# Bundle Public Board 30 May 2019

1 09:30 - Public Forum / Fforwm Cyhoeddus

1.1 Open Agenda for Responding to Questions Raised in Advance by Members of the Public / Agenda Agored er mwyn ymateb i gwestiynau a godwyd o flaen llaw gan aelodau'r cyhoedd

*Presenter: Chair*

- Public Questions Response Template Bill Parker
- Public Questions Response Template Jonathan Rose

2 09:45 - Patient/Staff Story / Stori Claf/Staff

2.1 Staff Story / Stori Staff

*Presenter: Lisa Gostling*

- Apprenticeship Academy Board Presentation
- Videos to Accompany Staff Story

3 10:00 - Governance / Llywodraethu

3.1 Apologies / Ymddiheuriadau

*Presenter: Chair*

3.2 Declaration of Interests / Datganiad o Ddiddordeb

*All*

3.3 Minutes of the Public Meeting held on 28 March 2019 / Cofnodion y Cyfarfod Cyhoeddus ar 28 Mawrth 2019

*Presenter: Chair*

- Unapproved Board Minutes 28 March 2019

3.4 Matters Arising & Table of Actions from the Meeting held on 28 March 2019 / Materion sy'n Codi a Thabl o Gamau Gweithredu o'r cyfarfod ar 28 March 2019

*Presenter: Chair*

- Table of Actions from Health Board Meeting in Public held on 28 March 2019

3.5 Report of the Chair / Adroddiad y Cadeirydd

*Presenter: Chair*

- Chair's Report May 2019

3.6 Report of the Chief Executive / Adroddiad y Prif Weithredwr

*Presenter: Steve Moore*

- Chief Executive's Report May 2019
- Appendix A - Register of Sealings May 2019
- Appendix B - Consultation Report May 2019
- Appendix C - Maternity Letter to AG 14 5 2019
- Appendix C - Assurance framework v 0 4 May 2019 Mat Services
- Appendix D - 190515 - VH to LHBs - Thoracic Surgery
- Appendix D - 190516 - VH to LHBs - Commissioning Proposal - Thoracic Surgery

3.7 Report of the Audit & Risk Assurance Committee / Adroddiad y Pwyllgor Archwilio a Sicrwydd Risg

*Presenter: Paul Newman*

- ARAC Update Report May 2019

3.7.1 Revised Standing Orders, Standing Financial Instructions and Committee Terms of Reference / Rheolau Sefydlog Diwygiedig, Cyfarwyddiadau Ariannol Sefydlog a Chylch Gorchwyl y Pwyllgorau

*Presenter: Joanne Wilson*

- SBAR Standing Orders, Standing Financial Instructions and Committee Terms of Reference May 2019
- Model Standing Orders (Updated April 2019)
- Model Standing Financial Instructions (Updated April 2019)
- Charitable Funds Committee Terms of Reference v16
- Finance Committee Terms of Reference v6
- Primary Care Applications Committee Terms of Reference v7

Healthcare Professionals Forum Terms of Reference v11

3.8 10:50 - Morning Break / Egwyl Fore

4 11:00 - Strategic Issues/For Decision / Materion Strategol/I'w Penderfynu

4.1 Partnership Agreements – Pooled Funding and Ceredigion Community Equipment Services: Section 33 Agreement / Cytundebau Partneriaeth – Cyllid Cyfun a Gwasanaethau Offer Cymunedol Ceredigion: Cytundeb Adran 33

*Presenters: Sarah Jennings/Jill Paterson*

SBAR Partnership Agreements May 2019

Appendix 1 - Ceredigion CC - Section 33 - 2019-20

5 11:20 - Quality, Safety & Performance / Ansawdd, Diogelwch a Pherfformiad

5.1 Focus on Healthcare Services in Carmarthenshire / Y Ffocws ar Wasanaethau Gofal Iechyd yn Sir Gâr

*Presenter: Joe Teape*

SBAR Focus on Healthcare Services in Carmarthenshire May 2019

Focus on Healthcare Services in Carmarthenshire

5.2 Report of the Finance Committee / Adroddiad y Pwyllgor Cyllid

*Presenter: Michael Hearty*

Finance Committee Update Report May 2019

5.3 Finance/Turnaround Update – Month 12 2018/19 / Diweddariad Cyllid/Trawsffurfio – Mis 12 2018/19

*Presenters: Huw Thomas/Andrew Carruthers*

Finance and Turnaround Update Month 12 2018/19

5.4 Finance/Turnaround Update – Month 1 2019/20 / Diweddariad Cyllid/Trawsffurfio – Mis 1 2019/20

*Presenters: Huw Thomas/Andrew Carruthers*

Finance and Turnaround Update Month 1 2019/20

5.5 Report of the Business Planning & Performance Assurance Committee / Adroddiad y Pwyllgor Sicrwydd Cynllunio Busnes a Pherfformiad

*Presenter: David Powell*

BPPAC Update Report May 2019

5.6 12:30 - Lunch Break / Egwyl Ginio

5.7 13:00 - Integrated Performance Assurance Report – Month 12 2018/19 / Adroddiad Sicrwydd Perfformiad Integredig – Mis 12 2018/19

*Presenter: Karen Miles*

M12 IPAR SBAR

M12 IPAR

Managed GP Practices

Primary Care Quality & Assurance Report - May 2019

Dementia Training

Improving the Health and Well-being of Homeless & Specific Vulnerable Groups

Accessible Communication and Information for People with Sensory Loss

Advancing Equality and Good Relations

Implementation of the Welsh Language Actions

5.8 Integrated Performance Assurance Report – Month 1 2019/20 / Adroddiad Sicrwydd Perfformiad Integredig – Mis 1 2019/20

*Presenter: Karen Miles*

M1 IPAR SBAR

M1 IPAR

5.9 Corporate Risk Register / Y Gofrestr Risg Gorfforaethol

*Presenter: Joanne Wilson*

SBAR Corporate Risk Register May 2019

Corporate Risk Report May 2019

5.10 Report of the Quality, Safety & Experience Assurance Committee / Adroddiad y Pwyllgor Sicrwydd Ansawdd, Diogelwch a Phrofiad

*Presenter: Professor John Gammon*

QSEAC Update Report May 2019

5.11 Nurse Staffing Levels (Wales) Act – Annual Report 2018/19 / Deddf Lefelau Staff Nyrsio (Cymru) – Adroddiad Blynyddol 2018/19

*Presenter: Mandy Rayani*

SBAR Nurse Staffing Levels (Wales) Act May 2019

Appendix 1 - NSLWA Annual Report May 2019

5.12 Evaluation of Unscheduled Care Performance through Winter 2018/19 / Gwerthusiad o Berfformiad Gofal heb ei Drefnu trwy Gaeaf 2018/19

*Presenter: Joe Teape*

Winter USC Performance Evaluation May 2019

5.13 Health & Care Standards Fundamentals of Care 2018 Annual Report / Adroddiad Blynyddol 2018 Hanfodion Gofal Safonau Iechyd a Gofal

*Presenter: Mandy Rayani*

SBAR H&C Standards Fundamentals of Care 2018 Annual Report

HDdUHB H&C Standards FOC 2018 Annual Report

6 15:00 - Committee Update Reports / Adroddiadau Diweddaru Pwyllgorau

6.1 Committee Update Reports / Adroddiadau Diweddaru Pwyllgorau

*Presenters: see below*

SBAR Committee Update Reports May 2019

6.1.1 Board Level Committees Update Report / Adroddiad Diweddaru Pwyllgorau Lefel Bwrdd

*Presenters: Joanne Wilson/Committee Chairs*

CFC Update Report May 2019

MHLAC Update Report May 2019

6.1.2 In-Committee Board / Bwrdd Y Pwyllgor

*Presenter: Chair*

In-Committee Board Update Report May 2019

6.1.3 HDdUHB Advisory Groups / Grwpiau Cynghori BIPHDd

*Presenter: Advisory Group Chairs*

PF Update Report May 2019

SRG Update Report May 2019

HPF Update Report May 2019

6.2 HDdUHB Joint Committees & Collaboratives / Cyd-bwyllgorau a Grwpiau Cydweithredol BIPHDd

*Presenter: Steve Moore*

HDdUHB Joint Committees and Collaboratives Update Report May 2019

Joint Committees and Collaboratives Update

6.3 Statutory Partnerships Update / Diweddariad ar Bartneriaethau Statudol

*Presenter: Sarah Jennings*

Statutory Partnerships Update May 2019

7 15:25 - For Information / Er gwybodaeth

7.1 Board Annual Workplan / Cynllun Gwaith Blynyddol Y Bwrdd

Board Work Programme 2019-20

8 Date and Time of Next Meeting / Dyddiad ac amser y cyfarfod nesaf

*9.30am, Thursday 25th July 2019, venue TBC*

9 In Committee Session / Sesiwn Y Pwyllgor

*Motion to exclude the public from the meeting in accordance with the provisions of section 1 (2) and (3) of the Public Bodies (Admissions to Meetings) Act 1960*
*Cynnig i eithrio'r cyhoedd o'r cyfarfod yn unol â darpariaeth Adran 1 (2) a (3) o Ddeddf Cyrff Cyhoeddus (Derbyniadau i Gyfarfodydd) 1960*

# PUBLIC FORUM – QUESTIONS AND RESPONSES

**Question a)**

**Name**

Mr Bill Parker

**Question**

**Background Information**

The Board has what appears to be a very robust prevention, treatment, reporting and investigation regime in its hospitals to minimize the incidence of pressure sores and ulcers and to deliver early treatment when they do occur.

' A Healthier Mid and West Wales' puts the bed count across all Hywel Dda hospitals at 1084.

Only frequent symptom aware observation by nurses and health care support workers coupled with appropriate action when the problem arises can minimize the impact of the condition and lead to satisfactory outcomes for patients. The Board, I am sure, knows that neglect or delay in taking preventative action or treatment can result in dire consequences.

I believe that whatever the partnership staffing arrangements for delivery of care at home, the Health Board has prime responsibility for the patients' health and therefore must ensure that pressure sore and ulcer awareness, prevention, treatment, reporting, investigation, and delivery of early treatment when they occur, should be identical and be of the highest standard as is being delivered in hospitals.

It seems my opinion is supported in the document: Pressure Ulcer Reporting and Investigation – All Wales Guidance Final Version 2 January 2018; Section 3, Scope of the document reads:

> 'These guidelines have been developed for use within all NHS Trusts and Health Boards in Wales. These organisations are also required to ensure that care services within commissioned services also meet the requirements set out in this guidance. Further as a result of revisions to the Regulation and Inspection of Social Care (Wales) Act 2016, a Regulation 38 notification will be required to be completed for residents with pressure injuries in the Care Home sector from April 2018. The adoption of these guidelines is therefore advocated in the Care Home sector.'

# PUBLIC FORUM – QUESTIONS AND RESPONSES

The document also refers to the Welsh Government targets for zero tolerance to pressure damage.

In March 2018 there were 1478 profiling beds issued for use in patients' homes across the Hywel Dda area and it is likely that there are now close to 50% more beds in private homes than in hospitals.

It is difficult to imagine, given the dispersed geographic locations of patients to whom these beds have been issued, the inexperience and limited training of many commissioned domiciliary care workers, the time pressures upon them, and the lack of continuity due to turnover and absence, that they can employ the level of vigilance required to identify symptoms of pressure at early stages. Many informal carers will not be able for various reasons to examine a patient for symptoms or know what they are looking for.

**Question**
Can the Board categorically confirm that it considers itself fully compliant with the above guidance in its hospitals and in delivery of Care at Home?

If it is unable to give that confirmation, by when does it expect to be able to do so?

**Response from Mandy Rayani, Director of Nursing, Quality and Patient Experience**

The focus on preventing and improving the management of pressure damage within both the hospital and community setting remains a clear priority for the Health Board. Indeed one of the quality priorities agreed by the Board is 'Protect patients from avoidable harm from care'. The prevention of pressure damage is complex and multi-factorial which is why the hospital and community based teams have introduced scrutiny panels to ensure that all incidents of healthcare related pressure damage is reviewed and better understood to support learning. The wider system approach to preventing pressure damage is being progressed through a number of avenues, namely the Health Board improvement programme and workshops, the Regional Safeguarding Board which has pressure damage prevention as a priority area for action for 2019/20, as well as work that will be progressed through the Regional pilot of the Health & Social Care Joint Induction Training model which brings together induction training for the health and social care workforce. District Nursing teams also provide spot training for carers in patients own homes and residential care homes as and when identified as necessary. In addition to this activity the Health Board is in the process of reviewing the information available to patients, carers and the general public to raise awareness and improve opportunities for self-care and prevention of pressure damage in the home.

# PUBLIC FORUM – QUESTIONS AND RESPONSES

| **Question a)** |
|---|
| |
| **Name** |
| Mr Jonathan Rose |
| **Question** |
| Last year, HDdUHB set out its vision for the future of our local NHS. Has this been financially costed and what is the timescale on its implementation? |
| **Response from Huw Thomas, Director of Finance** |
| In order to inform the consultation that was launched following the Board Meeting of the 18th April 2018, there was a published suite of technical documents including activity and financial modelling, outlining the impact of each option. Since the Board meeting following the closure of the consultation, work has concentrated on the establishment of the Transformation Programme to deliver the health and care strategy 'A Healthier Mid & West Wales'. This will include the development of more detailed costings that will be part of the business plans which will be required in order to approve future investment. |

# PUBLIC FORUM – QUESTIONS AND RESPONSES

| **Question b)** |
|---|
| |
| **Name** |
| Mr Jonathan Rose |
| **Question** |
| The poorest and most vulnerable in our society are struggling to access the NHS, seeing extended waiting times due to not being able to make it to appointments outside their local area. Has a portion of next year's budget been dedicated to enable access for those who are struggling? |
| **Response from Joe Teape, Deputy Chief Executive** |
| Hywel Dda University Health Board (UHB) supports vulnerable people with non-emergency patient transport through a number of means which are detailed below:<br>Non-Emergency Patient Transport – The Welsh Ambulance Service Trust provides transport services on behalf of HDUHB, free to patients who meet an eligibility criteria as defined by the Welsh Government in WHC(2007)005 on the grounds of requiring support due to medical need. This includes:<br>o Need a stretcher for the journey<br>o Require oxygen or other medical gases during transit<br>o Need to travel in a wheelchair (providing they do not have a specially adapted vehicle or are unable to use the vehicle for that journey).<br>o Are receiving regular dialysis or cancer treatment<br>o Cannot walk without continual support<br>o Cannot use public transport because they:<br>• Have a medical condition that would compromise their dignity or cause public concern<br>• Have severe communication difficulties<br>• Experience side effects as a result of their medical treatment or condition |

# PUBLIC FORUM – QUESTIONS AND RESPONSES

HDUHB patients can contact the WAST Non-Emergency Patient Transport booking centres directly to find out if they are eligible and to make a journey booking - 0300 123 2303. Transport is provided for both clinic appointments, admissions and discharge where the eligibility is met.

Local transport schemes - there are numerous schemes across the three counties. Some examples of UHB funded schemes are included below:

- Free bus tickets for vulnerable families;
- Glangwili Hospital Park & Ride Service;
- PIVOT community transport service in Pembrokeshire
- Red Cross discharge support service in Carmarthenshire

Out of hours discharge - It is very unusual to be discharged from an inpatient ward overnight. An Emergency Department will discharge a patient when they are clinically fit. Normally patients are expected to organise their own transport home. Free phone facilities for taxis are available in each hospital. A local transport scheme may also be available. Ward Sisters and Hospital Site Managers can also consider using Health Board money to pay for a contracted taxi in the circumstance of no alternative transport for:

- frail elderly patients;
- young vulnerable families;

NHS Travel cost scheme - Patients can get help with the necessary travel costs to receive NHS treatment under the care of a consultant, if they:

- Are included in the assessment of someone getting: Income Support, Income-based Jobseeker's Allowance, Universal Credit (Incapacity Benefit or Disability Living Allowance does not count as they are not income related), Income related Employment and Support Allowance, Pension Credit Guarantee Credit
- Are entitled to, or named on, a valid NHS tax credit exemption certificate.
- Are named on a valid HC2W certificate (Low Income Scheme) (includes travel by dependent children).
- Are a war pensioner and the treatment is for accepted disablement.
- Partial help: If they are named on a valid HC3W certificate (Low Income Scheme) they may get some help.

Public Transport – HDUHB has worked closely with its council partners to enhance public transport links to acute and community hospital

# PUBLIC FORUM – QUESTIONS AND RESPONSES

sites. Those who are not eligible for NHS funded transport can contact traveline cymru to identify suitable public transport links to allow them to access our sites. A link to their travel planner is provided below. They can also be contacted by telephone on - 0800 464 0000

Bwcabus – Those patients living in rural parts of Carmarthenshire, Ceredigion and Pembrokeshire have access to the Bwcabus service. This service enables those residents living in rural parts of the region to access the wider public transport network but collecting them from the place they live, at the time they need to allow them to connect to the main bus routes. This means that even if there is not a scheduled bus route in a patients area, transport can still be provided. Those interested in utilising this service can find out more by visiting the link provided below, or calling the service directly on - 01239 801 601

Community Transport Associations can help patients find community or voluntary transport providers in the event they are not eligible for NHS funded transport. This is useful for those who have no way of getting to hospital or other locations on their own and cannot use public transport. There are the following organisations:

- Pembrokeshire Association of Community Transport Organisations (PACTO)
- Ceredigion Association of Voluntary Organisations (CAVO)
- Community Transport Association (CTA)

In addition and as part of the implementation of the health and care strategy we will be continually assessing the needs of all of our population in relation to access to services and ensuring that this is an ongoing consideration in all aspects of service design.

Further details of the assistance offered can be found on the following websites:
UHB's: http://www.wales.nhs.uk/sitesplus/862/page/83744#Transport_Schemes
NHS Wales: http://www.healthcosts.wales.nhs.uk/travel-costs
Traveline cymru: https://www.traveline.cymru/
Bwcabus: http://www.bwcabus.traveline-cymru.info/?force=1

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**Lisa Gostling - Director of Workforce & OD**
**Sally Owen - Interim Head of Strategic Resourcing**
**Amanda Glanville - Senior Workforce Advisor**
**Shelley Dony - Future Workforce Development Manager**

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# Apprenticeship Academy

- Creating pathways to produce the workforce of the future
- Combine practical training with paid employment ‘earn while you learn’
- Access to professional training across rural areas
- Nationally recognised qualification, with no tuition fees
- Providing increased opportunities for our local population
- Full collaboration with all local colleges and universities
- In addition to existing workforce development

Healthcare Apprentice

Engineering Apprentice

Health Science Apprentice

Administration Apprentice

IT & Informatics

Prifysgol Cymru
Y Drindod Dewi Sant
University of Wales
Trinity Saint David

COLEG Sir Benfro
Pembrokeshire COLLEGE

Swansea University
Prifysgol Abertawe

1872 PRIFYSGOL ABERYSTWYTH UNIVERSITY

colegceredigion

colegsirgâr

The Open University
Y Brifysgol Agored
WALES CYMRU

50 YEARS MLYNEDD

Calon Iechyd Lleol
The Heart of Local Health

# Apprentice levels

Apprenticeships are available at four levels:

- **Foundation Apprenticeships** - follow work-based learning towards level 2 – equivalent to GCSEs level/level 2 qualifications
- **Advanced Apprenticeship** - follow work-based learning towards level 3 – equivalent to A-levels/level 3 qualifications
- **Higher Apprenticeships** - follow work-based learning towards levels 4 & 5 – equivalent to a foundation degree and above
- **Degree Apprenticeships** - follow work-based learning towards levels 6 & 7 – equivalent to a full bachelor's or master's degree

# Kerry's story

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Hywel Dda
University Health Board

# Health Care Apprentice Programme

Foundation Apprenticeship → Employability Enhancement Programme → Level 3 Apprenticeship → Nursing Degree


Ceredigion 10 Apprentices + Pembrokeshire 10 Apprentices + Carmarthenshire 20 Apprentices = **40 Health Care Apprentices**

| Programme Outline for the Health Care Apprentice Programme | | | | | | |
|---|---|---|---|---|---|---|
| **Level 2 Foundation Apprenticeship in Health Care Support Services** | Sept 2019 – March 2021 | | | | | National Minimum Apprenticeship Wage |
| **Further Education Employability Enhancement Programme** | | March 2021 – Sept 2021 | | | | £14,265 per annum* |
| **Level 3 Apprenticeship Clinical Health Care Support** | | | Sept 2021 – March 2023 | | | £14,557 per annum, increasing to £15,596 after 6 months* |
| **Level 4 Certificate in Health Care** | | | | March 2023 – March 2025 | | £16,633 per annum, increasing to £17,821 after 12 months |
| **BSc in Adult General Nursing (Degree)** | | | | | March 2025 – December 2027 | £18,813 per annum, leading to £24,214 once qualified |

*National Minimum Wage rates apply. Rates of pay correct as of May 2019.

*Hywel Dda University Health Board have the right to modify qualifications based on changes to qualifications, sector requirements or funding.

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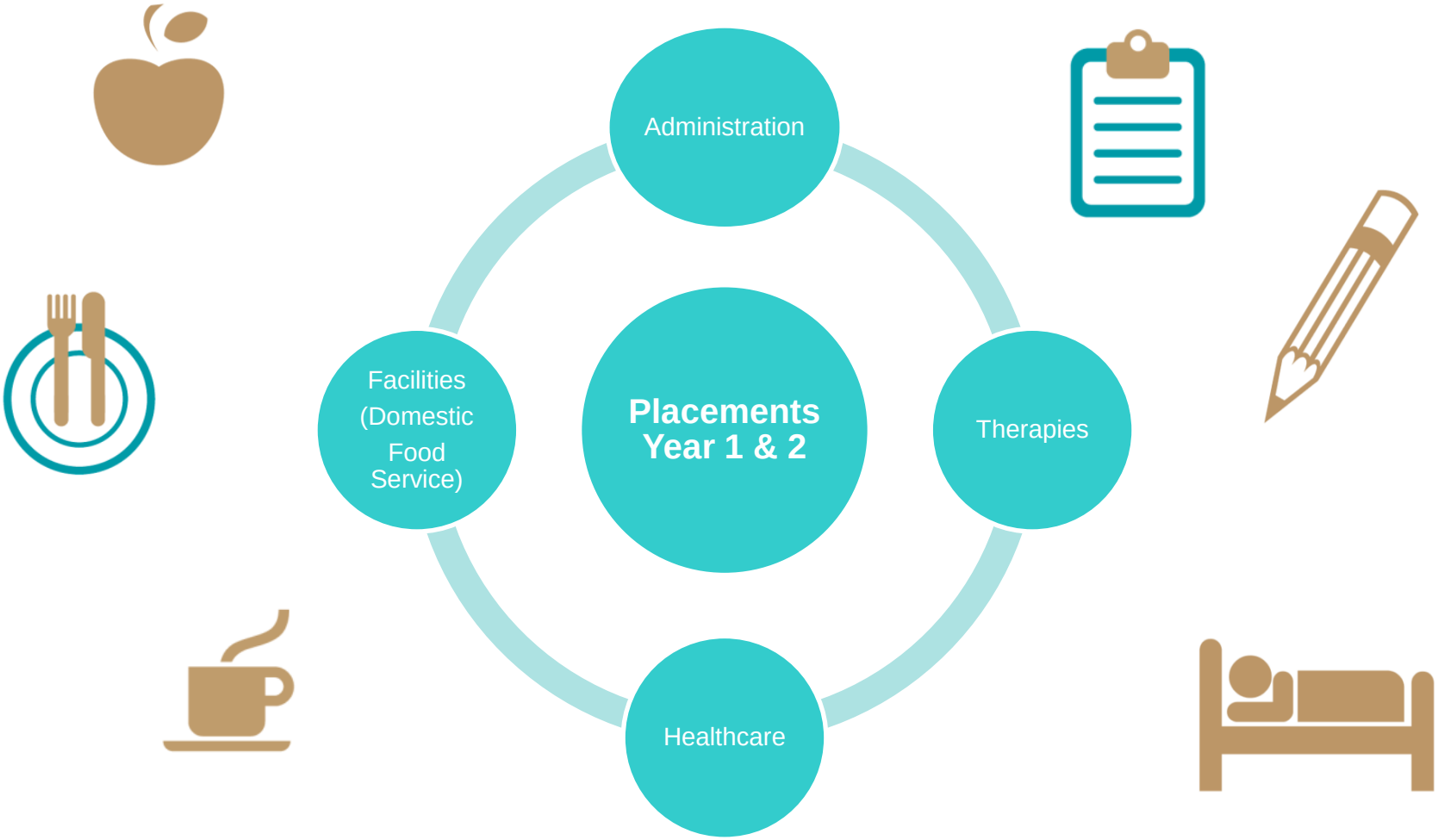
Hywel Dda
University Health Board

# The Holistic Experience

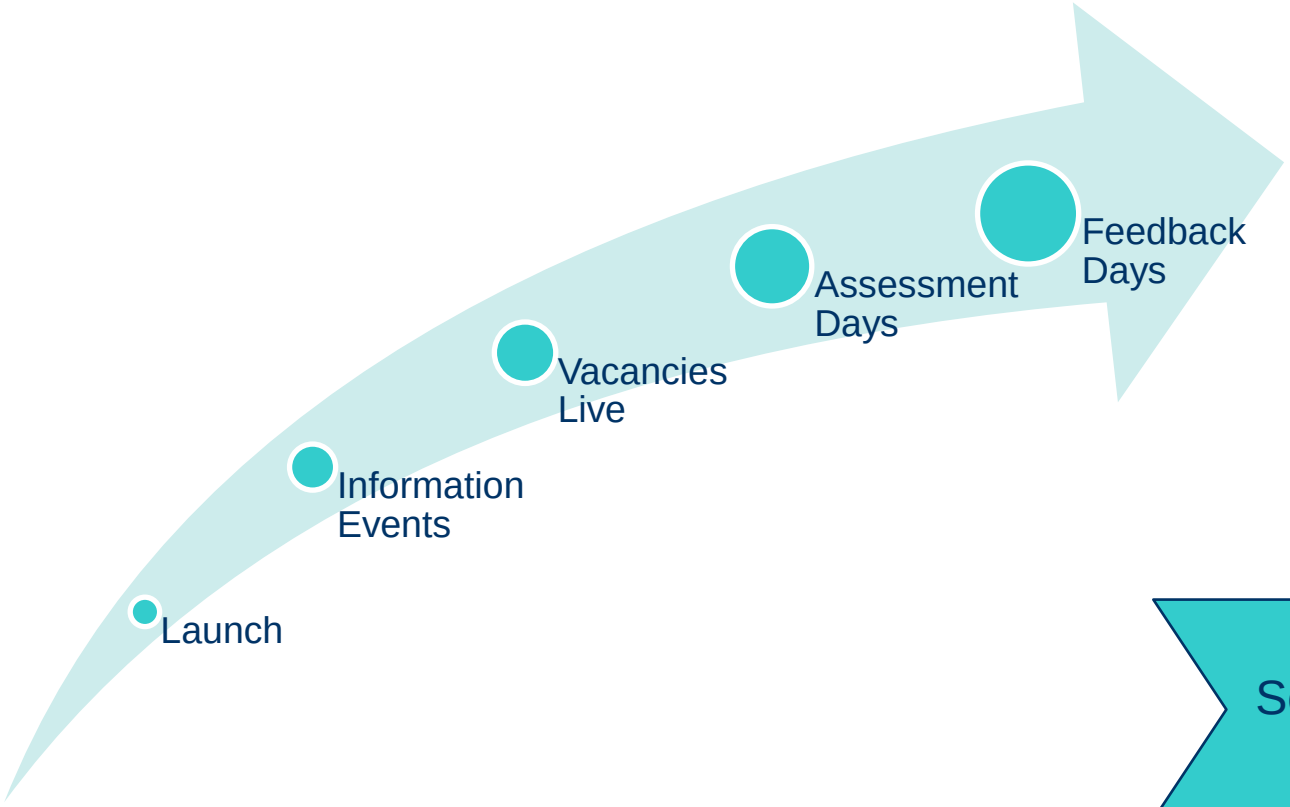


# Governance

Apprentice Governance Group:

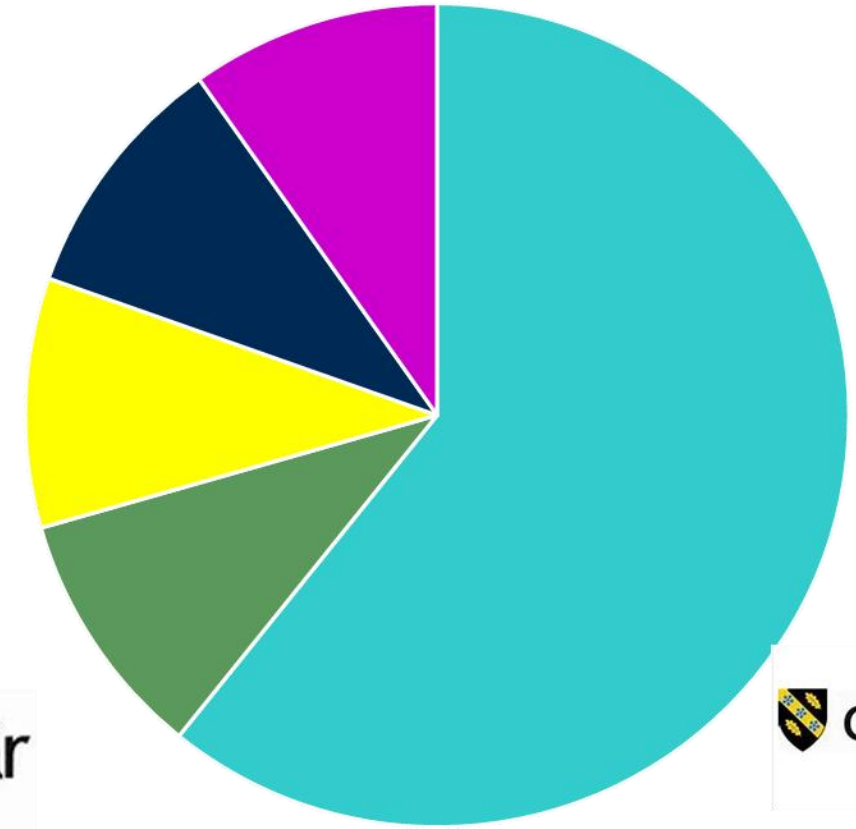
- Robust mentorship and support
- Competency framework
- Scope of practice
- Training
- Evaluation
- Panel reviews

# Key Events

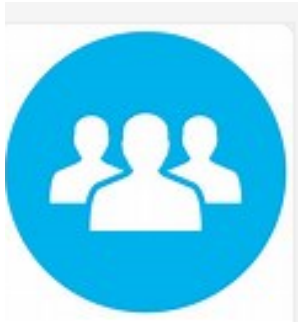



Start September 2019

# Target Audience



# The Campaign


# “Is Nursing a Girls Job?”

## LINK TO FILM

## https://youtu.be/B9lRnfz_WO4

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# Advertising

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NHS Jobs

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Hywel Dda
Health Board



# Assessment Days

# Thanks for Listening

# Any questions?

Videos to Accompany Staff Story

Kerry's Film: https://youtu.be/Xgg3HzgT4lY

'Isn't Nursing a Girls Job?' Film: https://youtu.be/B9lRnfz_WO4

**COFNODION Y CYFARFOD BWRDD IECHYD PRIFYSGOL**
**HEB EU CYMERADWYO/UNAPPROVED**
**MINUTES OF THE UNIVERSITY HEALTH BOARD MEETING**

| | |
|---|---|
| Date of Meeting: | **9.30AM, THURSDAY 28TH MARCH 2019** |
| Venue: | **CEREDIGION COUNTY COUNCIL CHAMBERS, PENMORFA, ABERAERON, CEREDIGION SA46 0PA** |

| | |
|---|---|
| Present: | Mrs Judith Hardisty, Interim Chair, Hywel Dda University Health Board<br>Mr Paul Newman, Interim Vice-Chair, Hywel Dda University Health Board<br>Mr Owen Burt, Independent Member<br>Professor John Gammon, Independent Member<br>Cllr. Simon Hancock, Independent Member<br>Ms Anna Lewis, Independent Member<br>Mr Mike Lewis, Independent Member<br>Mr David Powell, Independent Member<br>Ms Delyth Raynsford, Independent Member<br>Mr Steve Moore, Chief Executive<br>Mr Joe Teape, Deputy Chief Executive/Director of Operations<br>Mrs Lisa Gostling, Director of Workforce & Organisational Development<br>Mrs Ros Jervis, Director of Public Health<br>Dr Philip Kloer, Medical Director and Director of Clinical Strategy<br>Mrs Karen Miles, Director of Planning, Performance & Commissioning<br>Ms Mandy Rayani, Director of Nursing, Quality & Patient Experience<br>Ms Alison Shakeshaft, Director of Therapies & Health Science<br>Mr Huw Thomas, Director of Finance (part) |
| In Attendance: | Mrs Joanne Wilson, Board Secretary<br>Mr Michael Hearty, Associate Member<br>Ms Jill Paterson, Director of Primary Care, Community & Long Term Care<br>Ms Sarah Jennings, Director of Partnerships and Corporate Services<br>Mr Andrew Carruthers, Turnaround Director<br>Mrs Libby Ryan-Davies, Transformation Director<br>Dr Kerry Donovan, Chair, Healthcare Professionals Forum<br>Mr Jonathan Griffiths, Pembrokeshire County Council Director of Social Services, Local Authority Representative<br>Ms Hilary Jones, Chair, Stakeholder Reference Group (part)<br>Mr Sam Dentten, Chief Officer, Hywel Dda Community Health Council<br>Mr Peter Skitt, County Director Ceredigion (part)<br>Ms Jina Hawkes, General Manager, Community Primary Care (part)<br>Mrs Rosie Frewin, Partnership Governance Officer (part)<br>Ms Clare Moorcroft, Committee Services Officer (Minutes) |

| | | |
|---|---|---|
| **PM(19)32** | **PUBLIC FORUM** | |
| | The Interim Chair, Mrs Judith Hardisty, welcomed everyone to the meeting. Mrs Hardisty advised of several questions received from two members of the public for the Public Forum section of the meeting, indicating that copies of the questions and the responses had been provided to members of the public present and to Board Members. These would also be published on the University Health Board website and formal letters of response provided. | **JH** |

| PM(19)33 | PATIENT STORY | |
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| | Mrs Hardisty introduced Ms Eve Lightfoot, Community Infection Prevention Nurse and Nurse of the Year Winner at the Royal College of Nursing (RCN) Wales Nurse of the Year Awards 2018. Ms Lightfoot gave a presentation entitled 'Sepsis – acute deterioration. A community problem?' inviting Members to imagine the contrast between treating patients on a hospital ward and in the community, which reflected Ms Lightfoot's experience when she moved from acute to community nursing. Sepsis has been perceived as a secondary care, rather than a community, issue. However, the District Nursing caseload has significantly changed in recent years and this is no longer the case, as confirmed by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) 'Just say sepsis' report, published in 2015, which estimated that over 70% of sepsis cases arise in the community. Subsequently, National Institute for Health and Care Excellence (NICE) sepsis guidelines had been published, although not until 2016, which demonstrates the complexity of this condition.<br><br>Members heard that there are 250,000 cases of sepsis per year in UK, with 44,000 recorded deaths, although it is likely that the mortality figure is higher – perhaps 60,000 – and improved clinical coding will confirm this. Clearly, for every death from sepsis, there is an impact on that patient's family. Ms Lightfoot explained that she had undertaken a District Nursing degree and research internship, during which it had become apparent that community nursing staff were not supplied with the appropriate equipment to conduct basic observations, which is particularly important for suspected sepsis. This has now been addressed, and all HDdUHB District Nurses now undertake sepsis awareness training as part of their annual update. Sepsis score cards, which are used widely outside the community, have also been introduced, together with an SBAR escalation form. The Rapid Response for Acute Illness Learning Set (RRAILS) Group ensures that the appropriate standards are in place. Educational sessions are provided for District Nursing staff and Care Home staff. There is also a drive to roll out sepsis awareness into Primary Care, including GPs, some of whom do not regard it as within their remit. This is a work in progress. The National Early Warning Score (NEWS) and the SBAR are now included in District Nursing patient assessment across HDdUHB. In relation to transfer from acute care to the community, a Transfer of Care document and discharge policies are being developed. The document will provide a standardised summary of information District Nurses require about a patient. Members were shown photos of HDdUHB staff participating in networking and various events to raise awareness around sepsis. A slide of the new SBAR form was also presented. This is intended to provide the required information, in a standardised format, to whomever the District Nurse may be handing a patient onto. Ms Lightfoot emphasised that this work is also to ensure that healthcare professionals 'do the right thing' for their patients, allowing them dignity in treatment, especially in terms of End of Life Care, for example.<br><br>Overall, Members heard that feedback had been extremely positive, from staff, patients and relatives. Ms Lightfoot's work had offered various opportunities to share her experiences, including winning the Nurse of | |

the Year Award. Whilst welcomed, this was unexpected, and Ms Lightfoot emphasised that her priority is improving patient experience rather than personal recognition. Whilst there had been successes, there were also a number of challenges and obstacles, including areas of resistance. Ms Lightfoot suggested, however, that conducting a full set of observations on patients in the community is a duty of care and is also a case of equality of care. In terms of the future, there is to be a national launch of NEWS to the community; and, whilst HDdUHB is ahead of others in many respects, there is much more which could be done. Sepsis awareness and the related tools need to be fully embedded into community nursing practice, and rolled out into Primary Care and the Care Home sector. A planned Quality Improvement (QI) project will offer an opportunity to write up work to date and demonstrate the positive effect this has had for patients and their families. Ms Lightfoot concluded by outlining the challenges and ongoing journey, highlighting the importance of networking and retaining the vision and purpose of the original project.

*Mr Huw Thomas joined the Board meeting.*

On behalf of the Board, Mrs Hardisty thanked Ms Lightfoot for her presentation and contribution. Mrs Mandy Rayani stated that she is immensely proud of Ms Lightfoot and her achievements, and that it is vital for this work to go from strength to strength under Ms Lightfoot's leadership. This is a valuable opportunity to take forward a piece of work which offers real impact for patients. Mr Sam Dentten congratulated Ms Lightfoot on her presentation and work, which goes well beyond the 'day job'. The safety of patients in the community is extremely important, particularly as HDdUHB moves towards implementation of its new Health & Care strategy. Mr Dentten enquired how the organisation is ensuring that innovative practice is embedded, and how it will ensure that the community is a safe setting in which to receive care. In response to the first query, Mrs Rayani advised that there are various 'strands' involved, including Research & Development, established practice, the new Quality Improvement Strategic Framework, all of which contribute to ensuring that innovative projects such as sepsis awareness become embedded into standard practice. The work around leadership development being undertaken by Mrs Lisa Gostling and her team will also contribute. In terms of the second query, Mrs Rayani assured Members that the organisation is considering how to ensure quality of care in the community. Initiatives include seeking feedback from staff regarding potential issues and areas for improvement and developing community and Primary Care performance metrics in addition to those which already exist for Secondary Care.

Ms Delyth Raynsford also commended the work by Ms Lightfoot, and enquired regarding the involvement of family members and the wider community in terms of increased sepsis awareness. Ms Lightfoot confirmed that this is part of the programme of work, with contributions to various events and provision of information to health centres. It is important, however, to maintain a balanced approach and not unduly worry patients, particularly as the symptoms of sepsis are similar to those of influenza, for example. The key is to provide the information and tools which will raise basic awareness of sepsis. 'Safety Netting',

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| | particularly for isolated individuals, is important; together with education and empowering patients to feel able to ask for further advice if they do not begin to feel better in the expected timeframe. Dr Philip Kloer also congratulated Ms Lightfoot on her achievements, noting that there has been a significant effort to raise awareness of sepsis, and rightly so, as it affects the lives of so many people. Members were reminded that there are annual Sepsis Awareness Days, and were encouraged to explore the resources provided by the Sepsis Trust. Dr Kloer noted that, until approximately 7 years ago, NEWS scores were not used in the hospital setting; however, they are now a common language among healthcare professionals. This is vital, as there are certain time-critical interventions and tests which are needed when sepsis is suspected. It is good to see that the NEWS score is being more widely utilised, as it is fundamental to sepsis diagnosis and treatment. Professor John Gammon agreed that sepsis can have a significant and devastating impact, causing a rapid deterioration in condition. On behalf of the patients in HDdUHB, Professor Gammon thanked Ms Lightfoot for her significant contribution to patient care.<br><br>*Ms Lightfoot and Mrs Rosie Frewin left the Committee meeting.* | |

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| **PM(19)34** | **INTRODUCTIONS & APOLOGIES FOR ABSENCE** | |
| | Apologies for absence were received from:<br>• Mr Adam Morgan, Independent Member<br>• Dr Owen Cox, LMC Representative | |

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| **PM(19)35** | **DECLARATION OF INTERESTS** | |
| | No declarations of interest were made. | |

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| **PM(19)36** | **MINUTES OF THE PUBLIC MEETING HELD ON 31ST JANUARY 2019** | |
| | **RESOLVED** – that the minutes of the meeting of the University Health Board (UHB) held on 31st January 2019 be approved as a correct record. As a matter of clarification in regards to the Llanelli Wellness Village update discussed on page 5; Mr Steve Moore advised that, whilst there will not be capital funding implications for the UHB, there will be revenue requirements. | |

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| **PM(19)37** | **MATTERS ARISING & TABLE OF ACTIONS FROM THE MEETING HELD ON 31ST JANUARY 2019** | |
| | An update was provided on the table of actions from the Public Board meeting held on 31st January 2019 and confirmation received that all outstanding actions had been progressed. In terms of matters arising:<br><br>**PM(19)18** – Mr Paul Newman enquired whether there was any update on the business cases relating to patient experience data collection. Mrs Rayani advised that there is no outcome as yet, and that she will be discussing this further with the Director of Finance. It was agreed this matter would remain open on the table of actions. | **MR** |

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| **PM(19)38** | **REPORT OF THE CHAIR** | |
| | Before presenting her report, Mrs Hardisty suggested that the Board should formally record its thanks to Mrs Bernardine Rees OBE for the significant work undertaken during her term as Chair of HDdUHB. At a | |

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| | recent meeting with Local Authority representatives, it had been specifically noted that there had been a 'change in the tone' of relations between organisations during her term of office. Mrs Hardisty then introduced the report on relevant matters undertaken as Chair of the University Health Board since the previous Board meeting, highlighting in particular staff successes including Emma Thomas' award of Emma's Diary Mums' Midwife of the Year 2019 for the Wales region. Mrs Hardisty also drew Members' attention to the Long Term Service awards, which rightly recognise the contribution of our longest-serving members of staff; and the increasing number of Employee and Team of the Month nominations, which is pleasing to see. The Independent Board Members Update on page 5, and the changes detailed therein, was highlighted and Members noted that the substantive role of Chair had been advertised, with a closing date of 19th April 2019. Mrs Hardisty also thanked those who had expressed an interest in the role of Interim Vice-Chair and welcomed Mr Newman, who had been appointed to this post.<br><br>Referencing the Employee/Team of the Month awards, Cllr. Simon Hancock thanked the Chair for offering Board Members the opportunity to present these awards and, as a result, visit the employees and services involved. This offers a valuable opportunity to see examples of the innovative and positive work taking place across the HDdUHB region. Cllr. Hancock emphasised that staff are the organisation's greatest asset and reiterated that it is only right to recognise and acknowledge their commitment and achievements. | |
| | The Board:<br>• **SUPPORTED** the work engaged in by the Chair since the previous meeting and to note the topical areas of interest. | |

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| **PM(19)39** | **REPORT OF THE CHIEF EXECUTIVE** | |
| | Mr Moore welcomed the opportunity to meet again as a Board in Ceredigion, and thanked Ceredigion County Council for providing the necessary facilities. Members heard that there has been positive feedback from various quarters, both external and internal, regarding the introduction of webcasting. In response to separate feedback regarding the content of recent Chief Executive Reports, Mr Moore advised that he intends to involve the UHB's staff to a greater extent in developing this, and would welcome other suggestions. Mr Moore presented his report on relevant matters undertaken as Chief Executive of the University Health Board since the previous Board meeting. Members' attention was drawn to the various workstreams in relation to developing the UHB's workforce, including collaborative work with Abertawe Bro Morgannwg University Health Board (ABMUHB), the Enfys Network and Apprenticeships. Mr Moore advised that, whilst Welsh Government recognises the progress made by HDdUHB, the escalation status of Targeted Intervention remains. Members were reminded that significant work is taking place in preparation for Brexit, some of which is briefly outlined within the report. Mr Moore also reported that the HDdUHB Quality Improvement Strategic Framework had been officially launched at an event on 21st March 2019. Concluding his report, Mr Moore thanked Mrs Libby Ryan-Davies, attending her final Board meeting as Transformation Director, for her significant contribution and achievements during this role. Mr Moore also added his thanks for the | |

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| | leadership and inspiration provided by Mrs Rees, particularly around partnership working, stating that she will be greatly missed.<br><br>Dr Kerry Donovan welcomed the introduction of apprenticeships, suggesting that this is long overdue and represents a valuable career opportunity for local people. Dr Donovan enquired whether any consideration has been given to the organisation's expectations in terms of commitment to a specific period of service, having completed an apprenticeship. Also, whether those participating are likely to have any expectations regarding a 'gap year', in common with many of those entering higher education. Noting that the apprenticeship programme is currently focused on developing nurses, Dr Donovan enquired whether this might be extended to include other professions, including therapists. Mrs Gostling confirmed that all of the above issues and suggestions are being considered. The first cohort of approximately 40 apprentices are due to join the organisation in September/October 2019 and will be participating in various 'tasters'. The programme is two years in length and is intended to offer a rounded experience of multiple departments and specialties. Individuals may choose to reroute at various points, and the organisation will create pathways into other professions such as therapies. Nursing has been selected for the apprenticeship programme, as there is already a recognised pathway into professional nurse education. It is hoped that, when other healthcare professions have developed similar, other apprenticeships will be offered. | |
| | The Board:<br>• **ENDORSED** the Register of Sealings since the previous report on 31st January 2019;<br>• **NOTED** the status report for Consultation Documents received/ responded to. | |

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| **PM(19)40** | **REPORT OF THE AUDIT & RISK ASSURANCE COMMITTEE** | |
| | Mr Newman, Audit & Risk Assurance Committee (ARAC) Chair, outlined the ARAC update report, drawing Member's attention to the Key Risks and Issues/Matters of Concern section. There were a number of concerns discussed by ARAC, including deficiencies and a lack of progress around medical records management. It had been agreed that the latter should be referred to the Business Planning & Performance Assurance Committee (BPPAC), to be addressed at pace. Mr David Powell, BPPAC Chair, assured Members that this matter is scheduled for discussion at the April 2019 meeting. | |
| | The Board **NOTED** the ARAC update report, and **ACKNOWLEDGED** the key risks, issues and matters of concern together with actions being taken to address these. | |

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| **PM(19)41** | **REVISED ARAC TERMS OF REFERENCE** | |
| | The Board **APPROVED** the revised Terms of Reference for ARAC. | |

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| **PM(19)42** | **HEALTH AND CARE STRATEGY: A HEALTHIER MID AND WEST WALES – PROGRAMME PLAN** | |
| | Dr Kloer introduced the Health & Care Strategy Programme Plan report, explaining that this also links with the next agenda item relating to Regional Partnership Board governance. Members were reminded that the Health & Care Strategy agreed by Board in November 2018 was the | |

output of 3-4 years' work. The strategy is a substantial piece of work, developed in conjunction with partners and stakeholders, and there are 400,000 people in the region now relying on the organisation to deliver. This is a 20 year strategy, which includes a number of significant expectations and impacts, and which offers various opportunities to make a real difference for the population, when compared with the usual 3 year cycle. Dr Kloer reminded Members that the new strategy does result in a need to reorganise the health system, in order to provide the best service and highest quality of care. The organisation also needs to consider how best to organise itself, and ensure that the appropriate communications and engagement plans are in place. Key staff members and the public will need to be fully connected and committed. Additional resource and capacity will also be required. Dr Kloer introduced Mrs Ryan-Davies, and paid tribute to her significant contribution to the development of the Health and Care Strategy to date.

Mrs Ryan-Davies highlighted the key areas for discussion, outlining the work which has taken place since the strategy was approved in November 2018, including the scoping exercise to determine the approach which best meets the needs of the UHB. Members' attention was drawn particularly to the change programmes and to the 'check and challenge' approach outlined within the report. There have been a number of discussions with various parties to develop the proposed portfolio of programmes and enablers as set out in the scoping, governance and delivery document. The three proposed change programmes detailed on page 4 have been refined following discussion, and therefore differ from the five previously outlined in November. These will not work in isolation, and Teulu Jones will be used to constantly check and challenge the approach taken. Initial programme delivery plans are described on page 5; these are constantly under review and are subject to change. The three change programmes will be supported by a number of enabling mechanisms, which includes an integrated enabling group, Terms of Reference for which are being developed. The change programmes and enablers will sit within a Transformation Programme Office which will bring together the required resources, including across health and social care and, in some cases, wider public sector partners. The office will bring together subject matter experts on a range of key areas including finance, workforce, governance, modelling and informatics, communication and engagement, diversity and inclusion, prevention and population health. It will ensure a consistent set of principles and way of working across the portfolio, and check and challenge will be an integral part of its approach. The Health & Care Strategy will move to a delivery arm from the current strategy arm. A Health and Care Strategy Delivery Group will be established, reporting directly to Board, and Terms of Reference for this group have been developed. The group will be responsible for monitoring progress of the portfolio of programmes and will be accountable for ensuring delivery of the health and care strategy in accordance with Board approved timescales. Mrs Ryan-Davies advised that a suite of communication products has been developed, with various versions and formats; these will be launched following Board approval of the proposals.

Dr Kloer emphasised that consideration has been given to the skills required to deliver the programme, noting that these will change and

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| | evolve over the lifetime of the programme. Members were reminded that the approach taken by other Health Boards, Trusts and healthcare organisations has been examined. Whilst various different elements of learning have been taken from each, all share the commonality of a core team. The establishment and funding of a Transformation Programme Office has been considered by the Executive Team as part of the organisation's Annual Plan. It is hoped that the UHB will receive Welsh Government support under Targeted Intervention arrangements; however, if this is not supported, it is recommended that the required investment be made. The report concludes by detailing the resource requirements for the proposed new build hospital. Mrs Ros Jervis suggested that the move away from a traditional healthcare approach to a prevention approach may be regarded as somewhat unconventional; however Members were reminded of discussions around the Health & Wellbeing Framework at the previous Public Board meeting in January 2019. It is the UHB's intention and ambition that the Health & Care Strategy and Health & Wellbeing Framework are aligned rather than separate. Additional resource may be required to support this approach.<br><br>Mr Powell stated that he fully supported the three change programmes proposed, which represent a fundamentally sensible approach, and welcomed the, albeit high-level, benefits outlined in Section 10 of the main document. It was suggested, however, that the information regarding benefits should have been included on page 5 of the SBAR, as this would provide a means of measuring delivery. Mr Michael Hearty suggested that the risk of 'scope creep' can be lost in the detail, and counselled against underestimating the importance of the integrated enabling group. Mr Hearty also suggested that the UHB should not limit its research to healthcare organisations, as many other organisations and industries have successfully undertaken transformation programmes, for example the nuclear energy industry. Cllr. Hancock reminded Members of the four central TCS principles – 'Safe, Sustainable, Accessible and Kind', and enquired whether the UHB could confidently assert that all risks have been considered, suggesting that the issue of access and transport could be given more focus in the document. Dr Kloer acknowledged this comment. Mr Dentten welcomed the proposals as a first step in providing the required clarity and assurances. However, the Community Health Council (CHC) are particularly concerned regarding the stated risk on page 26 of the main document around the UHB's capacity to maintain continuous engagement. Mr Dentten emphasised that this is a crucial and essential element of the process and that the CHC will be seeking early assurance that this will be appropriately resourced going forward, noting that if resource was an issue this should have been raised to the Board's attention when this framework was presented for approval. Dr Kloer agreed that the commitment to continuous engagement is a key component of consultation. Whilst there are concerns around capacity, it will be vital to utilise resources effectively and constantly test via engagement.<br><br>Ms Anna Lewis welcomed the thorough approach applied, whilst suggesting that programme management can be a somewhat draining process, and that steps should be taken to ensure that creativity is not sapped and time for reflection is available. Beyond the relatively small | **PK**<br><br>**PK** |

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| | team dedicated to delivery of the strategy, Ms Lewis enquired how the organisation intends to maintain 'humanity' around this process. Dr Kloer emphasised that not all of the strategy is within the UHB's direct control or gift to deliver. The organisation's interaction with partners and the public will be key. There have been previous successes in the past around check and challenge processes and engagement with the public, which have led to a much deeper understanding of their experience. This will need to continue, and the same processes and approach will need to be applied for our staff, and built into the programme. Professor Gammon enquired how the UHB intends to determine the effectiveness of delivery; the document mentions check and challenge, benchmarking and working with university partners. However, more detail is required around how the impact on patients during delivery will be assessed, in terms of wellbeing and health outcomes for both individual patients and communities. Professor Gammon suggested that an objective measure needs to be identified and applied. Whilst acknowledging this comment at a programme delivery level, Dr Kloer stated that specific programmes of work will have quite clear quality indicators/outcome measures; although certain of these will be short term, others longer term. The programme groups will determine and develop appropriate outcome measures. With regards to the potential impact on health and wellbeing, Mrs Jervis suggested that there is a question of whose perspective this should be from – the UHB's or patients/communities. It is for the population to tell the organisation what the impact should be or is, and the Health & Wellbeing Framework will take forward discussions with local people to develop this.<br><br>Referencing the Portfolio Establishment Milestones detailed on pages 21/22 of the main document, Mr Newman noted that several of these are due to occur at a time when the Programme Management Office is being instituted, and enquired whether there is confidence regarding the availability of sufficient resources. Mr Newman also suggested that the document should be more prescriptive in terms of reporting to Board than 'regular'. Dr Kloer acknowledged both these concerns, stating that although there are existing programme management resources, these are not yet scaled to the required level. There are two potential risks involved: the risk of a degree of short term slippage on timescales; and the risk that the process of defining the detail required will, in turn, result in additional complications and risks. Dr Kloer agreed to provide an update on these matters via the Table of actions to the next meeting. Mrs Ryan-Davies emphasised that, in developing the scope, the team has been mindful of what is realistic within the time and resources currently available. Whilst recognising this, Mr Newman reminded Members that there is also the factor of achieving these milestones in addition to 'the day job'. Mr Andrew Carruthers referenced Executive Team discussions, where it had been noted that Programme Management Office has different meanings in different settings. Within industry, these offices often have a role which relates more to governance and management. On behalf of Mr Adam Morgan, Mrs Hardisty enquired how staff will be involved in this process. Mrs Gostling advised that staff engagement has already commenced, with Trade Unions and at the Staff Partnership Forum. It was emphasised that the intended approach is one of asking staff about potential changes, rather than making assumptions and presenting proposals. | **PK** |

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| | Mr Moore welcomed the foregoing discussions, noting that delivery of the strategy represents a daunting challenge, whilst recognising that a great deal of work has taken place since November. Whilst it is important to maintain a long term view, the first priority must be to consider the immediate steps required. Mr Moore welcomed in particular discussions regarding risks, emphasising that improvements in the transport infrastructure are regarded as a clear requirement, and are at the forefront of consideration. The issue of continuous engagement is less about financial capacity and more to do with staff capacity/ability to undertake this in addition to their regular work. The impact of this is significant and should not be underestimated. Mr Moore agreed that it is vital to retain a sense of humanity and that there is a need to nuture and safeguard the relationship with staff. Also, that it is not for the organisation to determine what success looks like; there must be sufficient humility to accept that the outcome of engagement may not completely reflect what the UHB considers to be important. Mr Moore shared Mr Newman's opinion that Board needs to retain oversight of strategy delivery, and suggested that consideration be given to how the wider Board is kept engaged. Staff engagement is also crucial, in order that the strategy is regarded as their strategy. Concluding the discussion, Mrs Hardisty thanked all of those involved in developing and producing the documentation, and Board Members for their comments. | **PK** |
| | The Board:<br>1. **APPROVED** the Scoping, Governance and Delivery document (and the appended Programme Delivery Plans and Check and Challenge process), and in doing so approve the initiation of the portfolio of programmes, subject to the addition of information regarding benefits to the SBAR and increased focus on access and transport in the Scoping, Governance and Delivery document.<br>2. **APPROVED** the proposed portfolio governance (aligned to the Regional Partnership Board governance), with view to bringing together the portfolio programme outlined in the Scoping, Governance and Delivery document and the RPB priority groups and Transformation Fund groups in order that there is one key mechanisms reporting into shared governance.<br>3. **AGREED** to formally dis-establish the strategy development arm of the Health Board's governance arrangements (Health Strategy Committee) including the underpinning structure.<br>4. **APPROVED** the Terms of Reference of the Health and Care Strategy Delivery Group, subject to clarification regarding frequency of reporting to Board.<br>5. **APPROVED** the development of a Transformation Programme Office team to drive forward delivery of the health and care strategy, as part of business as usual. | |

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| **PM(19)43** | **WEST WALES REGIONAL PARTNERSHIP BOARD (RPB) – GOVERNANCE** | |
| | Ms Sarah Jennings presented the West Wales Regional Partnership Board Governance report, providing context and background to this report. Members were reminded that, previously, the UHB had health and wellbeing partners. These were replaced by the West Wales Regional Partnership Board (RPB), which has been in place since 2016. This body has a statutory foundation in law, with all of those involved | |

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| | expected to work in partnership to deliver on specific tasks and duties. Ms Jennings reiterated that RPB governance is linked with the previous agenda item, emphasising that she will now be leading the work stream to bring this tow elements together ensuring alignment between the two. Members noted that, whilst the governance behind delivery of patient care is extremely complex, it must be correct, and heard that there has been significant discussion of this topic among partners. Ms Jennings advised that the RPB signed up to the proposals presented, including the terms of reference, on 25th March 2019; the only change being the removal of an extraneous reference to the Health Board Vice-Chair in the terms of reference. Members were reminded that, in November 2018, the Board committed to an integrated health and social care model; and that 'A Healthier Wales', published in June 2018 by the Welsh Government, is an obligation of every Health Board and Local Authority. Robust governance will ensure that bodies make sound decisions together for the benefit of patients and the local population. Ms Jennings drew Members' attention to the agreed actions on page 5 of the report, emphasising that all of these are intended to improve integration wherever possible.<br><br>Referencing action 2 on page 5 around enhanced representation from the housing sector, Mr Owen Burt enquired what form this will take, in view of the diverse nature of this sector. Ms Jennings and Mr Jonathan Griffiths advised that the proposal is for 1 Local Authority representative and 1 representative from Registered Social Landlords (RSL). Mr Griffiths confirmed that there have been extensive discussions between partners on the proposed governance arrangements. Cllr. Hancock noted that the terms of reference mention national Third Sector representatives, and enquired whether local Third Sector representatives will also be involved, in view of the strong groups in existence across the region. Ms Jennings assured Members that these groups are already represented on the RPB, and that this will continue to be the case. Mrs Hardisty advised that on page 6 of Annexe 1, there is reference to '***An executive*** of Hywel Dda University Health Board' and that this should be amended to read '***A director*** of Hywel Dda University Health Board' due to both Health Board representatives not being Executive Members of the Board. All of those involved in preparing the proposals were thanked for their contribution. | **SJ** |
| | The Board:<br>• **APPROVED** (subject to the amendment of '***An executive*** of Hywel Dda University Health Board' to '***A director*** of Hywel Dda University Health Board) the Terms of Reference and **ENDORSED** the establishment of, a new Regional Leadership Group (RLG) comprising the four statutory Chief Executives, Chair and or Vice Chair of the Health Board and Cabinet Members for Social Services from the three local authorities. This will provide strategic advice and support in relation to setting an overall vision for the integration of health, care and support in the region, agreeing objectives in support of the vision, and ensuring appropriate links with other local and regional transformation programmes.<br>• **NOTED** the updated RPB membership and terms of reference. Membership has been extended to (1) reflect imminent changes to the Part 9 statutory guidance including representation from the housing sector and (2) enhance Health Board representation and (3) | |

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| | include agreed representation from the RLG.<br>• **NOTED** the plans to rationalise existing programme infrastructure for the WWCP to provide enhanced focus and streamline accountability; opportunities will be taken to have single, integrated programme groups for *A Healthier Mid and West Wales* and *A Healthier West Wales*, ensuring effective alignment and collaborative approaches where appropriate.<br>• **APPROVED** the creation of a new Integrated Executive Group (IEG) across the 4 agencies to support joint working and integration at an operational level and oversee delivery of the regional strategies. Membership would include the 3 statutory Directors of Social Services and lead Health Board Directors. This would replace the current Shadow Executive Board.<br>• **AGREED** to the further development of the three areas of work to align the RPB and Health Board governance and programme management:<br>o to bring the two routes of assurance together and find a way to provide oversight and assurance through a single Executive group;<br>o to bring together the change programme groups outlined by the Health Board and the RPB Priority groups and Transformation Fund groups in order that there is one key mechanism reporting into a single Executive group;<br>o To adopt a standard approach to programme management. | |

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| **PM(19)44** | **DRAFT INTERIM ANNUAL PLAN 2019/20** | |
| | Mrs Karen Miles introduced the Draft Interim Annual Plan 2019/20 report, reminding Members that, due to the significant scoping workload involved with the strategy, it has been agreed that the UHB will submit an Annual Plan rather than an Integrated Medium Term Plan (IMTP). The Annual Plan has been developed in alignment with the strategy work which has taken place. Mrs Miles assured Members that there has been constant and consistent engagement with Welsh Government (WG), who are fully conversant with all aspects of the UHB's Annual Plan. The Executive Team Planning Review Panel outlined on page 3 had proved extremely valuable, and the system approach has been vital in keeping the process on track. Local Authorities have welcomed the format, which provides the ability to examine individual elements of the Plan. Members were reminded that Welsh Government is extremely specific in its requirements in terms of format. It is hoped, however, that the format employed will assist BPPAC and the Quality, Safety & Experience Assurance Committee (QSEAC) in monitoring implementation. Mrs Miles stated that she would encourage Members to view the detailed supporting and enabling plans, to see how 'owned' these are by the relevant parties. Mrs Hardisty thanked Mrs Miles and her team for their work in drawing together the Annual Plan.<br><br>Mr Huw Thomas stated that the financial component of the Annual Plan, whilst challenging, was achievable. It will require the organisation to demonstrate continued and concerted financial discipline. Presenting a deficit to Board which will knowingly breach the UHB's financial duty is a challenging decision, and one which Standing Orders defines as a 'novel and contentious action'. Consequently, Mr Moore, as Accountable Officer, has written to Welsh Government to formally advise them of the | |

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| | UHB's intentions with regard to finances. Since there has not yet been confirmation of WG's willingness to underwrite the proposed deficit, the Financial Plan must be regarded as having draft interim status, as it was possible that WG may not accept the proposed control total. Mr Thomas assured Members that the finances have been discussed on various occasions at Finance Committee and at other forums, with the financial plan having been considered in draft form by Finance Committee on three separate occasions. There has also been increased engagement with management teams and a more robust budget-setting process. Mr Thomas drew Members' attention to the figures detailed on page 4, highlighting the intention to reduce the UHB's deficit from £35.5m in 2018/19, to £29.8m in 2019/20. This is predicated on delivering a greater proportion of savings from recurrent sources, with £24m of savings required over the coming year. The plan also includes a commitment to meet additional costs relating to maintaining Referral to Treatment (RTT) performance, £1m earmarked to support Winter Plan costs for the year, and a further £1m to support the continued rollout of the Nurse Staffing Act. Mr Thomas advised Members that the plan for delivery of the Health & Care Strategy does represent a financial risk. Delivery of savings will also be extremely challenging, as this figure represents 3.7% of the organisation's operational budget, excluding ring-fenced funds. To assist in this regard, the Turnaround process will remain in place. Mr Hearty advised that the Finance Committee had been required earlier this week to make a decision on whether or not to endorse the financial plan. The Committee had done so; whilst there were concerns around achieving the control total in a second year, there was an expectation that this can be realised again. The Finance Committee's priorities going forward would be delivery of non-recurrent savings opportunities throughout the year; examining and establishing the underlying causes for the UHB's deficit; and the evolution from Turnaround to Transformation.<br><br>Cllr. Hancock requested assurance that the impact of savings plans on patients has been considered via a rigorous equality impact process. Mr Thomas advised that a process has been introduced this year, which includes a set of documents with the required rigour in terms of impact assessment. Whilst not all of the savings plans may have concluded their impact assessment, all are required to do so. Mr Thomas was, however, able to assure Members that all savings plans are in line with the organisation's long-term strategy. Mrs Rayani confirmed that project initiation documents have been examined to ensure that quality and safety are taken into account, that equality is being considered and that a full equality impact assessment has taken place for all savings plans. Members heard from Mr Carruthers that Mrs Rayani has been involved in the Holding to Account process, and that her input has been extremely valuable. Mr Dentten shared Cllr. Hancock's concerns, whilst noting that savings requirements can also potentially result in missed opportunities for investment in services and questioned whether any of the savings plans would require service change in order for these to be realised. However, the Annual Plan in general offers cause for optimism, and the CHC welcomes the opportunity to discuss it further at forthcoming meetings. It was suggested that one challenge may be in ensuring that members of the public are able to understand their stake in the Annual Plan. Mrs Miles recognised this as a valid point, emphasising | |

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| | that this had been a focus for County Directors when they were preparing their supporting plans. There are services which are especially meaningful to local communities and/or individuals, and members of the public were encouraged to consult the relevant County supporting plans for this reason.<br><br>Ms Lewis noted that on page 10 of the Plan, it is suggested that three different lenses encapsulate the actions the UHB is taking from turnaround to transformation: the Turnaround programme; quality and patient pathway improvement; and strategy implementation. Ms Lewis queried whether these are actually different, or part of the same. Mr Carruthers conceded that they are not necessarily separate; all naturally align, although there may be small, subtle differences. All are crucial to building the service provision upon which the strategy depends. A standardised approach is required, as there are aspects of Turnaround which also form part of the earlier discussions regarding Transformation and the Health & Care Strategy. Ms Lewis suggested that, if it is the case that these are not fundamentally different, this section could be framed/worded differently, as language is extremely important. Mrs Hardisty felt that the work which has gone into the Annual Plan and the improvement in this should be recognised, and welcomed the focus on locality planning. Mr Moore accepted that, whilst the Annual Plan has been developed in parallel with the Strategy, the language may not be entirely consistent. This should be less of an issue in future years. The importance of language was acknowledged; discussions with Ceredigion County Council yesterday had confirmed that there were instances of terms having different meanings between different bodies. Mr Moore also endorsed Mr Hearty's comments regarding the challenge involved in delivering savings for a second year. It is important to recognise that the UHB is building in plans to meet RTT targets and Winter Pressures without additional Welsh Government funding, making these part of 'core business'; while also attempting to reduce the organisation's core deficit. Mr Moore accepted that there are risks associated with this, however believed that it is achievable. The focus needs to be on the detail required to deliver going forward. | **KM** |
| | Following endorsement from the Finance Committee the Board **AGREED** the onward submission to Welsh Government of the draft interim 2019/20 Annual Plan including the draft interim financial plan, noting the Welsh Government expectation that we submit an annual plan for 2019/20, rather than a 3 year Integrated Medium Term Plan for 2019/22. The Board also **NOTED** the ongoing role of the Finance Committee in scrutinising the financial plan. | |

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| **PM(19)45** | **PATHOLOGY STRATEGIC OUTLINE CASE** | |
| | Mrs Miles presented the Pathology Strategic Outline Case, outlining the background to this item. Members noted that the UHB became involved in this issue as part of A Regional Collaboration for Health (ARCH). The project represents an opportunity to develop a regional, future-proofed facility; this potential is acknowledged by Welsh Government. Mrs Miles thanked consultant leads in Pathology for their valuable contribution to the process. Members were advised that the proposals have been discussed at various forums and with WG, who are content with the level of detail being provided at this stage. Whilst it is not necessary to identify a preferred option at this juncture, one has been determined. Mrs Miles | |

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| | drew Members' attention to the financial implications of each option detailed on page 6 of the report, including the revenue impact. Members were assured that the workforce implications will also be considered, by both the UHB and by ARCH. Mrs Miles acknowledged that the cost of this project is considerable, whilst suggesting that it is realistic in view of the significant developments and challenges in this specialty. The proposed laboratory facilities will meet the requirements of both the UHB and wider region going forward.<br><br>Mr Powell welcomed and supported the proposals. Referencing the table on page 3 of the SBAR, Mr Powell queried whether, should the business case be approved, the UHB will be committing itself to refurbishment costs for existing facilities. Mrs Miles advised that in developing the business case, the consultants had expressed a desire to retain a presence (excluding laboratory facilities) in the acute hospitals. The reconfiguration and refurbishment costs outlined will not be funded from the UHB's Discretionary Capital Programme funds; it will form part of the business case. Dr Kloer, whilst recognising that issues with existing facilities create challenges for current staff, also emphasised that they create difficulties in attracting new staff and that this can lead to issues around service quality. In terms of risks, Dr Kloer suggested that there are three principal risks: the fact that this is a significant programme with a long timescale for implementation; the scale of capital request involved and the risk associated with revenue consequences. Dr Kloer expressed concern that the UHB is reliant on a significant capital scheme to solve issues in its departments, suggesting that progress and timescales will need to be closely monitored; and that consideration be given to developing an alternative plan.<br><br>Noting that the driver for this project is the specialty areas, due to changes such as digitalisation, Dr Donovan observed that more urgent testing needs to be conducted at source. Dr Donovan enquired with regard to the resulting interdependencies and potential impact on laboratory areas which will still need to conduct testing. Dr Kloer stated that there is a strong clinical case for the model being proposed, noting in particular that the digital aspect is key and that there will be significant advances in this area. Artificial Intelligence (AI) will also become important. Plans will need to be sufficiently flexible to adapt to advances in new technology. Mrs Miles assured Members that this issue has been discussed with the consultant body, who feel that the digital solution will fit with the future direction of travel. It was acknowledged, however, that precise details need to be worked through. Noting the statement on page 6 around the Royal College of Pathology workload points based system, Mrs Hardisty enquired whether this will take into account the introduction of new technology. Mrs Miles advised that this is certainly the intention. | |
| | The Board:<br>• **NOTED** the development of business continuity plans.<br>• **NOTED** the short-listed options with estimated capital and revenue costs and identification of the preferred way forward.<br>• **APPROVED** the SOC and **AGREED** it can be submitted to Welsh Government to support this project progressing to Outline Business Case stage. | |

| PM(19)46 | IMPLEMENTING THE WELSH LANGUAGE STANDARDS / GWEITHREDU SAFONAU'R GYMRAEG | |
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| | Ms Sarah Jennings outlined the Implementing the Welsh Language Standards report, advising that the Board previously made a fundamental commitment to the Welsh Language in 2011; also whilst undertaking the Strategic Framework 'More than just words' and more recently in 2016. The UHB has now received its compliance Notice. Ms Jennings drew Members' attention to the national context, which has been set out in the paper. Whilst the UHB has taken its statutory responsibilities for the Welsh language seriously, it is recognised that the organisation has not always done everything in the correct way. There is no doubt that the Standards ask the UHB to go further in respect of the Welsh language than it currently does. The organisation already implements a number of the Standards well, some in part, and there are other Standards that will be new to it. Whilst it is understood that certain of the Standards may present concerns, Ms Jennings suggested that if the UHB undertakes the Standards in a practical and timely manner, they can be fulfilled. If there are any barriers when attempting to accomplish the Standards, progress in delivering them will be discussed with the Welsh Language Commissioner. Elements of this work will require a culture change across the whole of the UHB and this will not happen overnight; however, together the organisation can achieve the long term objective – to improve the patient's experience and improve staff experiences. Members viewed a short video featuring 2 year old Ioan, whose first language is Welsh, which demonstrated the potential issues of not having the ability to communicate with patients in their mother-tongue. Ms Jennings was proud to announce that HDdUHB will be collaborating with the National Centre for Learning Welsh in a project during the next financial year which will also assist us in addressing Standard 99. As part of achieving the Standards, Ms Jennings requested that the Board approved the Policy Statement on the use of the Welsh language internally. Members were reminded that, although the UHB has a journey ahead to implement the Standards, Ms Jennings and the Welsh Services Team are available to provide support in realising the aim of Welsh Language Standards compliance. It is the UHB's intention to embrace their spirit and ensure as an organisation that the Welsh and English are treated with equal status. This should not be regarded as something which is 'nice to do'; it is a basic human right. HDdUHB has always said that it wants to lead the way and make a real difference to its population. This is the UHB's opportunity to make a tangible difference to people by providing access to its services in their language of need.<br><br>Thanking Ms Jennings for presenting the paper in Welsh, Ms Raynsford emphasised the importance of the Welsh Language to the UHB's patients and to the communities it serves. Ms Raynsford enquired what steps the organisation is intending to take to support new doctors to learn and improve their Welsh Language skills. Also, whether the UHB has any plans to create Welsh Language Champions, to support doctors to provide services to the population in their language of need. In response, Ms Jennings advised that she has attended a number of recent Advisory Appointments Committee (AAC) selection panels. Members were reminded that overseas doctors are often communicating in their second or third language at work, and are therefore more open | |

to learning a local language. The UHB already has Welsh Language Champions, although it needs to develop a larger network of these. Implementation of the Welsh Language Standards does, however, offer opportunities to consider different formats for learning.

Ms Hilary Jones also welcomed the use of the Welsh Language at today's Board meeting, and reiterated the importance of treating patients in the language of their choice. Having said this, Ms Jones suggested that the UHB should not be over-ambitious; it is not vital for every member of staff to speak Welsh, although there must be someone available who can communicate with patients in Welsh when required. Noting that making a commitment to implementing the Welsh Language Standards across the UHB is challenging, Ms Jones enquired how the organisation will ensure it measures Welsh Language usage in individual services. Ms Jennings suggested that how the standards are implemented will be key, in terms of balance, practicality and support, agreeing that it will not be necessary for every member of staff to speak Welsh. However, the increasing usage of the Welsh Language does need to be both acknowledged and accommodated. Members noted that the number of people speaking Welsh in Pembrokeshire has risen to 1 in 3, an increase of 10%. More than 1 in 2 people in Ceredigion and Carmarthenshire are Welsh speakers, meaning that more speak Welsh than do not. It will take the organisation time to ensure that those who wish to access services in Welsh can do so. Data collected via the Electronic Service Record (ESR) is assisting in evaluating the levels of Welsh speaking among UHB staff; various other changes will be required, such as bi-lingual signage and website development. The organisation will respond to issues as and when they are identified, and will support teams to appreciate the difference that Welsh Language usage makes to patient care. Members were advised that the UHB will submit an annual report to the Welsh Language Commissioner.

Echoing comments regarding the introduction of Welsh to the Board meeting, Mr Thomas noted that, whilst the importance of the Welsh Language in communicating with patients is often mentioned, there are also opportunities for utilising the medium of Welsh in everyday work such as meetings. Mr Thomas acknowledged, however, that the most important element is providing services to patients in Welsh; and gave two examples of his own experiences with family members, which emphasised the benefits of doing so and the potential detriment caused by failing to do so. Mr Thomas enquired how the UHB will measure the difference made to its population by implementing the Welsh Language Standards and how it will evaluate the effect on patient experience in particular. In response, Ms Jennings stated that the UHB will be able to monitor various aspects by various means; for example, the Fundamentals of Care Audit includes a question regarding the use of Welsh Language. Assessing how this makes people feel, however, presents more challenges. There is evidence of improved clinical outcomes if patients can communicate in their first language, including reduction in length of stay. However, Ms Jennings suggested that there is a need for qualitative, as well as quantitative, data around this issue. It would be beneficial to pilot a study around the benefits of using Welsh Language in speech and language therapies and/or stroke rehabilitation.

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| | Ms Jones emphasised the importance of including Welsh Language in the patient experience work being undertaken by Mrs Rayani and her team, in order to gather the spread of data required. Referencing the issue of patient safety, Professor Gammon requested assurance that ensuring that the Welsh Language standards are embedded in patient care will form part of the workplan for QSEAC. Mrs Rayani confirmed that this would be the case, advising that Welsh speakers will be involved in development of the Patient Charter. The Improving Experience Sub-Committee will receive reports on patient experience around Welsh Language implementation, and will report in turn to QSEAC. Ms Alison Shakeshaft noted that three specific services had been mentioned in terms of Welsh Language significance – dementia, speech and language therapy and stroke. Members were assured that planned stroke service redesign work will take into account Welsh Language usage. Ms Jennings reminded Members that there are various opportunities and formats for learning and improving Welsh and encouraged everyone to utilise these. | |
| | The Board **APPROVED** the Policy Statement on the use of the Welsh Language internally. | |

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| **PM(19)47** | **FOCUS ON HEALTHCARE SERVICES IN CEREDIGION** | |
| | *Mr Peter Skitt and Ms Jina Hawkes joined the Board meeting.*<br><br>Mr Peter Skitt introduced the Healthcare Services in Ceredigion: Into the Future report, explaining that this has been written from the standpoint of patient pathways. The report is intended to demonstrate the complexity and number of people involved in healthcare systems in Ceredigion, including integration and co-dependencies. The central philosophy is to provide care at home for people whenever possible, although a balance between Primary and Secondary Care is required. One significant shortfall within the County is Care Home provision. Mr Skitt reminded Members that Tregaron Hospital will close when Cylch Caron is opened. However, it is important to remember that buildings do not deliver care; they are a facilitator/enabler for care. It is people who make up the health and care system, and recruitment remains a key challenge. Jobs in the region need to be sufficiently attractive to recruit and retain staff. The report includes details of other challenges within the region, and requirements such as effective digital and electronic solutions, including Welsh Community Care Information System (WCCIS). It was emphasised, however, that Ceredigion has been fortunate in terms of recent investment in estates. The closure of Tregaron Hospital will be the next significant step; it is vital that local communities are provided with the information they require to understand the future model of care. Mr Skitt concluded by stating that feedback on the new report format would be welcomed.<br><br>Referencing information on pages 13 and 14 around the nursing and medical workforce, Professor Gammon welcomed the provision for nurses to be trained in Aberystwyth. Likewise, the work around the medical workforce, in terms of the Primary Care academy. Members were reminded that UHB policies and strategies are only as good as the organisation's workforce. Ms Lewis commended the report and its effectiveness in 'bringing services to life'. The cardiac care/dementia case study on pages 7 and 8 is a good example of how fragile the home | |

circumstances of certain individuals are. Noting that this had been identified during a crisis, Ms Lewis enquired how proactive the UHB is in terms of identifying those in similar circumstances before there is a crisis. Mr Skitt advised that the UHB know those individuals who are registered as carers, however the situation with regard to unpaid carers is less clear and further work in the community is required. The new locality/community based model should assist in this regard. Members noted that efforts are also required in terms of recruitment of care workers. Mr Moore suggested that not all carers see themselves as such, emphasising the need to consider how the UHB supports the entire family and take a wider view of who the organisation is trying to serve. Dr Donovan praised the use of case studies within the report. It was suggested that the challenges confronting Ceredigion are also faced by the other two counties, and recognition of these was welcomed. Dr Donovan noted that the shift of focus from Secondary to Primary Care will take time, and there is a need to change the mindset of the general public in this regard, to ensure that they recognise the skills of the multidisciplinary team.

Dr Kloer reported that he and Ms Jill Paterson had recently met with medical students on the Community and Rural Education Route (CARER) programme, as outlined on page 14 of the report. It had been interesting to hear their reflections on the experience and the confidence it has provided. The value of interaction with patients and experience in undertaking basic clinical procedures were noted in particular. Several of the students had said that they would not necessarily have considered a career in Primary Care before participating in the programme. Dr Kloer emphasised the innovative, creative nature of this model. Ms Raynsford queried whether there was any sense of whether these students will stay in the region following the programme. Dr Kloer explained that the programme is still very much in its infancy, and that those students participating are in the middle of their 5 year undergraduate medical course. Its success will, however, be monitored and assessed over time and representatives from the UHB will continue to meet with students on the CARER programme to discuss their experience. Dr Kloer suggested that the programme may represent a significant breakthrough in recruiting to rural medical practice.

Referencing the integrated care centres, Ms Raynsford advised that she had recently met with members of the community local to Cylch Caron, and enquired how the UHB is ensuring it learns from communities such as this. Mr Skitt assured Members that a great deal is being learnt from the stakeholders in Cylch Caron and that a number of those involved have been established stakeholders for many years. In addition, benefits registers exist for all the UHB's projects. There is a need, however, to ensure that the organisation delivers what it says it will. With regard to the CARER programme, Ms Shakeshaft noted that Therapy training has until now been very Cardiff-centric; however, a number of new trainees have been secured as a result of increased rural placements. It was suggested that a similar pattern could reasonably be expected for trainee doctors. Mr Burt reported that he had recently visited Borth Surgery, where he had met a Third Year medical student who had been extremely positive about his experience and impressed with the opportunities it had offered. Mrs Hardisty thanked Mr Skitt and his team

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| | for the report provided. | |
| | The Board **NOTED** the Healthcare Services in Ceredigion: Into the Future report. | |

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| **PM(19)48** | **REPORT OF THE FINANCE COMMITTEE** | |
| | Mr Hearty, Finance Committee Chair, outlined the Finance Committee update reports from meetings in January and February 2019. Members noted that the most recent meeting had taken place on 25th March 2019. The Finance Committee had agreed that baseline budgets are built on more robust discussions than in previous years, and that the baseline figures are, therefore, sound. There is also more confidence in delivery of savings targets. Future discussions will include consideration of Value Based Healthcare and a focus on the underlying reasons for the UHB's deficit, which has been a consistent area of WG concern. Mr Hearty commended the work being undertaken by Mrs Gostling and her team on Staffing Establishment Control. All of these matters are fundamental to a successful progression from Turnaround to Transformation.<br><br>Dr Kloer suggested that Value Based Healthcare will become extremely important in assisting the UHB to understand outcomes and patient pathways. Whilst this importance is increasingly recognised, to undertake this properly will be labour intensive and it cannot realistically be relied upon to provide answers in terms of reasons for the deficit. Mr Thomas agreed that measuring outcomes alongside finances will be challenging and suggested that a locality level review of how resources are utilised will be key. | |
| | The Board **NOTED** the Finance Committee update report and **ACKNOWLEDGED** the risk in delivering the Health Board's financial forecast position. | |

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| **PM(19)49** | **FINANCE/TURNAROUND UPDATE – MONTH 11 2018/19** | |
| | Mr Thomas presented the Financial Update and Turnaround Programme Update – Month 11 2018/19 report, reminding Members that this has been discussed in detail by the Finance Committee. It is anticipated that the forecast deficit of £35.5m would be achieved; Mr Thomas suggested that this represents a significant achievement. Discussions will, however, be taking place with those directorates who have not achieved their savings targets this year, to ensure that lessons are learned. As previously mentioned, a priority will be to identify the delivery of non-recurrent savings opportunities. Financial risks which will be carried into next year include disruption to the local service provision of aseptic services, resulting in outsourcing costs, and Primary Care prescribing. It is anticipated that these two issues will equate to a cost of approximately £0.5-0.75m. Members noted that the operational directorates have responded well to the control totals set. Mr Carruthers advised that the organisation has further reduced its forecast savings; this is primarily due to the costs outlined above around aseptic services and Primary Care prescribing. Whilst the next meeting will offer a better opportunity for full reflection, Mr Carruthers anticipated that the UHB's savings position for 2018/19 would be improved to the tune of approximately £9m in comparison to the previous year. In respect of WG's expectation that there be progress from Turnaround to Transformation, examples of | |

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| | this are starting to be seen through savings schemes. Members heard that the Chief Executive has requested a more formal report, which would be shared.<br><br>Mr Carruthers reported that the UHB is running a Patient Communications pilot. Although it has taken time to put the system in place, this is now being implemented in Respiratory Medicine. One of the Lung Cancer Nurses is using the system to manage patients at home and there are encouraging signs in terms of how it may help the UHB to manage certain of its Outpatient ambitions. Dr Kloer agreed that this is a significant breakthrough, which could offer considerable improvements and be applied in any specialty. Dr Kloer has changed his practice, so that any correspondence which is sent to a GP is also copied to the patient. This change has resulted in a great deal of positive feedback, and Dr Kloer has suggested that his consultant colleagues consider doing likewise, citing support for this approach in a recent letter from the Academy of Royal Colleges. Members noted that a great deal of the information which consultants require is now digitalised, including X-rays/scans, test results, letters, etc. Hospital consultants are now also able to access GP records electronically, which was not the case a year ago. Mrs Hardisty and Mr Moore welcomed this example of a Turnaround project resulting in improvements in the quality of service. In conclusion, Mr Moore noted that the UHB is at a point where it will see the first ever reduction in its financial deficit. HDdUHB has delivered the highest level of savings across all Health Boards in Wales, which reflects the efforts and dedication of staff. There is, however, still more which can be done and Mr Moore emphasised that the Executive Team is committed to this work. | |
| | The Board **NOTED** and **DISCUSSED** the financial position for Month 11. | |

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| **PM(19)50** | **REPORT OF THE BUSINESS PLANNING & PERFORMANCE ASSURANCE COMMITTEE** | |
| | Mr Powell outlined the Business Planning & Performance Assurance Committee (BPPAC) update report, advising that the BPPAC Terms of Reference had been reviewed and revised in September 2018, when the Finance Committee had been established. The Terms of Reference had not changed since. With regards to Clinical Coding, it is intended to await the findings of the two forthcoming audits around this topic; a report is scheduled for the June 2019 meeting of BPPAC. Concerns had been expressed regarding the proposed pre-commitments in terms of the Discretionary Capital Programme and how these might limit the organisation's flexibility. However, assurances had been provided around the mitigations which have been put in place. There had been discussion of the Single Cancer Pathway, with the Committee's main concern being around diagnostic capacity. Again, assurances had been provided in this respect. | |
| | The Board **NOTED** the BPPAC update report, and **ACKNOWLEDGED** the key risks, issues and matters of concern together with actions being taken to address these. | |

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| **PM(19)51** | **BPPAC TERMS OF REFERENCE** | |
| | The Board **APPROVED** the Terms of Reference for BPPAC. | |

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| **PM(19)52** | **INTEGRATED PERFORMANCE ASSURANCE REPORT – MONTH 11 2018/19** | |
| | Mrs Miles presented the Integrated Performance Assurance Report (IPAR) for Month 11 of 2018/19, briefly outlining the UHB's recent performance. Members heard that HDdUHB has received a congratulatory message from Welsh Government regarding the inroads and improvements made within the last 3 years in respect of RTT performance. Mrs Miles suggested that the efforts of Mr Joe Teape and his team should be recognised. The organisation is close to achieving a number of performance targets, and continues to focus on its finances.<br><br>Whilst acknowledging the achievements around RTT, Mr Teape reminded Members that this work has been supported by a significant amount of Welsh Government funding. It is vital to reflect on the learning obtained during this work, such as the teamwork involved between operational staff in both acute and community settings. Mr Teape emphasised that the improvements achieved are very much the result of a team effort. It had been agreed at Finance Committee that a 'lessons learned' exercise should be conducted. Mr Teape also highlighted the need to ensure that the improved performance is maintained and sustained; and that further work is undertaken to reduce waits further, with a focus on 26 weeks rather than 36 weeks. Members were reminded that 36 weeks is still a long time to wait for treatment when in pain and discomfort. Whilst agreeing that the £11.6m WG funding is a significant amount, Mrs Miles emphasised that Welsh Government has stated that HDdUHB has delivered the best value for money RTT improvements. Recalling that the Board has expressed concern previously regarding Therapy waiting times, Ms Shakeshaft advised that the Heads of Service have assured her that there will be no further routine breaches. Ms Lewis agreed that the improvements made in RTT should be recognised. There were, however, specific issues in terms of the reporting of breaches, and more general reporting, which require further consideration. Ms Lewis also queried whether the organisation can truly commit to a philosophy of continuous improvement. Mr Teape emphasised that many of the diagnostic services are extremely overstretched. He agreed, however, that consideration should be given to better reflecting trend reporting within the IPAR. Professor Gammon welcomed the positive trajectory seen in terms of performance; and Mrs Hardisty was pleased to note that future reports will include the number of patients waiting to start an Attention Deficit Hyperactivity Disorder (ADHD) or Autism Spectrum Disorder (ASD) neurodevelopment assessment.<br><br>*Mr Skitt and Ms Hawkes left the Board meeting.* | |
| | The Board **NOTED** the Integrated Performance Assurance Report for Month 11 of 2018/19. | |

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| **PM(19)53** | **REPORT OF THE QUALITY, SAFETY & EXPERIENCE ASSURANCE COMMITTEE** | |
| | Professor Gammon introduced the Quality, Safety & Experience Assurance Committee (QSEAC) update report, highlighting matters of concern which included fragilities in Mental Health. The discussions on this matter had offered certain assurance, however it would be revisited at a future meeting. Members noted that the QSEAC Terms of | |

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| | Reference had been considered and approved for onward ratification by Board. Professor Gammon advised that it had been agreed the approach to Board to Floor Walk Arounds would be reviewed. The Effective Clinical Practice Sub-Committee was not represented in the update report, as it had not met; Professor Gammon has discussed his concerns regarding this with Mrs Rayani and Dr Kloer. The positive Medicines Management Sub-Committee report regarding pharmacy services and the Dementia Care progress report were welcomed. Members noted that the new Patient Experience programme will be presented at the next QSEAC meeting.<br><br>Referencing the Board to Floor Walk Arounds, Dr Donovan noted that sites were selected based on geography and enquired whether there was scope to take a pathway approach. Mrs Rayani advised that consideration is being given to the logistics of this exercise; details will be finalised in due course. Members are reminded of the importance of Board visibility. Mr Teape reported that he and Mr Morgan had participated in a Board to Floor Walk Around on Cadog Ward, following which Mr Morgan had suggested that it would have been beneficial to follow a patient's journey from 'the front door'. This would, obviously, only be practical if all the relevant services are on one site. | |
| | The Board **NOTED** the QSEAC update report, and **ACKNOWLEDGED** the key risks, issues and matters of concern together with actions being taken to address these. | |

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| **PM(19)54** | **REVISED QSEAC TERMS OF REFERENCE** | |
| | The Board **APPROVED** the revised Terms of Reference for QSEAC. | |

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| **PM(19)55** | **DENTAL PLAN PROGRESS UPDATE** | |
| | *Ms Hilary Jones left the Board meeting.*<br><br>Ms Paterson presented the Dental Plan Progress update report, reminding Members of the background to this item. Whilst the plan has been based on an assumption that recruitment will not present an issue, it was emphasised that the UHB does rely upon staff from the EU for dental services. Members heard that the waiting time for Orthodontic Services has been reduced from 8.2 years to 5.5 years, and it is hoped that this will be further reduced. Ms Paterson stated that it is important for Board to be aware of the impact of investment in dental services, including areas of underperformance. As noted in the report, as a consequence of the UHB not having been able to fully utilise its ring-fenced allocation, it had not been awarded any inflationary uplift in 2017/18 and 2018/19, resulting in a loss of £800k across the two year period. This issue has been raised with Welsh Government. Ms Paterson concluded by drawing attention to the various investment priorities outlined on pages 4 and 5 of the report.<br><br>Mrs Hardisty thanked Ms Paterson for her report on a service area which does not necessarily receive the attention it might. Noting the statement around previous difficulties in securing contracts within Ceredigion, Mrs Hardisty suggested that this should be further discussed at BPPAC. Whilst Ms Paterson confirmed that there are significant challenges in this regard, she advised that the UHB is looking | |

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| | to be more creative and potentially explore alternative models. Mr Newman, whilst welcoming this useful update, suggested that it would be helpful to be provided with more information regarding potential solutions to the challenges detailed. Agreeing, Ms Paterson committed to provide a further update to a future meeting. Referencing waits for treatment, Ms Lewis enquired regarding the risk of potential harm to patients, and whether there is a sense of how this harm materialises and impacts upon individuals' day to day lives. Ms Paterson explained that there are instances of patients (children) being added to waiting lists too early, and it is important that the UHB works with its dental partners to address this issue. There is also a need for delineation between waiting for assessment and waiting for treatment. It is accepted, however, that certain individuals will have been impacted by the length of time they have been waiting for treatment, and these patients have been expedited. A report detailing this issue, together with other associated risks, is being prepared for QSEAC. | **JP** |
| | The Board was **ASSURED**:<br>• That investment has been made in ring fenced dental services even though this has been partially negated by underperformance in other areas;<br>• That the ongoing annual Contract underperformance issues with one Corporate Provider over several Practices are being managed in accordance with the Primary Care Dental Contract Regulations.<br>The Board **NOTED**:<br>• The contents of the letter from the Chief Dental Officer (CDO) regarding the ring-fenced allocation;<br>• The approach the CDO has adopted to funding ring-fenced dental inflation;<br>• The planning priorities for 2019/20. | |

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| **PM(19)56** | **COMMITTEE UPDATE REPORTS: BOARD LEVEL COMMITTEES** | |
| | Mrs Wilson outlined the Committee Update Reports relating to Board Level Committees, drawing Members' attention to those matters requiring consideration or approval by the Board and the areas of concern and risk which had been raised by the Committees. | |
| | The Board **ENDORSED** the updates, recognising any matters requiring Board level consideration or approval and the key risks and issues/ matters of concern identified, in respect of work undertaken on behalf of the Board at recent Committee meetings. | |

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| **PM(19)57** | **COMMITTEE UPDATE REPORTS: IN-COMMITTEE BOARD** | |
| | The Board **RECEIVED** the update report of the In-Committee Board meeting. | |

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| **PM(19)58** | **COMMITTEE UPDATE REPORTS: HDdUHB ADVISORY GROUPS** | |
| | Mrs Gostling reported that Mrs Wendy Evans, the previous Partnership Forum co-Chair, had recently retired following 44 years service. Mrs Evans had represented staff-side with exceptional credibility and had consistently 'held the mirror' up to the organisation and its processes. It was suggested that the Board should recognise this service and wish Mrs Evans well in her retirement. | **JH** |
| | The Board **RECEIVED** the update report in respect of recent Advisory Group meetings, and **APPROVED** the revised Stakeholder Reference | |

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| | Group Terms of Reference, subject to further amendment of Ms Jennings' title. | |

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| **PM(19)59** | **HDdUHB JOINT COMMITTEES AND COLLABORATIVES UPDATE REPORT** | |
| | The Board **RECEIVED** for information the minutes, summary reports and updates in respect of recent Welsh Health Specialised Services Committee (WHSSC), NHS Wales Shared Services Partnership (NWSSP) Committee and Joint Regional Planning & Delivery Committee (JRPDC) meetings. | |

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| **PM(19)60** | **HDdUHB UPDATE FROM PUBLIC SERVICES BOARDS** | |
| | Ms Jennings presented the HDdUHB Update from Public Services Boards (PSBs) report, advising that the PSBs are attempting to reduce duplication of work and streamline governance structures. Ms Raynsford welcomed the work being undertaken by Pembrokeshire PSB with the Youth Council and advised that she and Ms Jennings are exploring how this might be replicated within the UHB. | |
| | The Board:<br>• **NOTED** the links to the PSB websites where the agenda, papers and minutes of recent PSB meetings held in Carmarthenshire, Ceredigion and Pembrokeshire can be accessed.<br>• **NOTED** the progress updated for each PSB, and the key areas of discussion highlighted in the report. | |

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| **PM(19)61** | **BOARD ANNUAL WORKPLAN** | |
| | The Board **NOTED** the Board Annual Work Plan. | |

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| **PM(19)62** | **ANY OTHER BUSINESS** | |
| | Mrs Hardisty advised that this would be the final meeting attended by Dr John Morgan and Mr Sam Dentten on behalf of Hywel Dda CHC. Both were thanked for their contribution in ensuring that the patient voice is heard. Mr Dentten emphasised that Dr Morgan has made a significant impact during his time in the role of CHC Chair; this role will be taken over by current Vice-Chair Mr Mansell Bennett. Members were introduced to Ms Donna Coleman, who will be taking on the role of Chief Officer. Mr Dentten thanked HDdUHB Board Members for listening to and taking account of CHC input and for being fair when doing so. | |

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| **PM(19)63** | **DATE AND TIME OF NEXT MEETING** | |
| | 1.30pm, Wednesday 29th May 2019, Board Room, Ystwyth Building, St David's Park, Carmarthen, SA31 3BB (sign-off of Annual Accounts)<br>9.30am, Thursday 30th May 2019, Y Stiwdio Fach, Canolfan S4C Yr Egin, College Road, Carmarthen, SA31 3EQ | |

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

TABLE OF ACTIONS FROM
HEALTH BOARD MEETING IN PUBLIC
HELD ON 28TH MARCH 2019

| MINUTE REFERENCE | ACTION | LEAD | TIMESCALE | PROGRESS |
|---|---|---|---|---|
| **PM(19)32** | **PUBLIC FORUM:**<br>• To provide letters of response to the questions received and to ensure that responses are available on the UHB website. | JH | April 2019 | Completed. |
| **PM(19)37** | **MATTERS ARISING & TABLE OF ACTIONS FROM THE MEETING HELD ON 31ST JANUARY 2019:**<br>• To discuss with the Director of Finance progress on the business cases relating to patient experience data collection. | MR | May 2019 | Completed. Funding agreed to support enhanced provision and roll-out of the 'Friends and Family Test' system. |
| **PM(19)42** | **HEALTH AND CARE STRATEGY: A HEALTHIER MID AND WEST WALES – PROGRAMME PLAN:**<br>• To include information regarding benefits in the SBAR;<br>• To give more focus to the issue of access and transport in the Scoping, Governance and Delivery document;<br>• To be more prescriptive in terms of frequency of reporting to Board;<br>• To give further consideration to how the wider Board is kept engaged. | PK<br>PK<br>PK<br>PK | May 2019<br>May 2019<br>May 2019<br>May 2019 | Completed – Portfolio Scoping, Governance and Delivery document updated to address actions and circulated to Board Members<br>Completed – Dates confirmed for Health & Care Strategy Delivery Group meetings including arrangements for Board updates and key strategic items. |

| MINUTE REFERENCE | ACTION | LEAD | TIMESCALE | PROGRESS |
|---|---|---|---|---|
| **PM(19)43** | **WEST WALES REGIONAL PARTNERSHIP BOARD (RPB) – GOVERNANCE:**<br>• To amend the reference on page 6 of Annexe 1, to '***An executive*** of Hywel Dda University Health Board' to read '***A director*** of Hywel Dda University Health Board'. | SJ | May 2019 | Completed. |
| **PM(19)44** | **DRAFT INTERIM ANNUAL PLAN 2019/20:**<br>• To review the section on page 10 of the Plan, to assess whether this could be framed/worded differently. | KM | May 2019 | Completed. No action taken. |
| **PM(19)55** | **DENTAL PLAN PROGRESS UPDATE:**<br>• To provide a further update including information regarding potential solutions to the challenges detailed. | JP | July 2019 | Forward planned for 25th July 2019 Public Board meeting. |
| **PM(19)58** | **COMMITTEE UPDATE REPORTS: HDdUHB ADVISORY GROUPS:**<br>• To write to Mrs Wendy Evans, ex Partnership Forum co-Chair, to recognise her service and wish her well in retirement. | JH | May 2019 | Completed. |

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

**CYFARFOD BWRDD PRIFYSGOL IECHYD**
**UNIVERSITY HEALTH BOARD MEETING**

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| **DYDDIAD Y CYFARFOD:**<br>**DATE OF MEETING:** | 30 May 2019 |
| **TEITL YR ADRODDIAD:**<br>**TITLE OF REPORT:** | Report of the Chair |
| **CYFARWYDDWR ARWEINIOL:**<br>**LEAD DIRECTOR:** | Mrs Judith Hardisty, Interim Chair |
| **SWYDDOG ADRODD:**<br>**REPORTING OFFICER:** | Joanne Wilson, Board Secretary |

| **Pwrpas yr Adroddiad** (dewiswch fel yn addas)<br>**Purpose of the Report** (select as appropriate) |
|---|
| Ar Gyfer Penderfyniad/For Decision |

**ADRODDIAD SCAA**
**SBAR REPORT**

## Sefyllfa / Situation

To provide an update to the Board on relevant matters undertaken by the Interim Chair of Hywel Dda University Health Board (the UHB) since the previous Board meeting.

## Cefndir / Background

This overarching report highlights the key areas of activity and strategic issues engaged in by the Chair and also details topical areas of interest to the Board.

## Asesiad / Assessment

### Chair's Action

There may 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, supported by the Board Secretary as appropriate, may deal with these matters on behalf of the Board. There has been no such action to report since the previous meeting of the Board.

### Matters Arising since the Board Meeting Held on 28th March, 2019

### Board Seminar

On 11th April 2019, Board Members received a presentation from representatives of the Welsh Health Specialised Services Committee (WHSSC). This reminded members that the role of WHSSC is "On behalf of Health Boards, to ensure equitable access to safe, effective and sustainable specialised services for the people of Wales". The presentation outlined that, of WHSSC's £623m main sources of funding, Hywel Dda's contribution was £71.332m, equating to 11%. Members were also shown the Hywel Dda Specialised Services Activity and Financial Highlights for the four years ending 2018/19, including Specialised Services Activity Map, Activity by Main Providers, Top 5 Specialities by Volume and Top 5 Specialities by Cost. Making reference to the Hywel Dda Clinical Services Engagement and working better together, the presentation highlighted four areas where it was deemed that improvements are required - quality of care, meeting the changing needs of patients, making our resources go further and joining up services.

**In-Committee Board**

The In-Committee meeting consisted of a single agenda item regarding an update on the Annual Plan. It offered an opportunity to discuss the letter recently received from Welsh Government (WG), setting out the UHB's control total for delivery in 2019-20 for a maximum deficit of £25 million, together with outcomes from the Targeted Intervention meeting held on 10th April 2019.

The UHB has committed to embrace Welsh Government's additional challenge and will work through the opportunities available. WG is anticipating further detail of the UHB's plans at the next Targeted Intervention meeting and the Board will also need to discuss proposed plans for achieving the revised control total. A further update on the position is on the agenda for today's meeting. One item was considered under any other business, with a verbal update on discussions at Public Board on 28th March 2019 regarding Orthodontics provided, advising that a report would be submitted to a future In-Committee session of the Quality, Safety & Experience Assurance Committee.

**Board to Board with Public Health Wales**

A Board to Board meeting with Public Health Wales was held on 11th April 2019. After setting the scene, providing an overview of both organisation's strategies and approaches, a workshop was held where the following three key areas were discussed:

- Realignment of resources for wellbeing
- Engagement with the public and partners for wellbeing
- The best workforce for wellbeing

Moving forward, both organisations agreed to continue working closely together to enable transformation and collective action to occur.

**Key Meetings**

On behalf of the UHB, the Interim Chair has met with or attended the following meetings/events since the previous Board meeting:

- Joint Swansea Bay University Health Board / Hywel Dda Regional Working meeting with the Minister
- National Quality Improvement Collaborative Workshop
- West Wales Regional Partnership Board Meeting
- A variety of meetings with AMs and MPs
- Elizabeth Treasure, Vice Chancellor, Aberystwyth University
- Ceredigion Public Services Board
- National Programme Board for Unscheduled Care
- Joint Regional Planning & Development Committee
- Hywel Dda Internal Nursing Conference

**Celebrating Success/Awards**

**Hywel Dda Research Delivery Achievement**

Now in their second year, the Health and Care Research Wales Research Impact Awards took place at Jurys Inn in Cardiff, celebrating the achievements of those working within the support and delivery service. The Hywel Dda team were joint winners of the public award, which acknowledges the valuable research delivery achievements made by teams and individuals to increase opportunities for patients and the public to participate in, and benefit from, safe ethical research, regardless of geographical location.

The team is consistently among the top recruiters for studies in Wales and the UK and, during the awards, Hywel Dda's research teams were recognised for their "dedication" to providing access to clinical trials. The Director of Support and Delivery at Health and Care

Research Wales, Dr Nicola Williams, observed that double the amount of entries had been received this year, making it even more competitive and that they were really impressed by the nominations.

**National Hospital Radio Awards**
Prince Philip Hospital's very own Radio BGM has been recognised recently with a national award for their coverage of the NHS 70th Birthday Celebrations. The hospital radio station, which broadcasts online and internally 24 hours a day, 365 days a year, was presented with a silver award in the category for 'Best Special Event' at this year's national Hospital Radio Awards.

During the event in Stoke-on-Trent, Radio BGM was among some of the best hospital radio stations in the UK to be nominated. The national awards are an annual celebration of the excellent standards found in hospital radio stations across the country. Organised by the Hospital Broadcasting association and open to any member-station, the awards are divided into different categories, each one recognising a specific area of excellence, some to individuals and others to stations. Speaking about Radio BGM's entry the award judges described it as: "just a lovely entry, an uplifting, gentle, warm and well produced piece of radio that we loved".

**Recognition for doctors and dentists training Wales' future NHS workforce**
A Pembrokeshire GP is amongst several doctors and dentists from across Wales to be recognised for their invaluable commitment to educating the next generation of healthcare professionals. Health Education and Improvement Wales (HEIW) has recently awarded five winners, along with three runners up, in the BEST Awards 2018, which took place on 2nd April. The BEST Awards, now in their 11th year, are part of the BMA/BMJ Clinical Teacher of the Year Awards (a collaboration between Cardiff Medical School, Swansea Medical School and Health Education and Improvement Wales) and recognise those doctors and dentists at the forefront of delivering medical and dental education across Wales.

Dr Jennifer Boyce of Argyle Medical Group, Pembroke Dock, was announced as joint winner in the primary care category. As a GP trainer, Dr Boyce has been recognised for demonstrating professionalism and empathy while also bringing enthusiasm to the role of the GP in a rural area. The dedication of medical and dental trainers ensures NHS Wales is equipped to deliver excellent patient care now and in the future.

**Employee or Team of the Month**
Members of staff, patients, service users and the public are invited to nominate those who have gone above and beyond the call of duty and to highlight the excellent work being undertaken across the University Health Board. Since the Board was last updated at its March 2019 meeting, the following employees/teams have received the 'Employee or Team of the Month' award.

| Employee or Team | Reason for Nomination |
|---|---|
| Borth General Practice Surgery | The nomination was made by the Practice Development Nurse from the Quality Improvement Team at Bronglais Hospital. It was made in recognition of the tremendous effort the whole team puts into supporting the people of Borth in relation to health promotion, prevention of ill-health, providing information on external agencies and generally being part of the community. |

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| Coronary Care Unit & Ward 8 Team, Withybush Hospital | Nominated by the Head of Nursing for the way the nursing team throughout the Coronary Care Unit and Ward 8 have developed innovative and creative ways of supporting nursing staff to receive the training and education required to deliver the best care possible to patients. The team have developed a learning culture which covers several topics including cardiac care, recognising and managing deteriorating patients, sepsis, fluid balance and management, all of which are essential in ensuring patient safety. |
| Carol Williams, Health Care Support Worker, Cleddau River Day Unit, South Pembrokeshire Hospital | The nomination came from a nursing colleague for the assistance provided by Carol to her colleagues when ESR was introduced. Staff were required to input annual leave requests and complete mandatory training online, which some members of the team found very difficult. In addition to offering a helping hand to all of her colleagues, she also offered help to all staff on Sunderland Ward. Team work is an essential part of what we all do and Carol is the perfect example of someone who believes in Team Work; she is willing to share her knowledge to the good of others. |
| Claire Lee, Ward Clerk, Sunderland Ward, South Pembrokeshire Hospital | Nominated by a nursing colleague for the way she always goes that extra mile and is an outstanding ward clerk. Despite having her own pressurised workload, Claire is always prepared to support all other staff members. Not only is she the face of Sunderland, being the first point of contact, she is also the heart of the ward. |
| Katie Evans-Bundy Vascular Podiatrist & Mr Blaszcynski, Vascular Surgeon | This nomination was made by a relative in acknowledgment of the care provided to her elderly father. Following a GP referral, the patient was seen by Katie within days and having been assessed, a timely referral was made to the Vascular Surgeon, Mr Blaszcynski. Again, he was seen extremely quickly and Mr Blaszcynski took the time to explain the results of his investigations in a way that the patient could easily understand. This enabled him to make informed choices about the management of his condition and this was appreciated by the family. All in all, the care from all teams has been exemplary. |
| Vicky Hicks, Health Care Support Worker, Enlli Unit, Bronglais Hospital | Nominated by a member of the nursing staff, Vicky demonstrates strong personal and professional values on a daily basis and always helps maintain morale in what can be a very busy office. This nomination in particular however, is more regarding her participation in giving a talk to Sixth Form students about working in Mental Health. The compassion she possessed for the job and the skill she showed in delivering her talk was so clearly conveyed to these Sixth Form students, and |

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| | she represented the team beautifully. |
| Children's Community Nursing Services, Health Board Wide | The nomination came from senior nursing staff who consider that this team consistently and effectively provides both the clinical and emotional support required by parents/carers and their children, often at difficult periods. The team has attained and continue to maintain a high level of professionalism and skill and is adept at dealing with often fraught situations with warmth and compassion. The team's combined knowledge allows them to form and provide safe evidence based good practice, as well as the mentoring, involvement and development of new colleagues to the team. Additionally, they are a valuable resource to their acute service colleagues and are actively involved in the preceptorship of newly qualified paediatric staff nurses. The CCN team, whilst small, is a crucial and vital service whose efforts also have a huge impact in supporting children with complex care needs. |
| Mynydd Mawr Rehabilitation Team & Ty Bryngwyn Specialist Palliative Care Team | The nomination for two multidisciplinary teams working as one was made by the Macmillan Palliative Care Nurse Specialist. Following the closure of the Ty Bryngwyn Specialist Palliative Care Inpatient Unit for refurbishment, Mynydd Mawr made accommodation available for 4 beds for people with complex palliative care needs and the SPC team until the refurbishment was completed. The kindness, respect, collaboration and support between the two teams during a challenging time has been phenomenal. Practical challenges have been solved with novel solutions and patients being cared for by both teams have benefitted from pooled expertise and unwavering flexibility, demonstrating over this period all of the core values of the health board. |
| Nia Sheehan, Health Care Support Worker, North Ceredigion Crisis Resolution & Home Treatment Team | Nia, as a relatively new member of staff, was nominated by the North Ceredigion Team Manager for the way she has become very competent in delivering the Distress Tolerance and Crisis Kit sessions. She has used her own initiative and taken one element of this even further as in her own time, using her own funds, Nia has created crisis kits to give out to patients on the CRHTT caseload. The service users we work with are at their most vulnerable and find it very difficult to engage in therapy at these times. Nia, however, has been able to make this easier by providing something that can give immediate relief and reassurance. Feedback from all service users who have received one of these crisis kits has been very positive, with some even contributing their own ideas that helped them at times of distress. |

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| | Nia has made such an impact on patient engagement and care. |
| Vicki Tompsett, Community Support Worker, Heddfan, Canolfan Gwenog, Glangwili | The nomination came from a CPN in the CMHT team, in recognition of Vicki's outstanding ability and performance as a Community Support Worker. Vicki has shown initiative in complex cases, identifying with the service users, their carers' and the CMHT a recovery approach that clearly manages risk but deals with the long term complexity of their Mental Health needs. She has used her counselling skills to really tease out the underlying problems people find difficult to express to health care professionals and their loved ones and works closely with family members building rapport and a trusting environment. |
| Emma Reynolds, Community Health Care Support Worker, North Carmarthenshire Older Adult Mental Health Team | Nominated by the CMHT Manager, this was for all the work Emma does supporting staff and raising staff morale, especially in this current climate. Whilst our number one priority is always our service users, their cares and communities, we need to ensure we support, encourage and thank our staff. Emma has always been nominated as "team builder" and is the driver in getting the team together for activities and fund raising events. These kinds of events not only raise money for great causes, but really boost a team's spirit, keeping staff focused and positive about the work they do and the effect we can have. |
| Dafydd Pritchard, Physiotherapy Support Worker | Nominated by a CPN from the Carmarthen Learning Disabilities Team, Dafydd has developed the "Get Fit Together" group, supporting people in Carmarthen with basic exercise classes and helping people with a learning disability to be more confident in taking part in exercise. Dafydd has shown dedication to the group and never missed or cancelled a session and continues to show great enthusiasm for the group and encourages people with a learning disability to develop their skills and give them confidence to engage in activities they wouldn't have before. |
| Chris Phelan-Reardon & Rhian Walters, Breastfeeding Coordinators Maternity Services, Dinefwr Ward, Glangwili | This nomination was in recognition of the outstanding work with the breastfeeding clinics and ward support. Both have been seen to go above and beyond to ensure that women have support and good knowledge and are followed up when needed. |

On behalf of the Board, we are always immensely proud of every award winners' commitment and achievements, all of which benefit our patients across Hywel Dda.

**Independent Board Members Update**

- We are continuing to work with Welsh Government to recruit to the substantive post of Chair, a process which should be completed, with a new Chair in post, by the end of May 2019.
- I am pleased to confirm that, following approval by the Minister for Health & Social Services, Mr Owen Burt has been re-appointed as Independent Member (Third Sector) for a period of 2 years until 30th April 2021.
- I am also pleased to confirm that, following approval by the Minister for Health & Social Services, Mr Jonathan Griffiths, Director of Social Services, has been reappointed as an Associate Member of the Board for a period of one year until 31st March 2020.
- Adam Morgan, Independent Member (IM) Trade Union, has been successfully appointed to the post of Senior Negotiating Officer at the Chartered Society of Physiotherapy and will therefore be standing down from his role as Independent Member from 12th July 2019. On behalf of the Board I would like to thank Adam for his significant contribution as the Trade Union IM, bringing both fresh views and thinking to the Board; Adam, we are all going to miss working with you.

**Argymhelliad / Recommendation**

The Board is asked to support the work engaged in by the Chair since the previous meeting and to note the topical areas of interest.

| **Amcanion: (rhaid cwblhau)**<br>**Objectives: (must be completed)** | |
|---|---|
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:<br>Datix Risk Register Reference and Score: | Not Applicable |
| Safon(au) Gofal ac Iechyd:<br>Health and Care Standard(s):<br>Hyperlink to NHS Wales Health & Care Standards | Governance, Leadership and Accountability |
| Amcanion Strategol y BIP:<br>UHB Strategic Objectives:<br>Hyperlink to HDdUHB Strategic Objectives | Not Applicable |
| Amcanion Llesiant BIP:<br>UHB Well-being Objectives:<br>Hyperlink to HDdUHB Well-being Statement | Improve efficiency and quality of services through collaboration with people, communities and partners |

| **Gwybodaeth Ychwanegol:**<br>**Further Information:** | |
|---|---|
| Ar sail tystiolaeth:<br>Evidence Base: | Chairman's Diary & Correspondence |
| Rhestr Termau:<br>Glossary of Terms: | Contained within the report |
| Partïon / Pwyllgorau â ymgynhorwyd | Chairman |

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| ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol:<br>Parties / Committees consulted prior to University Health Board: | |

| **Effaith: (rhaid cwblhau)<br>Impact: (must be completed)** | |
|---|---|
| **Ariannol / Gwerth am Arian:<br>Financial / Service:** | No impact |
| **Ansawdd / Gofal Claf:<br>Quality / Patient Care:** | Ensuring the Board and its Committees makes fully informed decisions is dependent upon the quality and accuracy of the information presented and considered by those making decisions. Informed decisions are more likely to impact favourably on the quality, safety and experience of patients and staff. |
| **Gweithlu:<br>Workforce:** | No impact |
| **Risg:<br>Risk:** | No impact |
| **Cyfreithiol:<br>Legal:** | No impact |
| **Enw Da:<br>Reputational:** | No impact |
| **Gyfrinachedd:<br>Privacy:** | No impact |
| **Cydraddoldeb:<br>Equality:** | No EqIA is considered necessary for a paper of this type. |

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

**CYFARFOD BWRDD PRIFYSGOL IECHYD**
**UNIVERSITY HEALTH BOARD MEETING**

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|---|---|
| **DYDDIAD Y CYFARFOD:**<br>**DATE OF MEETING:** | 30 May 2019 |
| **TEITL YR ADRODDIAD:**<br>**TITLE OF REPORT:** | Chief Executive's Report |
| **CYFARWYDDWR ARWEINIOL:**<br>**LEAD DIRECTOR:** | Steve Moore, Chief Executive |
| **SWYDDOG ADRODD:**<br>**REPORTING OFFICER:** | Sian-Marie James (Head of Corporate Office) and Yvonne Burson (Head of Communications) |

| **Pwrpas yr Adroddiad** (dewiswch fel yn addas)<br>**Purpose of the Report** (select as appropriate) |
|---|
| Ar Gyfer Penderfyniad/For Decision |

**ADRODDIAD SCAA**
**SBAR REPORT**

## Sefyllfa / Situation

The purpose of this Report is to:

- Update the Board on relevant matters undertaken as Chief Executive of Hywel Dda University Health Board (the UHB) since the previous Board meeting held on 28 March 2019; and
- Provide an overview of the current key issues, both at a local and national level, within NHS Wales.

## Cefndir / Background

This Report provides the opportunity to present items to the Board to demonstrate areas of work that are being progressed and achievements that are being made, which may not be subject to prior consideration by a Committee of the Board, or may not be directly reported to the Board through Board reports.

## Asesiad / Assessment

### 1. Register of Sealings

The UHB's Common Seal has been applied to legal documents and a record of the sealing of these documents has been entered into the Register kept for this purpose. The entries at ***Appendix A*** have been signed by the Chair and Chief Executive or the Deputy Chief Executive (in the absence of the Chief Executive) on behalf of the Board (Section 8 of the UHB's Standing Orders refers).

### 2. Consultations

The UHB receives consultation documents from a number of external organisations. It is important that the UHB considers the impact of the proposals contained within these consultations against its own strategic plans, and ensures that an appropriate corporate response is provided to highlight any issues which could potentially impact upon the

organisation. A status report for Consultation Documents received and responded to is detailed at ***Appendix B***, should any Board Member wish to contribute.

## 3. News and what we have heard

We have a continuous conversation with our public through many means, including engagement, patient experience, concerns and through our frontline and support staff. We also try and share our news and respond to enquiries from our population through our social media sites, which are growing at a rapid speed. For example our corporate Facebook site reached a milestone this month in achieving more than 10,000 likes (10,336 followers). Members may be interested to see below a summary of news shared on this channel during the last quarter, which not only gives a snapshot into events and news in our organisation, but also demonstrates the scale of digital reach and more importantly engagement, which is when someone feels motivated enough to share our messages or engage in dialogue, both positive and negative. On writing this report (03 May 2019) the communications team had achieved a 100% response rate to social media direct enquiries within an average time of one hour. Whilst many of those messages are general enquiries, which are then signposted onwards, some can be extremely complex and sensitive and require a helpful and compassionate response and it is pleasing to note that many enquirers respond with thanks when they have received assistance.

Top 10 Facebook Posts viewed between January 2019 – March 2019:

10. Midwife bags -reach 16.2k, engagements 948
9. Out of hours call to arms - 18.2k / 256
8. Walk-in pharmacy video - 19.1k / 342
7. Grow your own launch video - 21.6k / 1k
6. RCN nurse of year - 22.7k / 686
5. Primary care campaign pharmacist video - 24.5k / 561
4. Midwife of the Year - 25.7k / 1.6k
3. Winter A&E call to arms video 29.1k / 943 *partly funded
2. Out of hours call to arms - 29.1k / 943
1. Winter call to arms for families to assist with discharge (image – generic) 44.6k / 1k

Videos are consistently reaching higher audiences and resulting in increased engagement. Our followers are particularly interested in stories which feature innovations in health care, and which champion the success of our staff. Other popular posts included updates on capital development projects and schemes to improve public health (such as Frisky Wales pilot).

Posts which attracted the highest levels of negative engagement and comments in the last quarter were about our workforce difficulties in the GP out-of-hours service and messages about high demand in our emergency departments during periods of high volume of activity. In both instances the public have assisted in spreading these messages to raise awareness about alternative support measures or pathways in place.

## 4. Strategic Issues

The following information is to update and advise Members of recent strategic issues affecting the UHB and NHS Wales:

<u>Cwm Taf Maternity Services Report</u>
Health Boards across Wales have taken the findings of a review by the Royal Colleges into maternity services at Cwm Taf extremely seriously. The report highlighted that the service

provided to many women and families fell below the quality and standards that we would expect from the NHS. Whilst the report is specific to another Health Board area, the Cabinet Minister for Health and Social Services is seeking reassurance that maternity services throughout Wales meet the standards required and we welcome this.

Here in Hywel Dda we have continued to review our quality governance and arrangements to scrutinise the quality and safety of our services in the Women and Children's Directorate, including maternity services. We investigate all incidents in order to learn and adapt and review our staffing levels on a daily basis, and following well established escalation procedures to maintain the safety of our services. During the past two years, we have enhanced the professional expertise of our midwifery teams to include specialist, senior clinical roles including consultant, practice development, and clinical risk midwives.

In addition to quality and safety data and information already considered through our governance arrangements, we have provided an initial letter to the Welsh Government in regards to this report in relation to our own services (see ***Appendix C***). There will be a deep dive into maternity services through our Quality, Safety and Experience Assurance Committee (QSEAC) and we will schedule an additional committee meeting to facilitate this. A Quality and Safety Summit will pull together a range of intelligence for a performance review in the Women and Children's Directorate and this will be part of the Chief Executive Officer performance review within the next couple of weeks. This more thorough response will be provided back to this Board and the Welsh Government. We will consider any opportunities for learning and reflection to further improve our services. The delivery of excellent, safe care to our mums and babies is an absolute priority and we are committed to engaging and listening to the needs of our patients.

Adult Thoracic Surgery for South Wales

Following a meeting of the Welsh Health Specialised Services Committee (WHSCC) on 14th May 2019 the Chair of WHSCC has written to all Health Boards to provide an update on the progress that has been made in relation to adult thoracic surgery services for South Wales. Copies of the correspondence are attached (see ***Appendix D***)

Development of a Major Trauma Unit and Network within Hywel Dda University Health Board (HDdUHB)

A Trauma Network continues to be developed across Wales with a view to being fully operational with effect from April 2020. The Board will recall that Glangwili General Hospital will serve as the interim Trauma Unit until the building of the new Urgent and Planned Care Hospital is completed.

A period of public engagement will be required, which builds on the formal consultation undertaken for Transforming Clinical Services. The University Health Board (UHB) attended a meeting with the Community Health Council on 9th May 2019, to present proposals and commence discussions regarding engagement requirements/timelines. It is understood that an engagement period of approximately 6-8 weeks will be required.

To enable more complex moderate trauma to be concentrated on the interim Glangwili Hospital site, discussions are taking place to improve capacity across the south of the area. Supporting operational policies and clinical pathways are being developed to provide assurance across all the hospitals within the UHB, particularly Bronglais General Hospital given its relative geographical isolation.

Work has commenced on assessing rehabilitation needs to meet the service specification/clinical indicators for rehabilitation within the Wales Trauma Network and a

mapping workshop for rehabilitation was held on 18th April 2019.

The governance framework for the UHB Major Trauma Unit and network is being refreshed to support all the work-streams. This will include the formation of sub groups around the Clinical Service Model, Enabling Infrastructure, Rehabilitation, Patient Flow Modelling & Transfers and Engagement & Equality Impact Assessment.

The Executive Lead for this development is now the Director of Planning, Performance and Commissioning. The Principal Project Manager along with administrative support are currently phasing into post, and are a shared resource with Swansea Bay University Health Board.

Update on Health Board's Targeted Intervention Status

Members of the Executive Team and I meet with the Chief Executive NHS Wales and members of his senior team in Welsh Government (WG), on a regular basis. The last meeting was held on 10 April 2019. At this meeting, the following matters were discussed:

(i) Performance

The meeting was positive in respect of the progress the UHB had made at the end of 2018/19 and the Chief Executive NHS Wales recognised the achievement made by the UHB in achieving its planned zero Referral to Treatment Time (RTT) breaches for patients waiting more than 36 weeks, in Diagnostics and in Therapies; the highest performance for six years.

For Unscheduled Care, WG felt that the UHB was achieving similar performance levels as other NHS bodies across NHS Wales however remained concerned regarding the A&E 12-hour position, which was mainly as a result of performance levels at Withybush General Hospital (WGH). An additional focus on this site had been positive with lessons learned and shared.

WG expressed concern about the dip in the UHB's Cancer performance as its general track record in this area was high. The UHB advised that this was due to a recent shortage in clinical support in the Dermatology Team which has now been addressed.

(ii) Finance and Turnaround

WG recognised that the UHB had slightly improved on its planned end of year deficit position with a final figure of £35.4m, due to an increase in savings in Month 12. This represents an important milestone for the organisation and whilst concern remains regarding the non-recurrent nature of a proportion of delivery, this means that the UHB has reduced its deficit run rate, year on year, for the first time.

On 5 April 2019, WG confirmed that the expected Control Total for 2019/20 had been reduced further to £25m. This will be challenging for the UHB, was discussed at an In Committee Board meeting on 11 April 2019 and will be subject to further discussions at both Board and Committee level.

In addition, WG will commission external support to help provide an assessment and a delivery plan that has a pipeline of opportunities for future years on behalf of the HB. This would aim to identify opportunities to accelerate the timescale for a balanced plan. Terms of Reference are being prepared and will be shared with Board Members.

(iii) Annual Plan 2019/20

The UHB was able to update WG on the planning processes to secure an Interim Annual Plan for 2018/19 by the required deadline. WG are currently reviewing the Draft Interim Plan

(submission approved by Board on 29 March 2019) and will feed comments back to the UHB in due course.

(iv) Transforming Clinical Services Phase 3 Delivery
The timeline and Check and Challenge assurance approach was discussed with WG to provide assurance about the governance of this work going forward. WG acknowledged the additional resource pressures, particularly on Executive Director leads, to deliver this programme.

Health & Care Strategy
The scope, delivery and governance plan for a portfolio of programmes to support delivery of the Health and Care Strategy was approved by Board in March 2019. Since then, the Transformation Programme Office (TPO) has worked with the Executive Team to progress significant work aimed at mapping ongoing work across our Directorates to further define the scopes of the three change programmes:

- Transforming Mental Health and Learning Disabilities
- Transforming our Hospitals
- Transforming our Communities

The outputs of the mapping work will inform the establishment of the programmes, which will be formally launched at an internal and external stakeholder workshop on 14th June 2019. Strategy resources including an animation, summary documents and alternative versions will be made available at the launch workshop, and can be downloaded from www.hywelddahb.wales.nhs.uk/healthiermidandwestwales

The launch of the programmes follow a workshop that was held in May which reviewed the design assumptions that underpinned the new models of care set out in our strategy. Attendance at the workshop included representatives from medical, nursing, therapist and support staff, and demonstrates our commitment to continuous engagement and co-production as we move towards delivery of our strategy. Further communication and engagement plans on each of the change programmes are under development and will include community based events in each of the seven localities on a continuous basis.

The TPO is also progressing work to initially implement and further refine the 'check and challenge' process The Executive Team has agreed for three distinct areas of work to test the check and challenge process in practise. These are:

- *A Healthier Carmarthenshire* programme initiation document
- The Transforming Mental Health and Transforming Learning Disabilities programme
- GP Out-of-Hours

Feedback from the process so far has been positive, and has led to the further refinement of the check and challenge process as a mutually supportive mechanism for delivering the strategy, supporting teams and individuals to develop and evaluate project activity that is truly transformative, evidence-based and aligned with our Board approved frameworks for health and wellbeing, continuous engagement, and quality improvement.

Ongoing work by the TPO also includes equality impact assessment and developing approaches to benefits realisation, evaluation and risk management. Detailed programme implementation plans are under development and will be finalised following the launch of the change programmes. The TPO is also working to establish the integrated enabling group, which will be chaired by the Director of Finance.

There are ongoing discussions with Welsh Government colleagues on the process and timescales for both land procurement and business case development. This relates to plans for our new urgent and planned care hospital and the repurposing of both Glangwili General Hospital and Withybush General Hospital.

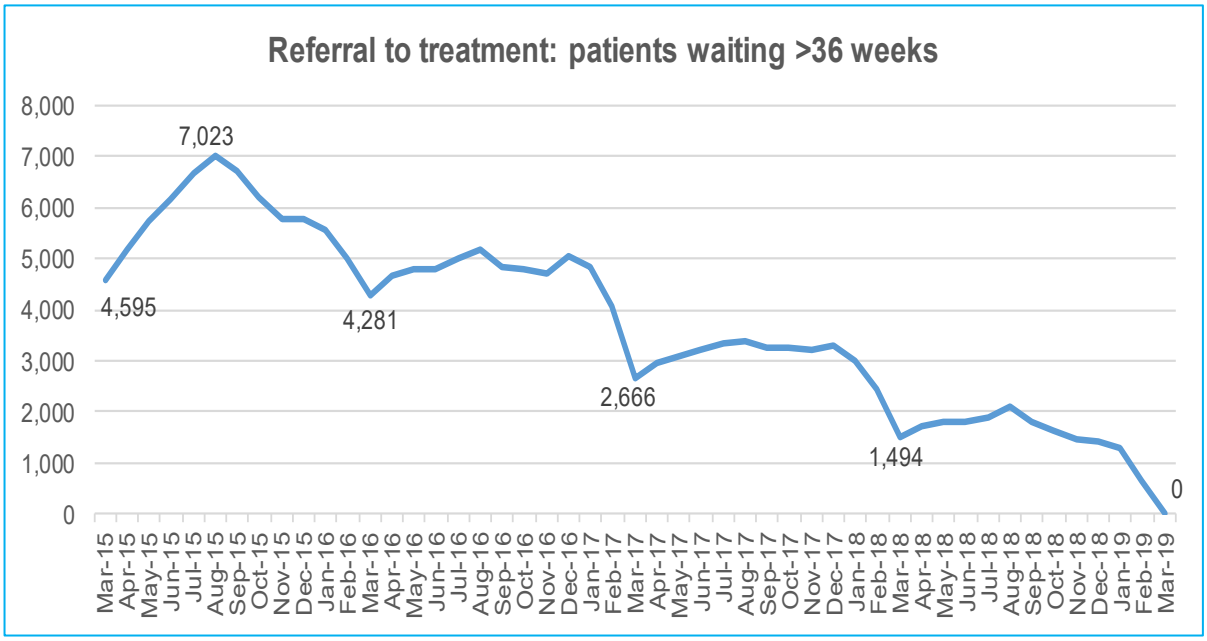
Additional resourcing of circa £2.6m was approved at the March 2019 Health Board meeting. Since then, the TPO has progressed work with the Executive Team to finalise the detail of the core team resource requirements, including the impact of the additional capacity on key delivery areas of our health and care strategy, turnaround programme and fragile services pathway re-design, for discussion with Welsh Government colleagues in June 2019. In the interim, we continue to use the available internal expertise and resource to our best ability to progress delivery with the pace and diligence it requires.

Brexit

Members will be aware that Article 50 has now been extended by six months and the next date where the UK could leave the EU without a deal is the 31 October 2019. If a deal is not agreed between now and September, the established Wales EU Transitional Senior Responsible Officers meetings (which are temporarily stood down) will reconvene to prepare for a possible no-deal scenario. In the meantime the Wales Leadership Group and the Communications Sub-Group will meet monthly and work to explore supply chains continue. The Hywel Dda UHB Brexit Steering Group will continue to meet to provide assurance that we are prepared for the forthcoming exit from the EU. Usual process and partnership working arrangements are in place with Dyfed Powys Local Resilience Forum.

## 5. Operational Issues

I want to take the opportunity to thank our front line operational teams for achieving zero patients waiting more than 36 weeks for treatment (referred to above). This has a positive impact on the timely care of our patients. Below is a graph showing the improvement on this target during the last three and a half years:




Whilst staff across our hospitals in many different roles have contributed to this improvement, I was delighted to meet and thank some of them when I went on a recent visit to Ward 6 at Prince Philip Hospital. I will be issuing a video of thanks on this important and ongoing improvement to reach our wider staff.

**Argymhelliad / Recommendation**

The Board is invited to:

**Register of Sealings: Appendix A**
**Endorse** the Register of Sealings since the previous report on 28 March 2019; and

**Consultation Documents: Appendix B**
**Note** the status report for Consultation Documents received/responded to.

| **Amcanion: (rhaid cwblhau)**<br>**Objectives: (must be completed)** | |
|---|---|
| Cyfeirnod Cofrestr Risg<br>Risk Register Reference: | Not Applicable |
| Safon(au) Gofal ac Iechyd:<br>Health and Care Standard(s): | Governance, Leadership and Accountability<br>All Health & Care Standards Apply |
| Amcanion Strategol y BIP:<br>UHB Strategic Objectives: | 9. To improve the productivity and quality of our services using the principles of prudent health care and the opportunities to innovate and work with partners.<br>10. To deliver, as a minimum requirement, outcome and delivery framework work targets and specifically eliminate the need for unnecessary travel & waiting times, as well as return the organisation to a sound financial footing over the lifetime of this plan |
| Amcanion Llesiant BIP:<br>UHB Well-being Objectives:<br>Hyperlink to HDdUHB Well-being Statement | Improve efficiency and quality of services through collaboration with people, communities and partners<br>Support people to live active, happy and healthy lives |
| | |
| **Gwybodaeth Ychwanegol:**<br>**Further Information:** | |
| Ar sail tystiolaeth:<br>Evidence Base: | Chief Executive's meetings (internal, external and NHS Wales wide), diary and correspondence |
| Rhestr Termau:<br>Glossary of Terms: | Explained in the body of the Report |
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol:<br>Parties / Committees consulted prior to University Health Board: | Not Applicable |

| **Effaith: (rhaid cwblhau)**<br>**Impact: (must be completed)** | |
|---|---|
| **Ariannol / Gwerth am Arian:**<br>**Financial / Service:** | Any financial requirements are identified in Appendices, where appropriate. |

| | |
|---|---|
| **Ansawdd / Gofal Claf:**<br>**Quality / Patient Care:** | Ensuring the Board and its Sub-Committees makes fully informed decisions is dependent on the quality and accuracy of the information presented and considered by those making decisions. Informed decisions are more likely to impact favourably on the quality, safety and experience of patients and staff. |
| **Gweithlu:**<br>**Workforce:** | No specific impact |
| **Risg:**<br>**Risk:** | This report provides evidence of current key issues at both a local and national level which reflect national and local objectives and development of the partnership agenda at national, regional and local levels. Ensuing that the Board is sighted on key areas of its business, and on national strategic priorities and issues, is essential to assurance processes and related risks. |
| **Cyfreithiol:**<br>**Legal:** | Any issues are identified in the Appendices. |
| **Enw Da:**<br>**Reputational:** | Any issues are identified in the Appendices. |
| **Gyfrinachedd:**<br>**Privacy:** | Not Applicable |
| **Cydraddoldeb:**<br>**Equality:** | • Has EqIA screening been undertaken? No<br>• Has a full EqIA been undertaken? No |

**Appendix A: Register of Sealings from 9th March – 10th May 2019**

| Entry Number | Details | Date of Sealing |
|---|---|---|
| 246 | Section 104 Agreement for the adoption of the Foul Sewer Drainage System in the Bath House Road in Cardigan between Hywel Dda University Local Health Board, DCWW & AVIVA Insurance Ltd | 27.03.2019 |
| 247 | Lease of Premises at Prince Philip Hospital, Bryngwyn Mawr, Llanelli; Glangwili General Hospital, Dolgwili Road, Carmarthen; Withybush Hospital, Fishguard Road, Haverfordwest; Bronglais Hospital, Caradoc Road, Aberystwyth; between Hywel Dda University Local Health Board and Welsh Ambulance Services NHS Trust (WAST), relating to Specialist Drugs Cabinets for WAST | 01.05.2019 |
| 248 | Agreement for Proposed Replacement MRI Facilities at Bronglais Hospital, Aberystwyth; between Hywel Dda University Local Health Board and T. Richard Jones (Betws) Ltd (Principal Contractor). | 01.05.2019 |

**Appendix B: Consultations Update Status Report up to 10th May 2019**

| Ref No | Name of Consultation | Consulting Organisation | Consultation Lead | Received On | CLOSING DATE | Response Sent |
|---|---|---|---|---|---|---|
| 378 | Draft additional learning needs code | Welsh Government | Alison Shakeshaft, Natalie Vanderlinden | 12.12.2018 | 22.03.2019 | 19.03.2019 |
| 379 | Pembrokeshire County Council Local Development Plan 2 - Review | Pembrokeshire County Council | Karen Miles, Paul Williams, Rob Elliot | 18.12.2018 | 04.02.2019 | 28.01.2019 - notification sent to PCC |
| 380 | Regulated services (Service providers and responsible individuals) (Wales) amendment regulations 2019 | Welsh Government | Alison Shakeshaft, Lisa Gostling, Mandy Rayani, Will Oliver | 22.11.2018 | 21.12.2018 | 20.12.2018 |
| 381 | Code of practice on the delivery of autism services | Welsh Government | Joe Teape, Liz Carroll, Angela Lodwick, Helen Matthews | 20.12.2018 | 01.03.2019 | 20.02.2019 |
| 382 | Draft Good Practice guidance for the Welsh Public Service on working with adult perpetrators of VAWDASV | Welsh Government | Mandy Rayani, Sian Passey | 03.01.2019 | 15.01.2019 | Response completed by Sian Passey via online survey 08.01.2019 |
| 383 | Shortage occupation list 2018: call for evidence | UK Government | Alison Shakeshaft, Will Oliver | 03.01.2019 | 06.01.2019 | Online response completed by Will Oliver from Therapies and Health Science perspective 04.01.2019 |
| 384 | Draft national violence against women, domestic abuse and sexual violence indicators | Welsh Government | Mandy Rayani, Sian Passey, | 07.01.2019 | 29.03.2019 | 19.03.2019 |

**Appendix B: Consultations Update Status Report up to 10th May 2019**

| Ref No | Name of Consultation | Consulting Organisation | Consultation Lead | Received On | CLOSING DATE | Response Sent |
|---|---|---|---|---|---|---|
| 385 | WHSSC PP177 Burosumab for treating X-linked hypophosphataemia in children and young people | Welsh Health Specialised Services Committee | Dr Phil Kloer, Karen Miles | 07.01.2019 | 04.02.2019 | No response required as this treatment not used in HDdUHB |
| 386 | WHSSC Hyperbaric Oxygen Therapy, Commissioning Policy CP07 | Welsh Health Specialised Services Committee | Dr Phil Kloer, Michael Martin, Jeremy Williams, Carol Llewelyn-Jones | 07.01.2019 | 04.02.2019 | No response required |
| 387 | Healthy Weight: Healthy Wales | Welsh Government | Ros Jervis, Beth Cossins - lead, Michael Thomas, Raymond Davies | 17.01.2019 | 12.04.2019 | 08.04.2019 |
| 388 | Measuring our Nation's progress | Welsh Government | Sarah Jennings-lead, Ros Jervis, Anna Bird | 29.01.2019 | 19.04.2019 | 05.04.2019 |
| 389 | Openness by Design' - our draft access to information | Information Commissioner | Sarah Jennings, Katie Jenner | 28.01.2019 | 08.03.2019 | 08.03.2019 |
| 390 | WHSSC consultation CP93, National Alternative and Augmentative Communication (AAC) Specialised Aids for Welsh residents | Welsh Health Specialised Services Committee | Alison Shakeshaft, Pippa Large | 12.02.2019 | 12.03.2019 | 12.03.2019 |
| 391 | Community and District Nursing Services | National Assembly for Wales | Mandy Rayani, Chris Hayes | 12.02.2019 | 08.03.2019 | 08.03.2019 |

**Appendix B: Consultations Update Status Report up to 10th May 2019**

| Ref No | Name of Consultation | Consulting Organisation | Consultation Lead | Received On | CLOSING DATE | Response Sent |
|---|---|---|---|---|---|---|
| 392 | Future Midwife | Nursing & Midwifery Council | Mandy Rayani | 19.02.2019 | 09.05.2019 | 08.05.2019 – online response completed by Julie Jenkins |
| 393 | WHSSC: Developing WHSSC Policies - Process and Methods | Welsh Health Specialised Services Committee | Alison Shakeshaft, Natalie Vanderlinden | 15.03.2019 | 12.04.2019 | 08.04.2019 |
| 394 | Abolition of Defence of Reasonable Punishments (Wales) Bill | National Assembly for Wales | Mandy Rayani, Mandy Nichols-Davies, Damitha Ratnasinghe | 02.04.2019 | 14.05.2019 | 13.05.2019 Mandy Nichols-Davies completed online response |
| 395 | WHSSC: Radiofrequency Ablation (RFA) for Barrett's Oesophagus in Adults | Welsh Health Specialised Services Committee | Dr Phil Kloer, Mark Henwood (Consultant Surgeon) | 23.04.2019 | 16.05.2019 | 14.05.2019 |
| 396 | Proposal to amend the Government of Wales Act 2006 (Budget Motions and Designated Bodies) Order 2018 | Welsh Government | Huw Thomas | 03.05.2019 | 31.07.2019 | |

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Swyddfeydd Corfforaethol, Adeilad Ystwyth
Hafan Derwen, Parc Dewi Sant, Heol Ffynnon Job
Caerfyrddin, Sir Gaerfyrddin, SA31 3BB

Gofynnwch am/Please ask for: Kelly Sursona
Rhif Ffôn /Telephone: 01267 239569
Dyddiad/Date: 14th May 2019

Corporate Offices, Ystwyth Building
Hafan Derwen, St Davids Park, Job's Well Road,
Carmarthen, Carmarthenshire, SA31 3BB

Dr. Andrew Goodall
Director General Health and Social Services
NHS Wales Chief Executive
Welsh Government
Cathays Park
Cardiff
CF10 3NQ

Dear Dr. Goodall,

Thank you for your letter dated the 30th April 2019 requesting assurances regarding the safety of the maternity services in Hywel Dda University Health Board (UHB) following the Royal College of Obstetricians and Gynaecologists (RCOG) report on the Maternity Services in the former Cwm Taf University Health Board.

I can advise that the Executive Director of Nursing, Quality & Patient Experience has worked with the Senior Management Team within the Women & Children's Directorate to prepare and provide this response. The template which has been completed and is attached, in draft status for your early information, is due to be presented and discussed at the UHB's Quality, Safety and Experience Assurance Committee (QSEAC) on 4th June 2019 and will be further considered at an extraordinary meeting of QSEAC within the July 2019. The outcome of the discussions at both the routine QSEAC and the extraordinary meeting will be shared with the Board at the meeting scheduled to be held on July 25th 2019. I will however be sharing this letter with the Board at the meeting scheduled to be held on May 30th 2019 as part of my Chief Executive Officer's report to Board.

**Current Position**

In August 2014 the UHB underwent a significant reconfiguration of the maternity, neonatal, paediatric and gynaecology services. The UHB was required by the then Health Minister to conduct an independent assessment of the impact of the changes.

The UHB invited the Royal College of Paediatrics and Child Health (RCPCH) in collaboration with four other Royal Colleges to carry out this work in 2015 in order to provide an external assessment of the service changes that had been implemented.

The report identified the UHB had a very dedicated multi-disciplinary team, committed to providing a quality service to women and children in their communities. The findings confirmed that there was no evidence of any worsened outcomes in maternity or paediatric care as a direct result of the reconfiguration and that there was improved compliance with Professional Standards. The report concluded that there was no clinical case for reverting to stand alone hospital provision.

The RCPCH report highlighted that the services provided were of a safe standard. However there were fifty-four recommendations relating to the Directorate which the Board accepted and subsequently agreed an action plan to address, with quarterly monitoring via the UHB's QSEAC. The Monitoring Group was chaired by the Executive Medical Director/Director of Clinical Strategy and included key clinical and managerial staff and partners from the Community Health Council (CHC).

There were five key areas identified within the recommendations and these included:

1. Strategy
2. Governance and Assurance
3. Leadership and Culture
4. Workforce
5. Service User Engagement

## 1. Strategic Planning

The UHB has developed a sustainable strategy for the Maternity Services by prioritising patient safety, patient access and quality of care. The Phase 2 Project, developed to provide a high quality environment for consultant-led maternity care and facilities for neonates, commenced in October 2018.

In conjunction with the UHB's strategy 'A Healthier Mid and West Wales: Our Future Generations Living Well', maternity services are involved in continually reviewing the provision of the service by benchmarking with similar units within Scotland and Europe to explore alternative models of care to ensure patients receive a safe quality service.

## 2. Governance and Assurance

The validity of clinical data and the under-reporting of clinical incidents via the Datix Incident Reporting System were key themes identified in the RCOG Report at the former Cwm Taf University Health Board.

Within the UHB the Maternity Trigger list is an integral part in ensuring that obstetric and midwifery concerns are escalated and investigated as a matter of routine. Data inputted into the reporting systems in the UHB is via the Myrddin IT system and Datix Incident Reporting System. These systems are validated by the Clinical Risk Midwife who compares Birth Register data against the Datix reported incidents on a weekly basis.

All Datix reported incidents are reviewed by the Operational Lead Midwives within each locality and overseen by the Clinical Risk and Governance Midwife and the Obstetric Lead for Risk and Governance. Monthly joint neonatal and maternity meetings are facilitated between the Clinical Risk Midwife and the Lead Nurse for SCBU.

All level 4 and level 5 clinical incidents are automatically escalated to the senior midwifery and Quality Assurance Leads for the UHB to ensure that the formal process is followed.

The Maternity Clinical Risk Multi-disciplinary Forum promotes engagement from Obstetrics, Neonatologists, Anaesthetists and Maternity staff and enables constructive analysis and review of all untoward clinical incidents. Lessons learnt are shared with the multi-disciplinary team via the Maternity Risk Newsletter, Perinatal Mortality Meetings, UHB forums and multi-disciplinary Learning Events. The appointment of 1.0WTE Diabetic Specialist Midwifery Role was established as a result of one such incident review. Whilst there is no evidence to indicate that there is a blame culture or a culture of under-reporting of clinical incidents using the Datix system within the Maternity service, this is an area that is kept under constant review across the entirety of the UHB.

The Women and Children's Directorate has established a significant governance framework inclusive of a monthly Quality and Safety meeting, Labour Ward Forum and Staff Forums. Monthly Maternity and Neonatal Clinical Dashboards, Datix Incident Overview are presented and discussed in the monthly Directorate Quality and Safety Meeting and these highlight any actions or audits required to ensure service improvements.

There is a Directorate Risk Register which is updated and reviewed on a monthly basis to ensure that appropriate actions are in place to mitigate any risks to the quality and safety of the service. There is a process whereby high level risks are escalated onto the Corporate Risk Register and monitored by this group to ensure evidence of improvement. The Corporate Risk Register is monitored via the Board and the relevant Committee.

Key risks identified on the Women and Children's Directorate operational Risk Registers are as follows:

- An increased demand on radiology services to adhere to GAP/GROW Guideline.
- The review of community-based Consultant-led Antenatal Clinic provision within Pembrokeshire.
- All Wales Neonatal retrieval (CHANTS) is not a 24 hour service in South Wales which is of significance for the UHB with level 1 SCBU facilities at Glangwili General Hospital (GGH) and the support required for the neonatal stabilisation unit at Bronglais General Hospital (BGH).
- Maintenance of midwifery staffing levels in line with the Birth Rate Plus Workforce Tool.
- Anaesthetic consultant staffing levels to support full compliance with RCOA standards regarding consultant sessions dedicated to Labour Ward training and development activities.

The Directorate has an established Obstetric and Audit Guideline Group represented by the multi-disciplinary team. Currently all Obstetric Guidelines are on the UHB Intranet and updated guidelines are shared via the Labour Ward Forum and Maternity Clinical risk Newsletter. A schedule is in place to ensure that all guidelines are reviewed and updated by December 2019.

The Wales Audit Office Review of maternity services undertaken in 2018 reflected the positive service improvements that had been actioned since the previous report in 2011. However service improvement is on-going to address the UHB caesarean section rate of 30% for 2018 which is above the Welsh Government target of 26% and there is evidence of improvement in this position to date for 2019.

**Key Areas for Improvement:**

- Appointment of a Clinical Director for the Women and Children's Services
- Clarify lead accountability for Audit within the Clinical Team
- Ensure prospective audit and analyse themes and trends for all caesarean sections
- Complete the process of updating Obstetric Guidelines and make available on the UHB's Intranet site.
- Exploration of opportunities to further enhance Anaesthetic consultant staffing levels

## 3. Leadership

There is a clear Directorate management structure which has been strengthened in the last two years with the appointment of key leadership roles to promote a safety culture with responsibilities highlighted within their current job plans and supported by the Executive Medical Director. This includes:

- A named Clinical Lead for Obstetrics and Gynaecology.
- A named Clinical Lead for Paediatrics.
- Consultant Midwife to enhance the leadership role for promoting normality of birth across the Health Board.
- Deputy Head of Midwifery.
- Three Operational Lead Midwives to develop Community and MLU services, GGH and BGH.
- Consultant Midwife.
- Clinical Risk and Governance Midwife.
- Obstetric Lead for Clinical Risk and Governance.
- Obstetric Labour Ward lead.
- Obstetric Lead for education and Training.
- Practice Development Midwives.
- Diabetic Specialist Midwives.
- Two Clinical Supervisors for Midwives in line with the All Wales restructured process for midwifery supervision.

The Deanery Review conducted in 2016 highlighted that improvements were required in respect of clinical leadership and support for junior staff members. Following internal UHB initiatives a review undertaken by the Deanery in 2018 confirmed positive improvement with evidence of leadership and clinical support in practice. Midwives are encouraged to be involved in the annual Royal College of Midwives Leadership programme.

**Key Areas for Improvement:**

- Continue to promote clinical and midwifery leadership development.

## 4. Workforce

With respect to the UHB's Birth Rate Plus compliance there are currently 160.9 WTE midwives in post. Birth Rate Plus advocates 171WTE midwives. The Directorate actively seeks to recruit into the vacancies and the UHB is part of the South Wales Midwifery Recruitment Programme whereby all Health Boards interview all student midwives graduating in South Wales each September. The vacancy position at the end of April 2019 identifies the following breakdown across the three counties: 3.14WTE vacancies at GGH, 3.0WTE vacancies in the community and 6.52WTE vacancies for specialist roles. As advocated by Birth Rate Plus our plan is to convert the 3.0WTE vacancies in the community into band 3 Maternity Care Support Workers to achieve the 90/10 skill mix.

Midwifery bank is used and weekly reviews of midwifery staff rosters has identified that staff do not work outside European Working Time Directive recommendations. There are clear escalation processes in place during periods of high activity and sickness.

The RCPCH Report in 2015 recommended that the Obstetric and Gynaecology out of hours Consultant rota at Withybush should be phased out in order to integrate and strengthen the Obstetric and Gynaecological consultant team at GGH. Following an extensive period of informal consultation with the multi-disciplinary clinical team a detailed proposal has been developed to facilitate the integration of the 'out of hours' cover at GGH. A formal consultation process has been commenced from 27th March 2019 with a target implementation date of September 2019.

Locum agency medical staff usage is low within the Directorate. There are currently 2WTE SAS doctor vacancies at BGH. There are challenges to recruiting to a small rural obstetric unit which is compounded by a recognised national shortage for doctors at this level. These vacancies are currently covered by NHS locums with minimal ad hoc agency usage. The Directorate is currently exploring alternative medical models of care for BGH.

There is a structured corporate induction programme for midwifery and clinical staff with specific induction programme for the Maternity Department.

**Key Areas for Improvement:**

- Formalised Induction Information documentation to be developed for short notice locum agency medical staff.
- To continue to explore initiatives for recruitment of midwifery and medical staff.

## 5. Service User Engagement

The Maternity Department received two CHC visits in 2018 with positive feedback noted. There has been active engagement with service users during the Phase 2 development of a new Labour Ward and Neonatal facility.

All patients using the Maternity Service are invited to complete a 'Did We Deliver' survey and the patient satisfaction survey in the Postnatal Record following birth which is reviewed by Operational Leads and the ward manager. Any themes or trends are fed back to staff via Ward area meetings and generically through the Maternity Risk Newsletter in order to improve the quality of the services and patient experience.

Patient stories are encouraged through social media platforms, Homebirth Forum and the UHB Birth Choices Clinic led by the Consultant Midwife. This has resulted in a birth partner's rest room being established to facilitate overnight stay at GGH, The Maternity Services Liaison Committee Bereavement Group has also been instrumental in refurbishing the Bereavement Room in 2019.

The Consultant Midwives' Survey in 2018 explored women's experiences of pregnancy and birth across Wales and noted that social media was a powerful tool to capture a wide variety of responses. There is a closed Facebook group for service users to feedback their experiences. This is used and responded to in 'real time'.

**Key Areas for Improvement:**

- Review engagement opportunities with service users.

I hope that this information is helpful and provides assurance that there are adequate arrangements in place for scrutiny and monitoring of clinical outcomes, escalation and risk management within the maternity services provided by the UHB. Please do not hesitate to contact me if you require any additional information.

