion when the number of nurses deployed varies from the planned roster are utilised.
- Ensure that all “reasonable steps” are undertaken to maintain the nurse staffing level.
- Ensure any staffing risks or concerns are managed appropriately and timely and that patient care and safety and that nurses are not compromised over Nurse Staffing Levels. Identify all risks that require a corporate management or professional intervention must be escalated to the appropriate Executive leaders within the organisation.
- Ensure adequate operational management capacity is in place to enable appropriate response to escalating staffing concerns both in and out of hours.
- Appropriate and timely use of the escalation policy relating to nurse staffing and reporting and management of risk

Clinical Service Group Managers

- Ensure own knowledge of this policy, the Act and the statutory guidance.
- Ensure systems are in place within Directorates/services to ensure that the nurse staffing level is calculated as per the requirements of the statutory guidance for the situations where Section 25B of the Act applies and annual for all other areas, including budget setting.
- Ensure systems are in place within Directorates/services to ensure that the nurse staffing level is calculated as per HB policy for the situations where Section 25A of the Act applies.
- Ensure that this policy, the Act and statutory guidance are applied to hospital site management decision making both in and out of hours.
- Ensure that systems are in place to enable any required multi-disciplinary team learning from individual as well as collated nurse-staffing related Datix reports within the service, ensuring trends identified and acted upon.
- Ensure that service planning (e.g. those within IMTP) takes account of the requirements set out in the Nurse Staffing Levels (Wales) Act. Ensure efficient and effective vacancy approval processes are in place within the Directorate/service to minimise delays within recruitment processes and escalate any delays that are outside the control of the operational team.

Senior Nurses

- Contribute to calculating the nursing staff levels for the situations where 25B applies every six months at minimum, and when there is a change in service/use which is likely to change the nurse staffing levels and on an annual basis for all other areas.

- Contribute to calculating the nursing staff levels for the situations where 25A applies
- Support teams within their service area to undertake the bi-annual acuity audits (or more frequently if required) and is responsible for validating and confirming the acuity data collected.
- Ensure effective and efficient use of nurse staffing resources to support safe, effective and fair advance planning by signing off the planner roster.
- In accordance with paragraph 14 of the statutory guidance the Senior Nurse, along with the Senior Sister/Charge Nurse, should continuously assess the clinical environment and keep the Head of Nursing formally apprised of the situation.
- Proactively manage daily workforce planning across areas of responsibility to ensure staff are distributed according to clinical need.
- Ensure risk assessment is complete.
- Ensure that all “reasonable steps” are undertaken to maintain the nurse staffing level and escalate any concerns.
- Escalate to relevant professional heads of nursing areas of concern or inability to fill shifts.
- Should ensure that on occasions when the nurse staffing level is not maintained that these occasions are reported as a Datix incident.
- Review, record and report every occasion when the number of nurses deployed varies from the planned roster, and ensure the mitigating actions are sufficient to maintain a safe service to both service users and staff.
- Review all Datix reports and undertake final grading of all investigations and identify any trends or issues that arise and that these are actioned.
- Ensure that the vacancy process is undertaken in a timely manner.
- Ensure that the “Temporary use of staff from other areas within the organisation Log” (Appendix 1) is complete in the event of staffing being moved from other areas within the organisation.
- Appropriate and timely use of the escalation policy relating to nurse staffing and reporting and management of risk
- Regular review of the acuity of the patients on the ward, including the identification and risk management of patients.

Sister / Charge Nurse

- Undertake the daily acuity audits
- Actively involved in review of the bi-annual acuity audits (or more frequently if required) within their area and is responsible for validating and confirming the accuracy and completeness of the acuity data collected.
- Responsible for assessing the holistic needs of the patients and for classifying these under the Welsh Levels of Care descriptors as part of the evidence based workforce planning tool process.

- Make available their opinions about the nurse staffing levels to the Head of Nursing/Senior Nurses when nurse staffing level for their ward is being calculated.
- Maintain the system for informing patients of the nurse staffing levels.
- Has 24hr responsibility for the standards of care on the ward; this includes responsibility for ensuring human resources are planned effectively and efficiently.
- Ensures effective roster management in line with the rostering policy.
- Use of a robust electronic rostering tool and strong governance systems to monitor and review the rosters and ensure effective utilisation of the nursing workforce (e.g. review the staffing roster on a day to day basis, explore with staff member rescheduling annual leave and/or change of shift, postponing staff training/ study leave);
- Effective resource management, utilisation and deployment of staff e.g. appropriate allocation of annual leave and study leave, staff working overtime (within WTE), additional hours or use of hours owed;
- Regular review of the acuity of the patients on the ward, including the identification and risk management of patients requiring 'enhanced patient support' in line with local policy and professional judgement;
- In accordance with paragraph 14 of the statutory guidance the Senior Sister/Charge Nurse should continuously assess the clinical environment and keep the Senior Nurse/Head of Nursing formally appraised of the situation.
- Ensure that all "reasonable steps" are undertaken to maintain the nurse staffing level and escalate any concerns.
- Should ensure that on occasions when the nurse staffing level is not maintained that these occasions are reported as a Datix incident
- Review, record and report every occasion when the number of nurses deployed varies from the planned roster.
- Appropriate and timely use of the escalation policy relating to nurse staffing and reporting and management of risk

Nurse in Charge of Shift

- Ensure own knowledge of this policy, the Act and the statutory guidance.
- Assess the holistic needs of the patients and classifying these under the Welsh Levels of Care descriptors as part of the evidence based workforce planning tool process.
- Ensure that all "reasonable steps" are undertaken to maintain the nurse staffing level and escalate any concerns.
- Appropriate and timely use of the escalation policy relating to nurse staffing and reporting and management of risk
- Ensure that on occasions when the nurse staffing level is not maintained that these occasions are reported as a Datix incident

Individual Registrant Responsibility

- Ensure own knowledge of this policy, the Act and the statutory guidance.

- Responsible for raising a concern with managers using the Datix concern and incident reporting system at times when the nurse staffing levels have not been maintained.
- Awareness that all staff may be moved to another area to work, if required. Any movement of staff will take into account the individual's competency and skills.

Clinical Site Manager / Bed Manager

During the out of hours periods, the Clinical Site managers are responsible for:

- Ensuring their own knowledge of this policy, the Act and the statutory guidance.
- Maintaining an overview of staffing and patient acuity across the site.
- At operational site meetings, escalating staffing issues to the responsible Senior Nurse.
- Ensuring that all “reasonable steps” are taken to maintain nurse staffing levels including adjusting the nurse staffing levels to match the patient workload or changing the workload to match the nurse staffing level and step down of any surged beds (Clinical Site Managers should consider and take due regard of the duty placed upon the organisation in section 25A to have sufficient nurses to allow the nurses time to care sensitively for patients wherever nursing services are provided).
- Ensuring that an appropriate risk assessment is complete if nurse staffing levels are not maintained.
- Completing the “Temporary use of staff from other areas within the organisation Log” (Appendix 1) in the event of staffing being moved from other areas within the organisation out of hours.
- Escalating concerns to the on call manager.

Senior Manager on-call

During the out of hours periods, the On Call Executive is responsible for:

- Ensuring their own knowledge of this policy, the Act and the statutory guidance.
- Ensuring that all “reasonable steps” are taken to maintain nurse staffing levels including adjusting the nurse staffing levels to match the patient workload or changing the workload to match the nurse staffing level and step down of any surged beds (the on call managers should consider and take due regard of the duty placed upon the organisation in section 25A to have sufficient nurses to allow the nurses time to care sensitively for patients wherever nursing services are provided).
- Ensuring an appropriate risk assessment is complete.
- Escalating concerns to the on call executive.

Executive on-call

During the out of hours periods, the on-call executive is responsible for:

- Ensuring their own knowledge of this policy, the Act and the statutory guidance.
- Ensuring that all “reasonable steps” are taken to maintain nurse staffing levels including adjusting the nurse staffing levels to match the patient workload or changing the workload to match the nurse staffing level and step down of any surged beds (the on call managers should consider and take due regard of the duty placed upon the organisation in section 25A to have sufficient nurses to allow the nurses time to care sensitively for patients wherever nursing services are provided).
- Ensuring an appropriate risk assessment is complete.

The detailed roles and responsibilities of post holders that sit within the Health Board’s ‘Nursing Management Structure’ are set out in appendix 2 of this document.

11.0 ESCALATION PROCEDURE

Escalation procedures for maintaining nurse staffing levels:

This escalation process reflects a risk assessment approach aimed at supporting staff who have a responsibility for maintaining nurse staffing levels. The procedures outlined in the Escalation Procedure (Appendix 1) are aimed at providing consistency with identified triggers and responsibilities, which staff may need to interpret and apply as circumstances determine.

The nurse in charge of the shift on the ward must escalate where it is assessed that the number of nurses deployed varies from the planned roster. In addition, the nurse in charge of the shift/Senior Sister/Charge Nurse should consider escalating the situation when the quality indicators in the table below - which reflect patient outcomes that are deemed to be nursing-sensitive - occur.

Quality indicators which reflect patient outcomes that are deemed to be nursing-sensitive Nursing ‘Red Flag’ Events (NICE 2014)
• Unplanned omission in providing patient medication
• Delay of more than 30mins in providing pain relief
• Patient vital signs are not assessed or recorded as outlined in the care plan
• Inability to undertake regular checks on patients to ensure their fundamental care needs are met as outlined in the care plan. This is often referred to as ‘intentional rounding’ and involves checks on aspects of care such as the following: - o Pain: asking patients to describe their level of pain level using the pain assessment tool. - o Personal needs: such as scheduling patient visits to the toilet or bathroom to avoid risk of falls and providing hydration.

- o Placement: making sure that items a patient needs are within easy reach - o Positioning: making sure that the patient is comfortable and the risk of pressure ulcers is assessed and minimised
• Less than 2 Registered nurses present on a ward during any shift
• A shortfall of more than 8 hours or 25% (whichever is reached first) of registered nurse time available compared with the actual requirement for the shift. - o For example, if a shift requires 40hrs of registered nurse, a red flag event would occur if less than 32 hours of registered nurse time is available for that shift. - o If a shift required 15hrs of registered nurse time, a red flag event would occur if 11 hours or less of registered nurse time is available for that shift (which is a loss of more than 25% of the required registered nurse time).



Determining the Risk Score

1. Describe the current risk status in terms of consequences to patient safety and experience
2. Score the consequences from 1 (no/low risk to patient safety) to 5 (serious patient safety concerns/risks) (see Table 1 for descriptors)
3. Score the likelihood of further deterioration to patient safety unless further actions are taken over and above the current levels from 1 (unlikely) to 5 (almost certain) (see Table 2 for descriptors)
4. Calculate the risk score by multiplying the consequences by the likelihood
 $\text{CONSEQUENCES} \times \text{LIKELIHOOD} = \text{RISK SCORE}$ (Table 3)
5. The resulting score determines the staffing escalation level
6. Is the score correct? – If the actions you need to take at this level are proportionate to the score then the assessed level is likely to be correct. If not, then review and reassess your score

Table 1 Consequences

CONSEQUENCES		
Frequency		Probability
1	Negligible	Negligible. Very low risk to patient safety, where harm to patients is highly unlikely
2	Minor	Low risk to patient safety, although harm to patients is very small or unlikely
3	Moderate	Risk to patient safety which required urgent 'same' day action
4	High Risk	High risk to patient safety and immediate action required e.g. <i>Recorded fall; Recorded pressure ulcer developed or worsened; Medication administration error (error in preparation, administration or omission of medication)</i>
5	Extreme	Significant risks to patient safety, which are likely to result in harm to patients. Immediate and extraordinary action required

Table 2 Likelihood Probability Descriptors

LIKELIHOOD		
Descriptor		Probability
1	Rare	<0.1 per cent
2	Unlikely	0.1 – 1 per cent
3	Possible	1 -10 per cent
4	Likely	10 - 50 per cent
5	Almost Certain	> 50 per cent

The risk score will put you in a range within an individual nurse staffing alert e.g. a consequence of 4 but a likelihood of 3 will give a score of 12 or 'low level' whereas the same consequence but with a likelihood of 4 will give a score of 16 or 'high level' amber. This should help Senior Nurses in the prioritisation of control measures for the management of different nurse staffing risks and whether they need to consider actions above those described at this level. For example, if the level is 16 then consideration of actions required at the red level maybe considered at this stage.

	Table 3 RISK SCORING MATRIX				
Consequences					
Likelihood	1	2	3	4	5
1	1	2	3	4	5
2	2	4	6	8	10
3	3	6	9	12	15
4	4	8	12	16	20
5	5	10	15	20	BCI

Once the risk score has been determined staff should refer to the Escalation Alert Level (Table 4) and follow the Nurse Staffing Escalation Plan (Appendix 1 below).

Table 4 Escalation Alert Levels				
GREEN	YELLOW	AMBER	RED	BCI

Steady State	Action Required	High Risk	Very High Risk	Business Continuity Incident
Score 1-4	5-10	12-16	20	25
Risk to Patient Safety and Experience				

12.0 TRAINING

Any training required for the operational teams will be professionally managed through the Hospital/Directorate management team.

Any training required from a corporate perspective will be professionally managed via the Nursing, Quality and Experience Support Teams.

13.0 MONITORING, REPORTING AND AUDITING

The Health Board will have systems in place to be able to monitor the level/frequency of compliance with the planned roster. In addition, systems will be in place in order to monitor incidents which may/have been impacted upon by the nurse staffing levels. The information generated from these monitoring processes will inform the professional judgement which is applied to each 6-monthly calculation cycle. The monitoring data described here will be shared as part of an annual report to the UHB as well as the statutory, three yearly report to Welsh Government.

A full review of this policy will be undertaken every two years or sooner if there are changes to guidance or legislation. On-going monitoring and auditing of this policy will be undertaken by Corporate Nursing who receive regular reports on compliance with the Act.

14.0 NON CONFORMANCE

All staff are required to comply with this Policy and where requested demonstrate such compliance. Failure to comply will be dealt with under the appropriate Workforce Policy.

15.0 RETENTION / ARCHIVING

Requests for information under the Act will be retained and archived in line with National Records Management Guidance. This Policy will be subject to version control and archived as required by local policy.

16.0 REFERENCES

Berwick (2013) *A promise to learn a commitment to act. Improving the Safety of Patients in England*. National Advisory Group on the Safety of Patients in England

Francis (2013) *Report of the Mid-Staffordshire NHS Foundation Trust Public Enquiry* London. The Stationary Office

Keogh Review (2013) *into the quality of care and treatment provided by 14 hospital Trusts in England*. NHS England

NICE (2014) safe staffing for nursing in adult inpatient wards in acute hospitals. NICE

NMC (2015) *The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives*

Welsh Government (2016) *Nurse Staffing Levels (Wales) Act (2016) Operational Framework*

Appendix 1



Nursing Staffing Levels (Wales) Act (2016) All Reasonable Steps

All Reasonable steps

Reasonable steps which should be taken at each of the following levels - national, strategic corporate (Local Health Board/ NHS Trust) and operational – to maintain the nurse staffing levels are considered to be:

National steps

- The sharing and benchmarking of corporate data.
- Leading of regular reviews of workforce and education commissioning requirements.
- Leading national initiatives to aid staff recruitment and retention.

Strategic corporate steps

- Workforce planning for a continued supply of required staff assessed using the Welsh Planning System.
- Active recruitment in a timely manner at local, regional, national, and international level.
- Retention strategies that include consideration of the NHS Wales Staff Survey results;
- Well-being at work strategies that support nurses in delivering their roles.
- Ensure strategic requirements of the Act embedded into the organisations IMTP/annual planning process.
- Robust workforce planning at ward/service level which are reviewed at least annually through IMTP education commissioning processes.
- Workforce policies and procedures which support effective staff management (eg: flexible working for staff).
- Robust organisational risk management framework.
- Effective risk assessment processes and systems are in place and utilised as required.

Operational steps

- Use of temporary staff from a nursing bank appropriate to the skill mix set out in the planned roster.

- Use of temporary staff from a nursing agency appropriate to the skill mix set out in the planned roster (once bank staff have been considered).
- Temporary use of staff from other areas within the organisation.
- The temporary closure of beds.
- Consideration of changes to the patient pathway (which should be clinically appropriate).
- Effective resource management, utilisation and deployment of staff e.g. appropriate allocation of annual leave and study leave, staff working overtime (within WTE), additional hours or use of hours owed.
- Use of a robust electronic rostering tool and strong governance systems to monitor and review the rosters and ensure effective utilisation of the nursing workforce (e.g. review the staffing roster on a day to day basis, explore with staff member rescheduling annual leave and/or change of shift, postponing staff training/ study leave).
- Ward sister/charge nurse to work within the planned roster.
- Regular review of the acuity of the patients on the ward, including the identification and risk management of patients requiring 'enhanced patient support' in line with local policy and professional judgement.
- "On Boarding". This is the term used when, in very unusual and exceptional circumstances, a patient is required to be placed on the ward and no bed is available. This practice has been extensively discussed within WG and NHS Wales and it is acknowledged that this is not best practice. In the rare event that this is deemed necessary, in line with NHS Wales escalation processes all Health Boards should have in place a clear escalation protocol that includes the circumstances in which this may be considered and the process for implementation. This should also include the requirement that any instance is immediately escalated/reported through the incident management systems within the Organisation and to the Chief Operating Officer and the Executive Nurse Director in hours and out of hours the Executive Director on call to be notified. On the rare occasion that on-boarding occurs this must be time limited and all HB's must have a de-escalation process in place. Should this rare situation occur, at the time of the audit, then the acuity of any such patient should be recorded on HCMS and the escalation / incident reporting situation must be followed.
- Appropriate and timely use of the escalation policy relating to nurse staffing and reporting and management of risk.
- Should this rare situation occur, at the time of the audit, then the acuity of any such patient should be recorded on HCMS and the escalation / incident reporting situation must be followed.

Appendix 2 – Nurse Staffing Escalation Procedure for Staffing Shortfalls

NURSE STAFFING ESCALATION PLAN				
GREEN	YELLOW	AMBER	RED	BLACK
STATUS	STATUS	STATUS	STATUS	STATUS
No reported concern or compromise to patient care or safety due to the available staffing in an area	Reported concern over the Nurse Staffing Level however there is no predicted risk to patient care or safety	Reported concern over the Nurse Staffing Level with risk of patient care being compromised impacting on the patients required care interventions (medication, observation, input or output), progress, outcomes, or dignity	Reported concern over the Nurse Staffing Level with a significant risk of patient care or safety being compromised	
TRIGGERS	TRIGGERS	TRIGGERS	TRIGGERS	TRIGGERS
Able to maintain the agreed staffing levels	- Deficits caused by unplanned absence - Redeployment or temporary staff utilisation unavailable - Increased activity/dependency e.g. enhanced patient support - One shift in 24 hours not staffed to agreed level but to a level that meets the current service demand (occupancy, dependency, activity and complexity)	- Multiple shifts not staffed to agreed level but to a level that meets the current service demand (Occupancy, Dependency, Activity and Complexity) - Shortfall of 25% RN time available for requirement of shift and skill mix is not met	- Significant or ongoing shifts not staffed to the agreed level - Compromised ability to meet current inpatients occupancy rate, dependencies, acuity or complexity - A deficit of 2 RNs present on a ward during any shift - Inability to de-escalate from high	Significant deficits of less than 2 RNs on multiple wards during any shift to agreed staffing template which may be short notice or persistent (Risk assessment matrix score 25) or Declaration of Business Continuity Incident (BCI)

	• RN numbers available however skill mix is not met • Nurse Staffing Level maintained but the qualifications, competency, skills and experience of the nurses providing care is insufficient		risk (amber) after 24 hrs	

ACTION	ACTION	ACTION	ACTION	ACTION
No action required All areas safely staffed and operational Continue to monitor	IN HOURS Consider: - Professional judgement of staffing needs - Realign rotas including skill mix - Divert internal resources to areas of greatest risk. - Consider utilisation of part time staff - Report exact shortage to Senior Nurse - Contact Nurse Bank Office - Report shortage and contingency plan at Site/Bed meeting - Report on DATIX including risk assessment and mitigating actions	IN HOURS Consider: - Escalate to Senior Nurse - Check Yellow action plan and risks identified completed - Senior Nurse review staffing across service area - Ask other care groups to review rotas and workload - Consider deployment of specialist nurses - Consider additional hours, overtime and agency authorisation - Consider cancelling of Management time and study leave. - Report shortage and contingency plan at Site meeting - Update DATIX including risk assessment and feedback outcome of escalation to Ward - Escalate to Head of Nursing if inadequate staffing levels still exist	IN HOURS Check Amber action plan and risks identified completed ESCALATION and REVIEW meeting with: - ILG Director of Nursing - Head of Nursing - CSG Director / Director of Operations Senior Team considers: - Temporary partial bed closure - Cancellation of non urgent electives - Cancellation of Outpatient activity - Cross organisation response and support - Divert options - Update DATIX and feedback outcome to Senior Nurse/ Site manager - Urgent implementation of plan to de-escalate staffing concerns and avoid need to declare a BCI - ASSESS and ADVISE timeframe for recovery/ de-escalation	N HOURS - ILG Nurse Director to escalate to the Executive Director of Nursing with Chief Operating Officer involvement in decision regarding: - Declaration of Business Continuity Incident (BCI) - Initiate (BCI) Plans

	Out of hours •Escalate to Clinical Site Manager	Out of hours • Escalate to Clinical Site Manager/Bed Manager • If unresolved Site Manager refers to Senior Manager On Call	Out of hours • Escalate to Senior Manager On Call (SMOC) • SMOC to escalate to to Executive On call	Out of hours • Senior Manager On Call (SMOC) escalates to Executive On call for decision re BCI • Declare Business Continuity Incident (BCI) • Initiate (BCI) Plans

Appendix 3

Equality Impact Assessment - Policies

Section 1: Preparation

This section must be completed at the beginning of a policy review. For advice on its completion please contact the Equality Team on 01443 744800. For examples of completed EIAs please see the Equality site under Useful Staff Information on Sharepoint.

Section 1 – Preparation		
1.	Title of Policy - what are you equality impact assessing? Please state whether it is a new or existing policy?	Nursing Staffing Levels and Escalation Plan: Acute Adult Services Policy
2.	Policy Aims and Brief Description	The purpose of this policy is to support the calculation and maintenance of nursing staffing levels in Adult Acute Services, and the actions that are taken to review, report and escalate where nurse staffing levels are not maintained. To provide open transparent information on nursing staffing levels within Adult Acute Services.
3.	Who Owns/Defines the Policy?	Executive Director of Nursing, Midwifery and Patient Services. Corporate Nursing
4.	Who is Involved in undertaking this EqIA	Head of Corporate Nursing
5.	Other Policies	Risk Management Policy Incident Reporting Policy Business continuity policy Flexible Working Policy Integrated Medium Term Plan (IMTP) 2019/20

Section 1 – Preparation		
7.	What might help/hinder the success of the policy?	Relevant staff working within the UHB may not being aware of the policy
8.	Is the policy relevant to “eliminating discrimination and eliminating harassment?”	The policy provides the structure and process for all other policies and therefore does not directly eliminate discrimination and harassment
9.	Is the policy relevant to “promoting equality of opportunity?”	The aim of all Cwm Taf Morgannwg UHB policies will be to promote the equality of opportunity.
10.	Is the policy relevant to “promoting good relationships and positive attitudes?”	The aim of this policy is to promote good relationships and positive attitudes.

Section 2. Impact	
Please answer the following Consider and refer to the information you have gathered from census data, relevant organisations and groups, staff groups, individuals etc. Please indicate the likelihood and risk associated with the issues raised.	
Do you think that the policy impacts on people because of their age? (This includes children and young people up to 18 and older people)	Not Specifically
Do you think that the policy impacts on people because of their caring responsibilities? I.e, would it affect their ability to care for somebody who is primarily dependant on them?	Not Specifically
Do you think that the policy impacts on people because of their disability? E.g. sensory loss, physical disability, Learning disability, some mental health issues	Not Specifically
Do you think that the policy impacts on people because of Gender reassignment? This includes	Not Specifically

Section 2. Impact	
all people included under trans* e.g. transgender, non-binary, gender fluid etc	
Do you think that the policy impacts on people because of their being married or in a civil partnership?	Not Specifically
Do you think that the policy impacts on people because of their being pregnant or having recently had a baby?	Not Specifically
Do you think that the policy impacts on people because of their race? (This includes colour, nationality and citizenship or ethnic or national origin such as Gypsy and Traveller Communities.)	Not Specifically
Do you think that the policy impacts on people because of their religion, belief or non-belief? (Religious groups cover a wide range including Buddhist, Christians, Hindus, Jews, Muslims, and Sikhs)	Not Specifically
Do you think that the policy impacts on men and woman in different ways?	Not Specifically
Do you think that the policy impacts on people because of their sexual orientation? (This includes Gay men, heterosexual, lesbian and bisexual people)	Not Specifically
Do you think that the policy impacts on people because of their Welsh language? (e.g. the active offer to receive services in Welsh, bilingual information etc)	Not specifically

The Human Rights Act contains 15 rights, all of which NHS organisation have a duty to act compatibly with and to respect, protect and fulfil. The 7 rights that are particularly relevant to healthcare are listed below. Consider the relevance of your Policy to these Human Rights and list any available information to suggest the Policy may interfere with, or restrict the enjoyment of these rights.

The right to life
No specific impact

The right not be tortured or treated in an inhuman or degrading way
No specific impact

The right to liberty
No specific impact

The right to a fair trial
No specific impact

The right to respect for private and family life, home and correspondence No specific impact
The right to freedom of thought, conscience and religion No specific impact
The right not be discriminated against in relation to any of the rights contained in the Human Rights Act No specific impact on human rights identified.

Section 3 Outcome Report

Policy Title:	Nursing Staffing Levels and Escalation Plan: Acute Adult Services Policy
Organisation:	Cwm Taf Morgannwg University Health Board
Name: Title: Department: Date:	Sharon O'Brien Head of Corporate Nursing Corporate Nursing 3 rd June 2019
Summary of Assessment: Please indicate issues of significant concern and changes that will be made to the policy accordingly. Please indicate whether these changes have been made.	This policy concerns the Nursing Staffing Levels and Escalation Plan for Acute Adult Services within Cwm Taf Morgannwg UHB. There are no specific issues of concern identified in relation to equality and diversity. No changes are required.
Please indicate where issues have been raised but the policy has not been changed and indicate reasons and alternative action taken where appropriate.	Not applicable
Monitoring Arrangements:	Annual review by the Head of Corporate Nursing or in response to a particular issue.
Review Date: This is usually the same as the policy review date.	The policy will be reviewed annually by the responsible manager and a date for review will be agreed with the Director.
Signature of all Parties:	

Appendix 4

Privacy Impact Assessment Screening Questions

Answer the questions below to identify whether your policy/ procedure or project is likely to need a PIA.

	<i>Questions – please tick appropriate answer</i>	Yes	No
1.	Will the policy involve the collection of new information about individuals?		✓
2.	Will the policy compel individuals to provide information about themselves?		✓
3.	Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information?		✓
4.	Are you using information about individuals for a purpose it is not currently used for or in a way it is not currently used?		✓
5.	Does the policy involve you using new technology which might be perceived as being privacy intrusive? For example, the use of biometrics or facial recognition.		✓
6.	Does the policy result in you making decisions or taking action against individuals in ways which can have a significant impact on them?		✓
7.	Is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For example, health records or other information that people would consider to be particularly private?		✓
8.	Will the policy require you to contact individuals in ways which they may find intrusive?		✓

Where you have answered yes to one or more of these questions, it is a likely indication that a PIA would be a useful exercise. If you are in any doubt as to whether a PIA is required, support is available the information governance team.



AGENDA ITEM

2.2.15

CTM BOARD

NURSE STAFFING LEVELS ANNUAL ASSURANCE REPORT 2020-2021

Date of meeting	27 May 2021
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Ben Durham, Lead Nurse for Professional Practice and Quality Assurance
Presented by	Greg Dix, Executive Director of Nursing
Approving Executive Sponsor	Executive Director of Nursing
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	Date	Outcome
(Insert Name)	(DD/MM/YYYY)	Choose an item.

ACRONYMS	
NSLWA	Nurse Staffing Levels Wales Act
ILG	Integrated Locality Group

1. SITUATION / BACKGROUND

The Nurse Staffing Levels (Wales) Act (NSLWA) 2016 became law in March 2016 with the final sections of the Act coming into effect in April 2018.

Section 25E requires Health Boards/Trusts to report their compliance in maintaining the nurse staffing level for each adult acute medical and surgical ward. The Health Board (HB) must submit a three-yearly report to Welsh Government. To facilitate this, a process of submitting an annual assurance report, using a nationally agreed template, to each Health Board has been agreed through the All Wales Nurse Staffing programme.

The aim of this report is to provide an overview of the Health Board's level of compliance with the agreed nurse staffing levels; the impact upon the quality of care where the nurse staffing level was not maintained and the actions taken in response to this position

This annual report represents the third of three annual reports which will, when aggregated at the end of the 2018-2021 reporting period, form the basis of the statutory three year report to Welsh Government required by the NSLWA. The Annual report covers the time period from 6th April 2020 to 5th April 2021.

During this reporting period the COVID-19 pandemic has created many challenges within the HB, the Welsh Government position associated with the Nurse Staffing Levels (Wales) Act 2016 during these exceptional circumstances was to postpone the annual report to Board, due May 2020 to September 2020. In addition there has been further disruption to some of the All Wales Nursing Staffing Programme work streams. Most notable was the extension to the Act's second duty to Paediatric inpatient wards which was postponed until October 2021. Also during the reporting period, the bi-annual acuity audit for January 2021 was cancelled due to the ongoing COVID-19 pandemic.

The Board is asked to formally receive and note the information contained within the 2020/2021 Nurse Staffing levels (Wales) Annual Assurance Report (Appendix A) which has been produced using the prescribed NHS Wales reporting template.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

The 2020-2021 Nurse Staffing levels (Wales) annual assurance report (Appendix A) sets out the progress made within CTMUHB during 2020/21 (6th April 2020 - 5th April 2021) in relation to meeting the various statutory requirements of the NSLWA. For ease of providing assurance, the report is divided into the following sections:

- Section 25A, which addresses the Health Boards/Trusts overarching responsibility to ensure appropriate nurse staffing levels in any area where nursing services are provided or commissioned, in addition to the detailed requirements relating to adult medical and surgical wards (pages 1-2 of the report).
- The actions taken in relation to calculating the nurse staffing level on wards where section 25B applies (page 4-7 of the report).
- The use made of the triangulated approach to calculate the nurse staffing level on section 25B wards; and the use made of the principles underpinning this approach to provide the foundation for the work being undertaken to ensure appropriate nurse staffing levels are calculated for all areas where nursing services are provided (page 8 of the report).
- How the CTMUHB responsibilities to inform patients about nurse staffing levels are being met (page 8 of the report).
- The extent to which the nurse staffing levels in Section 25B wards have been maintained (pages 9-11 of the report).
- The robustness of the systems and processes in place for maintaining the nurse staffing level (page 12 of the report).
- The impact on care quality as a result of not maintaining the nurse staffing levels (page 13 of the report)
- The actions taken when nurse staffing levels have not been maintained, both in relation to specific incidents and when considering the more strategic challenges in maintaining the calculated staffing levels (page 14-15 of the report).
- Report conclusion (page 15-16 of the report)

Health Boards are required to submit a nurse levels report following the bi-annual acuity audit that is routinely undertaken in June however due to the COVID-19 pandemic the Welsh Government decided to postpone the June bi-annual acuity audit until July 2020.

Following the acuity audit undertaken in July 2020, wards that are under Section 25B were reviewed in order to ensure the calculation of the nurse staffing levels using prescribed methodology. These establishments have been authorised by the ILG Directors of Nursing. Each ward has been subjected to the triangulated approach and the workforce planning tool to produce a ward template.

The Board is asked to formally receive and note the information contained within the Annual Presentation of Nurse Staffing Levels to the Board (Appendix A) which has been produced using the prescribed NHS Wales reporting template.

Between June 2020 and 30th September 2020 within CTMUHB there have been multiple changes to 22 of the 29 wards at various points in response to COVID-19. 8 wards have been repurposed and defined as purely covid-19 wards. The Chief Nursing Officer letter 15th October 2020 clarified that these repurposed wards would remain within Section 25B of the Act unless they have been repurposed for Critical

Care or high care (non-Invasive Ventilation (NIV) capacity. All wards that remain under Section 25B of the Act within CTMUHB are displayed in Appendix B.

The January 2021 bi-annual acuity audit was cancelled, however since November 2020 the Heads of Nursing for the 3 District General Hospitals (DGHs) agreed to provide weekly reports charting any changes to wards within the acute sites. During this height of the 2nd wave of the COVID-19 pandemic, 21 section B wards had been repurposed into Red, Amber and Green as defined by Welsh Government (2020) COVID-19 – 16 point plan.

The extension to the 2016 Act second duty for Paediatric inpatient wards was postponed until October 2021, but work continued and a position paper has been submitted to the Board informing them that under the current clinical model for paediatric inpatient wards within CTM, there will be requirement to fund 43.87 wte Registered Nurse (RN) and 9.81 wte Healthcare Support Workers (HCSW) to be compliant within the 2016 Act.

Changes to note

Due to Covid-19 some of the wards within Section 25B of the Act, required their staffing establishments to be temporarily revised as wards were repurposed in response to COVID-19. Some wards have been repurposed to provide dedicated additional Covid-19 positive, critical care beds and high care respiratory beds. Due to these changes, some wards that were initially sitting within Section 25B of the Act currently sit outside Section 25B. These changes are described in more detail within the Annual Presentation of Nurse Staffing Levels to the Board (Appendix A). All wards that remain under Section 25B of the Act within CTMUHB are displayed in Appendix B.

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

The Board is asked to note, in particular, under this section there is a requirement to report if there has been an impact on care quality due to not maintaining the nurse staffing levels. The incidents which need to be reported under the Act yearly are the number of serious incidents/complaints where failure to maintain the nurse staffing level was considered to have been a factor for the following patient harm incidents:

- Hospital acquired pressure damage (grade 3, 4 and unstageable).
- Falls resulting in serious harm or death (i.e. level 4 and 5 incidents).
- Medication related never events.

In addition, from 2019/20, we are also required to consider whether a failure to maintain nurse staffing levels played any part in any/all complaints received about nursing care.

Table 1 within Appendix A sets out the number of serious incidents/complaints that occurred on 25B wards between 6th April 2020 to 5th April 2021. There is also a requirement to report where failure to maintain the nurse staffing level was considered to have been a contributory factor. During this reporting period, there have been 2 identified incidents/complaints directly reported where failure to meet the nurse staffing level has been recorded. However none of these met the threshold to be reported to Welsh Government.

Detail is provided in the final section of the annual assurance report (Appendix A) in relation to the key actions taken in response to specific incidents / nursing care concerns when nurse staffing levels were not maintained as well as the broader, more strategic actions being taken to ensure that both the numbers and the skill set of the nursing workforce is appropriate to provide sensitive and individualised care to all CTMUHB patients.

It is envisaged that wards within Section 25B will continue to be repurposed in response to resetting post COVID-19 and it is recognised that this will continue to present challenges in relation to the workforce required in order to deliver care within these repurposed wards.

4. IMPACT ASSESSMENT

Quality / Safety / Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Staff and Resources
	Safe Care
Equality impact assessment completed	Yes
Legal implications / impact	Yes (Include further detail below)
Resource (Capital / Revenue £ / Workforce) implications / Impact	Yes (Include further detail below)
Link to Strategic Well-being Objectives	Provide high quality, evidence based, and accessible care

5. RECOMMENDATION

The Board is asked to:

- NOTE the position of the Health Board against its responsibilities within the NSLWA with regard to the annual assurance report.



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

- NOTE the conclusions and recommendations have been reported on pages 11-12 of the annual assurance report (Appendix A).

Annual Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act 2016	
Health board	Cwm Taf Morgannwg University Health Board
Date annual assurance report with compliance with the Nurse Staffing Levels (Wales) Act is presented to Board	Date this report presented to Board 27th May 2021
Reporting period	The reporting period is 6 th April 2020 -5 th April 2021
Requirements of Section 25A Section 25A refers to the Health Boards/Trusts overarching responsibility to ensure appropriate nurse staffing levels <u>in any area where nursing services are provided or commissioned, not only adult</u>	Section 25A of the 2016 Act relates to the overarching responsibility placed upon each Health Board, requiring Health Boards and Trust to ensure they have robust workforce plans, recruitment strategies, structures and processes in place to ensure appropriate nurse staffing level across their organisation. The 2016 Act came into effect in April 2017. This annual assurance report set out the progress made within Cwm Taf Morgannwg University Health Board (CTMUHB) during 2020-2021 in relation to meeting the various statutory requirements of the 2016 Act. Due to the ongoing COVID-19 pandemic there has been disruption to some of the All Wales Nurse Staffing Programme work streams. The Chief Nursing Officer letter of 24th March 2020 specifically referenced the disruption that the Covid pandemic would cause to the ongoing work to extend the Act's second duty to paediatric inpatient wards. In October 2020 Welsh Government advised that the coming into force date for the extension has been postponed provisionally until October 2021. The Nurse Staffing Programme Team and the paediatric work stream have devised a suite of supportive mechanisms to prepare Health Boards for the extension of the second duty of the Act. Following a consultation process during the Autumn of 2020, the Statutory Guidance has been revised to include paediatric inpatient wards. CTMUHB has representation on each of the work stream groups within the All Wales Nurse Staffing Programme and is actively contributing to the development of evidence based workforce planning tools in

<u>medical and surgical wards.</u>	preparation for further extension of the 2016 Act to other areas in the future. During 2020-2021 a new Integrated Locality Group (ILG) structure within CTMUHB has been fully implemented and these ILGs have responsibilities to ensure that there are processes in place to ensure appropriate staffing levels within all wards that fall under Section 25A of the 2016 Act. The Executive Nurse Director has determined that a review of nurse staffing level across all clinical areas across all settings when nursing care is either provided and or commissioned in line with the requirement in Section 25A wards provides assurance that the principles behind the 2016 Act are considered. Since February 2020 staffing levels are reviewed, calculated by Locality Groups Nurse Directors and this is reported via Nursing and Midwifery workforce meetings. Between March 2020 and March 2021 any area that provides nursing care or commissioned areas that have been repurposed due to COVID-19 has been calculated accordingly and reported via CTMUHB Executive Management Board meetings. In addition there has been workforce efficiency meetings where the Locality Groups discuss and plan to ensure that the required workforce is fulfilled to meet the statutory guidance of 2016 Act, this includes trajectories in relation to retirement, estimated turnover and student streamlining into the CTM UHB. Under section 25A, staffing levels for all inpatient wards across the Health Board have been calculated to ensure that they can provide the level of care required for the patients within that area. During this reporting year 2020-2021, this has been a dynamic process which was reviewed twice weekly via the Bronze meetings within each Locality Group and decision making logs have been used to document decisions made at each meeting. Staffing levels have been agreed and if required adjusted to meet clinical model and patient acuity.
Progress to support for suite of workstreams under the All Wales Nurse Staffing Programme	The Chief Nursing Officer letter of 24th March 2020 specifically referenced the disruption that the Covid pandemic would cause to the ongoing work to extend the Act's second duty to paediatric inpatient wards. In October 2020 Welsh Government advised that the coming into force date for the extension has been postponed provisionally until October 2021. The Nurse Staffing Programme Team and the paediatric work stream have devised a suite of supportive mechanisms to prepare Health Boards for the extension of the second duty of the Act. Following a consultation process during the Autumn of 2020, the Statutory Guidance has been revised to include paediatric inpatients. Paediatric in-patient work stream: Within CTMUHB a Paediatric in-patient sub-group has been in place since June 2019 and a detailed implementation plan has been developed. Regular update reports to Management Board have been provided with the aim of ensuring organisational readiness for the extension of the 2016 Act in October 2021. Thus far, the schedule for this work has been as follow:

Paediatric Welsh Levels of Care - Whilst in draft currently, this continues to be tested by paediatric nurses across Wales. Quality improvement methodology is being used to support health boards in scoring patients twice daily.

Quality Indicators - Four nurse sensitive quality indicators have been proposed. This will consider how the patient acuity, quality indicators and professional judgement will enable triangulation to calculate nurse staffing levels for health board

Paediatric Principles - Nine interim principles for nurse staffing on paediatric wards have been developed as a framework to support health boards in calculating nurse staffing levels while the evidence base for the triangulated methodology is being developed. The UHB is working to comply with the following nine principles and it is noted that all Health Boards will be required to submit a return against them biannually.

A Board paper has been submitted informing the Board of the staffing requirement within every paediatric acute inpatient ward. The current paediatric clinical model for CTM UHB requires an additional 43 wte Registered Nurses (RNs) and 9.8 wte Health Care Support Workers (HCSW) in order to meet the requirement of the 2nd extension of the 2016 Act. It is estimated there will be a cost of £2.1m to meet this requirement.

District Nurse Staffing Principles

During 2020 CTMUHB has provided a 6 monthly progress report on compliance against the District Nurse Staffing principles to the Chief Nursing Officer (CNO). The sixth collection exercise against the District Nurse Staffing principles that was undertaken in September 2020 demonstrates that CTMUHB is continuing to make progress against the principles.

In January 2021 The CNO for Wales issued a formal letter that stated that given the current outlook of rising Covid19 infection rates and increasing strain on nursing services, she decided to cancel the biannual interim District Nurse staffing principles compliance return scheduled for March 2021.

Formal feedback was received on the 16th November 2020 and there was a message that continue steady progress is being made.

Since the last submission CTMUHB District Nursing service has been working closely to align the service of former Cwm Taff and Bridgend. Funding has been applied for to recruit additional DN team leaders and

	Administrative posts to support the Malinko implementation. Bridgend is reorganising to align existing post to meet the District Nurse Staffing principles. CTMUHB's performance against the core principles remains very strong with full compliance against principles 2, 3 and 8. Principle 4 and 5 are over 90% (it is not expected to achieve 100% return on these principles due to staff turnover). Principle 6, at the last return 93.1 % of the DN teams were compliant. For principle 7, CTMUHB are reporting an average of 29.1% uplift across the Organisation, which exceeds the principal of 26.9%, however there still exist differences within the various teams in CTM UHB. Mental Health and Health Visiting The All Wales Nurse Staffing Group has agreed that these work streams will require refocussing and revisiting the work undertaken to date in order to produce the next steps. Within Mental Health the All Wales programme lead the COVID-19 pandemic has had a significant impact, with planned workshops being cancelled. There has been progress in the Health Visiting work stream with the agreement on the acuity tool and how this will be piloted across Wales.
Actions taken in relation to calculating the nurse staffing level on section 25B wards during the reporting period. • Adult acute <u>medical</u> in patient wards • Adult acute	For clarity when discussing section 25B wards of the (2016) Act, these are all acute medical and surgical inpatient wards within HB and will be referred to Section 25 B wards or 25B wards of the Act. A bi-annual acuity audit is undertaken in January and June. The annual Nurse staffing level presentation was reported to CTMUHB Board on the 30th September 2020. The Board would normally receive the annual assurance report in June 2020, but it was disrupted by the COVID-19 pandemic. The Chief Nursing Officer for Wales issued a formal letter on the 24 March 2020 to provide Health Boards and Trusts with clarity and assurances around how COVID-19 pressures would disrupt the business as usual processes of the Nurse Staffing Levels (Wales) Act 2016 (NSLWA). Welsh Government left it to the discretion of each Health Board to decide whether to proceed or cease work on the bi-annual recalculation of adult medical and surgical wards. In accordance with the 'Once for Wales' approach Nurse Directors agreed that their organisations would defer the bi-annual audit and subsequent calculations of nurse staffing level until July 2020. In April 2020 guidance and templates were issued to Health Boards/Trusts to enable organisations to evidence the approach taken to determine the staffing levels that are required on their inpatient wards where

<u>surgical</u> inpatient wards	the required staffing level has been affected during the COVID-19 pandemic. The organisation presented a paper to Board in May 2020 to provide assurance on how nurse staffing levels were being/to be calculated and maintained during this period. In October 2020 The CNO issued a follow up formal letter providing further clarity, reflecting the changes organisations had been required to make to patient pathways/ designation of wards across their acute sites, on the definition of wards for inclusion/exclusion under Section 25B of the Act, and the expectations upon Health Boards in relation to calculating the nurse staffing levels in such wards The Health Board has implemented new ways of working and model of care in order to respond and meet the extreme and unprecedented pressure that the UHB has experienced in the reporting period due to the COVID-19 pandemic. This has required an extremely flexible approach to the deployment of the nursing workforce across the Health Board sites and many wards have been repurposed more than once to accommodate the clinical demands to meet the rise in demand for patients who require in-patient care due to COVID-19. The attached All Wales template (Appendix A) provides a summary of the staffing levels that have been calculated for each adult ward prior to and during the Covid 19 pandemic. The template outlines the wards that remain under section 25B of the Act, wards that have been repurposed and the rationale during January and July 2020, as part of the bi-annual calculation cycle and where it has been deemed necessary, outside of that cycle. Following the acuity audit undertaken in July 2020 as part of the bi-annual recalculation process, wards that are under Section 25B were reviewed in order to ensure the calculation of the nurse staffing levels using prescribed methodology. Following the review there have been changes in staffing levels required on these wards. These establishments have been authorised by the ILG Directors of Nursing. Each ward has been subjected to the triangulated approach and the workforce planning tool to produce a ward template. The January 2020 bi-annual acuity audit was conducted within CTMUHB, no changes were made to existing and funded establishments following this. At the beginning of the reporting period CTMUHB had 29, section 25B wards. In the Annual Report to Board in September 2020 (deferred May 2020), it was highlighted that due to COVID-19 some of the wards within Section 25B of the Act, required their staffing establishments to be temporarily revised as wards were repurposed in response to COVID-19. Some wards have been repurposed to provide dedicated additional COVID-19 positive, critical care beds and high care respiratory beds. Due to these changes, the wards listed below that were initially sitting within Section 25B of the Act currently no longer classed as Section 25B wards.

The report highlighted 22 of the 29 wards that are classed as 25B wards had seen some changes to their function and or had been reorganised/changed location within the hospital. At the time of this report 8 wards had been repurposed and defined as purely COVID-19 wards.

The bi-annual calculation audit was conducted in July 2020 (postponed from June), no section 25B wards required a recalculation of the staffing levels. The only changes following this process were the inclusion and exclusion of wards within Section 25B due to COVID repurposing

Appendix A provides the detailed nurse staffing levels for wards to which section 25B pertains to, from the initial reporting period to ending of the period for 2020-2021, there have been several wards that have either repurposed and been included into 25B wards or have been temporary removed due to the ward being repurposed for critical care or high care (non-invasive ventilation (NIV) capacity. This was clarified by the Chef Nursing Officer letter dated the 15th October 2020.

In July, wards that were added to 25B section within CTMUHB:

- Ward 7 (PCH) was repurposed from a ward focussing mainly on rehabilitation to a Covid acute medical ward
- At Princess of Wales Hospital (PoWh) the following wards were added; Bridgend clinic was repurposed from Private ward to a general surgical and Gynaecology ward. Ward 18 was repurposed to a trauma and orthopaedic ward staff having moved from Ward 10 that had been closed.

Wards that no longer sat within as Section 25B and therefore there was no requirement to undertake to the bi-annual calculation:

- Ward 7 at the Royal Glamorgan Hospital and ward 4 at Prince Charles Hospital continues to operate as an additional Critical Care area
- Ward 3 at Prince Charles hospital has changed from a surgical T&O ward to a high care respiratory ward for COVID-19 positive patients
- Ward 1 in the Royal Glamorgan hospital increased its bed capacity from 16 to 28 beds and there was requirement for an additional 8.33 WTE Registered Nurses and 8.53 WTE health care support workers.

It then was closed with plans to reopen once it has been refurbished to accommodate cubicles within the ward area.

Other changes

- In Royal Glamorgan Hospital (RGH) Ward 4 was repurposed and ward 14 moved into the ward area

Therefore in July 2020 CTMUHB had 31 wards within section 25B of the 2016 Act. The COVID-19 Pandemic has required hospital and consequently wards within section 25B of the 2016 Act to organise, reorganise and at times reorganise again to ensure safe patient care, this includes the repurposing of wards Red, Amber and Green wards as defined by the Welsh Government (2020) COVID-19 – 16 Point Plan to limit, minimise and mitigate the risks associated with transmission in a healthcare setting. In total 21 wards have been, at one time included in the COVID-19 RAG rating. Within this, wards have either been physically moved, swapped or closed, however the bed capacity on each open ward has remained constant, it is noted and for reporting purposes no formal staffing re-calculation has been required outside the biannual calculation.

Since November 2020 following engagement with the Heads of Nursing for the 3 acute hospitals, a process has been developed to ensure a weekly nursing workforce review where any changes to nursing establishments due to repurposing of wards will be reported via the Lead Nurse for Professional Standards to ensure the NSLWA workforce planning templates are updated accordingly.

On 18/12/20 the Executive Nurse Directors and the CNO discussed whether to proceed with the January bi-annual audit given the significant and increasing operational pressures all Heath Boards/Trusts were experiencing. It was decided that the January audit will be cancelled and we will proceed with the audit in June 2021 as planned. Therefore professional judgement and local protocol will be used to assess any changes within section 25B wards

As the COVID-19 pandemic has started to recede within the CTM locality, the 25B wards within the three District General hospital sites has seen a reduction in number of COVID-19 defined wards and therefore it is anticipated that at there will gradual return to 'normal business' and this will be reflected at next bi-annual recalculation in June 2021.

Using the triangulated approach to calculate the nurse staffing level on section 25B wards	The triangulated methodology prescribed in the Nurse Staffing Level (Wales) Act (NSLWA) as the required approach to calculating the nurse staffing levels for each ward has become embedded for the period 2020-2021 as a routine, 6-monthly cycle that is undertaken with the nursing teams responsible for each ward within Section 25B. However as previously discussed the January 2021 cycle has not taken place due the ongoing COVID-19 pandemic. The nursing teams access the data they are required to take account of within this methodology is obtained via the IT performance reporting system 'Qlik Sense' The system provides information relating to patient flow, patient acuity and care quality metrics in a single report that is readily accessible to Ward Managers, Heads of Nursing and ILG Nurse Directors. The monitoring of nurse sensitive indicators are monitored by the Locality Group Nurse Directors via Quality & Safety governance reviews and reporting mechanisms. From a Once for Wales approach there will be the development of a national system to record and review the nurse staffing levels and collate the data required to inform the reporting requirements. An agreement to implement 'Allocate' Nationally (CTM already use this system) and further discussions with Allocate to inform adaptations to the Safecare system and the Implementation of a national system to aid reporting of incidents & complaints.
Informing patients	The Statutory Guidance (Appendix C) states that "LHBs and Trusts must make arrangements to inform patients of the nurse staffing level" (paragraph 20). The statutory requirements to inform patients of the nurse staffing levels by ensuring that the most up to date information is displayed on wards in relation to the staffing levels agreed by Board, this included ensuring the staffing numbers were in line with agreed workforce planning Template. Following the July 2020 bi-annual calculation audit, using the approved calculation templates each 25B ward has been refreshed and the informing patient templates have been reissued. During the 2nd wave of the COVID-19 pandemic no ward calculation templates or informing patient templates have been reissued if the staffing levels remained the same, due to the sheer number of changes seen during the 2nd Wave of the COVID-19 pandemic and where the change has been attributed to repurposing within COVID-19 RAG ratings for example the ward changing from a red ward to an amber ward. This approach had been discussed and approved by the Executive Nurse Director.

Section 25E (2a) Extent to which the nurse staffing levels are maintained
As the nurse staffing level is defined under the NSLWA as comprising both the planned roster *and* the required establishment, this section should provide assurance of the extent to which the planned roster has been maintained *and* how the required establishments for Section 25B wards have been achieved/maintained over the reporting period.

The extent to which the nurse staffing levels have been maintained	Period covered	Required establishment (WTE) of S25B wards at the beginning of the annual reporting period. (April)?? Need to include Nov 19		Required establishment (WTE) of S25B wards calculated during first cycle (May 2020 deferred Sept 2020)		WTE of required establishment of S25B wards funded following first (May) calculation cycle		Required establishment (WTE) of S25B wards calculated during second cycle (Nov 2020) July bi-annual review.		WTE of required establishment of S25B wards funded following second (Nov) calculation cycle	
		RN:	HCSW:	RN:	HCSW:	RN:	HCSW:	RN:	HCSW:	RN:	HCSW:
	April 2020-March 2021	607.86	476.65	469.7	346.6	469.7	346.6	630.75	450.51	630.75	450.51
Accompanying narrative: During the last reporting period there has been a number of wards under section 25B that have changed (for more details of individual wards and their calculated nurse staffing levels, refer to Appendix A), this can be seen by the differing required establishment for the 25B wards during this period. Briefly in March 2020, prior to the beginning of this annual reporting period the 25B wards within CTM UHB were relatively stable in regards to their required staffing establishment, however as a consequence of the COVID-19 pandemic and the need to repurpose wards to meet the demand wards to which section 25B applies have been affected. During the bi-annual calculation in May 2020 there were three wards that were repurposed into high care respiratory or ITU, 2 wards were closed and staff were redeployed elsewhere, 2 wards were repurposed into rehabilitation wards making a total of 7 wards being removed from section 25B whilst only one was added. Whilst at the second bi-annual calculation in November 2020 there appears to be an additional staffing establishment requirement, this is primarily due to wards either been repurposed and/or reopened and then being											

	included into the section 25B of the 2016 Act. These actions were taken to support capacity within the CTM UHB hospitals in relation to the going COVID-19 pandemic. At this time CTM UHB had 31 wards that were deemed to sit within 25B of the 2016 Act, where the required establishment for RN and HCSW had roughly returned to the requirement prior to the 1st cycle (April 2020). The ILGs Nurse Directors manage financial budgets and have realigned their budgets to meet the ongoing staffing requirements for section 25B wards.
Extent to which the nurse staffing levels are maintained within Section 25B wards	When the second duty of the Nurse Staffing Levels (Wales) Act 2016 (the Act) came into force in April 2018, there was no consistent solution to extracting all of the data explicitly required under section 25E, and health boards were using a variety of e-rostering and reporting systems. During the reporting period 2019/20, all health boards/trusts in Wales worked as part of the All Wales Nurse Staffing Programme to develop a consistent approach to capturing quantitative data on a daily basis (in lieu of a single ICT solution) to enable each organisation to demonstrate the extent to which the nurse staffing levels across the health board. For the 2018/9 and 2019/20 annual reports, this Health Board, together with all other health boards/trusts in Wales provided narrative to describe the extent to which the nurse staffing levels have been maintained in order to meet its statutory reporting requirement under Section 25E of the Act. During the reporting period 2020/21 all health boards/trusts in Wales have begun to implement and use the NWIS delivered enhancements to the NHS Wales Health and Care Monitoring System (HCMS). In light of this development, made available to Health Boards/Trusts across Wales on 1st July 2020, organisations have had access to a consistent approach to capturing quantitative data on a daily basis to enable each organisation to demonstrate the extent to which the nurse staffing levels across the health board have been maintained in areas which are covered by Section 25B/C of the Act: The limited quantitative data that this approach has provided for 2020/21 for this Health Board is presented and discussed below. As highlighted above since July 2020 CTMUHB has had access to capturing quantitative data on a daily basis using the existing Health Care Monitoring system, this has enabled the capture compliance against the planned rosters on a daily basis. Within this module there is a secondary data field to record when there has been a shortfall against the planned roster. The COVID-19 pandemic has had a profound effect within the three DGHs and how they have needed to respond to maintain patient safety and their staff that work within the wards. To assist in process of maintaining the extent to which staffing levels are maintained since November 2020 the Head of Nursing for the 3 principal hospital sites have provided weekly staffing profiles for all their section 25B/C of the 2016 Act.

Since Health Care Monitoring System (HCMS) system has become live in July 2020, daily patient acuity and staffing levels have been recorded daily. The aggregated percentage where staffing levels were maintained and remained compliant within the 2016 Act for the HB section 25B wards was 79.73%. There was a small variant between the 3 DGHs of 6% the lowest DGH having a compliance of 76.45 % and the highest hospital site recording a compliance rate of 82.16%.

Where the staffing levels were not met against the planned roster (21% of the time), the data obtained has demonstrated that professional judgement was made as to the extent that this impacted on the ward and patient care. Of that 21%, the data recorded that 20% of the time, where staffing levels were not met but were deemed safe, whilst 79 % of the time the shift was deemed to be unsafe within the HB section 25B wards. On these occasions, it would be routine practice for the escalation process within the Nursing staffing Levels Wales Act Operating Framework & Escalation Policy (Appendix D) to be followed and escalated via the ILG Nurse Directors and/or Silver meetings during COVID 19.

Mitigating factors and caveats within this data could be:

1. The figures were obtained during COVID-19 pandemic and the hospital wards were extremely busy and as a consequence the data was not captured daily as per protocol.
2. Due to the sheer internal ward moves within each HB site, the tracking of data for each of the wards within section 25B is not 100% accurate

Looking forward, NHS Wales is committed to utilising a national informatics system that can be used as a central repository for collating data to evidence the extent to which the nurse staffing levels have been maintained and to provide assurance that All Reasonable Steps (Appendix E) have been taken to maintain the nurse staffing levels required. It is anticipated that during the next reporting period (2021-2024) a once for Wales informatics system will be developed and will support Health Boards/Trusts in meeting the reporting requirements of the Act and the Once for Wales approach will ensure consistency. Discussions continue on a national basis to identify the national system and the Nurse Staffing Programme team is working with providers to ensure the system is able to support NHS Wales in collating the data required to inform the reporting requirements

**Process for
maintaining the
nurse staffing
level**

In June 2019, the Health Board commenced its Registered Nurse overseas nurse recruitment campaign to bring 215 wte nurses from India into the three acute hospital sites. This programme is now drawing to its conclusion with 213 nurses to date having successfully passed their OSCE and become NMC registrants with the remaining 2 awaiting to resist their OSCE test. In addition 61 wte RNs came into post in September 2020 from Student Streamlining.

Currently the Health Board is continuing to progress the appointment of over 400 Health Care Support Workers (HCSW) into the Health Board in response to the ongoing challenges of COVID-19. This is supported by a Workforce & OD training and educational framework.

Additional Registered Nurse education and training has been provided in readiness of ward nurses being deployed into additional critical care areas. This is part of the wider UHB COVID-19 Nursing Workforce Strategy.

The Nursing Staffing Levels (Wales) Act (2016) Operating Framework and Escalation Policy for CTMUHB supports the calculation and maintenance of nursing staffing levels in Adult Acute Medical and Surgical Wards and the actions that are taken to review, record and escalate where nurse staffing levels are not maintained.

Within the Acute Hospitals staffing levels are reviewed three times a day and if required staff are deployed accordingly using All Reasonable Steps together with professional judgement to draw on information at a local and national level to inform their decision as to the appropriate staffing levels required. The All Wales Directors of Nursing have agreed, and through the All Wales Nurse Staffing programme group have issued, further clarification on what constitutes the 'All Reasonable Steps' which are statutorily required to be taken in order to maintain the nurse staffing levels at the calculated levels. This document has been in place within CTMUHB since November 2019.

There are well embedded processes within the nursing structures on each of the acute sites for reviewing staffing levels operationally on a daily basis and for making operational, risk-based decisions about the deployment of staff via the bed/staffing meetings.

Since January 2020, in line with decisions made at all Wales level, the Health Board has commenced, formally recording the nursing staffing levels on each of the wards per day and the mitigating actions taken in order to maintain the nurse staffing levels on ward areas.

Section 25E (2b) Impact on care due to not maintaining the nurse staffing levels

Patients harmed with reference to quality indicators and complaints (*) which are classified as serious incidents and reported centrally NOTE: (*) complaints refers to those complaints made under complaints regulations (Putting Things Right (PTR))	1) Total number of closed serious incidents/complaints during <u>last</u> reporting period April 2019 – March 2020	2) Total number of closed serious incidents/complaints during <u>current</u> reporting period (April 2020-March 2021)	3) Total number of serious incidents/complaints not closed and to be reported on/during the <u>next</u> reporting period (April 2021-March 2022)	4) Increase/decrease) in the number of closed serious incidents/complaints between reporting periods (**)	5) Number of serious incidents/complaints where failure to maintain the nurse staffing level was considered to have been a factor
Hospital acquired pressure damage (grade 3, 4 and unstageable).	74 incidents received, 67 closed (7 still open) 2 Serious Incidents reported to WG, both closed	46 incidents received 22 closed 24 still open 0 Serious Incidents reported to WG	31 incidents (0 Welsh Government)	38% decrease in received 100% decrease WG	1 incident (0 Welsh Government)
Falls resulting in serious harm or death (i.e. level 4 and 5 incidents).	10 incidents received 5 closed (5 still open) 6 SI's reported to WG, 6 closed	4 incidents received 1 closed 3 still open, 2 SI's reported WG, 2 closed	8 incidents (0 Welsh Government)	60% decrease in received 67% decrease WG	1 (0 Welsh Government)
Medication related never events.	1 Medication Never Event received (1 closed)	0	0	100% decrease in received	N/A
Complaints about nursing care	8 received (8 closed)	3 received 3 closed	0	62.5% decrease in received	N/A

NOTE ():** In relation to the data presented in Column 4 above, direct comparison between the numbers of closed SI's/Complaints reported during 2019/20 and the number reported in 2020/21 should not be made due to the significant changes in the number/size/patient pathway etc of wards classified under Section 25B during 2020/21 as a result of operational changes made during the Covid-19 pandemic period.

Section 25E (2c) Actions taken if the nurse staffing level is not maintained

Actions taken when the nurse staffing level was not maintained

This reporting period has been a challenging year due to COVID-19 pandemic, for section 25B wards it has been at times difficult to update the relevant and corresponding reporting systems due to sheer number of internal moves made during this period.

For this reporting period there has been 2 incidents where not maintaining the planned nurse staffing level was deemed to have contributed to the incidents, 1 hospital acquired pressure damage and 1 fall. It should be noted however, that both of these incidents did not meet the threshold to be reported to the Welsh Government. Both incidents have been reviewed via the respective ILG's internal quality and safety, safeguarding processes and deemed that they were unavoidable although it was noted that staffing could have been a contributing factor.

Although there has been a reduction across all incidents between the reporting periods, it has been noted that comparison between reporting periods of 2019-2020 and 2020-2021 cannot be made due to the operational changes made during the COVID-19 pandemic. Therefore comparison for the next reporting period will also be difficult to access trends and or improvements.

All of the incidents and complaints included in this report have been reviewed by the Acute Hospital's Head of Nursing via their internal weekly scrutiny meetings to assess if the nurse staffing levels were maintained at the relevant time, and if not, whether failure to maintain the nurse staffing level contributed to any harm suffered by the patient but also to determine whether there are any other lessons to be learnt from the incidents that can be shared.

There are a range of both short and long term actions being taken by the Health Board in an attempt to improve the extent to which a sufficient workforce is available to work within the Registered Nurse and Health Care Support Worker posts on both Section 25B wards and across the wider nursing services. These include:

- The schemes being led by the Workforce and Organisational Development teams and Central Nursing to develop and implement innovative approaches to recruitment of Registered Nurses as well as new Health Care Support Workers.
- Continue to plan and provide a registered nurse workforce which includes a further business case for Phase 2 of the overseas RN recruitment which will provide a further 150 nurses into CTMUHB including the uplift of Practice Development Nurses to support this programme.

- Establishing educational partnerships arrangements with the University of South Wales and Swansea University in relation to the creation of new courses to support the extension of the Nurse Staffing Levels (Wales) Act 2016 to include paediatric inpatient wards, the district nursing principles and mental health work streams.
- Contributing to student streamlining for Adults, Paediatrics, Mental Health and District Nursing
- CTMUHB staff representatives on the Health Education and Improvement Wales (HEIW) programmes
- Creation of career pathways including exploring opportunity for Band 4 nursing roles to support CTMUHB Integrated Health & Care Strategy

Conclusion & Recommendations

In summary 2020-2021 has been a challenging year due to the COVID-19 pandemic within the Health Board and its communities

- Meeting the staffing levels for the 25B wards has been difficult due to higher levels of sickness and staff requiring to shield at home
- The repurposing of wards including retraining of staff to meet the clinical demands during the COVID-19 pandemic and the temporary re-deployment of staff to support the additional demands including high care respiratory wards, ITU and the temporary Field Hospital

However despite these challenges there continues to be successes and achievements within this reporting period

- The ability of the Health Board and its staff to adapt at short notice when needing to repurpose wards to meet the clinical needs of our population during the COVID-19 pandemic and the temporary re-deployment of staff to support additional areas including high care respiratory wards, ITU and the temporary Field Hospital
- The HB has continued to land overseas nurse from aboard (primarily from India) with an evolving governance framework that involved a robust isolation, educational and wellbeing process
- Virtual OSCE training continued, the adoption of the temporary NMC registered for the overseas nurses still in training. The continued success of 1st time pass rate for the nurses who undertook their OSCEs' tests.

- 411 student nurses/midwives these being 2nd or 3rd year Student nurses/midwife were employed as HCSW during the COVID-19 pandemic
- 400 HCSW recruited to the Call to Arms to support the hospital sites and are now supporting the mass vaccination programme
- The improvement in the availability of information to nurse leaders to support and inform their clinical decision making including the Nurse staff Level (Wales) Act (2016) Operating Framework and Escalation policy and All Reasonable Steps.
- Improvement with the information provision to our patients and public including the redesigned nurse staffing levels Informing Patient Templates within our hospitals
- ILGs governance system and processes in relation to NSLWA
- The continued preparation and preparedness for the extension to the 2016 Act in Paediatric and District Nursing

The Work programme associated with the NSLWA in 2020-2021 needs to include:

- Readiness for the Extension of Act for Paediatric in patient wards and the recruitment into 43 wte nurse vacancies to deliver this.
- The resetting and the realignment in the following work streams; District nursing, Mental Health and Health visiting. Within the HB these working groups for these work streams have now recommenced
- Enhanced information and increased intelligence for Safe Care, Concerns and incidents datix module for quality assurance processes in the Adult work stream.
- Accuracy and robust data collection in the use of the national HCMS
- Work internally to reset the 25B wards within HB

Appendix: Summary of Required Establishment

Health board/trust:	Name: Cwm Taf Morgannwg UHB	
Period reviewed:	Start Date: 6 th April 2020	End Date: 5 th April 2021
Number of wards where section 25B applies:	Medical: 17	Surgical: 11
	PCH – 2,7,9,10,11,12 PoWH- 4, 5, 6, 7, 8,11 RGH – 12,14,15,19,20	PCH – 5, 6, 8 PoWH- 18,19, 20, BC RGH – 2, 9,10,11

Prince Charles Hospital - Medical Wards

Ward	Required Establishment at the start of the reporting period (as at April 6 th 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (as of April 5 th 2021)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made July 2020			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
Ward 2	20.9	14.21	Yes	20.9	14.21	Yes	Yes	No		No	No	Note – ward has redefined within Covid RAG system several times during this report
Ward 3	40.8	90.96	Yes	23.74	17.06	Yes	No	No	Repurposed during COVID to create a COVID respiratory High care CPAP/NIV ward	No	No	Still defined as a mixed acute medical/ COVID high care respiratory area
Ward 4	91.96	45.48	Yes	NA	NA		No	No	Repurposed to ITU – sits outside section 25B			
Ward 7	20.9	14.21	Yes	20.9	14.21	Yes	No	No	At the beginning of the reporting period, the ward was Rehabilitation medical ward	No	No	Repurposed as COVID-19 palliative and Rehab post COVID ward, repurposed again on the 20/10/20 to Red pathway, then changed to Amber on 3/2/21 and ward closed on 23/2/21
Ward 9	20.9	14.21	Yes	20.9	14.21	Yes	Yes	No		No	No	Ward repurposed to Amber pathway, repurposed on the 28/1/21 to Medical ward Gastro – ward moved from ward 8
Ward 10	20.9	17.06	Yes	20.9	17.06	Yes	Yes	No		No	No	Ward repurposed to Red pathway on 8/12/20 and Amber 20/1/21
Ward 11	20.9	14.21	Yes	20.9	14.21	Yes	Yes	No		No	No	Ward repurposed to Amber pathway 15/12/20
Ward 12	23.74	17.06	Yes	23.74	17.06	Yes	Yes	No		No	No	Ward is an (contacts) amber pathway 18.12.21.

Princess of Wales Hospital - Medical wards

Ward	Required Establishment at the start of the reporting period (as at April 6 th 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (as of April 5 th 2021)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made July 2020			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
Ward 2	24.83	24.04	Yes				No	No	Previously was repurposed in April 2020 to COVID medical ward combined with Ward 4 to create a 37 bedded area	No	No	Repurposed to a Acute Medical Unit – Removed from section 25B
Ward 4	28.24	13.62	Yes	28.24	13.62	Yes	Yes	No	Returned from being a combined ward with ward 2	No	No	Ward 2 stroke moved from Ward 4 to ward 5 on 7/7/20. Ward 4 to return to it originally function
Ward 5	14.83	6.74	Yes	20.07	13.62	Yes	Yes	No	Ward from respiratory AGO COVID ward to surgical ward in Sep 2020.	No	No	Ward repurposed to stroke and rehab ward and Amber pathway (ward 2- 21/2/21 establishment as ward 2 meets this requirement as they had 22 beds) CLEAN/cold admissions
Ward 6	16.89	11.39	Yes	20.7	13.62	Yes	Yes	No	Repurposed During 1 st wave of COVID – beds reduced as 'gastro day unit' not being unitised- Ward repurposed in September 2020 to a T&O, with surgical patients	No	No	Ward 6 moved to ward 8 in 9/2020 with the same establishment requirements. Ward returned to medical Gastro ward with it original staffing levels
Ward 7	35.65	16.96	Yes	20.07	13.62	Yes	Yes	No	During the 1 st Wave of COVID -19 ward 7 and * were repurposed to create a high care Respiratory Unit (CPAP and NIV) Ward 7 was repurposed in September 2020 to a Stroke Ward. Ward 8 Was repurposed to a Gastro ward	No	No	Ward 20 has relocated to ward 6 on the 7/7/2020, Repurposed to a Covid-19 Amber pathway, then relocated with the whole team to Ward 7 in Feb 2021

Ward 8	36.65	16.96	Yes	20.07	13.62	Yes	Yes	No	Ward 8 moved to ward 19 week of 15/2/21	Yes	Yes	Ward 19 –Will become Acute Frailty (the Ward 19 team will move to this ward – again establishment is correct from this team for this ward) clean/cold admissions has been relocated to in January 2021, Care of elderly, ward 8 Covid Amber Pathway
Ward 9	20.07	13.62	Yes	24.52	13.62	Yes	Yes	No	In April 2020 the ward was closed as part of repurposing of wards due to COVID. Repurposed to receive Respiratory high care patients (NIV/Optiflow/CPAP) - Sits outside Section 25B wards	No	No	Previously the accepted T&O patients, ward and Staff all moved to ward 19 (Sep 2020)
Ward 11	16.46	11.61	Yes	16.34	10.9	Yes	Yes	No	Ward 11 – Mixed Surgical/medical ward moved to ward 5 in Sep 2020, then was moved again to Ward 20 in Feb 2021	Yes	Yes	Repurposed to make a Covid recovered and clean respiratory AGP Sep 2020
Ward 20	20.07	13.62	Yes	20.07	13.62	Yes	Yes	No	Ward 2 moved to ward 20 in October 2020 then moved to ward 5 on 21/2/21	No	No	Ward 7 team has been relocated to ward 5 then to ward 19 moved on 25/1/21 then moved to ward 20 in 21/2/21- Surgical Admission

Royal Glamorgan Hospital – Medical wards

Ward	Required Establishment at the start of the reporting period (as at April 6 th 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (as of April 5 th 2021)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made July 2020			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
Ward 4			Choose an item.	20.9	19.9	Yes	No	No	Ward 4 was not a section 25B in April 2020	Yes	No	Ward 14 and their staff were relocated to this ward but moved back to ward 20 on the 11/1/21. On the 1/3/21 Ward returned to AMU – outside section 25B
Ward 12	20.9	19.9	Yes	20.9	19.9	Yes	Yes	No		No	No	
Ward 14	20.9	19.9	Yes	20.9	19.9	Yes	Yes	No	Ward was repurposed to create a mixed surgical/Medical ward- Staffing level remained the same.	No	No	Ward 14 and their staff have been relocated several times during the this reporting period (Ward 4 and Ward 20), but have returned to Ward 14 on 1/3/21
Ward 15			Choose an item.	20.9	19.9	Yes	No	No		Yes	Yes	Repurposed from elderly Rehabilitation to Red COVID admission area during COVID October 2020
Ward 19	20.9	19.9	Yes	20.9	19.9	Yes	Yes	No		No	No	
Ward 20	20.9	19.9	Yes	20.9	19.9	Yes	No	Yes		No	No	Ward closed 25/11/20 Ward 20 moved to ward 11/1/21 and ward 4 (14) moved to ward 20.

Prince Charles Hospital - Surgical Wards

Ward	Required Establishment at the start of the reporting period (as at April 6 th 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (as of April 5 th 2021)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made July 2020			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
Ward 5	20.9	14.21	Yes	20.9	14.21	Yes	Yes	No		No	No	
Ward 6	20.9	14.21	Yes	20.9	14.21	Yes	Yes	No		No	No	
Ward 8	20.9	14.21	Yes	20.9	14.21	Yes	Yes	No		No	No	At the start of the report the ward was defined as medical ward, repurposed from Red to Amber pathway. On the 28/1/21 repurposed to T&O ward moved from ward 9

Princess of Wales Hospital – Surgical Ward

Ward	Required Establishment at the start of the reporting period (as at April 6 th 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (as of April 5 th 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made July 2020			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
Ward 10	20.07	13.62	Yes	NA	NA				Ward was repurposed to create additional Critical care capacity for COVID			
Ward 11	13.62	6.38	Yes	13.62	11.9	Yes	Yes	No	Repurposed/reduced capacity and therefore Staffing levels were temporary were reduced during COVID- ward moved to 7.	Yes	Yes	Repurposed COVID recovery and clean Respiratory AGP October 2020
Ward 18	20.07	13.62	Yes	20.07	13.62	Yes	Yes	No		No	No	Previous the ward and staff were on Ward 10 - Ward 18 was repurposed as T&O ward 23/9/2020
Ward 19				20.07	13.62	Yes	Yes	No	Ward 9 (T&O) and the staff were moved in 23/9/2020 Repurposed to make a Surgical ward and T&O	No	No	
Bridgend Clinic				11.9	2.72	Yes	Yes	No	Repurposed from a Private patient ward to a general Surgical / Gynae ward	No	No	

Royal Glamorgan Hospital – Surgical Wards

Ward	Required Establishment at the start of the reporting period (as at April 6 th 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (as of April 5 th 2021)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
Ward 1	12.37	8.53	Yes	17.19	11.37	Yes	Yes	Yes	Ward increased its capacity to 28 beds to accept COVID admission. Ward closed for Refurbishments	No	No	Ward Reopened 23/11/20- repurposed to a COVID ward awaiting results
Ward 2	20.9	19.9	Yes	17.91	11.37	Yes	Yes	No	Ward was a mixed Surgical/medical ward	No	No	Ward repurposed to a COVID ward awaiting results 26/2/21
Ward 3	20.9	19.9	Yes	N/A	N/A	Yes	Yes	No	Ward repurposed to Acute Medical Unit- sits outside Section 25 B wards			
Ward 5	20.9	17.06	Yes	N/A	N/A	Yes	Yes	No	Ward closed 23/11/20			
Ward 6	NA	NA	NA	20.9	17.06	Yes	Yes	No	Ward was AMU (not in Section 25B) Ward 2 moved 20/11/20	No	No	Ward 6 was on ward 5 from 23/10/2020 until it was repurposed to COVID Red
Ward 7	20.9	19.9	Yes	N/A	N/A	Yes	Yes	No	Ward closed 25/4/20 and reopened for ITU use- sits outside section 25B wards			
Ward 8	20.9	19.9	Yes	20.9	19.9	Yes	Yes	Yes	Ward closed on 23/3/20 as part of COVOD repurposing plans	No	No	Ward has moved and been repurposed several times moved to Ward 2 in Oct 2020, ward closed on 23/11/20 and the ward was moved to Ward 6, then moved to Ward 8 10/1/21
Ward 9	15.21	8.53	Yes	20.9	14.2	Yes	Yes	No		Yes	Yes	Temporary increased Capacity during COVID October 2020
Ward 11				17.06	14.21	Yes	Yes	No	Ward 11 was previously maternity ward	Yes	Yes	Surgical planned elective



Llywodraeth Cymru
Welsh Government



GIG
CYMRU
NHS
WALES

Nurse Staffing Levels (Wales) Act 2016

Statutory Guidance Version 2

Contents

	Page
<u>Introduction</u>	2
<u>Section 25B (Duty to calculate maintain nurse staffing levels)</u>	2
Designated person	2
Reasonable Requirements	3
Nurse Staffing Levels	3
Reasonable Steps	4
Informing Patients	5
Situations where Section 25B applies	6
<u>Section 25C (Nurse staffing levels: method of calculation)</u>	8
Introduction	8
Professional judgement	9
Evidence-based Workforce Planning Tools	11
Indicators of patient well-being which are particularly sensitive to care provided by a nurse	11
Varying Nurse Staffing Levels	12
<u>Review</u>	12

Introduction

1. This guidance should be read in conjunction with the provisions inserted into the National Health Service (Wales) Act 2006 (“the 2006 Act”) by the Nurse Staffing Levels (Wales) Act 2016 (“the 2016 Act”), the Explanatory Notes to the 2016 Act, and the 2021 regulations extending the legislation’s scope to include paediatric inpatient wards.
2. This document provides statutory guidance on sections 25B & 25C of the 2006 Act. It is the statutory guidance Welsh Ministers are required to issue pursuant to section 25D of the 2006 Act.
3. In accordance with section 25D, Local Health Boards (LHBs) and NHS Trusts (Trusts) to which the duties in sections 25B and 25C apply must have regard to this guidance when exercising their duties under those sections.

Section 25B (Duty to calculate and take steps to maintain nurse staffing levels)

4. Section 25B introduces a duty for LHBs and Trusts in Wales (where applicable) to calculate and take all reasonable steps to maintain nurse staffing levels and inform patients of the level. The nurse staffing level is the number of nurses appropriate to provide care to patients that meets all reasonable requirements in the relevant situation. The number of nurses means the number of registered nurses (this being those with a live registration on Sub Parts 1 or 2 of the Nursing and Midwifery Council register). In calculating the nurse staffing level, account can also be taken of nursing duties that are undertaken under the supervision of, or delegated to another person by a registered nurse.
5. In accordance with section 25B(3), the duty to calculate nurse staffing levels currently applies to adult acute medical inpatient wards, adult acute surgical inpatient wards. Section 25B(3)(c) gives Welsh Ministers the power to make regulations to extend the duty to calculate nurse staffing levels to other settings. Regulations [have been] made under this section that will extend the duty at section 25B to calculate and take steps to maintain nurse staffing levels to - paediatric inpatient wards.

Designated Person

6. Section 25B(1)(a) sets out that where a LHB or Trust in Wales provides nursing services in a clinical setting to which that section applies, it must designate a person or a description of a person, known as the “designated person” to calculate the nurse staffing level for that setting.

7. The designated person must act within the LHB's (or Trust's) governance framework authorising that person to undertake this calculation on behalf of the Chief Executive Officer of the LHB (or Trust). In view of the requirement to exercise nursing professional judgement when calculating nurse staffing levels, the designated person should be registered with the Nursing and Midwifery Council and have an understanding of the complexities of setting a nurse staffing level in the clinical environment.
8. The designated person should also be a person of sufficient seniority within the organisation, such as the Executive Director of Nursing for the LHB or Trust.

Reasonable Requirements

9. The designated person must calculate the number of nurses appropriate to provide patient-centred care that meets all reasonable requirements in that situation using the triangulated methodology set out in the guidance below.
10. *Reasonable requirements* means taking into consideration the holistic needs of the patient, including social, psychological, spiritual and physical requirements. The ward sister/charge nurse is responsible for ensuring that these needs are assessed and classified using the descriptors in the relevant Welsh Levels of Care tool, as set out in the relevant operational guidance for that care situation.

Nurse Staffing Level

11. The calculation undertaken by the designated person must result in the nurse staffing level for the ward area. In practice, the nurse staffing level will be the required establishment and the planned roster. The maintenance of the nurse staffing level should be funded from the LHB's (or Trust's) revenue allocation, taking into account the actual salary points of staff employed on its wards.

Term	Definition
Required Establishment	The total number of staff to provide sufficient resource to deploy a planned roster (determined using the triangulated method in section 25C) that will enable nurses to provide care to patients that meets all reasonable requirements in the relevant situation. This includes a resource to cover all staff absences, e.g. absence due to maternity leave and sick leave; and other staff functions that reduce the time available to staff to care for patients. Supernumerary persons such as students and ward sisters/charge nurses/managers should not be included in the planned roster.

12. The calculation should be undertaken: at least every six months; when entering the workforce planning tool data; when there is a change of use/service which is likely to alter the nurse staffing level; or if the designated person deems it necessary, for example following exception reporting by a ward sister/charge nurse. There should be a formal annual presentation by the designated persons to the Board of their respective LHB or Trust of the nurse staffing level of each individual ward to which sections 25B to 25E of

the Act pertain. In addition, they should receive a written update of the nurse staffing level of each individual ward (to which sections 25B to 25E of the Act pertain) when there is a change of use/service that has resulted in a changed nurse staffing level, or if the designated person deems it necessary.

Reasonable steps

13. Section 25B(1)(b) requires LHBs and Trusts to take all reasonable steps to maintain the nurse staffing level. Maintaining means having the number of registered nurses the required establishment and its planned roster require. This should be met with permanent staff, however-temporary workers can be deployed-if required. (See the professional judgement section for guidance on the effect of the use of temporary staff on the calculation.)
14. It is recognised that the clinical environment is complex and therefore the planned roster may, on rare occasions, be appropriately varied to respond to patients' dependency and acuity across the system. The ward sister/charge nurse and senior nurse should continuously assess the situation and keep the designated person formally apprised. The designated person should consider if a recalculation of the nurse staffing level is required (e.g. in the circumstances set out in paragraph 12).
15. LHBs and Trusts should put into place systems that allow them to review and record every occasion when the number of nurses deployed varies from the planned roster.
16. The responsibility for decisions relating to the maintenance of the nurse staffing level rests with the LHB (or Trust) and should be based on evidence provided by - and the professional opinions of - the Executive Directors with the portfolios of Nursing, Finance, Workforce, and Operations. The LHB (or Trust) should agree the operating framework for these decisions to include actions to be taken, and by whom.
17. Reasonable steps - which should be taken at national and LHB/Trust level to maintain nurse staffing levels - are considered to include:

National steps

- The sharing and benchmarking of corporate data.

Strategic corporate steps

- Workforce planning for a continued supply of required staff assessed using the Welsh Planning System.
- Active recruitment in a timely manner at local, regional, national, and international level.
- Programmes of continuous professional development for staff.
- Retention strategies that include consideration of the NHS Wales Staff Survey results.
- Well-being at work strategies that support nurses in delivering their roles.

Operational steps

- Use of temporary staff from a nursing bank appropriate to the skill mix set out in the planned roster.
 - Use of temporary staff from a nursing agency appropriate to the skill mix set out in the planned roster.
 - Temporary use of staff from other areas within the organisation.
 - The temporary closure of beds.
 - Consideration of changes to the patient pathway.
18. When undertaking these steps, LHBs and Trusts should consider and take due regard of the duty placed upon them in section 25A to have sufficient nurses to allow the nurses time to care sensitively for patients wherever nursing services are provided or commissioned.
19. These steps and the operating framework should be included in each Board's escalation policy and business continuity plans.

Informing Patients

20. Section 25B(1)(c) provides that LHBs and Trusts must make arrangements to inform patients of the nurse staffing level.
21. The LHB's (or Trust's) public Board papers should annually include the nurse staffing level of each individual ward to which sections 25B to 25E of the Act pertain. In addition the LHB (or Trust) should receive a written update from the designated person of the nurse staffing level of each of those wards when there is a change of use/service that has resulted in a changed nurse staffing level, or if the designated person deems it necessary.
22. Patients must be informed of the nurse staffing level on each ward to which sections 25B to 25E of the Act pertain and should also be informed of the date the nurse staffing level was presented to the Board of each LHB (or Trust). This should be easily visible to anyone attending the ward.
23. Patients should have easy access to 'frequently asked questions' on the Nurse Staffing Levels (Wales) Act 2016 and associated regulations. This should include how to raise concerns about nurse staffing levels.
24. The information should be set out in an easily accessible format that patients can understand.
25. Each LHB (or Trust) must comply with any relevant obligations to which they are subject under the Welsh Language Standards for the provision of this information.

Situations Where Section 25B Applies

26. Section 25B(3) stipulates the situations in which the duty to calculate, and to maintain, nurse staffing levels under section 25B applies. Section 25B currently applies to adult acute medical inpatient wards, adult acute surgical inpatient wards and, with effect from 1 October 2021, paediatric inpatient wards.

27. In all circumstances the definitions of wards set out below will apply according to the primary purpose of the ward.

Adult acute medical inpatient wards

28. “Adult acute medical inpatient ward” means an area where patients receive active treatment for an acute injury or illness requiring either planned or urgent medical intervention, provided by or under the supervision of a consultant physician. Patients on these wards will be aged 18 and over, however individuals up to their 18th birthdays may receive treatment in an adult acute medical inpatient ward on occasions where professional judgement deems it to be more appropriate based on the clinical needs of the patient while also taking into consideration the existing risk assessment protocols as well as the right of the child/guardian to take part in the decision. Patients are deemed to be receiving active treatment if they are undergoing interventions prescribed by the consultant, and/or their team, and/or advance practitioners for their acute injury or illness.

Exclusions:

The following care settings are not considered to fall within the definition of “adult acute medical inpatient wards”:

- acute admission/assessment units that have short term admissions for assessment purposes that are demonstrably different to acute medical inpatient wards;
- intensive care units;
- high dependency units;
- coronary care units;
- renal dialysis units;
- maternity services;
- mental health services;
- learning disability services;
- day care units or wards; and
- rehabilitation wards.

Note: this list is not exhaustive.

Adult acute surgical inpatient wards

29. “Adult acute surgical inpatient ward” means an area where patients receive active treatment for an acute injury or illness requiring either planned or urgent surgery, provided by or under the supervision of a consultant surgeon. Patients on these wards will be aged 18 and over, however individuals up to their 18th birthdays may receive treatment in an adult acute surgical inpatient ward on occasions where professional judgement deems it to be more appropriate based on the clinical needs of the patient while also taking into consideration the existing risk assessment protocols as well as the right of the

child/guardian to take part in the decision.. Patients are deemed to be receiving active treatment if they are undergoing interventions prescribed by the consultant, and/or their team, and/or advance practitioners for their acute injury or illness.

Exclusions:

The following care settings are not considered to fall within the definition of “adult acute surgical inpatient wards”:

- acute surgical decision units that have short term admissions for assessment purposes that are demonstrably different to acute surgical inpatient wards;
- intensive care;
- high dependency units;
- maternity services;
- day surgery units or wards;
- learning disability services; and
- mental health services.

Note: this list is not exhaustive.

Paediatric inpatient wards

30. “Paediatric inpatient ward” means an area where patients receive active treatment for an injury or illness requiring either planned or urgent medical or surgical intervention, provided by - or under the supervision of - a consultant physician or surgeon. Patients on these wards will be aged 0-17, however individuals up to their 18th birthdays may receive treatment in an adult inpatient ward on occasions where professional judgement deems it to be more appropriate based on the clinical needs of the patient while also taking into consideration the existing risk assessment protocols as well as the right of the child/guardian to take part in the decision.. Patients are deemed to be receiving active treatment if they are undergoing intervention(s) for their injury or illness prescribed by the consultant, and/or their team, and/or advanced practitioners.

Exclusions:

The following care settings are not considered to fall within the definition of “paediatric inpatient wards”:

- Acute admission/assessment units that have short term admissions for assessment purposes that are demonstrably different to paediatric inpatient wards;
- Paediatric intensive care units which are separately located;
- High dependency units which are separately located;
- Day case units which are separately located;

- Neonatal units;
- Specialised oncology units;
- Specialised cardiac wards;
- Specialised renal dialysis units and renal wards;
- Mental health units;
- Learning disability units;
- Paediatric outpatient units;
- Paediatric emergency departments.

Note: this list is not exhaustive.

31. LHBs and Trusts should determine which ward areas meet the definitions for the above wards. This should be included in the formal presentation of the nursing staff level to the Board of each LHB (or Trust) as set out in paragraphs 12 and 21.

Section 25C (Nurse staffing levels: method of calculation).