Yours sincerely,

Steve Moore
Chief Executive Officer

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

# Hywel Dda University Health Board Assurance Framework: Response to the RCOG Independent Review of Maternity Services at Cwm Taf Health Board

**Health Board:** Hywel Dda University Health Board

**Date of Completion**:

| Terms of Reference from the RCOG Review | Recommendations | Current Position (May 2019)<br><br>Assurance Evidence | Areas for Targeted Intervention or Improvement | RAG Rating<br>• Green – Compliance<br>• Amber – Improvements required<br>• Red – Immediate action |
|---|---|---|---|---|
| **1. To review the current provision of care within maternity services in relation to national standards and indicators, as well as national reporting.** | 7.1 Urgently review the systems in place for:<br>• Data collection.<br>• Clinical validation.<br>• Checking the accuracy of data used to monitor clinical practice and outcomes.<br>• What information is supplied to national adults. | **Data collection by:**<br>• Data inputted by clinicians onto the Myrddin Maternity IT system.<br>• Datix reporting system: This is a system validated by the Band 8a Clinical Risk Midwife who compares the birth register against Datix reported incidents with the Maternity Trigger List on a weekly basis. There is no evidence of non-reporting of incidents using the Datix system.<br>• Maternity Acuity Scorecard: This is a NPSA tool used by the Midwifery Co-ordinator on a four hourly basis to record activity across all maternity sites.<br>• Weekly Birth Register Review: This is reviewed by the Band 8a Clinical Risk Midwife along with a named Consultant Obstetrician and Clinical Supervisor of Midwives to ensure accuracy of data recorded and correct classification of Datix reported and that service improvements are actioned accordingly in a timely manner.<br>• Surgical Site Infection Rates (SSI): This is an All Wales report to highlight the trend of infections over time and for individual Health Boards to have the opportunity to monitor their own trends.<br><br>**Clinical Validation:**<br>• Appointment of the Band 8a Midwife for Clinical Risk and Governance to facilitate and cross-reference inputted data to ensure accuracy and timely identification of themes and trends.<br>• Maternity Dashboard: This is completed manually from the Birth Register on a monthly basis and presented to the Directorate Quality, Safety and Assurance Committee.<br>• Weekly Birth Register: This is reviewed by the Band 8a Clinical Risk Midwife along with a named Consultant Obstetrician and Clinical Supervisor of Midwives to ensure classification of Datix reported is correct and that service improvements are actioned accordingly in a timely manner.<br>The Community Health Database Team validates all birth numbers on a monthly basis by cross referencing Myrddin and the Birth register data. | | |

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| | | • Monthly joint neonatal and maternity validation reviews are facilitated between the Band 8a Clinical Risk Midwife and Lead Nurse for SCBU to review all admissions.<br>• Weekly dataset/dashboard from Myrddin IT system is forwarded to senior midwifery managers from the Information Manager to check the accuracy of the overall clinical data eview all clinical activity.<br>• SSI rates are co-ordinated manually by two senior midwives.<br><br>**Accuracy of Data:**<br>The following are scrutinised for accuracy of data in the weekly Senior Midwifery Management Meeting and monthly Directorate Quality, Safety Assurance Committee:<br>• Datix Incident Reporting/Corporate SI reporting processes<br>• Maternity Dashboard<br>• MBRRACE<br>• Each Baby Counts<br>• NMPA<br><br>**Information Supplied to National Audits:**<br>The following audits enable the Health Board to provide assurance by benchmarking performance against other Health Boards/Trusts throughout the UK:<br>• MBRRACE (is an established national standardised Perinatal Mortality Review Tool in order to report late miscarriages from 22 weeks of pregnancy and stillbirths from 24 weeks of pregnancy). This is completed jointly by the Band 7 Midwife and the Clinical Risk Midwife.<br>• Each Baby Counts (a national quality improvement programme led by the Royal College of Obstetricians and Gynaecologists (RCOG) to reduce the number of babies who die or are left severely disabled as a result of incidents occurring during term labour). This programme requires all stillbirths from 37 weeks of pregnancy occurring during labour, any neonatal death in the first 7 days of life and any babies born from 37 weeks of pregnancy requiring active cooling. This data is submitted by a Band 7 midwife overseen by the Clinical Risk Midwife.<br>• NMPA (data submission which is a large scale audit of the NHS maternity services across England, Scotland and Wales). This includes data such as normal birth rates, caesarean section rates and Public Health variables.<br>• All Wales Surgical Site Infection data collection (SSI. mandatory for all Health Boards in Wales to undertake surgical site infection surveillance of patients who have had a caesarean section).<br>• Public Health Wales Flu and Pertussis point of care audits. | | |

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| | | • Antenatal Screening Wales (ASW) Standards (benchmarking compliance with antenatal screening). | | |
| | 7.2 Identify nominated individuals (Consultant Obstetric lead and senior midwife) to ensure that all maternity unit guidelines:<br>• Are up to date and regularly reviewed.<br>• Are readily available to all staff, including locum staff and midwifery staff.<br>• Have a multi-disciplinary approach.<br>• Are adhered to in practice. | **Are up to date and regularly reviewed:**<br>• This meeting is held monthly.<br><br>**Have a multi-disciplinary approach:**<br>• There is a nominated Lead Obstetrician and a Lead Midwife for the Obstetric Guideline Group. The membership is multi-disciplinary and includes Midwives, Anaesthetists, Pharmacy and Paediatricians within the Health Board.<br>• We are in the process of updating all our Obstetric and Midwifery Guidelines into the Health Board format and to be accessible on the Health Board Intranet by 2019.<br><br>**Are readily available to all staff including locum staff and midwifery staff:**<br>• All up to date guidelines are on the Health Boards Intranet site and all policies are approved via the Health Boards process of ratification via Quality and Safety forum.<br>• All updated polices are shared via the Maternity Clinical Risk Newsletter and the Health Board Labour Ward Forum which is distributed monthly.<br>• There are hard copies of all guidelines in all clinical areas.<br><br>**Are adhered to in practice:**<br>• Compliance is identified using auditable standards during case note reviews and incident reporting mechanisms.<br>http://howis.wales.nhs.uk/sitesplus/862/page/43173#O | • To ensure all Obstetric Guidelines are reviewed and updated and available on the Intranet by December 2019.<br>• Ensure a robust process for dissemination to all staff of any guideline updates on the intranet.<br>• To initiate formal regular audit review of all Obstetric guidelines. | |
| | 7.3 Mandate and support a full programme of clinically-led audit with a nominated Consultant lead to measure performance and outcomes against guidelines. | **Mandate a programme of clinically led audit with a nominated consultant:**<br>• The Maternity Department process to support and mandate any clinical audits is authorised by the Obstetric Guideline and Audit group. This is to ensure that appropriate audits are conducted in line with the Health Board's Quality and Improvement plan.<br>• Auditable Standards are formatted for all guidelines. Currently audits are performed on an informal basis but require a more formal structure to ensure that these occur regularly and that any learning is circulated across the Health Board. | • A Clinical Lead for Performance and Audit is to be nominated to ensure annual appropriate allocation for the mandatory Clinical Audit Programme. | |
| | 7.4 Ensure that monitoring of clinical practice of all staff is undertaken by the Clinical Director and Head of Midwifery:<br>• To ensure compliance with guidelines.<br>• To ensure competency and consistency of performance is included in annual appraisal. | **To ensure compliance with guidelines:**<br>The Health Board does not have a Directorate Clinical Director however there is an Obstetric Clinical Lead.<br>• The Clinical Risk Midwife in conjunction with the nominated Consultant Obstetrician for Governance and Risk routinely review all clinical records reported | • The Directorate needs to consider the appointment of a Clinical Director as advocated within the Report. | |

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| | | on Datix and benchmark compliance with Health Board Guidelines.<br>• The Clinical Supervisor of Midwives undertakes audits to ensure compliance with standards and guidelines. This includes a review that all guidelines used are included in the maternal notes.<br>• The Senior Midwifery Co-ordinator reviews all CTGs during labour every two hours to ensure that standards are met.<br>• All CTGS in labour undergo hourly 'fresh eyes' review to ensure compliance.<br>• This issue has been added to the Directorate Risk Register until full compliance is achieved.<br><br>**To ensure competency and consistency of performance is included in annual appraisal:**<br>• PADR completed annually with all clinical midwives and any practice issues identified during clinical reviews by the Clinical Risk Midwife are addressed immediately and all learning facilitated with the support of the Clinical Supervisor of Midwives. The Clinical Supervisor of Midwives (CSfMs) maintains a database to review any themes and trends highlighting individual members of staff which are then actioned accordingly.<br>• The Health Board is fully compliant with CSfM ratio of 1.60WTE as stipulated by the Welsh Government.<br>• Annual Medical Appraisal is undertaken using the All Wales Medical Appraisal and Revalidation system (MARS) which is aligned to the General Medical Council revalidation requirements. These requirements are underpinned by the need for reflection, incorporating a range of Continuing Professional Development and Quality Improvement Activities (including audit), in addition to the discussion of significant events, compliments and complaints and patient and colleague feedback.<br>• As part of the appraisal process areas for improvement and development are identified, previous learning objectives are reviewed for completion and objectives set for the forthcoming year in the form of a personal development plan.<br>• Doctors are able to access information relating to performance from a number of sources including the Datix department, Information Reporting Intelligence System, the Audit department and the Revalidation Department and this information can be fed into appraisal and job planning to help inform development.<br>• As part of revalidation requirements, any fitness to practise issues are monitored and reported to the Responsible Officer as part of the monthly Responsible Officer Advisory Group meetings. These meetings bring together key individuals including the Responsible Officer, AMD for Professional Standards, AMD for Workforce and Primary Care, Assistant Director for Workforce, | | |

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| | | Assurance and Safety Lead and National Clinical Assessment Service representative. The meetings provide a forum for discussion and help to put plans in place to address any issues identified and help inform revalidation decisions.<br>• As of the 1st April 2019, 100% of Obstetric & Gynaecology staff had an up to date appraisal. | | |
| | 7.5 Agree a CTG training programme that includes a competency assessment, which is delivered to all staff involved in the care of pregnant women, both in the antenatal period and intrapartum. | A**gree a CTG training programme:**<br>The Health Board has implemented the All Wales Intrapartum Fetal Surveillance Standards which does not include an All Wales Competency Assessment Tool. Whilst the Health Board has adopted these standards it acknowledges that there is no All Wales Competency Assessment in the All Wales Standards and an assessment tool is in the process of being developed.<br>• Since April 2019 the Health Board has implemented the All Wales Intrapartum Fetal Surveillance Standards launched in March 2019. Prior to this all midwives and obstetricians undertook the RCOG CTG Learning Package. 85% of midwives and 100% of Obstetricians were complaint. Sickness and maternity leave affected the overall rate for midwives.<br>• In conjunction with the RCOG Standards the Health Board mandated all staff to attend an externally delivered expert CTG Master Class Workshop.<br>• A weekly review of CTG cases is undertaken by the Labour Obstetric Lead.<br>• Intrapartum CTG Stickers in line with the All Wales Intrapartum Fetal Surveillance Standards are used to ensure consistency and competency.<br>• Practice Development Midwives populate a database to ensure attendance at all Mandatory training which includes CTG classification and attendance at the CTG Masterclass.<br>• The Health Board has formatted a training portfolio for all midwives outlining expectation regarding CTG training on an annual basis.<br>• Please refer to 7.4 | • The need to develop a local competency assessment framework to ensure standards are met to the All Wales Standards.<br>• The need for a more robust process for capturing compliance of attendance at the weekly CTG case reviews. | |
| | 7.6 Obstetrician & Gynaecologist Consultant staff must deliver:<br>• A standard induction programme for all new junior medical staff.<br>• A standard induction programme for all locum doctors. | **A standard induction programme for all new junior medical staff:**<br>• There is a corporate induction programme for all new junior staff.<br>• There is a Departmental induction programme for all new junior staff.<br>• Medical Education manages the core induction programme for new Training Post doctors. The monitor Departmental Induction for Training Post doctors.<br><br>**A standard induction programme for all locum doctors:**<br>• There is an induction programme in place for NHS locum medical staff. | • Department Induction processes are being reviewed to ensure appropriate and consistent Induction arrangements for short-term agency staff when booked at short notice (for emergency cover reasons). | |

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| | 7.7 Ensure an environment of privacy and dignity of care for women undergoing abortion or miscarriage in line with agreed national standards of care. | **Ensure an environment of privacy and dignity of care for women under-going abortion or miscarriage:**<br>• There is a dedicated environment that ensures privacy and dignity for all mothers and their families who are under-going a miscarriage or termination of pregnancy at GGH.<br>• There are designated areas that ensure privacy and dignity for women and their families who are undergoing miscarriage or termination of pregnancy at BGH and WGH sites.<br>• Any examples of non-adherence to this standard is highlighted in the Gynaecology Datix reporting criteria.<br>• The Health Board facilitates medication managed termination of pregnancy at home to facilitate patient choice on chosen method of termination of pregnancy and miscarriage.<br>• Staff delivering care for these women undergo mandatory training and annual updating. | | |
| **2. Assess the prevalence and effectiveness of a patient safety culture within Maternity services including:**<br>• **The understanding of staff of their roles and responsibilities for delivery of that culture.**<br>• **Identifying any concerns that may prevent staff raising patient safety concerns within the Health Board.**<br>• **Assessing that services are well led and the culture supports learning and improvement following incidents.** | 7.8 Ensure external expert facilitation to allow a full review of working practice to ensure:<br>• Patient safety is considered at all stages of service delivery.<br>• A full review of roles and responsibilities within the obstetric team.<br>• The development and implementation of guidelines.<br>• An appropriately trained and supported system for clinical leadership.<br>• A long-term plan and strategy for the service.<br>• There is a programme of cultural development to allow true multi-disciplinary working. | **The understanding of staff of their roles and responsibilities for delivery of that culture:**<br>Patient safety was considered at all stages in the reconfiguration of the Maternity services in 2014. In order to ensure standardised practice throughout the Health Board a strong multi-disciplinary cohort was developed to include:<br>• Standardised Handover documentation that has been in place since 2017.<br>• A formalised documented multi-disciplinary handover by the on-call Consultant Obstetrician that occurs every morning to promote a culture of patient safety and defines roles and responsibilities. (Multi-disciplinary is defined as the attendance of midwives, Obstetricians, Anaesthetists and SCBU staff)<br>• In 2016 Band 8a Operational Lead Midwives were appointed to promote visible leadership, patient safety and ensure the quality of patient experience.<br>• Obstetric Labour Ward Lead was appointed to ensure a safe service and adherence to guidelines.<br>• Obstetric Anaesthetic Lead was appointed to ensure a safe service and adherence to guidelines.<br>• Appointment of a Consultant Midwife in December 2017 to promote leadership and the normality of birth across the Health Board.<br>• Supernumerary Band 7 Midwifery Co-ordinators were established in 2016 to ensure patient safety.<br>• Designated Ward Managers for the Labour Ward, Antenatal Ward, Postnatal Ward, alongside MLU, free-standing MLU to ensure patient safety.<br>• The appointment of Practice Development Midwives to clarify roles and responsibilities through multi-disciplinary training in 2017.<br>• The commencement of PROMPT multi-disciplinary training in 2019. | • To ensure all Obstetric Guidelines are reviewed and updated and available on the Intranet by December 2019.<br>• Ensure robust process for dissemination to all staff of any guideline updates on the intranet.<br>• To develop a local competency framework to ensure that All Wales Standards. | |

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| | | • The appointment of Clinical Supervisors for Midwives to ensure patient safety through support and clinical reflection in 2017.<br>• Following the RCPCH (the Royal College of Paediatrics and Child Health) review the Directorate undertook a 'Supporting Positive Staff Experience Project' in 2017 which demonstrated that the majority of staff had positively adapted to reconfiguration.<br><br>**Identifying any concerns that may prevent staff raising patient safety concerns within the Health Board:**<br>• Appointment of a Band 8a Midwife for Clinical Risk and Governance to ensure that concerns are raised and escalated and validate data.<br>• Named Consultant Obstetrician for Clinical Risk and Governance appointed.<br>• Supernumerary Band 7 Midwifery Co-ordinators were put in place to identify clinical and professional concerns.<br>• Designated Ward Managers for the Labour Ward, Antenatal Ward, Postnatal Ward, alongside MLU, free-standing MLU to identify clinical and professional concerns.<br><br>**Assessing that services are well led and the culture supports learning and improvement following incidents:**<br>• Defined Directorate Management structure following service reconfiguration in 2014.<br>• The Directorate is part of 'A Healthier Mid and West Wales Strategy'.<br>• The development of a robust framework for the Obstetric and Audit Guideline Meeting.<br>• Appointment of a Band 8a Midwife for Clinical Risk and Governance to ensure that learning points are identified and lessons are learned and disseminated across the Health Board.<br>• Named Consultant Obstetrician for Clinical Risk and Governance appointed.<br>• The establishment of a Maternity Clinical Risk Committee to discuss incidents and agree recommendations and action-plans.<br>• Circulation of the Maternity Risk Newsletter to support a learning culture.<br>• The establishment of Learning Events following serious incidents to promote learning and recommendations for improvements. | | |
| | 7.9 Develop a trigger list for situations which require consultant presence on the labour ward which must be:<br>• Agreed by all Consultants in Obstetrics, Paediatrics and Anaesthetics and Senior Midwives.<br>• Audited and reported on the maternity dashboard. | **Develop a trigger list for the Consultant present on labour ward:**<br>• A review of Datix and Serious Incidents has not revealed issues with Consultant Obstetrician attendance on Labour Ward when there is a serious clinical incident. However the recommendation for a | • Develop formalised Criteria for Consultant attendance for the Health Board in line with RCOG Standards (2016) 8.6.6 | |

# Hywel Dda University Health Board Assurance Framework:
# Response to the RCOG Independent Review of Maternity Services at Cwm Taf Health Board

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| | | formal trigger list for consultant attendance is recognised.<br>• All emergency caesarean sections/emergency situations 'out of hours' are discussed with the Consultant Obstetrician.<br>• The Health Board Maternity Scorecard is completed by the Band 7 Co-ordinator every 4 hours and records Consultant Obstetrician availability.<br>• There is a 'hot week' Consultant Obstetrician present on Labour Ward Monday to Friday between the hours of 09.00hrs – 17.00hrs | | |
| | 7.10 Introduce regular Risk Management meetings which must be:<br>• Open to all staff.<br>• Conducted in an open and transparent way.<br>• Held at a time and place to allow for maximum attendance. | **Regular Risk Meetings:**<br>• Monthly MDT Clinical Risk meetings are held within the Directorate with representation from across the Health Board.<br>• The Maternity Training Portfolio recommends staff attendance at these meetings.<br>• Terms of reference is formatted for this forum.<br>• Medical and midwifery trainees and staff are encouraged to attend these meetings. | | |
| | 7.11 Ensure mandatory attendance at the following meetings for all appropriate staff. Attendance must be recorded and included in staff appraisals. Ensure that meetings are scheduled or elective clinical activity modified to allow attendance at:<br>• Governance meetings.<br>• Audit meetings.<br>• Perinatal Mortality meetings. | **Ensure mandatory attendance at: Governance meetings, Audit meetings, Perinatal mortality meetings**:<br>• Directorate Quality and Safety Meeting held monthly with VC facilities for staff located across the Health Board.<br>• This has been included in the Midwifery Training Portfolio.<br>• A register is kept of attendance at all meetings.<br>• The process of revalidation is used to confirm attendance. | • Currently this is not formally incorporated into medical appraisals however individuals would be expected to record and reflect for their individual appraisal. | |
| | 7.12 Undertake multidisciplinary debriefing sessions facilitated by senior maternity staff after an unexpected outcome. | **Undertake multi-disciplinary debriefing sessions:**<br>• Debrief sessions are facilitated in a MDT approach following any clinical incident. This is facilitated by the Deputy Head of Midwifery in conjunction with the Clinical Risk Midwife and Consultant Obstetrician. Theatre staff, Paediatricians, Anaesthetist are invited as necessary to these debrief sessions.<br>• There is evidence of clear transparent debriefing sessions when cross boundary learning has been identified following incident review. | | |
| | 7.13 Identify a Clinical Lead for Governance from within the consultant body. This individual must:<br>• Be accountable for good governance.<br>• Attend governance meetings to ensure leadership and engagement. | **Identify a clinical lead for governance from within the consultant body:**<br>• The Health Board has a dedicated Consultant Obstetrician responsible for governance who works in partnership with the 8a Clinical Risk Midwife. | | |
| | 7.14 Consultant meetings should:<br>• Be regular in frequency.<br>• Have a standing agenda item on governance.<br>• Be joint meetings with anaesthetic and paediatric colleagues. | **Consultant meetings should be:**<br>• MDT Consultant Obstetrics and Gynaecology meeting is held monthly.<br>• Joint monthly Labour Ward meeting held with Paediatricians and Anaesthetists. | | |

# Hywel Dda University Health Board Assurance Framework:
# Response to the RCOG Independent Review of Maternity Services at Cwm Taf Health Board

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| | 7.15 Educate all staff on the accountability and importance of Risk Management, Datix reporting and review and escalating concerns in a timely manner. Include this at:<br>• Junior doctor induction.<br>• Locum staff induction.<br>• Midwifery staff induction.<br>• Annual mandatory training. | **Staff education regarding risk management, Datix reporting and escalation:**<br>• All Midwifery staff are provided with Datix training on commencement to the Health Board.<br>• All staff attend Mandatory and Statutory training on an annual basis and are reminded of the governance processes surrounding Maternity trigger list and appropriate mechanism via Datix.<br>• Datix incident reporting is discussed in MDT PROMPT and mandatory training.<br>• The Maternity Trigger List is disseminated across the Health Board and reviewed quarterly to identify any triggers that need to be captured. | • To be included formally in the locum medical staff induction. | |
| | 7.16 Urgent steps must be taken to ensure that Consultant Obstetricians are immediately available when on call (maximum 30 minutes from call to being present). | **Consultant availability on Labour Ward:**<br>• All Consultant Obstetricians with an on-call commitment are resident within a 30 minute radius. | | |
| | 7.17 Ensure training is provided for all SAS staff to ensure that they are:<br>• Up to date with clinical competencies.<br>• Skilled in covering high-risk antenatal clinics and outpatient sessions. | **Up to date with clinical competencies:**<br>• There is weekly dedicated and protected teaching session which is reflected in individual job plans.<br>• All SAS staff attend PROMPT.<br>• Attendance is monitored.<br><br>**Skilled in covering high-risk antenatal clinics and outpatient sessions:**<br>• All antenatal and outpatient clinics are delivered under the supervision of a Consultant Obstetrician/ Gynaecologist. | | |
| | 7.18 Agree cohesive methods of consultant working after the merger with input from anaesthetic and paediatric colleagues. | Following the reconfiguration of the maternity services in 2014 and a follow-up review by the RCPCH in 2015 it was recommended to:<br>• Phase out obstetric and gynaecology 'out of hours' consultant hours at WGH, integrating and strengthening the Obstetric and Gynaecology Team at GGH.<br>• Following an extensive period of informal consultation with the multi-disciplinary clinical team a detailed proposal has been developed to facilitate the integration of the 'out of hours' cover at GGH. A formal consultation process has been commenced from 27th March 2019 with a target implementation date of September 2019. | | |
| 3. **Review the RCA investigation process, how SIs are identified, reported and investigated with the maternity services; how recommendations from investigations are acted upon by the maternity services; how processes ensure sharing of learning amongst clinical** | 7.19 Ensure that a system for the identification, grading and investigation of SI's is embedded in practice through:<br>• Appropriate training to key staff members.<br>• Making investigations multidisciplinary and including external assessors. | **Ensure a system for the identification, grading and investigation of SIs**:<br>• Robust Health Board SI process in place with input from Directorate Nurse and Corporate Governance and Assurance, Safety and Improvement Team.<br>• Managers conducting SI reviews are RCA trained with additional help and support from the Corporate | | |

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| **staff, senior management and stakeholders and whether there is clear evidence that learning is undertaken and embedded as a result of any incident or event.**<br>**Work is required to address the culture in relation to governance and supporting all staff with their accountability in relation to incident reporting, escalation of concerns and review of Datix in a timely manner**. | | Governance and Assurance, Safety and Improvement Team to adhere to WAG timeframes.<br>• RCA have a MDT approach and are all discussed at the Directorate Clinical Risk committee and Directorate Quality and Safety meeting and are signed off by the Directorate team.<br>• At the discretion of the Health Board Corporate Governance Structure external assessors are requested for their clinical opinion on standards of care delivered. | | |
| | 7.20 Actively seek to remove the 'Blame Culture' to allow all staff to develop willingness to report and learn from SIs. | **Remove blame culture and develop reporting and learning from SIs:**<br>• The Health Board actively promotes a No Blame Culture and is not a theme identified when conducting SI's. There has to date been excellent engagement with all disciplines of staff and all midwifery, obstetric, anaesthetic and neonatal staff eagerly engage in the RCA process.<br>• From weekly reviews of Datix and validation of clinical data there is no evidence to highlight under-reporting of incidents. | | |
| | 7.21 Improve incident reporting by:<br>• Delivering training on the use of the Datix system for all staff.<br>• Encouraging the use of the Datix system to record clinical incidents.<br>• Monitor the usage of the incident reporting system. | **Improve incident reporting:**<br>• Clinical Risk and Governance Midwife oversees the Maternity risk management system and the Lead Nurse for SCBU, the Operational lead Midwives take responsibility for each clinical area and validate data during a weekly MDT meeting with the Consultant Obstetrician responsible for clinical risk.<br>• Datix reporting system is validated by the Band 8a Clinical Risk and Governance Midwife who compares birth register against Datix reported incidents with Maternity Trigger List on a weekly basis.<br>• See 7.15 and 7.20. | | |
| | 7.22 Actively discuss the outcomes of SIs which individual Consultants were involved in their appraisal. | • All RCA cases and action-plans are reviewed and agreed with the Consultant Obstetrician for Clinical Risk and Governance and the Clinical Obstetric Lead.<br>• The discussion of significant events is a GMC requirement for revalidation and consultants are encouraged to include SIs at each annual appraisal. There is a specific template on the MARS system for this purpose.<br>• Consultants are provided with Datix incident information reports which they were directly involved with, to include at appraisals. | | |
| | 7.23 Improve learning from incidents by sharing the outcomes from SIs on a regular basis and in appropriate, regular and accessible format. | • All SI's are discussed and feedback to all staff disciplines through the Labour Ward Forum.<br>• Desk top Learning Events are facilitated to share learning form serious incidents. | | |

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| | | • Learning from SI's are shared via the Clinical Risk Newsletter which is issued monthly.<br>• Staff briefings are forwarded as and when required to disseminate to all team members when an issue is identified. | | |
| 4. **Review how through the governance framework the Health Board gains assurance of the quality and safety of Maternity and Neonatal services.** | 7.25 Appoint of a Consultant and Midwifery Lead for Clinical Audit/Quality Improvement with sufficient time and support to fulfil the role to ensure:<br>• That clinical audits are multidisciplinary.<br>• That there is a clinically validated system for data collection.<br>• That the lead encourages all medical staff to complete an audit/quality improvement project each year to form part of their annual appraisal dataset.<br>• Sharing of the outcomes of clinical audits and the performance against national standards. | **Appoint a Consultant and Midwifery Lead for Clinical Audit/Quality Improvement. That the lead encourages all medical staff to complete an audit/quality improvement project each year to form part of their annual appraisal dataset:**<br>• The current process ensures that the Chair (Obstetric Lead) for the Obstetric Guideline and Audit Group facilitates the clinical audit process.<br><br>**Clinically validated system for data collection:**<br>• Validation of clinical data: see 7.1.<br><br>**Sharing of the outcomes of clinical audits and the performance against national standards:**<br>• See evidence from 7.25. | • The need to appoint a dedicated Consultant to lead on clinical audit along with a dedicated midwife. This will facilitate closer working with the Clinical Audit Team to establish an annual programme of clinical audit. | |
| | 7.26 Agree jointly owned neonatal and maternity services audits of neonatal service data including:<br>• Neonatal outcome data.<br>• Perinatal deaths.<br>• Transfer of term babies to SCBU.<br>• Babies sent for cooling.<br>• Each Baby Counts reporting.<br>• MBRRACE reporting.<br>• Breast feeding rates.<br>• Skin to skin care after birth.<br>• Neonatal infection.<br>• Baby Friendly accreditation.<br>• Bliss Baby Charter accreditation. | • Monthly Neonatal and Maternity Labour and Perinatal Forum held within Directorate involves close partnership working with Directorate Lead for Children's services and Clinical lead for Neonatal and Paediatric services.<br>• All unexpected SCBU admissions from 37 weeks gestation are reviewed by the Lead Nurse for SCBU and the Clinical Risk Midwife on a monthly basis.<br>• Monthly joint neonatal and maternity meetings are facilitated between the Band 8a Clinical Risk Midwife and Lead Nurse for SCBU to review all admissions.<br>• The monthly Directorate Maternity and Neonatal Dashboard record all neonatal outcomes and are benchmarked against national standards.<br>• Each Baby Counts (a national quality improvement programme led by the Royal College of Obstetricians and Gynaecologists (RCOG) to reduce the number of babies who die or are left severely disabled as a result of incidents occurring during term labour). This data is submitted by a Band 7 midwife overseen by the Clinical Risk Midwife. This is a joint review with the Paediatric Team.<br>• The Health Board's Breastfeeding rates are shared with the Welsh Government through the Performance Board and the data is obtained from the Child Health system. The Health Board is fully accredited by Baby Friendly 2018.<br>• The Health Board has a 1.0WTE Breastfeeding Co-ordinator to ensure Baby Friendly standards are maintained and the Health Board has been acknowledged for excellent initiation with skin to skin for both breast and artificial fed babies and for the continuous breastfeeding rates.<br>• The Health Board has submitted and completed the first phase of the audit process in relation to self- | • A second audit for Bliss Baby Charter accreditation will be undertaken on completion of Phase 2 | |

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| | | assessment phase of the Bliss Baby Charter accreditation. The Health Board has been successful in obtaining a large grant to improve family accommodation whilst Phase 2 is being completed at GGH. | | |
| | 7.27 Consider extra resources to the Maternity Governance and Risk team to ensure:<br>• Workload is manageable.<br>• That Datix are reviewed, graded and actioned in an appropriate and timely manner. | • A full time Band 8a Clinical Risk and Governance Midwife has been appointed.<br>• Weekly Datix meetings are held in conjunction with Ward Managers and the Consultant Obstetrician for Clinical Risk and Governance to ensure transparent review and grading of Maternity incidents. | | |
| | 7.28 Ensure that the Executive level lead role for maternity will work with the maternity department and this role is effective and supported. This individual should:<br>• Have a direct progress reporting responsibility to the Board, in particular while the issues raised in this report are being resolved.<br>• Understand and facilitate improvement in the reporting of safety issues and clinical risk.<br>• Provide a single point of reference for liaison with external agencies.<br>• Ensure all reports from external agencies and regulators are channelled through a single pathway to ensure priorities remain focussed. | | | |
| 5. **Review the current Midwifery and Obstetric workforce and staffing rotas in relation to safely delivering the current level of activity and clinical governance responsibilities.** | 7.29 Closely monitor bank hours undertaken by midwives employed by the Health Board to ensure:<br>• The total number of hours is not excessive.<br>• The Health Board complies with the European Working Time Directive.<br>• These do not compromise safety. | • Bank hours are reviewed weekly by the Operational Lead Midwives.<br>• The working pattern adheres to the European Working Time Directive.<br>• Staffing levels and working patterns are part of the Datix and SI review process. | • A robust process needs to be in place that highlights any midwives that has worked over EWTD hours over a 12 week period | |
| | 7.30 Ensure the Medical Director has effective oversight and management of the Consultant body by:<br>• Making sure they are available and responsive to the needs of the service.<br>• Urgently reviewing and agreeing job plans to ensure the service needs are met.<br>• Clarifying what is to be covered as part of SPA activity (audit, governance, teaching, guidelines, data assurance, train more consultant obstetricians as appraisers).<br>• Ensuring the most unwell women are seen initially by a Consultant and all women are seen by a Consultant within 12 hour NCEPOD recommendation (national standard). | There is a Medical Director for the Health Board who has a structure to support the role. The Medical Director is the Responsible Officer and Caldicott Guardian.<br><br>**Making sure they are available and responsive to the needs of the service:**<br>• There is an Assistant Medical Director for Quality and Safety and an Assistant Medical Director for Professional standards who supports the Medical Director.<br>• The Clinical Lead and Hospital Directors oversee operational delivery of services and report operational issues to the Director of Operations. Identified clinical and professional issues are reported to either one of the Assistant Medical Directors or the Medical Director.<br><br>**Urgently reviewing and agreeing job plans to ensure the service needs are met:**<br>• Up to date job plans have been completed by the Service Delivery Manager (SDM) and Obstetric Lead. These are reviewed by the Medical | • There is a need to audit NCEPOD recommendation.<br>• Appointment of a Clinical Director for Women and Children's Directorate.<br>• Need to ensure Educational Supervisors of Training Post doctors are provided with .25 of a session for each Trainee allocated to them. | |

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| | | Directorate and ultimately the Medical Director to ensure that these meet individual needs and the needs of the service.<br><br>**Clarifying what is to be covered as part of SPA activity:**<br>• SPA activity is detailed in the job plans with roles and responsibilities clearly defined and recorded.<br>• The Health Board has developed a comprehensive job planning toolkit which includes detailed SPA guidance incorporating roles and corresponding time tariffs.<br>• All Educational Supervisors have 0.25 of a session per trainee in their job plans.<br>• There are a total of 5 trained Consultant Obstetrician Appraisers.<br><br>**Ensuring the most unwell women are seen initially by a consultant:**<br>• Daily ward round completed by the Consultant Obstetrician at 09.00.<br>• Ward round completed by the Consultant Obstetrician for all high risk cases at 5pm prior to on call. | | |
| | 7.31 Ensure a robust plan of births anticipated in each midwifery led unit and consultant led unit it undertaken<br>• Ensure involvement of paediatric staff for all future service design reviews and actions. | **Ensure a robust plan of births**:<br>From the data collection there is a steady birth rate on a monthly basis in consultant-led units and in all MLU settings. It is of note that there has been a slight decline in birth numbers since 2017.<br>• The maternity services are staffed to Birth Rate plus Workforce tool which was undertaken in 2017. This is for review at the end of 2020.<br>• The Consultant Midwife holds a Birth Choices Clinic. Birth plans are developed in this for high risk women.<br>• The Health Board holds an anaesthetic referral for high risk women.<br><br>**Ensure involvement of paediatric staff for all future service design reviews and actions:**<br>• Phase 2 reconfiguration commenced for completion in 2020 which has included paediatric and anaesthetic involvement<br>• In the antenatal period there is a clear Paediatric Referral Form for high risk cases to ensure clear communication and care-planning. | | |
| | 7.32 Ensure Obstetric Consultant cover is achieved in all clinical areas when required by:<br>• Reviewing the clinical timetables to ensure that 12 hour cover per day on labour ward is achieved.<br>• Undertake a series of visits to units where extended consultant labour ward presence has been implemented. | **Review consultant clinical cover**:<br>• Currently there is a dedicated 8 hour Consultant Labour and Gynaecology Ward cover 40 hours per week Monday to Friday at GGH.<br>• Currently BGH has dedicated 32 hours per week. The remaining 8 hours is provided by the on call Consultant Obstetrician who is resident for the day. | • The Directorate is working towards 40 hour dedicated cover at BGH. Although acuity is low this risk is mitigated by cover forms other clinical activity. | |

# Hywel Dda University Health Board Assurance Framework:
# Response to the RCOG Independent Review of Maternity Services at Cwm Taf Health Board

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| | • Considering working in teams to ensure a senior member of the team is available in clinics and provide cross cover for each other.<br>• Considering the creative use of Consultant time in regular hours and out of hours to limit the use of locums. | • BGH is working towards 40 hours per week dedicated Labour Ward cover.<br>• There is on call consultant provision after 17.00hrs.<br>• Weekend on call cover includes daily ward rounds.<br>• No agency locum consultant obstetricians are used.<br><br>**Considering working in teams to ensure a senior member of the team is available in clinics and provide cross cover for each other:**<br>• A rota co-ordinator has been employed from 1st April 2019 to maximise efficient and appropriate cross cover is maintained. | | |
| | 7.33 Actively share the findings of the RCOG review with the Welsh Deanery and urgently encourage them to revisit the Health Board to:<br>• Reassess the quality of induction, training and supervision in obstetrics.<br>• Seek assurance on the suitability of this service for trainees.<br>• Appoint a named RCOG College tutor to provide support for the trainees currently with adequate time and resource to fulfil this function. | **Reassess the quality of induction, training and supervision in obstetrics:**<br>• The Deanery Review conducted in 2016 highlighted that improvements were required in respect of clinical leadership and support for junior staff members. Following internal Health Board initiatives a review undertaken by the Deanery in 2018 confirmed positive improvement with evidence of leadership and clinical support in practice.<br>• There is an appointed RCOG tutor to oversee training and supervision and induction.<br><br>**Seek assurance on the suitability of this service for trainees:**<br>• The Health Board is monitored by the Deanery and the AMD for Medical Education.<br><br>**Appoint a named RCOG College tutor to provide support for the trainees:**<br>• There are two named RCOG College tutors for the Health Board one based in GGH and one in WGH which is reflected in the individual job plans. | • To consider the feasibility of one College Tutor for the Health Board with a dedicated session in line with College recommendations. | |
| | 7.34 Allocate all trainees currently in post a clinical and educational supervisor:<br>• The role of clinical supervisor and educational supervisor should be documented and closely monitored by the Director of Medical Education.<br>• The competency assessments for trainees must be provided in-house under the supervision of the RCOG College Tutor. | **The role of clinical supervisor and educational supervisor should be documented and closely monitored by the Director of Medical Education:**<br>• All trainees have an identified clinical and educational supervisor.<br><br>**The competency assessments for trainees must be provided in-house under the supervision of the RCOG College Tutor:**<br>• These are provided by the clinical and educational supervisors. | | |
| | 7.35 Undertake a training needs assessment for all staff to identify skills gaps and target additional training. | • A Training Needs Assessment of Midwives and Health Care Support Workers is in operation in the Directorate.<br>• There is currently no robust documentation to confirm that this assessment is undertaken by medical staff. | • A database is to be developed for Medical staff. | |

# Hywel Dda University Health Board Assurance Framework:
# Response to the RCOG Independent Review of Maternity Services at Cwm Taf Health Board

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| | 7.36 Clinical supervision and consultant oversight of practical procedures must be in place of all staff including specialist midwives and doctors. | • Dedicated consultant cover for the Labour Ward to supervise and oversee clinical/practical procedures.<br>• There is a dedicated on call consultant as required out of hours. | • Develop formalised Criteria for Consultant attendance for the Health Board in line with RCOG Standards (2016) 8.6.6.<br>. | |
| | 7.37 Develop an effective department wide multi-disciplinary teaching programme.<br>• This must be adequately resourced and time allocated for attendance by all staff groups including specialist clinical midwives and SAS doctors.<br>• Attendance must be monitored and reviewed at appraisal. | **Attendance must be monitored and reviewed at appraisal:**<br>• Mandatory PROMPT training is undertaken in the Health Board and a database is kept by Practice Development Midwives for all staff.<br>• Attendance lists are kept for review by the Obstetric lead and senior midwifery management.<br><br>**This must be adequately resourced and time allocated for attendance by all staff groups including specialist clinical midwives and SAS doctors:**<br>• All SAS doctors attend the protected time teaching held weekly.<br>• Adequately resourced and time allocation for all staff groups.<br>• Attendance is monitored. | • There is a need for a consistent approach in logging attendance by SAS doctors. | |
| | 7.38 Ensure the Consultant on-call for the Labour Ward has ownership of all patients in the maternity unit for the period of the on-call.<br>• This must involve the Antenatal Ward round being performed by the consultant. | • Consultant On-call has ownership for all patients inclusive of Antenatal Ward round during Monday to Friday and over the weekend period. | | |
| | 7.39 Review the working practice for how consultant cover for Gynaecology services will be delivered after the merger.<br>• A risk assessment must be performed to determine the case mix of planned surgery when there is no resident gynaecology cover. | Not applicable to the provision of Maternity Services in the Health Board.<br><br>Following the reconfiguration of the maternity services in 2014 and a follow-up review by the RCPCH in 2015 it was recommended to:<br>• Phase out obstetrics and gynaecology out of hours Consultant hours at WGH, integrating and strengthening the Obstetrics and Gynaecology Team at GGH.<br>• Following an extensive period of informal consultation with the multi-disciplinary clinical team a detailed proposal has been developed to facilitate the integration of the 'out of hours' cover at GGH. A formal consultation process has been commenced from 27th March 2019 with a target implementation date of September 2019. | | |
| | 7.40 Review the skills and competencies of the senior clinical midwives covering for tier 1 doctors to ensure:<br>• Their scope of practice is clearly defined.<br>• The Health Board and the individuals are protected against litigation risk for their extended roles. | **Scope of practice clearly defined:**<br>• Within the Health Board there are 1.8WTE Band 7 Obstetrics and Gynaecology Practitioners (OGPs).<br>• There roles and responsibilities are delineated in their job descriptions.<br>• Annual appraisals are conducted by the Senior Midwifery management.<br>• They attend the mandatory PROMPT training and are also involved in delivering the training. | | |

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| | | **The Health Board and the individuals are protected against litigation risk for their extended roles:**<br>• The OGPs work within their competencies and responsibilities as outlined in their job descriptions.<br>• They do not undertake ventouse deliveries.<br>• They work under the supervision of the Obstetric middle grades in conjunction with the Band 7 Co-ordinators. | | |
| **6. Review the working culture within maternity including inter-professional relationships, staff engagement and communication between health care professionals and their potential impact on improvement activities, patients' safety and outcomes.** | 7.41 Consider the impact of the planned merger on the current culture of the organisation. The Board needs to carefully consider whether the planned merger of two units, both of which are described as having significant issues with their working culture, is likely to compound the problems rather than correct them. | **Working culture following reconfiguration of the Maternity Services in Hywel Dda University Health Board in 2014:**<br>• A review of the working culture was undertaken in 2015. The "*Supporting Positive Staff Experience Project*" was initiated as part of a wider Organisational Development Plan commissioned in September 2015 following the reconfiguration of maternity, neonatal and paediatric services at WGH and GGH.<br>• In 2017 a follow up review was undertaken. The feedback from staff covered their views on what was currently working well and the areas viewed as needing the most urgent attention in terms of improvement. | | |
| | 7.42 In conjunction with Organisational Development undertake work with all grades of staff around communication, mutual respect and professional behaviours.<br>• Staff must be held to account for poor behaviours and understand how this impacts on women's safety and outcomes. | **Staff must be held to account for poor behaviours and understand how this impacts on women's safety and outcomes:**<br>• The RCM and the Deanery have been proactively involved in the Health Board to raise awareness of undermining behaviours.<br>• All staff are aware of the Dignity and Respect Policy operating in the Health Board.<br>• The importance of professionalism has been communicated in the Maternity Risk Newsletter.<br>• The "*Supporting Positive Staff Experience Project*" initiated in 2015 as part of a wider Organisational Development Plan was reviewed again in 2017. It identified positive improvement in mutli-disciplinary relationships. | | |
| **7. Identify the areas of leadership and governance that would benefit from further targeted development to secure and sustain future improvement and performance.** | 7.43 Undertake an in-depth assessment of the service as it moves into the future with its new ways of working and the likelihood of an increased demand for services.<br>• This can determine the structures and competencies of clinical leadership and governance that will support the service. | • There has been an in-depth analysis of the services prior to reconfiguration in 2014.<br>• This resulted in two obstetric units – the main obstetric unit based in GGH supported by a level 1 SCBU and a bespoke obstetric unit in BGH with a neonatal stabilisation unit. There is a free-standing MLU in WGH and an along-side MLU in GGH;<br>• Appropriate structures for clinical leadership were identified and have been put in place to include:<br>  • Deputy Head of Midwifery.<br>  • Three Band 8a Operational Lead Midwives to develop Community and MLU services, GGH and BGH.<br>  • Consultant Midwife. | • There is an on-going review of staffing models in the community and free-standing MLU at Withybush to ensure continuity of carer. | |

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| | | • Band 8a Clinical Risk and Governance Midwife.<br>• Practice Development Midwives.<br>• Diabetic Specialist Midwives.<br>• A restructured process for midwifery supervision through the appointment of two Clinical Supervisors for Midwives.<br>• Obstetric Labour Ward.<br>• Obstetric Lead for Clinical Risk and Governance.<br>• The Maternity Services in the Health Board are actively involved in the 'Healthier Mid and West Wales Future Strategy' to ensure that our services with future planning. | | |
| | 7.44 Support training in clinical leadership:<br>• The Health Board must allow adequate time and support for clinical leadership to function. | • Midwives attend RCM Leadership programme on an annual basis.<br>• Senior management team are part of the Health Board's System Level Leadership Improvement Programme (SLLIP). | • To review opportunities for Obstetric staff to attend in house/ accredited leadership modules | |
| | 7.45 Provide mentorship and support to the Clinical Director:<br>• Define the responsibilities of this role.<br>• Ensure there are measurable performance indicators.<br>• Ensure informed human resource advice to consistently manage colleagues' absence and deployment of staff to cover the needs of the service.<br>• Consider buddying with a Clinical Director from a neighbouring Health Board. | **Define the responsibilities of the Clinical Director role:**<br>• There is no designated Clinical Director for the Women and Children's Directorate.<br>• There is an Obstetric Lead and a Paediatric Lead appointed to support their peers.<br><br>**Ensure there are measurable performance indicators**:<br>• The Obstetric lead has an active role in the governance around measurable performance indicators.<br>• The Obstetric Lead has appointed leads for Governance and Risk and a Labour Ward Lead for the Health Board who support in this.<br><br>**Ensure informed human resource advice to consistently manage colleagues' absence and deployment of staff to cover the needs of the service**:<br>• There is a dedicated human resource team that advises on this aspect.<br>• The dedicated Rota Co-ordinator who assists the SDM in the management of absence and deployment. | • To consider appointing a Clinical Director for Women and Children's Services. | |
| | 7.46 Appoint clinical leads in a structure that supports the service with defined role descriptions and job descriptions and objectives to include an individual response for each of the following:<br>• Governance and clinical quality to include guideline updating.<br>• Data quality.<br>• Medical staff education and training.<br>• Multi-disciplinary training.<br>• Audit.<br>• Risk management. | Currently the following have been appointed. Their responsibilities have been incorporated into their job plans:<br>• <u>Guideline update and development:</u> Obstetric Lead and Obstetric Labour Ward Lead.<br>• <u>Data quality, Governance and risk and incident review</u>: Obstetric Lead for Clinical Risk and Governance.<br>• <u>Medical staff education and training</u>: Obstetric Lead appointed.<br>• <u>Complaints handling</u>: Obstetric Lead. | • To review structures to incorporate clear and equitable roles and responsibilities specifically in relation to audit and data | |

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| | • Incident review.<br>• Complaints handling. | • Audit: This is overseen by the Obstetric and Labour Ward Leads. | | |
| **8. Assess the level of patient engagement and involvement within the Maternity Services and determine if patient engagement is evident in all elements of planning and service provision.**<br>**Assess whether services are patient centred, open and transparent.** | 7.47 Develop and strengthen the role and capacity of the MSLC to act as a hub for service user views and involvement of women and families to improve maternity care:<br>• Appoint a Lay Chair as a matter of priority and increase lay membership numbers with appropriate support and resources.<br>• Support lay members to engage with women using services in the FMU and RGH and at PCH to assess satisfaction and to identify issues relating to choices.<br>• Enhance the MSLC monitoring role in order to assess whether patterns of concerns are found and to ask for regular feedback on action taken. | In the Maternity Services the current structure for patient engagement and involvement is identified below:<br>• There is a specific Bereavement MSLC Group that has been involved in the recent refurbishment of the bereavement suite and in the development of the new bereavement suite in the labour ward and obstetric theatre Phase 2 development at GGH opening in 2020.<br>• There has been active engagement via social media platforms organised by the Health Board's Communication Team in relation to women's views regarding planning of service provision.<br>• The Maternity Services and the Communication Team visited breastfeeding groups, postnatal groups and women with complex social needs to explore their views on service requirements.<br>• There are established social media platforms for women and their families across the Health Board. | • The current structure around a generic MSLC group for the Health Board is being reviewed by senior midwifery management | |
| | 7.48 Utilising the role and strengths of the Community Health Council (CHC):<br>• Ensure appropriate resources to act effectively as an independent advocate.<br>• Ensure that information is available to families regarding its role and contact details.<br>• Explore provision of CHC to act as point of contact and provide direct support for women and families, in addition to acting as a conduit referring to other agencies and support. | • CHC conducted two visits in 2018.<br>• CHC have also disseminated posters to encourage service users to feedback their experience which are visible in the clinical area.<br>• CHC engaged with service change Pembrokeshire community.<br>• A CHC member is part of the Phase 2 project development group.<br>• CHC is involved when meeting with complaints. | | |
| | 7.49 Develop the range and scope of engagement with women and families:<br>• Review the effectiveness of patient experience methodology and its impact on service change and improvement as a result of feedback.<br>• As a priority, review and address the monitoring of the outcomes of patient experience as a key part of the governance structure.<br>• Feedback the outcomes of all engagement to women and families.<br>• Explore methods to hear directly from women and families about their experience including patient stories, diaries, 'mystery shopper' or observation techniques. | **Review the effectiveness of patient experience methodology and its impact on service change and improvement as a result of feedback**:<br>• All patients are invited to complete a 'Did We Deliver' survey following birth which is reviewed by Operational Leads and the Ward Manager.<br>• The Postnatal Record has an audited patient satisfaction survey which is completed prior to discharge from the maternity services.<br>• Themes and trends are identified from these formats and a complaint investigation is undertaken to improve the quality of the services provided.<br><br>**Review and address the monitoring of the outcomes of patient experience as a key part of the governance structure**:<br>• There is a robust Complaints and Incident Procedure within the Health Board that identifies key themes.<br>• These are disseminated through the Maternity Risk Newsletter and to specific leads for each area.<br>• Clinical Supervisors for Midwives and Operational Leads monitor all outcomes and actions. An example of a change in service provision following patient | | |

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| | | feedback was the development of a Birth Partner's Room for partners whose wives were in labour and the amendment of visiting hours for enhanced family focus.<br><br>**Feedback the outcomes of all engagement to women and families**:<br>• This occurs as part of the complaints process.<br><br>**Explore methods to hear directly from women and families about their experience:**<br>• Patient stories are encouraged on social media platforms specifically round the freestanding MLU experience.<br>• There is a Homebirth Forum which captures patient stories and experiences.<br>• The Consultant Midwife captures themes through the Health Board's Birth Choices Clinic.<br>• The MBRRACE Perinatal Review Tool specifically asks for the patient's perspective on their care in the event of a late fetal loss or stillbirth.<br>• Partnership working with the Neonatal Outreach Team ensures that the experience of women and their families is captured. | | |
| | 7.50 Continue to work with and build on the community based engagement approaches being suggested by the MSLC<br>• Explore working with external partners, including the CHC and community based organisations. | • Please refer to 7.47 and 7.48. | | |
| | 7.51 Ensure responses to complaints and concerns is core to the work being undertaken to improve governance and patient safety:<br>• Review and enhance staff training on the value of listening to women and families.<br>• Review the process of investigation of concerns, handling 'on the spot' issues and ensure that all responses and discussions are informed by comprehensive investigations and accurate notes.<br>• Priorities the key issues that women and families have highlighted to improve the response.<br>• Ensure that promises of sharing notes and providing reports to families are delivered.<br>• Clarify the process regarding the triangulation of the range of information sources on patient experience, Sis, complaints and concerns and other data and ensure that there is a rigorous approach to make sense of patterns of safety and quality issues.<br>• Review the learning from the Sis in relation to misdiagnosis, failure to seek a second opinion and inappropriate patient discharge. | **Review and enhance staff training on the value of listening to women and families:**<br>• All staff has training on the 'Putting Things Right' framework which includes resolving concerns at ward level to avoid escalation to minimise undue stress to mothers and their families.<br><br>**Review the process of investigation of concerns, handling 'on the spot' issues:**<br>• There is a formal Health Board process for investigating concerns.<br>• There is a monthly Directorate Complaints, Concerns, Incidents and Near-Miss meeting to ensure appropriate and timely resolution.<br><br>**Priorities the key issues that women and families have highlighted to improve the response:**<br>• Key concerns are identified by the Complaints Team and the lead investigator to improve the response and facilitate resolution.<br><br>**Ensure that promises of sharing notes and providing reports to families are delivered:**<br>• Patients are given a copy of the report and action plans. | | |

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| | | • Notes are shared as part of the Complaints process.<br><br>**Clarify the process to ensure that there is a rigorous approach to make sense of patterns of safety and quality issues:**<br>• All incidents, SIs and complaints are cross referenced with on-going and historical complaints, Datix incidents, Maternity Scorecards, databases completed by the Clinical Supervisor for Midwives and the Practice Development Leads in order to ensure safety and quality.<br><br>**Review the learning from the SIs in relation to misdiagnosis, failure to seek a second opinion and inappropriate patient discharge:**<br>• Action-plans are agreed by the multi-disciplinary Maternity Risk Committee.<br>• Learning is disseminated at individual level and Health Board wide via Labour Ward Forum, Maternity Risk Newsletter and Health Board Learning Events. | | |
| | 7.52 Learn from the experience of women and families affected by events:<br>• Respond and work with families in the way they require.<br>• Feed the learning into the design of a comprehensive training and support programme that will give women and families confidence in the skills, expertise, communication, and safety and quality of maternity care. | See above: 7.49 and 7.51. | | |
| | 7.53 Review the communications, support and engagement approach and strategy.<br>• Ensure that the focus is not solely on management of key messages.<br>• Demonstrate openness, honesty and transparency, admission of fault and learning from this. | • Early engagement with families when there is a serious incident in order to demonstrate to families the Maternity Services transparency and honesty in the investigatory process.<br>• Discussion with the Assurance, Safety and Improvement Team to ensure that the process in acknowledging accountability is robust and transparent.<br>• Early escalation to Welsh Government when a serious incident has occurred and early notification of potential serious issues.. | | |
| | 7.54 Prioritise an engagement programme with families at its heart.<br>• Women and families affected by events should be part of the improvement, co-design and culture change of the new service. | Please refer to 7.49 and 7.51. | | |
| | 7.55 Review the level and effectiveness of the bereavement service<br>• Ensure that appropriate support and counselling is available for all families as required.<br>• Consider implementing the National Bereavement Care Pathway that has been developed by SANDS | **Ensure that appropriate support and counselling is available for all families as required**:<br>• There is a dedicated 0.8WTE Bereavement Midwifery Team for the Health Board to ensure that there is appropriate support and counselling for mothers. | | |

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| | in collaboration with stakeholders including women and their families, RCOG and RCM. | • All midwives have mandatory annual updates on Bereavement care and guidelines.<br><br>**Consider implementing the National Bereavement Care Pathway that has been developed by SANDS:**<br>• The Health Board implements the current All Wales Bereavement Pathway in line with national standards. | | |
| | 7.56 Provide training for staff in communication skills, in particular on:<br>• Empathy, compassion and kindness. | Please see above. | | |
| **9. Consider the appropriateness and effectiveness of the improvement actions already implemented by the Health Board** | 7.57 Continue with efforts to recruit and retain permanent staff. | • The Directorate is actively part of the Health Board strategy to recruit and retain staff.<br>• The Directorate has 160.9WTE midwives compared to the Birth Rate Plus recommendation of 171WTE.<br>• The shortfall is covered by internal bank midwives.<br>• Birth Rate Plus advocates that for community midwifery and postnatal care there should be a 90/10 skill mix ratio with Band 3 Health Care Support Workers. This is currently being developed.<br>• There are currently 2WTE SAS doctor vacancies at BGH. There are challenges to recruit to a small obstetric rural unit which is compounded by a recognised national shortage for doctors at this level.<br>• These vacancies re currently covered by NHS locums with minimal ad hoc agency usage.<br>• The Directorate is currently exploring alternative medical models of care for BGH. | • The medical model of care for BGH is being reviewed.<br>• The midwifery shortfall (11.1WTE) is being reviewed | |
| | 7.58 Seek expert external midwifery and obstetric advice for support in developing the maternity strategy and use the opportunity of change to explore hew ways of working. | See above. | | |
| | 7.59 Urgently carry out a full risk assessment before committing to the merger on 9 March 2019 to ensure women's safety, including:<br>• Ensuring that length of stay is reduced safely to allow for sufficient capacity in the new merged unit. | | | |
| | 7.60 Monitor the effects of the reduced inpatient capacity to avoid any adverse effects on the safety or quality of the service. | | | |
| | 7.61 Develop a plan to increase inpatient capacity if that is seen to be required. | | | |
| | 7.62 Independent Board members must investigate the lack of action by the Executive Team and Board following receipt of the consultant midwife's report in September 2018.<br>• Independent Board members must challenge the Executive over the contents of this report. | | | |

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| | • Independent Board members must ensure they are fully informed on the monitoring of planned improvements. | | | |
| | 7.63 Independent Board members must challenge the quality of the data which informs the reports which they receive and rely upon for assurance. | • QSEAC receives an assurance report which is currently under regular review to ensure that it provides the Independent Members and other members of QSEAC with the assurance required.<br>• The Directorate has also been invited to an extraordinary In-Committee meeting to provide assurance on the Maternity service. | | |
| | 7.64 Independent Board members should receive training in the implications of the Corporate Manslaughter and Corporate Homicide Act 2007 to better understand their role in ensuring the safety of the services that the Board provides. | | This will be discussed with the Chair for consideration as part of the Board development programme. | |
| **10. To make recommendations based on the findings of the review to include service improvements and sustainability.<br>Advise on future improvements, future staffing and maintenance of quality, patient safety and assurance mechanisms** | 7.65 Ensure that criteria for the opening of the new FMU have been agreed by a multi-disciplinary maternity guidelines group and that readiness for the merger is assured. | | | |
| | 7.66 Update the risk register and review regularly at Board level. | • There is a monthly Directorate Risk Register Meeting to ensure that risks are reviewed and updated. | | |
| | 7.67 Develop a strategic vision for the maternity service and use the current opportunity of change to create a modern service that is responsive to the women and their families and the staff who provide care. | • Awaiting publication of the 'All Wales Maternity Strategic Vision'.<br>• To facilitate benchmarking exercise following publication. | | |
| | 7.68 Consider examining other UK maternity services to seek out models for delivery which could better serve their population regarding:<br>• Methods of service delivery.<br>• Consultant delivered labour ward care.<br>• The role of and function of a resident consultant.<br>• Achieving a balance between obstetrics and gynaecology commitments.<br>• Reducing the use of SAS doctors for out of hours service delivery and developing their in hours role. | Please see points above. | | |
| | 7.69 Identify and nurture the local leadership talent. | Please see above. | | |
| | 7.70 Ensure that any future service change for the development process of the maternity service as a whole is inclusive for all staff and service users.<br>• Ensure the service is adequately staffed so that all staff groups are able to participate in developing the vision.<br>• Consider an externally facilitated and supported process for review. | Please see comment above regarding the Health Board plan for a 'Healthier Mid and West Wales Strategy' that includes a robust staff engagement process. | | |

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| | • Consider seeking continued support from HIW and the Royal Colleges to undertake a diagnostic review of the service particularly in relation to changes in service provision. | | | |

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)
Welsh Health Specialised Services Committee (WHSSC)

Your ref/eich cyf:
Our ref/ein cyf: VH.KS.DD
Date/dyddiad: 15th May 2019
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The Chair and the Board Secretary:

Anuerin Bevan UHB
Cardiff & Vale UHB
Cwm Taf Morgannwg UHB
Hywel Dda UHB
Powys THB
Swansea Bay UHB

Dear Colleague

**Re: Adult Thoracic Surgery for South Wales: Update**

I am writing to provide an update on developments at yesterday's WHSSC Joint Committee meeting.

You will be aware that we had an agenda item to consider adult thoracic surgery for south Wales and accordingly received a paper on this subject. We had anticipated that the same paper would be forwarded to you for consideration at your health board May 2019 Board meeting with an endorsement from the Joint Committee.

In respect of the recommendation that a decision regarding the workforce arrangements that have been developed to provide thoracic surgical cover from Morriston Hospital, Swansea, for the MTC in UHW, Cardiff be deferred to July 2019, members decided, instead, to request Dr Sian Lewis (and the WHSS Team) to bring a WHSSC commissioning proposal back to the Joint Committee by the end of June 2019 that would take into consideration a number of matters and some uncertainties raised in the paper and during the meeting.

In relation to the other recommendations set out in the paper, after due consideration, Members:

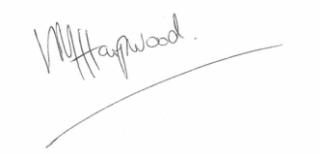
- **Noted and received assurance** that arrangements are in place to address the further issues raised by the affected health boards in November 2018;

- **Supported** the recommendations arising from the assessment of lessons learned from the engagement exercise and public consultation;
- **Noted** the development of the thoracic surgery commissioning plan; and
- **Noted** the implementation project led by SBUHB has commenced with project board and stakeholder meetings already held.

The final recommendation set out in the paper: "To support the recommendations going forward to the six affected health boards and the affected health boards being asked to confirm their unconditional approval for a single adult thoracic surgery centre for south Wales, and parts of mid Wales, based in Morriston Hospital, Swansea." was postponed.

Please circulate this letter to your directors for noting at your May 2019 Board meeting.

Yours sincerely



**Professor Vivienne Harpwood**
**Chair**

cc Andrew Goodall, Chief Executive, NHS Wales
Simon Dean, Deputy Chief Executive, NHS Wales

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)
Welsh Health Specialised Services Committee (WHSSC)

Your ref/eich cyf:
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The Chair and the Board Secretary:
Anuerin Bevan UHB
Cardiff & Vale UHB
Cwm Taf Morgannwg UHB
Hywel Dda UHB
Powys THB
Swansea Bay UHB

Dear All,

Further to my letter of the 15th of May I have been asked to provide further information regarding the work to be undertaken by the WHSS Team to develop the commissioning proposal for the consultant staffing model to be brought back to the Joint Committee for consideration at the end of June 2019. We have listed the actions identified in our meeting notes however it is important to note these have not yet been confirmed and are provided to give an indication to Boards on the scope of the work:

1. Detail regarding the anticipated demand for thoracic surgery in south Wales, this will include out-patient and surgical activity and allow for the planned 20% increase in activity.

2. Expert advice on the level of activity required to maintain consultant thoracic surgeons' skills.

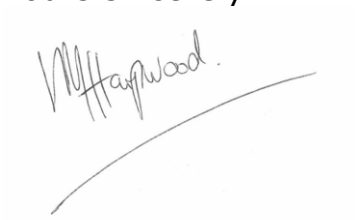
3. Development of indicative job plans for consultant thoracic surgeons to inform an assessment of the appropriate number of consultants.

4. Detailed costings for any proposed increase in consultant thoracic surgeons above the original WHSSC recommended level of six consultants.

5. Clarity on the role of trauma surgeons in the immediate management of emergency trauma patients and the requirement for input from thoracic surgeons (eg telephone advice or on site input)

6. Clarity on the interface of thoracic surgeons in managing trauma patients with other specialties (e.g. rib fixation with orthopaedic surgeons).

Yours sincerely



**Professor Vivienne Harpwood**
**Chair**

cc.


Welsh Health Specialised Services Committee
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| | |
|---|---|
| **Enw'r Pwyllgor: Name of Committee:** | Audit & Risk Assurance Committee (ARAC) |
| **Cadeirydd y Pwyllgor: Chair of Committee:** | Mr Paul Newman, Independent Member |
| **Cyfnod Adrodd: Reporting Period:** | Meetings held on 23rd April and 7th May 2019 |

**Y Penderfyniadau a'r Materion a Ystyriodd y Pwyllgor:**
**Key Decisions and Matters Considered by the Committee:**

In accordance with the guidance provided in the NHS Wales Audit Committee Handbook, the Board should look to their Audit Committee to review and report on the relevance and rigour of the governance processes in place and the assurances provided to the Board. Hywel Dda University Health Board's (HDdUHB's) Audit & Risk Assurance Committee's primary role is, as such, to ensure the system of assurance is valid and suitable for the Board's requirements and to support the Board by seeking and providing assurance that controls are in place and are working as designed, and to challenge poor sources of assurance.

This report summarises the work of the Audit & Risk Assurance Committee (ARAC) at its meetings held on 23rd April and 7th May 2019, in monitoring, reviewing and reporting to the Board on the processes of governance, and facilitating and supporting the attainment of effective processes. At its meeting on 23rd April 2019, the Committee critically reviewed governance and assurance processes for a number of service/business areas, with the following highlighted:

- **Matters Arising (Public Health Resources)** – the Committee heard that Public Health Wales are of the opinion that the allocations were agreed at an All Wales group and that due process has been followed. This line of enquiry has, therefore, been exhausted and this matter closed from the ARAC work programme.

- **Matters Arising (IM&T Directorate)** – an updated management response was presented; however, concern was expressed that this is still not sufficiently robust with actions not clearly identified regarding what actions are being taken in the short term to address non-compliance with the European Working Time Directive (EWTD). It was agreed that this issue would be discussed with the Director of Planning, Performance & Commissioning and that ARAC's concerns around non-compliance with EWTD should be reiterated in the update report to Board, with clarification expected by that point.

- **Annual Review of the Committee's Self-Assessment of Effectiveness** – the Committee received the survey results from this exercise. Overall, the survey results are positive, suggesting that ARAC is well chaired and operating effectively. Areas for potential improvement identified from responses include: Quality of papers; Quality of management responses; Independent Members' ongoing development; Understanding of Risk Registers. A more detailed report and analysis will be presented to the June 2019 ARAC meeting.

- **Targeted Intervention** – the Committee was provided with an update from the Targeted Intervention meeting held with Welsh Government (WG) on10th April 2019. The tone of the meeting had been positive, with the UHB's achievement of the zero target for Referral

to Treatment (RTT), described as a 'significant performance achievement. The UHB had also delivered on its year-end forecast defecit position.. WG continue, however, to focus on HDdUHB's finances, particularly the proportion of non-recurrent solutions utilised to achieve the year-end position. WG has outlined an expected reduction in the Control Total to £25m, which reflects their ambitions for HDdUHB. A further update would be provided at the next meeting. The UHB had requested financial support to increase capacity in the core team for implementation of the new Health & Care Strategy. There had been a meeting with WG representatives, and the Chief Executive was hopeful of a positive outcome.

- **Wales Audit Office Update Report** – the Committee received the Wales Audit Office (WAO) Update Report, providing an update on current and planned performance audit work. Members heard that interim Financial Audit work has been completed and a draft set of accounts prepared, with year-end work on target. In terms of performance audit, publication of the local Integrated Care Fund (ICF) Review has been delayed until June 2019 to link in with the national report on this topic. There will be meetings with UHB staff to discuss the local Quality & Safety Review work. Performance Audit work around Orthopaedics and Wellbeing of Future Generations is being taken forward, and work relating to Structured Assessment will begin shortly.

- **Wales Audit Office Annual Plan 2019** – the Committee received the updated Wales Audit Office (WAO) Annual Plan 2019.

- **WAO Structured Assessment 2017 and 2018** – a report updating the Committee on progress with WAO recommendations was presented. Members heard that a new performance mechanism is planned, centred around strategic team-based goals rather than individual objectives for Executive Directors. A workshop will take place in May 2019 to determine the organisational goals.

- **WAO Clinical Coding Follow-up Review** – the Committee considered the WAO Clinical Coding Review, which is a nationally-mandated follow-up review. Overall, it is felt that Clinical Coding has a much higher profile than it did in 2014, and that the situation has improved within HDdUHB. There has been restructuring of the service and additional resource allocation. However, there are ongoing workforce issues, which have impacted on the service. Findings suggest that Clinical Coding teams are extremely isolated, which significantly impacts on staff morale. There is poor clinical engagement, which is common across Wales, although this has deteriorated. It was suggested that this issue represents an ongoing issue – if coding is not undertaken in a timely fashion, clinicians see little value in it and do not provide the information, which leads to delayed or poor coding; it is a 'whole system' problem. Members heard that the Director of Finance has identified a non-recurrent source of funding which will be utilised to outsource the coding of 20,000 records by June 2019. However, there needs to be recognition that any increase in clinical demand/activity results in an increase in clinical coding. Whilst Clinical Coding is viewed as important, it is not high in the UHB's priorities for investment. Planned actions include raising the profile of coding generally, and specifically among clinicians; emphasising the impact of clinical coding in relation to Value Based Healthcare; establishing apprenticeships in clinical coding, which would require recurrent funding. WAO have made a number of helpful suggestions regarding the changes and investment made at the former Abertawe Bro Morgannwg University Health Board (ABMUHB). Whilst

acknowledging that discussions are likely to principally take place at the Business Planning & Performance Assurance Committee (BPPAC) and/or the Quality, Safety & Experience Assurance Committee (QSEAC), it was agreed that it would be useful for ARAC to monitor progress. An update would be scheduled for six months' time.

- **Clinical Audit** – the Committee received an update on Clinical Audit including the clinical audit plan for 2019/20. It was suggested that there has also been a 'step change' in terms of outstanding recommendations relating to clinical audit. An annual report will be presented to the August 2019 ARAC meeting, which will close off these outstanding actions. Clinical participation in audits has improved since last year, and partial participation rates have reduced/improved. It has been agreed that the Clinical Audit Group should be modified, with the membership reduced and the remit redefined to a scrutiny panel. This is to ensure a more structured approach, wherein actions which come out of clinical audits are tracked and those responsible are held to account. Members heard that a number of processes have been developed and added since the previous clinical audit update. There is improved 'buy-in' from services in terms of risk assessment, and the number of national audit meetings has increased. It was acknowledged that, whilst there has been a improvement, there are further opportunities. A systematic approach is required, with the findings from clinical audits synthesised, analysed and prioritised. In response to a query regarding consequences of non-participation in 'mandatory' audits, Members were informed that there is a nationally published report which would identify non-participation and might potentially impact on the UHB's reputation. It was suggested that the Clinical Audit Group will assist in this regard, as non-participation will be discussed and scrutinised. It was highlighted that non-participation impacts primarily on quality and safety, with the intention of clinical audit being to identify potential improvements in care. Concern was expressed regarding the UHB's non-participation in the National Ophthalmology Audit, in view of issues in this specialty. Members heard that there are IT/software issues which are impacting on the service's ability to collect the relevant data. This is a highly resource intensive audit in which to participate. A risk assessment has been completed, and there are plans to meet again with the service to consider potential solutions. It was noted that other performance indicators are used to assess service quality. Whilst acknowledging these points, it was emphasised that one of the key benefits offered by clinical audit is benchmarking the quality of services. Members heard that considerable efforts had been made in trying to identify a software solution, and that the newly-appointed Service Delivery Manager is exploring other potential mechanisms for data collection. Members were also advised that there is a particular focus on Ophthalmology within QSEAC, which is examining other performance indicators. The Committee discussed the Effective Clinical Practice Sub-Committee (ECPSC) and previously reported issues around regularity of meetings/quoracy at meetings. Members heard that the ECPSC is a somewhat disparate group, involving diverse activities, and there is uncertainty about its ability to enact change. The proposed new structure should assist in this regard, with information being submitted to sub-committees in a more effective format. The membership of groups is also being reviewed; in the short term, the Medical Director will Chair the ECPSC, with the expectation that this will change once the new Medical Director sub-structure is in place. The Committee recognised that the update represents an improvement from the previous position; and, whilst there is still scope for further improvement, those involved were thanked for their efforts. Members were reminded that Clinical Audit is due to be considered again by ARAC in August 2019.

- **Concerns Update** – an update was presented, with Members advised that, whilst the UHB has not been able to consistently meet WG targets around response times, there has been a considerable improvement in this regard. This has been achieved via increased engagement with services, and assisted by the Chief Executive performance review process. The position has improved since October 2018, although there had been a 50% increase in cases during February 2019. There has been an increase in the number of cases resolved at an early stage, and a reduction in the number of Ombudsman cases. The Improving Experience Sub-Committee (IESC) has demonstrated the positive impact of patient involvement. Future actions planned include refresher training for staff, development of a toolkit and handbook, and training additional investigators. IESC will also be strengthened, to deal with emerging trends going forward. Whilst the position has improved, this is fluid and fragile. Members felt that the figures presented suggest that the position relating to concerns is fairly static. However, the Committee was reminded that the percentage of concerns settled within 30 working days was previously approximately 30%, whereas this is now approximately 70%. This demonstrates the impact of working more closely with services. It was also emphasised that the figures referred to only relate to WG's 30 day target, with performance against other measures and targets having improved. Members were reminded of discussions at the previous meeting around the aspiration for higher quality outcomes/responses to concerns, rather than potentially compromising the standard of these in attempting to meet the 30 day target. It was suggested that a more complete picture would be provided by the full year figures.

- **Internal Audit (IA) Progress Report** – the Committee reviewed the Internal Audit Progress Report 2018/19, noting developments since the previous meeting.

- **Internal Audit Strategy, Plan and Charter** – the Committee approved the Internal Audit Strategy, Plan and Charter for 2019/20.

- **Internal Audit (IA)** – the Committee reviewed the following IA reports which had achieved substantial and reasonable assurance:

    - Annual Plan 2019/20 (Substantial Assurance)
    - Welsh Risk Pool Claims (Substantial Assurance)
    - Information Governance: General Data Protection Regulation (GDPR) (Substantial Assurance)
    - Primary & Community Care Pipeline Projects – Aberaeron Integrated Care Centre (Substantial Assurance)
    - Single Tender Actions (Reasonable Assurance)
    - Accounts Receivable (Reasonable Assurance)
    - Financial Ledger (Reasonable Assurance)
    - UHB Payroll (Reasonable Assurance)
    - Management of Controlled Drugs (Reasonable Assurance)
    - Cardigan Integrated Care Centre (Reasonable Assurance)
    - Withybush General Hospital Refurbishment of Wards 9 & 10 (Reasonable Assurance)
    - Data Centre Project (Reasonable Assurance)
    - Capital Follow-up (Reasonable Assurance)
    - Estates Follow-up (Reasonable Assurance)

- **Radiology Update** – an update was presented, with Members reminded of the background to this item. Scoping had now taken place, involving both the Finance and HR departments; and there has been a meeting with the Heads of Service to discuss the issues, from which it has become apparent that there is no straightforward solution, particularly as there are different on-call arrangements in all four acute sites. A follow-up meeting is scheduled for the week commencing 29th April 2019. It is intended to present a set of proposals/options to Executive Team by the end of May 2019. Whilst work has not progressed to the extent planned, it was suggested that this reflects the complexity of the issues involved. Following consideration of proposals at Executive Team, further work would then be required before any Organisational Change Process (OCP) could commence. A more realistic timescale for completion would be September/October 2019. Members were assured, however, that staff are aware of this process and are being kept informed. The ambition is for a common system across the UHB, and it was suggested that Workforce & OD Sub-Committee, reporting to QSEAC, would be the most appropriate forum for monitoring. This issue will also remain on the Audit Tracker. It was agreed that there should be a further update to ARAC in October 2019 to assess progress. If this is satisfactory, no further review will be required; if not, a further update will be required at ARAC.

- **Internal Audit National Standards for Cleaning Follow-up Report (Limited Assurance)** – this report, which had been awarded a Limited Assurance rating due to a number of high priority findings, together with other issues, was presented to the Committee. The audit had sampled 9 areas; however, to demonstrate the scale and challenge of the UHB's activities and estate involved, Members were advised that there are 141 relevant areas across its sites. There has been an evaluation of cleaning audits, and the figure achieved is 92%; whilst the organisation would like this to be higher, it was suggested by the Director of Estates that it is a reasonable figure. The UHB is working hard to avoid missed cleaning audits, with this being one of the few relevant indicators of quality and therefore an area requiring close monitoring. Repeat fails are the subject of a monthly report, although the organisation is seeing very few on cleaning audits; these tend to be related to estates. iPad usage is low and that there is a need to move to an IT based system. There are, however, issues in certain areas with Cloud coverage, and there have been suggestions that a paper-based system is more discreet than iPads in patient areas. It is anticipated that compliance will be 100% by the end of June 2019. The Committee suggested that there are issues with the management response due to the way in which it has been written, being a narrative rather than SMART (Specific, Measurable, Achievable, Relevant, Time-based) response. It was, therefore, agreed that the management response would be updated/revised accordingly and presented to the June 2019 meeting.

- **Internal Audit Water Safety Report (Limited Assurance)** – this report, which shared common themes with audits conducted in other Health Boards, was presented. The key findings of the audit were outlined, with 12 recommendations having been initially raised. 4 of these had been addressed by publication of the final report and the remaining 8 would be addressed by the end of April 2019. It was emphasised that this is an area of high potential risk to the organisation. Members heard that the relevant risks are being managed via the Water Safety Group and the Health & Safety and Emergency Planning Sub-Committee. Advice has also been obtained from various sources. The need to revise

certain processes and policies was recognised. It was agreed that a follow-up audit would be useful in evidencing what measures the UHB has already put in place, together with planned actions. Whilst the update provided an element of reassurance, the need to maintain assurance and document that risk is being managed was emphasised. Members were advised that all items are being managed via the Water Safety Group, which reports to the Infection Prevention and Control Group. Following further discussion, it was agreed that a follow-up audit be conducted, which would examine different sites to those in the original audit and, due to the seriousness of the report, ARAC would require assurance that the management actions have been implemented in accordance with the agreed timescales.

- **Management of Supply Chain Partners and Contracts** – in response to discussions around IA reports, the Committee agreed that there should be a piece of work in relation to ensuring the UHB is doing all it can to future proof contracts in light of the companies who have recently gone into liquidation, and ensuring that the UHB is protected from any extra costs and delays to capital projects.

- **Scrutiny of Outstanding Improvement Plans: Royal College of Paediatrics & Child Health** – the Committee received a report, with Members reminded that this has been a longstanding matter, dating back to 2015 and 2016. The combined action plan presented merges recommendations from the two reviews. Outstanding actions relate to areas where progress is subject to a number of issues. It is not felt that this matter justifies a separate monitoring group, when there are other Task & Finish groups and other measures in place. Certain of these fall into the remit of the Women & Children's Directorate work. This view is shared by the Hywel Dda Community Health Council (CHC). The Committee welcomed this useful update, recognising the work undertaken within a challenging environment. It was suggested that the outstanding actions form part of the UHB's overall service development, rather than a separate specific workstream. Whilst a separate group had been important in initially responding to the action plans, it was less crucial now that the organisation has the required 'line of sight' on progress. It was agreed that the Audit Tracker and Strategic Log should be updated to reflect these discussions (subject to agreement at Executive Team) and that this is not a matter for ARAC going forward. The issues have been largely resolved and those outstanding are part of the UHB's overall Health & Care Strategy. It was emphasised that these decisions do not minimise the significance of the outstanding actions, and Members noted that an update report on Paediatrics is due to be submitted to Public Board in July 2019.

- **Audit Tracker** – the UHB Central Tracker, which tracks progress against audits and inspections undertaken within the UHB, was presented.

- **Finance Committee Assurance Report around the Discharge of their Terms of Reference** – the Committee received a report detailing Finance Committee activities during 2018/19. The Committee was assured that the Finance Committee is operating in accordance with its Terms of Reference and discharging its duties effectively on behalf of the Board.

- **Charitable Funds Committee (CFC) Assurance Report around the Discharge of their Terms of Reference** – the Committee received a report detailing CFC activities during 2018/19. The Committee was assured that the CFC is operating in accordance

with its Terms of Reference and discharging its duties effectively on behalf of the Board.

- **Declaring, Registering and Handling Interests, Gifts, Hospitality, Honoraria and Sponsorship** – having considered the report presented, the Committee was assured by the adequacy of the arrangements currently in place and the proposed steps for 2019/20 to improve the adequacy of these arrangements.

- **HDdUHB's Standing Orders and Standing Financial Instructions** – the Committee considered the local amendments to HDdUHB's Standing Orders and Standing Financial Instructions and recommended the revised version for approval by the Board.

- **Financial Assurance Report** – the Committee received the Financial Assurance report. Members discussed the numbers and levels of medical negligence claims. Whilst there is an increase in claims across Wales, there does not appear to be any trend specific to HDdUHB. Levels of claims are being influenced by the ability to maintain life, and the consequent impact on the costs of maintaining life. The Committee approved the losses and debtors write-offs noted within the report.

- **Counter Fraud Annual Report** – the Committee received the Counter Fraud Annual Report 2018/19.

- **Counter Fraud Work Plan** – the Committee approved the Counter Fraud Work Plan 2019/20.

- **AGW Letter/Reports** – the Committee received the following:
  - AGW Letter: Consultation on Three-year Forward Programme of Work
  - AGW Report: Preparations in Wales for a 'no-deal' Brexit
  - AGW Report: What's the hold up? Discharging Patients in Wales
  - AGW Report: Waste Management in Wales – Preventing Waste

At its meeting on 7th May 2019, the Committee critically reviewed governance and assurance processes for a number of service/business areas, with the following being highlighted:

- **Assurance Arrangements in Relation to Health Board Statutory Obligations (Legislative Assurance Framework)** – the Committee considered the Legislative Assurance Framework, noting the detail contained within and the assurance it provides to the Committee and Board.

- **NHS Non-Statutory Instruments Update (Ministerial Directions)** – the Committee noted the Non-Statutory Instruments which have been issued and endorsed the confirmation that the University Health Board is compliant with these.

- **Welsh Health Circulars** – the Committee discussed the Welsh Health Circulars (WHCs) report and was assured that there is a process in place within the UHB to monitor the implementation of WHCs.

- **Draft Audit & Risk Assurance Committee Annual Report** – The Committee endorsed the content of the draft Audit & Risk Assurance Committee Annual Report 2018/19,

subject to any additional comments received prior to approval at the Board meeting scheduled to take place on 29th May 2019, noting this would be approved by Chair's action prior to the 29th May 2019 ARAC meeting

- **Draft Governance, Leadership and Accountability Standard** – the Committee considered the content of the Draft Governance, Leadership and Accountability Standard and, subject to the amendments received, was assured that it reflects the current systems and processes relating to governance, leadership and accountability within the UHB, noting this would be approved by Chair's action prior to the 29th May 2019 ARAC meeting.

- **Draft Accountability Report** – subject to amendments, the Committee supported the content of the draft Accountability Report, noting this would be approved by Chair's action prior to 29th May 2019 ARAC meeting.

- **Draft Annual Head of Internal Audit Report** – the Committee received the Draft Head of Internal Audit Report and Opinion 2018/19, and was informed that the UHB has achieved a Reasonable Assurance rating. Following discussion regarding hosted organisations and assurance relating to the services they supply to the UHB, it was agreed that relevant reports, particularly those rated Limited Assurance, should be considered by ARAC and issues addressed where possible.

- **Annual Quality Statement (AQS)** – the Committee received the draft AQS, with Members noting that the date by which this needs to be published has been brought forward by WG. The Committee noted the process followed by the UHB in order to compile the 2018/19 AQS and received assurance that the AQS complied with the requirements of the Welsh Health Circular.

- **Audit Enquiries to Those Charged with Governance and Management** – the Committee discussed the proposed response and, subject to minor amendments, approved its submission via the Annual Accounts process to the Auditor General for Wales.

- **Draft Annual Accounts 2018/19** – the Committee received the draft Annual Accounts 2018/19, which have been prepared in accordance with the Welsh Government timetable and guidelines. The draft accounts were reviewed, with it noted that the final annual accounts will be presented to both ARAC and Public Board on 29th May 2019.

**Materion y Mae Angen Ystyriaeth neu Gymeradwyaeth Lefel y Bwrdd ar eu Cyfer: Matters Requiring Board Level Consideration or Approval:**

- Continued concerns regarding EWTD non-compliance among switchboard lone-workers, originally identified within the IM&T Directorate report. Members felt that there is a lack of clarity around actions being taken in the short term to address this, or when the position will be resolved.
  - The Committee agreed that this matter should be raised again to Board.
- Concerns regarding outcomes of the WAO Clinical Coding Review.
  - To be monitored by BPPAC, with an update on progress scheduled for ARAC in six months' time.
- To recognise progress and improvements relating to Clinical Audit.

- Clinical Audit will continue to be monitored, with a further update due in August 2019.
- To note the update regarding Radiology and that timescales for actions have been extended.
  - The Committee agreed that there should be a further update in October 2019 to assess progress.
- To note discussions around the Internal Audit National Standards for Cleaning Follow-up report (Limited Assurance), particularly issues with the management response.
  - The Committee agreed that the management response would be revised and presented to the June 2019 meeting.
- Concerns regarding the Internal Audit Water Safety report (Limited Assurance).
  - It was agreed that a follow-up audit be conducted, which would examine different sites to those in the original audit and that, due to the seriousness of the report, ARAC would require assurance that the management actions have been implemented in accordance with the agreed timescales.
- To note discussions around Scrutiny of Outstanding Improvement Plans: Royal College of Paediatrics & Child Health.
  - The Committee agreed, subject to approval by the Executive Team, with the proposal that the Audit Tracker and Strategic Log should be updated to reflect discussions held in the meeting that the remaining recommendations required a strategic solution
- Declaring, Registering and Handling Interests, Gifts, Hospitality, Honoraria and Sponsorship – to note that the Committee reviewed and was assured by the adequacy of the arrangements currently in place and the proposed steps for 2019/20 to improve the adequacy of these arrangements;
- HDdUHB's Standing Orders and Standing Financial Instructions – the Committee considered the local amendments to HDdUHB's Standing Orders and Standing Financial Instructions and recommended the revised version for approval by the Board.

**Risgiau Allweddol a Materion Pryder:**
**Key Risks and Issues/Matters of Concern:**

- Concerns around the findings of the WAO Clinical Coding Follow-up Review, including staff morale and clinical engagement; and a lack of clarity around ownership;
  - An update would be scheduled for six months' time;
  - An update would be provided at the next meeting to provide assurance that this matter had been raised at Executive Team.
- Risks around performance in terms of Concerns.
  - ARAC will continue to monitor this area.
- Continued concerns regarding current patient feedback levels and lack of patient experience strategy and approach.
  - It was agreed that the Director of Finance would raise this issue at a meeting of the Executive Team.

**Busnes Cynlluniedig y Pwyllgor ar Gyfer y Cyfnod Adrodd Nesaf:**
**Planned Committee Business for the Next Reporting Period:**

**Adrodd yn y Dyfodol:**
**Future Reporting:**

In addition to the items scheduled to be reviewed as part of the Committee's work programme, following up progress of the various actions identified above will be undertaken.

**Dyddiad y Cyfarfod Nesaf:**
**Date of Next Meeting:**

29th May 2019 and 25th June 2019

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

# CYFARFOD BWRDD PRIFYSGOL IECHYD UNIVERSITY HEALTH BOARD MEETING

| | |
|---|---|
| **DYDDIAD Y CYFARFOD: DATE OF MEETING:** | 30 May 2019 |
| **TEITL YR ADRODDIAD: TITLE OF REPORT:** | Revised Standing Orders, Standing Financial Instructions and Committee Terms of Reference |
| **CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:** | Joanne Wilson, Board Secretary |
| **SWYDDOG ADRODD: REPORTING OFFICER:** | Alison Gittins, Head of Corporate & Partnership Governance |

| **Pwrpas yr Adroddiad** (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate) |
|---|
| Ar Gyfer Penderfyniad/For Decision |

## ADRODDIAD SCAA SBAR REPORT

### Sefyllfa / Situation

To present Hywel Dda University Health Board's (HDdUHB's) revised Standing Orders (SOs) and revised Standing Financial Instructions (SFIs) for approval to the Board, following agreement to these amendments by the Audit and Risk Assurance Committee (ARAC) on 23rd April 2019.

Welsh Government has made no recent amendments to the model SOs and SFIs however paragraph 11.0.2 of the SOs states that these should be reviewed annually by Health Boards and Trusts Audit Committees, and any proposed amendments reported to the Board for consideration.

Welsh Government has recently commenced a review of the model SOs and revised versions have been shared with members of the Board Secretaries Network and colleagues in Welsh Government for comment. It is intended that following consideration of these comments, legal advice will be sought prior to issuing the model SOs to the service with an anticipated time frame of Summer 2019.

The Terms of Reference of the following Board level Committees and Advisory Groups are also attached for the Board's approval:

- Charitable Funds Committee
- Finance Committee
- Primary Care Applications Committee
- Healthcare Professionals Forum

The following Terms of Reference have recently been approved by the Board on 28th March 2019:

- Audit & Risk Assurance Committee
- Business Planning & Performance Assurance Committee
- Quality, Safety & Experience Assurance Committee
- Stakeholder Reference Group

The following Terms of Reference will be presented to the Board for approval on 25th July 2019

following review by their respective Committees:

- University Partnership Board on 29th May 2019
- Mental Health Legislation Assurance Committee on 24th June 2019
- Remuneration & Terms of Service Committee on 27th June 2019

The following Terms of Reference will be presented to the Board for approval on 26th September 2019 following review by the Forum:

- Staff Local Partnership Forum on 5th August 2019

## Cefndir / Background

The Board approved the original version of the Standing Orders (SOs) and Standing Financial Instructions (SFIs) at its meeting in July 2010 and revised versions in September 2011, September 2012, May 2014, November 2015, January 2017 and March 2018.

In line with good governance practice, the SOs and SFIs have been reviewed and updated to account for any local amendments and these amendments have been presented to ARAC on 23rd April 2019 for comment, prior to recommending their onward submission for approval to the Board.

## Asesiad / Assessment

**Standing Orders (SOs)**
As Welsh Government has made no recent amendments to the model SOs, following on from the previously agreed changes to the SOs by the Board in March 2018, only the following further local amendment is required as summarised below:

| Section | What has changed? | Why? |
|---|---|---|
| **6.2** | **6. Meetings**<br>**Annual Plan of Board Business**<br>6.2.4 - amended 'The Annual Plan of Board Business up to March 20~~19~~20 can be found in Schedule 6'. | Change of date to reflect current 2019/20 period. |

**Schedule 1 – Model Scheme of Reservation and Delegation of Powers**

Following presentation to the Audit and Risk Assurance Committee in September 2018, the Scheme of Delegation was approved by the Board at its meeting on 29th November 2018. This detailed electronic scheme of delegation encompasses all delegations including Standing Orders, Standing Financial Instructions, financial delegations, legislative compliance, other delegations and responsibilities, both at delegated lead and operational responsibility level. It has been further expanded through Directorate delegations and is kept under regular review. It can be accessed via the following link:

http://www.wales.nhs.uk/sitesplus/862/page/49971

**Schedule 2 – Key Guidance, Instructions and Other Related Documents**
**Schedule 2.1 - Standing Financial Instructions (SFIs), Standing Orders (SOs)**
As Welsh Government has made no recent amendments to the model SFIs, following on from the previously agreed change to the SFIs by the Board in March 2018, which involved a change of title from the Director of Finance, Planning & Performance to the Director of Finance to reflect the distinct role of the post-holder, only the following further local amendment is required as summarised overleaf:

| Section | What has changed? | Why? |
|---|---|---|
| **1.1.3** | Amended 'These SFIs identify the financial responsibilities which apply to everyone working for the LHB and its constituent organisations. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Director of Finance and ~~Audit~~ Finance Committee. | Changed to reflect this is now a responsibility of the Finance Committee as per their Terms of Reference. |

**Schedule 3 – Board Committee Arrangements**

Terms of Reference for HDdUHB's Board level Committees were reviewed in 2016 to reflect the new committee structure from the findings of the External Governance Review. These were most recently presented to the Board as part of their annual review for approval in March 2018.

All Terms of Reference for Board level Committees have been reviewed and any changes approved by their respective Committees, with the exception of:

- University Partnership Board - to be reviewed at their next meeting scheduled for 29th May 2019
- Mental Health Legislation Assurance Committee – to be reviewed at their next meeting scheduled for 24th June 2019
- Remuneration & Terms of Service Committee – to be reviewed at their next meeting scheduled for 27th June 2019
- Staff Local Partnership Forum – to be reviewed at their meeting scheduled for 5th August 2019

All Terms of Reference for all Board level Committees are made available to Members within the Resource section of iBabs.

The Board is also asked to note the progress made against the remaining schedules, as follows:

**Schedule 4 - Joint Committee Arrangements**

No changes have been made to date to Joint Committee arrangements in terms of:

- Welsh Health Specialised Services Committee (WHSSC) - with links available to the latest version of their SOs and SFIs (16th November 2015) http://www.whssc.wales.nhs.uk/sitesplus/documents/1119/WHSSC%20GAF%20-%20Jan%202018.pdf
- Emergency Ambulance Services Committee (EASC) - SOs and SFIs reviewed and updated 2017/18 and available on request
- NHS Wales Shared Services Partnership Committee - with links available to the latest version of their SOs (1st March 2019), and SFIs (December 2015 - Velindre) http://www.nwssp.wales.nhs.uk/sitesplus/documents/1178/Standing%20Orders%20for%20Operation%20of%20SSPC%20-%20FINAL%2001032019.pdf http://www.nwssp.wales.nhs.uk/sitesplus/documents/1178/GC%2002%20Velindre%20Trust%20SOs%20and%20SFIs%20ver%2020.%20May%202016.pdf

Links have also been added into this section to the Terms of Reference for the following additional Joint Committees:

- Mid Wales Joint Committee for Health and Social Care - with links available to their Terms of Reference following their approval by the Board on 25th January 2018 http://www.wales.nhs.uk/sitesplus/documents/862/Item%206.5%20Mid%20Wales%20Healthcare%20Collaborative%20Update%20Report%20including%20Mid%20Wales%20Joint%20Committee%20for%20Health%20and.pdf
- Joint Regional Planning & Delivery Committee – with links available to their Terms of Reference following their approval by the Board on 28th September 2017 http://www.wales.nhs.uk/sitesplus/documents/862/Item24.JointRegionalPlanningandDeliveryCommitteeUpdateReport.v1final.pdf

Links to the Terms of Reference for all Joint Committees will be made available to Members within the Resource section of iBabs.

**Schedule 5 – Advisory Groups**

Terms of Reference for the Stakeholder Reference Group were approved by the Board on 28th March 2019. The Healthcare Professionals Forum Terms of Reference were reviewed at their meeting on 9th April 2019 and are presented to the Board for approval.

The Staff Local Partnership Forum Terms of Reference are due for consideration at the Forum meeting scheduled for 5th August 2019 and will be presented to the Board for approval on 26th September 2019.

All Terms of Reference for all Advisory Groups are made available to Members within the Resource section of iBabs.

**Schedule 6 – Board Business Plan**

This is an added Schedule to the Standing Orders which will contain the Board's Plan of Business (as per paragraph 6.2.4 of the SOs) and the Schedule of Board and Committee meetings up to March 2020.

The annual Schedule of Board and Committee meetings up to March 2020 is made available to Members within the Resource section of iBabs, and maintained and updated using version control.

**Argymhelliad / Recommendation**

The Board is asked to:

- Approve the revised version of HDdUHB's Standing Orders
- Approve the revised version of HDdUHB's Standing Financial Instructions
- Approve the following Board level Committee and Advisory Group ToRs:
  - Charitable Funds Committee
  - Finance Committee
  - Primary Care Applications Committee
  - Healthcare Professionals Forum

| **Amcanion: (rhaid cwblhau)**<br>**Objectives: (must be completed)** | |
|---|---|
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: | Not Applicable |

| | |
|---|---|
| Datix Risk Register Reference and Score: | |
| Safon(au) Gofal ac Iechyd:<br>Health and Care Standard(s): | Governance, Leadership and Accountability |
| Amcanion Strategol y BIP:<br>UHB Strategic Objectives: | Not Applicable |
| Amcanion Llesiant BIP:<br>UHB Well-being Objectives:<br>Hyperlink to HDdUHB Well-being Statement | Not Applicable |

| **Gwybodaeth Ychwanegol:<br>Further Information:** | |
|---|---|
| Ar sail tystiolaeth:<br>Evidence Base: | Model Standing Orders and Standing Financial Instructions |
| Rhestr Termau:<br>Glossary of Terms: | Included within the body of the report |
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol:<br>Parties / Committees consulted prior to University Health Board: | Audit & Risk Assurance Committee |

| **Effaith: (rhaid cwblhau)<br>Impact: (must be completed)** | |
|---|---|
| **Ariannol / Gwerth am Arian:<br>Financial / Service:** | Robust governance arrangements underpinning financial management contribute towards internal control and value for money being achieved. |
| **Ansawdd / Gofal Claf:<br>Quality / Patient Care:** | Where applicable, included within the report. |
| **Gweithlu:<br>Workforce:** | Where applicable, included within the report. |
| **Risg:<br>Risk:** | A sound system of internal control ensures that any risks to the achievement of the Health Board's objectives are identified, assessed and managed. |
| **Cyfreithiol:<br>Legal:** | Model SOs are issued by Welsh Ministers to Health Boards using powers of direction provided in section 12 (3) of the National Health Service (Wales) Act 2006. Health Boards in Wales must agree SOs for the regulation of their proceedings and business. 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 SFIs, they provide the regulatory framework for the business conduct of the Health Board. |
| **Enw Da:**<br>**Reputational:** | Not Applicable |
| **Gyfrinachedd:**<br>**Privacy:** | No direct impacts. |
| **Cydraddoldeb:**<br>**Equality:** | The model SOs and SFIs have been subject to an Equality Impact Assessment as part of the NHS Reform Programme, and the revised SOs were subject to an in-house EqIA screening in September 2012, the outcome of which indicated no negative impacts in relation to the Health Board's duties under the Equality Act 2010. A summary report was produced to this effect. The March 2014 revisions have been scrutinised with no negative impacts identified, therefore, no amendments will be made to the report produced in September 2012.<br><br>The most recent amendments, outlined above, are in the main associated with changes to titles and dates. It is not anticipated that this will have an adverse impact on any protected group. |

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# Model Standing Orders

## Reservation and Delegation of Powers

# for Local Health Boards

**Updated- April 2019**

Llywodraethu da.....calon iechyd da
Good Governance.....at the heart of good health care

# 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. They 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, 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 www.wales.nhs.uk/governance-emanual/

# Contents

# Section A – Introduction

**Statutory framework**

i) The Hywel Dda 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 (W.66))**, "the Establishment Order".

ii) The principal place of business of the LHB is Corporate Offices, Ystwyth Building, Hafan Derwen, St David's Park, Carmarthen, SA31 3BB.

iii) All business shall be conducted in the name of Hywel Dda LHB, and all funds received in trust shall be held in the name of the LHB as a corporate Trustee.

iv) LHBs are corporate bodies and their functions must be carried out in accordance with their statutory powers and duties. Their statutory powers and duties are mainly contained in the **NHS (Wales) Act 2006 (c.42)** which is the principal legislation relating to the NHS in Wales. Whilst the **NHS Act 2006 (c.41)** applies equivalent legislation to the NHS in England, it also contains some legislation that applies to both England and Wales. The NHS (Wales) Act 2006 and the NHS Act 2006 are a consolidation of the NHS Act 1977 and other health legislation which has now been repealed. The NHS (Wales) Act 2006 contains various powers of the Welsh Ministers to make subordinate legislation and details how LHBs are governed and their functions.

v) Under powers set out in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006, the Minister has made **the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 (S.I. 2009/779 (W.67))** ("The Constitution Regulations") which set out the constitution and membership arrangements of LHBs. 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 (W.147)).**

vi) 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.

vii) **The Welsh Health Specialised Services Committee (Wales) Directions 2009 (2009/35)** provide that the seven LHBs in Wales will work jointly to exercise functions relating to the planning and securing of specialised and

tertiary services and for the purpose of jointly exercising those functions will establish the Welsh Health Specialised Services Committee ("the Joint Committee"). Under powers set out in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006, the Minister has made **The Welsh Health Specialised Services Committee (Wales) Regulations 2009 (S.I. 2009/3097 (W.270))** which make provision for the constitution and membership of the Joint Committee including its procedures and administrative arrangements.

viii) In addition to directions the Welsh Ministers may from time to time issue guidance which LHBs must take into account when exercising any function.

ix) As a statutory body, the LHB has specified powers to contract in its own name and to act as a corporate trustee. The LHB also has statutory powers under sections 194 and 195 of the NHS (Wales) Act 2006 to fund projects jointly planned with local authorities, voluntary organisations and other bodies.

x) The **National Health Service Bodies and Local Authorities Partnership Arrangements (Wales) Regulations 2000 (S.I. 2000/2993 (W.193))** 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 health improvement plan of the relevant health plan.

xi) Section 72 of the NHS Act 2006 places a duty on NHS bodies to co-operate with each other in exercising their functions.

xii) Section 82 of the NHS Act 2006 places a duty on NHS bodies and local authorities to co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales.

xiii) Section 5 of the Welsh Language Act 1993 (c.38) places a duty on public bodies to implement a Welsh Language Scheme which outlines how the LHB will comply with its statutory responsibility to provide services through the medium of Welsh. The Welsh Language (Wales) Measure 2011 (2011 nawm 1) makes provision with regards to the development of standards of conduct relating to the Welsh language which will replace the existing system of Welsh Language Schemes provided for by the 1993 Act.

xiv) 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.

xv) 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”.

**NHS framework**

xvi) 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 Assembly 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 is expected at all levels of the service, locally and nationally.

xvii) 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.

xviii) 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.

xix) The Welsh Ministers, reflecting their constitutional obligations, has stated that sustainable development should be the central organising principle for the public sector and a core objective for the restructured NHS in all it does.

xx) 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 www.wales.nhs.uk/governance-emanual/. Directions or guidance on specific aspects of LHB business are also issued in hard copy, usually under cover of a Ministerial letter.

**Local Health Board Framework**

xxi) 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.

xxii) 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 Hywel Dda 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.

xxiii) 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 xxxi below).

xxiv) 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**

xxv) The SOs of the LHB (together with SFIs and the Values and Standards of Behaviour Framework), will, as far as they are applicable, also apply to meetings of any formal Committees established by the LHB, including any Advisory Groups, sub-Committees, joint-Committees and joint sub-Committees. These SOs may be amended or adapted for the Committees as appropriate, with the approval of the Board. *Further details on committees may be found in Schedule 3 of these SOs*.

xxvi) 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 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. **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**

xxvii) 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 Committee and is the subject of a formal report to the Board; and
- A notice of motion under Standing Order 6.5.14 has been given.

**Interpretation**

xxviii) During any Board meeting where there is doubt as to the applicability or interpretation of the SOs, the Chair of the LHB shall have the final say, provided that his or her decision does not conflict with rights, liabilities or duties as prescribed by law. In doing so, the Chair shall take appropriate advice from the Board Secretary and, where appropriate the Chief Executive or the Director of Finance (in the case of SFIs).

xxix) 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**

xxx) 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:

- 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.

xxxi) 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, and reports on a day to day basis to the Chief Executive.

xxxii) Further details on the role of the Board Secretary within Hywel Dda LHB, including details on how to contact them, are available upon request from the Corporate Offices, Ystwyth Building, Hafan Derwen, St David's Park, Carmarthen, SA31 3BB.

# 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 (W.66)) and most of its functions are contained in the **Local Health Boards (Directed Functions) (Wales) Regulations 2009** (S.I. 2009/1511 (W.147)). 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.

**Membership of the Local Health Board**

1.1.1 The membership of the LHB shall be no more than 20 members comprising the Chair and the Vice Chair (both appointed by the Minister for Health and Social Services), the Chief Executive (appointed by the Board with the involvement of the Chief Executive, NHS Wales) and officer and non officer members.

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 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.

*Associate Members*

1.1.5 The following Associate Members, appointed by the Minister for Health and Social Services, will attend Board meetings on an ex-officio basis, but will not have any voting rights:

- Director of Social Services (nominated by local authorities in the LHB area)
- Chair of the Stakeholder Reference Group
- Chair of the Healthcare Professionals' Forum

1.1.6 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'*

1.1.7 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.

**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.

**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 serve 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, with a maximum term of four years if re-appointed.

1.3.3 Executive Directors' tenure of office as Board members will be determined by their contract of appointment.

1.3.4 All Board members' tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements, so far as they are applicable, as specified in Schedule 2 of the Constitution Regulations. Any member must inform the Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office. The Chair will advise the Minister in writing of any such cases immediately.

1.3.5 The LHB will require Board members to confirm in writing their continued eligibility on an annual basis.

**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 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.

1.4.5 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.

1.4.6 **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.

1.4.7 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.

1.4.8 **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.

1.4.9 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.

1.4.10 **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.

1.4.11 **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 2.0.4, the LHB retains full responsibility for any functions delegated to others to carry out on its behalf. Where LHBs have a joint duty, e.g. to produce a Health, Social Care and Well Being Strategy or for the provision of Shared/Hosted Services, the LHB remains fully responsible for its part, and shall agree through the determination of a written Partnership Agreement the governance and assurance arrangements for the partnership, setting out respective responsibilities, ways of working, accountabilities and sources of assurance of the partner

organisations.

2.0.4 **NHS Wales Shared Services**

***Background Information***

In 2011 the NHS bodies in Wales, together with the Welsh Assembly Government (as it then was) decided to bring together various support services functions across the NHS in Wales under a single management team as a “virtual” Shared Services entity.

In September 2011 the Welsh Ministers gave authority to proceed with the transfer of responsibility for the provision of Shared Services from the virtual model to a body hosted within NHS Wales.

Following an invitation to all NHS bodies to express an interest in becoming the host organisation, Velindre NHS Trust was confirmed as the host organisation on 22nd November 2011.

***Arrangements from 1st June 2012***

From 1st June 2012 the function of managing and providing Shared Services to the health service in Wales was given to Velindre NHS Trust. The Trust’s Establishment Order has been amended to reflect the fact that the Shared Services function has been conferred on it.

The **Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012** (S.I. 2012/1261 (W.156)) (“the Shared Services Regulations”) require the Trust to establish a Shared Services Committee which will be responsible for exercising the Trust’s Shared Services functions. The Shared Services Regulations prescribe the membership of the Shared Services Committee in order to ensure that all LHBs and Trusts 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.

The Director of Shared Services will be designated as Accountable officer for Shared Services.

These new arrangements also necessitate putting in place a new Memorandum of Co-operation Agreement and a Hosting Agreement between all LHBs and Trusts setting out the obligations of NHS bodies to participate in the Shared Services Committee and to take collective responsibility for setting the policy and delivery of the Shared Services to the health service in Wales. Responsibility for the exercise of the Shared Services functions will not rest with the Board of Velindre NHS Trust but

will be a shared responsibility of all NHS bodies in Wales.

The Shared Services Committee is to be known as the Shared Services Partnership Committee for operational purposes.

## 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. The Board Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Board for consideration and ratification.

2.1.2 Chair's action may not be taken where either the Chair or the Chief Executive has a personal or business interest in an urgent matter requiring decision. In this circumstance, the Vice-Chair or the Executive Director acting on behalf of the Chief Executive will take a decision on the urgent matter, as appropriate.

## 2.2 Delegation of Board functions

2.2.1 The Board shall agree the delegation of any of their functions 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 shall agree and formally approve the delegation of specific executive powers to be exercised by Committees, Sub-Committees, joint Committees or joint sub-Committees which it has formally constituted.

## 2.3 Delegation to officers

2.3.1 The Board will 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 amendment 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.

### 3.3 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 (via Business Planning & Performance Assurance Committee structure);
- 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.

*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.*

3.4.3 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. *Detailed terms of reference and operating arrangements for the Committees established by the Board are set out in Schedule 3.*

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 normally be appointed as Committee Chairs, nor should they be appointed to serve as members on any Committee set up to review the exercise of functions delegated to officers or to review Mental Health Tribunals (in accordance with the Mental Health Act 1983). Designated LHB officers shall, however, be in attendance at such Committees, as appropriate.

### 3.5 Joint Committees established by the LHB

3.5.1 The LHB has a duty to co-operate with other NHS bodies in exercising its functions, and with local authorities in order to secure and advance the health and welfare of its citizens. To help discharge these duties and meet the Board's commitment to working in partnership, the Board may and, where directed by the Welsh Ministers must, establish joint-Committees to support it 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 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.

3.5.2 The Board shall establish, as a minimum, the following joint-Committee:

- The Welsh Health Specialised Services Committee (WHSSC).

*Joint Committee Standing Orders, terms of reference and operating arrangements*

3.5.3 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.

3.5.4 In doing so, the Board shall specify which aspects of these SOs are not applicable to the operation of the joint-Committee, keeping any such aspects to the minimum necessary. The detailed SOs or terms of reference and operating arrangements for those joint-Committees established by the Board are set out in Schedule 4.

## 3.6 Other Committees

3.6.1 The Board may also establish other Committees to help the LHB in the conduct of its business.

## 3.7 Confidentiality

3.7.1 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.

## 3.8 Reporting activity to the Board

3.8.1 The Board must ensure that the Chairs of all Committees operating on its behalf report formally, regularly and on a timely basis to the Board on their

activities. Committee Chairs' shall bring to the Boards specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

## 4. ADVISORY GROUPS

4.0.1 The LHB has a statutory duty to take account of representations made by persons 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.

4.0.2 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.*

4.0.3 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.

### 4.1 Confidentiality

4.1.1 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.

### 4.2 Reporting activity

4.2.1 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.

4.2.2 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.

4.2.3 Each Advisory Group shall report regularly on its activities to those whose interests they represent.

## 4.3 THE STAKEHOLDER REFERENCE GROUP (SRG)

*Role*

4.3.1 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.

4.3.2 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.

4.3.3 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.

4.3.4 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.

4.3.5 The LHB may specifically request advice and feedback from the SRG on any aspect of its business, and the SRG may also offer advice and feedback even if not specifically requested by the LHB. The SRG may provide advice to the Board:

- At Board meetings, through the SRG Chair's participation as Associate Member;
- In written advice; and
- In any other form specified by the Board.

## 4.4 Terms of reference and operating arrangements

4.4.1 The Board must formally approve terms of reference and operating arrangements for the SRG. 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 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 community partnerships such as Local Service Boards;
- Any budget and financial responsibility;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

4.4.2 In doing so, the Board shall specify which of these SOs are not applicable to the operation of the SRG, keeping any such aspects to the minimum necessary. The detailed terms of reference and operating arrangements are set out in Schedule 5.

4.4.3 The Board may determine that the SRG shall be supported by sub-groups to assist it in the conduct of its work, or the SRG may itself determine such arrangements, provided that the Board approves such action.

### 4.5 Membership

4.5.1 The membership of the SRG, including the approval of nominations to the Group; the appointment of Chair and Vice Chair; definition of member roles, powers and terms and conditions of appointment (including remuneration and reimbursement) will be determined by the Board, taking account of the views of its stakeholders.

4.5.2 There shall be no minimum or maximum requirement in terms of membership size. In determining the number of members, the Board shall take account of the need to ensure the SRG's size is optimal to ensure focused and inclusive activity.

4.5.3 Membership must be drawn from within the area served by LHB, and shall ensure involvement from a range of bodies and groups operating within the communities serviced by the LHB. Where the Board determines it appropriate, the LHB may extend membership to individuals in order to represent a key stakeholder group where there are not already formal bodies or groups established or operating within the area and who may represent the interests of these stakeholders on the SRG.

4.5.4 In determining the overall size and composition of the SRG, the Board must take account of the:

- Demography of the areas served by the LHB;
- Need to encourage and reflect the diversity of the locality, to incorporate different ages, race, religion and beliefs, sexual orientation, gender, including transgender, disability and socio-economic status. Where appropriate, the LHB shall support positive action to increase representation;
- Balance needed in both the range of difference stakeholders and the geographical areas covered, taking particular care to avoid domination by any particular stakeholder type or geographical area;
- Design and operation of the partnership/stakeholder fora already influencing the work of the LHB at local community levels;
- Need to complement, and not duplicate the work of CHCs; and
- Need to guard against the over involvement of particular stakeholders through their roles across the range of partnership/stakeholder arrangements in place.

4.5.5 The Board shall keep under review the size and composition of the SRG to ensure it continues to reflect an appropriate balance in stakeholder representation.

**4.6 Member Responsibilities and Accountability:**

*The Chair*

4.6.1 The Chair is responsible for the effective operation of the SRG:

- Chairing Group meetings;
- Establishing and ensuring adherence to the standards of good governance set for the NHS in Wales, ensuring that all Group business is conducted in accordance with its agreed operating arrangements; and
- Developing positive and professional relationships amongst the Group's membership and between the Group and the LHB's Board and its Chair and Chief Executive.

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

4.6.3 As Chair of the SRG, they will be appointed as an Associate Member of the LHB Board. The Chair is accountable for the conduct of their role as

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

*The Vice Chair*

4.6.4 The Vice-Chair shall deputise for the Chair in their absence for any reason, and will do so until either the existing Chair resumes their duties or a new chair is appointed, and this deputisation includes acting in the role of Associate Member of the LHB Board.

4.6.5 The Vice Chair is accountable, through the SRG Chair to the LHB Board, for their performance as Vice Chair, and to their nominating body or grouping for the way in which they represent their views at the SRG.

*Members*

4.6.6 The SRG shall function as a coherent Advisory Body, all members being full and equal members and sharing responsibility for the decisions of the SRG.

4.6.7 All members must:

- Be prepared to engage with and contribute fully to the SRG's activities and in a manner that upholds the standards of good governance – including the values and standards of behaviour – set for the NHS in Wales;
- Comply with their terms and conditions of appointment;
- Equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes; and
- Promote the work of the SRG within the communities it represents.

4.6.8 SRG members are accountable, through the SRG Chair to the LHB Board for their performance as Group members, and to their nominating body or grouping for the way in which they represent the views of their body or grouping at the SRG.

### 4.7 Appointment and terms of office

4.7.1 Appointments to the SRG shall be made by the Board, based upon nominations received from stakeholder bodies/groupings. The Board may seek independent expressions of interest to represent a key stakeholder

group where it has determined that formal bodies or groups are not already established or operating within the area that may represent the interests of these stakeholders on the SRG.

4.7.2 The nomination and appointment process shall be open and transparent, and in accordance with any specific requirements or directions made by the Welsh Ministers. The appointments process shall be designed in a manner that meets the communication and involvement needs of all stakeholders eligible for appointment;

4.7.3 Members shall be appointed for a period specified by the Board, but for no longer than 3 years in any one term. Those members can be reappointed but may not serve a total period of more than 5 years consecutively. The Board may, where it considers it appropriate, make interim or short term appointments to the SRG to fulfil a particular purpose or need.

4.7.4 The ***Chair*** shall be nominated from within the membership of the SRG, by its members, in a manner determined by the Board, subject to any specific requirements or directions made by the Welsh Ministers. The nomination shall be subject to consideration by the LHB Board, who must submit a recommendation on the nomination to the Minister for Health and Social Services. The appointment as Chair shall be made by the Minister, but it shall not be a formal public appointment. The Constitution Regulations provide that the Welsh Ministers may appoint an Associate Member of the Board, and the appointment of the Chair to this role is on the basis of the conditions of appointment for Associate Members set out in the Regulations.

4.7.5 The Chair's term of office shall be for a period of up to two (2) years, with the ability to stand as Chair for an additional one (1) year, in line with that individual's term of office as a member of the SRG. That individual may remain in office for the remainder of their term as a member of the SRG after their term of appointment as Chair has ended.

4.7.6 The ***Vice Chair*** shall be nominated from within the membership of the SRG, by its members, in a manner determined by the Board, subject to any specific requirements or directions made by the Welsh Ministers. The nomination shall be subject to consideration and appointment by the LHB Board. The Constitution Regulations provide that the Welsh Ministers may appoint an Associate Member of the Board. In the SRG Chair's absence, the Vice Chair shall also perform the role of Associate Member on the LHB Board. The appointment of the Vice Chair is therefore also on the basis of the conditions of appointment for Associate Members set out in the Regulations.

4.7.7 The Vice Chair's term of office shall be for a period of up to two (2) years, with the ability to stand as Vice Chair for an additional one (1) year, in line

with that individual's term of office as a member of the SRG. That individual may remain in office for the remainder of their term as a member of the SRG after their term of appointment as Vice Chair has ended.

4.7.8 A member's tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements determined for the position. A member must inform the SRG Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office. The SRG Chair will advise the Board in writing of any such cases immediately.

4.7.9 The LHB will require SRG members to confirm in writing their continued eligibility on an annual basis.

### 4.8 Resignation, suspension and removal of members

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

4.8.2 If the Board, having consulted with the SRG Chair and the nominating body or group, considers that:

- It is not in the interests of the health service in the area covered by the SRG that a person should continue to hold office as a member; or
- It is not conducive to the effective operation of the SRG

it shall remove that person from office by giving immediate notice in writing to the person and the relevant nominating body or group.

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

4.8.4 If an SRG member fails to attend any meeting of the Group for a period of six months or more, the Board may remove that person from office unless they are satisfied that:

i The absence was due to a reasonable cause; and
ii The person will be able to attend such meetings within such period as the Board considers reasonable.

4.8.5 Before making a decision to remove a person from office, the Board may suspend the tenure of office of that person for a limited period (as determined by the Board) to enable it to carry out a proper investigation of the circumstances leading to the consideration of removal. Where the Board suspends any member, that member shall be advised immediately

in writing of the reasons for their suspension. Any such member shall not perform any of the functions of membership during a period of suspension.

### 4.9 Relationship with the Board

4.9.1 The SRG's main link with the Board is through the SRG Chair's membership of the Board as an Associate Member.

4.9.2 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.

4.9.3 The Board shall determine the arrangements for any joint meetings between the LHB Board and the SRG.

4.9.4 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.

### 4.10 Relationship between the SRG and others

4.10.1 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., Local Service Boards.

### 4.11 Working with Community Health Councils

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

4.11.2 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.

### 4.12 Support to the SRG

4.12.1 The Director of Governance, Communications and Engagement,

supported by the LHB's Board Secretary, on behalf of the Chair, will ensure that the SRG is properly equipped to carry out its role by:

- Overseeing the process of nomination and appointment to the SRG;
- Co-ordinating and facilitating appropriate induction and organisational development activity;
- Ensuring the provision of governance advice and support to the SRG Chair on the conduct of its business and its relationship with the LHB and others;
- Ensuring the provision of secretariat support for SRG meetings;
- Ensuring that the SRG receives the information it needs on a timely basis;
- Ensuring strong links to communities/groups; and
- Facilitating effective reporting to the Board

enabling the Board to gain assurance that the conduct of business within the SRG accords with the governance and operating framework it has set.

## 4.13 THE HEALTHCARE PROFESSIONALS' FORUM (HPF)

*Role*

4.13.1 The HPF's role is to provide a balanced, multi disciplinary view of healthcare professional issues to advise the Board on local strategy and delivery. Its role does not include consideration of healthcare professional terms and conditions of service.

4.13.2 The HPF shall facilitate engagement and debate amongst the wide range of clinical interests within the LHB's area of activity, with the aim of reaching and presenting a cohesive and balanced healthcare professional perspective to inform the LHB's decision making.

4.13.3 The LHB may specifically request advice and feedback from the HPF on any aspect of its business, and the HPF may also offer advice and feedback even if not specifically requested by the LHB. The HPF may provide advice to the Board:

- At Board meetings, through the HPF Chair's participation as Associate Member;
- In written advice; and
- In any other form specified by the Board.

## 4.14 Terms of reference and operating arrangements

4.14.1 The Board must formally approve terms of reference and operating arrangements for the HPF. 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) as well as the National Professional Advisory Group;
- Any budget and financial responsibility;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements

4.14.2 In doing so, the Board shall specify which aspects of these SOs are not applicable to the operation of the HPF, keeping any such aspects to the minimum necessary. The detailed terms of reference and operating arrangements are set out in Schedule 5.

4.14.3 The Board may determine that the HPF shall be supported by a range of sub-fora to assist it in the conduct of its work, e.g., special interest groups, or the HPF may itself determine such arrangements, provided that the Board approves such action.

### 4.15 Membership

4.15.1 The membership of the HPF reflects the structure of the seven health Statutory Professional Advisory Committees set up in accordance with Section 190 of the NHS (Wales) Act 2006. Membership of the HPF shall therefore comprise the following eleven (11) members, as a minimum:

- Welsh Medical Committee
  - Primary and Community Care Medical representative
  - Mental Health Medical representative
  - Specialist and Tertiary Care medical representative

- Welsh Nursing and Midwifery Committee
  - Community Nursing and Midwifery representative
  - Hospital Nursing and Midwifery representative

- Welsh Therapies Advisory Committee
  - Therapies representative

- Welsh Scientific Advisory Committee

    - Scientific representative

- Welsh Optometric Committee
    - Optometry representative

- Welsh Dental Committee
    - Dental representative

- Welsh Pharmaceutical Committee
    - Hospital Pharmacists representative
    - Community Pharmacists representative

4.15.2 Where the Board determines it appropriate, the LHB may extend membership to other individuals in order to ensure an appropriate balance in representation amongst healthcare professional groupings and across the range of primary, community and secondary service provision.

**4.16 Member Responsibilities and Accountability:**

*The Chair*

4.16.1 The Chair is responsible for the effective operation of the HPF:

- Chairing meetings;
- Establishing and ensuring adherence to the standards of good governance set for the NHS in Wales, ensuring that all business is conducted in accordance with its agreed operating arrangements; and
- Developing positive and professional relationships amongst the HPF's membership and between the HPF and the LHB's Board, and in particular its Chair, Chief Executive and clinical Directors.

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

4.16.3 As Chair of the HPF, they will be appointed as an Associate Member of the LHB Board. The Chair is accountable for the conduct of their role as Associate Member on the LHB Board to the Minister, through the LHB Chair. They are also accountable to the LHB Board for the conduct of business in accordance with the governance and operating framework set by the LHB.

*The Vice Chair*

4.16.4 The Vice-Chair shall deputise for the Chair in their absence for any reason, and will do so until either the existing chair resumes their duties or a new chair is appointed, and this deputisation includes acting in the role of Associate Member of the LHB Board.

4.16.5 The Vice Chair is accountable through the HPF Chair to the LHB Board for their performance as Vice Chair, and to their nominating body or grouping for the way in which they represent their views at the HPF.

*Members*

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

4.16.7 All members must:

- Be prepared to engage with and contribute fully to the HPF's activities and in a manner that upholds the standards of good governance – including the values and standards of behaviour – set for the NHS in Wales;
- Comply with their terms and conditions of appointment;
- Equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes; and
- Promote the work of the HPF within the healthcare professional discipline they represent.

4.16.8 Forum members are accountable through the HPF Chair to the LHB Board for their performance as Group members, and to their nominating body or grouping for the way in which they represent the views of their body or grouping at the HPF.

### 4.17 Appointment and terms of office

4.17.1 Appointments to the HPF shall be made by the Board, based upon nominations received from the relevant healthcare professional group, and in accordance with any specific requirements or directions made by the Welsh Ministers. Members shall be appointed for a period specified by the Board, but for no longer than 4 years in any one term. Those members can be reappointed but may not serve a total period of more than 8 years consecutively.

4.17.2 The ***Chair*** will be nominated from within the membership of the HPF, by its members, in a manner determined by the Board, subject to any specific requirements or directions made by the Welsh Ministers. The nomination will be subject to consideration by the Board, who must submit a

recommendation on the nomination to the Minister for Health and Social Services. Their appointment as Chair will be made by the Minister, but it will not be a formal public appointment. The Constitution Regulations provide that the Welsh Ministers may appoint an Associate Member of the Board, and the appointment of the Chair to this role is on the basis of the conditions of appointment for Associate Members set out in the Regulations.

4.17.3 The Chair's term of office will be for a period of up to two (2) years, with the ability to stand as Chair for an additional one (1) year, in line with that individual's term of office as a member of the HPF. That individual may remain in office for the remainder of their term as a member of the HPF after their term of appointment as Chair has ended.

4.17.4 The ***Vice Chair*** will be nominated from within the membership of the HPF, by its members, in a manner determined by the Board, subject to the condition that they be appointed from a different healthcare discipline to that of the Chair, along with any specific requirements or directions made by the Welsh Ministers. The nomination shall be subject to consideration and appointment by the Board. The Constitution Regulations provide that the Welsh Ministers may appoint an Associate Member of the Board. In the HPF Chair's absence, the Vice Chair will also perform the role of Associate Member on the LHB Board. The appointment of the Vice Chair is therefore also on the basis of the conditions of appointment for Associate Members set out in the Regulations.

4.17.5 The Vice Chair's term of office will be for a period of up to two (2) years, with the ability to stand as Vice Chair for an additional one (1) year, in line with that individual's term of office as a member of the HPF. That individual may remain in office for the remainder of their term as a member of the HPF after their term of appointment as Vice Chair has ended.

4.17.6 A member's tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements determined for the position. A member must inform the HPF Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office. The HPF Chair will advise the Board in writing of any such cases immediately.

4.17.7 The LHB will require Forum members to confirm in writing their continued eligibility on an annual basis.

### 4.18 Resignation, suspension and removal of members

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

4.18.2 If the Board, having consulted with the HPF Chair and the nominating body or group, considers that:

- It is not in the interests of the health service in the area covered by the HPF that a person should continue to hold office as a member; or
- It is not conducive to the effective operation of the HPF

it shall remove that person from office by giving immediate notice in writing to the person and the relevant nominating body or group.

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

4.18.4 If a member fails to attend any meeting of the HPF for a period of six months or more, the Board may remove that person from office unless they are satisfied that:

i The absence was due to a reasonable cause; and
ii The person will be able to attend such meetings within such period as the Board considers reasonable.

4.18.5 Before making a decision to remove a person from office, the Board may suspend the tenure of office of that person for a limited period (as determined by the Board) to enable it to carry out a proper investigation of the circumstances leading to the consideration of removal. Where the Board suspends any member, that member shall be advised immediately in writing of the reasons for their suspension. Any such member shall not perform any of the functions of membership during a period of suspension.

### 4.19 Relationship with the Board

4.19.1 The HPF's main link with the Board is through the HPF Chair's membership of the Board as an Associate Member.

4.19.2 The Board may determine that designated Board members or LHB officers shall be in attendance at Advisory Group meetings. The HPF's Chair may also request the attendance of Board members or LHB officers, subject to the agreement of the LHB Chair.

4.19.3 The Board shall determine the arrangements for any joint meetings between the LHB Board and the HPF.

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

## 4.20 Rights of Access to the LHB Board for Professional Groups

4.20.1 The LHB Chair, on the advice of the Chief Executive and/or Board Secretary, may recommend that the Board afford direct right of access to any professional group, in the following, exceptional circumstances:

i Where the HPF recommends that a matter should be presented to the Board by a particular healthcare professional grouping, e.g., due to the specialist nature of the issues concerned; or
ii Where a healthcare professional group has demonstrated that the HPF has not afforded it due consideration in the determination of its advice to the Board on a particular issue.

4.20.2 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.

## 4.21 Relationship with the National Professional Advisory Group

4.21.1 The HPF Chair (or HPF Vice-Chair) will be a member of the National Professional Advisory Group.

## 4.22 Support to the HPF

4.22.1 The Medical Director and Director of Clinical Strategy, supported by the LHB's Board Secretary, on behalf of the Chair, will ensure that the HPF is properly equipped to carry out its role by:

- co-ordinating and facilitating any appropriate induction and organisational development activity;
- Ensuring the provision of governance advice and support to the HPF Chair on the conduct of its business and its relationship with the LHB and others;
- Ensuring the provision of secretariat support for Forum meetings;
- Ensuring that the HPF receives the information it needs on a timely basis; and
- Facilitating effective reporting to the Board

enabling the Board to gain assurance that the conduct of business within the HPF accords with the governance and operating framework it has set.

## 4.23 THE LOCAL PARTNERSHIP FORUM (LPF)

*Role*

4.23.1 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.

4.23.2 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.

4.23.3 The LHB may specifically request advice and feedback from the LPF on any aspect of its business, and the LPF may also offer advice and feedback even if not specifically requested by the LHB. The LPF may provide advice to the Board:

- In written advice; or
- In any other form specified by the Board.

## 4.24 Terms of reference and operating arrangements

4.24.1 The Board must formally approve terms of reference and operating arrangements for the LPF. 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);
- Meeting arrangements;
- Communications;
- Relationships and accountabilities with others (including the LHB Board, its Committees and Advisory Groups, and other relevant local and national groups);
- Any budget and financial responsibility (where appropriate);
- Secretariat and other support; and
- Reporting and assurance arrangements.

4.24.2 In doing so, the Board shall specify which aspects of these SOs are not

applicable to the operation of the LPF, keeping any such aspects to the minimum necessary. The LPF will also operate in accordance with the TUC six principles of partnership working. The detailed terms of reference and operating arrangements are set out in Schedule 5.1.

4.24.3 The LPF may establish sub-fora to assist it in the conduct of its work, to facilitate:

- Ongoing dialogue, communication and consultation on service and operational management issues specific to Divisions/Directorates/Service areas; and/or
- Detailed discussion in relation to a specific issue(s).

**4.25 Membership**

4.25.1 The LHB shall agree the overall size and composition of the LPF in consultation with those staff organisations it recognises for collective bargaining. As a minimum, the membership of the LPF shall comprise:

*Management Representatives*

- LHB Chief Executive
- Director of Finance,
- Director of Workforce and Organisational Development

together with the following

- Associate Directors/Divisional Managers (as locally identified)*: and*
- Workforce and Organisational Development staff (as locally identified)

4.25.2 The LHB may determine that other Executive Directors or others may act as members or be co-opted to the LPF.

*Staff Representatives*

4.25.3 The maximum number of staff representatives shall be 21, comprising representation from those staff organisations recognised by the LHB.

*In attendance*

4.25.4 The Trade Union member of the LHB Board shall attend LPF meetings in an ex officio capacity.

4.25.5 The LPF may determine that full time officers from those staff organisations recognised by the LHB shall be invited to attend LPF meetings

## 4.26 Member Responsibilities and Accountability

*Joint Chairs*

4.26.1 The LPF shall have two Chairs on a rotational basis, one of whom shall be drawn from the management representative membership, and one from the staff representative membership.

4.26.2 The Chairs shall be jointly responsible for the effective operation of the LPF:

- Chairing meetings, rotated equally between the Staff Representative and Management Representative Chairs;
- 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 framework; and
- Developing positive and professional relationships amongst the Forum's membership and between the Forum and the LHB's Board.

4.26.3 The Chairs shall work in partnership with each other and, as appropriate, with the Chairs of the LHB's other advisory groups. Supported by the Board Secretary, Chairs shall ensure that key and appropriate issues are discussed by the Forum in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.

4.26.4 The Chairs are accountable to the LHB Board for the conduct of business in accordance with the governance and operating framework set by the LHB.

*Joint Vice Chairs*

4.26.5 The LPF shall have two Vice Chairs, one of whom shall be drawn from the Management Representative membership, and one from the staff representative membership.

4.26.6 Each Vice Chair shall deputise for their Chair in that Chairs absence for any reason, and will do so until either the existing Chair resumes their duties or a new Chair is appointed.

4.26.7 The Vice Chair is accountable to their Chair for their performance as Vice Chair.

*Members*

4.26.8 All members of the LPF are full and equal members and collectively share responsibility for its decisions.

4.26.9 All members must:

- Be prepared to engage with and contribute to the LPF's activities and in a manner that upholds the standards of good governance set for the NHS in Wales;
- Comply with their terms and conditions of appointment;
- Equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes; and
- Promote the work of the LPF within the professional discipline they represent.

**4.27 Appointment and terms of office**

4.27.1 Management representative members shall be determined by the LHB Board.

4.27.2 Staff representatives shall be determined by the staff organisations recognised by the LHB, subject to the following conditions:

- Staff representatives must be employed by the LHB and accredited by their respective trade union; and
- A member's tenure of appointment will cease in the event that they are no longer employed by the LHB or cease to be a member of their nominating trade union.

4.27.3 The *Management Representative Chair* shall be appointed by the LHB Board.

4.27.4 The *Staff Representative Chair* shall be elected from within the staff representative membership of the LPF, by staff representative members, in a manner determined by the staff representative members. The *Staff Representative Chair's* term of office shall be for one (1) year.

4.27.5 The *Management Representative Vice Chair* shall be appointed from within the management representative membership of the LPF by the Management Representative Chair.

4.27.6 The *Staff Representative Vice Chair* shall be elected from within the staff representative membership of the LPF, by staff representative members, in a manner determined by the staff representative members. The *Staff*

*Representative Vice Chair's* term of office shall be for one (1) year.

4.27.7 A member's tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements determined for the position. A member must inform their respective LPF Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on the conduct of their role.

## 4.28 Removal, suspension and replacement of members

4.28.1 If an LPF member fails to attend three (3) consecutive meetings, the next meeting of the LPF shall consider what action should be taken. This may include removal of that person from office unless they are satisfied that:

(a) The absence was due to a reasonable cause; and

(b) The person will be able to attend such meetings within such period as the LPF considers reasonable.

4.28.2 If the LPF considers that it is not conducive to its effective operation that a person should continue to hold office as a member, it may remove that person from office by giving immediate notice in writing to the person and the relevant nominating body.

4.28.3 Before making a decision to remove a person from office, the LPF may suspend the tenure of office of that person for a limited period (as determined by the LPF) to enable it to carry out a proper investigation of the circumstances leading to the consideration of removal. Where the LPF 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.

4.28.4 A nominating body may remove and, where appropriate, replace a member appointed to the LPF to represent their interests by giving immediate notice in writing to the LPF.

## 4.29 Relationship with the Board and others

4.29.1 The LPF's main link with the Board is through the Executive members of the LPF.

4.29.2 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.

4.29.3 The Board shall determine the arrangements for any joint meetings

between the LHB Board and the LPF's staff representative members.

4.29.4 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.

4.29.5 The LPF shall ensure effective links and relationships with other groups/fora at a local and, where appropriate, national level.

### 4.30 Support to the LPF

4.30.1 The LPF's work shall be supported by two designated Secretary's, one of whom shall support the staff representative members and one shall support the management representative members.

4.30.2 The Director of Workforce and OD will act as Management Representative Secretary and will be responsible for the maintenance of the constitution of the membership, the circulation of agenda and minutes and notification of meetings.

4.30.3 The Staff Representative Secretary shall be elected from within the staff representative membership of the LPF, by staff representative members, in a manner determined by the staff representatives. The Staff Representative Secretary's term of office shall be for two (2) years.

4.30.4 Both Secretaries shall work closely with the LHB's Board Secretary who is responsible for the overall planning and co-ordination of the LHB's programme of Board business, including that of its Committees and Advisory Groups.

## 5. WORKING IN PARTNERSHIP

5.0.1 The LHB shall work constructively in partnership with others to plan and secure the delivery of the best possible healthcare for its citizens, in accordance with its statutory duties and any specific requirements or directions made by the Welsh Ministers, e.g., the development of Health, Social Care and Well Being Strategies.

5.0.2 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 Local Service Boards – of Board members and LHB officers with delegated authority to represent the LHB and, as appropriate, take decisions on its behalf.

5.0.3 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.

## 5.1 Community Health Councils (CHCs)

5.1.1 The **Community Health Councils Regulations 2004** (S.I. 2004/905 (W.89)) (as amended by the **Community Health Councils (Amendment) Regulations 2005** (S.I. 2005/603 W.51)) (to the extent they are still in force), the **Community Health Councils (Constitution, Membership and Procedures) (Wales) Regulations 2010** (S.I. 2010/288 (W.37)) and the **Community Health Councils (Establishment, Transfer of Functions and Abolition) (Wales) Order 2010** (S.I. 2010/289 (W.38)) place a range of duties on LHBs in relation to the engagement and involvement of CHCs in its operations.

5.1.2 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.

5.1.3 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*

5.1.4 The Board may determine that designated CHC members shall be invited to attend Board meetings.

5.1.5 The Board shall make arrangements for regular joint meetings between the CHC members and the Board, to be held not less than four times a year and ensuring attendance of at least one third of the Board's members.

5.1.6 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.

## 6. MEETINGS

### 6.1 Putting Citizens first

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

- Active communication of forthcoming business and activities;
- The selection of accessible, suitable venues for meetings;
- The availability of papers in English and Welsh languages and in accessible formats, such as Braille, large print, easy read 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 Welsh language requirements.

6.1.2 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.

### 6.2 Annual Plan of Board Business

6.2.1 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.

6.2.2 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.

6.2.3 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.

6.2.4 The Board shall agree the plan for the forthcoming year by the end of March, and this plan will be included as a schedule to these SOs. The Annual Plan of Board Business up to March 2020 can be found in Schedule 6.

*Annual General Meeting (AGM)*

6.2.5 The LHB must hold an AGM in public no later than the 31st July each year. Public notice of the intention to hold the AGM shall be given at least 10 days prior to the meeting, and this notice shall also be made available through community and partnership networks to maximise opportunities for attendance. 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 LHB's annual Equality Report. A record of the meeting shall be submitted to the next ordinary meeting of the Board for agreement.

## 6.3 Calling Meetings

6.3.1 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.

6.3.2 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.

## 6.4 Preparing for Meetings

*Setting the agenda*

6.4.1 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.

6.4.2 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*

6.4.3 Board members shall be sent an Agenda and a complete set of supporting papers at least 7 days before a formal Board meeting. This information will be provided to Board members in electronic form and made available electronically on the Hywel Dda LHB's website. 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.

6.4.4 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. Equality impact assessments (EIA) 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 EIA shall accompany the report to the Board to enable the Board to make an informed decision.

6.4.5 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.

6.4.6 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*

6.4.7 Except for meetings called in accordance with Standing Order 6.3, at least 7 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.

6.4.8 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.

## 6.5 Conducting Board Meetings

*Admission of the public, the press and other observers*

6.5.1 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 such as an induction loop system.

6.5.2 The Board 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).

6.5.3 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.

6.5.4 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.

6.5.5 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.

6.5.6 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*

6.5.7 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*

6.5.8 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.

6.5.9 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*

6.5.10 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.

6.5.11 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.

6.5.12 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*

6.5.13 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).

6.5.14 **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.

6.5.15 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.

6.5.16 **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.

6.5.17 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.

6.5.18 **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.

6.5.19 **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.

6.5.20 **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.

6.5.21 **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.

6.5.22 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*

6.5.23 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.

6.5.24 In determining every question at a meeting the Board members must take account, where relevant, of the views expressed and representations made by individuals 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).

6.5.25 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.

6.5.26 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.

## 6.6 Record of Proceedings

6.6.1 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.

6.6.2 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 1998, and the LHB's Communication Strategy and Welsh language requirements.

## 6.7 Confidentiality

6.7.1 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 or legislation such as the Freedom of Information Act 2000, etc.

# 7. VALUES AND STANDARDS OF BEHAVIOUR

7.0.1 The Board must adopt a set of values and standards of behaviour for the LHB that meets the requirements of the NHS Wales Values and Standards of Behaviour framework. These values and standards of behaviour will apply to all those conducting business by or on behalf of the LHB, including Board members, LHB officers and others, as appropriate. The framework adopted by the Board will form part of these SOs.

## 7.1 Declaring and recording Board members' interests

7.1.1 ***Declaration of interests –*** It is a requirement that all Board members must declare any personal or business interests they may have which may affect, or be perceived to affect the conduct of their role as a Board member. This includes any interests that may influence or be perceived to influence their judgement in the course of conducting the Board's business. Board members must be familiar with the Values and Standards of Behaviour Framework and their statutory duties under the Constitution Regulations. Board members must notify the Board of any such interests at the time of their appointment, and any further interests as they arise throughout their tenure as Board members.

7.1.2 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.

7.1.3 ***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.

7.1.4 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.

7.1.5 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.

7.1.6 ***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.

## 7.2 Dealing with Members' interests during Board meetings

7.2.1 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.

7.2.2 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.

7.2.3 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.

7.2.4 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.

7.2.5 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.

7.2.6 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.

7.2.7 ***Members with pecuniary (financial) interests –*** Where a Board member, or any person they are connected with[1] has any direct or indirect pecuniary interest in any matter being considered by the Board, including a contract or proposed contract, that member must not take part in the consideration or discussion of that matter or vote on any question related to it. The Board may determine that the Board member concerned shall be excluded from that part of the meeting.

7.2.8 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

[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.

with these definitions.

7.2.9 ***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.

## 7.3 Dealing with officers' interests

7.3.1 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.

## 7.4 Reviewing how Interests are handled

7.4.1 The Audit Committee will review and report to the Board upon the adequacy of the arrangements for declaring, registering and handling interests at least annually.

## 7.5 Dealing with offers of gifts[2] and hospitality

7.5.1 The Values and Standards of Behaviour Framework adopted by the Board prohibits Board members and LHB officers from receiving gifts, hospitality or benefits in kind from a third party which may reasonably give rise to suspicion of conflict between their official duty and their private interest, or may reasonably be seen to compromise their personal integrity in any way.

7.5.2 Gifts, benefits or hospitality must never be solicited. Any Board member or LHB officer who is offered a gift, benefit or hospitality which may or may be seen to compromise their position must refuse to accept it. This may in certain circumstances also include a gift, benefit or hospitality offered to a family member of a Board member or LHB officer. Failure to observe this requirement may result in disciplinary and/or legal action.

7.5.3 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:

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

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- **Relationship:** Contacts which are made for the purpose of information gathering are generally less likely to cause problems than those which could result in a contractual relationship, in which case accepting a gift or hospitality could cause embarrassment or be seen as giving rise to an obligation;

- **Legitimate Interest:** Regard should be paid to the reason for the contact on both sides and whether it is a contact that is likely to benefit the LHB;

- **Value:** Gifts and benefits of a trivial or inexpensive seasonal nature, e.g., diaries/calendars, are more likely to be acceptable and can be distinguished from more substantial offers. Similarly, hospitality in the form of a working lunch would not be treated in the same way as more expensive social functions, travel or accommodation (although in some circumstances these may also be accepted);

- **Frequency:** Acceptance of frequent or regular invitations particularly from the same source would breach the required standards of conduct. Isolated acceptance of, for example, meals, tickets to public, and sport, 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.

7.5.4 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.

## 7.6 Register of Gifts and Hospitality

7.6.1 The Board Secretary, on behalf of the Chair, will maintain a register of Gifts and Hospitality to record offers of gifts and hospitality made to Board members. Executive Directors will adopt a similar mechanism in relation to LHB officers working within their Directorates.

7.6.2 Every Board member and LHB officer has a personal responsibility to volunteer information in relation to offers of gifts and hospitality, 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 and hospitality are kept under active review, taking appropriate action where necessary.

7.6.3 When determining what should be included in the Register, individuals shall apply the following principles, subject to the considerations in Standing Order 7.5.3:

- **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.

7.6.4 Board members and LHB officers may accept the occasional offer of modest and proportionate hospitality but in doing so must consider whether the following conditions are met:

- Acceptance would further the aims of the LHB ;
- The level of hospitality is reasonable in the circumstances;
- It has been openly offered; and,
- It could not be construed as any form of inducement and will not put the individual under any obligation to those offering it.

7.6.5 The Board Secretary will arrange for a full report of all offers of Gifts and Hospitality recorded by the LHB to be submitted to the Audit Committee at least annually. The Audit Committee will then review and report to the Board upon the adequacy of the LHB's arrangements for dealing with offers of gifts and hospitality.

## 8. SIGNING AND SEALING DOCUMENTS

8.0.1 The common seal of the LHB is primarily used to seal legal documents such as transfers of land, lease agreements and other important/key contracts. The seal may only be fixed to a document if the Board or Committee of the Board has determined it shall be sealed, or if a transaction to which the document relates has been approved by the Board or Committee of the Board.

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[3] Examples of 'modest and proportionate' hospitality that need not be included in a Hospitality register include a working sandwich lunch or a buffet lunch incidental to a conference or seminar attended by a variety of participants.

8.0.2 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.

### 8.1 Register of Sealing

8.1.1 The Board Secretary shall keep a register that records the sealing of every document. Each entry must be signed by the persons who approved and authorised the document and who witnessed the seal. A report of all sealings shall be presented to the Board at least bi-annually.

### 8.2 Signature of Documents

8.2.1 Where a signature is required for any document connected with legal proceedings involving the LHB, it shall normally be signed by the Chief Executive, except where the Board has authorised another person or has been otherwise directed to allow or require another person to provide a signature.

8.2.2 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.

### 8.3 Custody of Seal

8.3.1 The Common Seal of the LHB shall be kept securely by the Board Secretary.

## 9. GAINING ASSURANCE ON THE CONDUCT OF LHB BUSINESS

9.0.1 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.

9.0.2 The Board shall ensure that its assurance arrangements are operating effectively, advised by its Audit Committee (or equivalent).

9.0.3 Assurances in respect of the Shared Services 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.

## 9.1 The role of Internal Audit in providing independent internal assurance

9.1.1 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.

9.1.2 The Board shall set out the relationship between the Head of Internal Audit (HIA), the Audit Committee 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.

## 9.2 Reviewing the performance of the Board, its Committees and Advisory Groups

9.2.1 The Board shall introduce a process of regular and rigorous self assessment and evaluation of its own operations and performance and that of its Committees and Advisory Groups. Where appropriate, the Board may determine that such evaluation may be independently facilitated.

9.2.2 Each Committee and, where appropriate, Advisory Group must also submit an annual report to the Board through the Chair within 6 weeks of the end of the reporting year setting out its activities during the year and including the review of its performance and that of any sub-Committees it has established.

9.2.3 The Board shall use the information from this evaluation activity to inform:

- The ongoing development of its governance arrangements, including its structures and processes;

- Its Board Development Programme, as part of an overall Organisation Development framework; and
- The Board's report of its alignment with the Assembly Government's Citizen Centred Governance Principles.

### 9.3 External Assurance

9.3.1 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 Wales Audit Office and Healthcare Inspectorate Wales.

9.3.2 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.

9.3.3 The Board shall keep under review and ensure that, where appropriate, the LHB implements any recommendations relevant to its business made by the National Assembly for Wales's Audit Committee, the Public Accounts Committee or other appropriate bodies.

9.3.4 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 under section 145 of and paragraph 17 to Schedule 8 of the Government of Wales Act 2006 (c.42).

## 10. DEMONSTRATING ACCOUNTABILITY

10.0.1 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.

10.0.2 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.

10.0.3 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.

10.0.4 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.

## 11. REVIEW OF STANDING ORDERS

11.0.1 A summary equality impact assessment has been carried out on these SOs prior to their formal adoption by the Board.

11.0.2 These SOs shall be reviewed annually by the Audit 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 equality impact assessment.

# Schedule 2.1

## MODEL STANDING FINANCIAL INSTRUCTIONS FOR LOCAL HEALTH BOARDS

**This Schedule forms part of, and shall have effect as if incorporated in the Local Health Board Standing Orders**

GIG CYMRU NHS WALES

Llywodraeth Cymru
Welsh Government

www.cymru.gov.uk

# Model Standing Financial Instructions for Local Health Boards



Llywodraethu da.....calon iechyd da
Good Governance.....at the heart of good health care

# Foreword

These Model Standing Financial Instructions are issued by Welsh Ministers to Local Health Boards using powers of direction provided in section 12 (3) of the National Health Service (Wales) Act 2006. Local Health Boards in Wales must agree Standing Financial Instructions (SFIs) for the regulation of their financial proceedings and business. Designed to achieve probity, accuracy, economy, efficiency, effectiveness and sustainability in the conduct of business, they translate statutory and Welsh Government financial requirements for the NHS in Wales into day to day operating practice. Together with the adoption of Standing Orders (SOs), a Scheme of decisions reserved to the Board and a scheme of delegations to officers and others, they provide the regulatory framework for the business conduct of the LHB.

These documents form the basis upon which the LHB's governance and accountability framework is developed and, together with the adoption of the LHB's Values and Standards of Behaviour framework, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

All LHB Board members and officers must be made aware of these Standing Financial Instructions and, where appropriate, should be familiar with their detailed content. The Director of Finance will be able to provide further advice and guidance on any aspect of the Standing Financial Instructions. The Board Secretary will be able to provide further advice and guidance on the wider governance arrangements within the LHB. Further information on governance in the NHS in Wales may be accessed at www.wales.nhs.uk/governance-emanual/

# Contents

## 1. INTRODUCTION

### 1.1 General

1.1.1 These Model Standing Financial Instructions are issued by Welsh Ministers to Local Health Boards using powers of direction provided in section 12 (3) of the National Health Service (Wales) Act 2006. Local Health Boards in Wales must agree Standing Financial Instructions (SFIs) for the regulation of their financial proceedings and business. They shall have effect as if incorporated in the SOs.

1.1.2 These SFIs detail the financial responsibilities, policies and procedures adopted by Hywel Dda ULHB (the LHB). They are designed to ensure that the LHB's financial transactions are carried out in accordance with the law and with Welsh Government policy in order to achieve probity, accuracy, economy, efficiency, effectiveness and sustainability. They should be used in conjunction with the Schedule of decisions reserved to the Board and the Scheme of delegation adopted by the LHB.

1.1.3 These SFIs identify the financial responsibilities which apply to everyone working for the LHB and its constituent organisations. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Director of Finance and Finance Committee.

1.1.4 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Board Secretary or Director of Finance must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the LHB's SOs.

### 1.2 Overriding Standing Financial Instructions

1.2.1 Full details of any non compliance with these SFIs, including an explanation of the reasons and circumstances must be reported in the first instance to the Director of Finance and the Board Secretary, who will ask the Audit Committee to formally consider the matter and make proposals to the Board on any action to be taken. All Board members and LHB officers have a duty to report any non compliance to the Director of Finance and Board Secretary as soon as they are aware of any circumstances that has not previously been reported.

1.2.2 **Ultimately, the failure to comply with SFIs and SOs is a**

**disciplinary matter that could result in an individual's dismissal from employment or removal from the Board.**

### 1.3 Financial provisions and obligations of LHBs

1.3.1 The financial provisions and obligations for LHBs are set out under Sections 175, and 177 of the NHS (Wales) Act 2006 (C.42). The Board as a whole and the Chief Executive in particular, in their role as the Accountable Officer for the organisation, must ensure the LHB meets its statutory obligation to perform its functions within the available financial resources.

## 2. RESPONSIBILITIES AND DELEGATION

### 2.1 The Board

2.1.1 The Board exercises financial supervision and control by:

a) Formulating the Medium Term Financial Plan as part of the Integrated Medium Term Plan;

b) Requiring the submission and approval of budgets within approved allocations/overall funding

c) Defining and approving essential features in respect of important policies and financial systems (including the need to obtain value for money and sustainability); and

d) Defining specific responsibilities placed on Board members and LHB officers, and LHB committees and Advisory Groups as indicated in the 'Scheme of delegation' document.

2.1.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the 'Schedule of matters reserved to the Board' document. All other powers have been delegated to committees, sub-committees, joint committees or joint sub-committees that the LHB has established or to an officer of the LHB in accordance with the 'Scheme of delegation' document adopted by the LHB.

### 2.2 The Chief Executive and Director of Finance

2.2.1 The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

2.2.2 Within the SFIs, it is acknowledged that the Chief Executive is

ultimately accountable to the Board, and as Accountable Officer, to the Welsh Government, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the LHB's activities; is responsible to the Chair and the Board for ensuring that financial obligations and targets are met; and has overall responsibility for the LHB's system of internal control.

2.2.3 It is a duty of the Chief Executive to ensure that Board members and LHB officers, and all new appointees are notified of, and put in a position to understand their responsibilities within these SFIs.

## 2.3 The Director of Finance

2.3.1 The Director of Finance is responsible for:

a) Implementing the LHB's financial policies and for co-coordinating any corrective action necessary to further these policies;

b) Maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

c) Ensuring that sufficient records are maintained to show and explain the LHB's transactions, in order to disclose, with reasonable accuracy, the financial position of the LHB at any time; and

d) Without prejudice to any other functions of the LHB, and Board members and LHB officers, the duties of the Director of Finance include:

(i) the provision of financial advice to other Board members and LHB officers, and LHB committees and Advisory Groups,

(ii) the design, implementation and supervision of systems of internal financial control, and

(iii) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the LHB may require for the purpose of carrying out its statutory duties.

2.3.2 The Director of Finance is responsible for ensuring an ongoing training and communication programme is in place to affect these SFIs.

## 2.4 Board members and LHB officers, and LHB Committees and Advisory Groups

2.4.1 All Board members and LHB officers, and LHB Committees and Advisory Groups, severally and collectively, are responsible for:

a) The security of the property of the LHB;

b) Avoiding loss;

c) Exercising economy, efficiency and sustainability in the use of resources; and

d) Conforming to the requirements of SOs, SFIs, Financial Procedures and the Scheme of delegation.

2.4.2 For all Board members and LHB officers, and LHB committees and Advisory Groups who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board, committee, Advisory Groups and employees discharge their duties must be to the satisfaction of the Director of Finance.

## 2.5 Contractors and their employees

2.5.1 Any contractor or employee of a contractor who is empowered by the LHB to commit the LHB to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

## 3. AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT

### 3.1 Audit Committee

3.1.1 An independent Audit Committee is a central means by which a Board ensures effective internal control arrangements are in place. In addition, the Audit Committee provides a form of independent check upon the executive arm of the Board. In accordance with SOs the Board shall formally establish an Audit Committee (or equivalent) with clearly defined terms of reference. Detailed terms of reference and operating arrangements for the Audit Committee are set out in Schedule 3 to the SOs. This committee will follow the guidance set out in the NHS Wales Audit Committee Handbook.

### 3.2 Chief Executive

3.2.1 The Chief Executive is responsible for:

a) Ensuring there are arrangements in place to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;

b) Ensuring that the Internal Audit function meets the NHS mandatory audit standards in accordance with the Internal Audit Manual and provides sufficient independent and objective assurance to the Audit Committee and the Accountable Officer;

c) Deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption;

d) Ensuring that an annual Internal Audit report is prepared for the consideration of the Audit Committee and the Board. The report must cover:

- a clear opinion on the effectiveness of internal control in accordance with guidance issued by the Welsh Ministers including for example compliance with control criteria and the *Doing Well, Doing Better: Standards for Health Services in Wales* (formally the Healthcare Standards),

- major internal financial control weaknesses discovered,

- progress on the implementation of Internal Audit recommendations,
- progress against plan over the previous year,
- a strategic audit plan covering the coming three years, and
- a detailed plan for the coming year.

3.2.2 The designated internal and external audit representatives are entitled (subject to provisions in the Data Protection Act 1998 (C.29)) without necessarily giving prior notice to require and receive:

a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

b) Access at all reasonable times to any land or property owned or leased by the LHB;

c) Access at all reasonable times to Board members and LHB officers;

d) The production of any cash, stores or other property of the LHB under a Board member or a LHB official's control; and

e) Explanations concerning any matter under investigation.

### 3.3 Internal Audit

3.3.1 The Accountable Officer Memorandum requires the Chief Executive to have an internal audit function that operates in accordance with the standards and framework set for the provision of Internal Audit in the NHS in Wales. This framework is defined within an Internal Audit Charter that incorporates a definition of internal audit, a code of ethics and Internal Audit Standards. Standing Order 9.1 details the relationship between the Head of Internal Audit and the Board. The role of the Audit Committee in relation to Internal Audit is set out within its Terms of Reference, incorporated in Schedule 3 of the SOs, and the NHS Wales Audit Committee Handbook.

### 3.4 External Audit

3.4.1 Pursuant to the Public Audit (Wales) Act 2004 (C.23), the Auditor General for Wales (Auditor General) is the external auditor of the LHB. The Auditor General may nominate his representative to represent him

within the LHB and to undertake the required audit work. The cost of the audit is paid for by the LHB. The LHB's Audit Committee must ensure that a cost-efficient external audit service is delivered. If there are any problems relating to the service provided, this should be raised with the Auditor General's representative and referred on to the Auditor General if the issue cannot be resolved.

3.4.2 The Auditor General's representative should be invited to attend every Audit Committee meeting. The cycle of approving and monitoring the progress of external audit plans and reports, culminating in the opinion on the annual report and accounts, is central to the core work of the Audit Committee.

3.4.3 The objectives of the external audit fall under three broad headings, to review and report on:

a) Whether the expenditure to which the financial statements relate has been incurred lawfully and in accordance with the authority that governs it;

b) The audited body's financial statements, and on its Annual Governance Statement[1];

c) Whether the audited body has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources including whether the LHB has in place effective and robust governance arrangements.

3.4.4 The external auditors should develop an audit strategy. The strategy should be developed to deliver a professional opinion on the financial statements and a conclusion on the arrangements to secure economy, efficiency and effectiveness in the LHB's use of resources. It should take into account the audit needs of the organisation, as assessed by the Auditor General's representatives, using a risk-based approach. The Audit Committee should formally consider and review the strategy.

3.4.5 The Auditor General's representatives should prepare an annual audit plan, designed to implement the audit strategy, for consideration by the Audit Committee. The annual plan should set out details of the work to be carried out, providing sufficient detail for the Audit Committee and other recipients to understand the purpose and scope of the defined work and their level of priority. The Audit Committee should review the annual plan and the associated fees, although in so doing it needs to

[1] Note: The Healthcare Inspectorate Wales will review and report on the Annual Quality Statement.

recognise the statutory duties of the Auditor General. The annual audit plan should be kept under review to identify any amendment needed to reflect changing priorities and emerging audit needs. The Audit Committee should consider material changes to the annual audit plan.

3.4.6 The Auditor General's representatives will liaise with Internal Audit when developing the external audit strategy and plan. The Auditor General's representative will ensure that planned external audit work takes into account the work of Internal Audit and considers where Internal Audit work can be relied upon for opinion purposes.

3.4.7 The Auditor General and his representatives shall have a right of access to the Chair of the Audit Committee at any time. As set out in paragraph 3.2.2a of these SFIs, the Auditor General and his representatives shall have access to all records, documents (including computerised records) and correspondence relating to any financial or other relevant transactions. This includes documentation of a confidential nature or which contains personal information. The Auditor General and his representatives may require any individual or organisation (including staff and NHS suppliers and contractors) holding information or explanation which the Auditor General deems relevant to the audit to appear before him to provide that information or explanation.

3.4.8 The LHB will provide the Auditor General and his representatives with whatever facilities are necessary to facilitate the audit, including audit accommodation and access to IT facilities.

3.4.9 The Auditor General will issue a number of reports over the year, some of which are specified in the Auditor General's Code of Audit and Inspection Practice and International Standards on Auditing. Other reports will depend on the contents of the audit plan.

The main mandatory reports are:

- Report to those charged with governance (incorporating the report required under ISA 260) that sets out the main issues arising from the audit of the financial statements and use of resources work
- Statutory report and opinion on the financial statements
- Annual audit report.

In addition to these reports, the Auditor General may prepare a report on a matter the Auditor General considers would be in the public interest to bring to the public's attention; or make a referral to the

Welsh Ministers if significant breaches occur.

3.4.10 The Auditor General also has the power to undertake Value for Money Examinations and Improvement Studies within the LHB and other public sector bodies. Where applicable, the Auditor General will take account of audit work when planning and undertaking such examinations and studies. The Auditor General and his representatives have the same access rights in relation to these examinations and studies as they do in relation to annual audit work.

### 3.5 Fraud and Corruption

3.5.1 In line with their responsibilities, the LHB Chief Executive and Director of Finance shall monitor and ensure compliance with Directions issued by the Welsh Ministers on fraud and corruption.

3.5.2 The LHB shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist (LCFS) as specified by the NHS Counter Fraud and Corruption Manual and guidance (Version 3).

3.5.3 The LCFS shall report to the LHB Director of Finance and the LCFS must work with NHS Protect (formerly the NHS Counter Fraud and Security Management Service) of the NHS Business Services Authority and the NHS Counter Fraud Service Wales (CFSW) Team in accordance with the NHS Counter Fraud and Corruption Manual.

3.5.4 The LCFS will provide a written report to the Director of Finance and Audit Committee, at least annually, on counter fraud work within the LHB.

3.5.5 The LHB must participate in the annual National Fraud Initiative. It must provide the necessary data for the mandatory element of the initiative by the due dates. The Audit Committee should consider the LHB's participation in additional dataset matching in order to support the detection of fraud across the whole public sector.

### 3.6 Security Management

3.6.1 In line with their responsibilities, the LHB Chief Executive will monitor and ensure compliance with Directions issued by the Welsh Ministers on NHS security management.

3.6.2 The Chief Executive has overall responsibility for controlling and coordinating security.

## 4. ALLOCATIONS AND FINANCIAL DUTY

4.0.1 Revenue and Capital allocations are determined by the Welsh Ministers in accordance with its allotted health budget and distribution policy.

4.0.2 The Director of Finance of the LHB will:

a) Prior to the start of each financial year submit to the Board for approval a report showing the total allocations received, assumed in-year adjustments and their proposed distribution including any sums to be held in reserve;

b) Ensure that any ring-fenced or non-discretionary allocations are disbursed in accordance with Welsh Ministers' requirements;

c) Periodically review any assumed in-year allocations to ensure that these are reasonable and realistic; and

d) Regularly update the Board on significant changes to the initial allocation and the application of such funds.

4.0.3 The LHB is required by statutory provision not to breach its 3 year rolling financial duty. The Chief Executive has overall executive responsibility for the LHB's activities and is responsible to the Board for ensuring that it meets its financial duty as set out in section 175 of the National Health Service (Wales) Act 2006 as amended by the National Health Service Finance (Wales) Act 2014.

## 5. INTEGRATED PLANNING

### 5.1 Integrated Medium Term Plan

5.1.1 The LHB will prepare an Integrated Medium Term Plan. The Integrated Medium Term Plan must reflect longer-term planning and delivery objectives and should be continually reviewed based on latest Welsh Government policy and local priority requirements. The Integrated Medium Term Plan will be a 3 year rolling plans. In particular the Integrated Medium Term Plan must reflect the Welsh Ministers' commitments on

- delivering Together for Health
- sustainable development as set out in *One Wales: One Planet*.

5.1.2 An Integrated Medium Term Plan should be based on a reasonable expectation of future service changes, performance improvements, workforce changes, demographic changes, capital, quality, funding,

income, expenditure, cost pressures and savings plans to ensure that the Integrated Medium Term Plan is balanced and sustainable and supports the safe and sustainable delivery of patient centred quality services. The Integrated Medium Term Plan will be the overarching planning document enveloping component plans and service delivery plans. The Integrated Medium Term Plan will incorporate the balanced Medium Term Financial Plan and will incorporate the LHB's response to delivering the

- Integrated Planning Framework,
- Quality Delivery Plan and
- Outcomes Framework

5.1.3 The Chief Executive will compile and submit to the Board, on an annual basis, the rolling 3 year Integrated Medium Term Plan. The Board approved Integrated Medium Term Plan will be submitted to Welsh Government in line with the requirements set out in the Integrated Planning Framework.

5.1.4 The finalised and approved Integrated Medium Term Plan will form the basis of the Performance Agreement between the LHB and Welsh Government.

**5.2 Plan details and approval**

5.2.1 The Integrated Medium Term Plan will be developed in line with the Integrated Planning Framework and include:

- A statement of significant strategies and assumptions on which the plans are based;
- Details of major changes in activity, service delivery, service and performance improvements, workforce, capital and resources required to achieve the plans; and
- Profiled activity, service, quality, workforce and financial schedules.
- Detailed plans to deliver the Planning Framework and Quality Delivery Plan requirements and outcome measures;

5.2.2 The Board will:

a) Approve the Integrated Medium Term Plan prior to the beginning of the financial year of implementation. Following Board approval the Plan will be submitted to Welsh Government prior to the beginning of the financial year of implementation.

b) Approve a balanced Medium Term Financial Plan as part of

the Integrated Medium Term Plan, which meets all probity and value for money requirements; and

c) Prepare and agree with the Welsh Government a robust and sustainable recovery plan in accordance with Welsh Ministers' guidance where the LHB plan is not in place or in balance.

## 6. BUDGETARY CONTROL

### 6.1 Budget Setting

6.1.1 Prior to the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval and delegation by the Board. Such budgets will:

a) Be in accordance with the aims and objectives set out in the Integrated Medium Term Plan and Medium Term Financial Plan, and focussed on delivery of safe quality patient centred quality services

b) Accord with Commissioning, Activity, Service, Quality, Performance, Capital and Workforce plans;

c) Be produced following discussion with appropriate budget holders;

d) Be prepared within the limits of available funds;

e) Take account of ring-fenced or specified funding allocations;

f) Take account of the principles of sustainable development; and

g) Identify potential risks.

6.1.2 The Director of Finance shall monitor financial performance against budget and plans and report the current and forecast position on a monthly basis and at every Board meeting. Any significant variances should be reported to LHB members as soon as they come to light and the Board shall be advised on any action to be taken in respect of such variances.

6.1.3 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled and managed appropriately.

6.1.4 All budget holders will sign up to their allocated budgets at the

commencement of the financial year

6.1.5 The Director of Finance has a responsibility to ensure that appropriate and timely financial information is provided to budget holders and that adequate training is delivered on an on-going basis to assist budget holders managing their budgets successfully.

## 6.2 Budgetary Delegation

6.2.1 The Chief Executive may delegate, via the Director of Finance the management of a budget to permit the performance of a defined range of activities, including pooled budget arrangements under Regulations made in accordance with Section 33 of the NHS (Wales) Act 2006 (C.42). This delegation must be in writing and be accompanied by a clear definition of:

a) The amount of the budget;
b) The purpose(s) of each budget heading;
c) Individual or committee responsibilities;
d) Arrangements during periods of absence;
e) Authority to exercise virement;
f) Achievement of planned levels of service; and
g) The provision of regular reports.

6.2.2 The Chief Executive, Director of Finance and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

6.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

6.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Director of Finance.

## 6.3 Budgetary Control and Reporting

6.3.1 The Director of Finance will devise and maintain systems of budgetary control. These will include:

a) Financial reports to the Board in a form approved by the Board containing as a minimum:

- income and expenditure to date showing trends and forecast year-end position,
- movements in working capital,
- movements in cash,

- capital expenditure and projected outturn against plan,
- explanations of any material variances from plan,
- details of any corrective action being taken as advised by the relevant budget holder and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation;

b) The issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

c) Investigation and reporting of variances from financial, activity and workforce budgets;

d) Monitoring of management action to correct variances;

e) Arrangements for the authorisation of budget transfers.

6.3.2 Each Budget Holder is responsible for ensuring that:

a) Any likely overspending or reduction of income that cannot be met by virement is not incurred without the prior consent of the Chief Executive subject to the Board's scheme of delegation;

b) The amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised, subject to the rules of virement;

c) No permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and workforce establishment as approved by the Board.

6.3.3 The Chief Executive is responsible for identifying and implementing cost and efficiency improvements and income generation initiatives in accordance with the requirements of the Medium Term Financial Plans.

### 6.4 Capital Expenditure

6.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure subject to any specific reporting requirements required by the Welsh Ministers.

## 6.5 Monitoring Returns

6.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring returns are submitted to the Welsh Ministers in accordance with published guidance and timescales.

6.5.2 All monitoring returns must be supported by a detailed commentary signed by the Director of Finance and Chief Executive. This commentary should also highlight and quantify any significant risks with an assessment of the impact and likelihood of these risks maturing.

**6.5.3** All information made available to the Welsh Ministers should also be made available to the Board. There must be consistency between the Medium Term Financial Plan, budgets, expenditure, forecast position and risks as reported in the monitoring returns and monthly Board reports.

## 7. ANNUAL ACCOUNTS AND REPORTS

7.0.1 The Board must approve the LHB's annual accounts prior to submission to the Welsh Ministers and the Auditor General for Wales in accordance with the annual timetable.

7.0.2 The Chair and Chief Executive have responsibility for signing the accounts on behalf of the LHB. The Chief Executive has responsibility for signing the Annual Governance Statement and the Annual Quality Statement.

7.0.3 The Director of Finance, on behalf of the LHB is responsible for ensuring that financial reports and returns are prepared in accordance with the accounting policies and guidance determined by the Welsh Ministers and the Treasury and consistent with International Financial Reporting Standards.

7.0.4 The LHB's annual accounts must be audited by the Auditor General for Wales. The LHB's audited annual accounts must be adopted by the Board at a public meeting and made available to the public.

7.0.5 The LHB will publish an annual report, in accordance with guidelines on local accountability, and present it at its Annual General Meeting. The document will comply with the Welsh Government's Manual for Accounts.

## 8. SHARED AND HOSTED SERVICES ARRANGEMENTS

8.0.1 Where the LHB uses a shared or hosted service provided by another NHS organisation to undertake part of its functions, these functions

shall remain the ultimate responsibility of the LHB.

8.0.2 From 1st June 2012 the functions of managing and providing Shared Services to the health service in Wales will be given to Velindre NHS Trust. The Trust is required to establish a Shared Services Committee (to be known for operational purposes as the Shared Services Partnership Committee) which will be responsible for exercising the Trust's Shared Services functions. However, responsibility for the exercise of the Shared Services functions will not rest primarily with the Board of Velindre NHS Trust but will be a shared responsibility of all NHS bodies in Wales.

8.0.3 A Senior Management Team, led by the Director of Shared Services, will be responsible for the delivery of Shared Services in accordance with an Integrated Medium Term Plan agreed by the Shared Services Partnership Committee. The Director of Shared Services shall hold Accountable Officer status, and shall retain overall accountability in relation to the management of Shared Services.

8.0.4 A Memorandum of Co-operation and a Hosting Agreement must be in place between the LHBs and Trusts within Wales setting out the obligations of NHS bodies to participate in the Shared Services Partnership Committee and to take collective responsibility for setting the policy and delivery of the Shared Services to the health service in Wales. The Hosting Agreement will provide the terms upon which Velindre NHS Trust provides the legal framework for the management and provision of Shared Services to the NHS in Wales.

## 9. BANKING ARRANGEMENTS

### 9.1 General

9.1.1 The Director of Finance is responsible for managing the LHB's banking arrangements and for advising the Board on the provision of banking services and operation of accounts. This advice will take into account guidance/ Directions issued from time to time by the Welsh Ministers. LHBs should consider using the Government Banking Service (GBS) for its banking services unless there is sound reasoning and value for money considerations to justify the use of commercial accounts.

9.1.2 The Board shall approve the banking arrangements.

### 9.2 Bank Accounts

9.2.1 The Director of Finance is responsible for:

a) Establishing bank accounts;

b) Establishing additional commercial accounts where there is sound reasoning and a value for money assessment;

c) Establishing separate bank accounts for the LHB's non-exchequer funds;

d) Ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made;

e) Reporting to the Board all arrangements made with the LHB's bankers for accounts to be overdrawn;

f) Monitoring compliance with Welsh Ministers' guidance on the level of cleared funds.

9.2.2 All accounts should be held in the name of the LHB. No officer other than the Director of Finance shall open any account in the name of the LHB or for the purposes of furthering LHB activities.

### 9.3 Banking Procedures

9.3.1 The Director of Finance will prepare detailed instructions on the operation of bank accounts which must include:

a) The conditions under which each bank account is to be operated;

b) Those authorised to sign cheques or other orders drawn on the LHB's accounts.

9.3.2 The Director of Finance must advise the LHB's bankers in writing of the conditions under which each account will be operated.

9.3.3 The Director of Finance shall approve security procedures for any cheques issued without a hand-written signature e.g. lithographed. Manually produced cheques shall be signed by the authorised officer(s) in accordance with the bank mandate. All cheques shall be treated as controlled stationery, in the charge of a duly designated officer controlling their issue.

### 9.4 Tendering and review

9.4.1 The Director of Finance will review banking arrangements of the LHB at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the LHB's banking business.

9.4.2 Within the banking tendering process, a GBS only account option must be included. Commercial bank accounts should only be used where there is sound reasoning and demonstrates value for money. The results of the tendering exercise should be reported to the Board.

9.4.3 A value for money review and tendering process is not necessary for GBS accounts.

## 10. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

### 10.1 Income Generation

10.1.1 The LHB shall only generate income for those goods and services that are approved by the Welsh Ministers. Any income generating activities must be complementary to the provision of NHS services and must be in accordance with the Welsh Ministers' policy and powers to raise money as set out in section 169 of the NHS (Wales) Act 2006 (c.42).

### 10.2 Income Systems

10.2.1 The Director of Finance is responsible for designing and maintaining procedures to ensure compliance with systems for the proper recording, invoicing, and collection and coding of all monies due.

10.2.2 The Director of Finance is also responsible for ensuring that systems

are in place for the prompt banking of all monies received.

### 10.3 Fees and Charges

10.3.1 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Welsh Ministers or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

10.3.2 All officers must inform the Director of Finance promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

### 10.4 Debt Recovery

10.4.1 The Director of Finance is responsible for the appropriate recovery action on all outstanding debts.

10.4.2 Income not received should be dealt with in accordance with losses procedures.

10.4.3 Overpayments should be detected (or preferably prevented) and recovery initiated.

10.4.4 The Chief Executive and the Director of Finance are responsible for ensuring the Welsh Ministers' guidance on disputed debt arbitration is strictly adhered to.

### 10.5 Security of Cash, Cheques and other Negotiable Instruments

10.5.1 The Director of Finance is responsible for:

a) Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

b) Ordering and securely controlling any such stationery;

c) The provision of adequate facilities and systems for officers whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

d) Establishing systems and procedures for handling cash and negotiable securities on behalf of the LHB.

10.5.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs.

10.5.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance.

10.5.4 The holders of safe/cash box combinations/keys shall not accept unofficial funds for depositing in their safe/cash box unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the LHB is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the LHB from responsibility for any loss.

10.5.5 The opening of coin operated machines (including telephone, if applicable) and the counting and recording of takings shall be undertaken by two officers together, except as may be authorised in writing by the Director of Finance and the coin box keys shall be held by a nominated officer.

10.5.6 During the absence (for example, on holiday) of the holder of a safe/cash box combination/key, the officer who acts in their place shall be subject to the same controls as the normal holder of the combination/key. There shall be written discharge for the safe and/or cash box contents on the transfer of responsibilities and the discharge document must be retained for inspection.

## 11. GRANT FUNDING, PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES

*Procurement or Grant Funding*

11.0.1 It is a matter for LHBs to determine whether individual activities should be procured, or be eligible to receive grant funding, seeking legal advice as necessary.

*Grant Funding*

### 11.1 Policies and procedures

11.1.1 The LHB shall maintain detailed policies and procedures for all aspects of grant funding. The policies and procedures shall comply with these SFIs, and where appropriate the Minister's Code of Practice to funding the third sector:

http://wales.gov.uk/topics/housingandcommunity/voluntarysector/publications/code/?lang=en

11.1.2 The Chief Executive is ultimately responsible for ensuring that the LHB's grant procedures:

- Are kept up to date;
- Conform to statutory requirements;
- Adhere to guidance issued by the Welsh Ministers;
- Are consistent with the principles of sustainable development; and
- Are strictly followed by all Executive Directors, Independent Members and staff within the organisation.

11.1.3 All grant guidance issued by the Welsh Ministers should have the effect as if incorporated in these SFIs.

### 11.2 Corporate Principles underpinning Grants Management

11.2.1 While there is a need to make the financial arrangements for awarding funding as simple and streamlined as possible, LHBs should also ensure that taxpayers' money is spent appropriately and that it provides good value for money.

11.2.2 The overarching principles for managing public resources in Wales are set out in Managing Welsh Public Money .The document states that the award of funding should be made in accordance with the law and the requirements of propriety, regularity and value for money.

11.2.3 Regularity requires compliance with appropriate authorities, regulations and legislation. Propriety requires both public authorities and funded bodies to deliver appropriate standards of conduct, behaviour and corporate governance. In addition, the public expects official decisions to be made fairly and impartially with public money spent wisely and appropriately, delivering value for money and ensuring that best use is made of resources.

11.2.4 The **corporate principles** of grants management are:

- The development of grant management processes and procedures that are transparent, accountable, proportionate and consistent;
- Delivery of a high quality regulatory framework that responds to demands but does not place unnecessary administrative burdens on LHBs or funded bodies;
- A regulatory framework that will take into consideration the need for proportionality; balancing the need for governance with the burden of administration. Thus striking an appropriate balance between accountability and simplicity;
- An effective grant management process to ensure funded bodies spend the funding efficiently, transparently and for the purpose intended, with a view to maximising the impact and outcome from budgets;
- Appropriate evidence-based approach to underpin the design and development of all new funding programmes to ensure efficient and effective use of public funds. Ensuring that the funding programme is the optimal solution and that funding is targeted where it is most needed and where it can have most impact;
- A consistent framework that will reinforce respect and effectiveness of the rules for both administrators and funded bodies.

## 11.3 Grant Procedures

11.3.1 It is vital that money is put to use in a way that delivers the maximum benefit to the people of Wales. Grants funding programmes need to be managed as efficiently and cost effectively as possible to make sure that every penny is spent appropriately and in an accountable manner. Information on grants management is available on the WAO website at:

http://www.wao.gov.uk/goodpractice/1821.asp

11.3.2 LHBs are responsible for ensuring that appropriate procedures exist in relation to all the grants and funding for which they are accountable. **They are also responsible for ensuring that any grant provided to**

**an entity that engages in economic activity complies with the State aid rules.**

11.3.3 LHBs are required to undertake due diligence checks on all potential delivery organisations to determine the economic and financial viability of any organisation(s) to administer public funds, and the reliability of the organisation(s).

11.3.4 The LHB must enter into legally binding funding agreements with all delivery organisations. Guidance is available on the WAO website at:

http://www.wao.gov.uk/goodpractice/1898.asp#q10

11.3.5 The LHB is responsible for ensuring that all third party delivery organisations comply with and adhere to the terms and conditions of the Funding Agreement.

*Procurement*

## 11.4 Policies and procedures

11.4.1 The LHB shall maintain detailed policies and procedures for all aspects of procurement including tendering and contracting processes. The policies and procedures shall comply with these SFIs and the supplementary guidance included at **Schedule 1**.

11.4.2 The Chief Executive is ultimately responsible for ensuring that the LHB's procurement, tendering and contracting procedures:

- Are kept up to date;
- Conform to statutory requirements;
- Adheres to guidance issued by the Welsh Ministers;
- Are consistent with the principles of sustainable development; and
- Are strictly followed by all Executive Directors, Independent Members and officers within the organisation.

11.4.3 All procurement guidance issued by the Welsh Ministers should have the effect as if incorporated in these SFIs.

## 11.5 Procurement Principles

11.5.1 The term "procurement" embraces the complete process from sourcing to taking delivery of all works, goods and services required by the LHB to perform its functions, and furthermore embrace all building, equipment, consumables and services including health services. Procurement further embraces contract and/or supplier management.

11.5.2 The main legal and governing principles guiding public procurement and which are incorporated into these SFIs are:

- Transparency: public bodies should ensure that there is openness and clarity on procurement processes and how they are implemented;
- Non-discrimination: public bodies may not discriminate between suppliers or products on grounds of their origin;
- Fair treatment: suppliers should be treated fairly and without discrimination, including in particular equality of opportunity and access to information;
- Legality: public bodies must conform to European Community and other legal requirements;
- Integrity: there should be no corruption or collusion with suppliers or others;
- Effectiveness and efficiency: public bodies should meet the commercial, regulatory and socio-economic goals of government in a balanced manner appropriate to the procurement requirement;
- Efficiency: procurement processes should be carried out as cost effectively as possible and secure value for money.

## 11.6 EU Directives Governing Public Procurement

11.6.1 EU Directives governing public procurement and UK Regulations implementing such Directives and setting out procedures for awarding all forms of regulated contracts shall have effect as if incorporated in the LHB's SFIs.

11.6.2 EU Directives and UK regulations (the Public Contracts Regulations 2006 (2006/5)) exist covering the whole field of procurement, and these Directives set thresholds above which special and demanding procurement protocols and legal requirements apply. All Directors and their staff are responsible for seeing that those Directives are understood and fully implemented. The protocols set out in the EU Directives are the model upon which all formal procurement shall be based.

11.6.3 Specialist procurement advice should be taken in respect of EU Directives covering the procurement and tendering for health services, including primary care services, as this remains a complex area.

## 11.7 Sustainable Development

11.7.1 Welsh Ministers have a duty under section 79 of the Government of Wales Act 2006 (c.32) to make a scheme setting out how they propose

to promote sustainable development in the exercise of their functions. The Welsh Government's Sustainable Development Scheme, *One Wales, One Planet (2009)*, establishes sustainable development as the central organising principle of the public sector in Wales. The LHB shall take a full part in meeting the Welsh Ministers' commitments on sustainable development, including procurement. The LHB shall adopt a Sustainable Development Strategy consistent with the NHS Wales Sustainable Development Strategy.

11.7.2 The LHB shall make use of the tools developed by Value Wales in implementing its Sustainable Development Strategy. The LHB shall benchmark its performance in sustainable procurement and produce annual action plans for improvement through its use of the Sustainable Procurement Assessment Framework (SPAF). For all contracts over £25,000, the LHB shall take account of social, economic and environmental issues when making procurement decisions using the Sustainable Risk Assessment Template (SRA).

### 11.8 Equality of opportunity

11.8.1 The LHB shall secure equality of opportunity in procurement through its application of the Sustainable Risk Assessment (SRA) tool developed by Value Wales for all contracts over £25,000, and its compliance with all relevant Welsh Ministers' guidance, as set out in Schedule 1 of these SFIs.

### 11.9 Procurement Procedures

11.9.1 To ensure that the LHB is fully compliant with EU Directives, UK Regulations and Welsh Ministers' guidance, the LHB shall ensure that it shall have procedures that set out:

a) Requirements and exceptions to formal competitive tendering requirements;
b) Tendering processes including post tender discussions;
c) Requirements and exceptions to obtaining quotations;
d) Evaluation and scoring methodologies
e) Approval of firms for providing goods and services.

11.9.2 All procedures shall reflect the Welsh Ministers' guidance and the LHB's delegation arrangements and approval processes.

11.9.3 Paragraph 13(3) of Schedule 2 to the National Health Service (Wales) Act 2006 places a requirement on LHBs to obtain the consent of the Welsh Ministers before:

- Acquiring and disposing of property;

- Entering into contracts; and
- Accepting gifts of property (including property to be held on trust).

11.9.4 The provision allows the Welsh Ministers to give consent, if they think fit, which may be given in general terms covering one or more descriptions of case.

11.9.5 General Consent has been granted to LHBs by the Welsh Ministers for individual contracts up to the value of £1 million in each case with the exception of those contracts specified in SO 11.6.7. All contracts exceeding this delegated limit, all acquisitions and disposals of land of any limit, and the acceptance of gifts of property, must receive the written approval of the Welsh Ministers before being entered into.

11.9.6 The letter that updates the process for LHBs to obtain consent to enter into contracts exceeding £1m and monitoring arrangements for contracts below £1m is at **Schedule 2**.

11.9.7 The requirement for consent does not apply to any contracts entered into pursuant to a specific statutory power, and therefore does not apply to:

i) Contracts of employment between LHBs and their staff;
ii) Transfers of land or contracts effected by Statutory Instrument following the creation of the LHBs;
iii) Out of Hours contracts; and
iv) All NHS contracts, that is where one health service body contracts with another health service body.

11.9.8 The Revised General Consent does not remove the requirement for LHBs to comply with SOs, SFIs or to obtain any other consents or approvals required by law for the transactions concerned.

11.9.9 Further detail in relation to fair and adequate competition is set out in **Schedule 1**.

### 11.10 Procurement Thresholds

11.10.1 The following table summaries the minimum thresholds for quotes and competitive tendering arrangements. The total value of the contract over its entire period is the qualifying sum that should be applied (except in specific circumstances relating to aggregation and contracts of an indeterminate duration) as set out in EU Directives and UK Regulations.

| **Contract value (excl. VAT)** | **Minimum competition[1]** |
|---|---|

| | |
|---|---|
| <£5,000 | At discretion of DoF&EC |
| £5,000 - £25,000 | 3 written quotations |
| £25,000 – OJEU threshold | 4 tenders |
| Above OJEU threshold | 5 tenders |
| Contracts above £1 million | WAG approval required[2] |

[1] subject to the existence of suitable suppliers
[2] in accordance with the requirements set out in SO 11.6.3

### 11.11 Small and Medium Sized Enterprises (SMEs), Third Sector Organisations (TSOs) and Supported Factories and Businesses (SFBs)

11.11.1 In accordance with Welsh Government policy set out in:

- Opening Doors – the Charter for SME Friendly Procurement and its Implementation Guidance;
- Procurement and the Third Sector: Guidance for the public sector in Wales;
- Supported Factories and Businesses Frequently Asked Questions; and
- The Construction Procurement Strategy

the LHB shall ensure that it provides opportunities for these organisations to quote or tender for its business.

### 11.12 Contract Management

11.12.1 Contract Management is the process which ensures that both parties to a contract fully meet their respective obligations as effectively and efficiently as possible, in order to deliver the business and operational objectives required from the contract and in particular, value for money. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the LHB so as to ensure that these implicit obligations are met.

11.12.2 Advice on best practice on Contract Management is available from Value Wales, through its *Procurement Route Planner*.

## 12. CONTRACTS FOR HEALTH CARE SERVICES

### 12.1 Health care agreements

12.1.1 The Chief Executive is responsible for ensuring the LHB enters into suitable Health Care Agreements (or Individual Patient Commissioning Agreements, where appropriate) for its provision of health care

services.

12.1.2 All Health Care Agreements should aim to implement the agreed priorities contained within the Integrated Medium Term Plan and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

- The standards of service quality expected;
- The targets required by the Quality Delivery Plan;
- The relevant national service framework (if any);
- The provision of reliable information on cost and volume of service; and
- That the agreements are based on integrated care pathways.

12.1.3 All agreements must be in accordance with the functions conferred on the LHB by the Welsh Ministers.

## 12.2 Statutory provisions

- The NHS (Wales) Act 2006 (C.42), sets out the responsibilities of LHBs in establishing contracts for healthcare services and in particular Section 7 which sets out the definition of an NHS contract being the arrangement between one health service body and another and the definitions of such bodies;
- Section 9 which sets out arrangements to be treated as NHS contracts for ophthalmic and pharmaceutical services;
- Sections 32 and 33 in relation to services provided by or jointly with local authorities;
- Part 4 in relation to primary medical services;
- Part 5 in relation to primary dental services;
- Part 6 in relation to general ophthalmic services;
- Part 7 in relation to pharmaceutical services;
- Section 188 which sets out the arrangements with the prison service;
- Section 194 which sets out the powers to make payments towards expenditure on community services; and
- Section 195 which sets out arrangements with voluntary organisations.

## 12.3 Reports to Board on Health Care Agreements (HCAs)

12.3.1 The Chief Executive will need to ensure that regular reports are provided to the Board detailing performance and associated financial

implications of all health care agreements.

## 13. PAY EXPENDITURE

### 13.1 Remuneration and Terms of Service Committee

13.1.1 This Standing Financial Instruction should be read in conjunction with Standing Order 3.4.

13.1.2 In accordance with SOs the Board shall establish a Remuneration and Terms of Service Committee, with clearly defined terms of reference and operating arrangements that specify which posts fall within its area of responsibility.

13.1.3 The Committee shall report in writing to the Board the basis for its recommendations. The Board shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of Directors and other senior employees, in accordance with the framework set by the Welsh Ministers. Minutes of the Board's meetings should record such decisions.

13.1.4 The Board will after due consideration and amendment if appropriate approve proposals presented by the Chief Executive for the setting of remuneration and terms of service for those employees and officers not covered by the Committee.

13.1.5 The LHB will pay allowances to the Chair, Chief Executive, Executive Directors and Independent Members of the Board in accordance with instructions issued by the Welsh Ministers.

### 13.2 Funded Establishment

13.2.1 The workforce plans incorporated within the approved Integrated Medium Term Plan will form the funded establishment, i.e. the budget for all approved posts.

13.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive or an officer with delegated authority.

### 13.3 Staff Appointments

13.3.1 No Board member or LHB official may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration outside the limit of their approved budget and funded establishment unless

authorised to do so by the Chief Executive.

13.3.2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for employees in accordance with pay, terms and conditions set out in Agenda for Change and other pay review bodies.

## 13.4 Payroll

13.4.1 The Director of Workforce and Organisational Development is responsibility for:

a) Securing the provision of an efficient, value for money payroll service;

b) Specifying timetables for submission of properly authorised time records and other notifications;

c) The final determination of pay and allowances including verification that the rate of pay and relevant conditions of service are in accordance with current agreements;

d) Agreeing the timing and method of payment with the payroll service;

e) Authorising the release of payroll data where in accordance with the provisions of the Data Protection Act 1998 (C.29);

f) Verification and documentation of data;

g) The timetable for receipt and preparation of payroll data and the payment of employees and allowances;

h) Maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

i) Security and confidentiality of payroll information;

j) Checks to be applied to completed payroll before and after payment;

k) A system to ensure the recovery from those leaving the employment of the LHB of sums of money and property due by them to the LHB.

13.4.2 The Chief Executive is responsible for:

a) Ensuring that any shared or hosted service arrangement is supported by appropriate contract terms and conditions, adequate internal controls and audit review procedures;

b) Ensuring a sound system of internal control and audit review of any internally provided payroll service;

c) Maintenance and/or the authorisation of regular and independent reconciliation of pay control accounts.

13.4.3 Appropriately nominated managers have delegated responsibility for:

a) Submitting time records, and other notifications in accordance with agreed timetables;

b) Completing time records and other notifications in accordance with the contract of Service Level Agreements; and

c) Submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Director of Workforce and Organisational Development and/or Chief Executive must be informed immediately. In circumstances where fraud is suspected, this must be reported to the Director of Finance.

### 13.5 Contracts of Employment

13.5.1 The Board shall delegate responsibility to the Director of Workforce and Organisational Development for:

a) Ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and

b) Dealing with variations to, or termination of, contracts of employment.

## 14. NON-PAY EXPENDITURE

14.0.1 This Standing Financial Instruction shall be read in conjunction with Standing Financial Instruction 11.

## 14.1 Delegation of Authority

14.1.1 The Chief Executive will approve the level of non-pay expenditure and the operational scheme of delegation and authorisation to budget holders and managers within the parameters set out in the LHB's scheme of delegation.

14.1.2 The Chief Executive will set out in the operational scheme of delegation and authorisation:

a) The list of managers who are authorised to place requisitions for the supply of goods and services; and

b) The maximum level of each requisition and the system for authorisation above that level.

14.1.3 The Director of Finance is responsible for ensuring that the authorisation processes within any automated procurement systems is through the provision of electronic "signatures" authorised in accordance with the access and authority controls as set out in the operational scheme of delegation and authorisation.

14.1.4 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

## 14.2 Requisitioning

14.2.1 The budget manager in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the LHB by asking the procurement to undertake quotation / tendering exercises on their behalf. In so doing, the LHB's approved supply contract / catalogue shall be used. Where a required item is not included within the catalogue, advice must be sought from the LHB's procurement advisor. All orders for goods and services must be accompanied by an official order number, available from the Procurement Department. In no circumstances must a requisition number be used as an order number.

## 14.3 The Director of Finance responsibilities

14.3.1 The Director of Finance will:

a) Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in SOs and SFIs and regularly reviewed;

b) Prepare procedural instructions or guidance within the Scheme of Delegation on the obtaining of goods, works and services;

c) Ensure systems are in place for the prompt payment of all properly authorised accounts and claims;

d) Ensure systems are in place for providing a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) A list of Executive Directors and officers (including specimens of their signatures) authorised to certify invoices.

(ii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct,
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct,
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined,
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained,
- the account is arithmetically correct,
- the account is in order for payment.

(iii) For the early submission of accounts subject to cash discounts or otherwise requiring early payment.

e) Ensure systems are in place for ensuring that payment for goods and services is only made once the goods and services are received. The only exceptions to this are set out in SFI 13.4.

f) Be responsible for ensuring compliance with the Public Sector Payment policy ensuring that a minimum of 95 percent of creditors are paid within 30 days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed.

## 14.4 Prepayments

14.4.1 Prepayments are only permitted where either:

- The financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to Net Present Value (NPV) using the National Loans Fund (NLF) rate plus 2%);
- It is the industry norm e.g. courses and conferences;
- There is specific Welsh Ministers' approval to do so e.g. voluntary services compact.

14.4.2 In **exceptional** circumstances prepayments can be made subject to:

a) The appropriate Executive Director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the LHB if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments;

b) The Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold); and

c) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

## 14.5 Official orders

14.5.1 Official Orders must:

a) Be consecutively numbered;

b) Be in a form approved by the Director of Finance;

c) State the LHB's terms and conditions of trade; and

d) Only be issued to, and used by, those duly authorised by the Chief Executive.

## 14.6 Duties of Budget Holders and Managers

14.6.1 Budget holders and managers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and that:

a) All contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of any commitment being made;

b) Contracts above specified thresholds are advertised and awarded in accordance with EU and HM Treasury rules on public procurement;

c) Contracts above specified thresholds are approved by the Welsh Ministers prior to any commitment being made;

d) Where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Welsh Ministers and internal procedures;

e) No order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to Board members or LHB officers, other than:

(i) Isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars,

(ii) Conventional hospitality, such as lunches in the course of working visits;

**This provision needs to be read in conjunction with Standing Order 7.5.**

f) No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;

g) All goods, services, or works are ordered on an official orders except works and services executed in accordance with a contract and purchases from petty cash;

h) Verbal order numbers must only be issued very exceptionally only in cases of emergency or urgent necessity and only by an officer designated by the Chief Executive. These must be confirmed by an official order and clearly marked "Confirmation Order";

i) Orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

j) Goods are not taken on trial or loan in circumstances that could commit the LHB to a future uncompetitive purchase;

k) Changes to the list of Board members and LHB officers authorised to certify invoices are notified to the Director of Finance;

l) Purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance; and

m) Petty cash records are maintained in a form as determined by the Director of Finance.

14.6.2 The Chief Executive and Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance issued by the Welsh Ministers. The technical audit of these contracts shall be the responsibility of the relevant Director as set out in the LHB's scheme of delegation.

## 15. CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

### 15.1 NHS Capital Investment

15.1.1 The Chief Executive:

a) Shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon plans;

b) Is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and

c) Shall ensure that any capital investment above the Welsh Ministers' delegated limit is not undertaken without approval of the Welsh Ministers and that confirmation of capital resources has been received;

d) Shall ensure that an annual capital programme is adopted by the Board prior to the commencement of the financial year;

e) Shall ensure the availability of resources to finance all revenue consequences of the investment, including capital charges; and

f) Shall ensure that any 3rd party use of NHS estate is properly controlled, reimbursed and reported. This will include ensuring that appropriate security, insurance and indemnity arrangements are in place and that there is a written agreement as to each party's responsibilities and liabilities.

15.1.2 For every capital expenditure proposal the Chief Executive shall ensure:

a) That a business case is produced in line with Welsh Ministers' guidance and where appropriate the 5-case Model;

b) That the Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case and involved appropriate LHB personnel and external agencies in the process.

15.1.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management in accordance with the Welsh Ministers' guidance.

15.1.4 The Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

15.1.5 The approval of a capital programme shall not constitute approval for the initiation of expenditure on any scheme.

15.1.6 The Chief Executive shall issue to the manager responsible for any scheme:

a) Specific authority to commit expenditure;

b) Authority to proceed to tender;

c) Approval to accept a successful tender.

15.1.7 The Chief Executive will issue a scheme of delegation for capital investment management in accordance with the Welsh Ministers' guidance and the LHB's SOs.

15.1.8 The Director of Finance shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the delegated limits for capital schemes set out in Welsh Ministers' guidance.

## 15.2 Capital Financing with the Private Sector

15.2.1 The LHB must not enter into any new capital financing arrangements with the private sector, including Private Financing Initiatives and 3rd Party Developments, without the consent of the Welsh Ministers.

## 15.3 Asset Registers

15.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Finance concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted periodically.

15.3.2 Each LHB shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be in accordance with the Welsh Ministers' guidance.

15.3.3 Additions to the fixed asset register must be clearly identified to the delegated budget holder and be validated by reference to appropriate documentation including:

a) Properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

b) Stores, requisitions and wages records for own materials and

labour including appropriate overheads; and

c) Lease agreements in respect of assets held under a finance lease and included on the LHB's balance sheet.

15.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate). Disposal receipts are to be treated in accordance with the Welsh Ministers' guidance.

15.3.5 The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

15.3.6 The value of each asset shall be considered annually in accordance with valuation guidance and methods specified by the Welsh Ministers. Assets should be considered for early revaluation where there is the likelihood of impairment as a result in a change of valuation or asset life.

15.3.7 The value of each asset shall be depreciated using methods and rates as specified by the Welsh Ministers.

**15.4 Security of Assets**

15.4.1 The overall control of fixed assets is the responsibility of the Chief Executive.

15.4.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance. This procedure shall make provision for:

a) Recording managerial responsibility for each asset;

b) Identification of additions and disposals;

c) Identification of all repairs and maintenance expenses;

d) Physical security of assets;

e) Annual verification of the existence of, condition of, and title to, assets recorded;

f) Identification and reporting of all costs associated with the retention of an asset; and

g) Reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

15.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance.

15.4.4 Whilst individual officers have a responsibility for the security of property of the LHB, it is the responsibility of Board members and senior LHB officers in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

15.4.5 Any damage to the LHB's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and LHB officers in accordance with the procedure for reporting losses.

15.4.6 Where practical, assets should be marked as LHB property.

## 16. STORES AND RECEIPT OF GOODS

### 16.1 General position

16.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

a) Kept to a minimum;
b) Subjected to annual stock take;
c) Valued at the lower of cost and net realisable value.

### 16.2 Control of Stores, Stocktaking, condemnations and disposal

16.2.1 Subject to the responsibility of the Director of Finance for the systems of financial control, overall responsibility for the control of stores shall be delegated to a senior officer by the Chief Executive. The day-to-day responsibility may be delegated by them to departmental officers and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Manager; the control of any fuel oil and coal of a designated estates manager.

16.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Manager. Wherever practicable,

stocks should be marked as health service property.

16.2.3 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores and losses.

16.2.4 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year.

16.2.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.

16.2.6 The designated Manager shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI 17, Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

### 16.3 Goods supplied by an NHS supplies agency

16.3.1 For goods supplied via NHS Wales Shared Services Partnership – Procurement Services (NWSSP-PS) or any other NHS purchasing and supplies agency central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Director of Finance or authorised officer who shall satisfy himself that the goods have been received before accepting the recharge.

## 17. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

### 17.1 Disposals and Condemnations

17.1.1 The Director of Finance must prepare detailed procedures for the disposal of assets, including condemnations, and ensure that these are notified to managers.

17.1.2 When it is decided to dispose of a LHB asset, the head of department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

17.1.3 All unserviceable articles shall be:

a) Condemned or otherwise disposed of by an officer authorised for that purpose by the Director of Finance;

b) Recorded by the Condemning Officer in a form approved by the Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second officer authorised for the purpose by the Director of Finance.

17.1.4 The Condemning Officer shall satisfy themselves as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

## 17.2 Losses and Special Payments

17.2.1 Losses and special payments are items that the Assembly Government would not have contemplated when it agreed funds for NHS Wales or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments, and special notation in the accounts to draw them to the attention of the Assembly Government.

17.2.2 The Director of Finance is responsible for ensuring procedural instructions on the recording of and accounting for losses and special payments are in place; and that all losses or special payments cases are properly managed in accordance with the guidance set out in the Assembly Government's Manual for Accounts.

17.2.3 Any officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and/or the Director of Finance or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Director of Finance and/or the Chief Executive.

17.2.4 Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Director of Finance must inform the LCFS, the CFSW Team and NHS Protect in accordance with Directions issued by the Welsh Ministers on fraud and corruption.

17.2.5 The Director of Finance or the LCFS must notify the Audit Committee, the Auditor General's representative and the fraud liaison officer within the Welsh Government's Department for Health, Social Services and Children – Finance Directorate (DHSSC–FD) of all frauds.

17.2.6 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Director of Finance must notify:

a) The Audit Committee on behalf of the Board, and

b) An Auditor General's representative.

17.2.7 The Director of Finance shall be authorised to take any necessary steps to safeguard the LHB's interests in bankruptcies and company liquidations.

17.2.8 The Director of Finance shall ensure all financial aspects of losses and special payments cases are properly registered and maintained on the centralised Losses and Special Payments Register and that 'case write-off' action is recorded on the system (i.e. case closure date, case status, etc.).

17.2.9 The Audit Committee shall approve the writing-off of losses or the making of special payments within delegated limits determined by the Welsh Ministers and as set out in Schedule 3 of the SOs.

17.2.10 For any loss or special payments, the Director of Finance should consider whether any insurance claim could be made from the Welsh Risk Pool or from other commercial insurance arrangements.

17.2.11 No losses or special payments exceeding delegated limits shall be authorised or made without the prior approval of the DHSSC Director of Finance.

17.2.12 All novel, contentious and repercussive cases must be referred to the Welsh Government's Department for Health, Social Services and Children – Resources Directorate, irrespective of the delegated limit.

17.2.13 The Director of Finance shall ensure all losses and special payments are reported to the Audit Committee at every meeting.

17.2.14 The LHB must obtain the DHSSC Director General's approval for special severance payments.

## 18. INFORMATION MANAGEMENT AND TECHNOLOGY

### 18.1 Information Management & Information Technology (IM&T) Strategy

18.1.1 The Board shall approve an IM&T strategy which sets out the development needs of the LHB for the medium term based on an appropriate assessment of risk. The Integrated Medium Term Plan shall include costed implementation plans of the strategy. It shall also ensure that a Director has responsibility for IM&T.

18.1.2 The LHB shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about the LHB that are made publicly available.

### 18.2 Responsibilities and duties of the responsible Director

18.2.1 The responsible Director for IM&T has responsibility for the accuracy and security of the computerised data of the LHB and shall:

a) Devise and implement any necessary procedures to ensure adequate (reasonable) protection of the LHB's data, programs and computer hardware for which they are responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998 (C.29);

b) Ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

c) Ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

d) Ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Director may consider necessary are being carried out.

e) Shall ensure that policies, procedures and training arrangements are in place to ensure compliance with

information governance law.

### ~~18.3~~ Responsibilities and duties of the Director of Finance

18.3.1 The Director of Finance shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

### 18.4 Contracts for computer services with other health bodies or outside agencies

18.4.1 The responsible Director for IM&T shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

18.4.2 Where another health organisation or any other agency provides a computer service for financial applications, the responsible Director for IM&T shall periodically seek assurances that adequate controls are in operation.

### 18.5 Risk assurance

18.5.1 The responsible Director for IM&T shall ensure that the risks to the LHB arising from the use of IT are effectively identified and considered and that appropriate action is taken to mitigate or control risk. This shall include the preparation and testing of an appropriate disaster recovery plan.

## 19. PATIENTS' PROPERTY

### 19.1 LHB Responsibility

19.1.1 The LHB has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of patients that lack capacity, or found in the possession of patients dead on arrival.

19.1.2 Where the Welsh Ministers' instructions require the opening of separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the Director of Finance.

19.1.3 In all cases where property, including cash and valuables, of a

deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates (Small Payments) Act 1965 (c.32)), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

19.1.4 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

19.1.5 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

## 19.2 Responsibilities of the Chief Executive

19.2.1 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

a) Notices and information booklets;

b) Hospital admission documentation and property records;

c) The oral advice of administrative and nursing staff responsible for admissions; and

d) That the LHB will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

## 19.3 Responsibilities of the Director of Finance

19.3.1 The Director of Finance must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

## 20. FUNDS HELD ON TRUST

### 20.1 Corporate Trustee

20.1.1 Paragraph (ix) of Section A to the SOs refers to the LHB acting as corporate trustee for the management of funds it holds on trust. SFI 20.2 defines the need for compliance with Charities Commission latest guidance and best practice.

20.1.2 The discharge of the LHB's corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

20.1.3 The LHB shall establish a Charitable Funds Committee as set out in Standing Order 3.4 to ensure that each trust fund which the LHB is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

### 20.2 Accountability to Charity Commission and the Welsh Ministers

20.2.1 The trustee responsibilities must be discharged separately and full recognition given to the LHB's dual accountabilities to the Charity Commission for charitable funds and to the Welsh Ministers for exchequer funds.

20.2.2 The Schedule of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Board members and LHB officers must take account of that guidance before taking action.

20.2.3 The LHB shall make appropriate arrangements for the audit of Funds held on Trust in accordance with Charity Commission requirements.

### 20.3 Applicability of Standing Financial Instructions to funds held on Trust

20.3.1 In so far as it is possible to do so, most of the sections of these SFIs will apply to the management of funds held on trust.

20.3.2 The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

## 21. RETENTION OF RECORDS

### 21.1 Responsibilities of the Chief Executive

21.1.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with the Welsh Ministers' guidance, the Data Protection Act 1998 (c.29) and the Freedom of Information Act 2000 (c.36).

21.1.2 The records held in archives shall be capable of retrieval by authorised persons.

21.1.3 Records held in accordance with regulation shall only be destroyed at the express instigation of the Chief Executive. Details shall be maintained of records so destroyed.

# Schedule 1

## PROCUREMENT OF WORKS, GOODS AND SERVICES

## Supplementary Guidance

**This Schedule forms part of, and shall have effect as if incorporated in the Local Health Board Standing Financial Instructions**

### 1. General

1.1 This document provides supplementary guidance to LHB SFIs Section 11. This guidance provides a high level governance framework and is not intended to act as a detailed procurement manual. Specific NHS guidance may also be found on the Welsh Government web site and guidance on best practice procurement can be found in the *Procurement Route Planner,* on the *National Procurement Web Site* www.buy4wales.co.uk. This guidance, together with all procurement guidance issued by the Welsh Ministers shall have effect as if incorporated in the SFIs.

1.2 The term "procurement" embraces the complete process from sourcing to taking delivery of all works, goods and services required by the LHB, and furthermore embrace all building, equipment, consumables and services including health services. Procurement further embraces contract and/or supplier management. EU Directives and UK regulations (including UK Public Contracts Regulations 2006 (2006/5)) exist covering the whole field of procurement, and these Directives set thresholds above which special and demanding procurement protocols and legal requirements apply. All Directors and their staff are responsible for ensuring that those Directives are understood and fully implemented. The protocols set out in the EU Directives are the model upon which all formal procurement shall be based. For the purpose of clarity it should be highlighted that the total value of the contract over its entire period is the qualifying sum that should be used to which the EU thresholds should be applied, save for contracts subject to aggregation rules or of an indeterminate duration.

1.3 The main legal and governing principles guiding public procurement are:

- Transparency: public bodies should ensure that there is openness and clarity on procurement processes and how they are implemented;
- Non-discrimination: public bodies may not discriminate between suppliers or products on grounds of their origin;
- Fair treatment: suppliers should be treated fairly and without discrimination, including in particular equality of opportunity and access to information;
- Legality: public bodies must conform to European Community and other legal requirements;
- Integrity: there should be no corruption or collusion with suppliers or others;
- Effectiveness and efficiency: public bodies should meet the commercial, regulatory and socio-economic goals of government in a balanced manner appropriate to the procurement requirement; and
- Efficiency: procurement processes should be carried out as cost effectively as possible and secure value for money.

1.4 EU Directives Governing Public procurement and UK Regulations implementing Directives of the European Union which set out procedures for awarding all forms of regulated contracts that exceed specific thresholds shall have effect as if incorporated in the LHB's SFIs.

1.5 The LHB shall comply with all requirements of the Welsh Ministers including but not exclusively:

- Duty of equality;
- Any requirement for the Welsh Ministers to be notified of any proposed contracts and to approve contracts let above £1 million not covered by general consent;
- The monitoring arrangements for contracts that fall below £1 million not covered by general consent;

- Public Sector Business Cases using the 5-case model;
- Estatecode;
- Procurement of Management Consultants within the NHS;
- Opening Doors – the Charter for SME Friendly Procurement and its implementation Guidance, which sets out the principles for working with Small and Medium Size Enterprises;
- Procurement and the Third Sector: Guidance for the public sector in Wales, which provides guidance on how to best work with voluntary and not for profit organisations;
- Supported Factories and Businesses Frequently Asked Questions, which provides legal guidance on how work can be reserved for organisations where more than 50% of the workers are disabled;
- Community Benefits Methodology, which provides guidance on how to work with contractors so that economically inactive people can be employed via major public sector contracts;
- Supply Void Methodology, which provides guidance on how to identify opportunities for Wales based suppliers in the supply chain;
- Construction Procurement Strategy, which sets out the Welsh Ministers' approach to construction projects;
- Strategic Sourcing Plan, which sets out how collaborative contracting is undertaken in Wales;
- The Xchangewales programme, which facilitates electronic procurement including use of the national procurement web site and the Welsh Purchasing Card.

1.6 The LHB should also follow any other best practice requirements as set out by Value Wales and available on its National Procurement Web Site.

1.7 For all procurement activities, the LHB will ensure it has processes in place to obtain best value for money. The Director of Finance shall ensure that there is a suitably qualified and experienced officer who shall oversee and manage procurement on behalf of the LHB.

1.8 Best value for money in a procurement context is defined as the "optimum combination of whole life costs and quality (or fitness for purpose) to meet the

user's requirements". This may not be the lowest price.

1.9 All relevant legislation should also be incorporated into procurement policies including the need to conduct Equality Impact Assessments.

## 2. Ordering

2.1 No goods or services shall be ordered except on an official order or though a specialised bespoke contract (e.g. IT systems), and contractors shall be notified that they should not accept orders other than in an official form or against a bespoke contractual arrangement.

2.2 Orders shall only be placed in accordance with the operational scheme of delegation and authorisation as approved by the Chief Executive. As it is the order that commits the LHB to expenditure, there must be tight control on the provision of requisitioning and ordering processes to those staff authorised to raise requisition / orders on behalf of the LHB.

2.3 In the case of an emergency, verbal orders can be issued by an authorised officer only, as set out in the LHB's scheme of delegation, and must be accompanied by an official order number. The order shall be confirmed electronically and/or in writing as soon as possible and in any case within 5 working days.

## 3. Quotations

3.1 Invitations to quote shall be issued in accordance with the LHB's Quotation Procedure.

3.2 For goods and services (including building and engineering) of a value between £5,000 and £25,000 exclusive of VAT, three or more written competitive quotations are to be sought. In determining which quotation is the best value the LHB may take into account whole life costs such as price, delivery date, running costs, cost effectiveness, quality, aesthetic and functional characteristics, technical merit, after sales services and technical assistance or clinical reasons. However, where the lowest quotation is not accepted, a formal written record is to be maintained as to why the lowest was not acceptable.

3.3 For goods and services of a value less than £5,000 exclusive of VAT, quotations shall be sought at the discretion of the Director of Finance or authorised officer.

3.4 Where it is intended that stage payments be made on a scheme the companies invited to quote shall be subject to a full financial vetting process.

3.5 Where the required number of quotations is not available the Director of

Finance or nominated deputy in their absence shall be authorised to accept a lower number subject to the principles of fair competition. A record of the decision will be kept for audit purposes.

3.6 Single quotations shall be the exception. They shall only be called for when a single firm or contractor or a proprietary item or service of a special character is required and must be formally authorised by the Director of Finance. A detailed record shall be maintained by the LHB and reported to the Audit Committee.

3.7 As soon as practicable after the date and time stated as being the latest time for receipt of quotations they shall be opened by two persons as set out in the LHB's scheme of delegation and who are independent of the person who has issued the request for quotation. Where the quotes are issued and received electronically, they shall be handled in accordance with the Electronic Tendering / Quotations Code which is set out in section 7.

3.8 Where the quotation is received in written format, the date and time of receipt of each quotation shall be endorsed on the unopened quotation envelope and a record made of its receipt on the schedule of quotations. Where the quotation is received electronically, it shall be handled in accordance with the Electronic Tendering / Quotations Code which is set out in section 7.

## 4. Competitive Tendering

4.1 Procurement of all works, goods and services, (including building and engineering) in excess of £25,000 exclusive of VAT, is to be by competitive tendering, taking care that where the estimated procurement value exceeds EU thresholds, the appropriate advertisement is placed in the Official Journal of the European Union. All such contracts shall be advertised via www.buy4wales.co.uk. Care must be exercised where potential contracts are mixed to identify which category the procurement falls into i.e. services, works or supplies. It is the total contract value exclusive of VAT over the period of contract and not the annual value to which the limits relate (total value of all goods and services required) as set out in the Public Contracts Regulations 2006 (2006/5). Any attempt to avoid these limits may expose the LHB to risk of legal challenge and result in disciplinary action against an individual[s].

4.2 Single tender action shall only be permitted when a single firm or contractor or a proprietary item or service of a special character is required and as set out in law. Single tender action shall only be employed following a formal submission and with the express written authority of the Chief Executive, or designated deputy having taken into consideration due regard of procurement requirements. A detailed record shall be maintained by the Chief Executive. All single tender action and extension of contracts must be reported to the Audit Committee.

4.3 The LHB's competitive tendering/quotation procedures may be waived where the LHB has legitimate access to a National Framework Agreement / All Wales contract or Supplies Consortium contract provided that the rules under such contract or framework agreement are adhered to.

## 5. Invitation to Tender

5.1 It is the responsibility of the Director of Finance to establish that all firms on the tender list are financially sound and professionally competent through a pre-qualification / financial vetting process undertaken by a suitably qualified and experienced procurement officer.

5.2 It is Welsh Government policy to foster the creation and development of small and medium sized businesses. If they are able to demonstrate sufficient capacity, the LHB should include them on appropriate lists of companies invited to quote or tender.

5.3 In accordance with best practice, the LHB should invite a minimum of four companies to tender for contracts of value between £25,000 and the prevailing OJEU threshold (exclusive of VAT). For contracts above the OJEU threshold, a minimum of 5 suppliers should be invited to tender. Should the above number not be available due to professional constraints or market conditions, then the Chief Executive or designated deputy shall be authorised to accept a lower number of tenderers, on the receipt of a full report detailing the reasons why the full number of tenderers cannot be represented. Should only one company be considered the requirements of paragraph 4.2 will apply and reported to the Audit Committee.

5.4 Every invitation to tender should be accompanied by the LHB's standard contract terms and conditions, and the basis on which the LHB shall engage in business with the contractor. Where appropriate a customised contract can be developed by senior procurement officers with appropriate legal advice and issued subject to approval by the Director of Finance.

5.5 The time allowed for the submission of bids shall be advised to all contractors invited to tender and shall be proportionate to the complexity of the procurement. Extensions of time shall not normally be permitted, but if for exceptional reasons an extension is required, then all potential tenderers shall be so informed and afforded the additional time. All such extensions are to be notified in writing or by email as well as by telephone. In the event of tenders already having been submitted by certain contractors they may be permitted to reconsider their bid.

## 6. Pre-tender discussions

6.1 In accordance with WHC (2006) 025, where appropriate, and being careful

to maintain fairness, the LHB may:

a) Make pre-tender contact with the market to discuss and clarify the specification and requirements, particularly if it is complex or unusual; and

b) Offer potential bidders opportunities to discuss and clarify any potential ambiguity about the interpretation of the services specification or requirement before tenders are submitted.

6.2 Prior to any officer entering into such discussions, advice must be sought from the procurement department who should also be afforded the opportunity to be party to any discussions.

## 7. Electronic Tendering / Quotations Code

*Introduction*

7.1 This Code shall apply to all tender invitations issued over a secure Internet based facility and will apply equally to electronic tendering processes undertaken by the LHB Procurement Department.

7.2 This Code shall have effect as if incorporated into the SFIs of the LHB.

7.3 Except as provided in this Code, tenders must be obtained in accordance with the requirements of these SFIs. The contents of this code do not preclude the requirements of SFI 12 where the processes detailed may be implemented.

7.4 Detailed operational guidance covering electronic tendering arrangements will be maintained separately by NWSSP–FS and LHB Procurement, which will be subject to regular audit review as part of electronic tendering processes.

*Invitation to tender*

7.5 All electronic tenders shall be invited via the secure externally hosted web site supporting the electronic tender Application.

7.6 A Service Level Agreement must be signed by Value Wales and the web site host, on behalf of the Welsh Public Sector, and should include the ability for the LHB to examine security procedures at the host site when required and to have access to any relevant security audit reports.

7.7 Tender documents shall be posted to the secure site and suppliers notified by e-mail of:

a. The availability of the tender for completion,
b. The date and time for the return of bids,
c. Any additional conditions, which must be considered by the tenderer and which, could affect the completion of the bid.

7.8 The electronic tender shall provide full details of the LHB's standard or bespoke contract terms and conditions.

7.9 The system allows the Contracts Officer to identify those tenderers who have not accessed their tenders. Tenderers who have not accessed the site in 5 working days shall be contacted to ensure they intend to bid.

7.10 The time allowed for the submission of bids shall be advised to all companies invited to tender. Extensions of time shall not normally be permitted but in the event that it is required all tenderers shall be advised by e-mail of the length of the extension and revised return date prior to the previously advised closing date.

7.11 Where a tender closing date needs to be extended, previously agreed dates can only be changed with approval from the Senior Manager/Director/Procurement Projects Officer or Commodity Manager within the issuing Department. Any extension agreed must be recorded for audit purposes using the proforma - Contracting File Note or by confirmation via email

7.12 The extension to the closing date can only be progressed once this approval has been given, and is actioned by altering the closing date within E tendering system.

7.13 Agreement to issue additional tender(s) must be given by the Senior Manager/Director/Procurement Projects Officer within the issuing Department (NWSSP–FS or LHB) and the reasons why fully documented. To issue an additional tender the supplier concerned is added to the supplier list for the ITT within the E tendering system.

*Receipt of tenders*

7.14 The System shall accept and store the tender returns in accordance with paragraphs 7.17 to 7.24 below.

7.15 Tenders will be completed and submitted in the secure external web site.

7.16 Tenderers who miss the closing date for receipt of tenders shall have no further opportunity to post bids to the external web site for that

particular tender issue.

*Opening and validity of tenders*

7.17 Prior to the start of the Tender process, the Contracts Manager shall designate one or more persons to form the “Designated Opening Committee” (DOC). The system will ensure that all members of the DOC are present at the opening by requesting that they each login to the system using their personal passwords.

7.18 As soon as possible after the expiry of the return date, the DOC shall open the Qualifying Envelopes firstly and then the Technical responses in the external web site.

7.19 Once the Technical responses have been opened they are visible to those users assigned access, the system shall prevent editing.

7.20 Once the criteria for the Technical responses have been scored, the Commercial responses can be opened by the DOC.

7.21 Once the Commercial responses have been opened they are visible to those users assigned access, the system shall prevent editing.

7.22 Parallel opening facility permits opening of the Commercial responses before scoring of the Technical responses

7.23 Parallel opening shall only be deployed with the authority of a senior or commodity manager and the rationale for such an action clearly documented for audit purposes.

7.24 Any scoring or analysis carried out in the external website will be fully auditable. Communication between NWSSP–FS or LHB Contracting Team and suppliers will be done using the messaging tool in the external website so that this is also auditable.

*Monitoring contracts*

7.25 Overall monitoring of the contracts awarded shall be the responsibility of the Director of Finance, who shall present a report annually to the LHB Board detailing the number and value of all contracts placed during the previous financial year in excess of the LHB’s tender limit.

## 8. Delivery, Receipt and Safe Custody of Tenders

8.1 This section relates to paper based procurement and should only apply in exceptional circumstances.

8.2 The time allowed for the submission of the tender shall depend on the scope and value of the goods or services. Tenders shall not be invited for return on public and bank holidays, nor on days prior to such holidays. The date and time of receipt of each tender shall be endorsed on the unopened tender envelope/packaging/label, and a record kept of its receipt in the 'Tender Received' log and later, on opening, in a properly constituted register.

8.3 The Director of Finance is responsible for the receipt, endorsement and safe custody of tenders until the time appointed for their opening and for the maintenance of records. The tender envelope must be retained after opening together with the opened tender documents and collected by the initiator of the tender.

8.4 If a tender is received after the date and time specified for return, and the other tenders have not yet been opened, then the Director of Finance, or in their absence a nominated deputy, shall have authority to decide whether or not the tender is to be considered valid. If considered valid, the tender should be included and opened in accordance with Section 8. If considered invalid, then it should be held until the valid tenders have been opened and listed as described in Section 8. It should then be opened solely for the purpose of determining the name and address of the company or trader and the party who invited the tender shall be responsible for returning the tender to its sender with a covering note to the effect that it had been received too late for inclusion in the competition.

8.5 All tender documents and envelopes once assessed shall be retained in secure storage. All contracts under seal i.e. deeds (inc. tenders) to be retained for a minimum of 12 years; contracts under hand for a minimum of 6 years; unsuccessful tender documents for 6 years.

**9. Opening and Validity of Tenders**

9.1 As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened by a person authorised by the Chief Executive in the presence of an independent witness. The independent witness shall not be an officer of the Directorate who has invited the tender being opened. Notwithstanding the above, no tender shall remain unopened for a period exceeding two working days after the due date for receipt of that tender. Any additional delay to be notified to the Chief Executive.

9.2 Every tender received shall be stamped with the date of opening and signed by those present at the opening. Each page of the tender (except for detailed bills of quantities) which provides relevant financial information and prices, must be initialled and date stamped by the persons opening the tender and any amendments signed. In addition, in the case of tenders that

contain a contract page signed by the tenderer, the opener and the witness shall also sign that page.

9.3 A record shall be maintained to show for each set of competitive tender invitations issued:

a) The names of all firms invited, which shall be recorded prior to the date for receipt of tenders, except in the case of tenders received as a result of public advertisement,

b) The names of, or the number of firms from which tenders have been received,

c) The date and time the tenders were received,

d) The date and time the tenders were opened,

e) The record shall be signed by the persons present at the opening.

The tender register must be a bound book kept by the Director of Finance in a secure place.

9.4 A record shall be maintained of all price alterations on tenders. Where a price has apparently been altered, the final price shown shall be recorded. The record shall be signed by those present at the opening. The use of liquid paper on any pages of the tender may invalidate the tender submission.

9.5 Tender documents, which do not comply with the guidelines issued with each invitation to tender, shall be invalidated, recorded accordingly and returned to the sender.

## 10. Evaluation, Acceptance and Extension of Tenders

10.1 Incomplete tenders, that is those from which information necessary for the adjudication of the tender is missing, and amended tenders, that is those amended by the tenderer upon his own initiative in writing after the due time for receipt, should be dealt with by a Tender Adjudication Panel to ensure there is no unfair advantage given to any tenderer.

10.2 Evaluation of tenders shall be entrusted to the appropriately qualified and experienced staff with the appropriate knowledge and skills to ensure that tenders are assessed in a robust and fair manner. This group shall be responsible for making a recommendation to the Chief Executive or where this has been formally delegated to the nominated committee, project board or officer that has the authority to approve such recommendations.

10.3 There is no legal requirement for the LHB to accept any tender or award any contract or part of a contract, and the LHB, may if it so adjudges, not proceed further at this stage. Evaluation shall be determined by either the lowest price or most economically advantageous tender.

10.4 In determining which tender is the most economically advantageous the LHB may take into account such matters as price, delivery date, running costs, cost effectiveness, quality, aesthetic and functional characteristics, technical merit, after sales services and technical assistance or clinical reasons. The final criteria (and any sub criteria) being used to evaluate tenders must be agreed and published to bidders/ interested parties, no later than the ITT (Invitation to Tender) stage and must be supported by an equitable and transparent weighting and scoring methodology in accordance with EU Procurement Regulations. Particular reference must be made, where this is pertinent, to Sustainable Development as evaluation criteria.

10.5 The area of environmental and sustainable purchasing is a developing one and advice must be sought from procurement professionals in terms of the options and issues around this matter. This will include issues around the use of sustainable products, cost implications, use in specifications, evaluation and value for money.

10.6 Necessary discussions with a tenderer to clarify technical aspects of his tender before the award of a contract need not disqualify the tender provided the discussions and changes to the tender are not material. Clarification of the technical aspects shall be confirmed by the tenderers in writing. Clarifications on commercial matters should only be undertaken by exception providing that such clarifications do not distort competition. The procurement department must be informed and involved in any such commercial clarifications to ensure probity and audit compliance.

10.7 The LHB shall confirm that referees are in a position to comment authoritatively on the capacity to provide the goods or services being tendered for, that referees have no potential conflicts of interest, and that all references are fully recorded and retained.

10.8 Subject to complying with any legal requirements and agreed contract conditions, a contract may be extended on a single occasion provided the additional cost does not exceed 50% of the original value of the contract to a maximum of £75,000 exclusive of VAT. Such extension must have the express approval of the Chief Executive or designated deputy in their absence. Where a contract was advertised and includes a legal clause providing the option to extend, such approval is not required unless there is a change to any of the current contract terms and conditions including price. Any contract extensions must be reported to the Audit Committee.

## 11. Post Tender Discussions

11.1 Post tender discussions [PTD] consists of clarifications with suppliers after receipt of formal tenders/quotations from suppliers but before letting a contract in the content of an offer without:

- Disadvantaging other tenderers;
- Distorting competition;
- Adversely affecting trust in the competitive tendering process;

11.2 Probity and transparency are required in PTD to ensure that a “Dutch auction” position is not conducted, i.e. one bidder being traded off with another.

11.3 PTD is a specialist area of activity and professional procurement support is essential to ensure fairness and equity where PTD is considered appropriate and justified.

11.4 More information on PTD best practice is available from the Value Wales website.

## 12. Notification of Results of Tenders

12.1.1 All unsuccessful tenderers must be advised in writing within seven working days of the award of the contract where this is below the OJEU threshold value. For OJEU procurements, the requirements of the Public Contracts Regulations 2006 (2006/5) shall apply including debriefing and placement of a mandatory 10 day (Alcatel ruling) Standstill period.

## 13. Contracts

13.1.1 The LHB may only enter into contracts within the statutory powers delegated to it by the Welsh Ministers and in accordance with EU Procurement Law and UK Procurement Regulations.

13.2 In every contract document a clause shall be included to secure that the LHB shall be entitled to cancel the contract and to recover from the contractor the amount of any loss resulting from such cancellation, if the contractor shall have prepared his tender in collusion with others or shall have offered or given or agreed to give any person any gift or consideration of any kind as an inducement or reward for doing or forbearing to do, or having done or forborne to do, any action in relation to the obtaining or execution of the contract or any other contract with the LHB or if the like acts shall have been done by any person employed by him acting on his behalf (whether with or without the knowledge of the contractor) or if in relation to any contract with

the LHB the contractor or any persons employed by him or acting on his behalf shall have committed an offence under the Prevention of Corruption Acts 1906 (c.34) and 1916 (c.64) and the Public Bodies Corrupt Practices Act 1889 (c.69) and as defined in the Standards of Business Conduct for Employees of the LHB.

13.3 Any contracts under £25,000 exclusive of VAT may be let by exchange of simple forms of contracts or official orders at the discretion of the Director of Finance provided that the following are specified:

- The work, materials, matters, or goods to be provided or undertaken,
- The price to be paid and payment terms, with a statement of discount or other deduction if any,
- The time or times within which the contract is to be delivered.

## 14. Contract Management

14.1 Contract Management is the process which ensures that both parties to a contract fully meet their respective obligations as effectively and efficiently as possible, in order to deliver the business and operational objectives required from the contract and in particular, value for money. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the LHB so as to ensure that these implicit obligations are met.

14.2 Where the LHB decides to award additional funding to contractors outside the terms of a contract, it should:

- Robustly assess the evidence that there are exceptional circumstances to justify the funding and that it is compliant with the applicable law;
- Ensure this does not adversely effect any competitive process;
- Fully record the basis of the decisions and report the decision to the Audit Committee.

14.3 Advice on best practice on Contract Management is available from Value Wales.

## 15. Collaborative Contracts

15.1 Where the LHB enters into a collaborative contract with other public sector organisations the LHB SFIs and procedures shall be used where the LHB is

the lead organisation. Where the LHB is not the lead organisation the SFIs and procedures of the host organisation shall be used.

15.2 Where joint schemes are undertaken with an outside agency that involve the outside agency guaranteeing to fund whole or part cost of the scheme, a written undertaking should be obtained from the outside agency guaranteeing the stated funding before the LHB contracts for the necessary services.

## 16. Construction Procurement

16.1 Construction procurement undertaken by the LHB will be conducted in accordance with the Welsh Government's Construction Procurement Strategy and the general principles of the OGC Achieving Excellence (AEC) in Construction initiative as applicable to NHS Wales.

16.2 The Welsh Ministers have developed a procurement strategy for construction which seeks to develop a more consistent approach to the procurement of works projects. The LHB will adopt and embed the outputs of this strategy that can be accessed at www.buy4wales.co.uk/prp

16.3 The LHB will engage with NHS Wales Shared Services Partnership – Facilities Services (NWSSP–FS) making use of the Designed for Life framework as appropriate for projects valued in excess of £6m. For procurement of projects below £6m, the latest guidance from NWSSP–FS should be followed.

## 17. Procurement for Supply of Health Care Services

17.1 Where the LHB is required or elects to invite tenders for the supply of healthcare services the LHB's SFIs and this supplementary guidance shall apply in relation to tendering procedures.

17.2 The procurement arrangements surrounding the provision of healthcare services is a complex area and as such legal advice must be secured where there is doubt over the applicability or not of applying competitive processes.

17.3 To assist with the assessment of appropriate procurement routes, the following process should be used in reaching a decision:

| Assess relevant markets | Evaluate existing contracts | Evaluate procurement options | Evaluate procurement routes |
|---|---|---|---|
| Need for services | Performance | Outcomes | Advice |
| Market structure | Efficiency | Attractiveness | EU Part B options |
| Competition | Demand | 'Lotting' strategy | Other |
| Capacity | Fitness | Single/multi-source | |
| Innovation<br>Interest | | | |

17.4 The key principles underpinning the process are:

a) **Transparency** – including the use of sufficient and appropriate advertising of tenders, transparency in making decisions not to tender, and the declaration and separation of conflicts of interest;

b) **Non-discrimination** – ensuring all providers and products are given an equal opportunity regardless of origin;

c) **Equality of treatment** – ensuring that all providers and sectors have equal opportunity to compete where appropriate; that financial and due diligence checks apply equally and are proportionate; and that pricing and payment regimes are transparent and fair;

d) **Proportionality** – making procurement processes proportionate to the value, complexity and risk of the services contracted, and critically not excluding potential providers through overly bureaucratic or burdensome procedures.

17.5 When awarding contracts for patient services to new suppliers, the LHB shall develop risk management and contingency plans proportionate to the risks in the case of service or financial failure.

17.6 All contracts or agreements for health services should be supported by appropriate documentation specifying as a minimum:

a) Volume of services

b) Quality and outcomes

c) Financial value and payment arrangements

d) Monitoring arrangements

e) Disputes and resolution processes.

17.7 For Health Care Agreements between NHS bodies in Wales, the standard documentation issued by the Welsh Ministers should be used.

## 18. Disposals

18.1 Competitive Tendering or Quotation procedures is discretionary in respect of the disposal of:

a) Any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or their nominated officer;

b) Obsolete or condemned articles and stores, which may be disposed of in accordance with applicable regulations and law at the prevailing time (e.g. WEEE) and the procedures of the LHB;

c) Items to be disposed of with an estimated sale value of less than £1000;

d) Items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract, in all other instances the best possible market price should be obtained.

# Schedule 2

## REVISED GENERAL CONSENT TO ENTER INTO INDIVIDUAL CONTRACTS UP TO £1M IN ANY ONE FINANCIAL YEAR

## Letter from Deputy Director of Finance, Department for Health, Social Services and Children

**This Schedule forms part of, and shall have effect as if incorporated in the Local Health Board Standing Financial Instructions**

**Mark Osland**
**Dirprwy Cyfarwyddwr Cyllid,**
**Yr Adran Lechyd, Gwasanaethau Cymdeithasol a Phlant**
**Deputy Director of Finance,**
**Department for Health, Social Services and Children**

Llywodraeth Cymru
Welsh Government

19 April 2012

Chief Executives
Local Health Boards
Wales

Eich cyf • Your ref:
Ein cyf • Our ref:

Dear All

**Re: UPDATED PROCESS FOR LOCAL HEALTH BOARDS TO OBTAIN CONSENT TO ENTER INTO CONTRACTS EXCEEDING £1M AND MONITORING ARRANGEMENTS FOR CONTRACTS BELOW £1M.**

1. Paragraph 13(3) of Schedule 2 to the National Health Service (Wales) Act 2006 places a requirement on Local Health Boards (LHBs) to obtain the consent of Welsh Ministers before:

   - Acquiring and disposing of property;
   - Entering into contracts; and
   - Accepting gifts of property (including property to be held on trust).

2. The provision allows the Welsh Ministers to give consent, if it thinks fit, which may be given in general terms covering one or more descriptions of case.

3. On 14th September 2009 following Ministerial approval the former Chief Executive NHS Wales issued a Revised General Consent by way of a letter to all LHB Chief Executives, which provided consent for LHBs to enter into individual contracts **up to the value of £1 million with the exception of those contracts specified in paragraph 5 below.** All contracts exceeding this delegated limit, all acquisitions and disposals of land or any limit, and the acceptance of gifts of property, must receive the written approval of the Welsh Government before being entered into.

BUDDSODDWR MEWN POBL
INVESTOR IN PEOPLE

Parc Cathays • Cathays Park
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CF10 3NQ

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GTN: 1208 3137
Chris.hurst@wales.gsi.gov.uk

4. As of 18th January 2012 the granting of consent to LHBs to enter into contracts exceeding £1 million ceased to be delegated to the Director General Health, Social Services & Children / Chief Executive NHS Wales and the Director of Finance. From this date consent for contracts exceeding £1 million will be exercised directly by the Minister for Health and Social Services.

5. The requirement for consent does not apply to any contracts entered into pursuant to a specific statutory power, and therefore does not apply to:

(i) Contracts of employment between LHBs and their staff;
(ii) Transfers of land or contracts effected by Statutory Instrument following the creation of LHBs;
(iii) Out of Hours contracts; and
(iv) All NHS contracts, that is where one health service body contracts with another health service body.

6. For LHB contracts to be let exceeding £1million, in order to allow the Minister to have timely sight of forthcoming approval requests, information will be required at the contract planning stage to note the proposed contract. This information should be provided in accordance with the 'How to Provide Initial Briefing' guidance in Appendix 2 to this letter and will use the Contract Briefing Paper template available from Shared Services Procurement. Contracts entered into under the All Wales Capital Programme are not covered by this requirement. The application and approval procedures for All Wales Capital Programme activity already embeds arrangements for Welsh Ministers consent into the overall project approval process.

7. Applications for approval of contracts exceeding £1million must be made in accordance with the 'How to Apply for Consent' guidance and template in Appendix 3 to this letter, except for contracts entered into under the All Wales Capital Programme as referred to above.

**NEW MONITORING ARRANGEMENTS**

8. The Minister has requested that additional monitoring arrangements are put in place for contracts that fall below £1million. The following process and information requirement is to be introduced;

(i) From 1st April 2012 for **individual contracts with a value exceeding £500,000 and up to £1,000,000**, a contract summary form should be provided for Ministerial review prior to entering into the contract. It is not necessary to obtain Welsh Ministers consent to enter into such contracts, however adequate information and time should be given (per guidance in Appendix 4) for the Minister to review the contract particulars.

(ii) From 1st April 2012 **for individual contracts with a value exceeding £250,000 and up to £500,000** a list of contracts let in the preceding 6 months is to be provided in the format set out in Appendix 5.

9. Chief Executives are reminded that to expedite the approval process the following should be maintained up to date and provided to Welsh Government:

- Details of signatories authorised to sign the application form to gain consent – endorsed by yourselves.
- At the beginning of each financial year, as far as is possible, a list of relevant contracts that are due to be let during each financial year and an indication of when those exceeding £1million will require approval.

10. As an aid to determining whether the contract requires the consent of the Welsh Ministers a decision tree is provided at Appendix 1 covering different contractual arrangements and their treatment.

11. The process changes outlined in this letter and accompanying guidance will come into effect immediately.

12. With the transfer of Shared Services Partnership service to Velindre NHS Trust from the 1st June 2012 changes or amendments to these processes may arise and will be notified in due course.

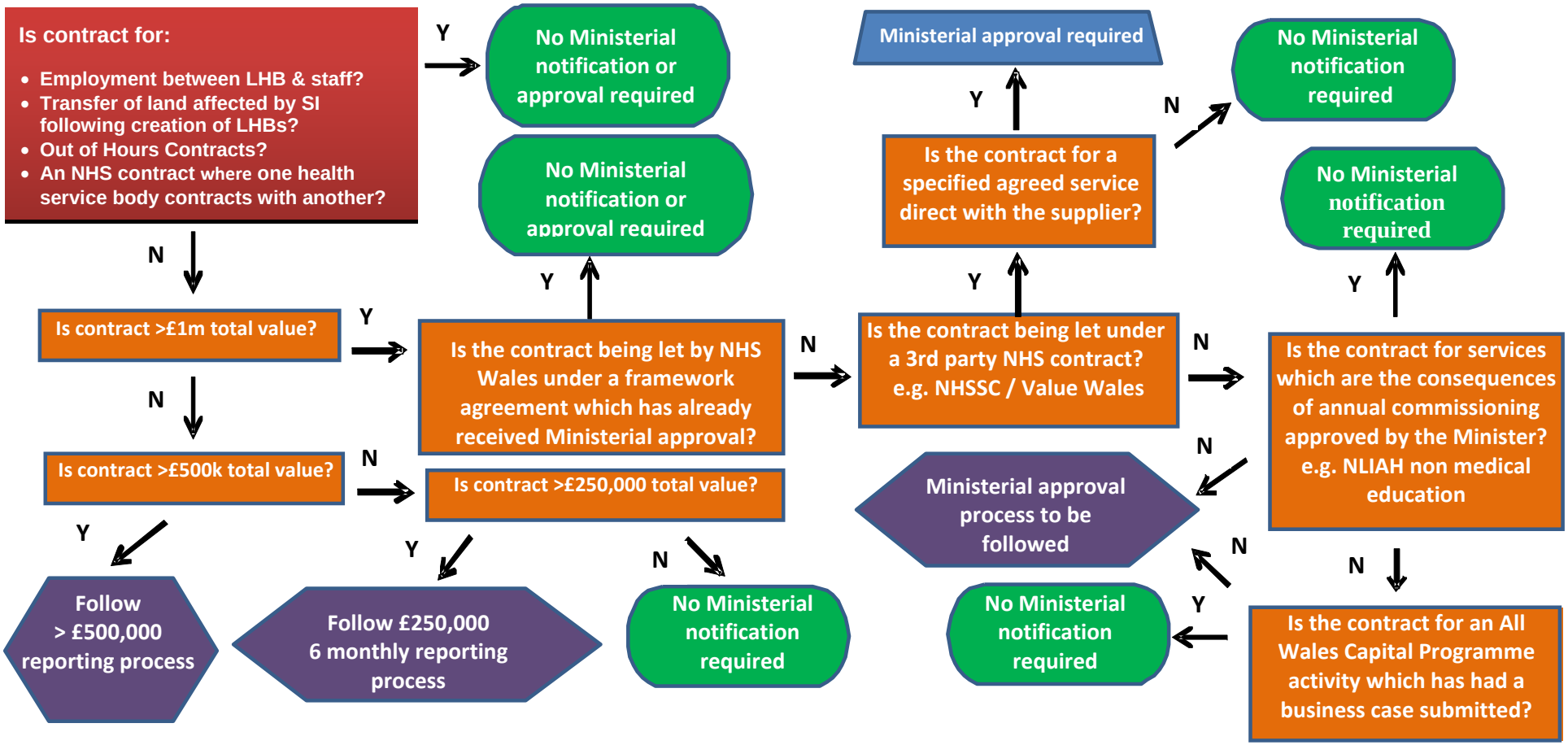
13. Enquiries regarding the How to Apply for Consent process, or the monitoring of contracts exceeding £250,000 to £1million should be directed to Kim Jenkins, Finance Directorate, Department for Health, Social Services and Children – kim.jenkins@wales.gsi.gov.uk.

Yours sincerely

Mark Osland
Deputy Director of Finance

**Appendix 1**

# Contracts – Consent and Monitoring Decision Tree


Is contract for:
• Employment between LHB & staff?
• Transfer of land affected by SI following creation of LHBs?
• Out of Hours Contracts?
• An NHS contract where one health service body contracts with another?
Y
No Ministerial notification or approval required
N
Is contract >£1m total value?
Y
No Ministerial notification or approval required
Y
Is the contract being let by NHS Wales under a framework agreement which has already received Ministerial approval?
N
Is the contract being let under a 3rd party NHS contract? e.g. NHSSC / Value Wales
N
Ministerial approval required
Y
Is the contract for a specified agreed service direct with the supplier?
N
No Ministerial notification required
Y
No Ministerial notification required
Y
Is the contract for services which are the consequences of annual commissioning approved by the Minister? e.g. NLIAH non medical education
N
Is contract >£500k total value?
N
Is contract >£250,000 total value?
Y
Follow > £500,000 reporting process
Y
Follow £250,000 6 monthly reporting process
N
No Ministerial notification required
N
Ministerial approval process to be followed
N
No Ministerial notification required
Y
N
Is the contract for an All Wales Capital Programme activity which has had a business case submitted?

# Appendix 2

## How to Provide Initial Briefing

1. LHBs should, at the contract planning stage consider whether it is a contract for which they require consent of the Welsh Ministers. The contract planning stage is either the 'contract planning stage' as set out in the Shared Services Procurement guidance, if following a Shared Service Procurement process, or at the point at which sufficient information is known to have clarity around the specification requirements.

2. As an aid to determining whether the contract requires the consent of the Welsh Ministers a decision tree is provided at Appendix 1 covering different contractual arrangements and their treatment. Any queries at this stage as to whether approval is needed should be directed to Kim.Jenkins@wales.gsi.gov.uk, cc'd to Mary.Swiffen-Walker@wales.gsi.gov.uk.

3. If the LHB decides that they wish to pursue a contract that does require consent of the Welsh Ministers (i.e. one not pursuant to their direct statutory powers), and which exceeds the general consent threshold of £1million, or is not covered by the general consent they should send the Contract Briefing Paper along with any supporting documentation via e-mail to Kim.Jenkins@wales.gsi.gov.uk, cc'd to Mary.Swiffen-Walker@wales.gsi.gov.uk. The Contract Briefing Paper form can be obtained from the Procurement Services website under the section for Policies, Procedures and Forms under the 'staff' tab (guidance or a copy of the form can be obtained from your Procurement Department) http://www.procurement.wales.nhs.uk/

4. The Contract Briefing Paper form should be provided at the 'contract planning stage' if following a Shared Service Procurement process, or at the point at which sufficient information is known to have clarity around the specification requirements.

5. Timely provision of Initial Briefing for Ministerial review is crucial to the smooth running of the approval process. Contracts for which an application for consent is received without the Initial Briefing having been provided may encounter delays in the approval stage.

6. Within the Contract Briefing Paper explanation is sought for Private Sector Procurement Rationale, this is the explanation as to why the goods / services were sought from private sector, rather than in-house NHS delivery. The purpose of this section is to explain what options were considered including in-house delivery and reasons for private sector procurement e.g. value for money, service quality, capacity etc.

The degree of detail required here will range dependant upon the goods or services being procured. If the contract is for the provision of goods which can only be bought from the private sector the rationale for private sector procurement is straightforward – as the only source of the goods is the private sector. If the contract is for the provision for example of homecare services, or services that may historically have been delivered by frontline healthcare professionals, or in a hospital / clinic setting, a more detailed explanation will be required setting out what options were considered for delivery within the NHS, and the improved outcomes (quality, cost, value) achieved by private sector procurement. If such a contract is being pursued under a strategy or policy direction this should be cited in the rationale.

7. Framework contracts. This information should be provided for the tender and letting of the overall framework contract. It will not be necessary to provide this information for subsequent individual contracts entered into if exceeding £1million.

8. These processes do not apply to All Wales Capital Programme contracts, as the application, business case and approvals process for such activity already encompasses Welsh Ministers approval.

9. These processes do not apply to situations where NHS Wales bodies access services which have been contracted for by a third party body e.g. Value Wales, NHS Supply Chain. In these situations NHS Wales is not the contracting body. However, if under such arrangements an LHB enters into a contract with a supplier for specified goods or services, this would be subject to the processes outlined above. See examples below for clarification:

    a. If an LHB were to access a Value Wales office supplies contract for standard office supplies exceeding £1million this would not require Ministerial consent.
    b. However, if under an NHS Supply Chain contract for consultancy services a specific consultancy project was scoped and tendered via mini-competition under the Framework, and a contract entered into between the LHB and successful supplier for more than £1million, Ministerial consent would be required.

10. The processes outlined above would not be applicable to situations where LHBs enter into contracts which are the consequence of an annual commissioning paper that is approved by the Minister before contracting arrangements are made e.g. NLIAH contracts with Universities for non-medical education.

11. No formal notification will be provided to LHBs that the Minister has noted the contract. Once the Initial Briefing has been provided the LHB

should allow a 10 day period for queries to arise. Officials will notify applicant LHBs of any queries or Ministerial requests if they arise from the Ministers' consideration of the contract. Once the 10 day period has passed the procurement procedure should progress.

# Appendix 3

## How to Apply for Consent

1. Local Health Boards (LHBs) should, prior to signing a contract, consider whether it is a contract for which they require consent of the Welsh Ministers.

2. As an aid to determining whether the contract requires the consent of the Welsh Ministers a decision tree is provided at Appendix 1 covering different contractual arrangements and their treatment. Any queries at this stage as to whether approval is needed should be directed to Kim.Jenkins@wales.gsi.gov.uk cc'd to Mary.Swiffen-Walker@wales.gsi.gov.uk

3. If the LHB decides that they wish to enter into a contract that does require the consent of the Welsh Ministers (i.e. one not pursuant to their direct statutory powers), and which exceeds the general consent threshold of £1million, or is not covered by the general consent, they should complete the application form for consent provided with this guidance and submit it along with supporting documentation via e-mail to Kim.Jenkins@wales.gsi.gov.uk cc'd to Mary.Swiffen-Walker@wales.gsi.gov.uk and Tracy.Jones3@wales.nhs.uk

4. If it is not possible to provide all documentation electronically, hard copies should be provided to Mary Swiffen Walker, Finance Directorate, Department of Health, Social Services and Children, Welsh Government, Cathays Park, Cardiff, CF10 3NQ.

5. In addition to the application form, applicants should ensure that all relevant documents required to consider the request are included with the application form.

6. **At the very minimum,** the documents attached to the application should include:
    - The proposed terms of the contract i.e. parties, period and consideration,
    - Evidence of Board approval of the contract, or evidence of appropriate sign off to procure by participating LHBs in the case of All Wales contracts. *(Shared Services Procurement to develop appropriate process guidance which will be incorporated into this guidance when available)*

- In the case of approval to dispose of land / buildings, evidence should be submitted that demonstrates market value has been achieved, or a reason given why this is not the case.

7. In order to ensure timely approval, Welsh Government require 15 working days in which to consider approvals. There may be occasions when an urgent decision is needed, and officials will endeavour to respond quickly and promptly in these cases to ensure no unnecessary delay arises. However this is expected to be in exceptional cases only. This does not remove the obligation to obtain consent / approval prior to entering into contracts over £1million.

8. Framework contracts. This information should be provided for the tender and letting of the overall framework contract. It will not be necessary to provide this information for subsequent individual contracts entered into if exceeding £1million.

9. These processes do not apply to All Wales Capital Programme contracts, as the application, business case and approvals process for such activity already encompasses Welsh Ministers approval.

10. These processes do not apply to situations where NHS Wales bodies access services which have been contracted for by a third party body e.g. Value Wales, NHS Supply Chain. In these situations NHS Wales is not the contracting body. However, if under such arrangements an LHB enters into a contract with a supplier for specified goods or services, this would be subject to the processes outlined above. See examples below for clarification:

    - If an LHB were to access a Value Wales office supplies contract for standard office supplies exceeding £1million this would not require Ministerial consent.
    - However, if under an NHS Supply Chain contract for consultancy services a specific consultancy project was scoped and tendered via mini-competition under the Framework, and a contract entered into between the LHB and successful supplier for more than £1million, Ministerial consent would be required.

11. The processes outlined above would not be applicable to situations where LHBs enter into contracts which are the consequence of an annual commissioning paper that is approved by the Minister before contracting arrangements are made; e.g. NLIAH contracts with Universities for non-medical education.

12. For volume estimate contracts, the criteria of whether the £1million level will be exceeded should be based upon the original estimates for the letting of the contract.

13. For contracts with an option to extend, if the exercise of the option would take the value of the contract over £1million, application for consent should be made at the point consideration is being given to exercising the option.

14. Within the application for consent explanation is sought for Private Sector Procurement Rationale, this is the explanation as to why the goods / services were sought from private sector, rather than in-house NHS delivery. The purpose of this section is to explain what options were considered including in-house delivery and reasons for private sector procurement e.g. value for money, service quality, capacity etc. The degree of detail required here will range dependant upon the goods or services being procured. If the contract is for the provision of goods which can only be bought from the private sector the rationale for private sector procurement is straightforward – as the only source of the goods is the private sector. If the contract is for example for the provision of homecare services, or services that may historically have been delivered by frontline healthcare professionals, or in a hospital / clinic setting, a more detailed explanation will be required setting out what options were considered for delivery within the NHS, and the improved outcomes ( quality, cost, value) achieved by private sector procurement. If such a contract is being pursued under a strategy or policy direction this should be cited in the rationale.

15. If, once a contract exceeding £1million is awarded, a challenge is raised on the contract, it is only necessary to seek Ministerial approval again if the challenge results in changes to the contract i.e. the contract would not be awarded in accordance with the Ministerial approval originally received.

# Appendix 4

## How to provide monitoring information for contracts exceeding £500,000 up to £1million

1. If the LHB decides that they wish to enter into a contract that falls below the Ministerial consent threshold, and is not pursuant to their direct statutory powers, information for all such proposed contracts with a value exceeding £500,000 up to £1million will be required. The LHB must complete the notification form provided with this guidance, (not the application for consent form), and submit it along with relevant supporting documentation via e-mail to Kim.Jenkins@wales.gsi.gov.uk cc'd to Mary.Swiffen-Walker@wales.gsi.gov.uk

2. As an aid to determining whether the contract requires the consent of the Welsh Ministers a decision tree is provided at Appendix 1 covering different contractual arrangements and their treatment. Any queries at this stage as to whether approval is needed should be directed to Kim.Jenkins@wales.gsi.gov.uk cc'd to Mary.Swiffen-Walker@wales.gsi.gov.uk

3. To ensure timely review, Welsh Government requires provision of this summary information at least 8 working days prior to the intended date of contract letting. There may be occasions when it is not possible to adhere to this timescale, officials will endeavour to respond quickly and promptly in these cases to ensure no unnecessary delay arises.

4. No formal notification will be provided to LHBs that the Minister has noted the contract. Once the notification has been provided the procurement procedure should progress. Officials will notify applicant LHBs of any queries or Ministerial requests if they arise from the Ministers' consideration of the contract.

5. Explanation of detail required:
    a. Contract Title – name by which contract is generally referred to
    b. Contract reference – reference to uniquely identify contract
    c. Purpose of the contract – why the contract is being entered into
    d. Contract description – description of goods or services or property covered by the contract
    e. Rationale for private sector procurement – explanation as to why the goods / services were sought from private sector, rather than in-house NHS delivery. The purpose of this section is to explain what options were considered including in-house delivery and reasons for private sector procurement e.g. value for money, service quality, capacity etc.

The degree of detail required here will range dependant upon the goods or services being procured. If the contract is for the provision of goods which can only be bought from the private sector the rationale for private sector procurement is straightforward – as the only source of the goods is the private sector.

If the contract is for the provision of Healthcare at Home services, or services that may historically have been delivered by frontline healthcare professionals, or in a hospital / clinic setting, a more detailed explanation will be required setting out what options were considered for delivery within the NHS, and the improved outcomes ( quality, cost, value) achieved by private sector procurement. If such a contract is being pursued under a strategy or policy direction this should be cited in the rationale.

f. Contractor details – details of the contractor(s) to whom the contract has been awarded, if a framework contract, information by lot of successful contractor(s)
g. Contract value – Total value and annual value
h. OJEU Requirements – Description of OJEU requirement and compliance
i. Contract duration – Length of contract being entered into, start date & end date, and details of any option to extend
j. Confirmation of Funding Stream – Description of funding source
k. Identified Risks – Key contract risks

6. This process does not apply to All Wales Capital Programme contracts, as the application, business case and approvals process for such activity already encompasses Welsh Ministers approval.

7. These processes do not apply to situations where NHS Wales bodies access services which have been contracted for by a third party body e.g. Value Wales, NHS Supply Chain. In these situations NHS Wales is not the contracting body. However, if under such arrangements an LHB enters into a contract with a supplier for specified goods or services, this would be subject to the processes outlined above. See examples below for clarification:

    a. If an LHB were to access a Value Wales office supplies contract for standard office supplies exceeding £1million this would not require Ministerial consent.
    b. However, if under an NHS Supply Chain contract for consultancy services a specific consultancy project was scoped and tendered via mini-competition under the Framework, and a contract entered into between the LHB and successful supplier for more than £1million, Ministerial consent would be required.

8. The processes outlined above would not be applicable to situations where LHBs enter into contracts which are the consequence of an annual commissioning paper that is approved by the Minister before contracting arrangements are made e.g. NLIAH contracts with Universities for non-medical education.

9. Framework contracts. This information should be provided for the tender and letting of overall framework contracts with a value exceeding £500,000 up to £1million. It will not be necessary to provide this information for subsequent individual contracts entered into if exceeding £1million.

# Appendix 5

## How to provide monitoring information for contracts exceeding £250,000 up to £500,000

1. If the LHB decides that they wish to enter into a contract that falls below the Ministerial consent threshold, and is not pursuant to their direct statutory powers, information for all such proposed contracts with a value exceeding £250,000 up to £500,000 will be required. Procurement services will collate from individual LHBs the details required and complete the summary details form provided with this guidance and submit it via e-mail to Kim.Jenkins@wales.gsi.gov.uk cc'd to Mary.Swiffen-Walker@wales.gsi.gov.uk

2. As an aid to determining whether the contract requires the consent of the Welsh Ministers a decision tree is provided at Appendix 1 covering different contractual arrangements and their treatment. Any queries at this stage as to whether approval is needed should be directed to Kim.Jenkins@wales.gsi.gov.uk cc'd to Mary.Swiffen-Walker@wales.gsi.gov.uk

3. The form should cover all relevant contracts let in the 6 months preceding the due date.

4. Explanation of detail required:
    a. Contract Title – name by which contract is generally referred to
    b. Contract reference – reference to uniquely identify contract
    c. Contract description – description of goods or services or property covered by the contract
    d. Contract value – Total value and annual value
    e. Contract duration – Length of contract being entered into, start date & end date, and detail of any option to extend
    f. Contractor details – details of the contractor(s) to whom the contract has been awarded, if a framework contract, information by lot of successful contractor(s)

5. This process does not apply to All Wales Capital Programme contracts, as the application, business case and approvals process for such activity already encompasses Welsh Ministers approval.

6. These processes do not apply to situations where NHS Wales bodies access services which have been contracted for by a third party body e.g. Value Wales, NHS Supply Chain. In these situations NHS Wales is not the contracting body. However, if under such arrangements an LHB enters into a contract with a supplier for specified goods or services, this would be

subject to the processes outlined above. See examples below for clarification:

g. If an LHB were to access a Value Wales office supplies contract for standard office supplies exceeding £1million this would not require Ministerial consent.
h. However, if under an NHS Supply Chain contract for consultancy services a specific consultancy project was scoped and tendered via mini-competition under the Framework, and a contract entered into between the LHB and successful supplier for more than £1million, Ministerial consent would be required.

7. The processes outlined above would not be applicable to situations where LHBs enter into contracts which are the consequence of an annual commissioning paper that is approved by the Minister before contracting arrangements are made: e.g. NLIAH contracts with Universities for non-medical education.

8. Framework contracts. This information should be provided for the tender and letting of overall framework contracts with a value exceeding £250,000 up to £500,000. It will not be necessary to provide this information for subsequent individual contracts entered into under a Framework if exceeding £250,000.

**Contract Details**

| | |
|---|---|
| **Contract Title:** | |
| **Contract Duration:** | |
| **Contract Date:** | |
| **Estimated Annual Value:** | |
| **Estimated Total Value:** | |
| **Responsible Contracts Officer:** | |
| **Lead Body LHB or Trust:** | |
| **Contracts Officer Contact Details:** | **E-mail address & phone number** |

## Contract Overview

Snap shot from contract plan

## Market Research

Summarise information from contract plan to include:
Market research
Other UK Practice
Benchmarking
Themes of SRA

## SWOT Analysis

| Strengths | Weaknesses |
|---|---|
| • | • |

| Opportunities | Threats |
|---|---|
| • | • |

**Private Sector Procurement Rationale**

*This is the explanation as to why the goods / services were sought from private sector, rather than in-house NHS delivery. The purpose of this section is to explain what options were considered including in-house delivery and reasons for private sector procurement e.g. value for money, service quality, capacity etc.*

*The degree of detail required here will range dependant upon the goods or services being procured. If the contract is for the provision of goods which can only be bought from the private sector the rationale for private sector procurement is straightforward – as the only source of the goods is the private sector.*

*If the contract is for example for the provision of homecare services, or services that may historically have been delivered by frontline healthcare professionals, or in a hospital / clinic setting, a more detailed explanation will be required setting out what options were considered for delivery within the NHS, and the improved outcomes ( quality, cost, value) achieved by private sector procurement. If such a contract is being pursued under a strategy or policy direction this should be cited in the rationale.*

**Contract Analysis / Proposal**

Provide details of contract strategy
Pricing strategy
Expected benefits - Savings / Standardisation / price containment

## Contract Proposal

1. **Tender Type**

2. **Term of the Contract**

3. **Supplier Selection**

4. **Award Criteria**

5. **Timeframes**

Provide indication of key dates

| Contracting Stage | Anticipated Date/Timescales | Responsibility |
|---|---|---|
| Briefing paper / Estimates return | | |
| OJEU/PQQ Issue | | |
| Supplier Selection Shortlist | | |
| Tender Return | | |
| Evaluation | | |
| Ratifications Out / Return | | |
| Publish Award | | |
| Contract Start | | |

## Contract Management

## Communications

## ACCEPTANCE

Please confirm your acceptance to participate in this procurement and your agreement to the proposal either by e-mail or by signing and returning this briefing paper.

Prepared by: Date:

Contract briefing presented/ circulated to: _____ Date: _____

Response required by date: _____

Trust agreement to participate:

Trust: _____

Trust decision maker: _____

Agreement to proceed *(if different from above)*: _____

Date: _____

| For Welsh Government Use Only | |
|---|---|
| **Date Received:** | |
| **Reference Number:** | |
| **Acknowledgement sent:** | |
| **Date complete information received:** | |

## LHB Application Form to Gain Consent from the Welsh Ministers to Enter into Contracts over £1 million

| | | | |
|---|---|---|---|
| Local Health Board: | | | |
| Contact Name: | | Position Held: | |
| Address: | | | |
| Contact Telephone No: | | E-mail: | |

| | |
|---|---|
| Contract Title & Reference: | |
| Purpose of the Contract: | |
| Contract Description: | |
| Rationale for Private Sector Procurement: | |
| Legal Advice Confirmed Consent from Welsh Ministers is Required: | Yes / No |
| If Legal Advice Does Not State Consent is Required, Please Give Reasons Why Consent is Being Sought: | |
| Name(s) of the Contractor(s) (Parties to the contract): | |
| What is included in the Contract (Goods / Services / Property): | |
| Total Value of the Contract (Consideration) – *if an option to extend provide for basic contract period and cost for option periods*: | |

| | |
|---|---|
| Annual Value of Contract: | |
| OJEU Requirements Satisfied: | Yes / No |
| If OJEU Requirements Not Satisfied, Please Give Reasons: | |
| Duration of the Contract including details of option to extend, start & finish dates: | |
| Confirmation of Funding Stream: | |
| Identified Risks: | |
| Any Other Relevant Information:*(Date of initial Contract Briefing Paper to be included here)* | |

Documents Included in this Application (please tick all that you are including; there are blank spaces left for you to list any other documents you are including with this application):

| * Board Papers[1]: | | Memorandum of Sale[2&3]: | | Invoice[2&3]: | | Documented Quote: | |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

* These documents must be provided for all applications for consent

*1. Board or equivalent papers from appropriate corporate governance group responsible for the endorsement of the contract, confirming they endorse the proposed contract. This could include contract adjudication minutes and approval process.*

*2. For contracts relating to the acquisition and disposal of land*

*3. For contracts relating to the acquisition and disposal of land*

I certify that the information given above is accurate; I also certify that all relevant documentation relating to this application for consent from the Welsh Ministers to enter into a contract is enclosed with this application; I understand that failure to include adequate information and/or relevant documentation will result in the application being returned to the Local Health Board and not considered further until the relevant information is provided. I also certify that I am content that correct procedure for letting contracts has been followed within the Local Health Board; that all necessary expert advice has been obtained; and that due diligence has been demonstrated.

**Name:**

**Position Held:**

**Signature:**

**Date:**

**NB: LHBs will be formally notified when consent has been given, and they should not "assume consent" if a response has not been received from the Welsh Government**

| For Welsh Government Use Only | |
|---|---|
| **Date Received:** | |
| **Reference Number:** | |
| **Acknowledgement sent:** | |

## LHB Notification to the Welsh Ministers of Contracts between £500,000 < £1 million

| | | | |
|---|---|---|---|
| Local Health Board: | | | |
| Contact Name: | | Position Held: | |
| Address: | | | |
| Contact Telephone No: | | E-mail: | |

| | |
|---|---|
| Contract Title & Reference | |
| Purpose of the Contract: | |
| Contract Description: | |
| Rationale for Private Sector Procurement: | |
| Name(s) of the Contractor(s) (Parties to the contract): | |
| What is Included in the Contract (Goods / Services / Property): | |
| Total Value of the Contract (Consideration) – *if an option to extend provide for basic contract period and cost for option periods*: | |
| Annual Value of the Contract: | |
| OJEU Requirements Satisfied: | Yes / No |
| If OJEU Requirements Not Satisfied, Please Give Reasons: | |
| Duration of the Contract, including any option to extend, start & finish dates: | |

| | |
|---|---|
| Confirmation of Funding Stream: | |
| Identified Risks: | |
| Any Other Relevant Information: | |

Documents Included in this Application (please tick all that you are including; there are blank spaces left for you to list any other documents you are including with this application):

| * Board Papers[1] | | Memorandum of Sale[2]: | | Invoice[3]: | | Documented Quote: | |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

* These documents must be provided for all notifications

*1. Board or equivalent papers from appropriate corporate governance group responsible for the endorsement of the contract, confirming they endorse the proposed contract. This could include contract adjudication minutes and approval process.*

*2. For contracts relating to the acquisition and disposal of land*

*3. For contracts relating to the acquisition and disposal of land*

I certify that the information given above is accurate; I also certify that all relevant documentation relating to this notification to the Welsh Ministers of intent to enter into a contract is enclosed with this application; I understand that failure to include adequate information and/or relevant documentation may lead to further requests for information and could therefore delay the process or result in the notification being returned to the Local Health Board and not considered further until the relevant information is provided. I also certify that I am content that correct procedure for letting contracts has been followed within the LHB; that all necessary expert advice has been obtained; and that due diligence has been demonstrated.

**Name:** _____

**Position Held:** _____

**Signature:** _____

**Date:** _____

**LHB Notification to Welsh Ministers of Contracts > £250,000 and < £500,000 that have been let in the last 6 months**

| | | | |
|---|---|---|---|
| Local Health Board: | | Period: | |
| Contact Name: | | Position Held: | |
| Address: | | | |
| Contact Telephone No: | | E-mail: | |

| **Contract Title** | **Reference** | **Contract Description** | **Total Value (for main contract duration and any option to extend) / Annual Value £'s** | **Duration (including Start / Finish Dates & extension options)** | **Contractor(s) Details** |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | |

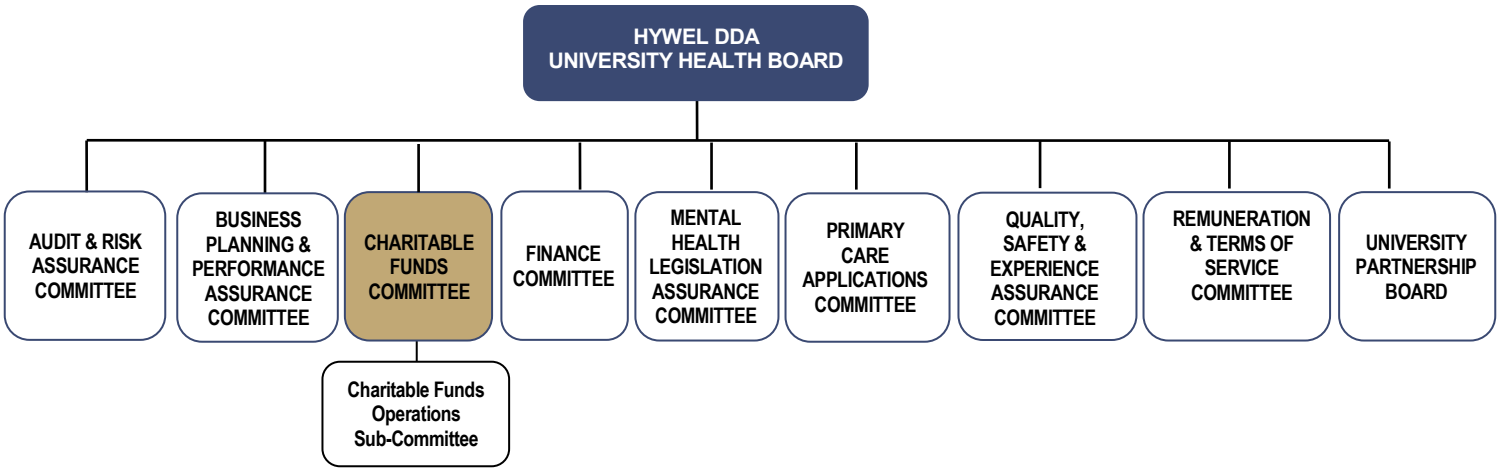
**I certify that the information given above is accurate. I also certify that I am content that the correct procedure for letting contracts has been followed within the LHB: that all necessary expert advice has been obtained; and that due diligence has been demonstrated.**

**Name:** _____

**Position Held:** _____

**Signature:** _____

**Date:** _____




# CHARITABLE FUNDS COMMITTEE

## TERMS OF REFERENCE

| Version | Issued To | Date | Comments |
|---|---|---|---|
| V0.1 | Charitable Funds Committee | 11.06.2012 | Approved |
| V0.2 | Hywel Dda Health Board (SO's) | 27.09.2012 | Approved |
| V0.3 | Charitable Funds Committee | 18.06.2013 | Approved |
| V0.4 | Charitable Funds Committee | 03.09.2013 | Approved |
| V0.5 | Charitable Funds Committee | 12.12.2013 | Approved |
| V0.6 | Charitable Funds Committee | 09.10.2013 | Approved |
| V0.7 | Charitable Funds Committee | 16.12.2014 | Approved |
| V0.8 | Charitable Funds Committee | 10.03.2015 | Approved |
| | Hywel Dda University Health Board | 26.03.2015 | Approved |
| V0.9 | Charitable Funds Committee | 29.06.2015 | Approved |
| V0.10 | Hywel Dda University Health Board | 26.11.2015 | Approved |
| V0.11 | Charitable Funds Committee | 29.11.2016 | Approved |
| V0.12 | Hywel Dda University Health Board | 26.01.2017 | Approved |
| V0.13 | Charitable Funds Committee | 15.06.2017 | Approved |
| V0.14 | Charitable Funds Committee | 15.03.2018 | Approved |
| V0.15 | Hywel Dda University Health Board | 29.03.2018 | Approved |
| V0.16 | Charitable Funds Committee | 14.03.2019 | Approved |
| V0.16 | Hywel Dda University Health Board | 30.05.2019 | |

# CHARITABLE FUNDS COMMITTEE

## 1. Introduction

1.1 The Hywel Dda University Local Health Board's standing orders provide that "*The Board may and, where directed by the Welsh Government must, appoint Committees of the UHB either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*".

1.2 In accordance with the Standing Orders (and the UHB's Scheme of delegation), the Board has nominated Committee to be known as the Charitable Funds Committee (the Committee). The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set out below.

## 2. Constitution

2.1 Hywel Dda University Local Health Board was appointed as corporate trustee of the charitable funds by virtue of Statutory Instrument 2009 No. 778 (W.66) and that its Board serves as its agent in the administration of the charitable funds held by the UHB.

2.2 The Committee has been established as a Committee of the Hywel Dda University Local Health Board (HDdUHB) and constituted from 22nd July 2010.

## 3. Membership

3.1 The membership of the Committee shall comprise of the following:

| Member |
|---|
| Independent Member (Chair) |
| Independent Member (Vice-Chair) |
| 4 x Independent Members |
| Chief Executive |
| Director of Finance |
| Director of Partnerships and Corporate Services (Executive Lead) for Hywel Dda Health Charities |

The following should attend Committee meetings:

| In Attendance |
|---|
| Assistant Director of Finance (Finance Systems and Statutory Reporting) |
| Senior Finance Business Partner (Accounting & Statutory and Reporting) |
| Deputy Director of Operations |
| Head of Hywel Dda Health Charities |
| Staff Side Representative |

3.2 A standing invitation is extended for a representative of the Hywel Dda Community Health Council to attend in an observer capacity.

3.3 Membership of the Committee will be reviewed on an annual basis.

## 4. Quorum and Attendance

4.1 A quorum shall consist of no less than four of the membership and must include as a minimum the Chair or Vice Chair of the Committee, and one other Independent Member, as well as the Director of Finance and the Executive Lead for Hywel Dda Health Charities (or their suitably briefed deputies).

4.2 The membership of the Committee shall be determined by the Board of the Corporate Trustee (HDdUHB), based on the recommendation of the UHB Chair, taking into account the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements of directions made by the Welsh Government.

4.3 Any senior officer of the UHB or partner organisation may, where appropriate, be invited to attend, for either all or part of a meeting to assist with discussions on a particular matter.

4.4 The Committee may also co-opt additional independent external 'experts' from outside the organisation to provide specialist skills.

4.5 The Chairman of the UHB reserves the right to attend any of the Committee's meetings as an ex officio member.

4.6 Should any officer member be unavailable to attend, they may nominate a deputy with full voting rights to attend in their place, subject to the agreement of the Chair.

4.7 The Head of Internal Audit shall have unrestricted and confidential access to the Chair of the Charitable Funds Committee.

4.8 The Committee will invite Internal Audit to attend once a year to provide the Committee with assurance on processes and end of year accounts.

4.9 The Committee may also extend the membership to include independent members outside of the Board (e.g. nomination from Stakeholder Reference Group).

4.10 The Chair of the Charitable Funds Committee shall have reasonable access to Executive Directors and other relevant senior staff.

4.11 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

## 5. Purpose

The purpose of the Charitable Funds Committee is:

5.1 To make and monitor arrangements for the control and management of the Board's Charitable Funds, within the budget, priorities and spending criteria determined by the Board and consistent with the legislative framework.

5.2 To provide assurance to the Board in its role as corporate trustees of the charitable funds held and administered by the Health Board.

5.3 To agree issues to be escalated to the Board with recommendations for action.

## 6. Key Responsibilities

The Charitable Funds Committee shall:

6.1 Within the budget, priorities and spending criteria determined by the UHB as trustee, and consistent with the requirements of the Charities Act 2011 (or any modification of these acts), to apply the charitable funds in accordance with its respective governing documents.

6.2 To devise, implement and approve appropriate procedures and policies to ensure that fundraising and accounting systems are robust, donations are received and coded as instructed and that all expenditure is reasonable, clinically and ethically appropriate.

6.3 To ensure that the UHB policies and procedures for charitable funds investments are followed.

6.4 In addition, to make decisions involving the sound investment of charitable funds in a way that both preserves their value and produces a proper return consistent with prudent investment and ensuring compliance with:

6.4.1 Trustee Act 2000
6.4.2 The Charities Act 2011
6.4.3 Terms of the fund's governing documents

6.5 To receive at least twice a year reports for ratification from the Director of Finance, and investment decisions and action taken through delegated powers upon the advice of the UHB's investment adviser.

6.6 To oversee and monitor the functions performed by the Director of Finance as defined in the UHB's Standing Financial Instructions.

6.7 To monitor the progress of Charitable Appeal Funds where these are in place and considered to be material.

6.8 To monitor and review the UHB's scheme of delegation for Charitable Funds expenditure and to set and reflect in Financial Procedures the approved delegated limits for expenditure from Charitable Funds.

## 7. Delegated Powers and Duties of the Director of Finance

7.1 The Director of Finance has prime financial responsibility for the UHB's Charitable Funds as defined in the UHB's Standing Financial Instructions. The specific powers, duties and responsibilities delegated to the Director of Finance are:

7.1.1 Administration of all existing charitable funds.

7.1.2 To identify any new charity that may be created (of which the UHB is trustee) and to deal with any legal steps that may be required to formalise the trusts of any such charity.

7.1.3 To provide guidelines with respect to donations, legacies and bequests, fundraising and trading income.

7.1.4 Responsibility for the management of investment of funds held on trust.

7.1.5 To ensure appropriate banking services are available to the UHB.

7.1.6 To prepare reports to the UHB Board including the Annual Report and Accounts.

## 8. Agenda and Papers

8.1 The Committee Secretary is to hold an agenda setting meeting with the Chair and/or Vice-Chair, the Lead Director for Hywel Dda Health Charities and the Director of Finance (or their nominated deputies) at least **six** weeks before the meeting date.

8.2 The agenda will be based around the Committee work plan, identified risks, matters arising from previous meeting, issues emerging throughout the year, and requests from Committee members. Following approval, the agenda and timetable for request of papers will be circulated to all Committee members.

8.3 All papers must be approved by the Lead/relevant Director.

8.4 The agenda and papers for meetings will be distributed **seven** days in advance of the meeting, electronically.

8.5 The minutes and action log will be circulated to members within **ten** days to check their accuracy.

8.6 Members must forward amendments to the Committee Secretary within the next **seven** days. The Committee Secretary will then forward the final version to the Committee Chair for approval.

## 9. In Committee

9.1 The Committee can operate with an In Committee function to receive updates on the management of sensitive and/or confidential information.

## 10. Frequency of Meetings

10.1 The Committee will meet no less than quarterly and shall agree an annual schedule of meetings. Additional meetings will be arranged as determined by the Chair of the Committee, in discussion with the Lead Executive.

10.2 The Chair of the Committee, in discussion with the Committee Secretary, shall determine the time and the place of meetings of the Committee and procedures of such meetings.

## 11. Accountability, Responsibility and Authority

11.1 Overseeing the day to day management of the investments of the charitable funds in accordance with the investment strategy set down from time to time by the Trustees, and in accordance with the requirements of the UHB's Standing Financial Instructions.

11.2 The appointment of an Investment Manager (where appropriate) to advise it on investment matters and the delegation of day-to-day management of some or all of the investments to that Investment Manager. The Investment Manager, if appointed, must actively manage the charitable fund on behalf of Trustees. In exercising this power the Committee must ensure that:

- 11.2.1 The scope of the power delegated is clearly set out in writing and communicated with the person or persons who will exercise it;
- 11.2.2 There are in place adequate internal controls and procedures which will ensure that the power is being exercised properly and prudently;
- 11.2.3 The performance of the person or persons exercising the delegated power is regularly reviewed;
- 11.2.4 Where an investment manager is appointed, that the person is regulated under the Financial Services Act 1986;
- 11.2.5 Acquisitions or disposal of a material nature outside the terms of agreement must always have written authority of the Committee or the Chair of the Committee in conjunction with the Director of Finance.

11.3 Ensuring that the banking arrangements for the charitable funds should be kept entirely distinct from the UHB's NHS funds.

11.4 Ensuring that arrangements are in place to maintain current account balances at minimum operational levels consistent with meeting expenditure obligations, the balance of funds being invested in interest bearing deposit accounts.

11.5 The amount to be invested or redeemed from the sale of investments shall have regard to the requirements for immediate and future expenditure commitments.

11.6 The operation of an investment pool when this is considered appropriate to the charity in accordance with charity law and the directions and guidance of the Charity Commission. The Committee shall propose the basis to the UHB Board for applying accrued income to individual funds in line with charity law and Charity Commission guidance.

11.7 Obtaining appropriate professional advice to support its investment activities.

11.8 Regularly reviewing investments to see if other opportunities or investment services offer a better return.

11.9 Reviewing alternative sources of funding to donations and legacies which could provide the Committee with additional leverage and access to additional funds.

11.10 By giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Board at any meeting.

11.11 The following thresholds are approved in the Charitable Funds Procedure:
*"Expenditure less than £5,000 shall only need approval by the nominated fund manager. All expenditure in excess of £5,000 and up to £25,000 will require the approval of the Deputy Director of Operations on behalf of the Charitable Funds Operations Sub-Committee. All expenditure in excess of £25,000 and up to £50,000 will require the approval of an Executive Director. Expenditure in excess of £50,000 will require the approval of the Charitable Funds Committee".*

.

11.12 In addition, further clarification is provided in the associated guidance to budget holders as follows:
*"Unusual or novel expenditure requests, and expenditure requests resulting in ongoing charitable fund commitment, or revenue resource commitment, will need prior Charitable Funds Committee approval prior to purchase, regardless of value. If this is deemed to be necessary [by senior finance staff], the authorised signatory will be advised."*

11.13 It also states that the following expenditure types requires Committee approval:

- *"Research & development expenditure"*
- *"Pay expenditure"*
- *"Training including conferences/seminars etc requiring attendance of participants outside the UK"*

Therefore, items requiring urgent Chair's action will generally be expenditure on equipment greater than £50,000 value, or anything that falls under the criteria above. All expenditure requests made via Chair's Actions will be considered on a case by case basis, as an exception rather than the rule. The presumption will be that other than equipment (in excess of £50,000) and smaller research projects (up to £25,000), items can be deferred to the next meeting.

11.14 The Chair's decision on which items can be approved outside the Committee will be final and all items approved outside full Committee will be reported to the next Committee for ratification.

11.15 The Committee shall embed the UHB's vision, corporate standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business.

11.16 The requirements for the conduct of business as set out in the UHB's Standing Orders are equally applicable to the operation of the Committee.

## 12. Reporting

12.1 The Committee Chair shall agree arrangements with the UHB's Chair to report to the Board in their capacity as Trustees. This may include, where appropriate, a separate meeting with the Board.

12.3 The Committee, through its Chair and members, shall work closely with the Board's other Committees, including joint/sub-committees and groups, to provide advice and assurance to the UHB through the:

12.3.1 joint planning and co-ordination of Board and Committee business;

12.3.2 sharing of information.

12.4 In doing so, the Committee shall contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

12.5 The Committee may establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee business. The Committee will receive an update following each sub-committee or task and finish group meeting detailing the business undertaken on its behalf.

12.6 The Committee shall establish the Charitable Funds Operations Sub-Committee to ensure that the UHB's policies and procedures are followed in relation to specialist designated and restricted funds.

12.7 The Committee Chair, supported by the Committee Secretary, shall:

12.7.1 Report formally, regularly and on a timely basis to the Board on the Committee's activities in their capacity as trustees. This includes the submission of a written Committee update report as well as the presentation of an annual report and accounts prior to submission to the Charity Commission.

12.7.2 Bring to the Board's specific attention any significant matter under consideration by the Committee.

12.7.3 Ensure appropriate escalation arrangements are in place to alert the UHB Chair, Chief Executive or Chairs of other relevant Committees of any urgent/critical matters that may compromise patient care and affect the operation and/or reputation of the UHB.

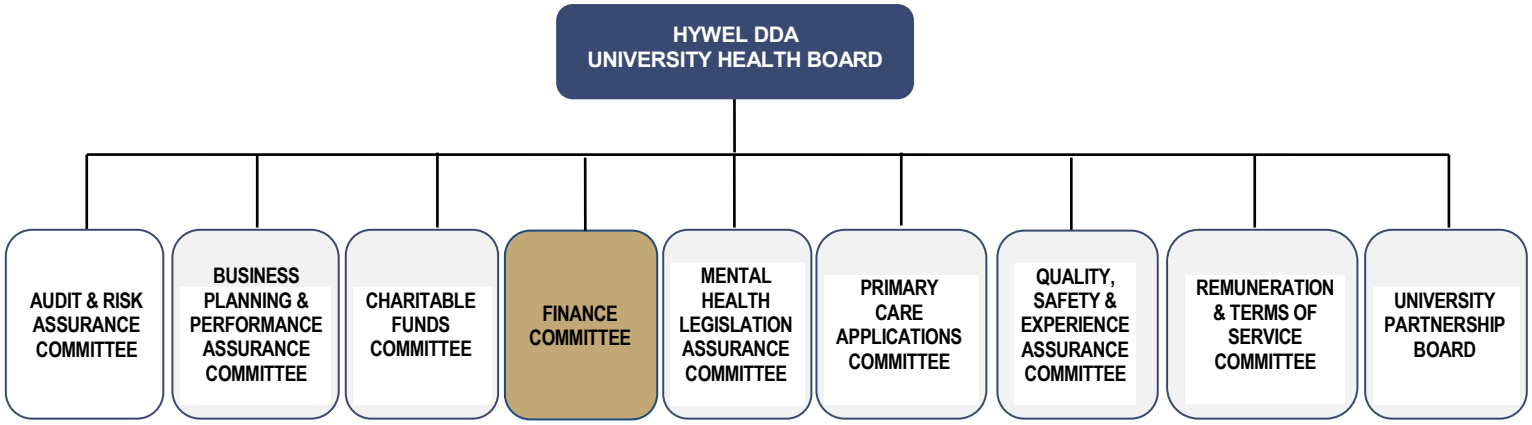
12.8 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any sub-committees established.

## 13. Secretarial Support

13.1 The Committee Secretary shall be determined by the Director of Partnerships & Corporate Services.

## 14. Review Date

14.1 These Terms of Reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board.




# FINANCE COMMITTEE

## TERMS OF REFERENCE

| Version | Issued to: | Date | Comments |
|---|---|---|---|
| V1 | Finance Sub-Committee | 08.11.2017 | Discussed |
| V2 | Finance Sub-Committee | 13.12.2017 | Approved |
| V2 | Business Planning & Performance Assurance Committee | 19.12.2017 | Approved |
| V3 | Finance Sub-Committee | 19.07.2018 | Discussed |
| V4 | Finance Sub-Committee | 23.08.2018 | Discussed |
| V5 | Hywel Dda University Health Board | 27.09.2018 | Approved |
| V6 | Hywel Dda University Health Board | 30.05.2019 | |

# FINANCE COMMITTEE

## 1. Constitution

1.1 The Finance Committee has been established as a formal Committee of the Board and constituted from 1st October 2018.

## 2. Membership

2.1 Formal membership of the Committee shall comprise of the following:

| Member |
|---|
| Associate Member of the Board (Chairman) |
| Independent Member (Vice Chairman) |
| Health Board Vice-Chair |
| Independent Member |
| *Invitation extended to the Chair of ARAC to attend (not counted for quoracy purposes) |

2.2 The following should attend Committee meetings:

| In Attendance |
|---|
| Chief Executive |
| Deputy Chief Executive/Director of Operations |
| Director of Finance |
| Turnaround Director |
| Other key Executive Directors/Directors to attend as and when the Committee request their attendance |

2.3 Membership of the Committee will be reviewed on an annual basis.

## 3. Quorum and Attendance

3.1 A quorum shall consist of no less than two of the membership and must include as a minimum the Chairman or Vice-Chairman of the Committee, and one other Independent Member, together with a third of the In Attendance Members.

3.2 The membership of the Committee shall be determined by the Board, based on the recommendation of the UHB Chair, taking into account the balance of skills and expertise necessary to deliver the Committee's remit, and subject to any specific requirements or directions made by the Welsh Government.

3.3 Any senior officer of the UHB or partner organisation may, where appropriate, be invited to attend, for either all or part of a meeting, to assist with discussions on a particular matter.

3.4 The Committee may also co-opt additional independent external "experts" from outside the organisation to contribute to specialised areas of discussion.

3.5 Should any officer member be unavailable to attend, they may nominate a deputy with full voting rights to attend in their place subject to the agreement of the Chairman.

3.6 The Chair of the UHB reserves the right to attend any of the Committee's meetings as an ex officio member.

3.7 The Chairman of the Finance Committee shall have reasonable access to Executive Directors and other relevant senior staff.

3.8 The Head of Internal Audit shall have unrestricted and confidential access to the Chairman of the Finance Committee.

3.9 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

## Purpose

4.1 To scrutinise and provide oversight of financial and the revenue consequences of investment planning (both short term and in relation to longer term sustainability).

4.2 Review financial performance, review any areas of financial concern, and report to the Board.

4.3 Conduct detailed scrutiny of all aspects of financial performance, the financial implications of major business cases, projects, and proposed investment decisions on behalf of the Board.

4.4 Regularly review contracts with key delivery partners.

4.5 Provide assurance on financial performance and delivery against Health Board financial plans and objectives and, on financial control, giving early warning on potential performance issues and making recommendations for action to continuously improve the financial position of the organisation, focusing in detail on specific issues where financial performance is showing deterioration or there are areas of concern.

## 5. Operational Responsibilities and Objectives

5.1 Advise the Chair, Chief Executive and Board on all aspects of finance and the revenue implications of investment decisions.

5.2 Provide assurance in respect of short, medium and long term financial performance and financial planning.

5.3 Seek assurance on the management of principle risks within the BAF and CRR allocated to the Committee (financial risks), and provide assurance to the Board that risks are being managed effectively and report any areas of significant concern e.g. where risk appetite is exceeded, lack of timely action.

5.4 Recommend acceptance of risks that can not be brought within the Health Boards risk appetite/tolerance to the Board through the Committee Update Report.

5.5 The Finance Committee will provide assurance, raising appropriate concerns and make recommendations to the Board as a consequence of the Committee's role in relation to short term focus, medium term focus and improving financial management, as follows:

Short Term Focus

5.5.1 Undertaking detailed scrutiny of the organisation's overall:

- Monthly, quarterly and year to date financial performance;
- Performance against the savings delivery and the cost improvement programme; assurance over performance against the Capital Resource Limit and cash flow forecasts;
- Oversee and monitor the Health Board's turnaround programme.

5.5.2 Receiving assurances in respect of directorate performance against annual budgets, capital plans and the cost improvement programme and innovation and productivity plans.

5.5.3 Reviewing the future annual revenue and capital budget.

5.5.4 Reviewing the treasury management and working capital policy as required.

Medium Term

5.5.5 Considering and keeping under review the organisation's medium term financial strategy in relation to both revenue and capital risks.

5.5.6 Reviewing financial proposals for major business cases (and investment decisions) and their respective funding sources.

5.5.7 Maintaining oversight of, and obtaining assurances on, the robustness of key income sources and contractual safeguards.

5.5.8 Reviewing major procurements and tenders, such as outsourcing in relation to achieving Referral to Treatment targets.

5.5.9 Commissioning regular reviews of key contracts, suppliers and partners to ensure they continue to deliver value for money.

5.5.10 Reviewing and monitoring progress against capital plans to be assured over delivery against the Capital Resource Limit.

5.5.11 Reviewing the financial aspects of the estates, medical devices and IM&T strategy, ensuring:

- Appropriate funding arrangements are in place; and the
- Appropriate utilisation of the strategy.

5.5.12 Reviewing any investment/disinvestment strategy, maintaining oversight of the investments and disinvestments, ensuring compliance with policies by:

- Establishing the overall methodology, processes and controls which govern investments and disinvestments, including the prioritisation of decisions;
- Ensuring that robust processes are followed; and
- Evaluating, scrutinising and monitoring subsequent investments/disinvestments.

Improving Financial Management

5.5.13 Developing and implementing a financial management improvement agenda across the organisation.

5.6 Subject to the Board's direction and approval, develop and regularly review the financial performance management framework and reporting approach, ensuring it includes meaningful, appropriate and integrated, timely performance data and clear commentary relating to the totality of the services for which the Board is responsible.

5.7 Review and approve financial procedures on behalf of the Health Board.

5.8 Approve policies within the scope of the Committee.

5.9 Agree issues to be escalated to the Board with recommendations for action.

## 6. Agenda and Papers

6.1 The Committee Secretary is to hold an agenda setting meeting with the Chairman and/or the Vice Chairman, at least **three** weeks before the meeting date.

6.2 The agenda will be based around the Committee work plan, identified risks, matters arising from previous meetings, issues emerging throughout the year and requests from Committee members. Following approval, the agenda and timetable for papers will be circulated to all Committee members.

6.3 All papers must be approved by the Lead/relevant Director.

6.4 The agenda and papers for meetings will be distributed **five** working days in advance of the meeting.

6.5 The minutes and action log will be circulated to members within **five** working days to check the accuracy.

6.6 Members must forward amendments to the Committee Secretary within the next **five** working days. The Committee Secretary will then forward the final version to the Committee Chairman for approval.

## 7. In Committee

7.1 The Committee can operate with an In Committee function to receive updates on the management of sensitive and/or confidential information.

## 8. Frequency of Meetings

8.1 The Committee will meet monthly and shall agree an annual schedule of meetings. Any additional meetings will be arranged as determined by the Chairman of the Committee.

8.2 The Chairman of the Committee, in discussion with the Committee Secretary, shall determine the time and the place of meetings of the Committee and procedures of such meetings.

## 9. Accountability, Responsibility and Authority

9.1 The Committee will be accountable to the Board for its performance in exercising the functions set out in these terms of reference.

9.2 The Committee shall embed the UHB's vision, corporate standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business.

9.3 The requirements for the conduct of business as set out in the UHB's Standing Orders are equally applicable to the operation of the Committee.

## 10. Reporting

10.1 The Committee, through its Chairman and members, shall work closely with the Board's other committees, including joint /sub committees and groups to provide advice and assurance to the Board through the:

10.1.1 joint planning and co-ordination of Board and Committee business;

10.1.2 sharing of information.

10.2 In doing so, the Committee shall contribute to the integration of good governance across the organisation, ensuing that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

10.3 The Committee may establish sub-committees, groups or task and finish groups to carry out on its behalf specific aspects of Committee business. The Committee will receive an update following each Group's meetings detailing the business undertaken on its behalf.

10.4 The Committee Chairman, supported by the Committee Secretary, shall:

10.4.1 Report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes the submission of a Committee update report as well as the presentation of an annual report within 6 weeks of the end of the financial year;

10.4.2 Bring to the Board's specific attention any significant matters under consideration by the Committee.

10.4.3 Ensure appropriate escalation arrangements are in place to alert the UHB Chair, Chief Executive, or Chairmen of other relevant Committees, of any urgent/critical matters that may compromise patient care and affect the operation and/or reputation of the UHB.

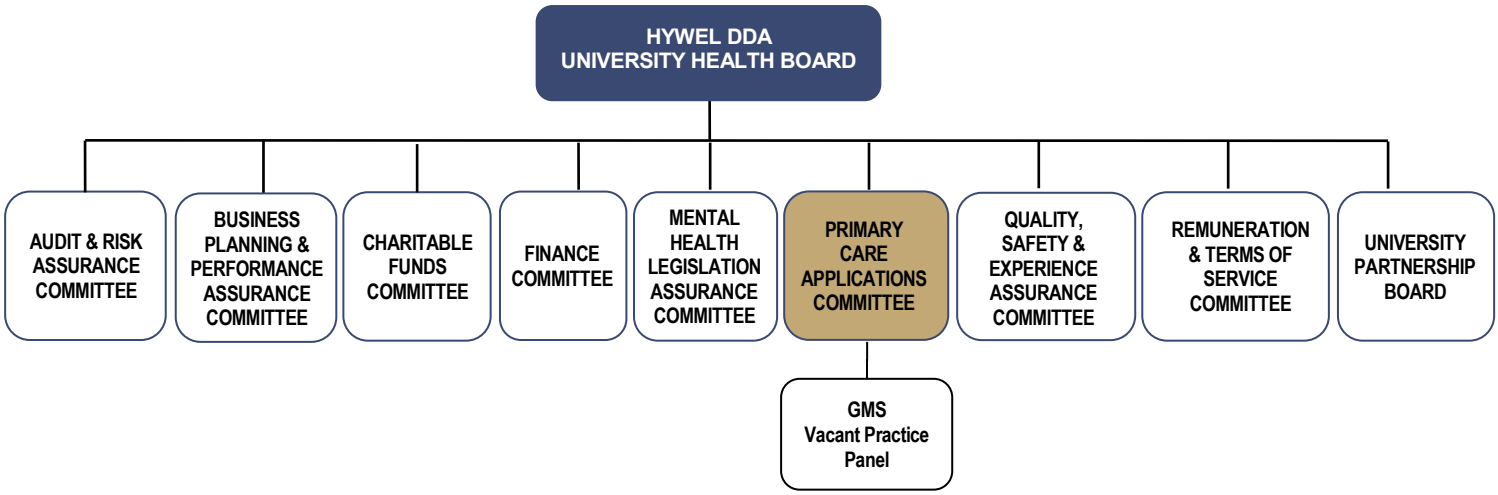
10.5 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self assessment and evaluation of the Committee's performance and operation, including that of any sub-committees established.

## 11. Secretarial Support

11.1 The Committee Secretary shall be determined by the Lead Executive Director (Director of Finance).

## 12. Review Date

12.1 These terms of reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board.




# PRIMARY CARE APPLICATIONS COMMITTEE

## TERMS OF REFERENCE

| Version | Issued To | Date | Comments |
|---|---|---|---|
| V0.1 | Assistant Director Primary Care and Hywel Dda University Health Board | 26.08.2015 | Approved |
| V0.2 | Vice Chair, Executive Director Commissioning, Therapies and Health Science, Deputy Director Primary, Community and Long Term Care, Associate Medical Director Primary Care, Corporate Secretary | 02.10.2015 | Approved |
| V0.3 | Primary Care Applications Committee | 13.10.2015 | Approved |
| V0.4 | Hywel Dda University Health Board | 26.11.2015 | Approved |
| V0.4 | Primary Care Applications Committee | 31.10.2016 | Approved |
| V.04 | Hywel Dda University Health Board | 26.01.2017 | Approved |
| V.05 | Primary Care Applications Committee | 27.03.2018 | Reviewed |
| V.06 | Primary Care Applications Committee | 10.05.2018 | Approved |
| V.06 | Hywel Dda University Health Board | 31.05.2018 | Approved |
| V.07 | Primary Care Applications Committee | 21.02.2019 | Approved |
| V.07 | Hywel Dda University Health Board | 30.05.2019 | |

# PRIMARY CARE APPLICATIONS COMMITTEE

## 1. Constitution

1.1 The Primary Care Applications Committee (the Committee) has been established as a Committee of the Hywel Dda University Health Board (UHB) and constituted from 1st June 2015.

## 2. Membership

2.1 Formal membership of the Committee shall comprise of the following:

| **Member** |
|---|
| University Health Board Vice Chair (Chair) |
| Independent Member (Vice-Chair) |
| 2 X Independent Members |
| Director of Primary, Community and Long Term Care |
| Associate Medical Director - Primary Care |
| Assistant Director of Primary Care |
| County Director/Deputy from the applicable locality |
| |
| **For Pharmacy Application Panels* - core membership must also include:** |
| Community Pharmacy Wales Representative<br>(**non-voting**, written information can be provided in lieu of attendance) |
| |
| **For Dental Application Panels - core membership may include:** |
| Associate Medical Director (Dental) |
| Dental Practice Advisor |

2.2 The following should attend Committee meetings:

| **In Attendance** |
|---|
| Head of GMS/Deputy |
| Head of Dental and Optometry/Deputy |
| Primary Care Manager (Community Pharmacy)/Deputy |
| Locality Development Manager from the applicable locality |
| Head of Financial Planning |
| Hywel Dda CHC representative |
| LMC representative |

2.3 Membership of the Committee will be reviewed on an annual basis.

***Pharmacy Application Panel - Disqualification because of interest :** No person who has any direct or indirect pecuniary interest in the application, or any other current personal interest, or who is associated with any person who has any current personal interest may take part in the proceedings at any stage. Any member who anticipates such an interest should declare it in advance in order that arrangements may be made for the attendance of a deputy.

## 3. Quorum and Attendance

3.1 A quorum shall consist of no less than two Independent Member(s), and must include as a minimum the Chair or Vice Chair of the Committee, one senior representative from the Primary Care Directorate, and any specific members identified for the purpose of the panels outlined in the membership.

3.2 The membership of the Committee shall be determined by the Board, based on the recommendation of the UHB Chair, taking into account the balance of skills and expertise necessary to deliver the Committee's remit, and subject to any specific requirements or directions made by the Welsh Government.

3.3 Any senior officer of the UHB or partner organisation may, where appropriate, be invited to attend, for either all or part of a meeting to assist with discussions on a particular matter.

3.4 The Committee may also co-opt additional independent external 'experts' from outside the organisation to provide specialist skills.

3.5 Should any officer member be unavailable to attend, they may nominate a deputy, with full voting rights (unless otherwise specified in the membership criteria) to attend in their place, subject to the agreement of the Chair.

3.6 The Chair of the UHB reserves the right to attend any of the Committee's meetings as an ex officio member.

3.7 The Head of Internal Audit shall have unrestricted and confidential access to the Chair of the Primary Care Applications Committee.

3.8 The Chair of the Primary Care Applications Committee shall have reasonable access to Executive Directors and other relevant senior staff.

3.9 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

## 4. Purpose

4.1 The Primary Care Applications Committee determines Primary Care contractual matters on behalf of the Health Board, and in accordance with the appropriate NHS regulations.

4.2 Performance issues are determined by the Performers Concerns Group and are therefore not part of this Committee.

## 5. Key Responsibilities

5.1 Consider options with regard to vacant GMS Practices and make recommendations on behalf of the Board in accordance with WHC (2006) 063 and locally agreed processes following a GMS Vacant Practice Panel.

5.2 Consider recommendations for support from GMS contractors made in accordance with the Local Sustainability Assessment Process following a GMS sustainability assessment panel (WG Correspondence 03.09.2015).

5.3 Consider applications made by GMS Contractors and make decisions on behalf of the Board in accordance with the NHS (General Medical Services Contracts) (Wales) Regulations 2004, including but not limited to:

- Applications for changes to a GMS practice boundary;
- Applications for closing a GMS contractor list;
- Applications to remove registered patients who live outside the agreed practice area;
- Applications to withdraw from the provision of Additional Services;
- Applications to close a branch or split site surgery;
- Applications to merge two or more GMS contracts/partnerships;
- Consider breaches to the GMS contract;
- Applications for new GMS contracts;
- Applications to dispense.

5.4 Consider applications in relation to pharmaceutical services provision in the UHB area, and make decisions on behalf of the Board and in accordance with NHS (Pharmaceutical Services) (Wales) Regulations 2013 including:

- Applications by NHS Pharmacists & NHS Appliance Contractors for inclusion in or amendment to pharmaceutical lists;
- Determination of applications to be included or for amendment in a pharmaceutical list;
- Determination of applications to be included or for amendment in a pharmaceutical list effect of earlier determination;
- For Controlled localities, determining whether reserved status is appropriate;
- Applications for preliminary consent & effect of preliminary consent;
- Applications involving minor relocations within Health Board area;
- Applications involving minor relocations between neighbouring Health Board areas;
- Applications involving temporary relocations;
- Applications involving a change of ownership;
- Applications to extend the relevant period (the time in which an application is to take effect);
- To review whether applications for change of “core” hours would be prejudicial to patients;
- To note all applications for change of ownership and minor relocations approved by Health Board officers and not considered formally by the Committee;
- Dispensing applications;
- Premises approval applications following the granting of outline consent.

5.5 Consider applications in relation to contractual dental services provision in the UHB area, and make decisions on behalf of the Board and in accordance with The National Health Service (Personal Dental Services Agreements) (Wales) Regulations 2006 and The National Health Service (General Dental Services Agreements) (Wales) Regulations 2006 including:

- Applications to change activity levels and type of activity, including carrying forward activity to the next financial year;
- Applications to change opening hours;
- Applications to change the contract type (partnership/individual/Dental Body Corporate);
- Applications to changes Partnerships including the sale of Practices.

5.6 Appeals will normally be heard by a separate panel in accordance with the appropriate regulations with the exception of issues not previously determined by this Committee.

## 6. Agenda and Papers

6.1 The Committee Secretary is to hold an agenda setting meeting with the Chair and/or the Vice Chair, at least **six** weeks before the meeting date.

6.2 The agenda will be based around the Committee work plan, identified risks, matters arising from previous meetings, issues emerging throughout the year, and requests from Committee members. Following approval, the agenda and timetable for request of papers will be circulated to all Committee members.

6.3 All papers must be approved by the Lead/relevant Director.

6.4 The agenda and papers will be distributed **seven** days in advance of the meeting.

6.5 The minutes and action log will be circulated to members within **ten** days to check the accuracy.

6.6 Members must forward amendments to the Committee Secretary within the next **seven** days. The Committee Secretary will then forward the final version to the Committee Chair for approval.

6.7 NHS Wales Shared Services Partnership (NWSSSP) – Primary Care Services will provide administrative and secretarial support to the Pharmacy Applications element of the Committee.

## 7. In Committee

7.1 The Committee can operate with an In Committee function to receive updates on the management of sensitive and/or confidential information.

## 8. Frequency of Meetings

8.1 The Committee will meet bi-monthly and shall agree an annual schedule of meetings. Any additional meetings will be arranged as determined by the Chair of the Committee in discussion with the Lead Executive.

8.2 The Chair of the Committee, in discussion with the Committee Secretary, shall determine the time and the place of meetings of the Committee and procedures of such meetings.

8.3 The Chair of the Committee, in discussion with the Committee Secretary, shall determine the need for additional interim meetings in order to make timely decisions, or determine whether these decisions can be made virtually and confirmed by Chairman's Action.

## 9. Accountability, Responsibility and Authority

9.1 Although, as set out within these terms of reference, the Board has delegated authority to the Committee for the exercise of certain functions, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens, through the effective governance of the organisation.

9.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

9.3 The Committee shall embed the UHB's vision, corporate standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business.

9.4 The requirements for the conduct of business as set out in the UHB's Standing Orders are equally applicable to the operation of the Committee.

## 10. Reporting

10.1 The Committee, through its Chair and members, shall work closely with the Board's other Committees, including joint/sub committees and groups to provide advice and assurance to the Board through the:

10.1.1 joint planning and co-ordination of Board and Committee business;

10.1.2 sharing of information.

10.2 In doing so, the Committee shall contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

10.3 The Committee may establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee business. The Committee will receive an update following each sub-committee or task or finish group meeting detailing the business undertaken on its behalf. There is one Sub-Committee reporting to this Committee:

10.3.1 GMS Vacant Practice Panel

10.4 The Committee Chair, supported by the Committee Secretary, shall:

10.4.1 Report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes the submission of a Committee update report, as well as the presentation of an annual report within six weeks of the end of the financial year.

10.4.2 Bring to the Board's specific attention any significant matters under consideration by the Committee.

10.4.3 Ensure appropriate escalation arrangements are in place to alert the UHB Chair, Chief Executive or Chairs of other relevant Committees, of any urgent/critical matters that may compromise patient care and affect the operation and/or reputation of the UHB.

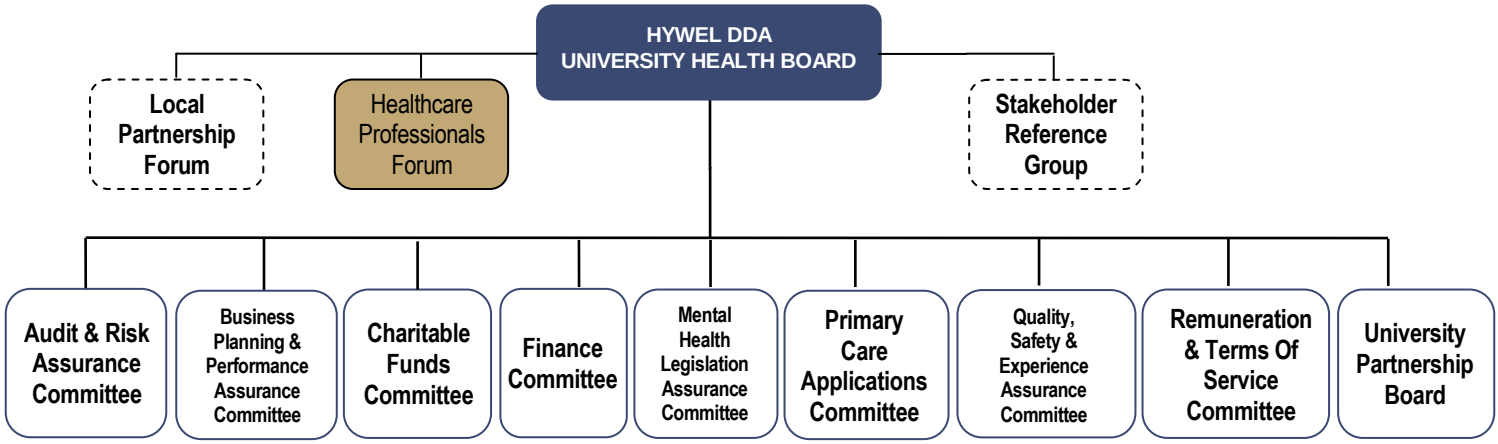
10.5 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self assessment and evaluation of the Committee's performance and operation, including that of any sub-committees established.

## 11. Secretarial Support

11.1 The Committee Secretary shall be determined by the Lead Director (Director of Primary, Community and Long Term Care).

## 12. Review Date

12.1 These terms of reference and operating arrangements shall be reviewed on at least an annual basis by the basis by the Committee for approval by the Board.




# TERMS OF REFERENCE

## HEALTHCARE PROFESSIONALS FORUM

| Version | Issued to: | Date | Comments |
|---|---|---|---|
| V0.1 | **Board** | 25/03/10 | Approved |
| V0.1 | **Board (SO's)** | 22/07/10 | Approved |
| V0.2 | **HPF** | 23/12/11 | Approved |
| V0.3 | **HPF** | 11/03/11 | Approved |
| V0.4 | **HPF** | 31/10/11 | Approved |
| V0.5 | **HPF** | 24/01/11 | Approved |
| V0.6 | **HPF** | 05/03/12 | Approved |
| V0.6 | **LHB Board** | 27/09/12 | Approved |
| V0.7 | **HPF** | 20/08/13 | Approved |
| V0.8 | **Board (SO's)** | 22/05/14 | Approved |
| V0.9 | **Board (SO's)** | 26/11/15 | Approved |
| V0.10 | **HPF** | 19/06/17 | Approved |
| V0.10 | **HPF** | 08/03/18 | Approved |
| V0.10 | **Hywel Dda University Health Board** | 29/03/18 | Approved |
| V0.11 | **HPF** | 09/04/2019 | Approved |

# HEALTHCARE PROFESSIONALS FORUM

## 1. Constitution

1.1 The Healthcare Professionals Forum (HPF) has been established as an Advisory Group of the Hywel Dda University Local Health Board (the Health Board) and was constituted from December 2010.

## 2. Membership

2.1 The membership of the Forum shall comprise:

**Chair** nominated from within the membership of the Forum by its members and approved by the Minister

**Vice Chair** nominated from within the membership of the Forum by its members and approved by the Board.

**Members** the membership of the Forum reflects the structure of the seven health Statutory Professional Advisory Committees set up in accordance with Section 190 of the NHS (Wales) Act 2006. Membership of the forum shall therefore comprise the following eleven (11) members:

<u>Welsh Medical Committee</u>
1. Primary and Community Care Medical representative
2. Mental Health Medical representative
3. Specialist and Tertiary Care Medical representative

<u>Welsh Nursing and Midwifery Committee</u>
4. Community Nursing and Midwifery representative
5. Hospital Nursing and Midwifery representative

<u>Welsh Therapies Advisory Committee</u>
6. Therapies representative

<u>Welsh Scientific Advisory Committee</u>
7. Scientific representative

<u>Welsh Optometric Committee</u>
8. Optometry representative

<u>Welsh Dental Committee</u>
9. Dental representative

Welsh Pharmaceutical Committee

10. Hospital Pharmacists representative
11. Community Pharmacists representative

## 2.2 In attendance

2.2.1 The Medical Director/Director of Clinical Strategy will be the Executive Lead and sponsor for the HPF. A minimum of one Director will attend all formal meetings.

2.2.2 The University Health Board (UHB) may nominate designated Board members or UHB staff be in attendance at Forum meetings. The Forum's Chair may also request the attendance of Board members or UHB staff, subject to the agreement of the UHB Chair. The following has been designated as an In Attendance member:

- Advanced Paramedic Practitioner representative

2.2.3 The University Health Board Chair and Chief Executive reserve the right to attend formal meetings.

## 2.3 Member Appointments

2.3.1 Appointments to the Forum shall be made by the Board, based upon nominations received from the relevant professional group, and in accordance with any specific requirements or directions made by the Welsh Government.

2.3.2 Members shall be appointed for a period of between 3 to 4 years in any one term. Those members can be reappointed but may not serve a total period of more than 8 years consecutively.

2.3.3 The *Chair* will be nominated from within the membership of the Forum, by its members, in a manner determined by the Board, subject to any specific requirements or directions made by the Welsh Government. The nomination will be subject to consideration by the HB, 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.

2.3.4 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 an additional one (1) year, in line with that individual's term of office as a member of the Forum. That individual may remain in office for the remainder of their term as a member of the Forum after their term of appointment as Chair has ended.

2.3.5 The *Vice Chair* shall be nominated from within the membership of the Forum, by its members by the same process as that adopted for the Chair, subject to the

condition that they be appointed from a different clinical discipline from that of the Chair.

2.3.6 The Vice Chair's term of office will be as described for the Chair.

2.3.7 A member's tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements determined for the position. A member must inform the Forum Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office. The Forum Chair will advise the Board in writing of any such cases immediately. The UHB will require Forum members to confirm in writing their continued eligibility on an annual basis.

2.3.8 If a member fails to attend any meeting of the HPF for a period of six months or more, the Board may remove that person from office unless they are satisfied that:

2.3.8.1 the absence was due to a reasonable cause; and
2.3.8.2 the member will be able to attend such meetings within such a period as the Board considers reasonable.

## 3. Quorum and Attendance

3.1 A quorum shall consist of at least half of the membership and must include the Chair or Vice Chair of the Committee.

## 4. Principal Duties

4.1 As an Advisory Group to Hywel Dda University Health Board, the purpose of the Healthcare Professionals Forum (hereafter referred to as "the Forum"), is to provide advice to the Board on all professional and clinical issues it considers appropriate. Its role does not include consideration of professional terms and conditions of service.

## 5. Operational Responsibilities

5.1 As an Advisory Group to the Board, the Forum's role is to:

5.1.1 provide a balanced, multi-disciplinary view of professional issues to advise the Board on local strategy and delivery;
5.1.2 facilitate engagement and debate amongst the wide range of clinical interests within the Health Board's area of activity, with the aim of reaching and presenting a cohesive and balanced professional perspective to inform the Health Board's decision making; and
5.1.3 link in with existing internal clinical engagement structures.

## 6. Agenda and Papers

6.1 The Forum Secretary is to hold an agenda setting meeting with the Chair, Vice Chair and the Lead Executive (the Medical Director/Director of Clinical Strategy) at least one month before the meeting date.

6.2 The agenda will be based around the Forum's work plan, matters arising and requests from Forum members. Following approval, the agenda and timetable for papers will be circulated to all Forum members.

6.3 All papers must be approved by the Chair.

6.4 The agenda and papers for meetings will be distributed eight days in advance of the meeting, whenever possible electronically. One hard copy will be maintained by the Secretary of the Forum.

6.5 The minutes and action log will be circulated to members within seven days to check the accuracy. The minutes must be an accurate record of the meeting which capture the discussions that take place.

6.6 Members must forward amendments to the Forum secretary within the next seven days. The Forum secretary will then forward the final version to the Forum Chair for approval.

## 7. Management of Meetings

7.1 The Forum will meet quarterly and shall agree a schedule of meetings at least 12 months in advance, consistent with the University Health Board's annual plan of Board Business. Additional meetings will be arranged as determined by the Chair of the Forum in discussion with the Lead Executive.

7.2 The Chair of the Forum, in discussion with the Forum Secretary shall determine the time and the place of meetings of the Forum and procedures of such meetings.

7.3 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.

7.4 Should it be necessary, components of the meeting will held in private or on an informal basis

## 8. Authority

8.1 The Health Board may specifically request advice and feedback from the Forum on any aspect of its business, and the Forum may also offer advice and feedback even if not specifically requested by the Health Board.

8.2 The Forum may provide advice to the Board:

8.2.1 at Board meetings, through the Forum Chair's participation as Associate Member;

8.2.2 in written advice; and
8.2.3 in any other form specified by the Board.

## 9. Reporting and Assurance Arrangements

9.1 The Chair is responsible for the effective operation of the Forum:

9.1.1 chairing meetings;
9.1.2 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
9.1.3 developing positive and professional relationships amongst the Forum's membership and between the Forum and Hywel Dda University Health Board, and in particular it's Chair, Chief Executive and Directors.

9.2 The Chair shall work in close harmony with the Chairs of Hywel Dda Health Board's other Advisory Groups, and, supported by the Board Secretary, shall ensure that key and appropriate issues are discussed by the Forum in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.

9.3 The Chair of the HPF will be appointed as an Associate Member of the Health Board on an ex officio basis. The Chair is accountable for the conduct of their role as Associate Member on the Hywel Dda University Health Board to the Minister, through the Health Board Chair. They are also accountable to Hywel Dda University Health Board for the conduct of business in accordance with the governance and operating framework set by the Health Board.

9.4 The Forum Chair shall:
9.4.1 report formally, regularly and on a timely basis to the Board on the Forum's activities. This includes written updates on activity after each meeting and the presentation of an annual report reviewing the Forum's activity and effectiveness against the ToRs within 6 weeks of the end of the financial year*;*
9.4.2 bring to the Board's specific attention any significant matters under consideration by the Forum;

9.5 All Forum members must:
9.5.1 be prepared to engage with and contribute fully to the HPF's activities and in a manner that upholds the standards of good governance – including the values and standards of behaviour – set for the NHS in Wales;
9.5.2 comply with their terms and conditions of appointment;
9.5.3 equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes; and
9.5.4 promote the work of the HPF within the healthcare professional discipline they represent.

9.6 Forum members are accountable through the HPF Chair to the UHB Board for their performance as Forum members, and to their nominating body or grouping for the way in which they represent the views of their body or grouping at the HPF.

9.7 The requirements for the conduct of business as set out in the UHB's Standing Orders are equally applicable to the operation of the Forum.

## 10. Relationship Accountabilities with the Board and Other Committees of the Board

10.1 The Forum's main link with the Board is through the Forum Chair's membership of the Board as an Associate Member.

10.2 The Board should determine the arrangements for any joint meetings between the UHB Board and the Forum.

10.3 The Health Board's Chair should put in place arrangements to meet with the Forum Chair on a regular basis to discuss the Forum's activities and operation.

10.4 The Health Board Chair, on the advice of the Chief Executive and/or Board Secretary, may recommend that the Board afford direct right of access to any professional group, in the following, exceptional circumstances:

- 10.4.1 where the Forum recommends that a matter should be presented to the Board by a particular professional grouping, e.g. due to the specialist nature of the issues concerned; or
- 10.4.2 where a professional group has demonstrated that the Forum has not afforded it due consideration in the determination of its advice to the Board on a particular issue, or
- 10.4.3 the Board may itself determine that it wishes to seek the views of a particular professional grouping on a specific matter.

10.5 The Medical Director/Director of Clinical Strategy, on behalf of the Chair, will ensure that the Forum is properly equipped to carry out its role by:

- 10.5.1 ensuring the provision of governance advice and support to the HPF Chair on the conduct of its business and its relationship with the UHB and others;
- 10.5.2 ensuring that the HPF receives the information it needs on a timely basis;
- 10.5.3 ensuring strong links to communities / groups;
- 10.5.4 facilitating effective reporting to the Board; and
- 10.5.5 enabling the Board to gain assurance that the conduct of business within the HPF accords with the governance and operating framework it has set.

## 11. Relationship with the National Joint Professional Advisory Committee

11.1 The Forum Chair will be a member of the National Joint Professional Advisory Committee.

## 12. Secretarial Support

12.1 The Forum Secretary shall be determined by the Medical Director/Director of Clinical Strategy.

## 13. Review Date

13.1 These terms of reference and operating arrangements shall be reviewed on at least an annual basis by the Forum for approval by the Board.

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

**CYFARFOD BWRDD PRIFYSGOL IECHYD**
**UNIVERSITY HEALTH BOARD MEETING**

| | |
|---|---|
| **DYDDIAD Y CYFARFOD:**<br>**DATE OF MEETING:** | 30 May 2019 |
| **TEITL YR ADRODDIAD:**<br>**TITLE OF REPORT:** | Partnership Agreements – Pooled Funding and Ceredigion Community Equipment Services: Section 33 Agreement |
| **CYFARWYDDWR ARWEINIOL:**<br>**LEAD DIRECTOR:** | Sarah Jennings, Director of Partnerships & Corporate Services & Jill Paterson, Director of Primary Care, Community & Long-Term Care |
| **SWYDDOG ADRODD:**<br>**REPORTING OFFICER:** | Sian-Marie James, Head of Corporate Office<br>Martyn Palfreman, Head of Regional Collaboration |

| **Pwrpas yr Adroddiad** (dewiswch fel yn addas)<br>**Purpose of the Report** (select as appropriate) |
|---|
| Ar Gyfer Penderfyniad/For Decision |

**ADRODDIAD SCAA**
**SBAR REPORT**

## Sefyllfa / Situation

This paper provides an update on the virtual pooled funds Agreement established under Part 9 of the *Social Services and Well-being (Wales) Act 2014* (the 2014 Act).

The paper is also seeking Board approval of an updated Agreement for Ceredigion's Integrated Provision of Community Equipment Services; pursuant to section 33 of *The National Health Service (Wales) Act 2006* (**Appendix 1**). The Agreement is for the provision of a service for the issue and retrieval of aids and equipment from the Joint Equipment Store based at Felinfach, Lampeter, in Ceredigion. The purpose of this updated Agreement for Ceredigion's Integrated Provision of Community Equipment Services is to formalise the legal arrangements. The revised Agreement will be for a further 12 months; from 1 April 2019 to 31 March 2020.

## Cefndir / Background

Part 9 of the 2014 Act requires Local Authorities and Local Health Boards to establish formal partnership arrangements and set up pooled funding arrangements. Aside from being a statutory requirement there is a compelling case for integration. Pooled budgets can, in some cases, result from the integration of health and social care services in a seamless service model which is based on a whole system approach.

A virtual pooled fund Agreement between the four statutory partners has been in place since 1 April 2018 for commissioned older adult care home placements, which expired on 31 March 2019, but is continuing in practice.

The Agreement covers all local authority residential placements, Funded Nursing Care (FNC) placements by Hywel Dda University Health Board, and 'standard' Continuing Health Care (CHC) placements. This addresses requirements under Part 9 of the 2014 Act.

The Agreement provides for identification of a combined regional budget for care homes and regular, formal reporting to the statutory partners on financial and performance information relating to the sector in West Wales.

It is proposed that the Agreement will be extended for a further 12 months and over this period the potential for building on current arrangements by establishing a cash-transfer fund will be actively explored with statutory partners. The Board will be kept informed of progress and any changes to the Agreement brought for ratification at the appropriate time.

A separate Agreement provides the framework for delivery of an Integrated Provision of Community Equipment Services, which is a vital component of Health and Social Care in the Community, preventing dependency, promoting independence and ensuring safety for our residents and their carers. The provision of Integrated Community Equipment Services has been operational in Ceredigion since 2009. A previous Agreement was in place (from 1 April 2009 to 31 March 2012) between Ceredigion County Council (1), Hywel Dda NHS Trust (2) and Ceredigion Local Health Board (3), and more recently from 31 March 2017 for a 12-month period, and then on 17 April 2018 for a further 12-month period. The terms of this Agreement are similar.

## Asesiad / Assessment

Since the virtual pooled fund Agreement became live in April 2018, partners have also made significant progress in the following areas:

- Development of a shared Pre Placement Agreement for the region (with certain schedules tailored to reflect county arrangements). This will be formally adopted by all partners early in the new financial year
- Commissioning of a fundamental, independent review of financial and performance data for the sector, identifying variances in spend and practice as a basis for future planning and adoption of best professional practice
- Further alignment of operational practice in terms of assessment, monitoring and quality assurance (including joint visits) across partner agencies, to support a consistent, seamless approach, timely transfers of care and equitable funding decisions
- Work is underway to align fees through the development and adoption of a common fees model for the Region
- Creation of a shared, real-time website providing up to date information for professionals and the public on care home vacancies. This will go live in the coming months and, as well as supporting informed choice for those eligible for social/ nursing care and self-funders, will also help with more effective and timely discharge and transfers of care. The site also functions as an information portal enabling providers to upload management information, such as that relating to vacancies, Additional Cost Contributions, and numbers of self-funded placements. The data will support understanding of trends and will complement the pooled fund dataset in supporting our ambitions for enhanced strategic regional commissioning

We will continue to build on these arrangements to further enhance our integrated approach to the commissioning and delivery of residential and nursing care. Opportunities will also be taken to establish pooled funding arrangements in relation to family support functions delivered jointly in response to the regional Population Assessment, as required under the 2014 Act. Further updates will be provided to the Board in relation to the above.

Regulation 4(2) of the *NHS Bodies and Local Authorities Partnership Arrangements (Wales) Regulations 2000*, provides that the partners may not enter into any partnership arrangements unless they have consulted jointly such persons as appear to them to be affected by such arrangements. As Ceredigion's Integrated Provision of Community Equipment Services has been in place since 2009, it is not considered that any party will be affected by the formalising of the legal position; therefore, no additional consultation has been undertaken at this stage.

This revised Integrated Provision of Community Equipment Services Agreement needs to be formally approved by Hywel Dda University Health Board under Section 33 of the *National Health Service (Wales) Act 2006*, in order to ensure that the shared responsibility for the future development of the services and any associated risks are identified through a clear governance framework.

It is proposed that the current Agreement for a Joint Equipment Store for the county of Ceredigion will continue for a further 12 month period from 1 April 2019 to 31 March 2020. This is, in essence, an interim arrangement to allow the service to continue whilst a broader regional review is undertaken by the Regional Partnership Board.

The only significant differences from the existing Agreement (approved by the Board Meeting in March 2018) are:

- Effective date: it is proposed that the Agreement will run from 1 April 2019, as this accurately reflects the arrangements between the parties. The Agreement cannot be sealed until such time as it has Board and Council approval;
- An update on references to the Data Protection Act 2018;
- References to the overarching Legislation and Regulations have been updated;
- Changes to officers in Ceredigion County Council;
- Definition changes to reflect the current position; and
- Schedule 4, Appendix 1 has been updated to reflect the total combined budget for the Integrated Community Equipment service for 2019/20 **-** £456k; the UHB's annual contribution is set at £333k (£27,750 per calendar month), an increase from 2018/19, with the Council's contribution decreasing by the same amount.

**Argymhelliad / Recommendation**

The Board is requested to:

- **NOTE** the update provided on virtual pooled funding Agreement; and
- **APPROVE** the revised Agreement (**Appendix 1**) for Ceredigion's Integrated Provision of Community Equipment Services made pursuant to Section 33 of the *National Health Service (Wales) Act 2006*, in order for this to be sealed and signed by both Hywel Dda University Health Board and Ceredigion County Council.

| **Amcanion: (rhaid cwblhau)**<br>**Objectives: (must be completed)** | |
|---|---|
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:<br>Datix Risk Register Reference and Score: | Not applicable |

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|---|---|
| Safon(au) Gofal ac Iechyd:<br>Health and Care Standard(s):<br>Hyperlink to NHS Wales Health & Care Standards | 2.9 Medical Devices, Equipment and Diagnostic Systems<br>Governance, Leadership & Accountability |
| Amcanion Strategol y BIP:<br>UHB Strategic Objectives:<br>Hyperlink to HDdUHB Strategic Objectives | 2. Living and working well |
| Amcanion Llesiant BIP:<br>UHB Well-being Objectives:<br>Hyperlink to HDdUHB Well-being Statement | Support people to live active, happy and healthy lives |

| **Gwybodaeth Ychwanegol:<br>Further Information:** | |
|---|---|
| Ar sail tystiolaeth:<br>Evidence Base: | Not applicable |
| Rhestr Termau:<br>Glossary of Terms: | Contained within the body of the report |
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol:<br>Parties / Committees consulted prior to University Health Board: | Ceredigion's Integrated Provision of Community Equipment Services has been subject to consultation and agreement with Ceredigion County Council |

| **Effaith: (rhaid cwblhau)<br>Impact: (must be completed)** | |
|---|---|
| **Ariannol / Gwerth am Arian:<br>Financial / Service:** | See Schedule 4, Appendix 1 of the Agreement: UHB's contribution is £333k (£27,750k per calendar month) |
| **Ansawdd / Gofal Claf:<br>Quality / Patient Care:** | The aim of the Integrated Provision of Community Equipment Services Agreement is to support patients to remain independent. |
| **Gweithlu:<br>Workforce:** | See Agreement |
| **Risg:<br>Risk:** | The updated s.33 Agreement should be renewed to ensure the revised terms (each party's contribution) is clear and unambiguous. |
| **Cyfreithiol:<br>Legal:** | • *Section 33 of the National Health Service (Wales) Act 2006*;<br>• Legal requirement under Part 9 of the *Social Services and Well-being (Wales) Act 2014;*<br>• *The National Health Service Bodies and Local Authorities Partnership Arrangements (Wales) Regulations 2000*, S.I. No. 2993 (W.193); as amended by *The National Health Service Bodies and Local Authority Partnership Arrangements (Wales) (Amendment) Regulations 2004*, S.I. No.1390; and any other regulations which may amend or replace these. |

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| **Enw Da:**<br>**Reputational:** | The pooling of relevant funds supports public and Welsh Government aspirations in respect of service integration. |
| **Gyfrinachedd:**<br>**Privacy:** | Not applicable |
| **Cydraddoldeb:**<br>**Equality:** | At this stage, it is not considered that the recommendation to approve the Draft Agreement for the Community Equipment Store will have a disproportionately adverse impact on any protected groups and therefore a full Equality Impact Assessment is not considered necessary.<br><br>Monitoring of the impact will be conducted through analysis of any complaints received in relation to equality, diversity or human rights, which will be addressed on an individual basis and appropriate action taken.<br><br>In making this decision the UHB must have regard to the public sector equality duty (PSED) the Equality Act 2010, to have due regard to the need to:<br><br>a) Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.<br>b) Advance equality of opportunity between people who share a protected characteristic and those who do not.<br>c) Foster good relations between people who share a protected characteristic and those who do not including tackling prejudice and promoting understanding.<br><br>The protected characteristics are age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation. The PSED covers service users, staff and members of public as a whole who are potentially affected by the Agreement. The PSED is a factor in making this decision but does not impose a duty to achieve the outcomes in s.149. It is a factor that needs to be proportionally considered and may be balanced against other relevant factors. It is, however, important to demonstrate that it has been considered. |

**DATED**

**(1) CEREDIGION COUNTY COUNCIL**

**and**

**(2) HYWEL DDA UNIVERSITY LOCAL HEALTH BOARD**

# AGREEMENT

**SECTION 33 OF THE NATIONAL HEALTH SERVICE (WALES) ACT 2006**

**PARTNERSHIP AGREEMENT**
**IN RESPECT OF**
**OF A POOLED FUND FOR THE INTEGRATED PROVISION OF**
**COMMUNITY EQUIPMENT SERVICES**

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**CLAUSE HEADING AND NUMBER** **PAGE NUMBER**

**THIS AGREEMENT** is made on the day of 2019 **BETWEEN** Ceredigion County Council (the Council) situate at Neuadd Cyngor Ceredigion, Penmorfa, Aberaeron, SA46 0PA, and Hywel Dda University Local Health Board (the University Health Board) whose principal office is situate at Ystwyth, Hafan Derwen, St David's Park, Jobs Well Road, Carmarthen, Carmarthenshire, SA31 3BB.

**WHEREAS:**

A The Partners are entering into this Agreement for community equipment in exercise of the powers referred to in Section 33 of the National Health Service (Wales) Act 2006 incorporating management of both:-

- a Pooled Fund; and
- the integrated provision of community equipment through staff of the Council and staff of the University Health Board where the Council is the Lead Provider for the purposes of the Regulations.

B Prior to the date of this Agreement, and from 1 April 2009, the Partners (and where relevant their predecessor organisations) have operated arrangements pursuant to Section 33 of the Act and the Regulations for the delivery of the Service. An Agreement dated 1st April 2009 between Ceredigion County Council (1) Hywel Dda NHS Trust (2) and Ceredigion Local Health Board (3) in similar terms to this Agreement expired on 31 March 2012 but the Service has been continuous throughout.

C On 31st March 2017, the Partners entered into a further Agreement for a 12-month period to expire on 31st March 2018.

D On 17th April 2018, the Partners entered into a further Agreement for a 12-month period to expire on 31st March 2019.

E The purpose of this Agreement is to continue to facilitate the provision of the Service and the development thereof in the manner and location specified in this Agreement for a further 12-month period. This Service is to be provided from a Pooled Fund, is within the University Health Board's, and the Council's powers and is limited to eligible people within the Council's administrative area and limited to the respective administrative local areas for the University Health Board.

F The Service incorporates certain equipment provisions secured for people through the University Health Board's NHS Health Care Functions and the Council's Health Related Care Functions to be provided or arranged for or by the Council as the Lead Provider of the Service for the Partners.

G The Partners shall carry out consultation on the proposals for any Scheme with those persons, user groups, staff and statutory and non-statutory providers, who appear to them to be affected by the arrangement, as required by Regulation 4(2) of the Regulations.

**IT IS AGREED AS FOLLOWS:**

**1. <u>DEFINITIONS AND INTERPRETATION</u>**

1.1 **In this Agreement, except where the context otherwise requires, the following expressions shall have the meanings respectively ascribed to them:-**

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| "Act'' | means the National Health Service (Wales) Act 2006; |
| "Agreement" | means this Agreement and any variation of it from time to time agreed between the Partners; |
| "Annual Summary" | means the list of policies of the partner organisations, insofar as they have a statutory duty to make such policy, that has an impact upon delivery of the Service; |

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| “Assessment Process” | means the single assessment by the Council, and the University Health Board jointly of prospective Service Users in accordance with national requirements and Guidance or Directions relevant to the provision of the Service or any part thereof as may be issued to the Council or the University Health Board in the future; |
| “Authorised Officers” | means the person nominated and notified by each of the Partners to the other from time to time as authorised to act on behalf of that Partner for the purposes of Clause 4 (which person shall until further notice be for the Council its Chief Executive, for the University Health Board its Chief Executive; |
| ’Community Equipment’’ | means all equipment provided to eligible individuals by the Service; |
| “Council” | means Ceredigion County Council (and any successor to its statutory function); |
| “Data” | means any data, document, code, information, Personal Data in connection with this Agreement. |
| “Data Incident” | means the reasonable suspicion of, discovery by, or notice to a party that (a) Data has been or is likely to be accessed or obtained by an unauthorised person; or (b) a party’s systems have been or are likely to be compromised or vulnerable; or a person has threatened the unauthorised access to or obtaining of any Data |
| “Data Protection Laws” | means applicable laws and regulations in any relevant jurisdiction relating to privacy or the use or processing of Personal Data relating to natural persons, including: (a) EU Directives 95/46/EC and 2002/58/EC (as amended by 2009/139/EC) and any legislation implementing or made pursuant to such directives, including the DPA and the Privacy and Electronic Communications (EC Directive) Regulations 2003; and (b) from 25 May 2018 EU Regulation 2016/679 (**"GDPR"**) and the e-privacy regulation; (c) any laws or regulations ratifying, implementing, adopting, supplementing or replacing GDPR; in each case, to the extent in force, and as such are updated, amended or replaced from time to time; and (d) the Regulation of Investigatory Powers Act 2000 and the Telecommunications (Lawful Business Practice) (Interception of Communications) Regulations 2000 |
| “Data Subject” | shall have meaning set out in the GDPR |
| “DPA” | means the Data Protection Act 2018 and any subordinate legislation |
| “DP Regulator” | means any governmental or regulatory body or authority with responsibility for monitoring or enforcing compliance with the Data Protection Laws. |
| “Effective Date” | means the 1 April 2019 and accurately reflects the arrangements between the parties as of that date. |

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| "Financial Year" | means the financial year from 1st April in any year to 31st March in the following calendar year; |
| "FOI Legislation" | means the Freedom of Information Act 2000 and subordinate legislation made under this and the Environmental Information Regulations 2004 |
| "Health Social Care and Wellbeing Strategy" | means the Ceredigion Well-being Plan |
| "Joint Management Board" | means the Joint Management Board responsible for the operational management of the Service in accordance with the provisions of Schedule 5; |
| "Lead Provider" | means the Partner undertaking the function of providing or arranging the Service on behalf of the Partners; |
| "Partners" | means the Council and the University Health Board, and the term "Partner" shall mean either one of them; the term "Partnership" shall be construed accordingly; |
| "Personal Data" | has the meaning set out in GDPR for personal data governed by such laws and shall also include "Personal Information" classified as "personal information" or "personally identifiable information" or similar term under the Applicable Law governing a person's processing of personal information about an individual; |
| "Pooled Fund Manager" | means the person determined from time to time under Clause 7.2 and who will at the outset of this Agreement be the Council's Corporate Lead Officer – Finance & Procurement; |
| "Pooled Fund" | means the joint fund of monies maintained by the Council comprising shared contributions from the Partners for the purpose of securing the Service pursuant to this Agreement; |
| ''Premises'' | means ground floor assessment/meeting rooms and workshop and storage area Unit 1, Aeron Enterprise Park, Felinfach, Lampeter, Ceredigion; |
| "Revised Annual Finance Agreement" | means the written confirmation of finance contributions and any change in procedures for operation of the Agreement as set out at Schedules 4 and 5; |

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| “Regulations” | means the National Health Service Bodies and Local Authorities Partnership Arrangements (Wales) Regulations 2000, S.I. No. 2993 (W.193); as amended by the National Health Service and Local Authority Partnership Arrangements (Wales) (Amendment) Regulations 2004, S.I. No.1390; and by the National Health Service Bodies and Local Authorities Partnership Arrangements (Amendment) Regulations 2015, S.I. No. 1940 and any other regulations which may amend or replace these; |
| “Service” | means the provision of equipment or any other related ancillary services or any arranged to, or for, a Service User by the Council in accordance with Guidance issued by Welsh Government in relation to the development of Integrated Community Facilities and/or such alternative or additional guidance or directions relevant to the Service as may be issued to the University Health Board or the Council in the future delivered according to the Aims and Objectives at Schedule 1 and in the manner and locations specified in Schedules 3 and 4; |
| “Service User” | means any person receiving the benefit of the Service; |
| “Staff” | means employees of the Council, and employees of the University Health Board, who are directly responsible for assessing and or providing care to Service Users as a part of the arrangements set out at Schedules 3 and 4; |
| “Term” | means the period from the Effective Date and ending on 31st March 2020 subject to earlier termination in accordance with the terms of this Agreement; |
| “University Health Board” | means Hywel Dda University Local Health Board (and any successor to its statutory functions). |

1.2 Save to the extent that the context or the express provisions of this Agreement otherwise require:-

1.2.1. obligations undertaken or to be undertaken by more than a single person shall be made and undertaken jointly and severally;

1.2.2. words importing any gender include any other gender and words in the singular include the plural and words in the plural include the singular;

1.2.3. references to any Statute or statutory provision shall be deemed to refer to any modification or re-enactment thereof for the time being in force whether by Statute, Regulation, Guidance, Direction or Directive which is intended to have direct application within the United Kingdom and has been adopted by the Council of European Communities;

1.2.4. headings and the Index are inserted for convenience only and shall be ignored in interpreting or in the construction of this Agreement;

1.2.5. references in this Agreement to any Clause or Sub-Clause or Schedule or Appendix without further designation shall be construed as a reference to the Clause or Sub-Clause of or Schedule or Appendix to this Agreement so numbered;

1.2.6. any obligation on either of the Partners to provide or procure for the Service shall be a direct obligation on all partners as the context requires;

1.2.7. any reference to "indemnity" or "indemnify" or other similar expressions shall mean that the relevant Partner indemnifies, shall indemnify and keep indemnified and hold harmless the other Partner; and

1.2.8. any reference to a person shall be deemed to include any permitted transferee or assignee of such person and any successor to that person or any person which has taken over the functions or responsibilities of that person but without derogation from any liability of any original Partner to this Agreement.

## 2. TERM

2.1 The Effective Date of this Agreement is the 1st April 2019 as this accurately reflects the arrangements between the parties as of that date and shall continue for the Term, subject to earlier termination as provided below.

## 3. AIMS AND OBJECTIVES

3.1 The Aims and Objectives of this Agreement are set out in Schedule 1.

## 4. CONTRIBUTIONS

4.1 Subject to the outcome of any review under Clause 9.1, the University Health Board's contribution to the Pooled Fund per calendar month shall be as specified in Appendix 1 of Schedule 4, subject to review annually as outlined in 9.3.

4.2 Subject to the outcome of any review under Clause 9.1, the Council's contribution to the Pooled Fund per calendar month shall be as specified in Appendix 1 of Schedule 4, subject to review annually as outlined in 9.3

4.3 The University Health Board shall make payments identified at Clause 4.1 and 4.2 above to the Council monthly on the 1st day of the month in accordance with the arrangements at Schedule 5.

4.4 Any variations to the amounts shown at Clauses 4.1, 4.2 and 4.3 above as additional payments shall be subject to separately agreed arrangements from time to time, as minuted in the Joint Management Board meetings.

4.5 The University Health Board shall make available for use by the Council in support of the Service any other goods or services described at Schedule 4 and which may subject to Joint Management Board agreement be included in the Pooled Fund as and when required or requested.

4.6 The Council shall make the Premises and any other goods or services set out at Schedule 4 available in support of the Service, but for the avoidance of doubt these will not to be considered as an asset under the Agreement or part of the Pooled Fund.

## 5. NHS HEALTH CARE FUNCTIONS AND HEALTH RELATED CARE FUNCTIONS

5.1 The University Health Board's NHS Health Care Functions and the Council's Health Related Care Functions are to be carried out pursuant (in whole or part) as set out in Schedule 2.

## 6. THE SERVICE AND ITS OPERATION

6.1 The Council shall be the Lead Provider and responsible for delivery of the Service.

6.2 The eligibility of Service Users to receive the Service shall be assessed in accordance with the provisions of Schedule 3.

6.4 The Partners agree that for these purposes that any of the Staff making a protected disclosure (as defined in Section 1 of the Public Interest Disclosure Act 1998) shall not be subjected to any detriment. The Partners declare that any provision in an agreement purporting to preclude the Staff from making a protected disclosure is void.

6.5 The Council, as Lead Provider, shall manage and direct the duties of all of the staff including any Seconded Staff as agreed and this function shall be undertaken according to the structures, duties and limitations of authority of each partner.

6.6 The Council, as Lead Provider, shall ensure that in undertaking any duties to fulfil the functions of this Agreement and in making any decision with respect to a Service User, due consideration is given to the Service User's gender, sexual orientation, religious persuasion, racial origin, cultural and linguistic background, with reference to the Equality Act 2010 and the Human Rights Act 1998 where appropriate as well any legislation or statutory guidance relating to disability of any kind.

6.7 The Council, as Lead Provider, shall comply with all Statutes, Regulations, Guidance, Directions, Directives and the Annual Summary relating to the provision of the Service or any part thereof and in particular, but without limitation, shall ensure that all Care Contracts require that the provision of the Service complies with the National Minimum Standards under the Care Standards Act 2000.

6.8 The University Health Board shall ensure the provision of Staff necessary for the provision of the NHS Health Care element of the Assessment Process and the Council shall ensure the provision of the Council staff necessary for the provision of the Health Related Care element of the Assessment Process.

6.9 The Council will provide annually on 1st October of each year the Annual Summary.

## 7. POOLED FUND MANAGEMENT

7.1 The Council is the lead provider for the purposes of the Regulations.

7.2 The Pooled Fund Manager will be Ceredigion County Council's Corporate Lead Officer – Finance & Procurement and shall be accountable directly to the Joint Management Board (or in any other case) the Council's Chief Executive.

7.3 The Pooled Fund Manager shall delegate to an Accountant with responsibility for authorising payments and the Council shall such make payments from the Pooled Fund in accordance with the Service description and the Aims and Objectives, as set out in the Schedules to this Agreement. The scheme of delegation is detailed in Schedule 5.

7.4 The Pooled Fund Manager shall delegate to a Finance Group Manager responsibility for managing the Pooled Fund and forecasting and reporting to the Joint Management Board upon the targets and information as agreed and any further targets or performance measures that may be set by the Joint Management Board from time to time.

7.5 The Pooled Fund Manager shall delegate to a Finance Group Manager reporting to both the Authorised Officers in accordance with the requirements of the Regulations. The Council's Authorised Officer shall in turn ensure reporting on the same to the officer of the Council responsible for the administration of its financial affairs.

7.6 The Pooled Fund Manager shall delegate to an Accountant submission to the Partners monthly reports within twenty (20) days of the end of the month thereof and an annual return by 1st October following the end of each year in line with statutory and local deadlines and requirements regarding the income of and expenditure from the Pooled Fund, reports on performance against budget and targets and other information by which the Partners can monitor the effectiveness of the Pooled Fund arrangements.

7.7 The Joint Management Board shall be responsible for any costs, claims, expenses or liabilities in excess of the Pooled Fund at any time, save that the Partners shall be individually responsible (in the proportions of their respective contributions of the Pooled Fund for the current Financial Year) for any such costs, claims, expenses or liabilities incurred with the agreement of the Partners in accordance with the terms of this Agreement.

7.8 The benefit of any financial surplus in the Pooled Fund at the end of each Financial Year shall:-

7.9.1 Be distributed to the Partners proportionate to the original contributions to the Pooled Fund;

7.9.2 Without prejudice to Clause 7.9.1 the Partners may agree to carry forward any such financial surplus in the Pooled Fund provided that such carrying forward will be in accordance with any relevant statutory or other legal requirements or guidance.

7.9 Any deficits or overspends will be managed in accordance with the Financial Performance/Risk Sharing arrangements detailed in Schedule 4.

7.10 The Pooled Fund Manager shall maintain and produce when requested by either of the Partners at the expense of that Partner such information as shall be appropriate to the provision of the Service for so long as any part thereof is being provided to Service Users in accordance with Clause 11, notwithstanding any notice of termination in accordance with Clause 10.

7.11 The governance arrangements shall be as set out in Schedule 5.

7.12 Each Partner shall pay its own costs and expenses incurred from time to time in the negotiation and management of this Agreement, save as expressly otherwise provided in this Agreement (including, without limitation the functions described at Schedule5)

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7:13 Any costs incurred by the Pooled Fund Manager or the Council acting as Lead Provider shall be a cost properly incurred and paid for out of the Pooled Fund.

## 8. INDEMNITY AND INSURANCE

8.1 The Council shall maintain public liability insurance which includes the Service to a minimum level of Ten million pounds (£10,000,000) per claim and aggregate cover of Ten million pounds (£10,000,000) of claims in any Financial Year and shall review the adequacy of such cover not less frequently than once in each Financial Year. The cost of the maintaining this insurance shall be a cost properly incurred and paid for from the Pooled Fund.

8.2 The Council shall provide to the University Health Board upon request such evidence as the University Health Board may reasonably require to confirm that the insurance arrangements are satisfactory and are in force at all times.

8.3 The Council shall indemnify the University Health Board and its employees and agents against all claims and proceedings (to include any settlements or ex gratia payments made with the consent of the Partners and reasonable legal and expert costs and expenses) made or brought (whether successfully or otherwise):-

8.3.1 by or on behalf of any Service User (or his or her dependants) against the University Health Board or any of its employees or agents for personal injury (including death) arising out of the provision of the Service; or

8.3.2 by the Council, its employees or agents or by or on behalf of a Service User for a declaration concerning the treatment of a Service User who has suffered such personal injury; and

8.3.3 which post-date the commencement of this Agreement.

8.4 The above indemnity by the Council shall not apply to any such claim or proceeding:-

8.4.1 to the extent that such personal injury (including death) is caused by the negligent or wrongful act(s) or omission(s) or breach of statutory duty by the University Health Board its employees or agents; or

8.4.1.1 to the extent that such personal injury (including death) is caused by the failure of the University Health Board, its employees or agents to provide a part of the Service in accordance with this Agreement; in which case and to such extent the University Health Board shall indemnify the Council against such claim or proceeding.

8.5 Neither the indemnity from the Council at Clause 8.3 nor that from the University Health Board at Clause 8.4 shall apply to any such claim or proceeding:-

8.5.1 unless as soon as reasonably practicable following receipt of notice of such claim or proceeding, the Partner in receipt of it shall have notified the other Partner in writing of it and shall, upon the latter's request and at the latter's cost, have permitted the latter to have full care and control of the claim or proceeding, using legal representation approved by the former Partner, such approval not to be unreasonably withheld; or

8.5.2 if the Partner in receipt of the claim or proceeding, its employees or agents shall have made any admission in respect of such claim or proceeding or taken any action related to such claim or proceeding prejudicial to the defence of it without the written consent of the other Partner (such consent not to be unreasonably withheld or delayed), provided that this condition shall not be treated as breached by any statement properly made by the former Partner, its employees or agents in connection with the operation of its internal complaints procedures, accident reporting procedures or disciplinary procedures or where such statement is required by law.

8.6 Each Partner shall keep the other Partner and its legal advisers fully informed of the progress of any such claim or proceeding, will consult fully with the other Partner on the nature of any defence to be advanced and will not settle any such claim or proceeding without the written approval of the other Partner (such approval not to be unreasonably withheld).

8.7 Without prejudice to the provisions of Clause 8.5.1, all Partners will use their reasonable endeavours to inform each other promptly of any circumstances reasonably thought likely to give rise to any such claim or proceedings of which they are directly aware and shall keep each other reasonably informed of developments in relation to any such claim or proceeding even where they decide not to make a claim under this indemnity.

8.8 The Partners will each give to the other such help as may reasonably be required for the efficient conduct and prompt handling of any claim or proceeding by or on behalf of any Service User (or his or her dependants) or concerning such a declaration as is referred to in Clause 8.3.2.

8.9 For the purposes of this indemnity the expression “agents” shall be deemed to include without limitation any nurse, social care or health professional providing services to the Council under contract for services or otherwise and any person carrying out work for the Council under such a contract.

## 9. REVIEW

9.1 The Partners shall review the provision of the Service and this Agreement after 1st April but no later than 31st October annually with a view to confirming the operation of the Pooled Fund and their respective contributions to this for the Financial Year.

9.2 The Partners shall use reasonable endeavours in each Financial Year to agree by 28th February for the following Financial Year.

9.3 The Partners shall confirm final budgets and any changes to financial procedures by no later than 28th February in each preceding financial year for the following financial year to operate and this shall form the Revised Annual Finance Agreement in the form as described at Schedule 4.

9.4 Reviews at Clause 9.2 and 9.3 shall be conducted in good faith and in accordance with the governance arrangements set out in Schedule 5 be based upon information to be provided as set out in Schedule 5.

9.5 No provision of this Agreement shall preclude the Partners, by mutual agreement, making additional contributions of non-recurring monies to the Pooled Fund. Any such additional contributions of non-recurring monies shall be explicitly recorded in Joint Management Board minutes and recorded in the budget statement as a separate item.

9.6 The Partners may review the operation of this Agreement on the coming into force (or anticipation of the coming into force) of any relevant statutory or other legislation or guidance affecting the terms of this Agreement so as to ensure that the terms of this Agreement comply with such legislation or guidance.

## 10. TERMINATION

This Agreement may be terminated by not less than three (3) months notice from either Partner to the other, if

10.1 either of the Partners has failed to confirm in writing its respective contribution for the coming financial year by Mid-January in accordance with Clause 9.1 or has failed in any subsequent Financial Year to confirm in writing its respective contribution by mid-January in the relevant year in accordance with Clause 9.2.

10.2 The University Health Board or the Council fails to meet any of its respective obligations under this Agreement the other Partner may by written notice require the Partner in default to take such reasonable action within a reasonable time-scale as the first Partner may specify to rectify such failure. Should the Partner in default fail to rectify such failure within such reasonable time-scale, the other Partner may give notice to terminate this Agreement immediately.

10.3 Either Partner shall be entitled to terminate this Agreement immediately by notice to the other, if the other Partner, its employees or agents either offers, gives or agrees to give to anyone any inducement or reward or confers any other benefit in respect of this or any other Agreement (even if the Partner is unaware of any such action) or otherwise commits any criminal activity or offence including offences under the Prevention of Corruption Acts 1889 to 1916 or Section 117(2) of the Local Government Act 1972.

10.4 In circumstances other than the above, either Partner may by not less than six (6) months notice to the other terminate this Agreement such notice to expire at any time.

10.5 Any purported termination of this Agreement under this Clause shall be without prejudice to any continuing obligations of the Partners under Clauses 7 and 11 and the continued operation of the Joint Management Board in accordance with Schedules 4 and 5.

10.6 In the event of termination of this agreement, for the avoidance of doubt, the Premises shall, subject to the terms and conditions of the Welsh Government Grant, remain the property of the Council, and the other partners may not be entitled to any proportion of the value of the premises, in accordance with Schedule 4

10.6 In the event of termination of this agreement, for the avoidance of doubt, all other assets of the service, after the costs of winding up the service and excluding the premises and including community equipment will be distributed in proportion to the partners' contributions in accordance with Schedule 4.

## 11 EFFECTS OF TERMINATION

11.1 Notwithstanding any notice of termination in accordance with Clause 10:-

11.1.1 the University Health Board, and the Council shall continue to be liable to provide the Service in accordance with this Agreement for all current Service Users at the date of service of the notice of termination until the actual date of termination;

11.1.2 the Partners shall remain liable to operate the Pooled Fund in accordance with this Agreement so far as is necessary to ensure fulfilment of the obligations in Clause 11.1.1; and

11.1.3 the University Health Board shall remain liable to contribute that proportion of the cost of the Service which either is its proportionate contribution in the current Financial Year or, if such contribution has not at the date of notice of termination yet been confirmed under Clause 9.1 or Clause 9.2, the University Health Board's contribution in the immediately preceding Financial Year represented as a proportion of the aggregate contributions of the University Health Board, and the Council in that preceding Financial Year;

such liabilities to continue for so long as the Service Users shall require the Service. or the obligations to third parties under contracts remain to be fulfilled and to include any additional costs attributed to termination which shall be borne in the same proportion as the Partners respective financial contributions herein.

11.2 Subject to the foregoing commitments of the Partners, following termination of this Agreement, the Council shall return to the University Health Board within three (3) months any of the Council's contribution to the Pooled Fund which has not been spent on the provision of the Service or any part thereof.

11.3 Assets purchased from the Pooled Fund will be disposed of by the Council for the purposes of meeting any of the costs of winding up the Service or where this is not practicable such goods will be shared proportionately between the Partners according to the level of past contributions to the Pooled Fund. Any shortfall in the costs of winding up the service shall be attributed proportionately to the partners.

11.4 In the event that this Agreement is terminated in whole or in part (howsoever terminated) the Partners agree to co-operate to ensure an orderly wind down of their joint activities as set out in this Agreement so as to minimise disruption to all Service Users.

## 12. VARIATION

12.1 No variation to this Agreement shall be effective unless it is in writing and signed by both the Partners or has been unanimously approved by the Joint Management Board.

## 13. CONFIDENTIALITY

13.1 The Partners shall:-

13.1.1 keep confidential any information obtained in connection with this Agreement and personal Service User data subject to the Data Protection Act 2018; the Freedom of Information Act 2000: or as directed by law or Court Order.

13.1.2 take appropriate technical and organisational measures against unauthorised or unlawful processing of such personal data and against accidental loss or destruction of or damage to such personal data.

13.2 The University Health Board and the Council shall keep confidential any information acquired through their conduct of this Agreement and will take all reasonable steps to ensure that their employees do not divulge such information to a third party, without the express consent of both Partners and the Service User, except in accordance with the requirements for external audit, as may be required by law or where such information is already in the public domain.

## 14. DISPUTE AND RESOLUTION

14.1 In the event of a dispute between the Partners over the application or interpretation of this Agreement, the dispute may be referred by the Partners in writing as follows:-

14.1.1 in the first instance to the Authorised Officers of the Health Social Care and Well Being Executive Group (as outlined in accountability in Schedule 5) to resolve; and

14.1.2 in the second instance to consider arbitration by an arbitrator to be appointed by the President for the time being of the Chartered Institute of Arbitrators if agreed by all partners . Any such reference shall be deemed to be a reference to arbitration within the provisions of the Arbitration Act 1996 or any statutory modification or re-enactment thereof for the time being in force and the allocation of the costs of any arbitration shall be borne by the Partners as determined by the arbitrator.

14.1.3 in default of agreement on how to resolve the dispute by the authorised officers or rejection of arbitration then the partners reserve the right to consider the commencement of court proceedings

## 15. EXCLUSION OF PARTNERSHIP AND AGENCY

15.1 The Partners expressly agree that nothing in this Agreement in any way creates a legal partnership between them.

15.2 Neither Partner nor any of its employees or agents will in any circumstances hold itself out to be the servant or agent of the other Partner, except where expressly permitted by this Agreement.

## 16. ASSIGNMENT AND SUB AGREEMENTS

16.1 The Partners shall not assign or transfer the whole or any part of this Agreement, without the prior written consent of the other partners expect where expressly permitted by agreement.

16.2 Either party shall be entitled to assign novate or otherwise transfer its rights and obligations pursuant to this Agreement to a statutory successor. This Agreement shall be binding on and shall ensure to the benefit of the University Health Board and the Council and their respective successors and permitted transferees and assignees.

## 17. THE CONTRACTS (RIGHTS OF THIRD PARTIES) ACT 1999

17.1 The Contracts (Rights of Third Parties) Act 1999 has no application whatsoever to this Agreement.

17.2 No variation to this Agreement and no supplemental or ancillary agreement to this Agreement shall create any such rights unless expressly so stated in any such agreement by the parties to this Agreement. This does not affect any right or remedy of a third party, which exists or is available apart from that Act.

## 18. PREVENTION OF CORRUPTION / QUALITY CONTROL

18.1 The Partners shall have mutual policies and procedures to ensure that relevant controls assurance, probity and professional standards are met.

## 19. COMPLAINTS

19.1 Complaints regarding the Service shall in the first instance be directed to the Council or the relevant Partner and if not resolved will be managed according to the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 or the Council's Complaints Procedure as appropriate and this will include information to all Service Users and their Carers or established representatives on how to complain, which will be made known at the point of commencement of assessment and after referral to the Service for any potential service or support. For the avoidance of doubt, any complaint relating to the clinical judgement or conduct of individual officers shall be directed to the relevant employing organisation utilising that partners respective statutory complaints procedures.

19.2 The Council shall ensure that all services provided and arrangements for complaints are in accordance with its policy and that of the Council for Equal Opportunities and all or any policies and procedures approved by the University Health Board as available through its web site under the Freedom of Information Act 2000.

19.3 Clinical governance would remain the responsibility of the University Health Board and for the avoidance of doubt the statutory responsibility of each partner will not change by the delegation of its functions or by anything in this Agreement.

## 20. NOTICES

20.1 All notices under this Agreement shall only be validly given if given in writing, addressed as follows:-

20.1.1 if to the University Health Board, addressed to its Chief Executive as above; or
20.1.2 if to the Council, addressed to its Chief Executive as above.

20.2 Any notices required to be given under this Agreement must be in writing and may be served by personal delivery, post (special or recorded delivery or first class post) or facsimile at the address set out at the beginning of this Agreement or at such other address as each party may give to the other for the purpose of service of notices under this Agreement. Notices shall be deemed to be served at the time when the notice is handed to or left at the address of the party to be served (in the case of personal delivery) or the day (not being a Saturday, Sunday or public holiday) next following the day of posting (in the case of notices served by post) or at 10 a.m. on the next day (not being a Saturday, Sunday or public holiday) following dispatch if sent by facsimile transmission.

20.3 To prove service of any notice, it shall be sufficient to show in the case of a notice delivered by hand that the same was duly addressed and delivered by hand and in the case of a notice served by post that the same was duly addressed prepaid and posted special or recorded delivery or by first class post. In the case of a notice given by facsimile transmission, it shall be sufficient to show that it was dispatched in a legible and complete form to the correct telephone number without any error message on the confirmation copy of the transmission.

## 21. NOTIFICATION TO WELSH GOVERNMENT

21.1 In accordance with the relevant guidance the Partners agree that they shall notify the Welsh Government of the exercise of the flexibilities in Section 33 of the Act and the Regulations in relation to the arrangements referred to therein.

21.2 The notification referred to at Clause 21.1 shall be in summary form of any Scheme Schedules in the manner required by Welsh Government, subject to such amendments as may be agreed in writing between the Partners.

## 22. GENERAL PRINCIPLES

22.1 In relation to the Service, the Partners shall:

22.1.1 treat each other with respect and an equality of esteem;
22.1.2 be open with information about the performance and financial status of each;
22.1.3 provide early information and notice about relevant problems; and
22.1.4 co-operate with each other to agree joint protocols and any variance in such protocols as may be required from time to time.

## 23. FORCE MAJEURE

23.1 In this Agreement "force majeure" shall mean any cause preventing either party from performing any or all of its obligations which arises from or is attributable to acts events omissions or accidents beyond the reasonable control of the party so prevented including without limitation act of God war riot civil commotion malicious damage compliance with any law or governmental order rule regulation or direction accident breakdown of plant or machinery fire flood storm or default of suppliers or sub-contractors.

23.2 If either party is prevented or delayed in the performance of any of its obligations under this Agreement by force majeure, that party shall forthwith serve notice in writing on the other party specifying the nature and extent of the circumstances giving rise to force majeure and shall, subject to service of such notice (and to Clause 23), have no liability in respect of the performance of such of its obligations as are prevented by the force majeure events during the continuation of such events.

23.3 The party affected by force majeure shall use all reasonable endeavors to bring the force majeure event to a close or to find a solution by which the Agreement may be performed, despite the continuance of the force majeure event.

23.4 If either party is prevented from performance of its obligations for a continuous period in excess of three months the other party may terminate this Agreement forthwith by written notice, in which case neither party shall have any liability to the other except that rights and liabilities which accrued prior to such termination shall continue to subsist.

## 24. SEVERABILITY

24.1 If at any time any part of this Agreement (including any one or more of the clauses of this Agreement or any sub-clause or paragraph or any part of one or more of these clauses) is held to be or becomes void or otherwise unenforceable for any reason under any applicable law, the same shall be deemed omitted from this Agreement and the validity and/or enforceability of the remaining provisions of this Agreement shall not in any way be affected or impaired as a result of that omission.

## 25. WAIVER

25.1 The rights and remedies of either party in respect of this Agreement shall not be diminished, waived or extinguished by the granting of any indulgence, forbearance or extension of time granted by such party to the other nor by failure of, or delay by the said party in ascertaining or exercising of any such rights or remedies. The waiver by either party of any breach of this Agreement shall not prevent the subsequent enforcement of any subsequent breach of that provision and shall not be deemed to be a waiver of any subsequent breach of that or any other provision.

## 26. INFORMATION SHARING

26.1 **Data Protection**

26.1.1 The Partners will act as joint data controllers in relation to the information processed as part of this Agreement.

26.1.2 The Partners shall comply with the provisions and obligations imposed on them by the Data Protection Laws at all times when processing Personal Data in connection with this Agreement. Details of the processing, including categories of Data Subjects, nature and purposes, and duration/retention periods, shall be set out in a document to be agreed by the Partners.