Introduction

32. Section 25C prescribes the method that the designated person must use to calculate the nurse staffing level. This method reflects a triangulated approach.

33. When calculating the nurse staffing level a designated person must:

- exercise professional judgement;
- take into account the average ratio of nurses-to-patients appropriate to provide care to patients that meets all reasonable requirements, estimated for a specific period using evidence-based workforce planning tools; and
- take into account the extent to which the well-being of patients is known to be particularly sensitive to the provision of care by a nurse.



34. The triangulation process facilitates validation of data outcomes from the evidence-based workforce planning tool and increases confidence through cross-verification from more than two sources.
35. These three elements are independent considerations which must be triangulated to calculate the nurse staffing level. There is no hierarchy for consideration; it is at the discretion of the designated person to determine the prioritisation in each situation. The rationale for this determination should be recorded.
36. The calculation made by the designated person should be informed by the registered nurses within the ward and the nursing management structure where the nurse staffing level applies. This means that the opinions of the ward sister/charge nurse, the senior nurse/matron/lead nurse, and the directorate/division nurse director/chief nurse/clinical board nurse, should be provided to the designated person.
37. The mechanism by which these views have been taken into consideration should form part of the operating framework referred to in paragraph 16 and the annual report of the nurse staffing levels to the Board of each LHB (or Trust) referred to in paragraph 12.

Professional Judgement

38. Professional judgement exercised by the designated person when making each calculation should include all the following aspects:
- I. The qualifications, competencies, skills and experience of the nurses providing care to patients. This includes consideration of the continuing professional development, revalidation, and mandatory training requirements of the nurses employed in the ward, and enabling nursing staff to have the time to receive the appropriate training for the care they are required to provide.

- II. The effect on the nurse staffing level of the use of temporary staff, for example consideration of the continuity of care for patients and the range of activities that temporary staff are able to undertake.
 - III. The conditions in which care by a nurse is provided including considerations of the patients' cultural needs. For example, taking into account religious and cultural practices which could impact on nurse staffing requirements.
 - IV. The conditions in which care by a nurse is provided including multi-professional team dynamics. For example, where treatment is provided by multi-professionals in addition to inpatient care.
 - V. The potential impact on care by a nurse of the physical condition and layout of the ward or other situation in which the care is provided. For example, the effect of multiple single rooms.
 - VI. The turnover of patients receiving the care and the overall bed occupancy. This includes other activities in the ward such as outpatient clinics/treatments and the use of flexible beds.
 - VII. Services or care provided to patients by other health professionals or other staff (for example, health care support workers), and their qualifications, competencies, skills and experience; in relation to the care that needs to be given, and the requirement for registered nurses to support, delegate and supervise. For example, the service of food and drinks, and the one-to-one supervision of patients.
 - VIII. Any requirements set by a regulator to support students and learners.
 - IX. The extent to which the nurses providing care are required to undertake administrative functions.
 - X. The complexity of the patients' needs in addition to their medical or surgical nursing needs. For example, patients with learning disabilities.
 - XI. A patient's linguistic needs and delivering the active offer of providing a service in Welsh without someone having to ask for it, as set out in the More Than Just Words strategic framework.
39. The professional judgement of the designated person should be informed by consideration of any relevant expert professional nurse staffing guidance, principles, research and current best practice standards.
40. Following consideration of these factors, an uplift of 26.9% should be levied once - before triangulation with the other elements - to cover staff absence from the ward (26.9% was agreed in 2011 as the evidence-based uplift factor for use in Wales by Nurse Directors). LHBs and Trusts will be informed of any

change to this uplift by the office of the Chief Nursing Officer (“CNO”) for Wales.

Evidenced-based Workforce Planning Tool

41. An evidence-based workforce planning tool must be used in the ward area. This is a tool that is either:
- An established theoretical tool that has been validated for use by establishing an evidence base of its applicability in Welsh clinical settings;
- Or
- A tool developed for use in NHS Wales that has been validated for use by establishing an evidence base of its applicability in Welsh clinical settings.
42. LHBs and Trusts will be informed of the tools that fulfil the definition set out in paragraph 41 by the office of the CNO. The CNO will determine that the tools utilise the best available evidence including ratios for total registered nursing time against patient need in its calculations.
43. Operational guidance on the use of the tools is issued by the CNO and NHS Executive Nurse Directors in Wales and updated as required. This operational guidance should be followed.

Indicators of patient well-being which are particularly sensitive to care provided by a nurse

44. The designated person must consider circumstances where patient well-being is particularly sensitive to care provided by a nurse as part of the triangulated method each time the nurse staffing level is calculated. On all wards to which sections 25B - 25E of the Act pertain, this consideration should include analysis of the data for the relevant care situation on the following quality indicators:
- a. Pressure ulcers - the designated person should consider any pressure ulcers a patient has developed and/or shown deterioration whilst receiving inpatient care.
 - b. Medication administration errors - the designated person should consider any error in the preparation, administration or omission of medication by nursing staff.

On adult acute medical and surgical inpatient wards, this consideration should also include:

- c. Patient falls - the designated person should consider any fall that a patient has experienced.

On paediatric inpatient wards, this consideration should also include:

- d. Infiltration/extravasation injuries – the designated person should consider any injury experienced by a patient during an intravenous infiltration.

In each case, consideration of the data relating to (a)-(d) above should include a review of whether the nurse staffing level was maintained at the relevant time, and if not, whether the failure to maintain the nurse staffing level contributed to the fall, ulcer, or error and to any harm suffered by the patient.

45. In addition to the indicators set out above, the designated person may consider any other indicator that is sensitive to the nurse staffing level they deem appropriate for the ward where the nurse staffing level is being calculated. Examples of other relevant indicators could be:

- patient experience;
- unmet care needs;
- failure to respond to patient deterioration;
- staff experience;
- staff well-being;
- staff ability to take annual leave entitlement;
- staff compliance with mandatory training and performance development reviews.

Varying Nurse Staffing levels

46. Section 25C(2) allows a designated person to calculate different nurse staffing levels in relation to different periods of time and depending on the conditions in which care is provided by a nurse. This should be present in the planned roster that is presented to the Board of each LHB (or Trust).

Review

47. This guidance will be kept under review and updated as necessary following consultation with LHBs, Trusts, and others likely to be affected by any changes to the guidance.

 Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board	Version Number: 2 Next Review date: 01/03/2023
Nursing Staffing Levels (Wales) Act (2016) Operating Framework and Escalation Policy	
Introduction The purpose of this Operating Framework is to support the calculation and maintenance of nursing staffing levels in Adult medical and surgical wards, and the actions that are taken to review and record every occasion when the number of nurses deployed varies from the planned roster. To provide open transparent information on nursing staffing levels within Acute Adult Medical and Surgical Wards.	
Objectives There are a number of objectives, including: Supporting the assessment of patients' care needs with processes which ensure that the nurse staffing levels reflect the care needs of patients at all times. To support the calculation and maintenance of the nurse staffing level, To provide guidance to nursing staff and managers to safely manage risk to patients safety and staff well-being when not able to maintain the nurse staffing level and ensure that this is reported and recorded monitored and all reasonable steps required are undertaken. To provide the mechanism through which open and transparent information on the nurse staffing level on each adult acute medical and surgical ward within the Health Board will be shared.	
Operational Date 01/03/2020	Expiry Date Formal – three years Informal – one year
Scope This Framework is relevant to all managers, registered nurses and health care support workers working within the Adult Acute Medical and Surgical Wards unless otherwise stated.	
Equality Impact Assessment	An Equality Impact Assessment has been undertaken (Appendix 3)
Distribution	Executive Directors Clinical Directors Associate Directors Nursing Medical Directors Heads of Nursing Directorate Managers University Health Board intranet site
To be read by	Executive Board Members Senior Managers on Call Directorate Managers

	Clinical Site Mangers Heads of Nursing Senior Nurses Ward Sisters/Charge Nurses Registered and Non-registered nurses
Documents to read alongside this Policy	Risk Management Policy Incident Reporting Policy Business continuity policy Flexible Working Policy
Approved by	Cwm Taf Morgannwg Executive Board
Accountable Executive / Lead Director (responsible for formal review every three years)	Executive Director of Nursing
Author / Management Lead (carries out informal review annually)	Sharon O'Brien, Assistant Director of Nursing & People's Experience
Freedom of Information Status	Open
If the review date of this policy has passed, please ensure that the version you are using is the most up to date either by contacting the document author or the Corporate Services Department. To avoid use of out of date policies please do not print and then store hard copy of this document. Out of date policies cannot be relied upon.	

		Page
1	Purpose	4
2	Policy Statement	4
3	Scope	5
4	Aim	5
5	Definition of Terms	6
6	Glossary of Terms	9
7	Legislative and NHS Requirements 7.1 Equality Impact Assessment 7.2 Privacy Impact Assessment	10
8	Calculating the Nurse Staffing Level 8.1 Section 25B:Adult Inpatient Medical & Surgical Wards 8.2 Nurse Staffing Level – Key principles 8.3 Informing Patients	10 10 12
9	Maintaining the Nurse Staffing Level 9.1 Systems and Processes for Reviewing	13 13
10	Duties and Responsibilities of Staff 10.1 Strategic duties & responsibilities 10.2 Acute Services Operational Teams (Site/Directorate)	14 14 17
11	Escalation Procedure	22
12	Training	25
13	Monitoring, Reporting and auditing	25
14	Retention / Archiving	26
15	Non Conformance	26
16	References	26
17	Appendices • Appendix 1 All Reasonable Steps • Appendix 2 Escalation Procedure for Staffing Shortfalls • Appendix 3 Equality Impact Assessment • Appendix 4 Privacy Impact Assessment	27

1.0 PURPOSE

The purpose of this Operating Framework is to support the calculation and maintenance of nursing staffing levels in Adult Acute Medical and Surgical Wards and the actions that are taken to review, record and escalate where nurse staffing levels are not maintained.

The purpose of this policy is to provide information and standards which will underpin

- The Health Board's overarching responsibility to provide sufficient nurses in all Adult Acute Medical and Surgical Wards
- The calculation of the nurse staffing levels in adult medical and surgical wards
- The "All Reasonable Steps" required to be taken to maintain nurse staffing levels; and
- The escalation process where staffing levels are not maintained.

It is intended that this policy works in conjunction with existing policies and other written control documents issued by the Health Board.

2.0 POLICY STATEMENT

The safety of our patients and the quality of the care we provide are more important than anything else for Cwm Taf Morgannwg CTM) Health Board. Nursing and health care staff, play a critical role in delivering safe, high quality care to patients and service users. The University Health Board (UHB) puts patients at the heart of all that it does. There is strong evidence that having the right number of nursing staff delivering care in the right place impacts positively on both clinical outcomes and patient experience (Francis 2013, Keogh 2013, and Berwick 2013). Addressing these issues ensures we prioritise the safety and experience of our patients and staff. Clearly safe staffing is not just about staffing ratios, but ensuring that we have the right staff, with the right skills, in the right place at the right time.

The Nurse Staffing Level (Wales) Act 2016 became law in Wales in March 2016. The Act requires health service bodies to make provision for an appropriate nurse staffing level, and to ensure that they are providing sufficient nurses to allow the nurses time to care for patients sensitively. This requirement extends to anywhere where the Health Board is securing the provision of nursing services, including care homes

The Act consists of 5 sections;

- 25A refers to the health boards'/NHS trusts' overarching responsibility to have regard to providing sufficient nurses in all settings.
- 25B & 25C require health boards/NHS trusts' to calculate and take "all Reasonable Steps" to maintain the nurse staffing level in all adult acute medical and surgical wards.
- 25D relates to the statutory guidance released by Welsh Government

- 25E requires health boards/NHS trusts to report their compliance in maintaining the nurse staffing level for each adult acute medical and surgical ward.

The National (UK) understanding of acute services professional nurse staffing standards are also made explicit within the NICE publication 'Safe staffing for nursing in adult inpatient wards in acute hospitals' (2014).

3.0 SCOPE

This Operating Framework is relevant to all healthcare professionals involved in the calculating and maintaining the nurse staffing levels, including the nursing management structure.

This Operating Framework applies to all Acute Services adult areas, including in particular, all wards where Section 25B of the Nurse Staffing Levels (Wales) Act applies.

This Operating Framework is to support the calculation and maintenance of nursing staffing levels in Adult medical and surgical wards, and the actions that are taken to review and record every occasion when the number of nurses deployed varies from the planned roster.

The Framework will provide guidance to nursing staff and managers to safely manage risk to patient's safety and staff well-being when not able to maintain the nurse staffing level and ensure that this is reported and recorded monitored and all reasonable steps undertaken.

Section 25B currently applies to adult acute medical inpatient wards and adult acute surgical inpatient wards.

The following care settings are also included in the scope of this policy:

- Acute medical and surgical admission/assessment units;
- Intensive care units;
- High dependency units;
- Coronary care units;
- Day care units or wards;
- Theatres; and
- Rehabilitation wards.

4.0 AIM

The aim of the Framework is to ensure that nursing staffing levels are in line with the requirements of the Nurse Staffing Level (Wales) Act 2016. The aims of this policy will be achieved by:

- Supporting the assessment of patients' care needs with processes which ensure that the nurse staffing levels reflect the care needs of patients at all times.
- To support the calculation and maintenance of the nurse staffing level,
- To provide guidance to nursing staff and managers to safely manage risk to patients safety and staff well-being when not able to maintain the nurse staffing level and ensure that this is reviewed, recorded, monitored and appropriate actions are taken
- To provide the mechanism through which open and transparent information on the nurse staffing level on each adult acute medical and surgical ward within the Health Board will be shared.

5.0 DEFINITION OF TERMS

Adult acute medical inpatient ward	An area where patients aged 18 or over receive active treatment for an acute injury or illness requiring either planned or urgent medical intervention, provided by or under the supervision of a consultant physician. Patients are deemed to be receiving active treatment if they are undergoing interventions prescribed by the consultant and/or their team, and/or advanced practitioners for their acute injury or illness. It is acknowledge that patients between 16-18 years of age are sometimes admitted to our adult acute medical inpatient wards, however, the primary function of these wards is for patients aged 18 or over.
Adult acute surgical inpatient ward	An area where patients aged 18 or over receive active treatment for an acute injury or illness requiring either planned or urgent surgical intervention provided by or under the supervision of a consultant surgeon. Patients are deemed to be receiving active treatment if they are undergoing interventions prescribed by the consultant and/or their team, and/or advanced practitioners for their acute injury or illness. It is acknowledge that patients between 16-18 years of age are sometimes admitted to our adult acute surgical inpatient wards, however, the primary function of these ward is for patients aged 18 or over.
Designated Person	A person designated by the health board/trust who is responsible for calculating nurse staffing levels on behalf of the CEO/Board. The designated person should be registered with the Nursing and Midwifery Council (NMC) and be of sufficient seniority within the health

board/trust, such as the Executive Director of Nursing for the Board.

Enhanced Patient Support	Enhanced Patient Support (EPS) is a framework through which clinical services assess the need for, and monitor the implementation of, heightened levels of observation and support for inpatients with particular care needs. Some inpatients require closer observation, often with the primary aim of reducing risk and protecting the inpatient and /or others (e.g. they have increased confusion or are at risk of falling and sustaining injury). This activity is often referred to as “specialling” or ‘one to one’ care; it is, however, important to recognise that ‘specialling’ is only one method of enhancing the level of patient support
Nurse	This means a registered nurse who has a live registration on sub parts 1 or 2 of the NMC register.
Nurse staffing level	The Nurse staffing level is the total number of Nurses (i.e. registered nurses) AND those staff undertaking nursing duties under the supervision of or delegated to by a registered nurse (e.g. HCSW). The nurse staffing level refers to the planned roster AND the establishment required to meet the planned roster.
Patient acuity	Acuity can be defined as the measurement of the intensity of nursing care required by a patient. For the purpose of this work we use the term ‘acuity’ as an umbrella term which encompasses other terms such as dependency, intensity and complexity to describe the amount of care that a patient requires based on their health needs. The term ‘Acuity’ has 2 main attributes: 1. Severity, which indicates the physical and psychological status of the patient; and 2. Intensity, which indicates the nursing needs, complexity of care and the corresponding workload required by a patient, or group of patients.
Planned roster	Refers to the number and skill mix of staff required to enable nurses to provide care to meet all reasonable care requirements. The Nurse Staffing levels (Wales) Act statutory guidance states that ‘Supernumerary persons such as students and ward sisters/charge

	nurses/managers should not be included in the planned roster’.
Professional judgement	An informed opinion on the factors that influence clinical decision making in relation to patient safety: Factors that need to be considered as part of professional judgement are listed within the Statutory guidance. The statutory guidance requires that the professional judgement of the Designated Person as well as the registered nurses working within the ward are taken account of when calculating the nurse staffing levels.
Quality indicators	Health boards are required to consider quality indicators which are a robust measure of those factors considered to demonstrate the outcomes for patients and staff that are impacted upon by nurse staffing levels. Some indicators are more sensitive to nursing than others. There are 3 nurse-sensitive indicators that it is required to consider within the Act/statutory guidance: • Patient falls - the designated person should consider any fall that a patient has experienced; • Pressure ulcers - the designated person should consider any pressure ulcers a patient has developed and/or shown deterioration whilst receiving inpatient care; and • Medication administration errors - the designated person should consider any error in the preparation, administration or omission of medication by nursing staff. In addition to these three indicators, the designated person may consider any other indicator that is sensitive to the nurse staffing level they deem appropriate for the ward where the calculation is taking place.
Reasonable requirements	The patients’ nursing needs/ activities of daily living as assessed by the ward nursing team. This means taking into consideration the holistic needs of the patient, including social, psychological, spiritual and physical requirements. The ward sister is responsible for ensuring that these needs are assessed and classified using the Welsh Levels of Care descriptors (see below for further information).
Reasonable steps	A series of national, strategic and operational steps that need to be undertaken when aiming to maintain the nurse staffing level.

Required establishment

The total number of staff required to provide sufficient resource to deploy a planned roster that will meet the expected workload to provide care to meet the patients' nursing needs for the area.

This includes a resource of 26.9% to cover all staff absences and other functions that reduce their time to care for patients. Supernumerary persons such as students and ward sisters/charge nurses/managers should not be included in the planned roster.

Triangulation/triangular approach

This refers to the method used when calculating the nurse staffing level. Triangulation is a technique that facilitates validation of information from the following three sources of data through a process of cross verification:

- patient acuity;
- professional judgement; and
- Quality indicators.

Welsh Levels of Care

Data from each of these three sources is taken into account when calculating the nurse staffing level. A tool developed within NHS Wales that has been validated for use by establishing an evidence base of its applicability in Welsh clinical settings, and determined by the Chief Nursing Officer as being suitable for use.

<http://fundamentalsofcare.dev.wales.nhs.uk/nurse-staffing/doclib/Welsh%20Levels%20of%20Care%20Edition%201.pdf>

6.0 GLOSSARY OF TERMS

EPS	Enhanced Patient Support
HCSW	Health Care Support Worker
AfPP	Association of Perioperative Practice
BADS	British Association of Day Surgery
GPICs	Guidelines for the Provision of Intensive Care Services
JAG	Joint Advisory Group
IMTP	Integrated Medium Term Plan
NICE	National Institute of Clinical Excellence
RN	Registered Nurse
BCI	Business Continuity Incident
TOIL	Time owing in Lieu
WTE	Whole Time Equivalent

7.0 LEGISLATIVE AND NHS REQUIREMENTS

7.1 Equality Impact Assessment (EIA)

Following assessment (Appendix 2) this policy is not felt to be discriminatory or detrimental in any way with regard to the following equality standards:

Gender; Race; Disability; Age; Sexual Orientation; Religion or Belief; Welsh Language or Human Rights.

7.2 Privacy Impact Assessment (PIA)

A privacy impact assessment has been undertaken (appendix 3).

8.0 CALCULATING THE NURSE STAFFING LEVEL

Section 25A

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. 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.

Calculating the nursing staffing levels will include giving consideration to any national recommendations/ standards or best practice recommendations that exists around the service e.g.

- British Cardiovascular Society standards for Acute Cardiac Care Units.
- Association for Perioperative Practice (AfPP) Staffing for Patients in the Perioperative Setting 2014.
- British Association of Day Surgery (BADs), Team Work & Staffing in Day Surgery.
- Guidelines for the Provision of Intensive Care Services (GPICs).
- Joint Advisory Group (JAG) guidelines for Endoscopy.
- Hyper Acute Stroke Units/Acute Stroke Units

[https://www.strokeaudit.org/SupportFiles/Documents/Guidelines/2016-National-Clinical-Guideline-for-Stroke-5t-\(1\).aspx](https://www.strokeaudit.org/SupportFiles/Documents/Guidelines/2016-National-Clinical-Guideline-for-Stroke-5t-(1).aspx).

8.1 Section 25B & 25C: Adult Acute medical and surgical wards

Section 25B&C of the Act relates to adult acute medical and surgical wards where there is a duty to calculate nurse staffing levels using a prescribed methodology and take all reasonable steps to maintain nurse staffing levels.

In every adult acute medical and surgical ward the method of calculation is a 'triangulated' approach which brings together three sources of information to determine the required nurse staffing level. In this situation the information triangulated is both qualitative and quantitative in nature. The triangulation process should include:

- Professional judgement including:
 - o The qualifications, competencies, skills and experience of the nurses providing care to patients.
 - o The effect of temporary staff on the nurse staffing level.
 - o The effect of a nurse's considerations of a patient's cultural needs.
 - o Conditions of a multi-professional team dynamic.
 - o The potential impact on nursing care of a ward's physical condition and layout.
 - o The turnover of patients receiving care and the overall bed occupancy.
 - o Care provided to patients by other staff or health professionals, such as health care support workers.
 - o Any requirements set by a regulator to support students and learners
 - o The extent to which nurses providing care are required to undertake administrative functions.
 - o The complexity of the patients' needs in addition to their medical or surgical nursing needs, such as patients with learning disabilities.
 - o Delivering the active offer of providing a service in Welsh without someone having to ask for it.
- Patient acuity - The Senior Sister/Charge Nurse is responsible for ensuring that the social, psychological, spiritual and physical care needs are assessed and classified using the Welsh Levels of Care descriptors. The calculation of the nurse staffing level will meet all these "reasonable requirements" of care; and
- Quality indicators – Consider "circumstances where patient well-being is particularly sensitive to care provided by a nurse as part of the triangulated method each time the nurse staffing level is calculated" in accordance with the Nurse Staffing Levels (Wales) Act statutory guidance. (e.g. medication administration errors, patient falls, and pressure ulcers).

In addition to these three indicators, the "designated person" may consider any other indicator that is sensitive to the nurse staffing level they deem appropriate for the ward where the calculation is taking place.

The nurse staffing levels will be calculated every 6 months as a minimum and more frequently if the use of the ward changes which alters the nurse staffing level, or if it is deemed necessary.

All the information collected must be reviewed and validated separately before being brought together through a triangulated methodology in order to arrive at an informed decision on the nurse staffing level for each ward.

The planned roster should be informed by the registered nurses within the ward as well as the nursing management structure where the nurse staffing level applies i.e. Head of Nursing and Senior Nurse Manager

The Executive Director of Nursing of Nursing, Midwifery & Patient Safety (as the “designated person”) must be provided with the rationale behind the calculation; must confirm the calculation based on the prioritisation that has been given to the information; and must make a recommendation to the Board regarding the nurse staffing level for each adult acute medical and surgical ward.

The evidence and rationale used to determine the nurse staffing level must be recorded. The nurse staffing level will be the planned roster and the required establishment. The nurse staffing level should be funded from the Health Board’s revenue allocation, taking into account the actual salary points of staff employed.

8.2 Nurse Staffing Level - key principles:

Determining the nurse staffing level for a ward is complex and assessing the individual needs of patients is vital when considering decisions about the nurse staffing levels. Nurse staffing levels will be calculated using a triangulated methodology that uses professional judgement to analyse and advice on the planned roster required to deliver quality patient care outcomes for the acuity and numbers of patients that are cared for within that ward.

Some key principles that are inherent within the required establishments calculated for all wards will include the following principles which are recognised in the literature as reasonable principles to work to, based on the evidence available, when calculating nurse staffing levels for adult acute medical and surgical inpatient wards.

The requirement of using the triangulated methodology to agree the planned roster for each ward included under Section 25B of the Act individually, is deemed to be a more sensitive methodology to calculating the required establishment for a ward than the use of the blunt instrument of specifying the ‘nurse per bed’ ratio.

For wards included under Section 25B of the Act, supernumerary persons such as students and ward sisters/managers should not be included in the planned roster.

8.3 Informing Patients

The Act requires that patients must be informed of the nurse staffing level for each adult acute medical and surgical ward and must be informed of the date the nurse staffing level was agreed by the Board. This should be easily visible to anyone attending the ward. A ‘frequently asked question’ leaflet must be available

on the wards where section 25B applies which include information on how patients/family/carers can raise a concern about the nurse staffing level.

9.0 MAINTAINING THE NURSE STAFFING LEVEL

The Health Board is required, as laid out in the statutory guidance, to ensure that “all reasonable steps” are taken to maintain the nurse staffing level in all Adult Acute Medical and Surgical Wards.

In practice, this will require that a range of actions are taken at a strategic level in the medium to long term, and operationally in the immediate and short term.

It is the responsibility of the Sister/Charge Nurse to ensure effective roster management and deployment of the nursing staff within the required establishment of their wards: It is the responsibility of the Senior Nurse to sign off the planned roster to authorise and confirm that it reflects an appropriate deployment of the nurse staffing resource that sits within the establishment for each ward.

9.1 Systems and Processes for Reviewing

The Health Board is required to put into place systems that allow them to review and record every occasion when the number of nurses deployed varies from the planned roster.

This will include making a record of the rationale that underpins a decision to appropriately vary the planned roster in response to patient acuity /dependency across the hospital system.

All reasonable steps taken to maintain the nurse staffing level as per the planned roster will be recorded and reviewed through the nursing management structure and reported/escalated to the designated person in line with the level of risk the situation demands.

The actions that would be seen to be ‘all reasonable steps’ at a strategic level include:

- Workforce planning for a continued supply of required staff.
- Active recruitment in a timely manner at local, regional, national and international level.
- Retention strategies that includes consideration of the NHS Wales Staff Survey.
- Well-being at work strategies that support nurses in delivering their roles.

The actions that would be recognised as ‘All Reasonable Steps’ in maintaining the nurse staffing level in the immediate to short term, at an operational level, include:

- Use of temporary staff from a nursing bank appropriate to the skill mix set out in the planned roster
- Use of temporary staff from a nursing agency appropriate to the skill mix set out in the planned roster (once bank staff have been considered)
- Temporary use of staff from other areas within the organisation. (When considering using staff from other areas within the organisation individuals should consider and take due regard of the duty placed upon the organisation in section 25A to have sufficient nurses to allow the nurses time to care sensitively for patients wherever nursing services are provided. In addition, decisions about moving staff should take into consideration the staff member's competency and skills).
- Considering the temporary closure of beds.

10.0 DUTIES AND RESPONSIBILITIES OF STAFF

The responsibility for meeting the requirements of the Act spans from the ward/ service to the Board.

10.1 Strategic duties & responsibilities

Chief Executive Officer of the Health Board

The Chief Executive Officer is ultimately responsible for ensuring the Health Board complies with the Nurse Staffing Levels (Wales) Act 2016.

Executive Board

When exercising their responsibilities, the Board should consider and have due regard of the duty on them (under section 25A of the Act) to have sufficient nurses to allow the nurses time to provide sensitive care wherever nursing services are provided.

Specific members of the Board - the Directors of Nursing, Workforce & Organisational Development, Finance and Operations - are required to provide evidence and professional opinion to the Board to assist with its decision making in relation to maintaining the nurse staffing level in adult acute medical and surgical in-patient wards.

The Board are required to:

- Designate a person (or a description of a person) to be responsible for calculating the nurse staffing level in settings where Section 25B of the Act applies;
- Determine which ward areas meet the definitions of the adult acute medical and surgical inpatient wards;
- Receive and agree written reports from the "designated person" on the nurse staffing level for each adult acute medical and surgical inpatient ward at a public board on an annual basis and at any other time when the "designated person" deems this to be required;

- Ensure that systems are place to record and review every occasion when the number of nurses deployed varies from the planned roster; and
- Agree the operating framework which will:
 - o Ensure there are systems and processes in place and specify the decisions in relation to maintaining nurse staffing levels.
 - o Specify the actions to be taken, and by whom, to ensure that all “reasonable steps” are taken to maintain the Nurse Staffing Level on both a long term and a shift by shift basis.
 - o Specify the arrangements for informing patients of the nurse staffing level on each ward along with the date this was agreed by the Board. The information should be set out in an easily accessible format and must comply with requirements under the Welsh Language standards

The Executive Director of Nursing

The Executive Director of Nursing of Nursing, Midwifery & Patient Safety:

- The “designated person” within the UHB who is authorised, on behalf of the Chief Executive Officer, to calculate the nurse staffing level for each adult acute medical and surgical inpatient ward. The ‘designated person’ will calculate the number of registered nurses appropriate to provide patient centred care that meets all “reasonable requirements” in adult acute medical and surgical inpatient wards and must undertake and record the rationale for the calculation.
- Will undertake the nurse staffing level calculation for the adult acute medical and surgical inpatient wards every 6 months or more frequently if there is a change in the use/service which is likely to alter the nurse staffing level, or if they deem it necessary.
- Must formally present the nurse staffing level for each adult acute medical and surgical ward to the Board on an annual basis. In addition, written updates will be provided to the Board if the nurse staffing level on any ward has been changed for any reason.

In addition the Executive Director of Nursing of Nursing, Midwifery & Patient Safety will:

- Advise members of the Board on professional nursing standards including those relating to Nurse Staffing Levels.
- Will undertake the nurse staffing level calculation in all areas where Section 25A applies
- Report to the Board the impact that not maintaining the nurse staffing levels has had on the care provided to patients by nurses and the actions taken in response to not maintaining nurse staffing levels.

Director of Workforce and OD

The Director of Workforce and OD is required to ensure:

- An effective system of workforce planning, based on the Welsh Planning System, is in place in order to deliver a continuous supply of the required numbers of staff;
- That there are systems to ensure active and timely staff recruitment (at both a local, regional national and international level);
- That there are effective staff well-being and retention strategies in place that take account of the NHS Wales Staff Survey;
- That, working in collaboration with the Executive Director of Nursing of Nursing, Midwifery & Patient Safety, there is a strategic recruitment plan in place for nurse staffing across the acute sector, and
- That there is a robust process in place for the management of recruitment into nurse staffing vacancies that is in line with agreed vacancy management plan for the area.
- Ensure strategic requirements of the Act embedded into the organisations IMTP/annual planning process;
- Robust workforce planning at ward/service level which are reviewed at least annually through IMTP /education commissioning processes;

Director of Operations:

The Director of Operations is responsible for ensuring that there are operational processes in place that enable:

- The use of appropriately skilled, temporary (bank or agency) nursing;
- The temporary redeployment of staff between areas;
- The temporary closure of beds ; and
- Consideration of changes to the patient pathway as means through which to maintain nurse staffing levels where required. These processes should be reflected in the Board's escalation policy and business continuity plans.

Director of Finance:

The Director of Finance is responsible for:

- Ensuring that the funding of the agreed nurse staffing level is from the health board's revenue allocation and that it takes into account the actual salary points of staff employed on the wards where section 25B applies.

Assistant Director of Nursing & People's Experience

The Assistant Director of Nursing with responsibility for workforce will:

- Provide leadership and direction for the development and implementation of consistent systems to enable operational compliance with the requirements of the Nurse Staffing Levels (Wales) Act.
- Ensure that support and training in the use of the various nurse staffing levels calculation and maintenance tools and systems (including risk assessment tools), is made available to operational teams in a timely manner

- Manage the processes for undertaking the six monthly re-calculation/review of the nurse staffing levels for all wards that fall under Section 25B of the Act in a timely manner.
- Provide Annual Reports to Board as per AWNSA Board reporting schedule.

10.2 Acute Services Operational Teams (Site/Directorate)

ILG Nurse Directors

- Provide professional guidance to Heads of Nursing in relation to the professional judgement to be applied to the data/criteria which must be used to inform the calculation of the Nurse Staffing Levels for wards included under Section 25B of the Act.
- Contribute to the 6 monthly, detailed discussions that are required when calculating the nursing staff levels for the wards where Section 25B applies and initiate /recommend a review when there is a change in service/use of any clinical ward /area which is likely to change the nurse staffing levels.
- Contribute to the processes to be implemented for calculating the nursing staff levels for the situations where 25A applies.
- Be responsible for monitoring and providing assurance that the professional standards in relation to the nurse staffing level at operational level are being maintained; and that the agreed systems and processes are being applied across all acute hospital sites.
- Be responsible for ensuring that the systems in place to review and record the occasions when the number of nurses deployed varies from the planned roster, are fully complied with at all times across all sites.
- Ensure that effective risk assessment processes and systems are in place and utilised as required.

Head of Nursing

- Provide professional leadership and guidance to their operational nursing teams in the calculation of the Nurse Staffing Levels based upon the requirements set out in section 25B & 25C of the Act.
- Contribute to calculating the nursing staff levels for the situations where 25B applies every six months at minimum, and when there is a change in service/use which is likely to change the nurse staffing levels; and on an annual basis for all other areas.
- Contribute to calculating the nursing staff levels for the situations where 25A applies
- Review the patient acuity and quality indicator data and provide information that enables the Executive Director of Nursing to exercise professional judgement when calculating the nurse staffing levels.
- Ensure that when the planned roster varies in response to the clinical situation, the ward sister/charge nurse and senior nurse are

continuously assessing the situation and keep the “designated person” appraised.

- Ensure that the systems in place to review, record and report every occasion when the number of nurses deployed varies from the planned roster are utilised.
- Ensure that all “reasonable steps” are undertaken to maintain the nurse staffing level.
- Ensure any staffing risks or concerns are managed appropriately and timely and that patient care and safety and that nurses are not compromised over Nurse Staffing Levels. Identify all risks that require a corporate management or professional intervention must be escalated to the appropriate Executive leaders within the organisation.
- Ensure adequate operational management capacity is in place to enable appropriate response to escalating staffing concerns both in and out of hours.
- Appropriate and timely use of the escalation policy relating to nurse staffing and reporting and management of risk

Clinical Service Group Managers

- Ensure own knowledge of this policy, the Act and the statutory guidance.
- Ensure systems are in place within Directorates/services to ensure that the nurse staffing level is calculated as per the requirements of the statutory guidance for the situations where Section 25B of the Act applies and annual for all other areas, including budget setting.
- Ensure systems are in place within Directorates/services to ensure that the nurse staffing level is calculated as per HB policy for the situations where Section 25A of the Act applies.
- Ensure that this policy, the Act and statutory guidance are applied to hospital site management decision making both in and out of hours.
- Ensure that systems are in place to enable any required multi-disciplinary team learning from individual as well as collated nurse-staffing related Datix reports within the service, ensuring trends identified and acted upon.
- Ensure that service planning (e.g. those within IMTP) takes account of the requirements set out in the Nurse Staffing Levels (Wales) Act. Ensure efficient and effective vacancy approval processes are in place within the Directorate/service to minimise delays within recruitment processes and escalate any delays that are outside the control of the operational team.

Senior Nurses

- Contribute to calculating the nursing staff levels for the situations where 25B applies every six months at minimum, and when there is a change in service/use which is likely to change the nurse staffing levels and on an annual basis for all other areas.

- Contribute to calculating the nursing staff levels for the situations where 25A applies
- Support teams within their service area to undertake the bi-annual acuity audits (or more frequently if required) and is responsible for validating and confirming the acuity data collected.
- Ensure effective and efficient use of nurse staffing resources to support safe, effective and fair advance planning by signing off the planner roster.
- In accordance with paragraph 14 of the statutory guidance the Senior Nurse, along with the Senior Sister/Charge Nurse, should continuously assess the clinical environment and keep the Head of Nursing formally apprised of the situation.
- Proactively manage daily workforce planning across areas of responsibility to ensure staff are distributed according to clinical need.
- Ensure risk assessment is complete.
- Ensure that all “reasonable steps” are undertaken to maintain the nurse staffing level and escalate any concerns.
- Escalate to relevant professional heads of nursing areas of concern or inability to fill shifts.
- Should ensure that on occasions when the nurse staffing level is not maintained that these occasions are reported as a Datix incident.
- Review, record and report every occasion when the number of nurses deployed varies from the planned roster, and ensure the mitigating actions are sufficient to maintain a safe service to both service users and staff.
- Review all Datix reports and undertake final grading of all investigations and identify any trends or issues that arise and that these are actioned.
- Ensure that the vacancy process is undertaken in a timely manner.
- Ensure that the “Temporary use of staff from other areas within the organisation Log” (Appendix 1) is complete in the event of staffing being moved from other areas within the organisation.
- Appropriate and timely use of the escalation policy relating to nurse staffing and reporting and management of risk
- Regular review of the acuity of the patients on the ward, including the identification and risk management of patients.

Sister /Charge Nurse

- Undertake the daily acuity audits
- Actively involved in review of the bi-annual acuity audits (or more frequently if required) within their area and is responsible for validating and confirming the accuracy and completeness of the acuity data collected.
- Responsible for assessing the holistic needs of the patients and for classifying these under the Welsh Levels of Care descriptors as part of the evidence based workforce planning tool process.

- Make available their opinions about the nurse staffing levels to the Head of Nursing/Senior Nurses when nurse staffing level for their ward is being calculated.
- Maintain the system for informing patients of the nurse staffing levels.
- Has 24hr responsibility for the standards of care on the ward; this includes responsibility for ensuring human resources are planned effectively and efficiently.
- Ensures effective roster management in line with the rostering policy.
- Use of a robust electronic rostering tool and strong governance systems to monitor and review the rosters and ensure effective utilisation of the nursing workforce (e.g. review the staffing roster on a day to day basis, explore with staff member rescheduling annual leave and/or change of shift, postponing staff training/ study leave);
- Effective resource management, utilisation and deployment of staff e.g. appropriate allocation of annual leave and study leave, staff working overtime (within WTE), additional hours or use of hours owed;
- Regular review of the acuity of the patients on the ward, including the identification and risk management of patients requiring 'enhanced patient support' in line with local policy and professional judgement;
- In accordance with paragraph 14 of the statutory guidance the Senior Sister/Charge Nurse should continuously assess the clinical environment and keep the Senior Nurse/Head of Nursing formally appraised of the situation.
- Ensure that all "reasonable steps" are undertaken to maintain the nurse staffing level and escalate any concerns.
- Should ensure that on occasions when the nurse staffing level is not maintained that these occasions are reported as a Datix incident
- Review, record and report every occasion when the number of nurses deployed varies from the planned roster.
- Appropriate and timely use of the escalation policy relating to nurse staffing and reporting and management of risk

Nurse in Charge of Shift

- Ensure own knowledge of this policy, the Act and the statutory guidance.
- Assess the holistic needs of the patients and classifying these under the Welsh Levels of Care descriptors as part of the evidence based workforce planning tool process.
- Ensure that all "reasonable steps" are undertaken to maintain the nurse staffing level and escalate any concerns.
- Appropriate and timely use of the escalation policy relating to nurse staffing and reporting and management of risk
- Ensure that on occasions when the nurse staffing level is not maintained that these occasions are reported as a Datix incident

Individual Registrant Responsibility

- Ensure own knowledge of this policy, the Act and the statutory guidance.

- Responsible for raising a concern with managers using the Datix concern and incident reporting system at times when the nurse staffing levels have not been maintained.
- Awareness that all staff may be moved to another area to work, if required. Any movement of staff will take into account the individual's competency and skills.

Clinical Site Manager / Bed Manager

During the out of hours periods, the Clinical Site managers are responsible for:

- Ensuring their own knowledge of this policy, the Act and the statutory guidance.
- Maintaining an overview of staffing and patient acuity across the site.
- At operational site meetings, escalating staffing issues to the responsible Senior Nurse.
- Ensuring that all “reasonable steps” are taken to maintain nurse staffing levels including adjusting the nurse staffing levels to match the patient workload or changing the workload to match the nurse staffing level and step down of any surged beds (Clinical Site Managers should consider and take due regard of the duty placed upon the organisation in section 25A to have sufficient nurses to allow the nurses time to care sensitively for patients wherever nursing services are provided).
- Ensuring that an appropriate risk assessment is complete if nurse staffing levels are not maintained.
- Completing the “Temporary use of staff from other areas within the organisation Log” (Appendix 1) in the event of staffing being moved from other areas within the organisation out of hours.
- Escalating concerns to the on call manager.

Senior Manager on-call

During the out of hours periods, the On Call Executive is responsible for:

- Ensuring their own knowledge of this policy, the Act and the statutory guidance.
- Ensuring that all “reasonable steps” are taken to maintain nurse staffing levels including adjusting the nurse staffing levels to match the patient workload or changing the workload to match the nurse staffing level and step down of any surged beds (the on call managers should consider and take due regard of the duty placed upon the organisation in section 25A to have sufficient nurses to allow the nurses time to care sensitively for patients wherever nursing services are provided).
- Ensuring an appropriate risk assessment is complete.
- Escalating concerns to the on call executive.

Executive on-call

During the out of hours periods, the on-call executive is responsible for:

- Ensuring their own knowledge of this policy, the Act and the statutory guidance.
- Ensuring that all “reasonable steps” are taken to maintain nurse staffing levels including adjusting the nurse staffing levels to match the patient workload or changing the workload to match the nurse staffing level and step down of any surged beds (the on call managers should consider and take due regard of the duty placed upon the organisation in section 25A to have sufficient nurses to allow the nurses time to care sensitively for patients wherever nursing services are provided).
- Ensuring an appropriate risk assessment is complete.

The detailed roles and responsibilities of post holders that sit within the Health Board’s ‘Nursing Management Structure’ are set out in appendix 2 of this document.

11.0 ESCALATION PROCEDURE

Escalation procedures for maintaining nurse staffing levels:

This escalation process reflects a risk assessment approach aimed at supporting staff who have a responsibility for maintaining nurse staffing levels. The procedures outlined in the Escalation Procedure (Appendix 1) are aimed at providing consistency with identified triggers and responsibilities, which staff may need to interpret and apply as circumstances determine.

The nurse in charge of the shift on the ward must escalate where it is assessed that the number of nurses deployed varies from the planned roster. In addition, the nurse in charge of the shift/Senior Sister/Charge Nurse should consider escalating the situation when the quality indicators in the table below - which reflect patient outcomes that are deemed to be nursing-sensitive - occur.

Quality indicators which reflect patient outcomes that are deemed to be nursing-sensitive Nursing ‘Red Flag’ Events (NICE 2014)
• Unplanned omission in providing patient medication
• Delay of more than 30mins in providing pain relief
• Patient vital signs are not assessed or recorded as outlined in the care plan
• Inability to undertake regular checks on patients to ensure their fundamental care needs are met as outlined in the care plan. This is often referred to as ‘intentional rounding’ and involves checks on aspects of care such as the following: - o Pain: asking patients to describe their level of pain level using the pain assessment tool. - o Personal needs: such as scheduling patient visits to the toilet or bathroom to avoid risk of falls and providing hydration.

- o Placement: making sure that items a patient needs are within easy reach - o Positioning: making sure that the patient is comfortable and the risk of pressure ulcers is assessed and minimised
• Less than 2 Registered nurses present on a ward during any shift
• A shortfall of more than 8 hours or 25% (whichever is reached first) of registered nurse time available compared with the actual requirement for the shift. - o For example, if a shift requires 40hrs of registered nurse, a red flag event would occur if less than 32 hours of registered nurse time is available for that shift. - o If a shift required 15hrs of registered nurse time, a red flag event would occur if 11 hours or less of registered nurse time is available for that shift (which is a loss of more than 25% of the required registered nurse time).



Determining the Risk Score

1. Describe the current risk status in terms of consequences to patient safety and experience
2. Score the consequences from 1 (no/low risk to patient safety) to 5 (serious patient safety concerns/risks) (see Table 1 for descriptors)
3. Score the likelihood of further deterioration to patient safety unless further actions are taken over and above the current levels from 1 (unlikely) to 5 (almost certain) (see Table 2 for descriptors)
4. Calculate the risk score by multiplying the consequences by the likelihood
 $\text{CONSEQUENCES} \times \text{LIKELIHOOD} = \text{RISK SCORE}$ (Table 3)
5. The resulting score determines the staffing escalation level
6. Is the score correct? – If the actions you need to take at this level are proportionate to the score then the assessed level is likely to be correct. If not, then review and reassess your score

Table 1 Consequences

CONSEQUENCES		
Frequency		Probability
1	Negligible	Negligible. Very low risk to patient safety, where harm to patients is highly unlikely
2	Minor	Low risk to patient safety, although harm to patients is very small or unlikely
3	Moderate	Risk to patient safety which required urgent 'same' day action
4	High Risk	High risk to patient safety and immediate action required e.g. <i>Recorded fall; Recorded pressure ulcer developed or worsened; Medication administration error (error in preparation, administration or omission of medication)</i>
5	Extreme	Significant risks to patient safety, which are likely to result in harm to patients. Immediate and extraordinary action required

Table 2 Likelihood Probability Descriptors

LIKELIHOOD		
Descriptor		Probability
1	Rare	<0.1 per cent
2	Unlikely	0.1 – 1 per cent
3	Possible	1 -10 per cent
4	Likely	10 - 50 per cent
5	Almost Certain	> 50 per cent

The risk score will put you in a range within an individual nurse staffing alert e.g. a consequence of 4 but a likelihood of 3 will give a score of 12 or 'low level' whereas the same consequence but with a likelihood of 4 will give a score of 16 or 'high level' amber. This should help Senior Nurses in the prioritisation of control measures for the management of different nurse staffing risks and whether they need to consider actions above those described at this level. For example, if the level is 16 then consideration of actions required at the red level maybe considered at this stage.

	Table 3 RISK SCORING MATRIX				
Consequences					
Likelihood	1	2	3	4	5
1	1	2	3	4	5
2	2	4	6	8	10
3	3	6	9	12	15
4	4	8	12	16	20
5	5	10	15	20	BCI

Once the risk score has been determined staff should refer to the Escalation Alert Level (Table 4) and follow the Nurse Staffing Escalation Plan (Appendix 1 below).

Table 4 Escalation Alert Levels				
GREEN	YELLOW	AMBER	RED	BCI

Steady State	Action Required	High Risk	Very High Risk	Business Continuity Incident
Score 1-4	5-10	12-16	20	25
Risk to Patient Safety and Experience				

12.0 TRAINING

Any training required for the operational teams will be professionally managed through the Hospital/Directorate management team.

Any training required from a corporate perspective will be professionally managed via the Nursing, Quality and Experience Support Teams.

13.0 MONITORING, REPORTING AND AUDITING

The Health Board will have systems in place to be able to monitor the level/frequency of compliance with the planned roster. In addition, systems will be in place in order to monitor incidents which may/have been impacted upon by the nurse staffing levels. The information generated from these monitoring processes will inform the professional judgement which is applied to each 6-monthly calculation cycle. The monitoring data described here will be shared as part of an annual report to the UHB as well as the statutory, three yearly report to Welsh Government.

A full review of this policy will be undertaken every two years or sooner if there are changes to guidance or legislation. On-going monitoring and auditing of this policy will be undertaken by Corporate Nursing who receive regular reports on compliance with the Act.

14.0 NON CONFORMANCE

All staff are required to comply with this Policy and where requested demonstrate such compliance. Failure to comply will be dealt with under the appropriate Workforce Policy.

15.0 RETENTION / ARCHIVING

Requests for information under the Act will be retained and archived in line with National Records Management Guidance. This Policy will be subject to version control and archived as required by local policy.

16.0 REFERENCES

Berwick (2013) *A promise to learn a commitment to act. Improving the Safety of Patients in England*. National Advisory Group on the Safety of Patients in England

Francis (2013) *Report of the Mid-Staffordshire NHS Foundation Trust Public Enquiry* London. The Stationary Office

Keogh Review (2013) *into the quality of care and treatment provided by 14 hospital Trusts in England*. NHS England

NICE (2014) safe staffing for nursing in adult inpatient wards in acute hospitals. NICE

NMC (2015) *The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives*

Welsh Government (2016) *Nurse Staffing Levels (Wales) Act (2016) Operational Framework*

Appendix 1



Nursing Staffing Levels (Wales) Act (2016) All Reasonable Steps

All Reasonable steps

Reasonable steps which should be taken at each of the following levels - national, strategic corporate (Local Health Board/ NHS Trust) and operational – to maintain the nurse staffing levels are considered to be:

National steps

- The sharing and benchmarking of corporate data.
- Leading of regular reviews of workforce and education commissioning requirements.
- Leading national initiatives to aid staff recruitment and retention.

Strategic corporate steps

- Workforce planning for a continued supply of required staff assessed using the Welsh Planning System.
- Active recruitment in a timely manner at local, regional, national, and international level.
- Retention strategies that include consideration of the NHS Wales Staff Survey results;
- Well-being at work strategies that support nurses in delivering their roles.
- Ensure strategic requirements of the Act embedded into the organisations IMTP/annual planning process.
- Robust workforce planning at ward/service level which are reviewed at least annually through IMTP education commissioning processes.
- Workforce policies and procedures which support effective staff management (eg: flexible working for staff).
- Robust organisational risk management framework.
- Effective risk assessment processes and systems are in place and utilised as required.

Operational steps

- Use of temporary staff from a nursing bank appropriate to the skill mix set out in the planned roster.

- Use of temporary staff from a nursing agency appropriate to the skill mix set out in the planned roster (once bank staff have been considered).
- Temporary use of staff from other areas within the organisation.
- The temporary closure of beds.
- Consideration of changes to the patient pathway (which should be clinically appropriate).
- Effective resource management, utilisation and deployment of staff e.g. appropriate allocation of annual leave and study leave, staff working overtime (within WTE), additional hours or use of hours owed.
- Use of a robust electronic rostering tool and strong governance systems to monitor and review the rosters and ensure effective utilisation of the nursing workforce (e.g. review the staffing roster on a day to day basis, explore with staff member rescheduling annual leave and/or change of shift, postponing staff training/ study leave).
- Ward sister/charge nurse to work within the planned roster.
- Regular review of the acuity of the patients on the ward, including the identification and risk management of patients requiring 'enhanced patient support' in line with local policy and professional judgement.
- "On Boarding". This is the term used when, in very unusual and exceptional circumstances, a patient is required to be placed on the ward and no bed is available. This practice has been extensively discussed within WG and NHS Wales and it is acknowledged that this is not best practice. In the rare event that this is deemed necessary, in line with NHS Wales escalation processes all Health Boards should have in place a clear escalation protocol that includes the circumstances in which this may be considered and the process for implementation. This should also include the requirement that any instance is immediately escalated/reported through the incident management systems within the Organisation and to the Chief Operating Officer and the Executive Nurse Director in hours and out of hours the Executive Director on call to be notified. On the rare occasion that on-boarding occurs this must be time limited and all HB's must have a de-escalation process in place. Should this rare situation occur, at the time of the audit, then the acuity of any such patient should be recorded on HCMS and the escalation / incident reporting situation must be followed.
- Appropriate and timely use of the escalation policy relating to nurse staffing and reporting and management of risk.
- Should this rare situation occur, at the time of the audit, then the acuity of any such patient should be recorded on HCMS and the escalation / incident reporting situation must be followed.

Appendix 2 – Nurse Staffing Escalation Procedure for Staffing Shortfalls

NURSE STAFFING ESCALATION PLAN				
GREEN	YELLOW	AMBER	RED	BLACK
STATUS	STATUS	STATUS	STATUS	STATUS
No reported concern or compromise to patient care or safety due to the available staffing in an area	Reported concern over the Nurse Staffing Level however there is no predicted risk to patient care or safety	Reported concern over the Nurse Staffing Level with risk of patient care being compromised impacting on the patients required care interventions (medication, observation, input or output), progress, outcomes, or dignity	Reported concern over the Nurse Staffing Level with a significant risk of patient care or safety being compromised	
TRIGGERS	TRIGGERS	TRIGGERS	TRIGGERS	TRIGGERS
Able to maintain the agreed staffing levels	- Deficits caused by unplanned absence - Redeployment or temporary staff utilisation unavailable - Increased activity/dependency e.g. enhanced patient support - One shift in 24 hours not staffed to agreed level but to a level that meets the current service demand (occupancy, dependency, activity and complexity)	- Multiple shifts not staffed to agreed level but to a level that meets the current service demand (Occupancy, Dependency, Activity and Complexity) - Shortfall of 25% RN time available for requirement of shift and skill mix is not met	- Significant or ongoing shifts not staffed to the agreed level - Compromised ability to meet current inpatients occupancy rate, dependencies, acuity or complexity - A deficit of 2 RNs present on a ward during any shift - Inability to de-escalate from high	Significant deficits of less than 2 RNs on multiple wards during any shift to agreed staffing template which may be short notice or persistent (Risk assessment matrix score 25) or Declaration of Business Continuity Incident (BCI)

	• RN numbers available however skill mix is not met • Nurse Staffing Level maintained but the qualifications, competency, skills and experience of the nurses providing care is insufficient		risk (amber) after 24 hrs	

ACTION	ACTION	ACTION	ACTION	ACTION
No action required All areas safely staffed and operational Continue to monitor	IN HOURS Consider: - Professional judgement of staffing needs - Realign rotas including skill mix - Divert internal resources to areas of greatest risk. - Consider utilisation of part time staff - Report exact shortage to Senior Nurse - Contact Nurse Bank Office - Report shortage and contingency plan at Site/Bed meeting - Report on DATIX including risk assessment and mitigating actions	IN HOURS Consider: - Escalate to Senior Nurse - Check Yellow action plan and risks identified completed - Senior Nurse review staffing across service area - Ask other care groups to review rotas and workload - Consider deployment of specialist nurses - Consider additional hours, overtime and agency authorisation - Consider cancelling of Management time and study leave. - Report shortage and contingency plan at Site meeting - Update DATIX including risk assessment and feedback outcome of escalation to Ward - Escalate to Head of Nursing if inadequate staffing levels still exist	IN HOURS Check Amber action plan and risks identified completed ESCALATION and REVIEW meeting with: - ILG Director of Nursing - Head of Nursing - CSG Director / Director of Operations Senior Team considers: - Temporary partial bed closure - Cancellation of non urgent electives - Cancellation of Outpatient activity - Cross organisation response and support - Divert options - Update DATIX and feedback outcome to Senior Nurse/ Site manager - Urgent implementation of plan to de-escalate staffing concerns and avoid need to declare a BCI - ASSESS and ADVISE timeframe for recovery/ de-escalation	N HOURS - ILG Nurse Director to escalate to the Executive Director of Nursing with Chief Operating Officer involvement in decision regarding: - Declaration of Business Continuity Incident (BCI) - Initiate (BCI) Plans

	Out of hours •Escalate to Clinical Site Manager	Out of hours • Escalate to Clinical Site Manager/Bed Manager • If unresolved Site Manager refers to Senior Manager On Call	Out of hours • Escalate to Senior Manager On Call (SMOC) • SMOC to escalate to to Executive On call	Out of hours • Senior Manager On Call (SMOC) escalates to Executive On call for decision re BCI • Declare Business Continuity Incident (BCI) • Initiate (BCI) Plans

Appendix 3

Equality Impact Assessment - Policies

Section 1: Preparation

This section must be completed at the beginning of a policy review. For advice on its completion please contact the Equality Team on 01443 744800. For examples of completed EIAs please see the Equality site under Useful Staff Information on Sharepoint.

Section 1 – Preparation		
1.	Title of Policy - what are you equality impact assessing? Please state whether it is a new or existing policy?	Nursing Staffing Levels and Escalation Plan: Acute Adult Services Policy
2.	Policy Aims and Brief Description	The purpose of this policy is to support the calculation and maintenance of nursing staffing levels in Adult Acute Services, and the actions that are taken to review, report and escalate where nurse staffing levels are not maintained. To provide open transparent information on nursing staffing levels within Adult Acute Services.
3.	Who Owns/Defines the Policy?	Executive Director of Nursing, Midwifery and Patient Services. Corporate Nursing
4.	Who is Involved in undertaking this EqIA	Head of Corporate Nursing
5.	Other Policies	Risk Management Policy Incident Reporting Policy Business continuity policy Flexible Working Policy Integrated Medium Term Plan (IMTP) 2019/20

Section 1 – Preparation		
7.	What might help/hinder the success of the policy?	Relevant staff working within the UHB may not being aware of the policy
8.	Is the policy relevant to “eliminating discrimination and eliminating harassment?”	The policy provides the structure and process for all other policies and therefore does not directly eliminate discrimination and harassment
9.	Is the policy relevant to “promoting equality of opportunity?”	The aim of all Cwm Taf Morgannwg UHB policies will be to promote the equality of opportunity.
10.	Is the policy relevant to “promoting good relationships and positive attitudes?”	The aim of this policy is to promote good relationships and positive attitudes.

Section 2. Impact	
Please answer the following Consider and refer to the information you have gathered from census data, relevant organisations and groups, staff groups, individuals etc. Please indicate the likelihood and risk associated with the issues raised.	
Do you think that the policy impacts on people because of their age? (This includes children and young people up to 18 and older people)	Not Specifically
Do you think that the policy impacts on people because of their caring responsibilities? I.e, would it affect their ability to care for somebody who is primarily dependant on them?	Not Specifically
Do you think that the policy impacts on people because of their disability? E.g. sensory loss, physical disability, Learning disability, some mental health issues	Not Specifically
Do you think that the policy impacts on people because of Gender reassignment? This includes	Not Specifically

Section 2. Impact	
all people included under trans* e.g. transgender, non-binary, gender fluid etc	
Do you think that the policy impacts on people because of their being married or in a civil partnership?	Not Specifically
Do you think that the policy impacts on people because of their being pregnant or having recently had a baby?	Not Specifically
Do you think that the policy impacts on people because of their race? (This includes colour, nationality and citizenship or ethnic or national origin such as Gypsy and Traveller Communities.)	Not Specifically
Do you think that the policy impacts on people because of their religion, belief or non-belief? (Religious groups cover a wide range including Buddhist, Christians, Hindus, Jews, Muslims, and Sikhs)	Not Specifically
Do you think that the policy impacts on men and woman in different ways?	Not Specifically
Do you think that the policy impacts on people because of their sexual orientation? (This includes Gay men, heterosexual, lesbian and bisexual people)	Not Specifically
Do you think that the policy impacts on people because of their Welsh language? (e.g. the active offer to receive services in Welsh, bilingual information etc)	Not specifically

The Human Rights Act contains 15 rights, all of which NHS organisation have a duty to act compatibly with and to respect, protect and fulfil. The 7 rights that are particularly relevant to healthcare are listed below. Consider the relevance of your Policy to these Human Rights and list any available information to suggest the Policy may interfere with, or restrict the enjoyment of these rights.

The right to life
No specific impact

The right not be tortured or treated in an inhuman or degrading way
No specific impact

The right to liberty
No specific impact

The right to a fair trial
No specific impact

The right to respect for private and family life, home and correspondence No specific impact
The right to freedom of thought, conscience and religion No specific impact
The right not be discriminated against in relation to any of the rights contained in the Human Rights Act No specific impact on human rights identified.

Section 3 Outcome Report

Policy Title:	Nursing Staffing Levels and Escalation Plan: Acute Adult Services Policy
Organisation:	Cwm Taf Morgannwg University Health Board
Name: Title: Department: Date:	Sharon O'Brien Head of Corporate Nursing Corporate Nursing 3 rd June 2019
Summary of Assessment: Please indicate issues of significant concern and changes that will be made to the policy accordingly. Please indicate whether these changes have been made.	This policy concerns the Nursing Staffing Levels and Escalation Plan for Acute Adult Services within Cwm Taf Morgannwg UHB. There are no specific issues of concern identified in relation to equality and diversity. No changes are required.
Please indicate where issues have been raised but the policy has not been changed and indicate reasons and alternative action taken where appropriate.	Not applicable
Monitoring Arrangements:	Annual review by the Head of Corporate Nursing or in response to a particular issue.
Review Date: This is usually the same as the policy review date.	The policy will be reviewed annually by the responsible manager and a date for review will be agreed with the Director.
Signature of all Parties:	

Appendix 4

Privacy Impact Assessment Screening Questions

Answer the questions below to identify whether your policy/ procedure or project is likely to need a PIA.

	<i>Questions – please tick appropriate answer</i>	Yes	No
1.	Will the policy involve the collection of new information about individuals?		✓
2.	Will the policy compel individuals to provide information about themselves?		✓
3.	Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information?		✓
4.	Are you using information about individuals for a purpose it is not currently used for or in a way it is not currently used?		✓
5.	Does the policy involve you using new technology which might be perceived as being privacy intrusive? For example, the use of biometrics or facial recognition.		✓
6.	Does the policy result in you making decisions or taking action against individuals in ways which can have a significant impact on them?		✓
7.	Is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For example, health records or other information that people would consider to be particularly private?		✓
8.	Will the policy require you to contact individuals in ways which they may find intrusive?		✓

Where you have answered yes to one or more of these questions, it is a likely indication that a PIA would be a useful exercise. If you are in any doubt as to whether a PIA is required, support is available the information governance team.



Nursing Staffing Levels (Wales) Act (2016)

All Reasonable Steps

All Reasonable steps

Reasonable steps which should be taken at each of the following levels - national, strategic corporate (Local Health Board/ NHS Trust) and operational – to maintain the nurse staffing levels are considered to be:

National steps

- The sharing and benchmarking of corporate data.
- Leading of regular reviews of workforce and education commissioning requirements.
- Leading national initiatives to aid staff recruitment and retention.

Strategic corporate steps

- Workforce planning for a continued supply of required staff assessed using the Welsh Planning System.
- Active recruitment in a timely manner at local, regional, national, and international level.
- Retention strategies that include consideration of the NHS Wales Staff Survey results;
- Well-being at work strategies that support nurses in delivering their roles.
- Ensure strategic requirements of the Act embedded into the organisations IMTP/annual planning process.
- Robust workforce planning at ward/service level which are reviewed at least annually through IMTP education commissioning processes.
- Workforce policies and procedures which support effective staff management (eg: flexible working for staff).
- Robust organisational risk management framework.
- Effective risk assessment processes and systems are in place and utilised as required.

Operational steps

- Use of temporary staff from a nursing bank appropriate to the skill mix set out in the planned roster.
- Use of temporary staff from a nursing agency appropriate to the skill mix set out in the planned roster (once bank staff have been considered).
- Temporary use of staff from other areas within the organisation.
- The temporary closure of beds.

- Consideration of changes to the patient pathway (which should be clinically appropriate).
- Effective resource management, utilisation and deployment of staff e.g. appropriate allocation of annual leave and study leave, staff working overtime (within WTE), additional hours or use of hours owed.
- Use of a robust electronic rostering tool and strong governance systems to monitor and review the rosters and ensure effective utilisation of the nursing workforce (e.g. review the staffing roster on a day to day basis, explore with staff member rescheduling annual leave and/or change of shift, postponing staff training/ study leave).
- Ward sister/charge nurse to work within the planned roster.
- Regular review of the acuity of the patients on the ward, including the identification and risk management of patients requiring 'enhanced patient support' in line with local policy and professional judgement.
- "On Boarding". This is the term used when, in very unusual and exceptional circumstances, a patient is required to be placed on the ward and no bed is available. This practice has been extensively discussed within WG and NHS Wales and it is acknowledged that this is not best practice. In the rare event that this is deemed necessary, in line with NHS Wales escalation processes all Health Boards should have in place a clear escalation protocol that includes the circumstances in which this may be considered and the process for implementation. This should also include the requirement that any instance is immediately escalated/reported through the incident management systems within the Organisation and to the Chief Operating Officer and the Executive Nurse Director in hours and out of hours the Executive Director on call to be notified. On the rare occasion that on-boarding occurs this must be time limited and all HB's must have a de-escalation process in place. Should this rare situation occur, at the time of the audit, then the acuity of any such patient should be recorded on HCMS and the escalation / incident reporting situation must be followed.
- Appropriate and timely use of the escalation policy relating to nurse staffing and reporting and management of risk.
- Should this rare situation occur, at the time of the audit, then the acuity of any such patient should be recorded on HCMS and the escalation / incident reporting situation must be followed.



AGENDA ITEM

4.1

CTM BOARD

HIW /AW JOINT REVIEW OF QUALITY GOVERNANCE
SUMMARY OF PROGRESS MADE - MAY 2021 FOLLOW UP REPORT

Date of meeting	27 th May 2021
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	G Galletly, Director of Corporate Governance
Presented by	Audit Wales & Healthcare Inspectorate Wales
Approving Executive Sponsor	Director of Corporate Governance
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)

Committee/Group/Individuals	Date	Outcome
Board Members via email (draft for factual accuracy)	April 2021	SUPPORTED

ACRONYMS

CTMUHB	Cwm Taf Morgannwg University Health Board

1. SITUATION /BACKGROUND

- 1.1 At the November 2019 CTMUHB Board meeting, Members received a report following a joint review undertaken by Wales Audit Office (now Audit Wales) and Healthcare Inspectorate Wales of quality governance arrangements at Cwm Taf Morgannwg University Health Board (CTMUHB).

- 1.2 The publication of the report highlighted a number of significant findings for CTMUHB to which the Health Board provided a comprehensive response to the recommendations which was received and approved at the subsequent Board meeting in January 2020.
- 1.3 Progress against these recommendations and the management actions in response, has been included in the wider monitoring by the Board and Welsh Government in the context of enhanced performance arrangements associated with CTMUHB being in Special Measures for maternity services and Targeted Intervention for quality & governance, leadership & culture and trust & confidence.
- 1.4 A year on from the original Joint Review Report, Audit Wales and Healthcare Inspectorate Wales undertook a follow-up review of the Health Board to assess progress against the original 14 recommendations made.
- 1.5 The findings of the follow-up review have been published in the attached report and will be presented to the Board by Audit Wales and Healthcare Inspectorate Wales colleagues at the Board meeting on 27th May 2021.
2. **SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)**
 - 2.1 The Health Board welcomes the report which recognises the commitment to and progress made in improving quality governance across our organisation despite the challenges posed by responding to the pandemic.
 - 2.2 It is acknowledged that whilst many positive changes have been put in place, there is still further work to do and the Health Board will continue to work with Healthcare Inspectorate Wales and Audit Wales to take all necessary action to continue to build on improvements made to ensure all the recommendations in the original report are fully implemented.
 - 2.3 The Health Board will now take the opportunity to reflect on the findings of this follow-up report to inform a review of the Health Board responses to the original recommendations to ensure they remain focused and addressed.
 - 2.4 A formal response to the report will be made by the Health Board to include an updated action plan to inform the extent and timing of any further follow up work by HIW and AW.

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

- 3.1 The Board is asked to note the continued commitment to improving quality governance of the organisation to support our staff and ensure the high quality and safety of the services provided to our communities.

4. IMPACT ASSESSMENT

Quality / Safety / Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Safe Care Continued implementation of the recommendations will improve the quality & safety of our services.
Equality impact assessment completed	No (Include further detail below)
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £ / Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Well-being Objectives	Provide high quality, evidence based, and accessible care

5. RECOMMENDATION

- 5.1 The CTM Board is asked to:

- NOTE the attached Joint Follow-Up Report from Healthcare Inspectorate Wales & Audit Wales.

An overview of Quality Governance Arrangements at Cwm Taf Morgannwg University Health Board: A summary of progress made against recommendations

May 2021

The Auditor General has prepared this report under section 61 of the Public Audit (Wales) Act 2004, and in accordance with section 145 of the Government of Wales Act 1998. The work has been undertaken jointly with Healthcare Inspectorate Wales.

Healthcare Inspectorate Wales is the independent inspectorate and regulator of healthcare in Wales. We inspect NHS services, and regulate independent healthcare providers against a range of standards, policies, guidance and regulations to highlight areas requiring improvement.

This document has been prepared as part of work performed in accordance with statutory functions.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000.

The section 45 code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales and Audit Wales are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to Audit W

We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay
yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

Contents

Introduction and background	4
Main conclusions	6
Recommendations	9
Recommendations to improve the strategic focus on quality, patient safety and risk	9
Recommendations for leadership of quality and patient safety	12
Recommendations for organisational scrutiny of quality and patient safety	14
Recommendations to improve the arrangements for quality and patient safety at directorate level	19
management of risk	22
Recommendations to improve the management of incidents, concerns, and complaints	24
Recommendations for organisational culture and learning	28

Introduction and background

1 Cwm Taf Morgannwg University Health Board (the Health Board) provides primary, community, and hospital services to the populations of Merthyr T Taf and Bridgend.

2 In November 2019, Healthcare Inspectorate Wales (HIW) and Audit Wales (AW) undertook a joint review of quality governance and risk management arrangements within the Health Board. This work followed a report by the Royal College of Obstetricians and Gynaecologists and the Royal

service failings with maternity services. The Royal Colleges' report threw into sharp focus the concerns we had previously articulated about the Health Board's quality governance and risk management arrangements. As a result of the Royal Colleges' report, in April 2019 the Health Board's maternity services were placed into special measures and the organisation was escalated to the status of 'targeted intervention' within the NHS Wales escalation and intervention framework¹.

3 Our November 2019 Joint Review² found a number of fundamental weaknesses in the Health Board's governance arrangements in respect of quality of care and patient safety. We made 14 recommendations for improving risk management, the handling of incidents claims and complaints (concerns), patient safety and organisational culture. The report's recommendations.

4 Since our review there have been changes to the senior leadership team within the Health Board. This includes a new Health Board Chief Executive who was appointed in September 2020, taking over from the interim appointment made in June 2019, following the departure of the previous Chief Executive. There have also been some changes to other key executive roles including the appointment of a substantive Director for People, Interim Executive Director of Therapies and Health Sciences, Interim Director of Planning and Performance and Interim Chief Operating

1 [The NHS Escalation and Intervention Arrangements](#)

2 [A joint review of quality governance arrangements at Cwm Taf Morgannwg University Health Board](#)

- 5 In addition, the Health Board has implemented a new operating model, creating three Integrated Locality Groups (ILGs) based around the geographical areas of Merthyr Tydfil, Rhondda, Taff Ely and Bridgend. The ILGs are clinically led and managerially supported to strengthen clinical leadership and to ensure a focus on quality and safety. ILGs and their Clinical Service Groups (CSGs) are responsible for delivering acute, primary, community and mental health services to meet the needs of their local communities.
- 6 This report provides a progress update against the original 14 recommendations made in our report. We have been mindful of the impact that the COVID-19 pandemic (the pandemic) has had on the ability of the Health Board to respond to the recommendations, however, given

to establish and assess what progress the Health Board has made. We undertook similar evidence gathering activities as in our previous review. The pandemic meant that our work was undertaken remotely given the ongoing requirements for social distancing and the suspension of our

Main conclusions

- 7 The Health Board is making good progress to address the recommendations that we made in 2019, particularly when taking account of the challenges it has faced in responding to the pandemic. This has impeded progress on improvements in some areas, meaning some actions haven't progressed as quickly as the Health Board originally intended.
- 8 The Health Board has made progress at a strategic level, ensuring a greater focus on quality, patient safety and risk. Through its Quality and care is, aligning this framework to its new operating model. However, the pandemic has impacted on the development of the Health Board's Quality Strategy and further work is needed in this area. Since completing the Quality Strategy into the Health Boards Integrated Health and Care Strategy which is being developed. The Health Board has also indicated its intent to align the Patient Experience Strategy to the overall Health Boards Engagement strategy. These strategies are due for completion by Autumn 2021.
- 9 Accountability and responsibility for quality and safety is now clearer. Leadership of quality and patient safety has been strengthened with collective responsibility being shared amongst the four clinical executive directors. responsibilities at an operational level through to the executive level. In addition, resources have been strengthened through the introduction of new roles to support quality and patient safety, within both the nursing
- 10 The Health Board has improved its organisational scrutiny of quality and patient safety. W assurance from service to Board which are now clearer and supported by improvements in the quality of information presented to the Quality and Safety committee. Independent members are now more supported in their scrutiny role through ongoing development and induction, and there is more focus on gathering and learning from patient experience.

- 11 Quality and safety are now a key focus of regular day to day business in terms of meetings at an operational and executive level. However, the suspension of some of the governance frameworks due to the pandemic means that more work is needed to fully embed these arrangements
- 12 strengthened.
Health Board to implement the new risk management strategy, and this is now in place and operating. Processes for managing, identifying, and mitigating risk have improved. Operationally contribution to this by reviewing risks in their areas to ensure that an accurate and up to date picture of risks is now being presented. Despite early progress, further work is needed to ensure that the highest rated CSG risks are appropriately escalated to the ILG risk registers.
- 13 The management of incidents, concerns and complaints has been improved. Oversight and governance of Datix³ is improving, with evidence both at an executive and operational level. Some challenges remain with the interrogation of data within the current system, but this should be assisted by the planned implementation of the new Once for Wales system in July 2021. Work to improve the management of complaints and incidents continues with additional resources now in place to support the concerns and complaints teams, and investment in ILG resources.
- responding to complaints and incidents, progress on this has slowed as a result of the Health Board's response to the pandemic and there is more for the Health Board to do to ensure it fully captures the learning from complaints and incidents.
- 14 Positive steps have been taken by the Health Board to improve organisational culture and learning. The Health Board launched its Values and Behaviours Framework in October 2020. Whilst it is too early to assess the impact of this framework, there are encouraging signs from its implementation and roll out. The framework was co-produced with a range
- Whilst plans are in place to strengthen the Health Board's processes for organisational learning e.g., the establishment of the Shared Listening and Learning forum, this is an area that will require continued focus and attention to ensure that improvement is sustained.

3 Datix is a web-based system that is used to manage incident reporting, risk registers, complaints and safety alerts.

- 15 In conclusion, against the backdrop of the pandemic, much work has been done by the Health Board to address the issues we raised in 2019. We interviewed, and a clear desire to get things right. This energy needs to be sustained to ensure that the work completed so far is built upon and embedded.
- 16 Notwithstanding the good progress we have recognised through our follow up, there is still work to do in each of the areas where we made recommendations in 2019. As such, each of the recommendations should remain open. We will continue to monitor the Health Board's actions further follow up work as part of our routine engagement with the Health Board.
- 17 More detailed information about progress against the individual recommendations made in 2019 is set out in the following sections of the report.

Recommendations

Recommendations to improve the strategic focus on quality, patient safety and risk

Recommendation made in November 2019

R1 The Health Board must agree organisational quality priorities and outcomes to support quality and patient safety.

within an updated version of the Health Board's Quality Strategy.

A summary of progress made by April 2021

The Health Board has defined what high-quality care means but its ambition to agree quality priorities, set out in a quality strategy, has been significantly delayed due to the pressures of the pandemic. In 2019, we found that the Health Board had not articulated organisational quality priorities. The Health Board's Quality and Patient Safety Governance Framework (Quality Governance

care as care that is safe, timely and patient-centred. These domains provide the framework against which organisational quality priorities can be

During 2020, the Health Board planned to develop a Three-year Quality Priority Strategy in partnership with the local community

The Health Board appointed an Associate Medical Director with responsibility for quality improvement to take forward development of the strategy with engagement and coproduction with the three ILGs. However, progress

pandemic. Nonetheless, it is important that progress is now made on developing the Quality Priority Strategy. Since

its intention to integrate the Quality Strategy into the Health Boards Integrated Health and Care Strategy which is due to be published by Autumn 2021.

Recommendation made in November 2019

A summary of progress made by April 2021

R2 The Health Board needs to take a strategic and planned approach to improve risk management across the breadth of its services. This must ensure that all key strategies and frameworks are reviewed, updated the latest governance

a The Board Assurance Framework (BAF)

set out in the current IMTP and the Health Board's quality priorities.

b The risk management oversight arrangements for the BAF, the quality and patient safety governance framework and any changes to the management of risk within the Health Board.

The Health Board has made good progress in this area through the introduction of the new risk management strategy which reflects the new operating model and has good alignment with the Quality Governance Framework.

The Board Assurance Framework (BAF) used by the Health Board is continuing to evolve to reflect the new operating model and strategic objectives.

In January 2020, the Board approved the new Board Assurance Framework. This was seen as an interim step

Health Board's processes for managing and identifying risk, agreeing the Health Boards risk appetite, and agreeing the principal risks.

updating the current BAF by undertaking a comprehensive review of its risk management approach. In September 2020, the Health Board agreed the key threats and principal

objectives and gained formal agreement from the Board of its current risk appetite. In November 2020, the Board received the new organisational risk register following a large-scale review of risks by the ILGs and the corporate departments. W identify the controls and sources of assurance is ongoing. Once complete, the Health Board intends to produce a more detailed Board Assurance Framework. The Health Board has also articulated its intention, by the end of 2021, to develop a Board Assurance Report (BAR), which will detail the principal risks rather than the operational risks as

Recommendation made in November 2019

A summary of progress made by April 2021

- c The quality and patient safety governance framework must support the priorities set out in the Quality Strategy and align to the values and behaviours framework.
- d Terms of reference for the relevant committees, including the Audit Committee, QSRC⁴ and CBM⁵ latest governance arrangements cited within the relevant strategies and frameworks.

There has been a comprehensive review of the Health Board's risk management approach since our 2019 review. The revised risk management strategy and Risk Management policy were agreed by the Board in January 2021, after

The new strategy clearly sets out the risk management process from service to board as described in the Quality, Patient Safety and Governance Framework, as well as articulating the intended plans for the Board Assurance Report process. The risk assessment Procedure was also reviewed and approved by the Management Board in January 2021 which further supports the risk approach and process within the Health Board.

Significant progress has been made on developing and implementing the Quality Governance Framework, however, more work remains to fully embed it within the organisation. Since our review there have been many iterations of the framework with the latest version setting out the structures and processes that need to be in place operationally and strategically within the Health Board. The

against recommendation 1) and aligns to the organisation's Values and Behaviours. During the pandemic it has been easier to operationalise the Quality Governance Framework at an organisation and ILG level, but work to embed the governance structures within the CSGs which sit beneath the ILGs is ongoing.

Terms of references for relevant committees have all been updated to reflect the new scheme of delegation and operating framework. In January 2021, the terms of reference

the updated risk management arrangements. The Health Board took the opportunity to update and revise the terms of reference for each committee following changes to the governance framework after our 2019 review. These will now be subject to an annual review as part of the ongoing governance processes and is captured in the cycles of business for Board Committees.

4 In December 2019 the Quality, Safety and Risk Committee became the Quality and Safety Committee, and the Audit Committee became the Audit and Risk Committee.

5 Clinical Business Meetings were stood down following the introduction of the new operating mode introduced in April 2020.

Recommendations for leadership of quality and patient safety

Recommendation made in November 2019

- R3 Ensure there is collective responsibility for quality and patient safety across the executive team and professional leads:
- a Strengthening of the role of the Medical Director and Clinical Directors in relation to quality and patient safety.
 - b Clarify the roles, responsibilities, accountability, and governance in relation to quality and patient safety within the directorates.
 - c Ensure there is support, at corporate and directorate level, dedicated to quality and patient safety.

A summary of progress made by April 2021

The Health Board has taken steps to strengthen responsibilities in relation to quality and patient safety both across the executive team and within its ILGs.

Collective responsibility for Quality and Safety is now shared by the four clinical executive directors.

The Medical Director, the Executive Nurse Director, the Executive Director of Therapies and Health Sciences and

quality and safety, as well as professional leadership across their respective disciplines, with the Executive Director of Nursing acting as executive lead. This is clearly set out in the Health Board's Quality Governance Framework.

The capacity of the clinical executive directors has been reduced for a number of years because of the challenge of recruiting a substantive Director of Therapies and Health Sciences. Since our last review, the Health Board did recruit substantively, however, this post became vacant once more.

Director of

Vale University Health Board who works across both Health Boards, the Health Board is also recruiting a full time Clinical Director for Allied Health Professionals (AHPs) to ensure professional leadership and capacity.

The Health Board has clarified the roles and responsibilities for quality and patient safety within the new ILGs and CSGs. The Quality Governance Framework aligns to the operating model that was introduced in April 2020. Responsibilities at an operational level for quality

Framework, which sets out the process and structure for the ILGs and their respective CSGs. The new operating model is helping to improve the focus on quality. For instance, ILGs are held to account by the Director of Operations, Nurse Director, Medical Director and Chief Executive for the delivery of high-quality patient centred care in line with the Quality Governance Framework.

**Recommendation made in
November 2019****A summary of progress made by April 2021**

The Health Board has invested in additional capacity to support quality and patient safety at a corporate and ILG level. The Health Board has invested in new roles to support quality and patient safety. Within the nursing management team, new posts include an Assistant Director for Nursing and Peoples Experience, Deputy Executive Director of Nursing, a Head of Corporate Nursing, and a Senior Nurse for Professional Standards and Quality Assurance. The Medical Director has also established several new roles for Associate Medical Directors to lead on development of the quality strategy and clinical audit. The Health Board has also recently established a Quality Improvement team and appointed an Associate Medical Director for Quality Improvement and the Director of Improvement started in post in April 2021. The Health Board is also in the process of establishing the systems and infrastructure to support the Health Board's improvement work. Newly appointed Nurse Directors are in place for each of the three ILGs, and they are responsible for supporting quality governance, which is a shared responsibility across the three ILG senior leaders. In addition, each ILG also has a Head of Quality and Safety in place to support the quality governance agenda. Their role is to support the work of quality and patient safety within the ILGs, linking with the central Patient Care and Safety Team and the Assistant Director for Quality, Safety and Safeguarding. Over the past few months ILGs locally

the team sizes across the ILGs. The Bridgend and Merthyr Cynon ILG also have a new appointed Head of Midwifery for their respective obstetric units under the leadership of our Director of Midwifery who commenced in post in Jan 2020.

Recommendations for organisational scrutiny of quality and patient safety

Recommendation made in November 2019

A summary of progress made by April 2021

R4 The roles and function of the QSRC need to be reviewed to ensure

Strategy, Quality and Patient Safety governance framework and key corporate [organisational] risks for quality and patient safety. This should include the following:

- a Implement the sub-groups to support QSRC must be completed ensuring there is (administratively and corporately) to enable these groups to function
- b Improvements to the content, analysis, clarity, and transparency of information presented to QSRC.

Although some aspects of this recommendation have been superseded, there has been good progress with establishing the new governance framework and reporting.

Plans for implementing subgroups to support the Quality, Safety and Risk Committee⁶ were stood down following a revision to the Patient and Safety Governance Framework, therefore this element of the recommendation is superseded. The Quality and Patient Safety Governance Framework has evolved in response to the new operating model introduced in April 2020. Quality governance arrangements have been established within each ILG and each ILG reports on quality and patient safety matters directly to the Quality and Safety Committee.

The quality of information presented to the Quality and Safety Committee for assurance and scrutiny is improving. The Committee routinely receives quality and patient safety reports from each ILG and an organisation wide Patient Safety Quality report. These reports cover all service settings including acute, primary and community and mental health services. They also include a set of overarching Health Board wide quality metrics. The reports contain information across a wide range of quality indicators and enable scrutiny of patient experience across all three ILGs in a standard template which enables comparisons. The content covers all service areas, and ILGs are

(concerns), and risks, and there is appropriate narrative to provide assurance. Reports are delivered by the ILG

⁶ This committee was replaced in December 2019 with the Quality and Safety Committee.

Recommendation made in November 2019

A summary of progress made by April 2021

c Focus should be given to ensure the Quality and Patient Safety Governance Framework is used to improve oversight of quality and patient safety across the whole organisation, including Bridgend services. This should be accompanied by the necessary resource for its timely implementation, internal communications, and training.

R5 Independent members must be appropriately supported to meet their responsibilities through the provision of an adequate induction programme and ongoing development

scrutinise the information presented to them.

teams themselves, which enables oversight and scrutiny from independent members. Our observations of Board and Quality and Safety committee meetings found appropriate levels of scrutiny and challenge with candid responses from

The improvements to the quality reports are positive and include the use of trend information but fall short of setting targets or thresholds where further work or escalation may occur, for instance if pressure ulcer occurrence in one ILG area goes higher than expected. There is an ambition to move to live dashboards to improve analysis and data interrogation and discussions have started to move this forward by the end of 2021. Plans have also been developed by the Nursing Directorate to introduce a 'focus on' section in the Health Board Quality and Safety report to address issues requiring greater interrogation and triangulation, and this will be presented to the next Q&S Committee in July 2021.

Independent Members receive appropriate support through the provision of an induction programme and ongoing development to support them in their scrutiny role.

induction and development programmes for Independent

Since then, the Health Board has introduced a more structured induction programme for IMs, which compliments the Welsh Government's all Wales induction process. Local support for IMs is provided by the corporate governance team. During 2020, all IMs received an appraisal with the Chair of the Health Board and the Director of Governance.

T

Plans (PDPs) recorded. A programme of external evaluation and observations of Independent Members (IMs) has taken place with feedback given on their performance. There has also been work on engagement and relationships, team building, coaching, direction-setting, scrutiny and the relationship between the Board and its committees. The initial external evaluation of this work has shown positive improvements in areas such as scrutiny of information, and improved relationships between board members.

Recommendation made in November 2019

R6 There needs to be

resources given to gathering, analysing, monitoring, and learning from patient experience across the Health Board. This must include use of real-time patient feedback.

A summary of progress made by April 2021

The Health Board has instigated several improvements related to this recommendation, to improve how it learns from patient experience. However, the pandemic response has impeded its ability to further progress and embed these improvements. In response to our review in 2019, the Health Board began the development of a comprehensive three-year Patient Experience Strategy, however, its completion and implementation has been impeded by the pandemic response, and we have not received an update on its progress and a completion date from the Health Board in this regard. Attention will be needed to complete this strategy which underpins the Health Board's approach to patient experience.

The Health Board has implemented a Shared Listening and Learning Forum, and its inaugural meeting was held on 17 February 2021. The forum has been established as part of the Health Board's framework for listening to and

experiences, and to promote and support a learning culture. We reviewed the forum's draft Terms of Reference, which appear appropriate. It is chaired by the Executive Director of Nursing and will meet quarterly, reporting directly to the Management Board. It is, however, too early for us to judge the forum's patient experience and learning.

Patient stories now form a regular part of the Board and sub-committee meetings, which was not always the case previously. The patient stories provide an opportunity for Board members to gain an insight into the experiences of individuals using the Health Board's services.

A consequence of the pandemic has been the curtailment of executive and independent board member's patient safety walkabouts, which includes visiting ward and patient areas. However, there are plans to resume the programme of visits in due course when safe to do so.

**Recommendation made in
November 2019****A summary of progress made by April 2021**

The ILGs have introduced dedicated leads to manage patient feedback, concerns, and incidents. This has improved reporting to the Quality and Safety committee, as well as the local ILG Quality, Safety and Patient Experience meetings. We saw evidence that themes and trends are

share and embed learning across the ILGs.

The Health Board implemented a Friends and Family Test (FFT) tool across the organisation to collect and report real-time patient feedback. It was piloted in early 2020 and subsequently rolled out across the Health Board. However, this was halted due to the pandemic and in April 2021 the Health Board are implementing the new national 'Civica' patient experience feedback monitoring system. There is a commitment to ensuring patient feedback is captured, and the impact of this should be seen soon.

Recommendation made in November 2019

R7 There needs to be improved visibility and oversight of clinical audit and improvement activities across directorates and at corporate level. This outliers and maximising opportunities for sharing good practice and learning.

A summary of progress made by April 2021

Good progress has been made by the Health Board in addressing visibility and oversight of clinical audit, but it could be better targeted to areas of organisational risk. In December 2019, the Health Board approved additional funding to strengthen the Clinical Audit and Quality Informatics Department's ability to monitor compliance with participation, and to improve the quality of data used for all national audits. with the appointment of a Deputy Assistant Medical Director for Clinical Audit, a dedicated clinical audit manager to lead on compliance with the national audit programme, a Quality Informatics Manager with responsibility for improving clinical data in Health Board systems and a Deputy Head and Lead The additional resources

inform quality improvement initiatives and service redesign, such as establishing major trauma centres at the Princess of Wales and Prince Charles Hospitals in partnership with the ILGs.

Oversight of the clinical audit programme is improving at a strategic level. The Audit and Risk Committee has received the clinical audit forward plan, and in February 2021 it also

progress of the plan. As part of its forward work plan the Quality and Safety committee plans to receive quarterly updates on the clinical audit plan. We would expect these updates to identify outcomes from the audit, actions being taken to share learning and to provide the committee with a source of assurance on the quality and safety of care being delivered. There is also the opportunity for clinical audit to be targeted to areas of organisational risk such as the impact on patients of Emergency Department overcrowding.

Recommendations to improve the arrangements for quality and patient safety at directorate level

Recommendation made in November 2019

R8 The Health Board needs to clarify accountabilities and responsibilities for quality and patient safety within directorates. This must include a review of the Heads of Nursing role in relation to site management and quality and patient safety.