26.1.3 Each Partner shall maintain records of all processing operations under its responsibility that contain at least the minimum information required by the Data Protection Laws, and shall make such information available to any DP Regulator on request.

26.1.4 To the extent any Partner processes any Personal Data on behalf of another Partner the processing Partner shall:

(i) Process such Personal Data only in accordance with the other Partner's written instructions from time to time and only for the duration of this Agreement.

(ii) Not process such Personal Data for any purpose other than those set out in this Agreement or otherwise expressly authorised by the other Partner.

(iii) Take reasonable steps to ensure the reliability of all its personnel who have access to such Personal Data, limit such access to its personnel who require access, and remove, when no longer required, such access to the Personal Data, and ensure that any such personnel are committed to binding obligations of confidentiality when processing such Personal Data.

(iv) Implement and maintain technical and organisational measures and procedures to ensure an appropriate level of security for such Personal Data, including protecting such Personal Data against the risks of accidental, unlawful or unauthorised destruction, loss, alteration, disclosure, dissemination or access.

(v) Not transfer such Personal Data outside the European Economic Area without the prior written consent of the other party.

(vi) Inform the other Partner within twenty four (24) hours if any such Personal Data is (while within the processing Partner's possession or control) subject to a personal data breach (as defined in Article 4 of GDPR) or within such other time period as required under other Data Protection Laws, or is lost or destroyed or becomes damaged, corrupted or unusable.

(vii) Only appoint a third party to process such Personal Data with the prior written consent of the other Partner.

(viii) Not use or disclose any Personal Data to any Data Subject or to a third party other than at the written request of the other Partner or as expressly provided for in this Agreement.

(ix) Return or irretrievably delete all Personal Data on termination or expiry of this Agreement and not make any further use of such Personal Data.

(x) Provide to the other Partner and any DP Regulator all information and assistance necessary or desirable to demonstrate or ensure compliance with the obligations in this clause and the Data Protection Laws.

(xi) Permit the other Partner or its representatives to access any relevant premises, personnel or records of the processing Partner on reasonable notice to audit and otherwise verify compliance with this clause.

(xii) Take such steps as are reasonably required to assist the other Partner in ensuring compliance with its obligations under Articles 30 to 36 (inclusive) of GDPR and other applicable Data Protection Laws.

(xiii) Notify the other Partner within two (2) Business Days if it receives a request from a Data Subject to exercise its rights under the Data Protection Laws in relation to that person's Personal Data; and

(xiv) Provide the other Partner with its full co-operation and assistance in relation to any request made by a Data Subject to exercise its rights under the Data Protection Laws in relation to that person's Personal Data.

26.1.5 If any Partner receives any complaint, notice or communication which relates directly or indirectly to the processing of Personal Data by another or to another Partner's compliance with the Data Protection Laws, it shall as soon as reasonably practicable notify the other Partner and it shall provide the other Partner with reasonable co-operation and assistance in relation to any such complaint, notice or communication.

26.1.6 If a Partner requires another Partner to make any disclosures or provide any information in respect of this Agreement in order to enable that party to meet its obligations under the Data Protection Laws the other Partner shall do so.

26.1.7 The provisions of this clause shall apply during the continuance of this Agreement and indefinitely after its expiry or termination.

**26.2 Freedom of Information**

26.2.1 Each Partner acknowledges that it and the other Partner is subject to the requirements of FOI Legislation and therefore recognises that information relating to this Agreement may be the subject of an Information Request.

26.2.2 Where a Partner receives a request for information under either the FOI Legislation in relation to information which it is holding on behalf of the other Partner in relation to this Agreement, it shall inform the Joint Management Board and the othwr Partner of the request and its response.

26.2.3 The Joint Management Board shall be required to assist the either of the Partners in responding to a request for information to the extent that it relates to this Agreement. This shall include co-ordinating the response when requested to do so by either Partner.

26.2.4 Either Partner which receives a request for information under FOI Legislation shall be responsible for determining in their absolute discretion whether any information requested under FOI Legislation:

(i) Is exempt from disclosure under FOI Legislation; and
(ii) Is to be disclosed in response to an Information Request.

26.2.5 Each Partner acknowledges that any of the Partners may be obliged under FOI Legislation to disclose information:

(i) Without consulting the other Partners where it has not been practicable to achieve such consultation; or
(ii) Following consultation with the other Partners and having taken their views into account.

## 27. GOVERNING LAW

27.1 This Agreement shall be governed by and construed in all respects in accordance with the laws of England and Wales, as they apply in Wales.

**IN WITNESS** whereof the Partners have executed this Agreement as a Deed the day and year first before written.

**THE COUNCIL**

Authorised Signatory

**The Common Seal of HYWEL DDA UNIVERSITY LOCAL HEALTH BOARD was affixed in this Deed in the presence of:**

Authorised Signatory

## SCHEDULE 1

## AIMS AND OBJECTIVES

### 1. Introduction: Description and Purpose of Agreement

This Agreement is in relation to the provision of a service for the issue and retrieval of aids and equipment from the Premises.

1.1 The primary aims of this agreement are:-

- To ensure the most cost-effective use of the combined resources of the Partners to address the NHS Health Care and the Health and Social Care Related equipment needs of community dwelling adults and children in the University Health Board's and the Council's respective administrative areas in an integrated way; and
- To secure through a Pooled Fund adequate arrangements for the commissioning of equipment services for community dwelling adults and children.

1.2 The primary objectives of this Agreement are:-

- To enable service users to get appropriate, clean and suitably maintained equipment within agreed timescales.
- To enable Service Users to make informed choices by accessing impartial advice on their equipment needs, through self assessment programmes, information, demonstration and trial facilities.
- To provide a single point of reference for staff to ensure that equipment prescribed can be sourced quickly and professional clinical time is used effectively.
- To reduce waste and negative environmental impact by efficient use of existing stock and by increasing recycling rates of equipment.
- Unit cost reduction through improved procurement.

1.3 The intended outcomes of the Partners in entering into this Agreement are:

- To provide an equitable, expanded and modernised service which will take full advantage of the latest advances in technology and allow more people to benefit from it.
- Keep people safer and more independent, reducing the risk of hospital admissions and falls
- Facilitate the transfer of care from hospital back to the community
- Support intermediate care and reablement programmes
- Support long term condition management.

1.4 Review of aims and objectives

A strategic and financial review of these objectives will be co-ordinated by the Joint Management Board from time to time during the Term as agreed between the Partners in accordance with the procedures for review of the Agreement annually.

## SCHEDULE 2

## THE UNIVERSITY HEALTH BOARD'S HEALTH RELATED CARE FUNCTIONS

The University Health Board's Health Related Care Functions means those health related care functions referred to in Regulation 5 of the Regulations and which are exercised by the University Health Board in the assessment for and management of the provision of the Service and in relation to the Pooled Fund. This is subject to any exclusions or additions contained in the Regulations or agreed between the Partners in writing from time to time.

The University Health Board's NHS Health Care Functions of providing, or making arrangements for the provision of, Services:-

(a) under the National Health Services (Wales) Act 2006 as defined by the Local Health Boards (Directed Functions) (Wales) Regulations 2009; and

(b) the Functions under the Mental Health Act 1983; and .

(c) the Functions under the Social Services and Well-being (Wales) Act 2014 and the Partnership Regulations made hereunder.

## THE COUNCIL'S HEALTH RELATED CARE FUNCTIONS

The Council's Health Related Care Functions means those health related care functions referred to in Regulation 6 of the Regulations and which are exercised by the Council in relation to the assessment for and management of the provision of the Service and in relation to the Pooled Fund. This is subject to any exclusions or additions contained in the Regulations or agreed between the Partners in writing from time to time.

The Council's Health Related Functions are:-

(a) the Functions specified in Schedule 1 to the Local Authorities Social Services Act 1970 except for the Functions under:-

  (i) sections 22, 23(3), 26(2) to (4), 43, 45 and 49 of the National Assistance Act 1948;

  (ii) sections 6 and 7B of the Local Authorities Social Services Act 1970;

  (iii) sections 1 and 2 of the Adoption Act 1976;

  (iv) sections 114 and 115 of the Mental Health Act 1983;

  (v) The Registered Homes Act 1984; and

  (vi) Parts VII to X and section 86 of the Children Act 1989; and

(b) the Functions under sections 5, 7, or 8 of the Disabled Persons (Services and Consultation and Representation) Act 1986 except in so far as they assign Functions to a Local Authority in its capacity of a Local Education Authority.

## SCHEDULE 3

## SERVICE DESCRIPTION

### 1. Introduction

The Service will be delivered in accordance with a jointly agreed Service Specification, which provides explicit detail of operational management for the service. Summarised below is the scope of the service, benefits and eligibility criteria.

### 2. Scope of Service

- Service Users shall have access to a Service which displays equipment and gives information and advice in a state of the art demonstration facility;
- Equipment is made available where and when Service Users need it including at the point of leaving hospital and/ or in their own home;
- Equipment is fitted as soon as reasonably practicable and any minor adaptations required may be undertaken;
- Priority and emergency needs for equipment are responded to quickly;
- Maintenance and repairs of equipment can be more easily arranged;
- Easy to follow instructions are provided to Service Users with all equipment;
- It is clear to Service Users whom to contact for return or repair of equipment

### 3. Service benefits:

- It will build upon the current joint equipment service to provide a seamless service across Health and Social Care and will set a benchmark for what can be achieved through integration of resources and finance.
- It will provide the potential for a seven day service.
- It will have a Joint Management Board to oversee the Operational Services.
- It will have a single operational manager who will be accountable on a day to day basis for the running of the Service.
- By integrating budgets, costs for ordering, storing, maintenance and delivery can be reduced with further cost savings being achieved by creating a robust recycling facility within the Service.
- It will give Service Users a single point of contact and a facility to see for themselves the range of Community Equipment available.
- Creating a 'core stock' of Community Equipment will ensure quick access to equipment needed at short notice, thereby facilitating more efficient hospital discharge.
- Having a stock of Community Equipment for 'Continuing Care' will ensure quick access to items for those Service Users with more complex health needs.
- The Service will have an up-to-date state of the art cleaning and sterilising unit to ensure all Community Equipment issued and re-issued meet current health and safety standards and decontamination requirements.

### 4. Eligibility

Eligible individuals for Council Services

- Are assessed as requiring Community Equipment in accordance with the eligibility criteria and guidance issued by the Welsh Government and locally agreed criteria, who are ordinarily resident within the County of Ceredigion.

Eligible individuals for Health Services,

- Are assessed as requiring Community Equipment essential for safe hospital discharge or to support nursing and/or independent living in the community; and are registered with a general practitioner associated with the University Health Board or who are not registered with a general practitioner associated with the University Health Board but for whom the University Health Board are statutorily obliged to provide such services.

### 5. Location

The Service will be located, at the Premises.

## SCHEDULE 4

## RESOURCES

**Introduction**
This Schedule provides details of the budgets, goods and services to be made available by the Partners and also outlines the principles governing budget setting and accounting for the use of resources.

**Financial Arrangements for the Operation of the Agreement**
The Joint Management Board will agree by 28th February each year financial procedures and arrangements for the operation of this agreement for the following financial year (1st April to following 31st March). This will act as a Revised Annual Finance Agreement, which sets out the budget. This is in accordance with clause 9.3 of the Agreement.

The proposed budget for the following financial year will be presented to and agreed by the Joint Management Board no later than 28th February. The budget as agreed by the Joint Management Board will take into account effects on other budgets and other financial flows of the Partners.

All activities by each of the partners will be reported on a quarterly basis to the Partnership Board. This Partnership Board meeting will be attended by each of the representatives of each Partner or their nominated representative who will have full delegated authority. Partner activity recorded between January and December in each preceding financial year for the following financial year to operate will be presented to the Joint Management Board no later than 31st January and the partner contributions for the following financial year to operate will be agreed by the Joint Management Board no later than 28th February

**Sources of Funding**
The funding comes from the following main sources:-

- University Health Board contributions
- Council contributions

**Budget Breakdown**
The detailed budget is attached Appendix 1.

**Financial Planning and Budget Setting Process**
The Partners will prepare planning assumptions of inflation allowances for pay and non-pay expenditure and income, together with proposed budget variations in respect of :-

- growth and demographic change;
- service enhancements or reductions;
- required efficiency / quality improvements;
- cost pressure funding; and
- national initiatives.

These will be considered in the context of the overall budgets of the University Health Board, or the overall Council budget, as applicable, and shall be presented to the Joint Management Board no later than 28th February for the following financial year's budget.

**Pooled Fund**
The Pooled Fund Manager shall ensure that any matters relating to the Pooled Fund, that might have a material effect on expenditure or income are identified and reported to the Joint Management Board no later than 1st October for the following financial year's budget as specified in Clause 9.1

These matters, together with the planning assumptions and proposed budget variations referred to above, are to be considered by the Joint Management Board in its approval by 28th February of the budget for the following financial year.

As part of the annual budget setting process, the Partners shall ensure that their managers provide advice as necessary.

**Financial Performance / Risk Sharing Arrangements**

The Council is the lead provider for the operation of this Agreement and will appoint a Pooled Fund Manager with responsibility for the integrated management of the Pooled Fund, subject to the governance arrangements set out in Schedule 5 to this Agreement.

The Pooled Fund is comprised of contributions from both Partners and forms a single fund.

The Pooled Fund is to be used solely to achieve the aims, objectives and functions set out in Schedules 1 and 2.

The Pooled Fund Manager shall provide quarterly reports to be reviewed at least biannually to the Joint Management Board on the information specified in the Appendix to Schedule 5. Information is to be reported separately in respect of the Pooled Fund. The Partners agree to provide all necessary information to the Pooled Fund Manager in time for the reporting requirements to be met.

The Pooled Fund Manager shall ensure that action is taken to manage any projected under or overspends from the budgets relating to the Pooled Fund reporting on the variances and the actions taken or proposed to the Joint Management Board.

If at any time during the financial year there is forecast a material projected under or overspend on the Pooled Fund, the Pooled Fund Manager will prepare an action plan to manage the material under or overspend, for presentation to the Joint Management Board within one month. The Joint Management Board will consider the action plan, amend if appropriate and agree the actions to be taken.

The Pooled Fund Manager will provide monthly progress reports to the Joint Management Board on implementation of the action plan, until such time that the material under or overspend has been dealt with to the satisfaction of the Joint Management Board.

In the event of there being no agreement between the Partners then the dispute resolution provisions of the Agreement will apply.

**Contributions**

The budget amounts to be contributed by the Partners to the Pooled Fund shall be in accordance with the revenue budget specified in Appendix 1 and partner activity recorded between January and December in each preceding financial year for the following financial year to operate, subject to review annually as outlined in Clause 9.3.

**Non- financial Resources Available outside the Pooled Fund**

The Partners shall ensure access to the following resources outside the Pooled Fund as necessary for the purposes of this agreement:-

- Contracts and procurement functions
- Operations functions
- IT functions
- Finance functions
- Property functions

Where the use of any such resources by any of the partners become greater than 2% of the total pooled fund then any partner is permitted to refer the use of that resource to the Joint Management Board to consider whether the use of such resources be paid for out of the pooled fund.

**The Equipment Store Premises**

In the event of termination of this agreement, for the avoidance of doubt, all the assets of the service, after the costs of winding up the service, but excluding the Premises, and including community equipment will be distributed in proportion to the Partner's contributions.

**IT System**

The capital cost of the IT system was provided by a one-off capital allocation from the Social Services Performance Management Development Fund from the Social Services Division within Welsh Government with on-going maintenance costs being met under this Agreement.

**Community Equipment**

All Equipment currently retained by all of the partners for use within the Community at the commencement of this agreement will be pooled. For the purpose of attributing value the equipment will be costed at new purchase price.

Reporting information will be provided as per Schedule 5 Appendix 1.

The Service Manager shall produce and keep updated an Equipment catalogue which will list the standard items held by the service and their purchase price.

**Appendix 1**

**Integrated Community Equipment Service Budget 2019/20**

| | Full Year Budget 2019/20 £ |
|---|---|
| **Total Employees** | **179,000** |
| | |
| **Total Premises** | **30,000** |
| | |
| **Total Transport** | **18,000** |
| **EQUIPMENT** | 205,400 |
| **Other Supplies & Services** | 23,600 |
| **Total Supplies & Services** | **229,000** |
| | |
| **Total Expenditure** | **456,000** |
| University Health Board | 333,000 |
| Council | 123,000 |
| **Total Income** | **456,000** |
| | |
| **Net Expenditure** | **0** |

**University Health Board Contribution per calendar month - £27,750**

**Council contribution per calendar month - £10,250**

## SCHEDULE 5

## JOINT MANAGEMENT BOARD AND GOVERNANCE

Overall accountability for this service and its development lies with the Health Social Care and Well Being Executive Group. The Group has senior representation from both Partners at Director Level. This will ensure ongoing strategic direction and accountability for the delivery of the terms of this Agreement. The Group will provide a means of resolution should any disputes occur.

The Joint Management Board has been established at the commencement of the Agreement and will be accountable to the Health Social Care and Well Being Executive Group (Illustrated in Figure 1 below).

### Joint Management Board Membership

The accountability and membership of the Joint Management Board will be as follows (as detailed in Figure 1 below:-

- the Council's , Head of Adult Social Care & Commissioning who will also provide the Secretariat function to the Joint Management Board or a deputy;
- the University Health Board's General Manager - Community & Primary Care (Ceredigion) or a deputy;
- the University Health Board's Community & Primary Care Nurse Manager (Ceredigion) or a deputy;
- the Pooled Fund Manager, or an Accountant who will act as the deputy ; and
- the University Health Board's finance representative.

### Role of Joint Management Board

The Joint Management Board shall:-

- receive the necessary information as set out in this Schedule;
- review jointly the operation of this Agreement and consider its renewal;
- review and agree annually the risk sharing arrangements.
- review and agree annually the Revised Annual Finance Agreement as at Schedule 4;
- set such protocols and guidance as it may consider to be necessary to enable the Pooled Fund Manager to approve expenditure from the Pooled Fund;
- consider progress on the Aims and Objectives at Schedule 1 and consult further where necessary; and
- provide an annual report on outcomes for information to the HSCWB Executive Group.

### Joint Management Board Support

The Joint Management Board will be supported by officers from the Council and the University Health Board from time to time and they may be involved in assisting the Joint Management Board in implementation of the Aims and Objectives set out in Schedule 1.

**Meetings**

The Joint Management Board will meet at least biannually, at a time to be agreed by the parties.

The quorum for meetings of the Joint Management Board shall be a minimum of two (2) members, one from each party, not counting the Pooled Fund Manager or their deputy.

Decisions of the Joint Management Board shall be made unanimously by those present. In instances where there is a dispute that cannot be resolved, the matter will be referred to the Health Social Care and Well Being Executive Group in accordance with the dispute resolution process (Clause 14)

Minutes of all decisions shall be kept and copied to the Authorised Officers within seven (7) days of every meeting.

**Delegated Authority**

The Joint Management Board is authorised within the limits of delegated authority for its members (which is received through their respective organisation's own financial scheme of delegation) to:-

- confirm and agree pursuant to Clause 9 the respective contributions of the Partners for the budget and the Revised Annual Finance Agreement;

- to identify commitments which exceed or are reasonably likely to lead to exceeding the contributions of the Partners to the aggregate contributions of the Partners to the Pooled Fund, confirmed or agreed pursuant to Clause 9.

**Pooled Fund Manager**

The Pooled Fund Manager will be the Council's Head of Finance and shall be accountable directly to the Joint Management Board (or in any other case) the Council's Chief Executive.

The Pooled Fund Manager may delegate the day-to-day management of the pooled fund in accordance with the Council's Standing Financial Instructions to a Finance Group Manager.

**Information and Reports**

The Pooled Fund Manager shall supply to the Joint Management Board on a quarterly basis the financial and activity information as referred to at Schedule 4 and as set out at Appendix 1 to this Schedule 5 except when there is forecast a material projected under or overspend on the Pooled fund. In these exceptional circumstances the Pooled fund Manager will prepare an action plan to manage the material under or overspend and once agreed by the Joint Management Board will provide monthly progress reports to the joint management Board on the implementation of the action plan.

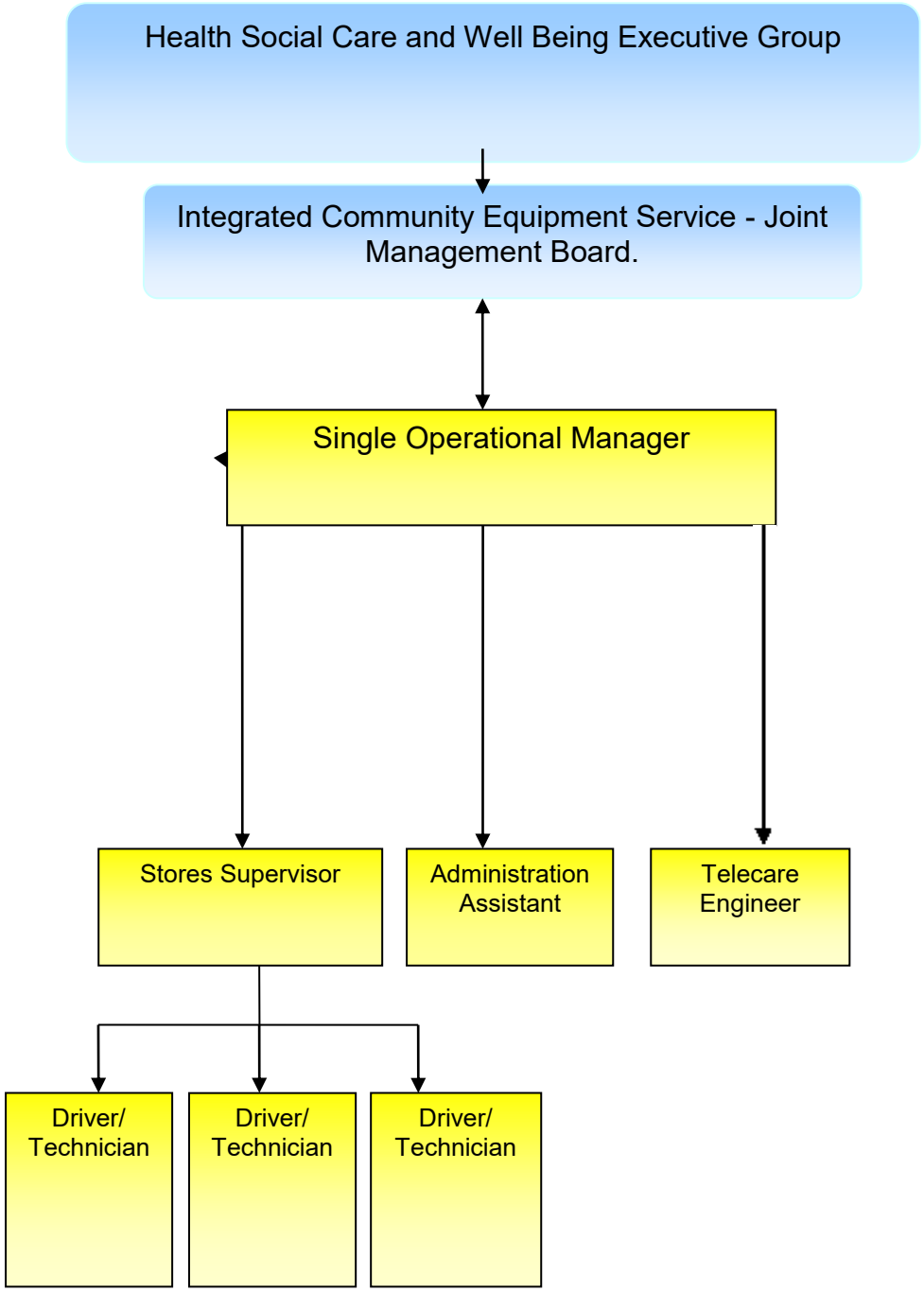
Activity reports will be prepared by the Operations Manager and distributed to Joint Management Board Members on a monthly basis

The Pooled Fund Manager will refine any remaining Aims and Objectives set out in Schedule 1 into targets for the Service and performance measures to be agreed by the Joint Management Board from time to time.

**Post-termination**

The Joint Management Board shall continue to operate in accordance with this Schedule following any termination of this Agreement under Clause 10 but shall endeavour to ensure that the benefits are received by the Partners in the same proportions as their respective contributions at that time.

**Figure 1 – Organisational Structure and Accountability**



**Appendix 1**

**FINANCIAL AND ACTIVITY REPORTING - Quarterly REPORT**

The Joint Management Board shall receive a quarterly Financial report and monthly Activity Report. These reports shall be prepared by the Pooled Fund Manager and the Operations Manager.

The report shall include any matters referred to the Joint Management Board and shall cover:-

**1. Finance**

Schedule 4 outlines the nature and detail of the financial contributions of the Partners.

**2. Service and Delivery Reporting**

Activity data and equipment supplied by Partners;

**3. External Performance Data**

Annual Information on specific national performance indicators as defined by Welsh Government.

**The information outlined at Paragraphs 1, 2 and 3 above shall be in the form and frequency as set out in the Summary Table below of Reporting to the Joint Management Board**

| | PERFORMANCE AREA | Key deliverables | FREQUENCY |
|---|---|---|---|
| **1.** | **FINANCE** | Monthly income and expenditure by service and total with comparisons to budget and a commentary on significant variances. | Quarterly |
| **2.** | **COMMISSIONING & SERVICE IMPROVEMENT** | Monthly activity reports distributed to Joint Management Board members on a monthly basis. | Monthly |
| **3.** | **External Performance Data - WG** | IT system generated reports that comply with the WG performance indicators for ICES. | Annually |

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

**CYFARFOD BWRDD PRIFYSGOL IECHYD UNIVERSITY HEALTH BOARD MEETING**

| | |
|---|---|
| **DYDDIAD Y CYFARFOD: DATE OF MEETING:** | 30 May 2019 |
| **TEITL YR ADRODDIAD: TITLE OF REPORT:** | A Healthier Carmarthenshire: Transforming Lives Through Technology |
| **CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:** | Joe Teape, Deputy Chief Executive/Director of Operations |
| **SWYDDOG ADRODD: REPORTING OFFICER:** | Rhian Dawson, County Director and Commissioner (Carmarthenshire) |

| **Pwrpas yr Adroddiad** (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate) |
|---|
| Ar Gyfer Trafodaeth/For Discussion |

**ADRODDIAD SCAA**
**SBAR REPORT**

## Sefyllfa / Situation

This report provides an update on how Carmarthenshire is responding to the transformation proposal outlined in ***A Healthier West Wales*** and provides a comprehensive background on service developments related to the action priority ***Transforming Lives through Technology***.

It summarises how services in Carmarthenshire are responding to delivering innovative models of care and service structure in line with the ambitions of ***A Healthier Wales*** as well as good practice in Technology Enabled Care (TEC). It updates on the Cross Hands Wellbeing Centre which will not only provide an environment for delivering integrated primary care and community services but links to a digital infrastructure to support service integration across acute, community, primary and social care, as well as capacity to host TEC programmes.

In this report, we focus on practical application of TEC and use “Teulu Jones” as an example of how this transformation programme will deliver high value person centred care and support services across the county.

## Cefndir / Background

The region’s response to the £100million transformation fund announced in ***A Healthier Wales*** has resulted in the successful allocation of £12 million. The transformation proposal outlined 4 action priorities and the approved programmes of work are in the following areas:

1) Transforming lives through technology (7.45 million)

3) Strengthening our integrated localities (3.2 million)

7) Connecting people ….. kind communities (1.8 million)


The transformation proposal, in conjunction with the Health Board's 'Transforming Clinical Services' agenda and 'A Healthier Mid and West Wales: Our Future Generations Living Well', all express an ambition of collective determination to improve the wellbeing of our citizens and find innovative ways to continue to deliver the best care in the most effective and efficient way.

The first programme *Transforming Lives through Technology* has been identified as a Welsh government flagship NTEC programme.

The transformation proposal is based on an innovative model of care and support in Spain which has the most widespread implementation of Technology Enabled Care (TEC) in the world, not only as a fundamental component of their care model, but also as a mechanism to deliver an integrated system of prevention and early intervention. Fundamentally, the model offers a bespoke support package which includes the following elements at different levels of intensity:

- Technology and equipment
- Proactive calls
- Specialist interventions
- 24/7 first response service

This programme of work will be integrated with digital and TEC innovation across the county to ensure alignment with strategic objectives and available funding. .

## Asesiad / Assessment

It is clear that improvements in health and care technology present opportunities for improve efficiency and outcomes. Whilst there is coherent and wide scale provision of technology enabled care (TEC) in the region, it is largely provided through a traditional model of reactive care. There are various telehealth initiatives in the region, some award-winning, such as the Virtual Pulmonary Rehabilitation (VIPAR) which links patients to professionals from their own homes where they receive advice on self-managing their long term health condition. However these are not integrated or linked to telecare; evidence shows that a whole system approach will deliver maximum benefits.

Indicators from the Department of Health's whole system demonstrator programme suggest that, if used correctly, TEC can reduce emergency admissions to hospitals by 15%, bed days by 14% and can demonstrate a 45% reduction in mortality rates.[1]

[1] tps://assets.publishing.service.gov.uk/government/.../system/...data/.../dh_131689.pdf

A number of local authorities have put more of their adult social care budgets into tele-assistance services as an invest-to-save model. After mainstreaming tele-assistance services in partnership with local NHS services, Hillingdon council saw savings of £4.7m over a year, care placements (residential and nursing) reduced from an average of almost nine per week to three-and-a-half, and a reduction in purchased homecare hours by 10%[2].

The aim of ***Transforming lives through technology*** is to:

- Test and evaluate a different model of proactive care and support as outlined in the region's transformation proposal A Healthier West Wales in order to deliver efficient, cost effective health and social care.
- Support Carmarthenshire to achieve the strategic aims of prevention, early intervention, innovation and use of TEC.
- Support the development of a sustainable health and social care economy.
- Address culture change of attitudes and expectation towards of care and support.
- Provide a systematic approach to long-term conditions management and anticipatory care planning.

**Argymhelliad / Recommendation**

The Board is asked to note and discuss any issues arising from the report.

| **Amcanion: (rhaid cwblhau)**<br>**Objectives: (must be completed)** | |
|---|---|
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:<br>Datix Risk Register Reference and Score: | 1, 3, 4, 5, 7, 11,12,13,16,17,19, 20, 23, 26, 28, 30 |
| Safon(au) Gofal ac Iechyd:<br>Health and Care Standard(s):<br>Hyperlink to NHS Wales Health & Care Standards | 1.1 Health Promotion, Protection and Improvement<br>2.3 Falls Prevention<br>1. Staying Healthy<br>6.1 Planning Care to Promote Independence |
| Amcanion Strategol y BIP:<br>UHB Strategic Objectives:<br>Hyperlink to HDdUHB Strategic Objectives | All Strategic Objectives are applicable<br>3. Growing older well<br>4. Improve the productivity and quality of our services using the principles of prudent health care and the opportunities to innovate and work with partners. |
| Amcanion Llesiant BIP:<br>UHB Well-being Objectives:<br>Hyperlink to HDdUHB Well-being Statement | Improve Population Health through prevention and early intervention<br>Support people to live active, happy and healthy lives<br>Improve efficiency and quality of services through collaboration with people, communities and partners<br>Develop a sustainable skilled workforce |

[2] https://www.theguardian.com/social-care-network/2012/nov/27/telecare-transforming-social-care

| Gwybodaeth Ychwanegol:<br>Further Information: | |
|---|---|
| Ar sail tystiolaeth:<br>Evidence Base: | Each programme is underpinned by specific evidence bases and can be found in more detail in full business case. |
| Rhestr Termau:<br>Glossary of Terms: | Included in document |
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol:<br>Parties / Committees consulted prior to University Health Board: | None |

| Effaith: (rhaid cwblhau)<br>Impact: (must be completed) | |
|---|---|
| **Ariannol / Gwerth am Arian:**<br>**Financial / Service:** | This is a multiagency / professional report and therefore each section has its own financial, quality, workforce, risk legal, reputation and equality registers. |
| **Ansawdd / Gofal Claf:**<br>**Quality / Patient Care:** | This is a multiagency / professional report and therefore each section has its own financial, quality, workforce, risk legal, reputation and equality registers. |
| **Gweithlu:**<br>**Workforce:** | This is a multiagency / professional report and therefore each section has its own financial, quality, workforce, risk legal, reputation and equality registers. |
| **Risg:**<br>**Risk:** | This is a multiagency / professional report and therefore each section has its own financial, quality, workforce, risk legal, reputation and equality registers. |
| **Cyfreithiol:**<br>**Legal:** | This is a multiagency / professional report and therefore each section has its own financial, quality, workforce, risk legal, reputation and equality registers. |
| **Enw Da:**<br>**Reputational:** | This is a multiagency / professional report and therefore each section has its own financial, quality, workforce, risk legal, reputation and equality registers. |
| **Gyfrinachedd:**<br>**Privacy:** | This is a multiagency / professional report and therefore each section has its own financial, quality, workforce, risk legal, reputation and equality registers. |
| **Cydraddoldeb:**<br>**Equality:** | This is a multiagency / professional report and therefore each section has its own financial, quality, workforce, risk legal, reputation and equality registers. |

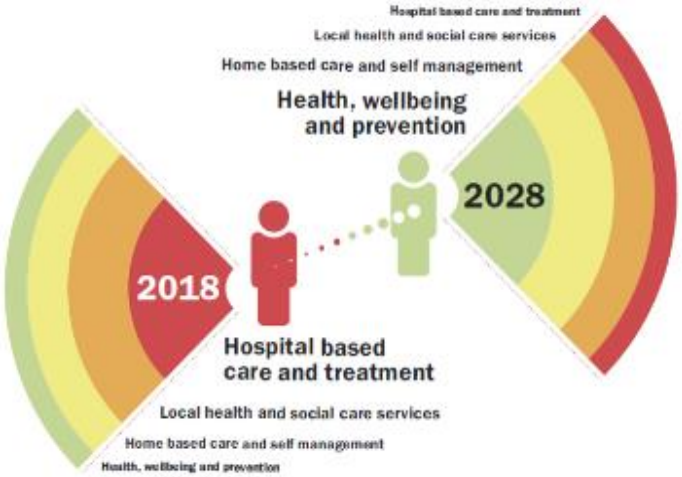
# A healthier Carmarthenshire

## Transforming lives through technology

### Delivering a healthier Mid and West Wales

# Context

The health board's recent strategy ***A Healthier Mid and West Wales*** *shows its* commitment to deliver the vision of ***A Healthier Wales*** and aims to revolutionise health and social care in the region. It outlines an integrated social model for health and well-being with greater emphasis on prevention; empowering individuals to manage their own health and wellbeing with care and support provided seamlessly at locality level.


Making this vision a reality can only be realised through strong, meaningful collaboration between health, local authorities, the third sector and wider stakeholders. This has been achieved by an integrated regional transformation proposal which has been successfully funded by Welsh Government through £12 million of investment in the region. The plan identifies 4 high impact areas for action which will deliver transformation of health and care services over the next 18 months.

# Transforming lives through technology

The first priority area has been awarded £7.5 million and supports the innovative use of technology, which is increasingly being seen as a vital component of meaningful transformation and sustainability of health and care provision.

Technology Enabled Care (TEC) is broadly defined as when 'outcomes for individuals are improved through technology as an integral part of quality, cost effective care and support'[1] and refers to all technologies that help people to prevent, manage chronic illness and sustain independence, such as telecare, telehealth, telemedicine/ teleconsultation and self care apps,

TEC aims to empower patients and citizens and support them to take greater control of their own health and care, working in partnership with health and care professionals, families, carers and the voluntary sector. Some TEC, such as telecare, is already well established within the social care and housing sectors.

> **We're at the start of a revolution of a system created after the war - it's incredibly expensive and not designed to cope with long term chronic diseases. There are huge opportunities through Technology Enabled Care to put patients right at the centre of care pathways.**[2]

For TEC to be most effective, it requires an integrated approach. The benefits of investment impact across health and care pathways and support service redesign. TEC can enable better continuity and coordination of care and improve the quality of life and ongoing independence. Joint care planning and sharing information across multidisciplinary teams is a key part of this. Involving the range of stakeholders across health and social care from the outset of the commissioning process will help achieve buy-in from staff, partners and citizens.

TEC is key to the Health Board's ambitions for transforming care and support . It makes a critical contribution to empowerment, self-management, independence and safety, It improves access to, and the efficiency of, information, advice, care and treatment services and should be considered a critical component of the Health Board's strategy to deliver high quality services, with a focus on prevention, early intervention and supported self-management.

1: TEC programme data review and evaluation: summary report https://www.gov.scot/publications/technology-enabled-care-programme-data-review-evaluation-options-study-summary/

2: https://www.theguardian.com/social-care-network/2012/nov/27/telecare-transforming-social-care

# TEC vision

## Starting and Developing Well

- Telecoaching to support healthy choices such as exercise, smoking cessation and dietary advice
- TEC support to creating connections and reducing loneliness
- Online community to support positive parenting
- Apps for self-mangement
- Text reminders
- Tele-consultation for all maternity, child and adolescent health services

## Living and Working Well

- Telehealth for mangement of long term conditions
- Online and teleconsultation for integrated information, advice and assistance
- Telecaoching and virtual support for mental health
- Online communty based carer support
- TEC for health screening and early intervention
- Digital support with employment, training and benefits
- Appointment and medication reminders

## Growing older well

- Virtual rehabilitation programmes
- Telecare to maintain independence
- Responsive falls and emergency pathway
- Online support for advanced care planning
- Online and virtual cognitive stimuation programmes and Reminiscence Interactive Therapy Activites (RITA)
- Virtual network to reduce loneliness and isolation
- Tele-medicine and skype consultations

# TEC in Carmarthenshire

- Carmarthenshire has an established and strong digital TEC monitoring platform
- Last year Carmarthenshire County Council (CCC) transformed traditional 'careline' services and established an innovative TEC company called Llesiant Delta Wellbeing
- Delta is a Local Authority Trading Company - 100% owned by CCC.
- Delta aims to become a centre of excellence for TEC and is already the largest digital monitoring platform in Wales.
- It is the TEC monitoring platform across the region as well as other authorities and associated services across Wales.
- Delta provides Carmarthenshire with a 24/7 single point of access for information, advice and assistance for adults (IAA).
- Wellbeing Officers based in Delta are trained and accredited to handle calls for both TEC emergencies and enquiries to the single point of access.
- During core hours, Delta has a multi-disciplinary team of occupational therapy, community nursing and social work which support effective and efficient access to IAA and provides an opportunity to enhance existing TEC usage and associated care pathways.
- Delta Wellbeing is committed to offering the most up to date technology through working with industry partners and groups to ensure a wide range of equipment enabling the development of bespoke solutions for individuals and organisations that an support and maintain wellbeing and independence for a wide range of needs.
- Carmarthenshire will build on the expertise and infrastructure of Delta to realise transformation in the county and deliver the ambitions expected through the transformation fund over the next two years.

LLESIANT DELTA WELLBEING

# TEC and teulu Jones

Everyone knows that smoking and being overweight is bad for you .. but it's so hard to change! My wife has a lot to worry about, her own health and the family so I don't want her worry about me as well. I saw an ad for Delta Wellbeing so I gave them a call. I spoke to Graham who was great. He told me about Dewis an online directory of all the things that were happening locally to help me with my health. I found a stop smoking support group and slimming club really near to me. He also called me a couple of weeks later to see how I was doing. I think I'm on the right road - I've got the diet club app on my phone and have an activity tracker to remind me to get moving. Best of all Graham gives me a call now an again to keep me motivated!

**Rhys** is 52 years old. He lives with his wife Sioned, he is a long distance lorry driver and is away from home a couple of nights a week. He smokes and is overweight due to a combination of diet and limited physical activity.

**Sioned** is 47 years old and is married to Rhys, she works part time as a healthcare suport worker but is also a carer to her parents and has been suffering with stress, anxiety and low mood.

Everything was getting on top of me recently .... Mum has dementia and is usually ok because Dad looks after her but he was admitted to hospital last month. Poor mum didn't cope without him, her confusion got even worse, she went missing looking for my Dad and I'm worried that she will leave the gas on. Rhys my husband had told me that he rang a Wellbeing Officer in Carmarthenshire County Council who gave him some really good information and advice so I thought I'd give it a go. 'Shereen' was great and gave me all the time I needed to talk and was really interested in 'what matters to me'. I told her I wanted to be able to go to work and not to have to worry about my parents. Now, my life is much less stressed; I have a Carers Emergency Card which is held by Delta Wellbeing so if there are any emergencies I know that they will contact me. Mum and Dad also had an assessment by a Technology Enabled Care officer and they have installed sensors in the house that will alert me and Dad to any gas fumes and also one on the front door. This means that Dad can go down the road for a pint with his friends and if the front door opens it will let him know. Mum also wears a special watch that is programmed to tell us if she goes anywhere outside of the usual local shop, the local school where she used to work or the community hall where she goes to Women's Institute. The watch will also tell us if Mum has a fall and also tells Delta so they can talk to her while she waits for us to arrive.

I normally go to the newsagent once a day to get the daily paper but I haven't been feeling up to it over the last couple of days. I know something is not quite right because for the last couple of years I have been monitoring my own condition. Every day I have to complete a questionnaire which asks me questions about my general health. I then have to take readings of my oxygen levels, my pulse and my temperature. I send these through to the chronic conditions nurses who review my results and let me know if I need to do anything. Yesterday my oxygen levels were low, my pulse and temperature were higher than they normally are so Helen the nurse called me and is dropping off some antibiotics for me to take. Some people might think that doing this every day is a pain but I would prefer to do this than wait for things to get worse and end up in hospital – Mari needs me at home!
Exercise is also good for my condition so as well as my daily walk I also attend a lung rehabilitation class in my local community hall. This is called 'VIPAR' and stands for VIrtual Pulmonary Rehabilitation. When Helen the nurse first told me about it I didn't know what to expect because the physiotherapist who leads the session is in Ceredigion! That's a long way from Llanelli! It's all done through something called video conferencing and basically a little bit like the exercise videos my daughter used to do in the living room years ago... but not as strenuous and I don't have to wear bright green leotard. The class is supported locally by two support workers with expertise in exercise physiology and rehabilitation prescription who help us with taking part and understanding what we need to do. Aside from the rehabilitation part I enjoy going because it's good to mix with people who have the same condition as me. We talk about how it's affecting us and share coping strategies – to be honest it feels like a social these days as we have become friends. They are doing much more with technology in health care these days. I can really see that technology will help the NHS support more people wherever they live in the future.

# Mari's story

Mari is married to Alun. She is 78 and is living with dementia. She is becoming increasing frail, Delta Wellbeing contacted Alun as Mari's TEC lifeline triggered a fall and they couldn't speak to Mari to see if she was OK. Delta called for an ambulance. Mari had broken her hip and whilst the operation to fix it went well when Mari woke up she was very confused and agitated. This can often to someone living with dementia as the drugs, strange environment and pain can increase confusion.

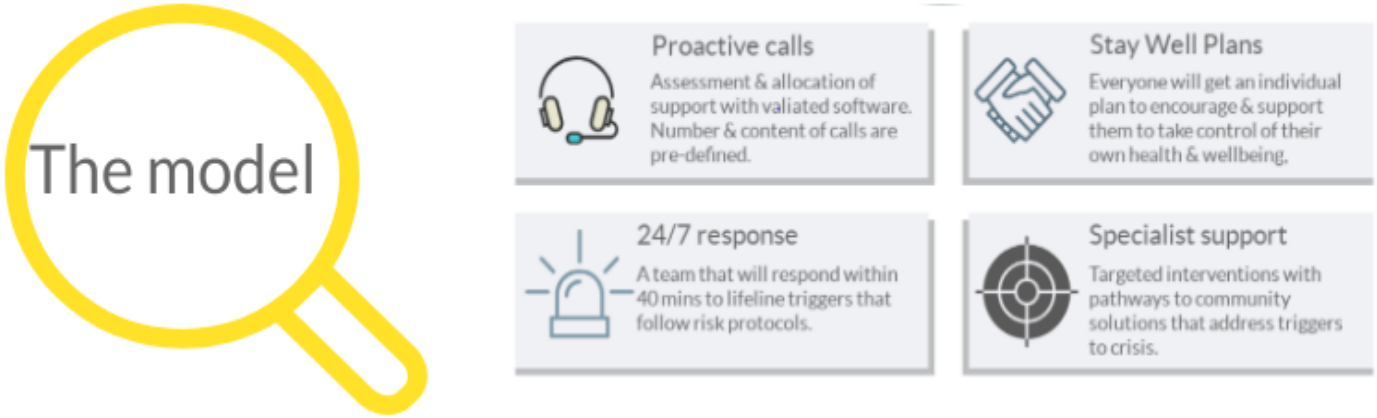
The ward gave Mari a RITA , which stands for Reminiscence Interactive Therapy Activities. The system is a new interactive touch screen system, which helps patients with dementia to have a more comfortable stay by prompting and providing access to past memories including music, games and even photos of family. The system can be used with individuals with varying levels of memory problems or confusion and including those who have lost the ability to verbalise. These systems have demonstrated that they can reduce the risk of falls in patients like Mari and can also help calm them down and the staff in both Glangwili Hospital and Prince Philip Hospital have said that they are making a difference. The staff have benefited also because RITA provides an opportunity for our staff to get to know the patients personality, likes and dislikes.

Mari has aTEC package at home which supported her to be discharged as quickly as possible and includes technology to restablish routine, maintain safety and independence and a similar RITA system.

**Alun** is 80 and married to Mari. He is a retired coal miner. Alun enjoys his daily walk to the local shop to get the newspaper but has recently been finding this difficult because his COPD is getting more troublesome.

# TEC transformation

The transformation programme funded by Welsh government aims to deliver change which is ambitious, innovative and reflects a long term ambition to embed prevention and early intervention across health and social care in West Wales through a TEC driven approach. It is based primarily on good practice delivered by Tunstall/ Televida in Spain. The project will adapt the model to make it work in the region to combine proactive integrated tele-monitoring, response and community based support. The programme is based on a model operating in Bilbao, Spain which has proven impact on the well-being of individuals and has reduced significantly the number of people needing longer term or acute care. We will adapt the Spanish model to ensure it meets differing needs across West Wales.




- ***TEC***: Bespoke and individualised equipment to support the service.
- ***Assessment***: an in-depth assessment through an academically validated tool which asks about individual likes and preferences which provides not only the basis for the management plan but a 'script' which will inform proactive calls. Alongside details of health, care and support needs, personal details will be captured and used to build understanding of individuals and rapport.
- ***Proactive call monitoring***: an individualised self-management plan will be implemented through a schedule of calls. In the winter people will be reminded about flu jabs or practical actions to reduce the risk associated with bad weather. Staff even call clients to wish them happy birthday! There will be prompts and reminders on identified trigger areas. If any concerns are picked up the call handlers will have a number of different ways in which to practically support individuals other than traditional statutory care routes.
- ***Well-being support***: there will be a team to work with individuals that will assess, co-design and review community based stay well plans . These plans will embrace the current community based provision as well as provide direct pathways to the specific interventions ; loneliness, falls and carer stress. The plans will be monitored through the proactive calls and if any issues are identified monitoring this team can be deployed to provide practical support.
- ***Rapid Response Units:*** when crisis occurs, a 24/7 mobile service will respond to calls within 60 minutes to facilitate community-based solutions, avoiding inappropriate hospital admission or other medical referral where possible.
- ***Community based support***: Enhanced community provision will address low level well-being needs, including strengthening and connecting impact of existing community provision.

# A digital centre in Crosshands

The development of a ***Cross Hands Health & Wellbeing Centre*** supports the ambitions of both the TEC agenda and ***A Healthier Mid and West Wales***. It will deliver a venue for integrated primary care and community services and support improved wellbeing through a 'whole systems' population health focus. It brings together a range of health and care services into one location to provide a sustainable model of care that best meet the needs of the local population through improved access and multidisciplinary working.

Key to the project is the development of a **digital infrastructure** to support service integration across acute, community, primary and social care . A key component of the proposed new build / service change is to ensure that community staff can deliver care closer to home. Historically the majority of Informatics investment has been focused on the acute sector and as a result community staff are poorly served by Informatics technologies. In addition the technical challenges of making our clinical applications work on a mobile platform and suitable mobile coverage has limited the functionality and practicality.

This proposal represents the realisation of digital transformation of community staff:

- Community staff will be issued technology from a list of standard equipment including smartphones, tablets and laptops to support agile working arrangements.
- Remote access to current Health Board systems over 3G/4G networks, public Wi-Fi and from home broadband.
- Mobile access to E-mail and Intranet resources.
- Access to Skype for Business for collaboration, instant messaging and voice and video conferencing. Potential adoption of Office 365 giving seamless online access to Microsoft Office productivity applications such as Word, Excel and PowerPoint as well as online file storage

IThe new Integrated Health and Wellbeing Centre will include a digital infrastructure to support further developments in telemedicine and video conferencing facilities The above will provide the platform for the forthcoming deployment of the National Welsh Community Care Information System which is an integrated system for health and social care and will be pivotal to enabling care to be provided closer to home and modernising community services.

The development of the business case to secure Welsh Government Primary Care Pipeline Funding is well underway with final approval anticipated in August 2020 with completion of construction expected in December 2021.

The project scope is wide and includes the relocation of two GP Practices and the provision of community health and social care services. The proposed facility will also provide a 'satellite' for the clinical skills unit, Swansea University School of Medicine which will be based in the Llanelli Wellness Village and will support clinical staffing sustainability in the locality. Wider IAA opportunities will include a community library, police hub and 'flexible space' for the community to host community group activities that meet population need. Commercial outlets eg Pharmacy and Opticians will also be considered.

| | |
|---|---|
| **Enw'r Pwyllgor / Name of Committee** | Finance Committee |
| **Cadeirydd y Pwyllgor/ Chair of Committee:** | Michael Hearty, Associate Member |
| **Cyfnod Adrodd/ Reporting Period:** | Meeting held on 25th March 2019 |

**Y Penderfyniadau a'r Materion a Ystyriodd y Pwyllgor / Key Decisions and Matters Considered by the Committee:**

The Finance Committee has been established to advise the Board on all aspects of finance and the revenue implications of investment decisions. Hywel Dda University Health Board's (HDdUHB's) Finance Committee's primary role is, as such, to provide assurance on financial performance and delivery against Health Board financial plans and objectives and, on financial control, giving early warning on potential performance issues and making recommendations for action to continuously improve the financial position of the organisation.

This report summarises the work of the Finance Committee at its meeting held on 25th March 2019, with the following highlighted:

- **Finance Report Month 11** – the Month 11 Finance Report was presented to Committee. The Committee was advised that the year to date variance to plan is currently £0.2m, and that continuing issues with the Aseptic Unit in Glangwili General Hospital represent an overall risk to the financial plan. However, the risk of delivery of the year end position has been reduced to 'medium'.

- **Financial Projections** – the Financial Projections report was presented to Committee. The Committee was advised that the year-end projected deficit is £35.5m after accounting for all quantifiable risks and opportunities, and that Finance Business Partners are working with Directorates to achieve their monthly controls. The Committee was informed that a key focus for next year would be medicines management together with arrangements for a new Aseptic Unit

- **Turnaround Report Month 11** – the Month 11 Turnaround Report was presented to Committee. The Committee was advised that quality and performance would be a key part of planning next year with the move towards community based healthcare being key to this.

- **Referral to Treatment Time (RTT) Financial Plan & Trajectory 2018/19 Month 11 update** – the Month 11 RTT Financial Plan & Trajectory was presented to Committee. The Committee was informed that every patient currently on the backlog list has a treatment plan in place, and assured that overall, the risk has been reduced, other than for a few high dependency risks.

- **Draft Financial Plan 2019/20** – the draft Financial Plan 2019/20 was presented to Committee. The Committee was advised that the baseline budget plan is £29.8m with RTT and Winter Plan funding included in this figure. The Committee was assured that a savings plan would be presented to the next Committee meeting in April 2019.

- **Capital Financial Management** – the Capital Financial Management report was presented to Committee. The Committee was advised of the significant growth in expenditure expected in Month 12 due to late variations and late capital anticipated. The Committee was informed that the Health Board had received assurances from the UK Government Cabinet Office regarding Interserve and Dawnus, which recommended trading continue with both. The Committee was assured that 2019/20 Capital Resource Limit (CRL) and profiling would be included in future reports, with the capital programme to be guided by planning.

- **Establishment Control** – The Establishment Control report was presented to Committee. The Committee was informed of the detail of the roll-out plan and confirmation received that a mass upload of WTE information from the general ledger into ESR would take place, incorporating an automated data cleanse of ESR positions to remove obsolete records. The Committee was assured that both Finance and Workforce teams are currently working to develop an integrated dashboard to combine both sets of key data to support decisions around earned autonomy relating to performance management.

**Materion y mae angen Ystyriaeth neu Gymeradwyaeth Lefel y Bwrdd are u cyfer / Matters Requiring Board Level Consideration or Approval:**

There were no matters requiring Board level consideration or approval from the meeting held on 25th March 2019.

**Risgiau Allweddol a Materion Pryder / Key Risks and Issues/ Matters of Concern:**

- Continuing issues with the Aseptic Unit in Glangwili General Hospital represent an overall risk to the Health Board's Financial Plan.
- Delivery of 2019/20 Savings Plan

**Busnes Cynlluniedig y Pwyllgor ar gyfer y Cyfnod Adrodd Nesaf / Planned Committee Business for the Next Reporting Period:**

**Adrodd yn y Dyfodol / Future Reporting:**

In addition to the standing agenda items, the next Finance Committee meeting will include reports relating to the RTT Plan 2019/20, the Draft Financial Plan Implementation 2019/20, and the Finance Committee Annual Report 2018/19 (for onward approval by the Board).

**Dyddiad y Cyfarfod Nesaf / Date of Next Meeting:**

25th April 2019

| | |
|---|---|
| **Enw'r Pwyllgor / Name of Committee** | Finance Committee |
| **Cadeirydd y Pwyllgor/ Chair of Committee:** | Michael Hearty, Associate Member |
| **Cyfnod Adrodd/ Reporting Period:** | Meeting held on 25th April 2019 |

**Y Penderfyniadau a'r Materion a Ystyriodd y Pwyllgor / Key Decisions and Matters Considered by the Committee:**

The Finance Committee has been established to advise the Board on all aspects of finance and the revenue implications of investment decisions. Hywel Dda University Health Board's (HDdUHB's) Finance Committee's primary role is, as such, to provide assurance on financial performance and delivery against Health Board financial plans and objectives and, on financial control, giving early warning on potential performance issues and making recommendations for action to continuously improve the financial position of the organisation.

This report summarises the work of the Finance Committee at its meeting held on 25th April 2019, with the following highlighted:

- **Finance Report Month 12** – the Month 12 Finance Report was presented to Committee. The Committee was advised that the Health Board's financial position at the end of Month 12 stood at £35.4m, an improvement on the year-end forecast of £35.5m. The Health Board also over-achieved on the expected savings delivery position by £0.2m in March.

- **Turnaround Report Month 12** – the Month 12 Turnaround Report was presented to Committee. The Committee took an assurance from the Holding to Account (HTA) scrutiny processes in place to recognise any non-recurrent and savings efficiencies. The Committee noted that receipt of the accountability letters and noted the organisations growing maturity in dealing with the risks involved and The Committee was assured that where risks are identified, mitigating actions must be articulated.

- **Finance Committee Annual Report 2018/19** – the Finance Committee Annual Report was presented to the Committee. The Committee endorsed the Finance Committee's Annual Report 2018/19, for onward submission to the Board on 29th May 2019 for approval.

- **Establishment Control** – The Establishment Control report was presented to Committee. The Committee was informed of the detail of the roll-out plan with confirmation received that the data collected is being actively reviewed by the Director of Workforce & OD, the Director of Nursing, Quality and Patient Experience and the finance team. Additionally, the data presented relating to rosters provides a forward look at the status at a ward and shift level, which is useful to identify any areas of concern or particular hotspots. The Committee was assured that that information will form part of the performance management framework where, for example, areas of high level sickness are scrutinised and subsequently targeted by the workforce team.

- **Capital Financial Management** – the Capital Financial Management report was presented to Committee. The Committee was assured that the Health Board met its capital expenditure limit at year end. The Committee was assured that the capital programme for 2019/20 was profiled to be spent more evenly throughout this year.

- **Savings Plan 2019/20 –** the Savings Plan 2019/20 was presented to Committee. The Committee was advised that savings of £24m are required in order to meet the year end position of a £29.8m deficit, although this figure may vary as a result of work being undertaken on Referral to Treatment Time (RTT). The Committee was further advised of the change in control total set by Welsh Government with a further £5m added pressure on this year. The Committee articulated its apprehensiveness in the organisation's ability to meet the savings plan challenge given the lack of assurance that could be provided at this point in time. However, the Committee was assured that all schemes now have Project Initiation Documents (PIDs) in place to provide greater assurance that plans are robust and can be managed effectively. Further work is being currently undertaken to meet the challenge.

- **Draft Financial Plan Implementation 2019/20 –** the Draft Financial Plan Implementation 2019/20 was presented to Committee. The Committee was advised the control total for 2019/20 stands at £25m. Current assessment against the control total identifies a £5.5 m resource requirement for RTT and identifies non-recurrent resources to manage the gap. The Committee was advised of the £10m risk associated with the Red and Amber rated schemes in delivering the £25 million control total, which poses a significant risk in addition to the gap, however acknowledged that the focus of the upcoming HTA meetings will be to de-risk these schemes. The number of signed accountability letters received to date was shared with the Committee, together with the assurance that any outstanding would be addressed via the HTA process and escalated accordingly if necessary.

- **Referral to Treatment Time (RTT) Month 12 Report –** the Referral to Treatment Time (RTT) Month 12 Report was presented to Committee. The Committee was advised that performance in respect of RTT, Diagnostics and Therapies targets is positive and delivered a £1.2m under-commitment with the avoidance of any resultant funding clawback. The Committee was advised of activity and capacity within Therapy services and the further work needed to address the current system of manual tracking as opposed to the electronic tracking of patients.

- **RTT Plan 2019/20 –** the RTT Plan 2109/20 was reported to Committee. The Committee was advised that the forecast of the delivery requirement for 2019/20 stands at £5.5m.

**Materion y mae angen Ystyriaeth neu Gymeradwyaeth Lefel y Bwrdd are u cyfer / Matters Requiring Board Level Consideration or Approval:**

- The Board, at its meeting on 29th May 2019, is asked to approve the Finance Committee Annual Report 2018/19

**Risgiau Allweddol a Materion Pryder /**
**Key Risks and Issues/ Matters of Concern:**

- Continuing issues with the Aseptic Unit in Glangwili General Hospital which represents an overall risk to the Health Board's Financial Plan.
- Delivery of the 2019/20 Savings Plan

**Busnes Cynlluniedig y Pwyllgor ar gyfer y Cyfnod Adrodd Nesaf /**
**Planned Committee Business for the Next Reporting Period:**

**Adrodd yn y Dyfodol / Future Reporting:**

In addition to the standing agenda items, the next Finance Committee meeting will include reports relating to the Finance Committee Outcome of Self-assessment of Performance 2018/19, Corporate Risks, Financial Operational Risks, Winter Planning 2019/20, Deep-dive into Medicines Management & Aseptic Unit, Deep-dive into CHC, and Draft Annual Accounts 2018/19 Review of Risks Arising from HTA Process, Debrief exercise from recent cycle of meetings.

**Dyddiad y Cyfarfod Nesaf / Date of Next Meeting:**

20th May 2019

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

**CYFARFOD BWRDD PRIFYSGOL IECHYD UNIVERSITY HEALTH BOARD MEETING**

| | |
|---|---|
| **DYDDIAD Y CYFARFOD: DATE OF MEETING:** | 30 May 2019 |
| **TEITL YR ADRODDIAD: TITLE OF REPORT:** | Finance and Turnaround Update – Month 12 2018/19 |
| **CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:** | Huw Thomas, Director of Finance |
| **SWYDDOG ADRODD: REPORTING OFFICER:** | Fiona Powell, Assistant Director of Finance |

| **Pwrpas yr Adroddiad** (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate) |
|---|
| Ar Gyfer Trafodaeth/For Discussion |

**ADRODDIAD SCAA**
**SBAR REPORT**

## Sefyllfa / Situation

The Health Board has a statutory duty to breakeven over a three-year rolling basis. This report updates the Board on the Health Board's financial position as at 31 March 2019. This result is still subject to the closure and submission, to Welsh Government, of the final accounts for 2018-19 and the subsequent audit by WAO.

## Cefndir / Background

The Health Board agreed an interim Annual Plan on 29th March 2018, which included a deficit budget of £62.5m. The Health Board has received additional funding of £27m in relation to the Zero Based Review giving a revised forecast deficit of £35.5m.

This required the achievement of £26.4m of savings schemes to be delivered in-year; which needed to be recurrent in order to sustain an improvement in the underlying financial position. In addition to this, individual budget managers needed to ensure that they operated within their delegated limit as outlined in the Accountability Agreement Letters which have been distributed for 2018/19.

## Asesiad / Assessment

The Health Board's financial position at the end of Month 12 represented a favourable variance against plan of £0.1m and has achieved an under-spend position of £0.2m in-month.

Performance against key financial targets is summarised in the table below.

| Key target | | Annual limit | Actual delivery |
|---|---|---|---|
| **Revenue** | **£'m** | 35.5 | 35.4 |
| **Savings** | **£'m** | 26.4 | 26.6 |
| **Capital** | **£'m** | 30.9 | 30.9 |
| **Non-NHS PSPP** | **%** | 95.0 | 96.1 |

**Argymhelliad / Recommendation**

The Board is asked to note and discuss the financial position for Month 12.

| **Amcanion: (rhaid cwblhau)**<br>**Objectives: (must be completed)** | |
|---|---|
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:<br>Datix Risk Register Reference and Score: | BAF S09-PR20<br>BAF SO10-PR33 |
| Safon(au) Gofal ac Iechyd:<br>Health and Care Standard(s): | 5. Timely Care<br>7. Staff and Resources |
| Amcanion Strategol y BIP:<br>UHB Strategic Objectives: | All Strategic Objectives are applicable |
| Amcanion Llesiant BIP:<br>UHB Well-being Objectives:<br>Hyperlink to HDdUHB Well-being Statement | Improve efficiency and quality of services through collaboration with people, communities and partners |

| **Gwybodaeth Ychwanegol:**<br>**Further Information:** | |
|---|---|
| Ar sail tystiolaeth:<br>Evidence Base: | Monitoring returns to Welsh Government based on the Health Board's financial reporting system. |
| Rhestr Termau:<br>Glossary of Terms: | BGH – Bronglais General Hospital<br>CHC – Continuing Healthcare<br>CIP – Cost Improvement Programme<br>ENT – Ear, Nose and Throat<br>DES – Direct Enhanced Services<br>DNA – Did Not Attend<br>FNC – Funded Nursing Care<br>FYE – Full Year Effect<br>GGH – Glangwili General Hospital<br>GMS – General Medical Services<br>IPFR – Individual Patient Funding Request<br>LTAs – Long Term Agreements<br>MHLD – Mental Health & Learning Disabilities<br>MDT – Multi-Disciplinary Team<br>NICE – National Institute for Health and Care Excellence<br>OOH – Out of Hours<br>PPH – Prince Philip Hospital<br>PSPP– Public Sector Payment Policy<br>RTT – Referral to Treatment<br>T&O – Trauma & Orthopaedics |

| | |
|---|---|
| | USC – Unscheduled Care<br>VC – Video Conferencing<br>VFM – Value For Money<br>W-AMD – Wet Age-related Macular Degeneration<br>WG – Welsh Government<br>WGH – Withybush General Hospital<br>WRP – Welsh Risk Pool<br>WHSSC – Welsh Health Specialised Services Committee<br>YTD – Year to date |
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol:<br>Parties / Committees consulted prior to University Health Board: | Health Board's Finance Team<br>Health Board's Management Team<br>Executive Team<br>Finance Committee |

| **Effaith: (rhaid cwblhau)<br>Impact: (must be completed)** | |
|---|---|
| **Ariannol / Gwerth am Arian:<br>Financial / Service:** | Financial implications are inherent within the report. |
| **Ansawdd / Gofal Claf:<br>Quality / Patient Care:** | The impact on patient care is assessed within the savings schemes. |
| **Gweithlu:<br>Workforce:** | The report considers the financial implications of our workforce. |
| **Risg:<br>Risk:** | Financial risks are detailed in the report. |
| **Cyfreithiol:<br>Legal:** | The Health Board has a legal duty to deliver a breakeven financial position over a rolling three-year basis and an administrative requirement to operate within its budget within any given financial year. |
| **Enw Da:<br>Reputational:** | Adverse variance against the Health Board's financial plan will affect our reputation with Welsh Government, the Wales Audit Office, and with external stakeholders. |
| **Gyfrinachedd:<br>Privacy:** | Not applicable |
| **Cydraddoldeb:<br>Equality:** | Not applicable |

# 1. Summary

## 1.1 Purpose

- The purpose of this report is to outline the Health Board's financial position to date against our Annual Plan.

## 1.2 Key messages

- The Health Board's financial position at the end of Month 12 represented a favourable variance against plan of £0.1m and has achieved an under-spend position of £0.2m in-month.
- This position has been delivered through the use of non-recurring and one off adjustments totalling £8.6m in the year to date (£nil in month).
- £2.5m of Savings schemes were delivered in Month 12. The total delivered savings is £26.6m, which is £0.2m higher than forecast in Month 11.
- As expected, operational savings fell short of the original target of £30.7m, however this is offset by the identification of an additional £4.9m of accountancy gains and £6.0m of corporate recovery actions.

## 1.3 Summary of key financial targets

- The Health Board's key targets are as follows:
    - Revenue: to contain the overspend within the Health Board's planned deficit
    - Savings: to deliver savings plans to enable the revenue budget to be achieved
    - Capital: to contain expenditure within the agreed limit
    - PSPP: to pay 95% of Non-NHS invoices within 30 days of receipt of a valid invoice
    - Cash: While there is no prescribed limit for cash held at the end of the month, WG encourages this to be minimised and a rule of thumb of 5% of monthly expenditure is used. For the Health Board, this is broadly £4.0m.

| Key target | | Annual limit | Actual delivery |
|---|---|---|---|
| **Revenue** | **£'m** | 35.5 | 35.4 |
| **Savings** | **£'m** | 26.4 | 26.6 |
| **Capital** | **£'m** | 30.9 | 30.9 |
| **Non-NHS PSPP** | **%** | 95.0 | 96.1 |
| **Period end cash** | **£'m** | 4.0 | 1.4 |

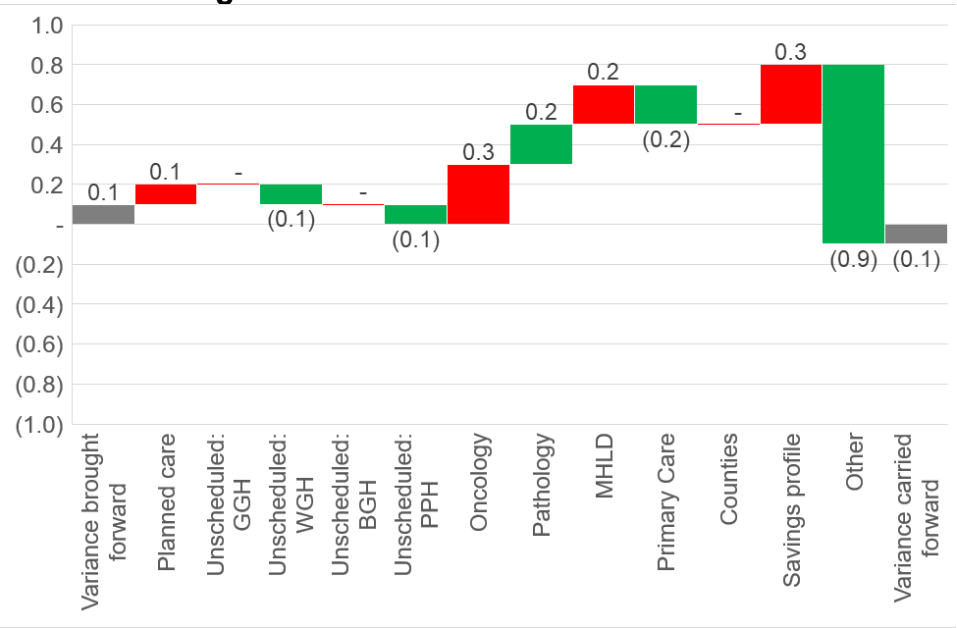
# 2. Directorate Revenue Position

## 2.1 Directorate financial performance

**Year to date**

| | Cered | Carms | | Pembs |
|---|---|---|---|---|
| | | PPH | GGH | |
| Planned | 3.3 | | | |
| Unscheduled | 1.7 | 0.7 | 1.8 | 0.7 |
| Radiology | (0.1) | | | |
| Pathology | 1.1 | | | |
| Women's and Children's | (0.1) | | | |
| Cancer | 0.6 | | | |
| County Teams | (0.2) | 0.4 | | 0.3 |
| MHLD | 0.5 | | | |
| Facilities | 1.2 | | | |
| Medicines Management | 1.6 | | | |
| Primary Care | (0.5) | | | |
| Corporate | 0.0 | | | |
| Commissioning | (3.2) | | | |
| Other | (9.9) | | | |
| Bottom line Savings profile | 0.0 | | | |
| **Variance against plan** | **(0.1)** | | | |

**In-month change**

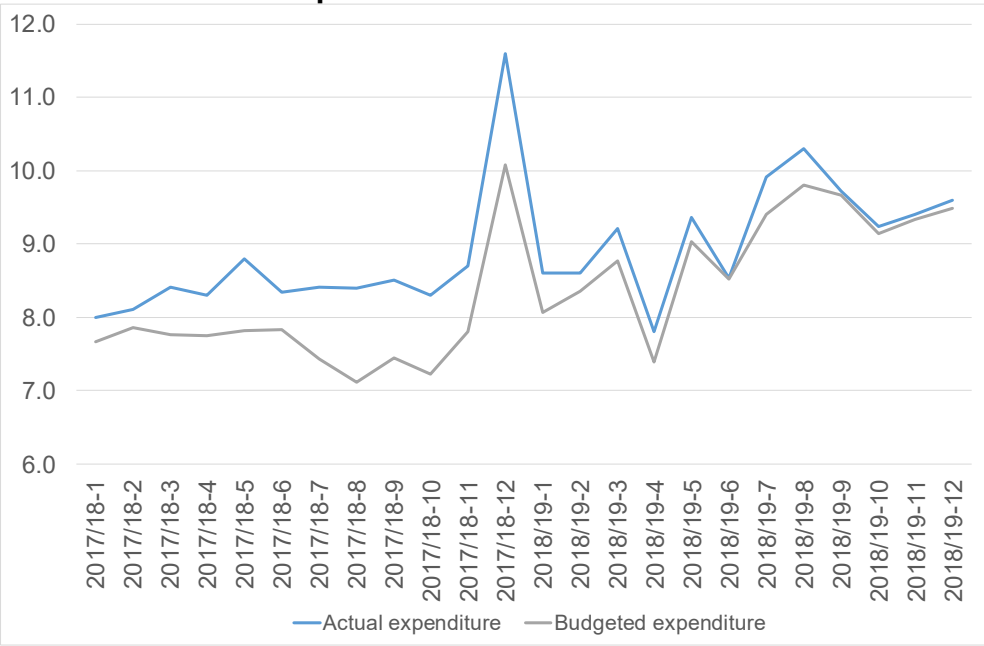



- The Health Board's reported bottom line variance has improved over the last five months. An under-spend was achieved in the current month, leading to a cumulative position of £(0.1)m to Month 12.
- The year to date pressure has been particularly pronounced in Unscheduled Care (£4.9m, driven by bed capacity), Planned Care (£3.3m, driven by non-delivery of savings) and Medicines Management (£1.6m, driven by NCSO drugs).
- Material positions are reported in Section 2.2.

# 2. Directorate Revenue Position

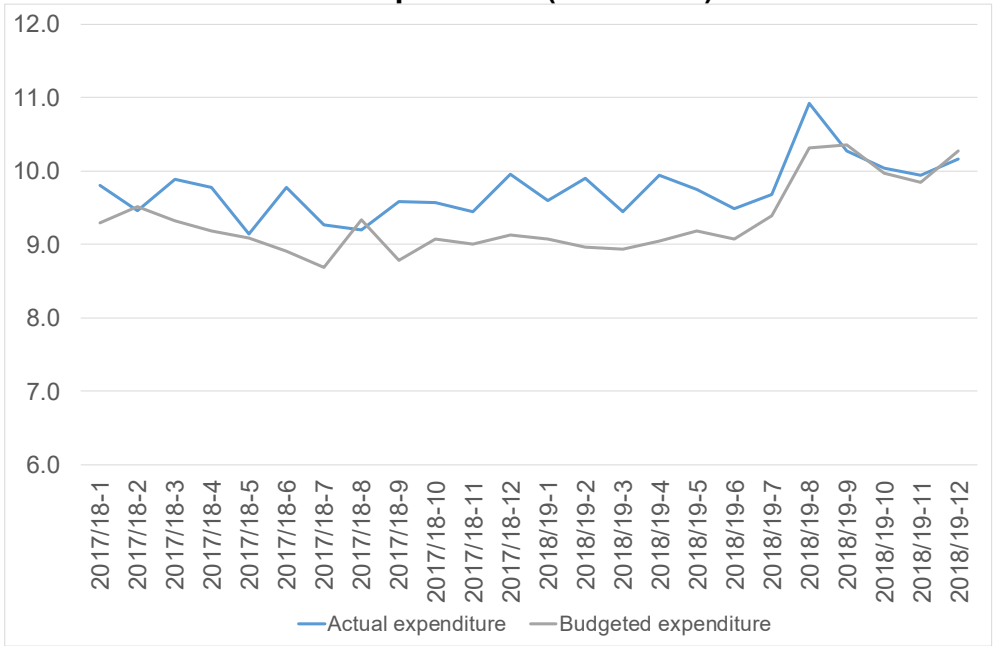
## 2.2 Material directorate area deficits

### 2.2.1 Planned care expenditure




- The in-month position showed a slight deterioration on Month 11, with over-spends in Clinical Supplies and Services offset by a reduction in Medical internal locum sessions.
- The Directorate has also seen a significant benefit in efficiency and productivity.

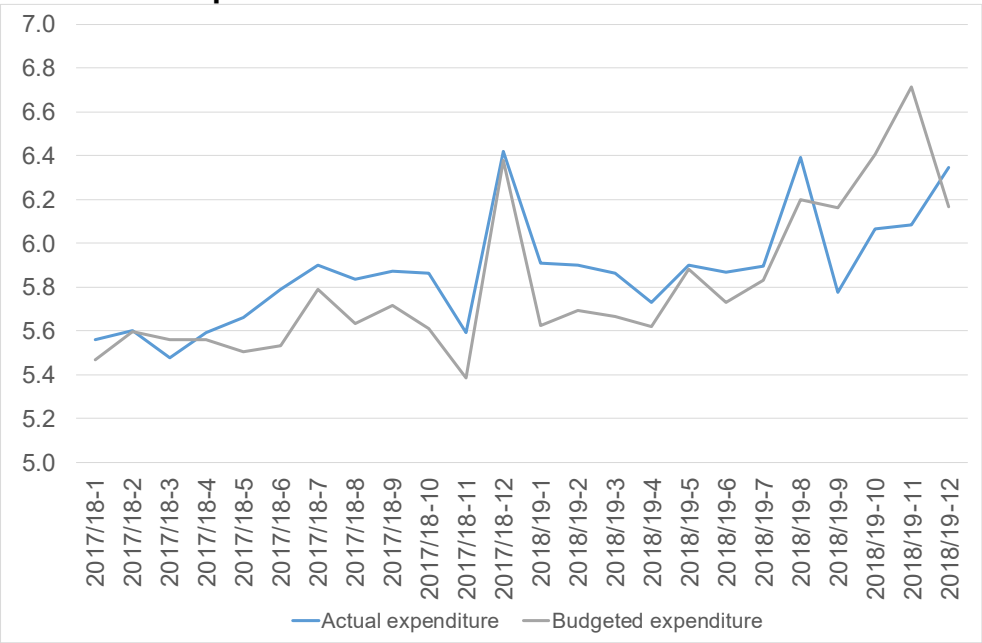
### 2.2.2 Unscheduled care expenditure (combined)




- Bronglais General Hospital (BGH) reported a slightly improved overspend to Month 11, predominately due to reduced recharges from Swansea Bay UHB and overachievement of drugs income. Withybush General Hospital (WGH) reported a slight improvement on the Month 11 position, largely due to a reduction in Nursing and clinical costs. Glangwili General Hospital (GGH) reported an improvement on the Month 11 position mainly due to a reduction in expenditure for maintenance and laboratory chemicals. PPH was again slightly under-spent in-month; the position is driven by Winter Pressures funding and a reduction in Nursing and Medical pay costs.
- Delayed discharges of medically fit patients and unfunded surge capacity remain key drivers to the costs, which requires a system-wide focus.

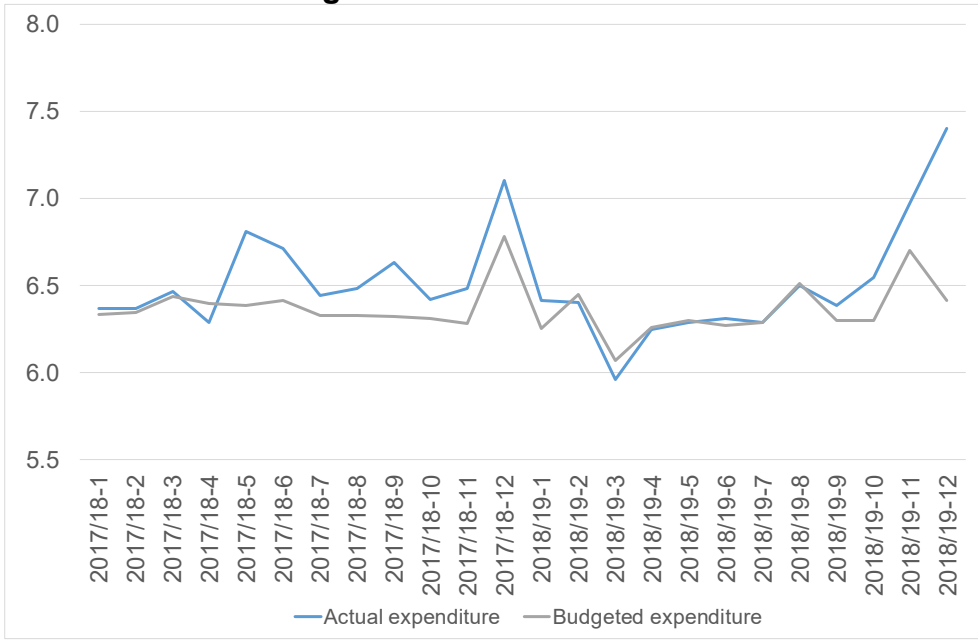
# 2. Directorate Revenue Position

### 2.2.3 MHLD expenditure




- The Directorate has reported a deterioration in variance against budget in-month, predominately due to increased CHC costs.
- The Directorate was challenged throughout the year in delivering against its savings requirement. There continues to be difficulty recruiting into medical posts resulting in extra locum sessions being incurred.
- The greatest pressure within MHLD is the continued growth in CHC placements and their associated costs. Client numbers were unchanged in month, although a higher number of clients were assigned complex packages of care. Careful control of CHC, within its growth assumptions, will be key to deliver an improvement in the expenditure run rate.
- Robust care review processes have been implemented in order to manage the risks arising under CHC.

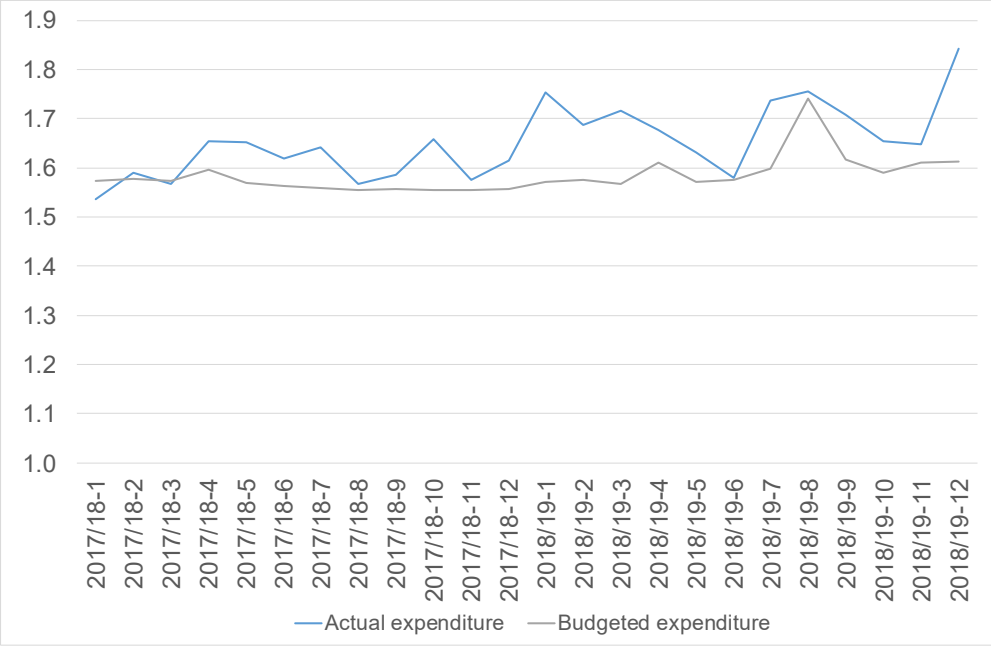
### 2.2.4 Medicines Management




- The directorate reported a further deteriorated position in-month, based on modelling outturn on a number of scenarios. The No Cheaper Source Obtainable (NCSO) drugs have remained at the higher levels seen since October 2018 which has impacted on the projection modelling. Higher than expected seasonal flu drugs have also had an adverse impact. Savings plans delivered ahead of plan.
- Item growth is in the range of -1% to 1% but there has been a significant increase in Category M prices.

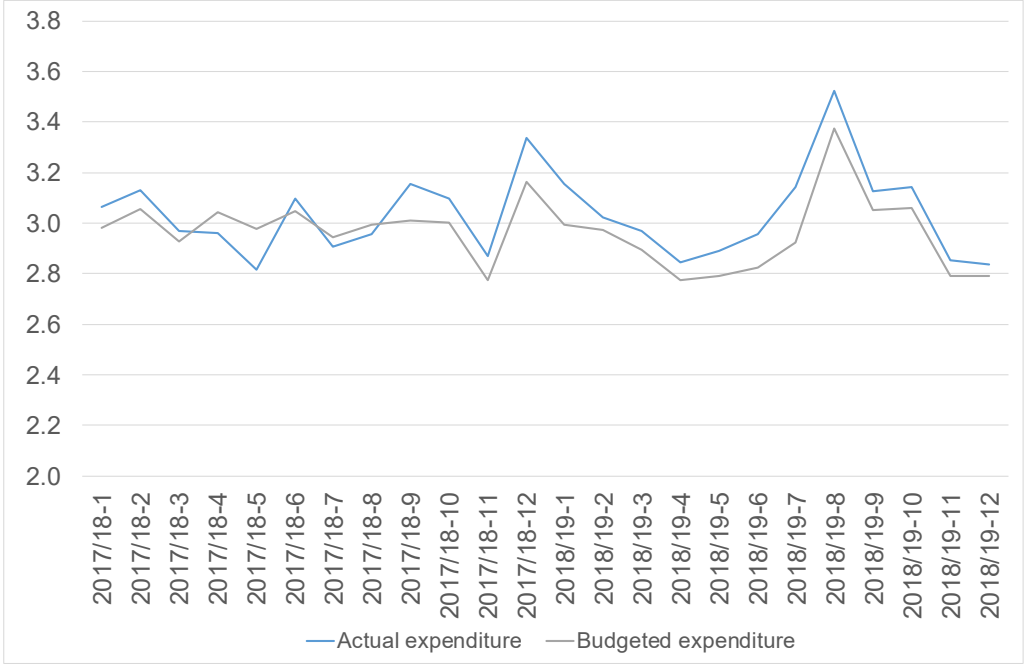
# 2. Directorate Revenue Position

### 2.2.5 Pathology




- There has been an over spend on medical staffing pay in month due to an increase in Medical Locums.
- Increased costs in year have arisen from Service Level Agreements, managed service contracts and non-delivery of savings partially offset by drugs costs. Income also under achieved in month in relation to mortuary fees.
- The Directorate is reviewing ways of working with services to reduce demand through ensuring only appropriate test requests and through avoiding duplication. Targeted diagnostics for high cost services has contributed a benefit to the position.

### 2.2.6 Facilities




The main areas of overspend continue to be:

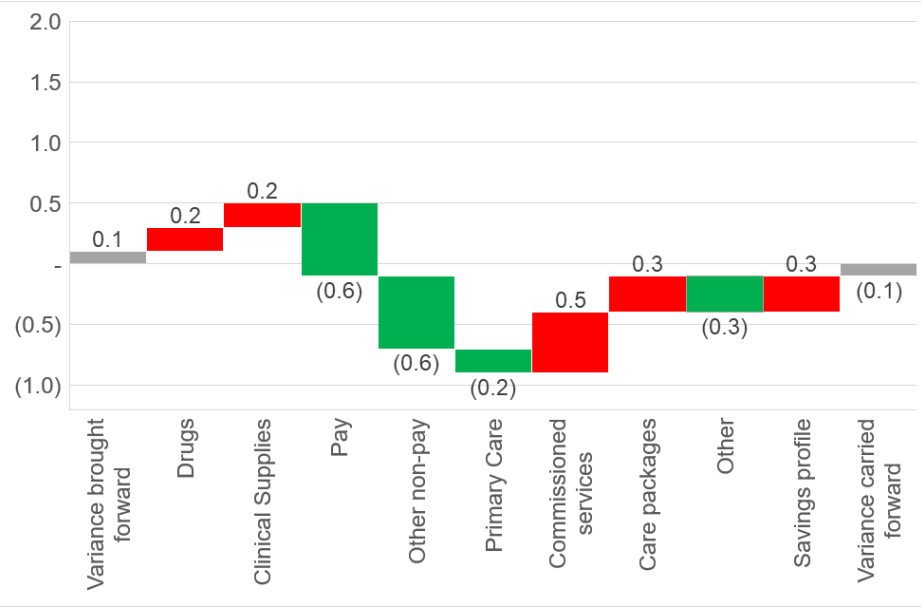
- Operations – bank Pay costs, postage costs, other general supplies, and grounds and gardens are the main contributors to the over spend of £0.1m.
- Property – overspend of £1.2m relating predominately to electricity. Costs have significantly increased due to the confirmed rate increase being higher than predicted, although usage in month reduced in PPH and WGH. Heating Oil is overspent due to being utilised as a back-up when the biomass is off-line and rate increases. Water consumption increased in PPH.
- Specialist Services – provisions account for the majority of the £0.2m overspend.

# 3. Subjective revenue position

### 3.1 Subjective summary

| | In-month | Cumulative | Imp ↓/ Det ↑ |
|---|---|---|---|
| Income | (0.9) | (2.5) | ↓ |
| Primary Care (excl prescribing) | (0.2) | (0.2) | ↓ |
| Prescribing | 1.1 | 1.1 | ↑ |
| Pay | (0.6) | 0.2 | ↓ |
| Clinical supplies | 0.2 | 1.6 | ↑ |
| Drugs | 0.2 | 2.3 | → |
| Other non-pay | (0.6) | (0.8) | ↓ |
| Commissioned services | 0.5 | (1.3) | ↑ |
| Care packages | 0.3 | 2.7 | ↑ |
| Other | (0.5) | (3.2) | ↓ |
| Savings profile | 0.3 | 0.0 | |
| **Total** | (0.2) | (0.1) | ↓ |

### In-month change

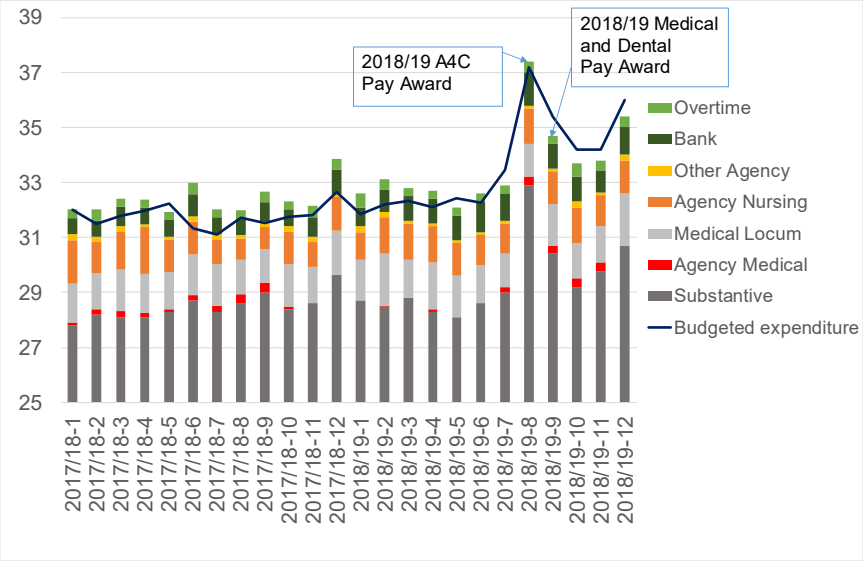



- The main pressures on the in-month position relate to Prescribing and Commissioned Services, offset by Income, Pay and Other Non-Pay.
- Detail on the changes in material cost drivers follows in Section 3.2.

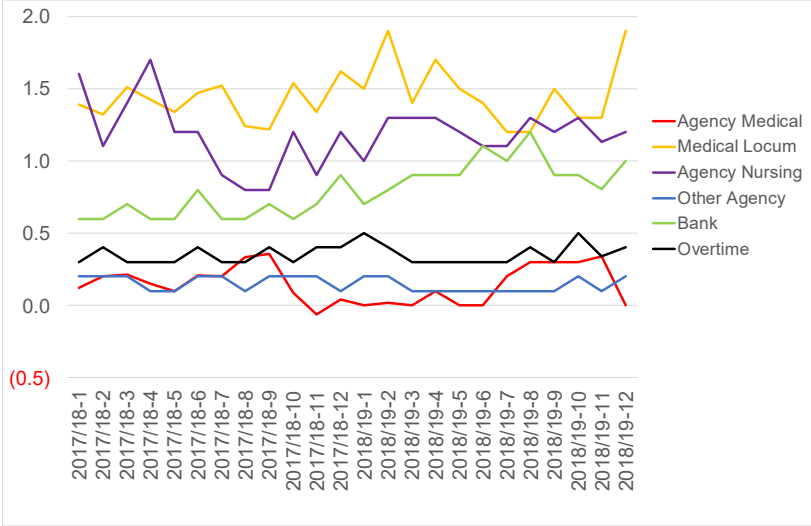
# 3. Subjective revenue position

## 3.2 Material Cost drivers

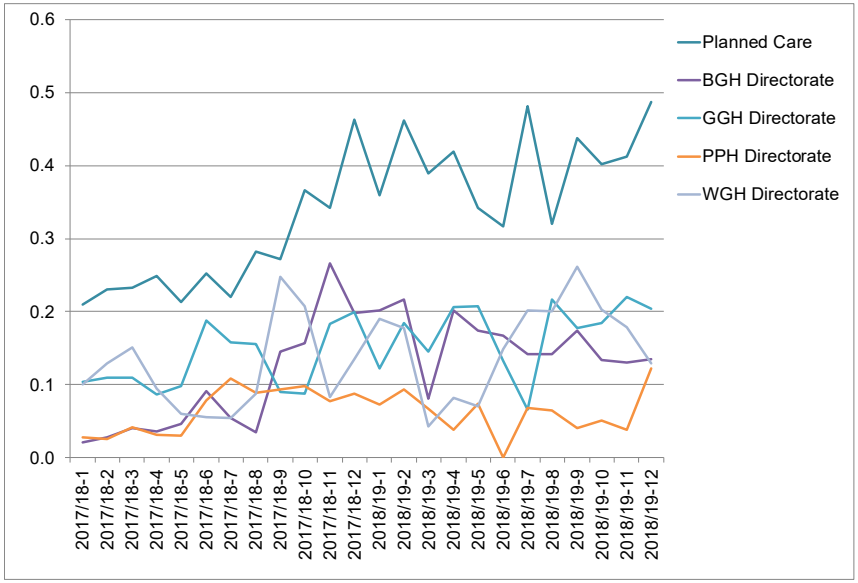
### 3.2.1 Pay




### Temporary pay costs



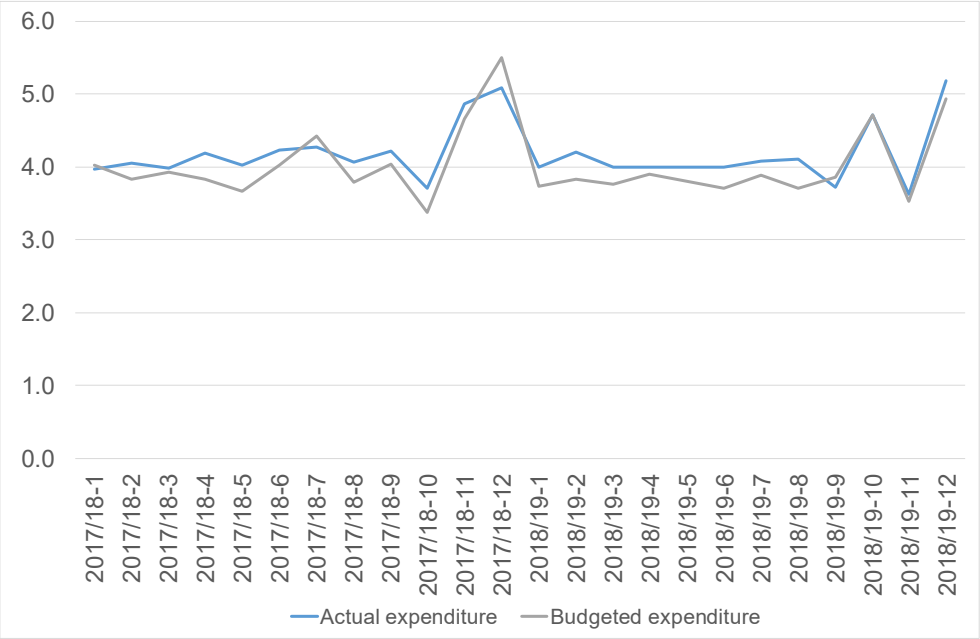

### Medical locum costs




- The Month 12 expenditure is lower than budget due to vacancies over and above those filled with Agency staff.
- Month 12 Pay costs include a provision of £1.1m in relation to Holiday Pay Entitlement on Overtime and Additional Hours. This was matched with a WG allocation of funding following an All-Wales decision in Month 12, which is included in the in-month budget.
- The cost of substantive staffing is greater than last year. In Month 12 total pay costs increased slightly compared with Month 11 – increases in substantive pay costs were partially offset by a reduction in Medical Agency costs.
- There was a large increase in Medical Locum and Bank costs, this was partially offset by a decrease in Medical Agency costs.

# 3. Subjective revenue position

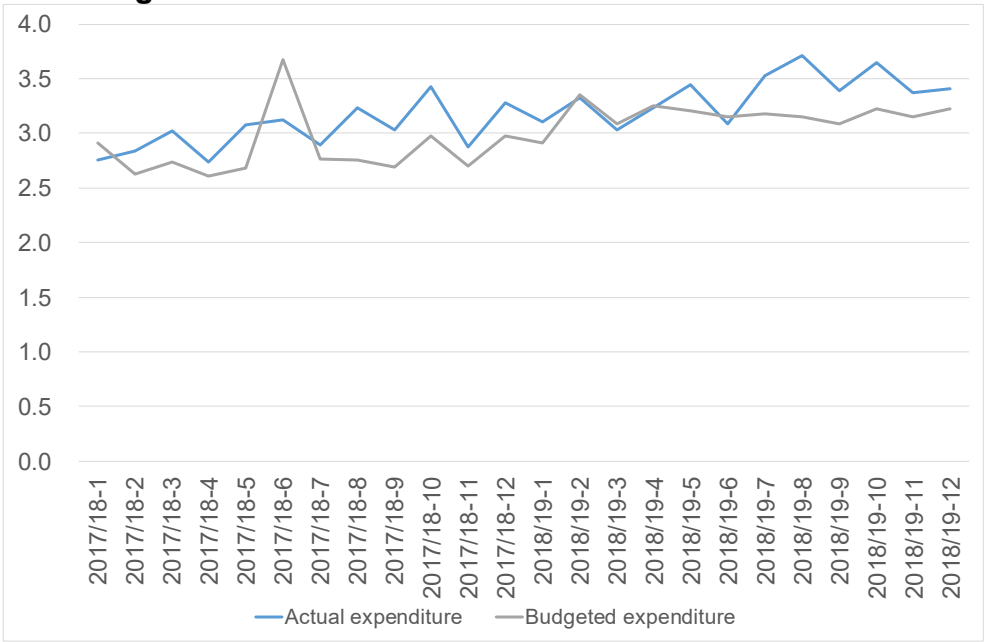
### 3.2.2 Care packages (CHC and FNC)




- The total number of cases decreased in-month. The increase in expenditure and budget in Month 10 and 12 relates to the recognition of an element of FNC rate changes and CHC inflation. The complexity of cases remains a key cost driver.
- Total spend to Month 12 is £48.0m resulting in an overspend of £2.4m, of which:

| £'m | Spend | Over/(under) spend |
|---|---|---|
| FNC/CHC | 23.8 | 0.4 |
| LD | 13.5 | 2.3 |
| MH | 9.5 | 0.2 |
| Children | 1.2 | (0.5) |
| **Total** | **48.0** | **2.4** |

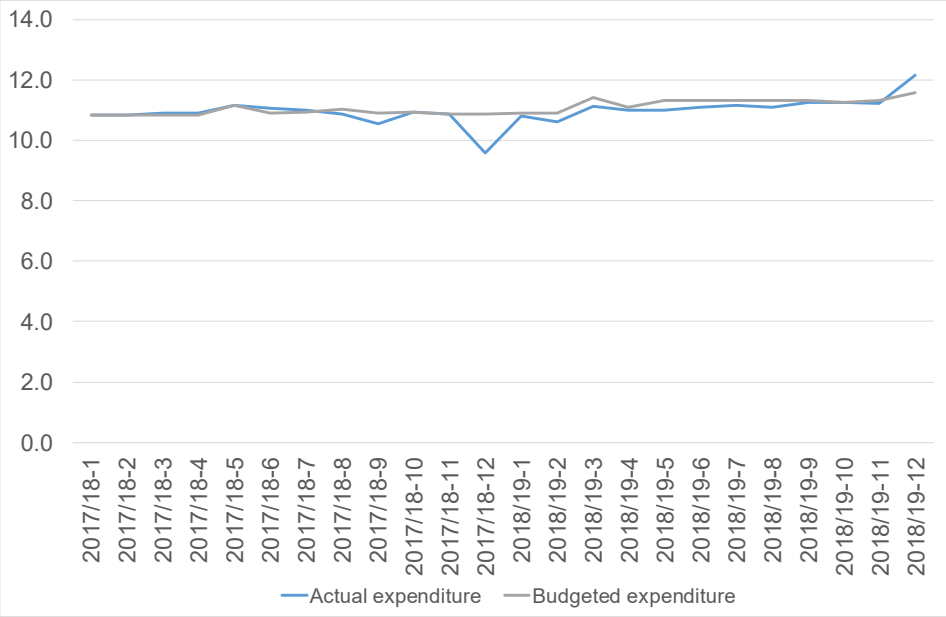
### 3.2.3 Drugs




- Drugs costs have increased over the past year, and continue with that trend for this year, with a significant in-month impact.
- Continued support will be needed from the Pharmacy team to address this growth and a number of initiatives are in place to do this. Whilst specific savings schemes are delivering, pressures are being seen in other areas, particularly Dermatology, Rheumatology and Ophthalmology. The Head of Medicines Management is working with Directorates to identify and mitigate the issues.
- There has been a disruption to the local service provision of Aseptic services; as a result work has been outsourced at a premium to another provider. This is expected to continue into 2019/20.
- Two high cost melanoma cases have again had a significant in-month impact.

# 3. Subjective revenue position

### 3.2.4 Commissioned services



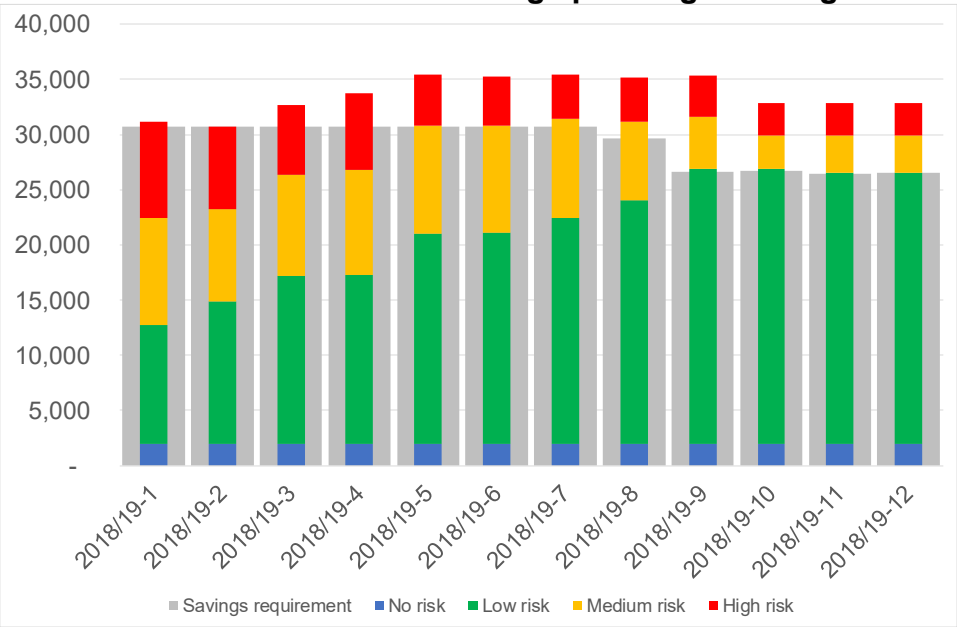

- Services that are commissioned from other NHS providers are based on activity data up to Month 11.
- The main cumulative under-spend relates to activity at Swansea Bay UHB (£1.4m) and Cardiff and Vale UHB (£0.8m).
- Pressures in the year have grown month on month in respect of Specialised Services, despite an increased budget for the current year of £2.3m. The WHSSC position is the key driver of the in-month over spend in respect of IPFR and Mental Health activity and prior year commitments being realised.

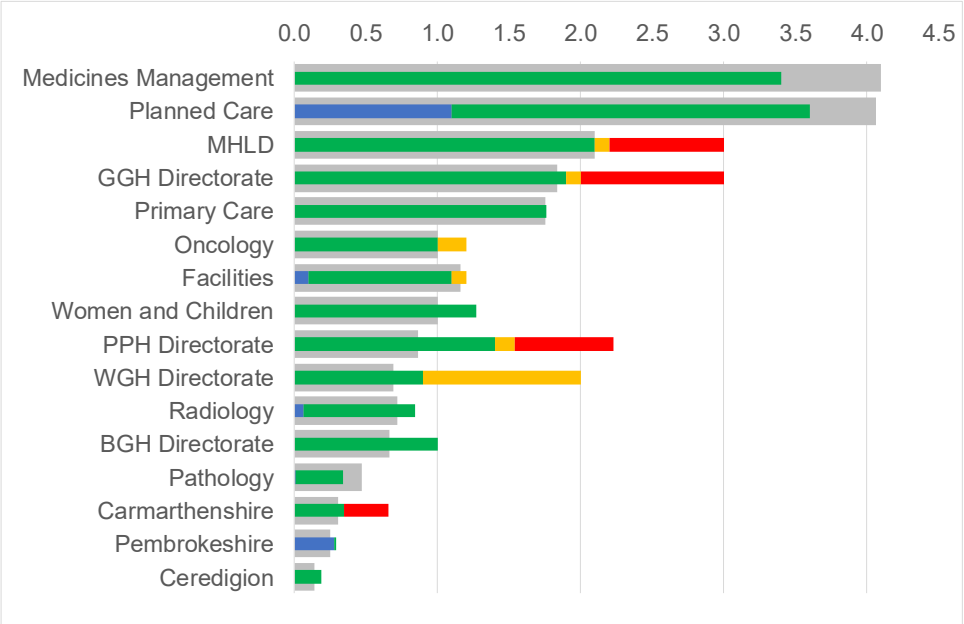
### 3.2.5 Income


- Income from other NHS bodies continues to cumulatively over perform against target.
- The in-month improvement is largely in relation to over-performance on a number of LTAs with Welsh Health Boards.

# 4. Savings and turnaround actions

### 4.1 Risk-assessed directorate savings plans against target



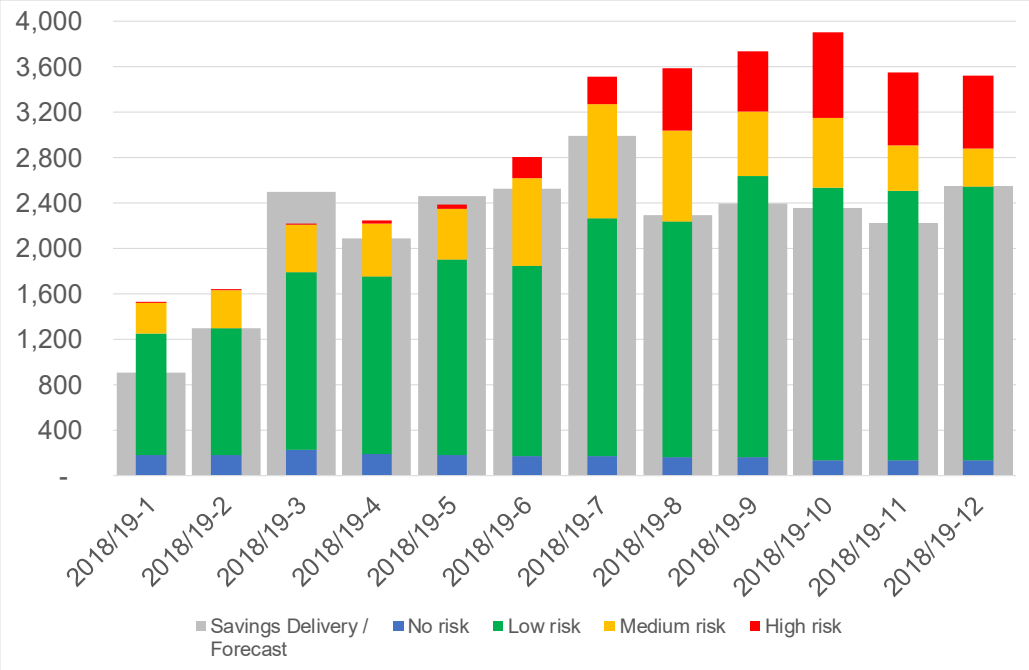




- Savings scheme achievement in month was £2.5m, which is ahead of the Month 11 forecast for Month 12, due to over achievement of savings in relation to Procurement and Medicines Management.

- Savings arising from Agency/Locum paid at premium rates in Month 12 was broadly in line with Month 11, and, as expected, was still significantly below Plan.

# 4. Savings and turnaround actions

### 4.2 Planned savings profile, risk and delivery




- Total schemes identified to Month 12 is unchanged from Month 11.

- As expected, operational savings delivery fell short of the original target of £30.7m, however this is offset by the identification of an additional £4.9m of accountancy gains and £6.0m of corporate recovery actions.

# 5. Financial position

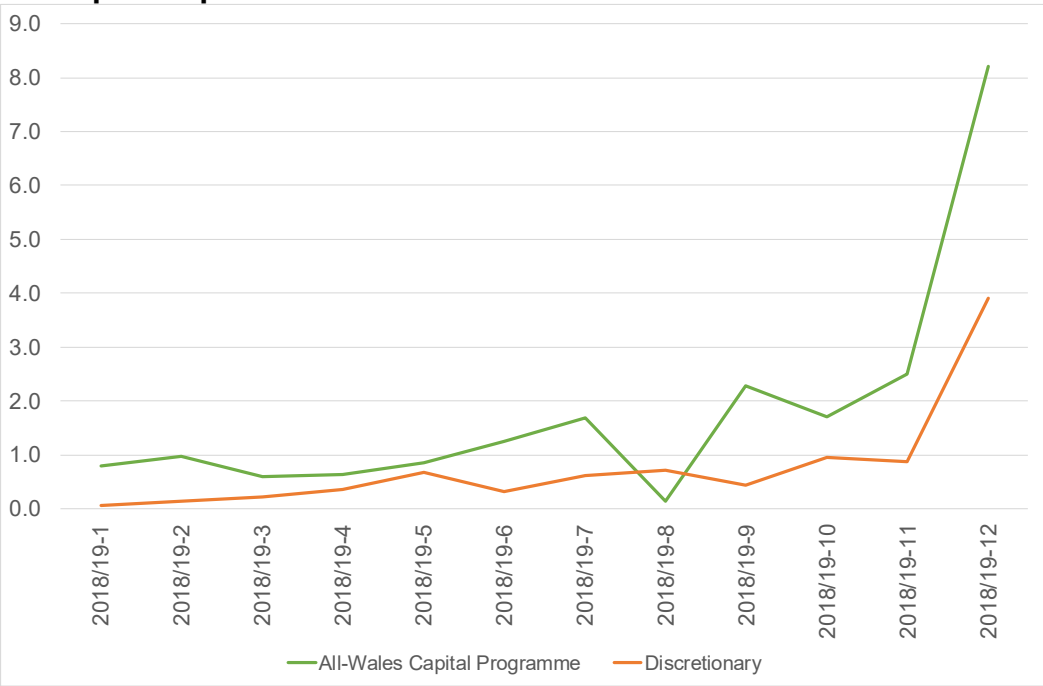
## 5.1 Operational Financial Position

The operational run rate has shown a significant improvement in Month 12, being at £(0.2)m in the current month. This is the result of recovery actions taken by Directorates in order to meet their Control Totals and over-delivery of savings in month.

| **Operational Financial Position £'m** | **M1** | **M2** | **M3** | **M4** | **M5** | **M6** | **M7** | **M8** | **M9** | **M10** | **M11** | **M12** | **YTD** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Actual In-Month Reported** | **0.4** | **0.3** | **0.2** | **0.0** | **0.0** | **0.0** | **0.0** | **(0.1)** | **(0.3)** | **(0.2)** | **(0.2)** | **(0.2)** | **(0.1)** |
| **Adjustments:** | | | | | | | | | | | | | |
| Medicines Management Savings Plan | | | 0.5 | | | | | | | | | | 0.5 |
| Recharge Revenue to Capital (Facilities) | | | | 0.2 | | | | | | | | | 0.2 |
| VAT Reclaim (2017-18) | | | | 0.2 | 0.4 | | | | | | | | 0.6 |
| Individual Patient Commissioning – review year-end commitments | | | | 0.3 | 0.2 | 0.2 | | | | | | | 0.7 |
| Medical and Dental back-pay | | | | | | | | | 0.5 | | | | 0.5 |
| Accountancy Gains | | 0.2 | 0.1 | 0.1 | 0.3 | 0.3 | 1.0 | 1.1 | 0.4 | 0.6 | 0.8 | | 4.9 |
| Other | | 0.3 | | 0.2 | 0.1 | | 0.3 | | 0.3 | | | | 1.2 |
| | | | | | | | | | | | | | |
| Total Adjustments | 0.0 | 0.5 | 0.6 | 1.0 | 1.0 | 0.5 | 1.3 | 1.1 | 1.2 | 0.6 | 0.8 | 0.0 | 8.6 |
| | | | | | | | | | | | | | |
| **Operational Financial Position** | **0.4** | **0.8** | **0.8** | **1.0** | **1.0** | **0.5** | **1.3** | **1.0** | **0.9** | **0.4** | **0.6** | **(0.2)** | **8.5** |

# 6. Capital expenditure and working capital management

## 6.1 Capital expenditure

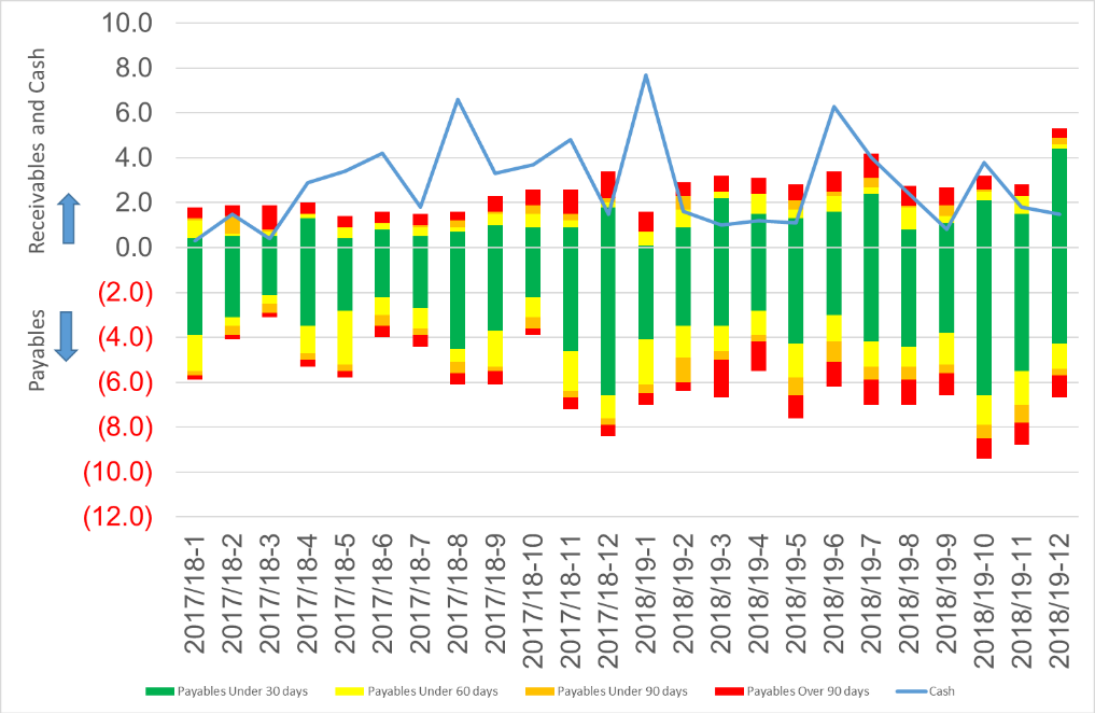



| Capital expenditure plan | £'m | £'m |
|---|---|---|
| Cardigan Integrated Care Centre | 9.5 | |
| Women and Children Phase II | 4.1 | |
| Wards 9 and 10 Withybush | 1.3 | |
| Aberaeron Integrated Care Centre | 1.5 | |
| Fishguard Primary Care | 0.6 | |
| Bronglais MRI | 0.3 | |
| Additional Discretionary IT | 1.4 | |
| Additional Discretionary Equipment | 0.9 | |
| Bronglais front of House Scheme | 1.0 | |
| Other all-Wales allocations | 1.1 | |
| **Total all-Wales funded schemes** | | **21.7** |
| Medical equipment | 3.0 | |
| Estates | 3.6 | |
| IM&T | 1.4 | |
| Other | 1.2 | |
| **Total discretionary** | | **9.2** |
| **Total capital** | | **30.9** |

- The Health Board had an approved Capital resource limit of £30.893m for 2018/19.
- Capital expenditure against the £30.893m funding allocation was £30.868m.

# 6. Capital expenditure and working capital management

## 6.2 Working capital management




- Income collected from sources other than Welsh Government is collected through the invoicing process. It is imperative that this is collected promptly to reduce reliance on cash support from WG. Balances owed to the Health Board are £5.3m in Month 12.
- We are focusing on overdue balances owed to the Health Board to minimise the risks to recovery, although the risk is deemed minimal.
- A process review of Accounts Receivables is currently underway to improve and streamline practices.
- It is also important that the Health Board pays its suppliers promptly. At the end of Month 12, £6.7m was owed to suppliers, of which £4.3m are less than 30 days old. Further work is ongoing with colleagues in NHS Wales Shared Services to address older balances through improving the purchase-to-pay cycle.
- Cash at the end of Month 12 was £1.5m.

# 7. Conclusions and recommendations

## 7.1 Conclusions

- The Health Board's financial position at the end of Month 12 represented a favourable variance against plan of £(0.1)m. This included an under-spend of £0.2m in month.

- On an operational basis, after adjusting for one off items, the position in month was a favourable variance against plan of £(0.2)m, which is an improvement of £0.8m compared to Month 11.

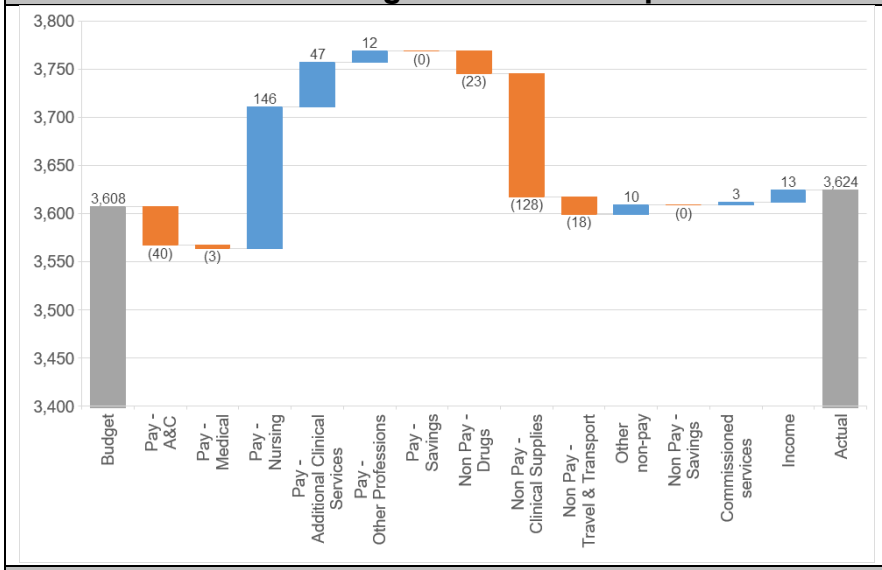
- Unscheduled Care (£4.9m, driven by bed capacity), Planned Care (£3.3m, driven by non-delivery of savings) and Medicines Management (£1.6m, driven by NCSO drugs).

- CHC represents the most significant cost driver (£2.7m), followed by Drugs (£2.3m) and Clinical Supplies (£1.6m).

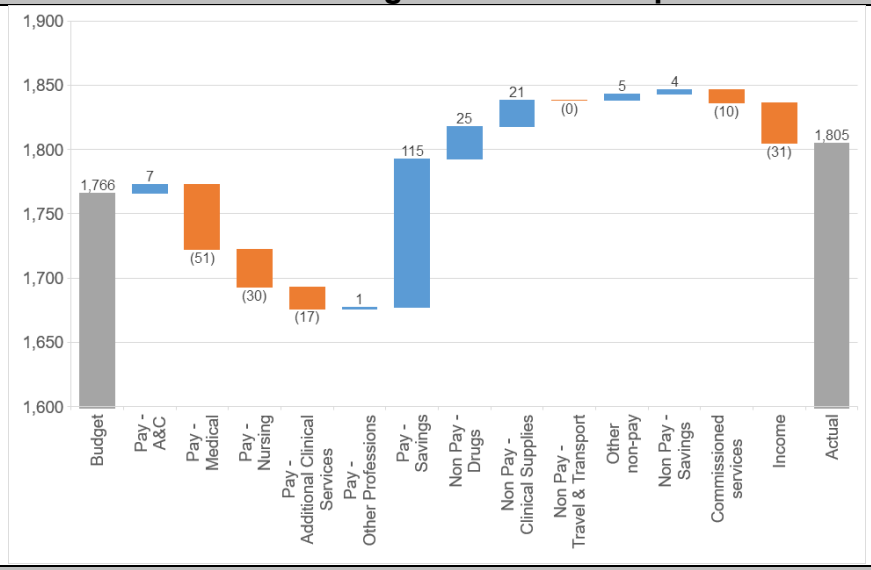
- These adverse variances mainly relate to savings delivery compared with the requirement.

# Appendix 1: Variance from Budget (in-month, £'000)

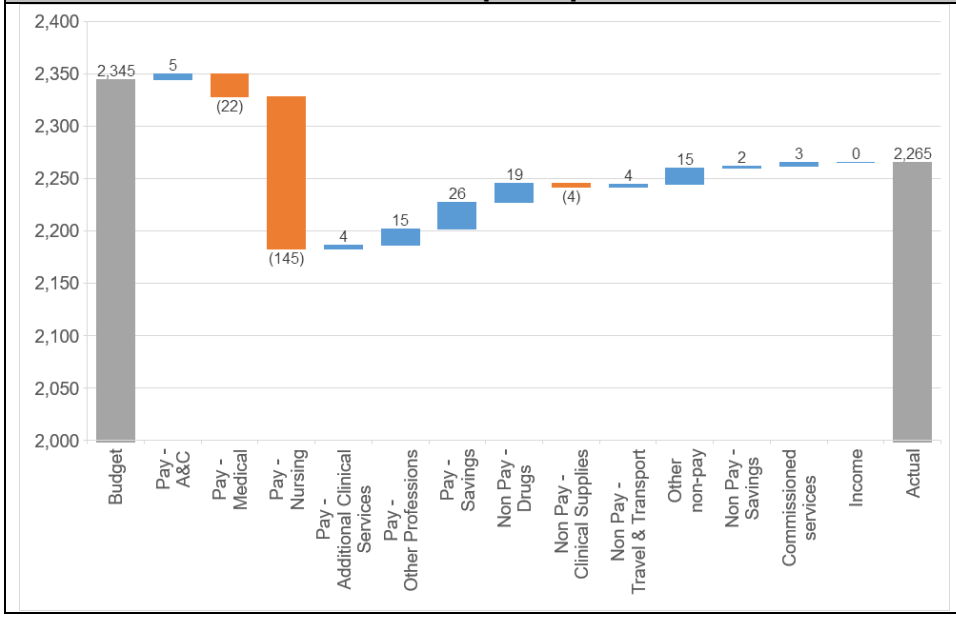
## Unscheduled Care: Glangwili General Hospital



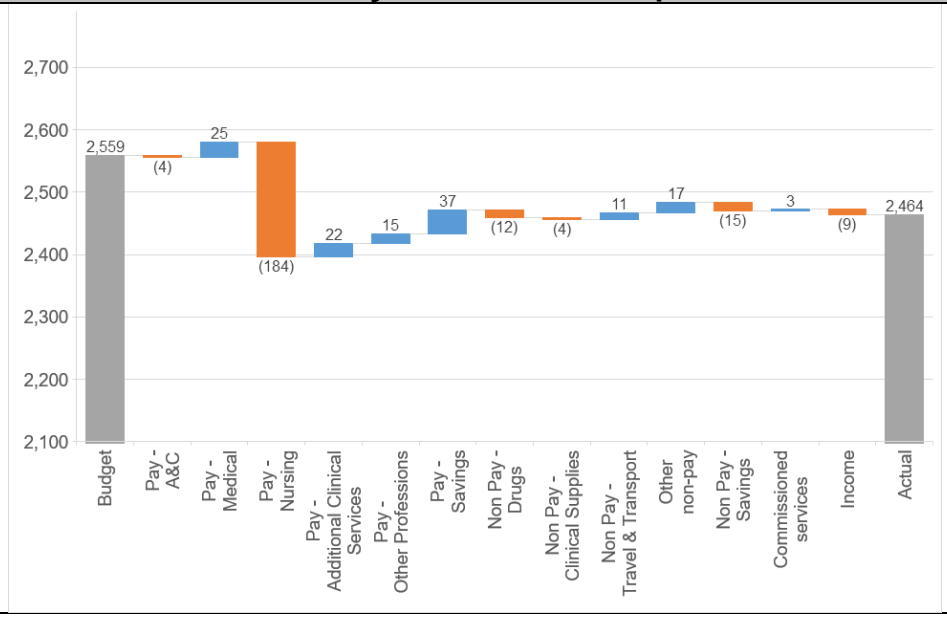

## Unscheduled Care: Bronglais General Hospital



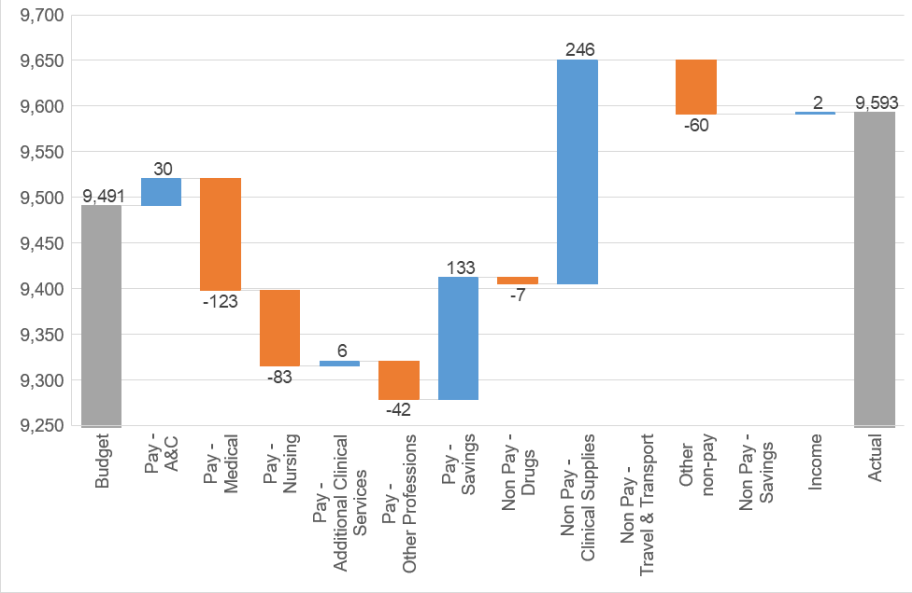
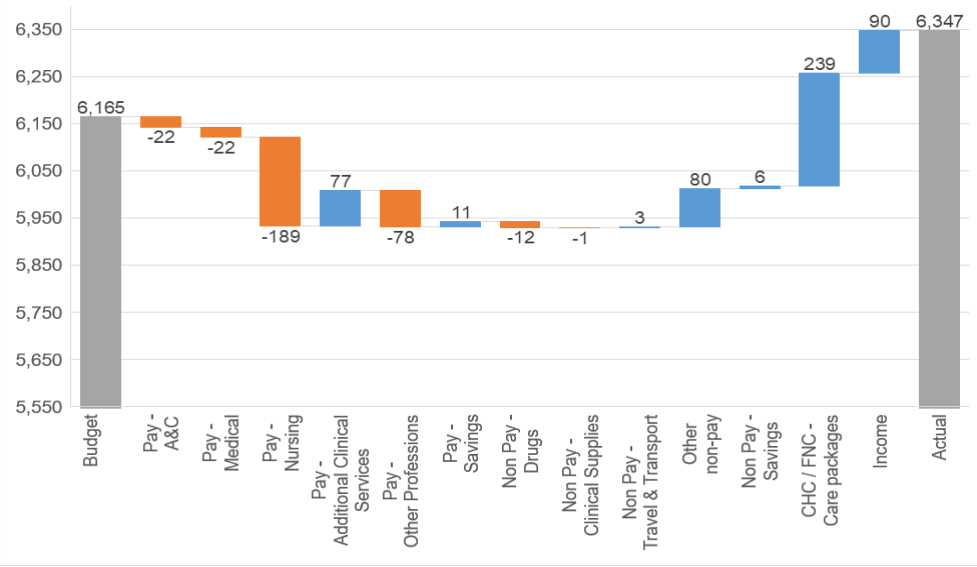

## Unscheduled Care: Prince Philip Hospital




## Unscheduled Care: Withybush General Hospital



# Appendix 1: Variance from Budget (in-month, £'000)

| Planned Care | MHLD |
|---|---|
|  |  |

# Appendix 2: Turnaround Update

## Turnaround update

**Section 1** – provides a summary of the 2018/19 year-end position for Directorates who are being monitored through the Chief Executive Holding to Account meetings. These Directorates were at an escalated status due to the assessed risk of them delivering their financial plans.

| Directorate | 18/19 savings plan £'000s | Savings delivered £'000s | Variance £'000s | Y/E position against budget £'000s |
|---|---|---|---|---|
| Facilities | 1,224 | 1,222 | 2 | 1,200 |
| MHLD | 2,957 | 2,101 | 856 | 500 |
| Pathology | 343 | 468 | (125) | 1,100 |
| Scheduled Care | 3,678 | 4,102 | (424) | 3,300 |
| BGH USC | 1,046 | 689 | 357 | 1,700 |
| GGH USC | 3,047 | 1,883 | 1,164 | 700 |
| PPH USC | 2,233 | 709 | 1,524 | 1,800 |
| WGH USC | 2,063 | 592 | 1,471 | 700 |
| Oncology & Cancer | 1,215 | 1,021 | 194 | 600 |
| **Total** | **17,806** | **12,787** | **5,019** | **11,600** |

# Appendix 2: Turnaround Update

**Section 2** - summarises the cumulative financial position and key actions for Directorates being monitored though the Turnaround Director Holding to Account meetings. These Directorates were considered to be on track with delivery of their financial plans.

| Directorate | 18/19 savings plan £'000s | Savings delivered £'000s | Variance £'000s | Y/E position £'000s |
|---|---|---|---|---|
| Carmarthenshire County | 656 | 265 | 391 | (200) |
| Ceredigion County | 191 | 143 | 48 | 400 |
| Pembrokeshire County | 295 | 252 | 43 | 300 |
| Women & Children's | 1,270 | 1,011 | 259 | (100) |
| Medicines Management | 3,407 | 4,124 | (717) | 1,600 |
| Radiology | 841 | 712 | 129 | (100) |
| Primary Care | 1,761 | 1,817 | (56) | (500) |
| **Total** | **8,421** | **8,324** | **97** | **1,400** |

# Appendix 2: Turnaround Update

**Section 3 –** provides an update position on the Turnaround 60 Day Cycle schemes.

| **Cataract pathway** | | | | |
|---|---|---|---|---|
| **Objective(s)** | **Savings identified 18/19 (£000's)** | **Savings delivered 18/19 (£000's)** | **18/19 achievements** | **19/20 Plan** |
| To increase cataract productivity so that the need to spend RTT is negated. | 140 | 140 | • Additional weekly session (6 procedures) introduced in Sept 2018.<br>• Direct listing developed and being implemented across the 3 Counties. This will reduce the number of hospital attendances for these patients, improving patient experience, will facilitate pathway redesign and joint working with the Community Optometrists. | Action Plan in place to increase cataract productivity so that the need to spend RTT is negated and to move W-AMD services to appropriate locations in order to free up theatre space for Cataracts. Project Group established in March 2019 and will report to the Turnaround Director at a fortnightly meeting. |
| **Continuing Health Care** | | | | |
| **Objective(s)** | **Savings identified 18/19 (£000's)** | **Savings delivered 18/19 (£000's)** | **Achievements** | **19/20 plans** |
| To strengthen the Long Term Care patient pathway through:<br>• The piloting of an expert nurse assessor role | 1,150 | 993<br><br>(FYE 18/19 savings to be worked | <u>Actual Efficiencies July – January 2019.</u><br>Cost avoidance (LTCNS in reach/named patient basis): £570k<br>Reduced LoS: £118k<br>Cease To Fund – Community LTCSN Pathway/named patient basis | Focus on:<br>• A review of the sustainability policy and how it can be utilised to maximum effect (this will make recommendations for further work )<br>• A scoping exercise/Training Needs |

# Appendix 2: Turnaround Update

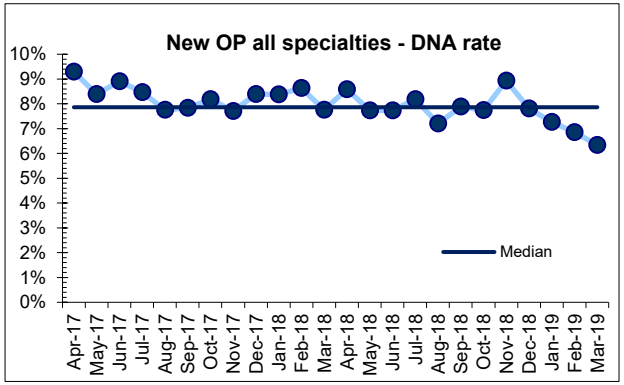
| | | | | |
|---|---|---|---|---|
| • Implementation of the Sustainability Policy<br>• Review of high cost packages of care. | | through, expected to achieve £1,150) | (cash savings): £305k<br>Total: £993k | analysis to inform training in CHC decision making and negotiation skills<br>• A root cause analysis of section 117 decisions in the context of the component part of the decision making process with EMI patients and where different decisions may be made in the future. The top 9 (expensive) Carmarthenshire cases will be reviewed. |
| To review externally funded Service Level Agreements and approved Welsh Government strategic bids. | 100 | 0 | | |
| To review the activity and impact of Neurology/Brain Injuries Community Team on CHC expenditure. | 0 | 0 | | |
| To review the pathway for young people who have a continuing care package or who are in receipt of Welsh Health Specialist Services Commissioning (WHSSC) (Transition Pathway). | 0 | 0 | | |

# Appendix 2: Turnaround Update

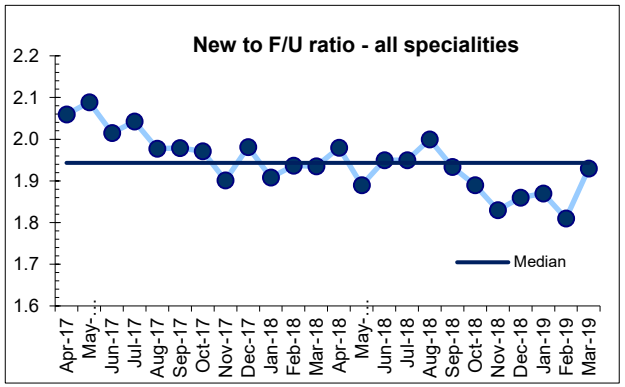
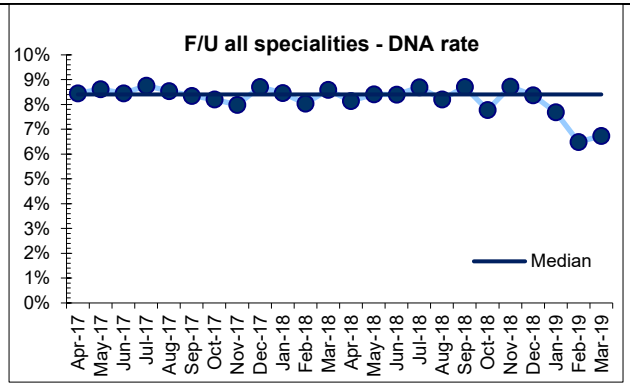
| **Non-medical furniture and equipment** | | | | |
|---|---|---|---|---|
| **Objective(s)** | **Savings identified 18/19 (£000's)** | **Savings delivered 18/19 (£000's)** | **18/19 achievements** | **19/20 Plan** |
| Explore feasibility of the benefits of introducing an electronic system for distributing, reusing and furniture, equipment, fixtures and fittings within the organisation. | 16 | 57 | • System commenced in August 2018<br>• HB has have avoided 1,545kg of waste and 5,290 KGeCO2 emissions<br>• Monthly cost (licence, a nominal cost for running the system) of £286 a month<br>• Full year effect of costs (8x£286) is £2,288<br>• Full cost avoidance is (£59,076 - £2,288) **£56,788** | The operations Board recognised the value of the system and Operations have supplied a dedicated resource to support roll-out. |
| **Operational Effectiveness** | | | | |
| **Objective(s)** | **Savings identified 18/19 (£000's)** | **Savings delivered 18/19 (£000's)** | **18/19 achievements** | **19/20 Plan** |
| To reduce Length of Stay by 1 day across the UHB, enabling the closure of unfunded surge capacity and further changes to capacity beyond that. | 4,700 | 1,284 | • Closure of 33 funded beds<br>• Surgical reconfiguration plan to maximise admission on the day of surgery<br>• Reconfiguration of ward into therapy-led reablement ward (GGH) | Terms of Reference of this group have been reviewed for 2019/20 with a view to strengthening alignment with the Unscheduled Care Board. All sites are developing detailed length of stay action plans that sit beneath the USC Board Action Plan. LOS plans will include |

| | | | | |
|---|---|---|---|---|
| | | | • Introduction of geriatrician in care homes in Llanelli (TOCALS+), Bridging service, Early Supported Discharge scheme (WGH)<br>• Bridging service - provides domiciliary care providers with additional funding allowing the recruitment of additional staff to meet increased demand.<br>• From November 2018 – improved process, function and flow at front door saw significant improvement in A&E performance and ambulance delay reduction (BGH)<br>• Sustained ambulatory and 'fit to sit' principle, maintained a CDU LOS of 23 hours or less (BGH)<br>• Safety huddles x 5 day in A&E (GGH)<br>• Fully recruited to acute physicians post – hot clinics in place (GGH)<br>• Ambulatory care pathway development (GGH)<br>• Electronic bed meetings in place (GGH) | metrics, measurements, timescales and anticipated outcomes. Operational Effectiveness dashboard will continue to be developed. |

# Appendix 2: Turnaround Update

| **Outpatients** | | | | |
|---|---|---|---|---|
| **Objective(s)** | **Savings identified 18/19 (£000's)** | **Savings delivered 18/19 (£000's)** | **18/19 achievements** | **19/20 Plan** |
| To make efficiency and productivity improvements that increase availability of core capacity and mitigate the need for other high cost, premium rate activity relating to national waiting times and access targets. E&P outpatient efficiency savings include a reduction in new to F/U appointments and DNA rates for all specialities, with specific schemes for dermatology, rheumatology, ENT, urology and general surgery. | 825 | 19 (reduction in RTT funding)<br><br>Efficiency savings of £283k have been identified in relation to DNAs.<br><br>Efficiency savings of £251 have been identified in relation to New to F/U ratios. | 7 services are now using E-referrals with more expected to come on line in the next few weeks. Discussions have taken place with Cluster leads with a view to rolling E-referrals out to GPs.<br><br>Follow up and discharge criteria has been developed for Gynaecology patients A case study produced by the SDM confirms a 69% reduction in Follow-ups Not Booked since April 2017.<br><br>Respiratory trial to undertake diagnostic tests prior to a new appointment has indicated that the sleep apnoea pathway has reduced from 174 days to 56 days.<br><br>New to Follow Up ratios and DNA rates have been showing signs of improvement over the last few months. | Continued focus on<br>• Outcome form compliance<br>• Virtual clinics<br>• Self-management – prostate patients<br>• Patient pathway management<br>• E-referrals<br>• Management of 'Seen on Symptoms' (SOS) patients<br>• Follow-ups not booked (FUNB)<br><br>  |

# Appendix 2: Turnaround Update

| | | | | |
|---|---|---|---|---|
| | | (As at Jan 19) |  |  |

| **Patient Communications** | | | | |
|---|---|---|---|---|
| **Objective(s)** | **Savings identified 18/19 (£000's)** | **Savings delivered 18/19 (£000's)** | **18/19 achievements** | **19/20 Plan** |
| To reduce the cost of patient communications in relation to appointment letters and results. | 230 (efficiency savings for Text Reminder Service) | Not confirmed | Phase 1 – Phase 1 of the text reminder service commenced in October 2018 for all speciality clinics managed through the Contact Centre (excluding paediatrics). Analysis is underway to map DNA rates by speciality to text reminders sent and to understand efficiency savings. | Key areas of continued focus for 2019/20 will include:<br>• Text reminder service<br>• Patient Knows Best (PKB)<br>• Electronic reporting of results<br>• Centralised post processing and distribution |

# Appendix 2: Turnaround Update

| | | | | |
|---|---|---|---|---|
| | | | Update on Phase 1 will be presented to the Executive Team in April 2019.<br><br>Phase 2 - A test plan has been developed for IVM, which will be circulated to patients who have signed up to the service. Now looking to implement a 1-way reminder service for patients that do not book their appointments through the Appointment Centre.<br><br>PKB - extensive engagement from ENT, Respiratory and other areas of the Health Board to understand desired transformations in clinical pathways. Non- integrated deployments have gone live with use of PKB (August - September 2018) in a number of teams. Since October 2018, a team has been established to use PKB to monitor nodule patients in the respiratory service. Patient Knows Best (PKB) – testing in progress. Once complete the system will go live. Mass registration options are being considered. | |

# Appendix 2: Turnaround Update

| | | | | |
|---|---|---|---|---|
| | | | The Orthopaedics pilot to longer send confirmation letters and using the new Text reminder service as an alternative will continue to run until the end of March 19. DNA rates are being monitored. Update not yet available.<br><br>The scoping exercise to identify opportunities to implement the electronic reporting of warfarin results back to patients has concluded. Update not yet available. | |

| **Roster Efficiency** | | | | |
|---|---|---|---|---|
| **Objective(s)** | **Savings identified 18/19 (£000's)** | **Savings delivered 18/19 (£000's)** | **18/19 achievements** | **19/20 Plan** |
| | | | | |

# Appendix 2: Turnaround Update

To reduce usage and expenditure on of temporary nursing staff and to ensure that temporary staffing (overtime, bank and agency) are only used when clinically assessed as necessary.

A savings figure has not been identified as this group focuses on supporting the corporate plan to reduce variable pay.

The number of wards running a 6 week roster increased from 7 at the start of this process (June 18) to 37 as at 9th April 19.

Improvements have been seen across all sites.

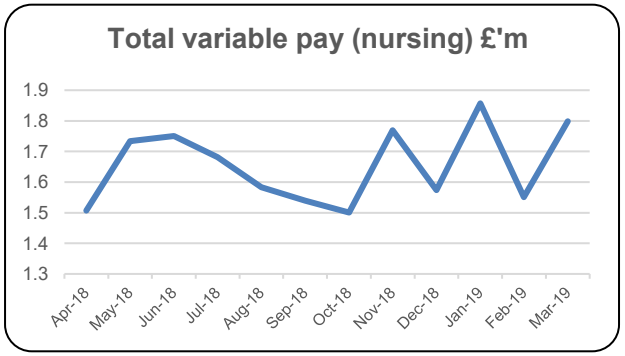
| | 6 week roster | |
|---|---|---|
| Site | % compliant June 18 | % compliant 09.04.19 |
| BGH | 20% | 83% |
| GGH | 23% | 78% |
| PPH | 10% | 100% |
| WGH | 20% | 89% |

| | A/L management | |
|---|---|---|
| Site | % compliant June 18 | % compliant 09.04.19 |
| BGH | 40% | 100% |
| GGH | 92% | 87% |
| PPH | 80% | 100% |
| WGH | 90% | 100% |

| | Time balance management | |
|---|---|---|
| Site | % compliant Day 0 | % compliant 09.4.19 |
| BGH | 60% | 80% |
| GGH | 62% | 85% |
| PPH | 70% | 100% |
| WGH | 80% | 100% |

A work plan for 2019/20 is being scoped and will include sites and wards that sit outside of the Nurse Staffing Levels Act section 25b.

Monthly variable pay costs have fluctuated over the winter months.



# Appendix 2: Turnaround Update

| | EWTD Compliance | |
|---|---|---|
| **Site** | **% compliant Day 0** | **% compliant 09.04.19** |
| BGH | 0% | 100% |
| GGH | 38% | 85% |
| PPH | 10% | 100% |
| WGH | 10% | 100% |

# Appendix 2: Turnaround Update

| **Theatres** | | | | |
|---|---|---|---|---|
| **Objective(s)** | **Savings identified 18/19 (£000's)** | **Savings delivered 18/19 (£000's)** | **18/19 achievements** | **19/20 Plan** |
| To reduce non-pay expenditure through better procurement and standardisation of items used. | 368 | 368 | • Sutures (potential 14k FYE)<br>• Trauma nails, screws and plates (potential 50k FYE)<br>• Loan kits – pilot almost complete. Aim is to limit to two suppliers. Engagement key to successful change.<br>• Maintenance of theatres and plant is now done collaboratively saving 300 operating sessions per annum<br><br>With some 3,600 items across the shelves and sites, this will be a perpetual piece of work, with items being reviewed in batches or specialties across the coming years. | Loan Kit – progress work to enable a move to two suppliers<br>Procurement<br>• Gloves<br>• Bone chips and putty<br>• Cement<br>• Hips<br>• Energy<br>• Knees<br><br>PICC Lines – Group established and working towards standardisation of products and application. |
| To focus on efficiency opportunities around process and pathways. | 0 | Unknown | The Theatre dashboard is active and available on IRIS. The data is highlighting some interesting patterns associated with avoidable cancelled operations. | An improvement plan is to be made developed after three months use (Apr-19) which will inform the work programme for 19/20. |
| To review maintenance contracts for Theatres | 0 | Unknown | Maintenance of theatres and plant review has saved 300 operating | Further opportunities being progressed in 2019/20. |

| | | | | |
|---|---|---|---|---|
| equipment and services. | | | sessions per annum. Some reductions achieved in 2018/19 with further opportunity being progressed in 2019/20 | |

| **Travel and Subsistence** | | | | |
|---|---|---|---|---|
| **Objective(s)** | **Savings identified 18/19 (£000's)** | **Savings delivered 18/19 (£000's)** | **18/19 achievements** | **19/20 Plan** |
| To identify and co-ordinate a consistent approach to travel and subsistence claiming processes with a view to supporting directorates to meet their savings targets for 2018/19. | 450 | 192 (as at Month 11 – Month 12 actual not available at time of reporting) | • Q&A briefing for staff agreed and with translation. To be circulated on global email and uploaded to intranet.<br>• E-expenses system updated to make it easier to search for addresses.<br>• Potential reduction in the number of subsistence claims for some items.<br>• Controls implemented on E-Expenses system to prevent out of policy claiming practices. | Key areas of focus for 19/20 will include:<br>• Reduction in use of grey fleet<br>• Study Leave<br>• Review of bases |

# Appendix 2: Turnaround Update

**Section 4** – Summarises 19/20 Directorate savings plans against their required savings target of 3.7%. The figures included in this section are based on the known position as at 9th April 2019 and will be subject to change with the identification of further savings opportunities.

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Facilities** | **19/20 target £'000s** | **1,385** | **Total plans £'000s** | | **1,324** | **Variance £'000s** | | **61** |
| | **Scheme** | | **Status** | | | **Total £'000 (PYE)** | **Total £'000 (FYE)** | |
| | | | **£'000 (PYE)** | **£'000 (PYE)** | **£'000 (PYE)** | | | |
| | Utilities – non pay | | 87 | 596 | 0 | 683 | 313 | |
| | Income generation - crèche, dining room – non pay | | 46 | 0 | 0 | 46 | 50 | |
| | Workforce – various schemes | | 408 | 0 | 187 | 595 | 517 | |
| | **Total** | | **541** | **596** | **187** | **1,324** | **880** | |
| **Mental Health** | **19/20 target £'000s** | **2,691** | **Total plans £'000s** | | **1,900** | **Variance £'000s** | | **791** |
| | **Scheme** | | **Status** | | | **Total £'000 (PYE)** | **Total £'000 (FYE)** | |
| | | | **£'000 (PYE)** | **£'000 (PYE)** | **£'000 (PYE)** | | | |
| | Service redesign and ward reconfiguration - pay | | 200 | 120 | 163 | 483 | 785 | |
| | Workforce – nursing variable pay and roster efficiency | | 144 | 36 | 0 | 180 | 180 | |
| | Workforce – various schemes | | 450 | 43 | 0 | 493 | 196 | |
| | Income generation – external funding | | 276 | 0 | 0 | 276 | 0 | |
| | Commissioned services | | 38 | 295 | 0 | 333 | 352 | |
| | Review of budgets - housekeeping | | 136 | 0 | 0 | 136 | 136 | |
| | **Total** | | **1,243** | **494** | **163** | **1,900** | **1,649** | |

# Appendix 2: Turnaround Update

| Pathology | 19/20 target £'000s | 741 | Total plans £'000s | 740 | Variance £'000s | 1 |
|---|---|---|---|---|---|---|

| Scheme | Status | | | Total £'000 (PYE) | Total £'000 (FYE) |
|---|---|---|---|---|---|
| | £'000 (PYE) | £'000 (PYE) | £'000 (PYE) | | |
| Demand optimisation – secondary care | 0 | 0 | 421 | 421 | 421 |
| Other non-pay schemes | 62 | 152 | 0 | 214 | 256 |
| Workforce – recruitment to substantive consultant post | 0 | 50 | 0 | 50 | 50 |
| Medicines management | 55 | 0 | 0 | 55 | 55 |
| **Total** | **117** | **202** | **421** | **740** | **782** |

# Appendix 2: Turnaround Update

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Scheduled Care** | **19/20 target £'000s** | **3,682** | **Total plans £'000s** | **3,667** | **Variance £'000s** | | **15** |
| | **Scheme** | **Status** | | | **Total £'000 (PYE)** | **Total £'000 (FYE)** | |
| | | **£'000 (PYE)** | **£'000 (PYE)** | **£'000 (PYE)** | | | |
| | Procurement | 78 | 0 | 0 | 78 | 121 | |
| | Housekeeping | 250 | 0 | 0 | 250 | 250 | |
| | Drug prescription scrutiny | 122 | 0 | 0 | 122 | 244 | |
| | Workforce – various schemes | 630 | 0 | 0 | 630 | 643 | |
| | Operational Effectiveness | 100 | 238 | 1,400 | 1,738 | 1,786 | |
| | Efficiency & Productivity | 0 | 179 | 0 | 179 | 200 | |
| | Outpatients – referral management and follow ups | 0 | 575 | 0 | 575 | 760 | |
| | Ophthalmology – Eye Care Measures | 0 | 50 | 0 | 50 | 60 | |
| | Commissioned services | 45 | 0 | 0 | 45 | 45 | |
| | **Total** | **1,225** | **1,042** | **1,400** | **3,667** | **4,109** | |
| **BGH USC** | **19/20 target £'000s** | **786** | **Total plans £'000s** | **966** | **Variance £'000s** | | **(180)** |
| | **Scheme** | **Status** | | | **Total £'000 (PYE)** | **Total £'000 (FYE)** | |
| | | **£'000 (PYE)** | **£'000 (PYE)** | **£'000 (PYE)** | | | |
| | Non-pay schemes | 48 | 0 | 0 | 48 | 48 | |
| | Workforce – nursing variable pay and roster efficiencies | 591 | 0 | 0 | 591 | 591 | |
| | Ward reconfiguration | 0 | 102 | 0 | 102 | 265 | |
| | Operational Effectiveness | 0 | 175 | 0 | 175 | 175 | |
| | Income generation – LTA/SLA opportunities | 0 | 50 | 0 | 50 | 50 | |
| | **Total** | **639** | **327** | **0** | **966** | **1,129** | |

# Appendix 2: Turnaround Update

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| GGH USC | **19/20 target £'000s** | **1,557** | **Total plans £'000s** | | **1,253** | **Variance £'000s** | **304** |
| | **Scheme** | | **Status** | | | **Total £'000 (PYE)** | **Total £'000 (FYE)** |
| | | | **£'000 (PYE)** | **£'000 (PYE)** | **£'000 (PYE)** | | |
| | Non-pay schemes | | 21 | 10 | 0 | 31 | 51 |
| | Workforce – roster control and nurse recruitment | | 843 | 0 | 0 | 843 | 885 |
| | Workforce – other | | 160 | 0 | 0 | 160 | 12 |
| | Operational Effectiveness | | 0 | 219 | 0 | 219 | 438 |
| | **Total** | | **1,024** | **229** | **0** | **1,253** | **1,386** |
| PPH USC | **19/20 target £'000s** | **931** | **Total plans £'000s** | | **686** | **Variance £'000s** | **245** |
| | **Scheme** | | **Status** | | | **Total £'000 (PYE)** | **Total £'000 (FYE)** |
| | | | **£'000 (PYE)** | **£'000 (PYE)** | **£'000 (PYE)** | | |
| | Non-pay schemes | | 9 | 15 | 0 | 24 | 33 |
| | Workforce- nurse recruitment | | 32 | 0 | 0 | 32 | 64 |
| | Workforce - MIU | | 0 | 104 | 0 | 104 | 235 |
| | Operational Effectiveness | | 0 | 526 | 0 | 526 | 1,054 |
| | **Total** | | **41** | **645** | **0** | **686** | **1,386** |

# Appendix 2: Turnaround Update

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **WGH USC** | **19/20 target £'000s** | **1,039** | **Total plans £'000s** | | **1,070** | **Variance £'000s** | **(31)** |
| | **Scheme** | | **Status** | | | **Total £'000 (PYE)** | **Total £'000 (FYE)** |
| | | | **£'000 (PYE)** | **£'000 (PYE)** | **£'000 (PYE)** | | |
| | Workforce – nurse variable pay | | 75 | 0 | 0 | 75 | 75 |
| | Workforce – medical staffing | | 459 | 0 | 0 | 459 | 433 |
| | Housekeeping | | 59 | 0 | 0 | 59 | 118 |
| | Operational Effectiveness | | 0 | 297 | 0 | 297 | 297 |
| | Ward refurb & relocation | | 180 | 0 | 0 | 180 | 0 |
| | **Total** | | **773** | **297** | **0** | **1,070** | **923** |
| **Carmarthenshire County** | **19/20 target £'000s** | **884** | **Total plans £'000s** | | **825** | **Variance £'000s** | **59** |
| | **Scheme** | | **Status** | | | **Total £'000 (PYE)** | **Total £'000 (FYE)** |
| | | | **£'000 (PYE)** | **£'000 (PYE)** | **£'000 (PYE)** | | |
| | Non-pay schemes | | 0 | 104 | 0 | 104 | 107 |
| | Commissioned services | | 0 | 100 | 0 | 100 | 100 |
| | Income generation | | 0 | 20 | 0 | 20 | 20 |
| | Workforce –nurse variable pay | | 0 | 39 | 0 | 39 | 39 |
| | Workforce – nursing other | | 0 | 277 | 0 | 277 | 44 |
| | Workforce – other | | 0 | 285 | 0 | 285 | 359 |
| | **Total** | | **0** | **825** | **0** | **825** | **669** |

# Appendix 2: Turnaround Update

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Ceredigion County** | **19/20 target £'000s** | **415** | **Total plans £'000s** | **190** | **Variance £'000s** | | **225** |
| | **Scheme** | **Status** | | | **Total £'000 (PYE)** | **Total £'000 (FYE)** | |
| | | **£'000 (PYE)** | **£'000 (PYE)** | **£'000 (PYE)** | | | |
| | Non-pay schemes (travel) | 0 | 5 | 0 | 5 | 5 | |
| | Commissioned services | 30 | 30 | 0 | 60 | 60 | |
| | Workforce- vacancies | 115 | 0 | 0 | 115 | 0 | |
| | Workforce - other | 10 | 0 | 0 | 10 | 10 | |
| | **Total** | **155** | **35** | **0** | **190** | **75** | |
| **Pembrokeshire County** | **19/20 target £'000s** | **729** | **Total plans £'000s** | **711** | **Variance £'000s** | | **18** |
| | **Scheme** | **Status** | | | **Total £'000 (PYE)** | **Total £'000 (FYE)** | |
| | | **£'000 (PYE)** | **£'000 (PYE)** | **£'000 (PYE)** | | | |
| | Non-pay schemes | 25 | 53 | 0 | 78 | 78 | |
| | Commissioned services | 9 | 0 | 0 | 9 | 9 | |
| | Workforce- nurse variable pay due to sickness | 50 | 0 | 0 | 50 | 50 | |
| | Operational Effectiveness | 50 | 0 | 0 | 50 | 50 | |
| | Community model slippage/OCP | 106 | 0 | 0 | 106 | 0 | |
| | CHC & FNC | 30 | 0 | 388 | 418 | 418 | |
| | **Total** | **270** | **53** | **388** | **711** | **605** | |

# Appendix 2: Turnaround Update

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Women & Children** | **19/20 target £'000s** | **1,359** | **Total plans £'000s** | **630** | **Variance £'000s** | | **729** |
| | **Scheme** | | **Status** | | | **Total £'000 (PYE)** | **Total £'000 (FYE)** |
| | | | **£'000 (PYE)** | **£'000 (PYE)** | **£'000 (PYE)** | | |
| | Non-pay schemes | | 108 | 0 | 108 | 216 | 338 |
| | Efficiency & Productivity | | 70 | 0 | 0 | 70 | 80 |
| | Workforce - nursing | | 18 | 90 | 0 | 108 | 144 |
| | Workforce – medical staffing | | 193 | 0 | 0 | 193 | 231 |
| | Workforce - other | | 43 | 0 | 0 | 43 | 34 |
| | **Total** | | **432** | **90** | **108** | **630** | **827** |
| **Medicines Management** | **19/20 target £'000s** | **2,934** | **Total plans £'000s** | **2,098** | **Variance £'000s** | | **836** |
| | **Scheme** | | **Status** | | | **Total £'000 (PYE)** | **Total £'000 (FYE)** |
| | | | **£'000 (PYE)** | **£'000 (PYE)** | **£'000 (PYE)** | | |
| | Prescribing | | 722 | 478 | 258 | 1,458 | 1,485 |
| | Secondary Care | | 383 | 257 | 0 | 640 | 892 |
| | **Total** | | **1,105** | **735** | **258** | **2,098** | **2,377** |
| **Oncology & Cancer** | **19/20 target £'000s** | **438** | **Total plans £'000s** | **314** | **Variance £'000s** | | **124** |
| | **Scheme** | | **Status** | | | **Total £'000 (PYE)** | **Total £'000 (FYE)** |
| | | | **£'000 (PYE)** | **£'000 (PYE)** | **£'000 (PYE)** | | |
| | Non-pay schemes | | 240 | 0 | 0 | 240 | 240 |
| | Workforce - oncology pharmacist | | 24 | 0 | 0 | 24 | 236 |
| | Medicines management | | 50 | 0 | 0 | 50 | 50 |
| | **Total** | | **314** | **0** | **0** | **314** | **526** |

# Appendix 2: Turnaround Update

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Primary Care** | **19/20 target £'000s** | **790** | **Total plans £'000s** | | **1,285** | **Variance £'000s** | **(495)** |
| | **Scheme** | | **Status** | | | **Total £'000 (PYE)** | **Total £'000 (FYE)** |
| | | | **£'000 (PYE)** | **£'000 (PYE)** | **£'000 (PYE)** | | |
| | Non-pay – return of GP practice to independent status | | 0 | 0 | 388 | 388 | 388 |
| | Workforce – medical staffing | | 670 | 70 | 0 | 740 | 740 |
| | Commissioned services – GP Hub | | 0 | 157 | 0 | 157 | 157 |
| | **Total** | | **670** | **227** | **388** | **1,285** | **1,285** |
| **Radiology** | **19/20 target £'000s** | **584** | **Total plans £'000s** | | **795** | **Variance £'000s** | **(211)** |
| | **Scheme** | | **Status** | | | **Total £'000 (PYE)** | **Total £'000 (FYE)** |
| | | | **£'000 (PYE)** | **£'000 (PYE)** | **£'000 (PYE)** | | |
| | Non-pay – reduction in outsourcing | | 390 | 0 | 0 | 390 | 390 |
| | Workforce – review of 24 hour provision | | 0 | 405 | 0 | 405 | 607 |
| | **Total** | | **390** | **405** | **0** | **795** | **997** |

# Appendix 2: Turnaround Update

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Therapies** | **19/20 target £'000s** | **669** | **Total plans £'000s** | | **249** | **Variance £'000s** | | **420** |
| | **Scheme** | | **Status** | | | **Total £'000 (PYE)** | **Total £'000 (FYE)** | |
| | | | **£'000 (PYE)** | **£'000 (PYE)** | **£'000 (PYE)** | | | |
| | Workforce – various schemes | | 233 | 0 | 0 | 233 | 142 | |
| | Housekeeping | | 16 | 0 | 0 | 16 | 16 | |
| | **Total** | | **249** | **0** | **0** | **249** | **158** | |
| **Corporate** | **19/20 target £'000s** | **1,319** | **Total plans £'000s** | | **1,209** | **Variance £'000s** | | **110** |
| | **Scheme** | | **Status** | | | **Total £'000 (PYE)** | **Total £'000 (FYE)** | |
| | | | **£'000 (PYE)** | **£'000 (PYE)** | **£'000 (PYE)** | | | |
| | Corporate schemes | | 1,005 | 26 | 179 | 1,209 | 1,092 | |
| | **Total** | | **1,005** | **26** | **179** | **1,209** | **1,092** | |
| **Total** | **19/20 target £'000s** | **22,933** | **Total plans £'000s** | | **19,913** | **Variance £'000s** | | **3,020** |
| | **Scheme** | | **Status** | | | **Total £'000 (PYE)** | **Total £'000 (FYE)** | |
| | | | **£'000 (PYE)** | **£'000 (PYE)** | **£'000 (PYE)** | | | |
| | **Total** | | **10,193** | **6,228** | **3,492** | **19,913** | **20,855** | |

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

**CYFARFOD BWRDD PRIFYSGOL IECHYD**
**UNIVERSITY HEALTH BOARD MEETING**

| | |
|---|---|
| **DYDDIAD Y CYFARFOD:**<br>**DATE OF MEETING:** | 30 May 2019 |
| **TEITL YR ADRODDIAD:**<br>**TITLE OF REPORT:** | Finance and Turnaround Update – Month 1 2019/20 |
| **CYFARWYDDWR ARWEINIOL:**<br>**LEAD DIRECTOR:** | Huw Thomas, Director of Finance |
| **SWYDDOG ADRODD:**<br>**REPORTING OFFICER:** | Fiona Powell, Assistant Director of Finance |

| **Pwrpas yr Adroddiad** (dewiswch fel yn addas)<br>**Purpose of the Report** (select as appropriate) |
|---|
| Ar Gyfer Trafodaeth/For Discussion |

**ADRODDIAD SCAA**
**SBAR REPORT**

## Sefyllfa / Situation

The purpose of this report is to outline the Health Board's financial position to date against our Annual Plan and Control Total requirement; and assess the key financial projections and risks for the financial year.

## Cefndir / Background

The Health Board's financial position at the end of Month 1 represented an adverse variance against plan of £0.4m. This position was driven by bed pressures in Unscheduled and Critical Care.

The Health Board's control total is £25m and plans are being developed to achieve this position. This is a required improvement of £4.8m on the Health Board's Annual Plan deficit of £29.8m, which will require the identification of further actionable savings schemes.

£0.8m of savings schemes were delivered in Month 1. The total required savings is £28.8m for the year. The current gap in identified assured savings schemes is £10.3m, against which there are identified pipeline opportunities of £8.3m.

The risk of delivering the forecast is rated High, given the balance remaining of pipeline and unidentified savings schemes and in recognition of the critical need for the delivery profile to accelerate significantly in order to achieve the full savings requirement.

With the in-month operational run rate being £0.4m, there must also be acknowledgment that there will always be an operational risk that needs to be managed. Escalated Holding to Account meetings are being held with the challenged Directorates to convert pipeline into robust schemes and identify additional recovery actions and opportunities.

## Asesiad / Assessment

The Health Board's key targets are as follows:

- Revenue: to contain the overspend within the Health Board's planned deficit
- Savings: to deliver savings plans to enable the revenue budget to be achieved
- Capital: to contain expenditure within the agreed limit
- PSPP: to pay 95% of Non-NHS invoices within 30 days of receipt of a valid invoice
- Cash: While there is no prescribed limit for cash held at the end of the month, WG encourages this to be minimised and a rule of thumb of 5% of monthly expenditure is used. For the Health Board, this is broadly £4.0m.

| Key target | | Annual limit | YTD limit | Actual delivery | Forecast Risk |
|---|---|---|---|---|---|
| **Revenue** | **£'m** | 25.0 | 2.5 | 2.9 | **High*** |
| **Savings** | **£'m** | 28.8 | 0.8 | 0.8 | **High*** |
| **Capital** | **£'m** | 39.3 | 1.7 | 1.7 | **Medium** |
| **Non-NHS PSPP** | **%** | 95 | 95 | n/a in Month 1 | **Low** |
| **Period end cash** | **£'m** | 4.0 | 4.0 | 2.7 | **Medium**** |

* Inclusive of the Welsh Government Control Total requirement.
** Assumes Welsh Government strategic repayable support for the planned deficit position.

## Argymhelliad / Recommendation

The Board is asked to note and discuss the financial position for Month 1.

| **Amcanion: (rhaid cwblhau)<br>Objectives: (must be completed)** | |
|---|---|
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:<br>Datix Risk Register Reference and Score: | BAF S09-PR20<br>BAF SO10-PR33 |
| Safon(au) Gofal ac Iechyd:<br>Health and Care Standard(s): | 5. Timely Care<br>7. Staff and Resources |
| Amcanion Strategol y BIP:<br>UHB Strategic Objectives: | All Strategic Objectives are applicable |
| Amcanion Llesiant BIP:<br>UHB Well-being Objectives:<br>Hyperlink to HDdUHB Well-being Statement | Improve efficiency and quality of services through collaboration with people, communities and partners |

| **Gwybodaeth Ychwanegol:<br>Further Information:** | |
|---|---|
| Ar sail tystiolaeth:<br>Evidence Base: | Monitoring returns to Welsh Government based on the Health Board's financial reporting system. |
| Rhestr Termau:<br>Glossary of Terms: | BGH – Bronglais General Hospital<br>CHC – Continuing Healthcare |

| | |
|---|---|
| | CIP – Cost Improvement Programme<br>ENT – Ear, Nose and Throat<br>DES – Direct Enhanced Services<br>DNA – Did Not Attend<br>FNC – Funded Nursing Care<br>FYE – Full Year Effect<br>GGH – Glangwili General Hospital<br>GMS – General Medical Services<br>IPFR – Individual Patient Funding Request<br>LTAs – Long Term Agreements<br>MHLD – Mental Health & Learning Disabilities<br>MDT – Multi-Disciplinary Team<br>NICE – National Institute for Health and Care Excellence<br>OOH – Out of Hours<br>PPH – Prince Philip Hospital<br>PSPP– Public Sector Payment Policy<br>RTT – Referral to Treatment<br>T&O – Trauma & Orthopaedics<br>USC – Unscheduled Care<br>VC – Video Conferencing<br>VFM – Value For Money<br>W-AMD – Wet Age-related Macular Degeneration<br>WG – Welsh Government<br>WGH – Withybush General Hospital<br>WRP – Welsh Risk Pool<br>WHSSC – Welsh Health Specialised Services Committee<br>YTD – Year to date |
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y pwyllgor cyllid:<br>Parties / Committees consulted prior to University Health Board: | Finance Committee |

| **Effaith: (rhaid cwblhau)<br>Impact: (must be completed)** | |
|---|---|
| **Ariannol / Gwerth am Arian:<br>Financial / Service:** | Financial impacts and considerations are inherent in the report. |
| **Ansawdd / Gofal Claf:<br>Quality / Patient Care:** | These are assessed as part of our savings planning. |
| **Gweithlu:<br>Workforce:** | The report discusses the impact of both variable pay and substantive pay. |
| **Risg:<br>Risk:** | Financial risks are detailed in the report. |
| **Cyfreithiol:<br>Legal:** | The Health Board has a legal duty to deliver a breakeven financial position over a rolling three-year basis and an administrative requirement to operate within its budget within any given financial year. |
| **Enw Da:<br>Reputational:** | Adverse variance against the Health Board's financial plan will affect our reputation with Welsh Government, the Wales Audit Office, and with external stakeholders. |

| | |
|---|---|
| **Gyfrinachedd:**<br>**Privacy:** | Not Applicable |
| **Cydraddoldeb:**<br>**Equality:** | Not Applicable |

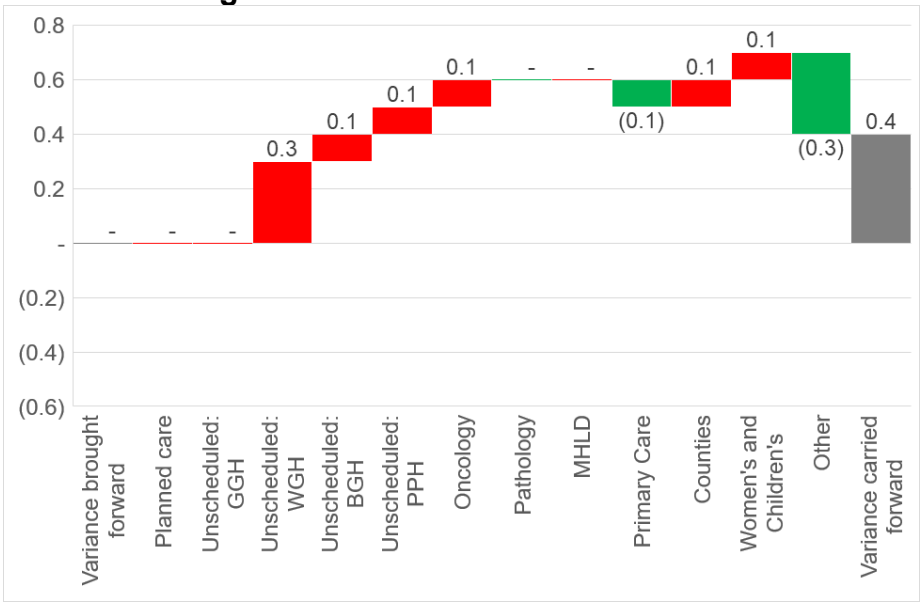
# 1. Directorate revenue position

### 1.1 Directorate financial performance

**Year to date**

| | Month 1 Actual £'m | Month 1 Variance £'m | % |
|---|---|---|---|
| Planned | 8.6 | 0.0 | - |
| Unscheduled - GGH | 1.9 | 0.1 | 5.3 |
| Unscheduled - PPH | 2.3 | 0.1 | 4.3 |
| Unscheduled - WGH | 3.6 | 0.0 | - |
| Unscheduled - BGH | 2.7 | 0.3 | 12.5 |
| Radiology | 1.4 | 0.0 | - |
| Pathology | 1.7 | 0.0 | - |
| Women's and Children's | 3.2 | 0.1 | 3.1 |
| Cancer | 1.2 | 0.1 | 9.1 |
| Carmarthen County | 1.0 | 0.0 | - |
| Pembrokeshire County | 2.1 | 0.0 | - |
| Ceredigion County | 1.8 | 0.1 | 5.9 |
| MHLD | 6.2 | 0.0 | - |
| Facilities | 3.2 | 0.0 | - |
| Medicines Management | 6.4 | 0.0 | - |
| Primary Care | 8.8 | (0.1) | (1.1) |
| Corporate | 3.2 | 0.0 | - |
| Commissioning | 8.2 | 0.0 | - |
| Other | 6.5 | (0.3) | (4.4) |
| **Total** | **74.0** | **0.4** | **0.5** |

**In-month change**

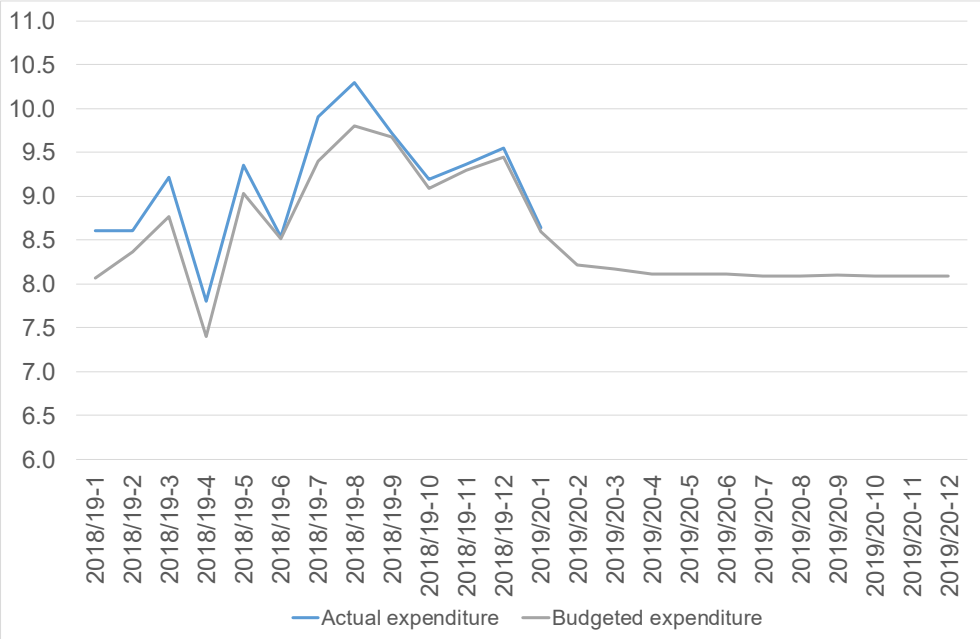



- In the current month was over spent by £0.4m due to bed pressures in Unscheduled and Critical Care.
- The year to date pressure has been particularly pronounced in Unscheduled Care (£0.5m, driven by bed capacity).
- Material positions are reported in Section 2.2.

# 1. Directorate revenue position

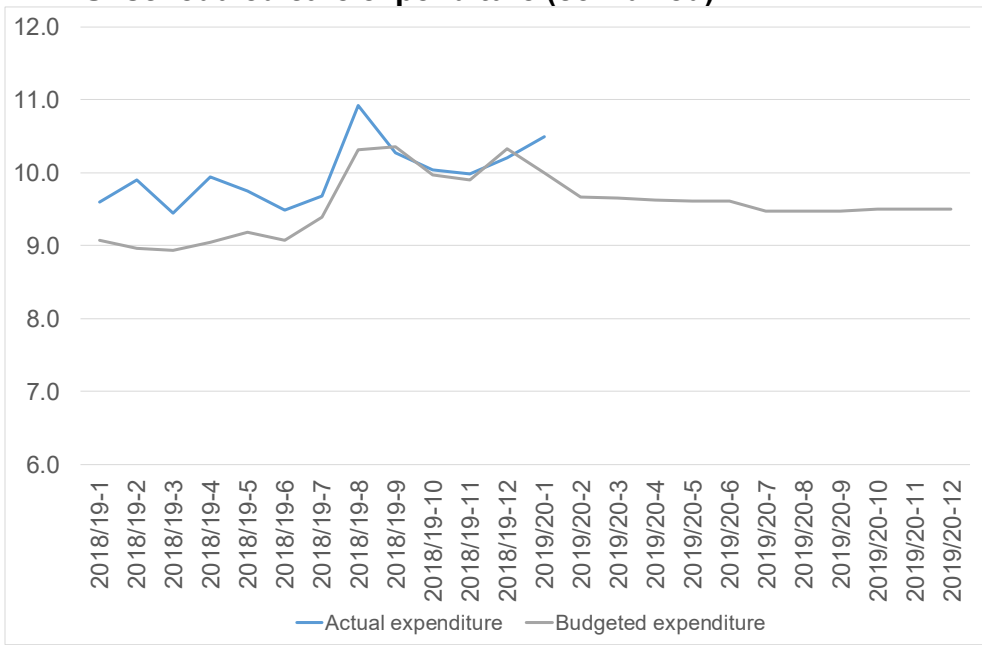
## 1.2 Material directorate area deficits

### 1.2.1 Planned care expenditure




- The in-month position showed a small adverse variance to budget of £36k, with over-spends in Medical and Nursing variable Pay due to excess surge in Critical Care, especially in Withybush General Hospital (WGH).
- The Directorate is expecting a significant benefit in efficiency and productivity, which will support the maintaining of our Referral to Treatment performance for the financial year.

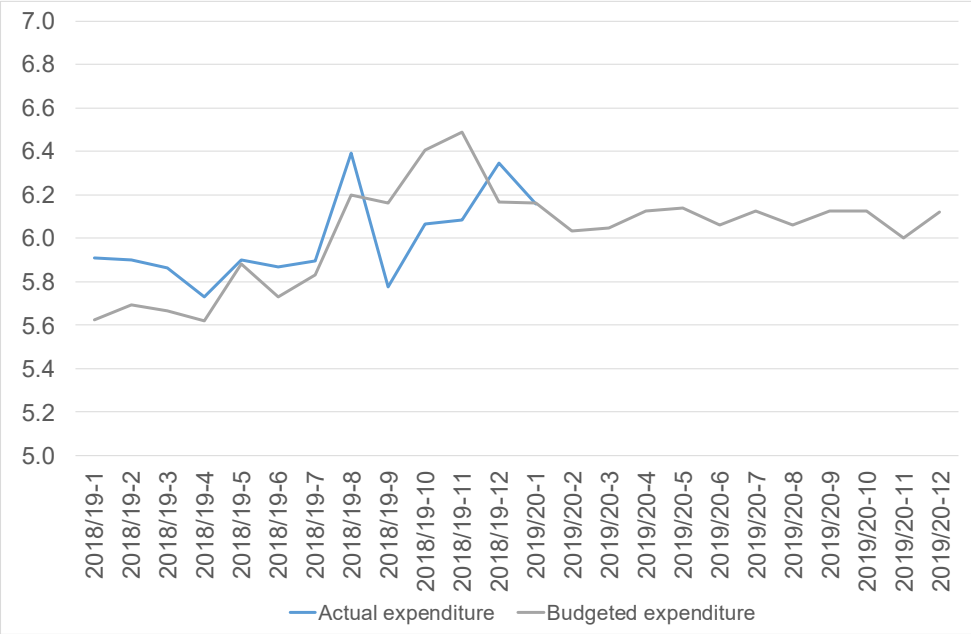
### 1.2.2 Unscheduled care expenditure (combined)




- Bronglais General Hospital (BGH) reported an over-spend in-month, driven by surge beds, with some use of off-contract agency workers. WGH reported a significant over-spend in-month, also driven by surge beds, leading to the use of off-contract agency Nursing and over-spend on Health Care Support Workers. Glangwili General Hospital (GGH) reported a slight in-month overspend mainly due to Qualified Nursing costs associated with excess surge, offset by Clinical Supplies. PPH was over-spent in-month, especially in Medical pay due to consultant and specialty registrar vacancies covered by Locums.
- Delayed discharges of medically fit patients and unfunded surge capacity remain key drivers to the costs, which requires a system-wide focus.

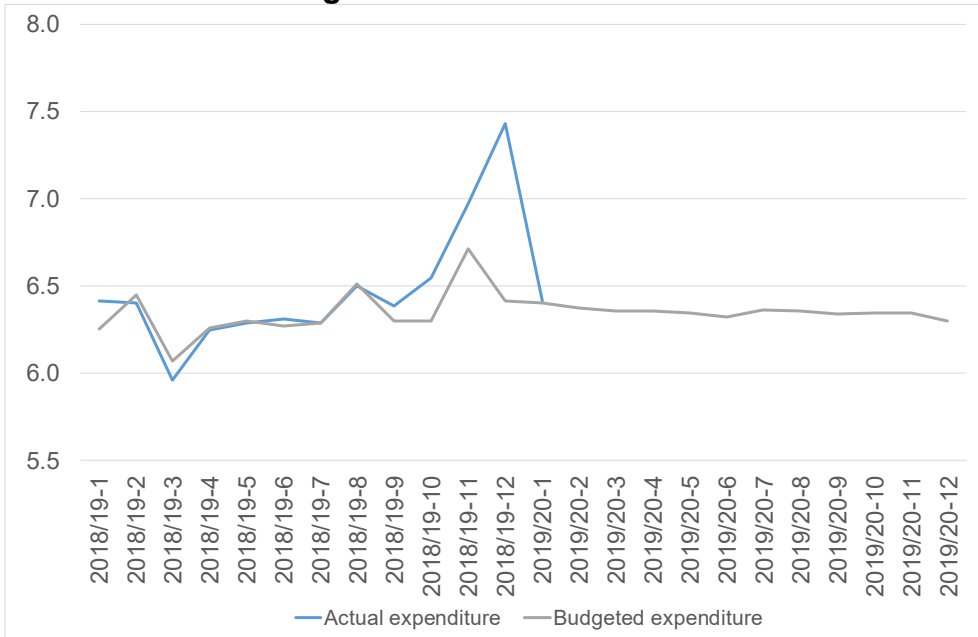
# 1. Directorate revenue position

### 1.2.3 MHLD expenditure




- The Directorate has reported a breakeven position in-month, predominately due to a high level of staff vacancies offsetting the pressures in CHC costs.
- There continues to be difficulty recruiting into medical posts resulting in extra locum sessions being incurred.
- The greatest YTD pressure within MHLD is the continued growth in CHC placements and their associated costs. Client numbers increased in month and a higher number of clients were assigned complex packages of care. Careful control of CHC, within its growth assumptions, will be key to deliver an improvement in the expenditure run rate.
- Robust care review processes have been implemented in order to manage the risks arising under CHC.

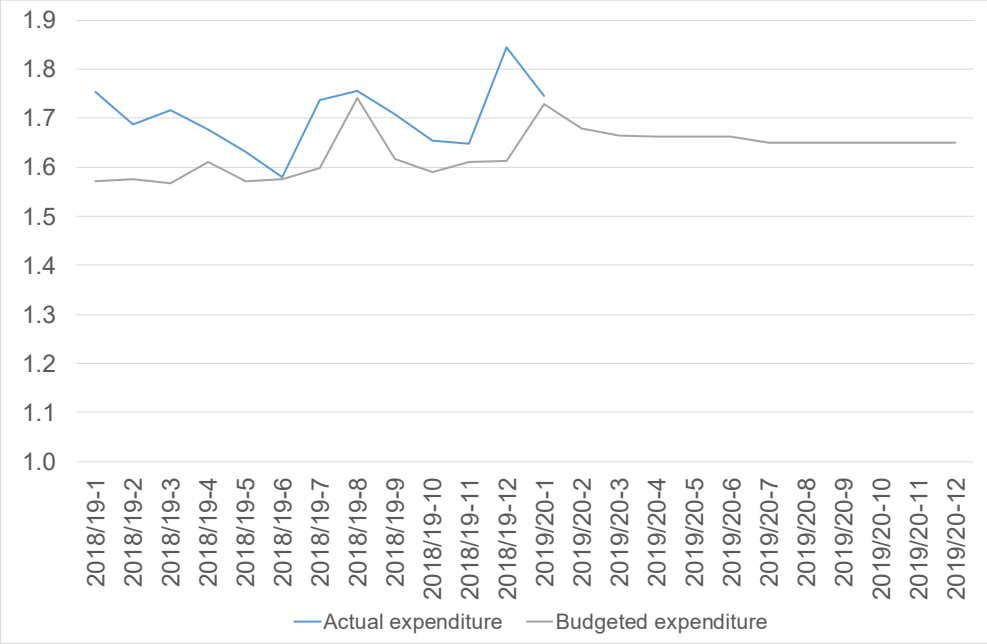
### 1.2.4 Medicines Management




- The directorate reported a slight over-spend in-month, which is projected to the end of the financial year based on modelling outturn on a number of scenarios. The latest data continues to cause concern around the ongoing impact of No Cheaper Source Obtainable (NCSO). However, we are confident that the risk from 2018/19 has been addressed; further modelling is required to gain assurance over 2019/20. The outturn is reliant on delivering the £2.9m savings plans, which are delivering on plan to Month 1, however further work is urgently required to address the unidentified balance of schemes.
- There are risks of £0.6m mainly associated with item growth, the New Oral Anti Coagulant Local Enhanced Service, NCSO and Category M. Item growth is in the range of -1% to 1% but there has been a significant increase in Category M prices.

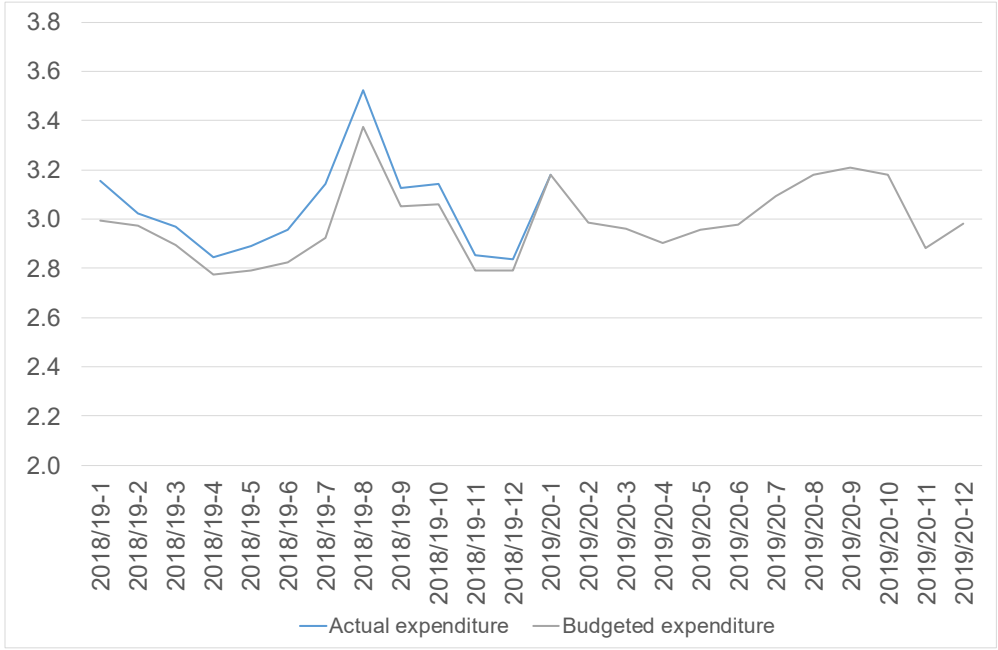
# 1. Directorate revenue position

### 1.2.5 Pathology




- The Directorate reported close to breakeven in-month.
- There has been an over-spend on medical staffing pay due to the use of agency locum consultants to cover vacancies.
- This was off-set by a decrease in costs arising from Service Level Agreements and Haematology drugs.
- The Directorate is reviewing ways of working with services to reduce demand through ensuring only appropriate test requests and through avoiding duplication.

### 1.2.6 Facilities




The Directorate reported a net breakeven position in-month.
The main areas of variance are:

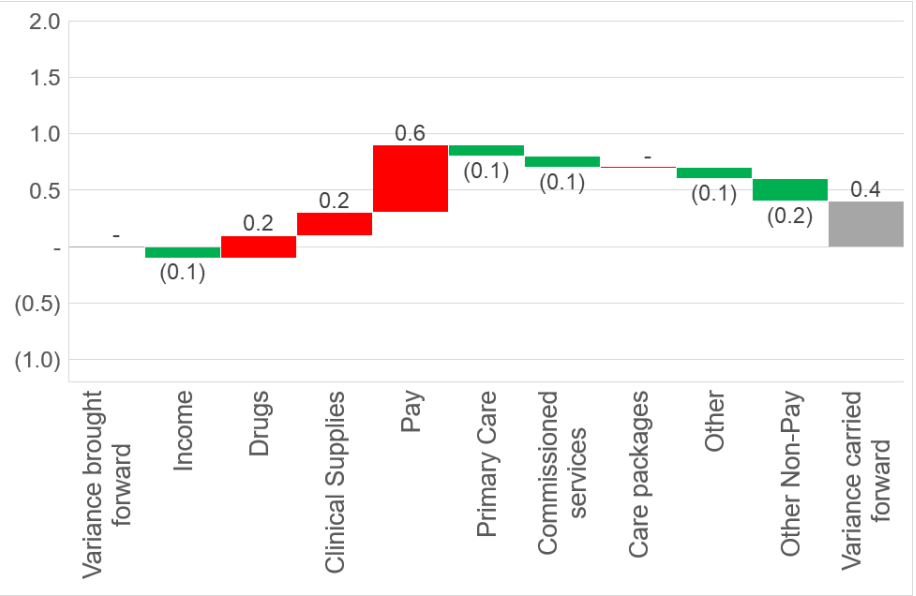
- Operations – an over-spend on bank Pay costs for Domestics staff and postage costs, partly offset by vacancies are the main contributors to the over spend of £50k.
- Property – small under-spend of £30k. Heating Oil is overspent due to being utilised as a back-up when the biomass is off-line. Water consumption remains high in PPH. This was offset by an under-spend on Gas consumption.
- Specialist Services – an over-spend on Pay, mostly in relation to Bank usage, was offset by under-spends in consumables and increased income from price increases.

# 2. Subjective revenue position

### 2.1 Subjective summary

| | Month 1 Actual £'m | Month 1 Variance £'m | % |
|---|---|---|---|
| Income | (4.1) | (0.1) | 0.0 |
| Primary Care (excl prescribing) | 10.3 | (0.1) | (0.0) |
| Prescribing | 5.7 | 0.0 | - |
| Pay | 35.6 | 0.6 | 0.0 |
| Clinical supplies | 2.6 | 0.2 | 0.1 |
| Drugs | 3.6 | 0.2 | 0.1 |
| Other non-pay | 4.7 | (0.2) | (0.0) |
| Commissioned services | 11.4 | (0.1) | (0.0) |
| Care packages | 3.8 | 0.0 | 0.0 |
| Other | 0.4 | (0.1) | (0.3) |
| **Total** | **74.0** | **0.4** | **0.0** |

### In-month change

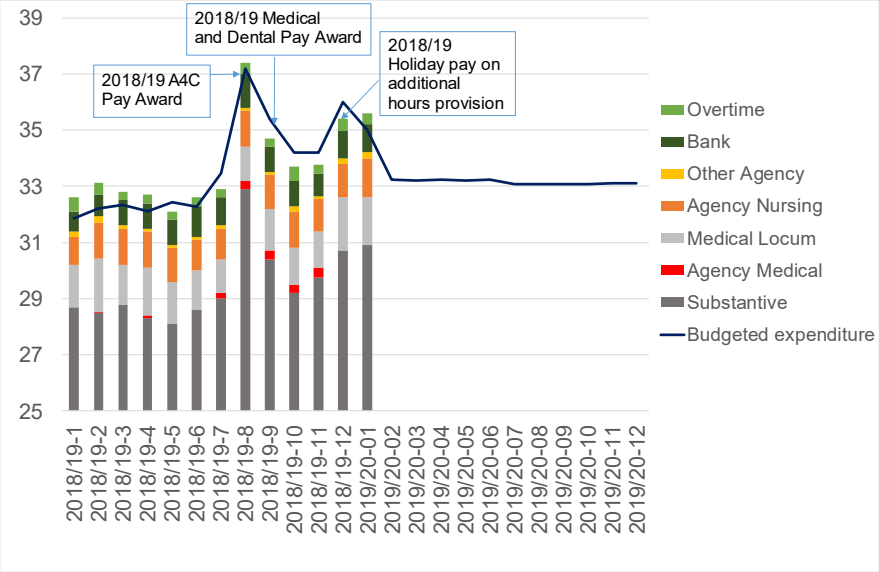



- The main pressures on the in-month position relate to Pay, Clinical Supplies and Drugs; offset by Income, Commissioned Services and Other Non-Pay.
- Detail on the changes in material cost drivers follows in Section 3.2.

# 2. Subjective revenue position

## 2.2 Material Cost drivers

### 2.2.1 Pay

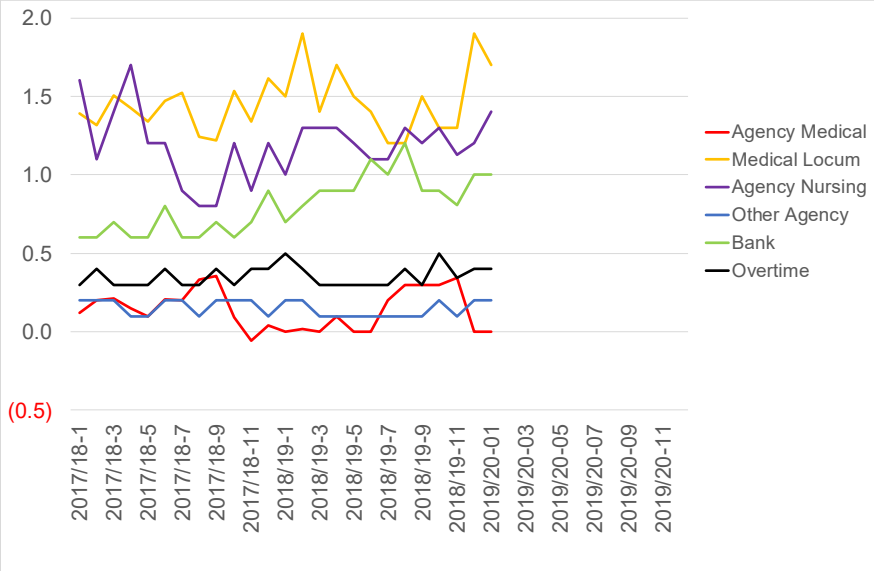



- The Month 1 expenditure is higher than budget due to the pressures arising from unfunded surge beds in Unscheduled and Critical Care.

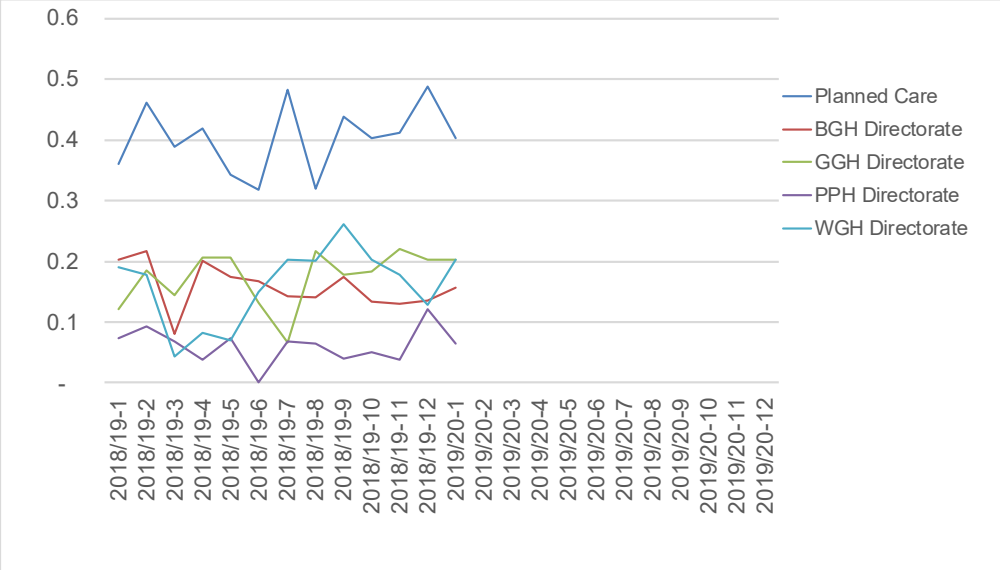
- The cost of substantive staffing is greater than last year. In Month 12 there was a one off provision for holiday pay on additional hours of £1.1m. In Month 1 there is a one off payment of £1.2m for all staff at the top of their respective bands at the end of March 2019 in line with the new Pay deal, which is the driver for the high in-month cost.

- Increases in substantive pay and Nursing Agency costs were partially offset by a reduction in Medical Locum costs.

### Temporary pay costs

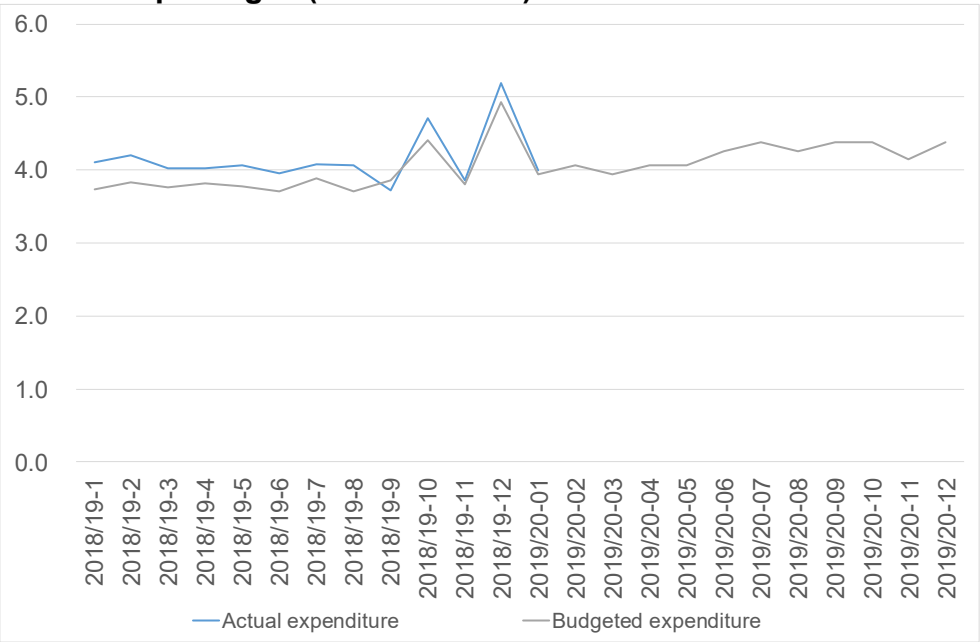



### Medical locum costs



# 2. Subjective revenue position

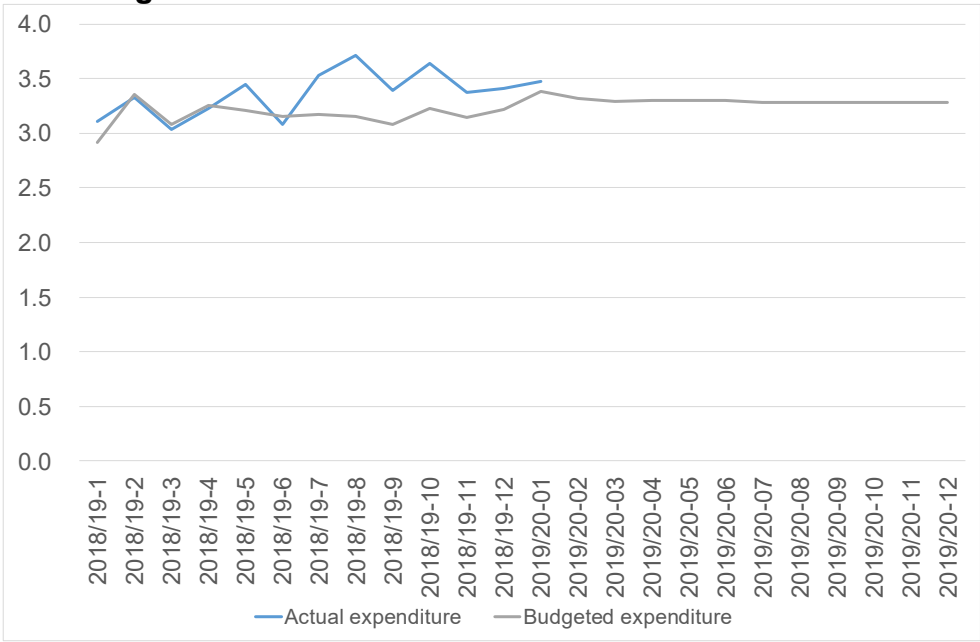
### 2.2.2 Care packages (CHC and FNC)




- The total number of cases increased in-month. The increase in budget from Month 6 relates to the recognition of expected FNC rate changes and CHC inflation. Full confirmation is awaited, and remains a risk to the position. The complexity of cases remains a key cost driver.
- Total spend to Month 1 is £4.0m resulting in an overspend of £0.1m, of which:

| £'m | Spend | Over/(under) spend |
|---|---|---|
| FNC/CHC | 1.9 | 0.0 |
| LD | 1.2 | 0.1 |
| MH | 0.8 | 0.0 |
| Children | 0.1 | 0.0 |
| **Total** | **4.0** | **0.1** |

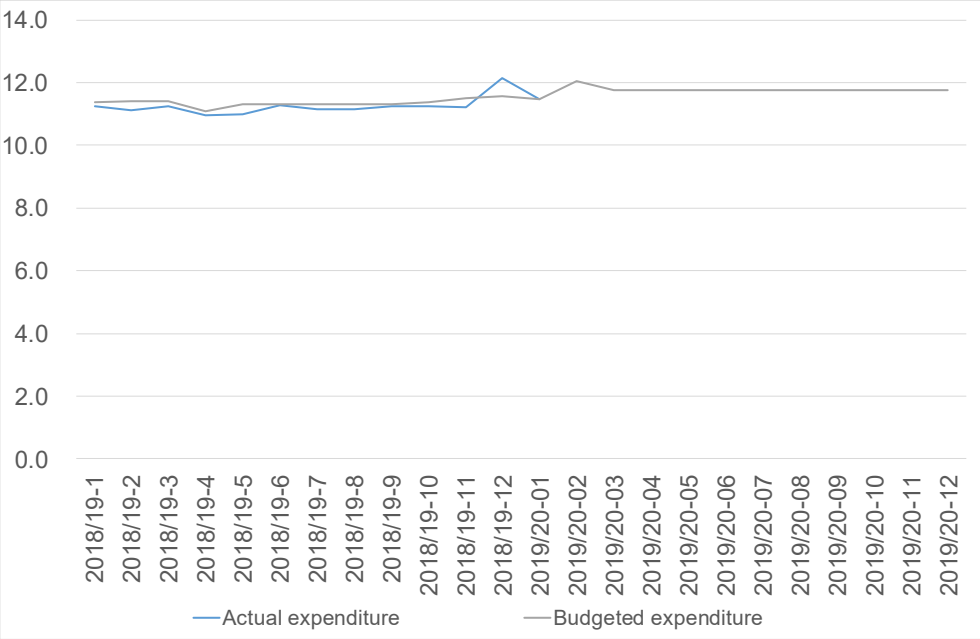
### 2.2.3 Drugs




- Drugs costs have increased over the past year, and there is a risk that this trend will continue for this year, with an adverse in-month impact.
- Continued support will be needed from the Pharmacy team to address this growth and a number of initiatives are in place to do this. Whilst specific savings schemes are delivering in-month, pressures are being seen in other areas, particularly Dermatology, Rheumatology and Ophthalmology. The Head of Medicines Management is working with Directorates to identify and mitigate the issues.
- There has been a disruption to the local service provision of Aseptic services; as a result work has been outsourced at a premium to another provider. This is expected to continue for a number of months, for which mitigating actions will need to be identified.

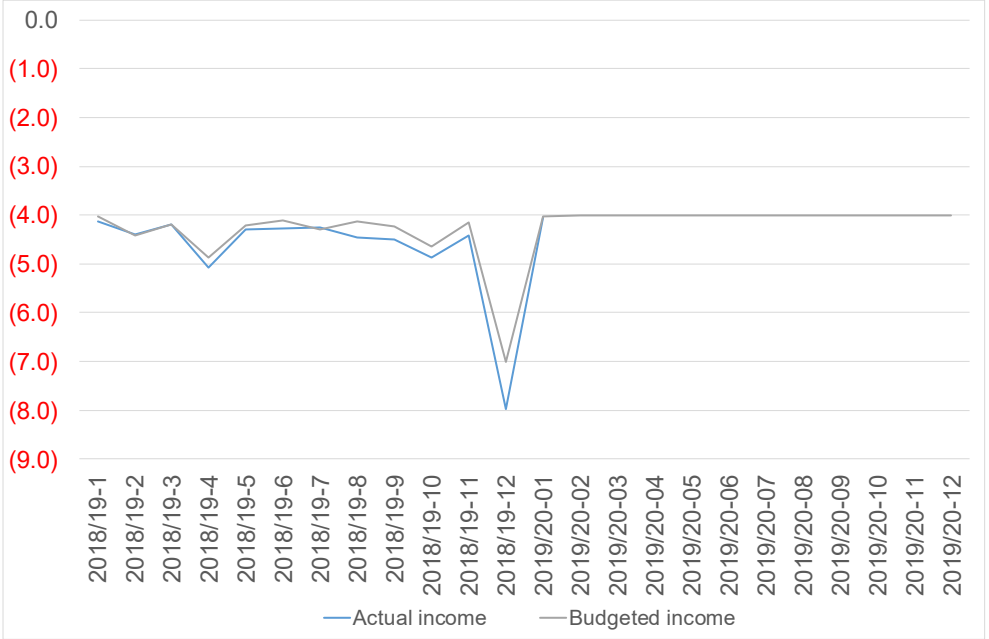
# 2. Subjective revenue position

### 2.2.4 Commissioned services




- Services that are commissioned from other NHS providers are based on activity data up to Month 12.
- As key LTA contracts have not yet been signed, an assumption of breakeven to budget has been made for Month 1 following a zero-based review of required budgets as part of the 2019/20 financial planning process. Until inflationary uplifts are confirmed this is the best estimate of the financial position.
- There is a risk of pressures in respect of Specialised Services given the significant impact in Month 12 2018/19 and Management Group discussions, despite a significant increase in budget for the current year.
- The impact of the re-basing of the Specialised Services Risk Sharing Framework is expected to be factored in to WG allocations, although the value has not yet been confirmed.

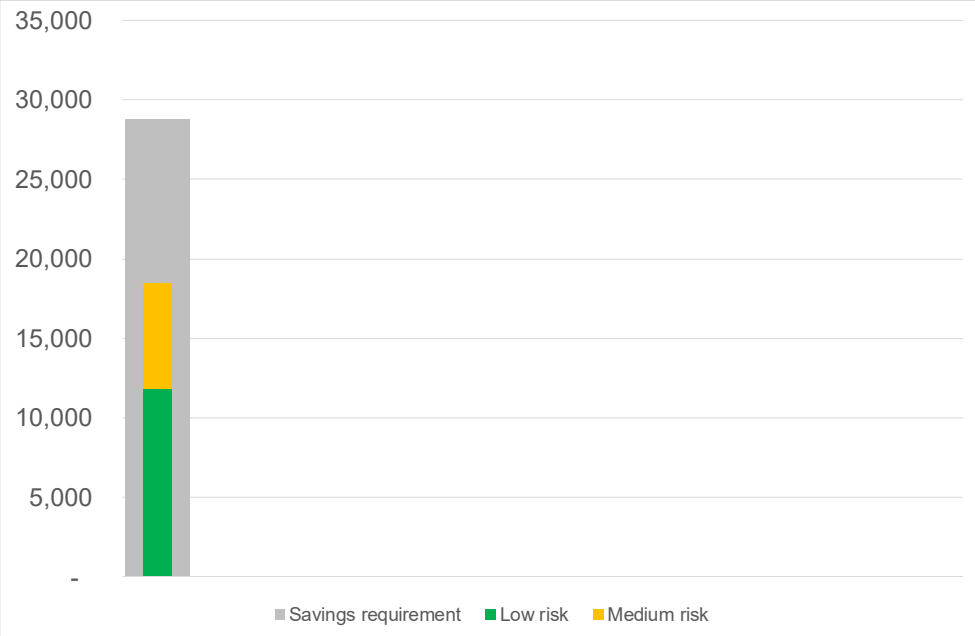
### 2.2.5 Income

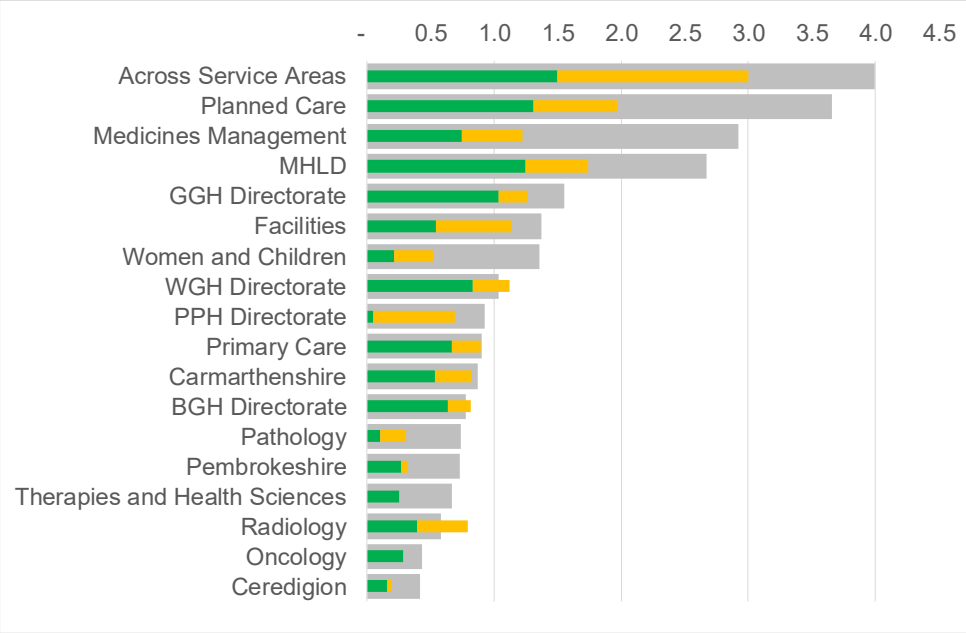



- As key LTA contracts have not yet been signed, an assumption of breakeven to budget has been made for Month 1 following a zero-based review of required budgets as part of the 2019/20 financial planning process. Until inflationary uplifts are confirmed this is the best estimate of the financial position.

# 3. Savings and turnaround actions

### 3.1 Risk-assessed directorate savings plans against target

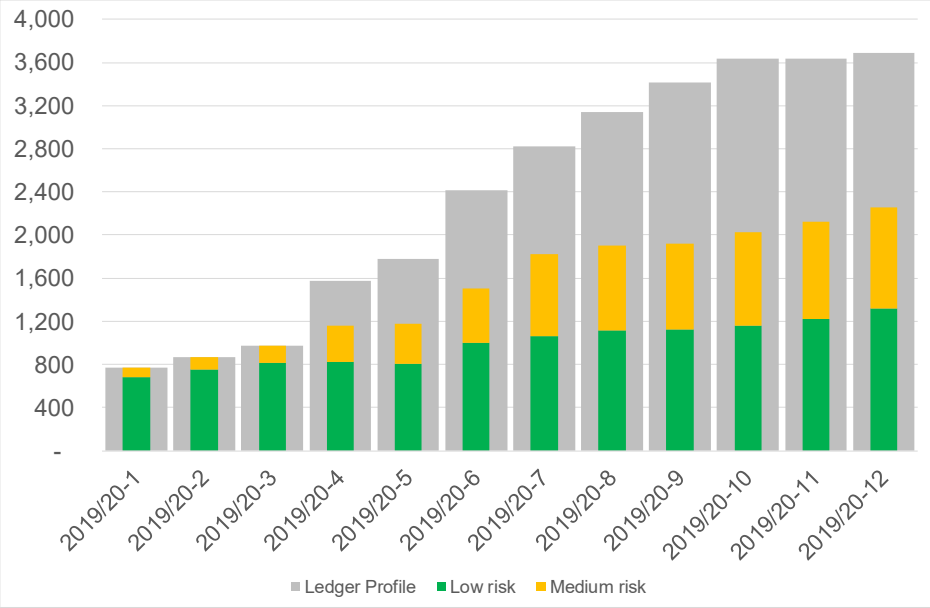



- Total Green and Amber schemes of £18.5m identified to Month 1, of which £11.9m are Green.
- Operational savings pipeline of £8.3m needs to be actively pursued and developed into actionable plans.
- Further opportunities required of £2.0m to close the gap in the savings pipeline.
- The Holding to Account process is focused on deliverable high value opportunities and the unidentified balance. Further opportunities are being identified using work underway in respect of Ward staffing, Establishment control and the benchmarking and opportunities framework.

# 3. Savings and turnaround actions

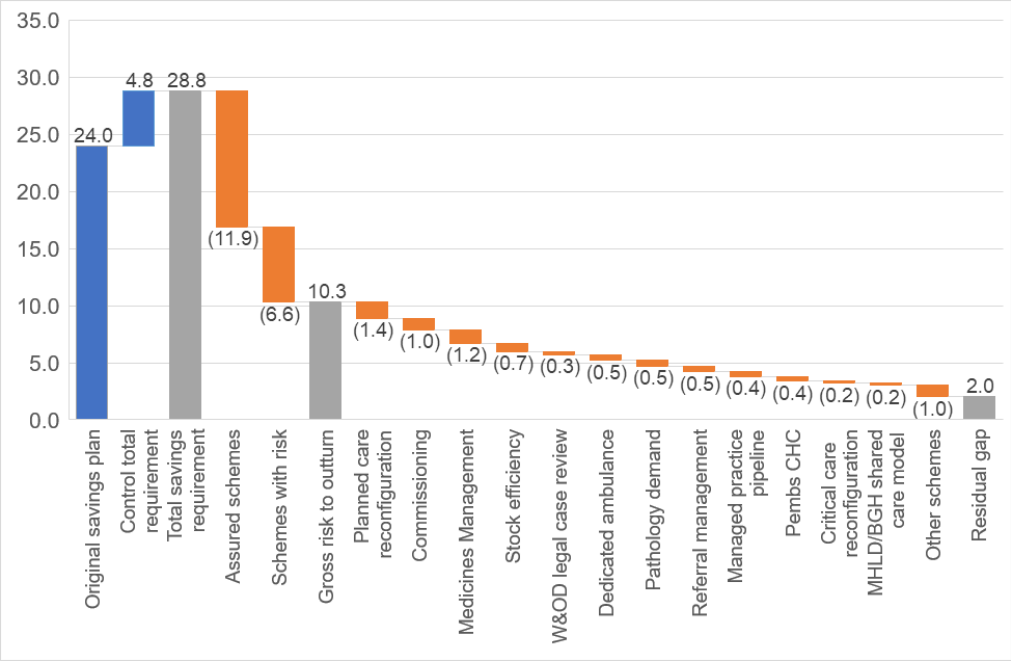
### 3.2 Planned savings profile, risk and delivery




- The forecast delivery for the remainder of the year is in line with the total requirement of £28.8m. This position has been reflected in the risk assessment in section 5.2 below.
- In-month delivery of £0.8m in line with the plan.
- Limited step required for remainder of first quarter as pipeline schemes are converted into robust actionable Plans. Significant acceleration in delivery is required from Month 4.

# 4. Financial projections, opportunities and risks

## 4.1 Financial projection




- While the financial position in Month 1 represents a significant risk to the Health Board, and there are significant risks to savings delivery and operational cost management, **the Health Board's financial forecast is to achieve the required Control Total of £25.0m.**

- The operational run rate is £0.4m in the current month. The risk of delivering the forecast is rated High given the balance remaining of pipeline and unidentified savings schemes. Escalated Holding to Account meetings are being held with all Directorates to convert pipeline into robust schemes and identify additional recovery actions and additional opportunities.

- We recognise that there are a number of gross risks that could materialise that, if mitigating actions were not identified, could affect the financial projection. These risks are presented below in section 5.2.

- This will require the Board as a whole to ensure a focus on ensuring that divisions operate within their budgets, deliver savings and manage their risks.

# 4. Financial projections, opportunities and risks

### 4.2 Risks and risk management strategy

| Potential Risk | £'m | Risk management approach |
|---|---|---|
| **Budget deficit** | **29.8** | |
| **Welsh Government Control Total requirement** | **(4.8)** | |
| **Restated budget** | **25.0** | |
| Residual gap in pipeline savings schemes | 2.0 | Escalated Holding to Account meetings are being held with all Directorates to convert pipeline into robust schemes and identify additional recovery actions and additional opportunities. |
| Non-delivery of savings schemes in pipeline | 8.3 | |
| Aseptic Unit closure | 0.5 | Action plan in place to escalate re-opening of local provision of Aseptic services |
| Total Planning Risk | **10.8** | |
| Unfunded Surge bed pressures are not contained | 1.5 | Work ongoing to triangulate bed base, establishment and budget to better target surge pressures |
| Medicines Management – NCSO | 0.6 | If item prices were to return to the level seen in late 2019; protracted Brexit period may impact on NCSO costs |
| Unfunded Dental inflation | 0.6 | Paper to next Executive |
| Inflationary pressures on CHC exceed budget | 0.2 | Fee rates are being negotiated, and this risk will need to be managed through the negotiation process. |
| Specialised activity exceeds available budget | 0.9 | Regular reports are received from WHSSC, and the Health Board is represented at the Committee. |
| **Total deficit forecast and risks** | **39.6** | |

### 4.3 Opportunities

- The focus is now being narrowed by considering the key drivers of the cost base identified through benchmarking with other Health Boards via national costing returns. Detailed information has been shared with Directorates and is being utilised as part of the Recovery Plan refinement in-year. We will continue to use this in conjunction with the Efficiency Framework to translate the opportunities identified into detailed Savings Plans in support of our Financial Plan. The Finance Committee has reviewed and endorsed this approach.

- Opportunities available via Invest to Save, Integrated Care Fund and Transformation funding are being explored. Key areas of operational inefficiency being targeted are: CHC and packages of care, unfunded escalation beds and patients awaiting tertiary referral.

# 4. Financial projections, opportunities and risks

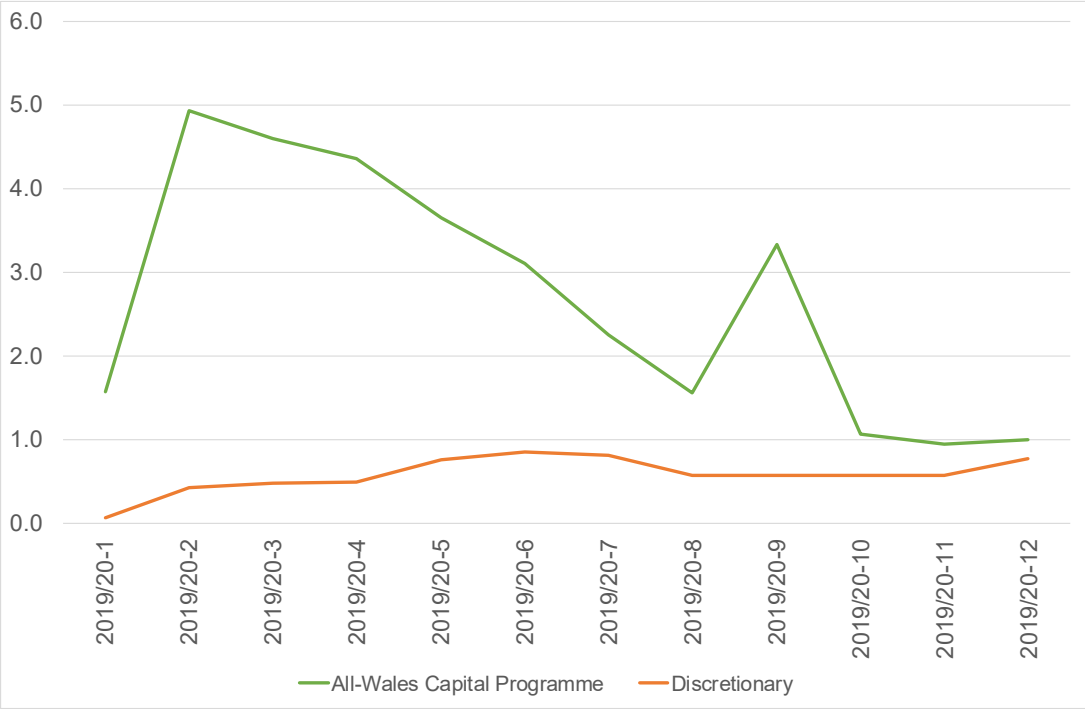
**4.4 Reserves**

| £'m | Month 1 close |
|---|---|
| ICF Bids | **10.7** |
| LTAs – Inflation, Pay Award, WHSSC | **3.4** |
| CHC Inflation and Growth | **3.2** |
| Hosted Allocation – Critical Care | **1.0** |
| Nursing Standards | **1.0** |
| Medical and Dental Pay Award | **1.0** |
| Winter Pressure reserve | **1.0** |
| RCCS | **0.5** |
| Primary Care Improvement grant | **0.4** |
| Eye Care Sustainability | **0.4** |
| Other | **0.1** |
| **Total** | **22.7** |

- The Health Board's centrally-retained reserves are committed and all relate to specific anticipated cost pressures.
- ICF funds will be distributed based on finalised plans for utilisation of the funds across Healthcare and Local Authority. As Plans are not yet agreed, the reserve has been phased based on draft plans and historical indicators.
- The LTA reserve is based on the anticipated value of contractual uplifts and will be distributed once these contracts are agreed and signed.
- CHC and FNC growth and inflation have been phased according to the timeframes in which costs are anticipated to impact.
- The Health Board holds funding of £1.0m on behalf of Welsh Government to support costs incurred on behalf of the Critical Care network across Wales.
- Nursing Standards reserve will be distributed following agreement and approval by the Executive Team.
- Winter Pressure Support will be allocated to Directorates based on finalised plans for utilisation of the funds. At present the assumption is that this Reserve will be drawn over Months 9 to 12.
- Reserves held for future cost pressures will be carefully managed and work is ongoing to ensure future cost pressures are minimised wherever possible.

# 5. Capital expenditure and working capital management

## 5.1 Capital expenditure

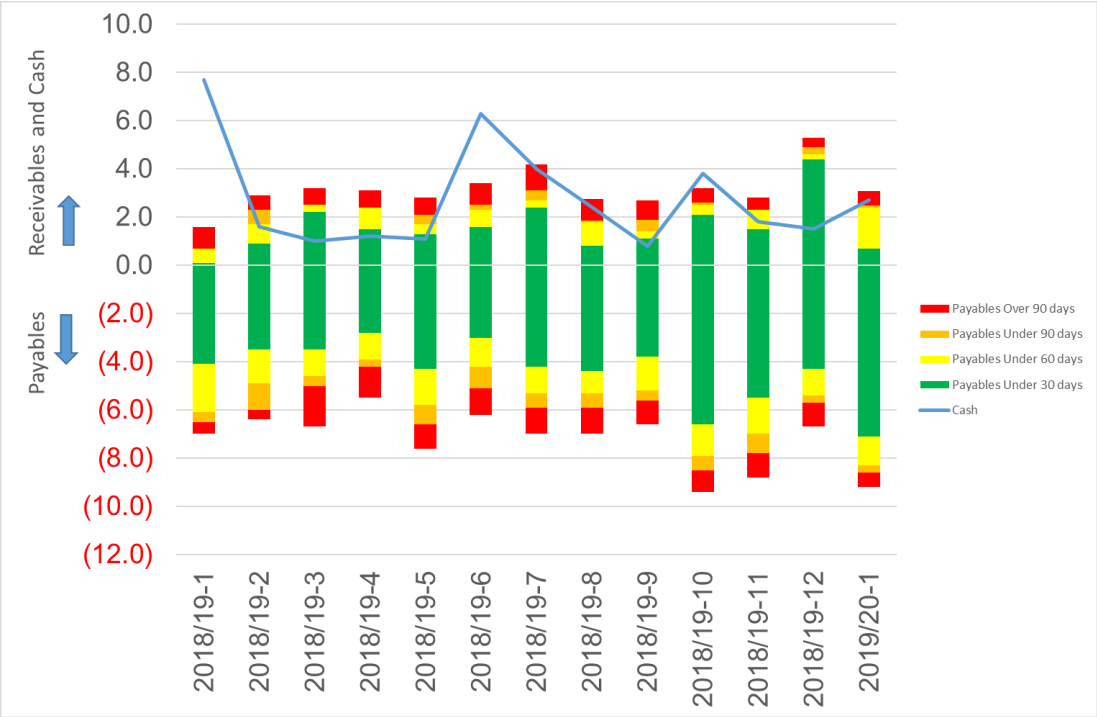



| Provisional capital expenditure plan | £'m | £'m |
|---|---|---|
| Bronglais MRI | 4.4 | |
| Women and Children Phase II | 13.8 | |
| Wards 9 and 10 Withybush | 1.8 | |
| Aberaeron Integrated Care Centre | 0.9 | |
| Cardigan Integrated Care Centre | 10.1 | |
| Fees for development of Cross Hands | 0.9 | |
| **Total all-Wales funded schemes** | | **31.9** |
| Medical equipment | 1.6 | |
| Estates | 1.9 | |
| IM&T | 1.1 | |
| Other | 2.8 | |
| **Total discretionary** | | **7.4** |
| **Total capital** | | **39.3** |

- The Health Board has an approved Capital resource limit of £39.3m for 2019/20.
- Capital expenditure against the £39.3m total funding allocation was £1.7m in Month 1.

# 5. Capital expenditure and working capital management

### 5.2 Working capital management




- Income collected from sources other than Welsh Government is collected through the invoicing process. It is imperative that this is collected promptly to reduce reliance on cash support from WG. Balances owed to the Health Board are £3.1m in Month 1.
- It is also important that the Health Board pays its suppliers promptly. At the end of Month 1, £9.2m was owed to suppliers, of which £7.1m are less than 30 days old. Further work is ongoing with colleagues in NHS Wales Shared Services to address older balances through improving the purchase-to-pay cycle.
- Cash at the end of Month 1 was £2.7m.

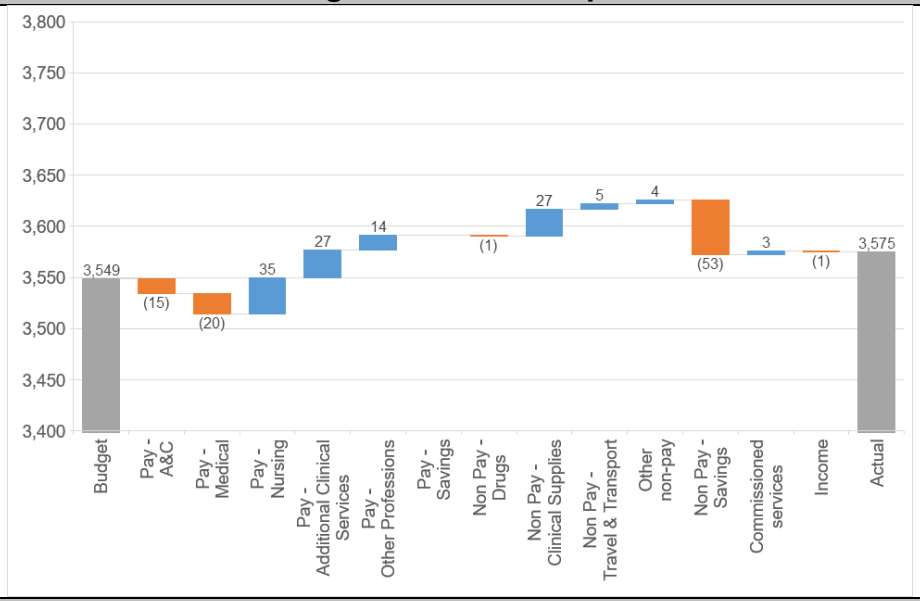
# 6. Conclusions

## 6.1 Conclusions

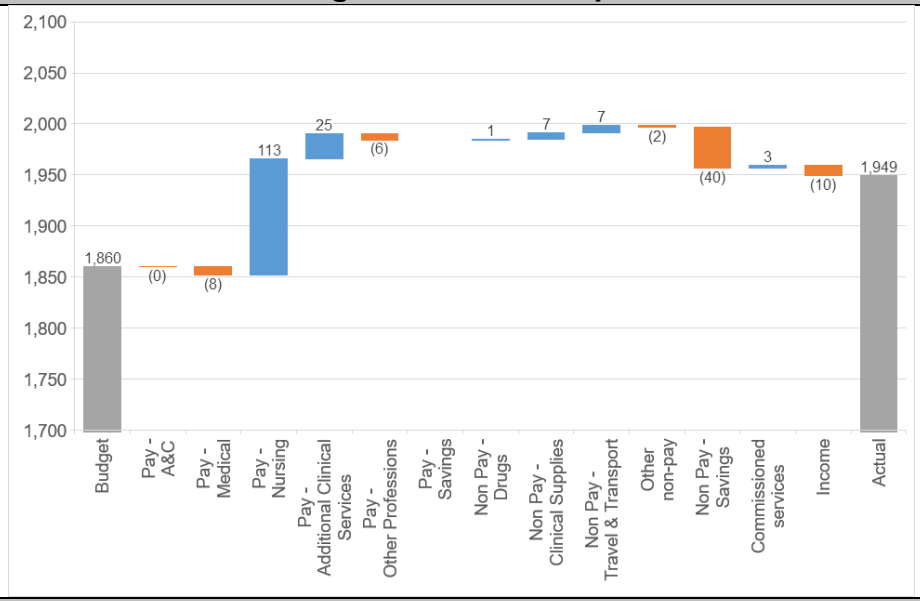
- The Health Board has a savings plan requirement for the year of £28.8m.
- Assured schemes of £11.9m and schemes with some risk of £6.6m are identified. Of the residual gap of £10.3m, pipeline opportunities of £8.3m are being actively pursued.
- The Month 1 deficit is £2.9m which is £0.4m adverse against Plan. This reflects pressures in Unscheduled Care, mainly in WGH and in Critical Care.
- The Health Board's control total is £25m but there are planning risks of £10.8m against this and operational cost management risks of £3.8m, which need to be carefully managed.

# Appendix 1: Variance from Budget (in-month, £'000)

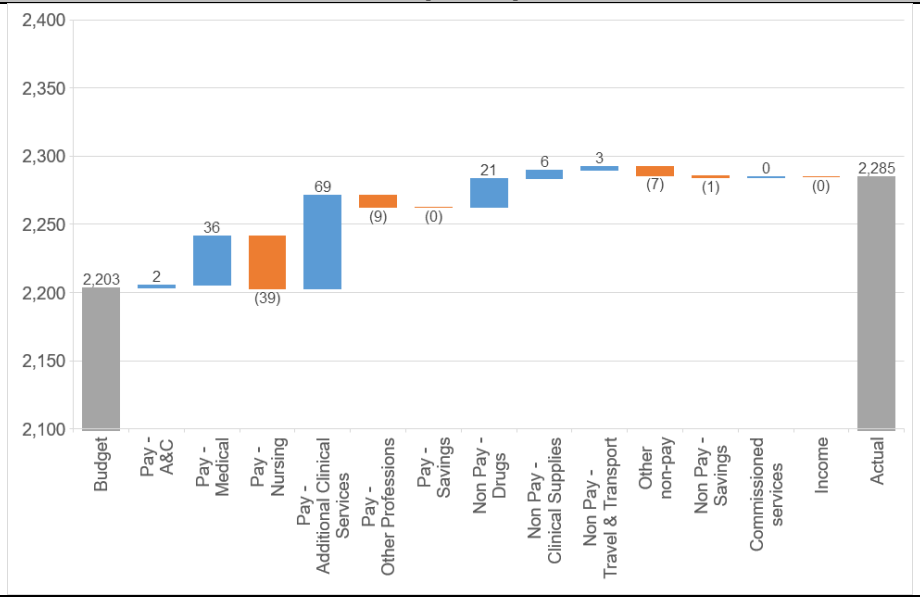
## Unscheduled Care: Glangwili General Hospital



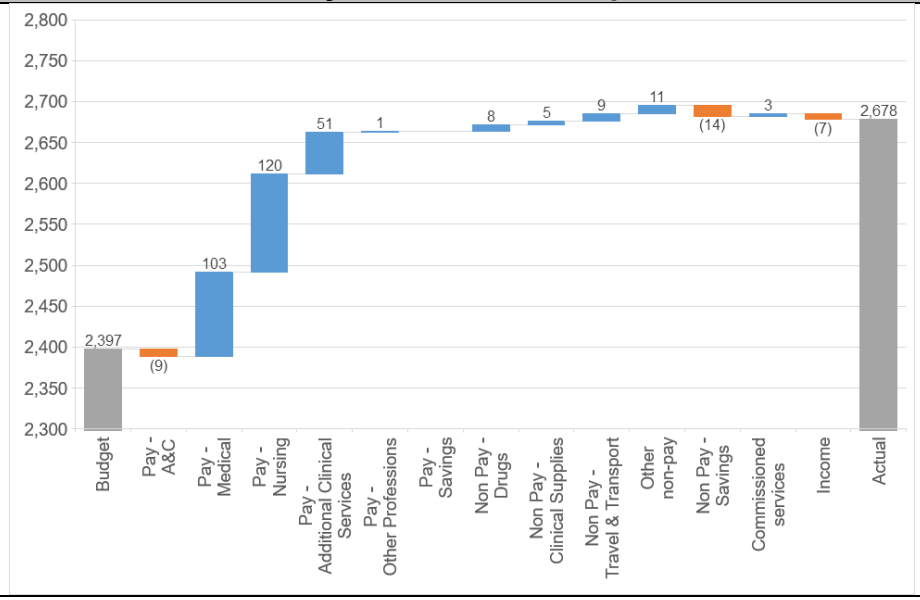

## Unscheduled Care: Bronglais General Hospital




## Unscheduled Care: Prince Philip Hospital

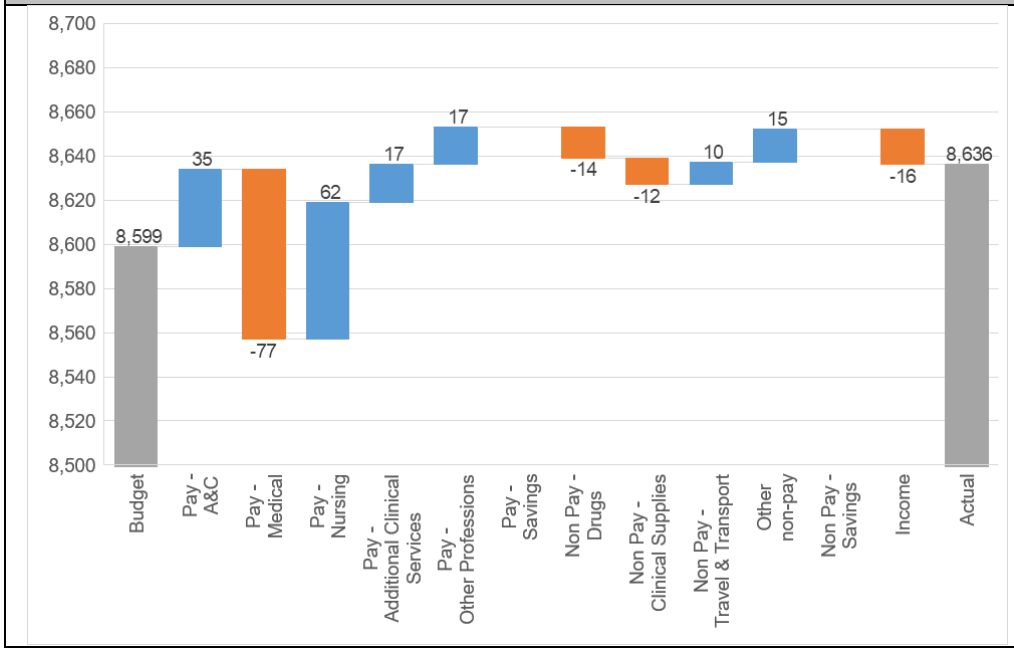



## Unscheduled Care: Withybush General Hospital

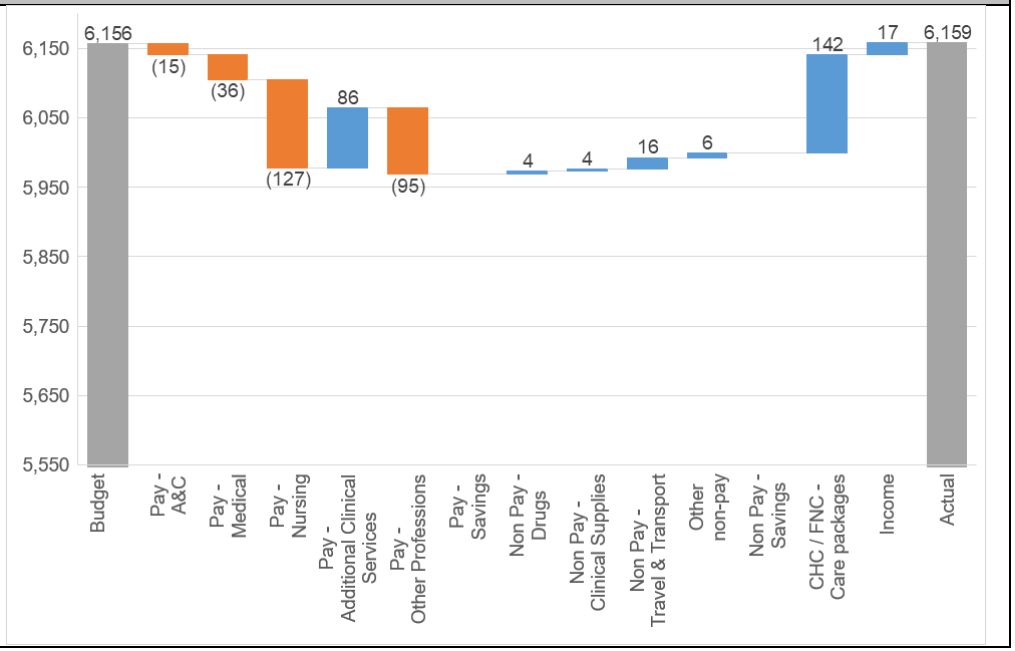


# Appendix 1: Variance from Budget (in-month, £'000)

**Planned Care**




**MHLD**



# Appendix 2: Turnaround Update

**Turnaround update**

**Section 1** – Summarises 19/20 Directorate savings plans against required savings target of 3.7% for Directorates that are escalated to the Chief Executive Holding to Account meetings. The figures included in this section are based on the known position of Month 1 as at 10th May 2019 and will be subject to change with the identification of further savings opportunities.

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Facilities** | **19/20 target saving £'000s** | **1,385** | **Total of saving plans £'000s** | | 541 | 596 | 187 | **1,324** | **Variance £'000s** | **61** |
| | **Schemes** | **YTD planned** | **YTD actual** | **YTD variance** | **Mitigating actions** | | | | | |
| | Green schemes | (39) | (38) | 1 | N/A | | | | | |
| | Amber schemes | 0 | 0 | 0 | Potential shortfall of £195k against utilities savings. Actions have been identified that could potentially mitigate £67k of this shortfall. The CEO has requested further work on the methodology used in this assessment by 17th May 19. | | | | | |
| | Red schemes | 0 | 0 | 0 | Visits have been arranged to other sites to understand other internal benchmarking opportunities, beyond the cleaning costs work already undertaken. £125k savings for internal benchmarking opportunities have been included in the plan, although as there is no clear scheme in place as yet, consideration needs to be given at the next CEO HTA meeting on 17th May 19 as to whether this scheme can be included within the savings plan. | | | | | |
| | **Total** | **(39)** | **(38)** | **1** | Other actions agreed<br>Further plans to be identified to meet the required target savings by 17th May 19. | | | | | |

# Appendix 2: Turnaround Update

| Mental Health | **19/20 target £'000s** | **2,691** | **Total plans £'000s** | 1,245 | 494 | 112 | **1,851** | **Variance £'000s** | **840** |
|---|---|---|---|---|---|---|---|---|---|
| | **Schemes** | **YTD planned** | **YTD actual** | **YTD variance** | **Mitigating actions** | | | | |
| | Green schemes | (176) | (176) | 0 | N/A | | | | |
| | Amber schemes | (54) | (54) | 0 | Non recurrent elements of LD Tudor house scheme are green. The longer term plan recurrently remains amber until the plan is signed off with LA. Changes to the TRAC system mean that all redeployed posts and change of circumstances need to be advertised, which could delay delivery. The Turnaround Director and Director of Nursing will raise this at the next Workforce Panel. | | | | |
| | Red schemes | 0 | 0 | 0 | Collaborative Care paper being presented to ET on 29th April 19. Concerns that clinical leadership constraints could delay the success of the pilot. Joint BGH and MH CEO HTA meetings may be required to ensure this scheme becomes green. To be considered at next meeting on 17th May 19. | | | | |
| | **Total** | **(230)** | **(230)** | **0** | <u>Other actions agreed</u><br>Further plans to be identified to meet the required target savings by 17th May 19. | | | | |

# Appendix 2: Turnaround Update

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Pathology** | **19/20 target £'000s** | **741** | **Total plans £'000s** | | 106 | 202 | 442 | **749** | **Variance £'000s** | **(9)** |
| | **Schemes** | **YTD planned** | **YTD actual** | **YTD variance** | **Mitigating actions** | | | | | |
| | Green schemes | (5) | (4) | 1 | The YTD variance is in relation to the Patient Access scheme. This will be discussed at the CEO HTA meeting on 17th May 19. | | | | | |
| | Amber schemes | (2) | (2) | 0 | Recruitment to substantive consultant posts is challenging. Turnaround Director to raise opportunities around workforce issues with the Director of Workforce & OD. | | | | | |
| | Red schemes | 0 | 0 | 0 | Information dept working on dashboard to support a programme of demand optimisation work. Assumptions for a £421k saving are based on a 10% reduction in activity. Demand optimisation plans appear to be having an impact. e.g. ESR test requesting has reduced from 5,000 per month down to 500. The CEO has requested a detailed delivery plan by the next CEO HTA meeting on 17th May 19. The CEO to ask the Director of Planning to be the Executive Lead for this scheme. | | | | | |
| | **Total** | **(7)** | **(6)** | **1** | <u>Other actions agreed</u><br>Further plans to be identified to meet the required target savings, including a review of what further mitigating actions can be taken in year non-recurrently to manage the in-year risk by 17th May 19. | | | | | |

# Appendix 2: Turnaround Update

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|---|---|---|---|---|---|---|---|---|---|
| **Scheduled Care** | **19/20 target £'000s** | **3,682** | **Total plans £'000s** | | 1,310 | 658 | 1,784 | **3,752** | **Variance £'000s** | **(70)** |
| | **Schemes** | **YTD planned** | **YTD actual** | **YTD variance** | **Mitigating actions** | | | | | |
| | Green schemes | (72) | (68) | 4 | The YTD variance is in relation to Loan Kit rationalisation and housekeeping schemes . These will be discussed at the CEO HTA meeting on 17th May 19. | | | | | |
| | Amber schemes | 0 | 0 | 0 | Demand management - work to be progressed on understanding what proportion of the £530k identified savings identified through a job planning exercise will be cash savings and what will avoid RTT spend. | | | | | |
| | Red schemes | 0 | 0 | 0 | <u>Other actions agreed</u><br>• A formal plan to deliver the Critical Care bed reduction scheme to be produced for discussion at the next CEO HTA meeting on 17th May 19 to ensure that the scheme is implemented by July 19.<br>• Orthopaedic plan (£1.4m). The CEO has requested that a plan be produced by the next CEO HTA meeting on 17th May 19 to include a breakdown of the two schemes (Ophthalmology 600k, Orthopaedics £800k), a clear mechanism for delivery, early Comms input and wider orthopaedic related savings particularly around procurement. | | | | | |
| | **All schemes** | **(72)** | **(68)** | **4** | | | | | | |

# Appendix 2: Turnaround Update

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|---|---|---|---|---|---|---|---|---|---|---|
| **BGH USC** | **19/20 target £'000s** | **786** | **Total plans £'000s** | | 639 | 175 | 162 | **976** | **Variance £'000s** | **(190)** |
| | **Schemes** | **YTD planned** | **YTD actual** | **YTD variance** | **Mitigating actions** | | | | | |
| | Green schemes | (34) | (36) | (2) | N/A | | | | | |
| | Amber schemes | 0 | 0 | 0 | Length of Stay plans being developed and progress monitored through the Operational Effectiveness Delivery Programme. Savings profiled to commence from Aug 19. | | | | | |
| | Red schemes | 0 | 0 | 0 | Collaborative Care paper being presented to ET on 29th April 19. Concerns that clinical leadership constraints could delay the success of the pilot. Joint BGH and MH CEO HTA meetings may be required to ensure this scheme becomes green. | | | | | |
| | **Total** | **(34)** | **(36)** | **(2)** | Other actions agreed<br>Whilst delivering on green savings schemes, BGH are showing an £89k overspend in Month 1. This has been driven by a one-off accrual from 18/19 and an increase in variable pay due to a couple of busy weekends at BGH during April 19. The Directorate will reduce the deficit through close monitoring of HCSW spend. The CEO has requested a plan to address the deficit by the next CEO HTA meeting in June 19. | | | | | |

# Appendix 2: Turnaround Update

| GGH USC | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | **19/20 target £'000s** | **1,557** | **Total plans £'000s** | | 1,032 | 229 | 0 | **1,261** | **Variance £'000s** | **296** |
| | **Schemes** | **YTD planned** | **YTD actual** | **YTD variance** | **Mitigating actions** | | | | | |
| | Green schemes | (44) | (57) | (13) | N/A | | | | | |
| | Amber schemes | 0 | 0 | 0 | Length of Stay plans being developed and progress monitored through the Operational Effectiveness Delivery Programme. Savings profiled to commence from Oct 19. | | | | | |
| | **Total** | **(44)** | **(57)** | **(13)** | Other actions agreed<br>Further plans to be identified to meet the required target savings by 17th May 19. | | | | | |

| PPH USC | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | **19/20 target £'000s** | **931** | **Total plans £'000s** | | 48 | 645 | 0 | **693** | **Variance £'000s** | **238** |
| | **Schemes** | **YTD planned** | **YTD actual** | **YTD variance** | **Mitigating actions** | | | | | |
| | Green schemes | (2) | (2) | 0 | Recruitment opportunities for nursing are being explored. | | | | | |
| | Amber schemes | (1) | (1) | 0 | • In the short-term, current MIU savings are based on opportunistic savings as a result of OOH vacancies. A longer-term solution is being worked through with the next steps being a discussion with Llanelli GPs.<br>• Recruitment to posts to support the Intermediate Care scheme is underway. | | | | | |
| | **Total** | **(3)** | **(3)** | **0** | Other actions agreed<br>Further plans to be identified to meet the required target savings by 17th May 19. | | | | | |

# Appendix 2: Turnaround Update

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|---|---|---|---|---|---|---|---|---|---|
| **WGH USC** | **19/20 target £'000s** | **1,125** | **Total plans £'000s** | | 828 | 297 | 0 | **1,125** | **Variance £'000s** | **0** |
| | **Schemes** | **YTD planned** | **YTD actual** | **YTD variance** | **Mitigating actions** | | | | | |
| | Green schemes | (33) | (41) | (8) | N/A | | | | | |
| | Amber schemes | 0 | 0 | 0 | Ambulatory care and ED streaming – The CEO has requested clarity on the impact of an enhanced ACU at WGH and an understanding of what action is necessary to turn this scheme by 17th May 19. Executive Director leadership to be confirmed. | | | | | |
| | **Total** | **(33)** | **(41)** | **(8)** | <u>Other actions agreed</u><br>Directorate to consider how the expected overspend from Month 1 is recovered as part of the savings plan in year and report back at next CEO HTA meeting on 17th May 19. | | | | | |

# Appendix 2: Turnaround Update

| Oncology & Cancer | **19/20 target £'000s** | **438** | **Total plans £'000s** | 284 | 0 | 0 | **284** | **Variance £'000s** | **154** |
|---|---|---|---|---|---|---|---|---|---|
| | **Schemes** | **YTD planned** | **YTD actual** | **YTD variance** | **Mitigating actions** | | | | |
| | Green schemes | (24) | (24) | 0 | N/A | | | | |
| | **Total** | **(24)** | **(24)** | **0** | Other actions agreed<br>• The Aseptic Unit issue is causing an in-year cost pressure of £500k. The CEO has asked for mitigating non-recurrent actions that can be taken to mitigate the 6 months cost pressure in year. Scoping work has also been requested to understand what opportunities there may be once the Aseptic Unit issue is resolved in the second half of FY20.<br>• The CEO has asked for a plan to mitigate the £94k high cost drug cost pressure. Finance are working with Pharmacy to ensure the risk is being closely monitored.<br>• Finance are working with the Directorate to look at vacancy opportunities and issues and will also review SLA to identify savings opportunities. | | | | |

# Appendix 2: Turnaround Update

**Section 2** – Summarises 19/20 Directorate savings plans against required savings target of 3.7% for Directorates that are monitored through the Turnaround Director Holding to Account meetings. The figures included in this section are based on the known position of Month 1 as at 10th May 2019 and will be subject to change with the identification of further savings opportunities.

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Carmarthenshire County** | **19/20 target £'000s** | **884** | **Total plans £'000s** | | 536 | 289 | 0 | **825** | **Variance £'000s** | **59** |
| | **Schemes** | **YTD planned** | **YTD actual** | **YTD variance** | **Mitigating actions** | | | | | |
| | Green schemes | (4) | (10) | (6) | A paper to be presented to the Executive Team in May setting out the plans for the Amman Valley Hospital Service scheme. | | | | | |
| | Amber schemes | (13) | (8) | 5 | Savings of high cost high frequency care packages on continence assessment to be confirmed. | | | | | |
| | **Total** | **(17)** | **(18)** | **(1)** | Other actions agreed<br>Review palliative care unit costs, service model and funding arrangements. | | | | | |

# Appendix 2: Turnaround Update

| Ceredigion County | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | **19/20 target £'000s** | **415** | **Total plans £'000s** | | 155 | 35 | 0 | **190** | **Variance £'000s** | **225** |
| | **Schemes** | **YTD planned** | **YTD actual** | **YTD variance** | **Mitigating actions** | | | | | |
| | Green schemes | (12) | (11) | 1 | N/A | | | | | |
| | Amber schemes | (1) | 0 | 1 | N/A | | | | | |
| | **Total** | **(13)** | **(11)** | **2** | Other agreed actions<br>• County and BGH to work together to identify actions that would release funds from the acute hospital to invest in community services in relation to discharges/LOS.<br>• A workshop to be arranged to consider opportunities to meet the savings target deficit.<br>• Update on bed plans for Tregaron Hospital to be provided for the next CEO HTA meeting in June 19. | | | | | |

# Appendix 2: Turnaround Update

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|---|---|---|---|---|---|---|---|---|---|
| **Pembrokeshire County** | **19/20 target £'000s** | **729** | **Total plans £'000s** | | 270 | 53 | 388 | **711** | **Variance £'000s** | **18** |
| | **Schemes** | **YTD planned** | **YTD actual** | **YTD variance** | **Mitigating actions** | | | | | |
| | Green schemes | (22) | (18) | 4 | To be discussed at TD HTA meeting on 15th May 19. | | | | | |
| | Amber schemes | 0 | 0 | 0 | Delivery from July 19 | | | | | |
| | Red schemes | 0 | 0 | 0 | To be discussed at TD HTA meeting on 15th May 19 | | | | | |
| | **Total** | **(22)** | **(18)** | **4** | Other actions agreed<br>• Finance to confirm the number of beds funded in the budget settlement.<br>• Formal plan to address 19/20 savings gap to be produced by next TD HTA on 15th May 19. | | | | | |

# Appendix 2: Turnaround Update

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|---|---|---|---|---|---|---|---|---|---|---|
| **Women & Children** | **19/20 target £'000s** | **1,359** | **Total plans £'000s** | | 211 | 312 | 108 | **630** | **Variance £'000s** | **729** |
| | **Schemes** | **YTD planned** | **YTD actual** | **YTD variance** | **Mitigating actions** | | | | | |
| | Green schemes | (7) | (3) | 4 | | | | | | |
| | Amber schemes | 0 | 0 | 0 | • Plans in place to operationalise Withybush MLU staffing model. Engagement has been started with staff, OCP process will need to be discussed at the Partnership Forum prior to progressing.<br>• Antenatal provision – premises issue. Paper to go to Executive Team in May 19. | | | | | |
| | Red schemes | 0 | 0 | 0 | • C-section Scheme – work to be done to understand the cost of C-sections in March 19 | | | | | |
| | **Total** | **(7)** | **(3)** | **4** | <u>Other agreed actions</u><br>Need to understand potential risks of cost increase for paediatric diabetic consumables. Potentially £260k - only £160k risk in the plan. | | | | | |

# Appendix 2: Turnaround Update

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Primary Care** | **19/20 target £'000s** | **790** | **Total plans £'000s** | | 670 | 227 | 388 | **1,285** | **Variance £'000s** | **(495)** |
| | **Schemes** | **YTD planned** | **YTD actual** | **YTD variance** | **Mitigating actions** | | | | | |
| | Green schemes | 0 | 0 | 0 | Planned delivery from Sept 19 | | | | | |
| | Amber schemes | 0 | 0 | 0 | • Directorate to work through the impact of delay in implementing local GP Hub.<br>• 4 GPs have moved to salaried status already, with a 5th in progress. | | | | | |
| | Red schemes | 0 | 0 | 0 | Planned delivery from May 19 | | | | | |
| | **Total** | **0** | **0** | **0** | Other agreed actions<br>Potential cost pressure identified in respect of Orthodontics and dental inflationary funding. Directorate to clarify the position on dental funding within the plan for FY20. | | | | | |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Radiology** | **19/20 target £'000s** | **584** | **Total plans £'000s** | | 390 | 405 | 0 | **795** | **Variance £'000s** | **(211)** |
| | **Schemes** | **YTD planned** | **YTD actual** | **YTD variance** | **Mitigating actions** | | | | | |
| | Green schemes | (20) | (20) | 0 | N/A | | | | | |
| | Amber schemes | 0 | 0 | 0 | Planned delivery from Aug 19 | | | | | |
| | **Total** | **0** | **0** | **0** | Other actions agreed<br>MRI issue in April 19 incur a cost pressure on the budget due to the need to outsource activity. Plan to be in place to address this within the next 2 weeks. | | | | | |

# Appendix 2: Turnaround Update

**Section 3 –** provides an update position on the Turnaround Delivery Programmes. The Delivery Programmes focus on pan-organisational opportunities to drive patient focused benefits and support Directorates to achieve their savings target. Savings highlighted here are not in addition to savings identified in Sections 1 and 2 above.

| **Operational Effectiveness – Length of stay** | | | | |
|---|---|---|---|---|
| **Objective(s)** | **Savings identified 19/20 (£000's)** | **Savings delivered 19/20 (£000's)** | **Update** | **Achievements** |
| To support the Health Board deliver a reduction in length of stay, enabling the closure of unfunded surge capacity, through a focus on demand and capacity opportunities, bed configuration and quality improvement. | 1,852 | 4 | Terms of Reference have been reviewed and membership and objectives updated to reflect the 19/20 work plan. All acute sites are developing detailed length of stay action plans that will sit beneath the USC Board Action Plan. LOS plans will include metrics, measurements, timescales and anticipated outcomes. | |

| **Operational Effectiveness - Cataract pathway** | | | | |
|---|---|---|---|---|
| **Objective(s)** | **Savings identified 19/20 (£000's)** | **Savings delivered 19/20 (£000's)** | **Update** | **Achievements** |
| To increase cataract productivity so that the need to spend RTT is negated. | 600 | 0 | A Project Group and Action Plan are place to progress the necessary actions to increase cataract productivity, including the move of W-AMD services to appropriate locations to free up theatre space. | |

# Appendix 2: Turnaround Update

| **Outpatients** | | | | |
|---|---|---|---|---|
| **Objective(s)** | **Savings identified 19/20 (£000's)** | **Savings delivered 19/20 (£000's)** | **Update** | **Achievements** |
| To make efficiency and productivity improvements that increase availability of core capacity and mitigate the need for other high cost, premium rate activity relating to national waiting times and access targets. | 796 | 0 | Outcome forms –the Health Board needs to improve compliance to ensure that it meets the new Welsh Government targets that will be introduced in shadow form from Sept 19. A process for the monitoring and reporting of compliance to be introduced in outpatients, with the support from clinic nurses<br><br>Implementation of a policy to manage non-responders to follow-up invitations to be discussed at the next meeting. | Orthopaedic virtual clinic started in March 19 - 8 patients per week are currently receiving this service, with a view to increasing this to 10. Plans are in place to commence virtual clinics in Bronglais in May 19. |

# Appendix 2: Turnaround Update

| Continuing Health Care | | | | |
|---|---|---|---|---|
| **Objective(s)** | **Savings identified 19/20 (£000's)** | **Savings delivered 19/20 (£000's)** | **Update** | **Achievements** |
| To improve the CHC patient pathway and strengthen in-house delivery. | 418 | 0 | The agreed focus following a workshop in February was:<br>• A review of the sustainability policy and how it can be utilised to maximum effect (this will make recommendations for further work )<br>• A scoping exercise/Training Needs analysis to inform training in CHC decision making and negotiation skills<br>• A root cause analysis of section 117 decisions in the context of the component part of the decision making process with EMI patients and where different decisions may be made in the future. The top 9 (expensive) Carmarthenshire cases will be reviewed. | |

# Appendix 2: Turnaround Update

<table>
<tr><th colspan="5">Patient Communications</th></tr>
<tr><th>Objective(s)</th><th>Savings identified 19/20 (£000's)</th><th>Savings delivered 19/20 (£000's)</th><th>Update</th><th>Achievements</th></tr>
<tr><td>To reduce the cost of patient communications in relation to appointment letters and results.</td><td>200</td><td>0</td><td>Key areas of continued focus for 19/20 will include:<ul><li>Text reminder service</li><li>Patient Knows Best</li><li>Electronic reporting of results</li><li>Centralised post processing and distribution</li></ul>No meetings have taken place in 19/20.</td><td>Compared to the same period last year, a simple data extraction shows that DNAs in orthopaedics have reduced since the confirmation letters have ceased.<br><br><table><tr><th></th><th>Jan</th><th>Feb</th><th>Mar</th><th>Apr</th></tr><tr><td>2018</td><td>107</td><td>75</td><td>75</td><td>112</td></tr><tr><td>2019</td><td>89</td><td>46</td><td>54</td><td>53</td></tr></table></td></tr>
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# Appendix 2: Turnaround Update

| **Theatres** | | | | |
|---|---|---|---|---|
| **Objective(s)** | **Savings identified 19/20 (£000's)** | **Savings delivered 19/20 (£000's)** | **Update** | **Achievements** |
| To reduce non-pay expenditure through better procurement and standardisation of items used. | 100 | 0 | PICC Lines – Group established and working towards standardisation of products and application.<br><br>Other opportunities to standardise items are being progressed. | Loan kit rationalisation has achieved £7.5k in April 19 with a further £12.5k anticipated in May. |
| To focus on efficiency opportunities around process and pathways. | TBC | TBC | An audit on Theatre start will commence on 20th May, with a session returns audit already underway. A data cleansing exercise is being undertaken to remove access for staff who no longer need to use the system. A process for the signing out of doctors is to be implemented.<br><br>Recycling - avoidance of clinical waste – the<br>Environment Team are looking at Theatres and Critical Care. | |
| To review maintenance contracts for Theatres equipment and services. | TBC | TBC | Plans ongoing. | |

# Appendix 2: Turnaround Update

| Workforce - Roster Efficiency | | | | |
|---|---|---|---|---|
| **Objective(s)** | **Savings identified 19/20 (£000's)** | **Savings delivered 19/20 (£000's)** | **Update** | **Achievements** |
| To reduce usage and expenditure on of temporary nursing staff and to ensure that temporary staffing (overtime, bank and agency) are only used when clinically assessed as necessary. | TBC | TBC | A work plan for 19/20 has been agreed and will include Theatres, Paediatrics, Maternity Services, Endoscopy and A&E sites (incl AMAU PPH). A Gantt chart is being developed to map out audits over the coming months. Progress will be monitored against a number of themes including 6 week rosters, management of time balances and annual leave.<br>Consideration is being given to aligning the Roster Efficiency and establishment Control Group work. | |

| Housekeeping - Travel and Subsistence | | | | |
|---|---|---|---|---|
| **Objective(s)** | **Savings identified 19/20 (£000's)** | **Savings delivered 19/20 (£000's)** | **Update** | **Achievements** |
| To identify and co-ordinate a consistent approach to travel and subsistence claiming processes. | 57 (TBC) | 1 | Although this group has not met in 19/20, work has been ongoing to understand the opportunities to reduce the use of grey fleet. An update on this work will be provided at the next meeting on 20th May 19. Other areas of focus for 19/20 will include the robust management of the Study Leave policy for non-mandatory training and a review of community staff bases. | |

| | |
|---|---|
| **Enw'r Pwyllgor / Name of Committee** | Business Planning & Performance Assurance Committee (BPPAC) |
| **Cadeirydd y Pwyllgor/ Chair of Committee:** | David Powell |
| **Cyfnod Adrodd/ Reporting Period:** | Meeting Held on 30th April 2019 |

**Y Penderfyniadau a'r Materion a Ystyriodd y Pwyllgor / Key Decisions and Matters Considered by the Committee:**

- **BPPAC Self-Assessment Committee Effectiveness Data Analysis** - the Committee received a verbal update on the outcome of the BPPAC self-assessment of effectiveness exercise 2018/19, with the full outcome report to be presented to the June 2019 BPPAC meeting. Members were advised that whilst a number of consistent themes have emerged, contradictory comments have also been received. The Committee agreed to extend the period for completion to enable further responses to be received from In Attendance Members.

- **Draft BPPAC Annual Report 2018/19**- the Committee received the Draft BPPAC Annual Report 2018/19, highlighting the work of the Committee during the reporting period. Following the suggestion of a number of minor amendments, Members approved the BPPAC Annual Report 2018/19 for submission to the Board on 29th May 2019 for approval.

- **Health & Safety and Emergency Planning Sub-Committee (H&SEPSC) Update Report** - the Committee received the H&SEPC Update Report. Members were advised that following a 6 month Needle Stick Injuries (NSIs) Audit, it had been agreed that a 'deep dive' would be undertaken by the Health and Safety team, with the findings reported to both BPPAC and Quality, Safety and Experience Assurance Committee (QSEAC). Members were informed that the Fire Safety Team structure is now complete and in regard to Fire Risk Assessments, whilst High Risks will be completed as agreed, a risk based approach has been taken for the Medium and Low Risks where the timescale for completion has been extended. Members welcomed the removal of confusion for staff booking fire training on the Electronic Service Record (ESR), which will not adversely affect the statistics involved.

- **Draft Health & Safety and Emergency Planning Sub-Committee Annual Report** - the Committee received the Draft Health & Safety and Emergency Planning Sub-Committee Annual Report 2018/19, noting the lack of consistent Primary Care representation on the Sub-Committee which would be addressed for 2019/20. The Committee approved the Draft Health & Safety and Emergency Planning Sub-Committee Annual Report 2018/19.

- **Information Governance Sub-Committee (IGSC) Update Report** - the Committee received a written update from the IGSC meeting on 15th February 2019 and a verbal update following the meeting held on 26th April 2019. Members were advised that following discussions at the recent Audit and Risk Assurance Committee (ARAC) meeting, an action plan for clinical coding is being developed and will be presented to the June 2019 meeting.

- **Draft Information Governance Sub-Committee Annual Report 2018/19** - the Committee received the Draft IGSC Annual Report 2018/19. Members commended the award of substantial assurance following a recent Internal Audit Report on compliance with the requirements of the General Data Protection (GDPR), particularly given the significant challenges within the team since GDPR came into force on 25th May 2018. Members approved the Draft Information Governance Sub-Committee Annual Report 2018/19.

- **Corporate Risks Allocated to BPPAC** - the Committee received the Corporate Risks Allocated to BPPAC Report and it was agreed to review in detail the 6 risks that are currently above the tolerance level in terms of their target risk scores agreed by the Board, to establish whether the Committee is satisfied with the sources of assurance in place for each risk, taking into account the action(s) identified to address the gap(s) in control. The Committee accepted that other than for Risk 29 - Thrombectomy services being withdrawn by Cardiff and Vale University Health Board - no further actions, other than those indicated, could be undertaken to support a reduction in the level of the risks reviewed, and agreed that as it would not be possible to meet the UHB's agreed risk tolerance levels for these five risks, to escalate these to the Board to determine whether it was appropriate to 'accept' the stated higher target risk score for each of these risks. To avoid duplication, the detail of each of these 5 risks and the concerns raised by BPPAC is included within the Corporate Risk Register Report to the May 2019 Board.

- **Operational Risks Allocated to Performance for BPPAC** - the Committee received the Operational Risks Allocated to Performance for BPPAC report, identifying the 3 operational risks assigned to BPPAC which were scrutinised in detail**.** Members received assurance from the relevant controls and mitigating actions in place for two of the three risks. For Risk 54: Non achievement of agreed performance for urgent & non-urgent suspected cancers affects the whole Health Board - given that performance rates had dipped in February and March 2019, Members were advised that the target score of 6 would be a challenge to achieve which may require the risk to be re-scored and agreed to escalate this to the Board as a matter of concern.
- **Integrated Performance Assurance Report Month 12** - the Committee received the Integrated Performance Assurance Report Month 12, which following a request from the previous BPPAC meeting, included data from Primary Care, and Child and Adolescent Mental Health Services (CAMHS). Members welcomed the positive trajectory in regard to RTT waiting times with zero breaches during the same period, however noted that unscheduled care performance had declined in March 2019 compared to the previous month. Discussions took place around the lack of care packages both for reablement and complex care, and queries were raised on whether the Home of Choice policy is consistently being applied. Members were advised that applying the policy can be a challenge and that patients sometimes stay in hospital for longer than necessary. It was recognised that Delayed Transfers of Care (DTOC) affect not only the patient, as well as family members, thus Members suggested including the patient's family at the earliest stage possible in the pathway. Members agreed that the impact of DTOC on other services should be escalated to Board. Members noted the decline in compliance within admissions units for the Sepsis Six Bundle applied within one hour compared to wards and

were advised that the reduction could be linked to recent capacity issues with options being considered to attain over 90% compliance.

- **Capital, Estates and IM&T Sub-Committee Update Report** - the Committee received the Capital, Estates and IM&T Sub-Committee update report from its meeting on 27th March 2019. Members were informed that the current year-end process had been challenging given the significant amount of late allocations required and thanks were expressed to the teams involved for their assistance in progressing them in order to provide assurance to the Sub-Committee. Members were informed that the Health Board is challenging the VAT decision with Her Majesty's Revenue and Customs (HMRC) regarding the Front of House & Fire Lift Scheme in Bronglais General Hospital (BGH).

- **Draft Capital, Estates and IM&T Sub-Committee Annual Report 2018/19** - the Committee received the Draft Capital, Estates and IM&T Sub-Committee Annual Report 2018/19. Members noted the key work undertaken by the Sub-Committee during the year, including major infrastructure projects to ensure maintenance of the existing hospital sites and improvements to the Residential Accommodation across the Health Board and the on-going commitment during 2019/20 to maintain this.

- **Planning Sub-Committee Update Report** - the Committee received the Planning Sub-Committee update report from 23rd November 2018 to 29th March 2019. Members were advised that the January 2019 meeting had been cancelled due to on-going discussions regarding the Annual Plan 2019/20. At the recent meeting on 29th March 2019, the Sub-Committee discussed the planning cycle for the coming year, recognising that the draft Annual Plan 2019/20 is still to be approved by Welsh Government.

- **Draft Planning Sub-Committee Annual Report 2018/19** - the Committee received the Draft Planning Sub-Committee Annual Report 2018/19, outlining the main achievements of the Sub-Committee during the reporting period. Members were assured with the progress made and approved the Planning Sub-Committee Annual Report 2018/19.

- **Draft Annual Plan 2019/20** - the Committee received a verbal update on the Draft Annual Plan 2019/20 and were advised that the Board is in a holding position at present given that no feedback has yet been received following the Health Board's submission to Welsh Government.

- **Annual Plan Quarter 4 Update** - the Committee received the Annual Plan Quarter 4 update report including detailed monitoring of all the actions contained in the 2018/19 Annual Plan and were advised that at the end of 2018/19, no action plans had been RAG rated as red. Members noted that going forward, following the findings and recommendations of the Welsh Audit Office Structured Assessment 2018, reporting of quarterly monitoring should be a formal part of the performance reviews in place with the directorates.

- **Together for Health Delivery Plans** - the Committee received the Together for Health Delivery Plans and were advised that whilst the Health Board will progress these as part of the 2019/20 Annual Plan, the status with WG is

unclear given that they are not being monitored in the same way as annual reports. Until clarification is received from WG on how these will be reflected in the planning cycle, Members were further advised that the Health Board will continue as previously given the significant work undertaken by the team involved to developing them for the transforming agenda. As the plans relate to the Health and Care Strategy recently approved by the Board, Members acknowledged that they would be prioritised by this programme, with discussions required on the most appropriate way forward.

- **Update On Capital Programme 2018/19 Year End** - the Committee received the Capital Programme 2018/19 Year End report which provided an update on the final 2018/19 capital resource limit and outturn position and the details of expenditure achieved throughout the year. Members were informed that it had been a positive year in regard to allocations and acknowledged the significant work that had been undertaken by the Operations Directorate in relation to the Medical Devices backlog position, enabling the Health Board to take risk based decisions as year-end capital allocations were released.

- **Discretionary Capital Programme 2019/20 and Capital Governance Update** - the Committee received the Discretionary Capital Programme 2019/20 and Capital Governance Update, outlining the capital funding position for the start of 2019/20 and the pre-commitments already agreed for this year's discretionary capital programme. Members were advised that a number of the priority areas had been identified for 2019/20, with a further £800,000 to be allocated when required, however it acknowledged that it would not be possible to approve all funding requests. Members welcomed the commitment of £200,000 to maintain the Residential Accommodation across the Health Board, noting that the improvements made during the previous year had received positive feedback from the Deanery. Members suggested that it may be prudent for the Health Board to accept some long standing estate issues which are not directly affecting patients and to change priorities in order to release capital for other projects.

- **Commissioning Framework** - the Committee received a verbal update regarding the Commissioning Framework. Members were advised that discussions are ongoing regarding the links to contracting and commissioning and the impact of the Turnaround plan, which may have an impact for commissioning services. Members, therefore suggested that agreement is required on the most appropriate process and whether commissioning would report in future to Finance Committee or BPPAC.

- **Policy 815 Counter Fraud, Bribery and Corruption Policy**- the Committee approved the Counter Fraud, Bribery and Corruption Policy following assurance that the policy had adhered to the written control document process within HDdUHB.

- **A Regional Collaboration for Health (ARCH)** - the Committee received an update on the activities of A Regional Collaboration for Health (ARCH) Portfolio for the period January to March 2019. Members noted the significant work undertaken between Hywel Dda and Swansea Bay University Health Board, in particular the Hyper Acute Stroke Unit which has an ambitious timeline for

completion by the end of 2019 and the Regional Neurological Conditions Service Model where Neurologists are progressing towards a community model. Members were advised that ARCH has supported some of the programmes with the Joint Regional Planning and Delivery Committee which should build on the aspirations of regional collaborations.

- **Llanelli Wellness and Life Science Village** - the Committee received an update on the Llanelli Wellness and Life Science Village focusing on the progress achieved since January 2019 on the development of concept design, the work programme going forward in relation to City Deal and wider financial planning and specific elements of service delivery in the Village.

- **BPPAC Workplan 2019/20** - the Committee received the BPPAC workplan for 2019/20 for information.

**Materion y mae angen Ystyriaeth neu Gymeradwyaeth Lefel y Bwrdd are u cyfer / Matters Requiring Board Level Consideration or Approval:**

- None

**Risgiau Allweddol a Materion Pryder / Key Risks and Issues/ Matters of Concern:**

- **Corporate Risks Allocated to BPPAC** – concerns regarding 5 of the 6 corporate risks allocated to BPPAC, and to avoid duplication, the detail of each of these 5 risks and the concerns raised by BPPAC is included within the Corporate Risk Register Report to the May 2019 Board.
- **Operational Risks Allocated to Performance for BPPAC** – concerns regarding Risk 54: Non achievement of agreed performance for urgent & non-urgent suspected cancers affects the whole Health Board - given that performance rates dropped in February and March 2019 making the target score of 6 a challenge to achieve.

**Busnes Cynlluniedig y Pwyllgor ar gyfer y Cyfnod Adrodd Nesaf / Planned Committee Business for the Next Reporting Period:**

**Adrodd yn y Dyfodol / Future Reporting:**

In addition to the items scheduled to be reviewed as part of the Committee's work programme, following up progress of the various actions identified above will be undertaken.

**Dyddiad y Cyfarfod Nesaf / Date of Next Meeting:**

27th June 2019

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

# CYFARFOD BWRDD PRIFYSGOL IECHYD UNIVERSITY HEALTH BOARD MEETING

| | |
|---|---|
| **DYDDIAD Y CYFARFOD: DATE OF MEETING:** | 30 May 2019 |
| **TEITL YR ADRODDIAD: TITLE OF REPORT:** | Integrated Performance Assurance Report – Month 12 2018/19 |
| **CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:** | Karen Miles, Director of Planning, Performance and Commissioning<br>In association with all Executive Leads |
| **SWYDDOG ADRODD: REPORTING OFFICER:** | Karen Miles, Director of Planning, Performance and Commissioning |

| **Pwrpas yr Adroddiad** (dewiswch fel yn addas)<br>**Purpose of the Report** (select as appropriate) |
|---|
| Ar Gyfer Trafodaeth/For Discussion |

## ADRODDIAD SCAA SBAR REPORT

### Sefyllfa / Situation

The Integrated Performance Assurance Report (IPAR) is being brought to the Board's attention to examine and consider Hywel Dda University Health Board's latest performance data, achievements, challenges and needs. This is a requirement of the NHS Wales Delivery Framework 2018/19.

Executive Team members were asked to highlight what their key concerns are and the following issues were raised:

| Executive Director | Key concerns |
|---|---|
| Joe Teape, Director of Operations/Deputy Chief Executive | • Unscheduled care is a major area of concern – especially 12 hours waits and ambulance offload delays. |
| Mandy Rayani, Director of Nursing, Quality and Patient Experience | • Health care acquired infection rates;<br>• Welsh Government compliance for Putting Things Right/concerns management;<br>• Serious incident reporting;<br>• Long ambulance waits;<br>• Capacity in our emergency departments. |
| Philip Kloer, Medical Director and Director of Clinical Strategy | • Unscheduled care pathway delays for patients;<br>• Health care acquired infection rates;<br>• Delayed follow ups (particularly Ophthalmology and Dermatology);<br>• Community Paediatric outpatient delays;<br>• Enabling continued medical engagement and leadership capacity;<br>• Supporting and managing fragile services. |
| Karen Miles, Director of Planning, Performance, Informatics and Commissioning | • 12 hour A&E/MIU waits;<br>• Delayed transfers of care;<br>• Delayed follow-up outpatient appointments;<br>• Healthcare acquired infections. |

The performance dashboards are available to NHS Wales staff and are updated monthly. New dashboards are available for Mental Health & Learning Disabilities and Theatre cancellations. The stroke dashboard has also been updated to include a summary by hospital site for the new quality improvement measures.

The Performance Team is working with the Programme Management Office to develop triggers to highlight indicators outside of expected ranges. This will involve the use of Statistical Process Control (SPC) charts.

A number of improvements / additions have been made to this IPAR:

- A new Cyber Compliance exception report has been added to describe our security patching status, related issues and actions;
- Data is included for neurodevelopment assessment waiting times for children and young people (autistic spectrum disorder (ASD) and attention deficit hyperactivity disorder (ADHD)). An exception report will be included in the IPAR moving forward;
- A briefing report on the Cardiac Transfer and Treat service is included;
- A dashboard has been developed to summarise the National Primary Care Measures. The dashboard is available via the intranet site and images of the charts are included in the Data section of this report. Also, supplementary Primary Care reports are provided for Managed GP Practices and Primary Care Quality and Assurance Performance. Within the Quality and Assurance Performance report, the Orthodontics section now includes data around the longest waits. The Primary Care Team and the Performance Team will work collaboratively over the coming months to further develop the Primary Care performance dashboard and to prepare a plan for adding data for the variety of Primary Care Services in the IPAR;
- The following NHS Delivery Framework update reports were submitted to the Welsh Government in April 2019 and are attached to this report for information:
    - Dementia Training;
    - Improving the Health and Well-being of Homeless & Specific Vulnerable Groups;
    - Accessible Communication and Information for People with Sensory Loss;
    - Advancing Equality and Good Relations;
    - Implementation of the Welsh Language Actions.

## Cefndir / Background

The NHS Wales Delivery Framework 2018/19 aims to have a 'Healthier Wales'. It identifies key areas to be monitored and, where relevant, improvements made for this aim to be achieved. The University Health Board is working to make improvements for its resident population, patients and staff and has identified some additional local performance indicators to further support the Framework.

## Asesiad / Assessment

- The IPAR consists of:
    - Title page – the buttons can be used to navigate to the different sections of the report;
    - Executive summary – provides an overview categorised by: where the UHB is doing well, where improvements are needed and potential challenges ahead;
    - Performance overview – the hyperlinked text can be used to directly access the relevant exception reports. Each exception report has a home button which will return you back to the latest performance overview section;
    - Integrated dashboards – summaries for unscheduled care, planned care, hospital acquired infections and oncology & cancer, showing finance and workforce. The dashboards have been reformatted to incorporate some of the finance dashboard charts and to make them more user-friendly;

- Domain topic pages – includes details of the Executive Leads and links to relevant exception reports;
- Exception reports – are included for areas where new data is available and either the targets are not being met or there is cause for concern;
- Additional reports – Primary Care, National Delivery Framework qualitative reports, Welsh Health Specialised Service Committee (WHSSC), Cardiac treat and transfer service;
- Supporting dashboards – Excel dashboards for RTT, Unscheduled Care, Diagnostics & Therapies, Mental Health, Stroke, Cancer and Primary Care.

- The following accompanying documents are also provided:
  - Key delivery target summary – performance trend and (where available) trajectories for the key delivery indicators.
  - Full performance summary – details of all performance indicators with reported data for this financial year to date and an indication of whether an exception report has been provided.
- The latest performance data shows:

| **28 key deliverable indicators** | | **All+ performance indicators** | | |
|---|---|---|---|---|
| 14 | 50% | 68 | 38% | target not delivered |
| 3 | 11% | 11 | 6% | within 5% of target |
| 11 | 39% | 98 | 55% | target delivered |

+ only those indicators for which is it possible to assign a red, amber or green rating are included here. Some indicators are under development and others do not have sufficient historical data to show an annual improvement or decline

The most recent all Wales data shows that the UHB ranked in the top 3 for 31 (40.7%) indicators, which is a 3.8% increase from the previous month's position.

## Spotlight on Unscheduled Care

Unscheduled care performance declined in March 2019 compared to the previous month:

- Ambulance handovers delayed over 1 hour increased from 294 in February to 407 in March;
- Patients seen in Accident and Emergency (A&E) and minor injury unit (MIU) within 4 hours declined from 84.4% in February to 81.7% in March;
- The number of patients waiting over 12 hours in A&E increased from 732 in February to 948 in March 2019. This is the highest number of 12 hour breaches the Health Board has seen in over 3 years.

A slight improvement was seen in average length of stay for medical emergency patients, which decreased from 8.7 in February to 8.6 in March 2019.

## Spotlight on Referral to Treatment (RTT), diagnostics and therapies

There were zero breaches in March 2019 for the following targets:

- Patients waiting over 36 weeks from referral to treatment;
- Patients waiting over 8 weeks for a diagnostic test;
- Patients waiting over 14 weeks for a specific therapy.

This was achieved through hardworking and dedicated staff, rigorous monitoring, outsourcing, and waiting list initiatives and overtime (funded with additional monies from Welsh Government).

Efforts are continuing into 2019/20 to maintain the excellent progress made in these areas in 2018/19.

## Where are we doing well?

- Hywel Dda ranked 1st in Wales for 9 national indicators including waiting times for diagnostic tests, stroke patients admitted to a stroke unit within 4 hours, waiting times for patients on the urgent suspected cancer pathway and mental health assessments;
- As mentioned above, the waiting time targets for RTT, diagnostics and therapies were all met;
- The Health Board performed well for three of the stroke targets i.e. stroke patients given a CT scan within 1 hour of diagnosis, admitted to a stroke unit within 4 hours and assessed by a stroke specialist within 24 hours;
- The three mental health key deliverable targets have all been met;
- The target has been met for smokers carbon monoxide validated as quit at 4 weeks;
- The postponed admitted procedures target met in March 2019, with 16 patients falling within the government commitment of which 8 patients were treated within the 14 day government target (in-month performance 50%). Of the remaining patients, 4 have since been treated, 2 have deferred treatment, 1 is awaiting a date and 1 has been removed from the waiting list;
- In 2018/19 the Out of Hours service successfully integrated all areas of the Health Board into the new 111 system, providing standardised access to urgent and unscheduled primary care clinicians in the out of hours period;
- The 12 month reduction targets were met for both new and follow up patients who did not attend (DNA) their new outpatient appointment;
- The 12 month mortality reduction target has been met in March for crude mortality rate, deaths within 30 days of admission for a hip fracture and deaths within 30 days of admission for a stroke;
- The 85% target has been met for the percentage of patients having a nutrition score completed and action taken within 24 hours of admission;
- The improvement target was met for inpatients receiving the sepsis six bundle within 1 hour;
- The rolling 12-month sickness reduction target has been met with the rate decreasing from 4.87% in February to 4.86% in March;
- The Health Board's PADR compliance is improving (78% in March) and above the NHS Wales average;
- Medical Appraisal (PADR) is far above target at 95% and has been above 90% for over 12 months;
- The National Intelligent Integrated Audit Solution (NIIAS) target was met in March for the number of staff accessing a family member's record (actual 11, target <=12);
- Consultants and SAS (staff grade and associate specialist) doctors are required as part of their contract to have an up to date job plan. The 85% target was met in March, with 92% of consultants / SAS doctors identified as having a job plan.

## Where are the improvements needed?

- Performance for the percentage of ambulances responding to red calls within 8 minutes has not met the 65% target (provisional 62.9% for March);
- As outlined above, unscheduled care performance declined in March and the targets were not met. Work is underway to make improvements around patient flow, ambulatory care, ambulance offload and accident and emergency 4 hour performance;
- The 12 month improvement target was not met in March for patients diagnosed with a stroke who were thrombolysed within 45 minutes;
- The 98% waiting time target for non-urgent suspected cancers was not met in March 2019

with 95.8% receiving treatment within 31 days;

- The 95% waiting time target was not met in March for urgent suspected cancers but an improvement was seen from 80.7% in February to 84.2% in March;
- As at March 2019, the Health Board has 4 safety notices that are overdue in compliance, all have been reported in detail to the Quality, Safety and Experience Assurance Committee (QSEAC);
- The target for hand hygiene compliance has not been met but performance improved from 87.3% in February to 91% in March;
- Non mental health delayed transfers of care rolling 12-month numbers decreased 495 in February to 489 in March but the 5% reduction target was not met;
- The 12 month reduction target for mental health delayed transfers of care was not met and the 12 month number increased slightly from 107 in February to 108 in March;
- The improvement target was not met for patients in emergency departments receiving the sepsis six bundle within 1 hour;
- The targets have not been met for the 3 reported health care acquired infections i.e. E.coli, C.difficile and S.aureus. An improvement plan is in place;
- With only 31.3% of serious incidents assured within the required timescale, the 90% target was not been met in March;
- The 5% annual reduction target for hospital initiated cancellations (HIC) has not been met and the number of HICs increased from 129 in February to 158 in March;
- The 75% target was not met in March (66%) for settling concerns within 30 days. However, performance improved by 8% from March 2018;
- With only 2.5% at quarter 3 of smokers attempting to quit via smoking cessation services, the 5% cumulative target has not been met;
- In October-December 2018, 94.1% of 1 year olds had been immunised with the '6 in 1' vaccine and 91.0% of 5 year olds had received 2 doses of the MMR vaccine. The 95% target for both indicators was not met;
- In March, there were 16,629 patients with delayed follow-up across trauma & orthopaedics, ear nose & throat, urology, dermatology or ophthalmology outpatient appointments. The 12 month reduction target was not met;
- Healthcare acquired pressure sores in a community setting decreased from 52 in February to 48 in March. However, the 12 month reduction target was not met; Whilst Healthcare acquired pressure sores in a hospital setting increased from 18 February to 23 in March, the 12 month reduction trend was met;
- The number of potentially preventable hospital acquired thrombosis was reported as 8 in October-December and the reduction target was not met;
- The percentage of hospital episode records clinically coded within one month dropped from 84.1% in December to 83.1% in January and the National target (95%) was not met. Local targets have been set with the aim of improving overall performance;
- The National Intelligent Integrated Audit Solution (NIIAS) target was not met in March for the number of staff accessing their own record (actual 12, target <=8);
- The planned preventative maintenance, fire safety assessments and facilities cleanliness targets were missed in March 2019;
- For babies born between October to December 2018, 91.1% were seen by a Health Visitor as part of the Healthy Child Wales Programme when they were 10 to 14 days old. This figure is above the Wales average (90.4%) but the 4 quarter improvement target was not achieved;
- The 12-month reduction mortality target was not met for deaths within 30 days of emergency admission for a heart attack.

**Potential challenges for the future**

- Mandatory Training compliance has not met the 85% target however performance has improved considerably (by 13.9%) over the past 12 months (now 79.6% March 2019);
- Non-medical appraisals continue to be below the 85% target, however compliance has improved by 15.6% in the last 12 months at March 2019;

There are concerted efforts across the Health Board to make further improvements for both mandatory training and appraisal compliance over the coming few months. This is key to ensure staff are able to have their pay increment as per the Agenda for Change pay deal agreed in 2018/19.

**Argymhelliad / Recommendation**

The Board is asked to discuss the report and raise any issues arising from its content.

| **Amcanion: (rhaid cwblhau)**<br>**Objectives: (must be completed)** | |
|---|---|
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:<br>Datix Risk Register Reference and Score: | Not Applicable |
| Safon(au) Gofal ac Iechyd:<br>Health and Care Standard(s):<br>Hyperlink to NHS Wales Health & Care Standards | All Health & Care Standards Apply |
| Amcanion Strategol y BIP:<br>UHB Strategic Objectives:<br>Hyperlink to HDdUHB Strategic Objectives | 5. Deliver, as a minimum requirement, outcome and delivery framework work targets and specifically eliminate the need for unnecessary travel & waiting times, as well as return the organisation to a sound financial footing over the lifetime of this plan |
| Amcanion Llesiant BIP:<br>UHB Well-being Objectives:<br>Hyperlink to HDdUHB Well-being Statement | Improve Population Health through prevention and early intervention<br>Support people to live active, happy and healthy lives<br>Improve efficiency and quality of services through collaboration with people, communities and partners<br>Develop a sustainable skilled workforce |

| **Gwybodaeth Ychwanegol:**<br>**Further Information:** | |
|---|---|
| Ar sail tystiolaeth:<br>Evidence Base: | NHS Wales Delivery Framework 2017-18 |
| Rhestr Termau:<br>Glossary of Terms: | Contained within the body of the report |
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Cynllunio Busnes a Sicrhau Perfformiad:<br>Parties / Committees consulted prior to University Health Board: | Finance, Performance, Quality and Safety, Nursing, Information, Workforce, Mental Health, Primary Care Business Planning and Performance Assurance Committee |

| Effaith: (rhaid cwblhau)<br>Impact: (must be completed) | |
|---|---|
| **Ariannol / Gwerth am Arian:**<br>**Financial / Service:** | Better use of resources through integration of reporting methodology |
| **Ansawdd / Gofal Claf:**<br>**Quality / Patient Care:** | Use of key metrics to triangulate and analyse data to support improvement |
| **Gweithlu:**<br>**Workforce:** | Development of staff through pooling of skills and integration of knowledge |
| **Risg:**<br>**Risk:** | Better use of resources through integration of reporting methodology |
| **Cyfreithiol:**<br>**Legal:** | Better use of resources through integration of reporting methodology |
| **Enw Da:**<br>**Reputational:** | Not applicable |
| **Gyfrinachedd:**<br>**Privacy:** | Not applicable |
| **Cydraddoldeb:**<br>**Equality:** | Not applicable |

# Integrated Performance Assurance Report (IPAR)

## Position as at 31st March 2019 (Month 12)

**Click one of the circles to navigate to that section of the report**



**Supporting documents**

Main Performance Matrix

Key Deliverables Performance Matrix

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

# Executive summary

This report includes detailed information on the key deliverable targets, workforce, finance, therapies and other local targets where new data are available. Exception reports are included for most areas where new data is available, where targets are not being met, or there is a cause for concern. Background information on the NHS Wales Delivery Framework 2018-2019 is available via the Welsh Government website.

## Spotlight on Unscheduled Care

Unscheduled care performance declined in March compared to the previous month:

- **Ambulance handovers** delayed over 1 hour increased from 294 in February to 407 in March;
- Patients seen in **Accident and emergency (A&E) and minor injury unit (MIU)** within 4 hours declined from 84.4% in February to 81.7% in March;
- The number of patients **waiting over 12 hours in A&E** increased from 732 in February to 948 in March. This is the highest number of 12 hour breaches the Health Board has seen in over 3 years.

A slight improvement was seen in average **length of stay** for medical emergency patients, which decreased from 8.7 in February to 8.6 in March.

## Spotlight on Referral To Treatment (RTT), diagnostics and therapies

There were zero breaches in March 2019 for the following targets:

- Patients waiting over 36 weeks from referral to treatment;
- Patients waiting over 8 weeks for a diagnostic test;
- Patients waiting over 14 weeks for a specific therapy.

This was achieved through hardworking & dedicated staff, rigorous monitoring, outsourcing, and waiting list initiatives & overtime (funded with additional monies from Welsh Government).

Efforts are continuing into 2019/20 to maintain the excellent progress made in these areas in 2018/19.

## Where are we doing well?

- Hywel Dda ranked 1st in Wales for 9 national indicators including waiting times for diagnostic tests, stroke patients admitted to a stroke unit within 4 hours, waiting times for patients on the urgent suspected cancer pathway and mental health assessments;
- As mentioned above, the waiting time targets for **RTT**, **diagnostics** and **therapies** were all met;
- The Health Board performed well for three of the **stroke** targets i.e. stroke patients given a CT scan within 1 hour of diagnosis, admitted to a stroke unit within 4 hours and assessed by a stroke specialist within 24 hours;
- The three **mental health** key deliverable targets have all been met;
- The target has been met for **smokers carbon monoxide validated as quit** at 4 weeks;
- The **postponed admitted procedures** target met in March 2019, with 16 patients falling within the government commitment of which 8 patients were treated within the 14 day government target (in-month performance 50%). Of the remaining patients, 4 have since been treated, 2 have deferred treatment, 1 is awaiting a date and 1 has been removed from the waiting list;
- In 2018/19 the **Out of Hours** service successfully integrated all areas of the Health Board into the new 111 system, providing standardised access to urgent and unscheduled primary care clinicians in the out of hours period;

### Key deliverable targets

| 14 | 3 | 11 |
|---|---|---|

### All targets+

| 68 | 11 | 98 |
|---|---|---|

+ Only those indicators for which it is possible to assign a red, amber or green rating are included here.

### All Wales rank*

Hywel Dda UHB ranked in the top 3 for 40.7% of indicators which is a 3.8% increase from the previous month's position.

1. 9 indicators
2. 15 indicators
3. 11 indicators
4. 16 indicators
5. 13 indicators
6. 11 indicators
7. 10 indicators
8. 1 indicators

- The 12 month reduction targets were met for both new and follow up patients who **did not attend (DNA) their new outpatient appointment**;
- The 12 month mortality reduction target has been met in March for **crude mortality rate, deaths within 30 days of admission for a hip fracture** and **deaths within 30 days of admission for a stroke**;
- The 85% target has been met for the percentage of patients having a **nutrition** score completed and action taken within 24 hours of admission;
- The improvement target was met for **inpatients receiving the sepsis six bundle** within 1 hour;
- The rolling 12-month **sickness** reduction target has been met with the rate decreasing from 4.87% in February to 4.86% in March;
- The Health Board's **PADR** compliance is improving (78% in March) and above the NHS Wales average;
- **Medical Appraisal (PADR)** is far above target at 95% and has been above 90% for over 12 months;
- The National Intelligent Integrated Audit Solution (**NIIAS**) target was met in March for the number of staff accessing a **family member's record** (actual 11, target <=12);
- Consultants and SAS (staff grade and associate specialist) doctors are required as part of their contract to have an up to date **job plan**. The 85% target was met in March, with 92% of consultants / SAS doctors identified as having a job plan.

## Where are improvements needed?

- Performance for the percentage of ambulances responding to **red calls** within 8 minutes has not met the 65% target (provisional 62.9% for March);
- As outlined above, **unscheduled care** performance declined in March and the targets were not met. Work is underway to make improvements around patient flow, ambulatory care, ambulance offload and accident and emergency 4 hour performance;
- The 12 month improvement target was not met in March for patients diagnosed with a **stroke who were thrombolysed** within 45 minutes;
- The 98% waiting time target for **non-urgent suspected cancers** was not met in March 2019 with 95.8% receiving treatment within 31 days;
- The 95% waiting time target was not met in March for **urgent suspected cancers** but an improvement was seen from 80.7% in February to 84.2% in March;
- As at March 2019, the Health Board has 4 **safety notices** that are overdue in compliance, all have been reported in detail to the Quality, Safety and Experience Assurance Committee (QSEAC);
- The target for **hand hygiene** compliance has not been met but performance improved from 87.3% in February to 91% in March;
- **Non mental health delayed transfers of care** rolling 12-month numbers decreased 495 in February to 489 in March but the 5% reduction target was not met;
- The 12 month reduction target for **mental health delayed transfers of care** was not met and the 12 month number increased slightly from 107 in February to 108 in March;
- The improvement target was not met for patients in **emergency departments receiving the sepsis six bundle** within 1 hour;
- The targets have not been met for the 3 reported **health care acquired infections** i.e. E.coli, C.difficile and S.aureus. An improvement plan is in place;
- With only 31.3% of **serious incidents** assured within the required timescale, the 90% target was not been met in March;
- The 5% annual reduction target for **hospital initiated cancellations (HIC)** has not been met and the number of HICs increased from 129 in February to 158 in March;
- The 75% target was not met in March (66%) for settling concerns within 30 days. However, performance improved by 8% from March 2018;
- With only 2.5% at quarter 3 of **smokers attempting to quit via smoking cessation services**, the 5% cumulative target has not been met;
- In October-December 2018, 94.1% of 1 year olds had been immunised with the **'6 in 1' vaccine** and 91.0% of 5 year olds had received **2 doses of the MMR vaccine**. The 95% target for both indicators was not met;
- In March, there were 16,629 patients with **delayed follow-up** across trauma & orthopaedics, ear nose & throat, urology, dermatology or ophthalmology outpatient appointments. The 12 month reduction target was not met;

- **Healthcare acquired pressure sores in a community setting** decreased from 52 in February to 48 in March. However, the 12 month reduction target was not met; Whilst **Healthcare acquired pressure sores in a hospital setting** increased from 18 February to 23 in March, the 12 month reduction trend was met;
- The number of potentially preventable hospital acquired thrombosis was reported as 8 in October-December and the reduction target was not met;
- The percentage of hospital episode records **clinically coded** within one month dropped from 84.1% in December to 83.1% in January and the National target (95%) was not met. Local targets have been set with the aim of improving overall performance;
- The National Intelligent Integrated Audit Solution (**NIIAS**) target was not met in March for the number of staff accessing their **own record** (actual 12, target <=8);
- The **planned preventative maintenance**, **fire safety assessments** and **facilities cleanliness** targets were missed in March 2019;
- For babies born between October to December 2018, 91.1% were seen by a Health Visitor as part of the **Healthy Child Wales Programme** when they were 10 to 14 days old. This figure is above the Wales average (90.4%) but the 4 quarter improvement target was not achieved;
- The 12-month reduction **mortality** target was not met for deaths within 30 days of emergency admission for a heart attack.

## Potential challenges for the future

- **Mandatory Training** compliance has not met the 85% target but performance has improved considerably (by 13.9%) over the past 12 months (now 79.6% March 2019);
- **Non-medical appraisals** continue to be below the 85% target but compliance has improved by 15.6% in the last 12 months at March 2019;

There are concerted efforts across the Health Board to make further improvements for both mandatory training and appraisal compliance over the coming few months. This is key to ensure staff are able to have their pay increment as per the Agenda for Change pay deal agreed in 2018/19.

## Performance management triggers

The Performance Team is working with the Programme Management Office to develop triggers to highlight indicators outside of expected ranges. This will involve the use of Statistical Process Control (SPC) charts.

## Improvements / additions / future developments

- A new Cyber Compliance report has been added to describe our security patching status, related issues and actions;
- Data is included for neurodevelopment assessment waiting times for children and young people (autistic spectrum disorder (ASD) and attention deficit hyperactivity disorder (ADHD)). This can be accessed via the mental health charts in the data section and in the performance overview. An exception report will be included in the IPAR moving forward;
- A briefing report on the Cardiac Transfer and Treat service is included;
- A dashboard has been developed to summarise the national Primary Care indicators. The dashboard is available via the intranet site and images of the charts are included in the 'Data' section of this report. Also, supplementary Primary Care reports are provided for Managed GP Practices and Primary Care Quality and Assurance Performance (PCQAP). Within the PCQAP report, the Orthodontics section now includes data around the longest waits. The Primary Care Team and the Performance Team will work collaboratively over the coming months to further develop the Primary Care performance dashboard and to prepare a plan for adding data for the variety of Primary Care Services in the IPAR;
- The following NHS Delivery Framework update reports were submitted to the Welsh Government in April 2019 and are attached to this report for information: Dementia Training, Improving the Health and Well-being of Homeless & Specific Vulnerable Groups, Accessible Communication and Information for People with Sensory Loss, Advancing Equality and Good Relations and Implementation of the Welsh Language Actions.

# Latest performance overview

## Key deliverable targets and workforce

| Staying Healthy | Safe | Dignified | Effective | Timely | | | Individual | Staff & Resources |
|---|---|---|---|---|---|---|---|---|
| % adult smokers make quit attempt | Clostridium difficile | Postponed admitted procedures | Mental health delayed transfer of care (DTOC) | Ambulance red calls | Admission to stroke unit <4 hours | Referral to treatment - % 26 weeks or less | Secondary mental health care and treatment plan | Finance |
| % smokers CO validated | E coli bacteraemias | | NMH DTOC<br>Carms<br>Cered<br>Pembs | Ambulance handover over 1 hour | CT scan within 1 hour | Referral to treatment - 36 weeks and over | | Sickness absence |
| | S aureus bacteraemia | | | A&E 4 hour waiting times | Assessed by stroke consultant <24 hours | Diagnostic waiting times | | Performance appraisals (PADR) combined |
| | | | | A&E 12 hour waiting times | Thrombolysed door to needle <= 45mins | Delayed follow-up appointments | | |
| | | | | | Urgent suspected cancer | Local primary mental health <28 days referral | | |
| | | | | | Non urgent suspected cancer | Local primary mental health <28 days assessment | | |

**KEY**

- Target delivered
- Within 5% of target
- Target not delivered

| Staying Healthy | Safe | Dignified | Effective | Timely | | Individual | Staff & Resources | |
|---|---|---|---|---|---|---|---|---|
| Uptake of Influenza Vaccination | Serious Incidents and Never Events | Concerns and Complaints | Hospital mortality<br>- Crude rates<br>- Hip fracture<br>- Stroke | Patients waiting > 14 weeks for therapies | Continuing Healthcare | % Mental Health patients offered advocacy | New outpatients did not attend rates | Job planning |
| Childhood Vaccinations | Healthcare acquired pressure sores | Hand hygiene | Hospital mortality<br>- Heart | Therapy waits:<br>- Speech & Language<br>- Audiology | Ambulance amber calls | Mental Health Outpatients | Follow-up did not attend rates | NIIAS - family record |
| Healthy Child Wales Programme (HCWP) | Patient Safety Alerts/Notices | Nutrition scores | Mortality reviews undertaken within 28 days | Therapy waits:<br>- Art Therapy<br>- Physiotherapy<br>- Podiatry | Individual Patient Funding | Substance Misuse | Planned Preventative Maintenance | NIIAS – own record |
| | Klebsiella sp. & Pseudomonas aeruginosa | Hospital initiated cancellations | Clinical coding | Therapy waits:<br>- Lymphoedema<br>- Dietetics<br>- CMATS | Access to an NHS dentist | | Facilities cleanliness standards - soft | Clinical Eng: Com. High |
| | Hospital acquired thrombosis | Dementia Training | Health & Care Research Wales portfolio studies | Therapy waits:<br>- Occ therapy | External RTT | | Facilities cleanliness standards - hard | Clinical Eng: Acute Low |
| | Sepsis - inpatients | | Health & Care Research Wales sponsored studies | Therapy waits:<br>- Pulmonary rehab | | | Facilities: fire safety | Clinical Eng: Acute H & M Com M & L |
| | Sepsis - emergency dept | | | | | | | |
| | RIDDOR Compliance | | | | | | Mandatory training | NHS external providers |
| | Antibiotics dispensed in the community | | | | | | Cyber compliance | |

# Integrated performance management dashboards

A set of four dashboards have been included in an attempt to contextualise the Directorates' overall performance:

- Unscheduled care;
- Scheduled care;
- Healthcare acquired infections;
- Oncology.

The dashboards include

1) Current performance for key metrics;

2) Latest sickness data;

3) Hywel Dda University Health Board (HDUHB) performance against All Wales.

Finances measures for March 2019 will be included in the final month 12 IPAR (publication May 2019);

In time, we aim to add a section to capture patient outcomes and experience.

# Unscheduled Care March 2019

**Lead Executive - Joe Teape**

**Responsible Officers - Sarah Perry, Hazel Davies, Brett Denning, Janice Cole Williams**

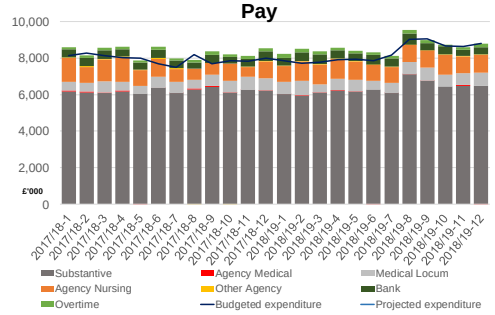
| Performance Metric | Latest Performance | Last available All Wales data Ranking (1st being the best and 7th being the worst) | | | |
|---|---|---|---|---|---|
| | | Hywel Dda | All Wales | Ranking | Time Period |
| Red Calls (estimate) | 62.9% | 62.9% | 71.2% | 6th out of 7 | Mar-19 |
| Ambulance handovers >1 hour | 407 | 407 | 2,544 | 3rd out of 6 | Mar-19 |
| A&E / MIU wait <4 hours | 81.7% | 81.7% | 78.7% | 3rd out of 6 | Mar-19 |
| A&E / MIU waits >12 hours | 948 | 948 | 4,472 | 5th out of 6 | Mar-19 |
| Direct to Stroke Unit <4 hours | 68.5% | 81.6% | 53.7% | 1st out of 6 | Feb-19 |
| Stroke patient CT scan <1 hour | 84.6% | 82.7% | 58.8% | 1st out of 6 | Feb-19 |
| Assessed by Stroke Consultant <24 hours | 98.5% | 90.4% | 80.4% | 2nd out of 6 | Feb-19 |
| Thrombolysed patients door to needle <=45 mins | 33.3% | 45.5% | 33.9% | 2nd out of 6 | Feb-19 |
| Number of DTOC (Rolling 12 month) | 489 | 495 | 4,431 | 4th out of 8 | Feb-19 |

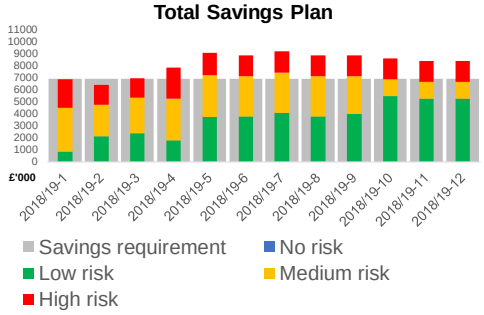
## Staffing

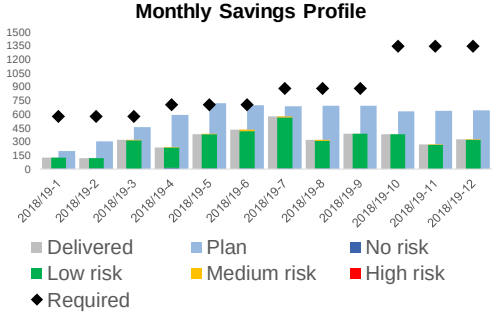
| Sickness (R12m end March 2019) | Proxy vacancies (budget vs actual wte) (Month 12) |
|---|---|
| 4.75% | 179.41 |

## Finance (Year to Date - Month 12) - excludes Pathology & Radiology

| | | | | | |
|---|---|---|---|---|---|
| In month RAG variance (Green favourable; Amber >0%; Red >3%) | -1.18% | Variance against YTD ave (↑ deterioration; ↓improvement) | ↓ | In month variance (£'m) (adverse is positive) | -0.122 |
| | | | | Cumulative variance (£'m) | 4.893 |
| | | | | Projected variance (£'m) | 4.893 |



## Scheduled Care March 2019

**Lead Executive - Joe Teape** | **Responsible Officers - Stephanie Hire**

| Performance | | | | Last available All Wales data Ranking (1st being the best and 7th being the worst) | | | |
|---|---|---|---|---|---|---|---|
| | | | | Hywel Dda | All Wales | Ranking | Time Period |
| **Referral to Treat** | **Total open pathways** | **Breaches** | **%** | | | | |
| Waits >36 wks | 53,793 | 0 | **0.0%** | 633 | 13,272 | 4th out of 7 | Feb-19 |
| Waits <26 Wks | 53,793 | **5,034** | **90.6%** | 90.4% | 88.6% | 3rd out of 7 | Feb-19 |
| **Diagnostics Waits >8 weeks** | | **0** | | 1 | 3,458 | 1st out of 7 | Feb-19 |
| **Postponed Procedures** | | **50.0%** | | - | - | - | - |
| **Delayed Follow Ups [all specialties]** | | **34,324** | | - | - | - | - |
| **Delayed Follow Ups [5 planned care specialties]** | | **16,629** | | 16,680 | 194,184 | 4th out of 7 | Dec-18 |
| **Outpatient DNA Rates (In Month)** | | **6.6%** | | 7.0% | 6.2% | 5th out of 7 | Feb-19 |
| **Follow Up DNA Rates (In Month)** | | **7.6%** | | 7.2% | 7.5% | 5th out of 7 | Feb-19 |

**Staffing**

**Sickness (R12m end March 2019)**

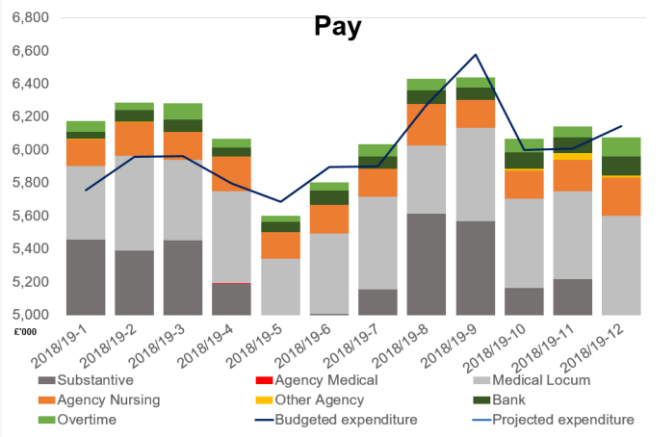
**4.35%**

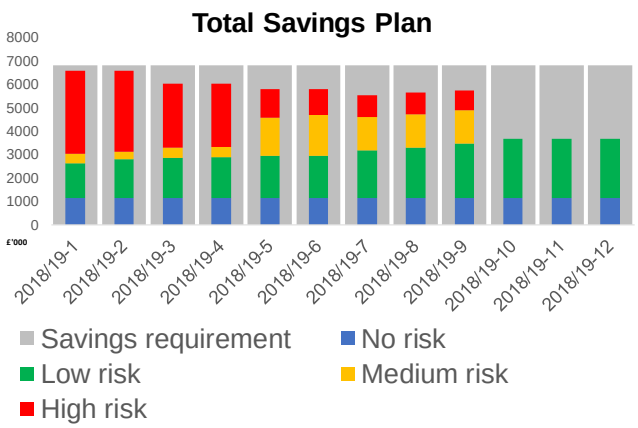
**Proxy vacancies (budget vs actual wte) (Month 12)**

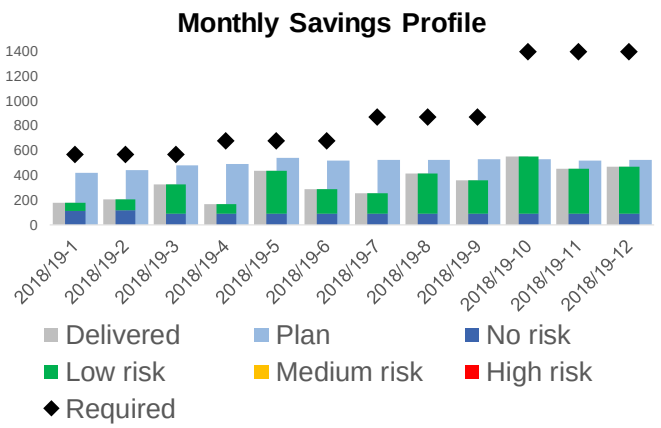
**71.62**

**Finance (Year to Date - Month 12)**

| In month RAG variance (Green favourable; Amber >0%; Red >3%) | Variance against YTD ave (↑ deterioration; ↓improvement) | | | |
|---|---|---|---|---|
| **1.22%** | ↑ | In month variance (£'m) (adverse is positive) | 0.101 |
| | | Cumulative variance (£'m) | 3.337 |
| | | Projected variance (£'m) | 3.342 |



# Oncology March 2019

**Lead Executive - Joe Teape**

**Responsible Officers - Keith Jones**

| Performance | | Last available All Wales data Ranking (1st being the best and 7th being the worst) | | | |
|---|---|---|---|---|---|
| | | Hywel Dda | All Wales | Ranking | Time Period |
| Urgent suspect cancer | 84.2% | 80.7% | 85.2% | 5th out of 6 | Feb-19 |
| Non urgent suspect cancer | 95.8% | 100.0% | 97.5% | 1st out of 6 | Feb-19 |

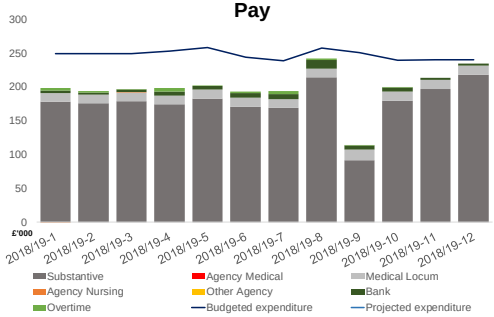
## Staffing

| Sickness (R12m end March 2019) | Proxy vacancies (budget vs actual wte) (Month 12) |
|---|---|
| 2.66% | -4.99 |

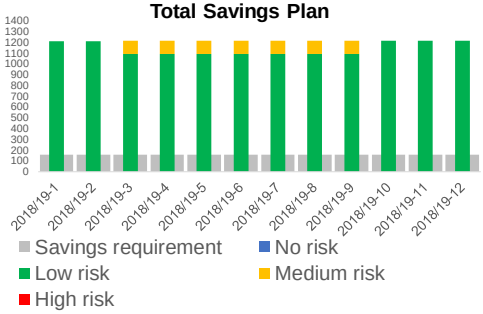
## Finance (Year to Date - Month 12)

| In month RAG variance (Green favourable; Amber >0%; Red >3%) | Variance against YTD ave (↑ deterioration; ↓improvement) | | |
|---|---|---|---|
| 31.08% | ↑ | In month variance (£'m) (adverse is positive) | 0.305 |
| | | Cumulative variance (£'m) | 0.575 |
| | | Projected variance (£'m) | - |

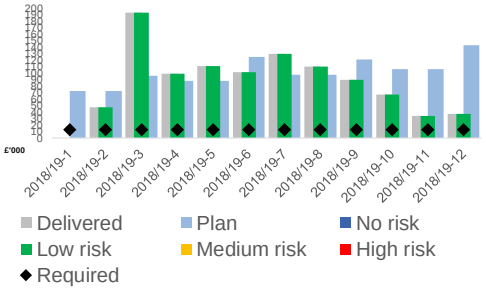
### Pay




### Total Savings Plan




### Monthly Savings Profile



## Healthcare Acquired Infections March 2019

**Lead Executive - Mandy Rayani** **Responsible Officers - Sharon Daniel**

| Performance | | Last available All Wales data Ranking (1st being the best and 7th being the worst) | | | |
|---|---|---|---|---|---|
| | | Hywel Dda | All Wales | Ranking | Time Period |
| **C.difficile** <=26 per 100,000 population (cumulative) | **37.48** | 37.48 | 26.59 | 6th out of 6 | Apr 18 - Mar 19 |
| **S.aureus bacteraemias (MRSA and MSSA)** <=20 per 100,000 population (cumulative) | **34.09** | 34.09 | 29.47 | 4th out of 6 | Apr 18 - Mar 19 |
| **E.coli bacteraemias** <=67 cases per 100,000 population (cumulative) | **91.09** | 91.09 | 79.42 | 4th out of 6 | Apr 18 - Mar 19 |

# Staying Healthy

I am well informed and supported to manage my own physical and mental health.

**Lead Executive**: Ros Jervis

**Exception reports:**

- Adult smokers who made a quit attempt
- Smokers CO validated
- Childhood Vaccinations
- Healthy Child Wales Programme (HCWP)

# Staying Healthy – Smoking cessation services

**Lead committee: BPPAC** | **Executive Lead: Ros Jervis** | **Senior Responsible Officer: Dawn E. Davies**

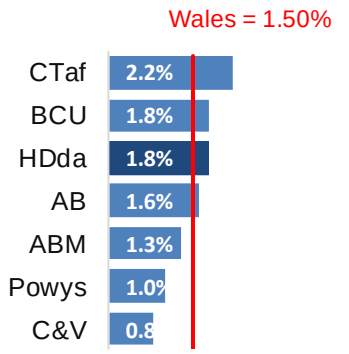
| Metrics (targets): | Status as at Q3 2018 | Performance the past 12 months |
|---|---|---|
| • % of adult smokers who make a quit attempt via smoking cessation services (5% annually) | 🔴 | Improving |
| • % of those smokers who are Carbon Monoxide (CO) validated as quit at 4 weeks (40% annually) | 🟢 | Improving |

## Latest data

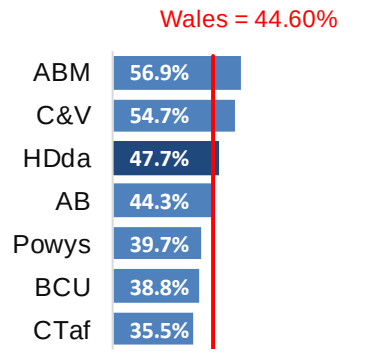
| | | | | | 2018-19 | | |
|---|---|---|---|---|---|---|---|
| | Mar-15 | Mar-16 | Mar-17 | Mar-18 | Q1 | Q2 | Q3 |
| % of adult smokers who make a quit attempt via smoking cessation services (5% annually) | 1.40 | 2.00 | 2.60 | 2.70 | 0.90 | 0.90 | 0.70 YTD* 2.5 |
| % pf those who smoke are Carbon Monoxide (CO) validated as quit at 4 weeks (40% annually) | 52.90 | 50.90 | 59.40 | 55.50 | 42.6 | 53.3 | 45.6 |

## Benchmarking (Q1 & Q2 18/19)

<u>% of adult smokers who make a quit attempt</u>




<u>% of those smokers who are CO validated</u>




*WG figures rounded to 1 d.p.*

## Where are we against target?

During quarter 3, 2018/19 the cumulative number of treated smokers increased to 1,409 (2.5%) compared to 1,164 (2.0%) treated smokers for the same period in 2017/18. Carbon Monoxide (CO) validated quit rates continue to be above the 40% target.

## Why has this situation occurred?

Baseline smoking prevalence has decreased in the 2018/19 reporting period with 18.7% (57,100) of the adult population continuing to smoke.

All local cessation services have seen an increase in the number of smokers accessing support and becoming treated.

The recruitment of Pharmacies to provide specialist smoking cessation support has continued to improve over quarters 1-3 with 53 pharmacies providing specialist smoking cessation support across Hywel Dda.

## What are the challenges?

Ensuring clear referral pathways are in place and utilised.

## What is being done?

- Ongoing recruitment of pharmacists and pharmacy technicians into the Pharmacy Level 3 Smoking Cessation Scheme to ensure services are provided across the Health Board area;
- Improving referral pathways for inpatients;
- Improving opt out referral pathways for outpatients;
- Improving service integration for smokers who may start their cessation journey in one service but finish within another;
- Research to improve uptake of smoking cessation service by pregnant women.

## When can we expect improvement and by how much?

Approximately 0.5% annually.

## How does this impact on both patients and finances?

While overall death rates from smoking are falling, it continues to be the largest single preventable cause of ill health and premature death. Reducing smoking has an immediate benefit for individuals and health care services through reduced rates of infection and length of hospital stay.

## Staying Healthy – Childhood vaccinations

**Lead Committee : BPPAC** | **Executive Lead: Ros Jervis** | **Senior Responsible Officer: Lynne Edwards/Lisa John**

| **Metrics (targets):** | **Status as at Dec 2018** | **Performance the past 12 months** |
|---|---|---|
| • % of children who received 3 doses of the '6 in 1' vaccine by age 1 (95%) | ● | Improving |
| • % of children who received 2 doses of the MMR vaccine by age 5 (95%) | ● | Improving |

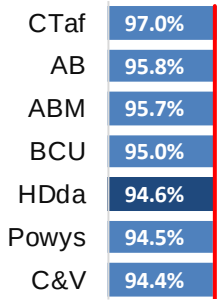
### Latest data

The latest COVER report published in March 2019 includes data for quarter 3 (Q3), October –December 2018.

### Benchmarking (Q2 2018/19)

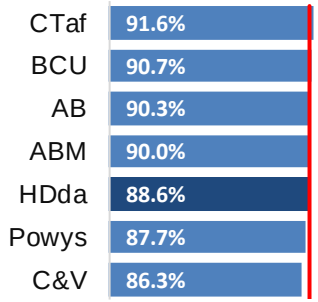
'6 in 1' vaccine by age 1

Wales = 95.30%




MMR vaccine by age 5.

Wales = 89.50%




### Where are we against target?

Uptake of the 3 doses of the 6 in 1 vaccine by age 1 was slightly below the 95% target, in October 2018 to December 2018 at 94.1% compared to the all Wales uptake of 95.7%. Broken down at county level, Ceredigion Local Authority (LA) uptake has shown a decrease to 92.0% from 95.9%. Pembrokeshire LA has remained stable this quarter at 93.3% (previously 93.5%), and Carmarthenshire LA has increased for the third consecutive quarter to 95.2%, and is above the WG target of 95%.

Uptake of 2 doses of the Measles, Mumps and Rubella (MMR) vaccine by age 5 remains below the 95% target, but with an increased uptake for October to December 2018 to 91.0%. Broken down to LA level, Carmarthenshire uptake has increased again to 91.3%, Ceredigion has increased to 90.9%, and Pembrokeshire continues to make improvements with a continued large increase to 90.6% (from 84.9%).

Public Health Wales Vaccine Preventable Disease Programme and Communicable Disease Surveillance Centre, working with Powys Teaching Health Board and the NHS Wales Informatics Service, have recently carried out a COVER data quality assurance project. This project has led to improvements in completeness of vaccination data in the national COVER dataset. The impact is that reported vaccination uptake has increased; primarily in children aged four years and older.

### Why has this situation occurred?

- Hywel Dda University Health Board (HDUHB) has similar challenges to other Health Boards (HB), with pockets of the population resisting childhood vaccination for cultural and ethical reasons;
- The rurality of many areas in HDUHB also impacts on uptake rates, with families having difficulty accessing clinics due to lack of transport and other issues with infrastructure throughout the area.

### What are the challenges?

There are variations in the delivery of the Childhood Immunisation Programme across the HB: in Ceredigion, with the exception of one GP practice, Health Visitors (HV) vaccinate, along with 3 practices in Carmarthenshire; in all other Carmarthenshire practices and in all Pembrokeshire surgeries, the Practice Nurses (PN) immunise.
HVs, whether they vaccinate or not, play a pivotal role in promoting Childhood Immunisations reflected in the Healthy Child Wales Programme (HCWP). There is currently a deficit of HVs across HDUHB which will impact on the delivery of the HCWP and the promotion and delivery of the Immunisation Programme. The deficit also impacts on the capacity to follow up with families who are not attending clinics.

### What is being done?

Following a review of governance arrangements for the immunisation and vaccination agenda in 2018, the Executive Immunisation and Vaccination (I&V) Group established three Sub Groups in order to develop delivery plans across specific work streams:

- Children's I&V Group;
- Workforce I&V Group;
- Primary Care I&V Group.

The uptake in relation to the childhood vaccinations above will be scrutinised in the Children's I&V Group and the Primary Care I&V group. At an operational level, a Childhood Immunisation Focus Group has also been developed to action recommendations from the above groups.

The following recommended work streams are already actioned by the Childhood Immunisation Focus Group to address some of the areas of low uptake identified from the COVER report:

- In relation to MMR a 'Think-Tank' was established to scrutinise at local level, and address any areas of concern. From this a pilot scheme is now in place to improve the uptake of MMR locally: children identified as having outstanding MMR (having not attended on more than 3 occasions for MMR) are offered bespoke immunisation sessions in alternative venues i.e. nurseries, giving parents more flexibility with venue and time to have their children immunised; 2 of these have taken place, with positive responses from parents so far, in relation to the improvement in accessibility of vaccination sessions. Data cleansing in preparation for this may have had some impact in the increase in MMR uptake in Carmarthenshire, although a continued increase has been evident in all 3 LAs in the last quarter;
- Development of a Community Nurse Immunising team continues. Two nurses were originally appointed in 2017, but this has had its own challenges as one of the 2 was uplifted to the role of Acting Immunisation and Vaccination Co-ordinator in the long- term absence of the substantive post holder, and there were issues with long-term sickness and resignation of the other. A new Band 5 Community Nurse Immuniser commenced work on 12 November 2018. This has allowed for cover of HV run immunisation clinics when needed, development of the bespoke vaccination sessions for 'hard to reach' families in alternative venues and, in exceptional circumstances, domiciliary vaccination, to recommence. An additional Community Nurse Immuniser is to be appointed in the near future;
- On benchmarking with other HBs regarding methods of improving immunisation uptake, data cleansing was identified as being integral to showing an increase in uptake as reflected in the COVER reports. A data cleansing exercise is to be undertaken simultaneously in 2 caseloads – 1 in Carmarthenshire and 1 in Pembrokeshire comparing cohort and uptake from Child Health Department against data on the respective GP systems.

**When can we expect improvement and by how much?**

When the Community Nurse Immuniser posts are back to full complement (June 2019) more focused and targeted vaccination sessions will be arranged; covering clinics, minimising queue lists, providing domiciliary service and alternative venues for immunisation for hard to reach families. The use of alternative venues for immunisations will continue, the focus being the MMR pilot discussed earlier. This will be audited and 'rolled-out' Health Board wide if found to be beneficial for families by improving accessibility, resulting in improvements in uptake. The development of the Childhood I&V Plan for 2019/20 is ongoing with the involvement of the relevant stakeholders. This will facilitate a focused and targeted approach to Childhood I&V.

**How does this impact on both patients and finances?**

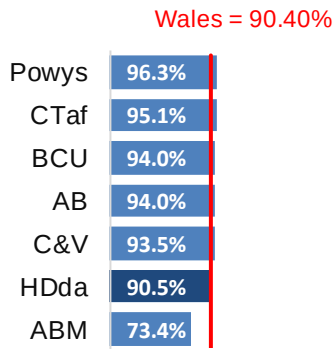
The uptake in vaccination measures will improve, to protect and prevent infection and support children to have a healthy start to life.

## Staying Healthy – Healthy Child Wales Programme (HCWP)

**Lead Committee: BPPAC** | **Executive Lead: Ros Jervis** | **Senior Responsible Officer: Lesley Hill/Lisa John**

| Metrics (targets): | Status as at Dec 2018 | Performance the past 12 months |
|---|---|---|
| • Percentage of children who are 10 -14 days old within the reporting period who have accessed the 10-14 days health visitor contact component of the Healthy Child Wales Programme (4 quarter improvement) | ● | Declining |

### Benchmarking (Q2 2018/19)




For future benchmarking, Welsh Government (WG) are working on an annual statistical report on Healthy Child Wales Programme (HCWP), which will be released in due course**.**

### Where are we against target?

As part of the HCWP, Health Visitors (HVs) are required to see all babies assigned to their caseload who are between 10 and 14 days old. By reviewing the data on Hywel Dda University Health Board (HDUHB) Child Health System, babies born between 1 September 2018 and 31 December 2018 there was 91.1% compliance.

### Why has this situation occurred?

Although the compliance has dipped by 0.9%, it is still above the all Wales figure of 90.4%.

There has been significant workforce challenges within the Health Visiting Service due to vacancies. Health Visitors are currently holding higher caseloads and a large proportion of the HV workforce are part time, which can make it difficult to see the babies within the 10–14 day window due to their working pattern.

### What are the challenges?

- Workforce – not enough Health Visitors which results in a large caseload. Therefore not enough time to allow for add on appointments;
- Unable to cover staff shortages such as sickness;
- Ensuring that the contact can be undertaken in the 10-14 day window – parents are not always available.

### What is being done?

- Reviewing the Child Health Reports retrospectively to identify which areas are failing so that a clearer understanding of the reasons why this is happening can be identified;
- Looking at the current skill mix with a view to increasing the workforce;
- Ongoing education and training to ensure HVs are clear regarding when visits need to be undertaken.

### When can we expect improvement and by how much?

HDUHBs position has dipped to 91.1% compared to 92% as at June 2018. The service will continue to monitor the position to ensure continued compliance.

The Senior Nurse for Quality Assurance attends the Welsh Head of Health Visiting and School Nursing Forum where it has been highlighted to WG that the accuracy of the data needs to be scrutinised and this is an ongoing issue.

### How does this impact on both patients and finances?

The impact on finances will be the need to recruit more staff in order to deliver the HCWP. There is no impact on babies, as they will always receive a birth visitor. Improve the current level of staffing so that the contacts can be made within appropriate timeframes.

## Safe Care

I am protected from harm and protect myself from known harm.

**Lead Executives**: Mandy Rayani and Joe Teape

**Exception reports:**

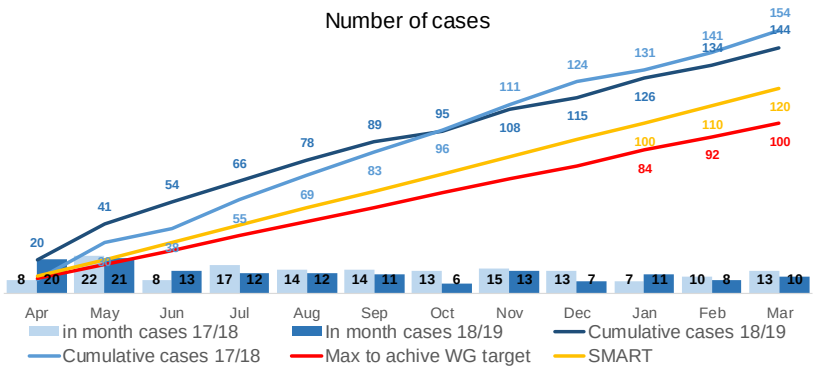
- Health care acquired infections - C.difficile
- Health care acquired infections - E.coli
- Health care acquired infections - S.aureus
- Health care acquired infections - Klebsiella sp. and Pseudomonas aeruginosa
- Healthcare acquired pressure sores
- Hospital acquired thrombosis
- Serious incidents and never events
- Safety alerts and notices
- Sepsis six bundle for inpatients
- Sepsis six bundle administered in emergency departments
- Antibiotics in the Community

# Safe Care – Healthcare Acquired Infections (HCAI) – cases per 100,000 population

**Lead committee: QSEAC** | **Executive Lead: Mandy Rayani** | **Senior Responsible Officer: Sharon Daniel**

| **Metrics (targets):** | **Status as at Mar 2019** | **Performance the past 12 months** |
|---|---|---|
| • WG -Cumulative rate of C.*difficile* cases (<=26 cases per 100,000 population) | 🔴 | Improving |
| • HD SMART – 20% reduction to 2017/18 reported cases (<=10 cases per month) | 🟢 | Improving |

## Latest data



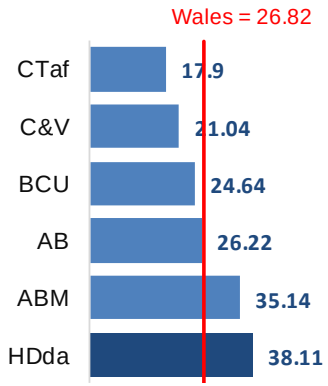

**SMART**

| Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 20 | 21 | 13 | 12 | 12 | 11 | 6 | 13 | 7 | 11 | 8 | 10 |

**Cumulative Rate per 100,000 population**

| Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 63.33 | 63.85 | 56.37 | 51.39 | 48.43 | 46.2 | 42.17 | 42.05 | 39.72 | 39.11 | 38.11 | 37.48 |

## Benchmarking (Apr 2018 – Feb 2019)




## Where are we and are we on target?

Performance at the end of March 2019 shows the in-month number of *C. difficile* Infections (CDI) is 10. The Health Board (HB) has not achieved the reduction expectation target set by Welsh Government (WG) for 2018/19.

## Why has this occurred?

The table below shows the reasons for infection:

| | Healthcare Associated Infection | Community Associated Infection |
|---|---|---|
| HAI[1] | **March – 6**<br>• 1x Antibiotics for abdominal sepsis, diarrhoea on admission;<br>• 1x no antibiotics, high dose proton pump inhibitor for gastric bleed;<br>• 2x Antibiotics for respiratory infections;<br>• 1x multiple antibiotics for cellulitis;<br>• 1x antibiotics following gastric surgery, known C.diff carrier. | **March – 0** |
| HCAI [2] | **March – 3**<br>• 1x GP sample, multiple antibiotics following Cardiac Surgery;<br>• 1x GP sample, received antibiotics following Appendicectomy;<br>• 1x prophylactic antibiotics during shoulder surgery. | **March – 1**<br>• 1x Care home patient no antibiotics |
| CAI [3] | **March – 0** | **March – 0** |

1. *Positive Stool Sample, patient admitted for more than 48 hours.*
2. *Healthcare Associated Infection - Positive Stool Sample, patient admitted within 48 hours of sample: Has been hospitalised in previous 30 days; received medical treatment in the last 30 days; lives in a nursing home or alternate care facility.*
3. *Community Associated Infection – Positive stool sample, patient admitted within 48 hours of sample who does not fulfil HCAI criteria*

## What are the challenges?

Reduction expectation target for Hywel Dda University Health Board (HDUHB) during 2018/19 for CDI is 26 per 100,000 population. HB SMART target; aspire to a target of 20% reduction (30 less CDI). This equates to less than 10 infections per month. Laboratory data for March 2019 indicates that there were 10 CDI:

Detailed in the above tables, the challenges are;

- Of the 10 cases this month, 8 were from Pembrokeshire; 2 GP and 6 Hospital samples. Over the last two months 3 wards have been identified in Withybush General Hospital (WGH) as having Periods Of Increased Incidence (PII);
- Cases requiring multiple antibiotic regimes due to infection and disease process;
- There is a need for review of all antibiotics at 48 hours, this is not always achieved.

## What is being done?

- WGH Triumvirate had a PII meeting; WG have been notified via 'No Surprises' proforma; Root Cause Analyses are underway on all cases and an Action Plan has been drafted which is to be monitored via further PII meetings and the Locality Infection Prevention meeting;
- The all Wales Antimicrobial Prescription Charts have been rolled out across the HB and will prompt clinicians to review antibiotics;
- Education around antibiotic prescribing will be provided across the HB to support the launch of the new Antibiotic Guidelines on June 3rd 2019.

## When can we expect improvement and by how much?

The HB achieved a 6% reduction for 2018/19 compared with the previous year and hoping that this work will continue with further work planned for 2019/20. The HB would hope to achieve a 10% reduction by the end of Q1 19/20, a reduction of 5 cases from 54 to 49.

## How does this impact on both patients and finances?

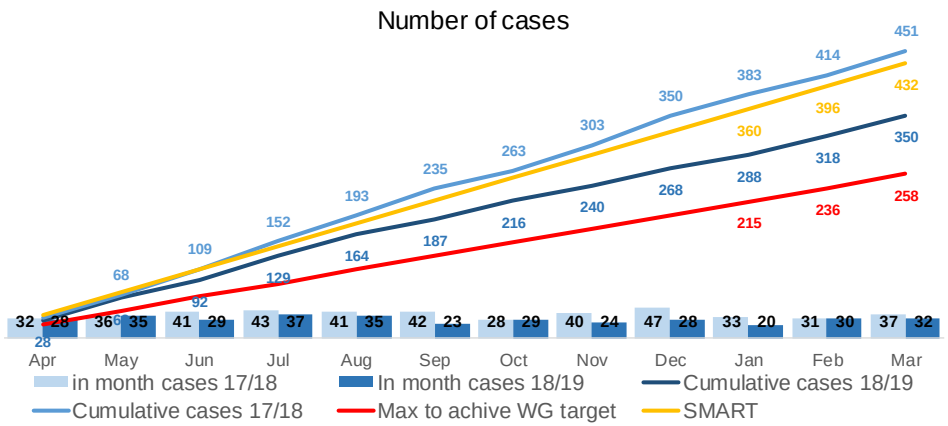
Each Hospital Acquired Infection is estimated to increase the average length of stay by 11 days together with additional pain and suffering which cannot be quantified. In 2014, the National Institute for Health and Care Excellence (NICE) attached a cost of £636 for each inpatient each day.

# Safe Care – Healthcare Acquired Infections (HCAI) – cases per 100,000 population

**Lead committee: QSEAC** | **Executive Lead: Mandy Rayani** | **Senior Responsible Officer: Sharon Daniel**

| Metrics (targets): | Status as at Mar 2019 | Performance the past 12 months |
|---|---|---|
| • WG -Cumulative rate of *E.coli* cases (<=67 cases per 100,000 population) | 🔴 | Improving |
| • HD SMART – 5% reduction to 2017/18 reported cases (<=36 cases per month) | 🟢 | Improving |

## Latest data



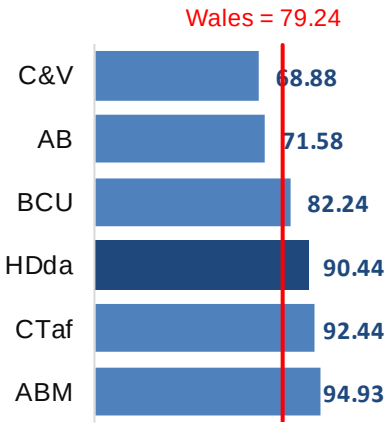

**SMART**

| Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 28 | 35 | 29 | 37 | 35 | 23 | 29 | 24 | 28 | 20 | 30 | 32 |

**Cumulative Rate per 100,000 population**

| Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 88.66 | 98.11 | 96.04 | 100.44 | 101.82 | 97.07 | 95.88 | 93.44 | 92.57 | 89.41 | 90.44 | 91.09 |

## Benchmarking (Apr 2018 – Feb 2019)




## Where are we and are we on target?

Performance at the end of March 2019 shows the in-month number of *E. coli* Blood Stream Infections (BSI) is 32.

## Why has this occurred?

The table below shows the reasons for infection:

| | Healthcare Associated Infection | Community Associated Infection |
|---|---|---|
| HAI[4] | **March –1**<br>• 1x Urinary source, patient has a long term urinary catheter (LTUC). | **March – 0** |
| HCAI[5] | **March – 6**<br>• 2x Urinary; 1x trial without catheter, 1x patient with nephrostomy tubes.<br>• 2x Respiratory; 1x Lung Cancer, 1x Pneumonia.<br>• 1x Hepatobiliary.<br>• 1x Systemic from chemotherapy patient. | **March –7**<br>• 3x Urinary; 2x Urinary catheters, 1x no catheter;<br>• 2x Gastric from abdominal sepsis;<br>• 2x Unknown source. |
| CAI[6] | **March – 0** | **March – 18**<br>• 8x Urinary; (7x Urosepsis, 1xRenal Abscess);<br>• 4x Hepatobiliary;<br>• 2x Gastric sources;<br>• 2x Skins and Soft Tissue infections;;<br>• 1x Musko-skeletal<br>• 1x Unknown. |

*1. Hospital Acquired Infection - Positive Blood Culture, patient admitted for more than 48 hours*
*2. Healthcare Associated Infection -Positive Blood Culture, patient admitted within 48 hours of sample: has been hospitalised in previous 30 days; has received medical treatment in last 30 days; has a long term indwelling device; lives in a nursing home or alternate care facility.*
*3. Community Associated Infection - Positive Blood Culture, patient admitted within 48 hours of sample who does not fulfil HCAI Criteria*

## What are the challenges?

The *E. coli* reduction expectation for HDUHB for 2018/19 is a rate of 67 per 100,000 population. HB SMART target; to report fewer cases than the previous year, aspire to a 5% reduction. Laboratory data for March 2019 indicates that there were 32 cases respectively:
Detailed in the above tables, the challenging cases were;

- 40% of cases are community related with only one case clearly identified as being from a nursing home;
- 4 cases related to devices - highlighting the need for good management and hydration of patients in hospital and the community.

## What is being done?

- Community Infection Prevention Team attending Primary Care Conference, making every contact count;
- Work being progressed in the Community with roll out of Aseptic Non Touch Technique competencies.

## When can we expect improvement and by how much?

The HB has achieved a 22% reduction in E.coli BSI over 2018/19 compared with the previous year. The expectation is that this reduction will continue but slow down over the coming year but estimating a 10% reduction to the number of cases, for the year ahead.

## How does this impact on both patients and finances?

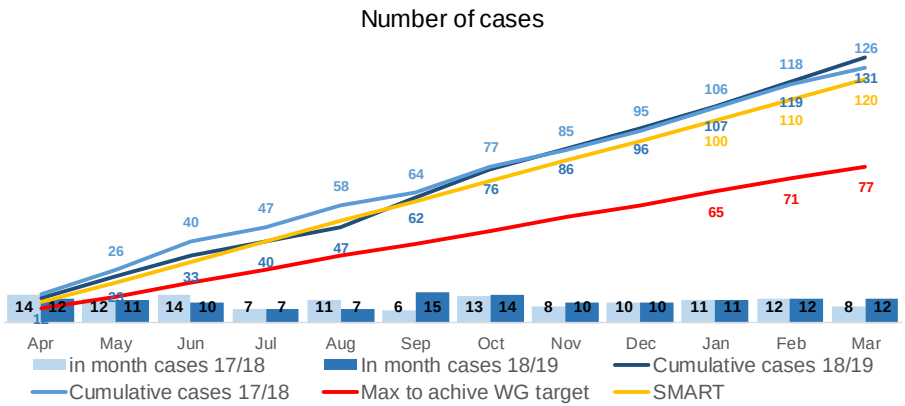
As reported under the C.*difficile* exception report - see link here

## Safe Care – Healthcare Acquired Infections (HCAI) – cases per 100,000 population

**Lead committee: QSEAC** | **Executive Lead: Mandy Rayani** | **Senior Responsible Officer: Sharon Daniel**

| **Metrics (targets):** | **Status as at Mar 2019** | **Performance the past 12 months** |
|---|---|---|
| • WG -Cumulative rate of *S.aureus* cases (<=20 cases per 100,000 population) | ● | Improving |
| • HD SMART – 15% reduction to 2017/18 reported cases (<=10 cases per month) | ● | Declining |

### Latest data



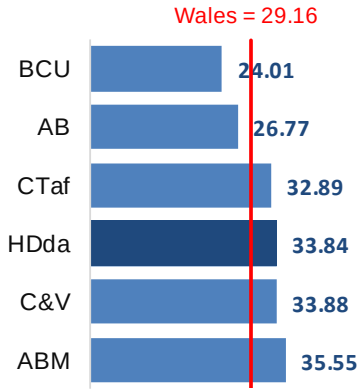

**SMART**

| Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 12 | 11 | 10 | 7 | 7 | 15 | 14 | 10 | 10 | 11 | 12 | 12 |

**Cumulative Rate per 100,000 population**

| Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 38 | 35.82 | 34.45 | 31.15 | 29.18 | 32.18 | 33.74 | 33.48 | 33.16 | 33.22 | 33.84 | 34.09 |

### Benchmarking (Apr 2018 – Feb 2019)




### Where are we and are we on target?

Performance at the end of March 2019 shows the WG in-month number of *S. aureus* Blood Stream Infection (BSI) is 12; 10 of which were Meticillin Sensitive *Staphylococcus aureus* (MSSA) and 2 are Meticillin Resistant *Staphylococcus aureus* (MRSA). The Health Board did not achieve the reduction expectation target set by Welsh Government for 2018/19.

### Why has this occurred?

The table below shows the reasons for infection:

| | Healthcare Associated Infection | Community Associated Infection |
|---|---|---|
| HAI[4] | **March – 4**<br>• 1x MRSA BSI source unknown;<br>• 1x MSSA Orthopaedic, patient with crush injuries and external fixation to pelvis;<br>• 1x Respiratory patient;<br>• 1x Cannula line infection - avoidable | **March – 0** |
| HCAI[5] | **March – 1**<br>• 1x MRSA BSI – dialysis patient, previous positive, unresolved. | **March – 1**<br>• 1x Urinary catheter change in the community, led to confusion and fall |
| CAI[6] | **March – 0** | **March – 6**<br>• 1x Respiratory;<br>• 1x discitis;;<br>• 1x Spinal abscess<br>• 1x cellulitis from insect bite;<br>• 1x Liver disease;<br>• 1x Unknown source. |

*1.Hospital Acquired Infection - Positive Blood Culture, patient admitted for more than 48 hours*
*2. Healthcare Associated Infection -Positive Blood Culture, patient admitted within 48 hours of sample: has been hospitalised in previous 30 days; has received medical treatment in last 30 days; has a long term indwelling device; lives in a nursing home or alternate care facility.*
*3. Community Associated Infection - Positive Blood Culture, patient admitted within 48 hours of sample who does not fulfil HCAI Criteria*

## What are the challenges?

The reduction expectation for HDUHB for 2018/19 for *S. aureus* is 20 per 100,000 population. HB SMART target; to report fewer cases than the previous year, aspire to a target of 15% reduction (20 less *S. aureus* BSIs). This equates to less than 10 *S. aureus* BSI per month. Laboratory data for March 2019 indicates that there were 12 cases; 10 MSSA BSIs and 2 MRSA:

Detailed in the above tables, the challenging cases were;

- One cannula related infection; management of lines remains a challenge in the Health Board (HB);
- Follow up of Dialysis patients remain a challenge, as the HB does not primarily manage them;
- Community cases relating to medical devices were previously followed up sporadically.