A summary of progress made by April 2021

The Health Board has made progress in clarifying the accountabilities and responsibilities for quality and patient safety across ILGs and within the CSGs, but more work is needed to ensure these improvements are embedded. Accountability and responsibility for quality and patient safety has been strengthened across the ILGs with the introduction of appropriate directives within accountability letters issued by the Chief Executive to the Director of Operations. The letters emphasise the need for quality and patient centred care, and appropriately highlight that ILGs and CSGs are accountable for delivering high quality services in line with the quality framework, and that high-quality clinical leadership, supported by strong service management is critical.

The Health Board has taken steps to strengthen clinical leadership across the organisation with a greater emphasis on quality and safety. This includes reviewing the accountability and responsibility of the Heads of Nursing roles within each ILG in relation to site management and quality and safety. In 2019 we found that the Head of Nursing was assuming responsibility for several non-clinical and estates related issues. In addition, because of taking over responsibility for the Bridgend County Borough Council, only two of three acute sites had a substantive Head of Nursing in post (Merthyr and Cynon and Rhondda and T

However, since the implementation of three ILGs, a Head of Nursing role is now in place for the Bridgend locality. Accountabilities and responsibilities for this role are now

in addition, there has been further recruitment to support quality and safety with the appointment of a Head of Nursing, a deputy Head of Nursing and a dedicated Head of Quality and Safety for each ILG.

**Recommendation made in
November 2019****A summary of progress made by April 2021**

Each ILG holds Patient Safety and Experience meetings, chaired by the ILG Nurse Director to provide assurance. This is a positive development albeit one that is continuing to develop, and our observations found that more coverage is needed in certain areas such as Infection, Prevention and Control. However, the Quality Governance Framework does not clearly articulate the quality governance arrangements for the CSGs that sit below each ILG. It has not been possible for some governance meetings to take place at CSG level due to the demand on clinical resources during the pandemic. Internal Audit's recent audit of Community and Adult Mental Health Services also found that the governance arrangements within the CSG were not clear with a lack of clarity about how they operate and function. This is an area that requires strengthening. In addition, whilst accountability and responsibility of the Heads of Nursing is clearly articulated, there appears to be an over-reliance on the Heads of Nursing to represent an overall clinical perspective during key quality and safety meetings, with limited input from medical teams. Due to the pandemic, the Health Board has had to delay its work on the clinical leadership and management development programme. This has impeded progress in terms of further embedding the quality and safety agenda within CSGs. This issue requires attention to ensure that responsibilities in relation to quality and safety are jointly demonstrated by both nursing and

mechanisms established by the Quality Governance Framework were temporarily stood down during recent pandemic outbreaks and have recently been re-established,

Whilst the Health Board has taken steps to address this recommendation, these improvements remain at an early stage and still need attention to ensure they are being embedded across the organisation.

Recommendation made in November 2019

A summary of progress made by April 2021

R9 The form and function of the directorate governance committees and CBMs must be reviewed to ensure there is:

- a Clear remit, appropriate membership, and frequency of these meetings.
- b analysis, and scrutiny of information in relation to quality and patient safety issues and actions.
- c Clarity of the role and decision-making powers of the CBMs.

Governance arrangements at an operational level have been strengthened. Since our 2019 review CBMs have been removed following the introduction of the new operating model. This recommendation is therefore superseded. As stated previously, in April 2020 the Health

manages its business, most notably establishing the three clinically led ILGs. The CBM process has been replaced.

Routine executive oversight of the ILGs is now maintained through the Integrated Locality Group performance reviews between the ILG triumvirate and the Executive Director of Operations. The Medical Director, Director of Planning & Performance, Director of Finance and Executive Director of Nursing also attend depending on their availability. These meetings are supported by the ILG business partners for quality and safety

Consistency of these meetings is ensured with a template slide pack covering information on quality, complaints and incidents, risks, sickness absence and performance. These meetings are an improvement on the CBMs with a

and safety issues. The Group ILG Directors are also formal members of the Management Board⁷ (MB) enabling them to escalate issues and concerns.

At the time of our follow-up work, minutes and actions from Integrated Locality Group Performance reviews were not formally shared within the MB meetings, and there is a need to strengthen arrangements for MB oversight of issues raised at ILG level, and action taken in response as this would improve the clarity of decision making. However due to the pandemic several of the planned Integrated Locality Group Performance review meetings were stood down and were restarted in March 2021 following the Health Board moving out of the emergency pandemic response phase.

of this process.

⁷ The Management Board is the executive team responsible for service delivery, which meets bimonthly to discuss operational delivery across the Health Board.

Recommendations to improve the identification and management of risk

Recommendation made in November 2019

R10 The Health Board must ensure there are clear and comprehensive risk management systems at directorate and corporate level, including the review and population of risk registers. This should include clarity around the escalation of risks and responsibilities at directorate and corporate level for risk registers.

the risk strategy.

A summary of progress made by April 2021

The Health Board has made good progress in addressing the serious concerns we identified in relation to risk management arrangements and has invested in dedicated support for governance and risk.

Since our 2019 review, the Health Board has reviewed its risk management systems and aligned them to the new operating model. This has been a root and branch review looking at arrangements from service to board. To ensure clarity, the Health Board has implemented a new Risk Management Strategy approved at Board in January 2021.

Corporate support for Risk Management has been improved through the appointment of an Assistant Director of Governance and Risk. This post supports the executive directors, ILGs and the Heads of Quality and Patient Safety to ensure a consistent approach to describing and scoring risks, compiling risk registers, and identifying mitigation actions. This has facilitated an increased focus on risk and driven the improvements that have been delivered.

There has been a Health Board wide review of risks at a corporate, ILG and CSG level. This was a large piece of work undertaken at a time of considerable service pressures and is to be commended. The product of this work was the revised organisational risk register, which was presented to the Board in November 2020.

improvement since the previous risk register, however there is recognition within the Health Board that more work is needed to improve the mitigations and actions as described. Also, some aspects of the CSG risk registers are still being

Integrated Locality Group registers.

**Recommendation made in
November 2019****A summary of progress made by April 2021**

The Risk Management Strategy sets out a clear route from service to board, showing the process for escalating risks through the ILG management tiers within the new operating model based upon risk score. Whilst there is evidence that risks are de-escalated where appropriate to do so, there is still more work to do in relation to where risks scoring less than eight are captured. At the time of our follow-up work, the Health Board had prioritised the capture of risks scoring nine and above on the Datix system given the ongoing response to the pandemic. However, where ILGs, CSGs or corporate teams identify risks that score 1-8, these are captured on local risk registers and not the Datix system. The Health Board acknowledges the risks of maintaining parallel systems and of the need to ensure clarity regarding the process for de-escalation. Internal Audit's recent assessment⁸ of one CSG found evidence that not all risks are escalated appropriately, again demonstrating the need to ensure that the improvements made at ILG level are still to be embedded across the CSGs.

8 Internal Audit Report

Recommendations to improve the management of incidents, concerns, and complaints

Recommendation made in November 2019

R11 The oversight and governance of DATIX must be improved so that management and learning tool. This should also include triangulation of information in relation to concerns, at a directorate or corporate level, and formal mechanisms to identify and share learning.

A summary of progress made by April 2021

Oversight and governance of DATIX is improving with more use made of information at corporate and ILG levels within the organisation. Further work is needed on strengthening organisational learning from incidents, claims and complaints (concerns). There is now clarity as to where the ILG Datix teams sits within the Health Board's structure, reporting through the Health and Safety team to the executive Director for People. The Health Board has indicated that these new accountability arrangements will be reviewed over the next three to six months.

There is now a renewed focus on ensuring that quality and patient safety is a priority. Mechanisms to improve oversight and scrutiny at an executive team level are in place. The Executive Director of Nursing and the Assistant Director of Quality, Safety and Safeguarding chair a short weekly meeting to review the previous week's complaints and incidents in conjunction with the quality metrics for nurse

At the beginning of December 2020, a report to the weekly executive Director-led Patient Safety weekly

within the prior six months that were yet to be allocated for investigation. The Health Board is working to address this backlog of investigations and completion of the appropriate

the severity of harm. Whilst the Health Board has informed us that since our work it has developed investigation and serious incident trackers to enhance monitoring in relation to incident management, more work is required to ensure that opportunities are taken for identifying early learning following incidents.

Use of Datix has improved, although there are some issues with the access to information at the Integrated Locality

reports. This is being addressed by the Datix team but does required a considerable amount of work. The Health Board will be implementing the Once for Wales system In July 2021.

**Recommendation made in
November 2019****A summary of progress made by April 2021**

Information provided by the Health Board indicated that

investigate incidents and undertake root cause analysis. Additionally, the Welsh Risk Pool (WRP) recently expressed concerns over the time being taken by the Health Board to complete timely Learning from Events Reports (LFER) in line with WRP reimbursement procedures. This has been a challenging area for the Health Board due to the high numbers of legacy and maternity cases and the WRP has expressed concerns around the quality and timeliness of information submitted by the Health Board. In response, further work and progress has been made, and a task force established with weekly progress meetings with a commitment made by the Health Board to submit all LFER by the 31 March 2021. We have also been informed that since February 2021 the Health Board has developed and launched its own root cause analysis module, which has enabled accurate tracking and monitoring of attendance.

The Assistant Director of Quality, Safety and Safeguarding holds biweekly meetings with the ILG Heads of Quality and Patient Safety with the aim of ensuring that appropriate actions are taken in response to complaints and incidents. Within the ILGs the monthly Quality and Patient Experience Meetings also scrutinises information from Datix to look at trends and analysis.

that analytical capacity is a barrier to using this data

a consequence.

in relation to DATIX and ensuring that the right people have access to the system. The January 2021 report to the Quality and Safety committee provided reassurance that feedback from incident reporting through DATIX was improving, however there is further work required to improve the quality of feedback provided to the reporter.

**Recommendation made in
November 2019****A summary of progress made by April 2021**

As noted earlier in the report, the Health Board has also established a Shared Listening and Learning forum which reports to the management board. Part of the forum's remit is to oversee the Health Board's framework for listening

and experiences. In addition, it champions a patient and

good practice. The forum's inaugural meeting was held in February 2021 with all ILGs presenting themes, issues and learning from incidents, claims and complaints (concerns). Whilst this is a positive development, it is too early to assess

Recommendation made in November 2019

R12 The Health Board must

appropriate training in the investigation and management of concerns. In addition,

be empowered to take ownership of concerns and take forward improvement actions and learning.

A summary of progress made by April 2021

Whilst the Health Board has made progress with addressing this recommendation, oversight of training corporately, and within each ILG, requires further attention.

the oversight and management of concerns. This included the operational processes for investigating and learning from concerns. Training on concerns management has been prioritised and has been provided across the Health Board for relevant individuals delegated with the responsibility for managing the concerns process. In addition, the Health Board's concerns policy was also reviewed and approved by the Board in August 2020. Training requirements for

. Whilst at the time of our work ILGs were not able to accurately report

to investigate concerns, incidents or undertake root cause analysis, we have been informed that since February 2021 the Health Board has developed and launched its own root cause analysis module enabling it to track who has received this training.

There now appears to be consistency of approach and clearer accountability in relation to concerns management across each ILG, with concerns managed within the relevant CSG before gaining ILG approval, and subsequent

response approval. We saw examples of this within quality and safety and experience groups across the ILGs,

taking greater ownership and responsibility for a concern, and for implementation of improvements where required. To further strengthen concerns management processes, recent recruitment has increased the size of locality and corporate concerns teams.

Recommendations for organisational culture and learning

Recommendation made in November 2019

R13 The Health Board must ensure the timely development of a Values and Behaviours Framework with a clear engagement programme for its implementation.

A summary of progress made by April 2021

The Health Board has made good progress in developing and rolling out its Values and Behaviours Framework, although it has needed to adjust the implementation timescales because of the pandemic.

At the time of our 2019 report, the Health Board was launching a programme of work to develop a Values and Behaviours framework for the organisation. Listening events

November 2019 and February 2020 to help identify the issues that such a framework would need to address. The outbreak of the pandemic meant further work on the Values and Behaviours Framework was delayed until June 2020. However, when the work resumed the Health Board was

well-being. In total the Health Board collected around 6,445

community which informed the framework.

To inform the development of its Values and Behaviours Framework, the Health Board undertook a series of listening events, engaging with approximately 8,000 people, including

to support this work and to develop the engagement methodology. The work appears to have had a positive impact on the development of the framework and in planning for the Patient Experience Strategy. The Health Board formally launched the Framework on World Values Day, 15 October 2020. There was a live interactive session with a keynote presentation from Professor Michael West on

participated in the event. The framework was also publicised on the Health Board's intranet and social media channels.

Recommendation made in November 2019

A summary of progress made by April 2021

A detailed implementation plan is in place to embed the Values and Behaviours, and this is monitored by the

were generally positive about the Values and Behaviours Framework. The Health Board recognises that it will take time to fully embed the Values and Behaviours across the organisation and to enhance employee experience.

To help embed them, the Health Board is revising its leadership programmes to incorporate the values and behaviours. The V Health Board documents, and they are visible on its website. Terms of Reference for the

ILGs.

R14 The Health Board must develop a stronger approach to organisational learning which takes account of all opportunities presented through concerns, clinical audit, patient and reviews and learning from work undertaken in the Princess of Wales hospital.

The Health Board has started to develop a stronger approach to organisational learning, although the pandemic has impeded progress against this recommendation. In 2019, we found a lack of formal processes to identify and share learning for improvement across the organisation to support the delivery of safe and Additionally, in 2019, the NHS Wales Delivery Unit also raised concerns about the management and learning from serious incidents and never events.

We have highlighted the Health Board's current position regarding learning and improvement in response to

has been made in strengthening the overall responsibility and management of clinical and serious incidents across the Health Board. A clinically-led Serious Incident team has been established, alongside a more robust process for the management of incidents, and learning resulting from them. Supporting this, the Health Board has implemented a Serious Incident Tool kit. This tool has reportedly assisted with consistency in managing incidents and supported sharing learning. The Serious Incident team undertakes a monthly clinical audit and super audit (quarterly) in collaboration with the Patient Care and Safety Team.

reported through the locality Quality, Safety and Executive groups, and into the Quality and Safety Committee.

**Recommendation made in
November 2019****A summary of progress made by April 2021**

The Health Board is also establishing an improvement function called 'Improvement CTM', which will bring together learning from audit activity and concerns. Improvement CTM is expected to empower the Health Board's workforce to take responsibility for implementing continuous improvement through organisational learning. This is still early in its implementation and therefore too early to assess its

improving organisational learning has been a challenge for the Health Board because of the pandemic response. Whilst there is some evidence of a stronger approach being taken to organisational learning, we have limited evidence

disseminated to all areas of the organisation and frontline

being shared within CSG and ILG quality and safety meetings. However, there is a need to strengthen overall arrangements for sharing learning across the ILGs. The Health Board is aware of this and hopes this will improve, particularly with the Heads of Quality and safety now in post across all ILGs.

Our observations of CSG and ILG quality and safety meetings found that external activity such as HIW inspections are being regularly discussed to ensure that action is taken to address recommendations, and learning is disseminated across CSGs and the Health Board. The previously mentioned Shared Listening and Learning forum will also focus on the learning and dissemination

audits, and inspections. However, there is limited evidence to demonstrate that wider learning beyond the clinical area

who are responsible for day-to-day care of patients.

**Recommendation made in
November 2019****A summary of progress made by April 2021**

Assurances are given to the Quality and Safety Committee about learning from incidents, but the reports do not provide examples of the learning and how it is being applied or shared more widely across the organisation. This is an aspect that needs to be strengthened.

Our previous review found that opportunities for learning following the Bridgend transfer in relation to undertaking FFT

Wales Hospital felt there had been little consideration of the , and its use for real-time patient feedback. However, since our review, the Health Board has embraced this learning and implemented the FFT throughout each site.



Audit Wales
24 Cathedral Road

CF11 9LJ

Tel: 029 2032 0500
Textphone: 029 2032 0660

We welcome telephone
calls in Welsh and English.

E-mail: info@audit.wales
www.audit.wales



Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr T
CF48 1UZ

Tel: 0300 062 8163

We welcome telephone
calls in Welsh and English.

E-mail: hiw@gov.wales
www.hiw.org.uk



AGENDA ITEM

4.2

CTM BOARD

MATERNITY AND NEONATAL SERVICES:
AN UPDATE

Date of meeting	27/05/2021
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Jane O'Kane, Systems Director preconception to 1000 days & Neonatal Service Improvement Director Val Wilson, Director of Midwifery, Gynaecology and Integrated Sexual Health, Maternity Services Improvement Director
Presented by	Jane O'Kane, Systems Director preconception to 1000 days & Neonatal Service Improvement Director Val Wilson, Director of Midwifery, Gynaecology and Integrated Sexual Health Maternity Services Improvement Director
Approving Executive Sponsor	Executive Medical Director and Executive Director of Nursing
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	Date	Outcome
Quality & Safety Committee	18/05/2021	NOTED
Management Board	19/05/2021	NOTED

ACRONYMS	
NNU	Neonatal Unit
PCH	Prince Charles Hospital



RGH POW RCOG IMSOP SIs	Royal Glamorgan Hospital Princess of Wales Hospital Royal College of Gynecologists Independent Maternity Oversight Panel Serious Incidents

1. SITUATION / BACKGROUND

- 1.1 This paper provides a position update with regard to the IMSOP review and associated improvements relating to Health Board Maternity services and Neonatal services.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 Neonatal Deep Dive

2.1.1 Internal communications and support

The IMSOP Neonatal Team will commence a deep dive review on 10 May 2021 with the same progressing over a 20 week period at PCH. Communications to key staff have been issued with offers of support and opportunities provided at regular intervals to keep staff updated. As part of facilitating that support, workforce and staff side colleagues have also been kept informed. It should be noted that this will involve staff working on all of the acute sites.

2.1.2 External communications with partners

The detail of the same is currently being agreed with IMSOP

2.1.3 Family engagement

IMSOP are planning to offer all families who accessed Neonatal services at PCH June 2020-December 2021 an opportunity to be part of the service review. The governance and the detail of this is being worked through with IMSOP

2.2 Progress in submission against the RCOG recommendations

Work is progressing to submit evidence against the remaining 7 of the 16 recommendations being monitored by IMSOP; by the end of June

2.3 Clinical Reviews

A small number of the Stillbirth IMSOP clinical reviews involve Neonatal services and as such Neonatal services have aligned to the Maternity service processes to manage and respond to the same

Information is pending from IMSOP with regard to the third phase of the IMSOP clinical reviews and when the Neonatal Morbidity and Mortality category will begin to be shared with the Health Board



2.4 Developments and progress

A prototype neonatal dashboard has been drafted using the All Wales Neonatal standards and is under review by the Maternity & Neonatal Improvement Board (MNIB) and the Integrated Locality Groups (ILGS).

2.3 Maternity Services

2.3.1

The service has completed 53 out of 70 recommendations.

The Maternity Improvement Team (MIT) have worked with work stream leads to undertake a review and 're-fresh' of the remaining recommendations and there are staff meetings in place to consider how we move forward post the current covid wave. The New Programme Director has commenced in post and further work will be undertaken to review the content of work stream plans in respect of delivering on the remaining recommendations, and also the role of the work stream lead and wider programme management and governance

2.3.2

We have now received all 63 of the cases in the stillbirth category. Action plans have been developed to address the review findings of each case by a multi-disciplinary team (MDT). Evidence of any completed actions is compiled and considered by the MDT Clinical Cabinet to ensure a robust response. IMSOP began writing to women in the Stillbirth Category in April to inform them the review of their care is complete. This will continue throughout May and June, and we continue to prepare Health Board responses detailing our improvement for each family requesting feedback, and to date two Health Board letters have been received by families, with a further 6 letters to be sent week commencing the 10 April 2021.

2.3.4

The Maternity and Neonatal Improvement Programme Director commenced in April 2021 and has begun an in-depth review of the programme and remaining recommendations.

The new MIT project officer will commence in role on the 17 May 2021.

The job description for the Quality Improvement Post has been approved and will be advertised shortly.

We await approval for the Engagement and Experience Lead post.

2.3.5

Maternity Services Serious Incident Backlog

The service has now completed 12 from the backlog of 43 (previously 44, 1 case now downgraded).



Maternity current SI Progress	28 th April	10 th May
Awaiting start	0	0
In progress Maternity	15 (9 requiring Neonatal review)	14 (13 requiring Neonatal review)
Senior Mat service QA	16 (11 require neonatal input prior to QA)	17 (13 require neonatal input prior to QA)
Senior Neo service QA	2 (of the 16 above)	2 (of the 17 above)
Exec Approval		
HB sign off	12	12
WG sign off		
	43	43

The new Senior Midwife (former Head of Midwifery) to support quality assurance to ensure on-going 'fresh-eyes' will commence shortly.

Welsh Government and the IMSOP panel have recently reviewed a number of the submitted investigations. There are clear improvements noted, however a number require further improvement relating to consultant engagement, and joint working. We are awaiting formal written feedback.

2.3.6

The review of Maternity Service at the Shrewsbury and Telford NHS Trust (Ockenden Report) was published in December 2020 which reports on the first 250 reviews of the 1,862 cases under consideration.

A number of themes have been identified (27 local and 7 for national consideration). The service has undertaken a detailed benchmarking exercise of both local and national actions. We are also working collegiately with other maternity leaders to consider the findings across Wales.

The service has 12 actions outstanding with clear actions plans in place.

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

3.1 The following summaries some of the key areas of work that are now being progressed

- The development of key neonatal performance indicators has been progressed and a prototype is under review by colleagues within the ILGs and through review at MNIB



- Whilst Quality Improvement (QI) training was unavailable the team continued to progress the development of a new health board wide Neonatal documentation and record keeping system and protocol; aiming for June 2021 launch
- QI methodology is proposed to support the innovations through an improvement framework; with a small QI team trained on each site and with training dates now being provided
- Engagement strategy development is underway with great examples of virtual activity including virtual ward rounds and virtual clinics with excellent feedback
- The Maternity PREM did not go live in April as planned due to issues with Health Board implementation, we await an update from the Health Board Lead
- Leadership development for new teams in the Women's and Children's Directorate is currently being scoped in house and the next meeting is taking place on the 14 May 2021
- The Health Board Strategic Lead for Wellbeing has now commenced meetings with staff from Maternity Services as part of the bespoke wellbeing project

4. IMPACT ASSESSMENT

Quality / Safety / Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Governance, Leadership and Accountability If more than one Healthcare Standard applies please list below: Safe care Effective care Timey care Dignified care
Equality impact assessment completed	Not required
Legal implications / impact	Yes (Include further detail below) Pending advice from the Coroner
Resource (Capital / Revenue £ / Workforce) implications / Impact	Yes (Include further detail below) See details of revenue within the body of the report
Link to Strategic Well-being Objectives	Provide high quality, evidence based, and accessible care

5. RECOMMENDATION

5.1

The Board is asked to NOTE the content of the paper.



AGENDA ITEM

4.3

CTM BOARD

CONTINUOUS IMPROVEMENT SELF ASSESSMENT PROCESS IN
RESPONSE TO TARGETED INTERVENTION (TI)

Date of meeting	27/05/2021
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Richard Morgan-Evans, Chief of Staff
Presented by	Richard Morgan-Evans, Chief of Staff
Approving Executive Sponsor	Chief Executive
Report purpose	FOR APPROVAL

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	Date	Outcome
CTMUHB TI Self Assessment Board session	26/04/21	ENDORSED FOR APPROVAL
Management Board	27/05/2021	ENDORSED FOR BOARD APPROVAL

1. SITUATION / BACKGROUND

- 1.1 This paper seeks to formally update the Board as to the progress within the Targeted Intervention Improvement Programme and specifically update on the maturity matrix position across the key improvement domains.
- 1.2 On the 26 April, a TI self-assessment board session was held involving all Directors and Independent Members as well as involving

members of staff including representatives from Integrated Locality Groups (ILGs). The session's purpose was to allow holistic updates to be delivered by the TI improvement domain Senior Responsible Officers (SROs) before inviting input and discussion from ILGs and wider members. By utilising this format it allowed a collaborative discussion and ensured all views were taken into account.

1.3 There were external observers also present including representatives of Welsh Government, who were invited to provide initial observations and feedback at the end of the session.

1.4 There were four key areas discussed, in line with the agreed improvement scope:

- Leadership & Culture
- Trust & Confidence
- Quality & Governance
- Special Measures update regarding Maternity & Neonatology

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 The general update overall was positive with a great deal of work being conducted despite the covid pressures experienced since the second wave. However it was fully acknowledged that covid had taken its toll and there had been an unfortunate loss of momentum as a result.

2.2 The three components of Targeted Intervention and the perceived progress was shared and agreed - outlined below:

Leadership & Culture

	Level 1 Basic	Level 2 Early Progress	Level 3 Results	Level 4 Maturity	Level 5 Exemplar
	Principle accepted and commitment to action	Early Progress in development	Initial achievements realised	Results consistently achieved	Others learning from our consistent achievements
Leadership, Capability, Development	✗	✗	✗		
Values and Behaviours	✗	✗	✗		
Inspired Shared Purpose	✗	✗	✗		
Employee Experience	✗	✗	✗		

✗ TI Self-assessment Score March 2020
 ✗ TI Self-assessment Score Sept 2020
 ✗ TI Self-assessment Score January 2021
 ✗ TI self-assessment Score April 2021



Re-building Trust & Confidence

	Level 1 Basic	Level 2 Early Progress	Level 3 Results	Level 4 Maturity	Level 5 Exemplar
	Principle accepted and commitment to action	Early Progress in development	Initial achievements realised	Results consistently achieved	Others learning from our consistent achievements
Patient and Public Engagement and Involvement	✗	✗ → ✗ → ✗			
Staff Engagement and Involvement		✗ → ✗ → ✗			
Partnership: Engagement and Involvement	✗	✗ → ✗ → ✗			
Promoting the work of the organisation	✗	✗ → ✗ → ✗			

✗ TI Self-assessment Score March 2020
 ✗ TI Self-assessment Score Sept 2020
 ✗ TI Self-assessment Score January 2021
 ✗ TI self-assessment Score April 2021

Quality & Governance

	Quality & Governance				
	Level 1 Basic	Level 2 Early Progress	Level 3 Results	Level 4 Maturity	Level 5 Exemplar
	Principle accepted and commitment to action	Early Progress in development	Initial achievements realised	Results consistently achieved	Others learning from our consistent achievements
Quality Planning	✗	✗ → ✗ → ✗			
Quality Assurance	✗	✗ → ✗ → ✗			
Quality Improvement	✗	✗ → ✗			
Risk and Assurance	✗	✗ → ✗ → ✗			
Governance	✗	✗ → ✗ → ✗			

✗ TI Self-assessment Score March 2020
 ✗ TI Self-assessment Score Sept 2020
 ✗ TI Self-assessment Score January 2021
 ✗ TI Self-assessment Score April 2021

*Please note that it was concluded at the self-assessment that Quality improvement should be put within Level 1 basic as there had been a lack of progress in this area. The Board agreed with this view.

Special Measures progression

The progress of the special measures improvement work, focussing on Maternity and Neonatal services, was also updated at the self-assessment session. Aligned with supporting evidence, the level of believed progress was shared against the three overall TI component areas (Quality & Governance, Trust & Confidence and Leadership & Culture). After a discussion it was felt that this was not the best way to articulate progress and therefore the original Matrices, as understood by the IMSOP panel, would continue to be used (Safe & Effective Care, Quality of Women's Experience, Quality of Leadership & Management).

It was agreed that there would be a future split out of 'maternity' service progress and 'Neonatal' progress. This would allow for a more focussed and informed discussion.

The special measures team shared that they felt good progress had been made and that they felt they were within the Level 3 results phase. Any formally agreed progression would be conducted in collaboration with the IMSOP panel, however the Board were pleased to see progress and acknowledged there were key elements of work to be undertaken.

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

- 3.1 Over the coming weeks plans will be drawn up to show the forward 'roadmap' of activities planned to develop the organisation. A new monthly working group has been established that will coordinate the progression of this plan and ensuring TI improvement work stays high up the organisational agenda.
- 3.2 The TI Improvement programme will seek to understand and demonstrate its progression / level of maturity by seeking objective and external views on the development of the Health Board. This will aid the Health Board in displaying progression as it look towards moving into the 'results' phase of improvement across all domains as well as beginning to consider activities to show a level of maturity.

4. IMPACT ASSESSMENT

Quality / Safety / Patient Experience implications	There are no specific quality and safety implications related to the activity outlined in this report.



Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below)
	If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below.
	If no, please provide reasons why an EIA was not considered to be required in the box below.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £ / Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Well-being Objectives	Co-create with staff and partners a learning and growing culture

5. RECOMMENDATION

- 5.1 The Board is asked to ENDORSE the agreed level of TI progression as outlined and agreed at the TI Self-Assessment Board on the 26 April.
- 5.2 The Board is asked to NOTE that the Special Measures Improvement work will continue to report under the originally agreed improvement headings, as aligned and understood by IMSOP. The Maternity and Neonatal progress will be separated to ensure a focussed understanding of onward improvement.
- 5.3 The Board is asked to SUPPORT the re-build in momentum planned to encourage onward progression of the TI agenda.



AGENDA ITEM

5.1

CTM BOARD

PRIMARY CARE UPDATE

Date of meeting

27/05/2021

FOI Status

Open/Public

If closed please indicate reason

Not Applicable - Public Report

Prepared by

Dr David Miller, Deputy Medical Director Professional Standards and Primary Care, and Ms Sarah Bradley, Assistant Director Primary Care

Presented by

Dr David Miller and Ms Sarah Bradley

Approving Executive Sponsor

Chief Executive

Report purpose

FOR DISCUSSION / REVIEW

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)

Committee/Group/Individuals

Date

Outcome

(Insert Name)

(DD/MM/YYYY)

Choose an item.

ACRONYMS

1. SITUATION / BACKGROUND

This paper will outline some of the developments, learning and opportunities in Primary Care Clusters, Digital Health, Primary Care Estates and the COVID-19 Recovery.

This paper has not considered developments in Primary Care Dental, Optometry and Community Pharmacy. These areas could be considered in future reports, as could areas of urgent primary care developments including Think 111 First and the introduction of an Urgent Primary Care Centre.

- 1.1 In common with all parts of the health and care sector, since the outset of the COVID pandemic, Primary Care has faced and responded to unprecedented challenge in sustaining existing services and supporting the community assessment and treatment of COVID-19, including both acute illness and continuing debility.

Within a matter of days in March 2020, the constraints of Infection, Prevention & Control (IPC) necessitated wholesale change to the traditional delivery of Primary Care. This was most visible with a switch to a remote first assessment model with controlled face to face where needed. Our 51 General Practices have shown flexibility in adapting their working patterns to best support the population.

- 1.2 The pandemic has provided an opportunity for revolution rather than the evolution in primary care that preceded it. Measures once considered quite radical such as digital imaging and video consulting to support remote assessment of patients are now widely accepted by professionals and patients.

In this context, there is positive and negative learning. Looking towards the next stage of digital development for Primary Care, the integration of the current multiple patient care record sources into a single accessible usable one is sought by users. This should be patient facing and transferrable with the patient across care settings.

- 1.3 Current demand in Primary Care is at unprecedented levels. The workforce is under the strain of high volumes of telephone enquiries, meeting urgent care requests and a dramatic uptake of digital consultation options. All of this in the setting of a deterioration in population wellbeing and mental health, which is in itself a reason for presentation, unhealthy lifestyle choices and a contributing factor to worsening physical health. In common with secondary care, there is a considerable backlog, specifically in review of long-term conditions, which has unavoidably accumulated during the pandemic. A whole system approach to this is needed with greater horizontal and vertical

integration with Community Services, Secondary Care, Local Government and the third sector.

- 1.4 In serving the whole spectrum of age and disease groups, Primary Care professionals are well placed to describe both unmet need and the opportunity for whole system improvement. There is an appreciation now of the need for significant change like never before, there is much potential for development of Primary Care, but this needs to attach resource to responsibility.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

CLUSTER DEVELOPMENT AND MULTIDISCIPLINARY WORKING

- 2.1 CTM has seven Primary Care Clusters; each has a Cluster Lead Clinician, a Practice Manager Lead and support from a full-time Cluster Development Manager.
- 2.2 In the early years, Clusters were very much General Practice focused concentrating on the sustainability of their services, but through this developed some links with other parts of the NHS, Local Government and third sector. By no means was CTM an outlier on this shortcoming, which has markedly improved with Allied Health Professionals represented now in all Clusters.
- 2.3 There is however, a persisting lack of consistency in the form of representation, and their contribution to decision making on allocation of resources and leadership. It is hoped that a recent national review of Clusters by the Strategic Programme for Primary Care led by Alan Lawrie, will provide answers to some of these difficult questions and much needed direction on the function, structure, relationships and funding.

An ambitious model of a significantly greater role for Clusters in the planning and delivery of services is being considered. There are likely to be opportunity for some Clusters to act as pacesetters for accelerated development. Within CTM, there are Clusters that have demonstrated a strong and consistent sense of their purpose and direction, coupled with at times frustration at some of the constraints imposed by their current structure, so it is likely at least some will express interest.

- 2.4 Work done in 2017 in conjunction with Dr David Carson of the Primary Care Foundation, highlighted to Practices that around 20% of patients seeing a General Practitioner could more appropriately see another professional. This in part reinforced Cluster thinking and practice in

putting engagement of other roles at the centre of their funded sustainability projects. The result was, whilst Practice Pharmacists, First Contact Musculoskeletal Physiotherapists, Mental Health Workers, Social Care Workers and Occupational Therapists were not widely involved in Cluster structures, they were very much part of clinical teams within Practices. The roles have been widely acknowledged to add value, but we have struggled collectively to achieve mainstream funding for Clusters to embed the roles. This has restricted some of the potential for Clusters to move on to more transformative projects. The reasons behind this inertia are in part the form of evaluation undertaken, and the difficulty of affecting considerable movement of funding within a complex organisation.

- 2.5 A selection of Cluster workforce development plans for 2021-22 include, the introduction of a Frailty Nurse to support Care Homes, Pharmacy Technicians in Practice to support quality and safety and Counselling Services. In Merthyr Tydfil there is the continuation of a bespoke Support Officer role, which guides patients in accessing Local Government and third sector resources.
- 2.6 Whereas no cluster has had resource to trial and evaluate all the roles simultaneously. The Community Health and Wellbeing Teams were an attempt to provide intensive case management to complex patients from a fully formed multidisciplinary team, whose needs could not be understood or met within existing teams or care pathways. The teams were aligned to Clusters but not managed by them, but this would appear to be a natural progression as Clusters develop.
- 2.7 The General Medical Services Contract has not seen a significant increase in funding since the introduction of the new contract in 2005. Therefore, there has not been funding potential for Practices to create new posts for some, let alone all, the new roles. Where practices have had either the capacity to fund, through General Practitioner recruitment failure, reprioritisation when vacancies arise or economies of scale with practice merger, we have seen the adoption of Pharmacists and First Contact Physiotherapists. In a couple of settings, Occupational Therapy and Mental Health Worker roles have been adopted. However, none of this is at sufficient scale to have meaningful whole system impact.
- 2.8 In summary, the role of wider healthcare professional teams within Primary Care is widely accepted and can reduce demand on other parts of the system, but a sustainable source of funding to embed this has yet to be found.

- 2.9 In keeping with the 'Wider Determinants of Health' (Marmot 2010), Primary Care has come to understand the importance of sign-posting to a wide range of non-medical interventions to support health and well-being, most visibly through the Community Co-ordinator roles and the 'Grow Rhondda' Therapeutic Gardening project. There is growing acceptance in our population for what is called 'Social Prescribing' and ease of access and a positive first experience are key in individual continued engagement.
- 2.10 From an early stage in their evolution Clusters have understood to utilise a wider team and social prescribing, Care Navigation is a pivotal role. Care Navigators are usually non-clinical staff trained to signpost to a range of resources both inside and outside Practices. Consistency of approach and public messaging across boundaries is key. The Communications Team with public campaigns, including Your Team and Choose Well, have supported this.
- 2.11 During the pandemic Clusters have become more unified. Practices have come to understand their interdependency and through the development of contingency plans have formed buddying and cross cluster support arrangements. Clusters have shown strong leadership and self-direction; daily communication and support has become embedded and is here to stay. This has facilitated a consistency of approach and public messaging in key areas of concern during the pandemic such as Personal Protective Equipment (PPE), Shielding and Vaccination.
- 2.12 Going forwards Clusters have the opportunity to be a strong voice, working with our Integrated Locality and Systems Groups in making our aspiration for disease prevention, population and value based health care of sustainable high quality services delivered close to home, whilst putting patients at the centre of everything we do.

DIGITAL INNOVATIONS DURING THE PANDEMIC AND FUTURE POTENTIAL

- 2.13 The pandemic has forced Primary Care as per other parts of the health and care system to adopt Digital Health models out of necessity. Video Consulting and digital images sharing had been discussed within CTM as far back as 2017 and formed part of the original Cwm Taf UHB transformation funding bid submission (prior to the merger with Bridgend). However the gains were considered hard to quantify; and with technical and data sharing agreement constraints also casting doubt over the project, it did not become part of the eventual transformation work within Primary Care. With the advent of the pandemic remote assessment by telephone, supplemented by video and still images, became undisputable

essentials overnight. This has provided a rich learning opportunity; some of the previous judgements about these forms of consulting have proved accurate, others less so.

- 2.14 To support video consulting Welsh Government procured the *Attend Anywhere* platform, and commissioned TEC (Technology Enabled Care) Cymru to support the roll out within Care Homes. Future video consulting platform procurement is the subject of an ongoing review.
- 2.15 A key change in Digital Health has been the implementation of the Wales Primary Care Access standards. These state ambitious targets for availability of the population to be able to contact their practice by “appropriate accessible alternative methods of contact, including digital solutions” and to “offer access to repeat prescriptions via a digital solution” (Standard 4) and “request a non-urgent consultation, including the option of a call back via email” (Standard 5). This is coupled with the requirement of 90% of incoming calls to be answered within two minutes of the end of the introductory message ending (Standard 2). The Health Board provided support in meeting the Standards for digital access by the fixed term procurement of the *eConsult* platform, which allows patients to send an administrative or clinical enquiry for a timed response.
- 2.16 The adoption of *eConsult* and the Wales Access Standards were prior to the pandemic leading to some unintended consequences. Under the combined influences of: assessment of suspected COVID-19 related illness; the time consuming nature of remote consulting (compared to the face to face model); a widespread deterioration in mental health and a steady absence level around 15% amongst Primary Care staff for much of 2020, led many practices to report demand has become unsustainable. Added to this the opening up of digital access via *eConsult*, without any increase in clinical staff to support and respond, has in the view of some opened up a new channel for a younger demographic who might have accessed other services or appropriately self-cared. By some, this was felt to be a self-created demand and capacity problem. With some practices electing to switch the platform off overnight and at weekends. To date the suppliers of *eConsult* have not proved entirely responsive to user requests for control of their practice configuration or input into development. The Primary Care team are progressing this with the providers.
- 2.17 A more predictable set common observations in respect of digital innovations has been success is limited to those areas where there is the capacity to adopt change in working patterns, technical support and IT infra-structure. Less success was noted where there existed problems with Wi-Fi networks (extending throughout a large building

such as a care home) or broadband coverage was poor. Further to this where multiple IT platforms are in use, multiple monitors are required and image and sound quality really matter in user experience and clinical effectiveness.

- 2.18 Despite these constraints a noteworthy positive has been the remote support for Community Teams and Care Homes using video consulting, particularly in the out of hours period. With the caveat that the viewing of video consulting at the clinician end within CTM Urgent Primary Care Services (formerly known as the GP Out of Hours Service) has been constrained by local network issues and the need to work across multiple clinical systems, which remains a live problem.
- 2.19 In the first wave of the pandemic, the Community Respiratory Hub sited at Ty Elai, used video consulting to provide remote support for COVID19 in the community including care homes, with urgent delivery of medication to patients receiving supportive care. However, this required the parallel use of four non-integrated systems which had no inter-operability. Whilst this was effective, and highlighted what could be done as a contingency, this would be far from ideal as a long-term solution to the challenge of providing a service and is emblematic of how Primary Care IT has developed.
- 2.20 There is an increasing strength of feeling within Primary Care that the need for a single integrated patient record and the case of Electronic Prescribing. Both of these needs have been long expressed but not delivered. One CTM Practice has been proactive in working with *Cegedim*, the providers of *Vision*, the most commonly used Primary Care system in use locally, to develop an application to integrate into one place the various existing silos of patient information. Coupled with this would be a patient facing view, with the ability for users to add agreed forms of information (such as symptom diaries, blood pressure and weight) and share in other settings such as the Emergency Department or Outpatient Clinic. The Application is in a testing stage using dummy patient data but could be ready for use within six months.
- 2.21 The national Primary Care Clinical System procurement exercise is due to be restarted in the coming months. The features promised by providers at the last procurement exercise have not been delivered to date. The two products in use in has remained largely unchanged over a decade and lack the essential digital consulting features previously described. A new nationally procured more integrated software system was expected in autumn 2021 for NHS 111 and Urgent Primary Care, but this is delayed.

- 2.22 Video Group Clinics, allowing a facilitator, who may or may not be a clinician, to host a virtual patient education session, has been taken up initially by two CTM practices. Used with appropriate consent and governance processes these have an evidence base and the potential to support chronic disease management, lifestyle interventions, mental health and more.
- 2.23 *Consultant Connect* was provided to Health Boards in Wales at the outset of the pandemic. This is a smart phone application, which gives community clinicians from all disciplines rapid phone advice from a Consultant. The system safely records the conversation and is configured to allow a rota of local Consultants to respond; with the back-up option of defaulting to a national network of Consultants provided by the supplier. Since launch in mid-July 2020, 626 have been answered with feedback provided on 42% of calls that a hospital attendance was avoided on 73% occasions. Users have expressed a strong preference for local Consultants to provide the advice. But this has been challenging for Secondary Care teams stretched like never before during the pandemic
- 2.24 Within Eye Care, there are a number of opportunities for value based pathway redesign with parts of service for Diabetic Retinopathy, Cataract and Glaucoma care long identified for movement from Secondary Care to Primary Care Optometry Services. Much of this is underpinned by IT challenges, which remains a challenge, and there is a danger of missed opportunity for Welsh Government funding if these are not resolved.
- 2.25 A summary of the high value Digital developments during the pandemic has been:
- (1) The remote support for Community Teams and Care Homes by video imaging.
 - (2) Digital still images for simple skin problems.
 - (3) Cluster level Primary Care records (read and write) access as part of the Community Health and Wellbeing Teams, extended to pan Health Board access as part of the Community Respiratory Hub in the first wave of the pandemic in the Spring of 2020.
 - (4) Digital Access platforms for in hours care in providing rapid access for a demographic who might not have previously accessed General Practice.

- (5) In terms of Digital inclusivity, many who were not immediately digitally enabled were able to access via support from friends, family, carers and community support agencies.

2.26 The negative findings in respect of Digital developments during the pandemic were:

- (1) IT infrastructure, including device compatibility and functionality, broadband access and Wi-Fi connectivity, were persistent constraints in some settings. This impacted image and sound quality and the judgement as to when this became unsatisfactory and to discontinue was a subjective one for the clinician concerned.
- (2) The creation of a new digital access channel may have increased demand that could have been met in other ways outside General Practice.
- (3) A small number of patients used the Digital Consulting platform outside guidance, ignoring entry level warnings and incorrectly completing filtering safety questions, to later enter free text describing symptoms potentially needing immediate medical attention such as, chest pain and significant bleeding, breathing difficulty or features of a Stroke.
- (4) The adoption of new Digital Health innovations coincided with the recent introduction of the Wales Primary Care Access standards putting a significant parallel pressure on practices during a pandemic.

PRIMARY CARE ESTATES

2.27 On 19 March this year, the Health Board celebrated the completion of Ty Calon Lan, in Mountain Ash. It is a £4 million Primary Care Centre, and it houses a GP practice (just over 11,000 patients) and a range of community services, including district nursing, health visiting and the cluster community, health and wellbeing team. This was a great achievement considering the challenges of the pandemic and it was the only scheme funded under the Welsh Government's 'Primary Care Pipeline' to be delivered within the original timeline.

2.28 We would like to build on the success of the two schemes above to continue to improve the primary care estate. This will be achieved through an Estates Strategy for Primary Care and Community. At present, a condition survey of all the GP primary care premises is being undertaken and this is due to be finalized by August 2021. This will feed into the overall Health Board Estates Strategy. There are

two important drivers: Cwm Taf Morgannwg population is projected to grow by 2.1% by 2026. Secondly, the Health Board actively promotes a social model of healthcare with a focus on building a multidisciplinary approach. A fundamental part of this model is the provision of a purpose built estate throughout the community to create a platform from which these multidisciplinary services can be delivered effectively and efficiently.

- 2.29 Running in tandem with the creation of the Estates Strategy is ongoing work to improve the primary care estates. This includes the development of the Bridgend Health and Wellbeing Centre. This is a larger scheme, which will combine health, social care and wellbeing services, and is due to be completed in August 2022. Early discussions and planning is also taking place for a couple of other priority areas, which include Llanharran, Llantrisant and Ton Pentre.

Primary Care pandemic recovery

- 2.30 In common with other parts of the health and care system Primary Care staff have worked tirelessly for a sustained period of time. Some have been ill and some have suffered bereavement during the pandemic. Practices have delivered 177,629 COVID19 vaccinations by 12 May 2021.
- 2.31 Data drawn from the Primary Care Information Portal on the position in respect of Long Term Condition (LTC) management provided to Wales Primary Care Assistant Medical Director's Group on 21 April, demonstrates a fall in the recording and achievement of targets in the areas of Diabetes, Chronic Obstructive Pulmonary Disease and Prescribing.
- 2.32 In the case of Diabetes, the percentage of CTM patients having completed all eight measures of care falling from 32.3% (2020-21 Quarter 1), by c. 1% per month, to 19.0% (2020-21 Quarter 4), with a Wales mean of 21%, range 14.2% to 25.7% (2020-21 Quarter 4). With a 40% relative reduction in those considered to have good outcome markers for all Diabetes indicators, falling from 24.6% (2020-21 Quarter 1) to 17.7% (2020-21 Quarter 4), with a Wales mean of 16.0%, range 13.0% to 17.7% (2020-21 Quarter 4). The Primary Care team is in the process of reviewing this data and working with GP Contractors to discuss potential supportive measures with a paper due to the Planned Care Board at the end of May 2021.
- 2.33 In line with the July 2020 Ministerial directive to Health Boards, as part of improving Urgent and Emergency Care, the Primary Care Team is preparing a proposal for a 'Flow Centre' known as '111 First' to navigate callers to NHS 111 identified as having a condition which

is urgent but not needing immediate attendance at an Emergency Department. This fits within the Urgent Care Improvement Programme and an options appraisal will be presented to the next Management Board Meeting. The launch is dependent upon the transfer of Bridgend Urgent Primary Care Service, which is currently provided by Swansea Bay, which is now delayed until September 2021.

- 2.34 In January 2021 four North Rhondda practices successfully bid for Welsh Government Urgent Primary Care Pathfinder funding and commenced an in hours Urgent Primary Care Service sited in Ysbyty Cwm Rhondda. The model is designed to allow care navigation of a range of urgent conditions from call reception in the participating practices to a Multi-Disciplinary Team (MDT) workforce. The service has been very well utilised since launch and an extension to funding has been obtained.
- 2.35 Other recent developments during the pandemic include the successful return of New Tynwydd Surgery to independent contractor status, leaving just one managed GP Practice in Ferndale and Maerdy. In respect of Ferndale and Maerdy, consideration is underway with partners about the future development of the practice including the possibility of GP training status for the practice.

3. KEY RISKS FOR CONSIDERATION

- 3.1 The Primary Care team has an ambitious vision of Multidisciplinary Care delivered by the independent contractors working closely together, empowered rather than impaired by IT, using consistent care navigation to access a wide range of resources, close to home to meet the needs of the population.
- 3.2 Despite successfully trialling, a number of workforce development projects involving Allied Health Professionals Clusters have not been able to consistently mainstream these roles. This has led to in some cases their continuation as cluster funded projects which supports the delivery of care, but restricts further innovation and support for Clusters.
- 3.3 During the pandemic Primary Care Clusters have become more cohesive with improved lines of communication and a greater understanding of the inter-dependency between General Practice, Community Pharmacy, Community Optometry and Dentistry.
- 3.4 At present, there is uncertainty on the future strategic direction, function and leadership of Primary Care Clusters. The Strategic Programme for Primary Care review of Clusters in Wales should help

clarify this, with an opportunity for accelerated development for some.

- 3.5 Digital innovations can only succeed with planning, communication, a change in working pattern, technical support and IT infrastructure.
- 3.6 Primary Care users want influence on the future development and integration of clinical systems, citing the current absence of integration and failure to deliver a single care record and electronic prescribing, as evidence of lack of sufficient voice.
- 3.7 Video Consulting and clinical image sharing have been widely accepted as essential for the future. There are some IT infrastructure barriers to realising the potential of current systems which are also needed for the development and integration work.
- 3.8 Electronic patient consulting has proved very popular such that previous concerns about potential low usage have been confounded. Meeting demand is proving highly challenging in some settings with the context of the pandemic and the pressure imposed by the Wales Access Standards for Primary Care.
- 3.9 Video Group Clinics have the potential for delivery of patient education, long-term condition management and supporting lifestyle interventions but are only at an infancy stage in CTM.
- 3.10 In the coming year, Primary Care faces a considerable backlog in Long Term Condition management, mixed with uncertainties around current GMS contract renegotiations, a review of Enhanced Services, an unpredictable Seasonal Influenza vaccination programme, further potential spikes in COVID19 infection and a possible COVID19 booster vaccination programme.
- 3.11 Addressing the Long Term Condition management backlog will require similar planning, resource and project management support as per the Secondary Care Elective Restart with Primary Care Clinicians from all disciplines integral to its development.
- 3.12 Primary Care has a developed Estates Strategy with a clear vision of the importance of collocating clinical services, training and professional development, collaborative working with partners and accessibility for patients.

4. IMPACT ASSESSMENT

Quality / Safety / Patient Experience implications	Yes (Please see detail below)
	Quality, Safety, Patient Experience
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below)
	If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below.
	If no, please provide reasons why an EIA was not considered to be required in the box below.
	This paper does not cover a new, changed, or withdrawn policy or service.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £ / Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Well-being Objectives	Provide high quality, evidence based, and accessible care

5. RECOMMENDATION

- The Board is asked to NOTE and consider the issues within this paper and in particular, the constraints on embedding established MDT roles within Primary Care, the case for a single patient clinical record and the support, which will be needed in addressing the pandemic related backlog in Primary Care.



AGENDA ITEM

5.2

CTM BOARD

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD AS A
POPULATION HEALTH ORGANISATION: A DISCUSSION AND OPTIONS
PAPER

Date of meeting 27/05/2021

FOI Status Open/Public

If closed please indicate reason Not Applicable - Public Report

Prepared by Kelechi Nnoaham, Director of Public Health

Presented by Kelechi Nnoaham, Director of Public Health

Approving Executive Sponsor Executive Director of Public Health

Report purpose FOR DISCUSSION / REVIEW

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)

Committee/Group/Individuals	Date	Outcome
Board Strategic Discussion	22/04/2021	SUPPORTED
Board Development Session	29/04/2021	SUPPORTED

ACRONYMS

1. SITUATION / BACKGROUND

- 1.1 It is broadly accepted that the duty of the Health Board to improve the health of its population effectively makes it more than a healthcare organisation delivering reactive healthcare services.

- 1.2 A population health organisation takes responsibility for improving the health of an entire population, not just of those who are care-seeking.
- 1.3 During April 2021, the Board held two sessions at which it discussed what it meant to be a population health organisation. Those discussions led to a number of high-level opportunities being identified.
- 1.4 This paper builds on those conversations by defining more specifically the potential opportunities available to the Health Board to embed a population health ethos in the organisation and secure continuous improvement in the health of the Cwm Taf Morgannwg population

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

- 2.1 The paper offers an evidence-based framework for action on population health.
- 2.2 Evidence-based rationale is offered for the potential action areas identified, along with proposed Executive leads.

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

- 3.1 Action is required by the Health Board in the areas of leadership, partnership, organisational structure and operational activities in order to secure sustainable improvements in the health of the population of Cwm Taf Morgannwg.

4. IMPACT ASSESSMENT

Quality / Safety / Patient Experience implications	There are no specific quality and safety implications related to the activity outlined in this report.
Related Health and Care standard(s)	Governance, Leadership and Accountability If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.



	Not Required
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £ / Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Well-being Objectives	Work with communities and partners to reduce inequality, promote well-being and prevent ill-health

5. RECOMMENDATION

- 5.1 There are 36 specific options offered in this paper. The Board is asked to DISCUSS these options.

Cwm Taf Morgannwg University Health Board as a Population Health Organisation: a discussion and options paper for Board

Author: Kelechi Nnoaham, Director of Public Health

Reviewed by: Angela Jones, Gemma Northey, Sara Thomas and Rebecca Cushen, Consultants in Public Health

May 2021

Contents

Background	3
A menu of goals for population health.....	3
A strategic framework for options	5
1. Improve care quality for key causes of Disability Adjusted Life Years (DALYs) lost in CTM.....	6
2. Become a Population Health-oriented Health Board, modelling priority action areas on the Ottawa Charter.....	7
3. Combine integration of health and care services with a population health approach.....	8
4. Function as an Anchor Institution for Cwm Taf Morgannwg's places and communities	12
5. Systems Leadership	14
Appendix 1.....	16

Background

At two sessions during the month of April 2021, the Board had strategic conversations about what it meant to be a population health organisation. The aim was to begin defining specifically what the Health Board needed to look like and how it needed to function if it must successfully tackle the population health challenges in Cwm Taf Morgannwg.

The input to the conversation included: (1) a reminder of our population health challenges, drawn from the 2017 DPH Annual Report – Frailty, Obesity, Inequalities and Loss of Wellbeing; (2) risk factors for COVID infection and mortality, and (3) reflection on the importance of hearing the community's voice in the collective response to these challenges.

Appendix 1 summarises the key outputs from those discussions.

Building on those conversations and drawing on best possible evidence, this paper defines, more specifically, potential opportunities which the Health Board could pursue in terms of strategy, leadership and operational activities. It does not rehearse the population health challenges in Cwm Taf Morgannwg but instead focuses on potential solutions for the Board's consideration.

A menu of goals for population health

The vision of the Health Board – becoming known as a population health organisation that works with its communities and partners to improve health and wellbeing - is already set out in key strategic planning documents. However, the strategic population health goals corresponding to this vision have not been made explicit, even though they are implied. Agreeing population health goals is important as it ensures that the organisation is clear with itself and partners exactly what it is seeking to achieve by pursuing specific actions and how it will hold itself to account for delivering on the ambitions.

To this end, the following menu of population health goals from 2021-2026 are supplied for discussion and consideration in Table 1.

Table 1 - Menu of potential goals for CTMUHB's population health system

S / N	Goal	Why (rationale)	Current
1	By 2026, in men and women in CTM, Life Expectancy at birth and Healthy Life Expectancy match the Wales average	Life expectancy and healthy life expectancy are good summary measures of the overall health of the population. The inequality gap should be measured in comparison to Wales as well as between deprivation groups within CTM	LE gap – average 1 year HLE gap – average 3.5 years
2	By 2026, the Slope Index of Inequality in Life Expectancy at birth and Healthy Life Expectancy between the most and least deprived population quintiles in CTM has been reduced by 20%		To Be Calculated
3	By 2026, Avoidable Mortality in CTM matches the Wales average	Avoidable mortality is a good summary measure of the performance of wider public health (preventable) and health & care (amenable) systems	Based on 2019 data (latest), CTM is at 300/100,000 population and Wales is at 260/100,000 population
4	By 2026, Life Expectancy in people with mental health problems in CTM matches that of those without	Physical health outcomes for people with mental health problems are unjustifiably poorer than those without. This is preventable and is responsive to co-ordinated action across public services	To Be Calculated
5	By 2026, the prevalence of key LTCs (stroke, diabetes, cancer and heart disease) in people with mental health problems in CTM matches that in those without		To Be Calculated
6	By 2026, Infant Mortality Rate (IMR) in CTM is lower than 2 per 1000 live births and percentage of Low Birth Weight (LBW)	Early life experience is predictive of future health and wider social outcomes. IMR is an important indicator of population health as it reflects the structural factors affecting population health	Latest data (2018/19) suggest IMR in CTM is approx. 4 per 1000 live births and % of live births with LBW approx. 7%
7	By 2026, the current inequality in smoking prevalence between groups at extremes of deprivation in CTM has been eliminated	Smoking rates are the largest single cause of inequalities in health	To Be Calculated. ¹
8	By 2026, the prevalence of overweight & obesity has been reduced by 5 percentage points from its current levels	Obesity influences life expectancy and is an important proximal risk factor for many long term conditions	Current prevalence of obesity & overweight in CTM is approx. 67%

¹ Population health management data for Rhondda in 2018 showed a prevalence gap of 15 percentage points between groups at extremes of deprivation

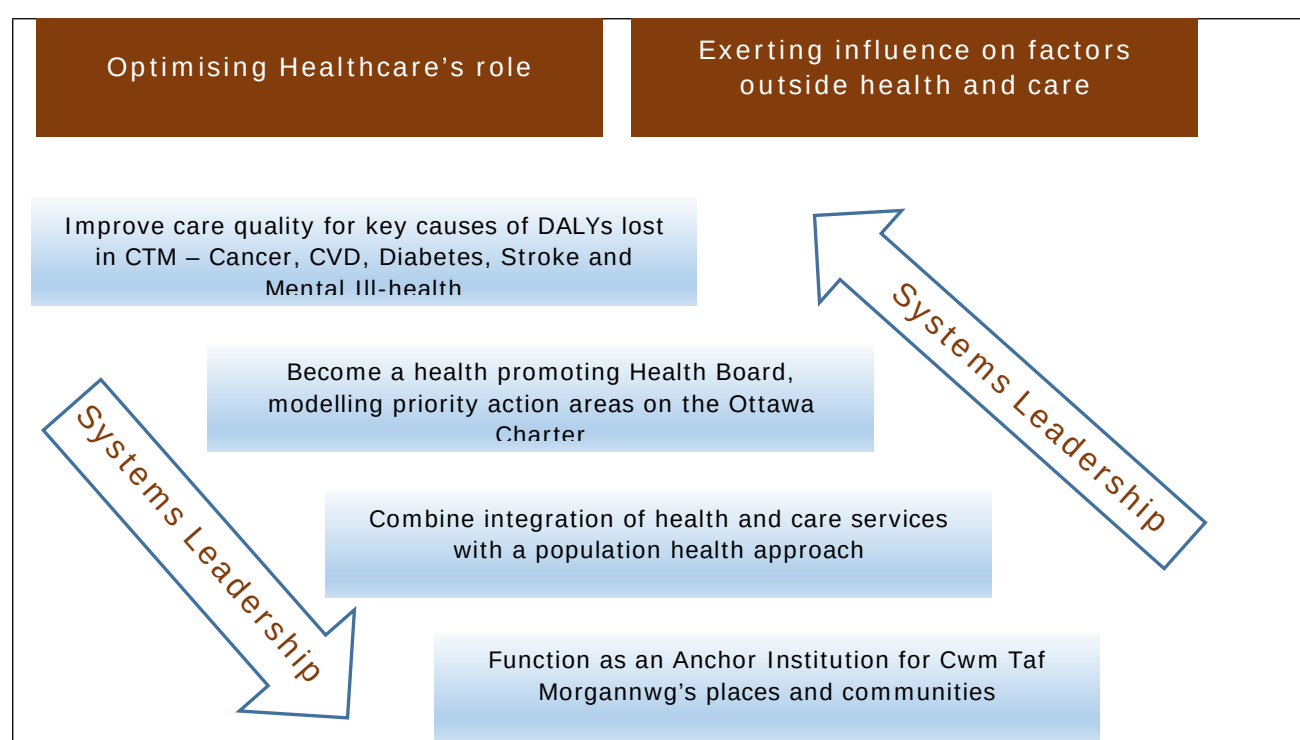
A strategic framework for options

In setting out a strategic framework for CTMUHB's population health approach, it is worth reiterating that population health is determined by a variety of factors acting in concert, including: (1) age, sex and constitutional factors, (2) individual lifestyle factors, (3) social and community networks and (4) wider socioeconomic, cultural and environmental conditions. Evidence demonstrates clearly that socioeconomic and environmental factors are the primary drivers of population health, and that health care determines 10-20% of population health.^{2,3} To improve population health therefore, the Health Board needs an approach that has at least two over-arching components, viz:

- Optimising healthcare services contribution, and
- Exerting influence on those factors that lie outside the health and care system.

As shown in Figure 1 below, under each component, ranging from those over which the health board has more direct control to those over which it has less direct control, 4 'pillars' of the population health approach align and will be further described in this paper.

Figure 1: A framework for population health in CTM



² J.M. McGinnis et al., "The Case for More Active Policy Attention to Health Promotion," Health Affairs 21, no. 2 (2002):78–93

³ B. Booske et al., "Different Perspectives for Assigning Weights to Determinants of Health," County Health Rankings Working Paper. Madison (WI): University of Wisconsin Population Health Institute, 2010d

1. Improve care quality for key causes of Disability Adjusted Life Years (DALYs) lost in CTM

Table 2 - Options for action on Improving care quality for key causes of DALYs lost in CTM

Option	Rationale	Exec Lead (and Support)
1. Implement Value-Based health in Diabetes	A Value-Based health approach emphasises operational success in healthcare based on a focus on outcomes	Director of Finance (Director of Public Health)
2. Implement pre-Diabetes Pathway improvement across CTM	The prevalence of diabetes is likely to rise in the wake of the COVID pandemic. Board strategic conversations highlighted need to focus on secondary prevention by minimising clinical risk factors for the long term conditions that cause most DALYs lost in CTM – high blood pressure, raised blood glucose, high blood cholesterol and high BMI. The pre-Diabetes pathway and Inverse Care Law programmes target these risk factors	Director of Public Health (Director of Primary Care and Mental Health)
3. Embed the Inverse Care Law Programme in CTM		
4. Conduct a Health Equity Audit for stroke in CTM	Equity is a key domain of the Institute Of Medicine 6-part approach to healthcare quality but is often neglected by health systems. The new Stroke Quality Statement in development will emphasise Equitable care and CTM can get on the front foot about this dimension of Quality that is fundamental to population health improvement	Director of Therapies and Healthcare Sciences (Director of Public Health)
5. Improve detection of atrial fibrillation and anticoagulation for people with atrial fibrillation in Primary Care	Atrial fibrillation increases the risk of stroke by 500% and the DPH annual report from 2019 demonstrated that only a fraction of cases were being detected in the community and only a fraction of detected cases were being properly anticoagulated	Director of Primary Care and Mental Health (Director of Public Health)
6. Implement an integrated Level 2/3 weight management service for CTM	2 in 3 adults are either overweight or obese and obesity contributes directly to morbidity with key causes of DALYs lost in CTM – CVD, Diabetes, Cancer, Stroke We need increased focus on secondary prevention - minimising clinical risk factors at the root of much DALYs lost in CTM - high BMI being a notable one.	Director of Public Health (Director of Therapies and Healthcare Sciences)

2. Become a Population Health-oriented Health Board, modelling priority action areas on the Ottawa Charter

The Ottawa Charter was set out over 30 years ago as a framework for organisations, governments and institutions for promoting health. Its priority action areas remain relevant as a framework for CTM's population health challenges.

A Health Promoting Health Board enables people – its patients, staff and communities - to increase control over, and to improve, their health. Looking to make healthcare delivery successful and sustainable, it puts preventative health high on its agenda and creates the conditions for population health responsibility and leadership at all levels of the organisation.

The Table below sets options for action discussed in recent Board strategy sessions against the priority action areas of the Charter.

Table 3 - Options for action on Population Health-oriented Health Board

Ottawa Charter domain	Options	Exec Lead (and support)
Develop a health promotion policy for CTMUHB	1. Enable healthy behaviours for staff, specifically: • Review current cycle-to-work scheme to ensure it facilitates access to e-bikes or e-scooters • Review active travel plans • Invest in staff stop smoking services • Develop a staff weight management service 2. Establish a policy of systematically applying a Brief Intervention to all patient contacts throughout our services	Director for People (Director of Public Health, Director of Therapies and Healthcare Sciences)
Create a supportive environment for health and wellbeing in CTM	3. Identify, incentivise and nurture staff Health Promotion champions in all sites and wards 4. Conduct fundamental review of catering services across CTM to ensure that the available food offer promotes healthy eating and makes the healthy choice the easy choice	Director for People (Director of Public Health, Exec Leads for Estates & Facilities - Chief Operating Officer)

	5. Explore the use of CTM UHB facilities for staff to undertake physical activity e.g. use of physiotherapy gyms/pools, large rooms for staff exercise classes	
Strengthen staff and community action for health	6. Identify clear preventative health target areas as objectives in job plans, and appraise against targets 7. Empower and support primary care clusters and GP practices to be 'health promoting' centres as well as 'disease managing' centres within the community	Director for People Director of Primary Care and Mental Health
Develop personal skills for staff in health promotion	8. Make MECC (Making Every Contact Count) training mandatory for all CTM staff 9. Empower staff to identify personal well-being goals, with risky behaviours and clinical risk factors open for discussion in all appraisals, with access to support to achieve goals.	Director for People
Re-orientate our acute health services towards increasing emphasis on prevention	10. include in job descriptions and appraisals action to reduce inequalities and shift services to prevention across their portfolio areas 11. Work with HEIW to a focus on health inequalities, brief intervention and prevention in the curriculum for training of health professionals	Director for People Director of Therapies & Health Sciences / Medical Director

3. Combine integration of health and care services with a population health approach

Like most health systems around the world, CTMUHB faces increasing challenges from growing numbers of complex multi-morbid patients, the rising costs of care and increasing recognition that a failure to address the wider determinants of health does impact the outcomes we achieve from our healthcare services.

The Board recognises that integrated health care delivery is a necessary innovation to tackle these challenges. The benefits of integrating health and care services however need to be extended to the general CTM population by combining the scope of integrated care with a population health approach.

The population health approach considers a wide range of factors and interrelated conditions that influence the health of populations over the life course, identifies systematic and unwarranted variations in their patterns of occurrence, and applies the resulting knowledge to improve the health and well-being of those populations.⁴

Although health and care integration and the population health approach are not entirely new concepts in the NHS, the concrete operationalisation of the strategies that link them is still largely missing in Wales. CTMUHB has a unique opportunity to blaze a trail here and the approach of some integrated healthcare organisations, such as Kaiser Permanente in the USA, demonstrates that it is possible to successfully adapt a broad population health approach to the way health and care services are organised and delivered.

Careful review of the literature demonstrates that combining integration of care with the population health approach requires cohesive strategies that bring together whole care cycle, medical and non-medical care, for defined population groups alongside their involvement in designing their care options. The establishment of System Groups and Integrated Locality Groups in CTM represents a bold step towards the re-design of service organisation and delivery that is necessary to effect this linkage.

The opportunity to be realised by the Health Board is that of making the new structures deliver on this population health promise. The Framework in Figure 2 articulates the key principles of the model of care that starts with people's needs and ensures that resources and co-ordinated efforts are directed at those needs.

⁴ Kindig, D and Stoddart, G. What is population health? *Am J Public Health* [Internet], 2003; 93(3): 380–3. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/12604476> DOI: 10.2105/AJPH.93.3.380 [PMC free article] [PubMed] [CrossRef] [Google Scholar]

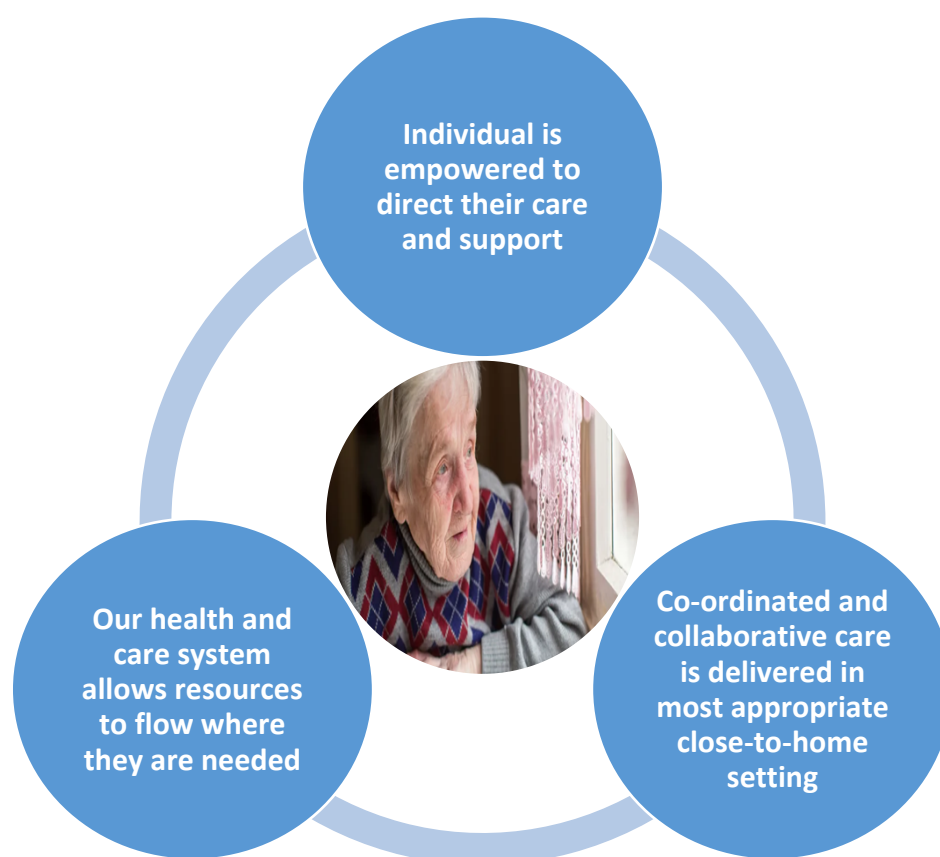


Figure 2 - A framework for Integrating Care in CTM

Table 4 - Options for action on combining integration of health and care services with a population health approach

Option	Rationale	Exec Lead (and Support)
1. Invest sustainably in Population Health Management by establishing a Population Health Management Unit	The CTM Local Public Health Team has the reputation across Wales for expertise in the nascent approach of population segmentation and risk stratification. We are already creating in-house capability for developing data-driven population segmentation algorithms using machine learning and other advanced statistical methodologies. Our goal is to become a centre of excellence in Wales for data-driven population health management innovations.	Director of Public Health (Director of Finance)
2. Invest in a Population Involvement Unit to ensure	Involvement of population groups is key to co-producing evidence based care options that meet the needs and are acceptable to our population.	Chief Executive Office / Director of

that our population are co-producing their care options		Communication s (Director of Public Health)
3. In each ILG, create 'Integrated Care Villages' of circa 20k population. A 'care navigator' is aligned to each ICV to oversee community referrals and to help support patients upon discharge from hospital.	Evidence shows that successful strategies that combine integrated care and population health approaches usually involve some level of integration of health and non-health services (and resources) to coordinate actions. To this end, each ICV in CTM would pool the professional knowledge of GPs, pharmacists, district nurses, social services and housing to create better co-ordinated and efficient hyper-local care systems. Population Segmentation & Risk Stratification data for each ICV will support anticipatory care and care for both vulnerable and non-care seeking populations.	Chief Operating Officer / Director of Primary Care and Mental Health
4. Engage Community Housing Cymru and CTM's network of Registered Social Landlords to design and implement a 'CTM Healthy Housing' Programme	Embracing inter-sectoral action and partnerships is critical to this approach. A housing programme in NZ involved house modifications to reduce overcrowding, insulation and ventilation improvements, and health and social service assessments, referrals and linkages. It resulted in a 21% reduction in emergency hospitalisation in 5-34 year olds.⁵	Director of Strategy and Transformation (Director of Public Health)
5. Review CTMUHB's offer and investment in social prescribing	Healthcare providers are well placed to facilitate ways for people to socially connect with others in their neighbourhood and community. Social prescribing is a key intervention to achieve this. In particular, we should review the extent to which we are either investing in or making our facilities available for: • Creative activities such as art or dance lessons, singing or gardening groups. • Connecting activities such as peer support services, time-banking • Active groups such as fitness, volunteering, employment support	Exec Leads for Estates & Facilities - Chief Operating Officer / Director of Finance Director of Strategy and Transformation (Director of Public Health)

⁵ Jackson, G, Thornley, S, Woolston, J, Papa, D, Bernacchi, A and Moore, T. Reduced acute hospitalisation with the healthy housing programme. *J Epidemiol Community Heal* [Internet], 2011; 65(7): 588–93.

	Ways to improve people's practical circumstances, looking at issues such as housing, debt, falls prevention, domestic abuse and benefits advice	

4. Function as an Anchor Institution for Cwm Taf Morgannwg's places and communities

The term 'anchor institutions' refers to large public sector organisations whose long-term sustainability is tied to the wellbeing of the populations they serve. They get their name because they are unlikely to relocate, given their connection to the local population, and have a significant influence on the health and wellbeing of communities.⁶

The size, scale and reach of CTMUHB means we have significant influence on the health and wellbeing of the CTM population. The Table below identifies key domains of the Anchor Institutions framework and aligns potential priorities for action in CTMUHB.

Table 5 - Options for action on functioning as an Anchor Institution for Cwm Taf Morgannwg's places and communities

Domain	Options	Rationale	Exec Lead
Employment	- Widen participation of CTM residents in the workforce by: - Targeting positions for local people - Creating pre-employment programmes, work placements and volunteer work experience - Create apprenticeships that target more vulnerable people in CTM – e.g. young people at risk of homelessness and	The HB employs over 13,000 staff, 80-90% of who live in the communities we serve. There is a strong link between 'good' work and good health. By helping more CTM residents – particularly those furthest from the labour market – into quality work, CTMUHB can improve the welfare of its local communities and begin to narrow inequalities.	Director for People

⁶ <https://www.health.org.uk/news-and-comment/charts-and-infographics/the-nhs-as-an-anchor-institution>

	the long term unemployed		
Procurement & Commissioning	3. Shift more spend locally by: • Building local capacity and • Supporting local supply chains.⁷ 4. Embed social value into purchasing decisions by prioritising and monitoring it.⁸	CTMUHB has significant purchasing power. Procuring and commissioning more goods and services from local small and medium-sized enterprises (SMEs) and voluntary and community sector organisations can have an important economic impact, as resources spent locally have a multiplier effect and are reinvested in the local community at a faster rate than resources spent with national corporations.	Director of Finance
Capital & Estates	5. Expand community access to CTMUHB's property 6. Develop accessible community green spaces on CTMUHB's land 7. Work in partnership across CTM to maximise the wider value of CTMUHB's estates 8. Create Housing-Health partnerships with RSLs – e.g. Rhondda Housing Association – to develop step-down and re-ablement facilities, extra support and care for people in their own homes	CTMUHB has physical assets that can be leveraged for community benefit. It could manage and develop these to support broader social, economic and environmental aims. Communities are more resilient when people are connected through social networks, and opening NHS buildings and land for community use or supporting the development of green spaces can provide vital opportunities for social interaction.	Director of Finance

⁷ If not already done, we can conduct an internal audit of procurement spend to identify the % of purchasing that stays within CTM, and then work out how to reallocate more of our purchasing budget towards local organisations. Having a baseline % and agreeing a target annual shift is key and this can then be monitored via the Population Health Primary Care and Partnerships Committee

⁸ There are good examples of NHS organisations that have embedded social value into procurement processes, either by introducing explicit weightings or designing core contract specifications so that suppliers must meet specific conditions – for example, creating local jobs and training opportunities, paying a living wage and adopting environmentally sustainable practices. Having said that, Wales' Community Benefit Measurement Tool is widely reputed as a good example of embedding social value into procurement process and it may well be that we have fully exploited the opportunities here.

Environmental Sustainability	9. Increase focus on and invest in embedding the Wellbeing of Future Generations Act Sustainable Development Principle		

5. Systems Leadership

As already set out in this paper, the Health Board's challenge of securing sustainable population health improvements in CTM requires action across domains both within and out with its direct control. 'Systems leadership' is an approach that is well suited to issues that require collective action, where no single organisation can control the outcomes. It is about local leaders from across the health and care system sharing a cohesive approach to working together to improve health and wellbeing for a population.

In a recent thematic analyses of three population health case studies, Bigland and colleagues⁹ identified three key themes around 'getting started,' 'maintaining momentum' and 'indicators of success' in systems leadership.

Getting started is about a 'call to action' and assembling a 'coalition of the willing'. Previous conversations at this Board show there is an organisation willingness around population health to which this paper hopefully speaks. The potential options are set out in Table 6 below.

Maintaining momentum principally relates to system structure and relationships. The organisational structure – through ILGs and SGs – ensures CTMUHB is already shaped to lead the system whilst the relationships built with our external stakeholder organisations in formal partnerships will prove essential.

Finally, indicators of success that capture resource gains to the system and shifts in data indicators at the population level need to become core to our

⁹ Bigland, C., Evans, D., Bolden, R. *et al.* Systems leadership in practice: thematic insights from three public health case studies. *BMC Public Health* 20, 1735 (2020). <https://doi.org/10.1186/s12889-020-09641-1>

systems leadership journey and Table 1 of this paper offers possible goals for adoption.

Table 6 - CTMUHB Leading the Population Health System in Cwm Taf Morgannwg

Domain	Option	Responsibility
Getting Started	1. Use influence to advocate for more resources to tackle health inequalities. 2. Instigate <i>Constructive Disruption</i> both in the Health Board and Welsh Government, for example: a. Re-balance between RTT vs. population health outcomes, and b. Change language from 'Demand/Capacity' to 'Need/Demand/Capacity' 3. Champion action and challenge proposals and Board papers to think of the impact on inequalities in health across the population. Useful tool could be the routine use of Health Equity Audits and Health Inequality Impact Assessments. 4. Connect with our communities and hold monthly surgeries in different localities to better understand the health issues and experiences of our population so that decisions are rooted in our communities' lived experiences.	Non-Executives
	5. Revise Job descriptions to include action to reduce inequalities and shift services to prevention across their portfolio areas	Executives

Appendix 1

Proposed actions for a Population Health organisational approach at the Board Strategic and Development Days, April 2021

Population Health Organisation:

- Requires leadership at all levels: non-executives, executives, senior managers, all staff, partners and the population we serve.
- It is about systematically applying all our resources to evidence based interventions that are important to the population we serve.

Population Health Management:

- Key to recognise that there is lots we can progress while we await the segmentation and risk stratification data. The latter is a tool to help us further define and refine our approach in an incremental process as we look to implement evidence based actions and interventions, involving patients in each segment.
- Anticipatory care – see it in the context of prevention, integration, collaboration and involvement (WBFG Act)
- Opportunity to use third sector data e.g. Citizens Advice

Non-Executives:

- Using influence to advocate for more resources, based on more need to tackle inequalities.
- Need for *Constructive Disruption* from UHB to Welsh Government e.g. move from RTT to population health outcomes - FGC will support
- Leadership role in championing action and challenging proposals thinking of the impact on inequalities in health across the population. Useful tool could be the routine use of Health Equity Audits and Health Inequality Impact Assessments.
- Have all sectors of the population been involved in developing proposals? Particularly those who may not be accessing services - think need and not demand
- Connect with our communities and hold monthly surgeries in different localities to better understand the health issues and experiences of our population so that decisions are rooted in our communities.

Executives:

- Revise Job descriptions to include action to reduce inequalities and shift services to prevention across their portfolio areas
 - Clear target areas identified as objectives in job plans e.g. DoF to move target %age of budget to prevention and early intervention, DoWF&OD employing staff from lowest quintiles of deprivation with support through volunteering options, training and supported career progression.
 - Appraisal against targets

Staff:

- Staff Champions at all levels – start small and build
- Mandatory MECC training and systematically applying a Brief Intervention to all patient contacts throughout our services – Leaders with patients
- Recognising most staff are residents of CTM and can also be empowered and motivated to be leaders in the community

- Staff empowered to identify personal well-being goals, with risky behaviours and clinical risk factors open for discussion in all appraisals. Identifying and agreeing well-being goals and support for delivery in the same way as PDPs
- Enable healthy behaviours for staff e.g. current cycle to work scheme does not facilitate the purchase or leasing of e-bikes or e-scooters and our topography prevents the use for many. Currently there are no bikes parked at many of our sites.

System Leaders:

- A coordinated and agreed approach across the system with partners, prioritising action on health improvement and health inequalities. An opportunity to build on the traction of the system response to Covid.
- Engage Health and social care in addressing health inequalities – equitable approach on the basis of need not demand.
- Enable healthy behaviours e.g. cycle paths from public transport hubs (train stations and Bus stations/stops) to public buildings
- Empower public and third sector staff e.g. champions, well-being appraisals, MECC training (24% of employed adults in CTM work in the public sector).

Leaders in Wales:

- Host a Wales Population Health Management Unit to support the development across Wales and share the learning

Integrated Health Strategy:

- Need to think long term – minimum of a 10 year strategy with a 30 year vision – break it up into 10 year chunks
- Clear 10 year targets e.g. increase healthy life expectancy to the Wales Average in 10 years, reduce the Slope Index of inequality for HLE to the Wales average. 20 year target to be the best in Wales, 30 year target to be the best in UK – need to be ambitious.
- It has to be everyone's business – owned by every member of staff and public/patients involved.
- Clinical services: *amenable mortality* avoided through effective and timely health care
- Population Health Management – aspiration to tackle health inequalities – *preventable mortality*
- Involve our communities:
 - Develop a *Population Health Involvement Unit* to share skills in involvement as services develop and implement this way of working.
 - Develop a deal for health and wellness e.g. Wigan approach: Our Part, Your Part.
- **Prevention: Systematically address risk factors**
 - ***Population Health Management***
 - Segmentation
 - Risk Stratification
 - Linked to VBHC agenda
 - ***Primary prevention: Enabling healthy behaviours***
 - Smoking prevalence
 - Promoting a health weight and diet

- o Increasing physical activity
- o Moderate alcohol consumption
- o ***Secondary prevention: Minimising clinical risk factors***
- o Blood Pressure
- o Blood Glucose
- o Body Mass Index
- o Cholesterol
- o ***A focus on early years***
- o Preconception to age 7 years
- o Targeted interventions based on need
- o ***Management of Ambulatory Care Sensitive Conditions***
- o Identify through PHM data
- o Target anticipatory care initiatives and management
- o ***Care coordination and social referral through integrated health care teams***
- o Care coordinators link to social and non-medical need to community assets
- o Co-produce plans for social needs with involvement of patients and carers.
- o Social referral schemes

Realising the potential of Technology (Malcolm Lowe-Laurie and Prof Sir John Tooke)

- Remote consultations, triage and follow up
- Specialist outreach: secondary and tertiary to primary care
- Use of remote monitoring and surveillance
- Need to overcome digital illiteracy and access issues. Is there an opportunity to gain sponsorship e.g. google – everyone wants to help the NHS right now.
- Use of decision aids for complex co-morbidity
- Machine learning and AI:
 - o OP attendance alerts – target those who most need it
 - o AI to predict A&E attendance and enable pre-emptive intervention
 - o Machine learning to detect sight threatening retinopathy
 - o Carefully select projects to embark on – project selection criteria
 - o Use of predictive models of demand vs presentation, based on social, demographic and economic indicators
 - o Execs to give “cover” for clinicians to do things differently.
- Key opportunity: match digital modelling with PHM to see who are we missing?
- Need to identify and target ever harder to reach/engage population.



AGENDA ITEM

5.4

CTM BOARD

SMOKE FREE PREMISES AND VEHICLES (WALES) REGULATIONS, 2020
CWM TAF MORGANNWG HEALTH BOARD POSITION ON ELECTRONIC
NICOTINE DELIVERY SYSTEMS (ENDS OR E-CIGARETTES)

Date of meeting

27/05/2021

FOI Status

Open/Public

If closed please indicate
reason

Not Applicable - Public Report

Prepared by

Helen Walters - Senior Public Health
Practitioner

Presented by

Kelechi Nnoaham, Executive Director of
Public Health

Approving Executive Sponsor

Executive Director of Public Health

Report purpose

FOR APPROVAL

Engagement (internal/external) undertaken to date (including
receipt/consideration at Committee/group)

Committee/Group/Individuals

Date

Outcome

Angela Jones, Deputy Director of
Public Health

(23/04/2021)

SUPPORTED

Chris Beadle, Head of Health,
Safety and Fire

(26/04/2021)

SUPPORTED

Hannah Miles, Workforce and OD

(26/04/2021)

SUPPORTED

Management Board

19/05/2021

ENDORSED FOR BOARD
APPROVAL

ACRONYMS

HMQ

Help Me Quit



NRT

Nicotine Replacement Therapy

1. SITUATION / BACKGROUND

As part of the Health Board's implementation plans for The Smoke Free Premises and Vehicles (Wales) Regulations which came in to effect on the 1st March 2021, a paper was submitted to Board with the argument to change the Health Boards' position statement from not allowing Electronic Nicotine Delivery Systems (ENDS or e-cigarettes) on hospital grounds to allowing e-cigarettes on hospital grounds. This was due to the increasing evidence that e-cigarettes can be a useful smoking cessation aid, and cause significantly fewer health problems than cigarettes, further detail below.

This change in position statement was agreed by Board on the 24 February 2021 and as such plans to implement this change across the Health Board were subsequently taken forward. The changes to the position on e-cigarettes have not yet been communicated internally or externally.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

In light of potential operational issues that have emerged during the planning stage of implementing this change with stakeholders including the Head of Health, Safety and Fire, Workforce and Organisational Development, Facilities, Cwm Taf Morgannwg (CTM) Smoke Free Policy group with Trade Union representation, the Help Me Quit CTM Service Delivery Manager and in consultation with National Tobacco Leads the Board is now being advised to revert back to the original policy position whereby e-cigarettes are not permitted on hospital grounds. The reasons for this request are detailed below.

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

Arguments for excluding the use of e-cigarettes in the CTM Smoke Free Policy

All other Health Boards in Wales have maintained their position on excluding the use of e-cigarettes as part of their smoke free policies along with all schools in the CTM area. Further arguments are detailed below:



Potential issues:

Health and Safety risk	There is a fire risk from charging e-cigarette devices.
Risk of COVID transmission	A study from Public Health Wales, which looks at the evidence from mass testing in Merthyr Tydfil and the Cynon Valley, suggests that smoking or vaping appears to have a small but significant effect on transmission.
Risk to children and young people	Schools are excluding the use of e-cigarettes in their smoke free policies not wanting to potentially increase vaping among young people. Note to consider here that children/young people are present at hospitals also.
Enforcement	It may be difficult to determine if the smoke is from a cigarette or an e-cigarette in order to issue a fine in line with the legislation
Operational	As the policy would need to ban the charging of e-cigarettes, due to fire risk, staff and inpatients would not be able to charge devices for use. This avoids the potential for conflict in in use and charging as both would be banned. The proposal at the moment is that e-cigarettes should be used during unpaid breaks, managed in the same way smoking off site is. However, this is potentially another example of having a policy allowing use as a cessation aid but practically limiting how devices are used on the ground. TU consensus is that if staff should go off site to smoke they should go off site to vape. Current policy states no one is allowed to smoke in uniform. Allowing the use of e-cigarettes presents the difficult position of whether or not staff are allowed to vape in uniform.
Communication	Including tobacco and e-cigarettes in the approach would present a clearer and consistent message to staff and the public.
Support to quit	Help Me Quit services support smokers who want to quit and are not currently set up to support people who want to quit vaping



Public Health viewpoint from Deputy Director of Public Health (DDPH)

The updated position is supported in large due to the potential fire risk to the organisation from the potential to charge devices, to there being other methods of Nicotine Replacement Therapy (NRT) available for those wanting to make a quit attempt and also the agreement that there should not be a discord between the approach taken at schools and at hospital grounds.

4. IMPACT ASSESSMENT

Quality / Safety / Patient Experience implications	Yes (Please see detail below)
	Potential fire risk from charging e-cigarette devices.
Related Health and Care standard(s)	Staying Healthy
	If more than one Healthcare Standard applies please list below: Safe Care Staff and Resources
Equality impact assessment completed	Yes
	Draft EIA has been completed and will be updated as the policy is developed and implemented
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £ / Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Main Strategic Objective	To protect and improve population health



Link to Main WBFG Act Objective	Work with communities to prevent ill-health, protect good health and promote better health and well-being

5. RECOMMENDATION

The recommendation for the Board is to APPROVE the position to exclude the use of ENDS on CTM premises.