## What is being done?

- Management of lines has seen improvement in the last year with the purchase of Vascular Access Trolleys in Withybush General Hospital; this reduced their line infections from 8 in 2017/18 to 2 in 2018/19. These trolleys are now being rolled out across the HB;
- The Team are liaising with the Renal Network to make them aware of cases for them to review;
- Community cases are followed up by the Community Infection Prevention Nurses, who are also supporting the roll out of Aseptic Non Touch Technique in the community.

## When can we expect improvement and by how much?

The HB is reporting a 4% increase compared to last year's figures at end of year. Work is currently being done across the Health Board with the roll out of Vascular Access Trolleys, this work and education around these trolleys should be complete by the end of Q1 19/20 with improvement then being seen.

## How does this impact on both patients and finances?

As reported under the C.*difficile* exception report - see link here.

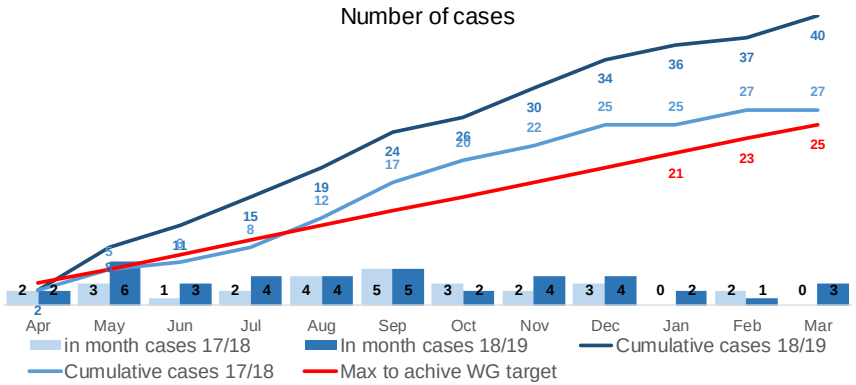
# Safe Care – Healthcare Acquired Infections (HCAI) – cases per 100,000 population

**Lead committee: QSEAC** | **Executive Lead: Mandy Rayani** | **Senior Responsible Officer: Sharon Daniel**

| **Metrics (targets):** | **Status as at Mar 2019** | **Performance the past 12 months** |
|---|---|---|
| • Cumulative number of cases of *Klebsiella* sp. Bacteraemia (10% baseline reduction to 2017/18) | ● | Declining |
| • Cumulative number of cases of *Pseudomonas aeruginosa* bacteraemia (10% baseline reduction to 2017/18) | ● | Declining |

## Latest data

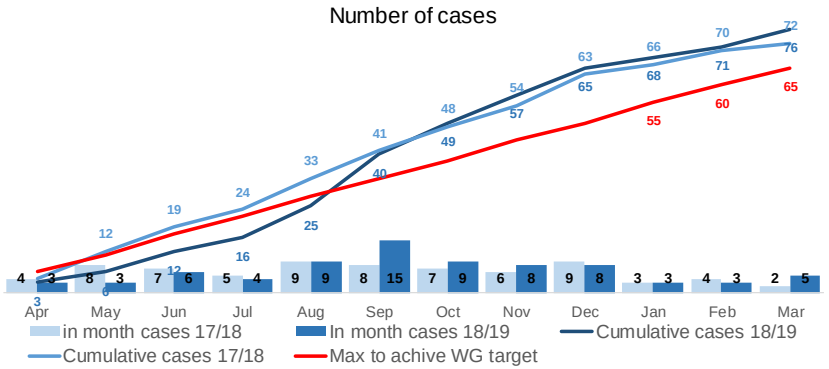
### *Pseudomonas aeruginosa*




**Cumulative Rate per 100,000 population**

| Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 6.33 | 12.46 | 11.48 | 11.68 | 11.8 | 12.46 | 11.54 | 11.68 | 11.74 | 11.18 | 10.52 | 10.41 |

### *Klebsiella* sp




**Cumulative Rate per 100,000 population**

| Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 9.5 | 9.34 | 12.53 | 12.46 | 15.52 | 20.76 | 21.75 | 22.19 | 22.45 | 21.11 | 20.19 | 19.78 |

## Where are we against target?

*Klebsiella* sp. and *Pseudomonas aeruginosa* have a reduction expectation of 10% in numbers of cases in 2018/19 compared to 2017/18.

- *Klebsiella* sp. have reported 5 cases this month.
- *Pseudomonas aeruginosa* have reported 3 case this month.

## Why has this occurred?

This is a new reduction target for 2018/19 and the Infection Prevention (IP) Team has only began basic surveillance of these cases, which will be reviewed for learning going in to 2019/20. It has already been identified that many of these cases are presenting from the community setting and those in hospital are seen to have a connection to Critical Care.

## What are the challenges?

These are gram-negative blood stream infections which have been noted to be increasing across the UK. The Team do not currently have enough surveillance information in place to identify themes that can be addressed for reduction.

## What is being done?

From the beginning of April 2019, the Team will be increasing the surveillance on all cases of *Klebsiella* sp. and *Pseudomonas aeruginosa,* seeking to identify avoidable and contributing themes that we can influence.

## When can we expect improvement and by how much?

Improvement is not expected until the end of Q2 19/20 as currently the Team does not have clear actions that can be taken for improvement.
Following that, the Health Board would want to see a 10% reduction to the number of cases in the second two quarters of 2019/20.

## Safe Care – Serious Incidents and Never Events

**Lead Committee: QSEAC** | **Executive Lead: Mandy Rayani** | **Senior Responsible Officer: Sian Passey**

| **Metrics (targets):** | **Status as at Mar 19** | **Performance the past 12 months** |
|---|---|---|
| • Percentage of serious incidents (SIs) assured within the agreed timescales (90%) | ● | Declining |
| • Number of new never events (0) | ● | Not Applicable |

### Latest data

| 698 Serious Incidents had been reported between 1st April 2015 and 31st March 2019, of which 71 remaining **OPEN** | Total |
|---|---|
| Absconded Patient | 6 |
| Alleged Abuse | 3 |
| Infection Control | 1 |
| Pressure Damage | 7 |
| Procedural Response to Unexpected Deaths in Childhood (PRUDiC) | 1 |
| Self Harm | 5 |
| Serious Harm | 3 |
| Serious Harm (inpatient falls) | 14 |
| Service Provision | 4 |
| Suspected Suicide | 14 |
| Under 18 admission (Child on Adult Mental health Ward) | 1 |
| Unexpected Death | 12 |
| Women & Children Directorate | 0 |
| **Total** | **71** |

### Where are we and are we on target?

The most recent Health Board data indicates that there were 698 serious incidents (SIs) that had been reported since 1st April 2015, of which 71 remain open. The Welsh Government (WG) compliance (in month rate) for March 2019 is 31.3%. In March 2019 Hywel Dda had no never events.

### Why has this situation occurred?

The ASI (Assurance, Safety and Improvement) team are continuing to meet with senior members of the service to highlight SIs. Two SI Panel meetings have taken place to date. Services were invited to present and share their reviews of SIs to the Director of Nursing Quality & Patient Experience, Medical Director, Deputy Medical Director, Director of Therapies and Health Sciences and Assistant Director of Nursing Assurance & Safeguarding. Emphasis was placed on carrying out robust and timely reviews to ensure assurance is provided via appropriate learning and actions taken. These monthly meetings run alongside the SI weekly meetings. The continuing reduction in compliance is reflective of the pressures the services are under and the complexity of incidents that require reviews.

### What are the challenges?

The challenge remains meeting the WG's compliance along with tackling capacity within the ASI and Mental Health quality assurance teams.

### What is being done?

With formal monthly Serious Incident panel meetings taking place, there is a focus on providing assurances and emphasis on meeting the WG compliance figures. The ASI Team are continuing to work closely with services to emphasise the requirement on SI management and help bring closures to fruition to ensure the compliance rate is met and sustained.

### When can we expect improvement and by how much?

Work is underway to improve compliance as outlined above with a predicted improvement to 60% next month, with work required to achieve compliance with the more complex serious incidents for investigation.

### How does this impact on both patients and finances?

With timely investigations, patients and their families can have the assurance that measures are being put in place to avoid reoccurrence and services are learning.

## Safe Care – Patient Safety Alerts and Notices

**Lead Committee: QSEAC** | **Executive Lead: Mandy Rayani** | **Senior Responsible Officer: Sian Passey**

**Metrics (targets):** | **Status as at March 2019** | **Performance the past 12 months**

- Number of Patient Safety Solutions Wales Alerts & Notices not assured within the agreed timescales | ● | Declining

**Latest data**

| | Welsh Government Patient Safety Alerts | Welsh Government Safety Notices |
|---|---|---|
| Issued since June 2014 | 9 | 48 |
| Overdue compliance | 0 | 4 |
| Alerts and notices not due | 1 | 2 |
| Compliance | 8/8 (100%) | 42/46 (91%) |

**Where are we and are we on target**
The All Wales target of the number of Patient Safety Alerts and Notices assured within agreed timescales is collected quarterly. In Quarter 3 (2018/19) Hywel Dda had one notice that was not assured within the agreed timescale. This relates to the management of life bleeds and is detailed below.

**Why has this situation occurred?**
Regarding the non-compliant notices, these are reported in detail via the Quality, Safety and Experience Assurance Committee (QSEAC):

- **Patient Safety Notice PSN030** The safe storage of medicines: cupboards (compliance date 26/08/16) - There are issues across Wales with compliance against this Notice and therefore discussions, in relation to this safety notice, are being held at Welsh Government level. Within the Health Board, this notice is being led by the Medicines Error Review Group;
- **Patient Safety Notice PSN040** Confirming removal or flushing of lines and cannulae after procedures (compliance date 12/09/18) - This notice, which is applicable to all hospitals and other units that undertake surgical interventions or other procedures involving anaesthesia or intravenous sedation, is being led by the National Safety Standards for Invasive Procedures (NatSSIPs) implementation group. 2 of the 4 actions are complete. The 2 outstanding actions, local documentation for handover and establishing systems of audit, will be discussed at the next NatSSIP meeting;
- **Patient Safety Notice PSN046** Resources to support safer bowel care for patients at risk of autonomic dysreflexia (compliance date 29/03/19) - The current health board policy will be reviewed in light of the notice. All Heath Boards are in a similar position and therefore, the All Wales continence forum has established a task & finish group to produce a national policy; the Health Board has local representation on this group;
- **Patient Safety Notice PSN048** Risk of harm from inappropriate placement of pulse oximeter probes (compliance date 29/03/19) - The notice has been circulated to all the Heads of Nursing across the Health Board for dissemination within the their clinical areas, it has also been circulated to the Service Delivery Manager for Theatres who will disseminate to the Consultant Anaesthetist team leaders in each hospital, the outpatient department and recovery team leaders for sharing with their colleagues. The notice will be discussed at the next Rapid Response to Acute Illness Learning (RRAILS) meeting on 16/04/19 and an action plan agreed, which is the final outstanding action.

**What are the challenges?**
These are detailed above.

**What is being done?**
Each Patient Safety Solution has been reviewed, RAG (Red, Amber, and Green) rated and allocated to an appropriate subcommittee of QSEAC for assistance in implementation.

**When can we expect improvement and by how much?**
This is detailed above.

**How does this impact on both patients and finances?**
Achieving compliance with Patient Safety Alerts and Safety Notices will minimise the risk of harm to patients. Robust investigations and learning from events will improve the quality of care delivered to patients. Significant investment is required to bring the Health Board into compliance with some Patient Safety Solutions.

## Safe Care – Healthcare acquired pressure sores in a hospital setting

**Lead committee: QSEAC** | **Executive Lead: Mandy Rayani** | **Senior Responsible Officer: Sian Passey**

**Metrics (targets):**

- Number of healthcare acquired pressure sores in a hospital setting (12 month reduction)
- Number of healthcare acquired pressure sores in a community setting (12 month reduction)

| Status as at March 19 | Performance the past 12 months |
|---|---|
| ● | Improving |
| ● | Declining |

### Latest data

The word grade has been changed to category in this report to reflect the language used in the Welsh Government reporting requirements which have come into effect in September 2018.

| Hospital Acquired | Apr 18 | May 18 | Jun 18 | Jul 18 | Aug 18 | Sep 18 | Oct 18 | Nov 18 | Dec 18 | Jan 19 | Feb 19 | Mar 19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Avoidable** | | | | | | | | | | | | |
| Category 1 | 1 | 1 | 3 | 1 | 0 | 4 | 1 | 3 | 1 | 4 | 1 | 2 |
| Category 2 | 11 | 10 | 8 | 10 | 9 | 2 | 7 | 8 | 5 | 9 | 2 | 8 |
| Category 3 | 0 | 4 | 0 | 0 | 1 | 0 | 0 | 2 | 0 | 1 | 0 | 0 |
| STDI | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 4 | 6 | 3 | 5 |
| Unstageable | 0 | 4 | 0 | 1 | 0 | 1 | 1 | 0 | 1 | 0 | 1 | 1 |
| Category 4 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 |
| **Sub total** | **14** | **19** | **11** | **12** | **10** | **8** | **10** | **13** | **11** | **20** | **7** | **16** |
| **Unavoidable** | | | | | | | | | | | | |
| Category 1 | 0 | 2 | 0 | 0 | 1 | 0 | 0 | 1 | 3 | 1 | 2 | 2 |
| Category 2 | 7 | 8 | 6 | 9 | 5 | 1 | 3 | 1 | 4 | 3 | 2 | 3 |
| Category 3 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 |
| STDI | 2 | 0 | 0 | 0 | 0 | 1 | 0 | 2 | 1 | 2 | 1 | 0 |
| Unstageable | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 |
| Category 4 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Sub total** | 9 | 10 | 8 | 9 | 6 | 3 | 3 | 4 | 9 | 7 | 5 | 5 |
| Unknown | 3 | 3 | 4 | 2 | 2 | 1 | 3 | 2 | 8 | 11 | 6 | 2 |
| **Total** | **26** | **32** | **23** | **23** | **18** | **12** | **16** | **19** | **28** | **38** | **18** | **23** |

| Community Acquired | Apr 18 | May 18 | Jun 18 | Jul 18 | Aug 18 | Sep 18 | Oct 18 | Nov 18 | Dec 18 | Jan 19 | Feb 19 | Mar 19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Category 1 | NA | NA | NA | NA | 4 | 9 | 7 | 10 | 5 | 9 | 6 | 5 |
| Category 2 | NA | NA | NA | NA | 25 | 17 | 38 | 27 | 27 | 30 | 31 | 28 |
| Category 3 | NA | NA | NA | NA | 2 | 2 | 1 | 2 | 4 | 2 | 1 | 1 |
| STDI | NA | NA | NA | NA | 6 | 2 | 2 | 3 | 7 | 8 | 10 | 10 |
| Unstageable | NA | NA | NA | NA | 4 | 7 | 5 | 3 | 7 | 6 | 3 | 3 |
| Category 4 | NA | NA | NA | NA | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 1 |
| **Sub total** | **51** | **44** | **37** | **56** | **41** | **37** | **53** | **45** | **51** | **55** | **52** | **48** |
| **Total Healthcare Acquired Pressure Ulcers** | **77** | **76** | **60** | **79** | **59** | **49** | **69** | **64** | **79** | **93** | **70** | **71** |

### Where are we against target?

The overall number of health care acquired pressure ulcers for March 2019 was 71. This is an increase of 1 from February 2019.

- 23 were hospital acquired pressure damage and, of these 16 were deemed avoidable (70%);
- 48 were community acquired pressure damage. The breakdown per category has been included in this report from August 2018. Of the 48 incidents reported for March, 33 were category 1 or 2.

The overall number of health care acquired pressure ulcers for the period April 2018 - March 2019 was 846.

- 276 were hospital acquired pressure damage;
- 570 were community acquired pressure damage.

There has been a 15% reduction in the number of hospital acquired pressure ulcers when compared to the 2017/18 position of 323.
16 wards from the Acute and Community hospitals have gone over 100 days without developing a hospital acquired pressure ulcer on their ward.

### Why has this situation occurred?

Hospital acquired pressure damage is being scrutinised by senior nurse teams to determine if damage could have been avoided. This process is identifying trends and actions plans are put into place.

### What are the challenges?

Although there has been a 15% reduction in the number of hospital acquired pressure ulcers when compared to the 2017/18 position, pressure damage prevention remain a challenge.
The challenges are multifactorial and multidisciplinary and include:

- Recognition of pressure damage;
- Assessment of risk skin assessments and reassessments;
- Accurate documentation; and
- Off loading pressure from heels.

There is still work to do on the scrutiny around Community Healthcare Acquired pressure ulcers and this forms part of the work of the Community Pressure Damage Improvement Group.

**What is being done?**

- The Pressure Damage Improvement group, set up by Assistant Director for Quality Improvement meets on a monthly basis;
- Foot care assessment piloted in Bronglais General Hospital (BGH) and there are plans to roll this work out to Glangwili General Hospital (GGH);
- Community group has met and agreed to map current DATIX reporting practice in the Community with the aim to improve accuracy;
- Introduction of the pressure damage passport in Prince Philip Hospital (PPH)
- New dynamic mattresses rolled out into BGH, PPH and GGH.

There are plans to introduce a new pressure damage risk assessment tool during 2019/20 which is include to the all Wales e-documentation work which aims to standardise the documents being sued across Wales as the first step to introducing an electronic patient record.

**When can we expect improvement and by how much?**

The aim for 2019/20 is to continue to reduce the number of pressure ulcers. This would be by looking at incidents from a whole system approach.

**How does this impact on both patients and finances?**

Pressure sores remain a serious and potentially life-threatening problem across all age groups, from the very young to the very old and across all medical specialties and care settings. The pressure ulcer productivity calculator was developed and published by the Department of Health 2010 to help NHS organisations and commissioners understand the productivity and cost elements associated with treating patients with pressure ulcers. The tool was developed using the results of research into the cost of pressure ulcers in the UK. By entering the Health Board (HB) figures for 2017/18 it is estimated that the potential financial cost of the incidents of pressure ulcers to the HB has been between £1.492m to £2.229m. In addition, there is the additional cost to the patient in terms of pain, loss of dignity and impact on long term quality of life. Link to the calculator can be found here.

## Safe Care – Number of potentially preventable hospital acquired thrombosis

**Lead Committee: BPPAC** | **Executive Lead: Mandy Rayani** | **Senior Responsible Officer: Mandy Davies/ Sian Hopkins/ Claire Rawlinson**

**Metrics (targets):**

- Number of potentially preventable hospital acquired thrombosis (HAT)

**Status as at Q3 2018/19:** ●

**Performance the past 12 months:** Declining

### Latest data

| Reporting Frequency - Quarterly | Target | Q4 2017/18 | Q1 2018/19 | Q2 2018/19 | Q3 2018/19 |
|---|---|---|---|---|---|
| The number of potentially preventable hospital acquired thrombosis | 4 quarter reduction trend | 3 | 6 | 2 | 8 |

**Where are we against target?**

The number of potentially preventable HATs (determined by Root Cause Analysis (RCA)) is reported as 8 in quarter 3. This is an increase from 2 in quarter 2 and 6 in quarter 1.

**Why has this situation occurred?**

The Thrombosis Committee has recently agreed that one missed dose of thrombo-prophylaxis, without clinical explanation is reportable as an avoidable case. The new criteria ensures that a robust process is followed across all specialities and sites within the Health Board. A standardisation of this criteria has contributed to the spike in avoidable cases in quarter 3.

**What are the challenges?**

- There is no dedicated thrombo-prophylaxis clinical lead within the Health Board (HB); responsibility sits with acute clinical teams;
- The themes identified from the RCA and from audits undertaken by the pharmacy, team have identified that compliance with the thrombo-prophylaxis risk assessment tool within 24 hours of admission remains poor;
- Ensuring that when thrombo-prophylaxis is prescribed that the prescription is administered appropriately;
- Historically, only 50% of notes can be obtained and reviewed, this low number has been noted by Welsh Government to be unacceptable and improvements have been made. Logistically, obtaining notes for all sites remains challenging due to notes not being tracked appropriately on some acute sites and notes being unavailable as required for clinical care.

**What is being done?**

- The Quality Improvement team meet with the Clinical Director/leads for each speciality on a quarterly basis to review each case;
- A detailed RCA is completed. A small number of Clinical Leads are completing the RCAs unsupported, which enables the Quality Improvement team to focus on the learning and improvements required. However, the majority of leads still require a significant amount of support to complete their RCAs;
- When learning is identified, this is communicated to the most appropriate team whether it is medical or nursing, in a variety of formats across the 4 acute sites;
- Efforts to improve clinical engagement have been made through the acute site governance meetings and through feedback to individual consultants;
- The Quality Improvement Team are working with Clinical Leads to improve risk assessment compliance, which has resulted in improvement in some areas. However, unfortunately this has not been sustainable and clinical engagement remains a concern;
- The Medical Director has recently written to all consultants reinforcing the risk assessment standard for thrombo-prophylaxis;
- A process for consideration of HAT cases under redress is in place.

**When can we expect improvement and by how much?**

It is anticipated performance will return to previous quarter levels when the standard is understood and the learning is embedded across all acute sites.

**How does this impact on both patients and finances?**

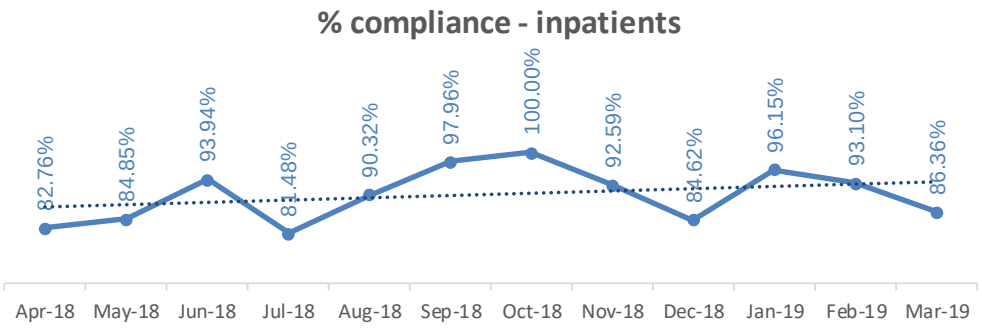
The impact on patients is that they require ongoing care following a hospital admission and suffer pain and discomfort. The financial impact from the redress process has yet to be established but is estimated from other Health Boards' experience as being a minimum of £7k per case.

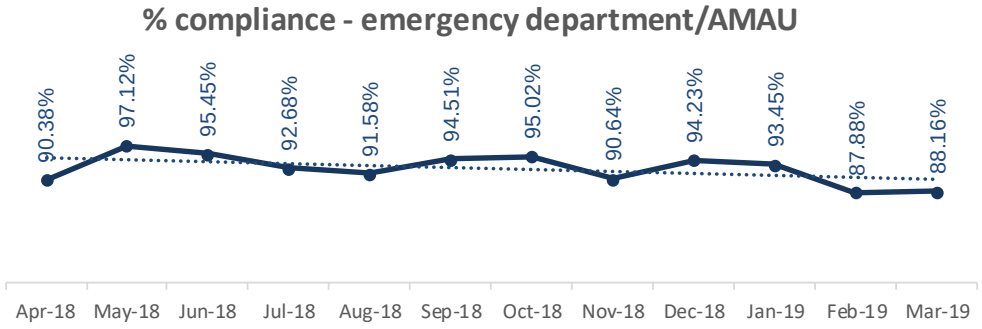
## Safe Care – RRAILS Sepsis Six Bundle applied within 1 hour

**Lead Committee: QSEAC** | **Executive Lead: Mandy Rayani** | **Senior Responsible Officer: Sian Hall**

| Metrics (targets): | Status as at Mar 2019 | Performance the past 12 months |
|---|---|---|
| • Percentage compliance with RRAILS Sepsis Six Bundle applied < 1 hr in Emergency Units/AMAU (Target – 12 month improvement trend) | ● | Declining |
| • Percentage compliance with RRAILS Sepsis Six Bundle applied < 1 hr in Wards (Target – 12 month improvement trend) | ● | Improving |

### Latest data




### Where are we and are we on target?

The Sepsis Six Bundle applied < 1 hr in wards has met the 12-month improvement trend from 82.76% in April 2018 to 86.36% in March 2019.

There had been a 2.2% decline in compliance for the admissions units, from 90.38% in April 2018 2018 to 88.16% in March 2019 and the target was not met.

### Why has this situation occurred?

- Ward compliance has improved since the introduction of sepsis compliance graphs at ward level, launch of new sepsis bundle and scrutiny of data at monthly assurance meetings;
- Since February 2019, 3 out of 4 of the admission units have reported a compliance below 90%, however compliance improved marginally in March;
- The 3 hospitals have reported increases in acuity and patient activity which resulted in 1-2 hour delays in administration of intravenous antibiotics.

### What are the challenges?

- Increased activity and acuity of patients within the admission units may result in delays in response;
- Clinical workload can result in staff not being released for mandatory training to reinforce principles of sepsis recognition and management.

### What is being done?

- Initial discussions have taken place with the Hospital Leads to identify a revised action plan to increase sepsis activity;
- The Resuscitation/Quality Improvement team are continuing to work closely to avoid further drop in compliance.

### When can we expect improvement and by how much?

- Dependant on clinical activity, the service expect to see a 1% or more improvement in the identified admission units.

### How does this impact on both patients and finances?

Delays in Sepsis Six treatment may result in increased bed stays, transfers to the Adult Critical Care Unit (ACCU) and an increase in mortality.

# Safe Care – Antibiotics dispensed in the community

**Lead committee: QSEAC** **Executive Lead: Mandy Rayani** **Senior Responsible Officer: Jenny Pugh Jones**

**Metrics (targets):**

- Fluroquinolone, cephalosoporin, clindamycin and co-amoxiclav (4C) items as a percentage of total antibacterial items dispensed in the community (Absolute measure < 7% or a proportional reduction of 10% against 16/17 baseline)

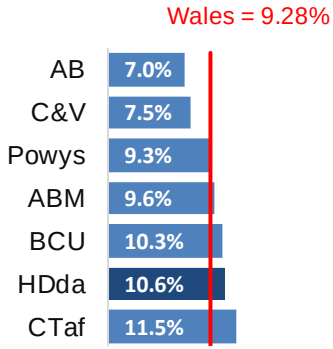
**Status as at Dec 2018** ●

**Performance the past 12 months** Declining

## Latest data

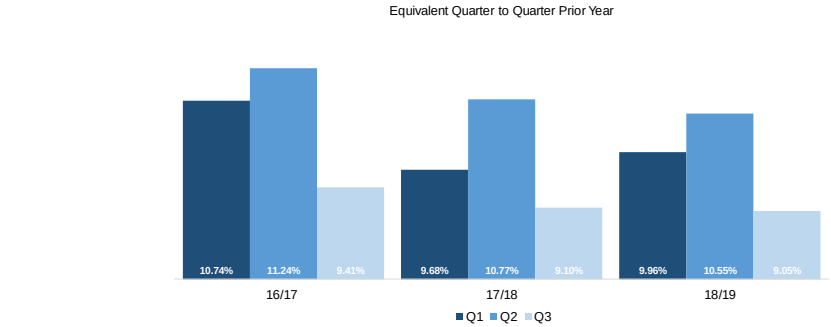
| Q4 17/18 | Q1 18/19 | Q2 18/19 | Q3 18/19 |
|---|---|---|---|
| 8.77% | 9.96% | 10.55% | 9.05% |

## Benchmarking (Q2, 2018/19)




## Where are we and are we on target?

The graph below shows the improvement in the quarter to quarter reduction of the amount of 4C antibiotics prescribed within the Health Board (HB) however the National target was not met. The 12 month performance trend is declining but this is due to the seasonal increase to the volume of antibiotics prescribed during Q4 Winter 17/18.




## Why has this occurred?

This can be partially explained by the fact that the total amount of antibacterials prescribed within the HB has been continuing to reduce, therefore as this is a percentage measure it is difficult to achieve the target of 7% or a proportional reduction of 10% as total antibiotic prescribing is also reducing.

## What are the challenges?

The challenges for the HB are:

- An elderly patient population with multiple co-morbidities who have a lower threshold for treatment with antibiotics and sometimes require treatment with broader spectrum agents;
- A rural population that require treatment with broad spectrum agents if they need treatment for what is deemed to be a dirty wound;
- Low uptake of the influenza vaccine compared with the rest of Wales which can lead to more post-flu respiratory tract infections that require broad spectrum treatment.

## What is being done?

A Primary Care antimicrobial pharmacist is currently working with practices to improve the appropriateness of their antibiotic prescribing, looking specifically at Co-amoxiclav, Quinolone and Cephalosporin prescribing. The pharmacist is also providing antimicrobial stewardship educational sessions at Prescribing Leads meetings and GP trainee teaching and also taking part in public engagement events promoting prudent use of antimicrobials. Due to time constraints only targeted work with certain practices is feasible as there is only one whole time equivalent Primary Care Antimicrobial Pharmacist in post for the whole of the HB.

## When can we expect improvement and by how much?

The aim would be to see a reduction in 4C prescribing rates by the end of Q4 19/20.

## How does this impact on both patients and finances?

High usage of 4C antibiotics is associated with a higher risk of acquiring antibacterial resistant organisms and health care associated infections. Antibiotics in general have low acquisition costs and therefore a failure to reach a reduction target would not be expected to have major financial implications. However, treating health care associated infections and multi-drug resistant organisms may have cost-implications.

# Effective Care

I receive the right care & support as locally as possible and I contribute to making that care successful.

**Lead Executives**: Phil Kloer, Jill Paterson, Mandy Rayani, Karen Miles and Joe Teape.

**Exception reports:**

- Delayed transfers of care (DTOC) – non mental health - Carmarthenshire
- Delayed transfers of care (DTOC - non mental health - Ceredigion
- Delayed transfers of care (DTOC - non mental health - Pembrokeshire
- Delayed transfers of care (DTOC) – mental health
- Crude mortality (under 75 years)
- Deaths within 30 days of emergency admission for a heart attack
- Deaths within 30 days of emergency admission for a stroke
- Deaths within 30 days of emergency admission for a hip fracture
- Health and Care Research Wales
- Clinical coding

# Effective Care – Delayed transfers of care (DTOC) – non mental health – Carmarthenshire

**Lead Committee: BPPAC** | **Executive Lead: Joe Teape** | **Senior Responsible Officer: Rhian Dawson**

**Metrics (targets):**

- Number of Health Board DTOC in rolling 12 months (Reduction <=5% of total number DTOC in 2017/18)

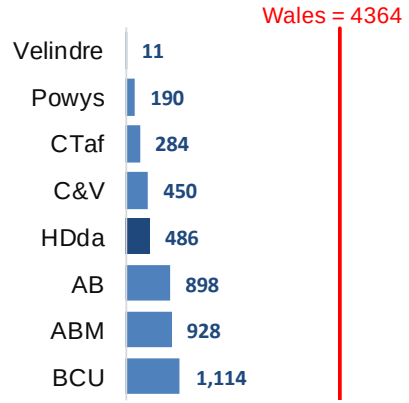
**HD Status as at Mar 2019** ●

**HD Performance the past 12 months** Declining

## Latest data

See the unscheduled care dashboard for the DTOC monthly trend chart.

## Benchmarking (January 2019)




## Where are we against target?

At the end of March 2019, the Hywel Dda University Health Board (HDUHB) rolling 12-month reduction target of 362 was not met and the number of in month patients for Carmarthenshire was 17 compared to 27 in February 2019, a decrease of 10.

Of the 17, the breakdown was as follows:

- Packages of Care (POC) (8) – 3 of these are reablement which only came to our knowledge 2 days before census day. The other POC were long term complex high frequency and time critical packages (not all were for social care, some were Continuing Health Care (CHC) requests) which were not picked up by the Bridging Service as these would have blocked up the service (NB the numbers would have been considerably higher without Bridging);
- Family dispute and Home of Choice (HOC) (5) - are consistent issues for delays recently and the team will relook at this;
- Care Home Assessments (3) – where the care home manager still needs to assess and determine that they can meet the patient's needs. There is no agreed standard with our providers;
- Housing (3) – these are amputees transferred from Morriston Hospital The Team are liaising with Occupational Therapy and the discharge team in Morriston to develop a pathway of care to enable a referral for housing sooner to mitigate these delays;
- The remaining ones are in connection with completion of social work assessments and the documentation and temporary placement for a learning disability patient.

## Why has this situation occurred?

- Packages of care both for reablement and complex care although it should be noted that the reablement ones were referred within 48 hours and were going to be discharged shortly afterwards;
- Family disputes. This is not necessarily linked to availability of residential and nursing care home placements, as there are a high level of vacancies across the County. It is more often the case that a patient and/or family are waiting for a specific care home which can cause significant delays if the home is a very good one and has a waiting list;
- Care Home assessments relates to the responsiveness of the Care Home Manager to assess the patient;
- Housing, although as noted this has arisen in specific circumstances with an action to follow up between the HDUHB and Abertawe Bro Morgannwg University Health Board (ABMU).

The above picture accords closely with the findings of the National Complex Discharge Review undertaken by the NHS Wales Delivery Unit (2018) that considered factors responsible for delays in hospital discharges**.**

## What are the challenges?

The challenge is to reduce not only the number of DTOCs, but to also reduce the associated number of days lost and improve other discharge rates for patients where the acute medical episode has ended. Across the HDUHB, the common challenges faced remain as previously reported in M9 IPAR (page 18).

## What is being done?

A variety of initiatives are undertaken continuously throughout the region. Best practice is being shared by each county and practice modified to improve performance. Key initiative details are in M9 IPAR (page 18):

- Sharepoint (IT system) to support early identification;
- Sharepoint Length of Stay (LOS) reporting is being monitored on a weekly basis and is proving useful in improving performance;
- Discharge Liaison and access to social workers is proving beneficial in earlier identification of complex patients;
- The Bridging (domiciliary care) service. Carmarthenshire commenced a bridging service in Prince Philip Hospital (PPH) and Glangwili General Hospital (GGH) respectively on 17th December 2018 and 21st January 2019. Based on the evaluation, the outcomes have proven positive in terms of expediting people from hospital;
- Care in the community is co-ordinated to facilitate discharges and prevention of admissions through the Acute Response Team working in partnership with British red Cross, Care and Repair and other Third Sector organisations to meet the needs of the patients and their carers;
- The Breaking the Cycle improvement plans will contribute to reducing LOS within community hospitals and reducing any delays in the system.

**When can we expect improvement and by how much?**

In recognition of the additional pressures placed on the whole health and social care system during winter periods, the service aimed to maintain the position over the period. February proved the most challenging with 27 reported against 17 in January and March 2019. From April, the Service is aiming to improve performance going forward building on the impact of the Bridging service (albeit this was funded from winter monies that have now concluded) and other measures that require consolidation and/or development (as indicated above).

**How does this impact on both patients and finances?**

The objective is to improve outcomes for patients and the performance of the health and social care organisations as previously reported in M9 IPAR (page 18).

# Effective Care – Delayed transfers of care (DTOC) – non mental health – Ceredigion

**Lead Committee: BPPAC** | **Executive Lead: Joe Teape** | **Senior Responsible Officer: Peter Skitt**

**Metrics (targets):**

- Number of Health Board DTOC in rolling 12 months (Reduction <=5% of total number DTOC in 2017/18)

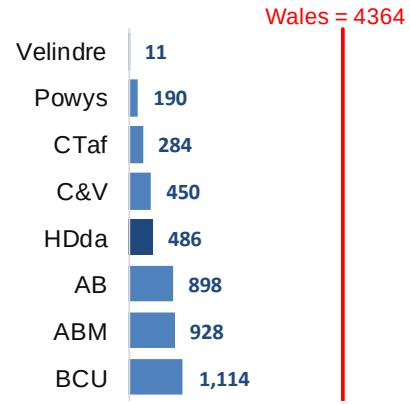
**HD Status as at Mar 2019**: ●

**HD Performance the past 12 months**: Declining

## Latest data

See the unscheduled care dashboard for the DTOC monthly trend chart.

## Benchmarking (January 2019)




## Where are we against target?

At the end of March 2019, the Hywel Dda University Health Board (HDUHB) rolling 12-month reduction target of 362 was not met and the number of in month patients for Ceredigion was 8 compared to 6 in February 2019, an increase of 2.

Of the 8, the breakdown is as follows:

- Packages of Care (1) patient was waiting for the commencement of a new package of care;
- Family Dispute, Home of Choice (HOC) and lack of availability of placements (5) - Availability of both residential and nursing home placement;
- Further assessments (2) – complex cases with multiple co morbidities requiring specialist assessments.

## Why has this situation occurred?

The main reasons as noted above were:

- Availability of domiciliary care packages in remote areas remains a challenge;
- Availability of residential and nursing home placements.

The above picture accords closely with the findings of the National Complex Discharge Review.

## What are the challenges?

As previously mentioned in the Carmarthenshire County DTOC report.

## What is being done?

A variety of initiatives are being undertaken continuously throughout the region. Best practice is being shared by each county and practice modified to improve performance. Key initiative details are in M9 IPAR (page 18):

- Sharepoint (IT system) to support early identification;
- The Breaking the Cycle improvement plans will contribute to reduce LOS within community hospitals and any delays in the system;
- Porth Gofal Multi agency triage is improving flow and informing priority areas;
- Third Sector Crisis Resolution Team (CRT) works closely with the Multi-Disciplined Team (MDT) to enable safe discharge;
- Community CRT provides in reach into the acute sites enabling timely discharge, this model of care is supported by access to interim beds in Nursing homes.

## When can we expect improvement and by how much?

In recognition of the additional pressures placed on the whole health and social care system during winter periods, the service aims to continually improve.

## How does this impact on both patients and finances?

As previously mentioned in the Carmarthenshire County DTOC report.

# Effective Care – Delayed transfers of care (DTOC) – non mental health – Pembrokeshire

**Lead Committee: BPPAC** | **Executive Lead: Joe Teape** | **Senior Responsible Officer: Elaine Lorton**

**Metrics (targets):**

- Number of Health Board DTOC in rolling 12 months (Reduction <=5% of total number DTOC in 2017/18)

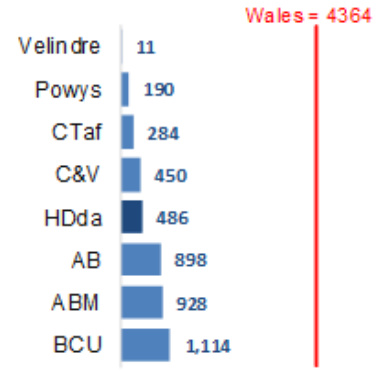
**HD Status as at Mar 2019:** ●

**HD Performance the past 12 months:** Declining

## Latest data

See the unscheduled care dashboard for the DTOC monthly trend chart.

## Benchmarking (January 2019)




## Where are we against target?

At the end of March 2019, the Hywel Dda University Health Board (HDUHB) rolling 12-month reduction target of 362 was not met and the number of in month patients for Pembrokeshire was 5, compared to 9 in February 2019,the lowest figure in the last 12 months.

Of the 5, the breakdown is as follows:

- Awaiting completion of arrangements for Continuing Health Care (CHC) in the community -1;
- Awaiting commencement of rehabilitation - In Patient - 1;
- Selecting residential care placement of choice – 1;
- Other family related reasons – 2.

## Why has this situation occurred?

The main reasons for the delays as noted above relate to:

- Availability of domiciliary care packages;
- Availability of reablement;
- Challenging family and home situations and expectations.

The above picture accords closely with the findings of the National Complex Discharge Review.

## What are the challenges?

As previously mentioned in the Carmarthenshire County DTOC.

There remains an overall lack of domiciliary care in Pembrokeshire. This results in longer time being spent in an acute setting, which can lead to deconditioning and longer rehabilitation support which is also constrained.

## What is being done?

A variety of initiatives are being undertaken and Winter Pressure funding has enabled additional pilots. Best practice is being shared by each county and practice modified to improve performance. Key initiative details are in M9 IPAR (page 18):

- Sharepoint (IT system) – supports earlier identification however more work is needed to ensure consistency of use and coding;
- Sharepoint Length of Stay (LOS) reporting is being monitored on a weekly basis and is proving useful in improving performance;
- Aligning Discharge Liaison Nurses and Social Workers to acute wards to support planning, board rounds and embed SAFER principles;
- Bridging care through Care at Home Team and Acute Response Team (ART).
- Community Pull meetings twice per week to identify support for flow including the use of community based resources;
- Daily Joint Discharge Team (Mon – Fri) Community Pull reviews of all stranded patients with targeted discharge plans shared with wards on a daily basis;
- Multi-Agency Care Assessment Meeting (MACAM) for complex cases - especially Learning Disabilities supporting early discharge;
- Introduction of “Time to Talk” meetings – piloting on Ward 12;
- Delivery Unit facilitated work to “Right-size community services” to support flow and complex discharge;
- Service Improvement Team facilitated acute programme to support flow and discharge decision-making.

**When can we expect improvement and by how much?**
Ongoing improvement is expected and will be measured both in terms of the number of delayed patients, but also the number of stranded patients and reduced bed days.

**How does this impact on both patients and finances?**
As previously mentioned in the Carmarthenshire County DTOC report.

Financial impact in Pembrokeshire relates to the costs of surge and emergency department pressures in Withybush Hospital and the unfunded cost of Community Care Beds.

# Effective Care – Delayed transfers of care (DTOC) – mental health

**Lead Committee: BPPAC** | **Executive Lead: Joe Teape** | **Senior Responsible Officer: Liz Carroll**

**Metrics (targets):**

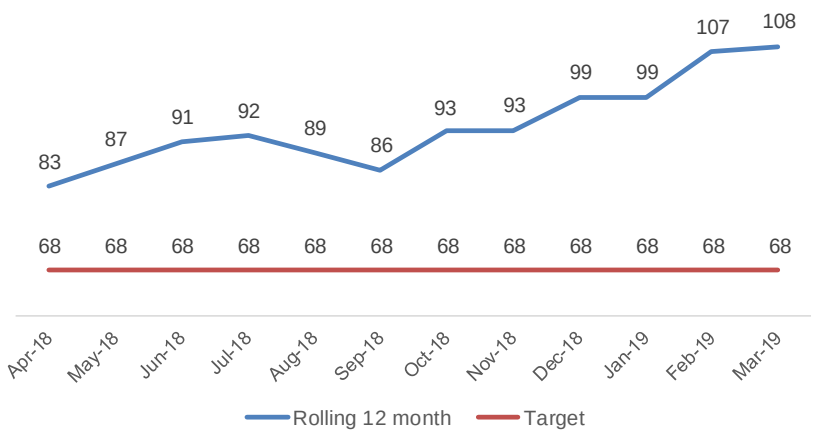
- Number of Health Board DTOC in rolling 12 months (Reduction <=10% of total number DTOC in 2017/18)

**Status as at Mar 2019**: ●

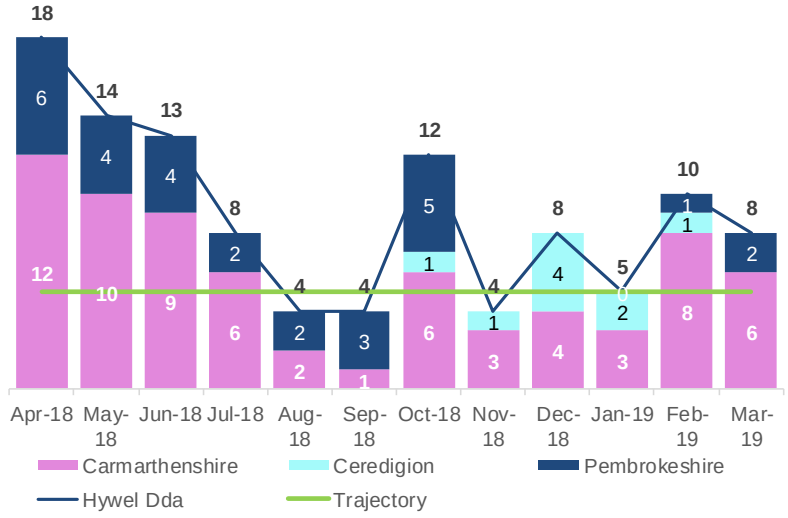
**Performance the past 12 months**: Declining

## Latest data

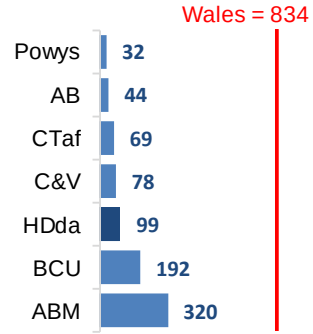
### HDUHB Rolling 12 month numbers




### HDUHB In month numbers




## Benchmarking (January 2019)




## Where are we against target?

At the end of March 2019, the rolling 12-month reduction target of 68 has not been met, the number of in month patient delays decreased to 8 compared with 9 in February 2019.

## Why has this situation occurred?

The in month position has reduced and this is due to a reduction in the number of Older Adult Mental Health (OAMH) patients identified as DTOC from 4 to 2 with Adult DTOC having increased from 5 to 6. Within the adult numbers between months this has resulted in movement of some patients and the addition of newly identified DTOC patients.

## What are the challenges?

- Availability of providers for those who require OAMH care; patients identified as DTOC from 4 to 2;
- When providers are subject to escalating concerns this limits the availability of appropriate placements;
- Placement of choice by patient or family is not available;
- Difficulty of obtaining package, which is bespoke to particular patient requirements;
- There is a delay in accessing a specialist NHS provision in England – current timescale is unknown, however, an interim placement is being sought;

- Lack of availability of domiciliary care to enable earlier discharge to less restrictive environments of care.

**What is being done?**

- Regular monitoring of the DTOC position is key within services;
- Care co-ordinators focus on discharge planning as early on in the patient pathway as possible.

**When can we expect improvement and by how much?**

Of the 8 individuals who are DTOC, 1 has now been discharged. For 1 there had been a funding query with a Local Authority outside the Hywel Dda University Health Board footprint, which has now been resolved. 1 is awaiting specialist placement whilst another one is awaiting an assessment from a specialist provider. Another individual is awaiting specialist NHS provision and as it is difficult to determine the timescale of availability, an interim alternative is being considered. For 1 individual the service is currently out to expressions of interest from potential providers with a further two still in the process of identifying suitable placements.

**How does this impact on both patients and finances?**

Patients may end up having to stay in environments that are more restrictive than they require for longer periods. Step down and step up facilities allow individuals to live as independently as possible.

# Effective Care – Mortality Indicators

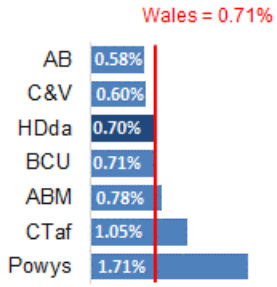
**Lead Committee: QSEAC** | **Executive Lead: Phil Kloer** | **Senior Responsible Officers: John Davies, L Davies & S Mansfield**

| Metrics (Targets – 12 month reduction trend): | Status as at March 2019 | Performance the past 12 months |
|---|---|---|
| • Crude Mortality (under 75 Years) | ● | Improving |
| • % of deaths within 30 days of emergency admission for a heart attack for patients aged 35 to 74 | ● | Declining |
| • % of deaths within 30 days of emergency admission for a stroke | ● | Improving |
| • % of deaths within 30 days of emergency admission for a hip fracture (Age 65+) | ● | Improving |
| • % of Universal Mortality Reviews undertaken within 28 days (Target 95%) | ● | Improving |

## Latest data

| 12 Months Rolling | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Crude Mortality Rate (74 years of age or less)** | | | | | | | | | | | | |
| Numerator | 647 | 648 | 634 | 618 | 618 | 617 | 603 | 606 | 601 | 599 | 591 | 589 |
| Denominator | 84,332 | 84,593 | 84,408 | 84,384 | 83,897 | 83,694 | 83,750 | 83,695 | 83,674 | 84,010 | 84,072 | 84,180 |
| Rate | 0.77% | 0.77% | 0.75% | 0.73% | 0.74% | 0.74% | 0.72% | 0.72% | 0.72% | 0.71% | 0.70% | 0.70% |
| **% of deaths within 30 days of emergency admission for a Heart Attack for patients aged 35 to 74** | | | | | | | | | | | | |
| Numerator | 7 | 8 | 8 | 8 | 7 | 7 | 6 | 7 | 6 | 5 | 6 | 5 |
| Denominator | 248 | 247 | 232 | 210 | 206 | 200 | 184 | 170 | 166 | 156 | 155 | 152 |
| Rate | 2.82% | 3.24% | 3.45% | 3.81% | 3.40% | 3.50% | 3.26% | 4.12% | 3.61% | 3.21% | 3.87% | 3.29% |
| **% of deaths within 30 days of emergency admission for a stroke** | | | | | | | | | | | | |
| Numerator | 108 | 113 | 109 | 102 | 105 | 105 | 104 | 107 | 100 | 97 | 99 | 89 |
| Denominator | 667 | 653 | 641 | 625 | 655 | 652 | 681 | 681 | 661 | 662 | 655 | 619 |
| Rate | 16.19% | 17.30% | 17.00% | 16.32% | 16.03% | 16.10% | 15.27% | 15.71% | 15.13% | 14.65% | 15.11% | 14.38% |
| **% of deaths within 30 days of emergency admission for a hip fracture (Age 65+)** | | | | | | | | | | | | |
| Numerator | 26 | 26 | 25 | 26 | 23 | 20 | 19 | 18 | 18 | 17 | 20 | 19 |
| Denominator | 507 | 489 | 486 | 479 | 493 | 494 | 507 | 507 | 515 | 499 | 481 | 445 |
| Rate | 5.13% | 5.32% | 5.14% | 5.43% | 4.67% | 4.05% | 3.75% | 3.55% | 3.50% | 3.41% | 4.16% | 4.27% |

## Benchmarking (February 2019)




## Where are we against target?

Throughout 2018/19 mortality rates have improved for all metrics except admission for a heart attack, which has low numbers. The latest all Wales data for Crude Mortality ranks Hywel Dda 3rd in this measure and below the all Wales average. Universal Mortality Review figures are again improving but not yet at the 95% target.

## Why has this situation occurred?

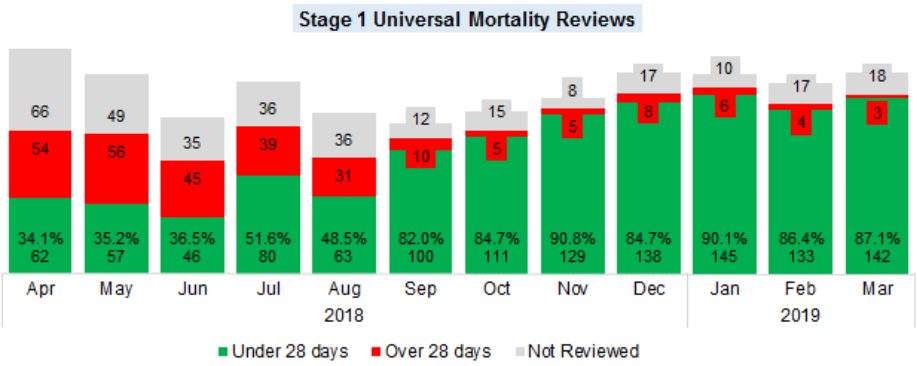
A detailed paper presented to QSEAC showed that the system is in control and there is no special cause variation. Having small numbers and a target that is cumulative means that any spike in one month has an impact for many months following. All sites are reviewing and prioritising these measures within their local plans.

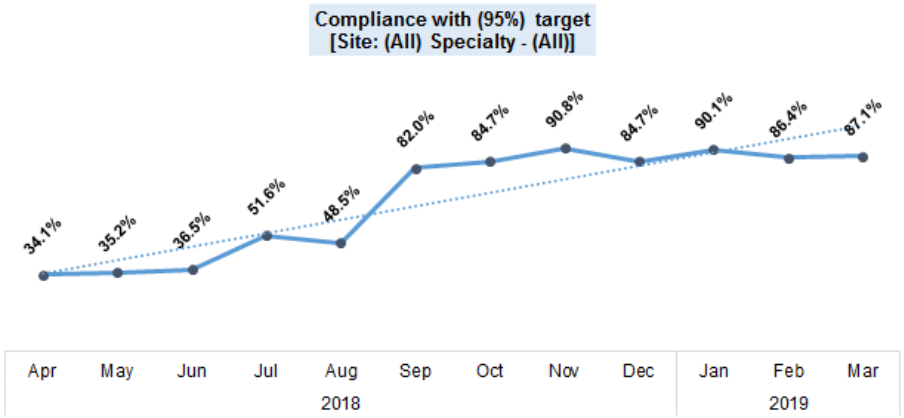
## What are the challenges?

Demonstrating improvement when numbers are very small is challenging. However, a mortality review group has been established and this group is driving the stage 1 process, taking forward the stage 2 process and ensuring that learning is embedded.

## What is being done?

It has been previously reported that a consistent stage 1 process is in place and that this was expected to ensure an improvement in the 28-day target.




The chart above continues to show the impact of the new process with a significant increase in the number of reviews undertaken within 28 days since September 2018 compared to the previous 6 months.

## When can we expect improvement and by how much?

Improvements are being seen with the target for crude mortality and hip fracture being met and a significant improvement since September 2018 seen in the 28 day stage 1 review target. The Mortality Review Group will continue to drive improvement.

## How does this impact on both patients and finances?

Improving outcomes has a clear impact on patients. The improvements highlighted over the past 12 months have led to better outcomes for patients and more effective use of resources.

## Effective Care – Health and Care Research Wales

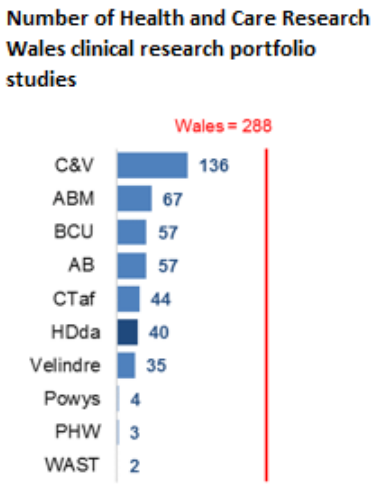
**Lead Committee: BPPAC** | **Executive Lead: Phil Kloer** | **Senior Responsible Officer: Lisa Seale**

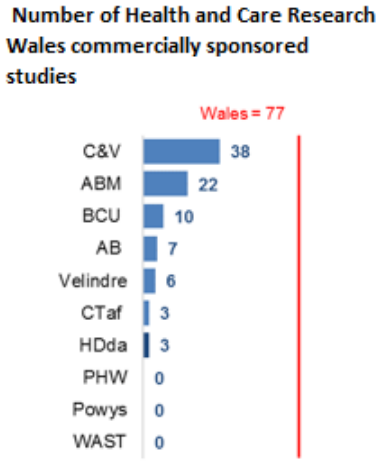
| Metrics (targets): | Status as at Dec 2018 | Performance the past 12 months |
|---|---|---|
| • Number of Health and Care Research Wales clinical research portfolio studies (10% annual improvement) | ● | NA |
| • Number of Health and Care Research Wales commercially sponsored studies (5% annual improvement) | ● | NA |
| • Number of patients recruited in Health and Care Research Wales clinical research portfolio studies (10% annual improvement) | ● | NA |
| • Number of patients recruited in Health and Care Research Wales commercially sponsored studies (5% annual improvement) | ● | NA |

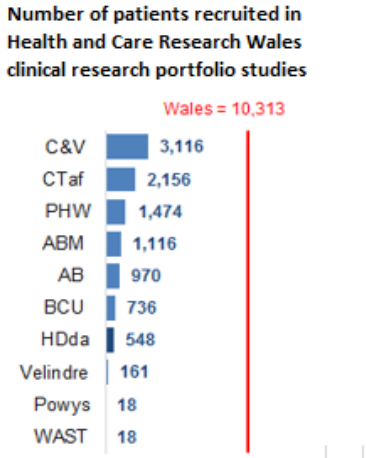
### Latest data

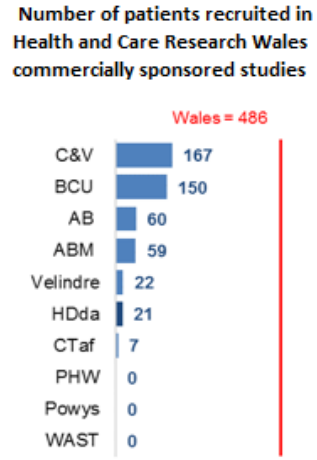
| Reporting Frequency - Quarterly | Target | Q3 2018/19 |
|---|---|---|
| Number of Health and Care Research Wales clinical research portfolio studies | 10% annual improvement | Target: 48, current: 52<br>% of target achieved: 107% |
| Number of Health and Care Research Wales commercially sponsored studies | 5% annual improvement | Target: 6, current: 3<br>% of target achieved: 48% |
| Number of patients recruited in Health and Care Research Wales clinical research portfolio studies | 10% annual improvement | Target: 1109, current: 847<br>% of target achieved: 76% |
| Number of patients recruited in Health and Care Research Wales commercially sponsored studies | 5% annual improvement | Target: 81, current: 30<br>% of target achieved: 37% |

### Benchmarking (Q1-Q2 18/19)




### Where are we against target?

- The number of Health and Care Research Wales clinical research portfolio studies (10% annual improvement), the service has achieved 107% of the target at the end of Q3 so above the target;
- The number of Health and Care Research Wales commercially sponsored studies (5% annual improvement), the service is 48% towards the target so 52% below the target at the end of Q3;
- The number of patients recruited in Health and Care Research Wales clinical research portfolio studies (10% annual improvement), the Service is 76% towards the target at the end of Q3 so above the target by 1%;
- The number of patients recruited in Health and Care Research Wales commercially sponsored studies (5% annual improvement), the service only reached 37% of the target at the end of Q3 so 63% below the target.

## Why has this situation occurred?

- The number of patients recruited in Health and Care Research Wales commercially sponsored studies - previously reaching the commercial recruitment targets has led to an inability to increase by the target (5% year on year) due to the workload involved with on-going studies (e.g. patient follow-up visits) and the finite capacity of the Research and Development (R&D) department;
- Commercial patient recruitment is 63% below target due to the loss of key research delivery staff in the department, which has resulted in reduced capacity to recruit patients into studies.

## What are the challenges?

- Staff retention within the R&D department is relatively stable, however, any loss of key staff may have a large impact on the targets;
- Increasing the number of Chief and Principal Investigators has proven difficult, hence we are limited in the number of new studies being opened;
- Dedicated clinical space for research activity continues to be an issue throughout the Health Board.

## What is being done?

- Promotion of Research and the R&D department is on-going;
- The Health and Care Research Wales pilot of the 'Expressions of Interest' scheme has been adopted by Hywel Dda which helps identify commercial research trials for new and existing investigators;
- The R&D department is developing a strategy to increase the numbers of new Chief and Principal Investigators.

## When can we expect improvement and by how much?

- The number of portfolio studies has already met the full year target, while the numbers of patients recruited into portfolio studies is set to reach its target by the end of Q4 2018/19;
- The Service hopes to achieve the target number of commercial studies by the end of Q4 2018/19;
- Based on current rates of patient recruitment into commercial studies, the service will be unable to reach the recruitment target by the end of Q4 2018/19.

## How does this impact on both patients and finances?

Not achieving the research activity targets means fewer than the anticipated numbers of research studies and clinical trials being available to patients, some of which may have offered them the most up-to-date treatments. Financially this may mean a reduction in Hywel Dda's future R&D Activity Based Funding allocation from Health and Care Research Wales, Welsh Government, reducing our ability to employ R&D staff, develop new researchers (Chief and Principal Investigators) and run research studies/clinical trials. This could also impact on R&D staff as any reduced funding could result in the department being unable to make temporary/fixed term posts permanent. This carries a risk of Hywel Dda UHB losing a sustainable research support service, as staff may leave to take up permanent positions at other Health Boards.

# Effective Care – Clinical Coding

**Lead Committee: BPPAC** | **Executive Lead: Karen Miles** | **Senior Responsible Officer: Anthony Tracey**

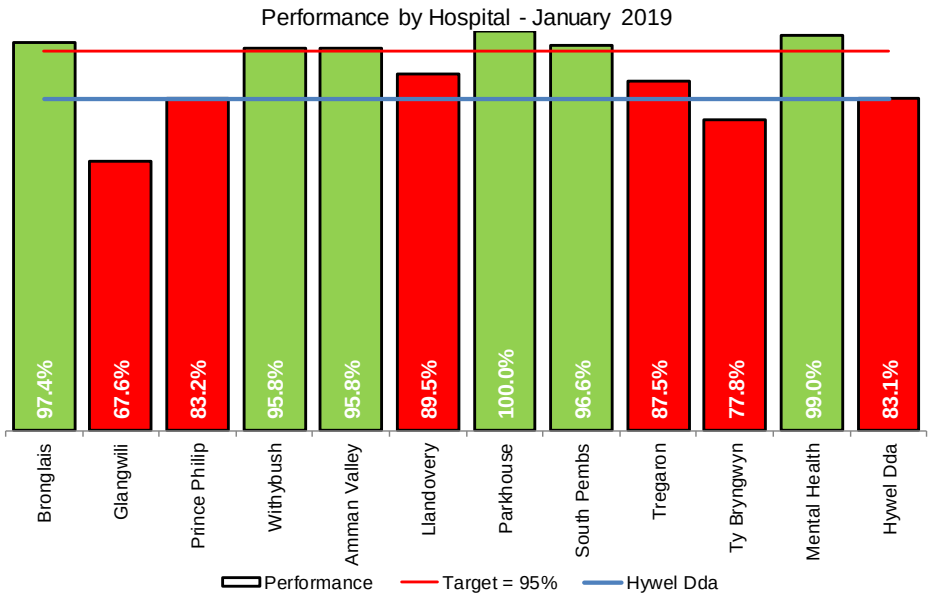
**Metrics (targets):**

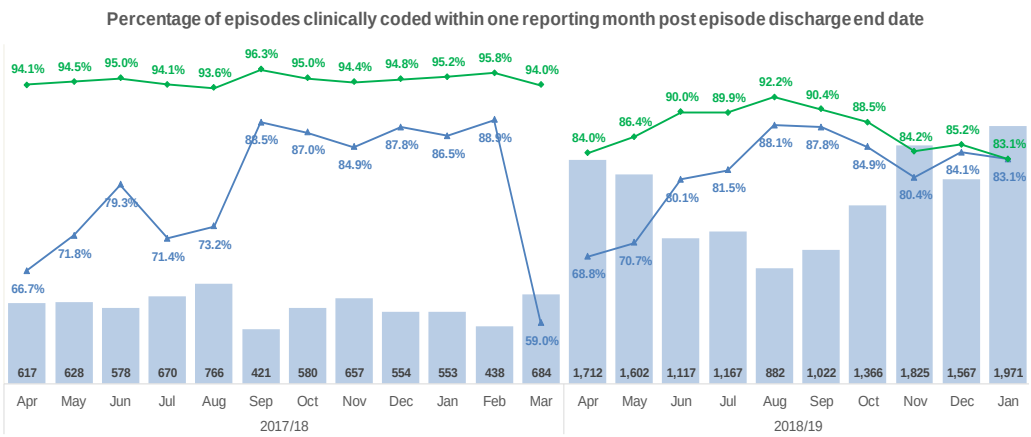
- % of episodes clinically coded within one month of episode end date, (95%)

**Status as at Jan 2019:** ●

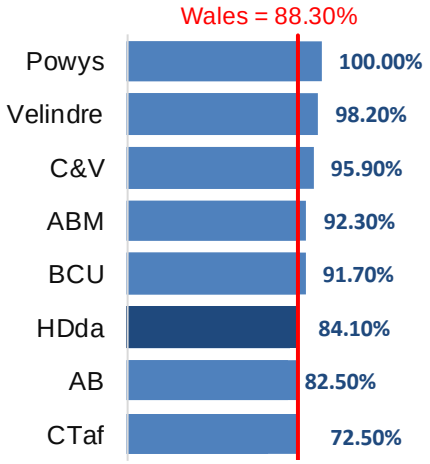
**Performance the past 12 months:** Improving

## Latest data




## Benchmarking (December 2018)




## Where are we against target?

Hywel Dda University Health Board (HDUHB) performance declined in January 2019 with 83.1% of episodes coded within one month, compared to 84.1% in December 2018. Performance for Bronglais General Hospital (BGH), Withybush General Hospital (WGH), Amman Valley, Park House Court and South Pembrokeshire Hospitals has achieved the 95% target for January 2019 episodes alongside Mental Health. HDUHB ranked 6th out of 8 across the Welsh Health Boards for December 2019 performance.

## Why has this situation occurred?

As previously reported in M6 IPAR (page 34).

- Team concentrated on coding the previous year's backlog;
- The department lost a full time Coder in February 2017 and part time coder in June 2018;
- Sickness levels impacts upon the ability of the team to code. Cumulative rates for rolling period to March 2019 is the highest in 3 years at 9.44% and continually increasing. This financial year, the team lost 1,176 days

to absence compared to 520 for the previous financial year, an increase of 656 days absence (+126%);
- Finished Consultant Episodes (FCE) are predominantly increasing year on year;
- 5 extra WTE Coders are needed to be able to hit the target and no longer deal with a backlog, based on 2017/18 activity.

## What are the challenges?

- There is a continual balancing act between achieving the target and preventing the backlog build up;
- Staff attending coding workshops impacts upon the time they have to code;
- Illegible and incomplete case notes and locating notes across the Health Board;
- Unavailability of case notes to code within 24 hours (where agreed) of patient discharge impacts on timeliness;
- Extra activity needs to be taken into account every year;
- Staff sickness;
- Potentially 6 or 7 members of the team will retire in the next 4/5 years;
- Incorrect data being entered on wards which impacts on the team being able to code accurately and timely;
- HDUHB need to give Supervisors (and possibly Band 4 Coders) the time to carry out monthly audits to help improve our accuracy.

Further details are M6 IPAR at the above link.

## What is being done?

- During 2018/19 an extra 25,109 episodes have been coded compared to the minimum expected from the team , this helps keep the backlog down and improves performance, however this is causing increasing pressure and leading to low morale due to being unable to achieve the target despite the amount of effort being put in;
- The team have been coding 'dailies' in the morning, in the afternoon, the team have been concentrating on the ‘performance month discharges;
- The Supervisors are also coding on a more regular basis to try and improve the performance;
- Overtime is also being utilised and the team are now coding the current month as part of overtime rather than the backlog. During 2018/19, an extra 3,740 episodes have been coded on overtime;
- New processes have started in Glangwili General Hospital (GGH) and Prince Philip Hospital (PPH) to deal with the coding of deceased patients;
- All hospitals code an episode for another site if they have the notes with them;
- Continued movement of case notes around the Health Board to improve the completeness levels;
- A member of the team works in South Pembrokeshire Hospital once a month to get these notes coded;
- Movement of staff on occasions to another hospital site to help cover for annual leave, training courses and sickness;
- Performance is monitored daily and shared with the clinical coding team and Head of Information Services on a weekly basis;
- From 6th April 2019, the use of contract coders has started for a 10-week period to help code the current 2018/19 backlog before the year-end submission in June 2019. The contract coders will be working weekends and some during the week with the aim of completing 20,000 episodes.

Further details are M6 IPAR at the above link.

## When can we expect improvement and by how much?

In the coming months there is an expectation performance will remain between 80% - 85% on a consistent basis. Each office has an internal target, which in turn, will improve HB performance. The Team will continue to achieve the 95% target for BGH and WGH and as much as possible for some of the community hospital activity.

## How does this impact on both patients and finances?

There is no direct impact upon patients or finances in the achievement of this target. However, there is currently overtime being offered to staff so that the department can try and code as much of the current month’s activity as they can to help performance. The use of contract coders will also have an impact upon finances as well as the cost in using Medical Records/Coding staff to pull around 13,000 case notes, which are needed to code the episodes.

# Dignified Care

I am treated with dignity and respect and treat others the same.

**Lead Executives**: Joe Teape and Mandy Rayani.

**Exception reports:**

- Postponed admitted procedures
- Hospital initiated cancellations (HIC)
- Compliance with Hand hygiene (World Health Organisation (WHO) 5 moments)
- Dementia Training at an Informed Level
- Concerns and Complaints

# Dignified Care – Postponed Admitted Procedures

**Lead Committee: QSEAC** | **Executive Lead: Joe Teape** | **Senior Responsible Officer: Acute Site General Managers**

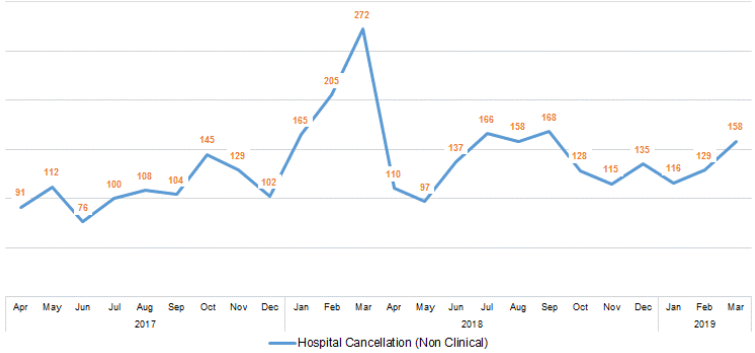
**Metrics (targets):**

- Postponed Admitted Procedures (12 month reduction target)
- Reduction in Hospital Initiated Cancellations (5% reduction to previous year).

| Status as at Mar 19 | Performance the past 12 months |
|---|---|
| ● | Improving |
| ● | Not Available |

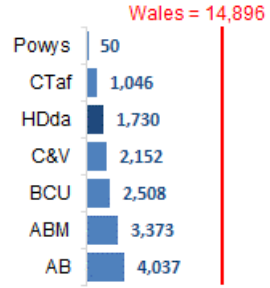
## Where are we and are we on target?

In March 2019, the number of Hospital Initiated Cancellations (HIC) was 158 which is 29 more than the reported 129 in the previous month. The majority of these cancellations (107) were at Withybush General Hospital (WGH).




In March 2019, following validation 16 patients fell within the government commitment. 8 patients were treated within the 14 day government target. In-month performance was 50%. 4 patients have since been treated, 2 have deferred treatment, 1 patient is awaiting a date and 1 patient no longer requires treatment and has subsequently been removed from the waiting list.

## Benchmarking data (February 2019)




The above benchmarking chart reflects the cumulative 12 month rolling number of procedures postponed either on the day of or the day before for specified non-clinical reasons. The target is to reduce by at least 5% (1,587 patients) on the previous financial year. The latest all Wales data ranks Hywel Dda third in this measure.

## Why has this occurred?

The most common reason for HICs is the lack of available capacity due to increased numbers of emergency admissions. Current performance reflects continuing unscheduled care pressures.

## What are the challenges?

- A combination of emergency demand pressures and the lack of available rebooking capacity can affect overall compliance with this measure;
- A significant deterioration in unscheduled care pressures at WGH due to a variety of factors including increased Length Of Stay (LOS), continuing challenges with consistency of middle grade medical cover for wards and an increase in the reported number of medically optimised patients awaiting discharge / transfer.

## What is being done?

- Service Delivery Managers (SDM), Service Managers (SM) and site Theatre leads are working daily with local Patient Flow teams to facilitate flow;
- Targeted unscheduled care improvement plans at WGH with a particular focus on improvements to acute (medical and surgical) assessment, enhanced frailty model designed to reduce avoidable emergency admissions and patient flow improvements;
- Actions to mitigate the risk of HICs are reflecting the broader unscheduled care improvement plans being progressed by each hospital site triumvirate team in partnership with supporting community teams. These actions will also be reflected in the associated winter plans for each location. The main themes reflect:
  - LOS reductions to mitigate the risk of medical patients being admitted to planned care beds;
  - Admission avoidance initiatives, planned reductions in the number of patients categorised as medically optimised for discharge and more targeted rehabilitation of patients. These initiatives are supported by broader improvement programmes including the Integrated Pathway for Older People (IPOP) and 'Breaking the Cycle'.

Successful delivery of these broader unscheduled care improvement plans will reduce the risk of HICs.

**When can we expect improvement and by how much?**
The unscheduled care improvement plan actions (as reflected in the unscheduled care exception report) are intended to deliver improvements in patient flow and discharge planning through 2019/20.

**How does this impact on both patients and finances?**
Reduced cancellations will significantly improve patient experience and the efficiency with which theatre and bed resources are utilised.

## Dignified Care – Dementia training at an informed level

**Lead Committee: QSEAC** | **Executive Lead: Lisa Gostling** | **Senior Responsible Officer: Cheryl Raymond/Sian Hall**

**Metrics (targets):**

- Percentage of employed NHS staff completing dementia training at an informed level (85%)

**Status as at Mar 19**



**Performance the past 12 months**

Improving

### Latest data

The latest information from the Dementia training monitoring return for 2018/19 indicates that 82.4 % of NHS staff have completed dementia training at an informed level (October 2018 – March 2019). This is an improvement compared to 45.7% in 2017.

### Where are we and are we on target?

| Period | 2018 | 2017 |
|---|---|---|
| Dementia Awareness, (Compliance Rates %) | | |
| October | 75.5% | 40.6% |
| November | 77.6% | 44.4% |
| December | 78.7% | 46.8% |
| | | |
| Quarter 3 Average (Oct – Dec) | 77.3% | 43.9% |
| | 2019 | 2018 |
| January | 80.0% | 49.9% |
| February | 81.2% | 53.5% |
| March | 82.4% | 56.3% |
| | | |
| Quarter 4 Average (Jan – Mar) | 81.2% | 53.2% |
| | | |
| | 2018/19 | 2017/18 |
| Average Annual Yearly Rate | 72.5% | 45.7% |

While not at target, we are now only 2.6% off the 85% target.

### Why has this occurred?

Staff release for training, IT access and sickness all have an impact on the ability to reach target.

### What are the challenges?

As with the all other mandatory e-learning training, the main challenges reported are time to undertake the training and access to the e-learning system.

### What is being done?

- Communicating training user guides to heads of service and via global emails.
- Advertising drop-in supported e-learning sessions.
- Staff who have difficulty accessing the system are supported to overcome this, and any issues raised that are outside of the Health Board remit are reported to the NHS Wales team.

### When can we expect improvement and by how much?

We would hope to reach the target in the next few months and maintain subsequently. It is the manager and the individual's responsibility to ensure that this support is accessed where required, and the Dementia module is completed.

### How does this impact on both patients and finances?

Increasing awareness of recognition of the needs of our patients with dementia will contribute to appropriate accessibility of services within our Health Board. This will impact on patient experience and the length of stay of our dementia patients.

## Dignified Care – Percentage Compliance with Hand Hygiene

**Lead committee: QSEAC** **Executive Lead: Mandy Rayani** **Senior Responsible Officer: Sharon Daniel**

**Metrics (targets):**

- % compliance with Hand hygiene (World Health Organisation (WHO) 5 moments) (95%)

**Status as at Mar 2019**

**Performance the past 12 months**

Improving

### Latest data

| Hand Hygiene Compliance Update | Mar 18 | Apr 18 | May 18 | Jun 18 | Jul 18 | Aug 18 | Sep 18 | Oct 18 | Nov 18 | Dec 18 | Jan 19 | Feb 19 | Mar 19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Bronglais | 83% | 71% | 68% | 86% | 73% | 85% | 87% | 83% | 79% | 72% | 81% | 81% | 86% |
| Glangwili | 93% | 88% | 90% | 89% | 88% | 87% | 88% | 87% | 89% | 84% | 91% | 90% | 93% |
| Prince Philip | 90% | 93% | 82% | 87% | 87% | 87% | 89% | 88% | 81% | 85% | 87% | 81% | 84% |
| Withybush | 92% | 93% | 94% | 93% | 88% | 91% | 92% | 95% | 89% | *91%* | 90% | 93% | 91% |
| Community | 98% | 80% | 98% | 96% | 72% | 96% | 100% | 91% | 91% | 100% | 91% | 80% | 88% |
| MH&LD | 97% | 97% | 98% | 100% | 98% | 100% | 98% | 100 | 96% | 92% | 95% | 96% | 99% |
| **Health Board** | 91% | 87% | 88% | 90% | 86% | 89% | 89% | 90% | 86% | 85% | 89% | 87% | 91% |

### Where are we and are we on target?

The Health Board compliance has increased during March 2019 and compliance is the same level as March 2018. Whilst the Health Board (HB) remains under the suggested compliance rate of 95%, it is within 5% of this target.

### Why has this occurred?

All areas have seen a general increase in compliance with all areas reporting above 85% apart from Prince Philip Hospital (PPH). Work undertaken in PPH with the Link Nurses in ensuring increased scrutiny of the audit process and a fresh approach to the audit process.

### What are the challenges?

- There has been some improvement in staff being Bare Below the Elbow but further work is needed to ensure compliance across all disciplines;
- There is a tendency that when staff wear gloves they multitask with them on and forget or do not feel that hand decontamination is needed between tasks.

### What is being done?

- Hand Hygiene Awareness Week has taken place with activities across the Health Board 5-11th April 2019;
- This was pre-empted by Glove Awareness Week:
  - Ward 5, Prince Philip Hospital (PPH) & Merlin Ward, Glanwili General Hospital (GGH) were pilot wards for appropriate glove usage;
  - The aim was to improve patient safety by making staff think more about when they should and should not be wearing gloves;
  - They received additional education around hand hygiene combined with training on the appropriate use of gloves;
  - This work was captured and shared by the RCN Wales Communications Team.
- Hand hygiene training kits have been obtained for Community Infection Prevention Nurses to provide training.

### When can we expect improvement and by how much?

While there has been some improvement this should have increased again for April following education and awareness raising and should continue to be above 90%.

### How does this impact on both patients and finances?

Reducing inappropriate glove usage improves patient safety by making staff think more about when they actually need gloves and when they should be washing their hands. It also promotes the positive aspect of touch as part of patient care improving the patient experience.

# Dignified Care – Concerns and Complaints

**Lead committee: QSEAC** | **Executive Lead: Mandy Rayani** | **Senior Responsible Officer: Louise O'Connor**

**Metrics (targets):**

- 75% of concerns that have received a final reply (under Reg. 24) or an interim reply (under Reg. 26) <=30 working days from the date the concern was first received by the organisation

**Status as at Mar 19:** ●

**Performance the past 12 months:** Improving

## Latest data

| Complaints investigated under Reg 24 from 1st Jan 2018 | Jan-18 | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan-19 | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| No. received during month | 59 | 51 | 41 | 42 | 46 | 49 | 41 | 43 | 31 | 38 | 48 | 43 | 34 | 65 | 62 |
| No. awaiting response | 220 | 239 | 233 | 214 | 214 | 214 | 196 | 199 | 190 | 169 | 182 | 185 | 176 | 184 | 181 |
| No. closed during month | 51 | 43 | 50 | 53 | 48 | 58 | 60 | 47 | 38 | 56 | 47 | 38 | 38 | 37 | 84 |
| No. re-opened during the month | 1 | 5 | 8 | 0 | 2 | 1 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Complaints Performance: concerns that remain open:** | | | | | | | | | | | | | | | |
| No breaching 30 working days | 174 | 158 | 189 | - | 147 | 156 | 143 | 148 | 143 | 130 | 123 | 122 | 123 | 120 | 116 |
| No breaching 127 working days | / | / | / | / | / | / | / | / | 10 | 22 | 11 | 13 | 31 | 31 | 31 |
| No breaching 12 months | / | / | / | / | / | / | / | / | 12 | 7 | 4 | 5 | 3 | 1 | 3 |
| **PALS Position from 1st Jan 2018** | | | | | | | | | | | | | | | |
| PALS received during month | 164 | 191 | 146 | 109 | 132 | 114 | 137 | 86 | 81 | 95 | 78 | 85 | 111 | 74 | 89 |
| PALS cases open | 47 | 50 | 51 | 34 | 41 | 49 | 55 | 30 | 36 | 29 | 30 | 24 | 30 | 21 | 8 |
| PALS closed during month | 206 | 171 | 170 | 115 | 118 | 139 | 123 | 113 | 91 | 98 | 71 | 100 | 99 | 80 | 86 |
| PALS breaching 30 working days | 5 | 13 | 4 | 3 | 5 | 6 | 8 | 4 | 11 | 5 | 3 | 7 | 3 | 2 | 4 |
| **Of the total number of concerns settled during the month, how many concerns had received a final reply (under Regulation 24) (figures supplied to Welsh Government):** | | | | | | | | | | | | | | | |
| Up to and including 30 working days | 62 | 61 | 81 | 54 | 117 | 122 | 99 | 119 | 87 | 124 | 105 | 101 | 114 | 80 | 126 |
| Between 31 and 127 working days | 40 | 20 | 32 | 36 | 33 | 59 | 38 | 39 | 33 | 36 | 34 | 20 | 30 | 29 | 51 |
| After 127 working days (6 months) | 17 | 20 | 15 | 23 | 15 | 6 | 20 | 14 | 10 | 22 | 11 | 13 | 12 | 13 | 14 |
| **Total % of concerns settled during the month:** | | | | | | | | | | | | | | | |
| Up to and including 30 working days | 52.1 | 60.4 | 63.2 | 57.6 | 66 | 65 | 63 | 69 | 61 | 68 | 70 | 75 | 73 | 66 | 66 |
| Between 31 and 127 working days | 33.6 | 19.8 | 25 | 29.80 | 24 | 32 | 24 | 23 | 29 | 20 | 23 | 15 | 19 | 24 | 27 |
| After 127 working days (6 months) | 14.2 | 19.8 | 11.7 | 12.58 | 10 | 2 | 13 | 8 | 10 | 12 | 7 | 10 | 8 | 11 | 7 |
| **Ombudsman Position from 1st Jan 2018** | | | | | | | | | | | | | | | |
| Cases proceeded to investigation | 35 | 37 | 38 | 39 | 2 | 3 | 4 | 6 | 7 | 11 | 14 | 17 | 19 | - | 21 |
| Cases received during the month | 3 | 2 | 1 | 1 | 1 | 1 | 1 | 2 | 1 | 4 | 3 | 3 | 2 | - | 2 |
| Final investigation reports received | 3 | 2 | 4 | 2 | 2 | 1 | 1 | 0 | 5 | 5 | 7 | 2 | 0 | - | 1 |
| Cases upheld or partly upheld | 2 | 2 | 2 | 2 | 1 | 1 | 1 | 0 | 4 | 5 | 5 | 2 | 0 | - | 1 |
| Cases not upheld | 1 | 0 | 2 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 2 | 0 | 0 | - | 0 |
| Early settlements/quick fixes | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | - | 0 |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Cases currently under investigation | 30 | 30 | 26 | 24 | 22 | 21 | 21 | 23 | 19 | 21 | 15 | 15 | 17 | - | 17 |
| Cases where final report received, but awaiting closure | 7 | 6 | 8 | 8 | 6 | 3 | 3 | 3 | 6 | 10 | 11 | 13 | 12 | - | 7 |

## Where are we against target?

- The Health Board has seen an overall continued improvement in the number of concerns settled within 30 working days compared with the previous financial year;
- The quarterly submission of data to Welsh Government demonstrates the improvements seen between Q4 of 2017/2018 (58%), Q1 (63%), Q 2 (66%) and Q3 (71%). Q4 for 2017/2018 is at 68% despite an increase in the numbers of concerns received in February and March. The overall figure at the close of the financial year 2018/19 is 66.6% an 8% increase compared to the previous financial year. The 'All Wales Reporting Framework' work continues and final guidance will be issued imminently;
- For March, the number of concerns awaiting a response has fallen by 2% (remaining lower than the annual average figure of 214 cases awaiting a formal response) despite an increasing number of cases being received and handled in accordance with Regulation 24. The number of cases closed this month has also substantially increased. Despite this, the number of cases open that are breaching 30 working days has consistently continued to fall and is at the lowest number since January 2018 which reflects the continued focus of the Concerns Team and the Directorates to settle concerns within 30 working days; however the number open over 127 working days remains a concern and escalation processes are in place. There are 3 concerns which have been open over 12 months;
- 56% of the total number of concerns and enquiries received in March have been dealt with 'on the spot' via the Concerns Call Handlers on first contact (via email or telephone) with the Health Board;
- March has seen an increased number of cases resolved for the patient within 30 working days and there has been an overall improvement by 8% compared to the previous financial year.

## Why has this situation occurred?

Since January, there has been a sustained 50% increase in the number of new cases received for formal investigation. This has had a detrimental impact on the number of cases awaiting a response, as there has not been the overall reduction in cases that would have been expected had this not occurred. However, the timeliness of the concerns process continues to improve overall, this is reflected by the number of cases breaching 30 working days – which has continued to reduce since January 2018.

## What are the challenges?

- The main challenge continues to be the completion of a complaint investigation within 30 working days, particularly where the cases are complex (suggestion that harm has been caused) and span a number of clinical areas, but this continues to be addressed by a strengthened escalation process, an executive level overview and a revised training programme;

## What is being done?

- Capacity is being reviewed. Additional staffing in the Patient Support Contact Centre will ensure a continued and increased number of concerns cases will be settled within 30 working days. Additionally, this will significantly enhance the client's experience of the service and the health and wellbeing of the staff;
- Improved escalation procedures to senior level as well as weekly reporting/meetings with Heads of Nursing and three weekly meetings with the Director of Nursing, Quality and Patient Experience continue;
- Performance Reviews have raised the profile of complaints and continue to have a positive impact on the complaints process;
- The Complaints Call Handlers (Hub) continue to provide 'on the spot' resolution to concerns received via the telephone and via email;
- In-house Datix Complaints Reporting workshops are being delivered to the Scheduled Care Directorate throughout April 2019 and a new toolkit is being developed to provide additional knowledge of the Datix Complaints system and improve on current processes, which will result in improved complaints performance and reporting of themes/trends.

## When can we expect improvement and by how much?

- 67% of concerns settled within the 30 working day target was achieved for the last financial year compared to 58% for the previous year;
- In addition to the revised WG reporting template, revised key performance indicators are continuing within the Concerns Department, to more accurately measure outcomes and levels of satisfaction;
- In accordance with the performance trajectory above, achievement of the WG target is expected to be January 2020.

## How does this impact on both patients and finances?

Timely resolution of complaints has a positive impact on patients and remains a priority for the Concerns Team (evidenced during weekly review and audit of the case management). There is a negative financial impact if, concerns which are not managed effectively, are referred to the Ombudsman as these can result in recommendations being made of financial redress.

# Timely Care

I have timely access to the services based on clinical need and I am actively involved in decisions about my care.

**Lead Executives**: Joe Teape and Karen Miles.

**Exception reports:**

- Red calls
- Amber calls
- Unscheduled care
- Stroke quality improvement measures
- Cancer - urgent
- Cancer – non-urgent
- Referral to treatment
- Referral to treatment – external providers
- Dietetics
- Occupational therapy
- Pulmonary rehabilitation
- Diagnostics
- Delayed follow-ups
- Continuing Healthcare
- Individual Patient Funding Request (IPFR)

# Timely Care – Red calls

**Lead Committee: BPPAC** | **Executive Lead: Joe Teape** | **Senior Responsible Officer: Rob Jeffery (WAST)**

**Metrics (targets):**
- % of Red Calls responded to within 8 minutes (65%)

**Status as at Mar 2019** ●

**Performance the past 12 months** Declining

## Latest data

See the supporting unscheduled care performance charts

## Where are we against target?

Provisional figures for March 2019:

| | Hywel Dda | Carms | Cere | Pembs |
|---|---|---|---|---|
| Red 8 min | 62.9% | 64.0% | 65.9% | 59.7% |
| Red 9 min | 69.0% | 70.3% | 68.2% | 67.5% |
| Red 10 min | 72.8% | 73.9% | 68.2% | 74.0% |
| Median red | 00:05:29 mins | | | |
| 95th percentile | 00:18:22 mins | | | |

Although Amber calls are not officially reported, Amber median response time for Hywel Dda University Health Board (HDUHB) was 00:25:38 minutes (3rd from 7), all Wales 00:26:13 minutes. 95th percentile 02:14:43 minutes (3rd from 7) with all Wales 2:42:54 minutes.

## Why has this situation occurred?

Notification to handover across Wales saw an increase in lost hours. The recent upward trend in HDUHB has also continued with 919.98 hours lost (February 532:38 hours). This would equate to 79 double manned shifts being removed from the system. A further 38 hours were lost by HDUHB vehicles delayed outside Abertawe Bro Morgannwg University Health Board (ABMUHB) hospitals.

## What are the challenges?

- In addition to the 919:98 hours lost to handover, the continued upward trend for inter-hospital transfers continues;
- The road infrastructure combined with the rural and sparsely populated nature of the HDUHB area which covers a quarter of the land mass of Wales;
- Of the 86 calls missed from 232 during March 2019, 59 were due to distance to travel or outside NDP (National Deployment Plan), 11 calls had no vehicle available at time of call, 1 due to delayed allocation, 4 slow mobilisation; 9 due to late booking on due to shift overrun from previous shift (11 hour break ); 2 late change of code;
- 7 frequent callers accounted for 19 ambulance responses which committed 23.5 ambulance hours;
- Sickness decreased slightly to 7.29% (February 7:63%) which was above the Welsh Ambulance Service Trust (WAST) target of 5.86%;
- Uniformed First Responders (UFR) and Community First Responders (CFR), although responding, did not contribute to Red performance;
- Conveyance rates across all localities remains above the 60% target at 70.9% (February 69.9%);
- Patients treated at scene was 9.7%, 334 patients (February10.5%, 322 patients);
- The number of patients referred to other providers accounted for 8.9% 305 patients (February 10.1% 312 patients).

## What is being done?

- In depth analysis is being undertaken across a number of areas to support a more detailed performance plan;
- Additional resources are being targeted to uplift Unit Hour Production (UHP) across all localities and all shifts are being extended wherever possible with the agreement of staff;
- The Advanced Practitioner (AP) rotational Out Of Hours (OOH) model continues with APs now moving it to Clinical Contact Centre (CCC) to ensure a more focused deployment of resources;
- A further 3 trainee APs have been recruited and should be operational in early May;
- A feasibility task and finish group has been formed to develop a standalone station in Milford Haven;
- Further funding has been secured from Welsh Government (WG) to recruit additional APs across WAST. It will be determined shortly where these will be allocated;
- WG have released funding to supply lifting aids across all care home in Wales;
- WAST has appointed a Health Board (HB) Clinical Lead who has now taken up post.

## When can we expect improvement and by how much?

The performance gain from the reduction in cross HB activity is currently being reduced by the increase in both hospital delays and internal hospital diverts and transfers, together with deployment issues. However, the expectation is that 65% Red performance should be achieved as a minimum.

## How does this impact on both patients and finances?

The maintenance of Red calls performance above the 65% performance, combined with continued improvement for both median and 95$^{th}$ percentile, will positively impact on patients although it is accepted that further work is required to maintain progress and will be undertaken as part of the demand and capacity review which will commence in 2019.

## Timely Care – Amber calls

**Lead Committee: BPPAC** | **Executive Lead: Joe Teape** | **Senior Responsible Officer: Rob Jeffery (WAST)**

| **Metrics (targets):** | **Status as at Mar 2019** | **Performance the past 12 months** |
|---|---|---|
| • % of Amber Calls responded to within 20 minutes (Amber 1) and 30 minutes (Amber 2) | Not applicable | Not applicable |

### Latest data
See the supporting unscheduled care performance charts.

### Where are we against target?
*Amber calls are not officially reported*

- Provisional March 2019 HDUHB Amber 1, 20 minutes closed at 52.6% of total call volume, 2,122, an increase of 257 patients on the February figure. Carmarthenshire 55.8 %, Pembrokeshire 52.0% and Ceredigion 53.2%;
- Amber 2, 30 minutes closed at 22.7% of call volume 891 patients Amber median response reported in the Red calls report.

### Why has this situation occurred?
The requirement to retain ambulance resource at Priority 1&2 (P1 & P2) cover points across the three localities does have a marginal impact on the ability to respond to the Amber category of patients. It should be noted that calls could be upgraded to Red if the patient's condition deteriorates.

### What are the challenges?
- Handover delays in March 2019 accounted for 919 lost hours (February 532 lost hours). This would equate to 79 double manned crews being removed from the Unit Hour Production (UHP);
- Increase in inter-hospital transfers;
- Slow development of additional pathways within Welsh Ambulance Service Trust (WAST) and Hywel Dda University Local Health Board (HBULHB) area;
- Upskilling WAST staff over the next 3 years – challenges with portfolio submissions by registrants.

### What is being done?
- A further demand and capacity review is currently out to tender;
- National Amber Category Review, headed by Chief Ambulance Services Commissioner, issued November 2018; this will need discussion with HDUHB to respond to the report findings; The Emergency Ambulance Service Committee implementation programme can be found at this link EASC Amber Review;
- Development and expansion of the AP rotational model to support Out of Hours (OOH) Service and provide capacity to target top 5 presenting conditions;
- Reinforce regular engagement and dialogue with HDUHB colleagues to ensure compliance against all Wales Handover Guidance and maximise the number of available resources;
- Advanced Practitioner (AP) rotational model with OOH, and Clinical Contact Centre (CCC);
- Implement audit report findings (Handover of Care at Emergency Departments); escalated to Chief Operational Officer (COO);
- Status Plan Management – the deployment of crews, reviewed regularly to ensure available crews are positioned most effectively;
- Fully embed Multi-Disciplinary Team (MDT) forum with each Health Board (HB) locality and key stakeholders to regularly review frequent service users (report will be refined);
- Identify the high volume activity nursing homes/residential homes across HDUHB and engage with them to reduce inappropriate calls;
- Roll out IStumble process to all nursing homes to reduce conveyance;
- Increased number of Automated External Defibrillators in the community; 2 deployed during March 2019;
- Roll out of 111 throughout Ceredigion and Pembrokeshire following successful implementation in Carmarthenshire;
- Integrated seasonal plans, supported by Local Development Plan;

### When can we expect improvement and by how much?
- As more alternative pathways become available the percentage of conveyances in the Amber category will reduce from the current 71.0%;
- Demand and capacity work ongoing to support realignment of rosters to ensure resources available at correct times to maximise performance.

### How does this impact on both patients and finances?
In line with the Transformation of Clinical Services (TCS) agenda, the implementation of alternative pathways combined with lower conveyance and further development of Advanced Practice will reduce the impact on Emergency Departments and reduce the cost base of hospital admissions.

## Timely Care – Unscheduled Care

**Lead Committee: BPPAC** | **Executive Lead: Joe Teape** | **Senior Responsible Officer: Acute Site General Managers**

| Metrics (targets): | Status as at Mar 2019 | Performance the past 12 months |
|---|---|---|
| • Number of ambulance handovers over one hour (0 target) | ● | Declining |
| • % of patients who spend less than 4 hours in A&E/MIU (95% target) | ● | Declining |
| • The number of patients who spend 12 hours or more in A&E/MIU (0 target) | ● | Declining |

### Latest data

See the unscheduled care charts and dashboard.

### Where are we against target?

- The daily average ambulance arrivals in March 2019 have decreased to 97.9 compared to 98.7 in March 2018;
- 86.6% of patients conveyed to the emergency care facilities by ambulance during March 2019 were handed over within 1 hour,
- There were 407 Ambulance handovers over 1 hour in March 2019, deterioration to the previous month and to March 2018 with performance of 303;
- March 2019 new A&E/MIU attendances compared to March 2018 have increased to 13,686; an increase of 6.2%;
- Year to date new A&E/MIU attendances compared to the same period last year increased by 4.0%, with Bronglais General Hospital (BGH) and Glangwili General Hospital (GGH) having the largest increases, 6.14% and of 6.54% respectively;
- New Major attendances have increased from 4,890 in March 2018 to 5,230 in March 2019; an increase of 6.95%;
- 81.7% of patients spent less than 4 hours in all emergency care facilities from arrival until admission, transfer or discharge. This is an improvement from 80.3% in March 2018;
- Non admitted 4 hour performance improved from 90.12% in March 2018 to 90.55% in March 2019;
- The highest breach reason across all sites continues to be lack of medical beds. This has continued from 2017/18 into 2018/19;
- 948 patients spent 12 hours or more in an emergency care facility from arrival until admission, transfer or discharge. This is deterioration from 861 patients in March 2018;
- The average Length of Stay (LOS) for medical emergency inpatients has improved from 8.7 last month to 8.6 in March 2019 but has deteriorated from 8.4 in March 2018. BGH reduced LOS from 8.0 February 2019 to 7.2 March 2019, all other acute sites increased;

### Why has this situation occurred?

- The 802 (6.2%) increase in new A&E attendances compared to March 2018 has created a significant strain upon the acute system;
- Delayed discharge resulting in lack of bed capacity continues to be the main issue. This is impacted by the relatively low availability of nursing and residential home capacity in Ceredigion, reducing community bed capacity further. Complex cross border discharges are also a factor;
- Delayed Transfer of Care (DTOC) numbers for Powys Teaching Health Board have remained high towards year end, which has affected their community capacity and therefore their opportunity to accept discharges out of Bronglais General Hospital (BGH). This is expected to improve in the new financial year;
- Prince Philip Hospital (PPH) saw an increase of 125 emergency medical admissions compared to March 2018. Other sites have not recorded increases in admissions, as a high proportion of medical patients are now completing their whole episode of care in the A&E department due to a shortfall in inpatient capacity which in turn reduces recorded numbers of admissions as they will be recorded as A&E attendances instead of emergency admissions;
- Nursing deficit continues to be a significant problem. In BGH, there are 62 Whole Time Equivalent (WTE) vacancies (40%). This deficit impacts directly on quality, ward function, discharge planning and patient experience. An agency nurse does not get involved in planning for discharge. Nursing deficits also continue to be an issue in Glangwili General Hospital (GGH) with 72 WTE Registered Nurse vacancies. This is further exasperated when it has been necessary to open Dewi Ward as a surge bed area;
- Reduced GP Out of Hours (OOH) provision, with repeated base closures in Carmarthenshire and Pembrokeshire, has contributed to Secondary Care demand;
- The number of patients attending PPH Minor Injury Unit (MIU) who cannot be treated by the Emergency Nurse Practitioner (ENP) has led to

long waits to see the single handed GP;

- 4 hour performance in Withybush General Hospital (WGH) was adversely affected by the GP (usually placed in A&E) being unavailable from the end of February and throughout March 2019. The number of A&E clinician breaches for March has increased significantly to 290, compared to 60 in February. The demand on the existing A&E medical team has increased, with no additional resource to cover the shortfall left by the GP being off work;
- A&E attendances are variable by day of week and do not follow any particular pattern. In GGH, the highest arrival day was 26th March 2019, where there are 170 new attendances. There are increasing number of Major attendances to the A&E department, again varies by day. The highest day being 29th March 2019 where there were 98 Major attendances. This resulted in 40 emergency admissions;
- LOS continues to be an issue resulting in lack of capacity in A&E to see new and presenting patients. For example in GGH in March, the average length of stay over 28 days or more was 54.2 days, accounting for 2,299 bed days;
- Middle Grade coverage continues to be challenging across Medicine and A&E in WGH as well as Juniors Doctors in Orthopaedics. A&E Medical staffing continues to be a challenge in GGH particularly overnight when it is not always possible to provide Middle Grade cover. This leads to increased waits for patients to be seen including Minors.

## What are the challenges?

- Increased A&E throughput, age, acuity and increased admission conversion rate has necessitated the use of unfunded surge bed capacity which puts additional pressure on the staff, the system as a whole and the financial position;
- Low levels of therapy capacity, particularly Occupational Therapy (OT) and Physiotherapy continues to be an issue affecting LOS and service quality across the Health Board. Due to vacancies and sickness, at times there is only 1 Occupational Therapist per site to cover all of the Medical wards. This leads to delays in assessments necessary for discharge and reduced therapy input for patients;
- Up to 42% of patients attending PPH MIU have needs outside the scope of the nursing staff and have to be seen and treated by the single handed GP leading to considerable waits for these patients;
- Variation in ambulance arrivals by day and peaks in evening activity (batching linked to GP surgery times) – all sites; particularly if there is a GP OOH deficit,
- BGH can be impacted from the North when Betsi Cadwaladr University Health Board (BCUHB) are on high escalation and the site is seeing more ambulance arrivals from further East in to Powys Teaching Health Board which adversely affects flow, particularly when these out of area patients have complex needs at the point of discharge;
- The number of medically optimised patients continues to sit between 35-40 in WGH with significant waits for social work allocation, assessment and care provision, resulting in a large number of lost bed days;
- A&E attendances day to day and week to week vary significantly, which makes staffing the units in order to meet demand difficult. For example in GGH there was a 64% variation in demand on Saturdays in March ranging from 97 on one Saturday through to 159 on another Saturday;
- In GGH and WGH the number of overnight patients in A&E waiting for beds can at times exceed 20, which makes it extremely difficult for new patients to be assessed and treated and adds pressure on our Nursing staff who have to provide the care needs of dependent Medical patients on top of A&E demands;
- Due to retirements, there will be limited consultant cardiology cover in PPH from the start of March 2019, which may affect patient flow
- Winter funded capacity initiatives come to an end in March 2019;
- Capacity issues to accommodate patients with Long Term Care needs in the Community continues to be a challenge for WGH.

## What is being done?

- Work with Community and Local Authority colleagues is ongoing. A joint discharge review of Acute and Community on the 26th March 2019 when GGH was on high escalation, resulted in 66 patients discharged. Work is ongoing to normalise this level of discharge;
- Between January and March, PPH piloted the Cardiac Treat and Transfer Service with Morriston Hospital for patients with Acute Coronary Syndrome (ACS). Patients from BGH & WGH were transferred to the additional 6 bed ACS bay in PPH and then transferred to Morriston Hospital for Cardiology treatment, meeting the target of treatment within 72 hours of admission to hospital;
- At BGH – review and revision of site meetings – reduced to 2 meetings at 8am to review the site plan for the day and 3pm to plan for the evening. The aim is to establish a full once a day Safety Huddle for BGH to allow staff the time to focus on flow;
- In WGH the internal escalation policy has been reviewed and disseminated, together with the ambulance offload policy, as a reminder of roles and responsibilities to the site and on call management teams;
- Significant service improvement projects at BGH – ongoing joint therapy, mobilisation and social integration sessions on Ceredig Ward. Next plan

from April 2019 onwards is to target a single consultant on improvement of ward round communication and the principle that “every patient has a plan” in order to roll out to the full Medical team;

- A large piece of work is being undertaken to understand the underlying reasons why the reduction in discharges has been seen over the past six months in WGH. WGH will then launch an improvement programme that will include a focus on A&E streaming, Ambulatory Care, Frailty Assessment Model, Assessment returning to the Clinical Decisions Unit (CDU) & Surgical Assessment Unit, Hot Clinics and Inpatient flow management**.** A whole systems workshop planned for May 9th 2019 to provide an overview of the programme and to engage with teams across Acute and Community. Changes will occur to the Ambulatory Care & Acute Clinical Decisions Unit (ACDU) model as of 24th April 2019. In addition, stranded patient reviews (those with a length of stay greater than 7 days) will be reviewed 3x weekly commencing 15th April 2019;
- Nurse staffing levels in BGH will be addressed through the implementation of strategic partnership with 3 agencies – up to 60 additional nurses will be coming to BGH under this arrangement (at time of writing 48 are in and working). This will enable us to eliminate use of off framework agency and provide quality and stability on our wards;
- Recruitment to a 2nd Acute Physician post at BGH in April 2019;
- BGH to implement consistent frailty model and team at front door once therapists recruited (links to financial plan for 2019/20). Recruitment to take place in June 2019;
- An Advanced Practitioner will be rostered to cover the evening shift in WGH when the GP is not working;
- At GGH & WGH Safety Huddles in A&E are being held to escalate any delays and to plan the patient journey within 4 hours. In GGH this has been extended so these are now done 5 times throughout the 24 hour period;
- Ambulatory care review has been undertaken by the Delivery Unit which will support further development of ambulatory care services across the Health Board.
    - GGH has a specific action plan, all acute physicians are in post. Hot clinics are in place and will be expanded. Post Easter ambulatory care will be ring fenced and not used as a bedded area overnight. Weekly meetings are in place to progress the actions and development;
    - WGH, complete in March 2019 and matrix circulated by unscheduled care Service Delivery Manager (SDM). This is being used to inform our local Ambulatory Care Review;
- Working with Carmarthenshire County and Local Authority to develop pathway improvement plans avoiding Acute hospitals. Crisis response Service is being implemented to avoid social admissions to the acute hospital and to care for patients in the community with minor health conditions but where increased social support is needed;
- BGH implementation of a multidisciplinary frailty clinic by end of April 2019;
- In GGH, the review of extended Physiotherapy in A&E until 8.00pm. Findings to be presented to LOS meeting in April 2019 with a view to a further extension. Frailty support workers have been introduced into CDU to prevent patients deconditioning and to increase mobility. This will be extended beyond Winter pressures monies with the use of vacant posts to fund this for a further 6 months;
- At GGH, review documentation of Board Rounds in CDU incorporating SAFER principles then roll out to all wards in April/May 2019;
- Refocus on implementation of SAFER bundle, including weekend discharges, across WGH with particular focus on medical wards;
- Reviews planned of WGH A&E attenders aged over 75 who are ‘frequent attenders’ or attended WGH A&E after a fall**.** It has been identified that a significant number of patients who present with a fall and are discharged from the Emergency Department, re-present on at least one further occasion. This data will be used to feed a falls pathway and bundle development with the intention of reducing attenders and re-attenders due to falls.

### When can we expect improvement and by how much?

- Fill Nurse vacancies at BGH with partnership agency support to provide time for the longer term actions within the Nursing Strategy, including establishment of a local Faculty of Health Sciences and School of Nurses which is planned to come to fruition by September 2020;
- From April 2019, establish a Quality and Patient Pathway forum at BGH to review options for improved form and function around discharges;
- Continue to the successful work undertaken during March which aims to protect elective work and ensure good patient experience for planned care patients at BGH;
- GGH - Continued Nurse recruitment is undergoing with 35 places offered for September 2019 cohort and continued ongoing external recruitment;

- Continued focus on ambulance performance 4 and 12 hour breaches at weekly operational group, which is underpinned by the LOS meeting to deliver performance improvement.

**How does this impact on both patients and finances?**

- Improved patient flow has a positive impact on both patients and finances. Elimination of unnecessary stays in hospital reduces the risk of iatrogenic (relating to illness caused by medical examination or treatment) events such as falls or hospital acquired infections. It also saves money by reducing or eliminating the needs for surge bed capacity staffed by agency;
- Improved recruitment will reduce reliance on agency nursing staff and deliver a better financial balance; however the interim measure (working with partnership agencies) will also improve the financial position at BGH due to greater stability within the existing framework and eradication of off framework agency need for the site;
- Improved recruitment leading to team working and better focus, impacts positively on patient experience.

# Timely Care – Stroke Quality Improvement Measure

**Lead Committee: QSEAC** | **Executive Lead: Joe Teape** | **Senior Responsible Officer: Simon Mansfield**

| Metrics (targets): | Status as at Mar 2019 | Performance the past 12 months |
|---|---|---|
| % of patients with direct admission to an acute stroke unit < 4 hours (Target – 60.2%) | ● | Improving |
| % of patients thrombolysed <45 minutes (door to needle) (Target – 12 month improvement trend) | ● | Declining |
| % of patients who receive a CT scan < 1 hour (Target – 54.3%) | ● | Improving |
| % of patients assessed by a stroke specialist consultant physician < 24 hours (Target – 84.2%) | ● | Declining |

## Latest data

| Admission to Stroke Unit < 4 hours (Target: 60.2%) | | | |
|---|---|---|---|
| **UHB/Site** | **No. met target** | **No. eligible** | **Performance** |
| HDUHB | 37 | 54 | 68.5% |
| Bronglais | 5 | 5 | 100.0% |
| Glangwili | 12 | 20 | 60.0% |
| Prince Philip | 12 | 17 | 70.6% |
| Withybush | 8 | 12 | 66.7% |
| **% Patients Thrombolysed <=45 minutes from clock start (Target: 12 month improvement trend – RAG rating is based on the overall 12 month trend, not in-month performance)** | | | |
| **UHB/Site** | **No. met target** | **No. eligible** | **Performance** |
| HDUHB | 3 | 9 | 33.3% |
| Bronglais | 1 | 1 | 100.0% |
| Glangwili | 0 | 1 | 0.0% |
| Prince Philip | 0 | 1 | 0.0% |
| Withybush | 2 | 6 | 33.3% |
| **% CT scan within 1 hour (Target: 54.3%)** | | | |
| **UHB/Site** | **No. met target** | **No. eligible** | **Performance** |
| HDUHB | 55 | 65 | 84.6% |
| Bronglais | 5 | 5 | 100.0% |
| Glangwili | 17 | 21 | 81.0% |
| Prince Philip | 18 | 20 | 90.0% |
| Withybush | 15 | 19 | 78.9% |
| **% Assessed by a Stroke consultant < 24 hours (Target: 84.2%)** | | | |
| **UHB/Site** | **No. met target** | **No. eligible** | **Performance** |
| HDUHB | 64 | 65 | 98.5% |
| Bronglais | 5 | 5 | 100.0% |
| Glangwili | 21 | 21 | 100.0% |
| Prince Philip | 19 | 20 | 95.0% |
| Withybush | 19 | 19 | 100.0% |

See the stroke performance charts and dashboard for benchmarking and further information.

## Where are we against target?

As a Health Board (HB), the targets were met in March 2019 for all measures apart from the thrombolysis door to needle <45 minutes target.

- The admission to the stroke unit <4 hours in March 2019 met the target (60.2%) with performance of 68.5%. The target was met in all sites apart from GGH (60%);
- The percentage of patients thrombolysed <=45 minutes March 2019 did not meet the rolling 12 month improvement trend target for the HB (33.3%);
- In March 2019, the percentage of patients having a Computerised Tomography (CT) scan within the one hour target (54.3%) was met in all sites with an overall performance of 84.6%;
- The percentage of patients assessed by a stroke consultant in March 2019 met the target (84.2%) with performance of 98.5%. The target was met in all sites;
- The latest available All Wales data is for January 2019 and ranked Hywel Dda University Health Board (HDUHB) 1st out of 6 for admission to stroke unit within four hours and CT scan within one hour and 2nd out of 6 for thrombolysis <45 minutes and stroke patients assessed by a stroke consultant <24 hours.

## Why has this situation occurred?

During March 2019, Glangwili General Hospital (GGH) did not meet the admissions to the stroke unit within 4hrs target. March has been a particularly challenging month for the acute sites, particularly GGH and Withybush General Hospital (WGH). GGH missed the target for 8 patients, 7 of whom were waiting for beds. Although the target of 60.2% was met in WGH, 4 patients missed the target.

In March 2019, 6 patients across the Health Board missed the thrombolysis within 45 minutes target. Out of these 6 patients, 4 were missed in WGH, 1 due to the management of blood pressure before thromboylsis, 1 due to incorrect history provided by the patient and 2 patients who presented out of hours with a fully escalated Emergency Department. In GGH, 1 patient missed the target due to presenting out of hours and a delay in CT reporting.

## What are the challenges?

March 2019 has proven to be a very challenging period, with extreme pressures being placed on medical bed capacity in all sites, but particularly in GGH and WGH. At times of extreme pressure, it has been difficult to maintain stroke pathway beds.

Thrombolysis performance remains challenging, particularly out of hours, where Medical Middle Grades manage the thrombolysis pathway. Due to the small number of stroke presentations and infrequency of exposure of the middle grades working on the rota, the levels of confidence in managing the thrombolysis pathway are less than the stroke specialist teams available within normal working hours.

## What is being done?

- Based upon the feedback from the Delivery Unit review, an action plan has been developed to further develop the thrombolysis performance in Hywel Dda from the current 'B' grade towards an 'A' grade;
- As part of this action plan, more frequent feedback will be provided to site teams when stroke pathways are compromised. Furthermore, training of middle grade and nursing staff will focus on improved history taking and a move to a consolidated Hywel Dda thrombolysis protocol;
- This work continues to be coordinated through the weekly performance meetings and the HB wide Stroke Steering Group meetings;
- This work is also being considered as part of a wider re-design of stroke services throughout the HB.

## When can we expect improvement and by how much?

Thrombolysis performance is expected to improve incrementally through continued focus but with a more structured action plan to be put in place within the next month.

## How does this impact on both patients and finances?

It is recognised that timely thrombolysis provides eligible patients with the greatest chance of salvaging brain function and, as a result, the improvement of this measure is of critical importance to all of the Stroke teams across the HB.

Early thrombolysis can improve patient outcomes and can lead to lesser levels of dependence post stroke. This is of significant benefit to the patient and carers, but also places less of an ongoing burden of care on health and social care in the future.

# Timely Care – Cancer

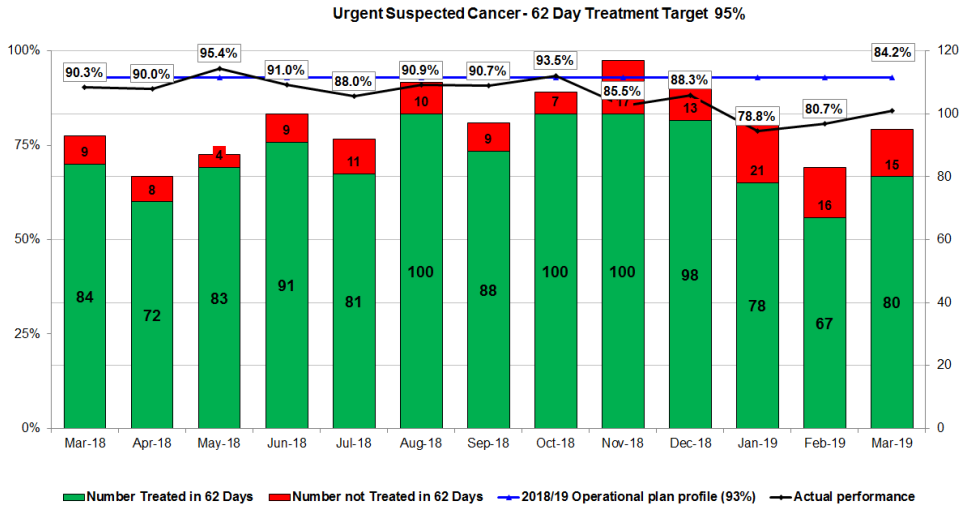
**Lead committee: BPPAC** | **Executive Lead: Joe Teape** | **Senior Responsible Officer: Keith Jones**

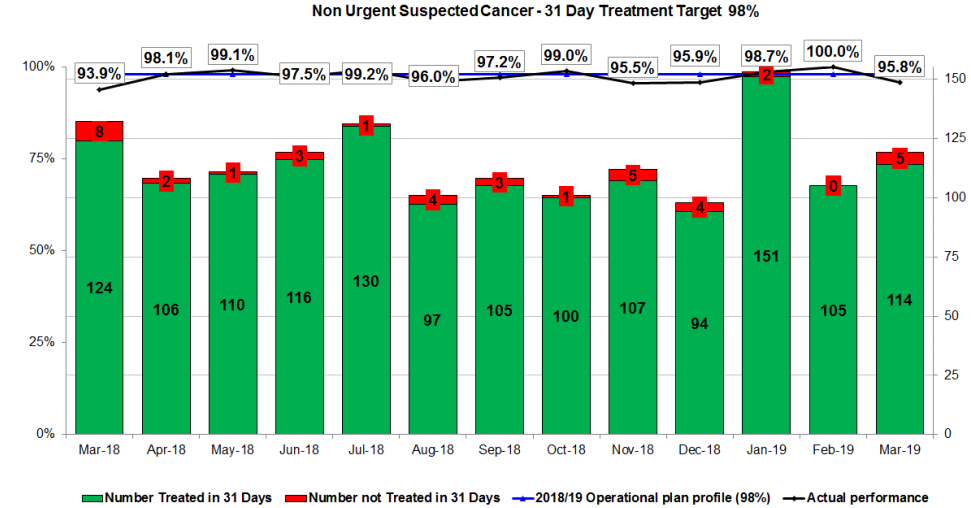
**Metrics (targets):**

- % of patients referred as urgent suspected cancer seen within 62 days – Target 95%
- % of patients referred as non-urgent suspected cancer seen within 31 days – Target 98%

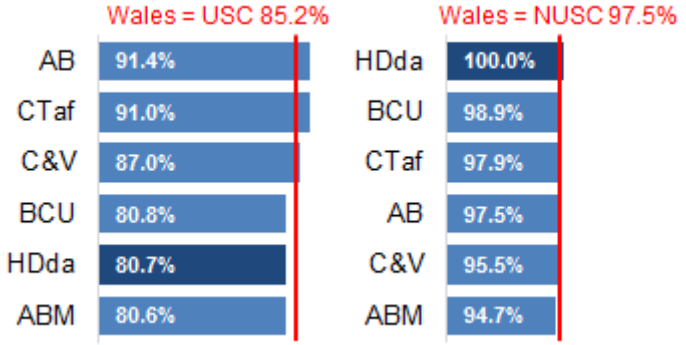
| Status as at Mar 19 | Performance the past 12 months |
|---|---|
| ● | Declining |
| ● | Declining |

## Latest data




## Benchmarking (February 2019)




The latest all Wales benchmarking data puts Hywel Dda ranked 1st in Wales for Non Urgent Suspected Cancer (NUSC) and 5th for Urgent Suspected Cancer (USC).

### Where are we and are we on target?

**USC** – confirmed March 2019 USC performance was 84.2% based on 15 breaches for the following reasons/areas:

- 8x tertiary surgery delays (3x Gynaecology, 1x Skin, 1 x UGI, 3x Urology);
- 1x tertiary oncology delay (1x LGI);
- 3x multi-factorial delays (including delays to tertiary surgery - 1x Gynaecology, 1x Skin, 1x Urology);
- 2x complex diagnostic pathways (1x Lung, 1x Haematology);
- 1x local diagnostic delay (1x Urology).

**NUSC** – confirmed March 2019 NUSC performance was 95.8% based on 5 breaches for the following reasons/areas:

- 3x Breast (1x tertiary surgery delay, 2x delay to local surgery);
- 2x Urology (2x delay local surgery).

**Why has this occurred?**

**USC** – whilst performance in March 2019 showed a further partial recovery following January & February 2019, further improvement in the month was compromised primarily due to a significant volume of tertiary service breaches with 8 tertiary surgery delays and 1 tertiary oncology delay (in addition to 3 further breaches where delays to tertiary surgery were one of several factors which led to treatment being delayed outside of the 62 day target).

Encouragingly, Dermatology pathway breaches reduced to 2 in the month which reflects further progress in addressing the backlog of outpatient assessments/treatment reported in previous months.

- Local diagnostic service pressures within Radiology & Pathology services, which led to delays in the investigation and reporting of results (5x related to the Urology pathway).

**NUSC** – performance was disappointing following 100% performance in February 2019. The deterioration in performance primarily reflected local delays in Breast surgery (due to consultant absence) and Urology (due to pressures on critical care capacity). 1 beach was due a delay in tertiary (Plastic) surgery for a breast pathway patient.

**What are the challenges?**

- **Tertiary centre capacity pressures** - continue to present a risk to the Health Board's performance across a number of USC and NUSC pathways. These pressures are similarly reflected in performance at Abertawe Bro Morgannwg University Health Board (ABMUHB), which continue to run significantly below the Welsh average. Lead in times to radiotherapy treatments regularly exceed 4 weeks for many patients and delays for Gynaecology surgery continue to feature as major breach reason. Concerns regarding Tertiary Centre capacity and associated delays continue to be escalated at operational and executive levels. The extent to which these tertiary capacity risks impact upon overall performance varies month to month depending on the volume of Hywel Dda patients requiring tertiary treatment and overall demand at ABMUHB;
- **Complex pathway delays** – the nature and complexity of tumours for some patients do not support rapid diagnosis and treatment as these patients are often subject to multiple investigations and Multi Discipline Team (MDT) reviews to determine the most appropriate clinical management plan;
- **Local service capacity pressures** – capacity pressures within Radiology & Pathology services continue to present a risk of delays in the investigation and reporting of results which ultimately impact upon delivery of any necessary treatments within the 62 day target.

**What is being done?**

The table below provides a current status assessment of the key risks:

| **Dermatology** | **Current Position:** |
|---|---|
| • Local diagnostic/treatment delays due to significant vacancy factor within service. | • Performance in March 2019 showed an improvement compared to previous months.<br>• 1 staff grade doctor has been appointed and locum consultant is due to commence early summer 2019 along with continued utilisation of an external provider to supplement local capacity.<br>• A joint planning workshop has been held with ABMUHB to consider further opportunities for regional solutions and a development/supervision programme for GPs with an interest in Dermatology;<br>• The Dermatology backlog has now reduced to 8 (with only 2 patients with confirmed cancer). |
| **Urology** | **Current Position:** |
| • Delays for tertiary surgery;<br>• Incidence of local diagnostic delays due to pressure on diagnostic service capacity. | • Pressures on the tertiary surgical and oncology service escalated with ABMUHB actively seeking additional capacity to reduce delays;<br>• Pressures impact upon waiting times for tertiary surgery and radiotherapy treatments;<br>• ABMUHB unable to confirm robust plans to mitigate these risks in the short term, although locum recruitment attempts are continuing;<br>• Locum solutions continue to be explored to support Radiology & Pathology capacity investigations and local pathology reporting. |
| **Gynaecology** | **Current Position:** |
| • Delays for surgical treatment at the tertiary centre in Swansea;<br>• Situation reflects capacity pressures within the ABMUHB Gynaecology consultant team and periodic bed capacity pressures at Morriston. | • This remains a risk to sustained performance improvement until Autumn 2019;<br>• ABMUHB have confirmed that a 4th Gynaecology Cancer Surgeon has been appointed but the successful candidate will not join the service until September 2019;<br>• No available interim capacity at alternative units in Wales. |

**When can we expect an improvement and by how much?**
Data for April 2019 indicates that USC performance will show a further recovery compared to March 2019 towards 88% with recovery above 90% expected by the end of Quarter 1 – this is subject to current review and validation.  NUSC performance is expected to be between 96-98%.

**How does this impact on both patients and finances?**
Evidence suggests early diagnosis and treatment of cancer can significantly influence longer term clinical outcomes for patients.  The impact of diagnostic and treatment pathways for individual patients will reflect a number of different factors including length of time between development of symptoms and initial presentation, the relative stage/progression of the tumour at the time of presentation, the nature of the tumour and treatment options available.

# Timely Care – Referral to Treatment (RTT)

**Lead Committee: BPPAC** | **Executive Lead: Joe Teape** | **Senior Responsible Officer: Keith Jones / Steph Hire**

| Metrics (targets): | Status as at Mar 2019 | Performance the past 12 months |
|---|---|---|
| • % patients waiting less than 26 weeks from referral to treatment (target = 95%) | 🟡 | Improving |
| • Number of patients waiting 36 weeks and over (target = 0) | 🟢 | Improving |

## Latest data

Please refer to the RTT charts.

## Where are we and are we on target?

- The number of 36 week+ breaches in March 2019 was zero which represents a 633 reduction compared to February 2019 and compares favourably to 1,494 reported breaches in the same month last year (100% reduction);
- The percentage of patients waiting less than 26 weeks from Referral To Treatment (RTT) was 90.6% in March 2019 (48,759 patients) which is the highest compliance in several years;
- Both metrics have shown considerable improvement during the past 12 months and the target has been met for the number of patients waiting over 36 weeks.

## What are the challenges?

The main challenges that needed to be addressed were:

- Orthopaedics – continuing challenges to secure the necessary volume of in-month and overall cohort treatments via St Joseph's Hospital in Newport to match both monthly breach profiles and the total contracted volume. There was also an ongoing risk of cancellations of planned treatments due to unscheduled care pressures;
- ENT – recruitment / retention challenges within the supporting Audiology service and medical team;
- Ophthalmology – the failed appointment of 2 planned consultant posts during the Autumn 2018 necessitated the arrangement of additional outsourcing capacity to replace lost internal capacity;
- Dermatology – major challenges regarding the effective and timely recruitment of replacement locum or substantive clinical capacity to support the service in the short /medium term.

## What is being done?

Operational planning and delivery in respect of the RTT key deliverable performance target during 2018/19 was undertaken successfully.
This was achieved as a result of:

- the commitment and focus on delivery from specialty management teams, clinical teams and broad range of supporting services and departments;
- a continuous review of increased efficiency & productivity opportunities and the flexibility and commitment of multi-disciplinary clinical and supporting teams in facilitating the delivery of additional activity levels, often at short-notice to mitigate the impact of under-delivery via outsourcing providers and/or cancelled procedures due to unscheduled care bed related pressures.

## When can we expect improvement and by how much?

Consolidation of waiting times improvements achieved during 2018/19 and sustained delivery of zero 36 week + breaches from end quarter 1 onwards.

## How does this impact on both patients and finances?

Achievement of zero 36 week breaches represents a significant improvement in service quality and experience for our patients. Specialty teams continue to work on efficiency and productivity plans to address capacity pressures and improve sustainability in the shorter term whilst working on regional collaboration with regard to some specialties in the mid and long term. The Health Board is working closely with Abertawe Bro Morgannwg University Health Board (ABMUHB) and Welsh Government to address this.

# Timely Care – External Health Board Referral to Treat (RTT)

**Lead Committee: BPPAC** | **Executive Lead: Huw Thomas** | **Senior Responsible Officer: Rhian Davies**

**Metrics (targets):**

- RTT - Hywel Dda residents waiting over 36 weeks for treatment by other providers (0)

**Status as at March 2019:** ●

**Performance the past 12 months:** Improving

## Where are we against target?

As at the 31st March 2019, there were 5,222 Hywel Dda University Health Board residents on open pathways at other provider sites, 98% are waiting to be treated in Wales. Of these 5,222 residents, 198 patients were breaching the maximum backstop of 36 weeks (196 in Wales; 2 in England).

**English Provider Sites:**

The main three hospitals in England treating Hywel Dda residents are, University Hospital Bristol, Robert Jones & Agnes Hunt (RJAH) and University Hospital Birmingham.

- There are 2 patients breaching in RJAH, both in Trauma & Orthopaedics with the longest week wait of 52 weeks;
- There are no patients breaching in University Hospital Birmingham and University Hospital Bristol.

**Welsh Provider Sites:**

**Swansea Bay University Local Health Board (SBULHB)**

83% of Hywel Dda patients waiting to be treated outside Hywel Dda in Wales are in SBULHB. In the SBULHB IMTP 2018/19 plan, the following commitments have been made to reduce waiting times:

- There will be no patients waiting over 26 weeks for a first new outpatient appointment (stage 1) by March 2019;
- To clear over 36 week waits in all specialities other than, Orthopaedics, General Surgery, Spinal, Oral Maxillo-Facial Surgery, Cardiology, ENT, Plastic Surgery and Urology by March 2019. These specialties are ranked in order of highest patient numbers.

**Outpatients** - At the end of March 2019 there were 46 patients waiting at stage 1 over 26 weeks as follows:

| Specialty | Total Patients | Longest Week Wait |
|---|---|---|
| Oral Surgery | 46 | 35 |
| Total | 46 | |

**36 Week Target** – At the end of March 2019 there were 178 patients with waiting times in excess of 36 weeks with the longest wait being 105 weeks:

| Specialty | Total Patients | Longest Week Wait |
|---|---|---|
| Oral Surgery | 29 | 105 |
| General Surgery | 11 | 105 |
| Cardiology | 8 | 80 |
| Trauma And Orthopaedics | 112 | 105 |
| ENT | 2 | 57 |
| Plastic Surgery | 16 | 61 |
| Total | 178 | |

SBUHB has confirmed that due to increased non-elective pressures and some issues over sufficient capacity to meet the Referral to Treatment Time Targets, not all patients could be seen. It was confirmed that all patients are seen in strict date order irrespective of residency.

**Cardiff & Vale University Health Board** - 16% of Hywel Dda patients waiting to be treated in Wales are in Cardiff & Vale.

**Outpatients** - At the end of March 2019 there were 32 patients waiting at stage 1 over 26 weeks as follows:

| Specialty | Total Patients | Longest Week Wait |
|---|---|---|
| Ophthalmology | 4 | 34 |
| Urology | 3 | 29 |
| Trauma And Orthopaedics | 3 | 35 |
| Clinical Immunology & Allergy | 12 | 34 |
| Neurology | 6 | 33 |
| Rheumatology | 1 | 30 |
| Dermatology | 1 | 26 |
| General Surgery | 2 | 31 |
| Total | 32 | |

**36 Week Target** – At the end of March 2019 there were 17 patients with waiting times in excess of 36 weeks with the longest week wait being 73.

| Specialty | Total Patients | Longest Week Wait |
|---|---|---|
| Trauma And Orthopaedics | 17 | 73 |
| Total | 17 | |

**Other Providers in Wales** - There is an additional breach reported. In Aneurin Bevan University Health Board, there is one patient with the longest weeks wait at 45 weeks in Trauma & Orthopaedics.

# Timely Care – Dietetics - Therapy waits over 14 weeks

**Lead Committee: BPPAC** | **Executive Lead: Joe Teape** | **Senior Responsible Officer: Zoe Paul-Gough/Karen Thomas**

| Metrics (targets): | Status as at Mar 2019 | Performance the past 12 months |
|---|---|---|
| • Number of patients waiting 14 weeks plus for Dietetics (Target = 0) | ● | Improving |

## Latest data
The latest available data can be viewed within the therapies graphs.

## Where are we and are we on target?
There were no patients waiting over 14 weeks at the end of March 2019.

## Why has this occurred?
There was sustained additional clinic activity which enabled the service to meet the waiting time target.

## What are the challenges?
The service continues to have a ~20% vacancies & maternity rate meaning core clinic capacity is very difficult to sustain in addition to the growth in demand.

## What is being done?
Maintaining the waiting times below 14 weeks will be dependent on delivery of additional sessions and sustaining like for like Locum cover until vacancies are covered more sustainably by recruited new graduates (due to join the service between M3 & M4).

## When can we expect an improvement and by how much?
The aim is to maintain zero breaches, however this is dependent on being able to sustain like for like Locum cover and some additional paid sessions in addition to no further loss of core capacity due to further vacancy or sickness.

## How does this impact on both patients and finances?
Delays in Dietetic access lead to increased clinical risk for patients with potential for escalation of healthcare needs. Being unable to respond in a timely way to patients referred for weight management services can adversely impact on subsequent engagement. There will be budget pressure if Locums need to be used to maintain core clinic activity.

# Timely Care – Occupational Therapy (OT) – Therapy waits over 14 weeks (excludes MHLD)

**Lead Committee: BPPAC** | **Executive Lead: Joe Teape** | **Senior Responsible Officer: Alison Shakeshaft/Claire Sims**

| Metrics (targets): | Status as at Mar 2019 | Performance the past 12 months |
|---|---|---|
| • Number of patients waiting 14 weeks plus for Occupational Therapy (Target = 0) | ● | Improving |

## Latest data
The latest available data can be viewed within the therapies graphs.

## Where are we against target?
There were no patients waiting over 14 weeks at the end of March 2019.

## Why has this situation occurred?
Following short term funding in 2018/19 for additional capacity, the number of patients waiting over 14 weeks has been reduced to 0 at the end of March 2019.

## What are the challenges?
- Sustaining the improvement in Paediatric Occupational Therapy without additional capacity. This service has a small workforce across 3 counties which is vulnerable to fluctuations in capacity (due to recruitment, planned and unplanned leave), as well as the nature of the caseload. The caseload is predominantly complex and progressive, often requiring long term service involvement;
- Service continues to undertake activity for social care and housing in Carmarthenshire within core capacity, pending agreement to reinstate ongoing funding.

## What is being done?
- Monitoring of performance against target;
- Vacancy is being progressed through recruitment process;
- Long term sickness absence being managed in line with policy;
- Progressing agreement with Carmarthenshire Social Care & Housing to fund capacity;
- Care Aims approach is being implemented in paediatric service, which will contribute to managing service demand in the longer term;
- Additional capacity to sustain waiting times position after April 2019 has been submitted to inform Annual Plan.

## When can we expect improvement and by how much?
If no further significant challenges in workforce capacity arise, paediatrics improvement will be sustained in the short term. Longer term sustainability will be dependent on resolution of agreement with Carmarthenshire County Council and predicted impact of Care Aims approach and other strategies being realised.

## How does this impact on both patients and finances?
Children now have more timely access to Occupational Therapy to support them to overcome significant problems participating in everyday activities that are vital for their health, well-being, and development, this may include developing skills in self-care, having a bath, learning to feed, being able to play with their friends or engage in education. This improvement also impacts on the health and well-being of the child's family and carers, who may experience significant challenges physically and psychologically caring for the child. Earlier occupational therapy assessment and subsequent intervention/rehabilitation for children can resolve issues and improve lifelong outcomes, reducing need and costs of treatment, equipment, and long term care.

# Timely Care – Therapy waits - Pulmonary Rehabilitation

**Lead Committee: BPPAC** | **Executive Lead: Joe Teape** | **Senior Responsible Officer: Alison Shakeshaft/ Vicky Stevenson**

**Metrics (targets):**

- Number of patients waiting 14 weeks plus for Pulmonary Rehabilitation (Target = 0)

**Status as at Mar 2019:** ●

**Performance the past 12 months:** Improving

## Latest data

| Location | Under 14 Weeks | 14 to 35 Weeks | 36 to 52 Weeks | Over 52 Weeks | Total Waiting more than 14 weeks |
|---|---|---|---|---|---|
| Amman Valley | 7 | 10 | 7 | 9 | 26 |
| Glangwili | 17 | 10 | 14 | 3 | 27 |
| Prince Philip | 23 | 27 | 6 | 31 | 64 |
| North Ceredigion | 1 | 3 | 0 | 43 | 46 |
| South Ceredigion | 3 | 1 | 0 | 5 | 6 |
| Withybush | 39 | 10 | 3 | 1 | 14 |
| **Total** | **90** | **61** | **30** | **92** | **183** |

## Where are we against target?

At present, the waiting times are in excess of 52 weeks. The total number of patients waiting over 14 weeks has reduced from 192 at the end of February 2019 to 183 at the end of March 2019.

## Why has this occurred?

Extremely long waits are due to very limited staffing capacity for demand in this speciality and significant variation in service delivery across the Health Board localities. The number of waits has reduced this month due to some patients being offered a course and declining Pulmonary Rehabilitation (PR).

## What are the challenges?

There is currently no robust provision in Ceredigion. In Pembrokeshire, the location of programme delivery impacts on the individual's ability to access PR within a recommended timescale i.e. the programme rotates around the county. Carmarthenshire service is provided by single-handed practitioners within Physiotherapy and Occupational Therapy. Each county is experiencing significant numbers of patients admitted and re-admitted to all four hospitals with Chronic Obstructive Pulmonary Disease (COPD) and referred for PR as part of their management.

## What is being done?

The service has worked collaboratively with Primary Care to develop and pilot an innovative approach using a Hub and Spoke model and digital technology. Following the success of this, the service is working to roll this model of care out across the Health Board. A business case has been developed and a sustainable plan has been included in the Annual Plan for consideration.

## When can we expect an improvement and by how much?

The service requires a clear plan of direction in terms of Health Board priorities. To date the service has prioritised delivery through the Hub and Spoke model pilots, alongside core delivery. A multi-disciplinary team business case Virtual Pulmonary Rehabilitation (VIPAR) supporting 2 Hub and 2 Spoke models which evidences prudency and efficiency has been submitted and will form part of Integrated Medium Term Plan (IMTP) submission. This supports redesign of PR and a decision in terms of support for this model of delivery will be considered. Delivery of on Hub and Spoke until end of March 2019 has been agreed to address waits in Ceredigion.

## How does this impact on both patients and finances?

Pulmonary Rehabilitation is for people with Chronic Obstruction Pulmonary Disease. It is evidenced to:

- Reduce mortality;
- Support earlier discharge from Acute hospital care;
- Reduce unplanned readmissions;
- Increase positive health behaviours;
- Increase engagement with social and vocational activities.

# Timely Care – Diagnostic wait 8 weeks and over

**Lead Committee: BPPAC** | **Executive Lead: Joe Teape** | **Senior Responsible Officer: Sarah Perry**

**Metrics (targets):**

- Diagnostic wait 8 weeks and over (Target = 0)

**Status as at Mar 2019:** ●

**Performance the past 12 months:** Improving

## Latest data

| Reported Diagnostic Tests | Total Waiting List | Waiting List > 8 Weeks |
|---|---|---|
| Cardiology | 1,973 | 0 |
| Diagnostic Endoscopy | 1,003 | 0 |
| Imaging | 76 | 0 |
| Neurophysiology | 309 | 0 |
| Physiological Measurement | 9 | 0 |
| Radiology - Consultant referral | 3,412 | 0 |
| Radiology - GP referral | 2,585 | 0 |
| **Total** | 9,367 | 0 |

## Where are we and are we on target?

In March 2019, no 8 week diagnostic breaches were reported across all services and the National key delivery target was met.

## Why has this occurred?

- **Cardiology -** Staff undertook extra sessions utilising overtime and Referral To Treat (RTT) monies to increase in-house capacity. Outsourced Cardiac MRI and CT Coronary Angiography also supported achievement of this position;
- **Radiology** - Staff undertook extra sessions utilising overtime and RTT monies to increase capacity. This was sustainable on a short term basis but not ongoing.

## What are the challenges?

- **Cardiology**
  - Reduced Prince Philip Hospital (PPH) Cardiologist availability, Retire & Return work-break and vacancy;
  - Reduced Cardio-Respiratory capacity due at Withybush General Hospital (WGH) and Bronglais General Hospital (BGH);
  - Risk of 32 potential Echocardiography breaches projected for end of April 2019 at Glangwili General Hospital (GGH). This is due to inadequate Cardiac-Physiology capacity;
  - Pressures due to vacancy of Service Delivery Manager for Cardiology since November 2018.
- **Radiology**:
  - Shortages in consultant radiologists remain;
  - Single cancer pathway will require a shift in waiting times with increasing pressures on the front end of the pathway. This may cause routine patients to be pushed further towards 8 week breach;
  - Due to lack of consultants even if patients are scanned, reporting turnaround times will impact on delays;
  - Ongoing issues with aging equipment leads to unpredicted downtime especially for CT and MRI; MRI at BGH out of service during March and April 2019;
  - Particular challenges in nuclear medicine with capacity for cardiology and cancer work competing.

## When can we expect improvement and by how much?

- **Cardiology**
  - Further work is being progressed to confirm a more detailed capacity / demand assessment for the cardiology diagnostic service to inform more sustainable solutions for the remainder of 2019/20;
  - A project group has been set up and the focus is on 'phase 2' Myrddin booking of all activity and referrals in cardiology diagnostics. This aligns to other Health Boards in Wales as Myrddin has been updated and improved, this has enabled the booking process to be undertaken. Project commenced January 2019 at PPH and is planned to commence in GGH from April 2019. Solus will still be progressed for the pacing module;
  - PPH Cardiologist capacity will improve by the end of April 2019;
  - Develop a plan by end of April 2019 to recruit to PPH Consultant Cardiology vacancy;
  - Cardio-Respiratory long-term sickness will resolve early April 2019;
  - Fortnightly performance monitoring of diagnostic RTT with Cardio-Respiratory Heads of Departments and General Manager/Service Delivery Manager for Cardiology continue;
  - Particular emphasis and actions needed to avoid/reduce the 32 potential Echocardiography breaches projected for end of April 2019;

- Newly appointed Service Delivery Manager for Cardiology and Service Support Manager for Cardiology RTT currently undergoing induction, familiarisation with role and handover.

- **Radiology**
  - Improvements to the patient management system due to be completed in May 2019 will allow for more detailed planning and coordination of services and bookings across the Health Board;
  - Recruitment of further consultants due in summer 2019 will assist with turnaround;
  - Work on pathways over the next financial year to reduce level of unnecessary imaging;
  - Workforce and 24 hour service review will potentially free up staffing for increasing capacity with extended days;
  - Recruitment of additional staff in nuclear medicine to increase capacity.
  - Outsourcing of BGH MRI activity.

**How does this impact on both patients and finances?**

Early diagnosis can positively influence longer term clinical outcomes for the patients. The financial impact relates to the additional cost of any agency, locum, overtime, or bank working required to avoid breaches. Delays in diagnostic also contribute to delays in the outpatient Referral to Treatment (RTT) position. Whilst utilising capacity across the Health Board, patients are being asked to travel further from home.

# Timely Care – Delayed Follow Up Appointments

**Lead Committee: BPPAC** | **Executive Lead: Joe Teape** | **Senior Responsible Officer: Stephanie Hire/Keith Jones**

**Metrics (targets):**

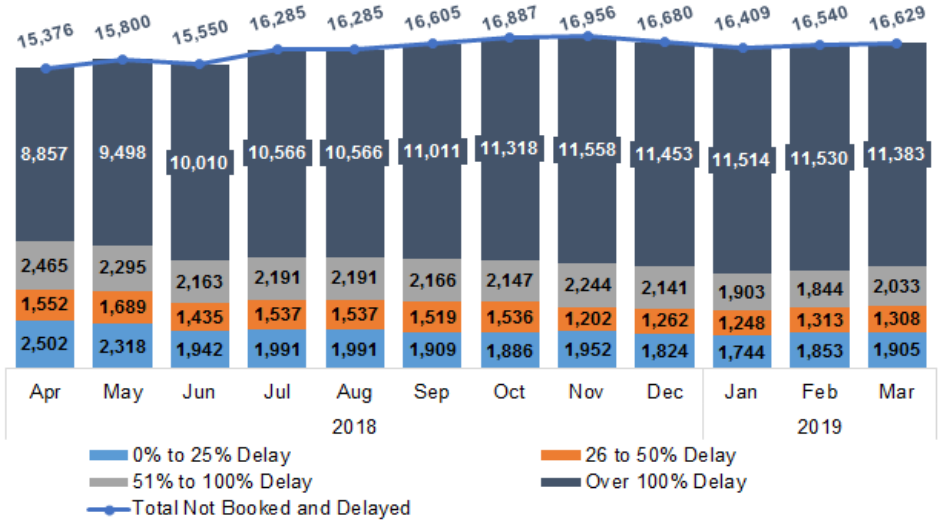
- Delayed follow-up appointments booked and not booked – 5 planned care specialties (12 month reduction target)

**Status as at Mar 2019**: ●

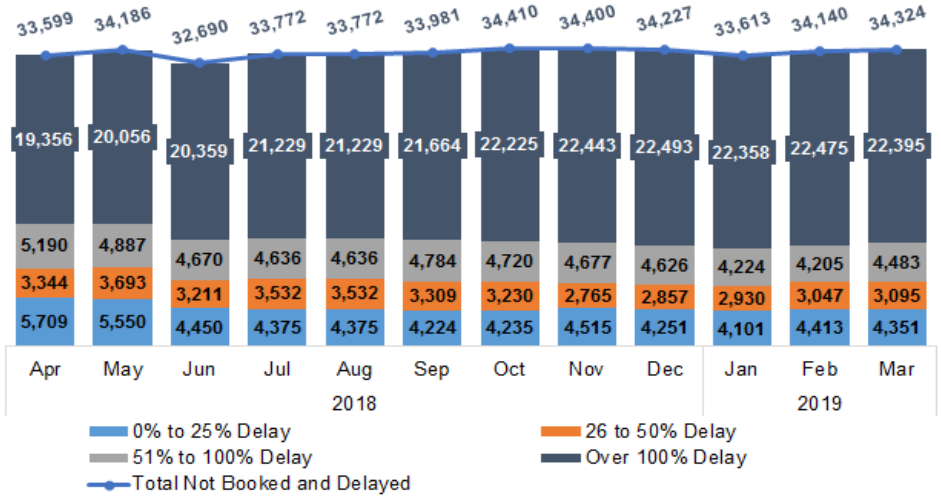
**Performance the past 12 months**: Declining

## Latest data

### 5 Planned Care Specialties




### All Specialties



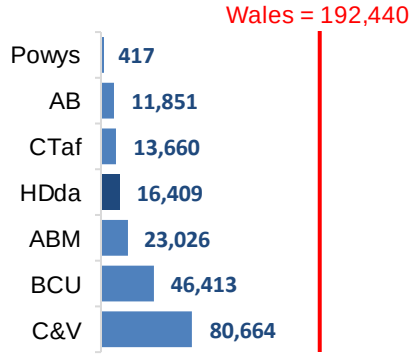

## Where are we and are we on target?

The total number of delayed follow-ups (booked/unbooked) in March 2019 was 34,324 which represents an increase of 184 patients compared with the previous month.

From April 2018 the 2018/19 Delivery Framework (page 26, measure 45) altered this metric to include the 5 Planned Care Programme (PCP) specialties only. These are Trauma and Orthopaedics, Ear, Nose and Throat, Urology, Dermatology and Ophthalmology. In February 2019, the total number of patients waiting for a follow-up appointment past their target date in these specialties was 16,629 (an increase of 89 compared to the previous month).

It is notable that for both metrics, the number of patients delayed in the 0%-25%, 26%-50% and 51%-100% delayed categories show an overall reduction year-to-date which indicates that improvement work to change follow-up practice in various specialties is having a positive effect. The Health Board (HB) is not currently meeting its 12 month reduction target and ranks 4th in Wales for this measure when benchmarked using the 5 planned care specialties (January 2019 data).

## Benchmarking (January 2019)



## Why has this occurred?

It is recognised that the overall volume of reported delayed follow-up appointments is inflated by data accuracy challenges which reflect a range of clinical, administrative and service transformation priorities. The increase in reported delayed follow-ups part reflects:

- prioritisation of outpatient clinic capacity in key specialties towards clearance of stage 1 RTT cohort patients, and;
- targeting of limited validation team capacity towards Referral to Treat (RTT)/PTL (Patient Tracking List) patients.

## What are the challenges?

Access Policy variations – review of administrative policies has highlighted variations in practice relating to new and follow-up appointments such that follow-up patients are not routinely discharged if they do not respond to appointment invitations. This consequently inflates reported delayed follow-up numbers. Action is being taken to address this variation in accordance with the Access Policy.

Service / clinical transformation – it is acknowledged that historical clinical practice and supporting administrative systems promotes the planning of outpatient department (OPD) based follow-up reviews without full consideration of alternatives and/or the clinical necessity of planned reviews.

## What is being done?

Our overall approach to reducing follow-ups not booked (FUNB's) is reflected in a number of parallel work streams and actions relating to administrative validation, clinical validation, informatics / administrative transformation, duplicate records and clinical transformation continue to be progressed. With specific reference to the 5 PCP specialties:

- ENT – continuing work within the specialty to identify alternatives to routine follow-up review and adoption of the clinical guidance developed by the ENT Planned Care Board. Positive progress is being achieved in reducing the total number of delayed follow ups (reduced 45%over the period);
- Orthopaedics – in accordance with national PCP guidance, the specialty is currently progressing plans to reduce the volume of routine follow-up appointments offered to patients who have undergone hip/knee replacement surgery. Early progress is being achieved in reducing the number of follow ups delayed by < 100% with a 20% improvement achieved since April 2018;
- Ophthalmology - the specialty is working towards implementation of the new Eye Care Measures and plans are the subject of a bid submitted to the Welsh Government (WG) Eye Care Sustainability Fund. Whilst significant improvement in the volume of delayed Ophthalmic follow-ups is not expected until full implementation of the supporting Eye Care Improvement Plan to review high priority glaucoma follow-up patients via community based Optometrists, early progress is being achieved in reducing the number of follow ups delayed by < 100% with a 27% improvement achieved since April 2018;
- Urology – the national PCP Board has confirmed approval in principle for an all Wales invest to save initiative to promote a self-care programme for prostate patients which is expected to significantly reduce the number of delayed Urology follow-ups across all Health Boards. Whilst significant improvement in the volume of delayed Urology follow-ups is not expected until full implementation of the self-care programme, small improvements have been achieved in the 0-25%, 25-50% and 50-100% delay categories.

In addition to these specialties, the Outpatient Turnaround process is continuing to focus on reducing delayed follow-ups across all specialties. Early progress is being achieved in Gynaecology, Paediatrics and Respiratory Medicine.

## When can we expect improvement and by how much?

The delayed follow-up improvement plan for 2019/20 is designed to support an approximate 25% improvement in reported delayed follow-ups by March 2020.

## How does this impact on both patients and finances?

See the Month 9 IPAR (page 37) for details.

## Timely Care – Continuing Healthcare and NHS Funded Long Term Care

**Lead Committee: BPPAC** | **Executive Lead: Jill Paterson** | **Senior Responsible Officer: Heledd Bingham**

**Metrics (targets):**

- Continuing Healthcare (CHC) - 458 Number of CHC packages delivered
- Continuing Healthcare (CHC) - £21.5m Total Health Board CHC spend

**Status as at Mar 2019:** Not applicable

**Performance the past 3 months:** Not applicable

### Latest data

| | | | | |
|---|---|---|---|---|
| **Number of current CHC packages delivered by category and by proportion of total CHC Spend (data excludes in house provision. FNC and joint funded LD/MH).** | **Category** | **Case Numbers (31.3.19)** | **Year-end forecasts (at 31.3.19)** | **%spend (against total HB CHC spend).** |
| | Nursing Homes (inc S117) | 340 | £15.93m | 74% |
| | Community (inc Palliative Care CHC) | 79 | £2.48m | 12% |
| | Children Continuing Care | 23 | £0.867m | 4% |
| | MH/LD CHC | 16 | £2.23m | 10% |

| | | | |
|---|---|---|---|
| **Total number and spend of CHC packages delivered (a) in a registered setting and (b) in the community. (Excludes Children / FNC and joint-funded LD/MH).** | **Setting** | **Numbers** | **Forecast Spend** |
| | **Residential / Nursing** | 346 | £16.77m |
| | **Community** | 89 | £3.87m |

| | | |
|---|---|---|
| **% of case reviews undertaken at 3 months** | **Category** | **%** |
| | General CHC(inc S117) | 95% |
| | Mental Health (CHC) | 100% |
| | Learning Disabilities | 100% |
| | Children CC | 100% |
| **% of case reviews undertaken at 12 months** | **Category** | **%** |
| | General CHC | 92% |
| | Mental Health CHC | 0% |
| | Learning Disabilities | 79% |
| | Children CC | 100% |
| **Number of staff who have received update training on the CHC framework in Q4** | **Department** | **Numbers** |
| | Long Term Care | Bespoke 121 training being provided in line with the roll out of the LTC Pathway. |
| | MH/LD | 0 |
| | Children | 0 |
| **Performance re Retrospective Reviews (Q4)** | 1 new case received;<br>14 cases were completed;<br>8 cases to be carried over to Q1 2019/20. | |

### Why has this situation occurred?

Welsh Government (WG) issued a revised policy document on Continuing NHS Healthcare (CHC) in 2014. The 2014 CHC National Framework included a Performance Framework specific to CHC, with a key requirement that each Health Board receive a formal quarterly CHC Position Report. This was subsequently revised in 2015 to require consideration either at Health Board or at an appropriate Board level Committee if this route allows for more detailed scrutiny and analysis. The quarterly reporting requirement has been supported by Wales Audit Office (WAO) in their 2013 and 2014 Reports, and compliance is drequired by the Assembly Public Accounts Committee (PAC).

### What are the challenges?

- Increase flow and demand from acute services is impacting on CHC spend and capacity within the community based priority services;
- Demand for Dementia Nursing remains high. This is reflected in the cost pressure in monthly forecasts;
- Financial pressure from inflationary CHC fee increases during 2018/19. Further financial pressure anticipated in 2019/20;
- The fragility of the Care Home sector across Hywel Dda University Health Board and a number of homes in Escalating Concerns or subject to Embargo;
- Limited capacity with providers especially for elderly mentally ill Nursing care home bed provision;
- Capacity within community based home care services is low. This is having an impact on the ability to source / commission timely packages of care across the Health Board footprint for patients assessed as eligible for CHC/ Fast Track;
- Availability of Social Workers to attend Multidisciplinary teams (MDTs) where Cease to Fund cases have been identified, this is especially the case on Older Adult Mental Health (OAMH) Wards;
- Out-of-panel requests for CHC funding at times when hospitals are on red/black status.

## What is being done?

- General Long Term Care (LTC) pathway (implemented July 2018);
- Roll out in WGH, Q1, 2019/20;
- Turnaround Process;
- Holding to Account meetings taking place;
- Weekly caseload scrutiny meetings to continue into 2019/20;
- Weekly review of 1-1 care (General LTC);
- Actively ceasing to fund cases where statutory reviews have identified change in need;
- Close scrutiny of new applications to ensure the process has been followed to avoid retrospective claims;
- Reduction of packages of care where equipment can provide an element of care required;
- Closer scrutiny of the sustainability of packages of care within the community setting. Long Term Care Specialist Nurse (LTCSN) has been reviewing long terms packages of care within the community in Pembrokeshire;
- Increased use of NHS In-house teams to deliver End of Life care within the home environment.

## When can we expect improvement and by how much?

There is no improvement target; however, it is the role of the LTC department to consider each case on its individual merit and to report on a quarterly basis in order to facilitate detailed scrutiny and analysis. The actions listed above set out the regular actions taken to address these issues. In addition, LTC/CHC remains subject to the Turnaround process, which commenced in August/September 2017 and will continue into the 2019/20 financial year.

## How does this impact on both patients and finances?

NHS continuing healthcare (CHC) is also known as "fully funded NHS care" is on-going care arranged, delivered and funded by the NHS - either within a hospital setting, a care home or a community setting. Care provision is determined on eligibility and assessed on-going needs. The Health Board has a process and pathway in place to ensure consistent, fairness and equity for all patients across the Health Board footprint, both in terms of assessment and care provision. Work is ongoing to ensure that packages of care continue to be safe and sustainable into the future, and proportionate to assessed need.

# Timely Care – Individual Patient Funding Request (IPFR)

**Lead Committee: BPPAC** | **Executive Lead: Professor Phil Kloer** | **Senior Responsible Officer: Karen Thomas**

| Metrics (targets): | Status as at March 2019 | Performance the past 12 months |
|---|---|---|
| • Individual Patient Funding Request - total, approved and declined | Not Applicable | Not Applicable |

## Latest data

| | | Approved | Not Approved | Deferred/returned | Total Number of IPFR's | Approved Costs £ | Totals £ |
|---|---|---|---|---|---|---|---|
| New IPFR's for Drugs | Cancer | * | * | * | * | | 3,000.00 |
| | Other | * | * | * | 5 | 3,000.00 | |
| Prev deferred IPFR's for drugs | Cancer | * | * | * | * | | |
| | Other | * | * | * | * | | |
| IPFR's for Continuation of Drug previously approved | Cancer | * | * | * | * | 4,452.00 | 4,452.00 |
| | Other | * | * | * | * | | |
| | | * | * | * | 6 | 7,452.00 | 7,452.00 |
| New IPFR's for Non Drugs | | * | * | 6 | 7 | | |
| prev deferred IPFR's for Non Drugs | | * | * | * | * | | |
| IPFR's for continuation of Non Drugs previously approved | | * | * | * | * | | |
| **Total Number of IPFR's** | | * | * | 10 | 13 | 7,452.00 | 7,452.00 |
| | | | | | | | |
| IPFR Reviews | Cancer | | | | | | |

### Where are we and are we on target?

Following the above the IPFR Panel had concluded that:

- 2 of these requests should be approved in view of significant clinical benefit likely to be gained;
- Less than 5 requests should be declined as significant clinical benefit likely to be gained had not been demonstrated;
- 10 requests should be deferred or returned as applications were incomplete and/or insufficient information had been provided.

### Why has this situation occurred?

See the Month 10 IPAR for details, link included below.

### What are the challenges?

See the Month 10 IPAR for details, link included below.

### What is being done?

See the Month 10 IPAR for details, link included below.

### When can we expect an improvement and by how much?

See the Month 10 IPAR for details, link included below.

### How does this impact on both patients and finances?

The impact on patients and finances remains the same and can be viewed in more detail in the Month 10 IPAR (see page 80).

# Individual Care

I am treated as an individual.

**Lead Executive**: Joe Teape

**Exception reports:**

- Mental Health Advocacy Services
- Mental Health Outpatient Waiting Times
- Substance Misuse

# Individual Care – Mental Health Advocacy Services

**Lead Committee: BPPAC** | **Executive Lead: Joe Teape** | **Senior Responsible Officer: Liz Carroll**

**Metrics (targets):**

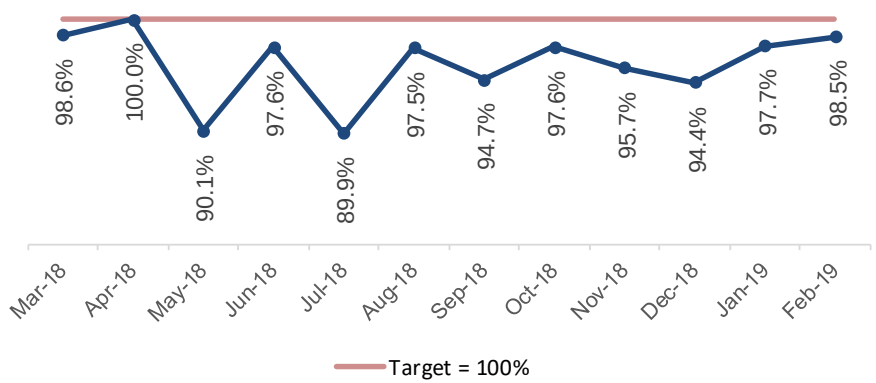
Tier 1 Part 4: Percentage of qualifying compulsory/voluntary patients have been offered advocacy services in the Mental Health Services (Target: 100%)

**Status as at Feb 2018**

**Performance the past 12 months**

Improving

## Latest data




## Where are we and are we on target?

In February 2019 the Directorate performance improved from 97.7% to 98.5%.

## Why has this situation occurred?

There are times when admissions occur during the night and at such times the priority for the ward team is to assess the patient and any associated risk. It is a less appropriate time to have the discussion in respect of advocacy. Ordinarily this would be a discussion that would be picked up the following day.

Within month it is the Adult Acute Inpatient services that have not reached the 100% target. This is due to the sustained service pressures that have increased the demand on inpatient staff. There have also been challenges in staffing the service with the right skill mix of nursing staff.

## What are the challenges?

The improvement has continued across the service. Adult Mental Health fluctuates a little more as this service receives a greater volume of admissions than other inpatient areas. Individual staff compliance is the main reason for not achieving 100% as well as failure to hand over in an effective way, that advocacy has not been offered if the patient has been admitted overnight.

## What is being done?

The Directorate reviews the advocacy figures recorded on a monthly basis, to identify those areas where performance is low. Where there are breaches this is down to single individuals not following the process in place and the service are reviewing these to ensure each breach is reviewed and the team involved learn and resolve any contributing factors.

## When can we expect improvement and by how much?

Close monthly scrutiny will continue until all areas achieve 100% consistently, as the process above takes effect there should be greater daily scrutiny by Ward Managers after each admission to rectify the position earlier to avoid a breach. The inpatient areas will from September be having the newly registered nurses to join the teams, which will help to improve both the skill mix and improve staffing level overall.

## How does this impact on both patients and finances?

The impact on patients is that there is a delay in accessing advocacy services should they wish to receive them. The financial impact is negligible.

# Individual Care – Mental Health Outpatient Waiting Times

**Lead Committee: BPPAC** | **Executive Lead: Joe Teape** | **Senior Responsible Officer: Liz Carroll**

**Metrics (targets):**

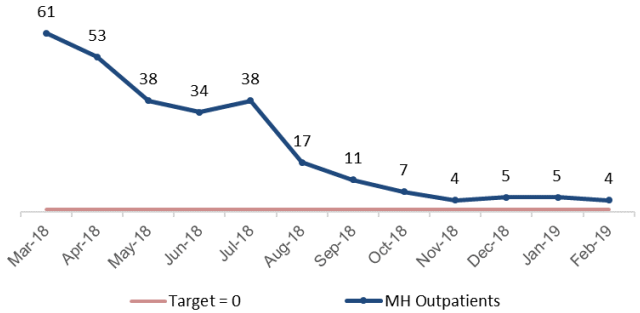
- To maintain a maximum waiting time for first outpatient appointments of 10 weeks (Target = zero patients waiting more than 10 weeks)

**Status as at Feb 2019**

**Performance the past 12 months**

Improving

## Latest data




## Where are we and are we on target?

The number of individuals waiting longer than 10 weeks for an appointment has decreased significantly within month.

The maximum outpatient wait over ten weeks is:

- Adult – 4
- Older Adult – 0
- Learning Disabilities – 0
- Child & Adolescent Services – 0

## Why has this situation occurred?

There continues to be significant challenges in terms of the Directorate's ability to recruit and retain medical staff across all specialties. This challenge is compounded by reduced availability at a national level. This is especially the case in the recruitment of Child and Adolescent Mental Health Services (CAMHS), General Adult and Older Adult psychiatry. However, given the current level of medical vacancy within the Directorate the number of waits is lower than the service would have anticipated.

## What are the challenges?

Sustaining consistency in improvement is difficult as vacancies change frequently which impacts on capacity. The medical workforce position continues to create significant challenges within the Directorate. This has been escalated through the Quality Safety Experience Assurance Committee to Board.

## What is being done?

The Mental Health Directorate continues to work very closely with the corporate Medical Staffing and Medical Recruitment teams to secure substantive appointments. The current vacant posts are covered by Agency Locums wherever possible to ensure the delivery of safe services. A Directorate specific recruitment campaign has been launched and further work is on going with the Recruitment Team.

The Mental Health Learning Disability Directorate continues to invest in expanding the Advanced Nurse Practitioner (ANP) and Non Medical Prescribers (working with Pharmacy colleagues to progress alternatives) training opportunities within the service. The Directorate is also exploring Physician Associate opportunities. This is an investment in building a more sustainable workforce for the future and will not have an impact on the current waiting time challenges.

The Associate Medical Director provides regular updates to the Workforce Panel and Executive Team in relation to medical staffing.

## When can we expect improvement and by how much?

Additional capacity will continue to be sourced until a sustained achievement of the target is seen.

## How does this impact on both patients and finances?

The impact on patients are the direct consequences of waiting longer to be seen by an appropriate qualified and experienced clinician, and the indirect consequences of a delay in diagnoses and the initiation of appropriate treatment. There is therefore a risk to the organisation with regard to the deteriorating position.

The financial implications and risks to the Directorate and organisation are significant both in terms of the cost implications of sustaining essential medical services by employing Agency Locums and in the context of not having Substantive Consultants that will drive forward further service improvements and service innovation within their Multi Disciplinary Teams. Medical recruitment challenges are on the Directorate risk register.

# Individual Care – Substance Misuse

**Lead Committee: BPPAC** **Executive Lead: Joe Teape** **Senior Responsible Officer: Joanna Dainton**

**Metrics (targets):**

- Increase the number of clients who engage with services between assessment and planned ending of treatment, by reducing the incidences of clients who do not attend (DNA) or respond to follow up contact post assessment date
- Achieve a waiting time of less than 20 working days between referral and treatment
- Substance misuse is reduced for problematic substance between start and most recent review/exit
- Quality of life is improved between start and most recent review/exit Treatment Outcome Profile
- Number/percentage of cases closed (with a treatment date) as treatment completed

**Status as at Mar 2019**
Not applicable

**Performance the past 12 months**
Not applicable

## Latest data

| | | Jan-19 | | | Feb-19 | | | Mar-19 | | |
|---|---|---|---|---|---|---|---|---|---|---|
| KPIs | Target | Carms | Ceredigion | Pembs | Carms | Ceredigion | Pembs | Carms | Ceredigion | Pembs |
| 1 - Post Assessment DNA | < 20% | 6.17% | 6.67% | 3.28% | 3.80% | 3.85% | 5.56% | 3.70% | 3.85% | 1.16% |
| 2 - Referral to Treatment | > 80% | 88.89% | 89.80% | 89.47% | 92.31% | 92.68% | 90.32% | 94.25% | 98.33% | 95.00% |
| 3 - Problematic substance reduced (TOP) | >=86.5% | 88.77% | 87.79% | 88.10% | 89.50% | 90.12% | 87.67% | 90.29% | 83.65% | 92.90% |
| 4 - Quality of Life improved (TOP) | >=84.2% | 95.60% | 74.63% | 87.23% | 82.19% | 84.09% | 89.55% | 92.59% | 82.35% | 87.01% |
| 5- Case closures as treatment complete | >=76.9% | 94.03% | 93.02% | 95.00% | 98.46% | 97.83% | 90.63% | 94.29% | 95.74% | 98.18% |

## Where are we and are we on target?

All key performance indicators (KPIs) relating to waiting times and did not attends (DNAs) are on green across the region, as are the case closures as treatment complete. The TOP data has improved during Q4 with Pembrokeshire now in the green. There have also been improvement in these figures for Ceredigion and Carmarthenshire.

## Why has this situation occurred?

The baselines for the KPIs relating to quality of life and reduction of problematic substance misuse are raised each year, which results in services having to meet increased targets year on year. In addition to this, the Tier 2 services are recording against the TOP and inputting onto the database but the tool is only validated for Tier 3 structured treatment which is affecting the overall figures.

## What are the challenges?

Services continue to work to improve the outcomes achieved by individuals accessing their services whilst recognising the challenges of continually improving upon an already high baseline position and note the work being undertaken by Welsh Government review this position. Dyfed Area Planning Board (APB) continue to request Tier 2 services to input data on the quality of life (TOP) to ensure that outcome data continues to be captured. The challenge remains to separate the Tier 2 TOP data and capture it in a way which does not affect the KPI.

## What is being done?

Treatment Outcome Profile scores are being scrutinised by team leaders in all areas to look for anomalies and a national working group has been set up by Welsh Government to review the KPI percentage targets to ensure that services are working to realistic targets. Dyfed APB are working with providers to find a solution to extract the TOP data from the data entered onto the data base which will provide a more accurate KPI result.

## When can we expect improvement and by how much?

Commissioners and service providers continue to work together to address this and it is hoped that the Welsh Government working group will develop new KPIs which reflect realistic targets and show the improving picture in services.

## How does this impact on both patients and finances?

Service providers are constantly striving to improve so treatment is meeting individual client need and are providing quality services. The improvement in the percentage of clients reporting an improvement in their quality of life in Q4 will have had a positive impact on clients in treatment. There are no impact on finances expected.

## Staff and Resources

I can find information about how the NHS is open and transparent on its use of resources and I can make careful use of them.

**Lead Executives:** Lisa Gostling, Joe Teape, Karen Miles and Huw Thomas.

**Exception reports:**

- Finance
- Mandatory training
- Sickness absence
- Medical Appraisal/Performance Appraisal and Development Review (PADR)
- Consultant/SAS Doctor job planning
- New and Follow-up Outpatient Did Not Attend (DNA) Rates
- NHS external providers – direct patient care
- Information Governance
- Facilities: Maintenance
- Facilities: Standards of Cleanliness - soft
- Facilities: Standards of Cleanliness - hard
- Facilities: Clinical Engineering – Com. High PPM
- Facilities: Clinical Engineering – Acute Low PPM
- Facilities: Clinical Engineering – Acute High & Medium PPM Com Medium & Low
- Facilities: Fire Safety
- Cyber Compliance

# Our Staff & Resources – Finance

**Executive Lead: Huw Thomas** | **Senior Responsible Officer: Rebecca Hayes**

**Metrics :** | **Status as at March 2019**

- Expenditure does not exceed the aggregate of the funding allotted to it over a period of 3 financial years (as agreed by the Planned Care Board) ●
- Stay Within Capital Resource Limit (cumulative year to date position) ●
- Cash Expenditure is less than the Cash Limit ●
- The Savings Plan is on target (cumulative year to date position) ●
- Variable pay (Agency, Locum, Bank & Overtime) ●
- Non NHS Invoices by Number are Paid within 30 Days (cumulative year to date position) ●

## Latest data

| Metric | Target | Mar-19 |
|---|---|---|
| Expenditure does not exceed the aggregate of the funding allotted to it over a period of 3 financial years (as agreed by the Planned Care Board) (cumulative year to date position) | <=0 | £35.438m Deficit |
| Stay Within Capital Resource Limit (cumulative year to date position) | <=0 | 0 |
| Cash Expenditure is less than the Cash Limit | Year end | £1.460m surplus |
| The Savings Plan is on target (cumulative year to date position) | 100% | 80.95% |
| Variable pay (Agency, Locum, Bank & Overtime) | Achievement of 2018/19 variable pay savings plans | £3.950m |
| **Metric** | **Target** | **Jan-Mar 19** |
| Non NHS Invoices by Number are Paid within 30 Days (cumulative year to date position) | 95% | 96.1% |

## Where are we against target?

- It is a statutory duty to achieve financial breakeven. On 29th March 2018, the Health Board approved the 2018/19 interim financial plan which outlined a deficit plan of £62.5m;
- During 2017/18, Welsh Government (WG) commissioned a 'Zero based budgeting review' of the Health Board's financial position, reflecting an assessment of the impact of rurality on our deficit. This has recognised that there are additional costs involved in providing health services in our rural communities. On 23rd May 2018, the Cabinet Secretary announced additional recurrent funding of £27m for the Health Board to recognise these costs. The revised deficit plan is therefore £35.5m;
- The Health Board's financial position at the end of Month 12 represented a favourable variance against plan of £0.1m;
- This deficit position will need to be recovered through a turnaround and recovery programme over the medium term.

## What are the challenges?

The detailed narrative setting out the key changes in the month and the main drivers affecting this position is contained within a separate paper on the agenda of the March 2019 Board.

## What is being done?

The actions being taken through increased control, use of slippage and reserves and the Turnaround process are detailed in the separate paper on the agenda.

| Performance Against Key Financial Targets Current Month (Statutory Financial Duties on Revenue & Capital) | | | | |
|---|---|---|---|---|
| | **Cumulative to Previous Month** | **Current Month** | **Cumulative to Current Month** | **Statutory Financial Duty** |
| **Revenue: Ytd Forecast/Outturn** | £32.687m deficit<br>£35.550m deficit | £2.751m deficit | £35.438m deficit<br>£35.550m deficit | Stay within Revenue Resource Limit |
| **Capital: Ytd Forecast/Outturn Current CRL** | £18.767m<br>£30.327m<br>£30.327m | £12.101m | £30.868m<br>£30.893m<br>£30.893m | Stay within Capital Resource Limit |
| **Performance Against Key Financial Targets Current Month (Other Financial Duties) Public Sector Payment Performance** | | | | |
| **Year to Date Forecast Year End** | Not available | This information is completed quarterly | 96.1%<br>>95% | Pay 95% of Non NHS Invoices within 30 days (basis of calculation changed in Nov 2015 to exclude Primary Care Contractor payments) |
| **Savings Schemes** | | | | |
| | **Cumulative to Previous Month** | **Current Month** | **Cumulative to Current Month** | **Savings Plans to achieve Statutory Duty** |
| **Ytd Full Year Forecast/Outturn** | £24.024m<br>£26.437m | £2.544m | £26.568m<br>£26.568m | These are gross savings as reported to Welsh Government, excluding the impact of cost pressures. |
| | | | | |
| **Closing Cash Balance** | £1.847m | | £1.460m | Cash management plans aim to deliver the 'best practice' period end balance 5% of the forecast monthly cash draw down from WG. |

# Our Staff & Resources – Mandatory Training

**Lead Committee: QSEAC** | **Executive Lead: Lisa Gostling** | **Senior Responsible Officer: Cheryl Raymond / Sian Hall**

**Metrics (targets):**

- % compliance for each completed Level 1 competency with Core Skills & Training (>85%)

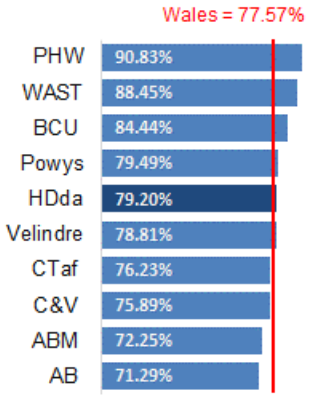
**Status as at Mar 2019:** ●

**Performance the past 12 months:** Improving

## Latest data

| Monthly Measures: Our Staff | Historical Data | | | |
|---|---|---|---|---|
| **Target >85%** | **Mar 19** | **Feb 19 %** | **Prior 12m %** | **Trend** |
| Core Skills Training Framework | 79.6 | 79.1 | 65.7 | ⇧ |
| Equality, Diversity & Human Rights | 80.5 | 79.8 | 66.2 | ⇧ |
| Fire Safety | 68.2 | 68.1 | 39.0 | ⇧ |
| Health, Safety and Welfare | 79.7 | 79.1 | 66.8 | ⇧ |
| Infection Prevention & Control - Level 1 | 81.7 | 82.2 | 76.5 | ⇩ |
| Information Governance | 79.1 | 78.5 | 64.5 | ⇧ |
| Moving and Handling - Level 1 | 78.6 | 78.2 | 71.5 | ⇧ |
| Resuscitation - Level 1 | 83.0 | 81.9 | 72.4 | ⇧ |
| Safeguarding Adults - Level 1 | 80.1 | 79.2 | 67.4 | ⇧ |
| Safeguarding Children - Level 2 | 77.4 | 76.4 | 59.1 | ⇧ |
| Violence & Aggression - Module A | 88.0 | 87.3 | 73.7 | ⇧ |

## Benchmarking (January 2019)




## Where are we and are we on target?

Whilst still not on target, the Health Board is improving each month and is now overall only 5.4 % below the Welsh Government target.

## Why has this situation occurred?

Staff who do not regularly use the ESR system, continue to have difficulty navigating the e-learning platform. It is the manager and the individual's responsibility to ensure that the help guides, on-line and telephone support is accessed and the modules are completed.

## What are the challenges?

The main challenges reported are the time to undertake the modules and access to the e-learning system. The Learning & Development department and the ESR team continue to offer support to alleviate these problems.

## What is being done?

Mandatory training days for Consultants continue to be rolled out. These face–to-face sessions concentrate on the Core Skills subjects which are assisting the rise in compliance. There remains focus through guides, on-line and telephone support along with facilitated e-learning sessions.

## When can we expect improvement and by how much?

All previous reports have shown month on month improvement so the Health Board expects this to continue to take us to full compliance.

## How does this impact on both patients and finances?

Completion of mandatory training underpins all other staff development, ensuring the Health Board has a skilled and trained workforce, able to work safely.

# Our Staff & Resources – Sickness absence

**Lead Committee: QSEAC** | **Executive Lead: Lisa Gostling** | **Senior Responsible Officer: Steve Morgan**

**Metrics (targets):**

- % of full time equivalent (FTE) days lost to sickness absence for rolling 12 months (Target = reduction)

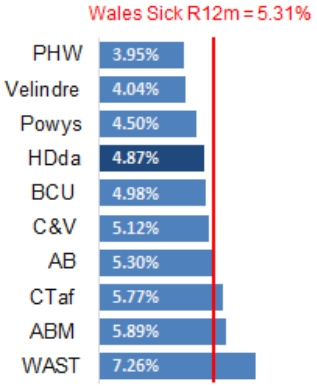
**Status as at Mar 19:** ●

**Performance the past 12 months:** Improving

## Latest data

| Monthly Measures: Our Staff | Current | Historical Data | |
|---|---|---|---|
| % of full time equivalent (FTE) days lost to sickness absence for rolling 12 month period | Mar 19 | Feb 19 | Mar 18 |
| Health Board Total | 4.86 | 4.87 | 5.02 |
| Unscheduled Care | 4.75 | 4.80 | 4.90 |
| Planned Care | 4.35 | 4.37 | 4.95 |
| Women & Children | 4.53 | 4.44 | 5.25 |
| Oncology & Cancer Care | 2.66 | 2.50 | 4.15 |
| **Monthly Measures: Our Staff** | **Current** | **Historical Data** | |
| % of full time equivalent (FTE) days lost to sickness absence – in month | Mar 19 | Feb 19 | Mar 18 |
| Health Board Total | 4.99 | 5.17 | 5.05 |
| Unscheduled Care | 4.46 | 4.67 | 5.23 |
| Planned Care | 4.51 | 4.65 | 4.69 |
| Women & Children | 5.26 | 5.38 | 4.72 |
| Oncology & Cancer Care | 2.88 | 4.24 | 1.06 |

## Benchmarking (February 2019)




## Where are we against target?

The sickness information reported relates to the position as at 31/3/19.
The in month actual figure reported for March 2019 equates to 4.99% which is a decrease on the previous month (5.17%) and also represents a decrease against the corresponding rate in 2018 (5.05%). The rolling 12 month rate has improved slightly and is now 4.86% which is fractionally above the Welsh Government (WG) target and remains the lowest rate of the larger Health Boards (HB) in Wales. Hywel Dda has therefore reached the end of the financial year with the lowest absence rate in Wales (of the larger HB's).

## Why has this situation occurred?

The in-month position at 31st March 2019 is slightly above the WG target although below the Wales average. There is a new All Wales Attendance Policy with training being rolled out across the HB. This policy offers managers more discretion when escalating staff through the policy and emphasises a more compassionate approach to the management of attendance.

## What are the challenges?

The challenge is to achieve and sustain the WG target especially in light of the new policy which provides and encourages more management discretion.

## What is being done?

The HB is continuing to monitor and manage sickness closely throughout the organisation; sickness auditing is targeted to the wards and departments with the highest levels of absence and training is continuing. In addition, the performance assurance process is continuing to maintain a focus on sickness. Training in the new All Wales policy is ongoing.

## When can we expect improvement and by how much?

It is anticipated that the rolling 12 month rate will continue to decrease and has remained the lowest of the larger Health Boards in Wales for this financial year. The HB has ended the year with an improved absence rate in comparison to last year.

## How does this impact on both patients and finances?

Poor sickness impacts on quality of care for patients and also on variable pay costs.

# Our Staff & Resources – Medical Appraisal/Performance Appraisal and Development Review (PADR)

**Lead Committee: QSEAC** | **Executive Lead: Lisa Gostling** | **Senior Responsible Officer: Rob Blake**

**Metrics (targets):**

- % staff undertaking PADR: Medical and Non Medical (Target > 85%)

**Status as at Mar 19**: ●

**Performance the past 12 months**: Improving

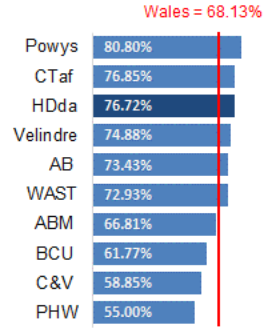
## Latest data

| Appraisal | Mar-19 | Feb-19 | 12m | Trend |
|---|---|---|---|---|
| Health Board Total (Combined) | **78** | **77** | **63** | ⇧ |
| Total Medical Appraisal | 95 | 96 | 96 | ⇩ |
| Total Non-medical appraisal | 76.04 | 75.31 | 60.41 | ⇧ |
| **Medical Appraisal** | | | | |
| Unscheduled Care | 92 | 92 | 94 | ⇔ |
| Planned Care | 96 | 95 | 97 | ⇧ |
| Women & Children | 94 | 94 | 97 | ⇔ |
| Mental Health & Learning Disabilities | 100 | 100 | 95 | ⇔ |
| **Non-Medical Appraisal** | | | | |
| Unscheduled Care | 74.50 | 70.35 | 53.21 | ⇧ |
| Planned Care | 72.75 | 71.54 | 55.28 | ⇧ |
| Women & Children | 73.95 | 79.56 | 73.03 | ⇩ |
| Mental Health & Learning Disabilities | 81.51 | 80.79 | 69.31 | ⇧ |
| Estates and Facilities | 86.78 | 87.99 | 68.47 | ⇩ |
| Carmarthenshire County | 82.02 | 83.99 | 57.27 | ⇩ |
| Ceredigion County | 68.64 | 63.91 | 64.33 | ⇧ |
| Pembrokeshire County | 83.03 | 88.41 | 65.07 | ⇩ |
| Director of Therapies & Health Science | 80.30 | 81.97 | 66.15 | ⇩ |
| Deputy CEO/DOE | 77.50 | 76.53 | 60.42 | ⇧ |
| Corporate Governance | 66.67 | 77.78 | 40.00 | ⇩ |
| Director of Finance | 76.40 | 67.82 | 38.27 | ⇧ |
| Director of PPIC | 87.34 | 86.08 | 59.87 | ⇧ |
| Director of Partnerships and Corporate | 80.00 | 64.44 | 43.14 | ⇧ |
| Medical Director | 70.24 | 72.94 | 75.31 | ⇩ |
| Director Nursing, Quality & Experience | 38.18 | 37.96 | 42.02 | ⇧ |
| Director of Public Health | 45.53 | 41.28 | 41.70 | ⇧ |
| Director of Workforce & OD | 93.82 | 94.94 | 88.75 | ⇩ |

## Where are we against target?

Hywel Dda compliance is higher than the NHS Wales average as of March 2019. Non-medical appraisal/PADR improved by 0.73% which hasn't met the required target of 5.5% improvement for the month. Medical Appraisal declined by 1% but remains above target. There have been increases from Feb 19 in 10 non–medical areas with compliance rates dropping in 8 from the previous month. The PADR is such an important tool in raising performance and staff engagement and it is vital they are undertaken as part of an employee performance culture.

## Benchmarking (January 2019)




## Why has this situation occurred?

Overall PADR performance improved by 15.63% over the last 12 months with the main reasons for this being the review of service/teams compliance rates within the performance monitoring process and the ongoing building of a culture that leaders are focused on the benefits of the PADR process. There remains ongoing focus through training and support mechanisms via the Workforce & OD teams, but improvement is still failing to meet required targets.

## What are the challenges?

The time taken to undertake the process effectively remains the main challenge, especially with leaders of large teams. There is also limited training available for managers with the Managers Passport the only recognised programme offering PADR training. It is vital that leaders are not only aware when PADR dates are due but they are completing and entering dates on ESR to ensure data quality.

**What is being done?**
Continuation of all support from the Corporate Workforce & OD function remains in place.  It remains the responsibility of managers to undertake meaningful PADRs with staff encouraged to engage with the process.

**When can we expect improvement and by how much?**
Focus on PADR continues. The organisation has not met the required target of 85% for 2018/19. The W&OD team are currently reviewing various support mechanisms to try and build on the excellent improving position to help the organisation achieve the desired target of 85%.

# Our Staff & Resources – Job Planning

**Lead Committee: QSEAC** | **Executive Lead: Phil Kloer** | **Senior Responsible Officer: John Evans Helen Williams**

**Metrics (targets):**

- Consultants/SAS Doctor have up to date job planning (Target 85%)

**Status as at Mar 2019:** ●

**Performance the past 12 months:** Improving

## Latest data

| Role | % in March 2019 | | | | % in March 2018 | | | |
|---|---|---|---|---|---|---|---|---|
| | None | Job plan in place needs review | Current Job plan in place | Current + Needs review | None | Job plan in place needs review | Current Job plan in place | Current + Needs review |
| Consultant | 0 | 17% | 83% | 100% | 15% | 50% | 35% | 85% |
| SAS Doctor | 24% | 16% | 60% | 76% | 65% | 20% | 15% | 34% |
| **Total** | 9% | 17% | 75% | 92% | 35% | 38% | 27% | 65% |

## Where are we and are we on target?

In March 2019 compliance across all roles has risen by 13% since February 2019, with an increase of 27% since March 2018. All Consultants now have a job plan, with 83% of those job plans being up to date and are a current reflection of those activities carried out by individuals. A further 4% of Consultant job plan reviews have been carried out and are awaiting workforce panel approval and sign off, 1% are in dispute and 3% cannot be completed due to reasons such as sickness, long term leave and secondment. The remaining 9% of Consultant job plan reviews remain outstanding due to changes in staffing within large service departments, however, it is anticipated that these job plan reviews will go ahead over the coming weeks. The numbers of SAS job plans has increased by more than double since March 2018 and by more than 33% since February 2019. As with the Consultant reviews, extenuating circumstances including sickness, job plan dispute, secondment and sign off make up 5% of those SAS job plan figures. Again, the 19% of outstanding SAS job plans are attributable to changes in staffing within large service areas and there will be a focus on getting these job plans in place over the coming weeks.

## Why has this situation occurred?

Consultants and SAS doctors are required as part of their contract to have an up to date job plan. Following receipt of the 2016 Welsh Audit Office report of the review of the job planning process across Hywel Dda, emphasis has been put on raising the standard of the job planning process across Hywel Dda and increasing the numbers of Consultant and SAS Doctor job plans. Well-constructed and current job plans are beneficial both to the doctor, the team they work in and the organisation as they can provide helpful information to support delivery of services. Job plan compliance has been traditionally very low across specialties in the Health Board and concerted effort has been made in the last year to increase the number and quality of job plans.

## What are the challenges?

Ongoing challenges include:

- Ensuring time is allocated to meet with clinicians to agree the content of individual job plans, which accurately reflects the work being undertaken, whilst also taking into account the needs of the service;
- Ensuring a consistent approach to the job planning process across sites and specialties;
- Changes in staffing within service areas can mean that there are relatively long periods of time where a post is vacant. This can mean delays in job plan reviews being undertaken and this is particularly difficult within large teams where there may be over 70 job plan reviews to be undertaken annually.

## What is being done?

Regular meetings are held to discuss job planning. General Managers and Service Delivery Managers are provided with job planning information on a regular monthly basis, in the form of a tracking report. Statistcs are being regularly reported to the Executive Team Performance Review Meetings.

## When can we expect improvement and by how much?

There has been a marked improvment in the job planning process in the year 2018/2019 and this improvment will be built upon in the year 2019/2020.

## How does this impact on both patients and finances?

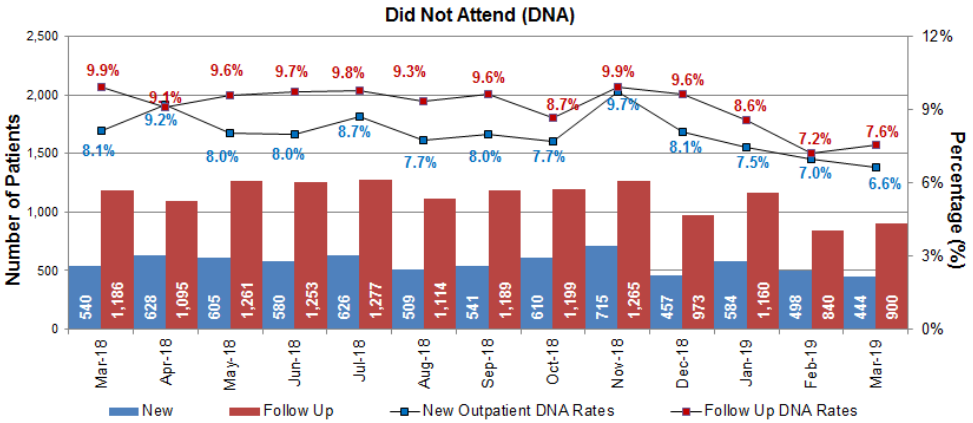
Effective job planning results in the alignment of individual's work, departmental objectives and strategic objectives resulting in a much more cost effective delivery of healthcare.

# Our Staff & Resources – New and Outpatient Did Not Attend (DNA) Rates

**Lead committee: QSEAC** | **Executive Lead: Joe Teape** | **Senior Responsible Officer: Keith Jones / Steph Hire**

| Metrics (targets): | Status as at Mar 2019 | Performance the past 12 months |
|---|---|---|
| • New Outpatient DNA Rates (Target = 12 month reduction trend) | ● | Improving |
| • Follow-up Outpatient DNA Rates (Target = 12 month reduction trend) | ● | Improving |

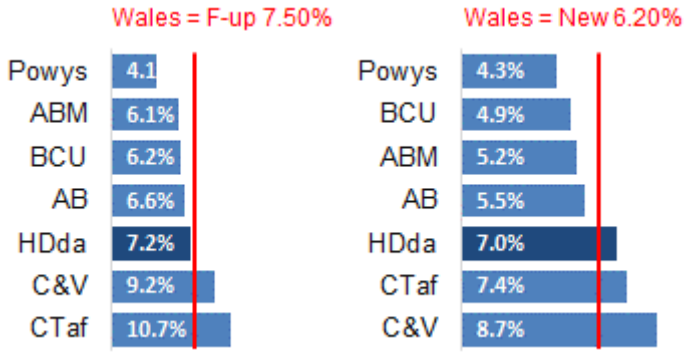
## Latest data




## Where are we and are we on target?

In March 2019, 440 (6.6%) patients did not attend their new outpatient appointment and 900 (7.6%) patients did not attend their follow-up appointment. Both metrics have improved since November 2018 and both metrics have met the 12 month reduction target. The slight deterioration in performance in the month for follow-up DNAs is currently being assessed.

## Benchmarking (February 2019)







Using the All Wales Benchmarking information Hywel Dda ranked 5th in February 2019 for both follow up and new DNA appointments.

## Why has this occurred?

Whilst the causes of DNAs are multi-factorial and require multiple solutions for improvement, best practice evidence indicates that partial booking and appointment reminder systems are key determinants of reduced DNA rates. The Health Board's pilot text reminder service has now been implemented and through the Scheduled Care Efficiency and Productivity programme, there is a key focus on the improvement of DNA work through access policy rules awareness, sharing of DNA rates with clinical teams and e-referral roll out.

November 2018 DNA performance for both New and Follow up figures deteriorated due to printing issues with a contracted supplier.

## What are the challenges?

DNAs are multi-factorial and analysis of all factors which influence DNA rates requires dedicated time and engagement to facilitate and demonstrate a significant measurable impact. Focus has been given to Health Board wide improvement work.

## What is being done?

- Fortnightly Outpatient Turnaround meeting which tracks performance each month on a cumulative and current month basis. The service is now able to identify specialties which show a statistically significant decline in order to prioritise the focus;
- The Patient Communication Turnaround meetings scope further opportunity to improve the way the Health Board communicates and interacts with patients avoiding unnecessary appointments;
- Text reminder service: The two way text reminder service went live on 8th October 2018 with specialties booked through the contact centre. Further rollout across all specialties is due to go live in April 2019;
- Specialty specific action plans which are discussed and monitored;
- Development of Follow up and discharge criteria procedures has been tested in Gynaecology and expected to be roll out to other specialties;
- Training is being developed for specific staff groups to ensure consistent management of the patient pathway;
- The E-referral system implementation is progressing.

**When can we expect improvement and by how much?**
A dashboard is now consistently updated with monthly data for new and follow-up DNA rates by specialty.  A baseline has been established which will allow each specialty to agree a SMART (Specific Measurable Achievable Relevant and Time bound) aim for reduction of DNA rates.

**How does this impact on both patients and finances?**
Patients, who do not attend their appointment, potentially negatively impact on their health and wellbeing, as well as that of others, as the creation of replacement appointments causes delay in accessing consultation / treatment for those on the waiting list. The financial impact is significant as the estimated cost of each missed appointment is approximately £154. For each missed appointment, the efficiency in the system decreases and rework and waste become an inevitable part of the process. In addition to this, it creates greater pressure for Referral to Treat (RTT) as appointment opportunities are lost. Reducing the DNA rate can lead to better management of existing capacity.

## Our Staff & Resources – Cyber Compliance - Security Patching Status

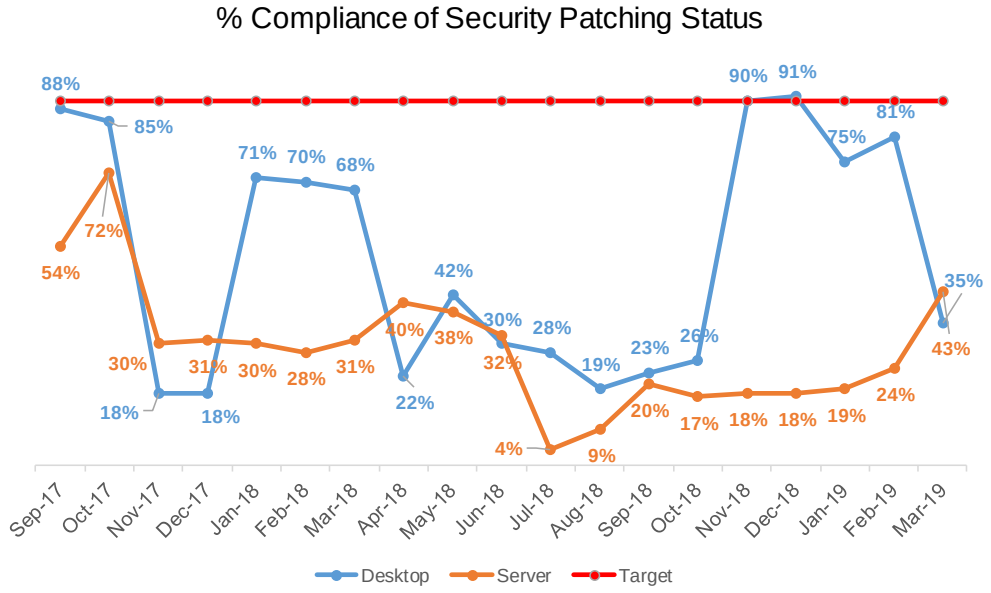
**Lead Committee: BPPAC** | **Executive Lead: Karen Miles** | **Senior Responsible Officer: Anthony Tracey**

**Metrics (targets):**

- 90% of Server infrastructure patched with the latest updates
- 90% of Desktop infrastructure patch with the latest updates

| Status as at March 19 | Performance the past 12 months |
|---|---|
| ● | Improving |
| ● | Declining |

### Latest data




### Where are we against target?

Following the WannaCry outbreak Hywel Dda Information and Communication Technology (ICT) invested significant resources in ensuring all desktop and server resources were patched for this vulnerability, this was made difficult due to the number of end of life systems within the Health Board (HB) and the fact there was no enterprise class patching management system within the organisation.

From September 2017, the HB has been capturing monthly key performance indicators (KPI) of the critical security patching status of the desktop equipment (PC's / Laptops) and servers hosting a range of administrative and clinical systems. The graph above highlights the patching levels for the ICT infrastructure.

- Patching status in the autumn of 2017 was high due to work undertaken to patch systems following the WannaCry outbreak;
- As new patches are released then this figure fluctuates and has remained low for servers since that time;
- Desktop devices dropped off in 2018 due to issues associated with Windows 10 deployment and associated Microsoft bugs in some of the patches that delayed deployment;
- Desktop patching has improved in October – December 2018 as the Team now forcibly reboot desktop PC's after patches are released to ensure continued compliance. Unfortunately, ICT are not able to undertake the same process on the server infrastructure. Each server has to be updated manually in order to reduce the disruption to the service. The server needs to be disconnected from the infrastructure, updated with the patches, tested, and then connected back to the infrastructure, all of which takes approximately 1-2 hours per server. Currently server infrastructure stands at 458, which would equate to 916 hours to update the overall infrastructure.

### Why has this situation occurred?

The number of patches that are released effects the ability of the ICT Team to continue to update servers / desktop. The HB also has a number of legacy systems, which require specific work with the information asset owner and or services to ensure that downtime is kept to a minimum.

### What are the challenges?

On average it takes 2-3 weeks for patches to be released to all PC's / Laptops. Many of the major software and hardware suppliers release patches / bugs on the second Tuesday of every month. Patch Tuesday (also known as Update Tuesday) which occurs is an unofficial term used to refer to when Microsoft regularly releases security patches for its software products.

### What is being done?

An all Wales working group has submitted a funding paper to Welsh Government for each Health Board / Trust to have 2 Whole Time Equivalent (WTE) Band 6's to ensure that all the desktop / server infrastructure is patched accordingly. Without this additional resource, the current levels may fluctuate due to the number of releases; however, limited improvements will be made until this resource is available.

The Committee should note that the anti-virus software has been removed from the information above as this is always at 100%. The updating of this software is given the highest priority as this is the first line of defence against an attack.

The ICT Team have developed a cyber-security dashboard within Power BI, which is linked to allow the monitoring software, which allows the Team to target servers / desktops which have outdated security updates.

**When can we expect improvement and by how much?**

Over the autumn of 2018 ICT have completed the implementation of Microsoft System Centre Configuration Manager (SCCM) and its deployment to all the servers and this will form the basis of the patching work in the future, however it will not remove the need to undertake some manual processes. Using SCCM the Team will continue to deploy patches when safe to do so however additional resources are required to undertaking patching on critical systems in the maintenance windows agreed by the Information Asset Owners, which is typically out of hours.

Improvements in the desktop patching levels is dependent upon the number of patches released by the vendors. With the movement to Windows 10, these updates will become more frequent.

**How does this impact on both patients and finances?**

Limited impact upon patients, as the server / desktop updates are planned with the service owner to be undertaken out of hours. However, when critical patches are required the ICT infrastructure could be effected, which in turn could have an effect upon patient services.

**Lead Committee: BPPAC** **Executive Lead: Huw Thomas** **Senior Responsible Officer: Rhian Davies**

## Latest data - End of Year 2018/19

## Financial Position – All Providers (to Month 12)

| Direct Patient Care Summary | SCNE Annual Budget | SCNE YTD Budget | YTD Expenditure | YTD Variance |
|---|---|---|---|---|
| | £'000 | £'000 | £'000 | £'000 |
| ABMU | 33,428 | 33,428 | 31,937 | (1,491) |
| C&V | 5,978 | 5,978 | 5,299 | (679) |
| Other Welsh | 2,912 | 2,912 | 2,863 | (49) |
| Other UK | 1,251 | 1,251 | 999 | (252) |
| NCA | 1,348 | 1,348 | 1,199 | (149) |
| IPC | 2,495 | 2,495 | 1,200 | (1,295) |
| WHSSC–Specialised Services | 63,560 | 63,560 | 64,537 | 977 |
| WHSSC - EASC | 21,103 | 21,103 | 21,019 | (84) |
| *WHSSC - Total* | *84,663* | *84,663* | *85,556* | *893* |
| **TOTAL - Direct Patient Care** | **132,076** | **132,076** | **129,054** | **(3,022)** |

## Current and Forecast Position – Activity (to Month 12)

| External Provider Agreements | Annual Target | YTD Target (M12) | YTD Actual | YTD Variance |
|---|---|---|---|---|
| Swansea Bay (Abertawe Bro Morgannwg) | | | | |
| Scheduled Care | 13,163 | 13,163 | 12,676 | (487) |
| Unscheduled Care | 7,285 | 7,285 | 6,321 | (964) |
| Cardiff & Vale | | | | |
| Scheduled Care | 5,513 | 5,513 | 5,024 | (489) |
| Unscheduled Care & Cancer | 462 | 462 | 412 | (50) |
| Orthopaedics | 481 | 481 | 402 | (79) |
| High Cost Contract Exclusions | 118 | 118 | 121 | 3 |
| Other Welsh Providers | | | | |
| Scheduled Care | 2,282 | 2,282 | 2,150 | (132) |
| Unscheduled Care | 2,078 | 2,078 | 1,899 | (179) |
| Other UK Providers | | | | |
| Scheduled Care | 1,765 | 1,765 | 1,624 | (141) |
| Unscheduled Care | 84 | 84 | 525 | 441 |
| **Total Direct Patient Care** | **33,231** | **33,231** | **31,154** | **(2,077)** |

## Why has this occurred?

### Year End Performance: External Referral to Treatment (RTT)

**Swansea Bay University Health Board (formally Abertawe Bro Morgannwg UHB)**

82% of Hywel Dda patients exceeding the RTT targets outside Hywel Dda in Wales are in Swansea Bay UHB.

- The number of patients waiting over 26 weeks for an outpatient appointment increased by 29 from 17 in February 2019 to 46 in March 2019;
- The number of patients breaching the 36 Week RTT pathway reduced by 20 from 198 in February 2019 to 178 in March 2019;
- Swansea Bay UHB has confirmed that due to increased non-elective pressures and some issues over sufficient capacity to meet the RTT targets, not all patients could be seen. It was confirmed that all patients are seen in strict date order irrespective of residency.

**Cardiff & Vale University Health Board**

16% of Hywel Dda patients exceeding RTT in Wales are in Cardiff & Vale.

- The number of patients waiting over 26 weeks for an outpatient appointment reduced by 3 patients from 35 in February 2019 to 32 in March 2019;
- The number of patients breaching the 36 week RTT pathway has reduced by 11 patients from 28 in February 2019 to 17 patients in March 2019;
- Although the number of patients exceeding the RTT pathway has reduced for Hywel Dda, despite an increase in elective activity in February and March, the Health Board experienced some capacity issues to meet the Welsh Government targets, but like SBULHB, all patients are seen in strict date order irrespective of residency.

**Other Welsh and United Kingdom Providers**.

- There are currently low number of patients breaching the RTT in the other Welsh and United Kingdom Providers;
- The number of patients breaching the 36 week RTT pathway in the other Welsh Providers has reduced by 1 from 2 in February 2019 to 1 patient in March 2019 and relates to a Trauma & Orthopaedic patient at Aneurin Bevan University Health Board;

- The number of patients breaching the 36-week RTT pathway in the other United Kingdom Providers has reduced slightly from 4 in February 2019 to 2 in March 2019 and relates to 2 T&O patients.

## What are the challenges?

- The information contained within this dashboard is based upon the full year 2018/19 position for completeness;
- The 2019/20 Long Term Agreements (LTA), to meet Welsh Government target, will be signed by 31st May 2019. Draft Provider activity for month 1 will be available at the end of May 2019, therefore it is not possible to identify any financial or activity variance at this stage. All Welsh LTAs will be subject to 2% inflationary uplift with the additional 1% uplift for 'A Healthier Wales' to be agreed based on the Provider's ability to demonstrate a positive impact for the relevant commissioner population;
- There was an issue with English Provider NHS Trusts and the agreement of Long Term Agreements using the HRG4+ Tariff due to different funding arrangements for both NHS Wales and England. The Welsh Government has now resolved this issue and this will assist the providers with the agreements.

**Welsh Health Specialised Services Commission (WHSSC)**

- The 2019/20 WHSSC and EASC (Emergency Ambulance Services Committee) LTAs have been agreed through the all Wales lead commissioner process. The change in the risk share agreement is also being enacted in 2019/20.

## What is being done?

- Requesting patient profile plans to address waiting time issues from the relevant providers, ensuring the providers meet Waiting Times Targets, as agreed with Welsh Government;
- Regular communications with WHSSC to understand the potential future impact of the Risk Sharing Arrangements for the services managed on the Health Board's behalf;
- Regular Long Term Agreement (LTA) meetings with Providers to review activity, resolve any capacity or service issues and to develop better working relationships;
- Validation of Long Term Agreement (LTA) performance activity and Non Commissioned Activity (NCA) invoices backing information to identify and challenge inappropriate charges.

## When can we expect improvement and by how much?

For non-WHSSC commissioned services, patient waiting times are heavily reliant on the other providers to deliver improvements in line with their RTT agreement with the Welsh Government. For WHSSC commissioned services, patient waiting times can be improved by the performance management escalation process implemented by WHSSC in problem areas, which is a system approved by the Joint Committee of which Health Board is a member.

Direct patient care is closely monitored by both the Health Board and the providers under the LTA contract mechanisms, which regulate costs and service developments. In order to achieve any significant reductions in costs over and above what has already been achieved, there needs to be a significant reduction in referrals to out of area providers. To deliver this, a fundamental review of the referral processes are needed in collaboration with the Referral Management Centre, Primary and Secondary Care Clinicians.

## Waiting Times / Referral to Treatment Time (RTT)

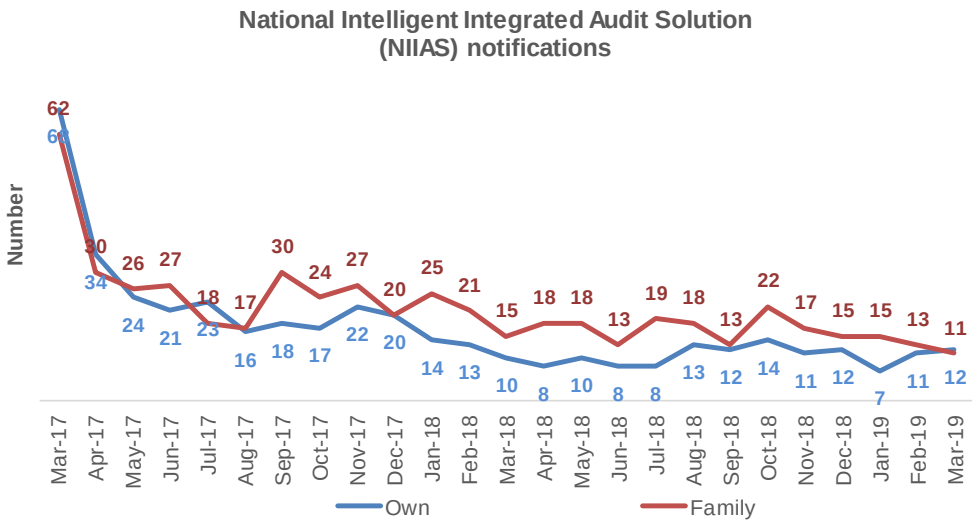
| Provider/Specialty | Abertawe Bro Morgannwg | | | | | | Cardiff & Vale | | | | | | Other Welsh Providers | | | | | | Other UK Providers | | | | | | Total Patient Breachers | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Patients Breaching | | | Longest Week Waits | | | Patients Breaching | | | Longest Week Waits | | | Patients Breaching | | | Longest Week Waits | | | Patients Breaching | | | Longest Week Waits | | | | | |
| | Mar | Feb | Var | Mar | Feb | Var | Mar | Feb | Var | Mar | Feb | Var | Mar | Feb | Var | Mar | Feb | Var | Mar | Feb | Var | Mar | Feb | Var | Mar | Feb | Var |
| *Outpatients Waiting Over 26 Weeks* | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Clinical Immunology & Allergies | | | | | | | 12 | 17 | (5) | 34 | 37 | (3) | | | | | | | | | | | | | 12 | 17 | (5) |
| Dermatology | | | | | | | 1 | 1 | | 26 | 32 | (6) | | | | | | | | | | | | | 1 | 1 | |
| ENT | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Gastroenterology | | | | | | | | 1 | (1) | | 31 | (31) | | | | | | | | | | | | | | | |
| General Medicine | | | | | | | | 1 | (1) | | 28 | (28) | | | | | | | | | | | | | | | |
| General Surgery | | | | | | | 2 | 1 | 1 | 31 | 27 | 4 | | | | | | | | | | | | | 2 | 1 | 1 |
| Neurology | | | | | | | 6 | 1 | 5 | 33 | 33 | | | | | | | | | | | | | | 6 | 1 | 5 |
| Ophthalmology | | | | | | | 4 | 3 | 1 | 34 | 45 | (11) | | | | | | | | | | | | | 4 | 3 | 1 |
| Oral Surgery | 46 | 15 | 31 | 35 | 31 | 4 | | | | | | | | | | | | | | | | | | | 46 | 15 | 31 |
| Paediatric Dentistry | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Paediatric Surgery | | | | | | | | 1 | (1) | | 29 | (29) | | | | | | | | | | | | | | 1 | (1) |
| Plastic Surgery | | 2 | (2) | | 28 | (28) | | | | | | | | | | | | | | | | | | | | | |
| Respiratory Medicine | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Rheumatology | | | | | | | 1 | 1 | | 30 | 33 | (3) | | | | | | | | | | | | | 1 | 1 | |
| Trauma and Orthopaedics | | | | | | | 3 | 8 | (5) | 35 | 39 | (4) | | | | | | | | | | | | | 3 | 8 | (5) |
| Urology | | | | | | | 3 | | 3 | 29 | | 29 | | | | | | | | | | | | | 3 | | 3 |
| **Total** | **46** | **17** | **29** | | | | **32** | **35** | **(3)** | | | | | | | | | | | | | | | | **78** | **48** | **30** |
| *Patients Waiting Over 36 Weeks* | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Anaesthetics | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Cardiology | 8 | 12 | (4) | 80 | 105 | (25) | | 1 | (1) | | 37 | (37) | | | | | | | | | | | | | 8 | 13 | (5) |
| ENT | 2 | 4 | (2) | 57 | 73 | (16) | | | | | | | | | | | | | | | | | | | 2 | 4 | (2) |
| General Surgery | 11 | 14 | (3) | 105 | 105 | | | 1 | (1) | | 48 | (48) | | | | | | | | | | | | | 11 | 15 | (4) |
| Gynaecology | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Neurosurgery | | | | | | | | 2 | (2) | | 49 | (49) | | | | | | | | | | | | | | 2 | (2) |
| Ophthalmology | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Oral Surgery | 29 | 31 | (2) | 105 | 105 | | | | | | | | | | | | | | | | | | | | 29 | 31 | (2) |
| Plastic Surgery | 16 | 20 | (4) | 61 | 65 | (4) | | | | | | | | | | | | | | | | | | | 16 | 20 | (4) |
| Rheumatology | | | | | | | | | | | | | | | | | | | | 1 | (1) | | 45 | (45) | | 1 | (1) |
| Trauma and Orthopaedics | 112 | 117 | (5) | 105 | 105 | | 17 | 22 | (5) | 73 | 69 | 4 | 1 | 1 | | 45 | 41 | 4 | 2 | 3 | (1) | 52 | 52 | | 132 | 143 | (11) |
| Urology | | | | | | | | 2 | (2) | | 41 | (41) | | | | | | | | | | | | | | 2 | (2) |
| **Total** | **178** | **198** | **(20)** | | | | **17** | **28** | **(11)** | | | | **1** | **1** | | | | | **2** | **4** | **(2)** | | | | **198** | **231** | **(33)** |

## Our Staff & Resources – Information Governance

**Lead Committee: BPPAC** | **Executive Lead: Karen Miles** | **Senior Responsible Officer: Anthony Tracey**

| Metrics (targets): | Status as at March 19 | Performance the past 12 months |
|---|---|---|
| • Number of National Intelligent Integrated Audit Solution (NIIAS) notifications for Own Record (target = 8) | ● | Declining |
| • Number of National Intelligent Integrated Audit Solution (NIIAS) notifications for Family Record (target = 13) | ● | Improving |

### Latest data




### Where are we against target?

The NIIAS reporting tool has been active across the Health Board since January 2016 and monitoring of staff access to systems has taken place since this date. The Information Governance (IG) Team are now actively enforcing access to own record since March 1st 2017 and actively enforcing access to family record since March 1st 2018, which is reflected within the graph above.

**Own Record -** Inappropriate access to own records has shown an overall increase of 17% over the rolling 12 months, however the average number of data breaches has risen since the last reporting period to 12 breaches within the month, and is above the agreed target of 8 per month.

**Family Record -** The number of inappropriate accesses by staff to family records has shown a 36% reduction over a rolling 12 month period. Notwithstanding this reduction the Health Board is still seeing an average of 16 breaches over the reporting period.

### Why has this situation occurred?

Accessing your own or family health record is contrary to the Data Protection Act 2018 and Health Board policy. This is because, before sharing any health information with an individual, the Health Board has a legal duty to determine in liaison with a relevant clinician whether access to the information will cause damage or distress to you or any other individual. By accessing your own record without going through the formal Health Board process for access to medical records, staff are preventing the Health Board from fulfilling this legal duty.

### What are the challenges?

The challenge is to ensure that all staff comply with the requirements of not viewing the medical record inappropriately.

### What is being done?

- Regular communications to staff through global e-mails, newsletters, posters, road shows, drop in events to promote the appropriate access to patient records;
- A number of confidentiality breaches have been used to further highlight the importance of appropriate access to patient records by staff (including their own record) through media, global e-mail and messages from the Senior Information Risk Owner (SIRO);
- During the period 12 NIIAS training awareness sessions have been held across Health Board sites and key messages re-iterated to staff, including the escalation process if any further breaches are reported against a staff member.

### When can we expect improvement and by how much?

A new communications plan has been agreed, and was completed during February 2019, it featured a screensaver and targeted communications to those areas which have been identified as requiring further work.

### How does this impact on both patients and finances?

The impact on patients is a reduced confidence that the Health Board is effectively looking after their records, and ensuring staff are not accessing them inappropriately. As the access of a health record is seen as a

significant data breach, and it is reportable to the Information Commissioners Office. Under the new General Data Protection Regulations (GDPR) there is a possibility of significant penalties. Smaller offences could result in fines of up to €10 million or two per cent of our turnover (whichever is greater). Those with more serious consequences can have fines of up to €20 million or four per cent of the Health Boards global turnover (whichever is greater).

## Our Staff & Resources – Estates

**Lead Committee: BPPAC** | **Executive Lead: Joe Teape** | **Senior Responsible Officer: Robert Elliott**

| **Metrics (targets):** | **Status as at Mar 2019** | **Performance the past 12 months** |
|---|---|---|
| • % completed Planned Preventative Maintenance (PPM) - high risk (target >95%) | ● | Declining |
| • % completed Planned Preventative Maintenance (PPM) - general (target >70%) | ● | Declining |

### Latest data

| | Jan 2019 | Feb 2019 | Mar 2019 |
|---|---|---|---|
| **PPM - high risk (target >95%)** | | | |
| Generated | 799 | 958 | 857 |
| Completed | 720 | 784 | 751 |
| % completed | 90% | 82% | 88% |
| **PPM – general (target >70%)** | | | |
| Generated | 750 | 836 | 676 |
| Completed | 421 | 406 | 396 |
| % completed | 56% | 49% | 59% |

### Where are we against target?

The target for High Risk PPMs was uplifted from 75% to 95% from April 2018, this was done to ensure that the available resources were being targeted appropriately. Work is ongoing to achieve compliance with this higher target and the table above shows performance over the last three months of 2018/19 (based on the 2017/18 High Risk PPM Target the 2018/19 RAG scores above would all have been Green).

The compliance achieved this year for both High Risk and General Risk PPMs continues to be an improvement on the 2017/18 scores.

The revised target is a significant 'step up' and is being very closely monitored. High Risk PPMs have been agreed with all the Ops Teams as the key focus and will continue to be prioritised above General Risk PPMs and Low Risk Breakdowns.

### Why has this situation occurred?

See the Month 10 IPAR for details, link included below.

### What are the challenges?

See the Month 10 IPAR for details, link included below.

### What is being done?

See the Month 10 IPAR for details, link included below.

### When can we expect improvement and by how much?

See the Month 10 IPAR for details, link included below.

### How does this impact on both patients and finances?

The impact on patients and finances remains the same and can be viewed in more detail in the Month 10 IPAR (see pages 98-99).

## Our Staff & Resources – Facilities Standards of Cleanliness (C4C)

**Lead Committee: BPPAC** | **Executive Lead: Joe Teape** | **Senior Responsible Officer: Robert Elliott**

| **Metrics (targets):** | **Status as at Mar 19** | **Performance the past 8 months** |
|---|---|---|
| • % (VHR) Very High Risk Audits – Soft FM (target >98%) | 🟡 | Declining |
| • % (VHR) Very High Risk Audits – Hard FM (target >98%) | 🔴 | Declining |
| • % (HR) High Risk Audits – Soft FM (target >95%) | 🟡 | Improving |
| • % (VHR) Very High Risk Audits – Hard FM (target >98%) | 🔴 | Improving |

### Latest data

| | Jan 2019 | | Feb 2019 | | March 2019 | |
|---|---|---|---|---|---|---|
| **VHR C4C Audits (target >98%)** | | | | | | |
| | **Soft FM** | **Hard FM** | **Soft FM** | **Hard FM** | **Soft FM** | **Hard FM** |
| **Audits Completed** | 39 | 39 | 37 | 37 | 38 | 38 |
| **Audit Score> Target** | 11 | 0 | 13 | 1 | 11 | 1 |
| **Average %** | **95.9%** | **68.2%** | **96.0%** | **68.8%** | **94.82%** | **68.6%** |
| **HR C4C Audits (target >95%)** | | | | | | |
| | **Soft FM** | **Hard FM** | **Soft FM** | **Hard FM** | **Soft FM** | **Hard FM** |
| **Audits Completed** | 84 | 84 | 81 | 81 | 74 | 74 |
| **Audit Score> Target** | 30 | 3 | 24 | 3 | 30 | 3 |
| **Average %** | **92.5%** | **62.5%** | **92.5%** | **62.5%** | **93.9%** | **61.4%** |

### Where are we against target?

The target for VHR and HR C4C audits to be completed was set at 100% from August 2018. This was done to ensure that the audits were being undertaken and data available to identify problem areas in good time for funding to be secured to address the issues identified, which would improve the patient environment and increase audit scores. VHR and HR audits are reported monthly and reviewed at the FM Operational Performance Meetings.

### Why has this situation occurred?

See the Month 10 IPAR for details, link included below.

### What are the challenges?

See the Month 10 IPAR for details, link included below.

### What is being done?

See the Month 10 IPAR for details, link included below.

### When can we expect improvement and by how much?

See the Month 10 IPAR for details, link included below.

### How does this impact on both patients and finances?

The impact on patients and finances remains the same and can be viewed in more detail in the Month 10 IPAR (see pages 100-101).

# Our Staff & Resources – Clinical Engineering

**Lead Committee: BPPAC** **Executive Lead: Joe Teape** **Senior Responsible Officer: Chris Hopkins**

| Metrics (targets): | Status as at Mar 19 | Performance the past 6 months |
|---|---|---|
| • Acute % completed HIGH Planned Preventative Maintenance (PPM) – All (target >100%) | 🔴 | Declining |
| • Acute % completed MEDIUM Planned Preventative Maintenance (PPM) – All (target >75%) | 🔴 | Declining |
| • Acute % completed LOW Planned Preventative Maintenance (PPM) – All (target >40%) | 🟡 | Declining |
| • Community (Com) % completed HIGH Planned Preventative Maintenance (PPM) – All (target >100%) | 🟢 | Improving |
| • Community (Com) % completed MEDIUM Planned Preventative Maintenance (PPM) – All (target >75%) | 🔴 | Improving |
| • Community (Com) % completed LOW Planned Preventative Maintenance (PPM) – All (target >40%) | 🔴 | Declining |

## Latest data

| | Jan-19 | Feb-19 | Mar-19 |
|---|---|---|---|
| **Overall compliance of medical devices - Acute** | 5% | 8% | 12% |
| **Overall compliance of medical devices - Community** | 4% | 6% | 8% |
| **High PPM acute compliance - HDUHB** | 100% | 100% | 99% |
| BGH | 100% | 100% | 100% |
| GGH | 100% | 100% | 95% |
| PPH | 100% | 100% | 100% |
| WGH | 100% | 100% | 100% |
| **Medium PPM acute compliance - HDUHB** | 68% | 61% | 55% |
| BGH | 74% | 72% | 69% |
| GGH | 68% | 57% | 35% |
| PPH | 71% | 60% | 77% |
| WGH | 60% | 56% | 38% |
| **Low PPM acute compliance - HDUHB** | 69% | 36% | 64% |
| BGH | 25% | 69% | 58% |
| GGH | 39% | 29% | 33% |
| PPH | 38% | 0% | 100% |
| WGH | 100% | 45% | 64% |
| **High PPM Community compliance - HDUHB** | 100% | 100% | 100% |
| BGH | 100% | 100% | 100% |
| GGH | 100% | 100% | 100% |
| PPH | 100% | 100% | 100% |
| WGH | 100% | 100% | 100% |
| **Medium PPM Community compliance - HDUHB** | 88% | 53% | 86% |
| BGH | 65% | 71% | 65% |
| GGH | 100% | 0% | 100% |
| PPH | 89% | 100% | 94% |
| WGH | 100% | 40% | 86% |
| **Low PPM Community compliance - HDUHB** | 75% | 69% | 51% |
| BGH | 75% | 50% | 81% |
| GGH | 100% | 100% | 100% |
| PPH | 100% | 92% | 20% |
| WGH | 26% | 33% | 4% |
| **75% Repair 48hr Response - HDUHB** | 99% | 99% | 99% |
| **85% Rolling 30 Day (Turnaround) Repair - HDUHB** | 90% | 90% | 90% |

## Where are we against target?

Target Jobs are completed within the expected month. All risk profiles were previously embedded under one Key Performance Indicator (KPI) and hence it was expected the achievement would be somewhat less due to all devices (whether high, medium or low) being included. The target for all Clinical Engineering Planned Preventative Maintenances (PPMs) was set at 60% for September 2018 (See M6 IPAR p.92). This was undertaken to ensure that the available resources were being targeted appropriately. Work is ongoing to achieve compliance with the higher targets and the table above shows the improvement made over the last five months of 2018/19. Improvement is due to the 7,000 additional inventory items being added within current resources.

Further targets have now been considered and introduced for high, medium and low risk devices and these have been implemented during October and November 2018. These devices have specific targets against them to take account of the priority presented to the organisation. High risks devices now have a higher priority target. Detailed site specific performance data will be presented in April 2019, which will provide more detail on activity..

## Why has this situation occurred?

A report submitted to the February 2018 session of the Quality, Safety and Experience Assurance Committee (QSEAC) highlighted the shortcomings and risks associated with the management, maintenance, and use of medical devices across the Health Board. The Committee was presented with a list of recommendations to address the issues raised. Decline in March performance was due to annual leave and ongoing Real Asset Management (RAM) improvement work, which resulted in additional inventory items added to the PPM schedules.

## What are the challenges?

- The focus placed on establishing a reliable inventory has resulted in a significant amount of ongoing work, removing, validating, standardising and cleansing the existing schedules together with adding any items found in service and not presently included in the inventory;
- Administrative support for the service is currently being addressed as part of the Organisational Change Process (OCP). This has raised some particular challenges due to the complex Facilities administrative structure;
- An update on organisational change leading to a modified structure is currently being implemented;
- Additional devices have been added to the PPM schedules, totalling over eight thousand devices. This has placed further pressure on the PPM requirements;
- The expected rate of completion for community equipment is lower than acute based devices due to the unknown locations of items. The service is presently reliant on community teams returning equipment for repair and service. In mitigation of this situation, however, the majority of equipment used in community settings is at the lower end of the risk scale i.e. there are no ventilators, anaesthetic machines or similar used in these settings and any higher end risk items have already been identified and scheduled for inspection;
- An ongoing need to address the risks posed by the absence of ultrasound governance within its scheme of delegation. Ultrasound governance group is established, Quality Assurance (QA) and PPMs sorted but ongoing risks are present with building the picture around user training etc.

## What is being done?

- Review the entirety of medical device resources at its disposal and make necessary adjustments such that there is available, a single medical devices management function providing a holistic approach to managing the risk. Strengthen its governance around decisions to depart from manufacturers' maintenance and operational use recommendations and report accordingly through the provisions made under the scheme of delegation;
- Responsibility for the management of medical devices transferred on 1st April 2018 from the Assistant Director of Facilities to the Deputy Director of Operations;
- Plans to redesign the Clinical Engineering service and create new roles to fill key gaps in service are nearing completion. All job descriptions have been prepared and evaluated and the proposed structure has met the affordability test. What remains is for the OCP to be operationalised which will take place within the new financial year 19/20;
- All historic vacant posts have now been filled. Funding for two WTE band 4 administrative posts have been transferred to the Central Operations Team as part of the transfer. The OCP will help shape the service for the next chapter;
- A report on medical devices held on the Estates inventory has been provided and the accountability for these devices was transferred to the Clinical Engineering inventory on 21st January 2019 to ensure that all devices are subject to final oversight by the Clinical Engineering team to ensure consistency in the monitoring and standards of maintenance and inspection. The means by which maintenance is delivered may vary according to the type of device, but all devices will have systems in place to ensure the correct level and source of oversight;
- The control group receives monthly reports setting out the latest performance position relating to the level of planned preventative maintenance completed. These reports continue to be scrutinised and subsequently revised to ensure they provide clear and definitive assurance. These revisions will continue until the Control Group is satisfied they are fit for purpose;
- Draft medical device procedures have recently been agreed at a Control Group meeting and agreed and ratified by the Medical Devices Governance. Assurance Group (MDGAG). These procedures are now being progressed through the relevant governance channels. A new Governance structure is being implemented with a new operational Medical Device Management Group now reporting into MDGAG and Operational QSEAC.

## When can we expect improvement and by how much?

It is anticipated that the progress already made will continue and further improvements in compliance will be evident by September 2019 as the impact of the new database software becomes evident. All jobs not completed in the month issued will be closely controlled via this new database system to ensure that jobs carried forward into future months are closely monitored or closed as required by a well-governed system.

## How does this impact on both patients and finances?

Effective maintenance performance links directly to the patient experience and supports effective clinical performance.

# Our Staff & Resources – Facilities: Fire Safety

**Lead Committee: BPPAC** | **Executive Lead: Joe Teape** | **Senior Responsible Officer: Robert Elliott**

**Metrics (targets):** | **Status as at Mar 19** | **Performance the past 6 months**

- Number of overdue fire risk assessments by Hywel Dda University Health Board | ● | Improving

## Latest data

### Overdue Fire Risk Assessments (FRA)

FRA Quantity

| Nov. 2018 | Dec. 2018 | Jan.2019 | Feb. 2019 | Mar. 2019 |
|---|---|---|---|---|
| 98 | 111 | 113 | 110 | 83 |

## Where are we against target?

Fire risk assessments (FRAs) are a fundamental requirement of the Regulatory Reform (Fire Safety) Order; Article 9 of which requires that fire risk assessments must be 'suitable and sufficient' as well as being maintained up-to-date by the organisation. The Health Board (HB) therefore has a legal obligation to ensure that it maintains all FRA's up to date.

FRA areas are typically defined by departmental boundaries; accordingly, the HB estate is divided into approximately 400 assessment areas. Each of these assessments need to be periodically reviewed and maintained up-to-date. The review frequencies should be determined by the risk assessor based on the circumstances encountered in each area.

Maintaining up-to-date FRAs for the HB is cyclical work which averages 25 risk assessments reviewed every month although this can vary depending on the number of risk assessments that become due for review. There are many factors that will influence the time needed to conduct and submit a 'suitable and sufficient' fire risk assessment. However, a conservative estimate would be in the region of one assessment per day. Maintaining up-to-date FRAs is not achievable within the current Fire Safety Management resources. A revised calculation taken on the 31st of January 2019 now shows that the number of overdue FRA's has increased to 113. This figure has reduced to 83 (31st March figures). Further calculation updates will be provided periodically.

## Why has this situation occurred?

It has been fully acknowledged and documented by Capital Audits and a further wider Fire Safety Review undertaken by NWSSP-SES that the scale of work required to continually maintain the up-to-date FRAs for the HB is not achievable with the current resource numbers within the Fire Safety Team.

This resulted in a full resource review undertaken by the compliance function. It also instigated a review of the fire safety function in terms of a resource plan which is detailed below.

## What are the challenges?

Currently the HB employs 2 WTE Fire Safety Advisors who undertake FRAs, across the HB. In addition to this work, there are a wide range of other activities within their roles including Fire Training (supporting Mandatory Training targets), Induction Training and supporting Investment Projects across the HB i.e. GGH WCS Phase 2, Cardigan etc. which are consuming significant resources. The geographical configuration of the HB has also put additional pressures on the current Fire Safety Team in their endeavour to provide effective arrangements for fire safety management.

## What is being done?

- A resource GAP analysis paper was submitted in August 2018 to the Executive Team outlining the resources required to ensure compliance with the Regulatory Reform (Fire Safety) Order 2005;
- This resource plan was also supported by the Fire Management Review undertaken by NWSSP-SES. The HB has now appointed a dedicated HB wide Head of Fire Safety, who took up appointment on the 28th of January 2018. A further 2 Fire Safety Advisors started in March 2019. This will mean that each Acute site will have a dedicated Fire Safety Advisor, immediately addressing the geographical issues noted as a challenge above;
- The additional Fire Advisor for PPH has been appointed (April) and the Fire Advisor position at WGH was appointed in March with a start date of April 15th 2019;
- The Resource Plan, once fully embedded, will provide the appropriate levels of assurance that are clearly required in respect of fire safety for the HB. This structure also allows for flexibility where Fire Advisors can assist in other HB areas where the need exists;
- Fire Advisors have been instructed to concentrate on the higher risk areas and additional monitoring has been introduced to ensure that the proposed timeline is on track for achievement.

**When can we expect improvement and by how much?**

In the interim the HB needs to manage the FRA shortfall and it has been agreed to redirect in-house resources to target the high risk areas. In addition, the HB also engaged consultants, who will support the HB to address some of the shortfall of overdue risk assessments across a range of areas. This approach was expected to have all high risk FRAs up-to-date by May 2019. However, the Head of Fire Safety reviewed the proposed timescales and determined that the May 2019 for having all fire risk assessments up to date was most likely not achievable.

This review identified additional risk assessment that would be added to the workload automatically by the online Shared Services risk assessment module. A new timeline was put forward to the Health and Safety Emergency Planning Sub-Committee on the 6th March 2019.

This outlined that a concentrated effort would be made to reduce the backlog in terms of higher risk areas by the end of May 2019 and a significantly improved situation overall would be evident by the end of August 2019.

The expanded Fire Safety Team structure has been designed to ensure the ongoing FRAs will be completed within the appropriate timescales.

The plan noted above has been designed in order to achieve compliance with up-to-date FRAs for the HB by the end of August 2019. This is a considerable task for the fire safety team, who are closely monitoring the progress on this and will escalate any issues directly to the Health & Safety and Emergency Planning Sub Committee.

The Head of Fire Safety Management is closely monitoring this position with the fire safety team and is also looking at the review frequencies of all of the health boards FRA's.

The completion figures at 31st March 2019 has seen a decrease in the number of overdue risk assessments, down from 110 in February to 83 (latest position at 31st March 2019).

In terms of projections, with the Fire Advisor now in post at Prince Philip Hospital and the Fire Advisor at Withybush being in place mid-April, it is with some confidence that that the targets set will be met.

**How does this impact on both patients and finances?**

There is no impact on patients. From a financial perspective, the increase in staff costs for the additional posts has previously been accounted for and agreed by the HB.

## Additional Reports

Cardiac Transfer and Treat
Welsh Health Specialised Services Committee (WHSSC) Management Group Meeting

## Cardiac Treat and Transfer Service

National treatment guidelines recommend that patients with Non-ST elevation acute coronary syndrome (ACS) are managed with immediate medical therapy followed by early coronary angiography within 72 hours of hospital admission.

Until recently, patients in South West Wales with ACS who present to their district hospital were admitted for 'medical stabilisation'. Subsequently, they are transferred to Morriston Hospital Cardiac Centre for coronary angiography and/or Percutaneous Coronary Intervention (PCI) when they reach the top of the ACS transfer waiting list, unless they become unstable and need to be transferred sooner. This care model has inherent time delays and rarely achieved evidence based treatment targets. Furthermore, prolonged admission of patients with ACS in district hospitals whilst they await transfer to Morriston Hospital is a waste of valuable NHS bed resources.

During the winter months, the wait for transfer to Morriston Hospital increases significantly due to the challenge placed on bed capacity across the health system. For example at the end of January 2018, there were 40 patients waiting for Morriston Hospital in Hywel Dda beds.

In order to address this problem, the "Treat and Repatriate Service" for Acute Coronary Syndrome has operated as a pilot using 18/19 winter planning monies. As part of the 18/19 Winter Planning cycle, Abertawe Bro Morgannwg University Health Board (ABMUHB) allocated winter resources to support the provision of additional Cardiac Catheter 'hot list' for Acute Coronary Syndrome. Hywel Dda Health University Board (HDUHB) created six additional bed spaces at Prince Phillip Hospital (PPH), with the aim of improving the flow of Tertiary Cardiology patients across the Health Board.

Prior to the Treat and Transfer pilot, Morriston Hospital Cardiac Centre was failing to meet the target of treatment within 72 hours of admission to hospital for patients on the ACS pathway. The average waits were 10 days and some patients, particular in Withybush General Hospital (WGH) and Bronglais General Hospital (BGH), had longer waits sometime lasting weeks.

The Cardiology teams in both Health Boards collaborated to develop the pilot proposal for a Treat & Repatriate Service for ACS patients, which began on 7th January 2019.

**The Pilot Service**

Under the protocol for the pilot, this cohort of patients from all HDUHB sites requiring ACS intervention, were transferred from BGH and WGH and either placed in the "ACS Bay" at PPH or within Cardiology beds at GGH. Here, they received all the necessary work up prior to referral and transfer to Morriston Hospital. Daily Cardiac Catheter "hot list" capacity and trolley space in the Cardiac Short Stay Unit at Morriston Hospital was ring fenced to allow two HDUHB patients per day to come via dedicated transport, to undergo their treatment. Patients were then repatriated back to PPH or GGH within a matter of hours post treatment.

**Evaluation**

Between 7th January 2019 and 14th March 2019 (10 weeks), 82 patients were referred via this service. In addition, 23 low risk patients had their diagnostic cardiac procedures in PPH, which avoided the need for onward referral to Morriston. There have been extremely positive results:

- A reduction in the average wait between referral to angiography from 10 days to 4 days;
- Increased throughput of activity through the Morriston catheter laboratory with less reliance on ad-hoc hot lists;
- Equitable waits for patients from ABMUHB and HDUHB;
- Virtual elimination of the backlog, as stated above in winter 2018/19 there were up to 40 patients waiting for ABMUHB at any one time. It is now common to have no patients at all waiting in HDUHB.

# Welsh Health Specialised Services Committee (WHSSC) Management Group meeting

The information below is an update from 28th March 2019 Welsh Health Specialised Services Management Group meeting:

**Minutes of the Previous Meeting and Action Log**

The minutes of the meeting held on 21 February 2019 were approved and

- It was agreed that a paper would be brought to a future meeting with more information on testing for Lynch Syndrome;
- Members noted the action log and received updates on:
    - MG086 In Vitro Fertilisation (IVF): Royal Shrewsbury Hospital Referral to Treatment Time (RTT) Escalation – A further meeting was due the following week but it appeared that waiting times were being exaggerated because the 'waiting time' within the policy was being included inappropriately;
    - MG119 Provision of Tertiary Cardiology Services – the Welsh Health Specialised Services Team was working with health boards on these issues and a response was anticipated by the May meeting following a workshop.

**Mother and Baby Unit**

Members received a paper that presented (1) potential options proposed by Abertawe Bro Morgannwg University Health Board to provide a Mother and Baby Unit in south Wales and (2) access to Mother and Baby beds for the population of mid and north Wales. It was noted that the latest view of revenue costs was up to £1m greater than previously anticipated in the Integrated Care Priorities (ICP) dependent upon which option was selected for the south Wales Unit. The Welsh Health Specialised Services Team would be briefing Welsh Government (WG) on this potential shortfall and would advise members on how this would be funded. Members were broadly supportive of the options presented and agreed that (1) all three capital options for south Wales should be kept open if possible, (2) further clarification on staffing models and revenue costs should be sought from Abertawe Bro Morgannwg University Health Board, (3) an appropriate contracting framework needs to be developed and the Finance sub-group should consider risk sharing, and (4) the Welsh Health Specialist Services Team should update Welsh Government. An update would be given to the May meeting of the Joint Committee.

**Report from the Managing Director**

Members received the Managing Director's report. The report included updates on the Development of the Cardiff & Vale UHB Cystic Fibrosis service; and Development of the Gender service.

**Replacement Wheelchair Programme for the Posture and Mobility Service in South Wales**

Members received a paper that sought approval for the release of funding for the Cardiff and Vales UHB Wheelchair Replacement Scheme as included in the 201821 Integrated Commissioning Plan. Members (1) approved the release of funding for the replacement wheelchair programme in south Wales for 2019-20 part year effect and recurrent funding for 2020-21 to 2022-23, (2) noted the comparison replacement programme submitted for by the north Wales service for consideration of funding in the Welsh Health Specialised Services Integrated Care Priorities (ICP) 2019-22, and (3) noted the evidence that there is a more rigorous performance management process being established for the Posture and Mobility Wheelchair Service.

**Specialised Rehabilitation – Monitoring Arrangements for Driving Change**

Members received a paper that provided an update on how the implementation of monitoring arrangements is driving change in Specialised Rehabilitation services. As a consequence, the previously introduced charging mechanism is being withdrawn.

**South Wales Blood and Marrow Transplant Programme: Review of Investment**

Members received a paper that (1) outlined the investment made in the south Wales Bone Marrow Transplant programme between 2014-15 and 2016-17 and the purpose of this investment, (2) set out what has been achieved with the additional investment with regard to meeting patient need and delivering on quality standards to meet the service specification and the Joint Accreditation Committee ISCT-Europe & E (JACIE) Bone Marrow Transplant accreditation requirements, (3) described the clinical outcomes achieved by the south Wales Bone Marrow Transplant service, (4) noted current risks in the service and the plans to address these risks, and (5) noted future service developments. In addition, a presentation on the service was delivered by Dr Keith Wilson. Members noted (1) the investment made in the south Wales Bone Marrow Transplant programme, (2) the confirmation that the investment has been implemented, (3) the increase in capacity to meet patient need and the achievement of the quality standards in the service specification and Joint Accreditation Committee ISCT-Europe & E (JACIE) Bone Marrow Transplant

accreditation requirements, (4) the excellent clinical outcomes achieved by the service and published by the British Society for Bone Marrow Transplant, (5) the current risks and the plans to address these risks, and (6) the future service developments.

**Welsh Health Specialised Services Commissioning Policy CP58: Trans-catheter Aortic Valve Implantation for Severe Symptomatic Aortic Stenosis**

Members received a paper that sought approval for the implementation of Welsh Health Specialised Services Commissioning Policy CP58: Trans-catheter Aortic Valve Implantation (TAVI) for Severe Symptomatic Aortic Stenosis (SSAS). The Welsh Health Specialised Services Team provided assurance that it had been prudent and as rigorous as possible in assessing the net financial impact of adopting the policy. Members (1) noted the information set out in the paper, and (2) approved the implementation of Welsh Health Specialised Services Commissioning Policy for Trans-catheter Aortic Valve Implantation for severe symptomatic aortic stenosis.

**Collective Commissioning of Specialised Paediatric Radiology Services**

Members received a paper that sought approval for the collective commissioning approach to take for Specialised Paediatric Radiology Services. The paper set out three options. It was agreed that the Welsh Health Specialised Services Team would bring the paper back with greater clarity of purpose and more information on the sub-sets of different types of paediatric radiology.

**Developing a Pulmonary Hypertension Services for Wales**

Members received a paper that sought to clarify the scope of the Pulmonary Hypertension project and to include the gap analysis, addressing the concerns previously raised by members.
Members approved the revised project initiation document for the development of an options appraisal for the future commissioning strategy for pulmonary hypertension services across Wales.

**Risk Sharing Review**

Members received a report that (1) provided an update on the process and principles adopted for the approved rebased risk-sharing framework to be implemented from April 2019, and (2) informed members of cost neutral implementation in line with the 2019-20 ICP. Members noted the information presented in the report.

**Welsh Health Specialised Services Policy Group: Update**

Members received a paper on the work of the Welsh Health Specialised Services' Policy Group and noted the information presented within the report. It was noted that the Welsh Health Specialised Services Policy Process document had been circulated to members for consultation and that a request had been received to discuss it at a meeting. It was agreed to consider this request, after the consultation closes, with the consultation feedback.

**Integrated Performance Report**

Members received a paper that provided a summary of the performance of services commissioned by Welsh Health Specialised Services for January 2019 and noted the actions being undertaken to address areas of non-compliance.

**Finance Report 2018-19 Month 11**

Members received a report that set out the estimated financial position for Welsh Health Specialised Services for the eleventh month of 2018-19. The Welsh Health Specialised Services year to date position was a £4,100k underspend and the year-end forecast was a £5,054k underspend. All HRG4+ reserves provided in 2017-18 have been released in 2018-19 and non-payment of HRG4+ in 2018-19 has now been confirmed. Members noted the current financial position and forecast year-end position.

**Integrated Commissioning Plan 2019-22 (ICP)**

Members were advised that WG had confirmed receipt of the Integrated Commissioning Plan and that it was described as 'satisfactory'.

**Horizon Scanning of Advanced Therapy Medicinal Products (ATMPs)**

Members were informed that the Welsh Health Specialised Services Team had undertaken some horizon scanning of Advanced Therapy Medicinal Product (ATMPs) and modelled the financial impact. This would be discussed with the Chief Medical Officer and Chief Science Officer at Welsh Government the following week and the feedback shared with members.

**Major Trauma**

Members were informed that a paper on Major Trauma had been taken to Joint Committee and that the Programme Business case would come to the Finance sub-group in due course.

## Supporting data

Supplementary dashboards have been developed for the areas listed below. Currently some users are unable to access the dashboards due to an IT issue so a selection of charts from each dashboard have been made available here as an interim solution.

Unscheduled care

Referral to treatment

Cancer

Stroke

Diagnostics

Therapies

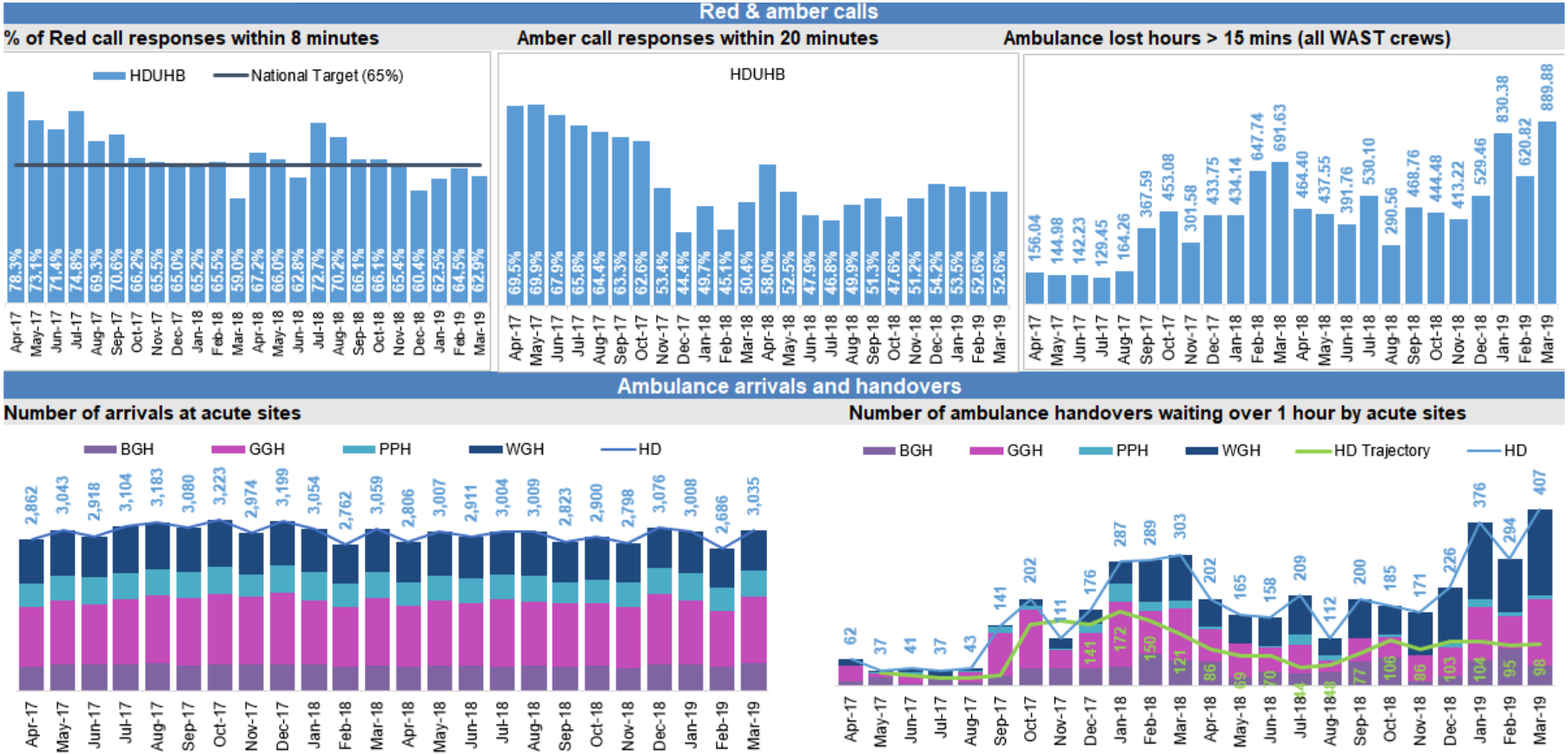
Mental Health

Primary Care

The dashboards can be accessed on the Hywel Dda University Health Board intranet site (NHS only) here.

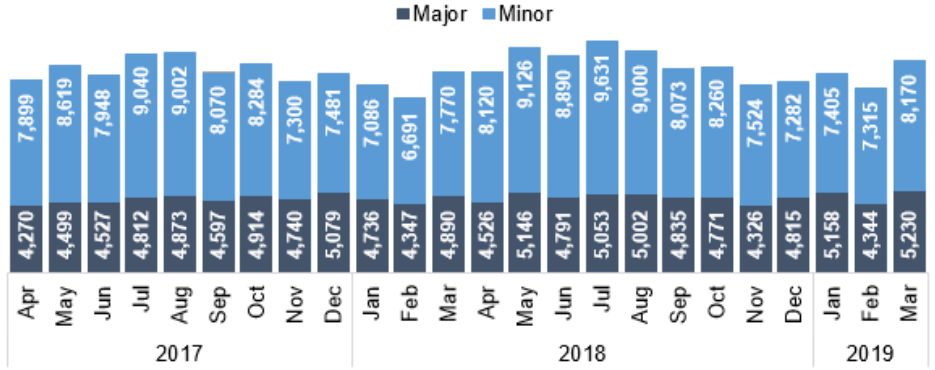
# Unscheduled care

The charts below show the Health Board's position. Charts are also available by acute site in the unscheduled care dashboard.



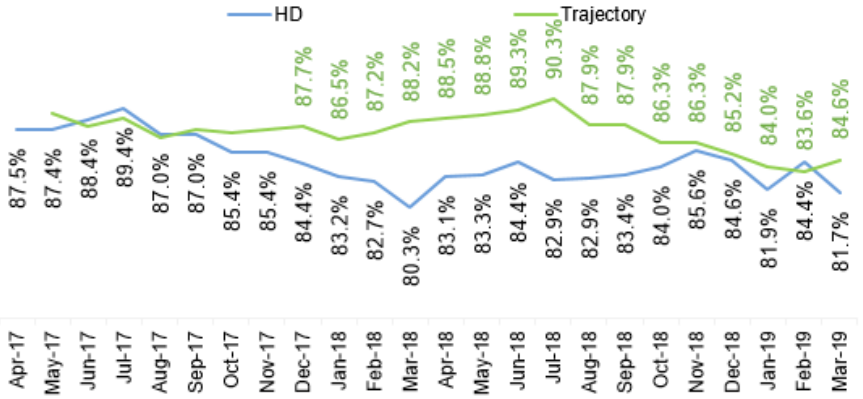
## Accident and emergency (A&E) and Minor injury unit (MIU) attendances

### A&E and MIU new attendances by type

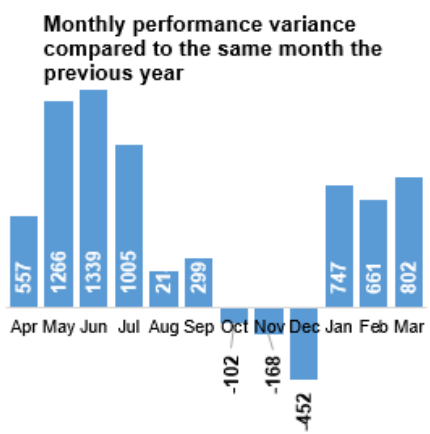


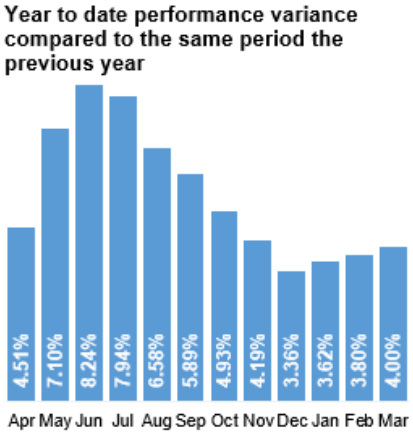

*Cardigan Hospital is not included*

### % new patients spending < 4 hours in A&E and MIU

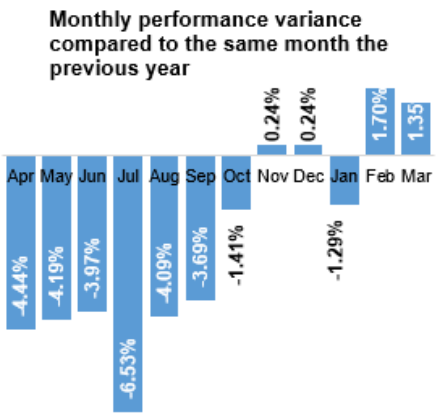


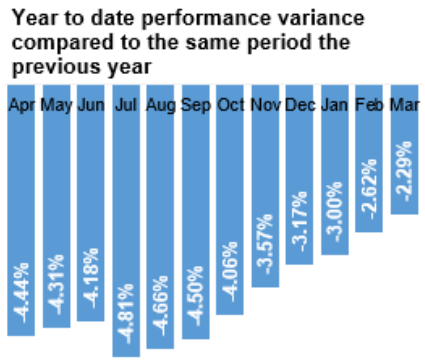

### A&E and MIU new attendance - 2 year comparison 18/19 to 17/18



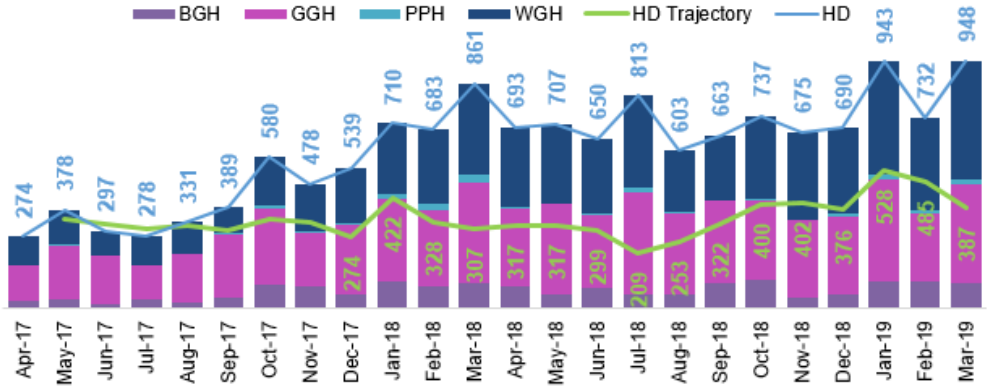




### % new patients spending < 4 hours in A&E/MIU - 2 year comparison 18/19 to 17/18

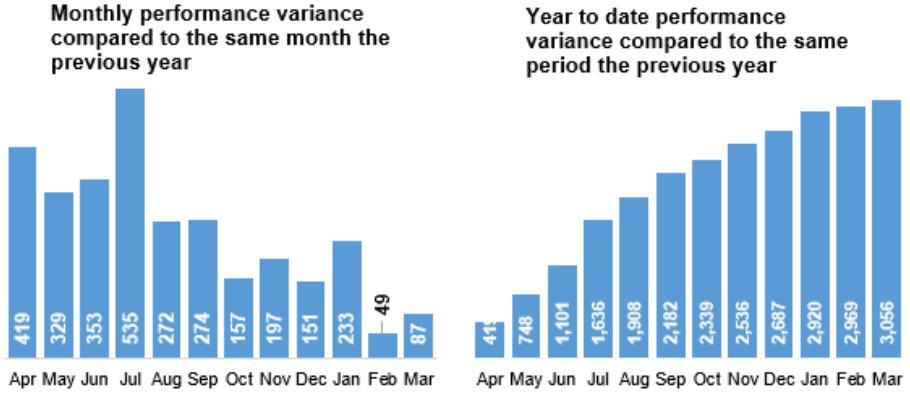


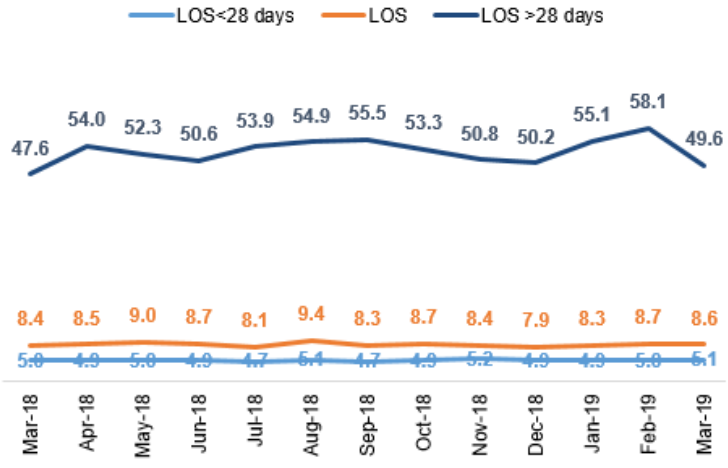
## Number of new patients spending > 12 hours in A&E and MIU by acute site



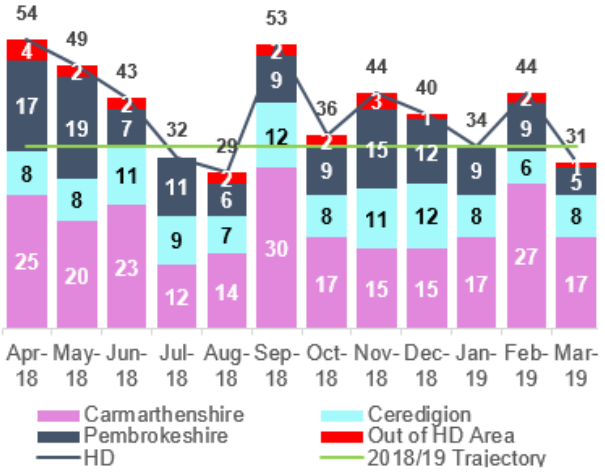

## New patients spending >12 hours in A&E/MIU - 2 year comparison 18/19 to 17/18



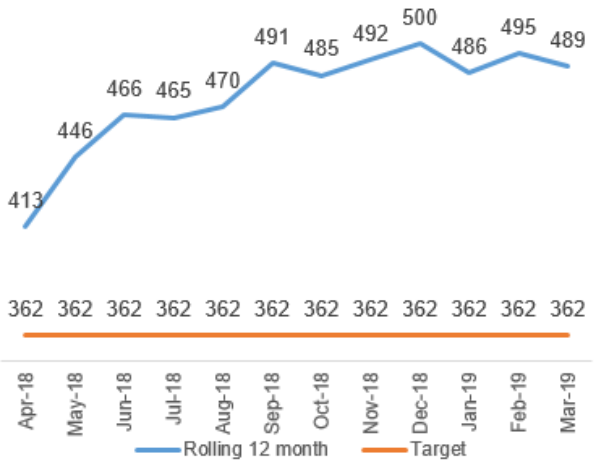

## Average length of stay (LOS) - medical emergency in patients including zero days



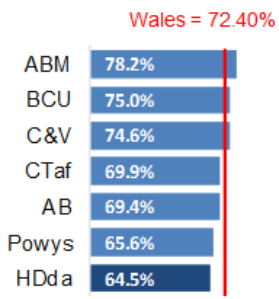

## Non mental health delayed transfer of care (DTOC) In month numbers

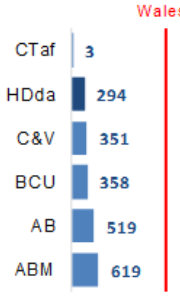


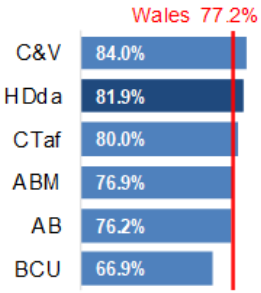

## Non mental health delayed transfer of care (DTOC) Rolling 12 month numbers to target

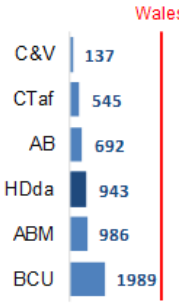


| Red calls | Ambulance handovers | Accident and emergency (A&E) and Minor injury unit (MIU) attendances | |
|---|---|---|---|
| % of Red call responses within 8 minutes (Feb-19) | Number of ambulance handovers waiting over 1 hour by Health Board (Feb-19) | % new patients spending less than 4 hours in A&E and MIU by Health Board (Jan-19) | Number of new patients spending more than 12 hours in A&E and MIU by Health Board (Jan-19) |



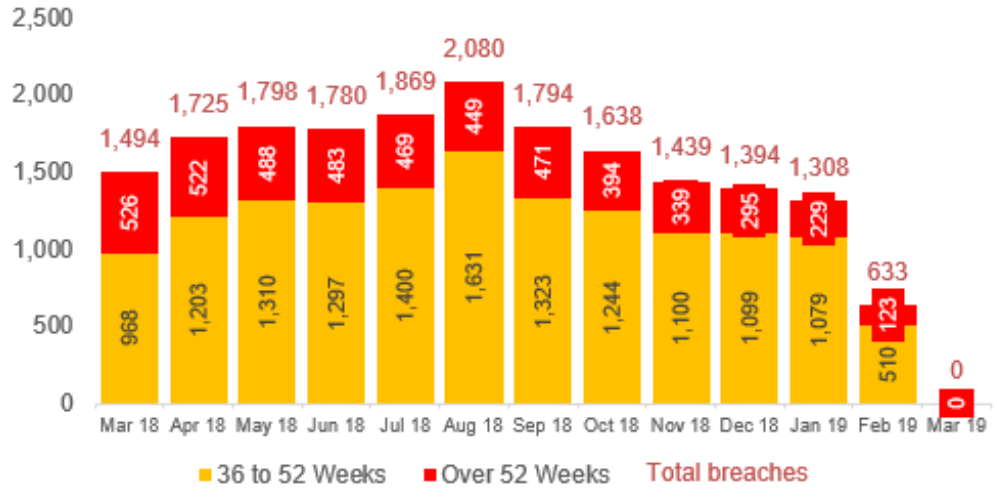



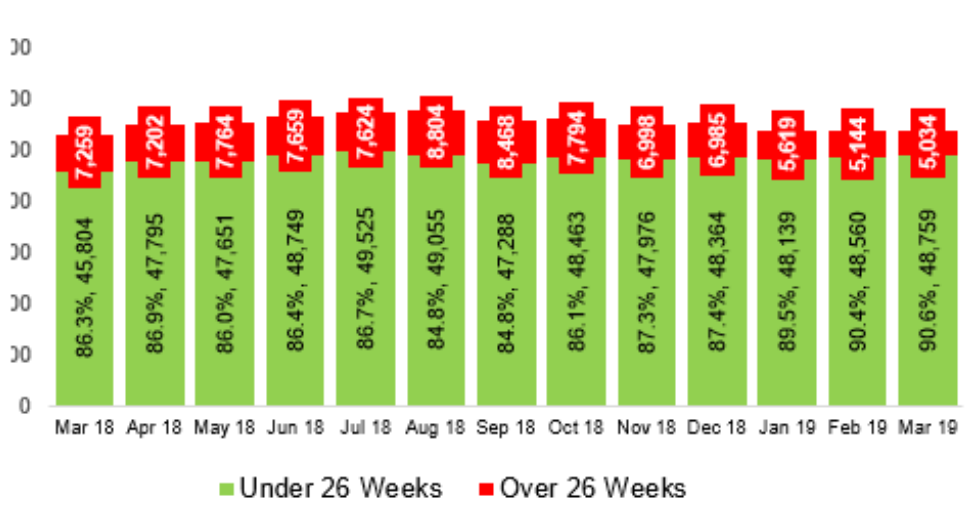



## Referral to treatment (RTT)

The charts below show the Health Board's position. In the RTT dashboard the 36 and 26 week charts below can be viewed by pathway stage and specialty.

**Graph Demonstrating: Specialty (All) & Pathway Stage - (All)**



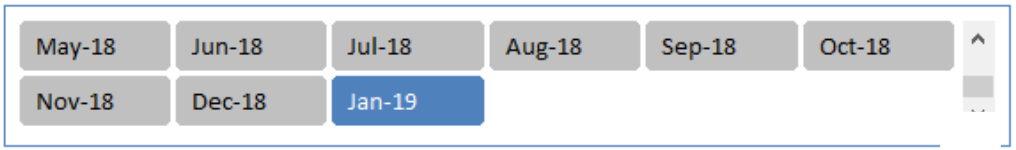
**Longest Weeks Wait for Pathway Stage (All):**

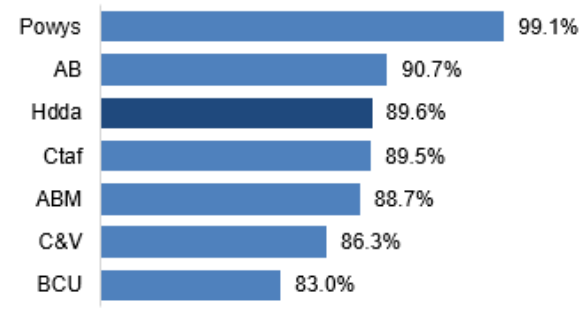
| Specialty | Longest Weeks Wait |
|---|---|
| Breast Surgery | 33 |
| Cardiology | 35 |
| Chemical Pathology | 24 |
| Clinical Haematology | 33 |
| Clinical Neuro-physiology | 32 |
| Colorectal Surgery | 35 |
| Dermatology | 35 |
| Diabetic Medicine | 33 |
| Endocrinology | 35 |
| ENT | 35 |
| Gastroenterology | 35 |
| General Medicine | 35 |
| General Surgery | 35 |
| Geriatric Medicine | 35 |
| Gynaecology | 35 |
| Nephrology | 33 |
| Neurology | 35 |
| Neurosurgery | 34 |
| Ophthalmology | 35 |
| Orthopaedics | 35 |
| Paediatrics | 35 |
| Pain | 35 |
| Rheumatology | 35 |
| Stroke Medicine | 28 |
| Thoracic/Respiratory | 35 |
| Unknown (998) | 7 |
| Urology | 35 |
| Vascular | 35 |
| **Grand Total** | 35 |

In the RTT dashboard the longest weeks wait chart above can also be viewed by pathway stage and month.

In the RTT dashboard the all Wales benchmarking charts below can also be viewed for previous months in the current financial year.

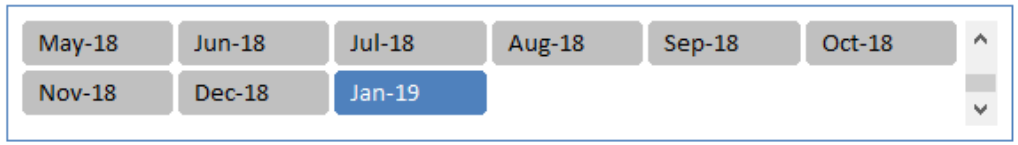
## % of Patients Referred for Treatment Within 26 Weeks (Target = 95%)

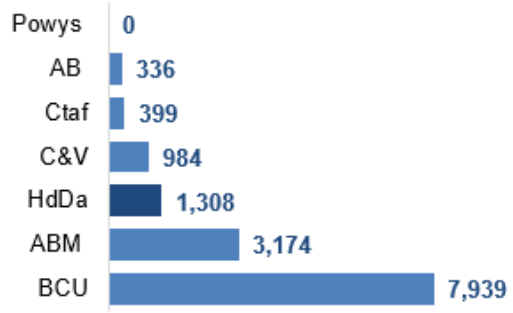




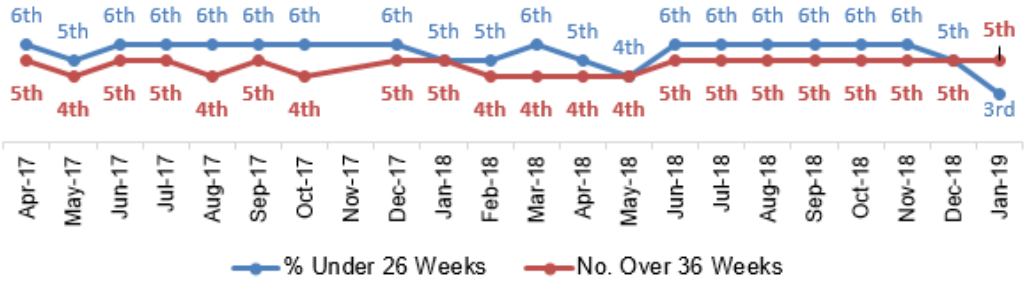
## Number of 36 Week Breaches (Target = 0)



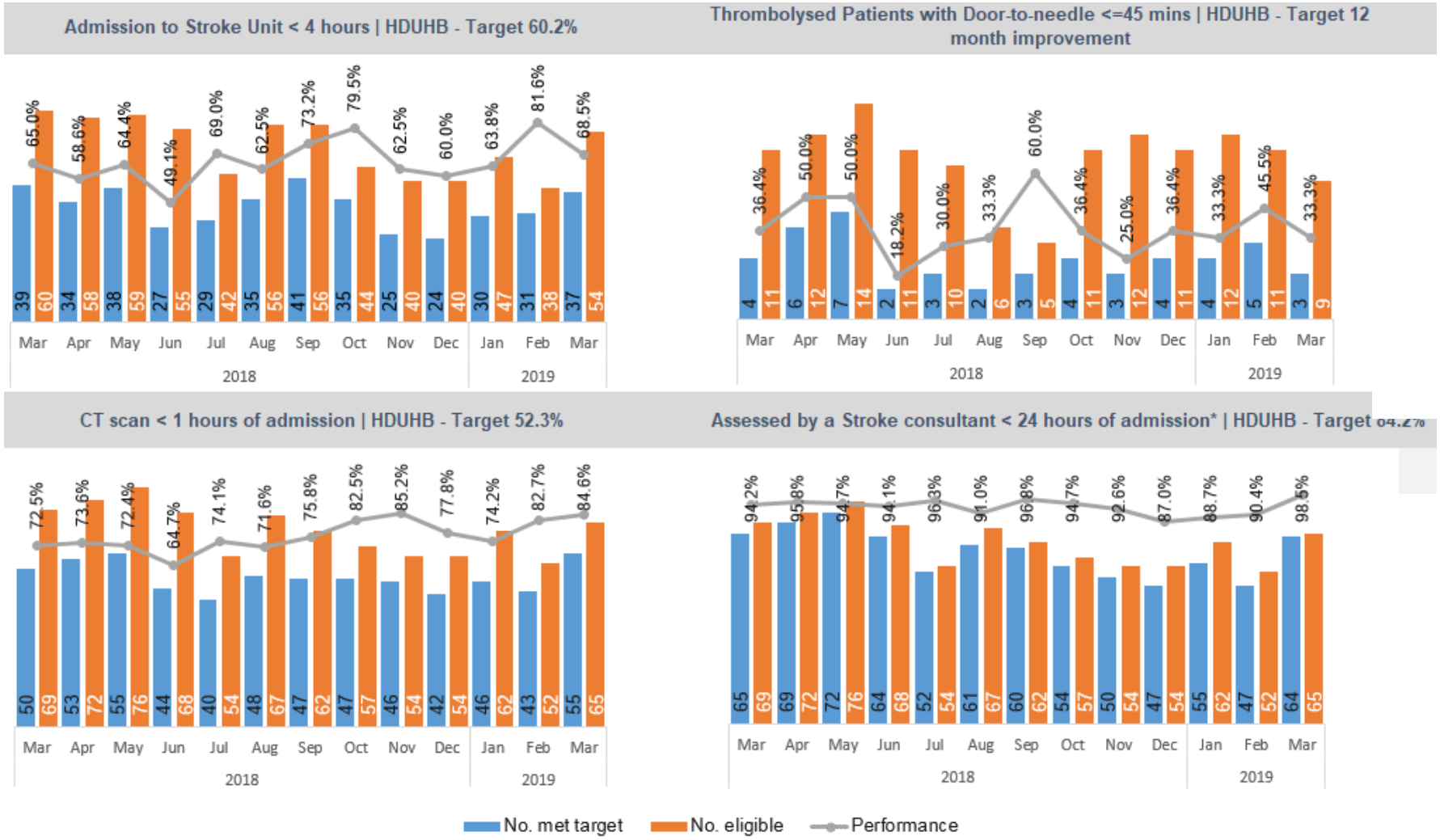


## All Wales Ranking (April to latest published data)

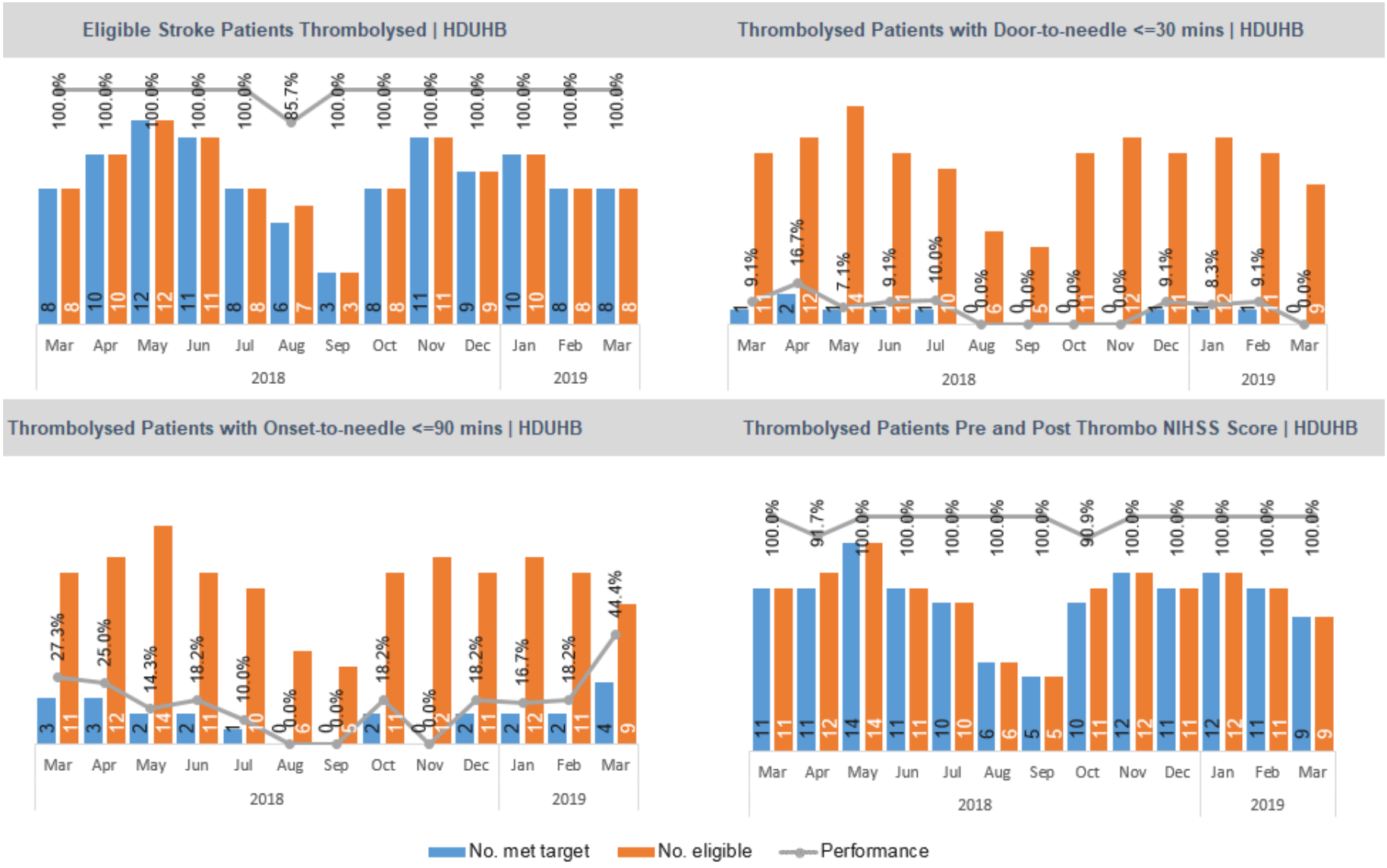


## Stroke

In the Stroke dashboard, the 4 Quality Measures below can be displayed by acute hospital site. Data for other stroke measures is also included.

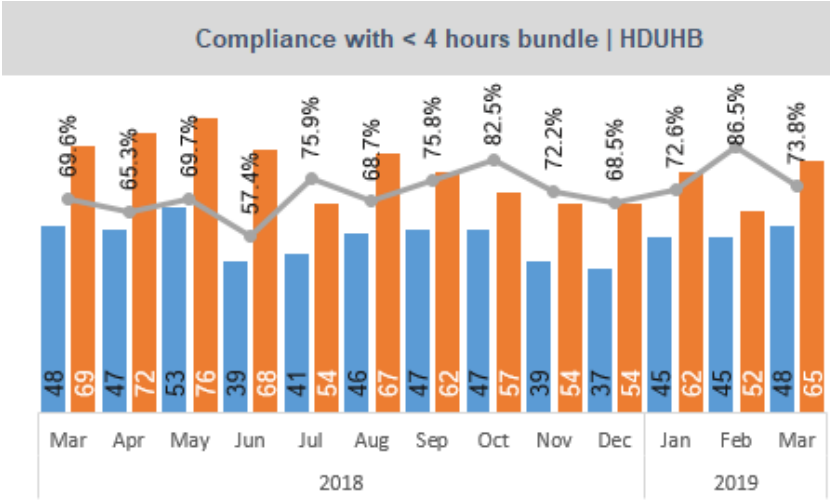


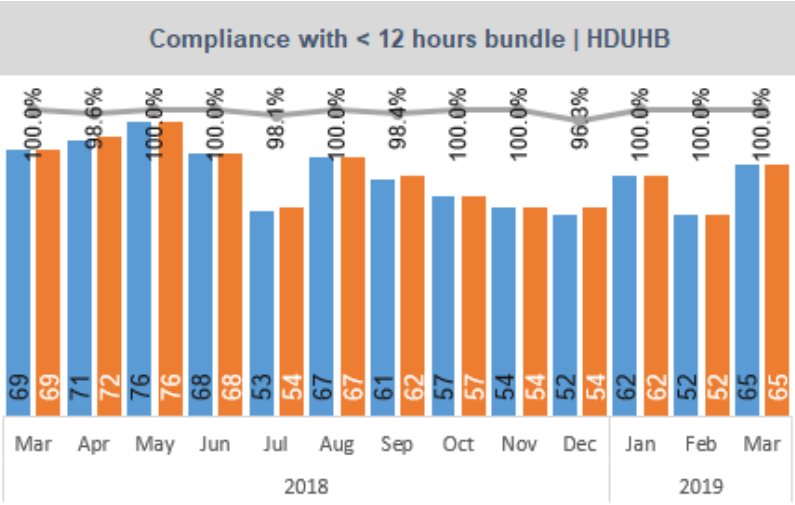

In the Stroke dashboard, the charts below can be displayed at the hospital site level.

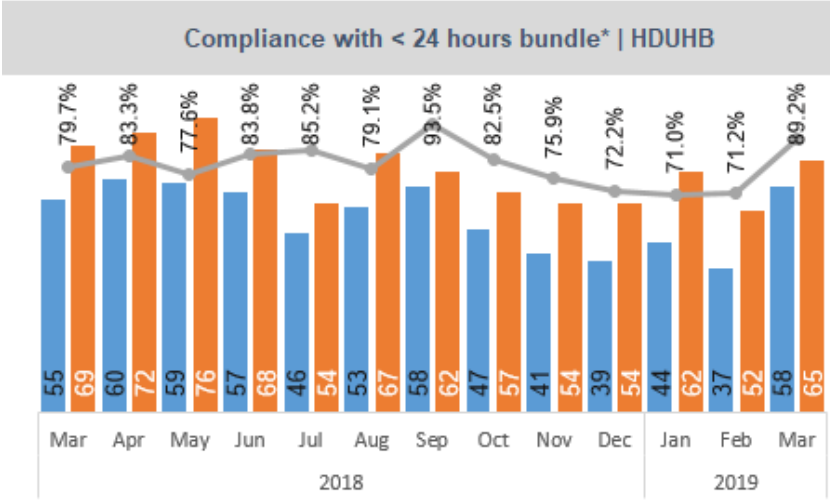


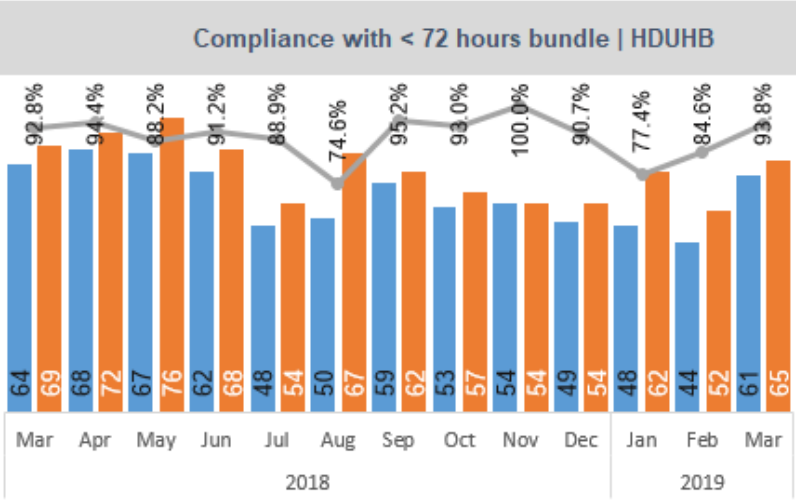

*Data source: Data extracted from NHS Wales Delivery Unit SSNAP (Sentinel Stroke National Audit Programme) Quality Improvement Measures Tool, published Feb 2019.*

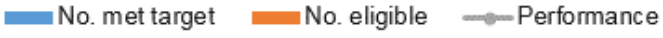
In the Stroke dashboard, the charts below can be displayed at the hospital site level.


Compliance with < 4 hours bundle | HDUHB
69.6%
65.3%
69.7%
57.4%
75.9%
68.7%
75.8%
82.5%
72.2%
68.5%
72.6%
86.5%
73.8%
48 69 47 72 53 76 39 68 41 54 46 67 47 62 47 57 39 54 37 54 45 62 45 52 48 65
Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2018
2019


Compliance with < 12 hours bundle | HDUHB
100.0%
98.6%
100.0%
100.0%
98.1%
100.0%
98.4%
100.0%
100.0%
96.3%
100.0%
100.0%
100.0%
69 69 71 72 76 76 68 68 53 54 67 67 61 62 57 57 54 54 52 54 62 62 52 52 65 65
Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2018
2019

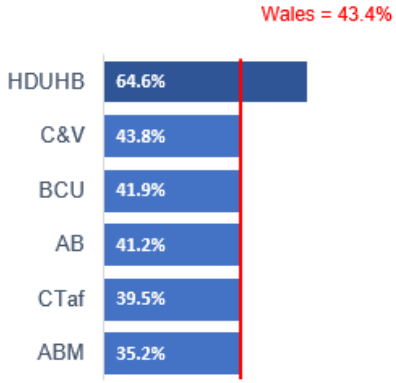

Compliance with < 24 hours bundle* | HDUHB
79.7%
83.3%
77.6%
83.8%
85.2%
79.1%
93.5%
82.5%
75.9%
72.2%
71.0%
71.2%
89.2%
55 69 60 72 59 76 57 68 46 54 53 67 58 62 47 57 41 54 39 54 44 62 37 52 58 65
Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2018
2019

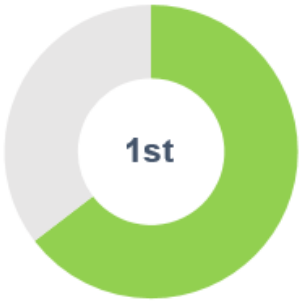

Compliance with < 72 hours bundle | HDUHB
92.8%
94.4%
88.2%
91.2%
88.9%
74.6%
95.2%
93.0%
100.0%
90.7%
77.4%
84.6%
93.8%
64 69 68 72 67 76 62 68 48 54 50 67 59 62 53 57 54 54 49 54 48 62 44 52 61 65
Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2018
2019

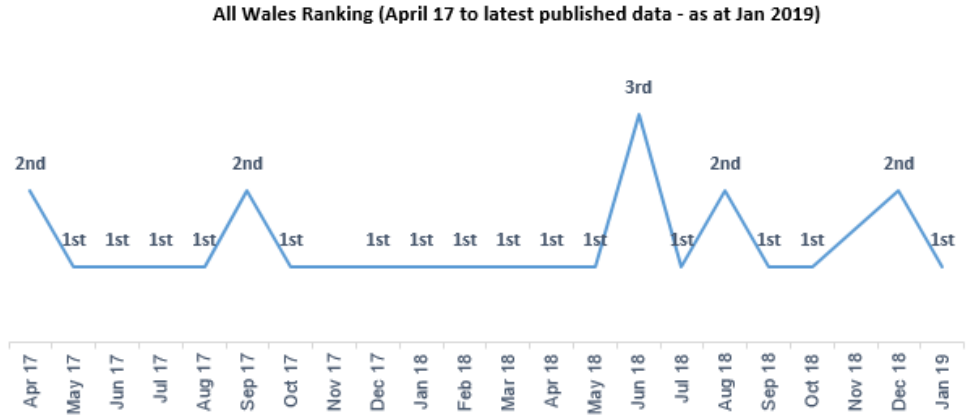

No. met target
No. eligible
Performance

In the Stroke dashboard, the all Wales benchmarking charts below can be also be displayed for previous months in the current financial year.

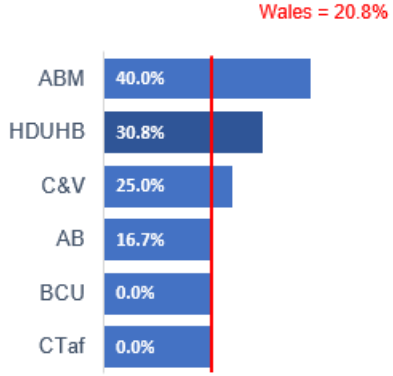
**Direct Admision to the Acute Stroke Unit < 4 hours (Target – 59.7%)**

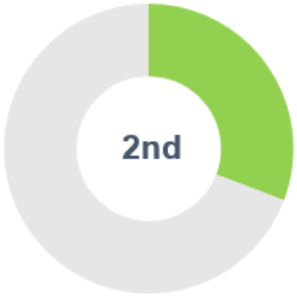


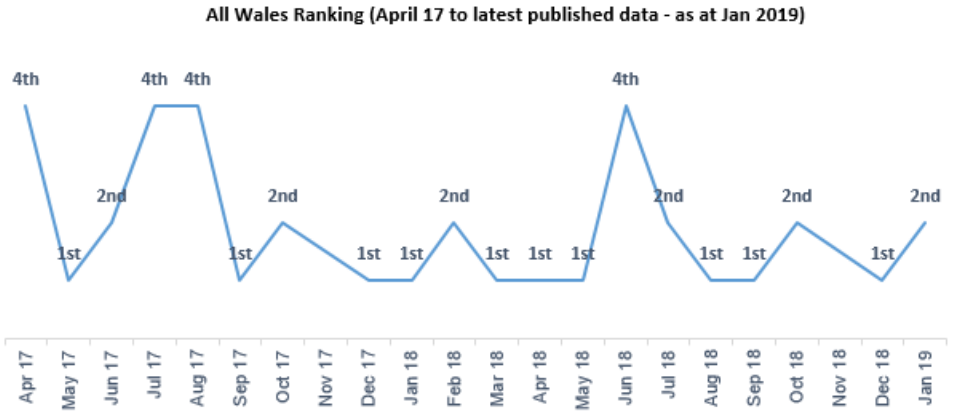



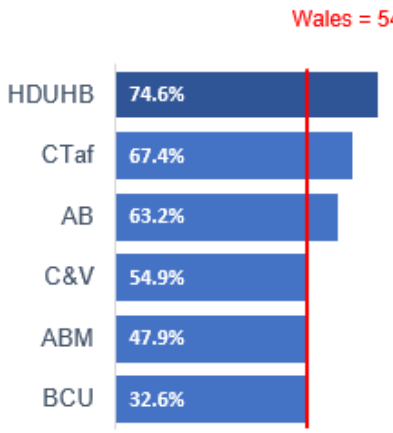

**Thrombolysis door to needle <= 45 minutes (Target – 12 month improvement trend)**

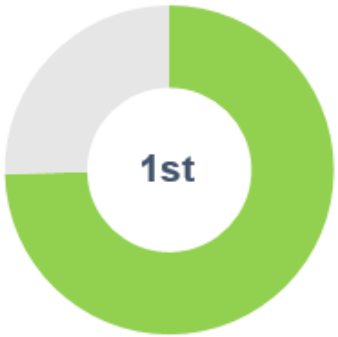


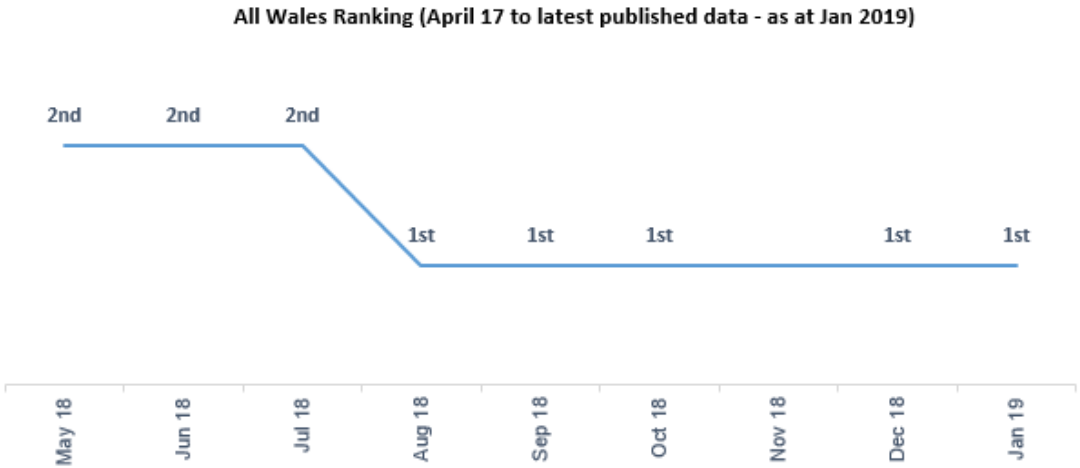



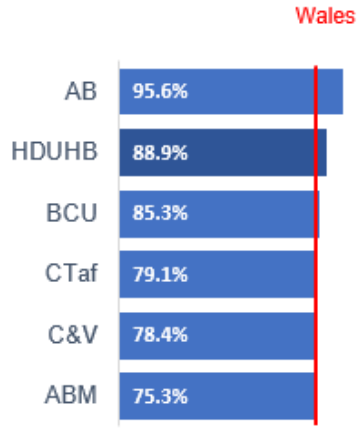
## CT scan <1 hour (Target – 12 month improvement trend)

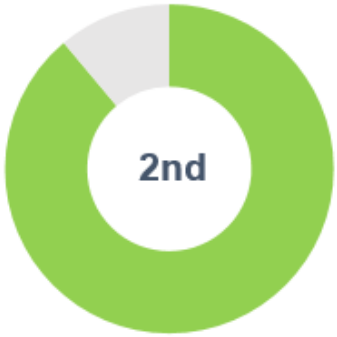


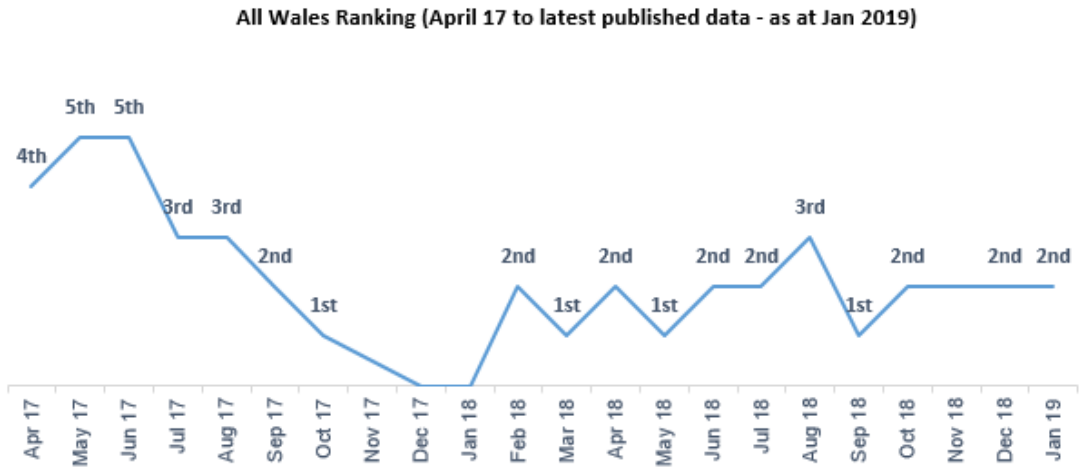




## Assessed by stroke consltant <24 hours (Target – 84.0%)

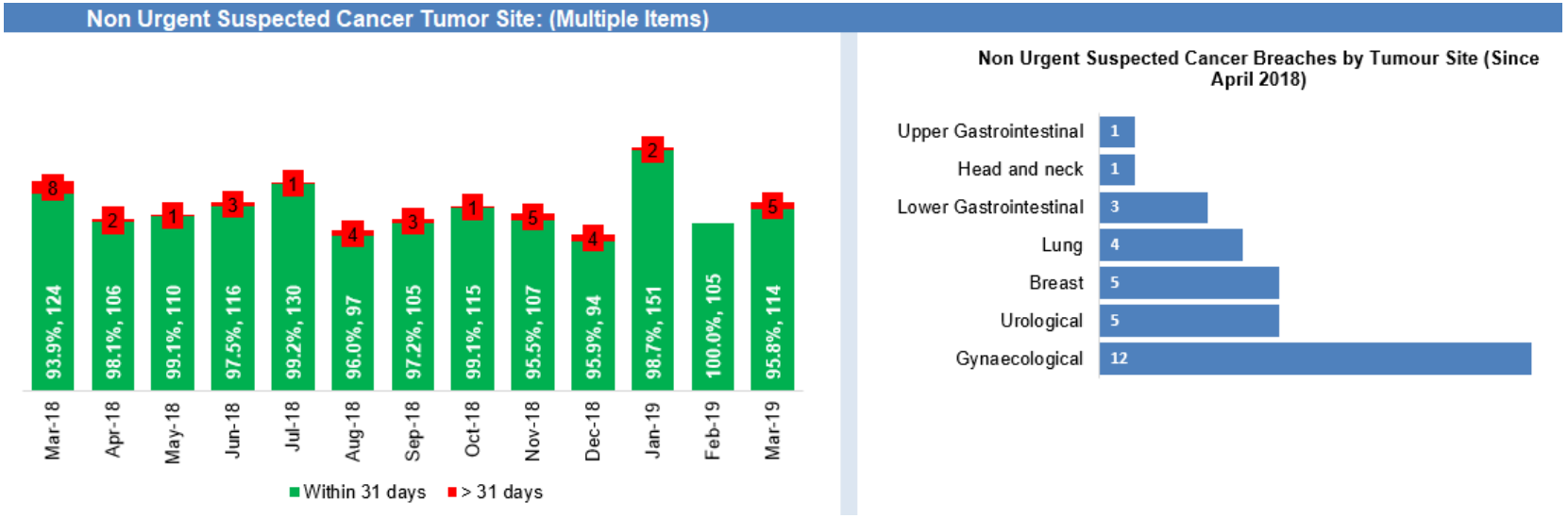


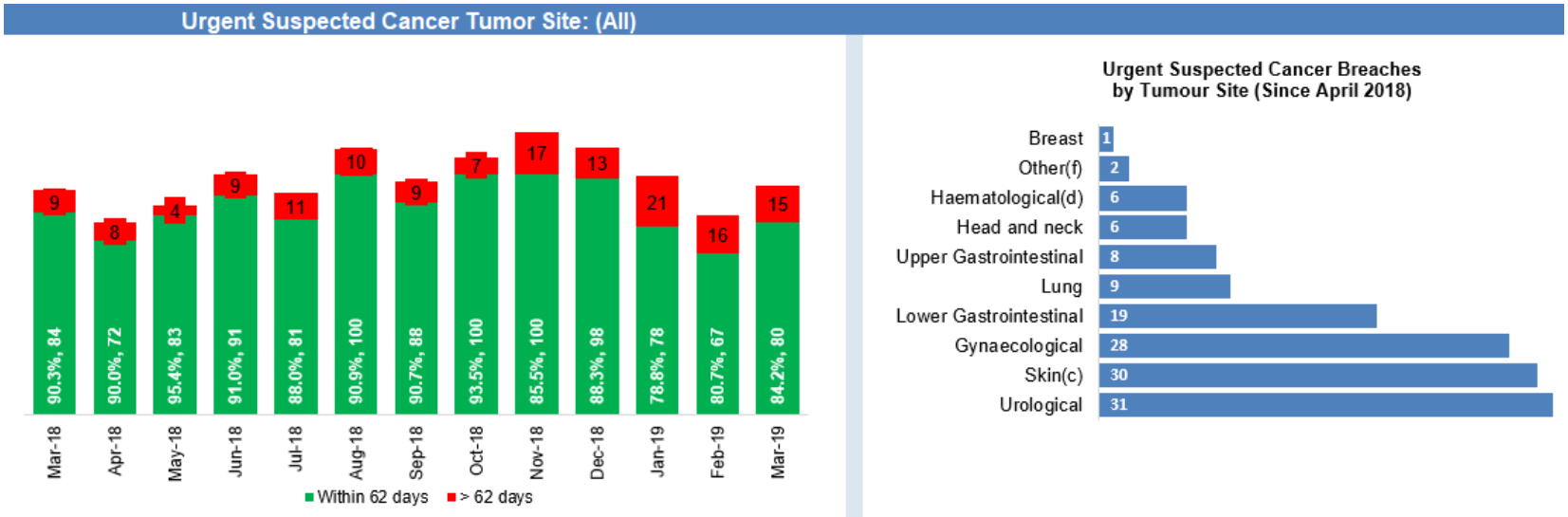



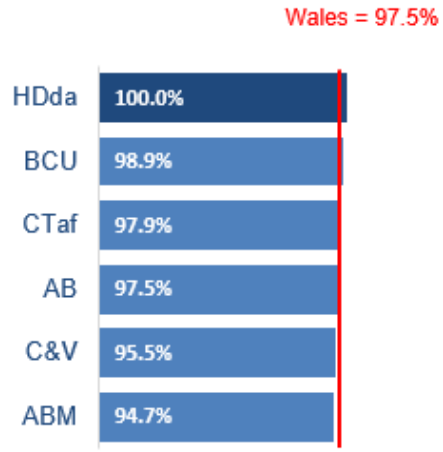
## Cancer

In the Cancer dashboard, the Health Board charts below can be also be displayed by Tumour site and month.

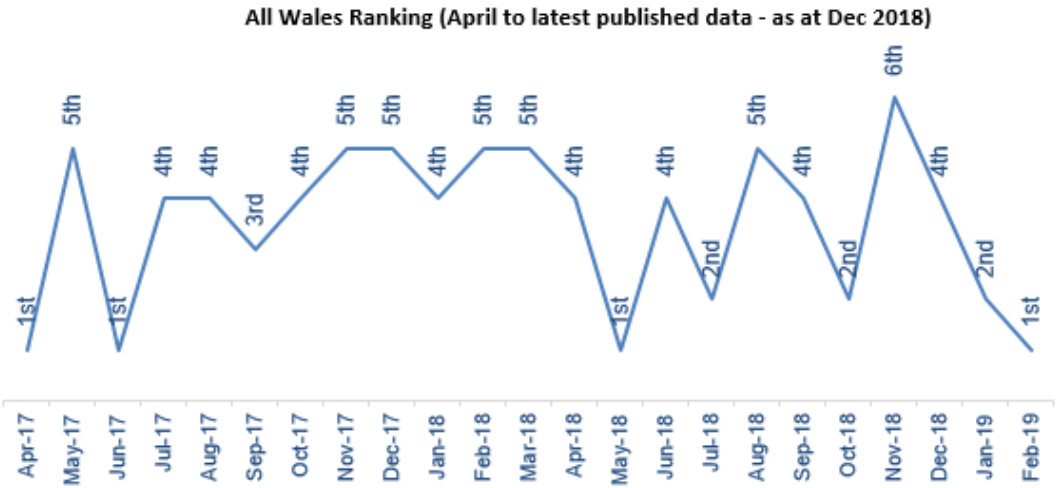


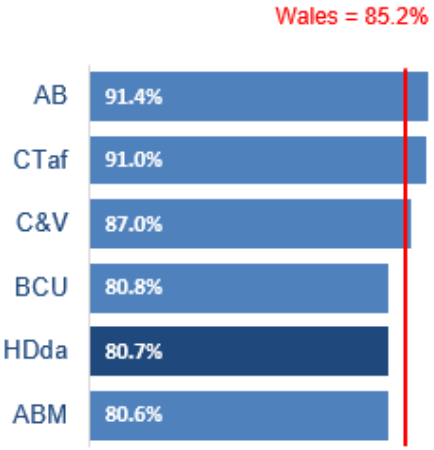
## Percentage of patients referred as non-urgent suspected cancer seen within 31 days – Target 98%

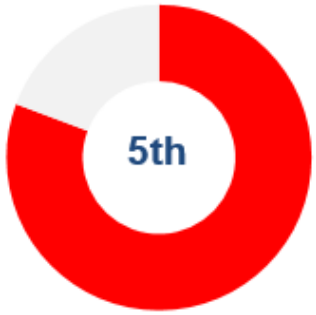


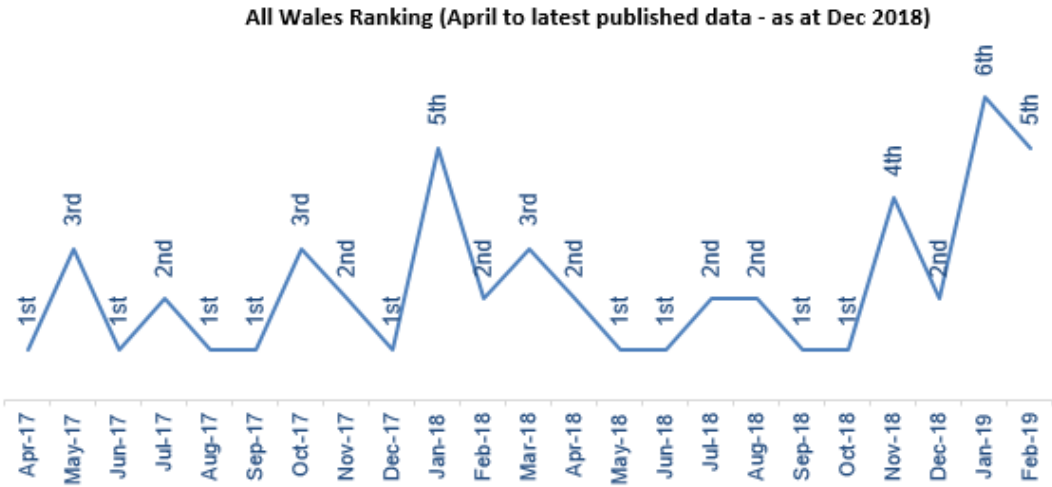





## Percentage of patients referred as urgent suspected cancer seen within 62 days – Target 95%



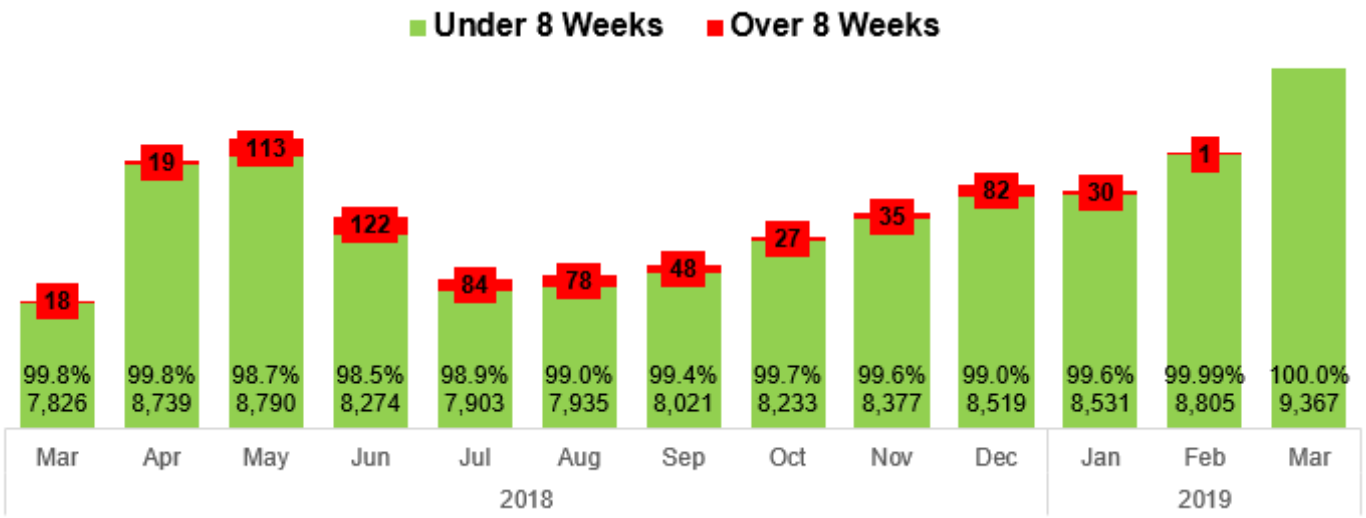



# Diagnostics

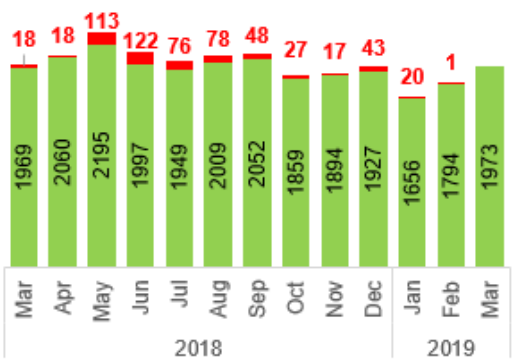
In the Diagnostics and Therapies dashboard the diagnostics metric can also be shown by acute hospital and service area.

**Note**
From April 2018/19 the diagnostics category was extended to include cardiology. For comparability, with the exception of the All Wales chart (by Health Board), the historic diagnostics figures below have been updated to include cardiology and as such the figures for 2017/18 are showing breaches which were not classed as or reported as breaches during that financial year.

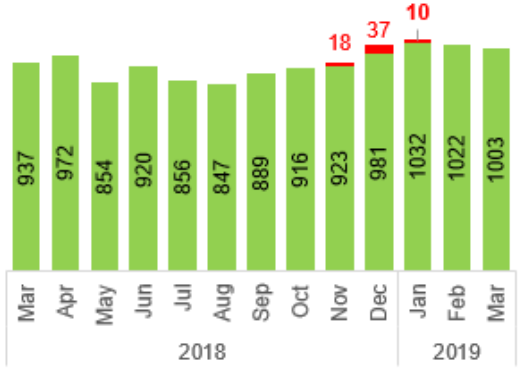
**Total number of patients waiting for all diagnostics (Target – 0)**



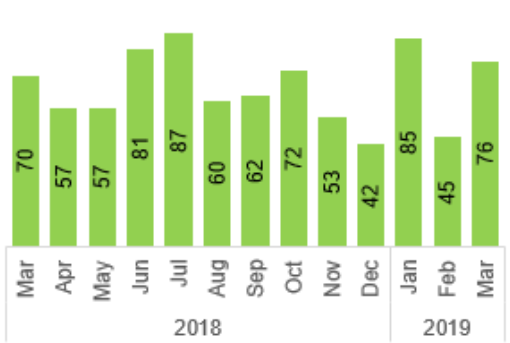
**Cardiology* (Target = 0)**



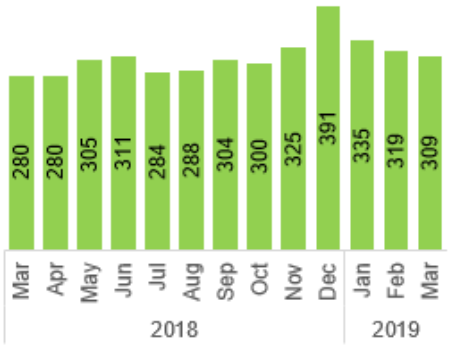

**Diagnostic Endoscopy (Target = 0)**




**Imaging (Target = 0)**

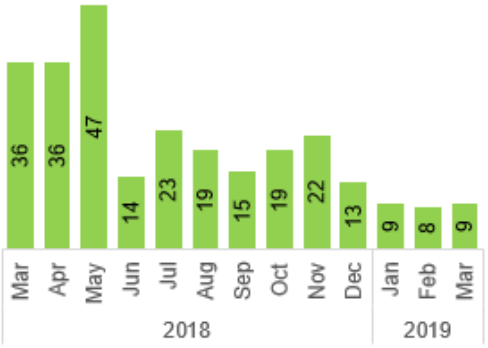



**Neurophysiology (Target = 0)**

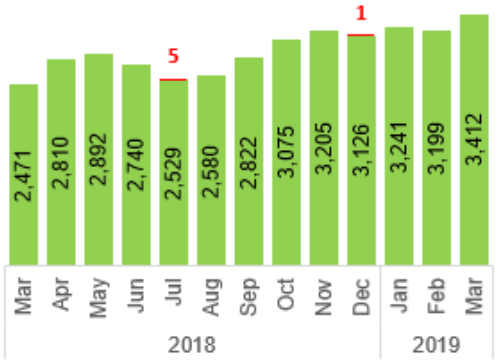



* See the 'Home' tab for information on definition change.

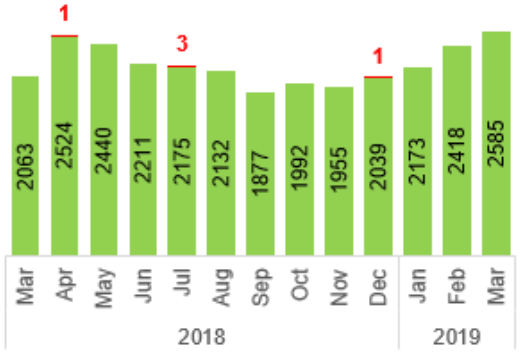
**Physiological Measurement (Target = 0)**



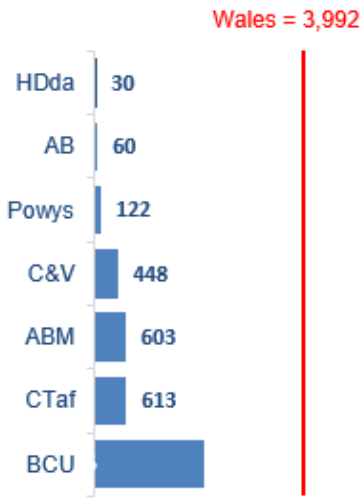

**Radiology - Consultant referral (Target = 0)**

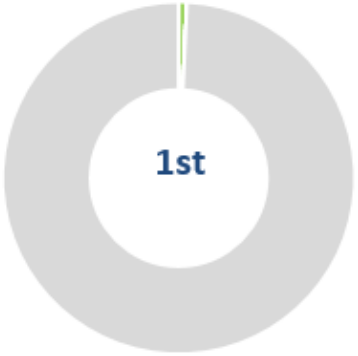


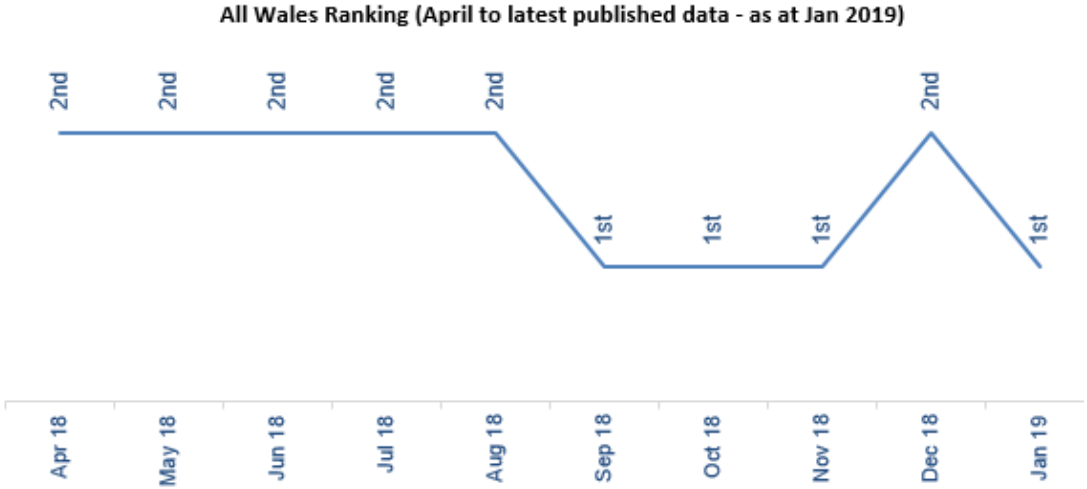

**Radiology - GP referral (Target = 0)**



**Number of patients waiting 8 weeks and over for a specified diagnostic (Target – 0)**



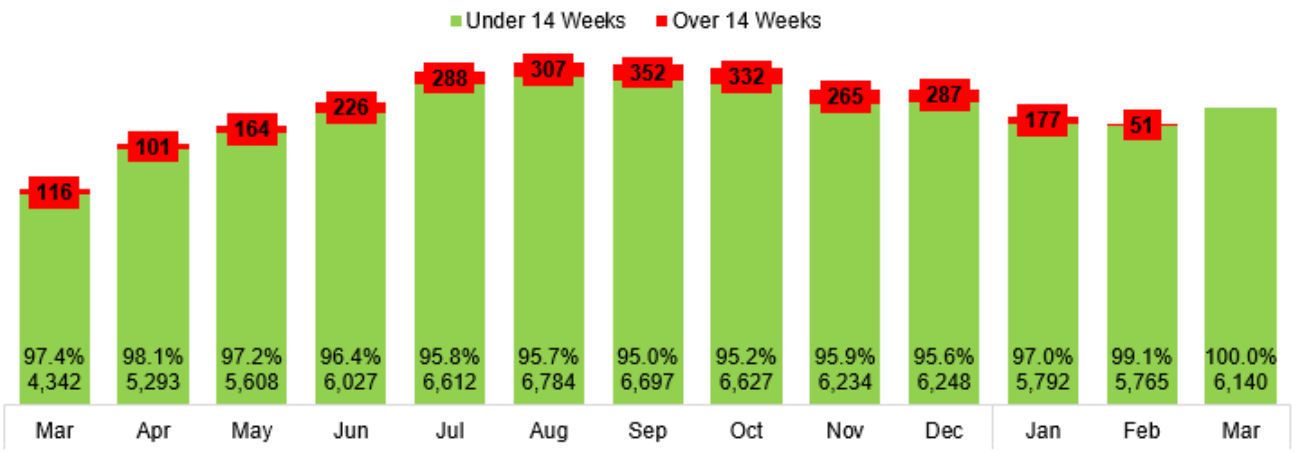



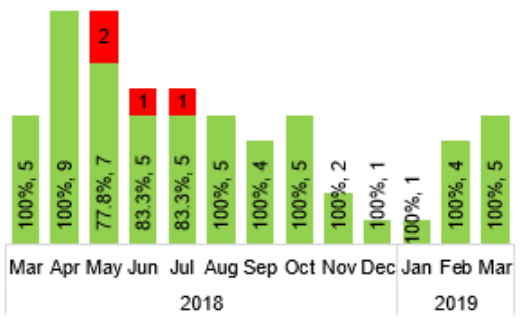
## Therapies

In the Diagnostics and Therapies dashboard the therapy waits metric can also be shown by acute hospital and service area.

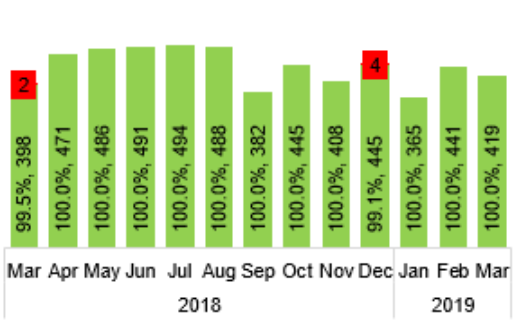
**Total number of patients waiting for all Therapies (Target - 0)**



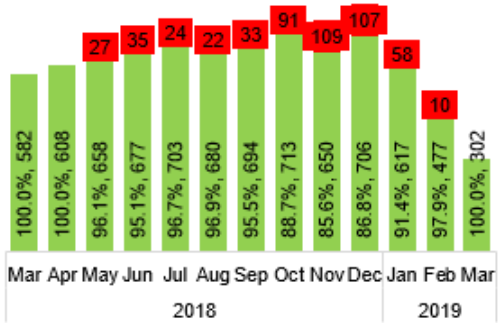
## Arts Therapies (Target = 0)



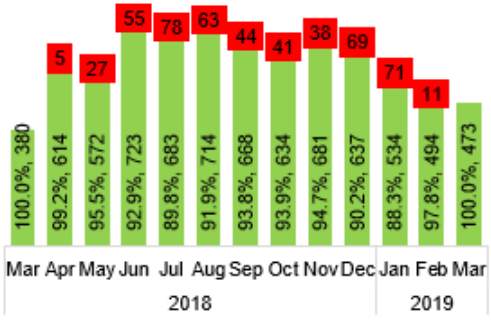

## Speech Language (Target = 0)



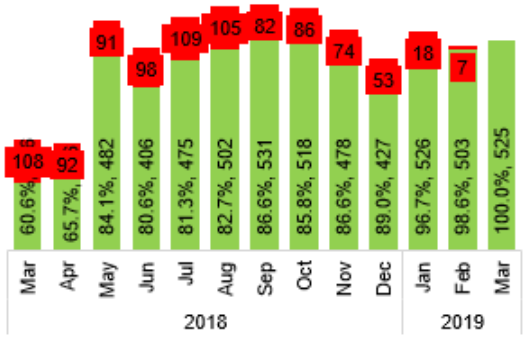

## Audiology (Adult hearing aids) (Target = 0)



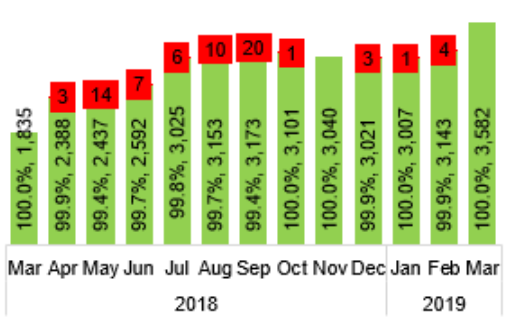

## Dietetics (Target = 0)



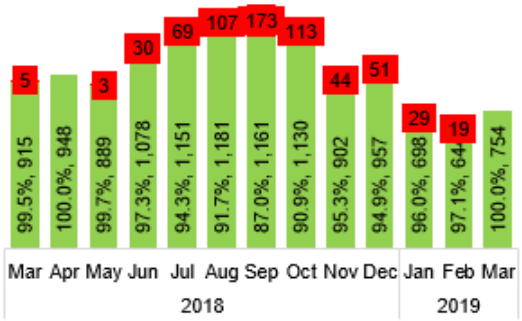

## Occupational Therapy (Target = 0)




## Physiotherapy (Target = 0)



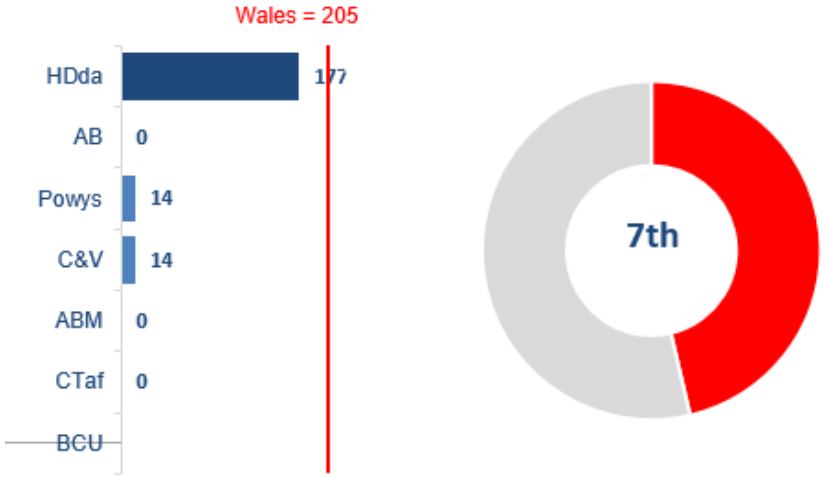

## Podiatry (Target = 0)



## Longest weeks wait for therapies – January 2019

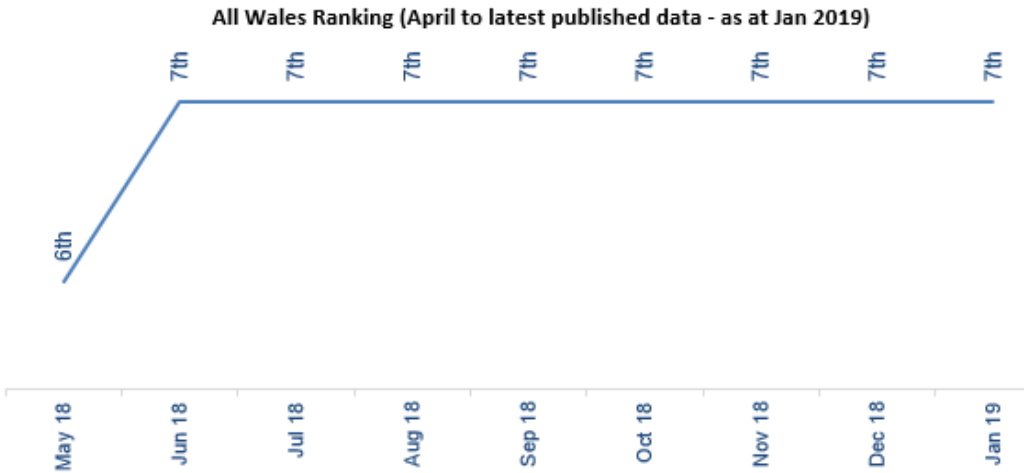
| Specialty | Longest Weeks Wait |
|---|---|
| Arts Therapies | 6 |
| Audiology (Adult hearing aids) | 10 |
| Dietetics | 12 |
| Occupational Therapy | 12 |
| Physiotherapy | 13 |
| Podiatry | 13 |
| Speech Language | 13 |
| **Grand Total** | 13 |

## Number of patients waiting more than 14 weeks for specific therapy (Target – 0)



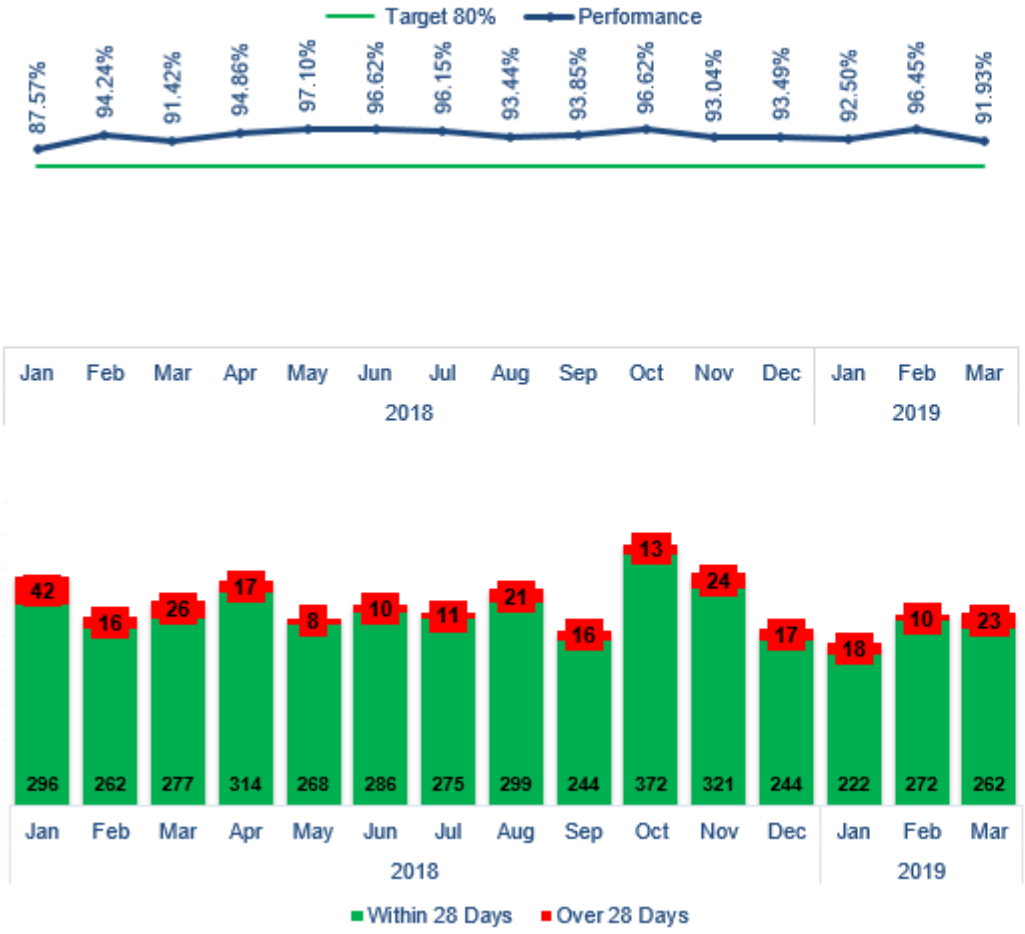




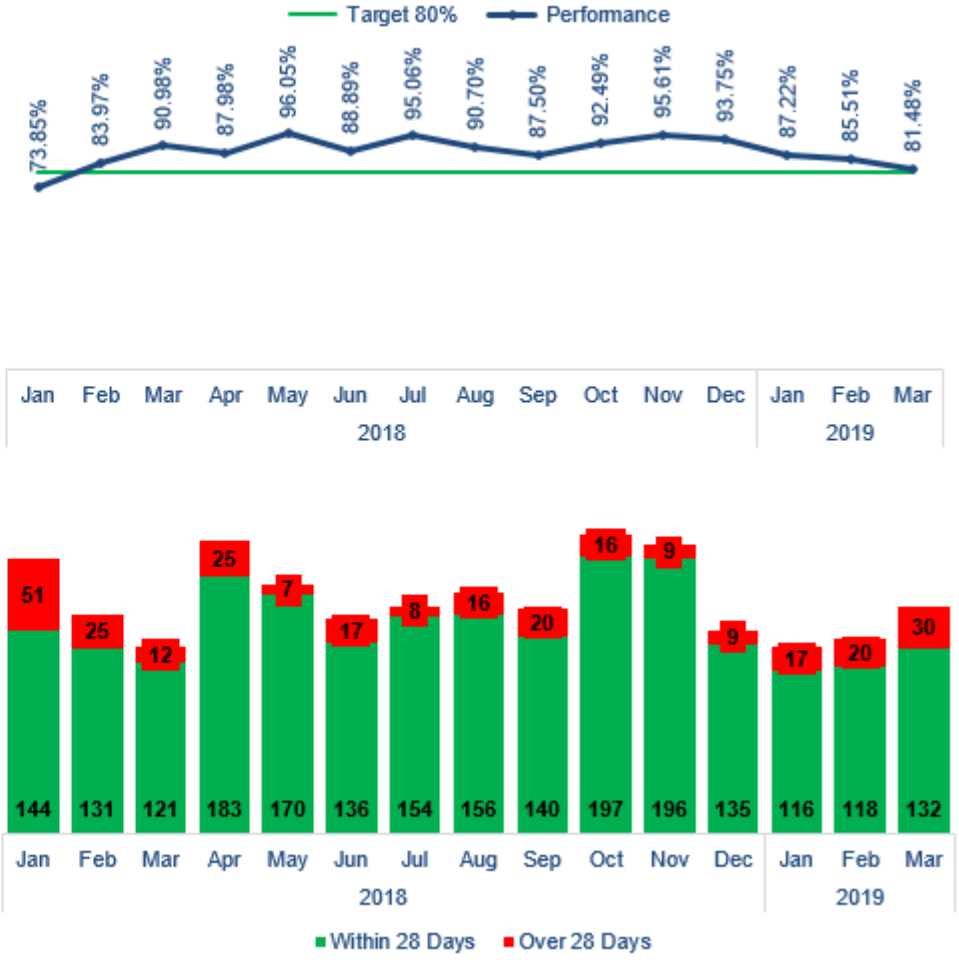


## Mental Health

### Part 1 (A) - assessed within 28 days of referral

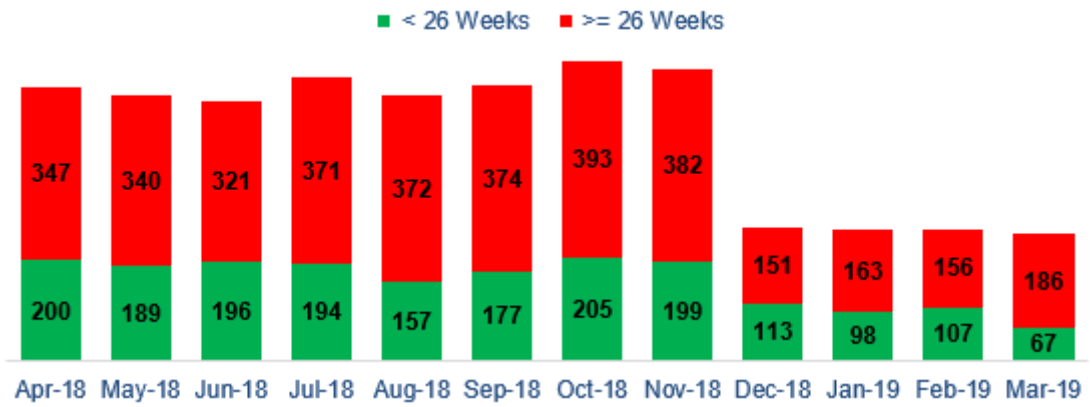



### Part 1 (B) - treated within 28 days of assessment

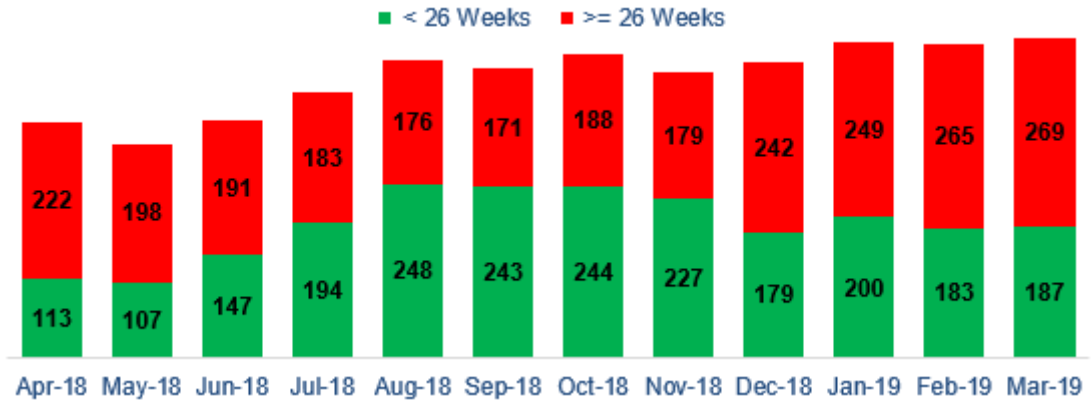


Neurodevelopmental waiting times for children and young people are included below:

**CAMHS ADHD**




**CAMHS ASD**

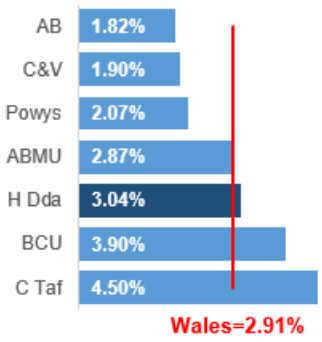


## Primary Care

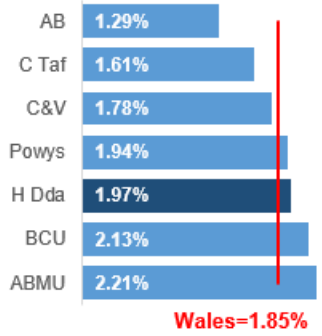
The charts below show the Health Board's position. Charts are also available by acute site in the Primary Care dashboard.

### PRESCRIBING

**Cephalosporin Items as % of Antibacterial Items, Quarter 3, 2017/18**

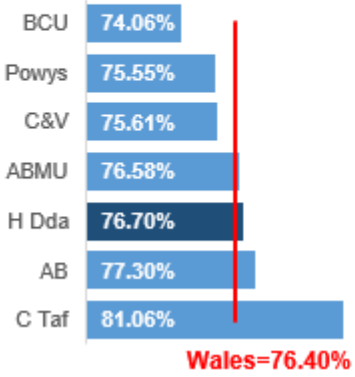



**Quinolone Items as % of Antibacterial Items, Quarter 3, 2017/18**

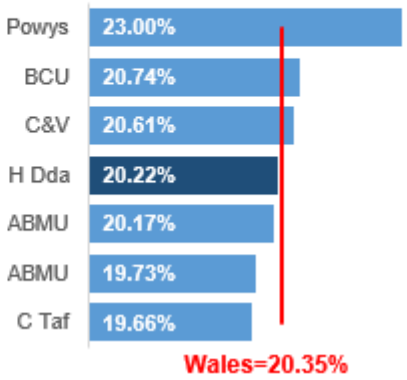



### ALCOHOL & SMOKING

**% of People Aged 16 and over with a record of alcohol intake, Quarter 3 2017/18**

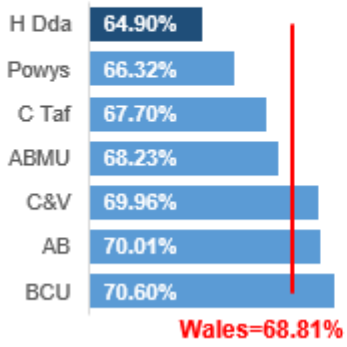



**% of Smokers who have been recorded as ex-smokers, Quarter 3 2017/18**

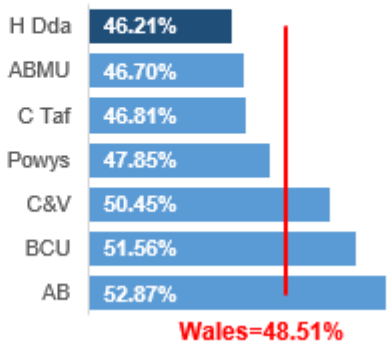


## IMMUNISATION - influenza

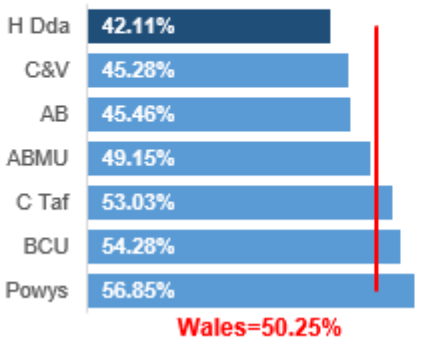
### Influenza vaccination in those 65y and older, 2017/18



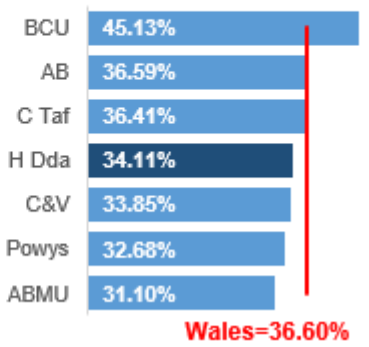

### Influenza vaccination in those at risk aged 6m to 64y, 2017/18




### Influenza vaccination in 2 & 3y olds, 2017/18

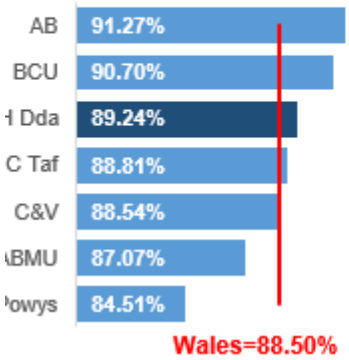



### Influenza vaccination in 2 - 4y olds, 2017/18

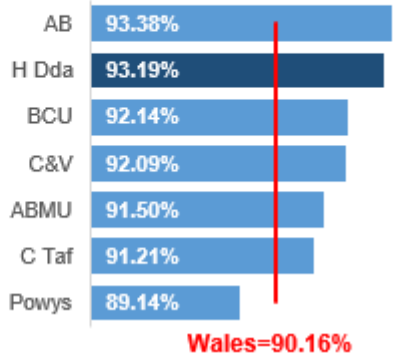



## IMMUNISATION - Childhood Vaccinations

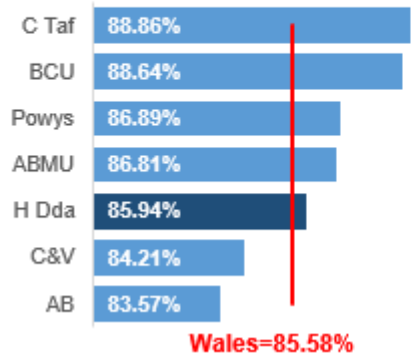
### MMR2 at 16y, 2017/18



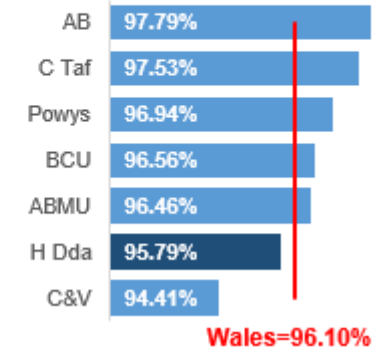

### MMR2 at 5y, 2017/18



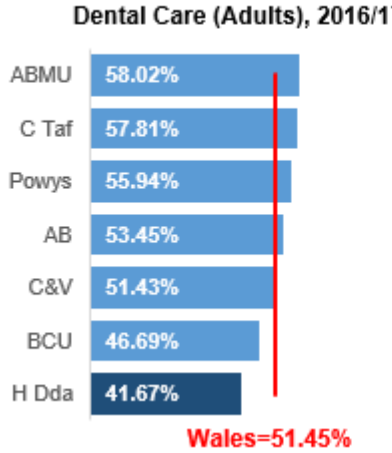

### Up to date with immunisations by age 4y, 2017/18

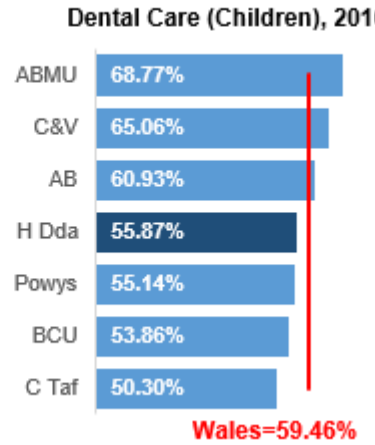



### Uptake of the 5 in 1 at 1y, 2017/18

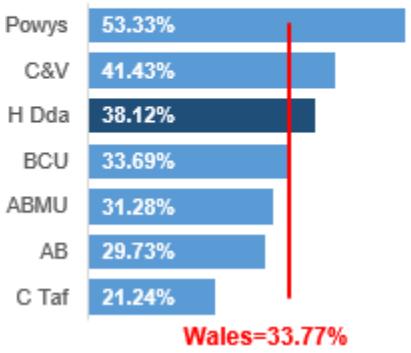


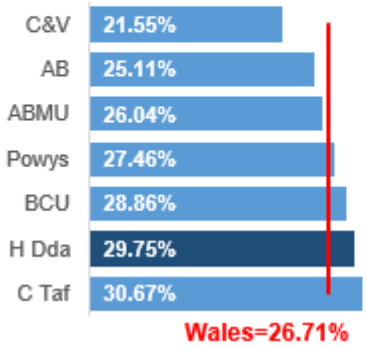
## DENTAL ACCESS ( Adults at least once every 2 Yrs, Children at least once a year)

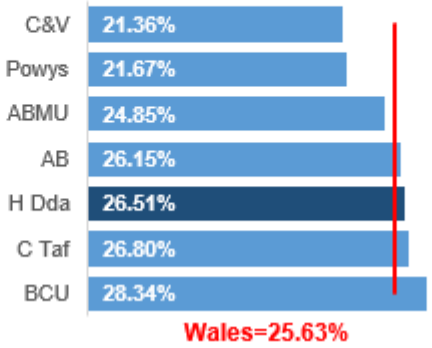


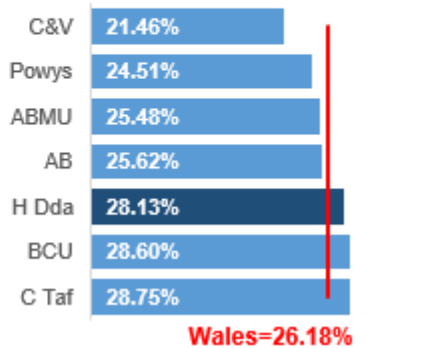




## MATERNITY & CHILD HEALTH



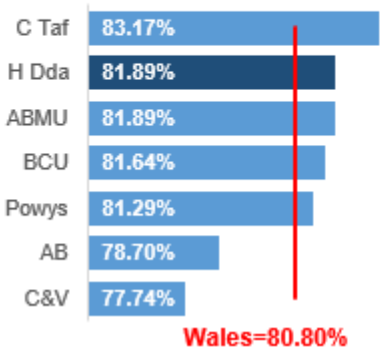



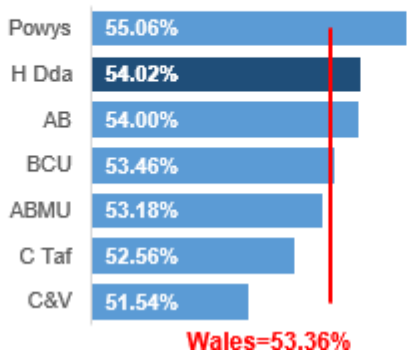



## SCREENING

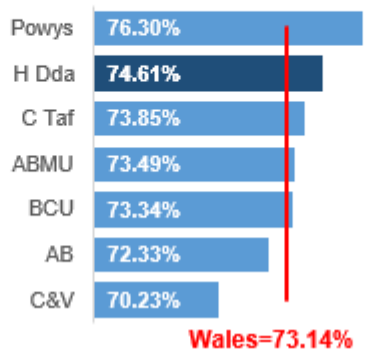
### Abdominal Aortic Aneurysm (AAA) Screening Uptake, 2016-17



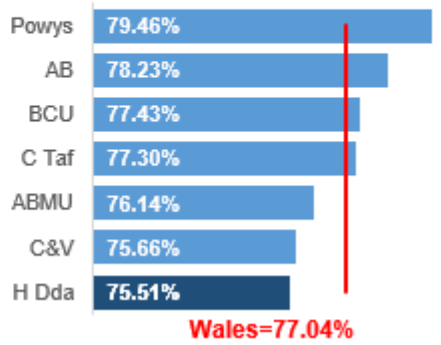

### Bowel Screening Uptake, 2016-17




### Breast Screening Uptake, 2016-17

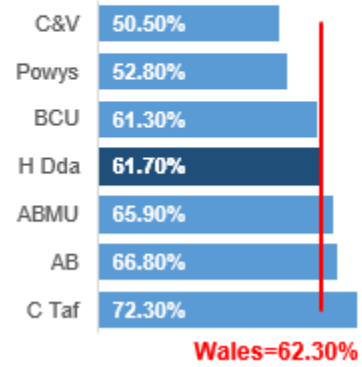



### Cervical Screening, 5-yr Coverage as at 01/04/2017

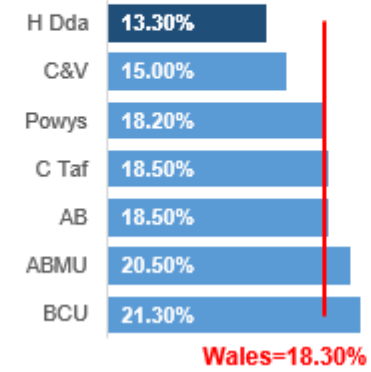



## CIRCULATORY DISEASE (Three Year Rolling Standardised Mortality Rates per 100,000 population under 75 years of age)

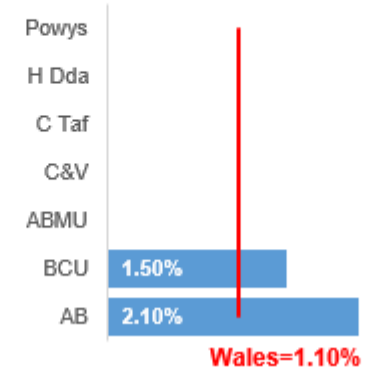
### Circulatory disease mortality - All Heart Disease, 2014-16



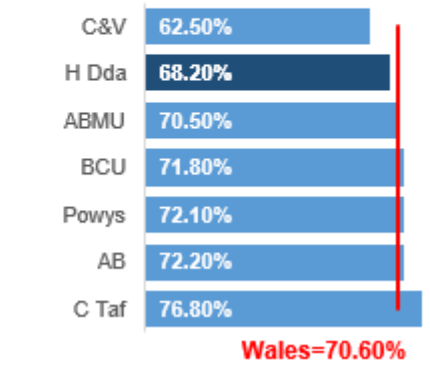

### Circulatory disease mortality - Acute Myicardial Infarction, 2014-16




### Circulatory disease mortality - Heart Failure, 2014-16

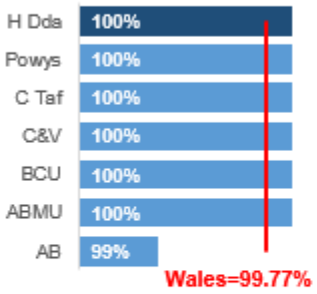



### Circulatory disease mortality - Stroke, 2014-16

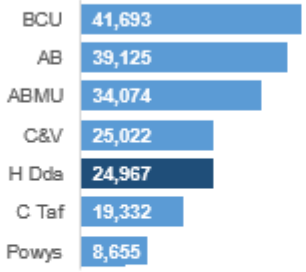


## DIABETES -People with diabetes who have received all key care processes

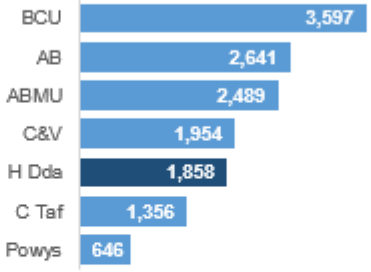
### Practice Participation , 2016-17



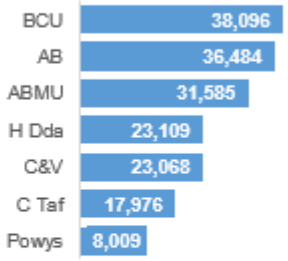

### Practice Registrations - All, 2016-17



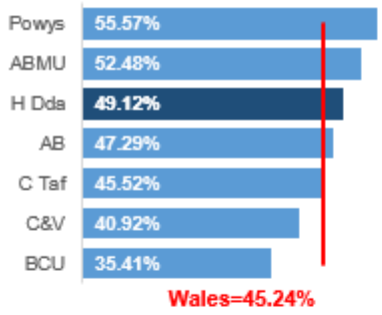

### Practice Registrations - Type 1, 2016-17



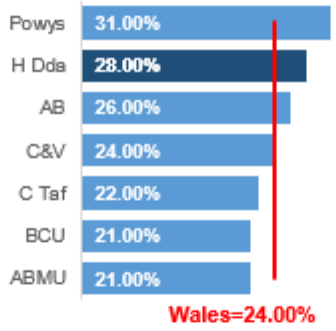

### Practice Registrations - Type 2 and Other, 2016-17



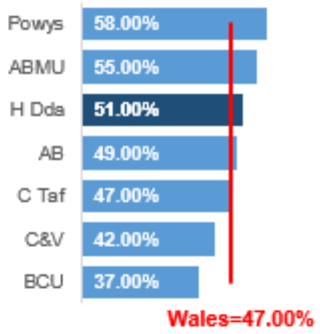

### Care Processes - All, 2016-17



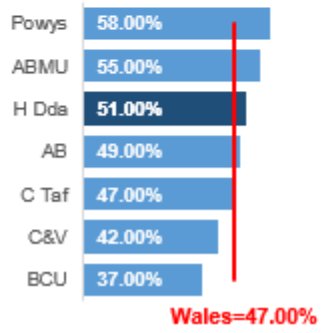

### Care Processes - Type 1, 2016-17



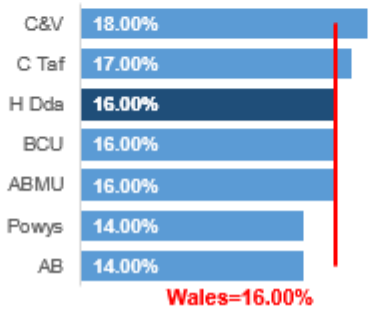

### Care Processes - Type 2 and Other, 2016-17



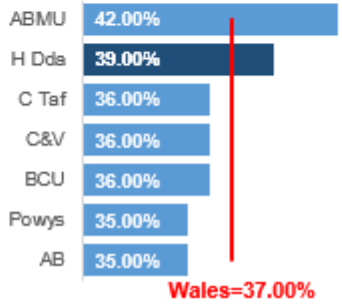

### Care Processes - Type 2 and Other, 2016-17



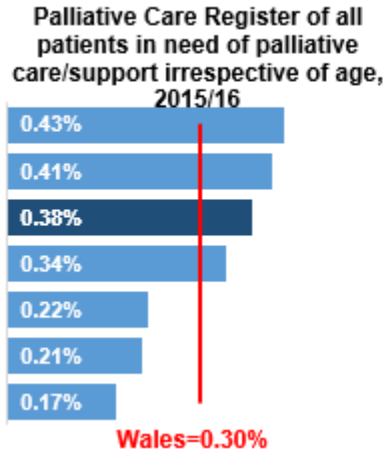

### Treatment Targets - Type 1, 2016-17



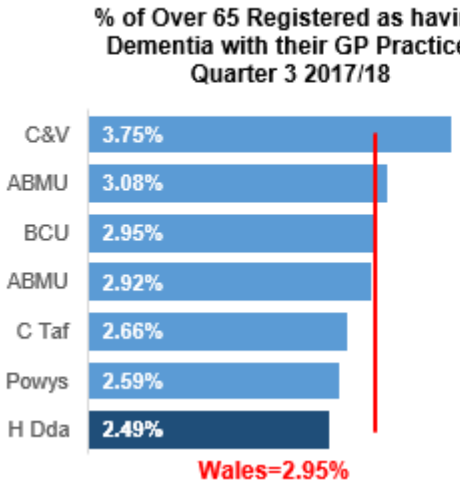

### Treatment Targets - Type 2 and Other, 2016-17

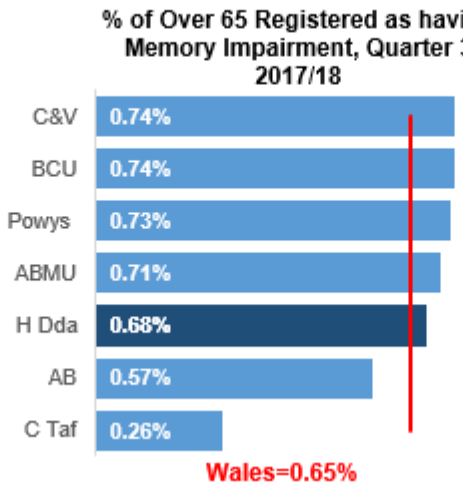


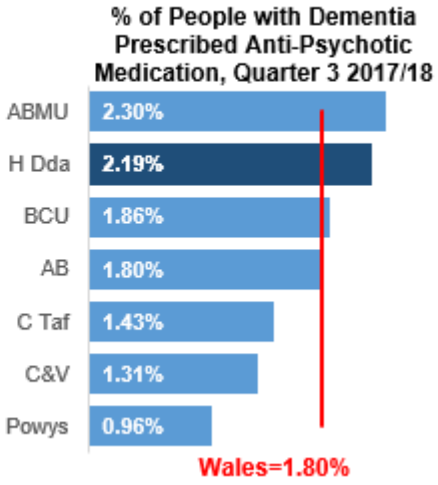
## DYING WELL - Palliative Care



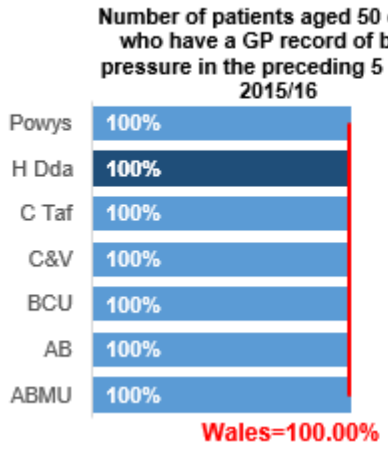

## DEMENTIA CARE



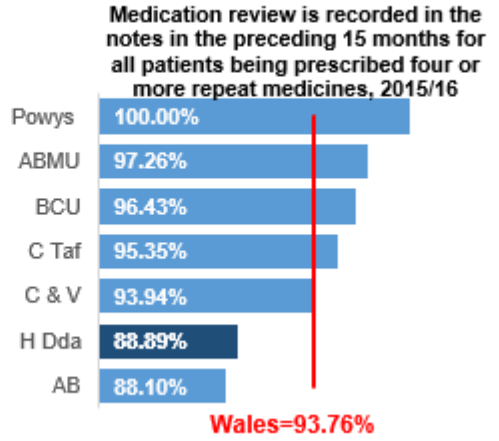



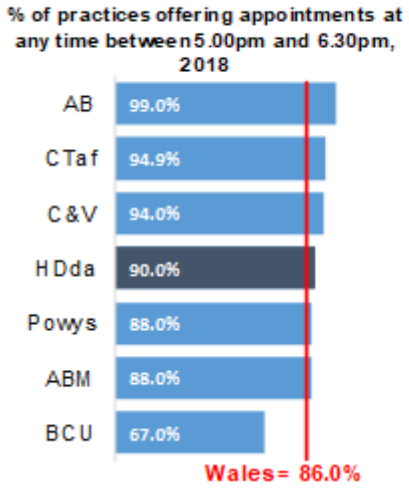
## HEALTH INEQUALITIES - Blood Pressure

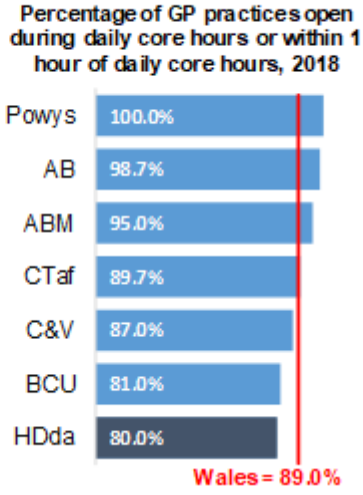



## MEDICATION REVIEW

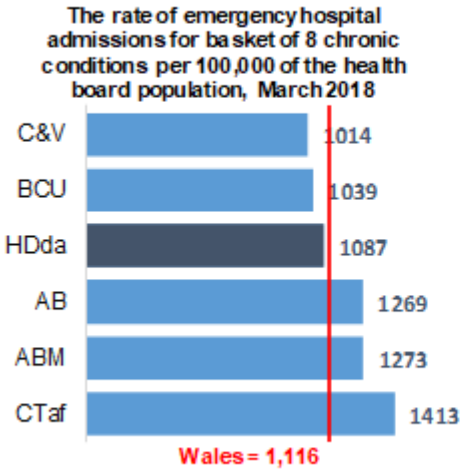


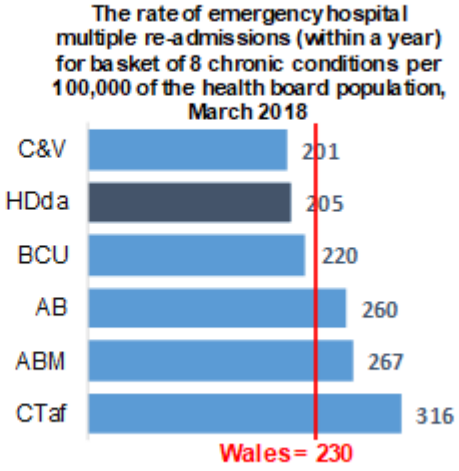

## GP ACCESS



## CHRONIC CONDITIONS



# Primary Care Update - Managed GP Practices

*as at April 2019*

## Meddygfa Minafon, Kidwelly

Meddygfa Minafon has been a Health Board Managed Practice since January 2015, when the independent contractor partnership terminated their contract due to their inability to recruit GPs, following the retirement of a senior partner. Prior to this date, there were 3.5 WTE GP partners and 1 WTE salaried GP in post. Meddygfa Minafon has a list size of 8,253 (1 January 2019) and the practice list size is increasing every quarter.