AGENDA ITEM

5.5

CTM BOARD

SOUTH EAST WALES VASCULAR NETWORK ENGAGEMENT

Date of meeting

27/05/2021

FOI Status

Open/Public

If closed please indicate reason

Not Applicable - Public Report

Prepared by

Marie-Claire Griffiths, Assistant Director of Strategic Planning & Commissioning

Presented by

Clare Williams, Executive Director of Planning & Performance

Approving Executive Sponsor

Executive Director of Planning & Performance

Report purpose

FOR APPROVAL

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)

Committee/Group/Individuals

Date

Outcome

Management Board / Executive Team

23/10/2019
28/10/2019
08/06/2020
19/08/2020
11/01/2021
27/01/2021

ENDORSED FOR APPROVAL

ACRONYMS

ABUHB Aneurin Bevan University Health Board

CHC Community Health Council

CTM Cwm Taf Morgannwg University Health Board

C&VUHB Cardiff & Vale University Health Board

RGH Royal Glamorgan Hospital

UHW	University Hospital of Wales
YCC	Ysbyty Cwm Cynon
YCR	Ysbyty Cwm Rhondda

1. SITUATION / BACKGROUND

- 1.1 This paper provides the outcome of the formal engagement which has taken place across 4 Health Boards, namely Aneurin Bevan University Health Board, Cwm Taf Morgannwg University Health Board, Cardiff and Vale University Health Board and Powys Teaching Health Board, regarding the reorganisation of localised Vascular Services into a 'Hub and Spoke' model vascular network for the South East Wales Region.
- 1.2 The current configuration of services across separate hospital sites are spread too thinly to meet the quality and safety standards set out by the Royal College of Surgeons and the Vascular Society of Great Britain and Ireland. The reorganisation of localised vascular surgery into a Vascular Network (South East Wales Vascular Network) is essential in providing a 24/7 high quality, consultant led vascular service that maintains proper clinical outcomes and patient care.
- 1.3 With a strong rationale, clinicians through their work over many years have arrived at a consensus opinion for a hub and spoke model, with the hub being at UHW and spokes remaining within Health Board footprints. For CTM the spoke site would be RGH with rehabilitation being undertaken in YCC and YCR. Clinicians agree that this is a sustainable delivery model that will provide the best outcomes to all patients within the region and best use of skill and staff as advised by the Vascular Society.
- 1.4 It is important to note Bridgend is served through the South West Wales Vascular Network which is already established and was in place prior to the Bridgend Boundary Change.
- 1.5 Between Friday 19th February and Friday 16th April 2021, the four Health Boards, ABUHB, CTM, C&VUHB and Powys Teaching Health Board (PtHB), ran a public engagement on a proposal for the reorganisation of localised vascular services into a 'hub and spoke' model Vascular Network for the South East Wales Region.
- 1.6 The vascular surgical and Interventional Radiology service for the Health Board were based in RGH until September 2020, when an urgent temporary change of service (service moved to UHW) due to a loss of specialist clinical staff.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

- 2.1 Attached as Appendix 1 is the report: “Reorganisation of localised Vascular Services into a ‘Hub and Spoke’ model Vascular Network for the South East Wales Region: A Report on Public Engagement 2021”.
- 2.2 The purpose of the report is to inform the CHC Joint Committee and affected Health Boards of the conduct and key findings of the public engagement.
- 2.3 Seven virtual public meetings were held as part of the public engagement. In agreement with CHCs each Health Board held a minimum of two public meetings via Teams, with Welsh translation available. There was also one Third Sector meeting and the proposals were discussed at a range of internal stakeholder meetings.
- 2.4 A total of eight people attended the two joint CTM and PtHB events. One event was held during the day with 3 attendees and one during the evening with 5 attendees in order to give the public as much opportunity to attend as possible.
- 2.5 Whilst it is acknowledged that attendance numbers were low, the event was advertised widely using both social media, posters, GP practice screens, circulation of posters to pharmacies. It should be noted that the total number of patients likely to need a vascular procedure across South East Wales is low at approximately 1250 each year (based on numbers treated across HBs in 2019). Out of Hours emergency vascular services have been provided from University Hospital of Wales, Cardiff for the entire region for a number of years.
- 2.6 A summary of the themes raised at the CTMHB & PtHB Engagement Events are:-
 - Transport and transport related costs
 - Health Board using face to face events for engagement going forward
 - Links for Bridgend questions
 - Llandough Hospital being the spoke for the University Hospital of Wales
 - Liaising with diabetic patients, national support groups and stakeholders
 - Site of follow up outpatient appointments.
 - Having two spokes in Aneurin Bevan and whether or not this was still valid after changes in the Royal Gwent as a result of the Grange Hospital opening.
 - The impact of covid recovery on the proposals.

- Obtaining views of patients who do not use IT or social media.
- Implications on Welsh Ambulance Services NHS Trust (WAST)
- Parts of Powys affected by changes

- 2.7 In total 110 people responded to the engagement via an online survey, 14 of which were from CTM. Of those who replied via the online survey, 72% agree with the national evidence and recommendation from the clinical option appraisal that a hub and spoke model would improve vascular services and patient outcomes in South East Wales.
- 2.8 It is very important to us that the public can make their voices heard throughout this service development process. We are grateful to all members of the public, staff, stakeholders, who have supported this engagement process. The contributions made by the public have provided a wealth of insight, from many differing perspectives, and will help to strengthen the service development process.
- 2.9 The CHC Executive Committee held an extraordinary meeting on 11th May and subsequently submitted comments by email. The CHC Executive Committee have a majority of members who have agreed that the Vascular Services engagement has been sufficient in CTMUHB and they do not feel the need to proceed onto consultation.
- 2.10 They believe the vascular services engagement exercise has been adequate given the current situation although it is disappointing that the responses were so low. While one of the members commented they were content with the engagement proposals for vascular services, it has been agreed with the proviso that any potential change in the future which might affect the current services for the Bridgend Area (served currently by Swansea Bay), be subject to its own full engagement and review process.
- 2.11 Powys CHC, South Glamorgan CHC and Aneurin Bevan CHC have also confirmed their support to move to implementation without the need for consultation.

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

- 3.1 As outlined in the Equality Impact Assessment and under sub themes within the report, a theme which is likely to have a negative impact on patients, relatives and carers from socio-economic disadvantaged areas is transport/travel and costs. It is anticipated that some may experience increased difficulty in travelling due to low income, disability, age, poor transport provision, lower number of households with access to their own car. Being required to travel to an unfamiliar

hospital and experience longer journey times could be particularly difficult and disorientating for people. Early transfer of the patient back to the 'local' hospital would help to mitigate long periods in unfamiliar surroundings. In addition to mitigate against the negative impact of transport it is considered that the service should promote transport links and provide easy to read information to patients, families and carers in order to make their journey as easy as possible.

- 3.2 The Covid-19 pandemic has altered the way in which this public engagement would otherwise be conducted. As a result, it has presented both opportunities and risks to the way that we engage with the public and led to a new approach which was developed collaboratively with the CHCs, and increase in the use of social media. All engagement events were held via online communication platforms such as Microsoft Teams and Zoom.

4. IMPACT ASSESSMENT

Quality / Safety / Patient Experience implications	Yes (Please see detail below)
	There is strong evidence that case volume influences patient outcomes with the highest volume hospitals (which undertake 57% of all elective Abdominal Aortic Aneurysm Repairs) have mortality rates under half those seen in hospitals with lowest Abdominal Aortic Aneurysm procedures. A minimum population of 800,000 is considered necessary for a AAA screening programme and is often considered the minimum population required for a centralised vascular service. This is based on the number of patients needed to provide a comprehensive emergency service, maintain competence among vascular specialists and nursing staff and the improvement in patient outcome that is associated with increasing caseload.
Related Health and Care standard(s)	Timely Care
	If more than one Healthcare Standard applies please list below: Safe Care Effective Care
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or	Yes
	Included in Appendix 1



withdrawn policies and services.	
Legal implications / impact	Yes (Include further detail below)
	Public Duty for Engagement & Consultation
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	Financial implications currently being worked through as part of the development of a business case to be submitted to Health Boards.
Link to Strategic Well-being Objectives	Provide high quality, evidence based, and accessible care

5. RECOMMENDATION

5.1 The Board is asked to:

- NOTE the content of the *Reorganisation of localised Vascular Services into a 'Hub and Spoke' model Vascular Network for the South East Wales Region: A Report on Engagement 2021*
- CONSIDER the views of the Community Health Council
- APPROVE the use of the engagement feedback to inform the implementation of the South East Wales Vascular Network
- APPROVE the recommendation to proceed the development without undertaking public consultation (a full business case will come to Boards in July)

Reorganisation of localised Vascular Services into a ‘Hub and Spoke’ model Vascular Network for the South East Wales Region: A Report on Public Engagement 2021

Status	Final report
Version Number	V1.6
Publication Date	06/05/2021

Table of contents

1. Executive Summary
2. Introduction
3. Background and Context
 - 3.1 Rationale for a regional vascular network
 - 3.2 Clinical option appraisal
4. Scope of Engagement
5. Approach to Communication and Engagement
 - 5.1 Engagement during pre-election period
6. Mid-point review
7. Responses to the engagement
 - 7.1 Key themes
 - 7.2 Analysis of online feedback by engagement question
 - 7.3 Analysis of survey respondent type
 - 7.4 Issues raised at public meetings
 - 7.5 Issues raised at stakeholder meetings
 - 7.6 Issues raised through social media
 - 7.7 Issues raised via email
8. Consideration of Engagement Responses
9. Equality Impact
10. Conclusion
11. Appendices
 - A. Engagement Document
 - B. Communication and Engagement Plan
 - C. Notes of Public meetings
 - C1. Cardiff & Vale University Health Board
 - C2. Cwm Taf Morgannwg University Health Board & Powys Teaching Health Board
 - C3. Aneurin Bevan University Health Board

D. Mid-point Engagement Review Report

E. Equality Impact Assessment

1. Executive summary

Collectively, Aneurin Bevan University Health Board, Cardiff and Vale University Health Board and Cwm Taf Morgannwg University Health Board provide vascular services in South East Wales. These services look after patients suffering from any condition that affects the network of blood vessels known as the vascular or circulatory system. The main aim of vascular services is to reconstruct, unblock or bypass arteries to restore blood flow to organs, often with the aim of reducing the risk of sudden death, prevent stroke, reduce the risk of amputation, and improve function. Vascular services are also provided to support patients with other problems such as kidney disease.

The populations affected are Blaenau Gwent, Caerphilly, Monmouthshire, Newport, and Torfaen; Cardiff and the Vale of Glamorgan; Rhondda Cynon Taff and Merthyr Tydfil (Bridgend is part of the South West Wales Network), and South Powys (other parts of Powys served by South West/North Wales Networks as well as networks in England).

There is an increasing demand on these services due an increasing and ageing population, as well as factors such as smoking and obesity. The current configuration of services across separate hospital sites in South East Wales are spread too thinly to meet the quality and safety standards set out by the Vascular Society and the Royal College of Surgeons, the total resident population of the Health Boards taking forward this proposal is approximately 1.5million.

Between Friday 19th March and Friday 16th April 2021, the four Health Boards, Aneurin Bevan University Health Board, Cwm Taf Morgannwg University Health Board, Cardiff and Vale University Health Board and Powys Teaching Health Board, ran a public engagement on a proposal for the reorganisation of localised vascular services into a 'hub and spoke' model Vascular Network for the South East Wales Region. Clinicians agree that this is a sustainable delivery model that will provide the best outcomes to all patients within the region and best use of skill and staff as advised by the Vascular Society.

This would mean that all major vascular operations and interventions are done in one hospital. It would not change citizens going to their local hospitals for non-complex, routine interventions, diagnostics, outpatient clinics, advice before an operation or for recovery and rehabilitation.

The purpose of this report is to inform the Joint Committee and affected Health Boards of the conduct and key findings of the public engagement on the proposal to locate a vascular surgery hub for South East Wales at University Hospital of Wales, Cardiff, with main spoke hospital services maintained at Royal Gwent Hospital, Grange University Hospital, Royal Glamorgan Hospital, University Hospital Llandough and University Hospital Wales, and care wherever possible maintained closer to home.

110 people responded to the engagement via an online survey.

There were 7 virtual public meetings, 1 Third Sector meeting and the proposals were discussed at a range of internal stakeholder meetings.

Of those who replied via the online survey, 72% agree with the national evidence and recommendation from the clinical option appraisal that a hub and spoke model would improve vascular services and patient outcomes in South East Wales.

A number of common themes emerged from the feedback received in response to the engagement questions and in other formats including comments made at the public and stakeholder events:

The Health Boards will need to give careful consideration to the feedback received and the views of the CHC's in determining their response to the engagement and agreeing a way forward.

2. Introduction

This engagement report provides:

- a summary of the rationale for a Vascular network for South East Wales
- an overview of the work that has been undertaken to develop recommendations for a vascular network for the region
- a summary of the resulting recommendations from an options appraisal from the 3 provider Health Boards
- a description of the process used to engage on the recommendations
- an analysis of the engagement responses
- conclusions drawn from the engagement

The engagement plan for the proposed development of vascular services in South East Wales was developed collaboratively by four Health Boards, namely Aneurin Bevan University Health Board, Cwm Taf Morgannwg University Health Board, Cardiff and Vale University Health Board and Powys Teaching Health Board.

The populations that are affected are:

- Blaenau Gwent, Caerphilly, Monmouthshire, Newport, and Torfaen
- Cardiff and the Vale of Glamorgan
- Rhondda Cynon Taff and Merthyr (Bridgend is part of the South West Wales Network)
- South Powys (other parts of Powys served by South West/North Wales Networks as well as networks in England).

The engagement period began on Friday 19th February and ended on the 16th of April 2021.

3. Background and Context

3.1 Rationale for a regional vascular network

Specialist vascular services aim to prevent death from aortic aneurysm, prevent stroke from carotid artery disease and prevent lower limb amputation from peripheral arterial disease and diabetes. In 2007 over 65,000¹ people in the UK

¹ https://www.vascularsociety.org.uk/_userfiles/pages/files/Document%20Library/National-Vascular-Database-2009-report.pdf

had surgery for a problem relating to vascular disease and, due to the increasing size of the aging population, demand for vascular services increase over time. The total number of patients likely to need a vascular procedure across South East Wales is approximately 1250 each year. In addition, there are currently an estimated 275,000 are living with diabetes in Wales.² and this prevalence is also increasing, 311,000 people in Wales could have diabetes by 2030³ with diabetic patients having a worse outcome, as evidenced by the increasing rate of lower limb amputation in this group. Patient outcomes in South East Wales are good however they are not sustainable in the way they are currently provided.

Nationally outcomes from vascular surgery in the United Kingdom have not compared well with other countries. Until recently the UK had the highest mortality rates in Western Europe for abdominal aortic aneurysm repair⁴. The Vascular Society of Great Britain and Ireland therefore published a series of recommendations⁵ describing how vascular services should be organised to deliver the best outcomes for patients. They recommend that high quality urgent vascular care should be organized and delivered using integrated vascular networks. Ensuring that local assessment, diagnosis, and rehabilitation of patients in non-arterial centres (spokes) is optimised, whilst also delivering high volume interventions at arterial centres. The goal being a service which balances the needs of patient access with the provision of comprehensive safe vascular care and intervention that is sustainable.

In light of these recommendations NHS England published a national specification for the provision of vascular services in July 2013. This specification was used to assess services across England and implement networked models of care. This specification was subsequently reviewed and supported by GIRFT (Getting it Right First Time) programme report on Vascular Surgery in 2018 which advocated as its guiding recommendation⁶, the development of Networked models of care for vascular services. Clinicians from across the three Heath Board Providers in South Wales have assessed this specification

²https://www.diabetes.org.uk/in_your_area/wales/diabetes-in-wales

³ *ibid*

⁴ Howell, S.J. (2017) Abdominal aortic aneurysm repair in the United Kingdom: an exemplar for the role of anaesthetists in perioperative medicine. British Journal of Anaesthesia.

⁵https://www.vascularsociety.org.uk/_userfiles/pages/files/Document%20Library/Provision-of-Services-for-Patients-with-Vascular-Disease.pdf

⁶ https://gettingitrightfirsttime.co.uk/wp-content/uploads/2018/02/GIRFT_Vascular_Surgery_Report-March_2018.pdf

and agree that the key elements of which are that providers of vascular services should:

- Serve a minimum population of at least 800,000 people to ensure an appropriate volume of procedures
- Ensure that highly experienced staff are treating sufficient numbers of patients to maintain competency
- Have 24/7 on site vascular surgery and interventional radiology on-call rotas that are staffed by a minimum of 6 vascular surgeons and 6 interventional radiologists.
- Provide access to cutting edge technology including a hybrid operating theatre for endovascular (minimally invasive) aortic procedures.
- Provide a dedicated vascular ward and nursing staff.
- Have a specialist team to manage patients with vascular disease that includes vascular surgeons, interventional radiologists, specialist nurses, vascular scientists, diabetes specialists, stroke physicians, cardiac surgeons, orthopaedic surgeons, and emergency medicine amongst other specialities to provide a comprehensive multi-disciplinary service.

Discussions on the sustainability of vascular services in South East Wales have been taking place for a number of years. In fact, clinicians have worked together to develop the out of hours services for Vascular emergencies with a shared emergency on call rota in place, which has been running for 20 years.

However, despite developments in the rest of the UK and other parts of Wales, the South East Wales region remains the only region in the UK without a formal networked arrangement of care for all vascular services. This, along with the fragility of the wider service sustainability for the future has resulted in our clinical teams giving consideration to how this current position can be improved, as well as developing the service to be an exemplar in Wales.

3.2 Clinical Options appraisal

A lot of work has been undertaken by clinical teams exploring potential future options for the delivery of the service in the area. This has been articulated in a non-financial clinical options appraisal, undertaken in October 2014, and included options for the clinical model as well as an assessment of potential sites for an arterial centre (hub).

Options were assessed against the following:

1. Quality and safety
2. Acceptability
3. Strategic fit
4. Sustainability
5. Access
6. Achievability

With a strong rationale, clinicians arrived at a consensus on the option for a hub and spoke model of care, with the arterial centre or 'hub' being at University Hospital of Wales and 'spokes' remaining within Health Board footprints allowing services where possible to be delivered closer to home and a number of complex emergency and urgent vascular interventions to take place in one hospital.

This option reflects the model of care advocated in recommendations from the VSGBI but was also consistent in other specialised services including Major Trauma Networks which were developed and launched in England in 2012. A hub and spoke model allow a balance between local access for the population and ensuring sustainability of service, improved access to training for staff with higher volumes of surgery or intervention in one centre leading to improved patient outcomes.

The recommendation on the hub site was also based on the 6 key criteria and included consideration of colocated services, including; Neurosurgery, Nephrology, Cardiology.

Clinical engagement has taken place throughout the service development process and there remains good clinical consensus. A letter confirming that the work undertaken during the clinical option appraisal process in 2014 remains valid has recently been received by the Chair of the Joint Vascular Programme Board. Indeed, the clinical body indicated the preferred option including the site choice for the hub had now been strengthened since the Major Trauma Centre was launched in September 2020 at University Hospital Wales.

4. Scope of the public engagement

During October 2020, a report was shared with the Vascular Programme Board which outlined a potential approach to engagement and consultation on the proposals for the service. This was supported and a two-stage process of

engagement followed by consultation agreed, subject to appropriate engagement with Community Health Council colleagues.

Organisations that were identified as needing to be part of the consultation and engagement were Aneurin Bevan University Health Board, Cardiff and Vale University Health Board, Cwm Taf Morgannwg University Health Board and Powys Teaching Health Board, as commissioners of these services for their local population.

Further to the decision made by Programme Board, a workshop was held in November 2020 to agree the scope of the engagement and consultation and to have discussions that would inform the gaps in a skeletal draft engagement document.

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

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

It was however noted that given the extensive work that had been undertaken on a clinical option appraisal and formulation of ideas regarding a hub and spoke model of delivery, that this information should also be shared at the engagement phase, so as to offer as much information as possible, in order to explore with members of the public, and interested stakeholder views on the process that has been followed and whether there is any other information that should be considered.

The affected Community Health Councils considered the proposals for engagement together at their meeting held on 13th January 2021. There was explicit support expressed by both Cwm Taf Community Health Council and Aneurin Bevan Community Health Council, with further discussions taking place with both Powys and South Glamorgan CHCs. Following further assurances relating to process and remit, there was subsequent agreement by all CHCs to commence the engagement as proposed.

5. Approach to communication and engagement

To ensure a consistent approach was adopted across the region, an engagement group was established comprising engagement, communications, workforce, clinical and planning leads from each of the affected Health Boards.

Plans for local engagement activity, to be undertaken in line with the overall plan, were agreed between each Health Board and the respective CHC. It was agreed that it is the responsibility of these organisations to lead the programme of engagement and consultation in their respective areas, however overall co-ordination is being held within the programme structure.

Recognising the limitations of undertaking this work during the pandemic, which prevented the use of face-to-face mechanisms for engaging with the public, the Health Boards worked closely with Community Health Councils (CHCs) to develop a blended approach to engagement. This was designed to draw on the learning and mechanisms for reaching people virtually which have evolved over the last year including advice from intermediary Third Sector organisations who have been finding ways to reach different communities. It had the following key features:

Core elements	- Telephone number and answer phone set up - Postal address and inbox - Specific email address for programme established - Survey form created online as well as being available in the summary document
Web pages	- Web pages hosted on each Health Board website - Template supplied with content and useful documents (including main document, summary, FAQs and easy read version of summary) - Link to survey and all relevant contact details including; telephone number, postal address etc.
Staff/ public updates	- Inclusion in newsletters

	- All staff emails - Digital screen tiles and posters - Letter and assets to GPs
Stakeholder outreach	- Stakeholder letter - Communications Toolkit
Social media	- Promotion of public engagement events - Series of social media posts and subsequent visuals - Videos of key spokespeople for the network talking about proposed changes
Promotional assets	- Posters - Digital screen tiles - Leaflets/flyers - Teams Background - PowerPoint template
Engagement events	- Public engagement events arranged in each Health Board area

Note: All assets were created bilingually

A mid-point review meeting took place on Wednesday 24th March, to review the processes and responses received to date and determine whether any adjustments needed to be made to the engagement for the remaining period.

Emerging themes were also shared with the steering committee for the programme.

Please see appendix 2 for the detailed Engagement Plan.

5.1 Engagement during the Pre-election period

After commencement of the public engagement on the 19th February pre-election dates were confirmed by the Welsh Government and advice provided via a Welsh Health Circular⁷ on the 11th March. The advice sets out the guidance on the permitted activity during a pre-election period and is set out below. In considering this guidance, further advice was sought from the Consultation

⁷ <https://gov.wales/sites/default/files/publications/2021-03/senedd-election-2021-guidance-for-nhs-wales.pdf>

Institute and discussion took place with the Board of CHCs. It was concluded that the engagement did not meet the criteria for pausing the process, however in order to mitigate the risk of politicisation within the engagement process, it was agreed public events would not be held during the pre-election period. Therefore, the engagement process was continued through this period.

5.2 Engagement questions

In agreement with the CHCs, the engagement asked for individuals in the region and organisations to consider the following specific questions:

1. From reading this discussion document, do you have a good understanding of what vascular services are?
2. From reading this document, do you understand how services are currently organised?
3. From reading this document, do you have an understanding of the challenges that are currently facing vascular services?
4. Is there any other information you think we should consider in order to decide whether we should move towards a networked arrangement for vascular services in South East Wales?
5. Do you agree/disagree with the national evidence and recommendation from the clinical option appraisal that a hub and spoke model would improve vascular services and patient outcomes in South East Wales?
6. What are your thoughts on the hub being identified as the University Hospital of Wales Cardiff given the dependencies on other services that are located there?
7. Would you agree/disagree that spoke arrangements need to have a consultant led ED and an emergency surgery response on site?
8. Subject to your view on the above, would you agree/disagree with the suggested spoke arrangements.
9. Do you have any thoughts on the process that has been followed to date to consider the future configuration of vascular services in South East Wales?
10. Is there any other information you think we should consider in order to decide whether we should move towards a networked arrangement in South East Wales?
11. Do you have a view on the options that have been considered as part of this, are there others we should consider?

12. Do you have any comments on the process that is being undertaken to consider the best configuration of vascular services in South East Wales?
13. Do you have an alternate view on the proposals put forward within this document for the configuration of services?

5.3 Public sessions

Public sessions were arranged for each Health Board area. Powys citizens were offered to attend online public sessions held by both Aneurin Bevan and Cwm Taf Morgannwg University Health Boards.

Minutes of the public meetings are attached (appendix 3). Attendance at the sessions was not high, however as members will note from the minutes attached, the conversations were rich and far-reaching.

The organising and delivery teams for each Health Board Areas were agreed as:

Cwm Taf Morgannwg & Powys

Clinical Leads: Mr Kevin Conway, Consultant Vascular Surgeon and Mr Mike Rocker, Consultant Vascular Surgeon

Management Lead: Marie-Claire Griffiths, Assistant Director of Strategic Planning and Commissioning

Business Support: Michelle Lloyd, Business Support Manager

Powys Teaching Health Board Lead: Adrian Osborne, Assistant Director, Engagement and Communication

Aneurin Bevan & Powys

Clinical Leads: Mr Peter Lewis, Consultant Vascular Surgeon and Mr David Lewis, Consultant Vascular Surgeon

Management Lead: Chris Dawson-Morris, Assistant Director of Planning

Powys Lead, Adrian Osborne, Assistant Director, Engagement and Communication

Cardiff and Vale

Clinical Leads: Mr Richard Whiston, Consultant Vascular Surgeon and Mr Kevin Conway, Consultant Vascular Surgeon, Mrs Cath Twamley, Head of Nursing for Surgery

Management Lead: Mr Mike Bond, Director of Operations Surgery Clinical Board
& Mr Alun Tomkinson Clinical Board Director Surgical Clinical Board

6. Summary of mid-point review report

A mid-point review of the engagement process was conducted by the engagement group on 24th March 2021 which aimed to scrutinise and evaluate progress in engaging with the public and staff. Following this initial review reviews took place between planning and engagement leads and CHCs.

At that time a total of 66 survey responses had been received and the public events had been completed. The survey responses at the time of the mid-point review had not been analysed by Health Board area.

Actions arising from the review:

- Following up with those who signed up to public events with a reminder to complete the survey.
- Agreement to continue through the pre-election period but not to hold any further public meetings.
- Agreement not to hold a planned Facebook Live Q&A session aimed at the public during the pre-election period.
- Check Facebook posts to identify any comments made which should be included in the consideration of feedback.
- Agreement on post engagement process and key dates to enable the CHC position to be considered as part of the presentation on the outcome of engagement at the May Health Board Boards.
- Additional FAQ to clarify spoke arrangements.
- Additional presentation slides to clarify potential impact on residents of each HB area.

Please see appendix 4 for the Mid-point Review report.

7. Responses to the engagement and reach

The below table outlines the feedback that was received during the engagement period including number of respondents and method of feedback:

Type of Feedback	Total number of respondents/reach	Comment
Survey respondents	110	

Email/correspondence received by email	3	
Public meetings	29	Minutes of meetings attached as Appendix 3
Third Sector Stakeholder meeting	4	4 third sector organisations represented Minutes of meeting attached as Appendix 3
Social media advertising reach	60,486	948 link clicks
Web page reach	Aneurin Bevan UHB English webpage: 1446 Welsh webpage: 30 Cardiff and Vale UHB English webpage: 631 Welsh webpage: Cwm Taf Morgannwg UHB English webpage: 1,132 Welsh webpage: 20 Powys THB English webpage: 270 Welsh webpage: 29	

Comments made at the public meetings were captured, verified by the CHCs and considered in the analysis. Key points made at the third sector stakeholder meeting, as detailed in the engagement plan, were also included in the analysis.

It should be noted that everyone was also encouraged to complete individual response forms so there may be an element of duplication in the points captured in meeting notes and those made in response forms. A full copy of all the feedback received via the survey and meeting notes has been shared with the CHC's.

7.1 Key Themes

The engagement survey contained a mix of closed and open-ended questions. A number of common themes emerged in the analysis of the feedback received via open questions in the survey, comments made at the public and stakeholder meetings, emails and social media posts. These key themes have been used as the basis of analysis of the qualitative feedback.

The key themes are set out below, with an indication of the number of comments relating to these themes were mentioned in survey responses:

All Questions	401	%
Organisation & Intergration of Network Services	86	21%
Location of Hub & Spoke	63	16%
Accessibility & Transport	52	13%
Care Provided	44	11%
Engagement Process	42	10%
Impact on other services	39	10%
Workforce	33	8%
Communication	15	4%
Financial Issues	13	3%
Request for information	8	2%
General Concerns	6	1%

7.2 High level summary of online feedback by engagement question

Question 1. From reading this discussion document, do you have a good understanding of what vascular services are?

ANSWER CHOICES	RESPONSES	
Yes	94.55%	104
No	1.82%	2
Not sure	3.64%	4
TOTAL		110

95% of respondents said they had a good understanding of what vascular services are, having read the discussion document.

The information from the respondents who submitted data for this question was categorised against the key themes. The themes are shown below:

Question1	5	%
Organisation & Intergration of Network Services	2	40%
Accessibility & Transport	1	20%
General Concerns	2	40%

Question 2. From reading this document, do you understand how services are currently organised?

ANSWER CHOICES	RESPONSES	
Yes	90.91%	100
No	4.55%	5
Not sure	4.55%	5
TOTAL		110

91% of respondents said they understand how services are currently organised, having read the document.

The information from the respondents who submitted data for this question was categorised against the key themes. The themes are shown below:

Question 2	5	%
Location of Hub & Spoke	1	20%
Workforce	1	20%
Care Provided	1	20%
Impact on other services	1	20%
Engagement Process	1	20%

Question 3. From reading this document, do you have an understanding of the challenges that are currently facing vascular services?

ANSWER CHOICES	RESPONSES	
Yes	89.09%	98
No	4.55%	5
Not sure	6.36%	7
TOTAL		110

90% of respondents said they have an understanding of the challenges facing vascular services, having read the document.

The information from the respondents who submitted data for this question was categorised against the key themes. The themes are shown below:

Questions 3	8	%
Location of Hub & Spoke	2	25%
Workforce	2	25%
Care Provided	1	13%
Financial Issues	2	25%
General Concerns	1	13%

Question 4. Is there any other information you think we should consider in order to decide whether we should move towards a networked arrangement for vascular services in South East Wales?

ANSWER CHOICES	RESPONSES	
Yes	30.84%	33
No	49.53%	53
Not sure	19.63%	21
TOTAL		107

31% of respondents felt there was other information we should consider.

The information from the respondents who submitted data for this question was categorised against the key themes. The themes are shown below:

Question 5	38	%
Request for information	4	11%
Location of Hub & Spoke	5	13%
Organisation & Intergration of Network Services	6	16%
Accessibility & Transport	2	5%
Workforce	4	11%
Care Provided	3	8%
Impact on other services	3	8%
Financial Issues	2	5%
Communication	4	11%
General Concerns	1	3%
Engagement Process	4	11%

Question 5. Do you agree/disagree with the national evidence and recommendation from the clinical option appraisal that a hub and spoke model would improve vascular services and patient outcomes in South East Wales?

ANSWER CHOICES	RESPONSES	
Agree	72.48%	79
Disagree	11.93%	13
Not sure	15.60%	17
TOTAL		109

72% of respondents agree that a hub and spoke model of care would improve vascular services and patient outcomes in South East Wales.

The information from the respondents who submitted data for this question was categorised against the key themes. The themes are shown below:

Question 5	38	%
Request for information	4	11%
Location of Hub & Spoke	5	11%
Organisation & Intergration of Network Services	6	11%
Accessibility & Transport	2	11%
Workforce	4	11%
Care Provided	3	11%
Impact on other services	3	11%
Financial Issues	2	11%
Communication	4	11%
General Concerns	1	11%
Engagement Process	4	11%

Question 6. What are your thoughts on the hub being identified as the University Hospital of Wales Cardiff given the dependencies on other services that are located there?

The information from the respondents who submitted data for this question was categorised against the key themes. The themes are shown below:

Question 6	86	%
Location of Hub & Spoke	17	20%
Organisation & Intergration of Network Services	25	29%
Accessibility & Transport	21	24%
Workforce	3	3%
Care Provided	7	8%
Impact on other services	10	12%
Financial Issues	1	1%
Engagement Process	2	2%

Question 7. Would you agree/disagree that spoke arrangements need to have a consultant led ED and an emergency surgery response on site?

ANSWER CHOICES	RESPONSES	
Agree	88.99%	97
Disagree	1.83%	2
Not sure	9.17%	10
TOTAL		109

89% of respondents agreed that spoke arrangements need an Emergency Department and emergency surgery response on site.

The information from the respondents who submitted data for this question was categorised against the key themes. The themes are shown below:

Question 7	22	%
Location of Hub & Spoke	4	18%
Organisation & Intergration of Network Services	9	41%
Workforce	3	14%
Care Provided	4	18%
Impact on other services	1	5%
Communication	1	5%

Question 8. Subject to your view on the above, would you agree/disagree with the suggested spoke arrangements.

ANSWER CHOICES	RESPONSES	
Agree	67.59%	73
Disagree	11.11%	12
Not sure	21.30%	23
TOTAL		108

68% of respondents agreed with the suggested spoke arrangements.

The information from the respondents who submitted data for this question was categorised against the key themes. The themes are shown below:

Question 8	25	%
Request for information	1	4%
Location of Hub & Spoke	4	16%
Organisation & Intergration of Network Services	6	24%
Accessibility & Transport	2	8%
Care Provided	5	20%
Impact on other services	1	4%
Financial Issues	1	4%
Communication	1	4%
Engagement Process	4	16%

Question 9. Do you have any thoughts on the process that has been followed to date to consider the future configuration of vascular services in South East Wales?

The information from the respondents who submitted data for this question was categorised against the key themes. The themes are shown below:

Question 9	39	%
Request for information	1	3%
Location of Hub & Spoke	3	8%
Organisation & Intergration of Network Services	5	13%
Workforce	1	3%
Care Provided	5	13%
Impact on other services	8	21%
General Concerns	1	3%
Engagement Process	15	38%

Question 10. Is there any other information you think we should consider in order to decide whether we should move towards a networked arrangement in South East Wales?

ANSWER CHOICES	RESPONSES	
Agree	36.96%	34
Disagree	16.30%	15
Not sure	46.74%	43
TOTAL		92

The information from the respondents who submitted data for this question was categorised against the key themes. The themes are shown below:

Question 10	60	%
Location of Hub & Spoke	4	7%
Organisation & Intergration of Network Services	13	22%
Accessibility & Transport	13	22%
Workforce	4	7%
Care Provided	3	5%
Impact on other services	8	13%
Financial Issues	3	5%
Communication	5	8%
Engagement Process	7	12%

Question 11. Do you have a view on the options that have been considered as part of this, are there others we should consider?

ANSWER CHOICES	RESPONSES	
Yes	16.98%	18
No	50.94%	54
Not sure	32.08%	34
TOTAL		106

The information from the respondents who submitted data for this question was categorised against the key themes. The themes are shown below:

Question 11	15	%
Location of Hub & Spoke	5	33%
Organisation & Intergration of Network Services	3	20%
Accessibility & Transport	1	7%
Workforce	3	20%
Impact on other services	1	7%
Financial Issues	1	7%
Engagement Process	1	7%

Question 12. Do you have any comments on the process that is being undertaken to consider the best configuration of vascular services in South East Wales?

The information from the respondents who submitted data for this question was categorised against the key themes. The themes are shown below:

Question 12	18	%
Organisation & Intergration of Network Services	2	11%
Accessibility & Transport	1	6%
Workforce	1	6%
Care Provided	4	22%
Impact on other services	2	11%
Financial Issues	1	6%
Communication	1	6%
Engagement Process	6	33%

Question 13. Do you have an alternate view on the proposals put forward within this document for the configuration of services?

ANSWER CHOICES	RESPONSES	
Yes	18.10%	19
No	71.43%	75
Not sure	10.48%	11
TOTAL		105

The information from the respondents who submitted data for this question was categorised against the key themes. The themes are shown below:

Question 13	31	%
Location of Hub & Spoke	13	42%
Organisation & Intergration of Network Services	3	10%
Accessibility & Transport	1	3%
Workforce	4	13%
Care Provided	4	13%
Impact on other services	2	6%
Financial Issues	1	3%
Communication	2	6%
Engagement Process	1	3%

7.3 Analysis of survey respondent type

In order to assess the public reach of the engagement, survey respondents were asked if they were a member of Health Board staff, the general public, a current or past patient, a carer of a current or past patient or a stakeholder.

Carer of a current/previous patient	7
Current / previous patient	24
General public	47
Not Stated	4
Staff	24
Stakeholder	4
Grand Total	110

The Geographical Profile of Respondents to the Survey

Health Board	Number	%

Aneurin Bevan University Health Board	42	38%
No Postcode	9	8%
Unidentifiable	6	5%
Powys	10	9%
Cardiff and Vale University Health Board	29	26%
Cwm Taf Morgannwg University Health Board	14	13%
Total	110	

Demographic Profile of Respondents to the Survey

The survey included a series of questions designed to help us understand the reach of the engagement.

Respondent Age profile

ANSWER CHOICES	RESPONSES	
18-24	0.00%	0
25-34	10.38%	11
35-44	11.32%	12
45-54	17.92%	19
55-64	29.25%	31
65 and over	31.13%	33
TOTAL		106

Respondent gender profile

ANSWER CHOICES	RESPONSES	
Male	39.62%	42
Female	56.60%	60
Prefer not to say	3.77%	4
TOTAL		106

Respondent Ethnicity

ANSWER CHOICES	RESPONSES	
White	97.12%	101
Mixed/multiple ethnic groups	0.96%	1
Asian/Asian British	0.00%	0
Black/Black British	0.00%	0
Arab	0.00%	0
Prefer not to say	1.92%	2
TOTAL		104

Welsh speaking respondents

ANSWER CHOICES	RESPONSES	
Yes	4.76%	5
No	95.24%	100
TOTAL		105

7.4 Issues raised at public meetings

In agreement with CHCs each Health Board held a minimum of 2 public meetings via Zoom, with Welsh translation available. A total of 29 people attended the meetings which are broken down as follows:

Health Board	Date	Time	Number of Attendees
Aneurin Bevan & Powys	Wednesday 10 th March, 2021	14:00 hrs	7 members of the public
	Tuesday 16 th March, 2021	18:00 hrs	5 members of the public
	Wednesday 17 th March, 2021	18:00 hrs	2 members of the public
Cardiff and Vale	Tuesday 16 th March 2021	19:00 hrs	1 member of the public

	Thursday 18 th March 2021	19:00 hrs	6 members of the public
Cwm Taf Morgannwg & Powys	Thursday 11 th March 2021	14:00 hrs	3 members of the public
	Tuesday 23 rd March 2021	18:00 hrs	5 members of the public

The notes of the public meetings are available as appendix 3.

The issues and themes raised in the public meetings are very similar to those represented in the analysis of the survey feedback.

The comments raised suggest support for the proposed model. Attendees were interested in the proposed location of and services delivered within the Hub and Spokes, and furthermore appeared interested in the issue of access and transport.

Themes from each of the public sessions are set out below:

Aneurin Bevan University Health Board & Powys teaching Health Board public engagement session themes identified were:

- Support of proposed change to services
- Travel and parking
- How will care pathways work in future
- How to make sure we are getting the services where possible closer to home and that we are not making people travel lots of miles
- Really clear on how people will flow through from local spokes to the hub
- Ensuring links with other services and development of benefits with centralisation of services and make sure that we get links with other services such as Rheumatology

Cwm Taf Morgannwg University Health Board, & Powys teaching Health Board themes identified were:

- Transport and transport related costs

- Health Board using face to face events for engagement going forward
- Links for Bridgend questions
- Llandough Hospital being the spoke for the University Hospital of Wales
- Liaising with diabetic patients, national support groups and stakeholders
- Site of follow up outpatient appointments.
- Having two spokes in Aneurin Bevan and whether or not this was still valid after changes in the Royal Gwent as a result of the Grange Hospital opening.
- The impact of covid recovery on the proposals.
- Obtaining views of patients who do not use IT or social media.
- Implications on WAST
- Parts of Powys affected by changes

Cardiff and Vale University Health Board themes identified were:

- The rationale for the creation of a Vascular Network is sensible and logical.
- Transport, parking, and accessibility needs to be considered throughout the design of this service.
- Suitability of University Hospital Wales in regard to impact on other services, geographic location and infrastructure requirements.

Attendees at all meetings were all asked to submit individual responses to the survey.

7.5 Issues raised at Third Sector meeting

Four Third sector organisations attended a dedicated engagement session.

Points were raised around:

- Support for the proposed model, in line with other similar services with high volume centres to improve patient outcome.
- Taking learnings from other networks
- Highlighting the importance of timely treatment and audit of outcomes

7.6 Issues raised through social media

The comprehensive social media programme supporting the engagement included regular posts about different aspects of the proposals, mainly through

Twitter and Facebook. A number of comments were posted and reviewed, largely echoing the themes already identified. Feedback included concerns about the impact of the provision for Bridgend citizens and the centralisation of services in Cardiff creating health inequalities. Other comments demonstrated praise for the proposed model.

It is important to note that 'reactions' to social media posts were positive with support shown through the use of 'like' or 'love' reactions. It is widely accepted that only the most vocal proportion of social media users comment on social media posts, similar to contributions seen at public events.

7.7 Issues raised via email

The South East Wales Vascular programme team received email correspondence that expressed a variety of views and issues. From the emails the following themes were identified:

- Support for digitalisation of services but with concern for health inequalities
- The logic of the Vascular Network is sensible and uncontroversial
- Patients hold the vascular surgery staff and services overall in extremely high regard
- The timing of the engagement may be unfortunate

8. Consideration of Engagement Responses and Vascular Programme response, action and mitigation

This section provides an analysis of the key themes that have emerged through the engagement, with a commentary regarding our response to the comments received and further action that will be taken.

The document is intended to demonstrate that all the issues and concerns have been considered in a balanced, rational, proportionate, and transparent way. In addition, we describe those areas where the engagement has identified issues that would require further action or mitigation to ensure the safe, effective, and sustainable delivery of a new model of care for vascular services.

Note that a number of sub themes have been grouped together for the purposes of response and to reduce duplication in response.

8.1 Organisation and integration of Networked services

Responses which highlighted issues relating to the implementation and organisation of a networked model of care formed one of the largest key themes with 113 comments. There were a number of comments that were supportive of the model proposed and several areas that highlighted specific ideas or issues related to service provision and integration within the proposed network and in both hub and spokes.

The table below quantifies the sub-themes identified in the responses and elaborates on what was considered important within this theme.

Organisation & Intergration of Network Services - Sub themes	Total = 113	%
Hub and Spoke issues	30	35%
Model of Care for the network	26	30%
Facilities at each hospital & are they sufficient for now/future	13	15%
Facilities in the spokes and how they will work	12	14%
How will you ensure better working collaboration with cross over services and Health boards	11	13%
Hub facilities requiring investment/expansion	9	10%
Facilities are in the hubs and how do they work	4	5%
Issues relating to confidence of health boards to deliver as promised	2	2%
Have other areas tried this model and what was the outcome?	2	2%
Preventative screening, assessments & follow up should be close to patients home	1	1%
There are too many services being located at the heath	1	1%
What happens to the vacant space at the Grange?	1	1%
Centralising all tertiary services does not work	1	1%

Sub themes – The proposed model of care, proposed services delivered at the hub and spoke facilities at each Hospital and adequacy for the future

The most common categories of responses related to the proposed model of care and clarity over current vascular services within the proposed hub and spokes and whether they were sufficient at present and in the future.

It is important to note that in response to the mid-point review additional steps were taken to ensure greater clarity around the proposed model for the spoke sites were clear.

Currently vascular surgery and intervention for local residents takes place at 3 main hospital sites:

- University Hospital Wales, Cardiff
- Grange University Hospital, Cwmbran

- Until September 2020 the Royal Glamorgan Hospital, Llantrisant⁸

Vascular surgical services for the Aneurin Bevan UHB population were previously provided at the Royal Gwent Hospital before the changes that took place in November 2020, resulting in a move of these services to the Grange Hospital.

“Run on weekends and open up the NHS system to a full 7 day a week service including doctors’ surgery”

Whilst vascular surgery units within South East Wales currently perform well, it is important to remember the context in which this engagement has been undertaken. The need for change arose out of a number of national reviews of

vascular services in the UK requiring a minimum population for safe, and effective and sustainable vascular surgery. The Royal Surgical Colleges and The Vascular Society of Great Britain & Ireland support the view that it is no longer desirable to provide urgent or emergency vascular surgery outside a fully centralised service or a formalised clinical network with a designated single arterial surgery centre providing a 24/7 on-site service. The evidence shows that patients have better outcomes if they receive their treatment at larger, high-volume specialist centres that are also fully equipped with the full range of necessary specialist support services e.g. 24/7 interventional vascular radiology.

Due to being one of the last areas in the UK not working as a part of a formalised vascular network, there is concern about key risks to the existing vascular surgical services in South East Wales, namely sustainability of services in the region. Other concerns include: vascular surgery being delivered across 3 (currently 2) hospital sites, several consultant staff approaching retirement age, and vascular surgery continuing to become specialised and distinct from the general surgery profession. Vascular arterial interventions and surgery require both a highly skilled and specialised surgical and radiological workforce and equipment. As the technology and equipment has developed over recent years, interventions and outcomes for patients have improved. Training and co-dependant services have also become more specialised – meaning that in order

⁸ At the time of writing there is an urgent temporary arrangement in place for Cwm Taf Morgannwg residents. Patients are currently being seen in Cardiff and Vale University Health Board as the service became undeliverable due to the lack of specialist staff.

to deliver this level of specialist and complex care, we need to concentrate our specialist staff and services in fewer places so that:

- they can be provided on a 24/7 basis,
- they have immediate access to supporting specialist services and;
- they provide sufficient volumes of patients to enable clinical staff to be trained in and maintain their specialist skills.

It will not be possible to attract or train the medical workforce required to maintain this level of specialist care on more than one acute site for the population of South East Wales.

This proposed direction of travel has already been partially implemented as Emergency Vascular surgery 'out of hours' for the region is already centralised at the proposed hub site and in October 2014, senior clinicians from across the region recommended the move towards a fully networked model of care for all complex vascular interventions, and more specifically, articulated their agreement on the hub and spoke model set out. This has been supported at the South East Wales Vascular programme board who have unanimously supported this proposed model of care to ensure that the services can deliver sustainable care for the future. This means that South East Wales will not only be able to deliver a service that has the capacity to meet the growing needs of patients, but also a service which would become a centre of excellence in the UK.

A single arterial centre (Hub) will offer enhanced opportunities for its surgeons to sub-specialise and promote innovation and research. Bringing the most complex vascular surgery and interventions into one unit as a part of a network of care gives us the opportunity to change the way the services work and build on best practice from all existing vascular units within South East Wales. Most importantly it will help us improve outcomes for patients whilst ensuring that care wherever possible, including investigations, appointments, and rehabilitation, will remain closer to home.

Sub themes - Collaboration

The variety of responses we received demonstrates that ensuring a high-quality service will mean ensuring that many different elements work well and will require effective partnership working and collaboration.

Importantly, the establishment of the network itself promotes and develops collaboration across health care providers to ensure better outcomes for patients.

As a part of the existing programme a variety of specialties and professions across Health Boards are engaged and involved. If the proposed model is supported any

implementation plan will ensure that each specialty, profession, and team involved in or impacted by the delivery of vascular services are included within the implementation planning. More specifically a more detailed staff engagement process will be undertaken across all provider Health Boards.

“Increase expertise at other hospitals as well”

We are also asking other vascular networks within Wales and the wider UK to advise us on delivering the best service for patients based on their experiences and learning as well as making links with other similar clinical networks within Wales.

Sub themes – Issues around centralising services and ensuring services closer to home

Several respondents emphasised the issue of centralising services and ensuring that services were delivered closer to where patients lived.

The nature of the proposed clinical model ensures that patients will only be treated at the proposed hub for a small but highly specialised part of their care. This means that wherever possible we will deliver care and treatment closer to a patient's home, this includes outpatient appointments, tests and rehabilitation.

There are both medium and long-term opportunities to strengthen and develop services closer to home that could reduce the need to travel to spoke hospital sites. Health Boards are committed to working with partners including other Health Board Partners in Powys but also local community services and third sector partners to develop plan that support care closer to home.

Sub themes - Resourcing, capacity and adequacy of facilities at the proposed Hub site, UHW

A number of respondents emphasised the issue of adequate resourcing at the proposed Hub and the need to ensure funding for any building work or new equipment. Because we are bringing three existing vascular units together, we

know that resources are already available to support the delivery of these services. If the model of care is supported and if existing resources and capacity is found to be inadequate for the increase in vascular activity within the Hub, we will deal with this through the programme process. Any investment for workforce, building work or new equipment will require a business case to be presented to the health board boards.

Specific issue - Capacity released at the Grange Hospital

There was one specific concern raised about the use of capacity that would be released as a result of the transfer of some vascular services to UHW.

Vascular patients utilised beds within the wider general surgery pool, rather than a physically separate area. The centralisation would give general surgery some additional flexibility for their activity planning, which will be particularly valuable when finalising and operationalising recovery plans over the coming months.

8.2 Accessibility & Transport (including parking)

Accessibility was the second most cited issue with 71 individual respondents. In order to further understand what was considered important within this category the table below quantifies the key sub-themes in the response.

Accessibility & Transport	Total = 71	%
Need to take into consideration the distance patients need to travel	18	35%
Car parking in the heath is an issue	17	33%
What public transport & cost have been taken into considerations for patients?	11	21%
Ease of access to the heath building need to be taken into consideration for elderly/ disabled	11	21%
Need to take into consideration patients ability to travel	5	10%
How will patient transport work between sites	5	10%
Has the carbon footprint of patient travel been taken into consideration?	2	4%
Ambulance times travelling to Cardiff are already high - rush hour traffic	1	2%
Has visitor access been taken into consideration for people being treated in the hub long term	1	2%

Sub theme – Car parking

There were several concerns raised about the congestion and lack of car parking at the UHW site.

The likely increase in the number of patients to UHW is moderate. Cardiff and Vale UHB recognises that it will be imperative to ensure that family and friends are able to access the hospital on a timely basis, particularly when the patient might have been

"I don't mind this, however the parking at UHW is a lot worse than Royal Glamorgan and the Grange. But perhaps more accessible via public transport. Is there already too many big services operating from UHW is there capacity for this hub too?"

transferred to the hospital for an emergency treatment. The UHB has been developing a new traffic management system for the University Hospital of Wales site as part of a wider Sustainable Travel Plan. Strict criteria for staff parking have been introduced and the UHB encourages staff and visitors to use alternative means of travel such as the park and ride scheme and public transport. This has resulted in reduced congestion on the site and has freed up parking spaces for visitors.

More recently, with a number of outpatient appointments taking place virtually an initiative to ensure the amount of time patients are waiting in the emergency department at UHW has resulted in fewer trips to hospital for many patients and reduced congestion on the Heath Park site.

It is also worth noting that there are no parking charges at hospitals in Wales.

Sub theme - Travel distance and costs

Those patients who are likely to be affected by increased travel are those living in the area of South Powys, with their nearest emergency hospital being the Prince Charles Hospital in Merthyr Tydfil or the Grange University Hospital in Cwmbran, the answer is potentially, but only if they are undergoing specialist or

"Patients have to travel further for treatment"

complex surgery or intervention and only for this specific part of their treatment.

There is a need to balance the potential benefits of a single larger centre with any extra time and distance to travel. Our intention when developing the proposed model of care is that we can improve the ways our multi-disciplinary teams work across the whole South East Wales Network. A Multi-Disciplinary Team includes surgeons, interventional radiologists,

physicians, nurses, therapists. This means that we ensure care, such as out-patient appointments with the surgeon can take place locally. Improving the way our teams work will also allow us to reduce the amount of time patients can expect to spend in hospital having their operations by using new techniques such as Enhanced Recovery After Surgery (ERAS), making use of minimally invasive (endovascular) technologies, as well as maximising the use of high-quality imaging and telemedicine.

The clinicians involved in the initial 2014 clinical options appraisal agreed that the University Hospital of Wales should act as the hub for the network based on a number of criteria including quality, safety, sustainability and strategic fit. This proposal decision was also made with the recognition that the proposed model of care will affect the highly specialist one component of the patient's health-care pathway and that wherever possible tests, outpatient appointments, and other routine treatments will be provided closer to home by their local hospital.

We recognise that regional centres do create challenges for patients, relatives and visitors, and should the proposed model be supported, we will work closely with teams at the University Hospital of Wales to build on their experience of delivering specialised care for Wales to deliver innovative solutions for visitor access.

Sub themes - Patient transport issues and impact on the Ambulance service

We recognise that travel to UHW may create challenges to some of our patients. For those unable to travel by private car, access to NHS transport, known as Non-Emergency Patient Transport ("NEPT") is an important service that will enable them to access health care services at the Hub. We are already working closely with the Welsh Ambulance Service Trust ("WAST") who provide the NEPT service. If the proposed model is supported, we will carry out thorough and robust planning measures alongside them to ensure that we can meet the increased needs that this service change will cause. As with travel by car, this proposed service change only affects one part of patients' care. Tests, out-patient visits and other treatment will continue to take place at the patient's local hospital. To reduce further the need for travel, we intend to improve the way our multi-disciplinary teams work. This means that we can re-organise the service so that even more of the care, such as out-patient appointments, can take place locally.

"It should be easy for patients to get to"

Sub theme - Access to the Heath site for elderly/disabled patients

Accessibility at the University Hospital Wales site is important for certain groups, such as persons with disabilities and the elderly. The UHW site is compliant with the Equalities Act (2010) that sets out a minimum threshold for disability-compliant access infrastructure. The UHW site benefits from:

- Park and ride access into the site
- Two disability lifts, one located at the rear near the Y Gegin restaurant and an access lift from the ground floor to the first floor located at the front of the building in the concourse
- Push-pads for doors are put at a disability-friendly height
- Wheelchairs that are available from the ambulance service desk in the concourse
- Additional lifts are located in the multi-story car park

In addition, the Patient Experience team organises the efforts of volunteers who are able to guide and direct patients and visitors to where they need to be, and assist them where necessary. We also work hand-in-hand with St Johns ambulance charity who provide transportation to members of the community.

However, we recognise that the size and age of the building does create challenges for those who do have mobility issues. The new Lakeside Wing has meant that although the overall amount of disability car parking spaces has increased, some of these spaces have been relocated in order to accommodate the new facility. Despite these changes, the drop off zones remain the same.

Recent changes to the way we work at UHW means that virtual appointments are being offered and provide an alternative to face-to-face consultations. We are also looking at innovations to our health care pathways to offer 'See-on-Symptoms' consultations.

Specific issue - Carbon footprint for increased travel times

The predicted volume and distance for additional travel is very small as CTM patients are already treated at UHW and distance between Newport and Cardiff for the AB patients is approximately 17 miles. For a significant proportion of the AB catchment population, UHW is only marginally farther than The Grange.

Specific issue – Ambulance travel times during rush hour

The access arrangements for blue light emergency transfers to UHW are well developed and will be improved following the lane enhancement work on Manor Way to enable timely access for time critical patients.

Specific issues – Visitor access for patients staying ‘long term’ at the hub

The proposed model of care aims to transfer patients to a hub for a small but specialised element of their care with the aim of ensuring that patients receive their as close to home as possible. If the proposed model is supported then Visitors' access will be addressed through the implementation planning which will take place through the Vascular Network Programme and by C&V UHB in respect of the development of the Hub.

As part of the development, we have been undertaking a number of interviews with patients looking at the experiences of patients, families and carers of existing vascular services and what could be improved. Work will be undertaken within the hub project to further develop outline plans to provide specialist support for families and carers. There will also be practical advice, signposting and support provided to families and carers to make appropriate accommodation and transport arrangements working alongside third sector and other public sector services should this be required.

8.3 Hub and spoke location

Issues and comments raised in relation to the hub and spoke locations and services delivered was the third largest theme.

The table below quantifies the sub-themes identified in the responses and elaborates on what was considered important within this theme.

Location of Hub & Spoke	Total = 68	%
Services should be provided at a local level (in the community)	25	40%
Residents of Powys are having services taken away from them.	9	14%
The Hub should be located in The Grange	8	13%
The Heath is already over crowded/ under performing	6	10%
What services will be delivered in the spoke?	6	10%
All sites should remain and their facilities expanded	4	6%
Spokes should provide emergency services and their facilities expanded	4	6%
The Hub should be located in Neville Hall	3	5%
The Hub should be located in the Royal Glamorgan Hospital	2	3%
Will there be room to expand the service in the Heath?	1	2%

Sub themes – Services should be provided locally

It is important to highlight that the benefits of a Hub and Spoke networked model of care allow the balance between sustainability of service, improved patient outcomes and services closer to home wherever possible.

The nature of the clinical model ensures that patients will only be treated at the proposed Hub for a small and highly specialised part of their care. This means that wherever possible we will deliver care and treatment closer to a patient's home, this includes outpatient appointments, tests and rehabilitation.

There are both medium and long-term opportunities to strengthen and develop services closer to home that could reduce the need to travel to spoke hospital sites. Health Boards are committed to working with partners including other Health Board Partners in Powys but also local community services and third sector partners to develop plans that continue to deliver on plans and support care closer to home wherever possible; the use of virtual outpatient clinics being an important example.

The proposed model of care for the network ensures that patients across South East Wales will still have access to a 24/7 emergency department and a general surgery emergency service in spoke hospitals, the main spoke sites for each of the areas are proposed as:

Aneurin Bevan University Health Board spoke arrangements– Grange University Hospital

The principal spoke hospital within the Health Board will be the Grange University Hospital, where our main emergency department is located. This site will provide initial assessment and stabilisation of any acute vascular patients who may present, prior to transfer to the hub at the University Hospital of Wales. In addition, as part of our 'Clinical Futures' model of care, other hospitals will be used for vascular surgical patients where care can be provided safely and effectively as close to their homes as possible e.g. for outpatient clinics and post-treatment rehabilitation.

A summary of services that would be provided on different sites is shown below:-

Health Board Site	Proposed Vascular Services
Grange University Hospital	Initial assessment and stabilisation of any patients presenting to emergency department with acute vascular conditions

(principal spoke site)	• Interventional radiology e.g. angioplasty • Non-invasive vascular imaging ('vascular lab' work) • CT angiography • On-demand inpatient assessment (nurse led)
Royal Gwent Hospital	• Day case procedures e.g. varicose veins • Outpatient clinics (vascular surgeon and vascular nurse delivered), including 'hot' clinics for rapid access • Ward assessment of patients on request e.g. diabetes and Care of the Elderly patients • Post-treatment rehabilitation / step down for general medical care • Non-invasive vascular imaging ('vascular lab' work) • CT angiography • Pre-operative anaesthetic assessment (face to face where required) • On-demand in/outpatient assessment (nurse led)
Nevill Hall Hospital	• Outpatient clinics, including 'hot' clinics for rapid access • Ward assessment of patients on request e.g. diabetes and Care of the Elderly patients • Post-treatment rehabilitation/ step down for general medical care • Non-invasive vascular imaging ('vascular lab' work) • CT angiography • On-demand patient assessment (nurse led)
Ysbyty Ystrad Fawr	• Possible future outpatient clinics • Ward assessment of patients on request e.g. diabetes and Care of the Elderly patients (vascular surgeon and vascular nurse delivered) • Post-treatment rehabilitation / step down for general medical care • CT angiography • On-demand patient assessment (nurse led)
Ysbyty Aneurin Bevan	• Post-treatment rehabilitation/ step down for general medical care • On-demand patient assessment (nurse led)

Chepstow Community Hospital	• Post-treatment rehabilitation/ step down for general medical care • On-demand patient assessment (nurse led)
County Hospital, Pontypool	• Post-treatment rehabilitation / step down for general medical care • On-demand patient assessment (nurse led)
Virtual / Telemedicine (where clinically appropriate)	• Outpatient appointments (consultant and nurse-led) • Pre-operative anaesthetic assessment

Cwm Taf Morgannwg University Health Board – Royal Glamorgan Hospital, Llantrisant serves the more densely populated area of the Health Board namely the Rhondda valley. The vascular surgical and Interventional Radiology service for the Health Board were based in this hospital until September 2020, until an urgent temporary change of service (service moved to University Hospital of Wales) due to a loss of specialist clinical staff. The Royal Glamorgan Hospital has retained the necessary therapy inputs to manage these patients with complex needs. Vascular outpatients clinics and ward-rounds take place twice weekly on the Prince Charles Hospital site. It is important to note Bridgend is served through the South West Wales Vascular Network which is already established and was in place prior to the Bridgend Boundary Change. The Bridgend Boundary Change was an administrative change that did not change the patient pathways to ensure continuity of care.

Cardiff and Vale University Health Board

It is important to note that there is no change to where services will be delivered for Cardiff and the Vale residents. Those requiring access to 24/7 emergency department and general surgery emergency service will continue to access this at the University Hospital of Wales.

Rehabilitation will be provided at Llandough Hospital Vale of Glamorgan.

As a part of the delivery of the Health Board strategy, Cardiff and Vale is developing a programme to develop and deliver a clinical services plan over the next 10 years that will continue to focus on care closer to home wherever possible which will include: delivery of some services where possible digitally (virtual appointments for example).

Sub themes - Sites should remain and facilities expanded

The Royal Surgical Colleges and The Vascular Society of Great Britain & Ireland support the view that it is no longer desirable from a service quality, safety and sustainability perspective to provide urgent or emergency vascular surgery outside a fully centralised service or a formalised clinical network with a designated single arterial centre providing a 24/7 on-site service. The evidence shows that patients have better outcomes if they receive their treatment at larger specialist centres serving a minimum population of 800,000 people. This number is required to provide a sufficient critical mass of patients, thereby providing the sufficient demand for specialised services and volume of demand to train for and maintain clinical specialist skills. No Health Board in the South East Wales region can meet this minimum population criteria alone.

A single arterial centre (hub) will offer enhanced opportunities for its surgeons to train, sub-specialise and promote innovation and research. Bringing the most complex vascular surgery and interventions into one unit as a part of a network of care gives us the opportunity to change the way the services work and build on best practice from all existing vascular units within South East Wales. Most importantly it will help us improve outcomes for patients whilst ensuring that care wherever possible including investigations, appointments and rehabilitation will remain closer to home.

Sub themes - Location of the hub

The most important driver for the development of vascular networks and establishing specialist centres are to improve patient outcomes.

During the 2014 clinical options appraisal and subsequent review earlier this year. Options on the hub site were reviewed against key criteria including: Quality and Safety, Acceptability, Strategic Fit, Sustainability (ability for the services to be fit for now and the future), Access and Achievability.

Quality and Safety was given the highest priority and alongside acceptability, strategic fit and sustainability, given the range of services established at the University Hospital Wales site, its position as a specialist provider of major trauma, interventional cardiology and cardio-thoracic surgery and the co-dependencies between them and the vascular service, the preferred option for the hub was identified by senior doctors from all three Health Board providers as the University Hospital of Wales, Cardiff.

There were concerns raised about performance and capacity at UHW. Questions of performance were due to a low submission of data to the National Vascular Registry in 2019. Cross checking with other data sources show the Cardiff and Vale Unit to have acceptable outcomes for vascular surgery and interventional radiology. Capacity on the vascular ward in University Hospital of Wales was reduced due to demands placed on the hospital by the Covid-19 pandemic. By August 2021 the unit will be returned to its former capacity of 36 acute vascular beds.

Cardiff and Vale UHB is working closely with other health boards on the following:

A review of services provided at a regional level to identify those that might safely and appropriately be delivered at other hospitals. This would free up theatre time and beds to support patients who require more complex care and treatment. Proposals for service change arising from this work would be subject to further engagement with stakeholders and the public.

Arrangements to ensure that patients are returned to their nearest hospital as soon as the specialist part of their treatment is complete, as the support of family and friends is important to a patient's recovery. Repatriation protocols are being developed to support this work. Existing protocols such as in neurosurgery and Major Trauma are already delivering benefits, enabling patients to return to a local hospital as soon as clinically appropriate, releasing capacity in the UHW specialist service.

Cardiff and Vale UHB is also developing a Clinical Services Plan as a part of the Shaping our Future Clinical Service Programme which will include consideration of what services could move off the UHW site to University Hospital Llandough which would similarly be subject to further engagement and consultation.

Cardiff and Vale UHB has identified a number of critical enablers that would support the delivery of a vascular hub service:

- Increased theatre capacity in line with modelling for additional vascular activity
- Increased ward capacity in line with modelling for additional vascular activity
- Additional theatre equipment – a detailed inventory of equipment and future anticipated needs is being compiled for planning purposes

- Hybrid theatre with timetabled sessions for vascular surgeons to deliver minimally invasive and “hybrid procedures”.
- High quality imaging in standard operating theatres as part of recommended quality assurance along with access to the highest quality surgical instruments.

There are plans being developed to address each of these, dependent on the outcome of engagement.

Sub theme – Powys residents will be disadvantaged as access to services will be reduced AB & CTM to review

A key principle of the proposed network model is that each element of the service is undertaken in the hub only if that is necessary on clinical grounds e.g. specialist inpatient care and vascular operations in theatre. All elements that can be delivered safely and effectively more locally e.g. rehabilitation and outpatient care will continue to be undertaken within the spokes. Access to all of the latter services will therefore remain unchanged for Powys residents.

“The travelling issues some patients may experience getting to a hospital possibly much further away”

8.4 Care provided

Care Provided	Total = 45	%
Specific suggestions for improvements to care	28	64%
Concern over patients not being treated promptly in vascular and other services	17	39%

There were a range of comments suggesting improvement in current vascular services, these comments will be reviewed by vascular teams within provider Heath Boards and also the programme team so that these can be taken in account in both the delivery of services now and development of services for the future.

“I do agree, the wait times are huge at the moment”

There is understandable concern about the impact of the COVID-19 pandemic on the delivery of services. All provider Health Boards have developed plans to

support both the response to COVID and recovery. The primary driver for this service development is to improve the quality and standard of care in line with national service recommendations and will be constantly monitoring progress and outcomes through the vascular clinical audit programme.

Provider Health Board have protected essential services throughout the pandemic but recognise that the pandemic has resulted in fewer consultations,

“Further delays on treatment delayed by COVID-19 need to be avoided at all costs”

diagnostic procedures and surgeries and a full recovery, therefore, will take careful planning over multiple years. Further details of the Health Board’s Annual Plan’s for 2021-22 will be published on websites in due course.

8.5 Engagement Process

A total of 44 comments related to the process undertaken.

The table below quantifies the sub-themes and specific comments identified in the responses and elaborates on what was considered important within this theme.

Engagement Process	Total = 44	%
Need more information before forming a view on the proposal	21	47%
Analysis - Has an options appraisal been done? What data has been analysed?	5	11%
Would like more clarity on some areas of proposal	4	9%
Time taken to undertake engagement	3	7%
Scepticism over process	3	7%
The consultation could have been better advertised	3	7%
General engagement comments	3	7%
Issues with digital engagement	1	2%
Engaging with hard to reach groups	1	2%

Sub themes – More information/clarity on the proposal before forming a view

Considerable emphasis was placed at the engagement sessions on ensuring that participants had full information and understood the nature of the service and of the proposals for change. A list of FAQs was maintained and updated in response to queries to further enhance information and understanding during the process.

Sub theme – Options appraisal and data in the engagement documentation to support the proposal

The options appraisal was again considered and supported by the programme clinical advisory group and steering committee in early 2021. This group includes senior clinicians from all three provider Health Boards from a range of professions.

The national vascular registry (NVR) provides an invaluable opportunity to benchmark the unit's performance in a UK wide context. The NVR provides comprehensive annual reports on process, performance and outcomes in vascular and endovascular surgery. These reports are in the public domain.

Sub theme - Time taken to undertake engagement

Although discussion started in 2014 this work was undertaken by the vascular surgeons to identify the options and test the need and appetite for service change. Following this process there was a view formed and supported across the 4 SE Wales Health Boards that this was a desirable proposed way forward. There have been a range of regional and local service changes that have taken corporate clinical and planning resources – both expected and unexpected - that have impacted on the timescale for this proposed service reconfiguration.

Since this time the body of evidence to support the options appraisal undertaken has grown and examples of improved care where networks have already been formed demonstrated.

More recently the COVID pandemic halted planning for a period of 12 months.

Sub themes - Reach of the engagement including digitally excluded

Running the public engagement during the pandemic is something that the Health Boards in partnership with the CHC discussed at length before the programme was launched. While COVID-19 has presented us with many challenges we have also recognised that we have a number of opportunities to reach communities digitally and support and seek feedback from specific stakeholders. It was agreed that seeking public feedback sooner rather than later would be beneficial given the current emergency temporary transfer of vascular surgery services away from Cwm Taf Morgannwg Health Board and the uncertainty around the relaxation of COVID restrictions.

We therefore developed a communication and engagement strategy that capitalised on digital adoption during the pandemic but also leveraged opportunities to reach third sector stakeholders and the digitally excluded through other channels as well as wider stakeholders.

Sub themes – Scepticism over process

There are 3 comments that relate to the process itself and the ability to influence a decision on the proposed model at this stage.

Although a number of discussions have taken place and a considerable body of evidence has been developed over the last few years that supports the principle of a regional network, the purpose of this engagement is to see if there is any other feedback, evidence or issues to take into account when considering the proposed model of care for the network in South East Wales. It is also important for us to understand the impact of the proposals so that we can mitigate possible adverse impacts of any change for patients, their carers or family.

8.6 Workforce

Workforce	Total = 38	%
Limited workforce presents a challenge to patient care/ treatment	12	36%
Staff could be shared between sites (if consultants would travel)	8	24%
How will staff skills be kept up to date?	10	30%
Services would benefit from an MDT approach	3	9%
Patients wanting to see their regular consultant	1	3%
Complaints of poor patient care	2	6%
Suggested collaboration with Bristol	1	3%
We need to make sure there is no compromise to working in unfamiliar environments with un	1	3%

Sub theme – challenges with limited workforce

One of the drivers for a move towards networked models of care has included the sustainability of workforce. With vascular surgery becoming increasingly specialised this challenge is likely to increase. Clinicians feel that the proposed model will attract skilled staff to Wales and to the region to ensure that these services can continue to develop by both attracting and retaining skilled staff by offering opportunities to work within a centralised vascular hub. This has been evidenced in similar networks such as the Major Trauma Network for South Wales launched in 2020, which attracted many staff from across the UK and from overseas.

It is also important that the network provides training and experience for all staff groups. A multi professional training and education plan for the region has been developed by the programme clinical advisory group.

Sub theme – Sharing of workforce across sites

The premise of a networked model of care is to allow the sharing of expertise across a number of organisations. Whilst we appreciate there may be a number of staff who will remain within their local Health Board, a network provides additional opportunities for professional development, joint working, communication and best practice sharing.

Sub theme – High Quality and well-trained staff including staff skills

One of the benefits and drivers of the development of a network for those services which are specialised or who have specialised elements are to ensure that high quality staff can be attracted and retained

“I am not sure of all the services which this hospital provides but I would assume it to be a busy hospital. As long as they have enough qualified staff for the operations is the main priority”

by offering increased opportunity to develop skills and knowledge within a specialised centre (hub). Through the development and regular review and assessment of whole network training and educational plans we can ensure equity of access for staff across the whole region, in turn ensuring improved outcomes for patients.

Specific issue - Collaboration with specialists in Bristol

The clinical teams collaborate regularly with colleagues in Bristol, sharing learning opportunities and when necessary, transferring patients for complex procedures that cannot be delivered at UHW. This collaboration will continue in a future network service.

Specific issue - Unfamiliar environments, travelling teams

We know we currently have expert teams working in three sites; by connecting them as a part of a network we will build on their strengths. It is important to emphasise that the surgical and Interventional radiology consultant teams already take part in a regional rota and therefore work together as one team and take part in a regular multi-disciplinary team meeting. If a fully networked model is implemented, then this will in practice be a natural evolution of existing collaborative practices and should drive up standards beyond the current performance.

If the model of care proposed is supported, the vascular hub will be double the size of the existing unit at UHW and will be developed by an implementation team drawing upon expertise from all three provider Health Boards.

We believe that a Hub of this size as a part of a wider network, properly implemented, will be highly attractive to medical staff. We accept that this may be different for certain other staff groups, and that these may be less inclined to transfer from their current posts. A strong training and development

programme starting very early in the process will therefore be an essential requirement. We will ensure that the programme team work closely with Health Improvement and Education Wales to facilitate this.

If the proposed model is supported, a skilled and dedicated workforce working as one team familiar with the network would be essential to its success and this would be a core element in implementing the network model.

8.7 Impact on other services

Impact on other services	Total = 52	
Services are interdependent on each other/ requires closer MDT working	11	28%
The Heath Hub would need sufficient services	2	5%
Other services should be engaged to assess the impact this will have	11	28%
Have future needs been taken into consideration	6	15%
Can the heath accommodate a Hub without negatively impacting on other services	7	18%
What is the impact on other departments (emergency transport/radiology/ all vascular/ Auto	15	38%

Sub themes – Service interdependencies, engagement and MDT working

We wholeheartedly agree with the requirement for closer working across multi-disciplinary teams and organisations. The aim of a network is to enable not only sustainable care for the future but to apply consistent high standards across the region and to ensure better, more joined up care for patients and their carers.

The selection of UHW as a proposed hub takes account of the importance of having key interdependent and complementary services co-located on that site (e.g. Neurosurgery, Cardiac Surgery, Major Trauma).

Sub theme – sufficient capacity within supporting services at the Hub to mitigate negative impact

Careful consideration of demand and capacity has been undertaken as part of the planning process. This has been informed by activity data from across the region and full reassurance has been achieved that the capacity plans for the new service are robust. If the proposals are supported, then more detailed planning will be undertaken across all supporting services within UHW.

8.8 Communication

Communication	Total = 21	%
Better communication between teams	7	47%
How will families and patients have the changed communicated to them	4	27%
Hub and Spokes need excellent communication	4	27%
How will patients and family remain in contact if they live far away?	6	40%

Sub theme – Communication between teams and between hub and spokes

The development of a formal networked model of care will provide a structure that allows not only the hub and spoke organisations but also teams and different professions to communicate more effectively with one another.

There has already been increased communication and collaborative working across the four Health Boards and different teams working within them, to develop the proposed model of care and to progress a number of work streams within the programme.

Improved communication has also been observed in the development of Networks across the UK and within other clinical networks within Wales.

Sub theme – Communication between clinicians and patients and their families/carers

The respective clinical teams place a high value on effective and compassionate communication with patients, and all see this as a priority to maintain and enhance within a future network model. Multi-disciplinary discussion and sharing of best practice will form the basis of achieving this

“How will patients get feedback /future appointments with consultants who carried out their operation?”

Sub theme – Contact and communication between patients and their families

In addition to the above, the teams will ensure that all facilities and opportunities (including use of technology) will be made available to allow for good communication between patients and their families e.g. during inpatient stays.

8.7 Financial issues

Financial Issues	Total = 13	%
The health board is under funded	3	23%
Request more money from Welsh Government	2	15%
What are the financial implications of this decision	2	15%
Investing in moving the department there is a waste of money	1	8%
Ensure adequate medicine cover factored in as part of costs	5	38%

Sub themes - Value for money and financial implications

“Involve the patient first not what just good for the NHS and it financial needs”

The clinical benefits for patients having access to a vascular network and centralised hub for complex vascular surgery have been clearly demonstrated. In launching this engagement, health boards

are already committed to ensuring the patients of South East Wales have access to equitable, appropriate care to meet their specialist needs. The matters being engaged upon relate to how this should be achieved. Ensuring value for money and optimising the quantum spent on vascular will be subject to further scrutiny through the commissioning process.

8.9 Requests for information & general concerns raised

Request for information	Total = 8	%
What affect will this have on patient outcomes/ waiting lists/ patient prioritisation	5	63%
Would like more information in the local community (GP's, community nurses etc.)	3	38%

General Concerns	Total = 6	%
Have other parts of the country tried this- how did it work?	1	17%
Are patient outcomes worse the further out a patient lives?	1	17%
Further delays on treatment delayed by COVID-19 need to be avoided at all costs.	1	17%
What services come under vascular?	2	33%
Does the need to treat patients need to rethinking?	1	17%

The continuous improvement in patient outcomes and waiting times is one of the major drivers of the network proposal, with all national evidence indicating that regionalisation will have a positive effect on these. This has been the documented experience of virtually all other networks in the UK.

There is no known evidence of patient outcomes being adversely affected by the distance between their homes and the hub. The key factor is the ability of a network to ensure that all patients requiring acute vascular care are brought to a hub with full expertise and critical mass to respond to all their needs in the most effective manner.

“Are sacrifices to be made in outlying areas to demonstrate an overall average improvement?”

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

improve function. Vascular services also provide support to patients with other problems such as kidney disease. Note that cardiovascular services are delivered by a separate specialty and are not covered by the vascular surgery team.

9. Equality Impact

We are particularly interested in identifying issues emerging from the engagement which relate to potential impacts, positive or negative, of our proposals on different members of our communities. This section highlights some of the key learning we have gained from this engagement in relation to equality impacts. This will help to inform and shape our approach going forward; the information has been used to update the Equality and Health Impact Assessment (attached as Appendix 5). This is to ensure that due regard is given to these issues in our planning and that appropriate action is built into implementation plans to mitigate any negative impacts and promote positive impacts.

Comments relating to equality impacts featured in the responses to the engagement survey questions.

Physical access and building design of healthcare facilities were major themes in the feedback we received. Ensuring good access to our sites, on our sites and within our buildings, is of particular significance to some members of our community. Poor access impacts negatively but ensuring that access is improved in the future could impact positively on people's ability to receive the care they need e.g. older people or people with a disability.

Another theme which is likely to have a negative impact on patients, relatives and carers from socio-economic disadvantaged areas is transport. It is anticipated that some may experience increased difficulty in travelling due to low income, disability, age, poor transport provision, lower number of households with access to their own car. Being required to travel to an unfamiliar hospital and experience longer journey times could be particularly difficult and disorientating for people. Early transfer of the patient back to the 'local' hospital would help to mitigate long period in unfamiliar surroundings. In addition, in order to mitigate against the negative impact of transport it is considered that the service should promote transport links and provide easy to

read information to patients, families and carers in order to make their journey as easy as possible.

Another theme which has the potential to impact on particular groups in our community is communication. Feedback through this engagement focused on the importance of clear information about service changes and how to access services written in a way that is easy for people to understand. How that type of information is communicated could impact differentially on different members of the community.

10. Conclusion

We are grateful to all members of the public, staff and the Community Health Councils who have supported this engagement process. The contributions have helped to strengthen the service development process providing insight from many perspectives.

In this report we have described the themes from the engagement process and set out from the Programme Team our response, action and mitigations. We believe this report provides a good reflection of the engagement process.

We look forward to discussing this report with Community Health Councils as we consider the next stages of the process.

11. Appendices

A. The Future Provision of Vascular Services for the Population of South East Wales: A Discussion Document

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



Aneurin Bevan University Health Board

Cardiff & Vale University Health Board

Cwm Taf Morgannwg University Health Board

Powys Teaching Health Board

CONTENT

	Forward from the Chair of the South East Wales Vascular Board and the 4 Chief Executives.	
1	Introduction	4
2	What are vascular services?	5
3	Who needs these services?	7
4	How services are currently provided?	9
5	How do we perform?	13
6	What are the challenges facing services?	17
7	What options have we considered to respond to the challenges?	22
8	Proposed service model	25
9	Advantages, disadvantages and impact	29
10	How can you contribute?	31

1. INTRODUCTION

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

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

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

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

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

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

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

2. WHAT ARE VASCULAR SERVICES?

Vascular disease is any condition that affects the network of your blood vessels. This network is known as your **vascular** or circulatory system. The main aim of

vascular services is to reconstruct, unblock or bypass arteries to restore blood flow to organs. These are often one off procedures, to reduce the risk of sudden death, prevent stroke, reduce the risk of amputation and improve function. Vascular services are also provided to support patients with other problems such as kidney disease

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

The core activities of vascular specialists are:

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

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

3. WHO NEEDS THESE SERVICES?

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

Risk factors for vascular disease include:

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

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

Patients who receive vascular services may have:

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

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

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

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

Matric	Period	Aneurin Bevan University Health Board	Cardiff & Vale University Health Board	Cwm Taf Morgannwg University Health Board	Powys Teaching Health Board	South East Wales Total
Population		600,000	472,000	450,000	132,500	1,654,500
Total Outpatient Appointments	2019		2391	2340	N/A	4731
New Patients	2019		867		N/A	867
Follow ups	2019		1524		N/A	1524
Total number of Cases/ Procedures	2019	456	437	355	N/A	1248

4. HOW ARE SERVICES CURRENTLY PROVIDED?

National Context

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

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

With the exception of the populations in South East Wales, all other parts of the country have networked arrangements in place for the provision of vascular services and have centralised vascular surgery.

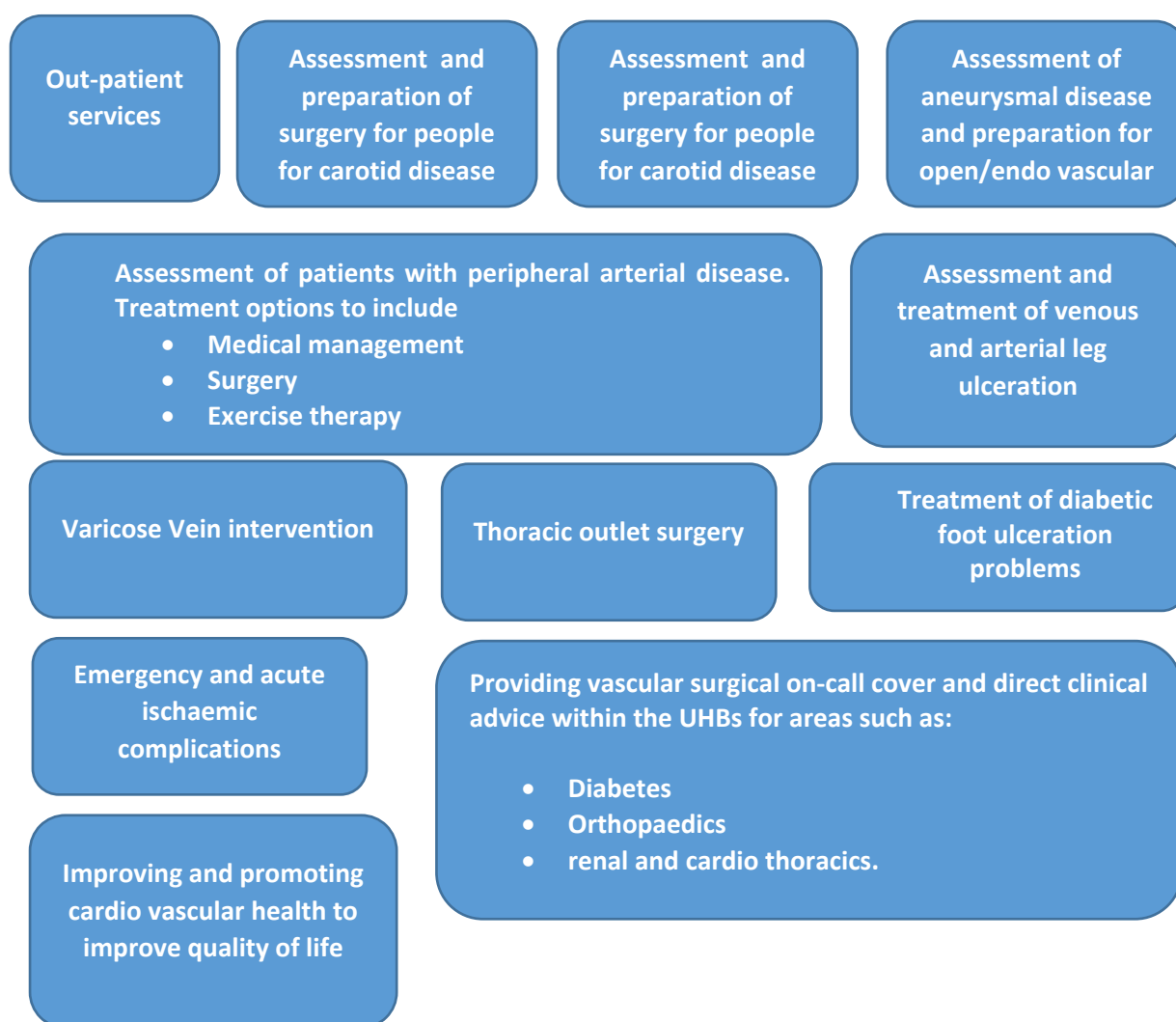
Local Context

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

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

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

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



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

- A vascular team that comprises vascular surgeons, vascular anaesthetists, vascular interventional radiologists, clinical nurse specialists, podiatrists, tissue viability nurses, physiotherapists, occupational therapists, social workers, pharmacists and members of the prosthetics team. The teams are used to working across Health Board boundaries.
- A dedicated vascular ward. There is a provision for inpatient facilities along with day case access for various veins and minor day case surgery. Outpatient clinics are held in each Health Board area.
- Access to Doppler ultrasound, Computer Tomography (CT) and Magnetic Resonance (MR) Angiography..
- Vascular clinics within their area and has weekly interventional radiology clinics in which patients are consented for interventional radiology procedures.
- An interventional radiology suite with high quality rotational fluoroscopic imaging, in a room which is equipped for a full range of anaesthetics. The rooms can be used for endovascular aneurysm repair, combined vascular surgery and interventional radiography techniques.
- Day Case and Short Stay Facilities for minimally invasive varicose veins procedures are performed under local anaesthetic.
- Operating Theatres
- Vascular team access to a critical care unit
- Pathways in place for those patients presenting with critical limb ischaemia (CLI)
- Out of hours arrangements (which are already managed across Health Board sites). Normally, vascular patients are referred to the admitting general surgical on call team and depending on the urgency, the patient is either assessed by the emergency surgeon or referred directly to the vascular surgeon.
- In hours interventional radiology
- Out of hours interventional radiology which is managed via an on call rota, meaning that outside of normal working hours, the patients are admitted by the on call surgical team at UHW and assessed. If emergency interventional radiology input is required, the case is discussed with the vascular surgeon on for the region, who will in turn contact the on call interventional radiologist.

It should be noted however that at the time of writing, temporary arrangements have had to be put in place to support Cwm Taf Morgannwg whose vascular

service has recently become unsustainable. There are therefore temporary arrangements in place with services being provided to patients from Rhondda, Cynon, Taff Ely and Merthyr Tydfil by vascular services in Gwent and Cardiff and the Vale of Glamorgan

5. HOW DO WE PERFORM?

The following information provides information about how well each of the Health Boards in South East Wales does in respect of the key areas of vascular service provision:

- **Abdominal Aortic Aneurysm**

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

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

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

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

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

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

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

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

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

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

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

- **Lower limb bypass angioplasty and stenting**

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

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

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

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

- **Major lower limb amputation**

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

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

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

- **Carotid endarterectomy**

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

75 of these patients were from the South East Wales region and were all treated underneath the minimum timescale of 14 days. The average national length of stay for patients who undergo this procedure is 2 days. 2 of the 3

Health Boards are within this range, with one reporting a higher length of stay than the national average.

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

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

6. WHAT ARE THE CHALLENGES FACING THESE SERVICES?

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

- **A growing need for the service** – There is an increasing demand on vascular services across the South East Wales region due an increasing population and worsening rates of diabetes. There are a number of issues that contribute to this:
 - o **Age** - Vascular disease and its consequences increase with age. Our 65 to 84 and 85+ age groups are projected to have the largest increase by 2036, when an estimated one in four people in Wales will be aged 65 and over. These projections will have significant implications for the way in which we design and provide health (and increasingly integrated health and social care) services. With an increasing population and especially an increasing older population it is even more important that we support the people living in our communities to live long and healthy lives, free from the limiting effects of multiple chronic conditions.
 - o **Diabetes** – There is a diabetes epidemic in Wales. There are more than 194,000 people over the age of 17 diagnosed with diabetes and, we estimate, a further 61,000 people living with undiagnosed Type 2. This takes the total number of people living with diabetes in Wales now to over 250,000. It is not just the raw figures that are concerning. Wales' prevalence as a proportion of its population is 7.4% - the highest in the UK and Western Europe. The number of people with diabetes has been steadily increasing and has doubled in the last 20 years. NHS Wales estimates 11% of our adult population will have the condition by 2032. This is mainly a result of the drastic increase in Type 2 diabetes. This is unsustainable, both for our health service and wider society. Vascular disease is the major cause of morbidity in diabetes and the risks of disease progression are higher. Prevalence of peripheral arterial disease was 4.5% in the general population but increased to 9.5% in people with diabetes. It is likely that the great increase in the number of patients with diabetes over the next decade will have the biggest impact on vascular services. Many of these patients present as an emergency and are at high risk of amputation. Prompt treatment of the infected diabetic foot can minimise the risk of subsequent amputation. Lower limb

amputation is carried out more than 20 times as often in people with diabetes than it is in people without diabetes. Only around half of people who have lost a leg because of diabetes survive for two years.

- o **Smoking** - Smoking is a major cause of vascular disease and over 80% of vascular patients are current or ex-smokers. Smokers are at greater risk of complications from vascular interventions because of cardiac and respiratory co-morbidity and the longer-term success of vascular intervention is reduced in patients who continue to smoke. (HSE 2007)
- o **Obesity** – Obesity and being overweight are linked to several factors that increase risk for cardiovascular disease. Almost 60% of adults in Wales are currently overweight or obese, of which 24% are obese. There is evidence of an upward trend in recent years. It is estimated that the percentage of adults who are overweight or obese will increase to around 64% by 2030 if the current pattern continues.
- **Minimum population requirements** - A minimum population of 800,000 is considered necessary for an Abdominal Aortic Aneurysm screening programme and is often considered the minimum population required for a centralised vascular service. This is based on the number of patients needed to provide a comprehensive emergency service; maintain competence among vascular specialists and nursing staff; ensure the most efficient use of specialist equipment, staff and facilities; and the improvement in patient outcome that is associated with increasing caseload. A minimum population of 800,000 would be appropriate but for a world class service a larger catchment area will be required. The population of SE Wales (the resident population of the Health Boards taking forward this proposal is approximately 1.6 million (StatsWales 2016). The current configuration of services across separate hospital sites across South East Wales are too small to meet the quality and safety standards set out by the Vascular Society and the Royal College of Surgeons. None of the current individual units meet this requirement.
- **Meeting quality standards** - Not all units are able to currently achieve the quality indicators individually as units. These are:
 - o The Vascular society recommends a vascular unit should be performing 60 elective aneurysm repairs per year. Collectively in SE Wales 99 aneurysm repairs were performed in 2019. No units individually reached the required number.

- o The Vascular society recommends a vascular unit should be performing 40 carotid endarterectomies per year. Collectively in SE Wales 75 were performed in 2019.
- o Between 2017-19 497 bypass procedures and 331 major limb amputations were performed in SE Wales.
- **Workforce** – A workforce survey undertaken by the Vascular Society for Great Britain and Ireland in 2019 concluded that both the number and complexity of vascular surgery procedures per capita population is increasing year-on-year. Worldwide there is a shortage of vascular surgeons to meet increasing demand and this shortfall is significant in the UK. There are a few workforce challenges to note:
 - o Vascular services need to be organised to allow reasonable volumes of elective activity to exist alongside an acceptable consultant emergency on call rota thus ensuring appropriate critical mass of infrastructure and patient volumes.
 - o The vascular society recommend 1 surgeon per 100,000 of population. (it was previously 1 per 130,000 population). This would mean that South East Wales should have 14 consultants supporting vascular services in the area. It actually has 9 surgeons across the 3 provider Health Boards. Seven of these cover on-call arrangements too which means there is very little opportunity to foster learning and growth in the workforce.
 - o There is challenge in recruiting to vascular posts in Wales and even where appointments happen, retention proves very difficult.
 - o The age profile of current consultants and vascular nurse specialists makes it very difficult to succession plan.
 - o Disparate teams mean that there is little opportunity for people to specialise however this is something that we know would attract more consultants and specialist therapists.
- **Services spread across South East Wales** – The National Vascular Registry has shown a constant improvement in vascular surgical outcomes over the last 10 years. However, as shown above this could be improved further by concentration of services into a single arterial hub. The Getting It Right First Time (GIRFT) report showed co-location of vascular services with other specialist services such as nephrology, major trauma and interventional radiology improve outcomes. This is not currently the case within the South East Wales region.

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

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

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

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

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

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

Our aim is to create vascular services that:

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

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

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

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

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

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

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

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

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

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

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

8. PROPOSED SERVICE MODEL

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

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

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

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

HUB	SPOKE
➤ Emergency Vascular Service: • Amputations and “nibbling” • Aneurysm surgery;	➤ Emergency Vascular Service:- • Angiogram; • Angioplasty

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

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

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

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

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

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

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

It is important to note that as patients begin their recovery and rehabilitation journey, that this too will be provided from a hospital/community setting which is much more local to them

Patient 1 : Mrs Edmunds

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

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

The Stroke Physician telephoned the Vascular Surgical Regional Coordinator on the same day that the duplex scan was performed. After discussion with the duty Vascular Surgeon Mrs Edmunds was offered the choice between an operation at University Hospital of Wales (UHW) to "clear out" the blockage in her carotid artery (carotid endarterectomy) or continuing with medication. The Vascular Surgeon at UHW felt that, on balance, the operation would reduce her risk of stroke more than medication alone.

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

9. ADVANTAGES/DISADVANTAGES & IMPACT

WHAT ARE THE ADVANTAGES OF THE PROPOSED CHANGES?

There are significant benefits to the model proposed:

- A sustainable delivery model that will provide the best outcomes to all patients within the region as advised by the Vascular Society. The vascular surgeons will work as a team to provide a resilient vascular surgical workforce model for the region's patients.
- Patients admitted to the 'Hub' will be nursed on a specialist vascular ward and receive daily review, including weekends, by a consultant vascular surgeon ('Consultant of the Week') working within a specialist multi-disciplinary team.
- Patients admitted to the 'Hub' will have on site access 24/7 to both vascular surgery and vascular interventional radiology.
- Aside of surgery, all other parts of a patient's treatment and rehabilitation will happen in their own area (with the exception of Powys residents who may access services in Cwm Taf Morgannwg or Gwent).
- Rapid access to diagnostics and interventions forms part of a high quality service. The need for this has been an important driver for centralisation, as it requires around the clock working, which larger units are better placed to provide. The units would be staffed by vascular specialists and would operate 24 hours a day, seven days a week.
- Performing all complex procedures at central units would ensure all patients have their surgery at a high volume hospital by an experienced vascular specialist, using the latest technology and techniques
- Centralisation should ensure improved facilities for patient care (dedicated vascular wards), investigation (larger radiology units with 24/7 interventional radiology) and treatment (vascular operating theatres and staff, vascular anaesthetists, improved facilities for endovascular management, better critical care).

WHAT WOULD THE IMPACT BE?

The proposals could mean:

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

ARE THERE ANY DISADVANTAGES TO THE PROPOSALS ?

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

10. HOW YOU CAN CONTRIBUTE : ENGAGEMENT AND CONSULTATION.

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

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

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

South East Wales Vascular Programme
Woodland House
Maes Y Coed Road
Cardiff
CF14 4HH

WHAT NEXT?

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

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

B. Engagement Plan

STAKEHOLDER GROUP	SPECIFICALLY	PRODUCT	RESPONSIBLE	HANDLING PLAN/RELEASE DATE
Comms leads	All affected HBs	All core documentation for posting on HB websites	Programme Manager	Ensure ready to run and cascade with: Launch of documents Cascade through established networks and mechanisms
General Public	Population of Aneurin Bevan University Health Board • Blaenau Gwent • Caerphilly • Monmouthshire • Newport • Torfaen	Core document Summary document EQIA Invite to online events/presentations Access to websites and on-line resources ie videos	ABUHB Planning/engagement lead	Day of launch through existing public cascade mechanisms
	Population of Cardiff & Vale University Health Board • Cardiff • Vale of Glamorgan	Core document Summary document EQIA Invite to online events/presentations Access to websites and on-line resources ie videos	C&V Planning/engagement lead	Day of launch through existing public cascade mechanisms
	Affected population of Cwm Taf Morgannwg University Health Board • Rhondda • Cynon • Taff Ely • Merthyr Tydfil	Core document Summary document EQIA Invite to online events/presentations Access to websites and on-line	CTM Planning/engagement lead	Day of launch through existing public cascade mechanisms

		resources ie videos		
	Affected population of Powys Teaching Health Board • South Powys	Core document Summary document EQIA Invite to online events/presentations Access to websites and on-line resources ie videos	PTHB Planning/engagement lead	Day of launch through existing public cascade mechanisms
Welsh Government	Director General Health and Social Care	Letter from chair of Vascular Joint Programme Board (Ann Lloyd) signposting towards resources website etc	Chair of Vascular Board – engagement lead (CH) to draft	Following approval at Boards and just before launch
Patients, their families and carers	Patients who have received services since 2019 (linked to timescales outcomes reported in NVR report) with reference to inviting views from families and carers too	Letter from relevant consultant/MDT Core document Summary document Invite to online events/presentations Access to websites and on-line resources ie videos Access to a telephone line for discussion	Planning leads with MDT teams	Week of launch
NHS Wales	All CEOs of HBs and Trusts in Wales: Aneurin Bevan University Health Board Betsi Cadwaladr University Health Board Cardiff and Vale	Letter from Chair of Joint Vascular Board Ann Lloyd identifying launch and signposting towards all products	Chair of Vascular Board – engagement lead (CH) to draft	Following approval at Boards and just before launch

	University Health Board Cwm Taf Morgannwg University Health Board Hywel Dda Health Board Powys Teaching Health Board Swansea Bay Health Board Velindre NHS Trust Welsh Ambulance Services Trust			

Community Health Councils	AB CHC C&V CHC CTMCHC PCHC	Report to joint Board CHCs 13 Jan 21 Receipt of all documentation	Programme Manager	Launch day
Third Sector Organisations	GAVO TVA PAVO CAVOC	Core document, summary document and signpost to online resources and opportunities	Health Board leads	Launch day
National bodies/organisations including Professional Societies and Royal Colleges concerned with the delivery of Vascular Surgery	Plotted by programme	Core document, summary document and signpost to online resources and opportunities	Programme Manager	Launch day
National Voluntary Organisations	Plotted by programme	Core document, summary document and signpost to online resources and opportunities	Programme Manager	Launch day

Local authorities and elected representatives	CEOs & Leaders of the councils	Core document, summary document and signpost to online resources and opportunities	Health Board leads	Via local cascade mechanisms requesting sharing with staff and members

National Politicians	Members of the Senedd and Members of Parliament	Core document, summary document and signpost to online resources and opportunities	Programme Manager	via a letter from Chair of vascular group
Stakeholder Reference Groups	ABUHB SRG C&V SRG CTM SRG PTHB SRG	Core document, summary document and signpost to online resources and opportunities	ABUHB lead C&V lead CTM lead Powys lead	Via local cascade mechanisms on day of launch
Trade Union Partnership Fora	ABUHB TUPF C&V TUPF CTM TUPF PTHB TUPF	Core document, summary document and signpost to online resources and opportunities	ABUHB lead C&V lead CTM lead Powys lead	Via local cascade mechanisms on day of launch
EQIA Targeted groups	Local Diabetic groups National Stroke Association and any local stroke groups	Core document, summary document and signpost to online resources and opportunities	Programme Manager as links to programme EQIA	Group contacts to be sourced by programme manager
Town and Community Councils	All town and community councils in Gwent, Cardiff, Vale of Glamorgan, Rhondda, Cynon, Taf Early and Merthyr and South Powys	Core document, summary document and signpost to online resources and opportunities	ABUHB lead C&V lead CTM lead Powys lead	Via local cascade mechanisms on day of launch
Local Medical Committees	Aneurin Bevan LMC	Core document, summary	ABUHB lead C&V lead	Via local cascade mechanisms on

	Cardiff and Vale LMC Cwm Taff Morgannwg LMC Dyfed-Powys LMC	document and signpost to online resources and opportunities	CTM lead Powys lead	day of launch
Public Service Board and Regional Partnership Boards	Powys Regional Partnership Board Powys Public Service Board	Core document, summary document and signpost to online resources and opportunities	ABUHB lead C&V lead CTM lead Powys lead	Via local cascade mechanisms on day of launch

C. Public Engagement notes

C1. Cardiff and Vale Public Engagement Notes - 16.03.021

Audience: Public Meeting

Meeting Details: Tuesday 16 March at 7.00 pm on Zoom

Number of attendees: 1

UHB Presenters: Alun Tomkinson; Kevin Conway; Gininna Conway; Abigail Harris

Also in attendance:

CHC - Malcolm Latham, Chair; Stephen Allen; Caroline Harris; Amy English

UHB - Victoria Legrys; Alaa Khundakji; Daniel Marsh; Andrea Bird; David Williams; Anne Wei

Interpreter – Gwnfor Owen

Following a welcome and introduction by the CHC and UHB, the UHB gave a presentation. The meeting was opened up for Q&A and discussion:

- A concern about repatriation. Currently there exists a problem in the system, won't this become more difficult with patients from additional Health Boards involved?

UHB response:

- *Cardiff and Vale UHB has been working with Cwm Taf for the last 6 months and repatriating to Cwm Taf hospitals. A good working relationship exists between the vascular teams and we are successful in discharging rapidly. We are planning a similar relationship with Aneurin Bevan UHB and they have multiple sites. Work is on-going at University Hospital Llandough to prepare for becoming a spoke site.*

- Recruitment. There is a national shortage of Interventional Radiologists and for this proposal a critical mass of support staff will be required. Are you preparing for this risk?

However, I believe the idea is very sound.

UHB response:

- *Currently, we have 24/7 on-call cover by interventional radiologists with 7 full-time consultants. For our population we should have 8. However, we have a trainee who has indicated a wish to work in SE Wales. There are shortages in the rest of Wales but we are in a fortunate position in SE Wales.*
- A related, supplementary concern about the availability of a critical mass of staff and being able to cope following the Covid pandemic. Would it be necessary to outsource work to address the backlog?

UHB response:

- *No vascular services are outsourced. Because of the immediate needs of those requiring vascular surgery we don't have waiting lists. While it may be necessary to wait in hospital for this, there is no list of people waiting at home.*
- I think the logic of the network for vascular services is sound but there may be some travel issues to deal with for those in other areas who must travel further.
- What will be the protocol for patients who experience problems following vascular surgery after they have left the hub?

UHB response:

- *Repatriation to the spoke hospital will enable physiotherapists, occupational therapists and others to offer rehabilitation but, if there is a problem, it will be picked up quickly by the vascular team. There will be cover at the spokes for wound care but if in-patient care at the hub is needed, the patient will transfer back.*

- Yn Gymraeg / In Welsh: A question about transport and the accessibility of University Hospital Llandough and a supplementary question about the possibility of patients being seen as close as possible to friends and family.

UHB response:

- *Consultant, Kevin Conway expressed an awareness of the difficulties having recently seen patients who'd needed to take 3 buses to see him at Prince Charles Hospital. He had been pleasantly surprised how well virtual clinics and phone clinics had worked during the pandemic and how they had saved the effort of travelling. He hoped to expand the use of virtual clinics having found that many elderly people could use the technology and responded well. However, there would always be hospital transport for those needing to be seen in person.*
- *In addition, the Health Board is working with the local authorities to improve transport links to both hospitals and there are Park and Ride services.*
- *The Health Boards will be seeking to see more patients closer to home and are mindful of access issues.*
- *In this model, the separation for rehabilitation allowed a model suitable for this service.*
- Yn Gymraeg / In Welsh: What are the day to day connections with cardiology services and will the change affect this?

UHB response:

- *Assurance was given that the vascular surgeons work closely with cardiologists and are in constant communication with them. These changes will further improve the close working.*
- From the point of view of the residents of Cardiff and the Vale of Glamorgan, do these changes mean any real change or improvement in service?

UHB response:

- *It would be an improved service, firstly because Cardiff and Vale UHB currently has 3 vascular surgeons and when the network is complete*

would have 11. It also gives people the opportunity to develop speciality intensivist and sub-speciality skills. This development gives the opportunity to develop our services significantly.

- *The emphasis on rehabilitation and prehabilitation is very important for outcomes and has probably been neglected in the past. This is good for the vascular surgeons but above all for the patients.*
- Will the fact that patients from neighbouring Health Boards are referred to UHW cause a delay in treatment for Cardiff and Vale residents?

UHB response:

- *The intention is to develop a consultant of the week and also a surgeon of the week timetable. Also, to develop 'hot clinics' where patients will be seen on the same day or the next day. The network will allow us to justify the case for a hybrid theatre and state of the art technology which without vascular redesign we couldn't have. In summary, this is a win-win improvement in service for all patients and staff alike.*
- Assurance was sought that Cardiff and Vale residents would not have to wait in a longer queue because of being treated alongside residents from elsewhere.

UHB response:

- *Assurance was given, supported by details: previously the service had access to 19 beds but it would have 38 beds; previously operations took place on 3 days but in future there would be 8 days of theatre per week. There would be an increase in radiology capacity and an increase in the capacity for out-patients. All the component parts would improve the robustness and resilience of the service for Cardiff and Vale residents.*
- *Additionally, the presence of vascular surgeons in a hospital provides a good resource for other surgeons, e.g. for those doing bowel or kidney operations. Having vascular surgeons nearby can make a real difference and is one of the key reasons why it has to be co-located with the Major Trauma Centre in Cardiff. The residents of Cardiff could be assured of being in a safer place.*

- Hospital acquired infection rates. Knowing that there were some problems in cardiac services last year, the public might like assurance that Cardiff and Vale UHB have this under control.

UHB Response:

- *Acknowledged that we had learnt a huge amount from Covid in the last 12 months and described how we had divided the hospital into zones and kept time critical surgery separate. In the green zones, 5000 patients had been treated and there had been no cases of Covid or MRSA or other hospital acquired infections. Noted that the Health Board was keen to maintain those protected elective zones. In the emergency zone it was more difficult to protect patients from post-operative infections. Overall there had been a significant learning and change in practice.*

At 7:52 pm, the CHC Chair called for final questions. There were none. The CHC Chair then thanked the speakers for their answers and those attending for their questions and observations. He noted that the CHC would formally respond to the Health Board and asked people attending to encourage others to fill in the questionnaire. Alun Tomkinson thanked people for spending their time on the engagement and hoped they were reassured.

18.03.2021

Audience: Public Meeting

Meeting Details: Thursday 18 March from 7:00 – 8:00 pm via Zoom

Number of attendees: 6

UHB Presenters: Richard Whiston; Mike Bond; Catherine Twamley

Also in attendance: CHC - Malcolm Latham, Chair; Stephen Allen; Amy English

UHB - Abigail Harris; Vicky Le Grys; Daniel Marsh; Andrea Bird; David Williams

Interpreter - Gwnfor Owen

Following a welcome and introductions to the presenters and his colleagues by CHC Chair, Malcolm Latham, the UHB gave a presentation. The meeting was then opened up for Q&A and discussion:

- Suitability of University Hospital of Wales (UHW) to be the hub. In acknowledging that surgery was the most complex part of the vascular service, asked whether the building had the capacity and was in good enough condition to take on the extra workload safely.
- Diagnostics. Wanted to check understanding that diagnostic procedures and other parts of the vascular service would be undertaken at spoke hospitals.
- Governance. Who would have oversight of the service if three Health Boards were involved? Would there be clear leadership and an integrated service, which would be what was required to produce the best outcomes?

UHB response:

- *Confirming the intention to bring expertise to the network hub at UHW, described the plans for a hybrid theatre which would have both surgical and x-ray capacity. There would be changes to accommodate patients from the other Health Boards, for example, the new rehabilitation facility at University Hospital Llandough (UHL) would release beds at UHW as South Glamorgan patients moved to their spoke.*
- *Regarding diagnostics, the plan was that these appointments should take place as close to home as possible to avoid travel to Cardiff. Recent*

positive experience of telephone and virtual appointments replacing outpatients' clinics was highlighted.

- *Advised that the Chief Executives of the three Health Boards had meet last week at Vascular Programme Board and approved key papers and that the Board met every 2 months to oversee the governance of the Vascular Programme.*
- *Noted that part of the work of the Vascular Programme, similar to that of the Major Trauma Centre Programme, was to put in place a robust structure. There were formal leads for the network e.g. the clinical lead was Peter Lewis, Vascular Surgeon, Aneurin Bevan UHB. This was intended to ensure transparency across the network. There were mutually agreed policies in place but the Health Boards had yet to define and agree a host organisation for vascular services. This role would usually be with the hub, i.e. with Cardiff and Vale UHB.*
- *Emphasised the experience of the Major Trauma Centre in showing successful practice where clear protocols and pathways facilitated working together and implementation across a network. Agreed that this was an important question and it was fortunate for the UHB that it had been raised to allow the opportunity to set out their position.*
- **Protocols.** In the case of someone suffering an embolism or aneurysm while out in Cwmbran, would s/he be taken to The Grange or UHW?

UHB response:

- *Speed of treatment is important but also expertise. Most such cases already come to UHW as emergencies. It is clear from data across the UK that it is important to get a patient to the right centre. For planned surgery, patients will be brought from the spoke to the hub as that is where the surgeons will be. There will be occasional instances where the consultants will need to go to spoke hospitals to treat and they are prepared to do that.*
- **Transfer of patients.** Would these transfers be by ambulance? Question whether the programme had worked with the Welsh Ambulance Service Trust (WAST) and whether they were fully aware of proposals.

UHB response:

- *Confirmation that discussions had taken place and arrangements were in place.*

At 19.57 hrs, Malcolm Latham, Chair asked for any final questions. He thanked the meeting for feeding in questions, comments and observations and noted that the CHC would formally respond to Cardiff and Vale UHB. The Health Board thanked the CHC for hosting and the audience for contributing to the event.

C2. Cwm Taf Morgannwg & Powys Teaching Health Board Public Engagement Notes - 11.03.2021

FIRST SOUTH EAST WALES VASCULAR ENGAGEMENT EVENT

11TH MARCH 2021

2:00PM – 3:30PM

(LIVE EVENT VIA TEAMS)

Panel Members

Mr Kevin Conway	Vascular Surgeon
Dr Stuart Hackwell	Locality Group Director, Rhondda & Taff Ely Locality
Marie-Claire Griffiths	Assistant Director of Strategy & Commissioning
Hannah Davies	Physiotherapy
Lee Leyshon	Assistant Director, Engagement & Communication

In Attendance:

Adrian Osborne, Assistant Director, Engagement & Communications, Powys Teaching Health Board

Michelle Lloyd, Business Support Manager, Cwm Taf Morgannwg University Health Board

Ben Screen, Senior Welsh Language Translator, Cwm Taf Morgannwg University Health Board

1. Marie-Claire Griffiths opened the public engagement event, welcome all and ran through the agenda for the day. Attendees were asked if they required Welsh language translation and it was noted that no Welsh language translation was required for this event.
2. Marie-Claire Griffiths commenced with a presentation around the South East Wales Vascular Network.
3. Panel members introduced themselves and gave a brief overview of their roles at slide 3 of the presentation.
4. Dr Stuart Hackwell presented slide 5 to the group which outlined what the aims are of the engagement i.e. to start a discussion with citizens about how vascular services are organised in the future.
5. Mr Kevin Conway presented slides 6 – 16 to the group which outlined:-

- What are vascular services?
 - Who needs vascular services?
 - How are services provided now?
 - Why are we talking about them?
 - Measures of how well organisation do?
 - History of discussion to date
 - Have we given thought to where the hub might be?
 - What about the spokes?
6. Marie-Claire Griffiths presented slides 17 to 20 which outlined:-
- What would this mean for patients?
 - How can you get involved?
 - We want to hear your views?
 - How can you contact us?
 - Questions?

Marie-Claire Griffiths outlined the areas where we would like people to get involved as part of the engagement, these included views on:-

- The recommendation that a hub and spoke model will improve patient outcomes
- The proposal for UHW in Cardiff to be the Hub
- The suggested Spoke arrangements
- Any other information we should consider in deciding the future of vascular services
- The process undertaken to reconfigure services
- Any alternative view on the proposals put forward

Attendees were encouraged that if they should have any further questions, thoughts, comments or views in addition to any that they may have today to visit the website at : <https://cwmtafmorgannwg.wales/sewalesvascular>

In addition, questions can also be received via email to: sewales.vascular@wales.nhs.uk, a phone line with voicemail is also available the number for which is: 02921 836068, or the public can search #sewalesvascular on social media.

7. Questions:

The following questions were asked:-

Question 1 - Whether there should be two spokes in Aneurin Bevan and whether or not this was still valid after changes in the Royal Gwent as a result of the Grange Hospital opening.

Mr Kevin Conway responded to say that he had spoken to his colleague David Lewis about this and although the original Options Appraisal said that there should be a single spoke in each Health Board, it is slightly more complicated because of the way that the Grange University Hospital is set up. It is actually a specialist care centre so that means it has all the emergency services so it has got an emergency unit, it has the operating theatres and critical care unit but it does not have all of the rehabilitation services and outpatient facilities that the Royal Gwent Hospital had before. So, it is not a straight answer but Mr Conway's understanding was that at least initially it will be spread across the Grange University Hospital and the Royal Gwent Hospital.

Question 2 – Marie-Claire Griffith took this question from the pre-prepared 'Frequently Asked Questions'. What is a vascular network?

The aim of a Vascular Network is to improve patient outcomes and ensure that services are sustainable and equitable for the population they serve. A vascular network provides coordinated vascular services for a population across a wide geographical area and involving a number of different hospitals. Vascular services across NHS England and North Wales and West Wales have already been reconfigured into network models of care for a number of years. Most networks operate a 'hub and spoke' model of care which focuses major urgent and emergency vascular surgical procedures to be performed in one specialist hospital, the 'Hub'. Whilst minor procedures, investigations assessments, recovery following surgery and outpatient appointments still take place in local hospitals, the 'Spokes'.

Question 3 - Marie-Claire Griffiths took this question from the pre-prepared 'Frequently Asked Questions. What is the difference between a hub and a spoke?

The crucial differences between a hub and a spoke are the seriousness of the conditions treated and the complexity of the procedures undertaken. The Hub

receives all vascular emergencies requiring vascular or endovascular intervention, along with all vascular inpatient urgent care. It has dedicated vascular inpatient beds in a ward staffed by nurses with an interest in vascular surgery. A spoke hospital provides everything other than complex and emergency vascular care and has no dedicated vascular hospital bed.

Question 4 - For those patients who do not have IT or social media how are their views obtained?

Marie-Claire Griffiths responded stated that posters have been developed and shared across GP surgeries, mass vaccination centres, posted on hospital TV screens which outlines that there are a number of options for the public to share their views with us. These include:-

- Via our website <https://cwmtafmorgannwg.wales/sewalesvascular>
- By email to the address: sewales.vascular@wales.nhs.uk
- By phone to 02921 836068 (there is also a voicemail service)
- Or via social media by searching #sewalesvascular

Lee Leyshon also advised that the public can also write to the Cwm Taf Morgannwg University Health Board with their questions, views or comments and also stated that the Health Board are open to any addition suggestions for engagement.

Question 5 – Which part of Powys does this affect?

Marie-Claire Griffiths responded stating that this change primarily affects the South Powys area as that is the area at the moment that receives its vascular services through Aneurin Bevan University Health Board, other parts of Powys are either served through the South West or the North of Wales and also England.

Kevin Conway – added that as the Network Representative he had met with Powys Teaching Health Board Commissioners recently and that we are currently just looking at South Powys but we are looking at the potential to cover as far West as Ystradgynlais and as far North as Llandrindod Wells but that is only discussion but going back to the answer primarily it is only South Powys that will be affected.

NOTE **further confirmation was received from Powys following this response to say that pathways for Ystradgynlais and Llandridod Wells patients are not affected by these proposals and their pathways remain unchanged.

Question 6 - Marie-Claire Griffiths took this question from the pre-prepared 'Frequently Asked Questions. How many patients do the changes affect?

The total number of patients likely to need a vascular procedure across South East Wales is approximately 1250 each year. This estimate is based on the numbers from the year 2019, which saw 456 patients treated at the Royal Gwent Hospital, Newport, 355 patients treated at the Royal Glamorgan Hospital, Llantrisant and 437 treated at University Hospital of Wales in Cardiff.

Question 7 - What are the implications on Welsh Ambulance Services NHS Trust? (WAST)

Marie-Claire responded to say that conversations are ongoing with the Welsh Ambulance Services NHS Trust ensuring that they are involved and engaged with all the plans. There may be some implications on patient transport but these will be able to be predicted and managed. Robust demand and capacity planning will be undertaken with WAST so that any implications are understood. We will be looking to support patients to their return to their own home for recovery in the first instance but if they can't they will go to their local hospital so there will be some impact for WAST in terms of patient transport but we are engaged with WAST so that they will be prepared for any changes that could happen.

Question 8 - Marie-Claire Griffiths took this question from the pre-prepared 'Frequently Asked Questions. Why do vascular surgical services need to be changed?

We want to make sure that we provide the best care possible for people needing vascular surgery in South East Wales. We know that:-

- Vascular surgery is becoming increasingly specialised and the evidence shows that patients have better outcomes if they receive their treatment at larger specialist centres
- The Royal Surgical Colleges and The Vascular Society of Great Britain & Ireland support the view that it is no longer desirable to provide urgent or

emergency vascular surgery outside a fully centralised service or a formalised clinical network with a designated single arterial centre providing a 24/7 on-site service.

- A lack of specialist staff to cover the existing vascular units means that we cannot deliver the service safely, the way we have done in the past, and provide the opportunities for staff development and training that other centralised vascular services can.

9. Why the University Hospital of Wales as the hub

Question 9 - Marie-Claire Griffiths took this question from the pre-prepared 'Frequently Asked Questions. How do vascular services work elsewhere in Wales?

The population of North Wales are served by a network with Ysbyty Glan Clwyd, in Rhyl, as the Hub. Vascular clinics, investigations, diagnostics, vascular access and varicose vein procedures are provided by three spoke district hospitals, in Betsi Cadwaladar University Health Board. In South West Wales the population are served by a network with Morriston Hospital as the hub site and spoke services provided in several hospitals in Hywel Dda and Swansea Bay University Health Boards areas.

Question 10 - Is there any impact of covid on recovery proposals we are all aware of long waiting lists after the pressures of the last year?

Mr Kevin Conway responded to say that we do not expect an impact as vascular care tends to be an urgent and emergency service, so if someone needs to have an operation or procedure we can do this within a few days or weeks. We do not tend to have waiting lists so do not expect it to be impacted by covid.

Question 11 - Marie-Claire Griffiths took this question from the pre-prepared 'Frequently Asked Questions. What happens next?

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

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

Question 12 - Can you clarify who will undertake the follow up outpatient appointments and where these will be undertaken?

Mr Kevin Conway responded to say that we will endeavour to do these in your local spoke hospitals, but some patients will need to go to hub hospitals where there are complex wounds but the majority will be in local spoke hospitals.

Marie-Claire Griffiths reiterated how people can contact us to ask questions, share comments and views. Comments to be received by the 16th April 2021. Attendees were informed that today's event was recorded and can be shared. Details of the second event were shared which is being held on the 23rd of March 2021 from 6pm – 7.30pm. Attendees and panel members were thanked and the event was closed.

Summary of Themes

- **Site of follow up outpatients appointments.**
- **Having two spokes in Aneurin Bevan and whether or not this was still valid after changes in the Royal Gwent as a result of the Grange Hospital opening.**
- **The impact of covid recovery on the proposals.**
- **Obtaining views of patients who do not use IT or social media.**
- **Implications on WAST?**
- **Parts of Powys affected by changes.**

23.03.2021

FIRST SOUTH EAST WALES VASCULAR ENGAGEMENT EVENT

23^{re} MARCH 2021

6:00PM

(LIVE EVENT VIA TEAMS)

Panel Members

Mr Kevin Conway	Vascular Surgeon
Dr Stuart Hackwell	Locality Group Director, Rhondda & Taff Ely Locality
Marie-Claire Griffiths	Assistant Director of Strategy & Commissioning
Jo McLaughlin	Physiotherapy
Kate Rowlands	Vascular Nurse Specialist
Lee Leyshon	Assistant Director, Engagement & Communication

In Attendance:

Michelle Lloyd, Business Support Manager, Cwm Taf Morgannwg University Health Board

Ben Screen, Senior Welsh Language Translator, Cwm Taf Morgannwg University Health Board

A minutes silence was held for all those lost during the Covid-19 pandemic.

1. Marie-Claire Griffiths opened the public engagement event and welcome all. It was noted that the event was being recorded so that it can be uploaded to the Cwm Taf Morgannwg Webpage so that those who were unable to join can watch the session and listen to the question raised. Attendees were asked if Welsh language translation service was require and it was noted that no Welsh language translation was required for this event.
2. Marie-Claire Griffiths commenced with a presentation around the South East Wales Vascular Network and rang through the agenda for the event.

3. Panel members introduced themselves and gave a brief overview of their roles at slide 3 of the presentation.
4. Dr Stuart Hackwell presented slide 5 to the group which outlined what the aims are of the engagement i.e. to start a discussion with citizens about how vascular services are organised in the future.
5. Mr Kevin Conway presented slides 6 – 16 to the group which outlined:-
 - What are vascular services?
 - Who needs vascular services?
 - How are services provided now?
 - Why are we talking about them?
 - Measures of how well organisation do?
 - History of discussion to date
 - Have we given thought to where the hub might be?
 - What about the spokes?
6. Marie-Claire Griffiths presented slides 17 to 20 which outlined:-
 - What would this mean for patients?
 - How can you get involved?
 - We want to hear your views?
 - How can you contact us?
 - Questions?

Marie-Claire Griffiths outlined the areas where we would like people to get involved as part of the engagement, these included views on:

- The recommendation that a hub and spoke model will improve patient outcomes
- The proposal for UHW in Cardiff to be the hub
- The suggested Spoke arrangements
- Any other information we should consider in deciding the future of vascular services
- The process undertaken to reconfigure services
- Any alternative view on the proposals put forward

Attendees were encouraged that if they should have any further questions, thoughts, comments or views in addition to any that they may have today to visit the website at : <https://cwmtafmorgannwg.wales/sewalesvascular>

In addition questions can also be received by letter to the Health Board Headquarter Offices, via email to: sewales.vascular@wales.nhs.uk, a phone line with voicemail is also available the number for which is: 02921 836068, or the public can search #sewalesvascular on social media. To be received by the 16th April 2021.

7. Questions:

Question - For those patients who do not have IT or social media how are their views obtained?

Marie-Claire Griffiths responding by stating that posters have been developed and shared across GP surgeries, mass vaccination centres, posted on hospital TV screens, GP practice screens which outlines that there are a number of options for the public to share their views with us. These include:-

- Via our website <https://cwmtafmorgannwg.wales/sewalesvascular>
- By email to the address: sewales.vascular@wales.nhs.uk
- By phone to 02921 836068 (there is also a voicemail service)
- Or via social media by searching #sewalesvascular

The public can also write to the Cwm Taf Morgannwg University Health Board with their questions, views or comments. The Health Board are open to any addition suggestions for engagement.

Question - Marie-Claire Griffiths took this question from the pre-prepared 'Frequently Asked Questions. How many patients do the changes affect?

Kevin Conway responded by stating that it is difficult to quantify exactly but we can look at the total population that the Health Board covers and we can tell you the number of operations that we undertake per year, realistically from the Cwm Taf area we are looking at several hundred patients per year will be affected whether they require inpatient treatment or outpatient treatment. I think there are a slightly higher number of patients from the Gwent valley will be affected, probably somewhere between 300 and 500 per year outpatient and inpatient treatment, for South Powys it is a smaller number probably less than 100 patients per year.

Marie-Claire Griffiths added that we do have some figures which are included in the engagement documentation which you can find on the website which show that the total number of patients likely to need a vascular procedure across South East Wales is approximately 1250 each year. This estimate is based on the numbers from the year 2019, which saw 456 patients treated at the Royal Gwent Hospital, Newport, 355 patients treated at the Royal Glamorgan Hospital, Llantrisant and 437 treated at University Hospital of Wales in Cardiff.

Question - What are the implications on Welsh Ambulance Services NHS Trust? (WAST) (this question was taken from the FAO's)

Marie-Claire responded to say that conversations are ongoing with the Welsh Ambulance Services NHS Trust ensuring that they are involved and engaged with all the plans. There may be some implications on patient transport but these will be able to be predicted and managed. Robust demand and capacity planning will be undertaken with WAST so that any implications are understood. We will be looking to support patients to their return to their own home for recovery in the first instance but if they can't they will go to their local hospital so there will be some impact for WAST in terms of patient transport but we are engaged with WAST so that they will be prepared for any changes that could happen.

Question – Have you engaged with diabetic patients in primary and secondary care yet? Also have you been in contact with national support groups, County Borough Councils and Stakeholder Reference Groups?

Marie-Claire Griffiths responded that yes we have, the Health Board has a robust stakeholder list with whom we ensured we shared the engagement documentation with, this list included local groups and County Borough Councils. The documentation has also been shared with the Cwm Taf Morgannwg Stakeholder Reference Group and our Chief Executive wrote a letter to all our stakeholders, including the Stakeholder Reference Group and invited them to attend the engagement events. Specifically because of the links with diabetes we have written to the diabetic associations and stroke associations and we have also undertaken an exercise where we have linked in and passed information to past patients of our vascular services as well.

Question – Does this mean that the University Hospital Llandough is the spoke hospital for Cardiff and Vale patients?

Kate Rowlands responded to say that at the moment there is a lot of planning that has been going on but it is hoped that all the plans are in place for us to have some beds over in Llandough Hospital so we would be able to use those to transfer patients from the acute ward at the University Hospital of Wales, for those patients who required further rehabilitation, in order to get them home, those patients will be moved to Llandough Hospital and their discharge further planned from there.

Question - Is there any impact of covid on recovery proposals we are all aware of long waiting lists after the pressures of the last year?

Kevin Conway responded to say that vascular services are probably unique, there is no waiting list for vascular services, most vascular conditions need to be treated promptly when they present. The plans sit outside the covid recovery plans and we do not envisage any impact either of covid recovery or vis versus us on the covid recovery plans.

Marie-Claire Griffiths reiterated how comments/views or questions can be shared with us.

Question - Can you clarify who will undertake the follow up outpatient appointments and where these will be undertaken?

Marie-Claire Griffiths responded to say that we will endeavour to do these in your local spoke hospitals. Kevin Conway stated that one of the areas that has been successful as a result of covid is virtual clinics, using both telephone follow up and video conferencing, feedback from patients has been really good so where we can patients will be followed up virtually, if the patient needs to be seen because they have a wound or because they have an ongoing problem, we will endeavour to see them at a local spoke hospital rather than bringing them back to a hub, although there is occasionally reasons to bring patients back if they require further imaging or further treatment but on the whole patients will be followed up virtually or at spoke hospitals.

Question – Will the Health Board provide transport or cover transport costs for patients or carers who need to travel to Cardiff?

Marie-Claire Griffiths responded to say that building on the response that Kevin just gave we will endeavour to minimise the transport that is required for follow up appointments to minimise the need for patients and carers to travel to Cardiff. If there is that requirement then there are already transport links that

are established between hospital sites so that we can look to support patients and carers to travel through those means and if there are any costs and if this is a problem for patients then we can certainly look into our policies that look at support covering costs for patients and carers who do struggle to be able to travel to Cardiff.

Question – So what are the next steps?

Marie-Claire Griffiths responded to say that this is our opportunity to speak to you and hear your views and we want to hear your thoughts and reflections and we want you to share your views with us. We will be collating all of the information we receive through all of the different channels and the South East Wales region, we will be making sure that we have addressed any concerns and captured any of the implications and thoughts as part of our planning process and we will be working closely with local Community Health Councils to share the views and any concerns that we might have had from the public or patients as part of this. We will then be having conversations with the Community Health Councils as to what the next steps for this are but we don't know the next steps explicitly until we have had the opportunity to hear from you and hear the views of the public.

Marie-Claire Griffiths reiterated that we will consider all of the feedback and share this with the individual Health Boards and the relevant Community Health Councils. We will also publicly make available a report that outlines a summary of comments, questions and suggestions that have been received. We will consider all of the issues and whether there are any mitigating actions that need to be taken. We will also use the information received to update the Equalities Impact Assessment. Subject to further discussions with the Community Health Councils, we may wish to enter a period of formal consultation and should we do that we will once again invite your views.

Marie-Claire Griffiths outlined again ways in which views and questions can be shared in relation to this engagement.

Question – Please can you inform the public that they can also contact the Cwm Taf Community Health Council with any comments/views or questions that they may have.

The contact number for the Cwm Taf Community Health Council is : 01443 405830

Marie-Claire Griffiths outlined that :-

Should you have any feedback in relation to today's event, our engagement and involvement processes or in particular around any of the following areas, we would be happy to receive your feedback by emailing it to: CTT_Planning&PartnershipsTeam@Wales.nhs.uk

- Timings of the event
- Format
- Speakers available
- Usefulness of visuals
- Usefulness of the session
- Feeling that queries were answered
- Or any other suggestions about how we can continue to improve the way we engage.

Question – For those of us in the Bridgend area, can you provide links for us to follow up with the same questions?

Marie-Claire Griffiths stated that any questions from the Bridgend area, firstly you can always contact the Community Health Council but equally if you want to use either the SE Wales Vascular email address or the Planning & Partnerships email address we would be happy to pick up your questions and link you with the most appropriate contact details for the SW Wales area.

Question – Are Cwm Taf Morgannwg planning to undertake more live events like this in the future?

Marie-Claire Griffiths responded to say, yes if there is a specific request to do another live event on the SE Wales Vascular Network then we would be happy to do that to support this engagement process. We would also be happy to undertake other live events in the future on areas.

Lee Leyshon informed attendees that certainly throughout the experience of covid where we have had to drive a lot of our work and day to day lives online, whether that is for schooling or whether it is for work, public engagement is there as well. It is strange to think about life without covid but the sort of access that online access gives us is really helpful and is something that we would want to keep in any engagement activity going forward but equally nothing substitutes face to face engagement which we would want to undertake as well after covid. Your feedback about these types of events, how the timing was, the format of the event is really helpful because we are testing these processes as

well, so any information that you can give us is really helpful and gratefully received as that will inform what we do going forward in the future.

Marie-Claire Griffiths thanked the panel and attendees and closed the event.

Summary of Themes

- **Transport and transport costs**
- **Health Board using live events for engagement going forward**
- **Links for Bridgend questions**
- **Llandough Hospital being the spoke for the University Hospital of Wales**
- **Liaising with diabetic patients, national support groups and stakeholders**

C3. Aneurin Bevan University Health Board

10.03.2021

Aneurin Bevan University Health Board

Vascular Services Network

Public Engagement Meeting

Date: 10/03/21

Time: 2pm

Attendees:

Name	Organisation	
Christopher Dawson-Morris	Assistant Director of Planning ABUHB	Panellist
Mr. David Lewis	Consultant Vascular Surgeon, ABUHB	Panellist
Mr. Peter Lewis	Consultant Vascular Surgeon, ABUHB	Panellist
Heather Barne	Head of Podiatry & Orthotics, ABUHB	Panellist
Annie Clothier	Vascular Clinical Nurse Specialist, UBUHB	Panellist
Kristian Glover	Assistant Vascular Practitioner, ABUHB	Panellist
David Hanks	Head of Service Planning, ABUHB	Panellist
Nicola Jones	GE Healthcare	Attendee
Liz Power	Citizen	Attendee
Pat Powell	Gwent Association of Voluntary Organisations	Attendee
Isobel Jones	Welsh Ambulance Services Trust	Attendee
Geoffrey Davies	Powys Community Health Council	Attendee
Rhiannon Davies	Citizen	Attendee
Gemma Lewis	Powys Teaching Health Board	Attendee

When a patient is referred to a spoke who would they be seen by? Will it be a consultant? Will it be a nurse? What will be the situation when they arrive at the spoke?

We will still take GP referrals in the same way as we do now. There is an electronic referral system where the consultants triage the referrals online. Depending on the referral the consultant will decide on the most appropriate clinic for the patient.

The choices now, due to COVID, have made us realise that a lot of patients like telephone consultations rather than face to face consultations. If you've got a wound, telephone consultations may not be suitable, if someone has a hearing problem then telephone consultations may not be suitable but for almost all other patients they appreciate the fact that they do not need to drive to the hospital and park and relatives don't need to take time off work. So in addition to the telephone consultations we do a virtual consultation via a video link and the software is called 'Attend Anywhere'. You only need a mobile phone or an iPad to do it and we've done a lot of successful online consultations like that and that means the patient or relative can show you a bit of the patient, so if they have a problem with their foot they can show you a picture over the internet. It's all secure so there are no problems with patient confidentiality. Other than that we will still be doing outpatient clinics in the spokes that I have mentioned and depending on the condition the patient may be seen by a Vascular Nurse Specialist or a Consultant.

Please could a copy of the presentation be sent to review the information in it and also to share it with Primary Care colleagues in Powys?

Yes of course this will be shared following the session to all that attended today. A similar version is included in the resources on the website.

Why has it taken this long and what are the timeframes for implementation of centralisation structure if it goes ahead?

I don't think it will help going back over the past history of this except to say that it has taken too long. We hope to start the new service off in September /October 2021. There is a fairly long history to developing this service and we are pleased to have got to this point.

You are saying that this new model, you are doing it to improve outcomes, am I right in thinking that the hub is the basis for the outcomes being improved? Why is the hub going to improve outcomes? Are you able to say how outcomes are going to be improved through the hub and spoke model?

In the UK, this dates back to publications by Professor Peter Holt who looked at volume outcome measures. For index operations namely aneurism repair in carotids and found out that there was an unacceptably high mortality rate in small centres. That there was an obvious link to volume in that the larger centres had much better outcomes that's stimulated a lot of centralisation in England and the improvement in outcomes was maintained. The National

Vascular Registry publishes those outcomes every year and you can see a funnel plot / graph showing the relationship between volume and outcome. You asked why that happens, it's been looked at and it's very difficult to put your finger on exactly why it happens. There's some research from the USA that shows that busy surgeons get better outcomes but that isn't a finding across the board, there are other studies that show that busy surgeons aren't the important thing. I think most of us believe that it is the whole package. As much as I or Peter would like to think that we are a really important link in the chain, equally as important are things like the care you get on the ward. The proposal is that we would have a ward of 35 beds and one would imagine and hope that those 35 beds will be over-seen by one or two Senior Sisters that are familiar in caring for vascular surgery patients and who have recruited and trained a team of highly skilled nurses under their wing who will also provide better care for patients. You've then got Emma Richards who is the Vascular Network Coordinator, and roles like that in a bigger unit make sure that patients get seen quicker and quicker in vascular surgery is better and you get better outcomes. It's multi-faceted the definite is that you can't argue with the data that you get better outcomes.

How will the hub model improve you working with other specialities such as Rheumatology?

We will still have a significant presence in spoke hospitals. I know I will be spending a significant proportion of my week here at the Royal Gwent Hospital doing my professional supporting activities. That means that people knock on my door and ask me vascular surgery questions. We have the Diabetes Service here at the Royal Gwent Hospital, which is important. Peter has made good relationships with multiple colleagues in multiple specialties and they know we are very easy to access and very happy to be spoken to at any time. I suspect we will be spending 50% or more of our time either at the Royal Gwent Hospital or up and down the valleys.

What change will it make to the patients in South Powys and more particularly Crickhowell area? Would it be fair to say that the principal difference to us is that for an initial consultation we would be directed to the Grange University Hospital and then onto University Hospital Wales? Nevill Hall Hospital to University Hospital Wales?

It is important to split outpatients and inpatients. The Outpatient service for patients in Gwent and South Powys will remain very similar to what it is at the moment and it may even be better, we may even provide more services in Nevill Hall Hospital or even Brecon on an outpatient basis.

All patients (and this is the minority) that need to go into hospital for a big operation instead of going to the Grange University Hospital will go to the University Hospital Wales.

It's a similar process that we underwent about six years ago when we transferred vascular services from Nevill Hall Hospital down to the Royal Gwent Hospital. We still provided an Outpatient service in Nevill Hall Hospital and Brecon but any of the smaller narrative patients that required admission for major surgery went down to the Royal Gwent Hospital which in the future will be University Hospital Wales.

We actually discussed South Powys among the four vascular surgeons in our weekly business meeting. The four of us are very keen to increase our presence in South Powys, and even venture further north seeing patients closer to their homes. The exact logistics of that still need to be worked out but there is certainly a willingness from our part.

I am a vasculitis patient. Vasculitis services in Wales in general are known to be particularly poor. Will this make any change to the Vasculitis Service?

No it won't. The only time we really get involved with vasculitis patients is for iloprost infusions and we don't do anything because the rheumatologists don't have inpatient beds they've used us in the past. There's no reason if a patient needs an iloprost infusion can be admitted under any speciality, General Medicine would be the ideal one because iloprost infusion is just a protocol for administering the infusion.

There may be some change in the course of time as we develop better relationships with Rheumatologists in Cardiff in particular as it is a bigger unit. If they are providing treatments for vasculitis that that we don't have locally then that would be much easier way for providing that for local patients.

With a centralised service there is much more potential for individuals to develop niche interests. If a surgeon wanted to link up with a Rheumatologist and do joint clinics I'm sure that would be exactly what a regional specialist centre would be expecting and wanting.

Main Themes of Session

- ☐ How our pathways work
- ☐ How to make sure we are getting the service right up front and that we are not making people travel lots of miles
- ☐ Really clear on how people will flow through from local hubs right to the centre
- ☐ We think about how we start to develop some of the specialties and some of the wider benefits that come from the centralisation of services and make sure that we get links with other services such as Rheumatology.

16.03.2021

Aneurin Bevan University Health Board Vascular Public Engagement Event

Tuesday 16th March, 2021

18:00hrs via Microsoft Teams

Name	Organisation	
Mr. David Lewis	Consultant Vascular Surgeon, ABUHB	Panellist
Mr. Peter Lewis	Consultant Vascular Surgeon, ABUHB	Panellist
Heather Barne	Head of Podiatry & Orthotics, ABUHB	Panellist
Kristian Glover	Assistant Vascular Practitioner, ABUHB	Panellist
David Hanks	Head of Service Planning, ABUHB	Panellist
Karen Newman	Assistant Director of Communications and Engagement, ABUHB	Staff Member
Amy Sullivan	Engagement Development Manager, ABUHB	Staff Member
Adele Skinner	Engagement Officer, ABUHB	Staff Member
Tony Crowhurst	Disability Advice Project	Attendee
Councillor Judith Pritchard	Caerphilly County Borough Council	Attendee
Janine Harrington	Citizen	Attendee
Susanne Maddax	GAVO	Attendee
Councillor Val Smith	Monmouthshire County Council	Attendee

Has there been technological progress that requires specialist equipment means it is more sensible to have services on one site?

Specialist equipment and medicines evolve all the time and Vascular Surgery went through an incredible evolution in the late 1990's and early 2000s minimally invasive techniques really catapulted us into the future. The procedures are ubiquitous throughout the Northern hemisphere, USA Europe. The demand for specialist equipment will always be there and always evolve and it's not a static playing field. Equipment is expensive being assessed and installed as we speak.

Is there going to be room within the University Hospital of Wales as there seems to be lots of things that seem to be pushed there? Will you have an extra building there and how are you going to manage that?

An extremely good planner called Johnathan Haxton, who has now very sadly passed away, completed an extremely complex piece of work on demand and capacity taking data from all three of the Health Board's and that data has been accepted. It means that we will have a large ward of 30 – 35 patients with the potential to have one ward sister or an old fashioned matron looking after a large ward with lots of senior nurses under their wing to make sure that they are all passionate about looking after Vascular Surgical patients. We don't have that at the moment and we think that's one of the things that will probably improve our outcomes in the short, medium and long term.

The other capacity issue is getting into an operating theatre as a surgeon and there are two types of operating theatres that we use: conventional ones and we have secured capacity for that and we also use what's called a hybrid operating theatre when we have fixed high quality imaging in a fully specked out operating theatre so that patients who will be advantaged by high quality imaging can get it immediately and there is a process where the business case for that is being sent to Welsh Government really as we speak.

You mentioned Neurosurgery and my question is based on that. You talked of the large ward of 30 patients, will the level of that be almost one down from Intensive Care? I have experience of T4 Neuro where it's not quite Intensive Care but it's a similar level of nursing. Is that the plan for this proposal that it will be a higher level than specialist care?

There are fairly strict definitions about Critical Care so there is level one and level two units and that depends on the organ support that the patient needs. We wouldn't be providing a Critical Care service on another ward but Vascular Surgical patients by definition often have multiple co-morbidities so they are often diabetic, they may have had strokes, they may have had heart disease, COPD and a lot of them have got social needs on top of that and you need a group of nurses that really understand the complexities of those patients not only to furnish the care they need but to also to get the outcomes that we are so passionate about achieving. Interestingly, this was one of the by-products of centralising Neurosurgery in Cardiff and prior to that Neurosurgical patients that needed support post operatively went to the general Critical Care unit but by putting the whole population into the South Wales centre meant that the

critical mass of patients meant that they were able to develop for all intents and purposes a specialist Neuro Intensive Care. This meant that the staff looking after them were dedicated specialists. Critical mass is a key element to making things viable.

Will a copy of today's presentation be available to be circulated?

Yes. They can be sent out following the meeting.

How do you link in with prevention services such as dietary advice?

As a Surgeon and a trainer I teach my medical students that although I can do some quite clever surgeries, if I make sure that every patient I see has their cardiovascular risk factors managed appropriately, I'm doing a lot better for society than I am by doing occasional big operations. So it is fundamental to us and that's only really happened over the last 20 years that our knowledge about risk factor management has increased but also Vascular Surgeons have taken on the role rather than just being a Surgeon and just operating, we have a more holistic approach to the patients now. That interaction goes on in every clinic and it goes on in every teaching session.

Comments:

- Your proposals are sensible and we are fully supportive of them. We wish you the best of luck. Thank you for a very informative talk and for making it so convenient as well. There is one thing that always concerns me and that is the transport issue and it can worry people that live in a rural area but that is something that needs resolving elsewhere.
- I represent a group of patients with Ehlers-Danlos Syndrome (EDS) and there is currently no centre of excellence in Wales. We have people in our group that have to go to London to get letters written by Consultants who will support their welfare rights and applications and we feel this is completely wrong. For a few years now, we have been endeavouring to convince the Welsh Government that some sort of centre of excellence should be established in South Wales to deal with the Welsh population. From our point of view, people in England are far better treated than people in Wales. If there is anyone with experience of EDS we are not allowed to swap from one Health Board to another. Coming into areas that we are talking about today, one of our people has had his gallbladder removed which we understand is a relatively simple operation but it wasn't taken into account that he has EDS and

the people operating on him were failing to understand why he wasn't healing. This is a classic instance of where a lack of knowledge and a lack of an operation being done by a group of people who knew exactly what was going on having a detrimental effect on this particular patient's outcome. The idea of you setting a group up here which brings together people who are excellent in the treatment of Vascular disease is a great idea and we would thoroughly support that but we would want there to be a way that when EDS is being treated on a pan Wales area, we plead that there will be a centre of excellence eventually but people from your group would need to offer their services to patients with EDS.

- *(Comment placed in meeting chat)* We waited a long time to get a hospital like the Grange but yet we would be using the Cardiff Heath again as the main centre. We have had issues with travel to Velindre for cancer services and dental hospital and out of county access being stopped. We are working in Gwent towards integration and care closer to home and preventative services to hopefully prevent people becoming more complex and needing surgical interventions in secondary Care.
- *(Comment placed in meeting chat)* It would be beneficial to engage third sector support for patients that spans secondary and community care

Main Themes of Session:

- Fully supportive of Vascular Service change
- How the pathways / service will work
- Travel and location

17.03.2021

Aneurin Bevan University Health Board

Vascular Services Network

Public Engagement Event

Wednesday 17th March, 2021

18:00hrs via Microsoft Teams

Name	Organisation	
Mr. David Lewis	Consultant Vascular Surgeon, ABUHB	Panellist
Mr. Peter Lewis	Consultant Vascular Surgeon, ABUHB	Panellist
Heather Barne	Head of Podiatry & Orthotics, ABUHB	Panellist
Christopher Dawson Morris	Assistant Director of Planning, ABUHB	Panellist
David Hanks	Head of Service Planning, ABUHB	Panellist
Amy Sullivan	Engagement Development Manager, ABUHB	Staff Member
Eddie Bowen	Citizen	Attendee
Richard Morgan Evans	Citizen	Attendee

If all major surgery is going to be carried out in UHW, what sort of affect will this have on parking there for visitors and the ambulance service delivering patients to the hub and then back out to the spokes?

The Health Board recently moved 900 administrative staff off the UHW site into a new Headquarters which has significantly increased the availability of parking. Also opened a new Park & Ride service two junctions down on the A48 so that has vastly improved the situation there.

With Ambulances queuing outside hospitals at A&E I'm not sure on what the effect of logistics of movement is going to be under these circumstances?

We work very closely with the Welsh Ambulance Service in terms of the service planning and the numerous committees that David

mentioned as part of his presentation. They are well involved in understanding any changes in journeys and flows that would be required. It is part of the planning process, making sure that we have that factored in.

What sort of time do you think this major surgery and rehabilitation will take?

It depends on the procedure being carried out. If you go in for a carotid operation on your neck you'll be out the following day.

If you go in for an amputation you'll probably be in UHW for a short period of time before being transferred for rehabilitation and ongoing care into one of the ABUHB hospitals.

What timelines are we looking at here if the more major vascular surgery is moving to UHW?

This is an engagement process and assuming we don't have to do a follow up public consultation then we'll be looking towards the end of this year to start to implement that change. We're looking at the autumn for implementation.

Why was UHW chosen? I'm conscious it is a tertiary centre for many services already.

There was a fairly rigorous option appraisal process that went on for quite some time and UHW came out on top. Aneurin Bevan and Cwm Taf were considered. That appraisal was around adjoining services, the major trauma centre and other services that are in UHW.

With initial surgery at UHW and then onwards journey back to peripheral hospitals for recovery – would you see that including the Grange University Hospital or are we talking Royal Gwent Hospital and Nevill Hall Hospital?

Much of the outreach work and repatriation will take place across all of our sites, in Nevill Hall, at the Royal Gwent and in the community as-well.

Comments:

- I have no objections whatsoever to the hub being in Cardiff.
- I have participated in Peter Lewis's clinics held in Cwmbran and think they are a very good idea particularly under the COVID circumstances.
- I accept the centralising of service and more people involved and gaining more experience.

Main Themes of Session

- Fully supportive of Vascular Service change
- Car Parking at UHW
- Timelines of implementation

D. Midpoint Review Report

VASCULAR SERVICES ENGAGEMENT MID POINT REVIEW REPORT

12/04/2021

1. Introduction

This report sets out the progress to date against the plan for public engagement on proposed changes to vascular services in South East Wales.

The public engagement plan for the proposed development of vascular services in South East Wales was developed collaboratively by four Health Boards, namely Aneurin Bevan University Health Board, Cwm Taf Morgannwg University Health Board, Cardiff and Vale University Health Board and Powys Teaching Health Board.

2. Background and Context

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

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

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

Clinical engagement has taken place throughout the service development process and there remains good clinical consensus. A letter confirming that

the work undertaken during the clinical option appraisal process in 2014 remains valid has recently been received by the Chair of the Joint Vascular Programme Board. Indeed the clinical body indicated the preferred option had now been strengthened since the location of the Major Trauma Centre was identified at University Hospital Wales.

2.1 Requirements on managing change in NHS Wales

The guidance on changes to NHS services in Wales proposes a two stage process to the management of change that requires consultation and engagement. It should be noted that there is also provision in the guidance for the management of urgent temporary change which is a situation that applies to Cwm Taf Morgannwg University Health Board who had to make this arrangement for vascular services during COVID-19 as the service became unsustainable. The approach to engagement has sought to enable good governance and management of the change as well as enabling the temporary arrangements in place for Cwm Taf Morgannwg to be formally engaged and consulted upon.

3. Engagement Plan

The engagement plan was developed in collaboration with health board engagement leads and the Community Health Councils to support the engagement process.

An Equality Impact Assessment was also completed and used to inform the engagement plan.

1. Scope of Engagement

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

Organisations that were identified as needing to be part of the consultation and engagement were Aneurin Bevan University Health Board, Cardiff and Vale University Health Board, Cwm Taf Morgannwg University Health Board and Powys Teaching Health Board, as commissioners of these services for their local population. It is the responsibility of these organisations to lead the

programme of engagement and consultation in their respective areas, however overall co-ordination is being held within the programme structure.

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

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

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

It was however noted that given the extensive work that had been undertaken on a clinical option appraisal and formulation of ideas regarding a hub and spoke model of delivery, that this information should also be shared at the engagement phase, so as to offer as much information as possible, in order to explore with members of the public, and interested stakeholders views on the process that has been followed and whether there is any other information that should be considered.

The affected Community Health Councils considered together, the proposals for engagement at their meeting of 13th January 2021. There was explicit support expressed by both Cwm Taf Community Health Council and Aneurin Bevan Community Health Council, with further discussions taking place with both Powys and South Glamorgan CHCs. Following further assurances about process and remit, there was subsequent agreement by all CHCs to commence the engagement as proposed.

2. Stakeholders

There are a number of stakeholders that have been considered in this engagement and a variety of methods employed to reach those stakeholders.

All Health Boards have well established mechanisms through which they enable cascade and delivery of engagement and consultation materials and these are being used for this programme. There are also national groups and professional bodies that have been given the opportunity to get involved in the engagement; these were profiled within the programme. Given that the engagement and consultation will be happening within a Covid19 context, different ways of engaging the population have been established

The table below outlines the stakeholder groups together with a high level summary of the actions and responsibilities being undertaken.

Please see appendix 1 for the Vascular Engagement Plan

3. The Engagement Document

The main engagement document and summary document were formally approved by the Health Boards at their meetings in January 2021.

4. Methods of Communication and Engagement

So far...

Web pages	• Web pages hosted on each Health Board website • Template supplied with content and useful documents; including FAQs, Easy Read etc • Link to survey and all relevant contact details including; telephone number, postal address etc Web pages: www.abuhb.nhs.wales/sewalesvascular www.cavuhb.nhs.wales/sewalesvascular cwmtafmorgannwg.wales/sewalesvascular www.pthb.nhs.wales/find/sewalesvascular
Staff/ public updates	• Inclusion in Health Board newsletter • All staff email • Digital screen tiles and posters

	• Letter and assets to GPs
Stakeholder outreach	• Stakeholder letter • Communications Toolkit
Social media	• Promotion of public engagement events • Ongoing social media posts • Videos of key spokespeople explaining rationale for the network
Promotional assets	• Posters • Digital screen tiles • Leaflets • Teams Background • PowerPoint template
Engagement events	• Online public engagement events run in collaboration with CHC

Note: All content translated into Welsh.

Next steps...

Advertising	• Facebook advertising • Digital displays and posters in MVCs
Outreach to public event attendees	• Email follow up to all sign ups, encouraging them to fill out the survey
Social media	• Updated Communications toolkit and social media assets

5. Responding to the Engagement

Responses are being captured using the following methods:

- Email via a generic email address
- Online
- Telephone
- Capturing of notes during public and stakeholder meetings

- Full and comprehensive analysis of survey data

4. Mid-Point Review

The rest of this document will review the responses received to date and has informed discussion around the need to make any adjustments to the engagement for the remaining period. It must be noted that a full and comprehensive analysis of the data received through the online survey has yet to be completed, however emerging themes have been captured through the summary data and notes from public engagements.

As of 23rd March 2021, 66 responses have been received with the majority being online responses to the survey.

All responses, including notes of public sessions are being shared with the Community Health Councils.

1. Responses to date

While a comprehensive analysis of the data is forthcoming, a summary of the data has been included in appendix 1. This details key insights from the 66 responses that we have had to date (23rd March 2021) from the online surveys and notes taken from the public engagements. The insights we can draw from the summary data do not differentiate responses from separate University Health Boards and Teaching Health Boards.

Number of attendees at public engagement events					
Cardiff and Vale UHB		Cwm Taf Morgannwg UHB		Aneurin Bevan UHB	
16/03/2021	1	11/03/2021	3	10/03/2021	7
1		1		1	
18/03/2021	6	23/03/2021	5	16/03/2021	5
1		1		1	
				17/03/2021	2
				1	

2. Key Emerging Themes

Please note that Powys Teaching Health Board has integrated with the three remaining University and Teaching Health Boards for public engagement, and therefore a discrete set of themes for Powys Teaching Health Boards cannot be offered here.

Cardiff and Vale University Health Board:

- The rationale for the creation of a Vascular Network is sensible and logical
- Transport, parking, and accessibility needs to be considered throughout the design of this service
- Suitability of University Hospital Wales in regards to impact on other services, geographic location and infrastructure requirements

Aneurin Bevan University Health Board:

- There is support for the rationale behind the creation of a Vascular Network
- Transport, parking, and accessibility needs to be considered in terms of becoming a spoke site
- How will pathways and services work after implementation

Cwm Taf Morgannwg University Health Board:

- Transport, parking, and accessibility needs to be considered in terms of becoming a spoke site
- Implications of the new service on other existing services, such as the Welsh Ambulance Service Trust
- The impact of Covid-19 recovery on the proposals for the Vascular Network

3. Demographic Profile of Respondents

From the summary data, which does not differentiate the responses collect by particular University or Teaching Health Board, the following insights can be drawn. Please note that each point is relative to the overall amount of

respondents who chose to answer each question:

- The majority of respondents are in the 45-45 years old category (37.50%). 16-24 and 16 Under categories are the least represented age demographic
- The majority of respondents are female (70.83%). Men are represented at 27.08% and 2.08% chose Prefer not to say.
- 100% of the respondents did not state that they identify as Trans
- The majority of respondents are in full time work
- The majority of respondents stated their ethnic group as White (95.24%)
- The majority of respondents stated that they do not consider themselves a fluent Welsh speaker (93.75%)

1. Public Event Schedule

Public online events have been arranged during the engagement period. An agreement was reached by the Health Boards and CHCs to complete all the public events by 25th March ahead of the Pre-Election period.

2. Additional Actions taken

A number of actions were agreed during the first half of the engagement to respond to issues raised at public sessions and to ensure sufficient information was in the public domain to allow intelligent consideration of the proposals:

- Additional FAQ to clarify spoke arrangements
- Additional presentation slides to clarify potential impact on residents of each HB area

5. Post Engagement Phase:

The programme team will continue to receive and log responses to the engagement. This information will be shared with health boards and CHCs.

Responses will be analysed by the programme team and themes identified.

A report will be produced which will include the findings of the engagement. This will be discussed with the CHCs in May and the Vascular Joint Programme

Board, to consider and agree next steps including whether to proceed to consultation.

E. Equality Impact Assessment

VASCULAR HUB AND SPOKE NETWORK FOR SOUTH EAST WALES EQUALITY IMPACT ASSESSMENT EVIDENCE DOCUMENT Introduction

This document presents the evidence collected to date in support of the equality impact assessment (EIA) process for the development of a Hub and Spoke Vascular Network service to serve South East Wales. The Equality Act 2010 places a positive duty on public authorities to promote equality for the nine protected characteristics ¹ and requires Welsh public bodies to demonstrate how they pay 'due regard' when carrying out their functions and activities. Equality is about making sure people are treated fairly. It is not about treating 'everyone the same' but recognising that everyone's needs are met in different ways. In the context of this work we are required to assess the impact of policies and services on equality. The purpose of this is to ensure that, as far as is practicably possible, the opportunities for promoting equality and human rights for people with protected characteristics are maximised and any actual or potential negative impact is eliminated or minimised.

The Human Rights Act 1998 also places a positive duty to promote and protect rights. We clearly recognise the importance of putting human rights at the heart of the way our services are designed and delivered. We believe this makes better services for everyone, with patient and staff experiences reflecting the core values of fairness, respect, equality, dignity and autonomy.

In addition we recognise that Wales is a country with two official languages: Welsh and English. We have a responsibility to comply with the new Welsh Language (Wales) Measure (2011). This will create standards regarding Welsh which will result in rights being established that will ensure Welsh speakers can receive services in Welsh. The importance of bilingual healthcare for all patients in Wales is fundamental and is particularly important for four key groups – people with mental health problems; those with learning disabilities; older people and young children. Research has shown these groups cannot be treated safely and effectively except in their first language (Welsh Language Services in Health, Social Services and Social Care, 2012)². Our consideration of equality takes account of this. EIA requires us to consider how the development of a centralised Vascular service, including an arterial centre (Hub), supporting non arterial units (spokes)

and a comprehensive rehabilitation pathway, operating within a network structure for South East Wales, may affect a range of people in different ways. The EIA will help us answer the following questions:

- Do different groups have different needs, experiences, issues and priorities in relation to the proposed service changes?
- Is there potential, or evidence that the proposed changes will promote equality?
- Is there potential for, or evidence that the proposed changes will affect different groups differently? Is there evidence of negative impact on any groups of people?
- If there is evidence of negative impact, what alternatives are available? What changes are possible?
- How will we monitor impact in the future?

This document is not intended to be a definitive statement on the potential impact of the vascular centralisation on protected characteristic groups. The document's purpose is to describe our understanding at this point in the EIA process of the likely impact.

Background

A collaboration between Cardiff and Vale, Cwm Taf Morgannwg and Aneurin Bevan University Health Boards, has been coordinating the development of proposals for a centralised vascular service for South East Wales. Emergency Vascular services have already been centralised at the University Hospital of Wales (UHW).

The project is being led through the SE Wales Vascular steering committee, which is overseeing the work, and is supported by a clinical advisory group, operational group and a number of workstreams. The work will lead on the development of a clinical model and pathways including a comprehensive rehabilitation pathway, operating within a network structure for the region.

Through the steering committee, clinical reference group, clinicians and stakeholders have been working together to examine national guidance and to develop service models to improve care, treatment, rehabilitation and outcomes for vascular patients.

Rationale

Vascular disease accounts for 40% of deaths in the UK, many of which are preventable. The report 'The provision of services for patients with Vascular Disease

(Vascular Society, 2014)³ compiles key recommendations to deliver standards for the care of vascular patients. The evidence is consistent that the best outcomes following elective and emergency interventions are achieved by concentrating inpatient care into arterial centres, this ensures the most efficient use of staff, specialist equipment and facilities.

A minimum population of 800,000 is often considered the minimum population required for a centralised vascular service. This is based on the number of patients needed to provide a comprehensive emergency service; maintain competence among vascular specialists and nursing staff; ensure the most efficient use of specialist equipment, staff and facilities; and the improvement in patient outcome that is associated with increasing caseload. A minimum population of 800,000 would be appropriate but for a world class service a larger catchment area will be required. The population of SE Wales (the resident population of the Health Boards taking forward this proposal is approximately 1.6 million (StatsWales 2016). The current configuration of services across separate hospital sites across South East Wales are too small to meet the quality and safety standards set out by the Vascular Society and the Royal College of Surgeons. None of the current individual units in SE Wales meet this requirement.

Benefits to the whole population will derive from an Inclusive Vascular System that provides for the needs of patients in its region by moving patients to the hospital best able to provide suitable care, freeing resources at other units.

At present, there is no vascular network or designated arterial centre operating across or within South East & Wales. Evidence demonstrates that the introduction of an arterial centre (hub) supported by non arterial units (spokes) and a comprehensive rehabilitation pathway, working in an integrated and mutually supportive way, is expected to raise the quality of services, reduce deaths, and reduce regional limitations and variations in services.

Expected outcome

The SE Wales Vascular service aims to ensure patients have appropriate, timely access to reliable, safe, high quality and sustainable services at all points along their care pathway, in line with best practice standard requirements, and evidenced through key performance indicators.

The proposal is to establish an arterial centre operating within an integrated Vascular network for South East Wales. This will provide patients with the right level of service 24 hours a day, 365 days a year. The arterial centre or 'hub' will be supported by a network of non-arterial units or 'spokes', and rehabilitation provided through specialist and local rehabilitation services.

Rehabilitation is a process of assessment, treatment and management with ongoing evaluation by which the individual, and their family and carers, are supported to achieve their maximum potential. It is a key part of the patient pathway, commencing before admission to an arterial centre, continuing through the inpatient phase to discharge from the hub or spoke into the community and is a true enabler to achieving the best outcomes for individuals.

How it will be delivered

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

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

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

HUB SPOKE

➤ Emergency Vascular Service: ➤ Emergency Vascular Service:-

- Amputations and “*nibbling*”
- Aneurysm surgery;
- Patients requiring CEA within 48 hrs of index event;
- Peripheral arterial reconstructions.
- Angioplasty

- Angiogram;
- As noted above, the “front door” will remain the patient’s local hospital, defined as a Local Hospital with an Emergency Department and an Emergency General Surgery Service;
- Rehabilitation.

➤ **Elective Vascular Service:**

- Abdominal Aortic Aneurysm
- Endovascular aneurysm repair
- Carotid endarterectomy

➤ **Elective Vascular Service:-**

- Venous surgery angiography and angioplasty;
- Outpatient clinics

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

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

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

HUB SPOKE

- Dedicated vascular surgery ward(s). Beds will need to be staffed by an appropriate skill mix of nurses who have been trained in the care of vascular patients. Doppler investigation will need to be available on the ward;
- Hybrid theatre, with experienced vascular theatre staff;
- Scheduled elective lists (IP / DC);
- Anaesthesia – elective vascular services will have dedicated vascular anaesthetic input, from anaesthetists experienced in dealing with vascular patients and with a special interest in this area. This may include anaesthetists from Spoke sites given the opportunity to support elective lists in the hub;
- Intensive Treatment Unit (ITU) and High Dependency Unit (HDU) – Facilities with full renal support must be available onsite to support the vascular

- Mixed surgical wards but with ring fenced vascular beds;
- CEPOD theatre model;
- Interventional radiology;
- Scheduled elective DC lists;
- Outpatient Clinics – including access to nurses/therapists experienced in ulcer and wound dressing. Doppler ultrasound machines should be available. To support this, it is also assumed that each of the spoke sites will have the following:
 - A consultant led Emergency Department (A&E);
 - An Emergency General Surgery service. service. Bookable HDU/ITU with sufficient beds will need to be available for elective patients
 - Interventional radiology suite with access to nursing staff trained in vascular procedures.
 - Out-patients clinics

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

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

It is important to note that as patients begin their recovery and rehabilitation journey, that this too will be provided from a hospital/community setting which is much more local to them.

Who needs these services?

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

morbidity in diabetes and the risks of disease progression are higher, with an epidemic of diabetic foot disease expected in the next decade.

1. Diabetes UK

Risk factors for vascular disease include:

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

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

Patients who receive vascular services may have:

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

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

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

Where are we now?

Equality impact assessment is an ongoing process that runs throughout the course of the decision making process, and through implementation

and review.

This paper defines the proposal for change and the rationale, sets out the expected outcomes and who will be affected by the proposal, and considers potential impacts on different groups and any possible actions for reducing or eliminating disadvantage.

Stakeholder engagement is an important part of the development of the proposals. Stakeholders have been involved in reviewing the EIA and further opportunities will be taken to assess the impacts as the work progresses.

What the evidence tells us on the need for change

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

1. Vascular Society of Great Britain and Ireland Provision of service for patients with vascular disease (2012)

<http://www.vascularsociety.org.uk/library/quality-improvement.html>

2. https://gettingitrightfirsttime.co.uk/wpcontent/uploads/2018/02/GIRFT_Vascular_Surgery_Report-March_2018.pdf

What are the potential impacts on protected characteristic groups?

EIAs require analysing impacts on the basis of protected characteristics: sex; disability; race; religion or belief/non belief; age (younger people and older people); sexual orientation (lesbian; gay and bi-sexual people); gender reassignment; pregnancy and maternity; and marriage and civil partnerships. We have been gathering evidence to inform our assessment of the potential impact of the proposed establishment of a vascular hub and spoke model network on patients, families and carers,

staff, and other stakeholders.

Looking at a range of national research evidence has helped us to consider the potential impact. In particular, we are aware that many people who share certain protected characteristics such as disability, older age, younger people and some minority ethnic groups also face social and or economic disadvantage. Looking at socio-economic disadvantage goes some way to showing due regard to equality considerations. There will also be other distinct areas that are not driven by socio-economic factors but which relate directly to people with different protected characteristics. The proposals under consideration for the establishment of a vascular network will result in the concentration of life-saving treatment for a relatively very small number of patients but with the most serious disease. Non arterial units and a comprehensive rehabilitation service will ensure that as a patient's condition improves responsibility for ongoing care will transfer to healthcare facilities closer to home. The key issue for the protected characteristic groups would seem to be one of access as evidence tells us that some traditionally underrepresented groups' access to health facilities is disproportionately low when compared to the general population. The same can be said with regard to good health outcomes.

Below, from review of national evidence and research, discussion concentrates on the 'at risk groups' and the sections of the population which are likely to be most affected by the Vascular proposals (those groups that are expected to experience impacts which are disproportionate to those experienced by the general population). There is also reference to health care needs in general.

The first observation to make is that Vascular disease tends not to be closely associated with particular equality groups; are not simple to predict on the basis of socio-economic characteristics. Of the protected characteristics, none are particularly susceptible to Vascular disease. However, a few groups are certainly key to consider in this assessment. A literature review was carried out as a first stage of gathering evidence to inform the EIA. The results are provided below against each of the protected characteristics. There has also been engagement with stakeholders through work to develop the rehabilitation pathway.

Age

Engagement with stakeholders on the rehabilitation element of the patient pathway identified that the involvement of carers and family in rehabilitation is more difficult the further away rehabilitation is from local

support mechanisms. It should be recognised that patients are not always able to return 'home', or to the setting they came from. Older patients will have different co-morbidities such as dementia or medical requirements, and it will be necessary to ensure that staff in the vascular network has all the skills required to care for these patients.

Race

There will be a need to consider requirements of those patients who may require translation or interpretation services, and access to volunteers or staff who can converse in a chosen language.

Disability

Rehabilitation services should give choice to patients with preexisting mobility issues. Specific patient needs, such as bariatric needs should be considered to ensure the ability to provide equipment across boundaries and within social care sector. As well as physical disability, there is a need to consider learning disabilities and mental health. It is recognised that the involvement of carers/family in any programme is more difficult the further away rehabilitation is from local support mechanisms, and patients are not always able to return to the 'home/setting' they came from.

Communication needs in these client groups may be more challenging and care should be adapted accordingly. There are specific standards under the All Wales Standards for Communication and Information for People with Sensory Loss⁴ that apply directly to emergency and unscheduled care and these outline the staff training requirements, communication systems and patient needs information which should be provided by health boards. Improved service will reduce the rates of disability and increase socioeconomic functioning.

Marriage and civil partnership

No impacts upon this protected characteristic are anticipated.

Pregnancy and maternity

No impacts upon this protected characteristic are anticipated.

Religion or belief (including lack of belief)

It will be important to note that staff consider and recognise that patients' personal beliefs may lead them to ask for a procedure for mainly religious, cultural or social reasons or refuse treatment that you judge to be of overall benefit to them⁵. There are also many issues in relation to

prayer, diet, death and dying rituals that would have to be considered.

Sexual orientation

Despite an appreciation that awareness of sexual orientation and gender identity issues in the health and social care sector has improved, Lesbian , Gay, Bisexual and Trans (LGBT) patients in Wales report significant barriers to health and social care services⁶ . Feedback provided at a Stonewall event indicated that service providers often use inappropriate language when dealing with LGBT patients, and make assumptions about patients' sexual orientation or gender identity. This makes LGBT people feel anxious about accessing health or social care and creates barriers to honest discussions about their health needs. Moreover, it can lead to serious health risks. There is a need to ensure that patients' needs and personal circumstances are taken into consideration when providing care along the patient pathway, including any implications for rehabilitation services.

Stonewall has commended work by healthcare employers around setting up LGBT staff networks, putting zero tolerance policies in place towards discrimination, and taking a more active approach to LGBT community engagement as having improved the experiences of staff and their patients. Health boards should continue to seek to make progress in this area.

Transgender

Trans* is an umbrella term used to describe the whole range of people whose gender identity/or gender expression differs from the gender assumptions made at birth. In 'It's just Good Care: A guide for health staff caring for people who are Trans' 2015¹⁹ Trans* people must be accommodated in line with their full-time gender expression. This applies to toilet facilities, wards, outpatient departments, accident and emergency or other health and social care facilities, including where these are single sex environments. Different genital or chest appearance is not a bar to this. Privacy is essential to meet the needs of the trans* person and other service users. If there are no cubicles, privacy can usually be achieved with curtaining or screens. For people who are still in transition, any compromise must be temporary. The wishes of the trans* person must be taken into account rather than the convenience of nursing staff. An unconscious patient should be treated according to their gender presentation. Absolute dignity must be maintained at all times. It also states that breaching privacy about a person's GRC or gender history without their consent could amount to a criminal offence. A medical emergency where consent is not possible may provide an

exception to the privacy requirements. All these issues, as well as others, could be mitigated through training.

Welsh Language

Public services have a responsibility to comply with the Welsh Language (Wales) Measure. This has created standards which establish the right for Welsh language speakers to receive services in Welsh. There is a risk that the location of the arterial centre within the Vascular network may impact negatively on Welsh language users. Service users who prefer to communicate in the medium of Welsh may be required to access services at sites which do not have sufficient Welsh speaking staff. This could affect the service user's ability to communicate with service providers in their preferred language. Meeting the information and communication needs of patients who speak Welsh will need to be taken into account. 'Language is the core of establishing and expressing identity. Responding sensitively to language, whilst focusing on the individual is an essential principle of maintaining dignity and respect in care within a bi-lingual setting (Welsh Language Services in Health, Social Services and Social Care, 2012)⁷.

Socio-economic status

While socio-economic status is not a protected characteristic under the Equality Act 2010, there are new legal socio-economic duties for public bodies that will come into force in March 2021 and will apply to any decision made from this date. The overall aim of the duty is to deliver better outcomes for those who experience socioeconomic disadvantage.

The report Transport and Social Exclusion: Making the Connections (Social Exclusion Unit, 2003) highlighted the current challenges faced by socially excluded groups in accessing health and other services. They found people who are socially excluded are more likely to experience a number of factors that in themselves have a negative impact on gaining access to health services. These may include low income, disability and age, coupled with poor transport provision or services sited in inaccessible locations. It also found that the location of health services and the provision of transport to health services can reinforce social exclusion and disproportionately affect already excluded groups.

What are the potential impacts on NHS staff?

Proposals to establish a Vascular network may affect NHS staff as the final configuration may require staff to have to travel to new workplaces and work more flexibly across health board boundaries.

There is anecdotal evidence that the establishment of a Vascular network and arterial centre within South Wales would improve recruitment and retention for those clinicians who wish to practise in such a structure. It would also ensure the arrangements for the delivery of Vascular services in South East Wales are on a par with the structures in the rest of the UK.

Staff will be engaged and consulted on the proposals and any staff affected by the final outcome will be supported by the NHS Wales Organisational Change Policy (2009). A partnership approach with trade union colleagues will be ensured to achieve an effective transition to any new arrangements.

What are the human rights implications of the Vascular development?

The EIA needs to be cognisant of the European Convention on Human Rights incorporated into domestic law through the Human Rights Act 1998 as well as international treaties.

Everyone has the right to participate in decisions which affect their human rights. The convention on the rights of people with disabilities contains protection of the right to participate in decisions and access to support for participation and access to information.

The assessment so far has indicated *Article two: the right to life*, and *Article eight: the right to respect for private and family life, home and correspondence*, are of particular relevance and potential impact to the development of the Vascular network.

Right to life (taking reasonable steps to protect life): It is anticipated that having a regionalised service, with the most complex care provided from an arterial centre, will improve clinical outcomes which will have a positive impact on individuals' right to have their life protected.

Right to respect for private and family life, home and correspondence: the improved quality of care possible through a vascular network structure should result in patients spending less time in hospital. However, increased travel distances could have a negative impact on the right to maintain family life. This would apply to the patient and individual members of the family. This is not an absolute right and any interference should be justified, lawful, necessary and proportionate.

Initial summary conclusion

We believe that the introduction of a vascular network, including rehabilitation and the development of both an arterial centre and nonarterial units, is intended to improve patient care and outcomes for

Vascular disease including timeliness of access, quality of outcome and improved equality of access and reduce inequalities. We believe that the proposed service redesign does not introduce any additional obstacles; improving standardisation for access and specialist treatment should improve outcomes across all social groups. At this stage, this assessment indicates that there are a relatively small number of cases not currently treated at a centralised site (UHW) and, from national evidence and research, the majority of cases are male and over aged 65.

For those visiting patients whilst being cared for at an arterial centre, longer and more complex journeys are likely to be necessary for some. Being required to travel to an unfamiliar hospital and longer distances could be particularly difficult and disorientating for people. Journey times will be increased for users of public transport, which is highly relevant in terms of equality groups. Car ownership amongst most equality groups and, particularly, socially deprived communities tends to be lower than average, requiring a high reliance on public modes. Early transfer of the patient back to a 'local' hospital would help to mitigate long periods in unfamiliar surroundings.

What happens next?

The work of the South East Wales Steering Committee, Clinical Advisory Group, Operational Group and a number of workstreams, is continuing to plan for a Vascular service, and enter a period of engagement with the arterial centre being located at UHW and a number of supporting non arterial units and a comprehensive rehabilitation pathway, operating within a network structure for South East Wales. The EIA will continue to be reviewed to further develop and refine this assessment and to ensure.



AGENDA ITEM

6.1

CTM BOARD

INTEGRATED PERFORMANCE DASHBOARD

Date of meeting

27/05/2021

FOI Status

Open/Public

If closed please indicate reason

Not Applicable - Public Report

Prepared by

Rowland Agidee, Head of Performance and Clinical Information

Presented by

Clare Williams, Director of Planning & Performance (Interim)

Approving Executive Sponsor

Executive Director of Planning & Performance

Report purpose

FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)

Committee/Group/Individuals

Date

Outcome

(Insert Name)

(DD/MM/YYYY)

Choose an item.

ACRONYMS

ILG	Integrated Locality Group
RTT	Referral to Treatment
FUNB	Follow Ups Not Booked
SOS	See on Symptom
PIFU	Patient Initiated Follow Up
DTOC	Delayed Transfers of Care
PMO	Programme Management Office
PCH	Prince Charles Hospital
RGH	Royal Glamorgan Hospital
CT	Cwm Taf

POW	Princess of Wales
YCC	Ysbyty Cwm Cynon
YCR	Ysbyty Cwm Rhondda
CTM	Cwm Taf Morgannwg
RCT	Rhondda Cynon Taff
SB	Swansea Bay
NPT	Neath Port Talbot
IMTP	Integrated Medium Term Plan
HMRC	HM Revenue & Customs
ED	Emergency Department
IPC	Infection Prevention and Control
SIs	Serious Incidents
NUSC	Non Urgent Suspected Cancer
USC	Urgent Suspected Cancer
SCP	Single Cancer Pathway
NOUS	Non Obstetric Ultra-Sound
SSNAP	Sentinel Stroke National Audit Programme
QIM	Quality Improvement Measures
SALT	Speech and Language Therapy
CAMHS	Child and Adolescent Mental Health Services
p-CAMHS	Primary Child and Adolescent Mental Health Services
s-CAMHS	Specialist Child and Adolescent Mental Health Services
SIOF	Single Integrated Outcomes Framework
ONS	Office for National Statistics
WAST	Welsh Ambulance Service NHS Trust
WPAS	Welsh Patient Administration System
MPI	Master Patient Index
RCS	Royal College of Surgeons
WCP	Welsh Clinical Portal
WHSSC	Welsh Health Specialised Services Committee
TAVI	Transcatheter Aortic Valve Implantation
QIA	Quality Impact Assessment

1. SITUATION / BACKGROUND

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

- 1.2 The Integrated Performance Dashboard (Appendix 1), provides the detail of the performance position, where in addition to the detail on key indicators, there is also the *At a Glance* summary of the indicators within the Quadruple Aims.
- 1.3 On the 6 April 2020, the Welsh Government issued the Delivery Framework 2020-21. The framework is an interim document whilst further work is undertaken to identify outcome focused measures that deliver the priorities of the Single Integrated Outcomes Framework for Health and Social Care (SIOF), a recommendation of A Healthier Wales.
- 1.4 This month sees a revised Quality quadrant in the Balanced Scorecard, the result of collaborative work between the Quality & Safety and Performance & Information teams, with further iterative enhancements expected in two months' time.
- 1.5 The associated narrative within this report is taken from the Quality Dashboard Report presented to the Quality & Safety Committee in May, resulting from the Patient Care and Safety team working in partnership with the ILGs. It is intended that this narrative will be detailed in the Dashboard itself in future months, consistent with the approach taken for the Performance quadrant.
- 1.6 This collaborative relationship is key to establishing an organisation wide systematic approach to maintaining consistently high quality services through target and outcomes setting, ongoing comparative measurement and reporting on safety, effectiveness and experience, identifying areas for improvement and enabling the sharing of good practice and lessons learned.
- 1.7 The health board is making good headway in respect of its Targeted Intervention status and DU recommendations for quality governance and incident management. The sustained effort to systematically improve and evidence the health boards position against the recommendations, provide meaningful assurance, leadership and delivery of measurable outcomes for those who use our services, and those who work within the health board, demonstrates continued commitment to progress the quality agenda.



2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

FINANCE					QUALITY				
Month 11 (Month 12 not available at the time of writing this report)									
	Variance from Plan				Indicators	Qtr 3 20/21	Qtr 2 20/21	Target	RAG
	Current Month	Year to Date	Forecast Full Year	Forecast Recurrent	% complaints final/interim reply within 30 working days	62.2%	61.7%	75%	
	£m	£m	£m	£m		Mar-21	Feb-21	Target	RAG
Pay	-1.0	-3.6			Single Cancer Pathway	56.9%	51.9%	75%	
Non-Pay	0.3	-1.6		5.0	Number of Never Events in Month	0	1	0	
Income	-0.6	-1.0			Thrombolysis for Eligible Stroke Patients within 45 Minutes	28.6%	87.5%	100%	
Efficiency Savings	-0.8	1.8		14.1		Apr 20 to Mar 21	Apr 20 to Feb 21	Target	RAG
Non-delegated (including WG allocations)	2.0	4.2		£15.0m (including £13.4m planned deficit)	Cumulative rate of bacteraemia cases per 100,000 population - E.coli	70.53	68.98		N/A
					Cumulative rate of bacteraemia cases per 100,000 population - S.aureus	26.06	25.53		
					Cumulative rate of bacteraemia cases per 100,000 population - C.difficile	25.16	24.55		
Total	-0.1	-0.2	0	34.1		Mar-21	Feb-21	Target	RAG
					Number of Serious Incidents	8	6		TBC
	Current Month	Year to Date	Forecast Full Year		Number of Formal Complaints Managed through Putting Things Right	126	114		
PSPP	96.7%	93.5%	93.5%	Target 95%	Falls Causing Harm (Moderate/Severe/Death) - Rolling 12 Month Position	18	13		
Capital Expenditure	£5.1m	£38m	£52.6m	Includes £3.9m of anticipated funding	Total number of instances of hospital acquired pressure ulcers (all hospital sites)	72	102		
Agency as % of total pay costs	6.5%	7.0%	6.8%		Hospital Acquired Pressure Ulcers (Grade 3/4) - Rolling 12 Month Position	3	3		
					Number of Potential Hospital Acquired Thrombosis (HATs)	8	11		
					Cardiac Arrest Calls	43	34		
PERFORMANCE					PEOPLE				
Indicators	Apr-21	Mar-21	Target	RAG	Indicators	Apr-21	Mar-21	Target	RAG
A&E 12 hour Waiting Times	718	533	Zero		Turnover	9.7%	9.4%	11%	
Ambulance Handover Times >1 Hour	296	142	Zero		Exit Interview by Leaver	4.7%	4.0%	60%	
RTT 52 Weeks	31,314	31,725	Zero		Sickness Absence Rate (in month)	N/A	5.20%		
Diagnostics >8 Weeks Waits	13,098	12,890	Zero		Sickness Absence Rate (rolling 12 month)	N/A	6.99%	4.5%	
% of Stage 4 Urgent Patients Clinically Prioritised	27.0%	30.5%	100%		Return to Work Compliance	N/A	39.84%	85%	
	Mar-21	Feb-21	Target	RAG	Fill Rate Bank	27.0%	36.0%		
Mental Health Part 1a- CAMHS	56.4%	16.7%	80%		Fill Rate On-contract Agency (RNs)	53.0%	62.0%	90%	
Mental Health Part 1b- CAMHS	77.8%	66.7%	80%		PADR	51.7%	50.5%	85%	
FUNB - Patients Delayed over 100% for Follow-up Appointment	28,009	27,974	14,815		Statutory and Mandatory Training - All Levels	57.8%	58.0%		
Admission to Stroke Unit within 4 hrs	12.0%	10.6%	SSNAP Average 54%		Statutory and Mandatory Training - Level 1	65.5%	66.3%	85%	
Out of Hours (OOH)/111	In development - data not yet available				Job Planning Compliance (Consultant)	18.0%	17.0%	90%	
	Apr-21	Mar-21	All Wales Average	RAG	Job Planning Compliance (SAs)	17.0%	15.0%		
Delayed Discharges rate per 100,000 population	7.68	7.78	2.93		Direct Engagement Compliance (M&O)	97%	97%	100%	
					Direct Engagement Compliance (ADP)	67%	69%	100%	
					RN Shift Fill by Off-contract	370.3	2130.0	0 Hours	

2.1 This is the emerging Balanced Scorecard, with indicators that bring together Quality & Safety, Finance, Workforce and Performance for the Health Board.

2.2 This particular report will concentrate on the Performance and Quality quadrants, with other reports on the agenda covering the remaining quadrants.

- Planned Care – Executive Lead, Director of Operations

2.3 Pages 2 and 3 of the Dashboard detail elective activity undertaken in both internal and independent hospital capacity. Whilst treatment continues to be undertaken in independent hospital capacity, the granularity of data has not been maintained.

2.4 The increasing trend in elective waiting times largely continues, albeit that the total Stage 4 waiting list has reduced, aided by the waiting list validation exercise.

2.5 The Planned Care Recovery Programme has commenced with demand and capacity work having been completed for both RTT and Cancer waiting times.

- **Unscheduled Care – Executive Lead, Director of Operations**
- 2.6 Unscheduled care indicators, are highlighted on pages 7 and 9, they show a reduction in the volume of unscheduled presentations at PCH from Aneurin Bevan UHB. The volume from Powys UHB remains fairly static.
- **Cancer Waiting Times – Executive Lead, Medical Director**
- 2.7 As at 7th May 2020 the total number of active patients waiting at first outpatient stage of their pathway has increased markedly to almost 74% (2,372 patients), while patients waiting at the diagnostic stage accounts for just over 18% (582 patients) of the total increase.
- **Quality Improvement Measures - Executive Lead, Director of Therapies & Health Sciences**
- 2.8 Current performance levels are detailed on page 8 of the Dashboard.
- 2.9 Stroke Performance has been referred to the Health Board Quality and Safety Committee for monitoring and oversight. A report will go to the May meeting of the committee, outlining the performance against the Stroke QIMs in comparison to other Health Boards across Wales. The CTM Stroke Delivery Group anticipates publication of the Quality Statement for Stroke, which will replace the Stroke Delivery Plan for Wales as a key driver for the improvement in stroke services across Wales.
- **Mental Health Measure – Executive Lead, Director of Operations**
- 2.10 Compliance against Part One of the Mental Health Measure fell below the 80% target for the first time since May 2020 during March to 75% (89.6% in February).
- 2.11 Further compliance figures across the range of services are shown on page 11 of the Dashboard, where compliance in Neurodevelopment and Specialist CAMHS services continue to be low. Part 1a of the Mental Health Measure for CAMHS continues to remain under target. However, there has been significant improvement this month to 56.4% from 16.7% in the previous month.
- 2.12 Psychological Therapy compliance continued to improve during March to 79.8%, with the vast majority of patients waiting in excess of 26 weeks within three specific teams. When Psychological Therapy reporting first began, the Bridgend LPMHSS had 63 out of 182 patients waiting over 26 weeks. Bridgend have improved from 65.4% to 96.2% and are now one of the top performing teams. RTE CMHT have also improved from 56.3% to 72%.



Psychological Therapy Waiting Times					
	M&C	RTE	Bridgend	CTM	CTM
	CMHT	CMHT	LPMHSS	All other PT services	Total
Reporting Period March 2021					
0 - 26 weeks	36	59	125	135	355
27 - 35 weeks	13	9	4	8	34
36 - 51 weeks	5	12	1	8	26
52+ weeks	15	2	0	13	30
Total Waits	69	82	130	164	445
% <26 weeks	52.2%	72.0%	96.2%	82.3%	79.8%
% >36 weeks	29.0%	17.1%	0.8%	12.8%	12.6%
% >52 weeks	21.7%	2.4%	0.0%	7.9%	6.7%

- WHSSC Commissioned Services – Executive Lead, Director of Planning & Performance

2.13 Using data collected and reported by Digital Health and Care Wales (DHCW) page 12 of the dashboard shows waiting times for CTM residents at other Welsh providers, though the actual Commissioner is not WHSSC in all instances.

- Never Events

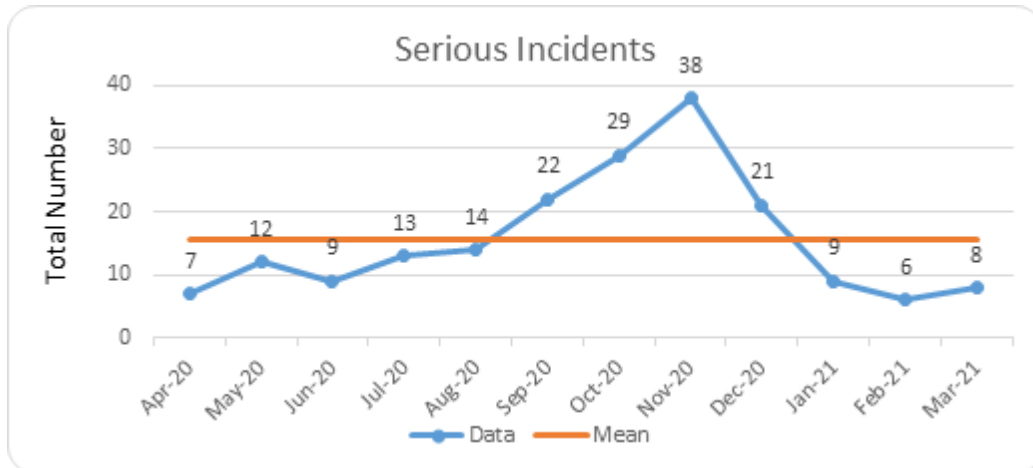
2.14 There was 1 never event reported in February 2021. This event related to a CTM patient receiving treatment at an English hospital where a swab was retained. Although the Never Event was not as a result of actions taken by CTMHB clinicians there has been organisational post-surgery involvement and joint investigation.

- Serious Incidents

2.15 During February to March 2021 a total of 3,478 Patient Safety incidents were reported. Of these, 188 were categorised as a serious incident i.e. resulting in avoidable severe harm or death. This is 0.40% of the total incidents reported.

2.16 Unexpected deaths of individuals known to our services as a result of apparent completed suicide remain a feature of SI reporting - 3 cases reported for February and March 2021. A desktop review of suspected suicides in contact with mental health services is in progress and early learning has been shared. There is a regional multi-agency approach to understanding, reviewing and preventing suicide within CTM, hosted by the Safeguarding Board.

2.17 HCAI-Covid 19 outbreak related deaths continue to be reported daily to the DU since December 2020 and account for the reduction in SI reporting after this date seen in the following chart.



2.18 As part of ensuring robust, continuous quality governance during the Covid-19 period, quality impact assessments (QIAs) are being undertaken for the key service changes underway to ensure any potential consequences on quality are considered and any necessary mitigating actions are outlined in a consistent way.

2.19 It is anticipated for the future that a QIA will be consistently considered as part of all development and proposal stage of new services, and when planning changes to existing services. This will ensure quality remains the driving component in CTM's provision of its services.

- Complaints

2.20 During February and March 2021, there were 240 complaints managed through Putting Things Right regulations. The main themes from complaints relate to Communication (104), Delays (56), Treatment Error (50), and Admission/discharge/transfer (ADT) concerns (15).

2.21 The complaints relating to communication are in the main concerned with attitude and behaviour of staff, perceived lack of communication and general communication issues regarding treatment.

2.22 The complaints regarding delays are in relation to treatment for surgery, follow-ups and investigations in the radiology service. The ADT complaints relate to potential inappropriate or unsafe discharge and poor discharge planning.

2.23 Treatment Errors relate to reported missed diagnoses, inappropriate treatment, and a perceived lack of duty of care. All complaints are responded to within the corresponding or host ILG, coordinated by the governance team and approved by group/nurse directors. Learning from complaints can be shared with the wider organisation.

2.24 Timely response rates have varied in this reporting period as a direct consequence of clinical teams not having the capacity to respond, despite relaxed requirements. Compliance varies across ILGs, reflecting not only resource allocation but also logistical management of the complaints process and differing hosting responsibilities. This variation offers an opportunity to establish a preferred and therefore consistent model across the UHB.

2.25 Learning from complaints will be strengthened by the appointment of a centrally based dedicated practitioner and within the locality and organisational governance structure, providing a more streamlined framework for cross pollination of learning and improvement.

- Compliments

2.26 During February and March 2021 there were 125 compliments reported to the PALS team, well down from December 2020 and January 2021 (196). The total number of compliments received for the year so far is 823.

2.27 Visiting has once again been restricted during this period and there is consequently less footfall on all of our sites. This is a difficult time for anything other than core business for colleagues however, reminders have been sent to colleagues to share any compliments with the PALS team for reporting on Datix.

- Hospital Falls

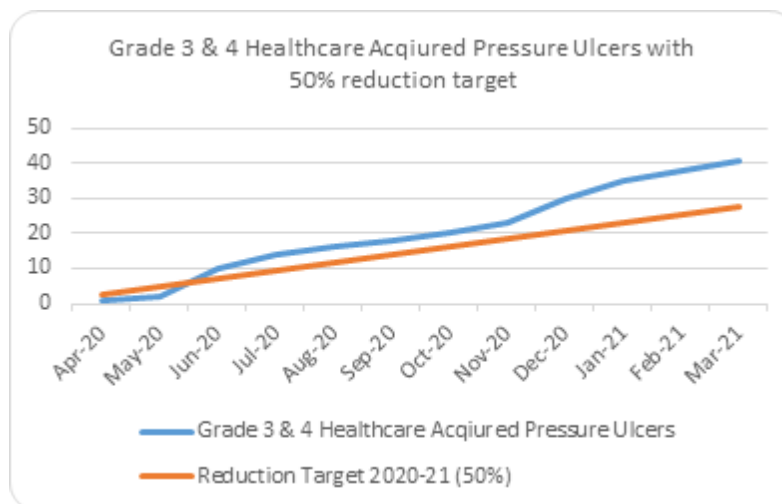
2.28 There was a marked reduction in falls reported for February and March 2021 (470) compared to the previous 2 months (576). The highest number of inpatient falls occurred within the Medicine specialty and Emergency Units at the Princess of Wales Hospital and Prince Charles Hospital.

2.29 Although severe harm from falls is very low in number there is an increasing incidence of moderate harm from falls reported. There is a Datix review underway of all falls within the past 24 months being carried out by the central patient care and safety team, in order to establish any themes, trends and opportunities for learning/practice development.

2.30 Over the past 12 months, a total of 3,245 falls were reported of which, 138 caused harm. This fell short of the planned improvement trajectory of a 20% reduction by 23 falls. It is anticipated that an ILG Nurse Director will lead on developing a CTM falls management strategy and progress improvement work on behalf of the Executive Director of Nursing.

- Hospital Acquired Pressure Damage

- 2.31 The number of reported pressure damage has decreased for February and March 2021 (174) compared to 253 for the previous 2 months. The highest number of pressure damage incidents reported occurred within the patient's home with District Nursing input.
- 2.32 There were double the number of pressure damage incidents reported for the Princess of Wales and Prince Charles hospitals compared to the Royal Glamorgan hospital, predominantly within Medicine, Care of the Elderly and Orthopaedics.
- 2.33 Over the past 12 months, a total of 1,148 hospital acquired pressure ulcers were reported across the Health Board, of which 42 were graded either as 3 or 4. All avoidable pressure damage must be reported to the Multi-Agency Safeguarding Hub (MASH), with varying compliance with this requirement across ILGs.
- 2.34 An improvement trajectory of a 50% reduction in grade 3 and 4 pressure ulcers was set for 2020-21. Whilst the actual figure has been above this run-rate since June, the variance is much greater from December onwards as shown in the following chart:



- 2.35 Given the financial and humanitarian cost of pressure ulcers, this potentially avoidable injury is increasingly becoming a key policy and professional target within the UHB.

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

- 3.1 The key risks for the Performance quadrant are covered in the summary and main body of the report.

- 3.2 The following issues/risks have been identified in relation to the Quality quadrant:
- 3.3 As in all public institutions the impact of the Covid-19 pandemic from both the first and second waves has had considerable and ongoing consequences on the ability of the UHB to provide continuity around its core business.
- 3.4 Gaining health board wide assurance of the breadth of UHB services and consideration of the four harms, with the changes in this month's report reflective of a greater ambition for assurance and measurement of quality.
- 3.5 An integral quality strategy and identification of priorities for the Health Board will be introduced at the next Quality and Safety Committee.
- 3.6 Progress has been sustained against recommendations and improvement action plans relating to the targeted intervention areas. Beyond this, ambitious pursuit of quality and safety in all aspects of the Health Board's work is imperative in order to provide excellence in service delivery to the population of CTM.

4. IMPACT ASSESSMENT

Quality / Safety / Patient Experience implications	Yes (Please see detail below)
	A number of indicators monitor progress in relation to Quality, Safety and Patient Experience, such as Healthcare Acquired Infection Rates and Access rates.
Related Health and Care standard(s)	Choose an item.
	The 22 Health & Care Standards for NHS Wales are mapped into the 7 Quality Themes. The work reported in this summary and related annexes take into account many of the related quality themes.
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below)
	Not yet assessed
Legal implications / impact	Yes (Include further detail below)



	A number of indicators monitor progress in relation to legislation, such as the Mental Health Measure.
Resource (Capital/Revenue £ / Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
	There are no directly related resource implications as a result of this report, although a number of improvement areas have underpinning financial plans.
Link to Strategic Well-being Objectives	Provide high quality, evidence based, and accessible care

5. RECOMMENDATION

- 5.1 NOTE the Integrated Performance Dashboard together with this report.

Materion Penodol i'w Hystyried / Specific Matters for Consideration Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board Mai 2021 / May 2021

Click on one of the boxes to navigate to that section of the report

Resetting Cwm Taf Morgannwg Morgannwg

Referral to Treatment Times

Diagnostics & Therapies

Surveillance Monitoring

Follow-Up Outpatients Not Booked (FUNB)

Unscheduled Care

Stroke Quality Improvement Measures

Delayed Transfers of Care

Emergency Ambulance Services

Single Cancer Pathways

Mental Health

WHSSC – Commissioning

Quadruple Aims At a Glance



Cenhadaeth / Mission:

Adeiladu cymunedau iachach gyda'n gilydd / Building healthier communities together

Quality Health and Care

for Mrs Jones, her family and her community

Person Centred Outcomes perspective

Prudent Services perspective

A Learning and Growth Culture perspective

Resource Sustainability perspective

Gweledigaeth / Vision:

Ym mhob cymuned mae pobl yn dechrau, yn byw ac yn gorffen bywyd yn dda, gan deimlo eu bod yn cymryd rhan yn eu dewisiadau iechyd a gofal / In every community people begin, live and end life well, feeling involved in their health and care choices

Strategic Well-being Objectives:

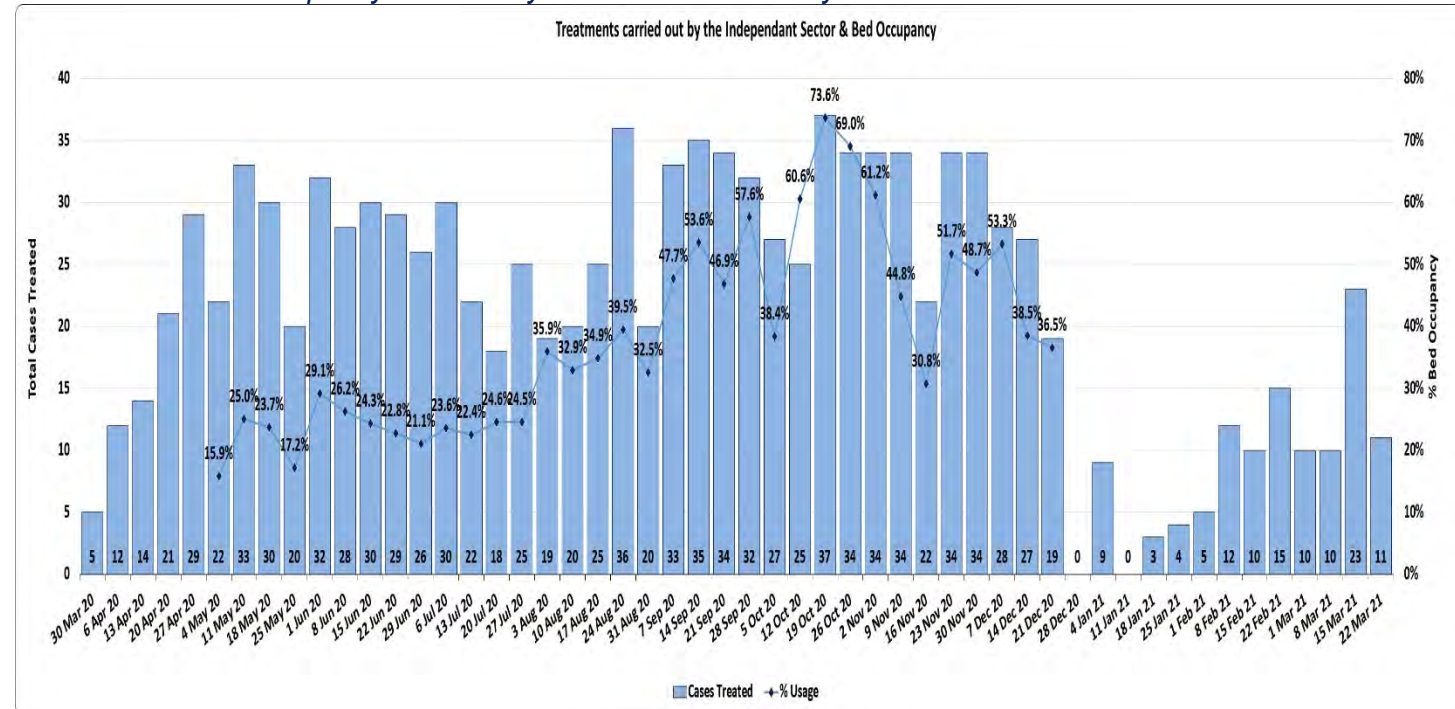
- Work with communities and partners to reduce inequality, promote well-being and prevent ill-health.
 - Provide high quality, evidence based, and accessible care.
- Ensure sustainability in all that we do, economically, environmentally and socially.
 - Co-create with staff and partners a learning and growing culture.

Inpatient & Day Case Activity

Cases Treated (Independent Sector)

Total treatments carried out by the Independent Sector Hospital to week commencing 22nd March 2021
1,147

Please note Bed Occupancy data is only available from 4th May to 21st December 2020



Treatments carried out by the Independent Sector from week commencing 30th March 2020 to 22nd March 2021										
Breast	Gynaecology	Urology	Dermatology	General Surgery	Maxillofacial	Ophthalmology	Orthopaedics	ENT	Pain Management	Total
270	387	262	4	46	1	12	134	12	19	1147

Utilisation of the Vale Hospital capacity was consistently high between August and November, but lower thereafter. As a part of CTM recovery efforts, a range of outsourcing and insourcing options are being explored to increase the elective capacity of the main acute sites. This is a key strand of the Planned Care Recovery Programme and is detailed within the IMTP.

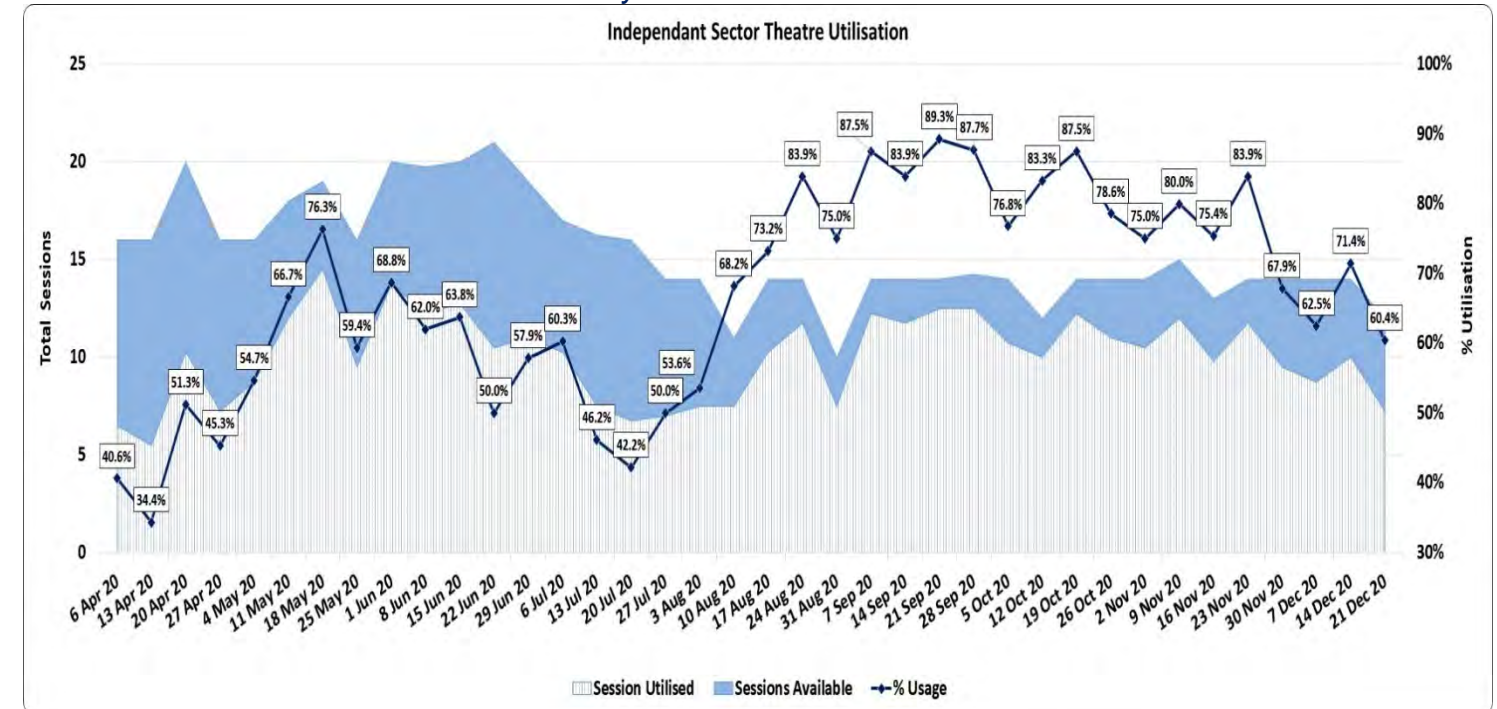
There has been an increase in internal elective activity lately, with the exception of over the Easter period. The chart to the right clearly demonstrates the increased levels of activity for May 2020.

In recent weeks, non-urgent activity include patients waiting in excess of 52 weeks.

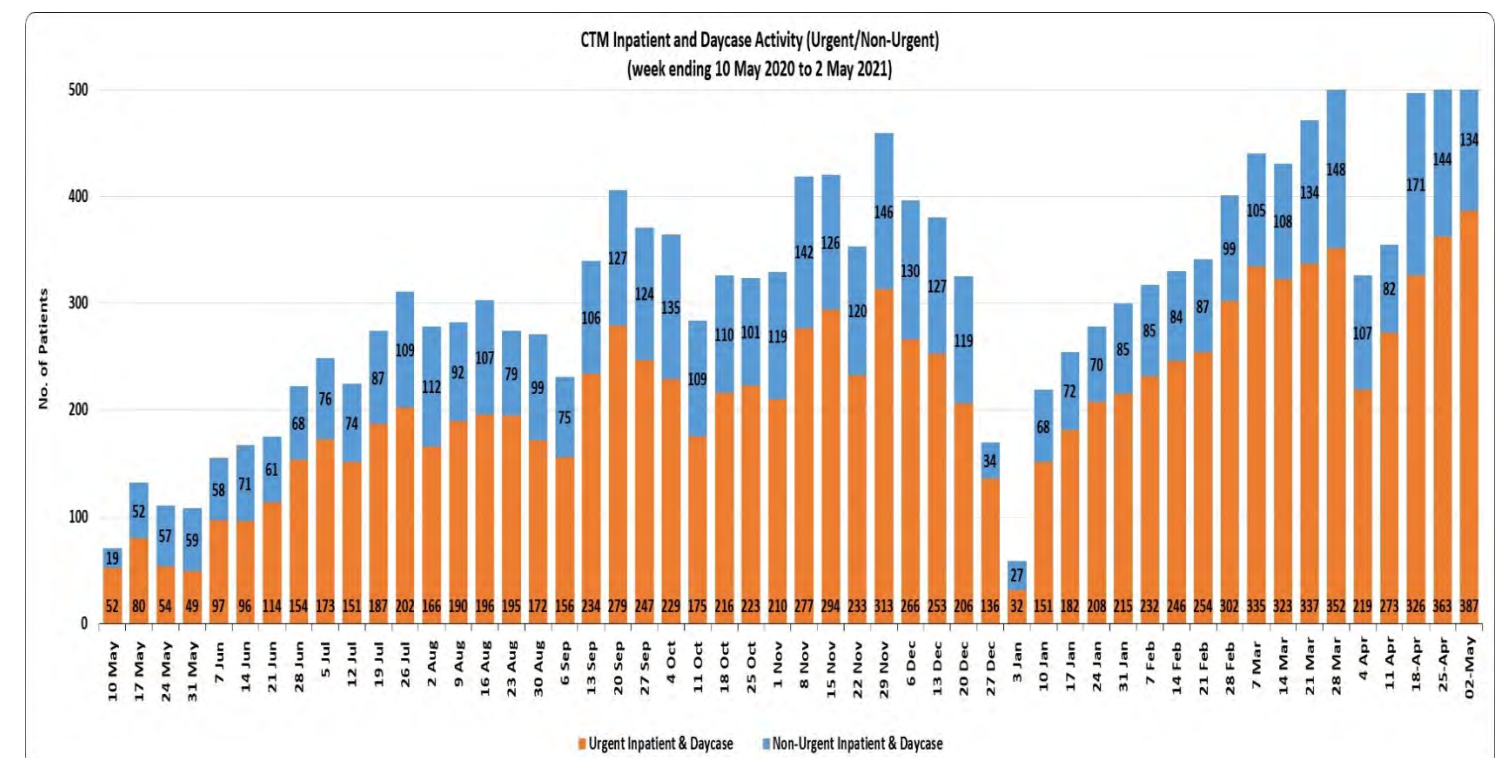
Theatre Utilisation (Independent Sector)

Theatre Utilisation within the Independent Sector Hospital to week commencing 21st December 2020

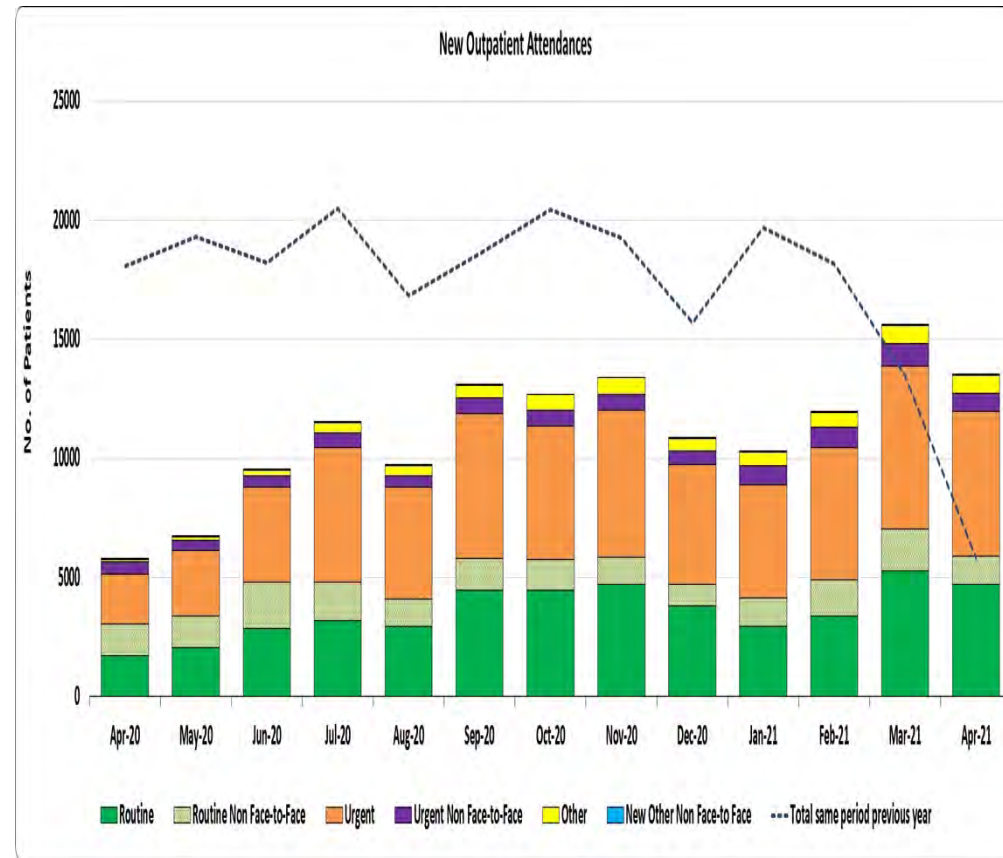
Please note that Theatre Utilisation data is only available to 21st December 2020



Activity Undertaken within Internal Hospital Capacity

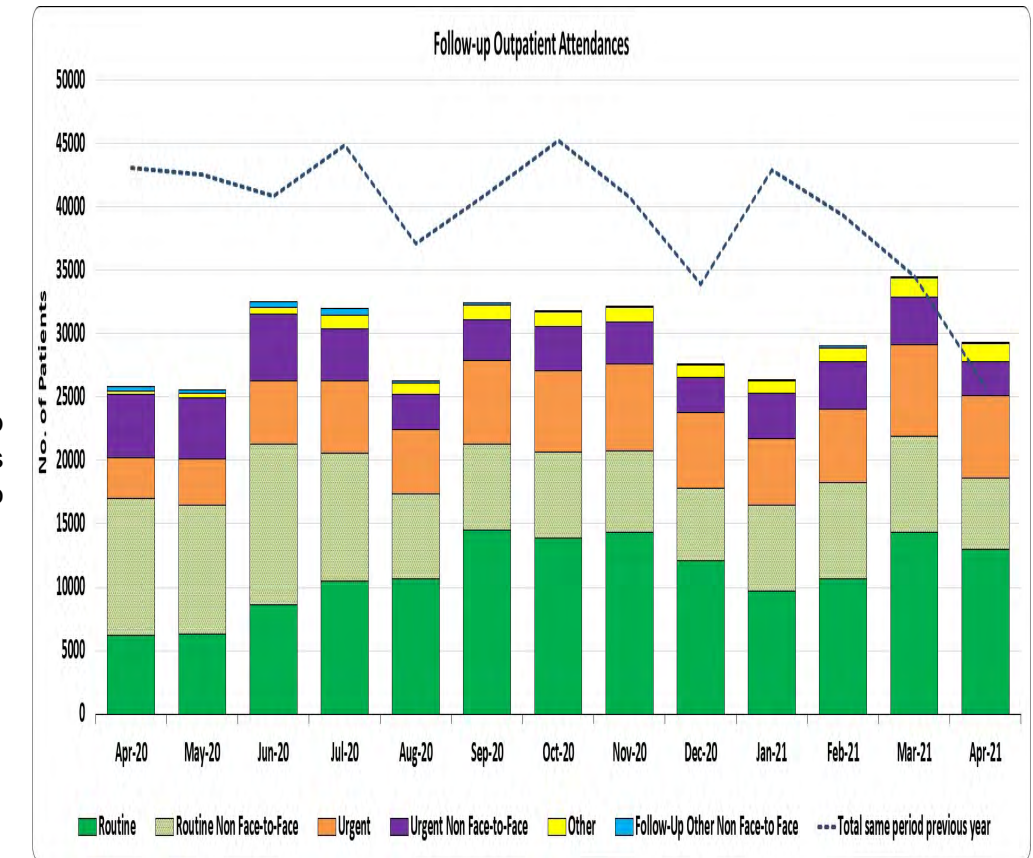


New & Follow-up Outpatient attendances versus same period previous year



% Difference in Outpatient Attendances compared to the same period in the previous year		
Period	New	Follow-up
Apr-20	-68%	-40%
May-20	-65%	-40%
Jun-20	-48%	-20%
Jul-20	-44%	-29%
Aug-20	-43%	-29%
Sep-20	-30%	-21%
Oct-20	-38%	-30%
Nov-20	-30%	-21%
Dec-20	-31%	-19%
Jan-21	-48%	-38%
Feb-21	-34%	-26%
Mar-21	16%	0%
Apr-21	132%	13%

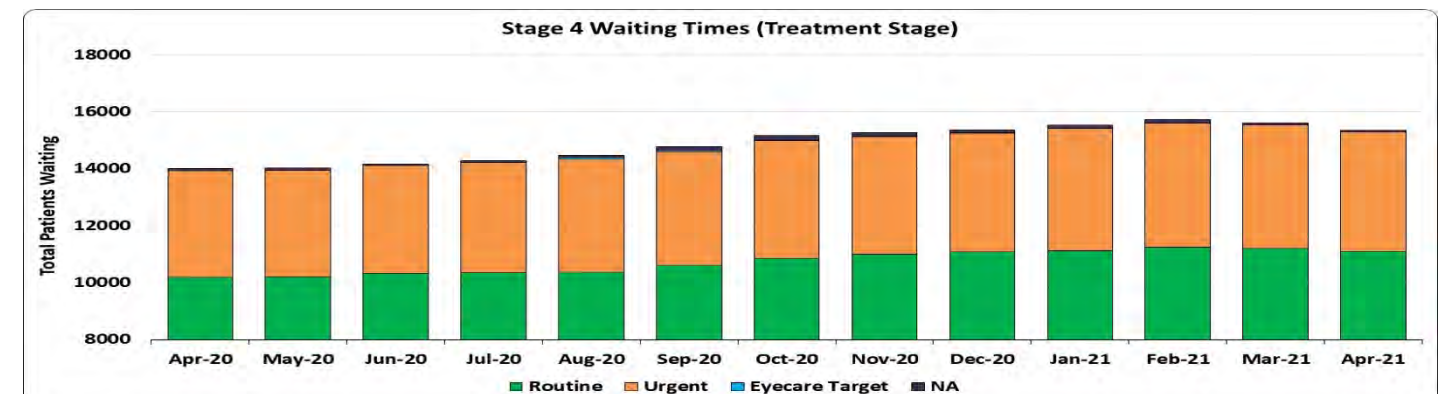
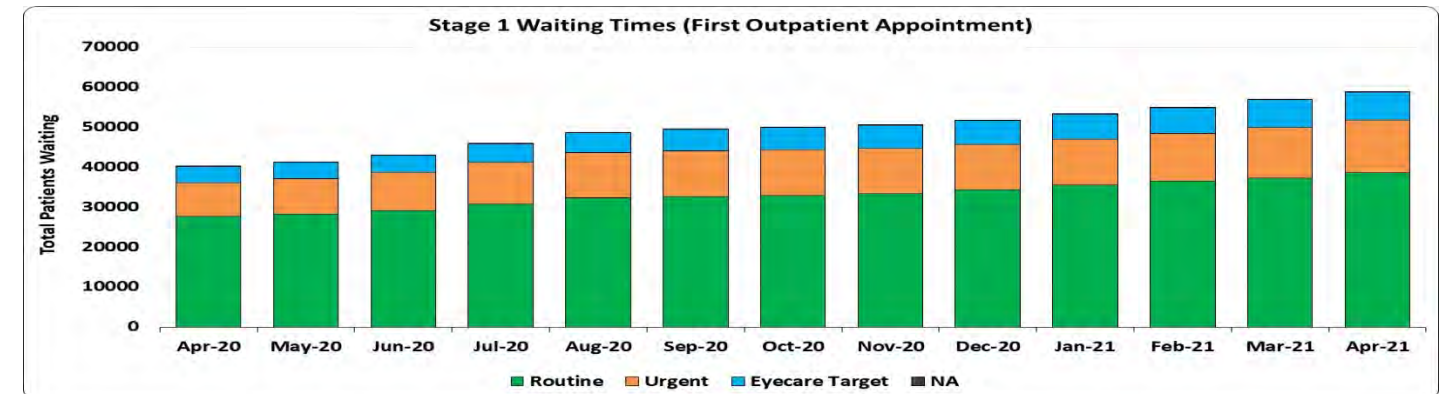
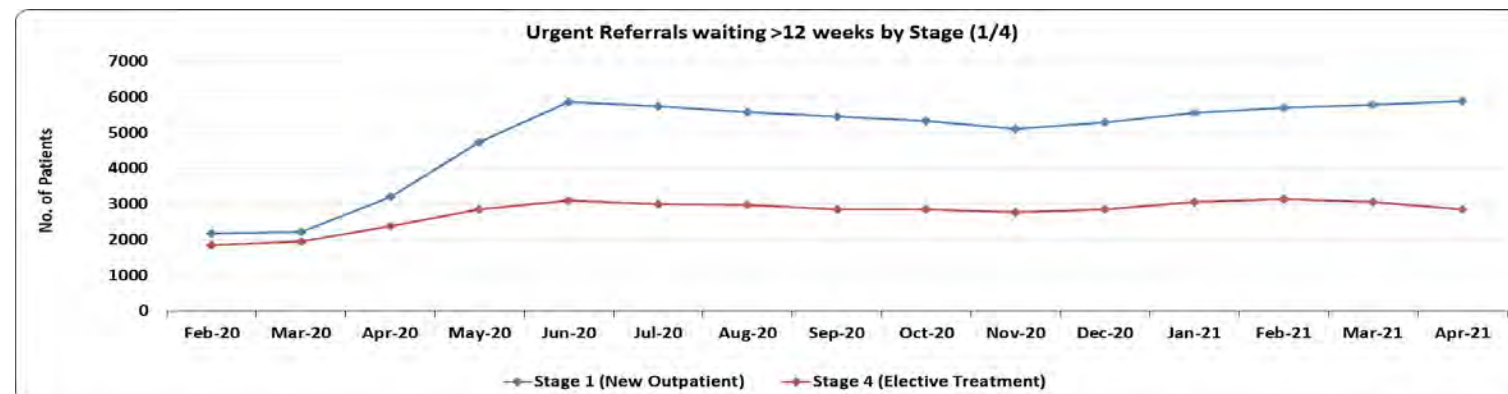
The table above details the difference between new and follow-up outpatient attendances compared to the same period in the previous year. There has been an improvement from March 2021 compared to the previous year, which was to be expected.



Waiting Times Stage 1 (New Outpatients) and Stage 4 (Treatments)

Given the continued increase in referral rates and reduced capacity levels, the wait times for first outpatient appointments continue to rise. Routine waiting lists contributes the most to this increase. Work has now begun to validate all Stage 1 waits in excess of 52 weeks as part of CTM Planned Care Recovery Programme as mandated by Welsh Government. It is expected this will have an impact on the total waiting list.

The recently completed internal validation of Stage 4 waiting lists has resulted in a 4% reduction in the reported position for March and April (final ILG review is still in progress). This work will continue throughout this financial year – another strand of the Planned Care Recovery Programme.



Referral to Treatment Times (RTT)

Referral to Treatment Times – April 2021 (Provisional Position)

Number of patients waiting >52 weeks – Target Zero

31,314

Patients waiting >52 weeks

The provisional position across Cwm Taf Morgannwg for patients waiting over 52 weeks for treatment at the end of April is 31,314, a reduction of 411 from March 2020. The breakdown by ILG is as follows:

- 9,373 patients relate to Merthyr & Cynon ILG waiting lists
- 13,131 patients relate to Rhondda & Taff Ely ILG waiting lists
- 8,810 patients relate to Bridgend ILG waiting lists

Number of patients waiting >36 weeks – Target Zero

40,519

Patients waiting >36 weeks

The provisional position for patients waiting over 36 weeks for April is 40,519 patients across Cwm Taf Morgannwg, which is an increase of 1810 from March 2020 (N.B. includes the 31,314 patients waiting over 52 weeks): The breakdown by ILG is as follows

- 11,914 patients relate to Merthyr & Cynon ILG waiting lists
- 17,047 patients relate to Rhondda & Taff Ely ILG waiting lists
- 11,558 patients relate to Bridgend ILG waiting lists

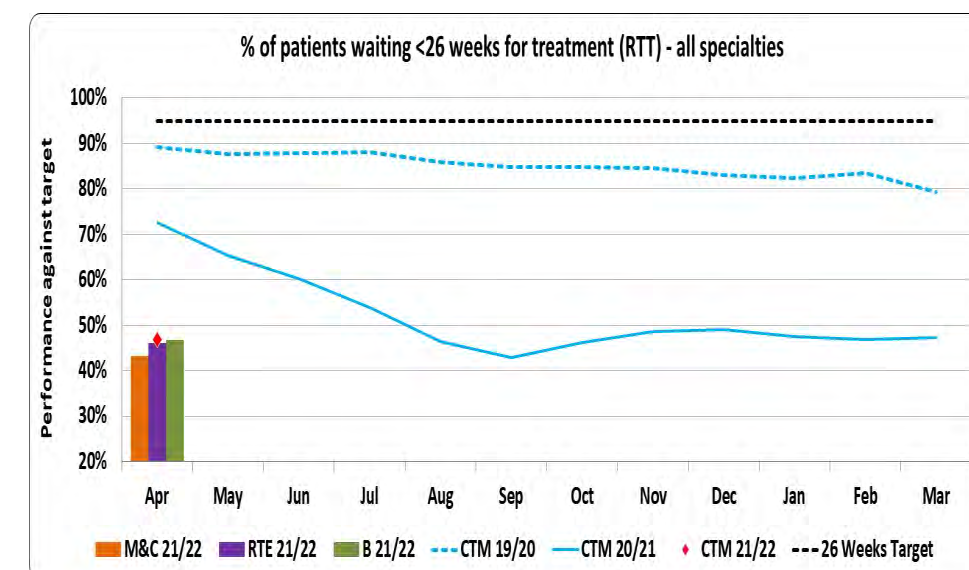
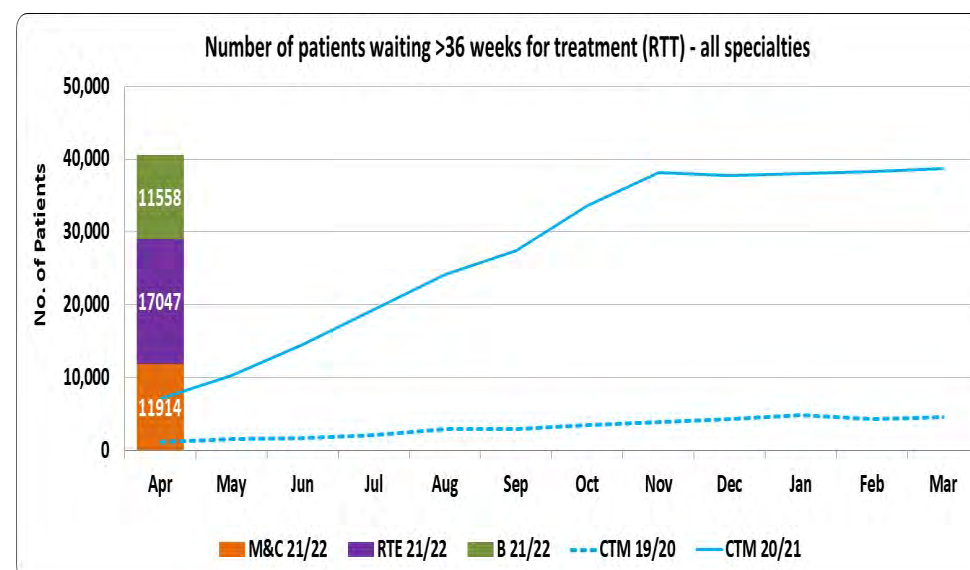
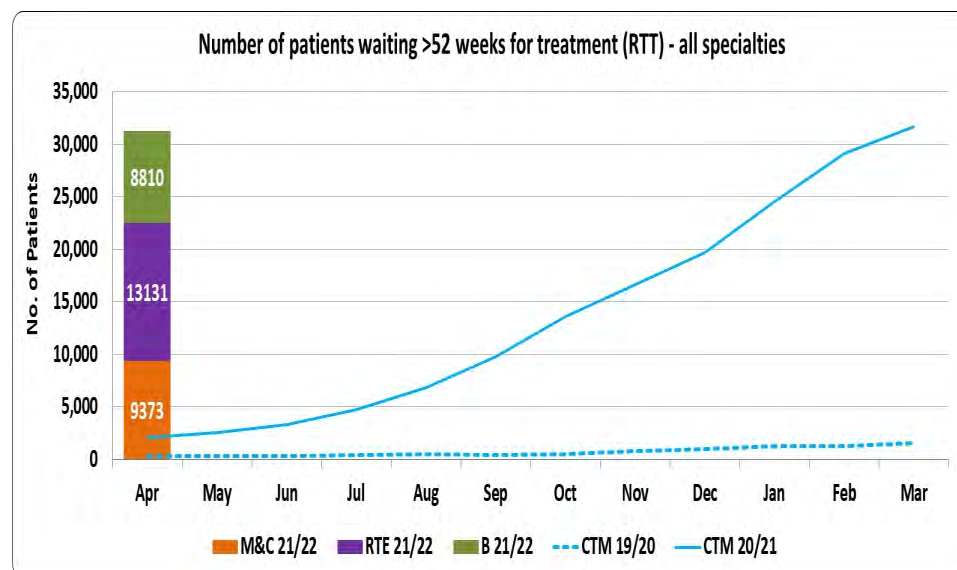
% of patients waiting under 26 weeks – Target 95%

46.8%

Patients waiting <26 weeks

The 26 week position includes the provisional direct access Diagnostic & Therapy figures. The provisional position for April across Cwm Taf Morgannwg is 46.8%, a level which has been relatively stable since October 2020. The position within each ILG is as follows:

- 43.2% Merthyr & Cynon ILG waiting lists
- 46.0% Rhondda & Taff Ely ILG waiting lists
- 50.9% Bridgend ILG waiting lists



The confirmed position at the end of March 2021 was 38,709 patients waiting over 36 weeks, of whom 31,725 patients were waiting over 52 weeks.

The clinical prioritisation of open pathways to reflect a risk based approach is an ongoing task, not all urgent pathways have been prioritised. The approach has been incorporated into the the CTM demand forecast and operational processes are being revised in line with this new requirement, taking advantage of the newly implemented functionality to record the clinical prioritisation on WPAS. Progress with updating all urgent stage 4 pathways will be monitored via these regular meetings. Welsh Government have indicated that this approach should be adopted for (i) all urgent patients waiting over 4 weeks since being listed for surgery, (ii) all patients waiting over 26 weeks since being listed for surgery and (iii) any planned pathways who are already over their agreed target date for next intervention.

The following data can now be recorded for all ILGs:

- Royal College prioritised code (range P2, P3, P4)
- The clinician who has made the assessment for the prioritised code
- The date the assessment is carried out
- The calculation of the deferred target date is from the date of the assessment for each pathway as specified in the Royal College guidance.

A re-assessment of prioritisation is required when a patient continues to wait over the deferred target date. The re-assessment of a pathway recorded for audit purposes, will result in a new deferment target, where the re-assessed deferred date should be considered as additional criteria for their prioritisation for treatment above a pathway that is still in their first deferment period.

Diagnostics – April 2021 (Provisional Position)

Number of Diagnostic patients waiting >8 weeks - Target Zero

13,098

Diagnostics >8 weeks

The provisional position for April has increased by 208 breaches since March, bringing the total to 13,098 patients waiting over 8 weeks, the highest level reported within the last 12 months.

While improvement is seen in most areas there are still significant challenges in clearing the vast backlog of patients waiting. Radiology number have increased by around 8% on the previous month.

Service	Sub-Heading	Waiting >8 weeks			
		M&C	R&T	Bridgend	CTM
Cardiology	Echo Cardiogram	164	52	958	1174
Cardiology Services	Cardiac CT	0	2	0	2
	Cardiac MRI	0	2	0	2
	Diagnostic Angiography	0	70	45	115
	Stress Test	7	43	22	72
	DSE	81	6	106	193
	TOE	3	0	9	12
	Heart Rhythm Recording	4	9	518	531
	B.P. Monitoring	1	2	37	40
Bronchoscopy		1	0	0	1
Colonoscopy		190	442	1	633
Gastroscopy		700	742	2	1444
Cystoscopy		0	318	134	452
Flexi Sig		386	609	2	997
Radiology	Non-Cardiac CT	2	2	0	4
	Non Cardiac MRI	6	34	290	330
	NOUS	2351	3567	682	6600
	Non-Cardiac Nuclear Medicine	2	24	0	26
Imaging	Fluoroscopy	8	61	0	69
Physiological Measurement	Urodynamics	24	43	161	228
Neurophysiology	EMG	17	107	0	124
	NCS	6	43	0	49
Total		3953	6178	2967	13098

Diagnostic Trend

The table below shows the Cwm Taf Morgannwg diagnostic position for the last 13 months:

Diagnostics	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2020/21	6338	10282	10508	10429	10561	10338	10631	11052	11747	12776	12759	12890
2021/22	13098											

Surveillance Monitoring – as at 3rd / 4th May 2021

Number of patients waiting past their review date

1,244

Endoscopy patients referred into the CTM service are managed through four referral pathways, each with their own waiting time target:

Urgent Suspected Cancer (target 2 weeks/14 days),

Urgent (target 2 weeks),

Routine (target 8 weeks/56 days),

Surveillance (target of 18 weeks/126 days). The table to the right shows the number of patients waiting across the four pathways:

Patient Category	PCH	RGH	POW	TOTAL
Cancer				
Waiting <14 days	108	172	14	294
Over Target	9	97	0	106
Total Patients Waiting	117	269	14	400
Urgent Non-Cancer				
Waiting <14 days	74	135	3	212
Over Target	939	1359	0	2298
Total Patients Waiting	1013	1494	3	2510
Routine				
Waiting <56 days	64	81	181	326
Over Target	438	649	0	1087
Total Patients Waiting	502	730	181	1413
Surveillance				
Waiting <126 days past review date	196	209	24	429
Waiting >126 days past review date	313	503	0	816
Total Patients Waiting Past Review Date	509	712	24	1245

Therapies – April 2021 (Provisional Position)

Number of Diagnostic patients waiting >14 weeks - Target Zero

370

Therapies >14 weeks

There are provisionally 370 patients breaching the 14 week target for therapies in April, an improvement of 225 patients on the reported position for March. This is due in part to the reduction in patient breaches in Audiology and Dietetics Bridgend.

The table to the right provides a breakdown of the areas that are breaching the 14 week target.

Service	Waiting >14 weeks			
	M&C	R&T	Bridgend	CTM
Audiology	0	130	47	177
Dietetics	12	26	88	126
Arts Therapy	7	0	0	7
Occupational Therapy	0	0	0	0
Physiotherapy	0	0	0	0
Podiatry	4	16	0	20
SALT	8	25	7	40
Total	31	197	142	370

Therapies Trend

The table below shows the Cwm Taf Morgannwg therapy position for the last 13 months, indicating that inroads are now being made in tackling the backlog that built up during the pandemic:

Therapies	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2020/21	109	396	1020	945	842	632	647	674	603	639	740	595
2021/22	370											

Princess of Wales Hospital Endoscopy Unit

As at 4th May the total waiting list (excluding surveillance patients) currently stands at 198, an increase of 18 patients on the previous month, with no routine patients waiting over the target time

Prince Charles

As at 3rd May the total list (excluding surveillance patients) has increased by 97 patients on the previous month bringing the total to 1,632 patients waiting, of whom 1,386 are waiting over target. The number of surveillance patients waiting has fallen from 513 in the previous month to a current position of 509. Surveillance patients waiting over target currently stands at 313 patients.

Royal Glamorgan

As at 3rd May the waiting list has increased by 67 patients to 2,493 of whom 2,105 patients are over target. Surveillance patients waiting over target currently stands at 503 patients.

In total Cwm Taf Morgannwg has 1,245 patients waiting past their review date, of which, approximately 65.5% of those patients are waiting more than 18 weeks past their review date.

Follow-Up Outpatients Not Booked (FUNB)

Follow-Up Outpatients (FUNB) – March 2021

Number of patients waiting for a Follow-up with documented target date - Target <=74,734

Number of patients waiting for a Follow-up delayed over 100% - Target <=14,815

No Target Date
49

Not Booked
75,021

Booked
30,312

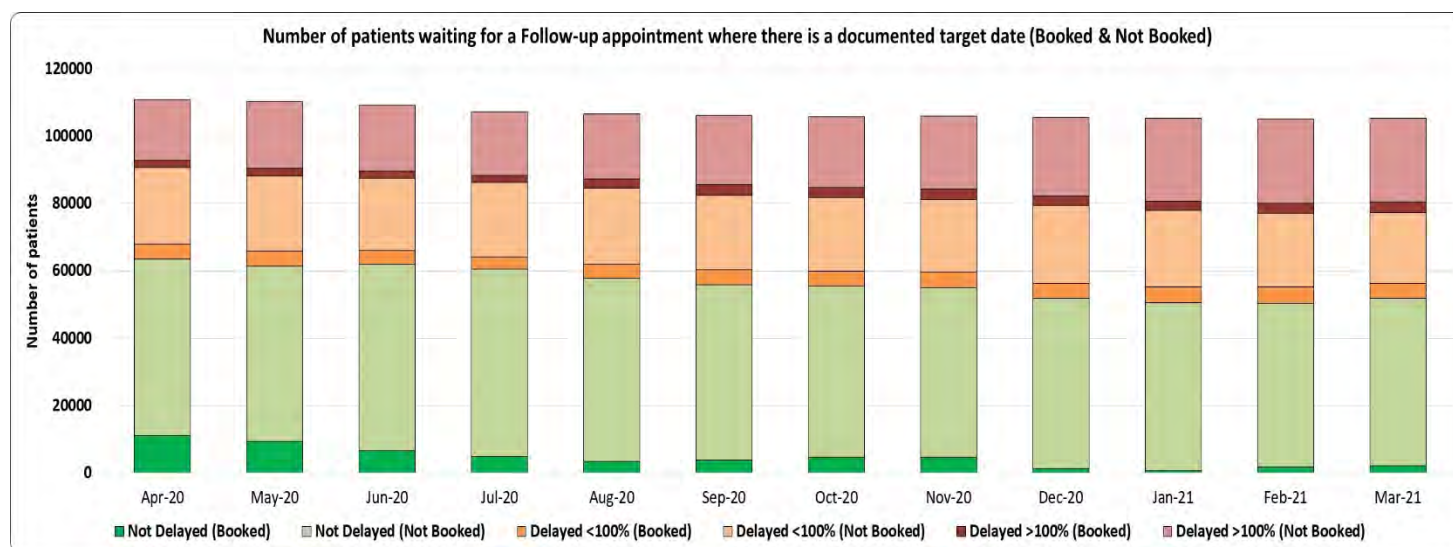
Total
105,382

Not Booked
24,930

Booked
3,079

Total
28,009

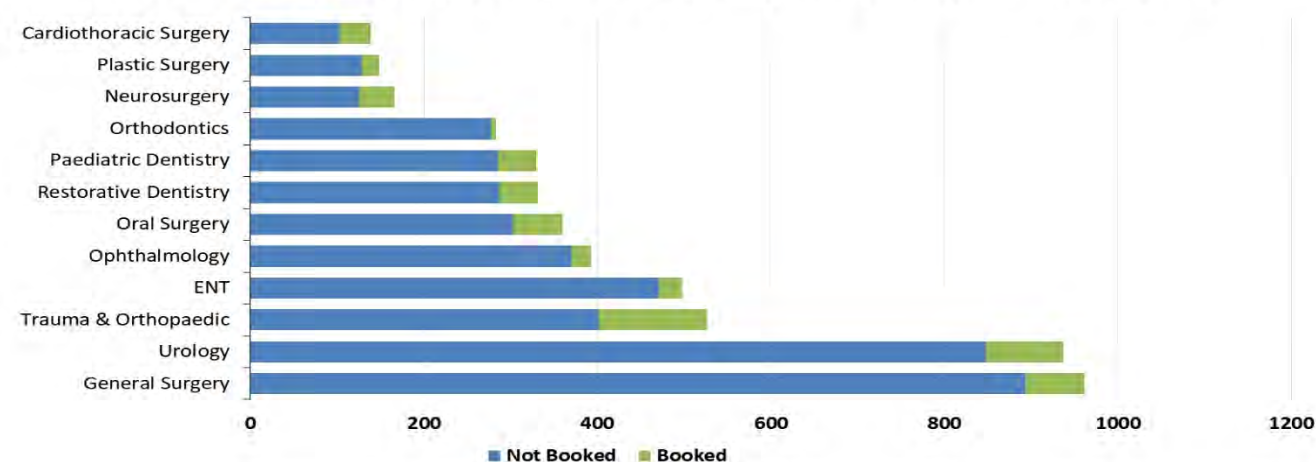
March 2021	No. of patients waiting for follow-up appointment				No. of patients delayed over 100% past their target date			
ILG	No documented target date	Not Booked	Booked	Total	Not Booked	Booked	Total	Compliance
Merthyr & Cynon	0	15713	6341	22054	4803	633	5436	24.6%
Rhondda & Taff Ely	2	23928	15755	39685	8642	1089	9731	24.5%
Bridgend	47	35380	8216	43643	11485	1357	12842	29.4%
CTM	49	75021	30312	105382	24930	3079	28009	26.6%



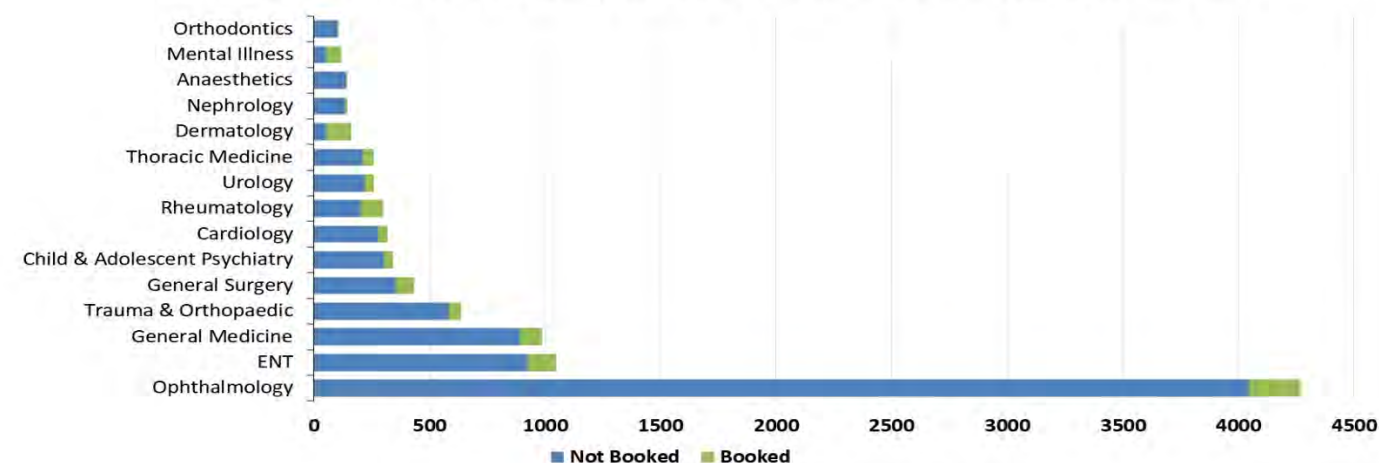
FUNB

FUNB working groups have not yet restarted work towards a consistent approach across all hospitals and services. This is on the agenda for the inaugural Outpatient Transformation programme meeting led by the COO on the 17th of May 2021.

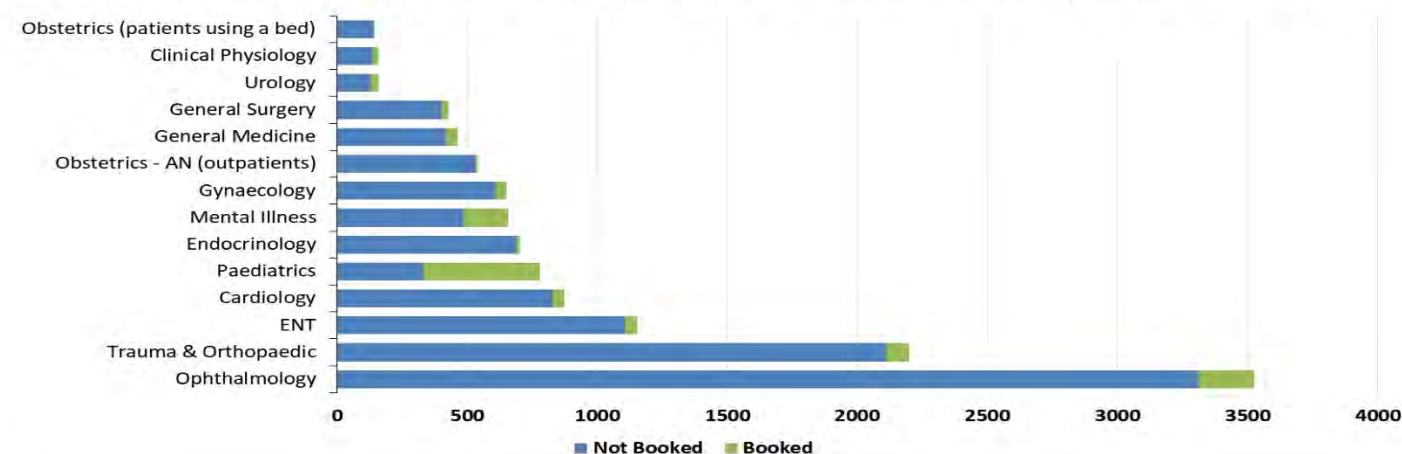
M&C - Follow-up patients delayed beyond 100% where total patient volumes exceed 100 (Mar 2021)



RTE - Follow-up patients delayed beyond 100% where total patient volumes exceed 100 (Mar 2021)



Bridgend - Follow-up patients delayed beyond 100% where total patient volumes exceed 100 (Mar 2021)



Number of Attendances

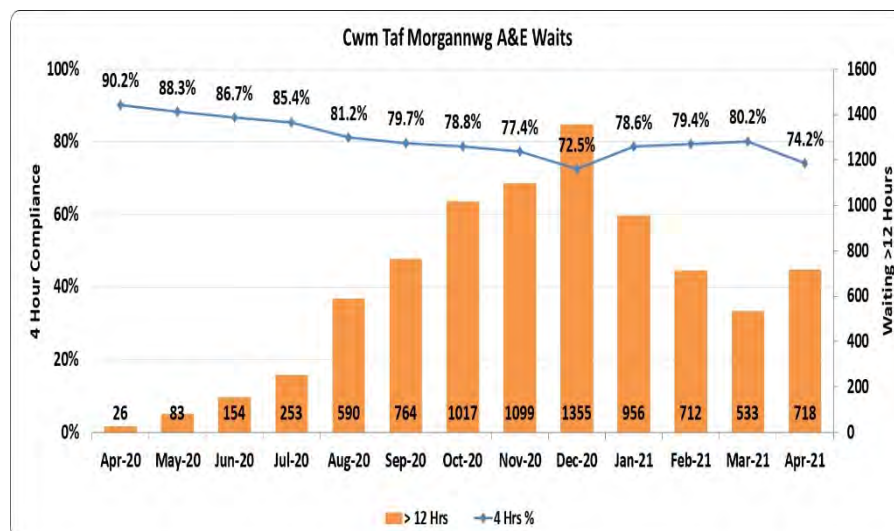
15,531

% of patients who spend <4 hours in all major and minor emergency care facilities from arrival to admission, transfer or discharge - Target 95%

74.2%

Number of patients who spend 12 hours or more in emergency care facilities from arrival to admission, transfer or discharge - Target Zero

718



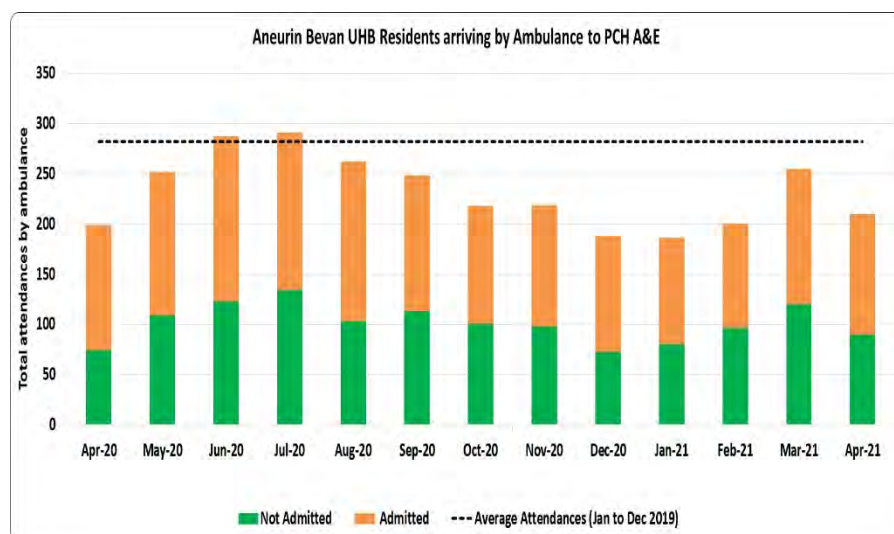
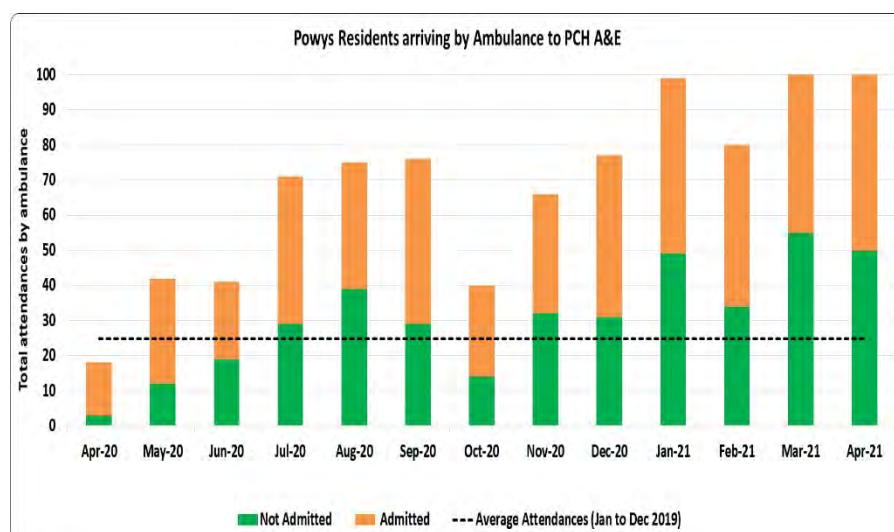
The CTM overall compliance is depicted in the chart (left) with individual departmental 4 and 12 hour performance displayed in the table (bottom right).

Overall attendances have continued to increase during April by 1,763 to a total of 15,531 and are now similar to the levels seen prior to Covid -19 and is an indication that consistently higher levels of activity are likely to be the case for 2021/22 than was the case in 2020/21. The average attendances 2019/20 were around 15,752 with the average 2020/21 being 11,931.

4 Hour Compliance - The combined performance for CTM for the four hour target fell during April to 74.2% and compliance declined in all of the major units.

For PCH in particular, whilst the impact of strategic changes within Aneurin Bevan UHB is on the one hand increasing the emergency patient flow from Powys, it is more than offset by the reduction in emergency patient flow from Aneurin Bevan. Whilst an increase from Aneurin Bevan was observed in March during April levels fell and continues to remain below the 2019 average. Further work is underway to review the casemix of the activity.

12 Hour Waits - The number of breaches of the 12 hour target increased during April by 185 to an overall total of 718. Once more PCH saw the largest number of breaches (405), an increase of 116 on the previous month, whilst POW recorded a total of 258 breaches in April (229 in March). The number of breaches also rose in RGH with the total number of patient breaches increasing to 55 from 15 in the previous month.



Period	PCH			RGH			POW			CTM		
	Attends	4 Hrs %	> 12 Hrs	Attends	4 Hrs %	> 12 Hrs	Attends	4 Hrs %	> 12 Hrs	Attends	4 Hrs %	> 12 Hrs
Apr-20	2691	95.8%	3	2588	91.7%	6	2501	81.6%	17	8075	90.2%	26
May-20	3866	91.3%	41	3518	90.9%	10	3801	81.5%	32	11592	88.3%	83
Jun-20	4177	88.8%	67	3813	89.3%	24	4222	80.4%	63	12791	86.7%	154
Jul-20	4602	82.2%	95	4338	92.7%	5	4540	79.6%	153	14148	85.4%	253
Aug-20	4849	76.7%	215	4512	93.5%	9	4819	71.5%	366	14855	81.2%	590
Sep-20	4460	73.9%	330	4243	88.6%	27	4292	73.6%	407	13716	79.7%	764
Oct-20	3972	78.4%	445	2861	79.6%	130	3741	74.9%	442	11241	78.8%	1017
Nov-20	3786	79.0%	387	3581	75.9%	267	3462	73.7%	445	11387	77.4%	1099
Dec-20	3707	75.7%	424	3394	71.1%	585	3459	66.7%	346	11019	72.5%	1355
Jan-21	3375	79.6%	451	3282	82.3%	116	3111	70.7%	389	10197	78.6%	956
Feb-21	3500	79.3%	391	3416	83.2%	19	3022	72.3%	302	10388	79.4%	712
Mar-21	4556	74.6%	289	4528	85.2%	15	3972	77.5%	229	13768	80.2%	533
Apr-21	4968	63.5%	405	4964	82.3%	55	4702	72.0%	258	15531	74.2%	718

Stroke Quality Improvement Measures (QIMs) / Delayed Transfers of Care

QIM's – March 2021

% compliance with direct admission to an acute stroke unit within 4 hours
12.0%

% compliance of thrombolysed stroke patients with a door to needle time within 45 mins
28.6%

% compliance of patients diagnosed with stroke received a CT scan within 1 hour
48.8%

% compliance assessed by a stroke consultant within 24 hours
79.8%

Period	Prince Charles Hospital				Princess of Wales Hospital				Cwm Taf Morgannwg			
	4 HRS	45 MINS	1 HR	24 HRS	4 HRS	45 MINS	1 HR	24 HRS	4 HRS	45 MINS	1 HR	24 HRS
Mar-20	45.9%	50.0%	78.4%	70.3%	42.1%	0.0%	52.6%	63.2%	44.6%	25.0%	69.6%	67.9%
Apr-20	69.2%	33.3%	71.2%	75.0%	30.0%	Nil	65.0%	85.0%	58.3%	33.3%	69.4%	77.8%
May-20	50.9%	60.0%	58.6%	69.0%	14.3%	Nil	57.1%	92.9%	43.7%	60.0%	58.3%	73.6%
Jun-20	53.2%	37.5%	56.3%	68.8%	20.0%	0.0%	40.0%	72.0%	41.7%	33.3%	50.7%	69.9%
Jul-20	28.0%	42.9%	68.6%	74.5%	9.1%	0.0%	45.5%	90.9%	22.2%	37.5%	61.6%	79.5%
Aug-20	25.5%	0.0%	61.5%	71.2%	11.1%	0.0%	50.0%	77.8%	21.7%	0.0%	58.6%	72.9%
Sep-20	30.2%	57.1%	63.6%	63.6%	21.7%	0.0%	62.5%	66.7%	27.6%	40.0%	63.3%	64.6%
Oct-20	31.4%	81.8%	80.6%	69.4%	0.0%	0.0%	53.6%	46.4%	17.5%	69.2%	68.8%	59.4%
Nov-20	26.1%	57.1%	66.7%	75.0%	0.0%	50.0%	63.3%	66.7%	16.0%	55.6%	65.4%	71.8%
Dec-20	9.3%	60.0%	60.0%	68.9%	0.0%	0.0%	42.9%	28.6%	6.3%	50.0%	54.5%	56.1%
Jan-21	2.5%	33.3%	69.0%	73.8%	0.0%	0.0%	57.9%	57.9%	1.7%	25.0%	65.6%	68.9%
Feb-21	16.3%	100.0%	68.2%	77.3%	0.0%	0.0%	54.2%	87.5%	10.6%	87.5%	63.2%	80.9%
Mar-21	11.3%	50.0%	47.2%	73.6%	13.3%	20.0%	51.6%	90.3%	12.0%	28.6%	48.8%	79.8%

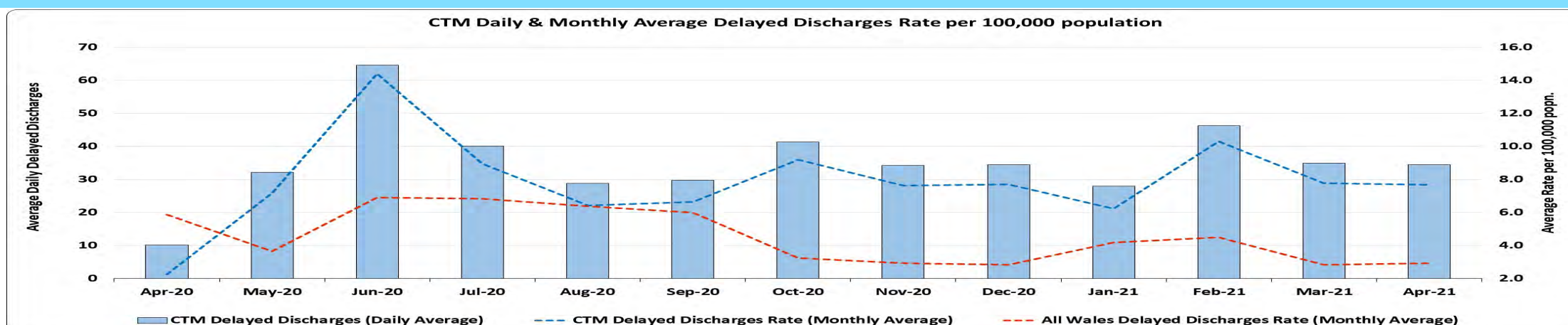
The table to the left details the compliance of the two acute stroke units at Prince Charles and Princess of Wales Hospitals against four QIMs up until the end of March. Achieving the targets has proved challenging over much of 2020/21, mainly as a result of the requirement to reconfigure services due to Covid inpatient demand. Acute stroke wards were significantly affected by increased Covid-19 admissions and infection control restrictions.

Performance varies between the sites, therefore the data is better not aggregated for analysis. To note, the report indicates 0% compliance for POW from October to February for admissions to a stroke ward in 4 hours, which directly related to the need for Covid swabbing requirements prior to admission, as well as periods of time where the stroke unit was closed to admissions for infection control reasons. Thrombolysis rates remained low in POW for this period, although clinical validation indicates no missed cases. Due to the low numbers, the percentage thrombolysed in 45 mins was extremely variable. However, March 2021 has seen a marked improvement for POW in performance against the two targets: 4 hour admission to an acute stroke unit (13.3%) and thrombolysed stroke patients with a door to needle within 45 minutes (20%). PCH has seen a decline in its achievement of the QIMs across the board in March 2021 compared to February, particularly with regard to the 45 minute thrombolysis target. This has been subject to some variation across 2020/21 attributed to the suitability of patients in month for thrombolysis compared with other months with reviews indicating that no cases have been missed in previous months.

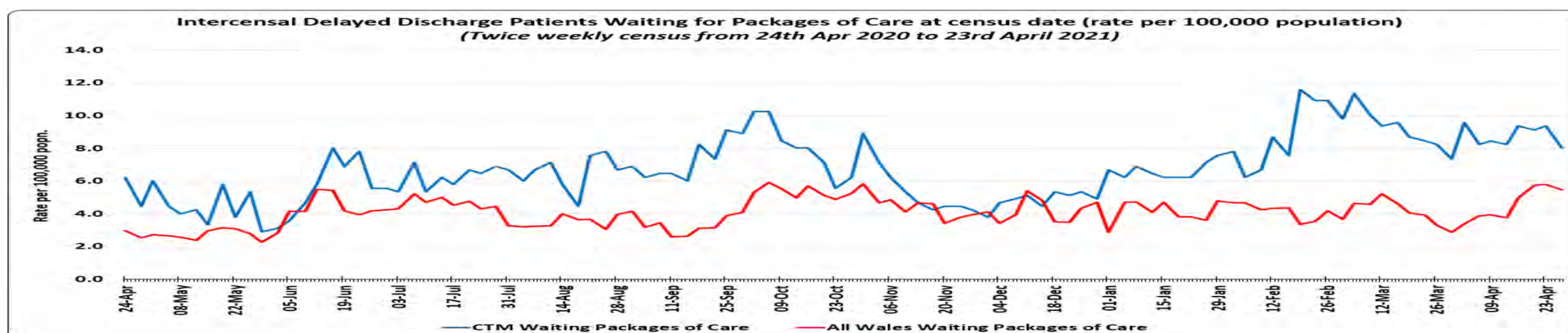
Stroke Performance has been referred to the Health Board Quality and Safety Committee for monitoring and oversight. A report will go to the May meeting of the committee, outlining the performance against the Stroke QIMs in comparison to other Health Boards across Wales. The CTM Stroke Delivery Group anticipates publication of the Quality Statement for Stroke, which will replace the Stroke Delivery Plan for Wales as a key driver for the improvement in stroke services across Wales.

Delayed Transfers of Care from the Planned Daily Discharge List – April 2021

This weekly return, which is taken from the daily discharge list will continue in the foreseeable future, with no plans to reintroduce the previous monthly return. The charts provide a trend for two aspects of this return, with CTM levels per 100,000 population generally above the all Wales level, particularly in terms of discharges delayed, albeit that there have been issues with the provision of all Wales data.



Whilst the return is weekly, data for delays is recorded daily, with data for the patients waiting for packages of care being recorded twice a week.

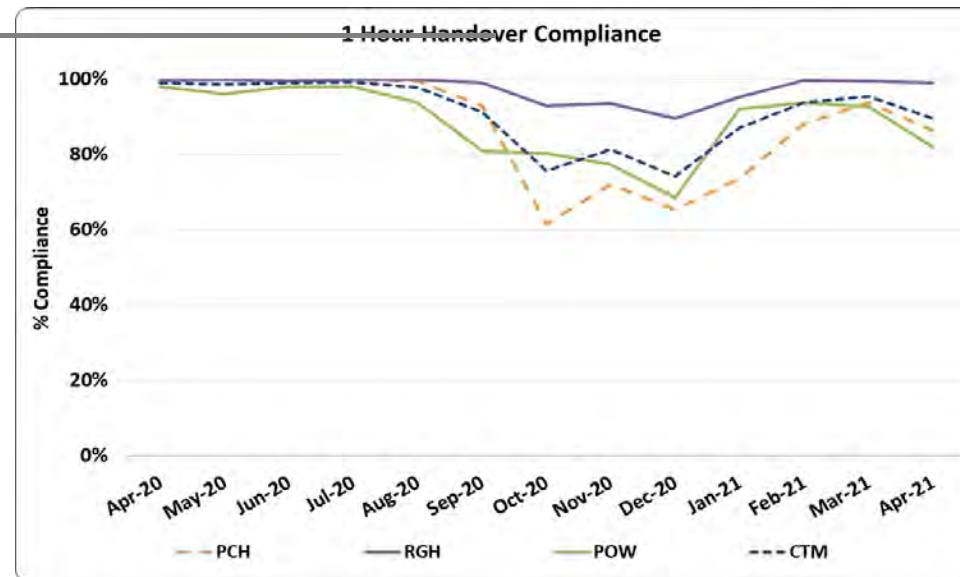
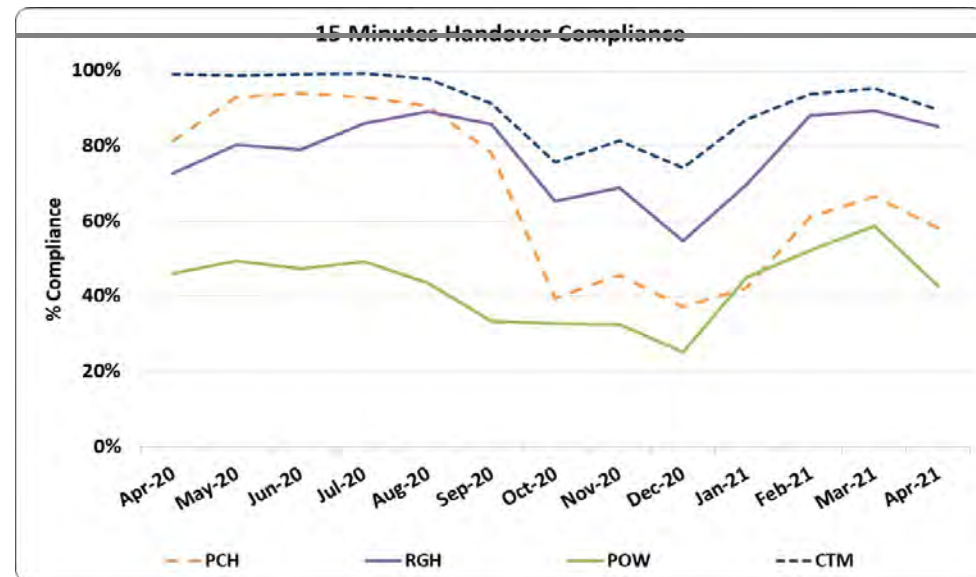


Number of ambulance handovers within 15 mins – Local Measure

1,811 handovers were within 15 mins (63.2%)

Number of ambulance handovers over 1 hour – Target Zero

296 handovers were over 1 hour (89.7% of handovers were within 1 hour)



Period	PCH			RGH			POW			CTM		
	Handovers	15 Mins %	1 Hour %	Handovers	15 Mins %	1 Hour %	Handovers	15 Mins %	1 Hour %	Handovers	15 Mins %	1 Hour %
Apr-20	767	81.5%	99.7%	800	72.8%	99.8%	706	46.0%	98.0%	2273	67.4%	99.2%
May-20	938	93.1%	99.9%	921	80.3%	100.0%	928	49.5%	96.2%	2787	74.3%	98.7%
Jun-20	985	94.1%	99.9%	940	79.0%	99.6%	979	47.4%	98.1%	2904	73.5%	99.2%
Jul-20	1122	93.0%	100.0%	999	86.0%	100.0%	1034	49.3%	98.0%	3155	76.5%	99.3%
Aug-20	1079	90.8%	99.6%	996	89.3%	100.0%	968	43.6%	93.9%	3043	75.3%	97.9%
Sep-20	1100	78.2%	93.0%	920	85.8%	99.0%	865	33.5%	80.9%	2885	67.2%	91.3%
Oct-20	1044	39.6%	61.7%	595	65.4%	92.9%	921	32.8%	80.3%	2560	43.1%	75.7%
Nov-20	870	45.6%	72.2%	878	68.9%	93.7%	753	32.5%	77.4%	2501	49.9%	81.3%
Dec-20	888	37.2%	65.3%	807	54.9%	89.7%	824	25.1%	68.6%	2519	38.9%	74.2%
Jan-21	912	42.3%	73.6%	950	69.9%	95.4%	917	45.0%	92.3%	2779	52.6%	87.2%
Feb-21	896	61.2%	88.2%	860	88.1%	99.8%	778	52.2%	93.8%	2534	67.6%	93.8%
Mar-21	1152	66.7%	93.8%	1084	89.4%	99.4%	883	58.9%	92.8%	3119	72.4%	95.4%
Apr-21	995	58.1%	86.4%	1022	85.1%	99.1%	850	42.7%	82.1%	2867	63.2%	89.7%

Handover Times

Individual departmental handover 15 minute and 1 hour handover times are depicted in the charts and table above. The improved performance seen in March for the 15 minute handover time did not continue through to April with all three major units experiencing a decline in compliance with overall CTM at 63.2% (72.4% in March) and the number of handovers down by 252 on the previous month bringing the total to 2867. CTM compliance for the 1 hour handover target also fell, achieving 89.7% overall with a total of 296 handovers exceeding 1 hour. Compliance for this measure remained fairly static at RGH (99.1%) (9 breaches), PCH falling from 93.8% to 86.4% (135 breaches), with POW falling by almost a 10% on the previous month at 82.1% (152 breaches).

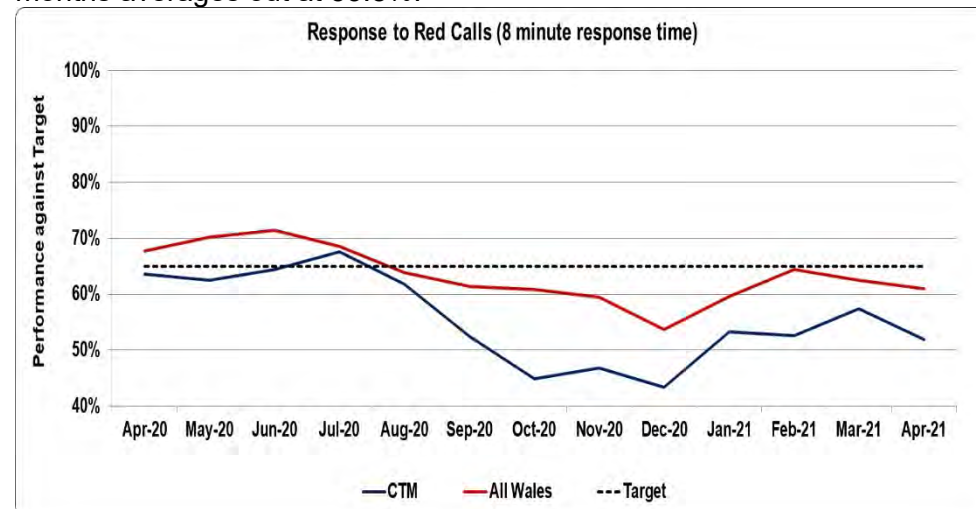
Response to Red Calls – April 2021

% of emergency responses to red calls arriving within 8 minutes – Target 65%

51.9%

Response to Red Calls

Response times declined during April to 51.9% from 57.4% in March and continues to remain under target, with July 2020 being the last time CTM achieved the target. The Welsh average continued to fall short at 61.0%, down from 62.5% in the previous month and continuing to remain below target for the ninth month in succession. CTM performance for the last 12 months averages out at 53.8%.



WAST Operational Area Response to Red Calls within 8 minutes - Target 65% (Please note that the data represents WAST Operational area and not ILG)												
Period	Merthyr			RCT			Bridgend			CTM		
	Total Responses	Responses within 8 mins	% within 8 mins	Total Responses	Responses within 8 mins	% within 8 mins	Total Responses	Responses within 8 mins	% within 8 mins	Total Responses	Responses within 8 mins	% within 8 mins
Apr-20	42	28	66.7%	162	102	63.0%	68	43	63.2%	272	173	63.6%
May-20	44	30	68.2%	126	73	57.9%	86	57	66.3%	256	160	62.5%
Jun-20	44	29	65.9%	146	92	63.0%	91	60	65.9%	281	181	64.4%
Jul-20	51	37	72.5%	156	99	63.5%	92	66	71.7%	299	202	67.6%
Aug-20	63	41	65.1%	194	112	57.7%	117	78	66.7%	374	231	61.8%
Sep-20	56	27	48.2%	200	101	50.5%	122	70	57.4%	378	198	52.4%
Oct-20	67	33	49.3%	237	97	40.9%	102	52	51.0%	406	182	44.8%
Nov-20	68	33	48.5%	227	104	45.8%	96	46	47.9%	391	183	46.8%
Dec-20	74	41	55.4%	254	95	37.4%	162	76	46.9%	490	212	43.3%
Jan-21	65	38	58.5%	199	99	49.7%	125	70	56.0%	389	207	53.2%
Feb-21	53	30	56.6%	177	85	48.0%	72	44	61.1%	302	159	52.6%
Mar-21	69	40	58.0%	234	127	54.3%	68	46	67.6%	371	213	57.4%
Apr-21	59	35	59.3%	240	111	46.3%	125	74	59.2%	424	220	51.9%

Red Call Volumes

The table to the left shows the WAST Operational Area responses to Red Calls and of those arriving at the scene within 8 minutes. As can be seen, during the past 12 months the Bridgend & Merthyr areas have seen the best response times averaging 58.1% & 58.7% respectively. RCT averages 46.3% and performance in all areas continues to be below the 65% target.

However, the table below highlights that Merthyr area continues to receive a higher response rate per head of population than the other two geographic areas of CTM.

Average Response rate per 10,000 population (period May 2020 to Apr 2021)		
Operational Area with Population Estimates		Response Rate Within 8 Mins
Merthyr	60,326	5.7
RCT	241,264	4.1
Bridgend	147,049	4.2

Single Cancer Pathway

Single Cancer Pathway (SCP) – March 2021

% of patients starting first definitive cancer treatment within 62 days from point of suspicion – Target 75%

56.9%

The Cwm Taf Morgannwg SCP performance for March improved to 56.9% from 51.9% in February.

CTMUHB - SCP % Treated Without Suspensions - March 2021			
Tumour site	Treated in Target Without Suspensions	Total Treated	% Treated in Target Without Suspensions
Head and neck	6	12	50.0%
Upper GI	10	26	38.5%
Lower GI	18	30	60.0%
Lung	17	32	53.1%
Sarcoma	2	4	50.0%
Skin (exc BCC)	44	47	93.6%
Breast	18	33	54.5%
Gynaecological	2	12	16.7%
Urological	19	48	39.6%
Haematological	9	13	69.2%
Other	4	5	80.0%
Total	149	262	56.9%

Number of Breaches by Tumour Site

The overall performance for CTM improved to 56.9% in March with a total of 113 patient breaches. The main contributory factor recorded being delays awaiting first outpatient appointment and access to diagnostics (endoscopy, hysteroscopy, flexible cystoscopy and LA PPB (prostate biopsies).

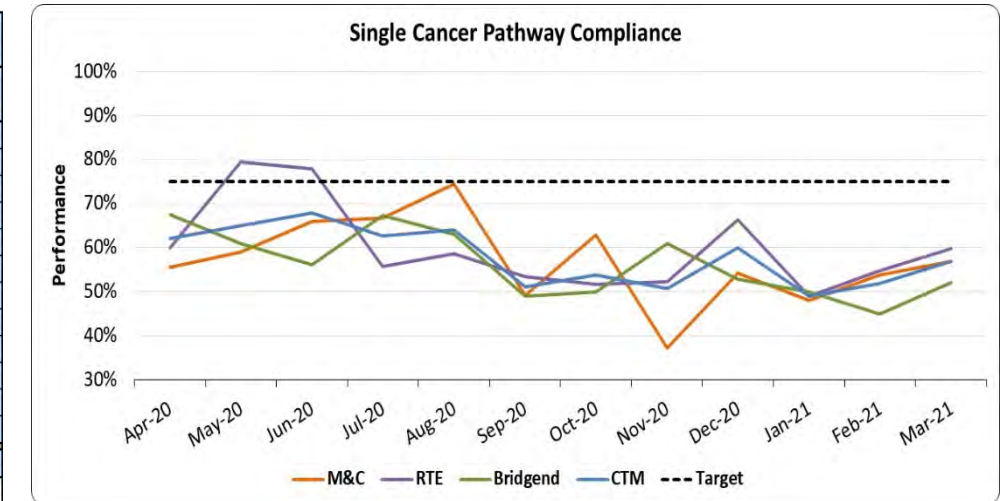
The table below details the treated patients and the patient breaches for March 2021:

Number of Breaches by Tumour Site	Merthyr & Cynon			Rhondda & Taff Ely			Bridgend			Cwm Taf Morgannwg		
	Treated in Target	Breaches	Total Treated	Treated in Target	Breaches	Total Treated	Treated in Target	Breaches	Total Treated	Treated in Target	Breaches	Total Treated
March 2021												
Head and Neck	0	1	1	6	3	9	0	2	2	6	6	12
Upper Gastrointestinal	2	7	9	4	6	10	4	3	7	10	16	26
Lower Gastrointestinal	9	6	15	1	3	4	8	3	11	18	12	30
Lung	7	5	12	5	4	9	5	6	11	17	15	32
Sarcoma	1	1	2	0	1	1	1	0	1	2	2	4
Skin(c)	14	0	14	20	3	23	10	0	10	44	3	47
Brain/CNS	0	0	0	0	0	0	0	0	0	0	0	0
Breast	0	0	0	12	10	22	6	5	11	18	15	33
Gynaecological	2	7	9	0	0	0	0	3	3	2	10	12
Urological	0	0	0	14	17	31	5	12	17	19	29	48
Haematological(d)	1	0	1	8	2	10	0	2	2	9	4	13
Other(f)	1	1	2	3	0	3	0	0	0	4	1	5
Total Breaches	37	28	65	73	49	122	39	36	75	149	113	262
Overall Compliance	56.9%			59.8%			52.0%			56.9%		

Single Cancer Pathway Compliance Trend

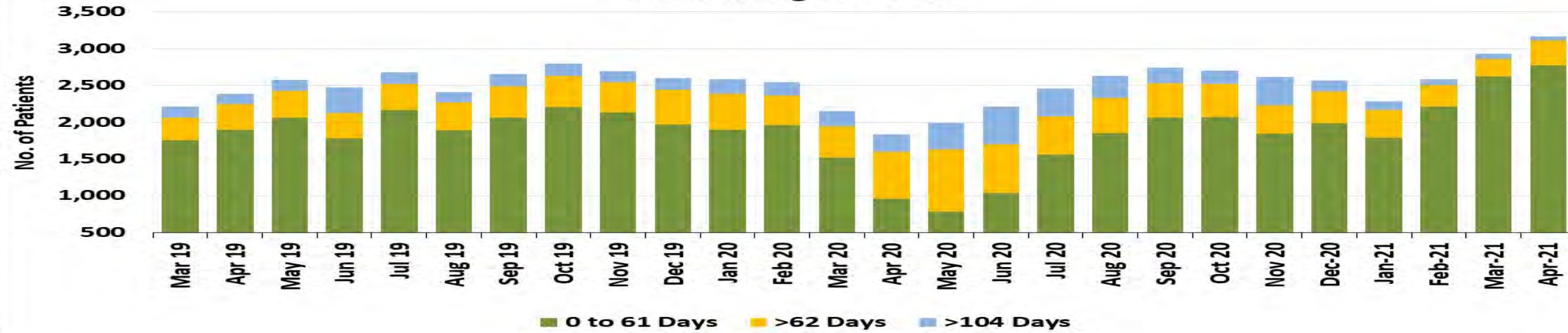
As can be seen in the graph below, overall CTM compliance has improved during February and March but remains well below the 75% target.

This situation can be attributed to the ongoing operational challenges in access to outpatients and diagnostics.



Patients Waiting on a Cancer Pathway – as at 4th May 2021

SCP Waiting List Trend



As at 4th May 2021, in terms of total waiting list size, the overall volume of open single cancer pathways stands at 3,148, where the volume of patients waiting up to 62 days has clearly stabilised. The volume of open pathways waiting in excess of 104 days currently stands at 64 and the patients waiting over 62 and 104 days in particular by ILG breakdown is as follows:

- In Merthyr Cynon, there were 114 patients waiting over 62 days of whom 18 were waiting more than 104 days
- In Rhondda Taff-Ely, there were 158 patients waiting over 62 days of whom 27 were waiting more than 104 days
- In Bridgend, there were 122 patients waiting over 62 days of whom 19 were waiting more than 104 days

Currently, 79% of the patients waiting over 62 days are for four tumour sites, Urology (115), Lower GI (85), Gynaecology (57) and Breast (54).

Merthyr & Cynon ILG	SCP Cases 62-103 days	SCP Cases >104 days
Breast	0	0
Lower Gastrointestinal	38	5
Upper Gastrointestinal	7	1
Gynaecological	40	11
Haematological	2	0
Head & Neck	1	1
Lung	2	0
Sarcoma	0	0
Skin	1	0
Urological	1	0
Unknown Primary	4	0
Grand Total	96	18
Rhondda & Taff Ely ILG	SCP Cases 62-103 days	SCP Cases >104 days
Breast	10	0
Lower Gastrointestinal	33	4
Upper Gastrointestinal	15	5
Gynaecological	2	0
Haematological	2	0
Head and Neck	4	2
Lung	4	2
Sarcoma	0	0
Skin	2	0
Urological	59	14
Other	0	0
Unknown Primary	0	0
Grand Total	131	27
Bridgend ILG	SCP Cases 62-103 days	SCP Cases >104 days
Breast	44	0
Childrens Cancer	0	0
Lower Gastrointestinal	4	1
Upper Gastrointestinal	2	1
Gynaecological	3	1
Haematological	1	0
Head & Neck	10	0
Lung	5	0
Skin	2	0
Urological	25	16
Other	7	0
Grand Total	103	19

% of assessments undertaken by LPMHSS within 28 days of receipt of referral – Target 80%

75.0%

% of therapeutic intervention started within 28 days following an assessment by LPMHSS - Target 80%

86.4%

% of HB residents who are in receipt of secondary MH services who have a valid CTP – Target 90%

84.9%

Part 1a.

Part One of the Mental Health Measure relates to primary care assessment and treatment and has a target of 80% of referrals to be assessed within 28 days. Overall, March's compliance fell to 75.0% from 89.6% in February.

Referrals in March continued to increase to 994 from 797 in February, and are nearing pre-Covid levels which were in the region of 1000 to 1100. The average referrals for 2020/21 equates to 703 per month.

Part 1b.

Overall the percentage of therapeutic interventions started within 28 days following an assessment by LPMHSS remained fairly static in March at 86.4% (86.6% in February) and continues to be above the 80% target.

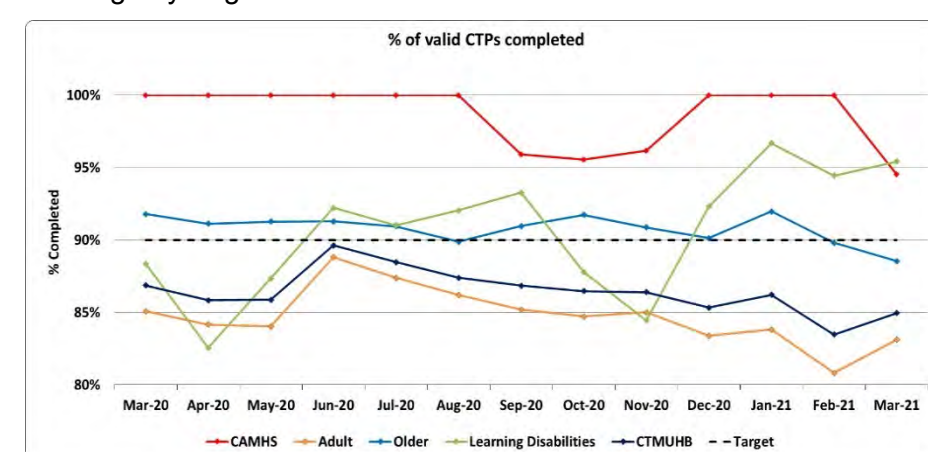
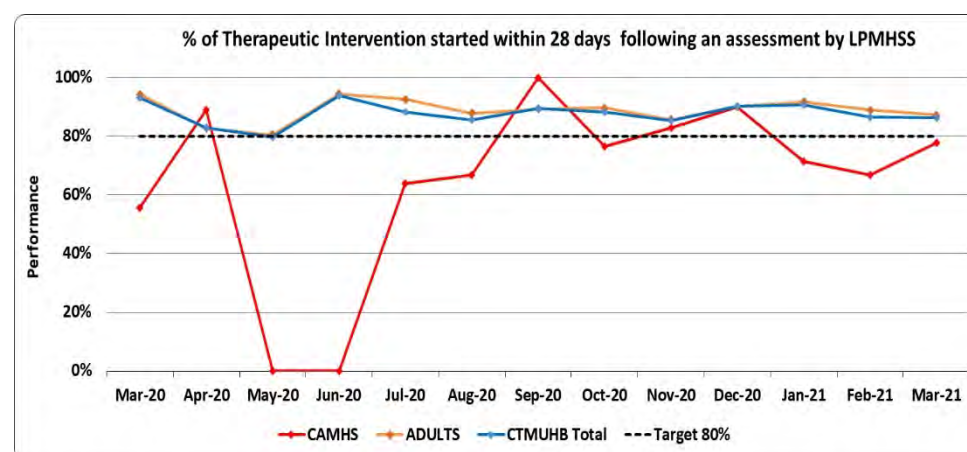
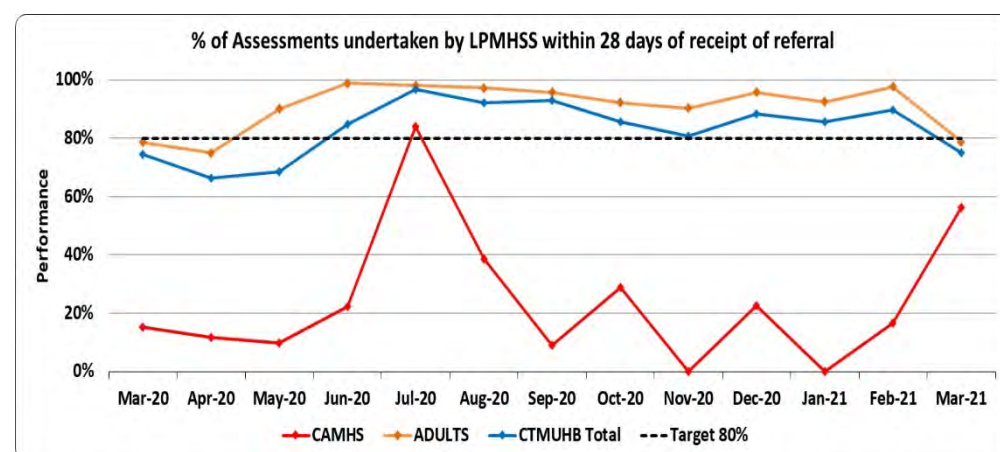
The number of interventions fell this month to 213 from 283 in February and remains well below the average of 392 per month seen in the previous year. Compliance in the CAMHS service improved to 77.8% in March from 66.7% in February with the number of interventions falling to 18 this month (30) in February.

Part 2

Part Two of the Mental Health Measure - i.e. % of residents who have a valid Care Treatment Plan completed by the end of each month improved marginally during March to 84.9% from 83.5% in the previous month, but continues to fall short of the 90% target. Overall the target has not been met since September 2019.

Part 3

Four outcome of assessment reports was sent during March for Part Three of the Mental Health Measure and all were sent within the 10 working day target.



CAMHS (including p-CAMHS)

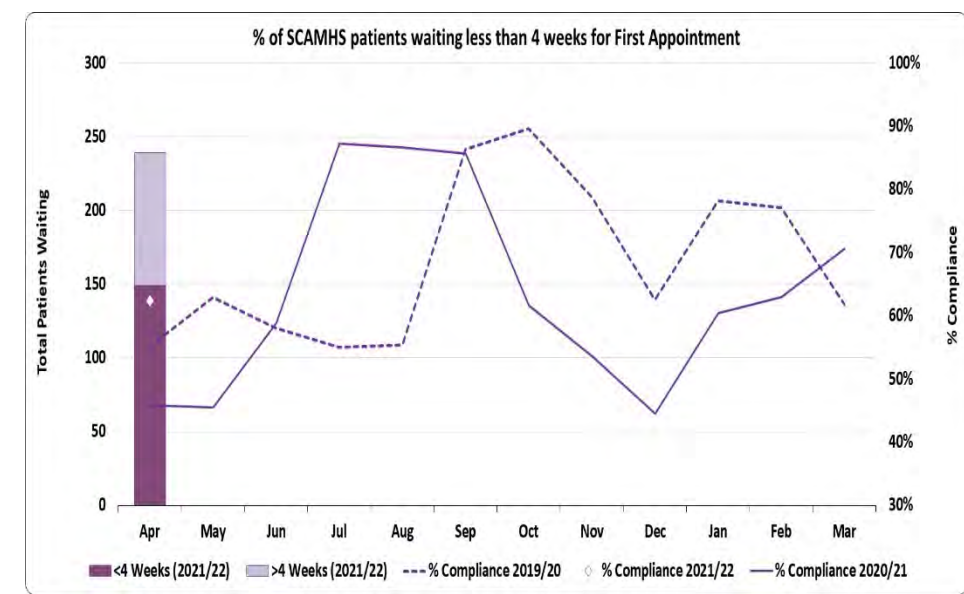
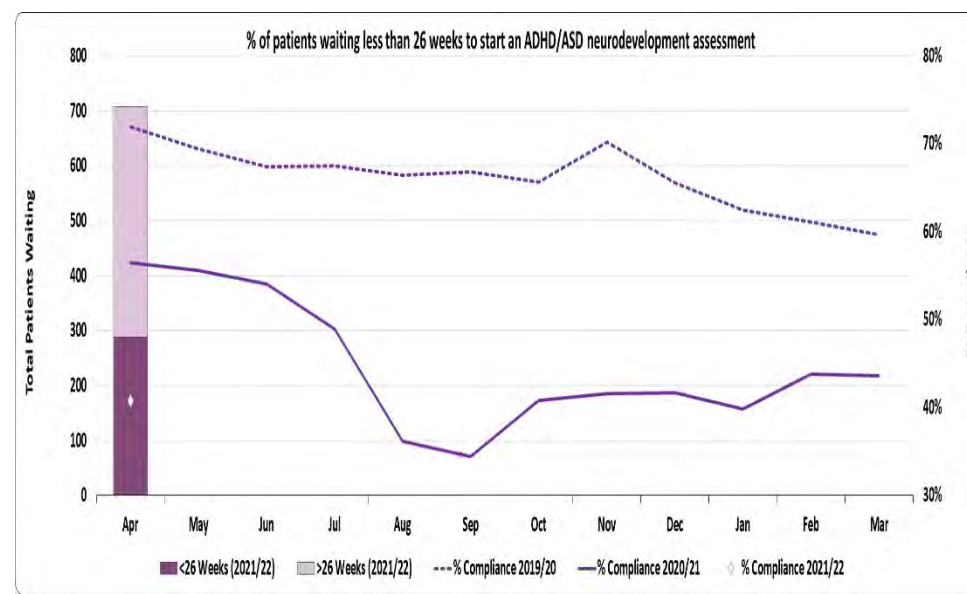
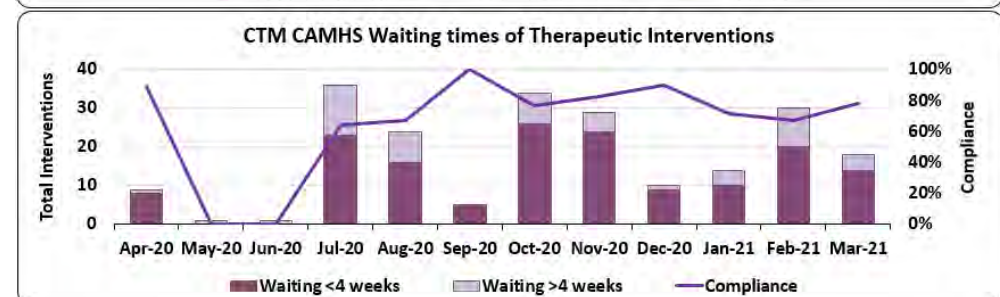
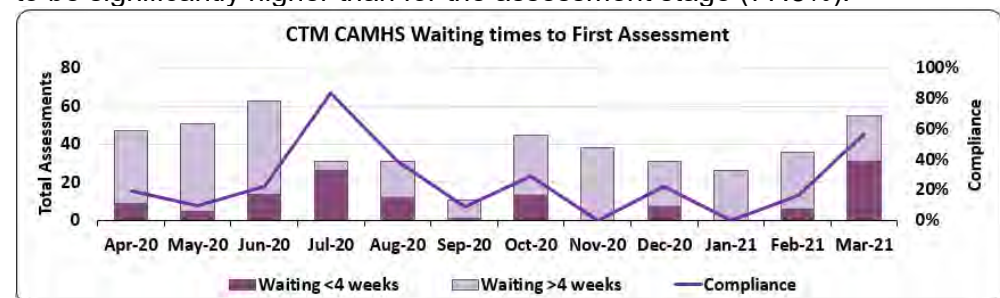
The charts show that the improvement in CAMHS compliance against the Mental Health Measure during the summer and has fluctuated since that time, improving during March with 31 patients assessed within 28 days. The most recent p-CAMHS compliance for Part 1 (a) is 90.5%, with 12 patients waiting over 4 weeks for assessment. The volume of interventions starting this month fell from 30 in the previous month to 18 in March, with compliance continuing to be significantly higher than for the assessment stage (77.8%).

Neurodevelopment

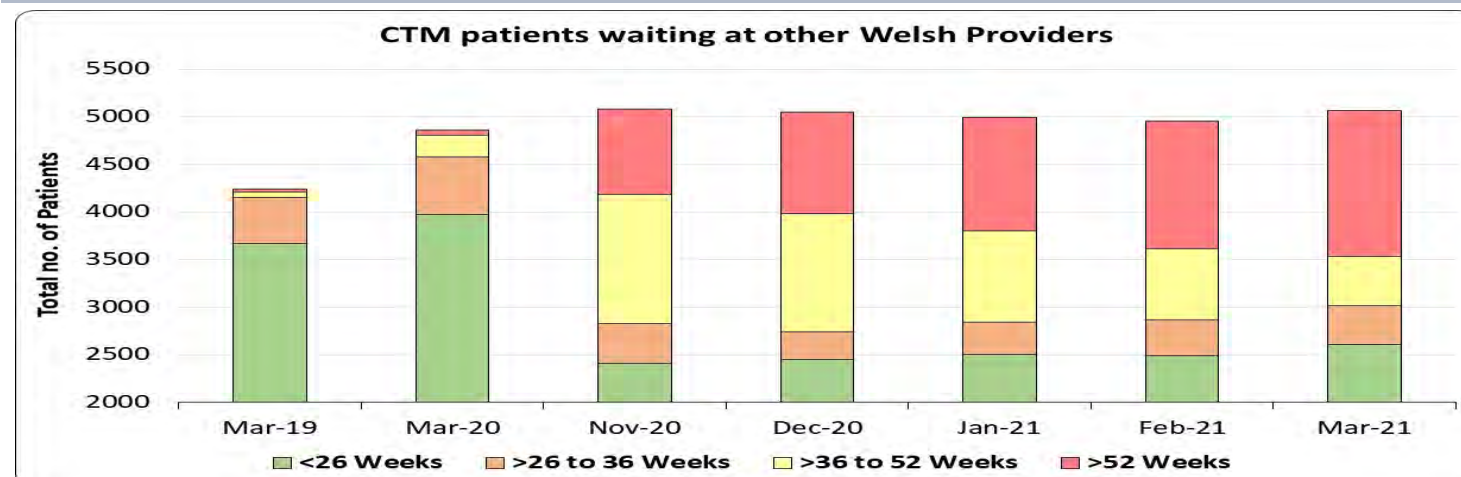
Compliance against the 26 week target for Cwm Taf area for Neurodevelopment services fell during April to a provisional 40.8%. The total waiting list continued to rise to 708, an increase of 48 on the previous month, with the number of patients waiting above the target time increasing to 419 from 372 in March. The average waiting time is currently 35.8 weeks (37.5 weeks in the previous month).

Specialist CAMHS (s-CAMHS)

The Cwm Taf Morgannwg position for specialist CAMHS waiting times fell during April to a provisional 62.3% from 70.6% in March. Currently the total waiting list has fallen to 239 from 269 in the previous month, with 90 patients waiting above the target time of 4 weeks which is a deterioration on March which stood at 79.



CTM Patients waiting for treatment at other Welsh Providers



There is limited information available from WHSSC updating the performance of specialised services. However using data collected and reported by Digital Health and Care Wales (DHCW), the chart above shows waiting times for CTM residents at other Welsh providers, though the actual Commissioner is not WHSSC in all instances.

Over 99% of the waiting lists for CTM residents awaiting services commissioned by WHSSC in other parts of Wales are in three Health Boards and overall there has been an increase of 110 patients since February.

The tables to the right provide the RTT, Diagnostic and Therapy waits for CTM patients waiting for treatment at three specific Welsh providers together with a specialty breakdown of the number of patients waiting. The number of CTM patients waiting over 36 weeks (RTT) at these three Health Boards fell from 2092 in February to 2049 in March. The number of patients waiting over 8 weeks for a diagnostic at these Health Boards are 388 and there is just 1 patients waiting over 14 weeks for a therapy.

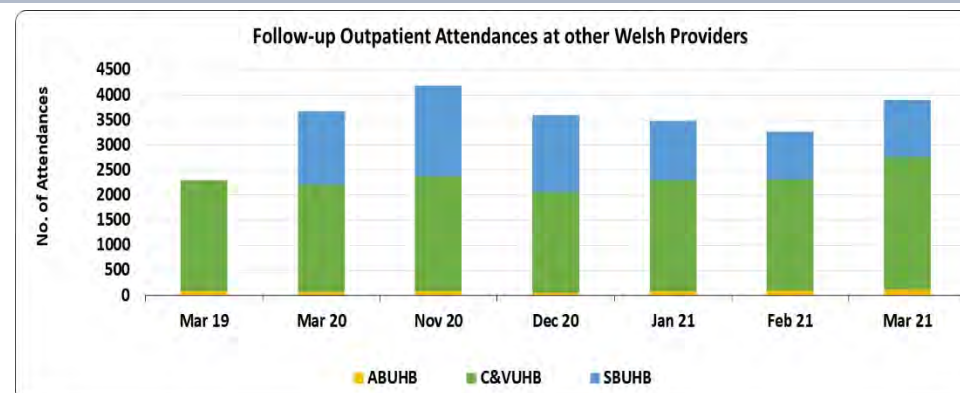
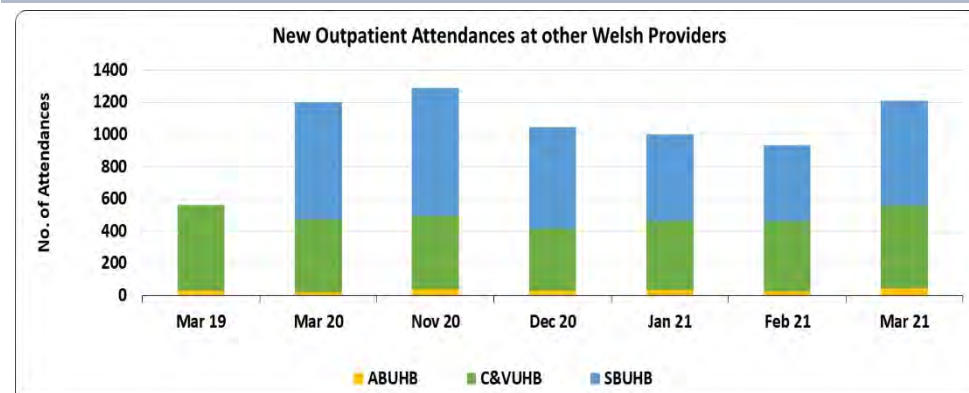
Patients Waiting more than 36 weeks at other Welsh Providers - Specialty Breakdown											
Cardiff & Vale UHB				Aneurin Bevan UHB				Swansea Bay UHB			
Specialty	>36 to 52 Weeks	Specialty	>52 Weeks	Specialty	>36 to 52 Weeks	Specialty	>52 Weeks	Specialty	>36 to 52 Weeks	Specialty	>52 Weeks
Trauma & Orthopaedics	123	Trauma & Orthopaedics	558	Trauma & Orthopaedics	5	Trauma & Orthopaedics	55	Plastic Surgery	23	Plastic Surgery	119
Ophthalmology	36	Ophthalmology	179	Urology	18	Urology	36	Oral Surgery	5	Oral Surgery	21
Neurology	158	Neurology	40	Ophthalmology	4	Ophthalmology	21	Trauma & Orthopaedics	1	Trauma & Orthopaedics	23
Clinical Immunology And Allergy	14	Clinical Immunology And Allergy	56	Oral Surgery	2	Oral Surgery	22	General Surgery	2	General Surgery	15
Oral Surgery	6	Oral Surgery	46	ENT	4	ENT	12	Allied Health	16	Gynaecology	9
ENT	7	ENT	37	General Surgery	2	General Surgery	8	Orthodontics	1	ENT	4
Gynaecology	7	Gynaecology	36	Dermatology	1	Dermatology	5	Diagnostic	3	Orthodontics	3
Paediatric Surgery	14	Paediatric Surgery	21	Gastroenterology	3	Gastroenterology	3	Gastroenterology	1	Urology	4
Cardiology	13	Cardiology	20	Geriatric Medicine	1	Gynaecology	1	Neurology	1	Gastroenterology	2
Neurosurgery	5	Neurosurgery	27	Neurology	1	Rheumatology	1	Clinical Haematology	1	Ophthalmology	3
General Surgery	4	General Surgery	23	Grand Total	41	Grand Total	164	Paediatrics	1	Neurology	1
Urology	8	Paediatric Dentistry	27					Cardiothoracic Surgery	1	Cardiology	1
Paediatrics	8	Urology	16					Grand Total	56	Respiratory Medicine	1
Cardiothoracic Surgery	2	Paediatrics	9							Paediatric Neurology	1
Dermatology	2	Cardiothoracic Surgery	14							Grand Total	207
Orthodontics	2	Dermatology	11								
Dental Medicine Specialties	2	Orthodontics	6								
Rheumatology	2	Dental Medicine Specialties	6								
General Medicine	1	Restorative Dentistry	8								
Respiratory Medicine	1	Rheumatology	4								
Grand Total	415	General Medicine	3								
		Pain Management	2								
		Anaesthetics	1								
		Grand Total	1150								
CTM patients waiting at specific health boards											
March 2021	Cardiff & Vale UHB		Aneurin Bevan UHB		Swansea Bay UHB						
	Number of Patients	% waiting at C&V	Number of Patients	% waiting at AB	Number of Patients	% waiting at SB					
Weeks Wait											
<26 Weeks	1999	51.6%	194	43.9%	403	56.4%					
>26 to 36 Weeks	313	8.1%	43	9.7%	49	6.9%					
>36 to 52 Weeks	415	10.7%	41	9.3%	56	7.8%					
>52 Weeks	1150	29.7%	164	37.1%	207	29.0%					
Total Waiting	3877		442		715						
% of Total Waiting	76.5%		8.7%		14.1%						

CTM Patients waiting for a Diagnostic at other Welsh Providers (Mar 21)					
Cardiff & Vale UHB			Aneurin Bevan UHB		
Service	Total Waits	>8 wks	Service	Total Waits	>8 wks
Cardiology	94	21	Cardiology	6	4
Endoscopy	29	17	Endoscopy	22	14
Radiology	209	49	Radiology	11	3
Physiological Measurement	16	11	Total	39	21
Neurophysiology	4	2			
Imaging	2	0			
Total	354	100			

CTM Patients waiting for Therapy at other Welsh Providers (Mar 21)					
Cardiff & Vale UHB			Aneurin Bevan UHB		
Service	Total Waits	>14 wks	Service	Total Waits	>14 wks
Physiotherapy	5	0	Audiology	2	1
Podiatry	2	0	Physiotherapy	5	0
Dietetics	10	0	Podiatry	1	0
SALT	3	0	Dietetics	2	0
Occupational Therapy	1	0	SALT	1	0
Total	21	0	Total	11	1

Swansea Bay UHB		
Service	Total Waits	>8 wks
Cardiology	71	30
Endoscopy	24	19
Neurophysiology	277	218
Physiological Measurement	1	0
Total	373	267

CTM Outpatient Attendances at other Welsh Providers

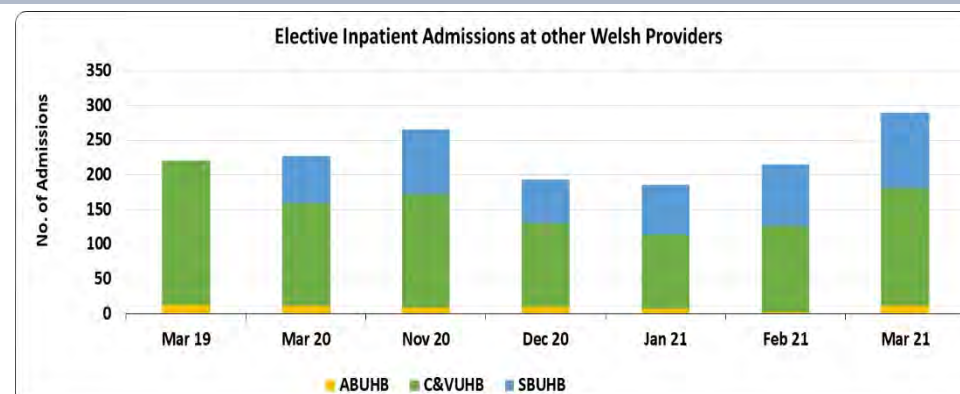
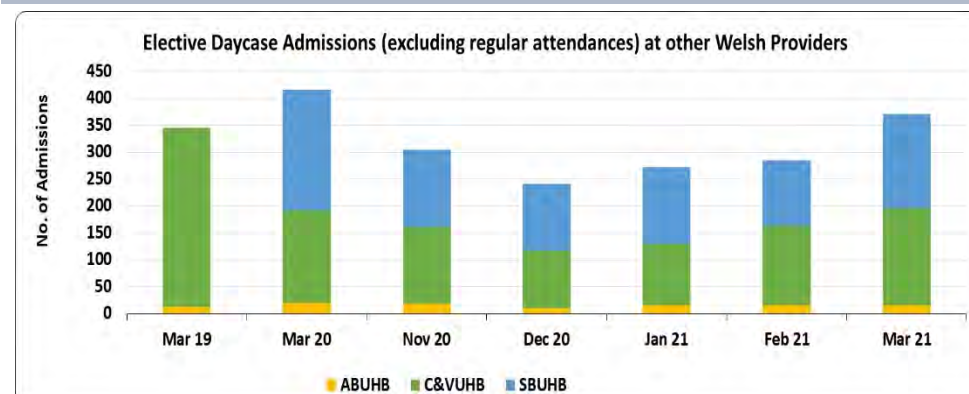


A greater understanding of activity delivered for CTM residents by other Welsh providers will come as more data becomes available, but even from the limited data shown here it is clear that Cardiff and Vale UHB have sustained activity levels, in contrast to Swansea Bay UHB.

Indeed, the level of activity currently being delivered by Cardiff and Vale UHB for CTM residents is consistent with pre-Covid levels.

For Paediatric Surgery delivered by the Children's Hospital of Wales, Cardiff, current performance is 53% of the activity undertaken in 2019/20 which contrasts with the 83% of activity that is being delivered in Alderhey for patients from North Wales.

CTM Elective Inpatients & Daycase Admissions at other Welsh Providers (please note Swansea Bay data not available for March 2019)



Inpatient and daycase activity for specialised services across all providers has decreased significantly between 2019-20 and 2020-21. During 19-20 it averaged 3,157 cases which included some drop off in activity in March at the start of the pandemic. Whilst activity increased to approx. 2500 cases between Sept-Nov 20, it has decreased again since, showing a 36% decrease in activity overall on the previous year. The levels of Cardiac Surgery being undertaken in the Welsh Centres remains a concern although in Cardiff it increased from 15% of commissioned levels in April 20 to 42% in February 21 although still a drop on the levels of activity undertaken between Sept-Nov 20. There is a more concerning position in Swansea which only undertook 3% of commissioned activity levels during January 21.

Quadruple Aims At a Glance

Quadruple Aim 1: People in Wales have improved health and well- being with better prevention and self-management

Measure	Target	Current Period		Last Period	
% of babies who are exclusively breastfed at 10 days old	Annual Improvement	2019/20	27.8%	not available	
% of children who received 3 doses of the hexavalent '6 in 1' vaccine by age 1	95%	Q3 20/21	96.4%	Q2 20/21	97.7%
% of children who received 2 doses of the MMR vaccine by age 5	95%		93.3%		92.4%
% of adult smokers who make a quit attempt via smoking cessation services	5% Annual Target	Q1 to Q2	2.05%	2019/20	3.6%
% of those smokers who are CO-validated as quit at 4 weeks	40% Annual Target	20/21	38.4%		38.4%
European age standardised rate of alcohol attributed hospital admissions for individuals resident in Wales (episode based)	4 Qtr Reduction Trend	Q3 20/21	311.6	Q3 19/20	419.7
% of people who have been referred to health board services who have completed treatment for alcohol misuse	4 Qtr Improvement Trend	Q3 20/21	64.7%	Q3 19/20	66.6%
Uptake of influenza vaccination among:	65 year old and over	not available		2019/20	68.9%
	under 65's in risk groups				40.3%
	pregnant women				81.7%
	health care workers				63.2%
Uptake of cancer screening for:	bowel	2018/19	56.8%	2017/18	54.8%
	breast		74.1%		73.9%
	cervical		72.8%		not available
% of health board residents in receipt of secondary mental health services who have a valid care and treatment plan (for those age under 18 years and 18 years and over)	under 18 years	Mar-21	94.5%	Feb-21	100.0%
	over 18 years		84.7%		83.1%
% of people in Wales at a GP practice (age 65 years and over) who are estimated to have dementia that are diagnosed	Annual Improvement	2019/20	51.9%	2018/19	50.0%

Quadruple Aim 2: People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement

Measure	Target	Current Period		Last Period	
% of GP practices that have achieved all standards set out in the National Access Standards for In-hours GMS	100%	2019/20	65.4%	not available	
% of children regularly accessing NHS primary dental care within 24 months	4 Qtr Improvement Trend	Q2 20/21	62.3%	Q1 20/21	64.2%
% of Out of Hours (OoH)/111 patients prioritised as P1CHC that started their definitive clinical assessment within 1 hour of their initial call being answered	90%	Jan-20	97.0%	Dec-19	91.2%
% of emergency responses to red calls arriving within (up to and including) 8 minutes	65%	Apr-21	51.9%	Mar-21	57.4%
Number of ambulance patient handovers over 1 hour	Zero		296		142
% 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	95%		74.2%		80.2%
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	Zero	Jan-21	718	Jan-20	533
% of survival within 30 days of emergency admission for a hip fracture	12 Month Improvement Trend		57.5%		72.7%
% of patients who are diagnosed with a stroke who have a direct admission to a stroke unit within 4 hours of the patient's clock start time	SSNAP Average 59.3%		12.0%	Feb-21	10.6%
% of patients who are assessed by a stroke specialist consultant physician within 24 hours of the patient's clock start time	SSNAP Average 85.2%	Mar-21	79.8%		80.9%
% compliance against the therapy target of an average of 16.1 minutes of speech and language therapist input per stroke patient	12 Month Improvement Trend	Mar-21	32.4%		31.7%
% of patients starting first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)	12 Month Improvement Trend		56.9%	Feb-21	51.9%
Number of patients waiting more than 8 weeks for a specified diagnostic	Zero	Apr-21	13,098	Feb-21	12,759
Number of patients waiting more than 14 weeks for a specified therapy			370		740
% of patients waiting less than 26 weeks for treatment	95%		46.8%		47.2%
Number of patients waiting more than 36 weeks for treatment	Zero	Mar-21	40,519	Feb-21	38,709
Number of patients waiting for a follow-up outpatient appointment	74,734		105,382		105,231
Number of patients waiting for a follow-up outpatient appointment who are delayed over 100%	14,815		28,009		27,974
% of ophthalmology R1 patients who are waiting within their clinical target date or within 25% in excess of their clinical target date for their care or treatments	95%	2019/20	33.5%	not available	32.4%
Rate of hospital admissions with any mention of intentional self-harm for children and young people (age 10-24 years) per 1,000 population	Annual Reduction		2.5		
% of patients waiting less than 28 days for a first outpatient appointment for Child and Adolescent Mental Health Services (CAMHS)	80%	Mar-21	64.9%	Feb-21	63.0%
% of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral (for those age under 18 years)		Mar-21	56.9%	Feb-21	25.0%
% of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral (for those age 18 years and over)			78.7%		97.5%
% of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS (for those age under 18 years)			73.9%		69.7%
% of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS (for those age 18 years and over)			87.2%		88.8%
% of children and young people waiting less than 26 weeks to start a neurodevelopment assessment		Apr-21	40.8%	Mar-21	43.6%
% of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health		Mar-21	79.8%	Feb-21	76.8%
Cumulative rate of laboratory confirmed bacteraemia cases per 100,000 population: E.coli; S.aureus bacteraemias (MRSA and MSSA) and; C.difficile	E.coli	To be confirmed	70.53	Apr-20 to Feb-21	68.98
	S.aureus bacteraemia		26.06		25.53
	C.difficile		25.16		24.55
	Klebsiella sp		21.56		21.11
Cumulative number of laboratory confirmed bacteraemia cases: Klebsiella sp and; Aeruginosa	Aeruginosa	Mar-21	4.49		4.66
Number of potentially preventable hospital acquired thromboses	4 Qtr Reduction Trend	Q1 - Q3 20/21	4	Q4 19/20	2

Quadruple Aim 3:
The health and social care workforce in Wales is motivated and sustainable

Measure	Target	Current Period		Last Period	
Average rating given by the public (age 16+) for the overall satisfaction with health services in Wales	Improvement	2018/19	6.33	2016/17	6.03
% of adults (age 16+) who reported that they were very satisfied or fairly satisfied about the care provided by their GP/family doctor	Annual Improvement	2019/20	90.8%	not available	
Overall staff engagement score	Annual Improvement	2018	3.79	2016	3.68
% of headcount by organisation who have had a Personal Appraisal and Development Review (PADR)/medical appraisal in the previous 12 months (excluding doctors and dentists in training)	85%	Apr-21	51.7%	Mar-21	50.5%
% of staff who have had a performance appraisal who agree it helps them improve how they do their job	Annual Improvement	2018	53.0%	2016	54%
% compliance for all completed level 1 competencies of the Core Skills and Training Framework by organisation	85%	Apr-21	65.5%	Mar-21	66.3%
% of sickness absence rate of staff	12 Month Reduction Trend	Mar-21	5.0%	Feb-21	5.9%
% of staff who would be happy with the standard of care provided by their organisation if a friend or relative needed treatment	Annual Improvement	2018	75%	2016	72%
% of complaints that have received a final reply (under Regulation 24) or an interim reply (under Regulation 26) up to and including 30 working days from the date the complaint was first received by the organisation	75%	Q3 20/21	62.2%	Q2 20/21	61.7%

Quadruple 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

Measure	Target	Current Period		Last Period	
Number of patients recruited in Health and Care Research Wales clinical research portfolio studies	1,848	Q2 20/21	940	2019/20	1680
Number of patients recruited in Health and Care Research Wales commercially sponsored studies	29		0		28
Crude hospital mortality rate (74 years of age or less)	12 Month Reduction Trend	Mar-21	2.09%	Feb-21	2.15%
% of in-patients with a positive sepsis screening who have received all elements of the ‘Sepsis Six’ first hour care bundle within 1 hour of positive screening	12 Month Improvement Trend	Mar-21	60.9%	Feb-21	80.0%
% of patients who presented to the Emergency Department with a positive sepsis screening who have received all elements of the ‘Sepsis Six’ first hour care bundle within 1 hour of positive screening			57.9%		76.9%
% of patients (age 60 years and over) who presented with a hip fracture that received an orthogeriatrician assessment within 72 hours	12 Month Improvement Trend	Jan-21	1.5%	Jan-20	0.5%
All new medicines recommended by AWMSG and NICE, including interim recommendations from cancer medicines, must be made available where clinically appropriate, no later than 2 months from the publication of the NICE Final Appraisal Determination and the AWMSG appraisal recommendation	100%	Q2 20/21	98.8%	Q1 20/21	98.7%
Total antibacterial items per 1,000 STAR-PU's (specific therapeutic age related prescribing unit)	To be confirmed		262.5		257.0
Number of patients age 65 years or over prescribed an antipsychotic	Qtr on Qtr Reduction		1474		1412
Number of women of child bearing age prescribed valproate as a percentage of all women of child bearing age			0.18%		0.18%
Opioid average daily quantities per 1,000 patients	4 Qtr Reduction Trend	Q2 20/21	5017.9	Q1 20/21	5005.1
Quantity of biosimilar medicines prescribed as a percentage of total ‘reference’ product including biosimilar (for a selected basket of biosimilar medicines)	Qtr on Qtr Improvement		72.3%		66.7%
% of adult dental patients in the health board population re-attending NHS primary dental care between 6 and 9 months	4 Qtr Reduction Trend	Q3 20/21	21.6%	Q3 19/20	23.3%
% of critical care bed days lost to delayed transfer of care (ICNARC definition)	Qtr on Qtr Reduction towards Target of no more than 5%	Q1 20/21	8.6%	Q4 19/20	14.7%
Number of procedures postponed either on day or the day before for specified non-clinical reasons	2,713	Jan-21	1,267	Dec-20	1,607
Agency spend as a percentage of the total pay bill	12 Month Reduction Trend	Aug-20	6.6%	Jul-20	6.8%
% of clinical coding accuracy attained in the NWIS national clinical coding accuracy audit programme	Annual Improvement	2019/20	94%	2018/19	not available



AGENDA ITEM

6.4

CTM BOARD

ORGANISATIONAL RISK REGISTER

Date of meeting

27/05/2021

FOI Status

Public

If closed please indicate reason

Not applicable – Public Meeting

Prepared by

Cally Hamblyn, Assistant Director of Governance & Risk

Presented by

Georgina Galletly, Director of Corporate Governance

Approving Executive Sponsor

Director of Corporate Governance

Report purpose

FOR REVIEW & APPROVAL

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)

Committee/Group/Individuals

Date

Outcome

Service, Function and Executive Formal Review

May 2021

RISKS REVIEWED

Management Board

May 2021

RISKS REVIEWED AND
MANAGEMENT SIGN OFF
RECEIVED

ACRONYMS

CSGs

Clinical Service Groups

ILG's

Integrated Locality Groups

1. SITUATION / BACKGROUND

- 1.1 The purpose of this report is for the Health Board to review and discuss the organisational risk register and consider whether the risks escalated to the Organisational Risk Register have been appropriately assessed.
- 1.2 The report should be considered in the context that risks within the organisation are still undergoing a robust review and therefore the organisational risk register remains a work in progress and activity continues in order to ensure a consistency of approach to the quantification of risk across the Health Board.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

- 2.2 The following progress has been made since the last report:
 - The ILGs are continuing to work to both rationalise and standardise the Clinical Service Group risk registers, the pace of this activity has been impacted by the operational pressures in response to Covid-19, however, activity has resumed with the target of October 2021 for all risks held on the Datix system to have been reviewed.
 - A draft Risk Training Needs Analysis has been developed in conjunction with other NHS Organisations in Wales to ensure a consistent approach. The training programmes required to support the TNA are currently being worked through.
 - The monthly risk management awareness sessions held virtually via Teams are being well received, 55 colleagues joined the session on the 14th April 2021 and 34 joined the session on the 13th May 2021.
 - The Risk Management Improvement Plan has been further progressed with updates outlined in Appendix 2.
 - Risks on the organisational risk register have been updated as indicated in **red**.
 - The timings for receiving the risk register at Board Committees is has been reviewed to ensure that Committees receive as timely an update as possible.
 - All risks on the Covid-19 risk log were reviewed as part of the closure report when the command structure was stood down.
 - It has been advised that Bridgend ILG is currently in the process of reviewing its risk register and has established a Task & Finish group to facilitate this. They have also reviewed their CSG /governance assurance meetings to ensure that the risk register is proactively managed going forward. CSGs have been tasked with the review of all open risks scoring 15 and above to be completed by 20th May 2021. All other open risks to be reviewed by 30th June 2021.
 - The ICT/Digital risks are in the process of a significant review by the Chief Information Officer, however these were not available at the time of submission.

3 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 NEW RISKS

Infection Prevention Control / Decontamination:

The Infection Control Lead and Deputy Director of Nursing undertook a review of the Infection Control and Decontamination risks this quarter and have escalated the following risks to the Organisational Risk Register:

1. Datix ID 4477 – There is no dedicated operational lead for decontamination in CTMUHB. Risk rated as a 20.
2. Datix ID 4478 – Inappropriate decontamination process in place for laryngoscope handles in RTE and M&C. Risk rated as a 16
3. Datix ID 2018 – Poor Compliance with Infection Prevention Control Training. Risk rated as a 16.
4. Datix ID 4217 – No Infection Prevention Control resource primary care. Risk rated as 16.
5. Datix ID 4476 – Manual decontamination of nasoendoscopes in RTE and M&C. Risk rated as 16.
6. Datix ID 4482 – Decontamination of dental equipment in the community. Risk rated as a 16.
7. Datix ID 4218 – Reduced on site Consultant Microbiologist cover for the Bridgend ILG. Risk rated as a 15.

Primary Care

The following risk was escalated from primary care this period:

8. Datix ID 4606 – Resumption of Orthodontic Services. Risk rated as a 15.

Rhondda Taf Ely Locality

The following risks were escalated from the RTE locality this period:

9. Datix ID 4152 – Backlog for Imaging in all modalities / areas and reduced capacity. Risk rating 16.
10. Datix ID 4577 – Impact of Speech and Language Therapy and Dietetics staffing capacity with relocation of tissue transfer and surgical procedures to Royal Glamorgan Hospital. Risk rated as a 15.

Financial Stability

The following financial stability risk was escalated this period:

11. Datix ID 4629 – Failure to achieve or reduce the planned recurrent deficit of £33.9m at the end of 2021-2022. Risk rated as a 20.

An emerging risk in relation to the implementation of the Once for Wales Datix programme is being considered and will be included in a future update as appropriate.

3.4 CHANGES TO RISK RATING

a) Risks where the risk rating INCREASED during the period
Nil this period.

b) Risks where the risk rating DECREASED during the period

1. Datix ID 4109 – Increase in requirement to store the patient record for longer due to the delay in the DPN project and the increased retention period due to the Infected Blood Inquiry. Risk rating reduced from a 16 to a 15.
2. Datix ID 4458 – Ambulance Handover Times. Risk rating reduced from a 20 to a 16.

3.5 CLOSED RISKS

1. Datix ID – 4331 – Covid-19 emergency flow and impact of the Royal Glamorgan Hospital (RGH) Flow. Closed as target score met. The rationale for closure has been captured in Appendix 1.

3.4 Organisational Risk Register - Visual Heat Map by Datix Risk ID (Risks rated 15 and above):

Consequence	5			4105 4186	4080 3826 4253	1793 4565	
	4				4070 4103 3584 2987 4235 3682 3008 4115 4148 3133 4417 4360 816 3656 4491 4292 4478 4217 4482	4149 4116 3585 4337 3562 4294 3958 3011 3654 4106 4156 4157 4392 4356 4401 4500 4152 2018 4476 4458	4060 4629 4477 4071
	3						3899 632 3638 3072 4110 3698 3685 4286 4306 4281 4606 4109 4577 4218
	2						



	1					
CxL	1	2	3	4	5	
Likelihood						

4. IMPACT ASSESSMENT

Quality / Safety / Patient Experience implications	Yes (Please see detail below)
	Aim to mitigate risks to patients and staff
Related Health and Care standard(s)	Governance, Leadership and Accountability
	All Health and Care Standards are included
Equality impact assessment completed	No (Include further detail below)
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Well-being Objectives	Provide high quality, evidence based, and accessible care

5. RECOMMENDATION

5.1 The Health Board are asked to:

- REVIEW the detailed Organisational Risk Register at Appendix 1.
- APPROVE the recommendations in relation to New Risks, Updated Risks and Closed risks in section 3.1.
- NOTE – the progress made against the risk journey milestones at Appendix 2.

Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date	Datix ID
Executive Director of Finance & Procurement	Ensure sustainability in all that we do, economically, environmentally and socially.	Financial Stability Risk	Failure to remain in financial balance in 2021/22, when the significant non-recurring Covid funding received in 2020/21 is likely to reduce.	IF: The Health Board is not able to plan changes which enable current run rates of expenditure to align with the available funding for 2021/22 (including Covid funding and Planned Care recovery funding) Then: The Health Board will not be able to develop a break-even financial plan for 2021/22 and deliver it . The context is that the draft plan for 21/22 currently shows a deficit of £19.8m which entirely relates to Q3 and Q4, since the Health Board has only received Covid funding for non programme costs for Q1 and Q2 only. Resulting in: Potential deficit in 2021/22 leading to potential short term unsustainable cost reductions with associated risks, qualification of the accounts and potential Welsh Government regulatory action. The context is that very significant non-recurring funding was allocated to the Health Board in 2020/21 which may not be at the same level in 2021/22, and 21/22 funding within initial allocations is predicated on a	Arrangements are being put in place to further develop the 2021/22 IMTP and financial plan, including the Covid response, TTP, planned care and diagnostics, including prioritisation of planned changes within the available resources. Developing the Health Board's understanding and use of Value Based Healthcare principles to drive service planning and improvement going forward. Developing a more project and programmatic approach to planning and delivery of efficiency savings schemes, with focus on pipeline schemes as well as schemes in delivery. Including the development and implementation of the CTM Improvement Plans. Routine monitoring arrangements in place. Regular reporting to Management Board and Planning, Performance & Finance Committee and Board.	Review bottom up savings plans and budget setting proposals received May/June. Develop the further savings planning process identified by the COO and DoF for implementation in July onwards. Further discussions needed with Welsh Government to understand likely funding position for 21/22.	Planning, Performance & Finance Committee	20	C4 x L5	12 C4 x L3	↔	27.01.2021	10.05.2021	30.06.2021	4060
Executive Director of Finance & Procurement	Ensure sustainability in all that we do, economically, environmentally and socially.	Financial Stability Risk	Failure to achieve or reduce reduce the planned recurrent deficit of £33.9m at the end of 2021/22.	IF: The Health Board is not able to plan changes which enable current run rates of expenditure to align with the expected available funding for 2022/23. Then: The Health Board will not be able to develop a break-even financial plan for 2022/23 and deliver it . The context is that a key issue beyond 21/22 is the recurrent impact of the plan in 22/23 when it is likely that the non recurring funding for Covid in 21/22 will end or significantly reduce as well as non recurring Transformation funding ending. Resulting in: Potential deficit in 2022/23 leading to potential short term unsustainable cost reductions with associated risks, qualification of the accounts and potential Welsh Government regulatory action.	Arrangements are being put in place to develop the 2021/22 IMTP, including the Covid response, TTP, planned care and diagnostics, including prioritisation of planned changes within the available resources. Developing the Health Board's understanding and use of Value Based Healthcare principles to drive service planning and improvement going forward. Developing a more project and programmatic approach to planning and delivery of efficiency savings schemes, with focus on pipeline schemes as well as schemes in delivery. Including the development and implementation of the CTM Improvement Plans. Routine monitoring arrangements in place. Regular reporting of the forecast recurring position to Management Board and Planning, Performance & Finance Committee and Board.	Review bottom up savings plans and budget setting proposals received May/June. Develop the further savings planning process identified by the COO and DoF for implementation in July onwards. Further discussions needed with Welsh Government to understand likely funding position for 22/23.	Planning, Performance & Finance Committee	20	C4 x L5	12 C4 x L3	New Risk	10.5.2021	New Risk	30.06.2021	4629
Executive Medical Director	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to recruit sufficient medical and dental staff	If: the CTMUHB fails to recruit sufficient medical and dental staff. Then: the CTMUHB's ability to provide high quality care may be reduced. Resulting in: a reliance on agency staff, disrupting the continuity of care for patients and potentially effecting team communication. This may effect patient safety and patient experience. It also can impact on staff wellbeing and staff experience.	- Associate Medical Director for workforce appointed July 2020 - Recruitment strategy for CTMUHB being drafted - Explore substantive appointments of staff undertaking locum work in CTMUHB - Feedback poor performance and concerns to agencies - Development of 'medical bank' - Developing and supporting other roles including physicians' associates, ANPs	The response to Covid-19 has impacted the original timeframes for these actions due to the requirement to focus on clinical operational service delivery during the pandemic. Revised dates have been included below: 1. AMD and workforce to develop recruitment strategy - 31.3.2021 – Revised Date September 2021. 2. AMD and DMD to develop retention and engagement strategy - 31.3.2021 – Revised Date September 2021. 3. Reduce agency spend throughout CTMUHB – ongoing - The agency spend reduction is dependent on recruitment aligned with the bank launch and switch to ADHs. The bank launch has been delayed due to problems with the rate card and recruitment through the pandemic has been challenging impacting our ability to appoint to positions. 4. Launch of 'medical bank' to Bridgend ILG locality Autumn/ Winter 2020 – Revised Date September 2021.	Quality & Safety Committee People & Culture Committee	20	C5 x L4	16 15 (C5xL3)	↔	01.08.2013	5.5.2021	31.07.2021	4080
Chief Operating Officer Bridgend ILG	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Emergency Department (ED) Overcrowding	If: As a result of exit block due to hospital capacity and process issues patients spend excess amounts of time within the Emergency Department. This is manifested by, but not limited, to significant 12 hour breaches currently in excess of 400 per month. There are also large numbers of patients spending longer than 24hrs and 48hrs within the ED (please see attached information). Then: patients are therefore placed in non-clinical areas. Resulting In: Poor patient experience, compromising dignity, confidentiality and quality of care. The ability for timely ambulance handover with extensive delays for patients requiring assessment and treatment. Filling assessment spaces compromised the ability to provide timely rapid assessment of majors cases; ambulance arrivals and self presenters. Filling the last resus space compromises the ability to manage an immediate life threatening emergency. Clinicians taking increasing personal risk in	Increased number of nursing staff being rostered over and above establishment. Additional repose mattresses have been purchased with associated equipment. Additional catering and supplies. Incidents generated and attached to this risk. Weekly report highlighting level of above risk being generated. Updated March 21 - All patients are triaged, assessed and treatment started while waiting to offload. - Escalation of delays to site manager and Director of Operations to support actions to allow ambulance crews to be released. - Rapid test capacity in the POW hot lab has recently increased with a reduction in swab turnaround times. - Expansion of the bed capacity in YS to mitigate against the loss of bed capacity in the care home sector and Maesteg community hospital. - Daily site wide safety meeting to ensure flow and site safety is maintained. - There is now a daily WAST led call (including weekends) with a senior identified leader from the Health Board representing CTM and talking daily through the plans to reduce offload delays across the 3 DGH sites. -Twice weekly meetings with BCBC colleagues to ensure that any delays in discharge are escalated at a senior level to maximise the use of limited care packages/ care home capacity. -Appointment of Clinical Lead and Lead Nurse for Flow appointed Feb 21	Continue to implement actions identified in the control measures. Action plans are in the process of being reviewed so a timescale will follow once the review has been undertaken by the lead.	Quality & Safety Committee	20	C5 x L4	16	↔	24.09.2019	4.5.2021	30.05.2021	3826

Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date	Datix ID
Chief Operating Officer All Locality Groups	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Ligature Points - Inpatient Services	IF: the Health Board fails to minimise ligature points as far as possible across identified sites. Then: the risk of patients using their surroundings as ligature points is increased. Resulting In: Potential harm to patients which could result in severe disability or death.	Increased Staff observations in areas where risks have been identified. Any areas of the unit not being occupied by patients are to be kept locked to minimise risks. Update March 2021 - Bridgend Locality - Risk assessment process Some ant-ligature work has been completed in some bedrooms which are used for patients assessed as being at higher risk. Action plan developed with support from the head of nursing within the ILG. Heath Board has approved additional staffing by night and to fund the outstanding capital anti ligature works. Guidance issued to all staff on the implementation of local procedural guidelines. Use of therapeutic activities to keep patients occupied Nurse Director of Bridgend ILG, together with corporate colleagues submitted a briefing paper to the executive team on the 17th August 2020 this paper highlighted the need to progress with outstanding capital anti-ligature work. In addition a local action plan has been developed to help mitigate current risks this includes increasing staffing levels and the locking off of more high risk areas. The Health Board has approved the capital expenditure on the anti ligature works and the additional staffing costs .	Continue to implement actions identified in the control measures. RTE Locality Update: Reviewed 26.02.2021 RTE score is 15 and target 10. All anti ligature works completed but environment not risk free.	Quality & Safety Committee Health, Safety & Fire Committee	20	C5 x L4	10 C5 x L2	↔	17.08.2020	2.3.2021	31.3.2021	4253
Chief Operating Officer / Executive Director of Nursing & Quality (Executive Lead IPC)	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Provision of negative pressure rooms in CTMUHB in line with WHC (2018) 033	If: there are no negative pressure rooms available in CTMUHB. Then: the service will be unable to isolate patients in an appropriate environment. Resulting In: Non compliance with national guidance/ WG expectation	Patients isolated in single rooms. Apply IPC precautions. Isolation policy in place. Alert organisms are dealt with by the IPCT. IPCN's liaison with wards/ departments giving IPC advice/ instruction. All alerts are discussed at weekly meetings. Patients with highly transmissible respiratory infections will be transferred to a regional centre with appropriate isolation facilities	Work with Executive Team, Capital, Estates and Shared Services colleagues to consider recommendations outlined in the WHC(2018)033 Risk currently being reviewed by the Chair of the Infection Prevention and Control Group. Update May 2021 - Lead Infection Control Nurse is engaging with the Estates / Capital Team on progress to date in relation to the provision of negative air pressure rooms. The risk therefore remains currently unchanged.	Quality & Safety Committee	20	C5 x L4	±2 10 (C5xL2)	↔	16.12.2014	04.05.2021	30.06.2021	1793
Executive Director of Nursing & Midwifery IPC - Decontamination	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	There is no dedicated operational lead for decontamination in CTMUHB	If there is no dedicated operational lead for decontamination in the Health Board. Then: compliance with best practice guidance/legislation will not be monitored. Resulting in: near misses/increased risk of infection/litigation risks.	The operational lead for decontamination role is undertaken by the Deputy Lead IPCN. The role is part time decontamination lead(0.5 WTE) and 0.5 WTE Deputy Lead IPC Nurse. The Health Board Decontamination Committee group meet quarterly. ILG decontamination meetings take place monthly. Annual audits are undertaken by Shared Services. AP(D) meetings have been set up by the assistant head of operational estates. Liaise with AE(D) and service group leads as required. The operational lead for decontamination/deputy lead IPCN participates in the all Wales decontamination meetings. Centralised decontamination facilities in RGH and PCH. A business case has been submitted to progress this forward in POW. External review of the decontamination infrastructure, governance systems and processes requested by Executive Nurse Director March 2021.	Working group to be set up to perform review. AE(D) Shared Services to form part of team. First meeting being set up to agree terms of reference/plan. Due Date: 30.06.2021	Quality & Safety Committee	20	C4xL5	8 (C4xL2)	New Risk escalated to Org RR	30.12.2020	11.05.2021	30.06.2021	4477
Executive Director of Planning & Performance (ICT)	Provide high quality, evidence based, and accessible care.	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Security at the Health Board's main Medical Records & Information Hub.	If: The security of the Information Hub is not improved and brought up to standard there is a risk of the hub being broken into out of hours Then: There is a risk that patient medical records files are stolen or damaged and equipment stolen. Resulting In: Potential loss of a patients medical records resulting in the ICO being informed and equipment being replaced	Additional temporary measures are in place to maintain 24 hour site security whilst a longer term solution is in place.	The Estates function has evaluated the property and detailed the requirements in order to make the area secure in the longer term. A meeting will take place w/c 1/3/2021 to review the potential plan to resolve the problem.	Digital & Data Committee	20	C5 x L4	9	↔	28.02.2021	New Risk	31.03.2021	4565
Chief Operating Officer	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to sustain services as currently configured to meet cancer targets.	IF: The Health Board fails to sustain services as currently configured to meet cancer targets. Then: The Health Boards ability to provide safe high quality care will be reduced. Resulting in: Compromised safety of patients, potential avoidable harm due to waiting time delays for treatment.	- Tight management processes to manage individual cases on the cancer Pathway. - Regular reviews of patients who are paused on the pathway as a result of diagnostics or treatment not being available. To ensure patients receive care as soon as it becomes available. - Regular Quality impact assessments with the MDTs, to understand areas of challenge and risk - Harm review process to identify patients with waits of over 104 days and potential pathway improvements. - Initiatives to protect surgical capacity at the Vale hospital for ASA 1+2 level patients until alternatives become available. - All three ILGs are working to maximising access to ASA level 3+4 surgery on the acute sites. - HB working to ensure haematological SACT delivery capacity is maintained. - Ongoing comprehensive demand and capacity analysis with directorates to maximise efficiencies. - Considerable work around recommending endoscopy and other diagnostic services whilst also finding suitable alternatives for impacted diagnostics. - Alternative arrangements for MDT and clinics, utilising Virtual options	Continue close monitoring of each patient on the pathway to ensure rapid flow of patients through the pathway. Active management of the diagnostic backlog (including endoscopy) and exploration of all options to reduce this. Comprehensive planning for repatriation of theatre and haematology services for when private provision is lost. This also needs to consider options for continuation during a potential second surge. These actions are ongoing and assigned to the EDO, DPC&MH and Medical Director. The Cancer Business Unit remain fully involved in the processes to improve care and that at present they are awaiting feedback from ILGs on their plans for restarting elective and other activity and their demand and capacity assumptions. Update April 2021 Each ILG are preparing a Cancer Recovery Plan for submission to Management Board in April 2021 that sets out clear performance targets by June 2021 and/or longer term plans for specific specialities that cannot be delivered to the June timescale.	Quality & Safety Committee	20	C4 x L5	12	↔	01.04.2014	7.4.2021	31.5.2021	4071

Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date	Datix ID
Chief Operating Officer	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Ambulance Handover Times	IF: Ambulance handovers are delayed. Then: Patients will be waiting in the ambulance rather than being transferred to the Emergency Department. Resulting In: A poor environment and experience to care for the patient. Delaying the release of an emergency ambulance to attend further emergency calls.	Senior Decision makers available in the Emergency Department. Regular assessments including fundamentals of care in line with National Policy. Additional Capacity opened when safe staffing to do so. Senior presence at Health Board Capacity Meeting to identify risk sharing. Winter Protections Schemes Implemented within ILG's.	Live Flow Information Dashboard being scoped - Target Date: 31.3.2021 Unscheduled Care Board focus on SDEC/AEC, D2RA - Contact ahead 111 - Target Date: Contact Ahead: March 2021, 111: January 2021. March 2021 - the 111 system commenced in RTE and M&C Locality in November 2020 - will commence in Bridgend Locality shortly. The Unscheduled Care Improvement Programme will be launched in April 2021. A focus of this forum will be on the improvement of the urgent care pathway through the Health Board with the primary benefits being the reduction/eradication of Ambulance Handover Delays. The Unscheduled Care Improvement Board will monitor progress on the programme on a monthly basis.	Quality & Safety Committee	16	C4 x L4	12 C4 x L3	↓ 20	04.12.2020	7.4.2021	31.5.2021	4458
Chief Operating Officer Bridgend Locality	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to sustain Child and Adolescent Mental Health Services	IF: The Health Board continues to face challenges in the CAMHS Service Then: there could be an impact in maintaining a quality service Resulting in: recruitment challenges, long waiting times and impact to the implementation of the new model of care. Difficulties remain in recruiting key staff and new model of care being implemented; waiting times for specialist CAMHS and the new neurodevelopmental service remains challenging. Rationale for target score: Increasing demands being placed on the Core CAHMS Services resulted in long waiting times and the service was experiencing difficulties in recruiting staff	- Reported local and Network pressures across the CAHMS Network with variable problems dependant on the area of the network. - Updates provided to Management Board on developing service model to address reported issues and additional investment secured to increase capacity within the service and to address service pressures. Waiting list initiatives in place whilst staff recruitment is being progressed. - Service Model developed around Core CAHMS in Cwm Taf Morgannwg which includes agreement with General Paediatrics to take the lead on Neurodevelopmental Services and shared care protocols with Primary Care. - New investment impact being routinely monitored A number of service reviews in relation to Ty Lliard undertaken and monitored via Q,S&R Committee	Commissioning discussions taking place across the Network in relation to service pressures and funding. Implementation of the Choice and Partnership Approach (CAPA) and being closely monitored. Internal Enhanced Monitoring Action Plan being progressed and monitored on a fortnightly basis by Bridgend ILG. Single Point of Access being developed. Full demand and capacity plans being developed with some assumptions about additional CAMHS demand as a consequence of the pandemic.	Planning, Performance & Finance Committee	16	C4 x L4	9	↔	01.01.2015	18.11.2020	31.3.2021	4149
Executive Director of Nursing and Midwifery	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Increasing dependency on agency staff cover which impacts on continuity of care, patient safety	IF: The Health Board increasingly depends on agency staff cover Then: the Health Board's ability to provide stability and consistency in relation to high quality care could be impacted. Resulting in: disruption to the continuity, stability of care and team communication. Potential to impact on patient safety and staff wellbeing. There are also financial implications of continued use of agency cover.	Recurring advertisements of posts in and nursing continue with targeted proactive recruitment employed in areas of high agency/locum use. Provision of induction packs for agency staff Agency nursing staff are paid via an All Wales contract agreement, any off framework agency requests must be authorised by an Executive Director prior to booking (system of audit trail in place). Fixed Term Contracts being offered to all existing HCSW and RN currently on the Nurse Bank. Redesign services wherever possible to embrace a healthier Wales and therefore impact upon the workforce required to deliver services. Overtime incentives offered to workforce in response to Covid-19 pandemic. The Health Board is continuing with the overseas recruitment campaign.	Deputy Exec DON is currently reviewing the nurse rostering policy in conjunction with the workforce team in order to put in place (in conjunction with workforce team) clear roster monitoring KPI's and Bank usage/recruitment KPI's. Established a new nursing workforce taskforce. Consultation with Local Partnership Forum undertaken and amendments to the policy have been made as appropriate, the policy will be seeking approval at the Quality & Safety Committee in May 2021- Timescale 31.5.2021. Bi-Annual Nursing Staffing Levels Wales Act - Acuity Audit to be undertaken in June 2021 to report to Board in October 2021. All Wales "Safer Care Module" on e-roster system due to be received in due course. WG led so await WG timescales. No Change as at 4.5.2021. Nursing & Midwifery Strategic Workforce Group, Chaired by the Deputy Director of Nursing to recommence in April 2021. The Nursing and Midwifery Strategic Workforce Group did not meet in April 2021 as planned due to the need to revise membership in line with ILG structure, however, bi-monthly nursing workforce operational task force meetings have been held chaired by the Deputy Director of Nursing since February 2021. the Strategic workforce group is scheduled to meet on the 11th May 2021.	Quality & Safety Committee People & Culture Committee	16	C4 x L4	9 12 (C4xL3)	↔	01.06.2015	04.05.2021	30.06.2021	4106
Executive Director of Nursing and Midwifery	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	There is a risk to the delivery of high quality patient care due to the difficulty in recruiting and retaining sufficient numbers of registered nurses and midwives	IF: the Health Board fails to recruit and retain a sufficient number of registered nurses and midwives due to a national shortage Then: the Health Board's ability to provide high quality care may be impacted as there would be an overreliance on bank and agency staff. Resulting in: Disruption to the continuity and stability of care and team communication Potential to impact on patient safety and staff wellbeing. There are also financial implications of continued use of agency cover.	- Proactive engagement with HEIW continues. - Scheduled, continuous recruitment activity overseen by WOD. Overseas RN project continues. - Targeted approach to areas of specific concern reported via finance, workforce and performance committee - Close work with university partners to maximise routes into nursing - Block booking of bank and agency staff to pre-empt and address shortfalls - dependency and acuity audits completed at least once in 24 hrs on all ward areas covered by Section 25B of the Nurse Staffing Act. - Deputy Exec DON is currently reviewing the nurse rostering policy in order to put in place (in conjunction with workforce team) clear roster monitoring KPI's and Bank usage/recruitment KPI's - Reporting compliance with the Nurse Staffing Levels (Wales) Act regularly to Board - Regular review by Birth Rate Plus compliant, overseen by maternity Improvement Board - Implementation of the Quality & Patient Safety Governance Framework including triangulating and reporting related to themes and trends. successful overseas RN recruitment. - There is an operational Nursing Act Group that reconvened from April 2021.	Established recruitment campaign - which is monitored at the Nursing Workforce Strategic Group - group due to meet/recommence in April 2021. The Nursing and Midwifery Strategic Workforce Group did not meet in April 2021 as planned due to the need to revise membership in line with ILG structure, however, bi-monthly nursing workforce operational task force meetings have been held chaired by the Deputy Director of Nursing since February 2021. the Strategic workforce group is scheduled to meet on the 11th May 2021. Revised nurse rostering policy currently being taken through the relevant approval process - Timescale 31.3.2021. Consultation with Local Partnership Forum undertaken and amendments to the policy have been made as appropriate, the policy will be seeking approval at the Quality & Safety Committee in May 2021- Timescale 31.5.2021. The operational Nursing Act Group to reconvene. Completed as reconvened in April 2021 - included as a control measure. Await review of Birth Rate Plus Compliant Tool by WG - Timescale - WG led so await WG timescales - No further update at this time.	Quality & Safety Committee People & Culture Committee	16	C4 x L4	9 12 (C4xL3)	↔	01.01.2016	04.05.2021	30.06.2021	4157

Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date	Datix ID
Executive Director of Nursing and Midwifery	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Patients and/or relatives/carers do not receive timely responses to matters raised under Putting Things Right	IF: The Health Board fails to provide timely responses to matters raised by patients, relatives and/or carers under Putting Things Right. Then: there will be a delay in identifying potential learning opportunities. Resulting in: variable quality in responses, not learning lessons, not meeting regulatory response times therefore increasing the number of concerns being escalated to the Ombudsman and not providing complainants with a resolution in a prompt and timely manner.	-Implementation of the Quality & Patient Safety Governance Framework - Values and behaviours work will support outcome focused care - supportive intervention from the Delivery Unit supporting redesign of complaints management - relocation of the concerns team into Integrated Locality Groups (ILGs) - Governance teams embedded within each ILG - Governance processes in place in relation to PTR guidelines and this provides assurance via their ILG Q&S committees and these report into the CTMUHB Q&S committee and Patient Experience Committee. - Corporate/Executive assurance and review undertaken weekly via Executive Director led Patient Safety review meetings and quarterly Concerns scrutiny panel meetings. - Ensure access to education, training and learning. - Review of systems in place to aid assurance and compliance with PTR guidelines in progress by Corporate Governance Team. Level 1 PTR training added to ESR training module and training ongoing for staff in the DLG's. Member of corporate team continues to provide training surrounding PTR guidelines and governance. - Shared Listening and Learning forum established with its inaugural meeting in February 2021. - ILG Concerns Management Performance is monitored via the regular Executive Led Performance Management Meetings. - Once for Wales Concerns Management System - Claims, Complaints, Incidents and others that were due to go live from 1st April delayed due to All Wales Technical issues, planned to implement 7th May 2021, which will provide greater integration across complaints, claims and incidents, it will also support All Wales learning and benchmarking.	Corporate Governance team reviewing current Datix system to reflect new DLG structures and working with WRP to ensure alignment with new Once for Wales System which is in progress. COMPLETED. Review of the Concerns Process within ILG's underway - Completed. Improvement trajectories to be established with ILG's - Completed. The Health Board has requested an external review of claims, redress and inquest processes and procedures. This review will be undertaken by the Welsh Risk Pool. Timescale: End of September 2021. The Health Board has requested an Internal Audit on the Concerns Process. Timescales: End of August 2021.	Quality & Safety Committee	16	C4 x L4	9 12 (C4xL3)	↔	01.04.2014	04.05.2021	31.08.2021	4156
Executive Medical Director Chief Operating Officer Integrated Locality Groups Bridgend Locality	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Implementing a sustainable model for emergency medicine and inpatient paediatrics across the CTMUHB footprint	IF: The Health Board is unable to deliver a sustainable model to deliver Emergency Medicine (EM) and inpatient paediatrics across the Health Board Footprint. Then: The Health Board will be unable to deliver safe high quality emergency medicine and inpatient paediatrics services. Resulting in: Compromised safety of patients and Staff.	Successful recruitment to EM in Royal Glamorgan Hospital and Prince Charles Hospital continues at consultant and middle grade. Model for delivery of Paediatric care in RGH significantly clearer and this is contributing to some recruitment success.	Recruitment drive continues.	Quality & Safety Committee	16	C4 x L4	6	↔	01.07.2019	18.11.2020	31.3.2021	4115
Chief Operating Officer	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to achieve the 4 and 12 hour emergency (A&E) waiting times targets	IF: The Health Board fails to achieve the 4 and 12 hour emergency (A&E) waiting time targets. Then: The Health Boards ability to provide safe high quality care will be reduced. Resulting in: Compromised safety of patients, potential avoidable harm due to waiting time delays. Potential of harm to patients in delays waiting for treatment.	Need to strengthen minors streams at DGH sites to sustain improved delivery of performance against the 4, 8 and 12 hour targets. Also variable practice across A&E departments. Consultant and middle grade gaps in RGH now filled. PCH DU report delivered and being enacted. PoW handover performance reviewed by DU & EASC/CASC team and being enacted. PoW/RGH/PCH provided full Safety and Dignity analysis to September QSR committee and Safety Briefing sitrep model and SAFER being rolled out across sites. Programme of improvement work with AM&ED, HR and Retinue teams to improve medical booking and staffing to raise shift fill (ADH initiative has been successful). Winter Plan in train through directorate and partners (RPB). Interim Site Management arrangements coming into place. Systems model in development. 1) Clear discharge planning processes in place. 2) Improvements in the patient flow and investments to support Winter planning. 3) Stay Well At Home (SW@H) Service introduced and evaluated (6 month). Transformation funding will initiate Jan/Feb 2020. 4) SW@H 2 developments and Enhanced Community Clusters being progressed through Transformation bid.	The existing controls will be maintained and developed, with monitoring in place via internal ILG meetings and the monthly ILG meetings with Directors. Given the pressure upon the UHB in the covid-19 environment, the risk will remain at level 16, with review in March .	Planning, Performance & Finance Committee & Quality & Safety	16	C4 x L4	12 C4 x L3	↔	01.04.2013	11.01.2021	31.3.2021	4070
Chief Operating Officer Bridgend ILG	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Sustainability of a safe and effective Ophthalmology service	IF: The Health Board fails to sustain a safe and effective ophthalmology service. Then: The Health Boards ability to provide safe high quality care will be reduced. Resulting in: Sustainability of a safe and effective Ophthalmology service	Measure and ODTC DU reviews nationally. . Clinical staffing structure stabilised and absence reduced (new consultant, nurse injectors, ODTC's, weekend clinics). . On going monitoring in place with regards RTT impact of Ophthalmology. . In line with other services, to meet the RTT requirement services are being outsourced - maintaining this level of performance will be challenging going forward. . Additional funding for follow up appointments provided and significant outsourcing undertaken (6,500 cases) with harm review piloting to assess all potential harms. . Additional services to be provided in Community settings through ODTC (January 2020 start date). . Intravitreal injection room x2 established with nurse injectors trained. Follow up appointments not booked being closely monitored and outsourcing enacted. Regular updates re follow up appointments not booked being monitored by Management Board / Q&SR (patient safety issues) and Finance, Performance and Workforce Committee (performance issues). Reviewing UHB Action Plan in light of more recent WAO follow up review of progress. Primary and Secondary Care working Groups in place.	Action plan developed and on going monitoring - consolidated plan coming forward covering Eye Care. The service has transitioned to Bridgend ILG and Bridgend ILG has engaged in potential national solutions to address FUNB.	Quality & Safety Committee	16	C4 x L4	12 C4 x L3	↔	01.04.2014	1.3.2021	31.3.2021	4103
Chief Operating Officer RTE Locality	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Back log for Imaging in all modalities / areas and reduced capacity	If: there is a backlog of imaging and reduced capacity Then: waiting lists will continue to increase. Resulting in delay and diagnosis and treatment. Due to the Covid-19 outbreak, all routine imaging has stopped and there is reduced capacity for imaging of USC and Urgent patients.	Currently looking at plans for capacity for the whole service - unlikely to see much change in the near future. Locums to support CT service CT vans on site RGH/PCH MRI running at higher capacity Ultrasound concerning 3.2.21 Whilst mobile scanner presence allowed us to reduce the backlog (CT/MRI) routine imaging has since been stopped and has not been reinstated, which will result in a build up of back log. 19.3.21 No change.	Capacity and Demand Review required - timeframe 10.08.2021	Quality & Safety Committee	16	C4 x L4	4 (C2xL2) Target score being revisited.	New Risk escalated to Org RR	01.06.2020	10.05.2021	14.06.2021	4152
Executive Director of Nursing & Midwifery IPC - Decontamination	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Inappropriate decontamination process in place for laryngoscope handles in RTE & MC	If: the current decontamination process for laryngoscope handles continue Then staff are not following manufacturer instructions/Welsh Government guidance. Resulting in: possible infection transmission/poor patient care/litigation risks. A Welsh Health Circular was distributed in September 2020 outlining that laryngoscope handles must either be single use or decontaminated/sterilised in between use following manufacturer instructions via an accredited Sterile Service Department.	A wipe system is being used to decontaminate handles following use. Risk assessment completed to continue using the current process due to the additional funding required to comply with the WHC. Sheaths used to minimise contamination to the handle which is changed following use.	Assistant Medical Director for QSCE has been tasked to progress the requirements of WHC 2020 15 - Larynscope Handles - Due Date: 30.06.2021	Quality & Safety Committee	16	C4 x L4	4 (C4xL1)	New Risk escalated to Org RR	30.12.2020	11.05.2021	30.06.2021	4478

Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date	Datix ID
Executive Director of Nursing & Midwifery Infection Control	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Poor compliance with IPC training	If there is poor compliance with IPC training Then IPC practice will be compromised Resulting in transmission of infection/ poor patient care	Level 2 training is mandatory and delivered via e.learning Managers to monitor compliance with IPC training and report compliance to Directorate and at IPCC meetings	IPC training is available via e.learning and is a mandatory requirement for staff to complete. Reinstate face to face IPC training sessions once COVID situation improves. IPC team to arrange and discuss with Heads of Nursing/ ILG Nurse Directors. Update: 12.5.2021 -- face to face training being reinstated as COVID numbers fall. Review in June 2021.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	New Risk escalated to Org RR	04.09.2015	11.05.2021	30.06.2021	2018
Executive Director of Nursing & Midwifery Infection Control	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	No IPC resource for primary care	If there is no dedicated IPC resource for primary care. Then: the IPC team is unable to provide an integrated whole system approach for infection prevention and control. Resulting In: non compliance with the reduction expectations set by WG. A significant proportion of gram negative bacteraemia, S.aureus bacteraemia and C.Difficile infections are classified as community acquired infections.	Liaise with specialist services in primary care eg. bowel and bladder service IPC team investigate all preventable community acquired S.aureus and gram negative bacteraemia and share any learning with the IPC huddles arranged in primary care to look at community acquired C.Difficile cases - back log of cases and unsustainable 03/03/2021 - there is a back log of IPC investigation relating to community cases due to the additional demands on the IPC service due to the COVID pandemic.	A business case for additional resources for an IPC team for primary care to be developed. Due Date: 31.08.2021	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	New Risk escalated to Org RR	44028	11.05.2021	30.06.2021	4217
Executive Director of Nursing & Midwifery IPC - Decontamination	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Manual decontamination of nasoendoscopes in RTE & MC	If the current decontamination process (Tristel 3 Step)/continues to be used in RTE & MC. Then: inadequate decontamination of the scopes is possible resulting in transmission of infection/poor patient care. It is impossible to guarantee effective decontamination of the scopes every time due to the human factor. Resulting In: in variable techniques. The current manual process is not in line with WHTM guidance which recommends an automated system	A risk assessment to be completed for the use of Tristel 3 step by the ENT service group in RGH, YCR and PCH. SOPs in place for users Decontamination lead to complete assurance audits in the departments. Staff in the ENT department to undertake annual training by the representatives for Tristel 3 Step.	Naso-endoscopes should be processed using a validated and automated process in line with WHTM 01 06. Working group to be established to discuss options available to decontaminate naso-endoscopes. SBAR (options appraisal) to be developed and shared with Exec team Evidence of SOPs for manual process to be shared at local decontamination meetings Risk assessments to be shared/agreed at local decontamination meetings - Due Date: 30.06.2021	Quality & Safety Committee	16	C4 x L4	4 (C4xL1)	New Risk escalated to Org RR	30.12.2020	11.05.2021	30.06.2021	4476
Executive Director of Nursing & Midwifery IPC - Decontamination	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Decontamination of dental equipment in the community	If dental equipment continues to be decontaminated in community dental facilities. Then: the equipment may not be decontaminated effectively as a consequence of the equipment/facilities available to staff. Resulting In: transmission of infection/near misses/poor patient care. Some of the hand pieces cannot to processed in an automated washer/disinfector and are manually cleaned before being processed/sterilised in an autoclave. There are also difficulties maintaining clean to dirty workflows in the decontamination areas due to space restrictions. One of the main recommendations from the Welsh Government audit undertaken in November 2019 was to transport community dental equipment into an accredited Sterile Service Department in the Health Board for processing/sterilisation.	Agreed SOPs in use Maintenance programmes in place for decontamination equipment Hand pieces are serviced annually Water dip tests performed quarterly Quarterly water testing performed by estates in line with WHTM Cleaning schedules in place Nominated dental nurse lead for IPC/decontamination Dental Nurse attends Decontamination committee Plans to centralise decontamination of dental equipment in CSSD/HSDU	Dental Nurse Manager to provide SOPs and Equipment Maintenance - Due Date: 25th June 2021. Action Plan to be developed - Due Date: 30.06.2021 Centralise dental equipment decontamination from Pontypridd Health Park to RGH HSDU - Due Date 30.06.2021	Quality & Safety Committee	16	C4 x L4	4 (C4xL1)	New Risk escalated to Org RR	30.12.2020	11.05.2021	30.06.2021	4482
Executive Director of Nursing & Midwifery	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Non-compliance with DoLS legislation and resulting authorisation breaches	IF: due to current capacity the Health Board fails to fully comply with the DoLS legislation. Then: the Health Board may have to operate outside the current legislative process. (a change in legislation is coming which will hopefully improve lawfulness) Resulting in: the rights, legal protection and best interests of patients who lack capacity potentially being compromised. Potential reputational damage and financial loss as a result of any challenge by the ombudsman or litigation.	Updated Narrative March 2021: - Training and DOLS Process impacted by Covid-19 pandemic due to not being able to undertake face to face capacity assessments. Staff recruited to manage demand e.g. independent best interest assessors, a full time secondment transition post and nurse bank hours. As a matter of routine the HB remain in the position that it is encouraging urgent authorisations by the managing authorities and undertaking virtual capacity assessments with standard authorisations and reviews. - Virtual DoLS processes established and in place within the HB during Covid19, this is subject to regular review and monitoring. Urgent authorisations are prioritised over standard authorisation. Although this process is effective in terms of identifying patients deprived of their liberty, it is not a lawful process and does not comply with legislation. The HB is therefore at greater risk of breaching the legislation and the rights of those who lack capacity are potentially compromised. - Monthly Safeguarding People training for Covid 19 - there has been a pause in training as a result of the second wave of the pandemic as patient facing activity takes precedence. Training restrictions have also impacted upon the numbers of authorisations requested and alternative ways of delivering Level 3 DoLS & MCA awareness has been developed via TEAMS and will commence in April 2021. - DoLS legislation will subject to change following enactment of the new legislation and statutory guidance. Whilst requirements have increased, mitigation has also been revised to manage increased risk, the HB will need to be prepared for new legislation. Further conversations with our 3 local authorities have been undertaken to recommence a CTM regional understanding and preparation for the changes in legislation, supported by the Safeguarding Board. - Audits are undertaken on time to respond to requests. Virtual capacity and best interest assessments involve family, patient representatives and those who care for the patient. Streamlining and target setting implemented which has led to more authorisations taking place in a more timely manner. - Authorisation breaches are required to be reported on Datix. - The DoLS team maintain an accessible level of virtual support and advice to wards, have supported the development of a consent form for Covid testing for those who lack capacity and the nursing workforce are strong advocates for the rights of individuals who lack capacity. A	The Health Board has transitioned back to face to face capacity assessments, following a return of staff from re-deployment. Funding has been received from Welsh Government to support the improvement of the Health Boards compliance with DoLS legislation. This funding will support the Health Board to improve capacity for authorisation and prepare for the new Liberty Protection Safeguards. A review will be undertaken in June 2021.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	01.10.2014	29.4.2021	30.06.2021	4148

Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date	Datix ID
Director of Corporate Governance Chief Executive	Provide high quality, evidence based, and accessible care.	Adverse publicity/ reputation	Organisational Reputation - Lack of confidence in the services and care provided by the organisation.	IF: the Health Board does not effectively engage with its stakeholders, communities and staff to demonstrate listening and learning from external reviews and more recently the Health Boards response to Covid-19 Then: Trust and confidence in the services of the Health Board will be negatively impacted. Resulting in: negative media coverage, lack of credibility with our communities and staff, ineffective communication, loss of commitment, deteriorating morale, increase in staff turnover and recruitment.	Rebuild trust and confidence programme under Targeted Intervention Improvement Programme underway. Maintaining public confidence in the Health Boards response to the Covid-19 Pandemic through regular and robust communication and messaging through the Health Board's communication channels. Improved staff engagement and involvement, new approaches to partnership engagement and involvement. Additional capacity bid included in TI investment bid under the TI programme to WG. Additional capacity bid included in TI investment bid under the SW Programme. Ensure balanced news stories are regularly reported and communicated. Relationships with the media have been strengthened. Partnership working with Channel 4 and proactive engagement with other media outlets - resulting in positive working relationships and fair media coverage. 'In Committee' meetings have been significantly reduced. TTP Communications work stream focussed on provision of accurate and timely information to the Public. Live streaming of the Board meetings now in place to improve transparency and involvement. New Health Board Values and Behaviours were officially launched in October 2020, World Values Day, following the Let's Talk staff engagement programme. The launch was further complemented by a peer recognition 'wall of thanks' campaign throughout Oct/Nov/Dec and a Staff Gratitude Event in December which recognised all CTM staff for their contributions throughout 2020 pandemic year. High visibility, communications and engagement from CEO office internally with staff and externally with key stakeholders since Sept 2020.	Stakeholder engagement survey planned for August 2020 -Stakeholder engagement survey delayed due to Covid-19 outbreaks in autumn but re-scheduled for spring 2021.	Quality & Safety Committee	16	C4 x L4	6 8 (C4xL2)	↔	01.07.2019	5.5.2021	31.5.2021	4116
Chief Operating Officer. Bridgend ILG	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Neonatal Capacity/Stabilisation cot at Princess of Wales	IF: The neonatal unit at POW is required to deliver ITU level care in the stabilisation cot Then: This cot is not staffed, therefore the overall staffing position on the unit is depleted while this is managed, noting that in the absence of a 24/7 retrieval service this can be for extended periods. The stabilisation cot requires 1:1 nursing which is the equivalent of staffing for 2 HDU costs or 4 SCU cots. Resulting In: A risk of being unable to provide appropriate levels of care to the babies on the unit as staffing will be below the required levels as per BAPM requirements	* Utilise available staff as effectively as possible depending on the capacity position at the time * Escalation policy in place to limit maternity services to reduce the risks of further admissions to neonates * Seek additional staffing e.g. through bank, agency, overtime when required	Funding required - included on IMTP. Review date extended until end of March 2021. SBAR and Business cases for funding of the stabilisation cot have also been submitted to various meetings . Core Workforce requirements are being reviewed with a view to enhancing the Nursing workforce model and increasing medical consultant workforce capacity. NN services are aligning with Maternity Improvement programme of work whilst developing elements that are defined for neonatal provision including a Quality improvement programme of work	Quality & Safety Committee	16	C4 x L4	3	↔	31.05.2019	22.12.2020	31.03.2021	3584
Chief Operating Officer Bridgend ILG	Provide high quality, evidence based, and accessible care.	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Princess of Wales Emergency Department Hygiene Facilities	IF: the toilet and shower facilities are not increased within the Emergency Department. Then: at times of increased exit block the facilities are insufficient for the needs of the patients in the department. Resulting In: Poor patient experience, complaints and further concerns raised from the Community Health Council have repeatedly flagged this issue on visits to the department.	There are additional toilet facilities in the radiology department that mobile patients can be directed to however staff do whatever they can within the constraints that they have.	Additional facilities being explored as part of departmental capital works. There is a capital plan for improvement works in ED. The improvements will be – 1. NIV cubicle 2. Creation of a second patient toilet 3. Improvement to HDU area 4. Relocation of Plaster Room 5. Creation of 2 paediatric bays with adjoining paediatric waiting room 6. Redesign of waiting room and reception desk Prior to the Covid pandemic, improvements 2-6 were planned, but the creation of an NIV cubicle has taken priority. The plans are in the process of being signed off for all areas but there is no confirmed start date yet. There was / is potential for delays in sourcing materials by contractors and we need to consider the need to keep contractors as safe as possible from any Covid contact. Patient numbers are now increasing daily but we are restricting visitors and relatives attending with patients (unless required as carers etc). We have also developed a remote waiting room for patients who can safely wait in their cars. This will help to mitigate the footfall in the department when the capital work commences.	Quality & Safety Committee	16	C4 x L4	1	↔	31.05.2019	10.03.2021	31.03.2021	3585
Executive Director of Planning & Performance (ICT) Bridgend ILG	Ensure sustainability in all that we do, economically, environmentally and socially.	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	IT Systems	IF: The Health board is unable to deliver vital clinical information services to the Bridgend locality affecting many clinical systems that are not compatible with Cwm Taf University Morgannwg Systems. Then: The Health board will be unable to deliver safe, high quality care to patients without vital clinical information available. Resulting In: Compromised safety of patients needing treatment that are reliant on clinical test results and information being available to clinicians to plan and deliver the treatment plan.	IT maintenance is currently supported by Swansea Bay UHB via a service level agreement. There are currently a number of systems that are not compatible with Cwm Taf Morgannwg systems and we are 18months post boundary change.	Progress in line with the existing plans which were agreed on the primary basis of their need to be affordable, has been made over 2020/21 with a number of new systems, such as pharmacy management introduced as pan-CTM products. However there is still considerable work required to create a unified digital infrastructure for CTM = around the clinical systems and the remainder of the ICT SLA. The business case details a funding requirement of £8 million. This was discussed at the Digital cell with WG in February 2021 and a further funding request has been submitted to WG at their request.	Quality & Safety Committee Digital & Data Committee	16	C4 x L4	8	↔	14.10.2020	16.02.2020	31.03.2021	4337

Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date	Datix ID
Chief Operating Officer Merthyr & Cynon ILG	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Health & Safety risk of patients and staff in A&E Corridor at the Prince Charles Hospital	IF: Patients are waiting within the corridor of the A&E Department within PCH due to a lack of capacity. Then: there is an increased risk of an unsafe evacuation due to corridor space, personal accidents, breach in confidentiality and poor patient experience. Resulting In: Potential harm to patients, staff and visitors, poor patient experience, increase in incidents and complaints. Failure to comply with legislation if confidentiality is breached due to overcrowding in corridors.	Fire safety checks are to be carried out daily by the NIC to ensure all fire exits are accessible. When patients are nursed in the corridor due to lack of capacity, the emergency pressures escalation procedure is to be followed to de-escalate as quickly as possible. At times of high escalation it is challenging to clear the corridor of patients on trolleys It is policy for RGH and PCH to offload all WAST patients with 15 minutes of arrival regardless of how many patients are in the department. There needs to be a review of how many patients is safe to hold inside the department at any given time.	Action to develop an escalation policy. Update October 2020: HB policy SoP approved by Management Board with regards to the care of patients in corridors.	Health, Safety & Fire Sub Committee of the Quality & Safety Committee	16	C4 x L4	9	↔	22.05.2019	12.10.2020	31.3.2021	3562
Chief Operating Officer Merthyr & Cynon ILG	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Fire enforcement order is in place for the ground and first floor PCH due to inadequate fire compartments to prevent spread of fire, smoke and noxious gasses	IF: The Health Board fails to meet fire standards required in this area. Then: the safety of patients, staff, contractors/visitors etc. and the protection of the buildings could be compromised. Resulting in: potential harm, risk of fire.	Fire Enforcement Order. An action plan and target dates for the 1st and ground floor areas at PCH is available and is subject to available finance for completion. Phase 1b of the wider programme has progressed to the point that the UHB has now achieved remediation for physical fire issues identified in the FEN in the majority of the new Pharmacy, Dining Room and Kitchen areas at PCH which opened in January 2021. This has tackled the higher risk for fire areas of the old kitchens and improved the fire stopping below ITU as well as reducing the overall volume of area remaining in the FEN to be remediated. In addition the UHB secured Welsh Government approval in October 2020 for the Phase 2 FBC, in the sum of £220m, which will see progressive improvement of the majority of the remaining G&FF areas to be remediated for fire over the next 5 and a half years. As a reminder these works are progressive due to the need to balance them against maintaining service delivery as best as we are able and are intended to be supplemented (to run concurrently with final years of the Phase 2) by a final Phase 3 business case intended to address the final physical accommodation areas included within the FEN.	Please see detailed update in control measures.	Health, Safety & Fire Sub Committee of the Quality & Safety Committee	16	C4 x L4	6	↔	29.11.2017	02.02.2021	30.04.2021	2987
Chief Operating Officer Merthyr & Cynon ILG RTE Locality	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Long waiting times and large backlog of patients awaiting Cardiac Echo	IF: The health Board is unable to meet the demands for patients awaiting Echo scans for both follow up surveillance Then: The RTT WG target will not be met and waits may be 26weeks Resulting in: Potential risk to patients from delays in identifying and treating disease and progression of disease	Forms were verified and triaged by Cardiology team. Patients prioritised in relation to clinical need and rated between urgent and routine. I/P room identified away from main department to increase outpatient capacity and to prevent cross infection risks to outpatient services for both staff (inc returning shielders)and patients Clinically urgent completed and move to routine. New forms triaged as received. Overall loss of capacity post Covid circa 56 / month due to test time changes. (+ currently 1.0 wte lts further 120/month. Will submit SBAR to highlight capacity deficit and cost solutions	See Control Measures Risk also raised via Rhondda Locality which will be reviewed alongside this risk - Datix ID 4292.	Quality & Safety Committee	16	C4 x L4	6	↔	14.09.2020	12.10.2020	31.03.2021	4294
Chief Operating Officer Merthyr & Cynon ILG	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Cancer Performance - Gastroenterology Outcome of Covid-19	IF: Routine diagnostic activity is not recommenced in full during the C19 pandemic Then: there will continue to be a backlog of patients awaiting diagnostic investigations Resulting in: Potential harm to patients due to delay in diagnosis and treatment	Endoscopy services have restarted as part of new normal timetables. Backlog is being booked and should be cleared by end of July. 22.9.20 Discussions health board wide to reduce overdue and to work to safe capacity.	See Control Measures	Quality & Safety Committee	16	C4 x L4	9	↔	27.07.2020	02.11.2020	31.03.2021	4235
Chief Operating Officer Merthyr & Cynon ILG	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Elective patients surgery cancelled when high level bed pressures are experienced	IF: Elective patients surgery is cancelled when high bed pressures are experienced Then: There will continue to be a backlog of patients awaiting treatment/procedures to improve their health and wellbeing Resulting in: Potential harm to patients due to delay in treatment/procedures	Consultants are asked clinical opinion when each patient case is cancelled. 12/10/20 insufficient capacity to meet current trauma demand and no short term plan to re-introducing elective orthopaedics during C19 pandemic. Seal area identified but delayed due to RGH IPC issues. As per UHB SoP, clinical prioritization undertaken weekly to list patients with high clinical need. Risk to patients who cannot access. Feasibility study undertaken for elective list in YCC.	See Control Measures	Quality & Safety Committee	16	C4 x L4	8	↔	14.01.2020	14.01.2020	31.03.2021	3958
Chief Operating Officer Merthyr & Cynon ILG	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Risk to Obstetric Theatres National Standards	If: There is an aim for 'Gold standard' compliance with theatre staffing standards. Workforce is used from midwifery establishment, and the establishment is impacted by this. Then: Midwifery workforce reduced to undertake theatre roles and undertake an agreed robust there is a competency training Programme in the UHB for midwifery staff who scrub Resulting In: inefficient staff utilization, where there is a national shortage in the workforce.	Scrub training in place and a rolling programme organised with main theatres There is a business case that has been previously been partially approved for revised staffing levels to achieve compliance with the national standards Acuity impact with no additional resource when midwives are used as scrub midwives impacting on ability to provide a full compliment of midwives for labour ward. Staffing and birth-rate acuity compliance.	Action: Service to update and re submit business case for the Surgical CSG to take ownership of maternity theatres.	People & Culture Committee	16	C4 x L4	6	↔	26.06.2019	4.12.2020	31.3.2021	3682

Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date	Datix ID
Chief Operating Officer Merthyr & Cynon ILG	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Non compliance with appropriate fetal growth detection and management guidance	This is an All Wales risk for all HB's If: there is a lack of USS slots to address the demand we will not be in compliance with the guidance for fetal surveillance and wellbeing. Then: 1. Compliance against the Growth Assessment Protocol (GAP) cannot be met. CTMUHB does not have a 7 day USS service which would support compliance and the management of the small for gestation age (SGA) fetus. Resulting In: Women at the greatest risk of SGA receive less surveillance of growth than women with uncomplicated pregnancies resulting in potential harm.	1. Capacity to comply with GAP/GROW 3 weekly - current regime 3-4 weekly 2. Woman are risk assessed, they are allocated one of two pathways. One pathway SFH can be delivered, Serial scanning (37% of population) unable to receive full recommended scanning regime or protocol due to scanning capacity issues. Current regime 4 weekly as apposed to three weekly. 4. The Directorate is working closely with the Radiology department to review low value scans requested. 5. The Directorate is reviewing the option of midwife sonographers being employed. 7. Scanning group for the UHB established. 8. Continued to be reviewed with changes to patient flow due to 'The Grange'	See Control Measures. Radiology to develop sustainable service plan to increase capacity and workforce.	Quality & Safety Committee	16	C4 x L4	6	↔	01.06.2017	4.12.2020	31.3.2021	3011
Chief Operating Officer Merthyr & Cynon ILG	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Risk of injury due unavailability of opportunities to train and maintain compliance with Manual handling training.	If: There is a lack of manual handling training there is the risk of potential injury to a member of staff or injury to the patient. Then: There are a number of clinicians who have not had the opportunity to meet the requirements for manual handling training. Resulting In: Potential harm being caused to both staff and patients.	1. Staff are aware of the risks associated with manual handling. 2. All staff have been informed to consider the ergonomics of the environment that this activity is being undertaken. 3.Appropriate equipment is available in the clinical areas or on request from the MH team e.g. pat slides, slide sheets, hoists. 4. Manual Handling risk assessments are incorporated into the admission bundles 5. The training group are planning training for clinical staff with the manual handling department - current position that this can not be supported 7. Ask other HB's their MH requirements SBUHB online training package to be shared. 8. Directorate will Seek out any opportunities for online updating to support current practice 9. E-learning module has been sourced for all staff to complete on line update for manual handling.	Organisational plan for compliance training.	Health, Safety & Fire Sub Committee of the Quality & Safety Committee	16	C4 x L4	12	↔	01.05.2017	01.12.2020	31.3.2021	3008
Chief Operating Officer Merthyr & Cynon ILG	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Gynaecology Cancer Service	This affects Gynaecology services across CTMUHB - delay in the pathway requiring multiple consultations on site - Service relies on an individual practitioner - Demand is currently in excess of agreed manageable caseload - Hysteroscopy service capacity requires business case supporting for service development - Gynae Rapid access service development is slow progression	Hysteroscopy service business case is being updated - Increased cancer tracking - Review of pathways and service - tracking of results G17Scrub training in place and a rolling programme organised with main theatres	Action: Agreed COVID pathways. Service to re-submit gynaecology 'one stop' Service.	Quality & Safety Committee	16	C4 x L4	9	↔	18.06.2019	30.09.2020	31.3.2021	3654
Chief Operating Officer	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Due to capacity issues to deal with Covid-19 staff not attending medical gas safety training and courses being rescheduled.	(Facilities Risk Register Reference CE11) ILG: CSO Facilities Hub If: Staff are not able to attend Medical Gas Safety training or courses are being continuously rescheduled. Then: Staff are not being trained in safe storage and flow of cylinders (e.g. oxygen). Resulting In: Failure to adequately and safely obtain and continue flow of cylinders (e.g. oxygen), potentially causing harm to patients.	PSN041 Patient Safety Notice and local safety alert disseminated to all staff. Posters developed and displayed in areas to encourage attendance. New staff trained at induction. TNA has been undertaken. Refresher training is undertaken, however current attendance levels by clinical staff for Medical Gas Safety training is poor, hence the current risk score. Medical Gas Cylinder Policy developed with training section completed by Medical Device Trainer, referencing the mandatory requirement for training by all users. Completed To make it a key requirement that staff can be released to attend training to re-enforce safety and operating guidelines of medical gas cylinders.Completed. Medical Device Trainer has put in place a B4 role who is undertaking a rolling programme for Medical Gas Training, with two sessions, twice a month, at each ILG every month. However, although training has been undertaken for Porters and graduate nurses, nursing staff currently in post are still not attending and attendance continues to be poor due to current circumstances with Covid-19 and due to not being able to be released for the 2 hours of training. Medical Device Trainer and Assistant Director of Facilities to request again for the Executive Director of Nursing Midwifery and Patient Care to review nursing attendance and make the necessary arrangements to allow nursing staff to attend training and also to look at the possibility of introducing a 'training day' that will allow nursing staff to be released to attend those courses that are struggling with attendance levels.	Issue of limited attendance raised at Medical Devices Governance Board on 08/04/2021 and Assistant Director Facilities agreed to take forward with Chief Operating Officer (COO). Training dates and flyer have been provided by Medical Device Trainer to Assistant Director Facilities so that he can take to ILG Directors next meeting to be held 13/04/2021. Action: ILG Director leads to improve take up of Medical Gas Training. Timescale: 31/07/2021. Based on this update the risk rating remains unchanged until the required attendance for Medical Gas Training is being consistently achieved. (DW 12/04/2021).	Quality & Safety Committee.	16	C4 x L4	8	↔	01.05.2018	21.04.2021	31.07.2021	3133
Executive Director for People Chief Operating Officer and All Locality Groups	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Management of Security Doors in all Hospital Settings	IF: the Health Board do not comply with the notice. THEN: the Health Board may be subject to prosecution by the HSE RESULTING IN: Large Fines and poor publicity. Following several serious incidents following patients absconding from clinical areas, the HSE have issued an Improvement Notice on Bridgend Integrated Locality Group (see Documents) outlining the following actions: In consultation with employees and involving competent persons: 1. Identify the units, wards and premises where in-patients may be at risk from wandering, absconding or escaping. 2. For each of these, undertake a suitable and sufficient risk assessment of physical and procedural measures to prevent in-patients from wandering, absconding or escaping. 3. Identify the measures needed to protect patients at risk 4. Record the significant findings. Any lessons learned from the above should be formally shared with the other 2 Integrated Locality Groups for action.	Clinical areas across the Health Board should have in place local arrangements/procedures to prevent patients from absconding.	Identify the measures needed to protect patients at risk and enter them on to the Risk Register for consideration. Discussions with Bridgend ILG and Capital/Estates - Due by 31.12.2020. Merthyr/Cynon and Rhondda/Taf Ely ILGs will work closely with Bridgend ILG to identify any learning and implement any recommendations, Bridgend ILG Update: Full review of door security undertaken across the ILG. Works to fit door alarms at Ty Lliard currently in progress and due to be completed by the end of March.	Health, Safety & Fire Safety Sub Committee of the Quality & Safety Committee	16	C4 x L4	8	↔	30.09.2020	14.12.2020	31.3.2021	4417

Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date	Datix ID
Executive Director for People	Provide high quality, evidence based, and accessible care.	Legal / Regulatory Statutory duty, regulatory compliance, accreditation, mandatory requirements	Overdue fire risk assessments	If: Fire Risk Assessments are not completed and reviewed in a timely manner. Then: Significant findings on the FRA may have changed which could compromise the safety of patients, staff, visitors/contractors and building fabric. Resulting in: Increased risk of fire/harm, enforcement action by Enforcing Authority i.e. Notification of Deficiencies (IN01) which will further escalate to Enforcement Notices (EN01) if no remedial action is taken. At time of assessment there are 138 FRA's overdue, resulting in non compliance with the RR(FS)O 2005.	There are FRA's in place however a substantial number have not been reviewed by the review date. Fire safety advisors are reviewing FRA's in areas where it is safe to do so (Covid restrictions are in place in many areas). A concentrated effort will be necessary to reduce the number of overdue FRA's.	It is recommended that additional fire safety resources are provided to support the work of the fire officers to undertake FRA reviews. As referred to in Risk ID:4315, 2 x Band 5 additional fire safety trainers to be appointed. Agreement on additional fire safety training resource (Risk ID 4315) will create additional time for the Fire Officers to undertake this activity - Due by date 31.03.2021.	Health, Safety & Fire Safety Sub Committee of the Quality & Safety Committee	16	C4 x L4	6	↔	26.10.2020	30.10.2020	31.03.2021	4356
Executive Director for People	Provide high quality, evidence based, and accessible care.	Legal / Regulatory Statutory duty, regulatory compliance, accreditation, mandatory requirements	Changing the use of rooms/departments without input/advice from the relevant fire advisor.	CTMUHB have access to Fire Build Forms, these are in place to document the required action necessary to change either the use of a single room (FB1) or more than one room (FB2). These forms provide documented evidence that the user has the necessary information to perform the change effectively and that the correct advice has been given. The consequences of not seeking the relevant information prior to change the use of an area could result in a number of failings relating to fire safety and would only be recognised when the fire advisor carries out a FRA or the Enforcing Authority/Shared Services carry out an audit which may result in enforcement action under the RR(FS)O 2005. Typical failings are: Plans not being updated Fire Alarm Cause and Effect not being amended Rooms not being made up as hazard room enclosures when necessary Fire alarm system not being extended Emergency lighting not being extended Breaches in compartmentation.	The Fire Build forms have been available for some considerable time across the Health Board. There appears to be a reluctance to use them, or simply staff/contractors are unaware of them. Staff/contractors should made aware of the Fire Build Forms and the consequences to the Health Board for not using them. http://ctuhb-intranet/dir/fire/Change%20of%20Use%20%20Room/Forms/AllItems.aspx	A communications plan to be developed to ensure all relevant managers are aware of the need to complete the appropriate Fire Build Forms for room/departmental changes. Non compliance with this requirement identified via Fire Risk Assessment reviews will be reported as an incident via the Health Board's Incident Management System (Datix) Reinforce previous communication across all Health Board wards/departments about the need to complete the Fire Build Forms prior to making any changes to a room or department. Due Date 31.12.2020.	Health, Safety & Fire Safety Sub Committee of the Quality & Safety Committee	16	C4 x L4	9	↔	28.10.2020	28.10.2020	26.04.2021	4360
Chief Operating Officer RTE Locality	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Risk of absconding from Ward 23.	If: Estates work and Covid-19 pathway remodelling is not undertaken urgently Then: Mental health patients may continue to abscond Resulting In: Potential harm to themselves or the public	All patients risks for suitability of admission to ward 23 assessed. Patients discouraged from smoking where possible. Any patient who goes out into garden is supervised by ward staff at all times. All staff will try to de-escalate increasingly volatile situations. Prompt alert if patients can not safely be stopped from absconding. Staff to follow guidance for managing absconding patients. All patients are risk assessed.	Work with Estates ongoing. A Statement of Need has been submitted to fund additional fencing being installed.	Quality & Safety Committee	16	C4 x L4	4	↔	04.11.2020	26.2.2021	30.04.2021	4401
Executive Director of Therapies & Health Sciences	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	There is a risk to the delivery of high patient care due to the difficult in recruiting sufficient numbers of registered therapists and health scientists.	If: the Health Board fails to recruit and retain a sufficient number of therapists and health scientists due to increasing numbers of vacancies and shortages of professional staff. Then: the Health Board's ability to provide certain services may be compromised. Resulting in: increased waiting times for diagnosis and treatment, missed opportunities to diagnose at an earlier stage, potential for poorer outcomes for patients.	Links via the Director Therapies to HEIW for planning. Proactive recruitment for difficult to fill posts. Use of Agency/Locum staff where available. Update as at April 2021 Director of Therapies & Health Sciences have supported participation in streamlining to appoint AHP summer 2021 graduates to band 5 vacancies. This is the first time AHPs have recruited in this way and it is too soon to ascertain whether this will impact positively on staff retention.	Continue with active recruitment wherever possible. Ensure workforce plans included and supported in the Integrated Medium Term Plan (IMTP). Utilise 'novel' staffing approaches where indicated. April 2021 The review of the graduate approach to the Band 5 Vacancies will be on a 6-9 month timeline as the graduates are not due to commence until late summer.	Quality & Safety Committee People & Culture Committee	16	C4 x L4	9	↔	21.12.2020	12.04.2021	31.5.2021	4500
Chief Operating Officer Rhonddda Taf Ely ILG	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Follow up capacity and clinic cancellations (FUNB)	If: The Health Board is unable to control and meet the capacity and demand to accommodate all hospital follow up outpatient appointments. Then: the Health Board's ability to provide high quality care may be reduced. Resulting in: Potential avoidable harm to patients	Organisation plan in place to address the FUNB position across all specialties. Additional funding requirements identified. Regular meetings in place to monitor the position.	Harm review processes being implemented. Further discussions underway with Assistant Director of Nursing.	Quality & Safety Committee	16	C4 x L4	12	↔	18.11.2013	10.05.2021	10.08.2021	816
Executive Director of Workforce & OD Health & Safety	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Health Surveillance	If: There is an absence of a robust Health Surveillance (HS) Scoping Report. Then: The Organisation will not be able to identify the areas and department within the organisation that require Health Surveillance Intervention. Resulting In: The Health Board not being able to develop a HS Programme for the organisation as required by the Health & Safety Executive (HSE). Employees working in specific areas/conditions without the relevant health surveillance.	Directors and line managers responsible for own areas and should have own Health & Safety measures such as risk assessments, safe systems of work in place however this does not address any Health Surveillance needs of CTM employees. Require scoping report to inform the development of a robust Health Surveillance programme. Collaborative working will be required between OHWB, H&S, Workforce, staff side and line managers to implement the programme.	As at March 2021. Head of Health, Safety and Fire agreed to review the risk and associated action plan requirements.	Health, Safety & Fire Sub Committee of the Quality & Safety Committee	16	C4 x L4	8	↔	18.06.2019	5.1.2021	31.3.2021	3656

Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date	Datix ID
Chief Operating Officer	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to meet the demand for patient care at all points of the patient journey.	IF: The Health Board is unable to meet the demand upon its services at all stages of the patient journey. Then: the Health Board's ability to provide high quality care will be reduced. Resulting in: Potential avoidable harm to patients	Controls are in place and include: - Technical list management processes as follows: - Speciality specific plans are in place to ensure patients requiring clinical review are assessed. - All patients identified will be clinically reviewed which will include an assessment of avoidable harm which will be reported and acted upon accordingly. - A process has been implemented to ensure no new sub speciality codes can be added to an unreported list, this will be refined over the coming months. - All unreported lists that appear to require reporting have been added to the RTT reported lists - All unreported lists that are to remain unreported (as they do not form part of the RTT criteria) are being reviewed and will be visible and monitored going forward. - Patients prioritised on clinical need using nationally defined categories - Demand and Capacity Planning being refined in the UHB to assist with longer term planning. - Outsourcing undertaken when needed. - The UHB will continue to work towards improved capacity for Day Surgery and 23:59 case load. - A Harm Review process is being piloted within Ophthalmology – it will be rolled out to other areas. - The UHB has taken advice from outside agencies especially the DU when the potential for improvement is found. - Appropriate monitoring at ILG and UHB levels via scheduled and formal performance meetings with additional audits undertaken when areas of concern are identified	The existing controls will be maintained and developed, with monitoring in place via internal ILG meetings and the monthly ILG meetings with Directors. Given the pressure upon the UHB in the covid-19 environment, the risk will remain at level 16, with review in March .	Quality & Safety Committee	16	C4 x L4	9	↔	11.01.2021	11.01.2021	31.03.2021	4491
Chief Operating Officer Rhonddda Taf Ely ILG	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Long waiting times and large backlog for Cardiac Echo	If: For old Cwm Taf template Total of 2720 pts awaiting Echo scans for both follow up surveillance to monitor disease progress and new referrals governed by RTT. RT -ILG 1520 pts of which 873 would form part of RTT 570 pts waiting greater than 8 weeks longest wait 45 weeks. Then: Potential risk to patients from delays in identifying and treating disease and progression of disease e.g. valves, LV function . Resulting in: Delays in receiving appropriate treatment pharmacological, intervention , surgical. Potential risk litigation. triage process reliant on available referral information to assess urgency.	Forms were verified and triaged by Cardiology team. Patients prioritised in relation to clinical need and rated between urgent and routine. I/P room identified away from main department to increase outpatient capacity and to prevent cross infection risks to outpatient services for both staff (inc returning shielders) and patients Clinically urgent completed and move to routine. New forms triaged as received. Overall loss of capacity post Covid circa 76 / month due to test time changes. Ill health retirement further 97 / month capacity loss.	Plans to submit SBAR to highlight capacity deficit and cost solutions.	Quality & Safety Committee	16	C4 x L4	9	↔	10.09.2020	14.09.2020	19.05.2021	4292
Executive Director for People	Provide high quality, evidence based, and accessible care.	Legal / Regulatory Statutory duty, regulatory compliance, accreditation, mandatory requirements	Site Specific Fire Documents Require updating on some sites.	Site specific documents on a number of sites have outdated information. We have a duty under the RR(FS) 2005 to provide site specific information for oncoming fire crews. Hospital and other healthcare estates are constantly evolving environments that must be flexible enough to accommodate new layouts and changes of use as and when required. It is important to provide up to date site specific information for attending fire crews to highlight hazards etc., and for the crews to make informed decisions, failure to do so could put persons at risk and the possibility of enforcement action from the Enforcing Authority.	There are site specific documents available on a number of our sites throughout CTMUHB, however where changes to our sites have occurred it should be ensured the site specific documents are updated to reflect the change.	Agreement on additional fire safety training resource (Risk ID 4315) will create additional time for the Fire Officers to undertake this activity. Additional 2 x band 5 fire safety trainers approved until 31 March 2021 by Director of Workforce and OD.	Health, Safety & Fire Safety Sub Committee of the Quality & Safety Committee	16	C4 x L4	9	↔	30.10.2020	30.10.2020	12.04.2021	4392
Executive Director of Public Health	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Potential Harm and poor experience for Patients as a result of the Health Board's focus and response to the Covid-19 Pandemic	IF: the Health Boards resources and focus is directing into managing the response to the Covid-19 pandemic. Then: the Health Board's ability to provide high quality care may be reduced. Resulting in: potential harm to patients as a result of reduced service provision and capacity to respond to other areas of the Health Board's population Health need.	Planning preparedness, contingency structures through the Resetting CTM structures. Critical services are operating. Governance process in place for financial and non-financial decision making to support, all predicated on Quality Impact Assessments. Quality & Safety Committee has continued to meet to ensure scrutiny and assurance on behalf of the Board. Indicators of quality and patient safety for all services continue to be closely monitored throughout Covid-19. Processes and guidance in place to ensure clarity on areas such as safeguarding and child protection. Implementation of the Test Track and Trace Programme in June 2020. Regular Population Health Surveys conducted in relation to Covid-19 to gauge attitudes and risk perception within communities. Compliance with National Guidance. The QIA process for service changes relating to Covid-19 management will include an assessment of related impact on any existing service delivery. Deaths are monitored via the mortality review process. Monitoring incidents, complaints and feedback through social media. Monitoring Core quality and safety metrics. The Health Board's vaccination programme continues to move at a fast pace which will ease pressure on the hospitals as case numbers and severity reduce in time.	The QIA process for services changes relating to COVID-19 Management will include an assessment of related impact on any existing service delivery. Continuing to roll out the Health Boards Vaccination Programme.	Quality & Safety Committee	15	C5 x L3	12	↔	23.03.2020	08.02.2021	30.04.2021	4105

Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date	Datix ID
Chief Operating Officer	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Covid 19 - Gold Risk - 002 Critical Care Beds and Equipment	IF: there is an insufficient number of critical care beds, medicines and ventilators. Then: the Health Board's ability to provide high quality and safe care would be reduced. Resulting in: potential harm to patients.	- Suspend non-urgent outpatient appointments and ensure urgent appointments are prioritised - Suspend non-urgent surgical admissions and procedures (whilst ensuring access for emergency and urgent surgery) - National work regularly shared - Local model well underway and informing capacity planning. - More detailed capacity plan available and being shared with WG as requested - Redeploy and retrain staff released from inpatients, day cases and outpatients - UK government removing restrictions on the export of any UK bound stocks. - New systems in place for the assessment and management of stock in hospitals. - Movement of stock between health boards. - Minimising wastage of critical care medicines in the ward and in aseptic production units. - Daily situation report providing stock levels relative to critical care bed usage by health board. - Regular calls between NHS pharmacy procurement leads used to support mutual aid through the movement of stock between health boards. - USC dashboard (to remain Level 1 Green / Level 2 Amber) - Capacity Plan in place with modelling throughout the covid-19 period	- Ensure local stock levels are maintained at levels proportionate to anticipated short term demand, underpinned by regular replenishment from normal supply routes and NHS Supply Chain - under constant review. - Working to ensure robust arrangements are in place to identify and move stock rapidly between hospitals and health boards should the need arise.	Quality & Safety Committee	15	C5 x L3	10	↔	13.05.2020	18.11.2020	31.3.2021	4186
Executive Director of Nursing & Midwifery	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Clinical staff resuscitation training compliance	IF: there continues to be poor compliance with resuscitation training in relation to clinical staff. Then: the Health Board's ability to provide high quality and safe care would be reduced. Resulting in: a risk that clinical staff are not up-to-date with their resuscitation training and therefore potentially not able to offer the most up-to-date evidence based care to patients requiring resus. There is a secondary risk that if ESR records are not accurate there is no clear organisational picture which of our staff are resus trained and who are not, presenting a particular risk for rota planning.	ESR record is being reviewed and data checked for accuracy - doctors records need updating as currently ESR not routinely used by Medical staff. New models of training with robust demand and capacity training planning in place need to be identified. This will need to have appropriate resus officer training capacity. An internal restructure has now taken place to ensure a more robust management line. Resus dept is now managed by the Senior Nurse Clinical Education. 2 x band 7 resuscitation practitioner posts successfully recruited to and both in post end of May 2020. Covid re-emergence in September / October will have a further impact on training availability & compliance levels. Staff availability for training also impacted. All training taking place is compliant with social distancing / PPE requirements for COVID. High turnover/ retirement / long term sickness/ redeployment due to Covid of qualified Resuscitation staff recently have all impacted on capacity to deliver training. Key appointments have now been made, redeployed staff are returning and recruitment to current vacancies in is place.	At the December 2020 meeting the RADAR Committee received an update on the Resuscitation Training Compliance Risk and were advised that the compliance position has deteriorated further during 2020 due to Covid pressures. Training was cancelled in the first wave and release of staff for training has also impacted through the second wave. The Committee has agreed a number of actions to be presented at the March 2021 meeting: - Review of agreed training standards against which compliance is measured. - Review of training formats to include e-learning options. - Review resus departments demand and capacity for training. Timescale - 31.3.2021 Situation reviewed at March 2021 Radar. E-Learning options have now been incorporated into our training standards and key appointments in the Resus department have now started in their posts. Training compliance however has deteriorated further due to a second wave of covid impacting on release of staff and continuing difficulties in securing adequate training accommodation particularly in RTE and Bridgend localities. Work continues to assess training demand and capacity. Risk however cannot be reduced until improvement is seen. Next review at RADAR June 2021	People & Safety Committee	15	C3 x L5	6 9 (C3xL3)	↔	20.11.2019	29.04.2021	30.06.2021	3899
Executive Director of Planning, Performance & ICT	Ensure sustainability in all that we do, economically, environmentally and socially	Operational: - Core Business - Business Objectives - Environmental / Estates Impact - Projects Including systems and processes, Service /business interruption	Shortage of IT Storage space. (The ground and first floor work at PCH requires the ICT store and build areas to be relocated to alternative accommodation. As yet a suitable area has area has not been found. The accommodation will need to be suitable for large delivery trucks to deliver ICT equipment and either ground floor or lift access to the area.)	IF: The lack of enough storage space for ICT equipment is not sufficient. Then: Equipment will be required to be stored in temporary locations which are not designed for storage. Resulting In: a risk to the Health and Safety of ICT staff and the risk to the equipment being either damaged, lost or stolen.	- Ensuring regular disposal of old redundant hardware using third party company, to keeping stock down to a minimum - Vigorous and robust procedures in place for the procurement of new equipment. - Identifying fully any additional storage requirements of every new system requested. - Due to the progression of Ground and first discussions are underway around possible areas that ICT can move into for build and storage which is key to be able to deliver a service	- To identify extra/sufficient storage space for obsolete and new equipment. Completed extra storage space secured. - The temporary storage of the ECC area now under discussion.	Digital & Data Committee	15	C3 x L5	3 3x1	↔	02.05.2011 -	07.12.2020	01.04.2021	632
Chief Operating Officer Pharmacy & Medicines Management	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Pharmacy & Medicines Management - Training & Development Infrastructure	IF: the planned HEIW led changes to the education and training of pharmacists and pharmacy technicians with increased numbers of trainees across both primary and acute care are fully implemented Then: the there will be insufficient capacity within the medicines management team to provide the required training, supervision and management of the planned trainees. Resulting in: a lack of appropriately qualified pharmacy professionals to meet future service demands in all sectors and particularly in hard to recruit to ILGs such as Merthyr where we have established a "grow our own" model. This can impact the primary care sustainability MDT model. Also a reduction in reputation of a HB that has a very high level of % qualifying and a reduction in future applicants. Current capacity is overstretched and a robust education, training and development infrastructure is needed to meet these demands for specialist & advanced practitioners in primary and secondary care.	SBAR submitted to CBM in March 18 to increase training capacity in order to meet the demand. Included in IMTP and prioritised as number one priority. A bid was included as part of the primary care pacesetter for education and development in primary care academic hubs and was successful. This element of the ed/tr will be implemented in 2018 for 3 years with evaluation. The secondary care elements were not supported in the IMTP prioritisation process and so this still leaves significant risks. SBAR needed to describe the impact of the new technicians training qualification. Funding approved for primary care lead pharmacist - commenced in post April 2019. Included a new case in 2019/20 IMTP as high priority. SBAR for Nov CBM on new technician training requirements. Progress and evaluate primary care pacesetter plan to increase training infrastructure to inform business case to continue funding and scale up.	June 2019: Briefing paper detailing risks and recommendations to be submitted to CBM summer 2019 Dec 2019: All Wales working groups established and discussions ongoing with HEIW regarding changes and capacity and resources required. Jan 2020: SBAR submitted to HEIW and CBM in response to consultation on pre-registration pharmacist proposals Oct 20 discussions on going with HEIW and COVID impact on training now to be included in this risk. SBAR to be included in 2021/22 IMTP Review of mitigating action scheduled for April 2021.	People & Culture Committee	15	C3 x L5	6	↔	02.01.2018	04.02.2021	01.04.2021	3638

Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date	Datix ID
Chief Operating Officer Pharmacy & Medicines Management	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Temperatures in medicines storage room on the wards in Prince Charles Hospital not fit for purpose.	If there is no control of the temperatures in all the medicines storage rooms on the wards in Prince Charles Hospital. The medicines storage room have pipes in ducts which give off significant heat year round and increased issues in the summer months. Then: medicines are being kept above the required temperatures as stated in their specifications of storage as part of their license from MHRA. Resulting in: medicines stored at a higher temperature than their specifications which could result in them being less active or denatured and affect patient outcomes.	Some wards are placing small fans in rooms but this does not reduce the temperature. alternative rooms for storage have been discussed but unable to progress due to other ward priorities A SON for air conditioning for each ward will be progressed by medicines management on behalf of ILG	A SON for air conditioning for each ward will be progressed by medicines management on behalf of ILG, however, due to COVID-19 this will be considered in 21-22. Risk will be reviewed in May 2021.	Quality & Safety Committee	15	C3 x L5	6	↔	05.02.2018	04.02.2021	03.05.2021	3072
Executive Director of Workforce & Organisational Development	Provide high quality, evidence based, and accessible care.	Legal / Regulatory Statutory duty, regulatory compliance, accreditation, mandatory requirements	Failure to fully comply with all the requirements of the Welsh Language Standards, as they apply to the CTMUBH)	If: the Health Board fails to comply with all the Welsh Language requirements Then: the Health Board's will not be compliant with the duties outlined in the Welsh Language Standards. Resulting in: damage to the reputation of the Health Board, negative publicity and contact with the Welsh Language Commissioner. As a consequence of an internal assessment of the Standards and their impact on the CTMUBH, it is recognised that the Health Board will not be fully compliant with all applicable Standards. This risk is particularly high in: translation services due to demand exceeding capacity.	The Welsh Language team has undertaken a self-assessment of the requirements of the Standards and how they apply to Cwm Taf Morgannwg. Close constructive working relationships are in place with the Welsh Language Commissioner's Office. Strong networks are in place amongst Welsh Language Officers across NHS Wales to inform learning and development of responses to the Standards. Regular reports to the Board to raise awareness. Working Group set up to support managers. Developing a new bilingual skills strategy. Welsh courses provided to staff. Ward Audits to monitor progress with compliance - ongoing and options to revisit are currently being discussed.. Continue to review and act on the UHBs Self-Assessment findings and related improvement actions; ensure Board is fully sighted. Implement the first year of a 5 year plan outlining the extent to which the health board can carry out consultations in Welsh. All nursing JDs are translated and advertise bilingually. Compliance with Statutory requirements outlined in Welsh Language Standards.	Welsh Language in Primary Care Policy developed and being progressed for Board Committee approval - Completed. Begin a programme of translation focusing on the job descriptions advertised most frequently - e.g. nursing vacancies. Compliance with this standard with take many years due to the limited capacity of the translation team. Action plans have been given to the heads of ILGs, Corporate Services and Workforce and OD to ensure senior management are aware of their WL responsibilities. Completed. Continue to develop the Welsh Language skills of the workforce through online learning. Due date for remaining actions :31.3.2021	People & Culture Committee	15	C3 x L5	9	↔	02.07.2018	1.3.2021	31.3.2021	4110
Chief Operating Officer Bridgend ILG	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Waiting List for Autism Diagnostic Observation Schedule (ADOS) assessments and Attention Deficit Hyperactivity Disorder (ADHD) medicals over 1 year.	If: there are delays in diagnosing children with ADHD and Autism. Then: this results in a delay in management including appropriate school placements Resulting in: potential harm to patients, poor patient experience, dignity, staff morale. Complaints.	* The team have reviewed their clinical practice in line with the rest of CTM e.g. no longer undertaking ADOS for all children * Discussions underway re: repatriating service from Swansea Bay and investing funding into enhanced local service in Bridgend * New Consultant starting June 2020 with 3 sessions to support community paed	Vacant sessions to be recruited to - Additional staff appointed who could undertake assessments would ensure this activity was managed in a timely manner.	Quality & Safety Committee	15	C3 x L5	4	↔	02.07.2019	16.09.2020	01.06.2021	3698
Chief Operating Officer Merthyr & Cynon ILG	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	No Midwifery Specialist for pregnant women with vulnerabilities	If: there is no dedicated services for substance misuse women, prescription medication, or women with vulnerabilities (social) - national best practice is for there to be a lead in vulnerabilities to see women in a dedicated clinic with the multidisciplinary teams which without leads to disjointed care for our most at risk patient group. Then: unidentified opportunities to co-ordinate risk management and support in 'A Healthier Wales' in pregnancy will be missed. Resulting In: potential harm to mothers and babies care provision and outcomes.	Women in PCH/RGH are seen in a general Ante Natal clinics Women in POW currently seen in a dedicated clinic, with an SLA agreement with Swansea Bay UHB .2 resource. The directorate need to develop a Statement of need to secure resources to support services across the HB and ensure standardised service delivery.	Action: Service to develop business case for implementing specialist service for women with vulnerabilities.	Quality & Safety Committee People & Culture Committee	15	C3 x L5	6	↔	26.06.2019	01.12.2020	31.3.2021	3685

Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date	Datix ID
Chief Operating Officer Executive Director of Planning, Performance and ICT	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Telecommunications upgrade required with operational components for cardiac arrest and emergency fire numbers.	(Facilities Risk Register Reference 11480B) ILG: CSO Facilities Hub If: The telecommunications system for cardiac arrest and emergency fire numbers is not upgraded. Then: Potential for system crashes. Resulting In: Potential delay in contacting the necessary person(s), leading to patient not having efficient and effective treatment.	Contingency plan for telecommunications in place. Working with ICT team to attempt to implement technical solutions available as quickly as possible. ICT funding agreement in place, no SON requirement. Contingency plan reviewed and there is a contingency where radios are provided and all emergency calls only are communicated via this link should the system crash. Commission management consultancy firm to undertake strategic review of existing ICT infrastructure. Completed. Review contingency plan for telecommunications to ensure adequacy in light of risk. Contingency plan reviewed and internally there is a contingency where radios are provided and all emergency calls only are communicated via this link should the system crash. Completed. 4C's management consultancy firm commissioned, undertaking review currently with a view to making recommendations for solutions. ICT still looking at compatible solutions, starting with RGH. Solutions now found and 4 companies are in the running for bids. 4 companies are currently attending site in order to provide bids. Bids have now been received and are being reviewed in order to choose suitable company to install. New telecomm system still on course to be installed across PCH and RGH by 31st March 2021.	Work on the new telecomm system installation has now started and is still ongoing currently due to covid pressures. At the current stage of this work there will be a number of porting exercises taking place within switchboard RGH over the coming weeks. This will mean switchboard RGH will be out of operation for approx. 6 minutes, however there is a possibility that it could not work which could result in being out of use for a longer period. Contingency has been put in place for this work as the contractors will be on site as well as our IT Comms team, however it has been included together with the contingency within this risk as it will affect the Cardiac arrest line. Action: New telecomm system to be installed across PCH and RGH. Timescale: 31/07/2021 Based on this update the risk remains unchanged until installation of new telecommunication system is complete and is compliant (DW 21/04/2021).	Digital & Data Committee	15	C3 x L5	6	↔	21.08.2017	22.4.2021	31.7.2021	4286
Chief Operating Officer Executive Director of Planning, Performance and ICT	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Potential cyber security risk relating to brand of medical device monitoring system.	(Facilities Risk Register Reference S9) ILG: CSO Facilities Hub If: Potential cyber security risk (CVE-2020-1472) identified relating to a specific brand of medical device monitoring system. Should a threat be successful. Then: Potential changes and disruption to the operation of monitoring equipment could occur. Resulting In: Service/business interruption and potential harm to patients being treated.	The medical device system is protected by firewalls but these will not prevent access. Clinical Engineering have discussed with manufacturer about software patching to find and implement a solution. Contacted manufacturer and problem now identified on the manufacturers online support portal as a vulnerability. Received response from the manufacturer that the software patch will be available in January. Once patch has been installed by manufacturer Clinical Engineering will install the patch on the two servers and equipment affected within the Health Board and check issue has been resolved for compliance. Clinical Engineering has reviewed all other medical device systems and has identified no other medical device systems that are vulnerable to this threat.	The Specialist Healthcare Scientist in Clinical Engineering has continued to chase the manufacturer for a solution. Following a meeting with them held on 13/01/2021, the manufacturer has accepted fault and has agreed to installing a newer version of software as a solution. The solution will involve a significant amount of downtime of equipment in all critical areas which is not viable during covid pressures. Due to this Clinical Engineering are now awaiting an action plan from the manufacturer for installing the newer software whilst minimising disruption to services. Specialist Healthcare Scientist provided an update on 13/04/2021 that Clinical Engineering have had a commitment from the company to install the update with an expectation that they will be able to start planning the work in May. The supplier has stated that they have a huge backlog on high level engineering work currently. However, Clinical Engineering will engage with them to expedite this. Action: Supplier to install new software patch. Timescale: 31/07/2021. Based on this update the risk remains unchanged until work has begun from the supplier and the newer version of software has been successfully installed by the manufacturer and the issue has been resolved for compliance by Clinical Engineering.	Digital & Data Committee	15	C3 x L5	5	↔	23.09.2020	21.04.2021	31.07.2021	4306
Chief Operating Officer Rhonddda Taf Ely ILG	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Delivery of the rehabilitation for repatriated major trauma patients.	If: The business case for enhanced rehabilitation services linked to Major Trauma is not supported. Then: Patients will not receive the appropriate level of clinical intervention. Resulting In: Poorer clinical outcomes, increased lengths of stay (with associated clinical risks) and poor patient experience.	Ensuring current nursing and therapies have access to a training programme - however there are concerns about deliverability during Covid pandemic. The new rehabilitation coordinator post will support the delivery of the immediate care planning once a patient is repatriated. Advance notice means we can ensure staff are aware of immediate needs. The network has systems in place to support early care planning and preparation where possible i.e. The health board is aware of the number of patients likely to be transferred 'Rehabilitation prescription' describes nursing and therapy needs prior to repatriation. Rehabilitation coordinators link with counterparts in UHW to ensure our rehabilitation offer is clear to the patient and their family prior to transfer.	Develop a business case to identify and address the specific rehabilitation needs of patients repatriated to CTM from the Major Trauma Centre. This would need to encompass inpatient and community needs across the whole of the Health Board. The Business case will require Management Board / IMTP approval and release of funding. Recruitment and training of required staff then needs to take place. Timescale: 30.9.2021 changed from 31.3.2021 due to the impact of the Covid-19 impact.	Quality & Safety Committee	16	C4xL4	9	↔	10.09.2020	09.04.2021	30.09.2021	4281
Chief Operating Officer Primary Care	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Resumption of Orthodontic Services	If: In compliance with WG guidance, if the Health Board is unable to resume orthodontic services over the next 2 years where patients (under 18) do not meet the IOTN of over 4. If: the Health Board does not secure funding for establishing a new Orthodontic contract to meet demand following boundary changes. Then: patients will experience significant delays in accessing treatment. Resulting in: • Those patients with milder cases incurring further delays in addition to having already experienced long waits for treatment. • It is likely this will increase the number of appeals/challenges/complaints from families, currently CTM does not have an appeals process in place. • Pressure on GDPs to communicate this to families and manage patient/family expectation • Risk that patients/families will be offered/coerced into private treatment as an alternative	The Health Board will continue negotiations with the relevant Health Board regarding treatment/payment of historic patient on waiting lists/ and new referrals.	1. Health Board to address concerns regarding guidance directly with WG and through local ortho MCN Chair. 2. Appeals process to be developed to manage complaints/challenges 3. Raise issue regarding additional ortho funding in June during annual WG Dental Team visit to Health Board.	Quality & Safety Committee	15	C3 x L5	12 (3x4)	New Risk	23.04.2021	07.05.2021	TBC	4606

Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date	Datix ID
Chief Operating Officer RTE Locality	Provide high quality, evidence based, and accessible care.	Legal / Regulatory Statutory duty, regulatory compliance, accreditation, mandatory requirements	Increase requirement to store the paper patient record for longer due to: <i>Delay in the DPN project & the Increased retention period due to the Infected Blood Inquiry</i>	IF: The Health Board fails to ensure there is sufficient storage capacity to safely and securely store paper patient records as destruction of the files is delayed. Then: there could be potential data loss and poor records management processes and communication. Health, Safety and Fire risks will escalate due to overcrowded and inappropriate storage. Resulting in: possible breaches to the GDPR, safeguarding and information governance risks. Possible injuries to staff due to manual handling/trip hazards and breaches of Fire Safety procedures. <i>These hazards extend to record stores across the Health Board as capacity to accept their excess records is compromised.</i>	Digitisation of general patient records commenced on 18/3/21. This will gradually create storage space at the central records hub over 2 years, to ensure a sustainable, safe and secure storage solution. Interim storage may be required in the meantime, due to the impact of delayed digitisation and Infected Blood Inquiry embargo on managed record destruction until late 2023. Impact being closely monitored as areas outside the Hub are being affected due to compromised capacity to store additional records and destroy their excess. An Electronic Document Management System, Clinical Portal interface have been introduced; E-forms will follow as part of the project over the next year. Ensure Records management processes fully applied in all record stores to maximise use of available physical capacity. N.B. Limited opportunity for this, as destruction procedure cannot be applied to non-digitised records. Ensure no temporary storage solutions are agreed, without full consideration of the Executive.	Digital Patient Notes (Phase 1) was delayed but has now gone live. This will enable a limited regular destruction of digitised notes from this point forward, despite the continued record destruction embargo, as the content is held digitally. All other non-digital records are still under embargo until late 2023. This overarching record storage risk now also incorporates Bridgend Medical Records stores, where no digitisation can begin for at least 2 years, hence the overall consequence of 3 and likelihood of 5. The impact being closely monitored. Areas outside Medical Records are also being affected, due to inability to destroy their archived records at the Hub; this prevents them transferring their excess records to this site. All possible measures are being taken to manage the storage areas and maximise use of the space. Digitisation of general patient records commenced on 18/3/21. This will gradually create storage space at the central records hub over 2 years, to ensure a sustainable, safe and secure storage solution. An Electronic Document Management System and Clinical Portal interface have been introduced via this programme; E-forms will follow over the next year. To date, @13,500 deceased and live records have been digitised and @244 consultant and nurse-led teams are live on the use of the DPN software. Procurement of digital dictation for 400 users will also assist by reducing paper content of non-digital records.	Digital & Data Committee	15	C3 x L5	9 (C3xL3)	↓ 16	02.07.2018	07.05.2021	31.07.2021	4109
Chief Operating Officer RTE Locality	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Impact on Speech and Language Therapy (SLT) and Dietetics staffing capacity with relocation of tissue transfer surgical procedures to RGH	Patients undergoing this type of surgery require intensive SLT and Dietetics due to the impact on eating drinking and communication and all of this care will now be provided in CTM rather than jointly with another Health Board. Possible delay in discharge from hospital if waiting for SLT/dietetics input.	Patients will be seen by SLT and Dietitian but there will be a delay in response due to no increase in staffing to accommodate this increase in demand from 15th March and will need to monitor quality of input that can be given.	See Control Measures	Quality & Safety Committee	15	C3 x L5	2 Target score to be revisited.	New risk added to org RR	10.03.2021	23.04.2021	10.06.2021	4577
Executive Director of Nursing & Midwifery Infection Control	Provide high quality, evidence based, and accessible care.	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Reduced on site Consultant Microbiologist cover for the Bridgend ILG	The Microbiology cover for the Bridgend locality is provided by Public Health Wales Microbiologists via a SLA with Swansea Bay UHB. There are differences in policies/procedures and therefore a lack of standardisation across CTM. There is also a lack of standardisation for multi resistant organism definitions and sampling methods for C.Difficile infection. If: there is no dedicated on site Microbiology cover Then: there will be no antimicrobial/ ITU ward rounds, no root cause analysis to learn from incidents. Resulting in: mismanagement of patients/ inappropriate treatment and no learning to influence practice.	Senior Infection Prevention and Control Nurse on site to support Bridgend ILG with IPC related issues. Lead/ Deputy IPC Nurse to support. IPC Nurses to discuss any concerns with Microbiologist on call for Bridgend ILG The Medical Director for the Bridgend ILG has arranged a meeting to discuss	SLA for Microbiology cover for Bridgend ILG - To revisit SLA with Public Health Wales laboratory. Medical Director for Bridgend ILG to email Medical Director to discuss concerns regarding the SLA. Due date: 1.09.2021	Quality & Safety Committee	15	C3 x L5	3 (C3xL1)	New risk added to org RR	16.07.2020	11.05.2021	30.06.2021	4218

Closed Risks
November 2020 (Management Board 18.11.2020)

Datix ID	Executive Portfolio	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)	Trend	Opened	Last reviewed	Comments
4331	Chief Operating Officer Merthyr & Cynon ILG	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Covid 19 emergency flow and Impact of Royal Glamorgan Hospital (RGH) flow	IF: The continued high rates of admissions continue with increased numbers of Covid-19 patients during autumn 2020 Then: there will be a reduction in non Covid-19 attendances causing significant constraints with regards to the safe flow of patients in Prince Charles Hospital (PCH). Resulting in: Lengthy Welsh Ambulance Service Trust (WAST) waits and delays and inability to increase Covid-19 capacity on PCH site.	Associated plans opening of surge capacity of SSU and Ysbyty Seren and agreed support from C&V and ABHB and new pathways in development for RGH	See Control Measures	Quality & Safety Committee	10 (5x2)	12	↓ 20	12.10.2020	7.4.2021	Closed as target score met. The Surge Action Plans and reduction in flow has reduced the likelihood of this risk.

RISK MANAGEMENT IMPROVEMENT PLAN

	TASK	TIMELINE	STATUS UPDATE
Health Boards Approach to Risk Management	1. Confirm that one systematic approach to risk management is required i.e. move away from directorate DATIX risk register and corporate excel risk register with a view to integrated Datix-based register	January 2020 COMPLETED IN JUNE 2020	1. The Principal has been agreed with the Executive Team – COMPLETE. 2. DELAYED DUE TO COVID-19. The corporate risk register still needs transfer to DATIX. COMPLETE - all organisational risks now added to the Datix system. Further structure alignment required within the system.
	2. Write and ask that the Service General Managers ensure Directorate risk registers are up to date, with risks articulated with; IF (this happens) THEN (impact will be).....	January 2020 COMPLETED	COMPLETE - Email circulated on the 31.01.2020
	3. Draft Risk Management Strategy and Board Assurance Framework to go to MB.	February 2020 COMPLETED	COMPLETE - Approval received at Health Board meeting in March 2020.
	4. Arrange a facilitated workshop with the ILG Directors and Service General Managers and H&S Lead to: - Review the draft Risk Management Strategy and BAF - Discuss/confirm proposed process to include triggers and hierarchy, how risks get into the corporate risk register and Principal risks onto the BAF (informed by the IMTP) - The role of Management Board in owning the corporate risk register - The role of Board in overseeing the Principal risks and BAF - Review risk scores on existing Directorate risk registers and reconcile to the current risk register	March 2020 Revised Date: July 2020 COMPLETED IN JUNE 2020	DELAYED DUE TO COVID19 Process reviewed and discussed at Management Board on 20.02.20 with ILG representation. Update May 2020: Corporate Risk Lead to meet with ILG's in June to understand their requirements to safely manage risk in accordance with the Revised Risk Management Strategy & the new Operating Model. COMPLETE – workshop held on the 15 th June 2020. Further sessions being rolled out as required.
	5. Consider the transfer Datix Risk Management System and associated resources to Director of Governance to support integrated reporting of risk.	July 2020 Delayed – review in February/March 2021	Update May 2021- Initial discussions underway with Executive Leads.
	6. Risk Management training to be provided to ILGs/Directorates to cover: - The basics of risk management - The process for escalating risk - The triggers for escalating risk - How risk will be discussed and reviewed at the ILGs/Management Board	March 2020 Revised Date: July 2020 COMPLETED IN JUNE 2020	ORIGINAL DATE DELAYED DUE TO COVID19 COMPLETE 15 th June COMPLETE – workshop held on the 15 th June 2020. Further sessions being rolled out as required.
	7. Introduce new risk management strategy and process – New Operating Model. - Datix to be used for Directorates, ILG risk registers to inform corporate risk register - New corporate risk register in use (via Datix)	May 2020 Revised Date: July 2020 COMPLETED IN JUNE 2020	DELAYED DUE TO COVID-19 Update May 2020 Process may developed that will be shared with ILG's outlining the process through the new strategy and operating model. Corporate Risks are in the process of being uploaded to Datix. The next stage is review and train Management Board and Executive Leads in their role. COMPLETE – workshop held on the 15 th June 2020 and ILG's added to Datix to use going forward. Organisational Risk Register is on Datix.
	8. Datix Restructure and New Once for Wales Risk Module	TBC. Now split into two actions. Datix Restructure in Risk Model – 31 st January 2021 Once for Wales Risk Module Milestone – 31.3.2022	Completed – being managed through the Datix Management Group. Presentation of the new Once for Wales System received and Assistant Director of Governance & Risk attends the working group for the new system module.

RISK MANAGEMENT IMPROVEMENT PLAN

	9. Training Needs Analysis – Risk Training Roll out to Corporate Functions, ILG's and CSG's.	ON HOLD – Review January 2021. 31 st March 2021 31 st May 2021	Update January 2021 – Training has been delivered upon request and monthly sessions scheduled with an open invite to ILG's and CSG's. Currently working with Learning & Development to develop a TNA – however the timing around undertaking the TNA will be progressed once the response to Covid-19 has eased due to the challenges and pressures facing these key service groups and functions. Update March 2021 – Task and Finish Group established with other Health Boards developing a Risk TNA which will support a consistent approach to risk management training in Wales. Inaugural meeting scheduled for late March and an update will follow. Update May 2021 – Draft TNA developed with colleagues across NHS Wales.
	10. Review Risk Management Strategy following work to date and discussion at the Board Development Session on the 3 rd September 2020.	31 st January 2021 COMPLETED	Update January 2021 – Endorsed for approval at the Audit & Risk Committee in December. Board approval will be sought on the 28 th January 2021. Update March 2021 - COMPLETE - Approved at January 2021 Health Board Meeting.
	11. Review of the following supporting policies and information points in respect of Risk: - Risk Management Policy Documents - SharePoint page dedicated to risk - Risk Templates - Supporting information and contact points	31 st March 2021 COMPLETED	Update January 2021 – review of the Risk Assessment Procedure and Risk Management Policy is completed and approvals are being sought in January 2021. Update March 2021 – COMPLETE – Policy and Procedure documents approved in January 2021. SharePoint page updated with revised risk templates and supporting information.
	12. Detailed review of stagnant trends, control measures and mitigation of all risks on the Organisational Risk Register.	31 st December 2021 Delayed due to Covid-19 – 31 st March 2021 COMPLETED	Update January 2021 – this was undertaken on some risks during December 2020, however due to the focus on responding to the pandemic not all risks were reviewed in this detail during December. Update March 2021 – COMPLETE review undertaken in February 2021. Reviews will be ongoing as risks are updated.
Understanding the Risk Domains and Principal Risks that may impact the Strategic Objectives	13. CTMUHB objectives to be confirmed via the IMTP 2020-23 process	March 2020 COMPLETED	COMPLETE - Approved at March 2020 Health Board Meeting.
	14. Principal risks in achieving the IMTP 2020-23 to be tested for inclusion in the BAF.	April 2020 Revised Date: July 2020 COMPLETED IN AUGUST 2020	DELAYED DUE TO COVID19 Tested/approved at Management Board 15.04.20. COMPLETE – scheduled for consideration at the July Management Board.
	15. Grading the Principal Risks	31 st December 2020 31 st March 2021	Principal Risks agreed by the Management Board – the grading has been delayed due to the focus on the Covid-19 pandemic response. Update January 2021 – in light of the current focus on the Covid-19 pandemic this action will be revisited in the new year.

RISK MANAGEMENT IMPROVEMENT PLAN

		31st July 2021	Update March 2021 – the impact of Covid-19 has impacted the pace of the further development and review of grading of principal risks and risk appetite tolerance levels as the Organisational Risk Register in its revised format needs time to mature and embed before the Health Board shifts to reporting on strategic risks.
BOARD ASSURANCE: Defining the Health Board's Risk Appetite and Tolerance Levels	16. Workshop on agreeing Board risk appetite	April 2020 Revised Date: August 2020 COMPLETED IN SEPTEMBER 2020	DELAYED DUE TO COVID19 Rearranged from April 2020 to August 2020. COMPLETE – workshop held and actions agreed that will now be taken forward by the Assistant Director of Governance & Risk
	17. Agree Principal risks to include in the BAF at Board, with controls, assurance and gaps identified.	May 2020 Revised Date August 2020 COMPLETED IN SEPTEMBER 2020	DELAYED DUE TO COVID19 Delayed due to impact on other milestones as a result of Covid-19. To be addressed in Board Development session planned for August 2020. COMPLETE – workshop held and principal risk approach and proposals supported. Further actions agreed that will now be taken forward by the Assistant Director of Governance & Risk which will include the further work on the Board Assurance Report.
	18. Further develop the Board Assurance Report – triangulating performance, assurance and risk.	December 2021	Aspirations for the Board Assurance Report are outlined in the Risk Management Strategy approved by the Board in January 2021.



AGENDA ITEM

7.2

CTM BOARD

FINANCE UPDATE – MONTH 1 of 2021/22

Date of meeting	27/5/2021
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Mark Thomas, Deputy Director of Finance
Presented by	Steve Webster, Director of Finance & Procurement
Approving Executive Sponsor	Executive Director of Finance & Procurement
Report purpose	FOR DISCUSSION / REVIEW

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	Date	Outcome
Welsh Government	14/5/2021	NOTED

ACRONYMS			
A&C	Administration & Clerical	I&E	Income & Expenditure
AWCP	All Wales Capital Programme	LTA	Long Term Agreement
AME	(WG) Annually Managed Expenditure	M1	Month 1 (M2 Month 2 etc)
CHC	Continuing Healthcare	PCMH	Primary Community & Mental Health
COO	Chief Operating Officer	PCH	Prince Charles Hospital
CRES	Cash Releasing Efficiency Savings	POW	Princess of Wales Hospital



CRL	Capital Resource Limit	RGH	Royal Glamorgan Hospital
FNC	Funded Nursing Care	PSPP	Public Sector Payment Policy
HCHS	Healthcare & Hospital Services	WG	Welsh Government
IHI	Institute of Healthcare Improvements	WHSSC	Welsh Health Specialised Services Committee
IMTP	Integrated Medium Term Plan	YTD	Year to Date

FINANCE REPORT – MONTH 1 of 2021/22

1. SITUATION / BACKGROUND

The purpose of this report is to highlight the key messages in relation to the current month, year to date and forecast year-end financial position of Cwm Taf Morgannwg (CTM) University Health Board as at Month 1 (M1). This report should be read in the context of the CTM Integrated Medium Term Plan for 2021/22 to 2023/24 which is available on the website.

The draft financial plan for 2021/22 can be broken down into three separate elements:

- The core plan
- Covid response
- Planned care recovery

The three key elements of the financial plan are summarised below:

Summary of Core Plan, Covid, & Planned Care Recovery	Q1	Q2	Q3	Q4	Total
	£m	£m	£m	£m	£m
Core plan - assuming even phasing over Q1-4 initially	5.7	5.7	5.7	5.7	22.8
Covid costs net of WG funding	-7.4	-4.0	4.5	3.9	-3.0
Planned care recovery (costs assumed matched by funding)	0.0	0.0	0.0	0.0	0.0
Total	-1.7	1.7	10.2	9.6	19.8
Cumulative total	-1.7	0.0	10.2	19.8	

This shows that over Q1 and Q2, the deficit in the core plan is offset by the surplus against Covid funding, giving an overall breakeven position. Over the year as a whole the draft plan currently has a deficit of £19.8m, which entirely relates to Q3 and Q4.

The table below shows our initial assessment of our Covid response costs and income assumptions for 21/22.



Covid costs and funding 2021/22	Q1 £m	Q2 £m	Q3 £m	Q4 £m	Total £m
Programme costs:					
TTP	2.9	2.5	2.7	2.7	10.8
Mass Vaccination	3.2	2.0	2.2	2.2	9.6
Cleaning Standards	0.6	0.6	0.6	0.6	2.3
CHC/FNC Support	0.9	0.9	0.9	0.9	3.6
PPE	0.6	0.5	0.3	0.3	1.7
Sub total	8.2	6.4	6.6	6.6	27.9
Assumed funding- programme element	-8.2	-6.4	-6.6	-6.6	-27.9
Total	0.0	0.0	0.0	0.0	0.0
Other Covid costs:					
Long COVID	0.1	0.1	0.1	0.1	0.5
Field Hospital	1.0	0.5	0.3	0.3	2.2
Primary care prescribing	0.9	0.9	0.9	0.9	3.6
Dental income Loss	0.4	0.3	0.6	0.5	1.8
IT	0.2	0.2	0.2	0.2	0.7
Planned care exp're reductions	-1.5	-0.8	0.0	0.0	-2.3
Secondary care reactive costs	3.4	1.8	1.4	0.9	7.5
Undelivered Savings	4.0	1.0	0.0	0.0	5.0
Costs to transition back out of Covid operating models	1.0	1.0	1.0	1.0	4.0
Sub total	9.6	5.1	4.5	3.9	23.1
Confirmed funding- formula element	-17.0	-9.1			-26.1
Total	-7.4	-4.0	4.5	3.9	-3.0

It is important to note that the confirmed funding of £26.1m has been phased in M1-M6 based on the estimated spend profiles.

The WG Monitoring return guidance for 21/22 acknowledges that, due to the reduced status of the plans this year and the assessed maturity of the draft plans received at the 31 March 2021, the period from which the plan is 'fixed' is to be extended from M1 to M3. Further work is therefore still needed to produce a balanced plan for 21/22.

The following sections are included in this report:

Section No.	Section	Page Number
2.1	Headline Messages and key actions	6
3.1	Financial Position and Key targets	8
3.2	Revenue performance by Expenditure category	9
3.3	Pay expenditure trends	10
3.4	Revenue performance by Area	12
3.5	Forecast position	13
3.6	Covid costs	14
3.7	Savings Performance by Area	16
3.8	Non Delegated budgets	17
3.9	Key Risks and Opportunities	18
Appendix		
A	Welsh government Allocations	20
B	Public Sector Prompt Payment (PSPP) Performance	21
C	Balance Sheet	M2 onwards
D	Performance against Capital Resource Limit	M2 onwards
E	Cash position	M2 onwards

Note 1: Please note that this is a shortened version of the usual monthly finance report. We are reviewing the Board reporting formats for 21/22 and a full report will be provided from M2.

2. HEADLINE MESSAGES AND KEY ACTIONS

2.1. Headline Messages

Key aspects of the 2021/22 financial plan and financial outlook

Key aspects of the financial plan

- The plan assumes that around £9m of existing cost pressures projected by ILGs & Directorates are avoided or managed out. There is a £4m transitional budget to support this and Covid funding for Q1 may also provide some temporary headroom if actual costs are lower.
- The plan assumes recurrent savings delivered will be £16.1m and in year savings £11m. In comparison with this, bottom up savings plans are so far falling significantly short of this.
- The provision for new investment in the plan is relatively low (£1m enabling and £1m transitional, of which c £0.3m has been committed), and a small amount of non-recurring funding.
- The plan is breakeven over Q1/2 based on unused reactive Covid funding for Q1/2 offsetting a core plan deficit, but has a deficit of £19.8m in Q3/4 for which period no reactive Covid funding has been allocated.
- The plan is bolstered on a one off basis in 21/22 by release from the balance sheet of over £6m and by £4.7m non-recurring release of budgets committed to out of hospital transformation from 22/23. Therefore the underlying recurrent position is worse and is a £32m deficit provided that the assumptions above are delivered.

There is therefore a lot of risk in the plan, and even if it is delivered in 21/22, there will remain a large recurrent deficit to address in 22/23 onwards.

The overall funding position across WG is such that there is likely to be further funding potentially becoming available, particularly around planned care recovery. This may be at a level that exceeds what the NHS in Wales could practically spend in 21/22, and so an element may be made available for other initiatives on a one-off basis.

However:

- This is predicated on the plan being delivered internally
- And on WG first utilising some of the resource not yet allocated to address planned deficits across most Health Boards.

We will identify priorities for any non-recurring investment, and this can initially be prioritised against the internal sums set aside in the plan, but the focus needs to be on delivering the plan above, which we need to do from a sustainability perspective anyway, and this will put us in the best position to be able to utilise any non-recurring WG funding which does become available.

As at Month 1, with very significant uncertainty that always comes with Month 1 reporting, we are broadly at break even, but £0.6m over the phased plan for Month 1 (which was a £0.6m surplus):

	M1 Actual	M1 Opening Plan
	£m	£m
Core plan	2.5	1.9
Covid 19	(2.5)	(2.5)
Planned care recovery	0	0
Total	0	(0.6)

3. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

3.1 Financial Position and Key Targets – Month 1

The Health Board has a statutory duty to achieve a break even position over a period of three financial years. This applies to both revenue and capital expenditure. Over the last two financial years, the Health Board has achieved a surplus of £971k and £71k for revenue and capital expenditure respectively. This means that the Health Board can overspend by £971k and £71k for revenue and capital expenditure respectively in 2021/22 and still meet its three year statutory duty. The Health Board also has an administrative duty to pay a minimum of 95% of all non-NHS invoices within 30 days.

The table below details the Health Board's 2021/22 current and forecast performance against these key financial targets:

Target	Unit	Current Month	Year to Date	Trend	Forecast Year End
Revenue To ensure that the Health Board's revenue expenditure does not exceed the aggregate of it's funding in each financial year. Measured by variance against plan to break even.	£'000 +Adverse ()Favourable	9	9		19,800
Capital To ensure net capital spend does not exceed the Welsh Government Capital Resource Limit. Measured by variance against plan to manage to the Resource Limit	£'000 +Adverse ()Favourable	To be reported from M2 onwards			
Public Sector Payment Policy To pay a minimum of 95% of all Non NHS invoices within 30 days. Measured by actual performance	%	89.0%	89.0%		95 %

3.2 Revenue Performance by Expenditure Category

	Annual Budget £'000	Over / (Under) Spend	
		Current Month £'000	Year to Date £'000
Delegated Budgets			
Pay	541,637	2,601	2,601
Non Pay	670,332	(1,977)	(1,977)
Income	(138,785)	81	81
Delegated Savings Plans	(12,420)	(10)	(10)
Total Delegated Budgets	1,061,765	694	694
Non Delegated Budgets	80,820	(685)	(685)
WG COVID Allocations	(50,175)	0	0
WG Allocations	(1,091,409)	0	0
GRAND TOTAL M1	0	9	9
GRAND TOTAL Previous month	0	0	0

The key issues to highlight in the M1 position are as follows:

- The delegated overspend of £694k is mainly due to timing issues which are expected to reverse in the coming months. This includes a £300k overspend on the Transformation project where the M1 costs are greater than the M1 budget which is based on the agreed WG funding for 21/22 of £7.0m. Further work is ongoing to finalise the Transformation budget for 21/22 and the associated spending plans.
- As at M1 the pay overspend is overstated and the non pay overspend is understated. This is due to the phasing of Delegated reserve budgets in M1 and this will be corrected in M2.
- The key components of the £685k Non Delegated underspend is shown in Section 3.8.

3.3 Pay Expenditure trends

The M1 Pay expenditure was £49.3m and the monthly trend is summarised below.

	M1	M12	M11	M10
	£'m	£'m	£'m	£'m
A&C	6.4	15.3	6.3	6.7
Medical	12.1	23.3	11.5	8.7
Nursing	15.6	30.4	15.6	17.9
ACS	6.4	14.6	6.2	7.4
Other	8.8	19.6	8.54	9.4
Total	49.3	103.2	48.1	50.1

The Key issues to highlight are as follows:

- The M12 position included additional accruals for NHS Pensions, NHS Staff bonus, Annual Leave not taken & study leave, which totalled £52m.
- Medical costs include accountancy gains in M10 and M11 of £3.6m and £0.4m respectively. The gross cost excluding accountancy gains would be £12.3m and £11.9m respectively.
- The increase in Nursing & ACS costs in M10 was due to the introduction of a new accruals methodology (Nursing £1.9m and ACS £1.2m).

After taking account of the above comments, the M1 position is broadly consistent with the previous 3 months.

The M1 agency expenditure was £3.53m and the monthly trend (excluding accountancy gains) is summarised below.

	M1	Q4 Ave	Q3 Ave
	£'m	£m	£m
Medical	1.3	1.3	1.27
Nursing	1.37	2.04	1.82
Other	0.86	0.87	0.69
Total	3.53	4.21	3.78

The Key issues to highlight are as follows:

- Medical agency costs and other agency costs in M1 are broadly consistent with the averages for Q4 and Q3.
- Nurse agency costs in M1 were below the Q4 average by circa £680k. This reduction includes a £300k reduction Ward Costs, a small change in A&E and a £280k reduction in other areas excluding A&E and Wards. This reduction is attributed to establishments starting to return to normal levels.

3.4 Revenue Performance by Area

		Over / (Under) Spend	
	Annual Budget £'000	Current Month £'000	Year to Date £'000
Integrated locality groups:			
Bridgend	194,588	106	106
Merthyr & Cynon	196,718	164	164
Rhondda & Taff Ely	205,571	(176)	(176)
Total ILGs	596,877	94	94
Delivery Executive:			
Medicines Management	141,604	(308)	(308)
Primary care	114,936	(53)	(53)
Facilities	14,329	142	142
COVID Planned projects	3,113	371	371
Other	1,460	26	26
Total Delivery Executive	275,442	178	178
Contracting & Commissioning	115,672	(49)	(49)
Corporate Functions	72,774	472	472
Total Delegated Budgets	1,060,764	694	694
Non Delegated budgets	(1,060,764)	(685)	(685)
GRAND TOTAL M1	0	9	9
GRAND TOTAL Previous month	0	0	0

The key issues to highlight in the M1 position are as follows:

- The Medicines Mgt underspend of £300k is mainly due to increased rebates from suppliers.
- The £371k overspend on COVID projects includes a £239k overspend on the Field Hospital due to increased medical staff costs plus £130k of General COVID costs for which there is no budget. A large number of transactions are still being reported against a General COVID code which should now be reported in local service areas in 21/22. This position will be reviewed for M2.
- The £472k overspend on Corporate functions includes a £183k overspend in Planning & Partnerships. This includes £135k of the £300k total overspend on Transformation in M1.

3.5 Forecast Positions

As at Month 1 we are reporting a forecast In year deficit of £19.8m and a forecast recurrent deficit of £32.2m. This is consistent with the draft financial plan submitted to WG as part of the IMTP submission.

	M1 In year Forecast	M1 Recurrent Forecast
	£m	£m
Core plan	22.8	32.2
Covid 19	(3.0)	0
Planned care recovery	0	0
Total deficit or (surplus)	19.8	32.2

3.6 Covid Position

A summary of the additional revenue costs being classified as Covid is provided below.

	M1 Actual	M1 Opening plan	M1 Forecast	Opening plan Forecast
Programme costs	£m	£m	£m	£m
TTP	0.77	1.19	9.88	10.82
Mass Vaccination	1.1	1.1	9.6	9.6
Extended Flu	0	0	0	0
Cleaning standards	0.19	0.19	2.32	2.32
CHC/FNC support	0.3	0.3	3.6	3.6
PPE	0.15	0.2	1.6	1.65
Sub total	2.5	2.98	27.04	27.99
Assumed funding – programme element	(2.5)	(2.98)	(27.04)	(27.99)
Total Programme costs	0	0	0	0
Other Covid costs:				
Field hospital	0.61	0.46	2.28	2.13
Primary care prescribing	0.3	0.3	3.6	3.6
Dental income loss	0.34	0.37	3.02	3.05
Undelivered savings	1.34	1.34	5.0	5.0
Operational expenditure cost reduction	(0.5)	(0.5)	(2.25)	(2.25)
Slippage on Planned investments and re-purposing of development initiatives	0	0	0	0
Other covid costs (including Long covid, IT, Secondary care reactive costs and Costs to transition out of Covid operating models)	1.34	1.34	11.49	11.49
Sub total	3.43	3.31	23.14	23.01



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Confirmed funding	(5.89)	(5.89)	(26.1)	(26.1)
Total Other Covid costs	(2.46)	(2.58)	(2.96)	(3.09)

The opening plan for TTP included £0.3m for the Community testing across CTM in M1 (forecast £0.3m). No costs have been reported for M1 pending confirmation of funding from WG

There are no other significant issues to note at M1.

3.7 Savings Performance by Area

The financial plan for 2020/21 includes a £16.2m recurring savings target which has been reduced by £5.0m on an In year basis only to reflect the ongoing impact of Covid 19 on savings delivery at the beginning of 21/22.

The savings plans being reported at M1 are consistent with the IMTP submission at the end of March:

	Month 1		
	M1 YTD	20/21	Rec
	£m	£m	£m
Savings targets	1.3	16.2	16.2
Actual and Forecast Savings	0	(7.8)	(10.8)
Sub total	1.3	8.4	5.4
Covid funding abatement	(1.3)	(5.0)	0
Total	0	3.4	5.4

Further work is ongoing to close the £3.4m gap for 21/22 and this will continue to be updated during Q1.

An analysis by ILG, service area and Corporate directorates will be provided from M2 onwards.



3.8 Non Delegated budgets

The Month 1 position is summarised below:

	M1
	£k
Savings Contingency - £0.46m	(38)
Planned Deficit - £22.8m	1,903
Forecast COVID Surplus (Apr – Sept) £11.3m	(2,458)
Forecast COVID Deficit (Oct – Mar) £8.3m	-
Other variances	(92)
Total	(685)



3.9 Key Risks and Opportunities

The key financial risks and opportunities for 21/22 are summarised below. These are consistent with the draft financial plan submitted to WG as part of the IMTP submission. These will be reviewed and updated as part of the wider plan update in Q1.

	Month 1	
	Opps	Risk
	£m	£m
Risk of under delivery against forecast savings of £7.8m where existing savings plans are being reported as Amber		2.9
Risk of not closing the gap between the In year savings target of £11.2m and the latest forecast savings of £7.8m		2.5
Underlying deficit cannot be brought back in line with plan assumption		3.0
Unavoidable costs associated with TI status exceeding funding		0.5
Unavoidable recurring service/cost pressures exceeding plan		1.0
Potential LTA differences		0.25
COVID reactive costs exceeding plan		2.0
Delay and/or stop new investments	(0.5)	
Further balance sheet review	(1.25)	
Potential for annual leave reduction being greater than costs incurred	(1.0)	
Total	(2.75)	12.15

4. IMPACT ASSESSMENT

Quality / Safety / Patient Experience implications	There are no specific quality and safety implications related to the activity outlined in this report.
Related Health and Care standard(s)	Governance, Leadership and Accountability
Equality impact assessment completed	Not required
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £ / Workforce) implications / Impact	Yes (Include further detail below)
	The paper is directly relevant to the allocation and utilisation of resources.
Link to Main Strategic Objective	To provide strong governance and assurance
Link to Main WCFG Act Objective	Service delivery will be innovative, reflect the principles of prudent health care and promote better value for users

5. RECOMMENDATION

The Board is asked to:

- DISCUSS the contents of the Month 1 Finance report for 2021/22.

APPENDIX A

WELSH GOVERNMENT ALLOCATIONS

	Annual Budget
	£k
Confirmed funding	1,051,092
Unconfirmed funding	90,492
TOTAL	1,141,584

Key Issues

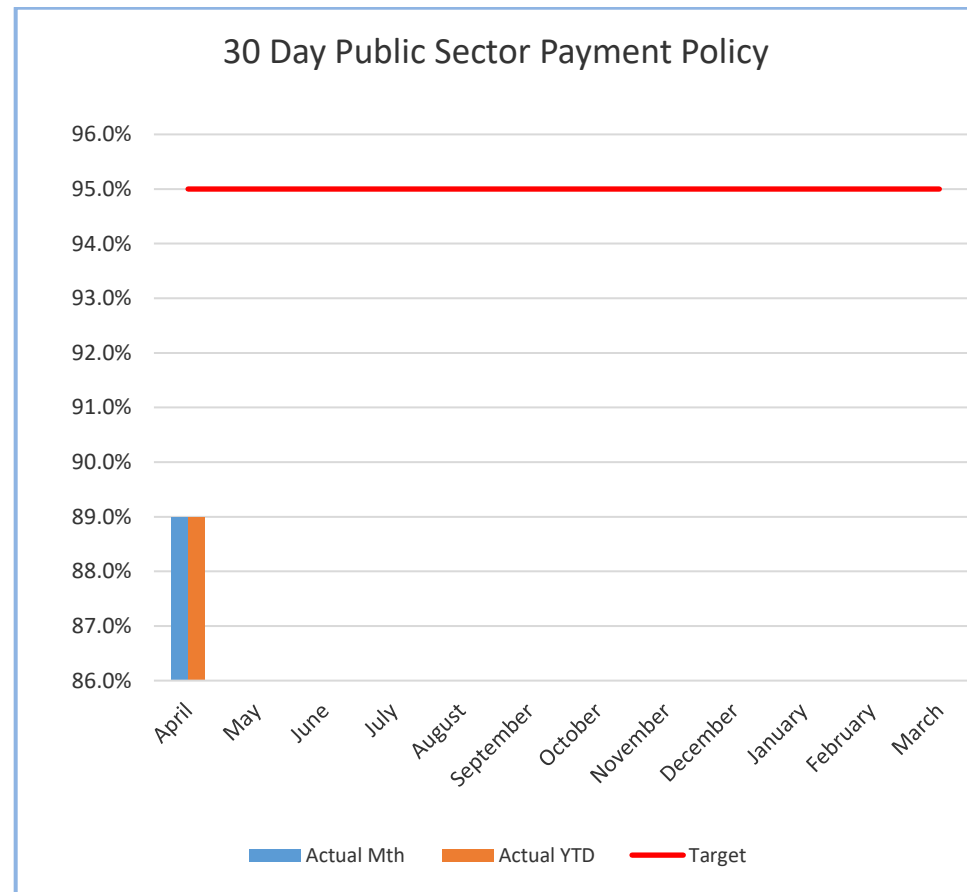
The most significant anticipated allocations include:

- COVID support (April to Sept)- £26.1m
- COVID Pass through Programmes - £27m
- Planned Care Recovery - £16.8m
- Transformation Fund - £7m
- Substance Misuse - £3.7m
- Targeted Intervention Support - £2.5m
- Invest to Save Funding - £2.1m
- ICF Dementia Funding - £1.2m
- Healthier Wales Prevention & Early Years Funding - £1m

APPENDIX B

Public Sector Prompt Payment (PSPP) Performance

The Health Board's monthly performance against the 95% public sector payment target is detailed in the graph below:



Key Issues:

- The percentage for the number of non-NHS invoices paid within the 30 day target for April was 89.0%.
- This reduction in performance was due to over 1,100 nurse agency invoices not being processed within the target (6% impact).
- As a consequence of the low percentage performance in April, there is a high risk that the Health Board may not achieve the 95% target for 21/22. The forecast percentage for Month 12 is 95%, but this will require future months to achieve 96% compliance.