The Practice continues to operate with a mix of salaried and locum GPs (with one salaried GP taking the role of Clinical Lead) and work is ongoing to continue to review the skill mix required to support the development and implementation of the Primary Care Model for Wales. Additionally, the practice is supported by telephone consulting/triage by GP Hub who provide 30 telephone-consulting slots per day.

In March 2018, dispensary services at Ferryside Surgery were suspended pending a formal decision on their continuation, due to concerns raised about the clinical safety of the service. An interim arrangement was established with a local Community Pharmacy and a wider consultation is planned to assess the impact of this change and to consider options for future dispensing and future General Medical Service (GMS) services across Kidwelly, Trimsaran and Ferryside.

Current Risks

- Long term sick leave for a key member of staff;
- Providing safe and sustainable services over three different sites with an increasing practice list size;
- Some reliance on locum GPs when it would be preferable to move to a salaried GP model; or return the practice back to independent contractor status;
- Regular cancellation of branch surgery GP sessions due to lack of clinical cover.

Consideration needs to be given to seeking opportunities to return the practice to independent contractor status and a viability scoping exercise will be undertaken during 2019 to assess the potential for other options.

## Meddygfa Sarn, Pontyates

Meddygfa Sarn has been a Health Board Managed Practice since October 2017, when the independent contractor partnership terminated their contract due to their inability to recruit GPs, following the resignation of a partner who secured an overseas post. Prior to this date, there were 3.5 WTE GP partners. The practice operates from a single site. Meddygfa Sarn in Pontyates has a list size of 4,143 (1st January 2019) and the practice list size is decreasing every quarter since becoming a Managed Practice.

There are currently two salaried GPs employed at the practice including a Clinical Lead GP. Additional support is being provided by a neighbouring Practice (Tumble Surgery) and this collaboration is working extremely well. Locums are also used regularly and the practice is supported by telephone consulting/triage by GP Hub who provide 30 telephone consulting slots per day.

Current Risks

- Long term sick leave for a key member of staff;
- Some reliance on locum GPs when it would be preferable to move to a salaried GP model; or return the practice back to independent contractor status

Consideration needs to be given to seeking opportunities to return the practice to independent contractor status and a viability scoping exercise will be undertaken during 2019 to assess the potential for other options.

## Tenby Surgery, Tenby

Tenby Surgery became Health Board managed on 1 August 2018. The Practice is largely dependent on locum GPs for its medical cover. A core group of the GP locums who were employed by the Independent Contractor during the notice period have remained with the Practice and have formed a stable core for GP provision. The medical rota is stable and filled, and greater control has been possible over rates charged. Additionally, the practice is supported by telephone consulting/triage by GP Hub who provide 30 telephone-consulting slots per day. Tenby Surgery currently has a list size of 7,497 (1 January 2019) and the practice list size is decreasing every quarter, although the rate has slowed more recently.

The Practice has a small team of Advanced Practitioners (1.6 WTE) comprising of Advanced Nurse Practitioners and Advanced Paramedic Practitioners. A Practice Nurse vacancy has recently been filled but a

retirement has been notified. The South Pembrokeshire Cluster Lead GP is covering the GP Clinical and Prescribing Lead role in a locum capacity (1 day per week). Prior to the Health Board taking over the management of the practice, there was a limited history of collaboration on the development of services in the locality. Since August, collaborative working with the Walk-In Centre (WIC) has become established and the practice provides a small number of Advanced Practitioner appointments daily for the WIC to refer. Moves to expand services to include Minor Surgery clinics by an accredited locum are underway.
A practice newsletter has been devised, and an informal 'meet the team' drop-in event for patients was held in December 2018. Interest has been noted in the establishment of a Patient Participation Group (PPG). Queues outside the front doors before opening at 8.30am have long been a feature of Tenby Surgery. From January 2019, the doors have been open from 8am to allow patients to wait inside to make same day appointments. A review of the practice is due to further determine the strategic future in the context of wider services in the locality.
Current risks:

- Although stable, the medical rota remains dependent on locums;
- Financial risk of on-going GP locums costs;

Consideration needs to be given to seeking opportunities to return the practice to independent contractor status and a viability scoping exercise will be undertaken during 2019 to assess the potential for other options.

## Ash Grove, Llanelli

Ash Grove Surgery became a Health Board managed practice on 1 September 2018, following a three-month notice period. The practice is now in a period of stabilisation with staff and systems. Ash Grove Surgery has a list size of 7,661 (January 2019) and the practice list size is showing a downward trend overall.
Ash Grove surgery did not retain any of the former GP partners. The Practice Manger has made significant progress with recruitment and 5 Salaried GP's including a highly experienced full time Clinical Lead GP have been appointed and are at various stages in the recruitment process. Feedback indicates that this success is largely down to the effective management of the practice and the structure of the working day. There has been significant focus on how demand is managed and through Multi Discipline Team (MDT) working, GPs now enjoy working in Ash Grove and actively seek to secure sessions there.
Ash Grove staff who have TUPE'd over include a full time Advanced Paramedic, a Respiratory Nurse and a Nurse Practitioner. The practice is supported by telephone consulting/triage by GP Hub who provide 30 telephone consulting slots per day.

Current Risks:

- A licence to occupy the premises has not been secured and there are ongoing negotiations with the Landlord's solicitors. A paper has been drafted to consider the long-term lease options and as soon as this has been finalised and approved it will go the Executive Team for consideration.

## Summary

Considerable work has been undertaken to seek appointments to salaried posts wherever possible across the Managed Practices; this in addition to the implementation of a cap on locum fees has seen the costs associated with the Managed Practices start to decrease over recent months.
A baseline assessment of the workforce in Managed Practices has been undertaken and this will now be expanded out to some Independent Contractor Practices for a comparison to be established.
Clinical Leads have been secured in each of the Practices and a monthly meeting has been established to bring them all together to share learning and best practice enabling a consistent approach to be put in place to systems and processes.
Work is ongoing to scope the potential to seek expressions of interest for three out of the four remaining Managed Practices which will indicate if there is any genuine interest in them being taken back into Independent Contractor status.

# Primary Care Quality and Performance Assurance Report
# May 2019

## HIW/CHC Visit Updates

| Visit | Practice | Update |
|---|---|---|
| Community Health Council | Meddygfa Tywyn Bach | The visit took place on 12 March 2018 and the Practice has responded to the issues raised. CHC report link here |
| Community Health Council | Church Surgery | The visit took place in May 2018 and the Practice has responded to the recommendations that were made. CHC report link here |
| Health Inspectorate Wales | St Thomas Surgery | The visit took place in May 2018 and all recommendations were implemented. HIW report link here |
| Health Inspectorate Wales | Meddygfa Minafon | This was a follow up visit to a previous inspection by HIW. An improvement plan has been submitted following the visit with the overall completion date being 30 September 2019. |
| Health Inspectorate Wales | Meddygfa Sarn | The visit was undertaken on 5 September 2019; an improvement plan was submitted on 17 October 2018 with completion due by 30 April 2019. |

| Visit | Practice | Update |
|---|---|---|
| Health Inspectorate Wales | Celtic Dental Practice | A visit took place in February 2019; an improvement plan was submitted with 7 actions to be completed. These are to be completed by the end of July 2019. |
| Health Inspectorate Wales | Robert Street Dental | A visit took place in November 2018 and an action plan was submitted that included one action. This action is due to be completed by the 1st of May and the Dental Services Team have requested confirmation that this will happen. |

## Practice Development Visits – GP Practices

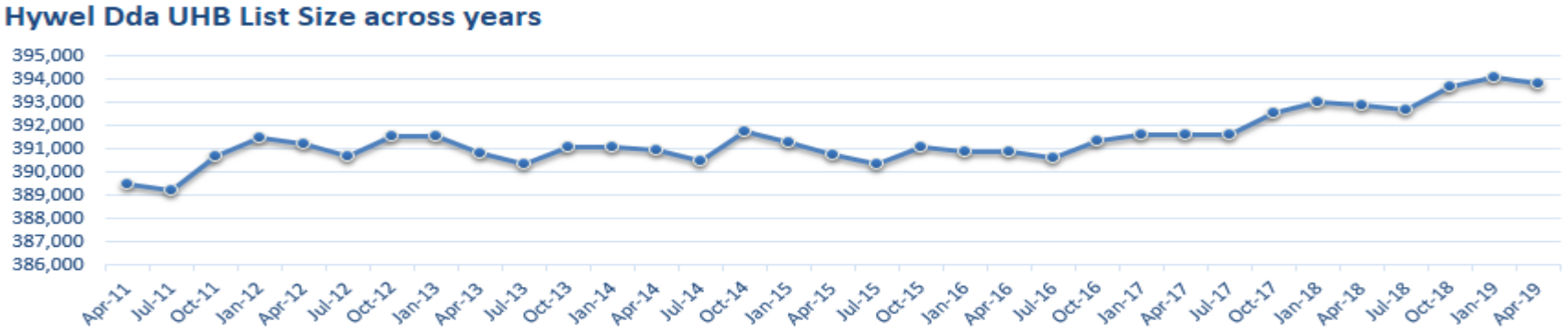
The following GP practice visits have been undertaken in 2018/19:

- Argyle Surgery;
- Goodwick Surgery;
- Barlow House;
- Tenby Surgery;
- Brynteg Surgery;
- Tanyfron Surgery;
- Bro Pedr Surgery;
- Robert Street Surgery;
- Llangennech Surgery.

The Practice visits have been undertaken by the Associate Medical Director either for Primary Care, or by the county Associate Medical Directors for Primary Care, Quality Manager for Primary Care and a member of the GMS team or a Locality Development Manager. There has also been Nursing and Medicines

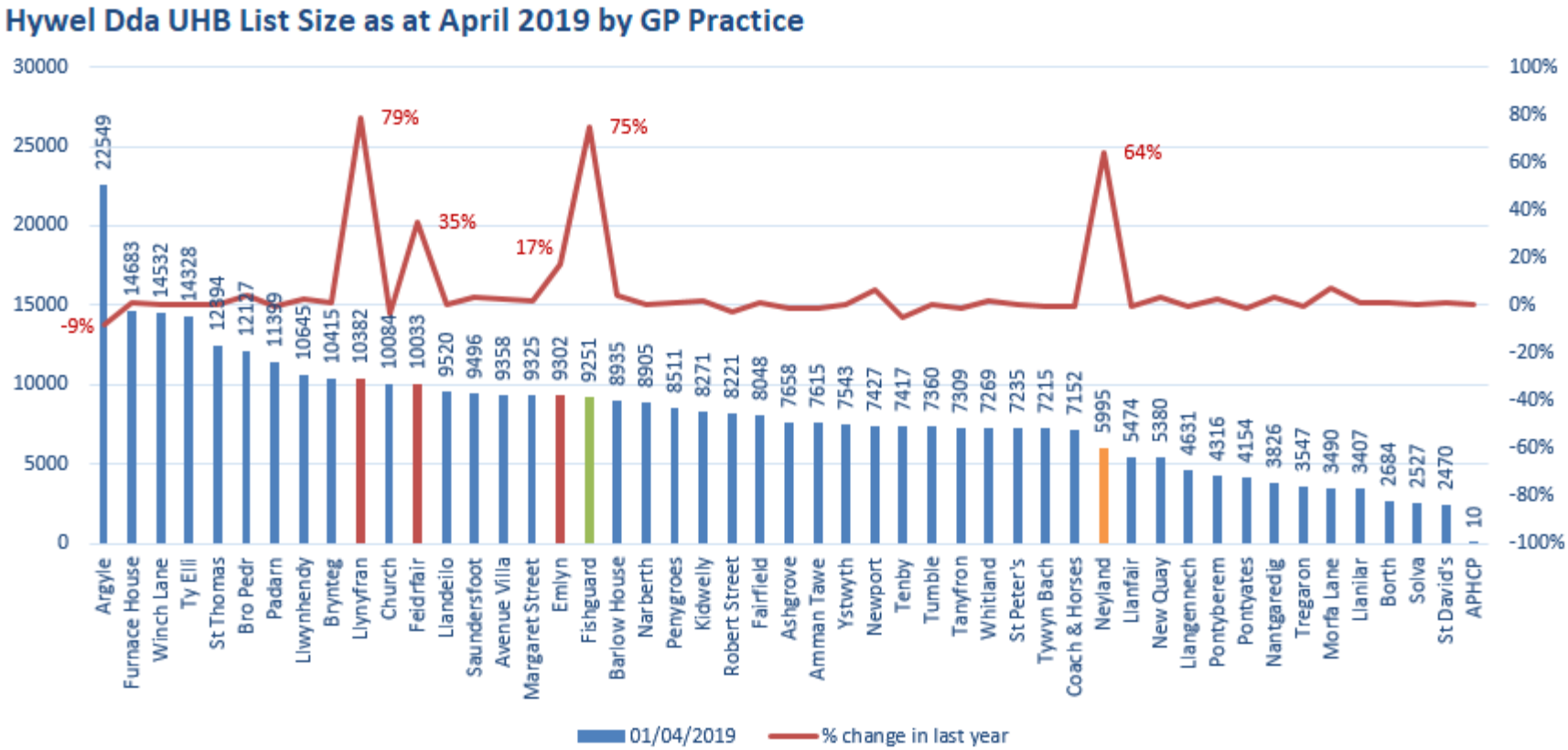
Management input where appropriate and coordination with the Primary Care Support Team Manager. The programme is currently under review to ensure that it remains fit for purpose for the current and subsequent years.

## Hywel Dda UHB List Size across years




| | 2011/12 | 2012/13 | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | % change |
|---|---|---|---|---|---|---|---|---|---|---|
| Apr | 389,474 | 391,227 | 390,833 | 390,921 | 390,761 | 390,886 | 391,604 | 392,895 | 393,825 | -0.1% |
| Jul | 389,192 | 390,697 | 390,354 | 390,475 | 390,372 | 390,600 | 391,589 | 392,694 | | in last quarter |
| Oct | 390,677 | 391,529 | 391,090 | 391,740 | 391,112 | 391,355 | 392,559 | 393,660 | | **0.2%** |
| Jan | 391,501 | 391,577 | 391,114 | 391,293 | 390,899 | 391,587 | 392,984 | 394,079 | | **in last year** |

There tends to be either a slight decrease or plateau in list size at this time of year. However, overall the trend is increasing.




The final quarter of 2018/19 has seen a significant amount of change in General Medical Services. Two contracts were terminated by their partnership in the South Ceredigion Cluster (Ashleigh and Teifi). Both practice lists were redistributed to neighbouring practices. The effect of this can be seen in particular in Llynyfran (increase in list size of 79%), Feidrfair (increase of 35%) and Emlyn (increase of 17%).

In the North Pembrokeshire cluster Goodwick Surgery (a Health Board Managed Practice) closed; all of the patients were transferred to Fishguard Surgery, which saw their list size increase by 75%. In South Pembrokeshire cluster, Argyle closed their Neyland Branch Surgery at St Clements; all patients were transferred to Neyland and Johnstone Surgery, which resulted in a list size increase of 64%. Due to the significance of the Argyle list size, the decrease to Argyle was only 9%.

## Access

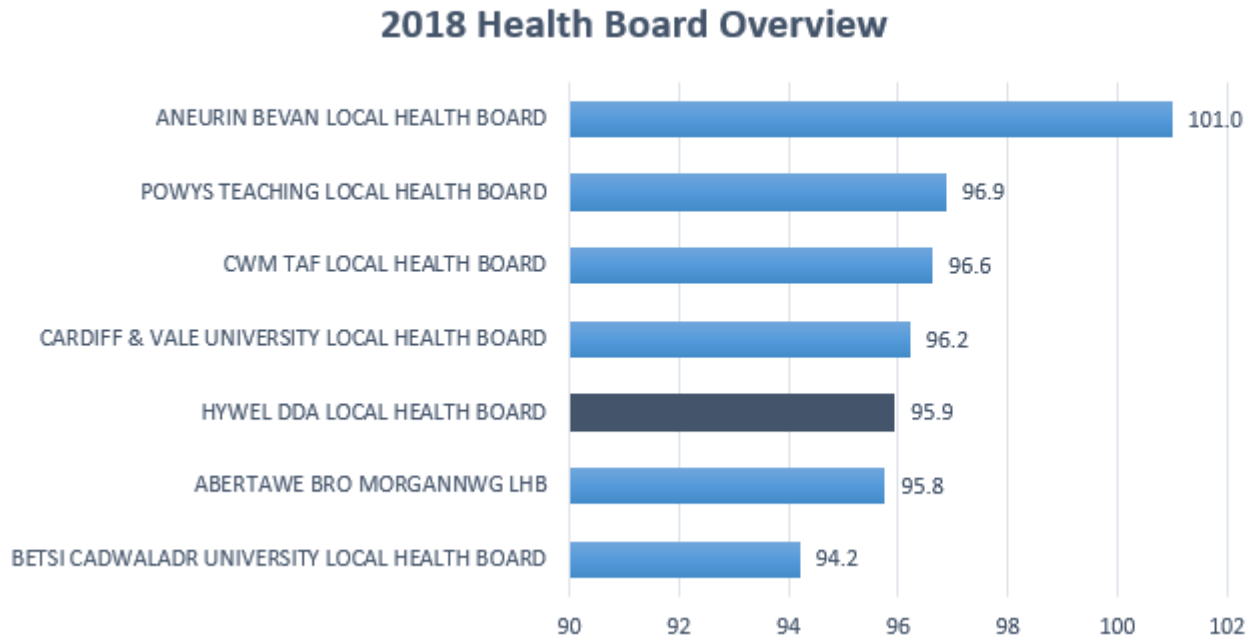
# Opening hours

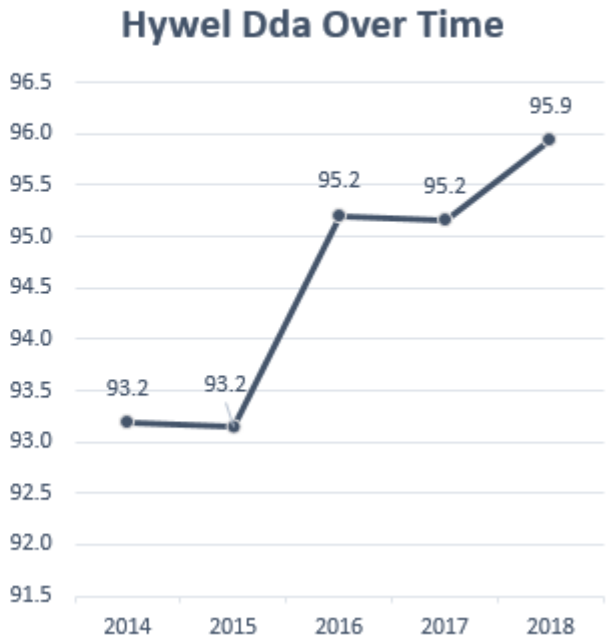
"Opening hours" are defined as the times when the main surgery doors are physically open and a patient can have face to face contact with a receptionist. Therefore, it does not include any hours where a telephone service is provided prior to doors opening, which is offered in some GP practices.

**Opened for daily core hours** is defined as practices which were open Monday to Friday from 08:00 to 18:30 each day, with no lunch time closure (as set under the General Medical Services contract).

2018 data is as at December 2018.

## Average Percent of weekly core hours achieved by GP Practices



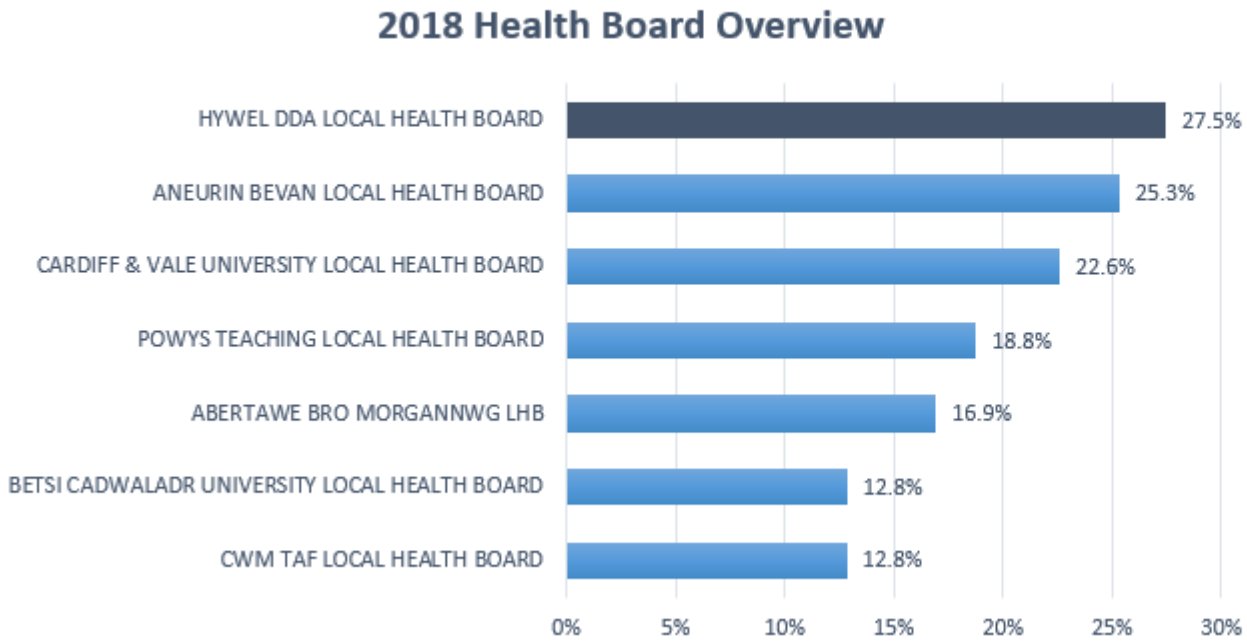



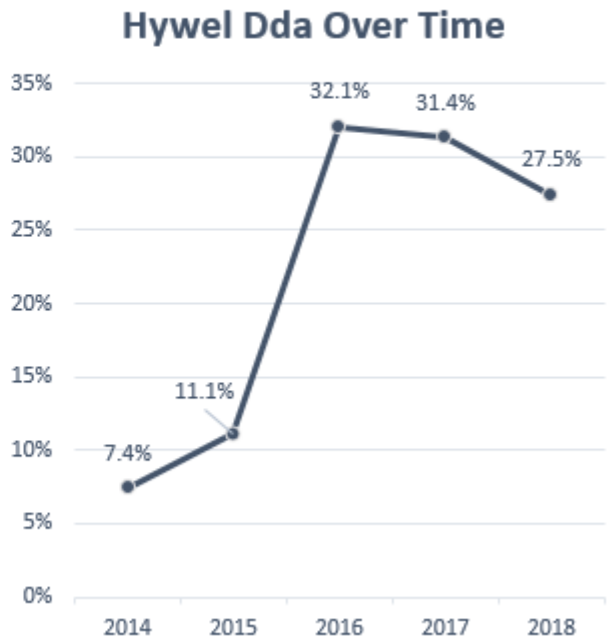

The average percentage of weekly core hours achieved by GP Practices in Hywel Dda is 95.9%. Hywel Dda continues to improve, and we suspect there may be some underreporting in this area. We will be undertaking a full review of GP access arrangements over the course of the next quarter.

## Appointment times

'Appointment times' are defined to be the times when the practice regularly offers planned consultation sessions with a GP to patients. This only considers appointment times offered to patients and where a patient can have a face-to face contact with a GP, and does not account for any other the other range of contacts offered at general practices.

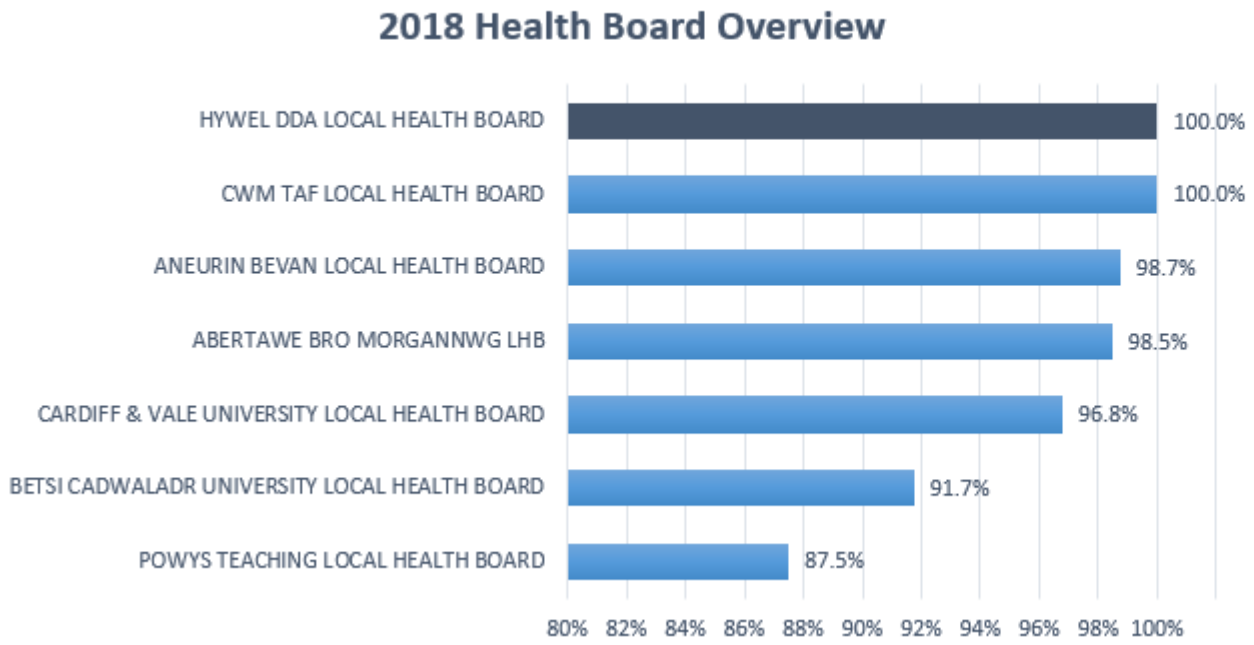
### Percentage of practices offering appointment before 08:30 at least two week mornings

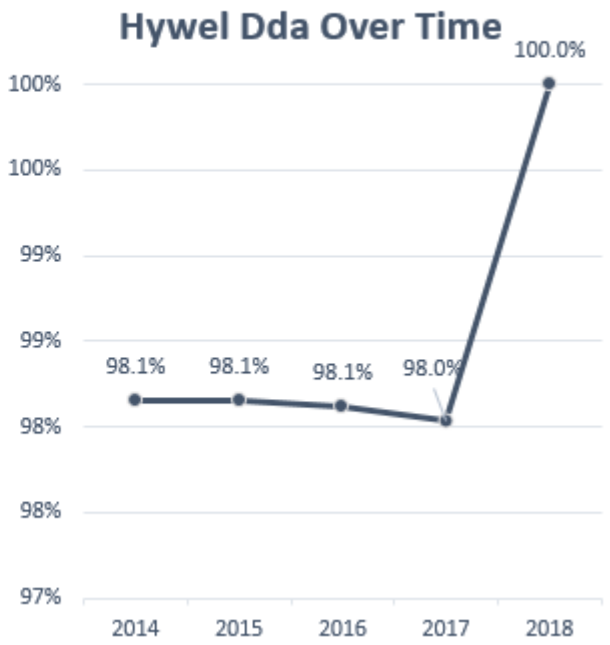



In Hywel Dda 27.5% of practices offer a GP appointment before 8:30am at least two week mornings. Hywel Dda compares favourably to other Health Boards.

## Percentage of GP Practices offering appointments at any time between 17:00 and 17:30, at least two week days




All GP Practices in Hywel Dda offer appointments at some time between 5 and 5:30pm on at least two days a week. Again Hywel Dda compares favourably to other Health Boards.

The Minister for Health and Social Services announced a new set of standards around access to General Medical Service, which is intended to raise and improve the level of service for patients in Wales from their GP practices. We will be reviewing the new standards in due course to establish what improvements are required going forward.

## Enhanced Service Delivery

| 2018-19 TO DATE | 17/18 Baseline *(per month)* | April 2018 | May 2018 | June 2018 | July 2018 | Aug 2018 | Sept 2018 | Oct 2018 | Nov 2018 | Dec 2018 | Jan 2019 | Feb 2019 | Mar 2019 | April 2019 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Flu Vaccinations | 14,374 | 238 | 44 | 6 | 90 | 4 | 0 | 4,165 | 37,634 | 24,100 | 8,328 | 2,451 | 771 | 235 |
| Pneumovax | 428 | 280 | 294 | 282 | 285 | 274 | 304 | 289 | 818 | 657 | 357 | 401 | 381 | 258 |
| Minor Injuries | 733 | 685 | 699 | 767 | 947 | 1,000 | 913 | 652 | 709 | 526 | 408 | 524 | 422 | 537 |
| Wound Care | 3,159 | 2,956 | 3,141 | 2,989 | 3,516 | 3,931 | 4,228 | 3,088 | 3,623 | 3,460 | 3,021 | 3,237 | 3,217 | 3,528 |
| INR* | 4,885 | 4,072 | 4,280 | 6,377 | 4,466 | 4,136 | 4,236 | 3,668 | 4,196 | 3,649 | 4,095 | 3,821 | 3,755 | 5,574 |
| Near Patient Testing | 3,126 | 3,024 | 3,224 | 2,874 | 3,311 | 2,667 | 2,965 | 3,052 | 3,023 | 2,595 | 3,019 | 2,783 | 2,849 | 3,662 |

**For 2018-19 this figure includes the Warfarin DES, the NOAC LES & phlebotomy for Level B Warfarin patients; flu is just vaccinations given and does not include the Flu Outbreaks enhanced service for giving prophylaxis to care homes patients.*
*The figures in the table relate to the month of payment which will be at least 1 month after delivery. Flu claims in July almost certainly relate to late claiming for 2017-18 activity.*

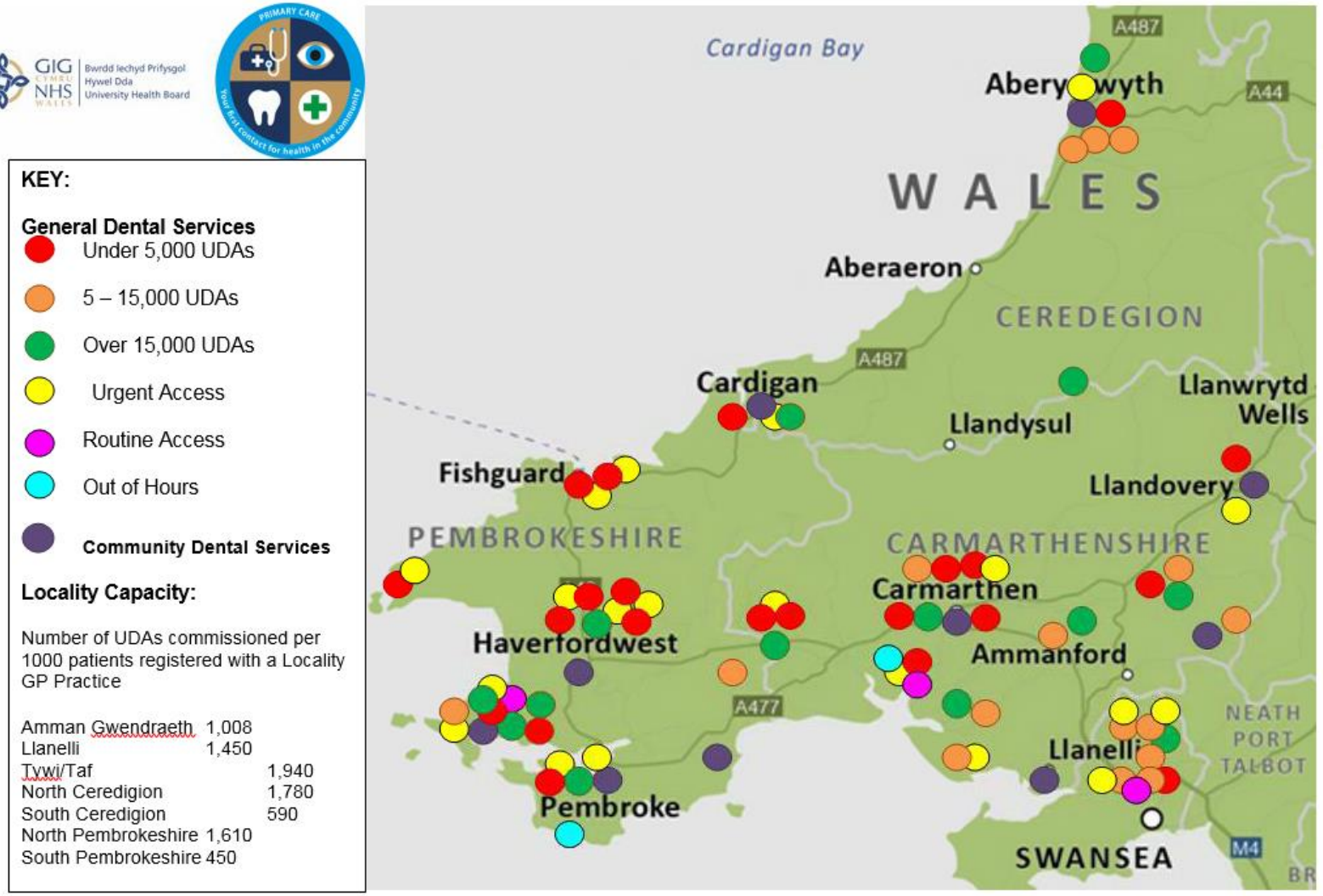
Key:

| | |
|---|---|
| | 10%+ over baseline activity |
| | 2 – 10% over baseline activity |
| | Less than 2% over baseline activity |

The changes in enhanced service delivery could relate to either a change in core services workload, which would affect the amount of time GPs have for providing enhanced services, or a change in patient demand for these services.

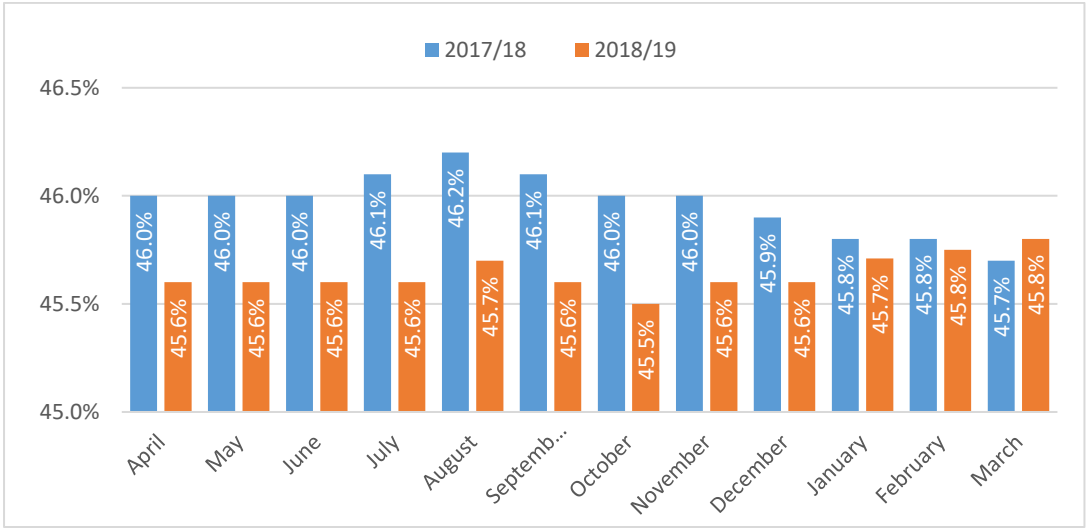
## General Dental Services (GDS) & Orthodontics

The map below provides an overview of the level and location of contracted dental services with urgent and OOH access provision included.

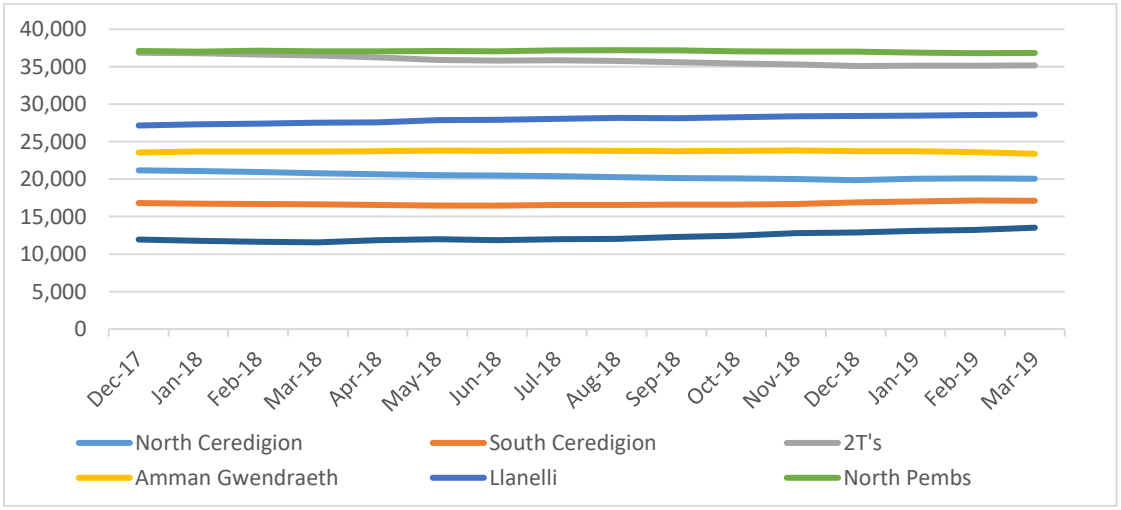


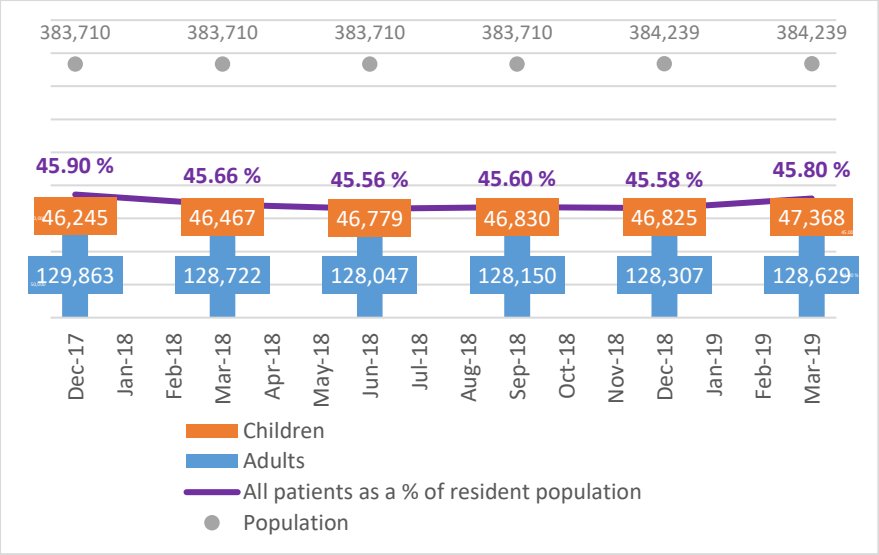
## Access

The chart below illustrates the proportion of patients seen against the population (target = quarterly improvement).

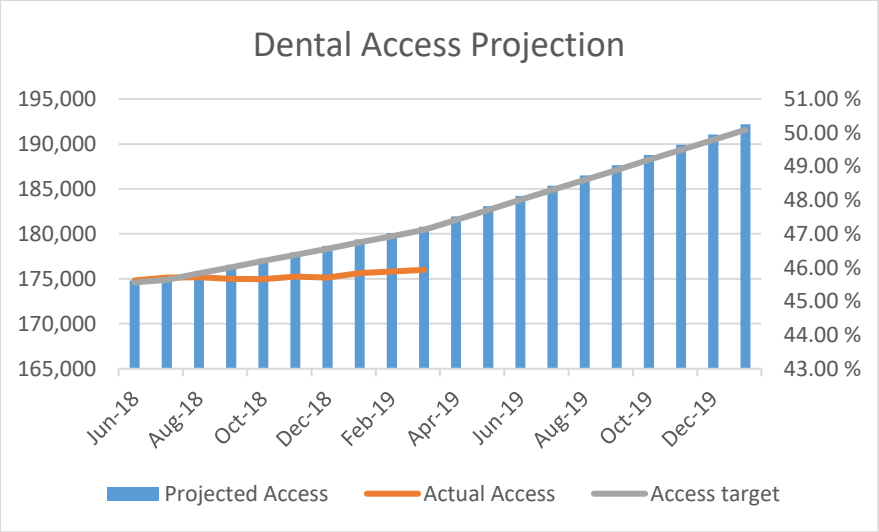



The chart below provides a further expansion on the percentage figures provided above by cluster. The majority of clusters appear stable in terms of access levels however, Llanelli and South Pembrokeshire appear to show an improvement, with the 2T's cluster having decreased but now appearing to stabilise.






This chart details the number of patients seen over the previous 24 months – this is split by adults and children. It also provides the population figure and the percentage of patients seen. The figures suggest a relatively steady increase in the number of adult patients seen in since June 2018, with an increase in the number of children seen in quarter 4 of 2018/19.




This graph presents the projected rate of increase in dental access, based on the Health Boards current commissioning plans. It is difficult to project dental access improvement within a short time frame. The usual monitoring period is 2 years, which is deemed to be the cycle of treatment in dental services. The Dental Services Team (DST) need to undertake some analysis work on an individual practice basis to understand the number of unique patients seen each month. This will involve requesting additional data from the NHS Business Services Authority (BSA) to track this against recruitment and retention issues, identified by practices which may be impacting on this forecast. Additionally those Contracts with newly commissioned activity have identified that new patients now being treated who have not had access to dental care previously are extremely high need. As a consequence, this has resulted in practices not being able to offer care to the number of patients in the initial period following Contract Award due to the clinical work required.

## Contract Reform

As of April 2019, there is a total number 12 practices involved in Contract Reform. This is an increase of three practices since October 2018. There remains to be a general feeling of reluctance to engage with Contract Reform at its current stage. Notwithstanding this, the Welsh Government (WG) target for 20% of Health Board's Practices to be engaged has been met. There are no dental practices in Hywel Dda progressing onto stage two at present. Of the 21 Practices engaged in Contract Reform across Wales (Phase 1) only one Practice is moving onto stage 2.

## Unscheduled Care Access Performance

The figures below include the available appointments of both mid-week and weekend urgent appointments across the Health Board during 2018/19, and percentage of the total appointments used. Baseline figure has been taken from March 2017. Due to limited availability of both general and urgent dental Services throughout Ceredigion, accessing suitable appointments for patients in this area remains difficult, and as such, they are having to travel into Pembrokeshire or Carmarthenshire, and potentially Powys Teaching Health Board to access urgent dental services. The DST continues to receive concerns from both the public claiming they are unable to access urgent services and the Health Boards A&E departments regarding the number of dental patients attending A&E, as such review of the mid-week urgent access appointment structure is underway as the data does not support the claims of there being a lack of available services.

In light of the ongoing issues in terms of dental access for urgent care as detailed above, via the 111 project the DST were successful in bidding for non-recurrent funding to support Winter Pressures. Utilising this funding weekend appointments have been placed in Penclawdd (8 appointments Sunday mornings) and Newcastle Emlyn (8 appointments Saturday mornings) with the Community Dental Service (CDS) providing an additional four mid-week appointments in Aberystwyth. These additional services commenced in February and have been extended from 31st March 2019 to 31st May 2019. Initial responses from patients, new service providers and existing providers of the urgent access service have been positive. Sessions appear to be fully booked with a reduction of patients failing to attend appointments, cases being seen are reported as true urgent cases and patients are having to potentially travel shorter distances to access dental care when in pain. Further review of the service needs to be undertaken to determine the benefits and ability to continue commission this service.

| | No. Appointments Available | % of Appointments Booked |
|---|---|---|
| **17/18 Baseline** | 590 | 92% |
| **April 2018** | 595 | 92% |
| **May 2018** | 707 | 89% |
| **June 2018** | 596 | 86% |
| **July 2018** | 586 | 93% |
| **August 2018** | 708 | 92% |
| **September 2018** | 590 | 89% |
| **October 2018** | 680 | 93% |
| **November 2018** | 566 | 94% |
| **December 2018** | 604 | 97% |
| **January 209** | 718 | 92% |
| **February 2019** | 647 | 91% |
| **March 2019** | 686 | 89% |

| | |
|---|---|
| | Less than 90% capacity utilised |
| | 90-95% capacity utilised |
| | 95%+ capacity utilised |

## 2019-20 Dental E-referrals

It is part of a new digital dental referral system, funded by Welsh Government. Dental E-referrals service commenced in March 2019, with Hywel Dda University Health Board and Abertawe Bro-Morgannwg University being early-adopter sites. Benefits include a faster referral process and will support the planning of commission services; however there have been some initial problems with the pathways which has resulted on some delays in the system.

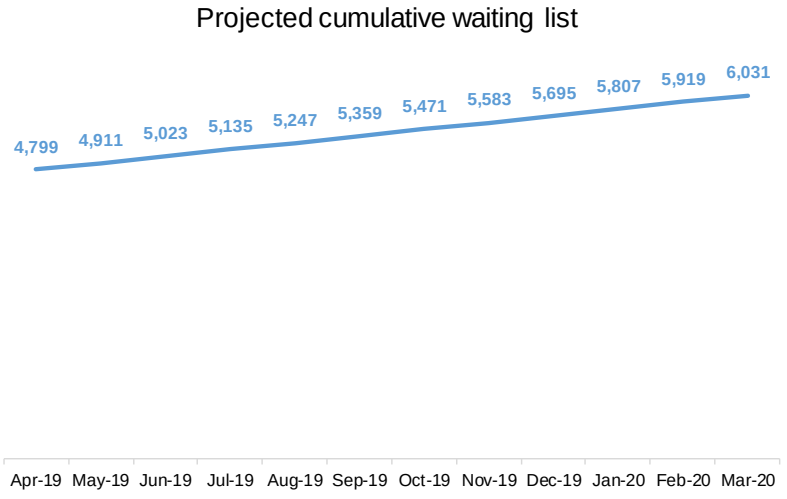
## 2019-20 Commissioning Plan

The Dental Team are currently in the process of commissioning a five year Orthodontic. It is intended that the contract will be awarded with effect of 1 June 2019. The 2019/20 commissioning plan concentrates on investment in South Ceredigion, reviewing the Units of Dental Activity (UDA) rates of those contracts below £25 and the provision of urgent dental care across the Health Board. It is anticipated that the procurement process will commence in May 2019.

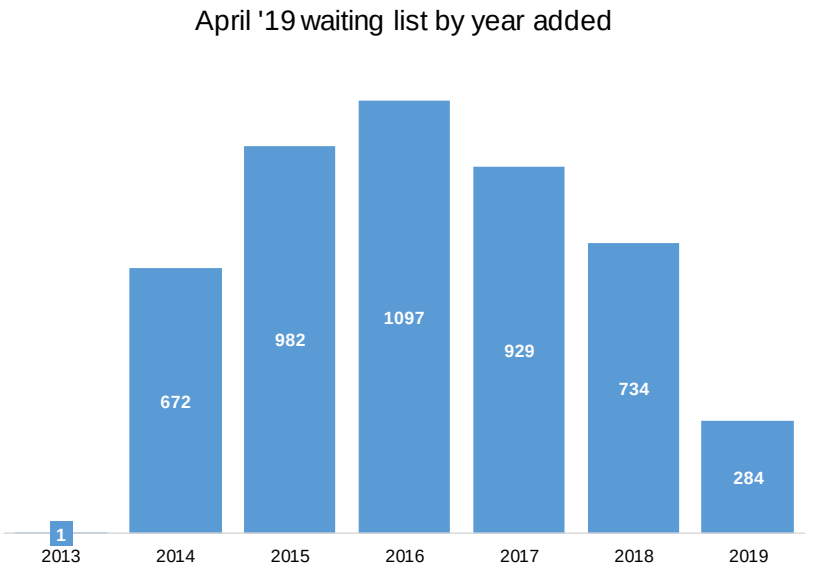
## Orthodontic Service

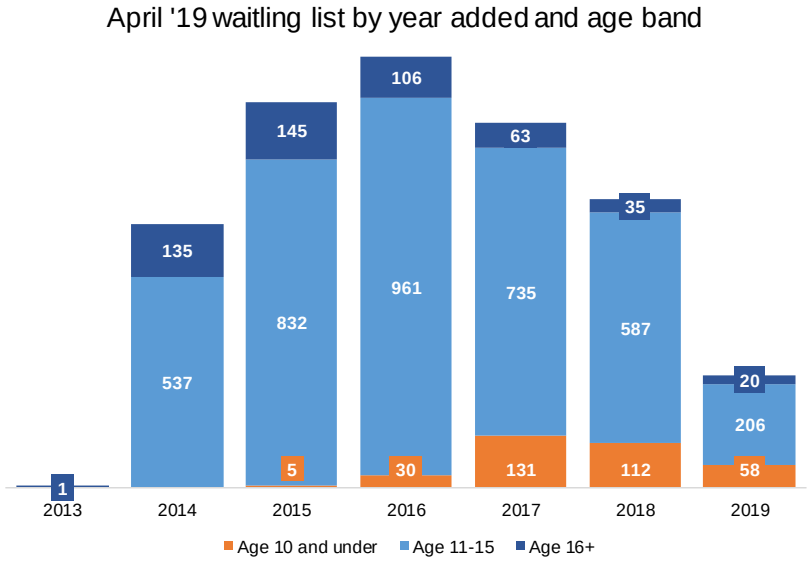
The Dental Team are currently working on proposals to improve the current waiting times with non-recurrent funding and to improve the longer term access issues by commissioning a service from April 2019 based on population need. The table below sets out the plans and their current status

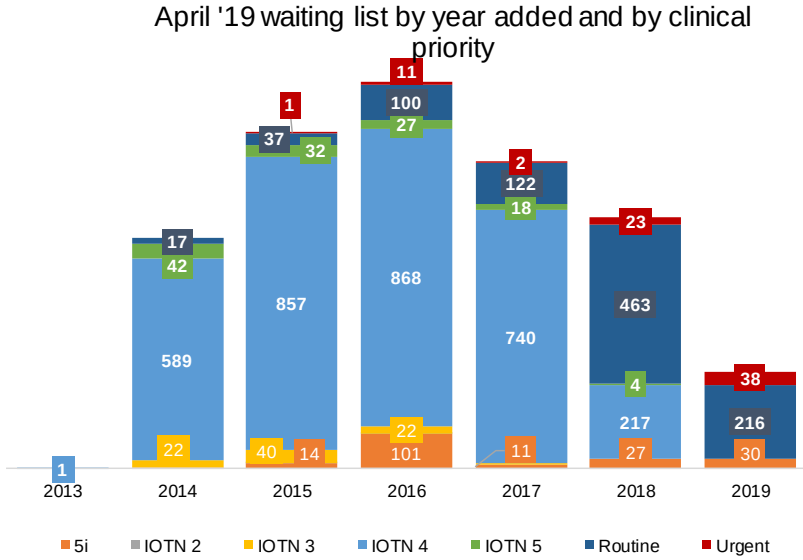
| Orthodontic Proposal | Non-recurrent or Recurrent | Projected start date | Comments |
|---|---|---|---|
| New Contract based on population need | Recurrent | 1st April 2019 | Tender processes will be awarded in the next two weeks |
| Waiting list Initiative to remove 250 patients from the waiting list | Non-recurrent | 1st December 2018 | As part of this Waiting List initiative (WLI) a select number of patients have been allocated to orthodontic practices.<br>All orthodontic assessments have been completed and<br>the majority of patients who require orthodontic treatment have commenced treatment. |
| Waiting list to validate 3000 assessment referrals | Non-recurrent | 1st January 2019 | To date 2,772 referrals have been triaged. |
| Orthodontic under 10 years old patients reviewed and either treated with functional treatment or discharged with appropriate advice to the General Dental Practitioner (GDP) | Non-recurrent | 1st January 2019 | As on 21st March 2019, a total of 260 patients have received an assessment appointment. Patients requiring treatment have commenced treatment. |




* 100 extra patients added for risk assumption




## Risks

| Risk | RAG Score |
|---|---|
| If there are delays in Procurement awarding the contracts the Dental Team may need to negotiate a contract extension with the current contract provider beyond what has already been agreed (June 2019). They may decline this extension, which means that there is the potential that there will be no service for a period of time until the procurement exercise is completed. | |

## Community Pharmacy

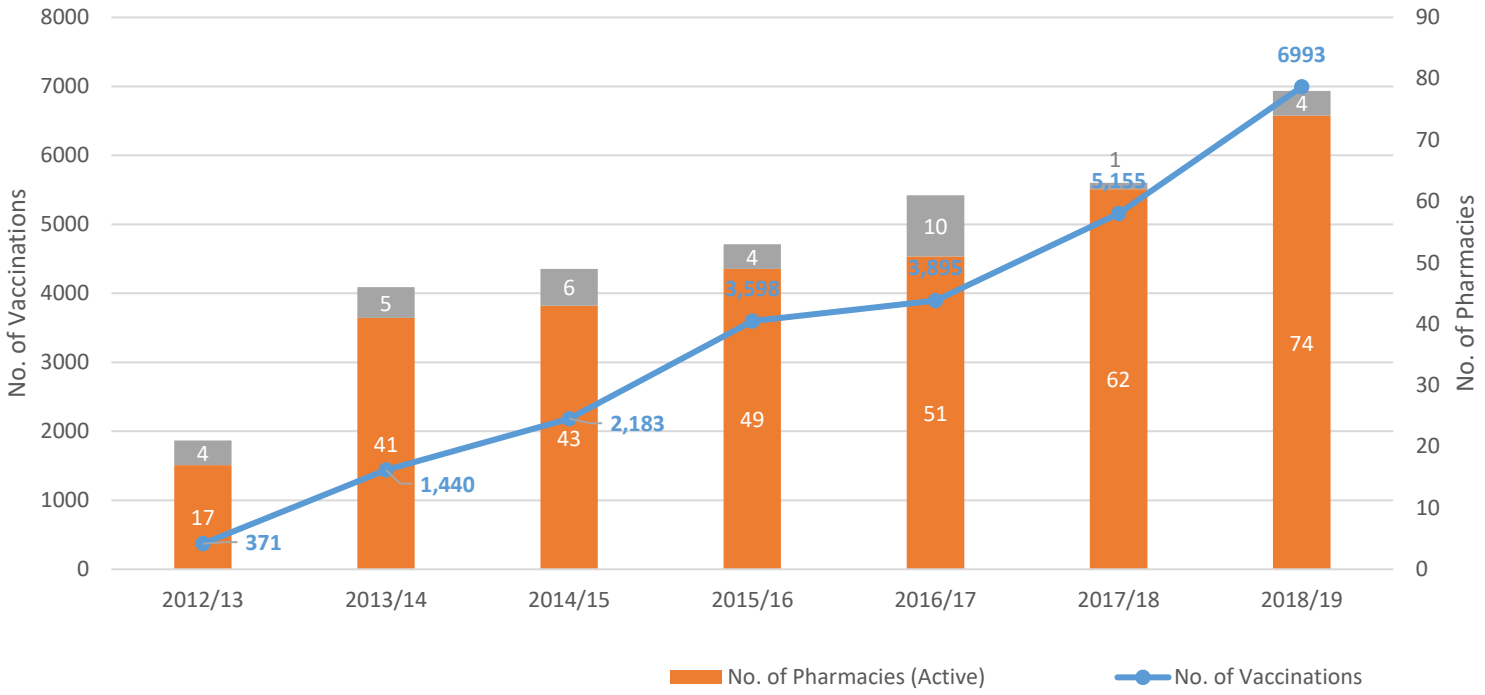
The number of Community pharmacies within Hywel Dda remains constant at 99. All must comply with the Essential Services within the NHS Pharmacy contract and each one provides at least one Enhanced Service. There is a range of Enhanced Services commissioned from community pharmacies, many of which support our population in accessing unscheduled care services. Current activity for the unscheduled care type Enhanced Services is shown in Appendix A.

To provide a National Enhanced Service, a pharmacist, or technician (for certain services) must complete an accreditation process via Health Education & Improvement Wales (HEIW). This process standardises the training and accreditation for all pharmacists within Wales. There are two elements within the process;
Step one requires completion of 9 key Skills & Competency modules - Information Governance, IQT Bronze, Equality Act, Mental Capacity, Patient Group Directions, POVA, Safeguarding Children & Young People Level 2, Patient Centred Consultation Skills, MECC (Brief Intervention & Motivational Interviewing Skills)
Step two is completion of a specific clinical knowledge based module relating to the specific service that the pharmacist wishes to provide.

A wide range of National and locally developed Enhanced Services are available for commissioning from community pharmacies. The ones relating to unscheduled care e.g. flu vaccinations, emergency supply of medication, common ailments, are open to all pharmacies to offer. A small number of specialised services will be commissioned in a more targeted way or where a need in a specific location is identified. The range of Enhanced Services for community pharmacies is constantly changing and developing and the pace will increase as more pharmacists complete Independent Prescriber training.

### Flu vaccinations – National Enhanced Service

Community pharmacies have been a provider of the NHS flu vaccination for over 6 years. Each year the number providing the service has increased (see chart below) as more pharmacists become trained. The activity has also increased over the years and in terms of the number of vaccinations per head of population, Hywel Dda is one of the top performing Health Boards. During the 2018/19 flu season, community pharmacies provided 6,993 vaccinations, compared to 5,155 in 2017/18. This represents a 36% increase and is against a flu season which saw supply issues with vaccines for over 65s.
For the 2018/19 flu season, community pharmacies were tasked by Welsh Government with providing NHS vaccinations for the usual eligible patients and also for Care Home staff.

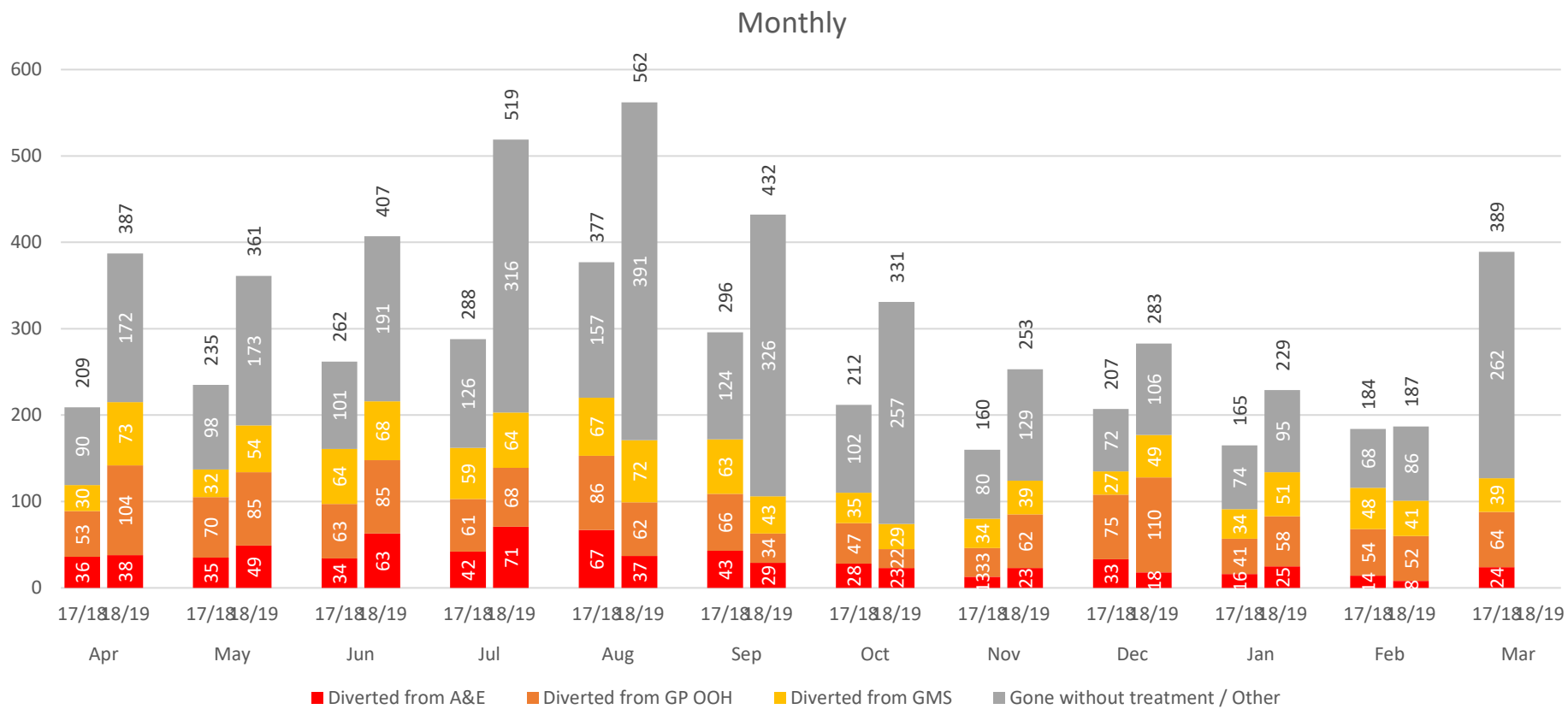



*Flu activity and participating pharmacies since 2012/13*

**Emergency Supply of Medication – National Enhanced Service.**

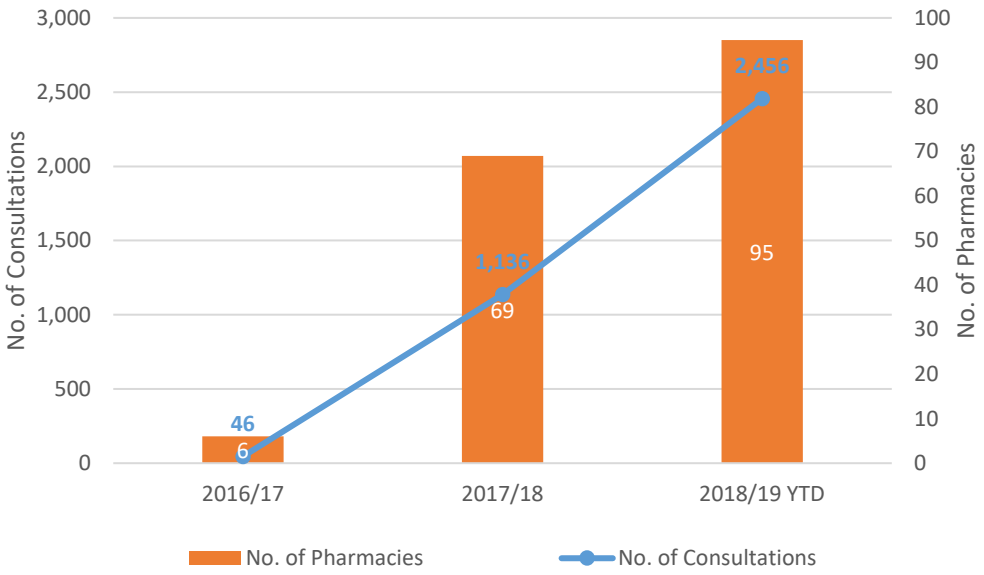
This service enables participating pharmacies to supply repeat medication to patients without the need for a prescription if they cannot obtain any before their next dose is due. The service continues to be rolled out to more pharmacies to improve accessibility and the numbers have increased from 65 at the end of March 2018 to 90 at the end of March 2019. The service continues to have a positive impact on reducing attendances at A&E and diverting individuals from contacting the Out of Hours service, where the individuals need is for medication only. The fee for the pharmacy service at £10.30 for a consultation and supply of 1st item and £2 for each additional item compares favourably with the cost of a GP appointment or A&E attendance to source urgently required medication.

Data on the number of individuals accessing the service and diverted from other NHS services can be found in the chart below (with 2017/18 comparison). NB the data for March 2019 is not yet available.




## Common Ailment Service – National Enhanced Service

This national service enables participating pharmacies to provide advice and in most cases treatment at no charge, for 27 common conditions. This particular service has the potential to grow and support GMS sustainability by diverting patients with one of the 27 conditions from making GP appointments to accessing the pharmacy-based service. At the end of 2017/18, there were 69 pharmacies out of the 99 in Hywel Dda linked to the new Choose Pharmacy IT platform that allows delivery of the Common Ailments Service. During 2018/19 more pharmacies were scheduled by NHS Wales Informatics Service (NWIS) for the Choose Pharmacy IT platform and by the end of March 2019, 95 pharmacies are able to offer the Common Ailment Service. The four remaining pharmacies had specific situations that did not enable them to take up the service. These will be reviewed during early 2019/20.




## Smoking Cessation Level 3 – National Enhanced Service

The level 3 smoking cessation service offers a one stop service for individuals that wish to quit smoking. Community pharmacies are part of the Help me Quit family that is the branding for Wales for all NHS smoking cessation services.

The number of pharmacies providing the Level 3 service has increased during 2018/19 from 43 to 56.

| Year | Total Clients | Clients quit | Quit rate |
|---|---|---|---|
| 2015/16 | 266 | 103 | 39% |
| 2016/17 | 334 | 149 | 45% |
| 2017/18 | 561 | 253 | 45% |
| 2018/19 YTD | 506 | 213 | 42% |

**Triage & Treat - Local Enhanced Service**

This local service enables patients to obtain assessment and where appropriate, treatment for low-level injuries. Only a small number of pharmacies offer this service currently, so the activity levels are quite low, but the service has the potential to support GMS sustainability and divert low level cases from A&E. Discussions are on-going with the Nursing Director re-establishing a new phase of training in 2019 with the aim of the service being more widely available. The Primary Care Team has developed a Community Pharmacy Dashboard to support development and performance management. The dashboard includes activity data on selected enhanced services, pharmacy closures, Datix incidents etc.

## Community Optometric Services

### Eye Health Examinations Wales (EHEW) accredited practices as at September 2018

| Health Board | Accredited | HB % | Non Accredited | HB % | Total |
|---|---|---|---|---|---|
| HDUHB | 48 | 93.9% | 3 | 6.1% | **51** |
| All Wales | 348 | 94.1% | 22 | 5.9% | **370** |

There are no changes to report from the previous month, as updated figures of accredited practices have not yet been provided. The Health Board receives practice figures annually within the Annual Report; however a request for updated figures has been made to the service.

It is important to note that although the Health Board appears to have less than 100% accreditation, the actual number is likely to be higher as EHEW can only be provided by premises and not domiciliary providers, both of which are included in the total number of providers per Health Board.

### EHEW provision within HDUHB as at March 2019

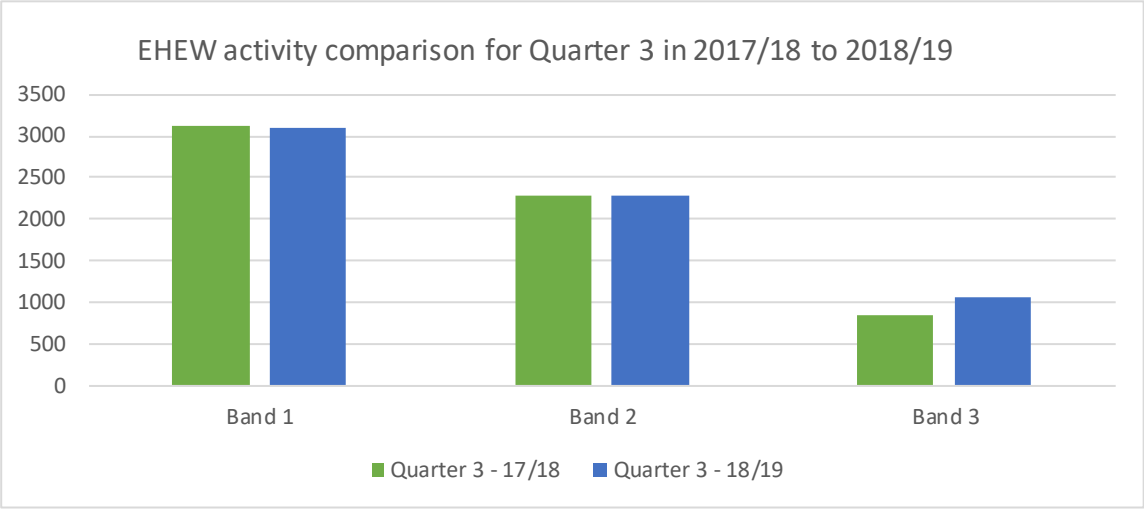
There are no changes to report from the previous month. An update is unlikely to show a marked difference in the Health Board's current EHEW profile.

## Number of EHEW claims per month

| 17/18 Baseline (per month) | April 2018 | May 2018 | June 2018 | July 2018 | Aug 2018 | Sept 2018 | Oct 2018 | Nov 2018 | Dec 2018 |
|---|---|---|---|---|---|---|---|---|---|
| 2001 | 2,186 | 2,047 | 2,579 | 2,366 | 2,060 | 2,130 | 2,054 | 2,178 | 2,208 |
| 976 | 1108 | 970 | 1,237 | 1,175 | 1,011 | 1,032 | 988 | 1,070 | 1,030 |
| 725 | 735 | 712 | 885 | 833 | 739 | 722 | 694 | 777 | 814 |
| 300 | 343 | 365 | 457 | 358 | 310 | 376 | 372 | 331 | 364 |

| |
|---|
| 10%+ over baseline activity |
| 2 – 10% over baseline activity |
| Less than 2% over baseline activity |

The table above shows the number of EHEW claims against the previous year's baseline. The majority of the RAG score being green indicates the number of claims per month show at least a 10% increase compared to the previous financial year. This indicates that the Health Board is continuing to transform Ophthalmology services by moving appropriate work into Primary and Community Care.

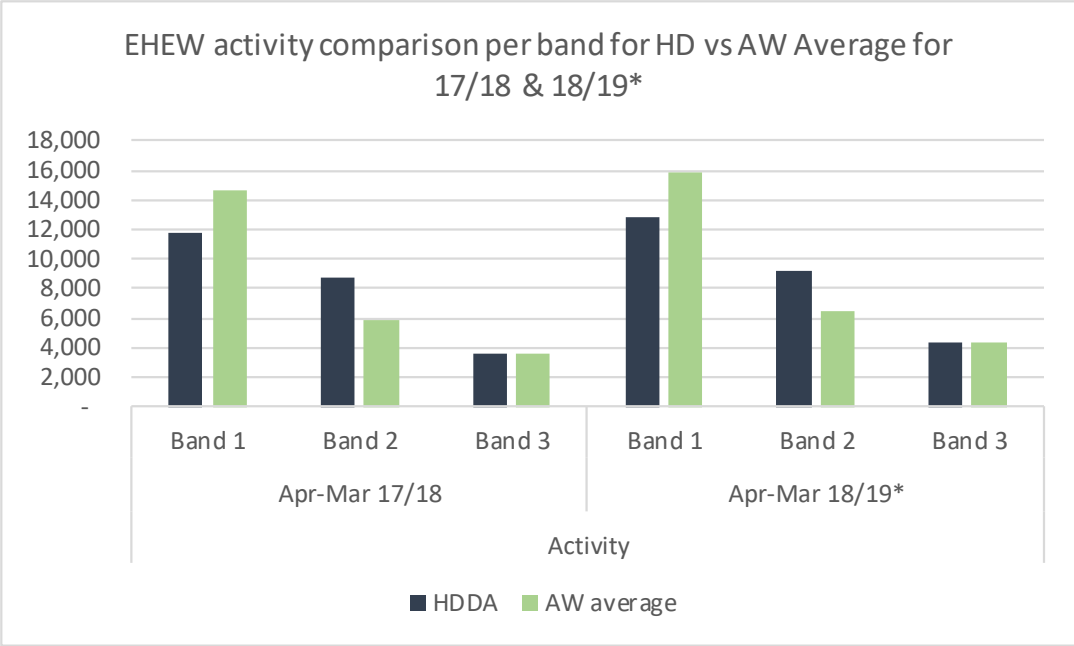



The graph shows a comparison of quarter three figures from this financial year to 2017/18. There is only a slight reduction in Band 1 and 2 claims in 2018/19, however the Band 3 claims have seen an increase, which is a common theme for 2018/19 to date.

## Hywel Dda University Health Board activity compared to All Wales activity by Health Board.

The graph below shows that the Health Board is seeing an improvement in access to the service. This is also true for the average access levels for the rest of Wales. Monitoring of this will be continued.

The data for activity are currently only available for quarters 1, 2 and 3. As a result, the figures in the graph contain quarter 4 activity figures that have been forecast based on year to date activity.

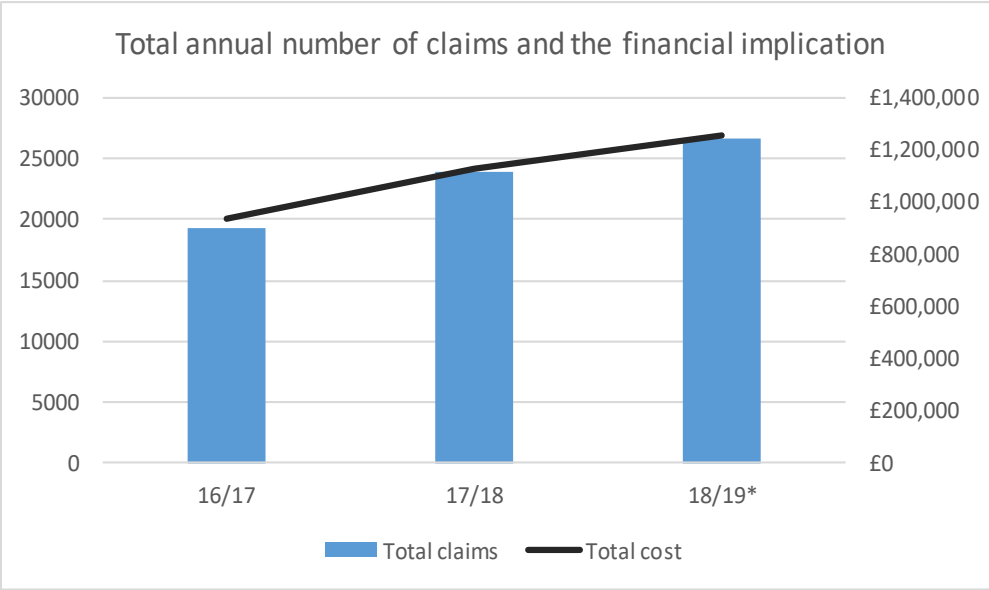



The activity is demonstrating progress, which is having a negative impact on Primary Care budgets that are overspent in this area. The payment methodology, unless reduced on an all Wales basis, does not provide an opportunity to renegotiate the tariff to bring the service back in line with the budget. The only way to achieve break even against the budget is to cap activity and this would have a detrimental effect on the transformation of Ophthalmology services. An analysis of the budget is set out below. The all Wales budget allocation average per head of registered population is £2.32, the Health Board's budget per head of registered population is £2.31.

| | 2017/18 | | 2018/19* | |
|---|---|---|---|---|
| | Spend | Budget | Spend | Budget |
| Band 1 | £708,554 | | £779,865 | |
| Band 2 | £350,926 | | £373,516 | |
| Band 3 | £72,691 | | £88,509 | |
| Total | £1,132,171 | £906,435 | £1,241,890 | £915,499 |

The table shows the Health Board's budget compared to the annual spend. Figures for 2018/19 are currently only available up until December, therefore the annual spend has been estimated based on the year to date actual figures.

The graph depicts the rise in number of EHEW claims and the associated costs since the budget was initially set. Work is being done to understand the reasons for the increase. Possible reasons may include better signposting and the redirection of patients requiring urgent eye care from GP practices and secondary care settings and the use of EHEW for some patients with glaucoma and cataract post-operative patients.

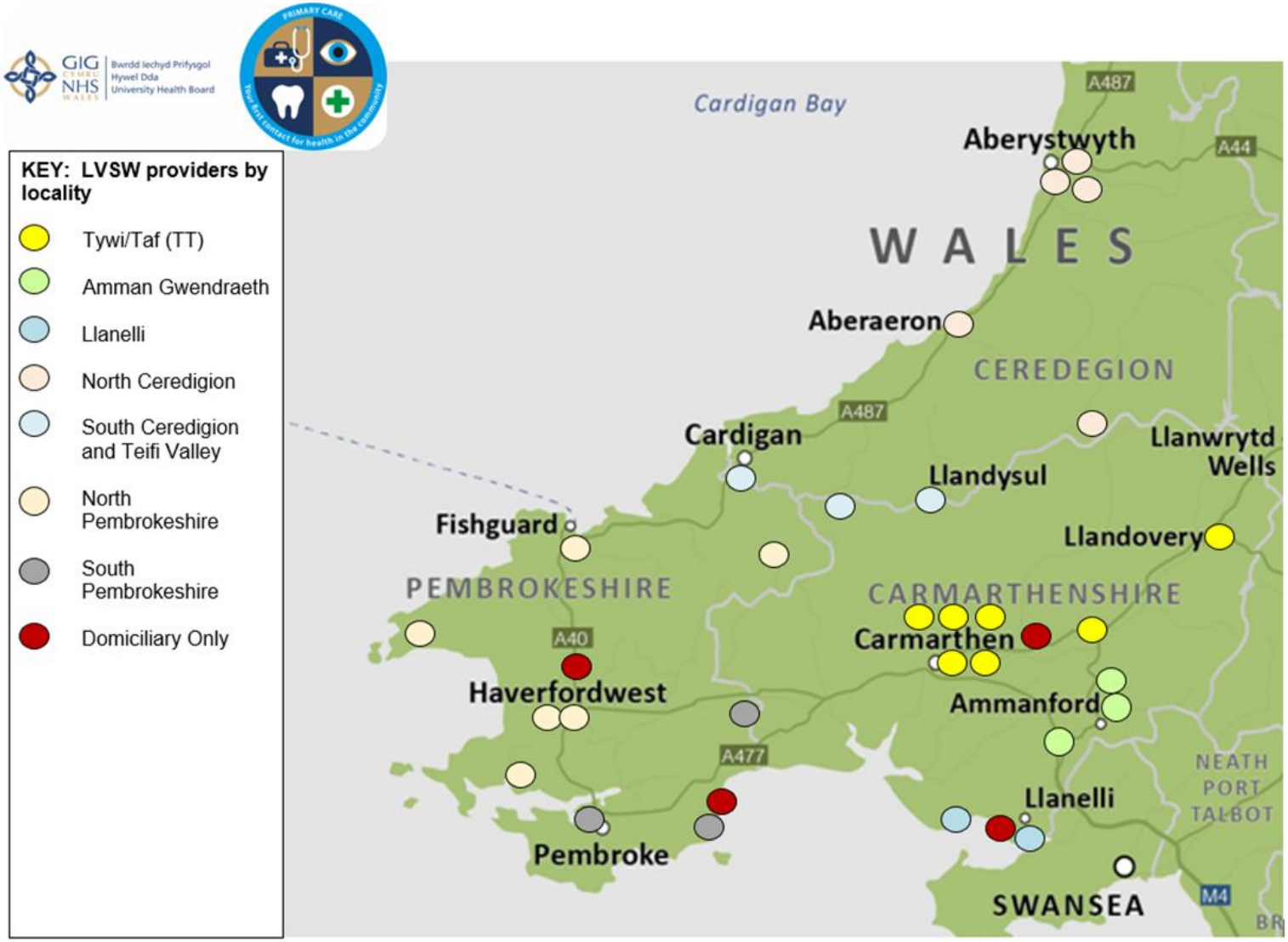



## Glaucoma Data Capture

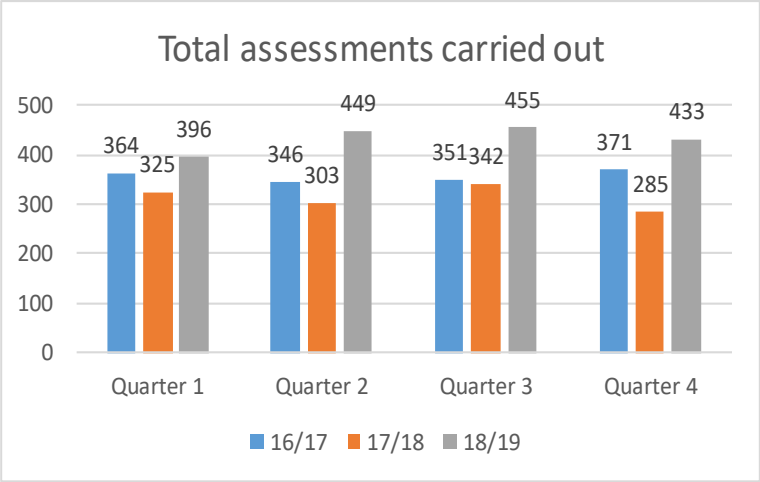
There is work currently being undertaken which will allow involved practices to provide an important role within the Glaucoma pathway. The new service, which is in its final stages before going through a tender exercise, will see Optometrists capturing data from patients in a Primary Care setting, which will be fed back to the Hospital Eye Service (HES). This data is then reviewed by a Consultant Ophthalmologist who will make the decision as to whether the patient will need to come into Secondary Care for an assessment. It is anticipated that this will increase capacity within the HES by ensuring patients who are able to be managed in Primary Care are not coming in to the HES unnecessarily. An update will be provided once the service has been rolled out.

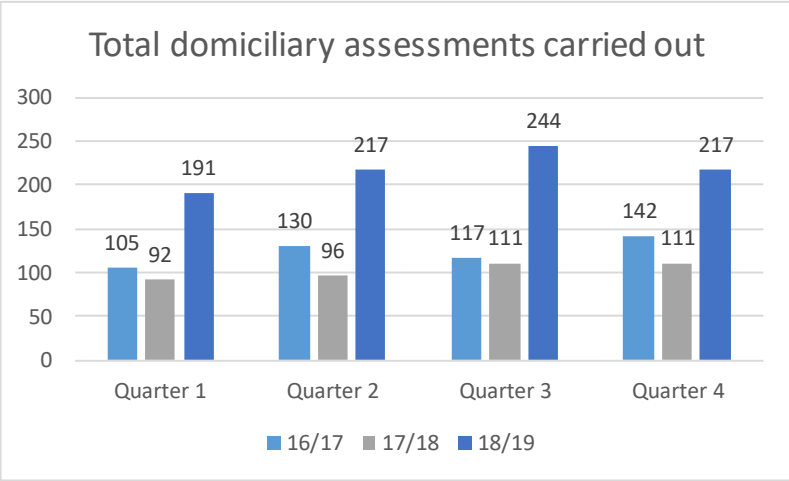
## Low Vision Service Wales (LVSW)

Currently within the Health Board, there are 33 premises able to provide LVSW, four of which in a domiciliary only capacity. LVSW figures are provided quarterly in line with the all Wales LVSW Joint Committee, and are included below. A map presenting the geographical spread of the service can be found below.



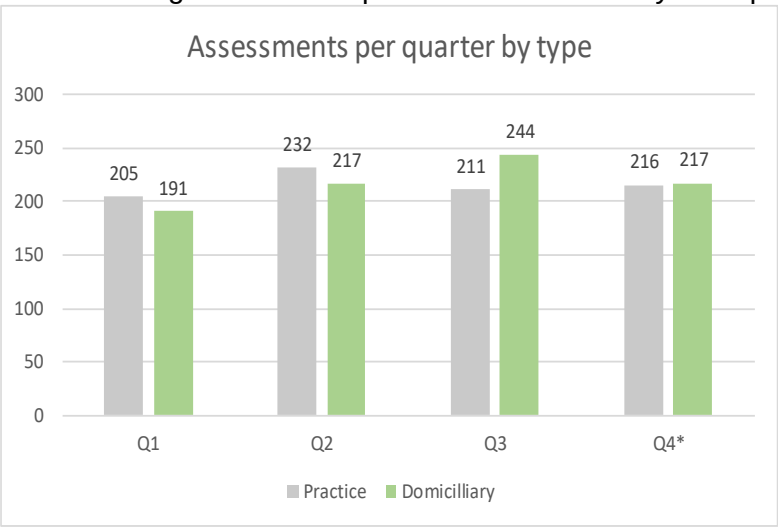
## Number of LVSW Claims



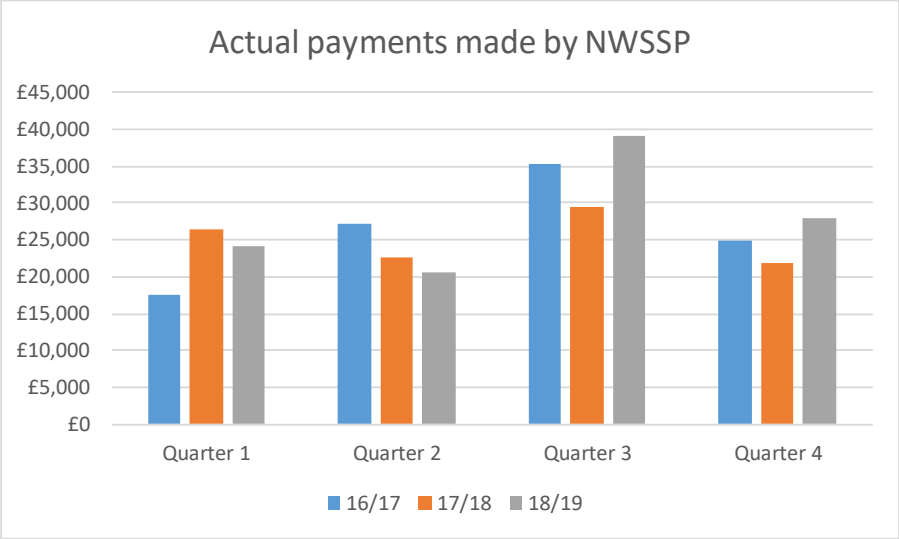




The graphs above show the total number of assessments and the number of domiciliary assessments carried out per quarter for the last three years. As depicted, the LVSW has seen a significant increase to the number of assessments carried out in 2018/19 compared to the previous two years. Figures are currently only available for quarters 1, 2 and 3, therefore quarter 4 figures have been forecast.

The graph to the below shows the number of assessments for 2018/19 split by whether they were completed at a practice or as a domiciliary visit. Hywel Dda has seen a significant increase to the number of domiciliary assessments from approximately 35% of all assessments in 17/18 to approximately 50% of all assessments carried out in 2018/19. The increase in domiciliary visits may be a result of the service meeting a previously unmet need. This will, however bring with it a cost pressure on the already overspent budget.



Currently the Health Board receives the spend data for the actual payments made. The graph below shows the actual payments made by NHS Wales Shared Services Partnerships (NWSSP) during each quarter for the last three years. Optometrists have 12 months to claim payment for a Low Vision assessment, therefore, the current reports do not show an accurate representation of the spend the Health Board can expect each quarter. The service seen a reduction in assessments in 2017/18 which may be the reason for the reduction in payments made in quarter 1 and 2 in 2018/19. However, activity has increased again which will be evident in payments made in the coming months.




| | 2017/18 | | 2018/19* | |
|---|---|---|---|---|
| | Spend | Budget | Spend | Budget |
| Total | £100,468 | £85,000 | £112,026 | £86,708 |

Work is being undertaken to understand the actual costs expected from the numbers of assessments completed in order to monitor the service effectively. The table above shows the spend against the budget for both 2017/18 and 2018/19. The spend data is only available up until December 2018, therefore the final quarter has been forecast and the service is looking to be overspent. As with EHEW, the budget and payment methodology is set nationally, resulting with any renegotiations being done on a national level.

LVSW also has an appliance budget that is managed centrally by the host Health Board. The increase in domiciliary assessments has the potential to have an impact on this budget and it needs to be understood from the Joint Committee how this overspend will be met. The Health Board is looking to understand the impact the service is having and any outcomes that can be used to manage the service going forward. Monitoring of the Health Board's data compared to the all Wales average for 2018/19 will be available for the next report.

## General Ophthalmic Services (GOS)

### GOS

Analysis is currently being undertaken on the non-cash limited division of Optometry and this will be continually monitored and reported going forward.

### Concerns

There are currently no open concerns for Optometric services.

**Appendix A**

# Community pharmacy Services – Unscheduled Care 2018/19

| Service | Number of Pharmacies providing the service | | 2017/18 Baseline | April 2018 | May 2018 | June 2018 | July 2018 | Aug 2018 | Sept 2018 | Oct 2018 | Nov 2018 | Dec 2018 | Jan 2019 | Feb 2019 | Mar 2019 | Total 2018/19 (to date) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Flu Vaccinations (Oct – Mar)** | **Oct: 74** | | **5,155** | **Service only in operation Oct - Mar** | | | | | | **3347** | **2157** | **887** | **221** | **281** | **100** | **6,993** |
| **Triage & Treat** | **2018-19 12** | Pts seen | **103** | **5** | **8** | **14** | **15** | **10** | **6** | **11** | **9** | **6** | **3** | **2** | **4** | **93** |
| | | Pts treated | **93** | **5** | **6** | **14** | **14** | **9** | **6** | **11** | **9** | **6** | **2** | **1** | **2** | **88** |
| | | Diverted from A&E | **55** | **4** | **2** | **8** | **8** | **4** | **1** | **2** | **3** | **2** | **1** | **0** | **1** | **36** |
| | | Diverted from GMS | **20** | **0** | **1** | **3** | **3** | **3** | **0** | **2** | **5** | **2** | **1** | **0** | **2** | **21** |
| **Emergency Dispensing** | **Apr: 65 Aug: 75 Sept: 77 Mar: 90** | No. of patients supplied | **2,984** | **387** | **361** | **407** | **519** | **562** | **432** | **331** | **253** | **283** | **229** | **187** | **305** | **4,256** |
| | | Diverted from A&E | **385** | **38** | **49** | **63** | **71** | **37** | **29** | **23** | **23** | **18** | **25** | **8** | **30** | **414** |
| | | Diverted from GP OOH | **713** | **104** | **85** | **85** | **68** | **62** | **34** | **22** | **62** | **110** | **58** | **52** | **71** | **813** |
| | | Diverted from GMS | **532** | **73** | **54** | **68** | **64** | **72** | **43** | **29** | **39** | **49** | **51** | **41** | **59** | **642** |
| **Common Ailment** | **Apr: 69 Aug: 77 Mar: 95** | Consultations | **1,136** | **217** | **235** | **268** | **253** | **191** | **198** | **216** | **217** | **173** | **214** | **274** | | **2,456** |

# Dementia Training

| | |
|---|---|
| **Reporting Schedule** | |
| **Health Board/Trust** | Hywel Dda University Health Board |
| **Date of Report** | 9th April 2019 |
| **Completed By** | Cheryl Raymond |
| **Contact Number** | 01437 773048 |
| **E-mail** | Cheryl.raymond@wales.nhs.uk |

**Reporting Template:** As outlined in the 'Good Work - dementia learning and development framework' all staff who work for NHS Wales need to have a solid awareness of dementia and the issues that surround it, to ensure that their approach supports people with dementia and carers to live well. This reporting template monitors the percentage of employed staff who have completed dementia training at an informed level and the actions being implemented to ensure the appropriate staff groups receive dementia training at a skilled and influencer level. Data is to be sourced from the Electronic Staff Record (ESR).
Target**:** For 2018-19, 85% of staff who come into contact with the public will have completed the appropriate level of dementia/education training.
**Reporting Schedule:** Dementia training is to be reported bi-annually. This form is to be submitted on 21 October (for data collected at 30 September) and 21 April (for data collected at 31 March).
**Form to be returned to: hss.performance@gov.wales**

| Data at: | Target | Total number of staff on ESR | Total number of staff on ESR who have completed dementia training at an informed level | Percentage of staff who have completed dementia training at an informed level | Update on issues impacting delivery |
|---|---|---|---|---|---|
| **30 September 2018** | **85%** | 10196 | 7345 | 72.04% | Staff release does impact on the ability to reach 85%, however our compliance is improving month on month and we are on target to reach 85% by 31st March 2019 |
| **31 March 2019** | **85%** | 9976 | 8223 | 82.4% | Whilst we are now only 2.6% off the 85% target, we will continue to support staff to access the e-learning system and complete the module. |

| **What actions have been implemented to identify staff groups who require dementia training at a skilled and/or influencer level*? What has been put in place to deliver and record training for these groups?** |
|---|
| At present, the identification of the staff groups who require dementia training at skilled or influencer level has not been completed due to the scale of the task. We are however in the process of commissioning a piece of work to undertake a baseline assessment of training needs based on the 'Good Work framework'' in order to produce a detailed map of training needs and target relevant training. Once the identification of the staff group has taken place, the competency will be attached to the job roles in ESR ensuring an accurate process for recording and reporting. |

*Further information on the staff groups that are required to complete dementia training at a skilled and/or influencer level and the training topics to be covered are available in 'Good Work - dementia learning and development framework'. https://socialcare.wales/resources/good-work-dementia-learning-and-development-framework.

# Improving the Health and Well-being of Homeless & Specific Vulnerable Groups

| | |
|---|---|
| **Health Board** | Hywel Dda University Health Board |
| **Date of Report** | April 2019 |
| **Report Prepared By** | Gareth Morgan, Strategic Partnership Manager<br>Joanna Dainton, Head of Commissioning & Partnership Strategy Development – Drug and Alcohol Misuse |

Health Boards are expected to have in place assessments and plans to identify and target the health & well-being needs of homeless & vulnerable groups of all ages in the local area. **Vulnerable groups are people identified as: homeless, asylum seekers & refugees, gypsies & travellers, substance misusers, EU migrants who are homeless or living in circumstances of insecurity.**

| **Standards** | **Key Actions Achieved**<br>April to September 2018 | **Key Actions Achieved**<br>October 2018 to March 2019 | **Risks to Delivery** | **Corrective Actions** |
|---|---|---|---|---|
| **1. Leadership**<br>The Health Board demonstrates leadership driving improved health outcomes for homeless and vulnerable groups. | HDUHB has contributed to the regional homelessness strategy across Mid and West Wales. This is an overarching and developing strategy supplemented by individual work-streams, such as armed forces and Syrian Vulnerable Persons Resettlement Programme (SVPRP).<br><br>The Director of Public Heath continues to Chair the multi-agency Area Planning Board (APB) for drug and alcohol misuse. The Board is in the process of reviewing its Vision, Strategy and Service model supported by the Institute of Public Care (IPC) with members of the APB Executive Board and sessions were delivered in May and July 2018.<br><br>The Health Board has signed | One key demonstration of our leadership during this interval was to support the development of the regional homelessness plan through the Regional Commissioning Collaborative for Supporting People. HDUHB were an ever present member of the work of the RCC, as well as having presence at local county forums.<br><br>The Director of Public Health continues to Chair the Area Planning Board for substance misuse, with its new strategy at completion. In March 2019, proposals for its commissioning intentions going forward were agreed and spending plan submitted to Welsh Government. The new strategy identifies housing as a key priority and the spending plan includes a contribution to a supported | As with all strategic programmes, delivery is contingent on ongoing commitment. In this situation, there is a further risk of work-streams becoming divergent across the different target groups, which could undermine progress.<br><br>Our challenge going forward is to maintain and enhance this input, so risks to delivery and corrective actions remain as shown in columns to the right. | It will be essential for HDUHB to maintain presence at the Regional Commissioning Collaborative (RCC) for Supporting People. Ongoing work-streams such as SVPRP and armed forces will also need to be continued and reported on in a coherent way to ensure improved patient experience.<br><br>Collaborative working across organisations and with the target groups could help to identify both shared challenges and opportunities, thereby assisting progress. |

| | | | | |
|---|---|---|---|---|
| | the first Memorandum of Understanding and Risk Sharing agreement. The document makes a shared commitment, with other statutory responsible members of the APB, to lead on efforts to address drug and alcohol misuse with vulnerable groups. | housing project to increase available beds from 5 to 9. | | |
| **2. Joint Working**<br>The Health Board works in partnership with the Local Authority, service users, third sector and stakeholders to improve health of vulnerable groups and contribute to the prevention of homelessness. | HDUHB attends the multi-agency Regional Commissioning Collaborative and related multi-agency county panels for armed forces, homelessness, SVPRP and supporting people<br><br>The Health Board continues to work with partners via the Area Planning Board to implement its drug and alcohol strategy, reporting progress quarterly to Welsh Government via a dashboard submission. The Hywel Dda APB had the lowest rate of DNAs (non – attendance for treatment appointments following assessment) and highest rate of treatment completions across Wales in September 2018.<br><br>Alongside this, significant work continues to be undertaken to review fatal and non fatal drug overdoses. A key issue that has emerged in such reviews | There are plans to further develop the VPR database and keep this up to date.<br><br>The Health Board is working closely with the recently appointed RAFLCO which will provide welcome focus and capacity for the Regional Armed Forces Covenant Forum work.<br><br>A Service development Manager post will be recruited through the APB during 2019 with part of its role to develop a service user involvement process. This will include engagement with homeless and other vulnerable groups. | There will be capacity challenges managing this programme across the 3 counties, with additional regional groups also in existence such as the Armed Forces Forum / Regional Covenant.<br><br>Whilst it is believed that HDUHB is the first Health Board to co-ordinate a regional working group with Local Authorities, voluntary sector partners and Welsh Local Government Association / Welsh Migration Partnership, there remain challenges to gathering and maintaining momentum. | To maintain our joint working it is important that firstly this work is seen as a priority. Secondly, drawing in additional resources will be helpful, such as a recent regional post on armed forces work |

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| | relate to housing and homelessness and these issues are likely to form a key component of the new APB Substance Misuse strategy | | | |
| **3. Health Intelligence**<br>The Health Board works in partnership with the Local Authority, service users, third sector and stakeholders and demonstrates an understanding of the profile and health needs of homeless people & vulnerable groups in their area. | Work is ongoing to ensure that the number of SVPRP registered is up to date. We are also doing work on WHC (2017) 41 17 – Healthcare Priority for Veterans – to implement this for the benefits of veterans.<br><br>A Needs Assessment has been produced as a component of the emerging APB substance misuse strategy and will continue to be reviewed on a regular basis to inform local service development | We continue to work with GP practices, and through the LMC, to increase awareness of WHC (2017) 41 – Healthcare Priority for Veterans and to encourage recording of Veteran status on the clinical systems.. An analysis of data from 2 GP practices with a combined list of of over 15,000 patients has shown an estimated 10% recording rate for veterans.<br><br>A new cross partnership Data and Intelligence Officer role will be created by the APB in 2019 to better assess need across a range of vulnerabilities. | We now have over 100 people within the SVPRP. The risk is that with incoming arrivals, there can be poor communication between organisations. As for the priority policy, there may be lack of awareness or misunderstanding of the eligibility for it being used.<br><br>Non-identification and recording of Veterans status can risk individuals not receiving the priority treatment that they may be eligible for. It also impacts on our ability to undertake a robust needs assessment | Links have been established between HDUHB and Local Authority colleagues to ensure SVPRP records are updated.<br><br>We are working to boost the number of veterans known in a variety of ways, including posters in GP practices, working with third sector partners such as SAFFA, RBL and media (including social media and local press releases). |

| **Standards** | **Key Actions Achieved**<br>April to September 2018 | **Key Actions Achieved**<br>October 2018 to March 2019 | **Risks to Delivery** | **Corrective Actions** |
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| **4. Access to Healthcare**<br>Homeless and vulnerable groups have equitable access to a full range of health and specialist services. | Please refer to earlier comments on WHC (2017) 41. During this interval, further discussions have also been initiated about developing a decision making tool to improve inter-agency work<br><br>Internal global updates advising staff | In order to meet the challenges we face in ensuring homeless people have equitable access to services, we are working collaboratively on a pilot of a 'Housing First' project in Aberystwyth. This will help | Time and capacity constraint will always determine what can be achieved and over what timescales. This still remains a work in progress. | Reminders to staff of the veterans priority policy is also aimed at increasing uptake. Working on key areas of 'early wins' such as the priority policy as well as continuing to |

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| | of the veterans priority policy have been issued to raise staff awareness and encourage uptake.<br><br>Extensive consultation with protected and vulnerable groups around the Health Board's Transforming Clinical Services proposals has enabled the health board to gain information on how access can be improved<br><br>DDAS continues to provide substance misuse services, engaging with hard to reach and vulnerable groups delivering Needle Syringe provision, Blood Borne virus testing and access to treatment from within known hot spots in community settings. In addition to this naloxone kits are delivered to those at risk of overdose to reduce harm<br><br>The Hospital based Alcohol Liaison Service continues to be successful with services delivered from PPH, Bronglais and Glangwlli with approval to recruit to a post at Withybush Hospital about to commence The service is identifying many individuals who have not previously accessed treatment for their alcohol issues, | identify the barriers homeless people face and the results of this pilot will help inform future work across the regional footprint.<br><br>The Withybush Alcohol Liaison Service post is now out to advert, meaning there will be equitable access in all of the four HDUHB hospital sites. | | use evidence to inform our work eg from complaints |

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| **5. Homeless & Vulnerable Groups' Health Action Plan (HaVGHAP)**<br>The Health Board leads the development, implementation & monitoring of the HaVGHAP (as an element of the Single Integrated Plan & regional commissioning strategies) in partnership with the Local Authority, service users, third sector & other stakeholders. | Within the Health Board, we have established a small email internal group which can provide information sharing and co-ordination across all the vulnerable groups. Externally, we are linked into a range of different work programmes as evidenced earlier, such as the RCC. This provides a framework for a HaVGHAP. | The Health Board is currently reviewing the terms of reference for its Improving Experience Sub-Committee to strengthen the formal monitoring and consideration of the experience of vulnerable groups.<br><br>The internal virtual in-house group has been boosted and expanded following discussions / correspondence with senior nurse colleagues. This has resulted in work to advance the delivery of a hospital discharge protocol for homeless people, and work is being progressed on this. This includes a generic framework that will be customised for individual settings. | The internal and external work being undertaken will need to be balanced. It is also dependent on the level of 'buy-in' from colleagues. It is also important that the context of this work is considered, for example service changes in HDUHB. | During our recent Transforming Clinical Services consultation, groups involved included Llanelli Veterans Association. It is important that where possible, the work on the HaVGHAP is part of our wider service planning processes. |

# NHS Delivery Framework Report: Accessible Communication and Information

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| **NHS Organisation** | Hywel Dda University Health Board |
| **Date of Report** | March 2019 |
| **Report Prepared By** | Gareth Morgan, Strategic Partnership Manager<br>Anna Bird/Jackie Hooper – Strategic Partnership, Diversity & Inclusion Team |

The All Wales Standard for Accessible Communication and Information for People with Sensory Loss sets out the standards of service delivery that people with sensory loss should expect when they access healthcare. These standards apply to all adults, young people and children. The Accessible Information Standard requirements sit alongside the "Standards" as an enabler to implementing them.

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| **Does the organisation have an action plan in place to implement the All Wales Standard for Accessible Communication & Information for People with Sensory Loss?** | Updated Action Plan to follow. |

**Update on the Actions to Implement the All Wales Standards for Accessible Communication & Information for People with Sensory Loss:**

| Needs Assessments | Key Actions Achieved during 2018-19 | Risks to Delivery | Corrective Actions |
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| All public & patient areas should be assessed to identify the needs of people with sensory loss. | Development of Hywel Dda University Health Board Sensory Loss Friendly Award (SFA) achieved.<br><br>Pilot of SFA in a ward at Withybush General Hospital, Haverfordwest – achieved and assessed.<br><br>Roll out of SFA to additional wards/departments and, over time Primary Care and Community – pending with plans for subsequent roll out.<br><br>Work is continuing to assess public and patient areas across the Health Board. For example, following the sensory loss awareness month, the HDUHB Estates Department visited Amman Valley Hospital and a number of improvements are being considered externally and also to the eye clinic. | Potential lack of buy in to roll out from wards and departments due to competing demands.<br><br>Competing demands on resources for improvements to the Health Board estate. | Sensory loss awareness month provides a focus for our activity where we can encourage wards and departments to participate in the SFA scheme.<br><br>The sharing of good practice could help boost the roll out across HDUHB.<br><br>Following the Eye Health Conference there could be some opportunities to focus our work, for example on dementia and stroke in the first instance.<br><br>The sensory loss friendly award provides a framework for consideration of appropriate corrective actions. |

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| | As part of the implementation of our Health and Care Strategy, and the specific transformation projects, consideration of the needs of people with sensory loss (and other disabilities) are embedded into the development of new builds or refurbishments e.g. Crosshands Hub. | | |
| All public information produced by organisation should be assessed for accessibility prior to publication. | Continuing to communicate in a variety of ways to meet the needs of our audiences, internally and externally – an example being the publications issued during engagement and consultation around Transforming Clinical Services between April – July 2018 were available in a range of formats such as Welsh, English, Polish (plus other languages on request), large print, EasyRead, video and audio, and Braille (on request).<br><br>The Health Board had endorsed a Health and Care Strategy which provides a 20 year vision for the delivery of services with a focus on patient centred care, involvement and wider well-being. A summary of the document is being developed for the public and will be available in a variety of formats including audio and a BSL animation. Larger print and Braille will be available on request.<br><br>Discussions have commenced on the development of an Accessible Communication and Information policy to ensure equitable access to information. | No obvious risks to delivery.<br>No specific risks identified at this stage. | The UHB tailors communication to meet the needs of individuals. We provide materials, such as leaflets and public reports, in hard copy format. These are made available in high footfall patient areas and key community locations and posted to members of our Siarad Iechyd/Talking Health scheme, as well as bespoke stakeholders depending on the particular product.<br><br>Any requests for Health Board documents to be provided in an alternative format are reasonably considered.<br><br>Our website also utilises Browsealoud which can assist people with vision impairment.<br><br>The Health Board is transferring to a new website platform which will increase compatibility with a wider range of audio readers and Apps. |

| Standards of Service Delivery | Key Actions Achieved during 2018- 19 | Risks to Delivery | Corrective Actions |
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| **Health Prevention** (Promotion Screening, SSW, Flu Vaccination, Bump Baby & Beyond). Priority areas include: | | | |
| ➢ Raising staff awareness | The NHS CEHR Sensory Loss E-Learning package is available to staff. Currently, staff are able to read through the course information only.<br><br>Through Patient Stories and awareness raising sessions provided to teams and departments, staff become aware of the need to provide information in accessible formats.<br><br>The Health Board is offering a refreshed induction session with opportunities for additional active discussion in relation to recognising the need of patients with sensory loss who are accessing services. All new staff are encouraged to be proactive in meeting the needs of people with sensory loss who access their services. | Problems have been experienced accessing the assessment section of the e-learning package. Information can be read through via ESR, but assessment is linked through learning@nhswales, which is currently inaccessible.<br><br>Take up of sensory loss training patchy, lack of awareness by staff in some areas of the needs for people with sensory loss. | The Issue has been logged with Learning and Development Department and is awaiting investigation and an IT fix.<br><br>Encourage staff who have undertaken training to spread the word among colleagues advise on good practice.<br><br>Raising awareness of the availability of the Sensory Loss E-learning package even as a read through only will assist staff to learn about meeting the needs of people with sensory loss.<br><br>No further corrective actions identified or taken. |
| ➢ Ensuring all public information is accessible for people with Sensory loss | Continuing to communicate in a variety of ways to meet the needs of our audiences, internally and externally.<br><br>Discussions have commenced on the development of an Accessible Communication and Information policy to ensure equitable access to information. | No obvious risks to delivery | No further corrective actions identified or taken. |
| ➢ Accessible appointment systems | Continuing to use patient and carer feedback to provide assurance that accessible appointment systems are in place.<br><br>No additional updates. | Digital infrastructure is variable across health board sites and availability of funds to upgrade these can create a risk to delivery. | No further corrective actions identified or taken. |

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| ➢ Communication models | Ensuring a range of communication models are available to support patients to access healthcare information, on prevention and healthy lifestyle choices, screening and treatment.<br>Decisions on production of information in formats accessible to people with sensory loss are made on a case by case basis.<br><br>No additional updates. | No obvious risks to delivery | N/a |
| **Primary and Community Care.** Priority areas include: | | | |
| ➢ Raising staff awareness | The NHS CEHR Sensory Loss E-Learning package is available to staff. Currently, staff are able to read through the course information only.<br><br>Through Patient Stories and awareness raising sessions provided to teams and departments, staff become aware of the need to provide information in accessible formats.<br><br>A presentation was given to the 3 counties primary care meeting in December 2018 to raise awareness of the sensory loss information standard and encourage staff to record sensory loss in the patient record. | Problems have been experienced accessing the assessment section of the e-learning package.<br><br>Take up of sensory loss training patchy, lack of awareness by staff in some areas of the needs for people with sensory loss.<br><br>Competing pressures in primary care mean this recording of information is not always undertaken consistently. | The Issue has been logged with Learning and Development Department and is awaiting investigation and an IT fix.<br><br>Encourage staff who have undertaken training to spread the word among colleagues advise on good practice.<br><br>Raising awareness of the availability of the Sensory Loss E-learning package even as a read through only will assist staff to learn about meeting the needs of people with sensory loss.<br><br>An audit is being planned to assess the progress and help inform future actions. |
| ➢ Accessible appointment systems | Continuing to use patient and carer feedback to provide assurance that accessible appointment systems are in place.<br><br>The Sign and Share Club in Pembrokeshire and the Action on Hearing Loss project for armed forces veterans are examples of two community projects that are helping patients with hearing loss access appointments. This has improved access for one veterans to audiology due to military attributable injury sustained during their service. | Digital infrastructure is variable across health board sites and availability of funds to upgrade these can create a risk to delivery. | Feedback is being used to inform on-going service developments and service delivery. |

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| ➢ Communication models | Continuing to ensure access to BSL interpreters for patients with sensory loss accessing primary and community care through an externally commissioned source.<br><br>Each year, via a memorandum of understanding with the Wales Council for Deaf, we continue to provide sensory loss support to over 200 patients and the highly cost-effective model has been recognised nationally by the Wales Audit Office Good Practice Team.<br><br>Discussions are on-gong in relation to extending support for deaf patients into nursing and residential homes.<br><br>Work has been on-going to streamline and simplify booking procedures for interpretation and translation support in primary and secondary care. | Capacity of service provider to continue or meet demand. | Some staff have undertaken BSL training to facilitate in-house provision of interpretation services in some areas. |

| **Secondary Care.** Priority areas include: | | | |
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| ➢ Raising staff awareness | The NHS CEHR Sensory Loss E-Learning package is available to staff. Currently, staff are able to read through the course information only.<br><br>Through Patient Stories and awareness raising sessions provided to teams and departments, staff become aware of the need to provide information in accessible formats<br>We delivered a range of activities to promote sensory loss awareness month in November across all our 4 main hospitals in Llanelli, Carmarthen, Haverfordwest and Aberystwyth. We worked in partnership with Wales Council for Blind, International Glaucoma Association, Macular Society, Local Authority sensory loss teams, Guide Dogs, Wales Council for D/deaf People. This generated interest from staff and patients, many of whom had not previously been aware of the help that was available.<br><br>Part of the legacy from sensory loss awareness month has also resulted in an initiative whereby the Macular Society now attend eye clinics to offer advice and support to patients and staff.<br>Deaf Blind Cymru also delivered a training session to medical staff at Glangwilli Hospital in March.<br><br>A Senior Sister at Outpatients in Glangwili Hospital helped raise awareness of sensory loss with staff and patients by displaying a BSL greetings poster. This encourages and supports staff to communicate effectively with patients who are D/deaf. | Problems have been experienced accessing the assessment section of the e-learning package.<br><br>Patients should have the "T" loop function active on their hearing aid for them to benefit from the loop system and staff should make people aware that this system is available.<br><br>Take up of sensory loss training patchy, lack of awareness by staff in some areas of the needs for people with sensory loss.<br><br>The breadth of awareness raising delivery is driven by the capacity of external partners and this could pose a risk to future sustainability. | Issue has been logged with Learning and Development Department and awaiting IT fix.<br><br>*Adult Audiology Quality Standards*<br>7a.5. - All clinical staff and volunteers participate in CPD activity. Ensuring awareness of “T” loop and how this can be used to best effect.<br><br>Encourage staff who have undertaken training to spread the word among colleagues advise on good practice.<br><br>Raising awareness of the availability of the Sensory Loss E-learning package even as a read through only will assist staff to learn about meeting the needs of people with sensory loss.<br><br>During Induction sessions the recently introduced combined Diversity and Inclusion, Carers and Well-being of Future Generations session encourages staff to demonstrate the values of the health board in their day to day behaviours when carrying out their duties. This includes keeping fairness, dignity and respect for **all** at the forefront of their minds and taking action to meet the needs of individuals to ensure they are treated equitably.<br><br>Work with partners to secure on-going commitment to joint initiatives. |
| ➢ Accessible appointment systems | Using patient and carer feedback to provide assurance that accessible appointment systems are in place. | Digital infrastructure variable across health board sites and availability of funds to upgrade as | Feedback is being used to inform on-going service developments and service delivery. |

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| | *Adult Audiology Quality Standards*<br>2a.12 At clinics, up-to-date technology is used to support communication with patients. Technology currently used includes message boards and loop systems.<br>Audiology Department maintains a log of staff who have received training on use of technology. There is also a log kept of regular servicing to ensure that the Loop is working effectively<br><br>We have introduced a new text messaging service and an appointment reminder service to improve patient experiences. | necessary | |
| ➢ Communication models | Continuing to ensure access to BSL interpreters for patients with sensory loss accessing primary and community care through an externally commissioned source. Each year, via a memorandum of understanding with the Wales Council for Deaf, we continue to provide sensory loss support to over 200 patients and the highly cost-effective model has been recognised nationally by the Wales Audit Office Good Practice Team.<br><br>We continue to monitor the provision of the communication support service. It has levelled to about 250 appointments a year with variation each month. Analysis of uptake showed a low amount in Ceredigion. A hard of hearing club has now been started and hosted in Bronglais Hospital.<br><br>Discussions are ongoing within the Health Board about piloting a portable electronic translation system in response to the feedback that has been received from the D/deaf community. | Capacity of service provider to continue to meet demand. | Some staff have undertaken BSL training to facilitate in-house provision.<br><br>Raise staff awareness of the process for booking of BSL interpretation services. |

| Standards of Service Delivery | Key Actions Achieved during 2018-19 | Risks to Delivery | Corrective Actions |
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| **Emergency & Unscheduled Care.** Priority areas include: | | | |
| ➢ Raising staff awareness | The NHS CEHR Sensory Loss E-Learning package is available to staff. Currently, staff are able to read through the course information only.<br><br>Through Patient Stories and awareness raising sessions provided to teams and departments, staff become aware of the need to provide information in accessible formats<br><br>During sensory loss awareness month, a session was delivered to staff working in emergency and unscheduled care to promote awareness of the existing Communication Guide. | Problems have been experienced accessing the assessment section of the e-learning package.<br><br>Take up of sensory loss training patchy, lack of awareness by staff in some areas of the needs for people with sensory loss | The Issue has been logged with Learning and Development Department and is awaiting investigation and an IT fix.<br><br>Encourage staff who have undertaken training to spread the word among colleagues advise on good practice.<br><br>Raising awareness of the availability of the Sensory Loss E-learning package even as a read through only will assist staff to learn about meeting the needs of people with sensory loss. |
| ➢ Communication models | Continuing to ensure access to BSL interpreters for patients with sensory loss accessing Emergency and Unscheduled care through an externally commissioned source.<br>Each year, via a memorandum of understanding with the Wales Council for Deaf, we continue to provide sensory loss support to over 200 patients and the highly cost-effective model has been recognised nationally by the Wales Audit Office Good Practice Team. | Capacity of service provider to continue to meet demand. | Some staff have undertaken BSL training to facilitate in-house provision |
| **Concerns & Feedback (CF).** Areas include: | | | |
| ➢ Highlighting current models of CF in place which would support individuals with sensory loss to raise a concern or provide feedback | The Health Board is striving to make the process of providing feedback as simple and easily accessible as possible. In support of this aim, we have a number of avenues that patients can use to comment on the services we provide. Our Patient Advice and Liaison Service (PALS) can be contacted by telephoning 0300 0200 159 or by visiting our website: **http://www.wales.nhs.uk/sitesplus/862/page/65382** You can also feedback your experiences using our "Big Thank You" form: | One of the key risks could be that be that whilst useful feedback is provided, concerns raised and patient stories developed to assist with raising awareness, lessons are not fully learned or implemented across the Health Board. | Patient stories are developed from concerns and feedback and shared at Board level, at the Patient Experience Committee and a variety of training sessions and presentations to teams and groups as and when opportunities arise. We endeavour to ensure this lessons are learned and appropriate action implemented through our work. This includes the in-house sensory |

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| | **http://www.wales.nhs.uk/sitesplus/862/page/76043** or by completing our online survey: **http://www.wales.nhs.uk/sitesplus/862/page/76043** In our online survey, we ask the question "Using a scale of 0 – 10, where 0 is very bad and 10 is very good, how would you rate your overall experience?"<br><br>Although this might apply more generally to all patients, the provision for text messaging, voice message and patient's home phone makes it more accessible to people with sensory loss<br><br>Patient Experience Strategy is currently being refreshed and updated and current draft includes the following statement :-<br><br>We recognise the need to give particular focus to the experience of specific groups including those who have learning disabilities, dementia, hearing or sight problems and those who are elderly and frail. Carers are a particular group of people who often go unrecognised. This strategy acknowledges the importance of identifying those individuals and of meeting their needs.<br>It also includes the following aims:-<br>• Improve our communication with patients, relatives and carers to ensure it is effective, timely, open and honest.<br>• Provide clear and concise patient information to ensure patients and their families are fully involved and able to contribute effectively to decisions about their care and treatment.<br>• Respond effectively to patient feedback and share examples of changes and improvements that we have made.<br>• Quickly respond to concerns and constantly improve our services, shaped by what our patients and staff tell us.<br>• Listen to our staff and create a positive culture, improving staff engagement to identify and implement ideas for improvement included in our Patient Experience Framework. | | loss friendly award which can be used to monitor performance progress around meeting the needs of people with sensory loss. We also use the opportunities provided by sensory loss awareness month to help raise awareness and encourage staff to be pro-active about meeting the needs of people with sensory loss. We are also part of the national officers group and this provides opportunities for reflective practice.<br><br>The Patient Experience Committee provides a channel to discuss progress and identify gaps in mechanisms put in place to improve the patient experience for people with sensory loss e.g. where there has been a repeat of an incident of complaint previously received. |

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| ➢ Highlight any CFs received in sensory loss and actions taken | One case is currently under scrutiny. It is not possible to provide any further details at this time. | One of the key risks could be that be that whilst useful feedback is provided, concerns raised and patient stories developed to assist with raising awareness, lessons are not fully learned or implemented across the Health Board | Patient stories are developed from concerns and feedback and shared at Board level, at the Patient Experience Committee and a variety of training sessions and presentations to teams and groups as and when opportunities arise. We endeavour to ensure this lessons are learned and appropriate action implemented through our work. This includes the in-house sensory loss friendly award which can be used to monitor performance progress around meeting the needs of people with sensory loss. We also use the opportunities provided by sensory loss awareness month to help raise awareness and encourage staff to be pro-active about meeting the needs of people with sensory loss. . We are also part of the national officers group and this provides opportunities for reflective practice.<br><br>The Patient Experience Committee provides a channel to discuss progress and identify gaps in mechanisms put in place to improve the patient experience for people with sensory loss e.g. where there has been a repeat of an incident of complaint previously received.<br><br>Although this might apply more generally to all patients, the provision for text messaging, voice message and patient's home phone makes it more accessible to people with sensory loss. |

| Patient Experience* | Key Actions Achieved during 2018-19 | Risks to Delivery | Corrective Actions |
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| Mechanisms are in place to seek and understand the patient's experience of accessible communication and information | **Friends and Family Survey**<br>The survey was launched in Spring 2017 and at the end of March 2018, since which time, over 92,000 surveys have been sent. The Friends and Family survey is an opportunity for people to provide feedback on their experience of our services. It involves asking a standard question after you have received your care and treatment: "How likely are you to recommend our service to friends and family if they need similar care or treatment?" Patients are also given the opportunity to leave a comment on why they have responded in the manner they have. The survey is being piloted in all Accident & Emergency and Minor Injury Units across the Health Board and is carried out either by text message to the patient's mobile phone or by interactive voice message to the patient's home phone. | .One of the key risks could be that be that whilst useful feedback is provided, concerns raised and patient stories developed to assist with raising awareness, lessons are not fully learned or implemented across the Health Board | Patient stories are developed from concerns and feedback and shared at Board level, at the Patient Experience Committee and a variety of training sessions and presentations to teams and groups as and when opportunities arise. We endeavour to ensure that lessons are learned and appropriate action implemented through our work. This includes the in-house sensory loss friendly award which can be used to monitor performance progress around meeting the needs of people with sensory loss. We also use the opportunities provided by sensory loss awareness month to help raise awareness and encourage staff to be pro-active about meeting the needs of people with sensory loss. . We are also part of the national officers group and this provides opportunities for reflective practice.<br><br>The Patient Experience Committee provides a channel to discuss progress and identify gaps in mechanisms put in place to improve the patient experience for people with sensory loss e.g. where there has been a repeat of an incident of complaint previously received.<br><br>Although this might apply more generally to all patients, the provision for text messaging, voice message and patient's home phone makes it more accessible to people with sensory loss.<br><br>Partnership working continues. Wales Council for Blind, Deaf/Blind Cymru and Wales Council for D/deaf People<br><br>We have also received and actively considering the Wales Audit Office report 'Speak my language'. This is part of a submission to the Improving Patient Experience Subgroup and links across the Patient Experience Strategy, of which this could be a part going forward. |

| | Key Themes | Corrective Actions |
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| The key themes to emerge from patient experience feedback (both positive and negative) | Themes emerging from Transforming Clinical Services engagement and consultation included :-<br><br>Accessing GP appointments<br>Sufficient time during clinical appointments – need more time than traditionally allocated.<br>Staff awareness – attitudes/ communication needs<br>Access to interpreters<br>Transport and access<br>Clinical environment needs to be suitable for people with sensory loss<br><br>The Diversity and Inclusion Team have continued to engage with Llanelli Deaf Club and have been able to provide feedback on a range of issues of concern that were raised. This has included arranging for project and service lead to attend meetings to actively engage with the group and support the Health Board's commitment to continuous engagement and co-production. | We continue to learn any lessons from any patient experiences, both in terms of their experience and also their ability to access the concerns process.<br>Note: Some all Wales work is being undertaken on this situation.<br>Workstreams established to consider the outcomes of the Transforming Mental Health and Transforming Clinical Services consultations will take into account specific feedback from people with sensory loss. This does not preclude action that may be taken currently, such as further training for staff around customer care and awareness of sensory loss issues. This can be provided to teams and departments on request.<br><br>Partnership working continues. Wales Council for Blind, Deaf/Blind Cymru and Wales Council for D/deaf People.<br><br>We have also received and actively considering the Wales Audit Office report 'Speak my language'. This is part of a submission to the Improving Patient Experience Subgroup and links across the Patient Experience Strategy, of which this could be a part going forward. |

# Advancing Equality and Good Relations

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| **NHS Organisation** | Hywel Dda University Health Board |
| **Date of Report** | 30 April 2019 |
| **Report Prepared By** | Strategic Partnerships, Diversity and Inclusion Team<br>Anna.bird@wales.nhs.uk<br>Jackie.hooper@wales.nhs.uk<br>Rhian.evansad7e@wales.nhs.uk |

The Public Sector Equality Duty seeks to ensure that equality is properly considered within the organisation & influences decision making at all levels. To meet the requirements of the Equality Act 2010 (Statutory Duties) (Wales) Regulations 2011 Health Boards & NHS Trusts must consider how they can positively contribute to a fairer society through advancing equality & good relations in their day-to-day activities. The equality duty ensures that equality considerations are built into the design of policies & the delivery of services and that they are kept under review. This will achieve better outcomes for all.

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| Does the organisation have a Strategic Equality Plan (SEP) in place, setting out how tackling inequality and barriers to access improves the health outcomes and experience of patients, their families and carers? Does the SEP include equality objectives to meet the general duty covering the following protected characteristics: age, disability, gender reassignment, pregnancy and maternity, race (including ethnic or national origin, colour or nationality), religion or belief (including lack of belief),marriage and civil partnership, sex, sexual orientation? | **Yes** |

**Update on the Actions implemented during the current <u>operational year</u> to advance equality & good relations in the health board's day to day activities**

| | **Key Actions Planned** | **Risks to Delivery & Corrective Actions** | **What was achieved** |
|---|---|---|---|
| **Planning and Performance Management** | | | |
| IMTPs clearly demonstrate how the NHS organisation meets the duties associated with equality and human rights and the arrangements for equality impact assessment. | The University Health Board views addressing inequalities as a guiding principle underpinning activity across all sections of University Health Board's service provision and employment.<br><br>The drive towards achieving equality aims and objectives will be supported by the mechanisms set in place to provide assurance to Board. The commitments to promoting equality duties are clearly set out in the Annual Plan/IMTP. | No risks identified and no corrective actions required. | Good practice feedback has been received from WG on the Equality section of our Annual Plan/IMTP. Reducing health inequalities remains one of the overarching aims of the Health Board in its works to become a population health organisation. Issues impacting on health are much wider than the NHS alone and the work of Public Service Boards, Regional Partnership Boards and other partnerships are vital to inform collaborative, cross sector working which will drive down health inequalities. The Annual Plan/IMTPs was clearly aligned with the Well-being and Area Plans, as well as the Strategic Equality Plan.<br><br>The Health Board has developed " A Healthier Mid and West Wales – Our Future Generations Living Well" This |

| | Key Actions Planned | Risks to Delivery & Corrective Actions | What was achieved |
|---|---|---|---|
| | | | 20 year strategy adopts the social model of health which will drive cultural change throughout the organisation and which presents opportunities for us to work with key partners,(including service users, staff and carers) to develop and deliver services in a way which best meets their needs.<br><br>http://www.wales.nhs.uk/sitesplus/documents/862/A%20Healthier%20Mid%20and%20West%20Wales%20FINAL%20amended%20-%2028.11.18.pdf |
| Steps have been taken where possible, to align equality impact and health needs assessments to ensure they take account of the "protected characteristics" & utilise specific data sets & engagement activity. | Ensure that the information presented in the Health Boards integrated impact assessment toolkit promotes consideration of equality and wider health needs assessment, and takes account of protected characteristics.<br><br>To ensure that within the design phase of Transforming Clinical Services, the application of this information included within the integrated impact assessment is used to inform service transformation. | | The Consultation Institute awarded the UHB Best Practice in relation to the TCS Consultation, including the equality element. 45 out of the 140 consultation events were specifically focused on capturing feedback from protected groups.<br><br>Our commitment to work in an integrated way across health and social care at regional and locality level is helping us to plan, develop and deliver services that work better for people and are far less complicated and quicker to access. It also enables us to build our shared ambition to develop community resilience, prevent ill health, improve well-being, and promote independence and interconnectedness. This is demonstrated through work we are achieving on developing and implementing new models of service delivery and care pathways in our Transforming Mental Health Services and Transforming Clinical Services programmes. It is also demonstrated in our newly developed clinical strategy "A Healthier Mid and West Wales."<br>http://www.wales.nhs.uk/sitesplus/documents/862/A%20Healthier%20Mid%20and%20West%20Wales%20FINAL%20amended%20-%2028.11.18.pdf |
| IMTPs set out equality impact assessment is embedded into service change plans & informed by the findings from | The Annual Plan/IMTP confirms the organisational commitment to engaging and involving key stakeholders in planning, development, delivery and | Capacity to resource continuous engagement activities. Consultation fatigue | We are committed to ensuring that the way in which we plan, develop and deliver services involves a process of continuous engagement, appropriate consultation and monitoring. |

| | Key Actions Planned | Risks to Delivery & Corrective Actions | What was achieved |
|---|---|---|---|
| engagement & consultation and other evidence. | review of services.<br><br>The Health Board will launch a formal public consultation on the TCS programme which builds on the organisation's commitment to continuous engagement. The consultation will help us to identify opportunities where service re-design may support the reduction of health inequalities or inequities of access. | which impacts on the number of individuals from a range of protected groups. | Our Formal Consultation Exercise on Transforming Clinical Services was open, accessible and fair to all people/organisations across the Health Board area. Ensuring that our population has equitable access to services and information to improve health and well-being is one of our main priorities.<br><br>The Consultation Institute awarded the UHB Best Practice in relation to the TCS Consultation, including the equality element. 45 out of the 140 consultation events were specifically focused on capturing feedback from protected groups. As a result of the evidence gathered during the consultation process the UHB is reviewing its plans for specific elements of its service transformation proposals.<br><br>Through the process of service transformation, we have further developed our organisational understanding about the principles of Equality Impact Assessment (EqIA). We aim to ensure<br>that as far as possible, our decision making, strategy and policy development and service delivery is fair, accountable and transparent, taking into account the needs and rights of all those who may be affected.<br><br>Formal consultation on the Transforming Clinical Services Programme ("Our Big NHS Change") took place between April and June 2018. Link to information below:-<br><br>http://howis.wales.nhs.uk/sitesplus/862/page/73478<br>In January 2019 the Health Board approved a Framework for Continuous Engagement which will embed our approach to involvement. In addition, a "check and challenge" process has been designed to provide assurance that the delivery of the three change programmes, associated projects, service changes and pathway re-design is consistent with the principles set out within the health and care strategy and is fully aligned across the whole portfolio. This check and challenge |

| | Key Actions Planned | Risks to Delivery & Corrective Actions | What was achieved |
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| | | | process has been built on the significant learning throughout phases 1 and 2 of the TCS programme and the success of check and challenge session with a wide range of stakeholders. The check and challenge process includes input from the Engagement Team and Diversity and Inclusion Team, who work closely together to advise and support on mechanisms to engage with protected characteristic and other vulnerable/under-represented groups.<br><br>We have embarked on a series of planned continuous engagement events. with our staff, patients, people in our communities and those delivering, or interested in, health, care and well-being. The first series of events took place in February/March 2019 and more are scheduled throughout the year. Events take place across our three counties in locality hubs at a variety of accessible community venues. |
| Service Plans include clear measurable objectives for reducing health inequalities & are aligned to the equality priorities set out in the Strategic Equality Plan | The UHB is developing a Planning Assurance tool to provide assurance to the Board and to external regulators (WAO) on planning governance for 2019/22. | As the IMTP plans are developed, the level of detail in the IPLAR will increase both to show progress but also to identify work still to be undertaken. | Integrated Planning Assurance Report (IPLAR) has been created to aid the development of the Integrated Medium Term Plan (IMTP) for 2019/22, This approach is currently being tested and a report was presented to the Board's Planning Sub-Committee on 28th September 2018.<br><br>The Business Planning and Performance Assurance Committee report template includes a specific section on equality impact assessment:-<br><br>http://howis.wales.nhs.uk/sitesplus/862/document/402038 |
| **Governance** | | | |
| The Health Board/NHS Trust receives assurance that processes are in place to identify Equality Impact, undertake engagement and that mitigating actions are | The reporting templates for Board and Committee Papers include both integrated and Equality Impact Assessment information to ensure that these are considered as part of the decision making process. | Any risks to delivery would be identified as the year progresses and corrective actions taken as deemed necessary at the time. | Progress on the Health Board's stated Equality Objectives is reported to and scrutinised by the following group/committees prior to presentation at Board and subsequent publication in our Annual Equality Report: |

| | Key Actions Planned | Risks to Delivery & Corrective Actions | What was achieved |
|---|---|---|---|
| clearly set out. Committee or Sub-Committees confirm that equality impact assessments inform decision making. | All new Board members are issued with and have access to guidance in the scrutiny of equality impact assessments of all proposals considered at Board and Committees.<br><br>http://www.wales.nhs.uk/sitesplus/862/page/61516<br><br>A programme of awareness raising training is delivered for staff working at all levels across the University Health Board. Individual training needs are identified through the Personal Annual Development Review process to assist in increasing skills and knowledge as appropriate. | | • Workforce and Organisational Development Sub-Committee;<br>• Improving Experience Sub-Committee;<br>• Local Partnership Forum;<br>• Quality, Safety & Experience Assurance Committee<br><br>These groups/committees constitute wide representation across all functions, facilitating action directly targeted at improving staff and patient experience.<br><br>Each Board/Committee/Sub Committee report is accompanied by an SBAR including equality considerations and accompanied by associated Equality Impact Assessment documentation as appropriate:-<br><br>Board Meetings 2019 - http://www.wales.nhs.uk/sitesplus/862/page/97274<br><br>Board Meetings 2018:- http://www.wales.nhs.uk/sitesplus/862/page/89388 |
| The Health Board/NHS Trust ensures that equality considerations are included in the procurement, commissioning and contracting of services. | The *NHS Wales Standard Terms and Conditions for the Provision of Goods and Services* is utilised for the procurement of goods and services across NHS Wales. These Terms and Conditions cover the following areas:<br>• Section 49 – Human Rights Act 1998<br>• Section 52 – Well-being of Future Generations (Wales) Act 2015<br>• Section 58 – Equality and Non-discrimination | Any risks to delivery would be identified as the year progresses and corrective actions taken as deemed necessary at the time. | The procurement process both undertaken locally and also centrally by the NWSSP Sourcing Team fully meets the requirements set out opposite.<br><br>The Welsh Government Code of Practice on Ethical Employment focuses on 12 key commitments which are designed to eliminate modern slavery and unethical employment practices. The Executive Team reviewed the Health Board's position against the requirements of the Code of Practice and working with its partners and suppliers implemented an action plan with a view to achieve full compliance by March 2019.<br>Supporting information was also provided by NWSSP colleagues within the Sourcing Team.<br>During the tendering process, as part of the pre-contract questionnaire, potential suppliers are assessed against whether or not they have a policy which explicitly bans |

| | Key Actions Planned | Risks to Delivery & Corrective Actions | What was achieved |
|---|---|---|---|
| | | | discrimination, bullying and harassment in relation to any protected group/s and whether or not staff receive equality and diversity training. |
| **Quality and Safety** | | | |
| Each service change programme/plan as a minimum includes: equality implications, including positive and negative impacts on patients; public and staff and mitigating actions to reduce any anticipated negative impact. | Each service change/transformation programme is supported by an Equality Impact Assessment which is informed by engagement and consultation as appropriate. This makes provision to ensure that the voices within our diverse communities are heard, their specific needs identified, considered and addressed. The key priority for 2018/19 will be supporting the delivery of the Transforming Clinical Services formal consultation process and the subsequent work that arises.<br><br>The University Health Board will have in place a Quality Improvement Strategic Framework which clearly describes a whole system approach to quality improvement. | Where a formal engagement or consultation process is required, we acknowledge that to deliver a complaint, legally sound process requires appropriate input of resources, both staff skill and finances. This may require external resourcing, including design, print, translation, accessibility activities, independent analysis and quality assurance commensurate to the proposed service change/improvement. | The Quality Improvement Strategic Framework is aligned to the UHB's approach to quality assurance, organisational development and service transformation arrangements with a key focus on quality goals and annual priorities which deliver improved outcomes and overall experience of care. Stakeholder involvement and co-production is a central pillar within the Quality Improvement Strategic Framework, listening to and involving those receiving and giving care. Alongside traditional methods of communication, we will use new technology and social media opportunities to reach new and wider audiences, our priority being to ensure that voices from all sections of our community are heard.<br><br>Please also refer to earlier evidence of engagement and Equality Impact assessment processes relating to TCS.<br><br>The Health Board launched a Quality Improvement Framework in March 2019 and discussions took place during the event (which included senior managers from across the health board), on the next steps, how staff could get involved and potential projects to be taken forward. |
| Equality is clearly linked to quality initiatives and are informed by the needs assessment findings; the risk register and the challenges and improvement priorities set out in the Annual Quality Statement. | The University Health Board will have in place a Quality Improvement Strategic Framework which clearly describes a whole system approach to quality improvement including equality elements.<br><br>In line with the Framework for Assuring Service User Experience, we will implement new systems to enable | It is recognised that progressing the equality agenda beyond the basics requires commitment at all levels throughout the organisation. This is being addressed through awareness | The UHB continues to develop and embed its approaches to risk management to ensure that the risks we carry inform the UHB's priorities and decision making.<br><br>Work is on-going to develop overarching guidance for staff, to support implementation of the approach the Health Board adopts to ensure meaningful engagement, co-production and feedback from our patients, service users and carers to better facilitate learning and improvement. |

| | Key Actions Planned | Risks to Delivery & Corrective Actions | What was achieved |
|---|---|---|---|
| | patients to provide “real time” feedback on the care and treatment they have received and a range of different ways for patients, their families and carers to provide feedback on the services provided by the Health Board.<br><br>Our key quality goals and associated indicators will define our focus during 2018/19 including care that is patient centred and equitable. | raising training and the delivery of specific bespoke training for teams/departments across the Health Boards. | The Health Board launched a Quality Improvement Framework in March 2019 and discussions took place during the event (which included senior managers from across the health board), on the next steps, how staff could get involved and potential projects to be taken forward.<br><br>Our Patient Advice and Liaison Service (PALS) Team regularly visit our wards and clinic areas to engage with people using our services. We are ensuring all staff have access to the patient feedback we collect immediately so that it can be acted on.<br><br>We are introducing a new digital (electronic) system that will allow all staff to capture patient experience feedback (both positive and negative), in real time so that it can be escalated as necessary in a timely manner. The system allows us to review this feedback against other sources of information from across the organisation to identify where we need to make improvements or share good practice that others can learn from. Following a robust pilot on Ward 5 at Prince Philip Hospital and a selected area in Glangwili General Hospital in January 2019, the new module will be rolled out across the Health Board in 2019/20.<br><br>New Putting Things Right Leaflets and Posters have been distributed to all wards, receptions and public areas in Primary Care and the replenishment of leaflets and posters is ongoing. Patients can easily access written information regarding the Putting Things Right process with the relevant contact information for our Health Board. |
| **Workforce** | | | |
| There is evidence that employment information informs policy decision making and workforce planning | We will publish our Annual Workforce Equality Report 2017/18 by 31 March 2019 | Information gathered to inform the Annual Workforce Equality Report is collected | The draft Annual Workforce Equality Report, along with the Health Board’s Strategic Equality Plan Annual Report is currently being considered through our Committee structures prior to presentation to Board for approval. |

| | Key Actions Planned | Risks to Delivery & Corrective Actions | What was achieved |
|---|---|---|---|
| | We will establish a Staff Inclusion Group to facilitate robust and ongoing analysis of workforce intelligence information.<br><br>We recognise that we can no longer deliver services in the traditional ways and must seek innovative solutions in delivering care to our population. We are embarking on a high profile workforce transformation programme, which will see changes in the way we currently work, and the increasing development of new roles and expansion of roles we currently have in place at pace and scale.<br><br>We will maintain volunteer numbers at 350 (recruited from a wide ranging population demographic) – recruiting additional where appropriate. We will expand volunteering coverage by increasing opportunities across the UHB by 10%.<br><br>We aspire to be an employer of choice and wish our staff experience to be the best possible. We will undertake regular staff surveys including exit interviews and pulse surveys to monitor improvement. | from three different systems which are nationally managed and for Grievance and Disciplinary statistics, manually in-house. Information provided by staff to populate equality data monitoring forms is provided on a voluntary basis and staff may choose not to answer every question. Therefore reports produced may not provide a wholly accurate picture of staff demographics.<br><br>All new staff are encouraged to complete the equality data monitoring sections of their Electronic Staff Record at Induction. Periodic reminders to existing staff are issued by global email & through Team Brief. | The inaugural meeting of the Staff Inclusion Group took place in September and a programme of future meetings has been arranged<br><br>We have developed and launched “Destination NHS” in partnership with Pembrokeshire College and Swansea University to year 12 and 13 students. As the programme develops, it will encompass all professions within the NHS, including human resource management, hotel management and trades<br><br>We have expanded the “Grow your Own” programmes, a range of initiatives which combine to deliver our workforce sustainability programme specifically targeted at developing a committed and local workforce.<br><br>We are continuing to work with “LIFT” Engage to Change and Work Choice to increase suitable candidates by 30% for 2018/19<br><br>An Anti-Bullying and Harassment Group has been established to address issues identified through our specified monitoring systems.<br><br>Work is ongoing on all the above projects. Within the “Grow Your Own initiative, during 2018/19 we have supported 17 health care support workers to enrol on undergraduate nursing degrees and 36 staff are participating in professional development as part of the scheme.<br><br>A new Apprenticeship Scheme – “Made in Hywel Dda” is under development and due to launch in September 2019. |
| Numbers of staff who have completed mandatory equality and human rights training “Treat Me Fairly” (TMF) | Incrementally increase the percentage of staff completing Treat Me Fairly. Compliance percentage as at 31 March 2018 was 65.7% | Competing demands on staff restricting time for completion of e-learning package. Computer literacy | Compliance rates for mandatory “Treat Me Fairly” increased to 73.35% at the end of Quarter 2.<br><br>The latest available figures as at February 2019 indicate that the compliance rate for mandatory “Treat Me Fairly” |

| | Key Actions Planned | Risks to Delivery & Corrective Actions | What was achieved |
|---|---|---|---|
| | A programme of awareness raising training will be delivered for staff working at all levels across the University Health Board. | variable among staff. Dedicated Mandatory Training Days offered in Learning and Development departments with assistance available. | training has increased to 79.8%<br><br>In addition to mandatory training the Equality and Diversity Team offer a programme of awareness raising training and bespoke sessions to address specific needs identified by teams and departments.<br><br>A new Induction session was launched on 1 October 2018 in order to integrate awareness raising in relation to diversity and inclusion and the links to Wellbeing of Future Generations (Wales) Act 2015 and encouraging consideration from the perspective of carers.<br><br>In response to a request from Senior Nurse Management Team a session on LGB&T issues was delivered in September 2018. Additionally, a session on Unconscious Bias was delivered to the Health Board's Recruitment Team on request in October 2018.<br><br>Training sessions on LGBT issues have been conducted in conjunction with Macmillan colleagues for Sexual Health Services and Unscheduled Care Services representatives since the beginning of 2019. |

## Implementation of the Welsh language actions as defined in 'More Than Just Words'

| | |
|---|---|
| **NHS Organisation** | Bwrdd Iechyd Prifysgol Hywel Dda University Health Board |
| **Date of Report** | 30 April 2019 |
| **Report Prepared By** | Enfys Williams |

Each Health Board and Trust is expected to put in place actions to deliver the strategic framework for Welsh language services in health, social services and social care: 'More Than Just Words'. This has been developed to meet the care needs of Welsh speakers, their families or carers. Actions to deliver the framework are to cover both primary and secondary care sectors.

**Reporting Schedule:** Progress against actions to deliver More Than Just Words is to be reported bi-annually. This form is to be submitted on 31 October and 30 April.

**Update on the actions to deliver the More than Just Words Strategic Framework**

| **Priority Area** | **Yes or No** | **Supporting Evidence** | | |
|---|---|---|---|---|
| | | **Key Actions Achieved** | **Risk to Delivery** | **Corrective Actions** |
| **Population Needs Assessment**<br>The organisation has identified the Welsh language needs of its population and has used it to plan services. | | The Health Board's Annual Plan has been approved by the Board. Welsh language considerations are both an explicit and integral part of the service planning throughout.<br><br>Welsh language is also an integral part of the Integrated Impact Assessment process that is currently being developed within the UHB. | | Continue to implement the Bilingual Skills Strategy. This includes community profiles of Welsh speakers on a county basis.<br><br>Continue to offer training to staff to increase competence in relation to Welsh language and planning.<br><br>Use flexible delivery methods to accomodate service needs. |
| **Welsh Language Skills**<br>The organisation has identified the Welsh language skill levels of its workforce and is using this information to plan services. | | 87% of employees Welsh language skills have been assessed across the organisation | Completion of 'Welsh language competency ' is not a mandatory field on ESR and not all UHB staff are on ESR self service yet; this is an obstacle as some information has to be collected on | |

| | | | | |
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| | | | paper and manually updated on ESR.<br><br>The lack of fluent Welsh speakers recorded illustrates the scale of the challenge in providing a fully bilingual service.<br><br>Anecdotal evidence suggests that staff may be reluctant to declare their Welsh language skills for fear that it may lead to extra work e.g. translation. | |
| Where there are gaps in Welsh language skills the organisation has ensured that vacancies are advertised as 'Welsh language essential'. | | The UHB has a Bilingual Skills Strategy. To date this year 9 posts have been advertised as Welsh essential. | There is no current system/process in place to ensure that Welsh language is being considered when advertising a vacancy. This is happening on an ad-hoc basis. | Discussions at a local level and with shared services to see if it possible to collate evidence of consideration to Welsh Language skills. |
| How many members of staff have undertaken a course to learn Welsh or to increase their confidence to speak Welsh during this operational year? | | | | 40 |

| **Priority Area** | **Yes or No** | **Supporting Evidence** | | |
|---|---|---|---|---|
| | | **Key Actions Achieved** | **Risk to Delivery** | **Corrective Actions** |
| **Patient Preference and Experience**<br>The organisation has processes in place to record when an Active Offer has been made and ensure that the language preference of patients is noted across primary and secondary care. | | There are various processes in place to ensure patients language need is recorded at the first point of entry to the service. | Language choice is not recorded on referral, especially from Primary Care.<br><br>Even when language choice is recorded it is not always transferred within secondary care as some wards/departments work to an electronic system and some work to a paper system. | |
| The organisation has methods in place to communicate to staff the importance of | | All new staff are made aware of the importance of recording language | Language choice is not transferred with the patient. | |

| | | | | |
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| making an Active Offer. | | choice and making the Active Offer at induction sessions. All existing staff are made aware through Welsh Language Awareness sessions and through normal communication methods – Hywel's Voice; Global email and Welsh Language section on intranet. | | |
| The organisation is mainstreaming experience of Welsh language services as part of the information received/ feedback from patients. | | | | |
| How many patients have been asked their language preference and have had this preference noted on their records? | | | | Not known |
| **Commissioned and Contracted Services** The organisation ensures that Welsh language considerations are included in the commissioning and contracting of services including primary care services | | The NHS Wales standard terms and conditions produced in Feb 2012 have specific clauses relating to Welsh. | There is currently a lack of capacity to effectively monitor whether the Welsh language requirements of all contracts are implemented. | The Welsh Language Services team needs to find capacity to work with Shared Services to improve the current situation. |
| **Sharing Best Practice** Best practice in providing Welsh language services is shared with all relevant staff in the organisation and the organisation also shares best practice with other health boards and trusts. | | Best practice is shared within the organisation through the staff newsletter Hywel's Voice; through Health Board meeting papers and meetings. Hywel Dda has shared good practice with other Health Boards – our videos are available for all to use and we have shared our Give it a Go merchandise. | | Continue to share good practice whenever possible. |

**Completed form to be returned to: hss.performance@gov.wales**

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

**CYFARFOD BWRDD PRIFYSGOL IECHYD**
**UNIVERSITY HEALTH BOARD MEETING**

| | |
|---|---|
| **DYDDIAD Y CYFARFOD:**<br>**DATE OF MEETING:** | 30 May 2019 |
| **TEITL YR ADRODDIAD:**<br>**TITLE OF REPORT:** | Integrated Performance Assurance Report – Month 1 2019/20 |
| **CYFARWYDDWR ARWEINIOL:**<br>**LEAD DIRECTOR:** | Karen Miles, Director of Planning, Performance and Commissioning<br>In association with all Executive Leads |
| **SWYDDOG ADRODD:**<br>**REPORTING OFFICER:** | Karen Miles, Director of Planning, Performance and Commissioning |

| **Pwrpas yr Adroddiad** (dewiswch fel yn addas)<br>**Purpose of the Report** (select as appropriate) |
|---|
| Ar Gyfer Trafodaeth/For Discussion |

**ADRODDIAD SCAA**
**SBAR REPORT**

**Sefyllfa / Situation**

The Integrated Performance Assurance Report (IPAR) is being brought to the Board's attention to examine and consider Hywel Dda University Health Board's latest performance data, achievements, challenges and needs. This is a requirement of the NHS Wales Delivery Framework 2019/20.

The performance dashboards are available to NHS Wales staff and are updated monthly.

The Business Planning Performance Assurance Committee (BPPAC) have requested, moving forward, Executive Directors highlight their key concerns. These will be included in the accompanying SBAR for future BPPAC IPARs. The first summary of issues from our Executive Team is included in the month 12 final IPAR SBAR and includes:

- 12 hour waits in our Accident & Emergency departments/Minor Injury Units;
- Delayed transfers of care;
- Health care acquired infection rates;
- Welsh Government compliance for Putting Things Right/concerns management;
- Serious incident reporting;
- Long ambulance waits;
- Delayed follow up outpatient appointments;
- Community Paediatric outpatient delays;
- Enabling continued medical engagement and leadership capacity;
- Supporting and managing fragile services.

The Performance Team is working with the Programme Management Office to develop triggers to highlight indicators outside of expected ranges. This will involve the use of Statistical Process Control (SPC) charts.

The 2019/20 NHS Delivery Framework was published on 2nd May 2019. The stroke and delayed transfers of care indicators have been revised. Delayed transfer of care data is included and the revised stroke data will be included in the month 2 IPAR.

In 2019/20, Public Health Wales are providing each Health Board with individual improvement targets for Health Care Acquired Infections. These will be made available to us in June and will be included in next month's IPAR.

The Unscheduled Care report format has changed to make performance challenges easily identifiable by acute site. This format will be extended to the "What is being done?" section next month.

## Cefndir / Background

The NHS Wales Delivery Framework 2019/20 aims to have a 'Healthier Wales'. It identifies key areas to be monitored and, where relevant, improvements made for this aim to be achieved. The University Health Board is working to make improvements for its resident population, patients and staff and has identified some additional local performance indicators to further support the Framework.

## Asesiad / Assessment

- The IPAR consists of:
  - Title page – the buttons can be used to navigate to the different sections of the report;
  - Executive summary – provides an overview categorised by: where the UHB is doing well, where improvements are needed and potential challenges ahead;
  - Performance overview – the hyperlinked text can be used to directly access the relevant exception reports. Each exception report has a home button which will return you back to the latest performance overview section;
  - Integrated dashboards – summaries for unscheduled care, planned care, hospital acquired infections and oncology & cancer, showing finance and workforce. The dashboards have been reformatted to incorporate some of the finance dashboard charts and to make them more user-friendly;
  - Domain topic pages – includes details of the Executive Leads and links to relevant exception reports;
  - Exception reports – are included for areas where new data is available and either the targets are not being met or there is cause for concern;
  - Additional reports – Primary Care, National Delivery Framework qualitative reports, Welsh Health Specialised Service Committee (WHSSC), Cardiac treat and transfer service;
  - Supporting dashboards – Excel dashboards for RTT, Unscheduled Care, Diagnostics & Therapies, Mental Health, Stroke and Cancer.

- The following accompanying documents are also provided:
  - Key delivery target summary – performance trend and (where available) trajectories for the key delivery indicators.
  - Full performance summary – details of all performance indicators with reported data for this financial year to date and an indication of whether an exception report has been provided.

- The latest performance data shows:

| 28 key deliverable indicators | | All+ performance indicators | | |
|---|---|---|---|---|
| 10 | 48% | 63 | 40% | target not delivered |
| 2 | 9% | 17 | 11% | within 5% of target |
| 9 | 43% | 78 | 49% | target delivered |

+ only those indicators for which is it possible to assign a red, amber or green rating are included here. Some indicators are under development and others do not have sufficient historical data to show an annual improvement or decline

The most recent all Wales data shows that the UHB ranked in the top 3 for 40.7% indicators, which is a 3.8% increase from the previous month's position.

## Where are we doing well?

- Hywel Dda ranked 1st in Wales for 9 national indicators including waiting times for diagnostic tests, stroke patients admitted to a stroke unit within 4 hours, waiting times for patients on the urgent suspected cancer pathway and mental health assessments;
- The three mental health key deliverable targets have all been met;
- The postponed admitted procedures target met in March 2019, with 16 patients falling within the government commitment of which 8 patients were treated within the 14 day government target (in-month performance 50%). Of the remaining patients, 4 have since been treated, 2 have deferred treatment, 1 is awaiting a date and 1 has been removed from the waiting list;
- The new delayed transfer of care (DTOC) 12 month reduction target for mental health patients has been met;
- The 12 month reduction target has also been met for non mental health DTOCs;
- The rolling 12-month sickness rate decreased from 4.87% in February to 4.86% in March and the target was achieved;
- Medical Appraisal (PADR) is far above target at 95% and has been above 90% for over 12 months;
- Performance for the percentage of ambulances responding to red calls within 8 minutes has met the 65% target (provisional 67.9% for April).

## Where are the improvements needed?

- Unscheduled care performance declined in April and the targets were not met (1 hour ambulance handovers = 417; 4 hour A&E/MIU waits = 81.1%; 12 hour A&E waits = 959). Work is underway to make improvements around patient flow, ambulatory care, ambulance offload and accident and emergency 4 hour performance;
- With 213 patients waiting more than 36 weeks from referral to treatment (RTT), the target RTT target has not been met. The Health Board aims to be back at target by the end of June 2019 with zero patients waiting over 36 weeks;
- In April there were 56 patients waiting more than 8 weeks for a diagnostic and the zero target was not met;
- There were 41 patients waiting over 14 weeks for a specific therapy in April, therefore the target for zero patients waiting was not met;
- The 98% waiting time target for non-urgent suspected cancers was not met in March 2019 with 95.8% receiving treatment within 31 days;
- The urgent suspected cancers 95% waiting time target was not met in March but an improvement was seen from 80.7% in February to 84.2% in March;

- The 5% annual reduction target for hospital initiated cancellations (HIC) has not been met and the number of HICs increased from 129 in February to 158 in March;
- With only 2.5% at quarter 3 of smokers attempting to quit via smoking cessation services, the 5% cumulative target has not been met;
- In April, there were 18,199 patients with delayed follow-up across trauma & orthopaedics, ear nose & throat, urology, dermatology or ophthalmology outpatient appointments. The 12 month reduction target was not met.

**Potential challenges for the future**

- Mandatory Training compliance has not met the 85% target but performance has improved considerably (by 11.4%) over the past 12 months (now 80.1% April 2019);
- Non-medical appraisals continue to be below the 85% target but compliance has improved by 15.1% from April 2018 to April 2019.

There continues to be concerted efforts across the Health Board to make further improvements for both mandatory training and appraisal compliance over the coming few months. This is key to ensure staff are able to have their pay increment as per the Agenda for Change pay deal agreed in 2018/19.

**Argymhelliad / Recommendation**

The Board is asked to discuss the report and raise any issues arising from its content.

| **Amcanion: (rhaid cwblhau)**<br>**Objectives: (must be completed)** | |
|---|---|
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:<br>Datix Risk Register Reference and Score: | Not Applicable |
| Safon(au) Gofal ac Iechyd:<br>Health and Care Standard(s):<br>Hyperlink to NHS Wales Health & Care Standards | All Health & Care Standards Apply |
| Amcanion Strategol y BIP:<br>UHB Strategic Objectives:<br>Hyperlink to HDdUHB Strategic Objectives | 5. Deliver, as a minimum requirement, outcome and delivery framework work targets and specifically eliminate the need for unnecessary travel & waiting times, as well as return the organisation to a sound financial footing over the lifetime of this plan |
| Amcanion Llesiant BIP:<br>UHB Well-being Objectives:<br>Hyperlink to HDdUHB Well-being Statement | Improve Population Health through prevention and early intervention<br>Support people to live active, happy and healthy lives<br>Improve efficiency and quality of services through collaboration with people, communities and partners<br>Develop a sustainable skilled workforce |
| **Gwybodaeth Ychwanegol:**<br>**Further Information:** | |
| Ar sail tystiolaeth:<br>Evidence Base: | NHS Wales Delivery Framework 2017-18 |

| | |
|---|---|
| Rhestr Termau:<br>Glossary of Terms: | Contained within the body of the report |
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Cynllunio Busnes a Sicrhau Perfformiad:<br>Parties / Committees consulted prior to University Health Board: | Finance, Performance, Quality and Safety, Nursing, Information, Workforce, Mental Health, Primary Care Business Planning and Performance Assurance Committee |
| **Effaith: (rhaid cwblhau)**<br>**Impact: (must be completed)** | |
| **Ariannol / Gwerth am Arian:**<br>**Financial / Service:** | Better use of resources through integration of reporting methodology |
| **Ansawdd / Gofal Claf:**<br>**Quality / Patient Care:** | Use of key metrics to triangulate and analyse data to support improvement |
| **Gweithlu:**<br>**Workforce:** | Development of staff through pooling of skills and integration of knowledge |
| **Risg:**<br>**Risk:** | Better use of resources through integration of reporting methodology |
| **Cyfreithiol:**<br>**Legal:** | Better use of resources through integration of reporting methodology |
| **Enw Da:**<br>**Reputational:** | Not applicable |
| **Gyfrinachedd:**<br>**Privacy:** | Not applicable |
| **Cydraddoldeb:**<br>**Equality:** | Not applicable |

# Integrated Performance Assurance Report (IPAR)

## Position as at 30th April 2019 (Month 1)

**Click one of the circles to navigate to that section of the report**

**There are no exception reports for Staying Healthy or Individual Care this month**



**Supporting documents**

Main Performance Matrix

Key Deliverables Performance Matrix

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

# Executive summary

This report includes detailed information on the key deliverable targets, workforce, finance, therapies and other local targets where new data are available. Exception reports are included for most areas where new data is available, where targets are not being met, or there is a cause for concern.

The 2019/20 NHS Delivery Framework was published on 2nd May 2019. The stroke and delayed transfers of care indicators have been revised. Delayed transfer of care data is included and the revised stroke data will be included in the month 2 IPAR.

The Unscheduled Care report format has changed to make performance challenges easily identifiable by acute site. This format will be extended to the " What is being done?" section next month.

## Where are we doing well?

- Hywel Dda ranked 1st in Wales for 9 national indicators including waiting times for diagnostic tests, stroke patients admitted to a stroke unit within 4 hours, waiting times for patients on the urgent suspected cancer pathway and mental health assessments;
- The three **mental health** key deliverable targets have all been met;
- The **postponed admitted procedures** target met in March 2019, with 16 patients falling within the government commitment of which 8 patients were treated within the 14 day government target (in-month performance 50%). Of the remaining patients, 4 have since been treated, 2 have deferred treatment, 1 is awaiting a date and 1 has been removed from the waiting list;
- The new delayed transfer of care (DTOC) 12 month reduction target for mental health patients has been met;
- The 12 month reduction target has also been met for non mental health DTOCs;
- The rolling 12-month **sickness** rate decreased from 4.87% in February to 4.86% in March and the target was achieved;
- **Medical Appraisal (PADR)** is far above target at 95% and has been above 90% for over 12 months;
- Performance for the percentage of ambulances responding to **red calls** within 8 minutes has met the 65% target (provisional 67.9% for April).

## Where are improvements needed?

- **Unscheduled care** performance declined in April and the targets were not met (1 hour ambulance handovers = 417; 4 hour A&E/MIU waits = 81.1%; 12 hour A&E waits = 959). Work is underway to make improvements around patient flow, ambulatory care, ambulance offload and accident and emergency 4 hour performance;
- With 213 patients waiting more than 36 weeks from referral to treatment (RTT), the target RTT target has not been met. The Health Board aims to be back at target by the end of June 2019 with zero patients waiting over 36 weeks;
- In April there were 56 patients waiting more than 8 weeks for a **diagnostic** and the zero target was not met;
- There were 41 patients waiting over 14 weeks for a **specific therapy** in April, therefore the target for zero patients waiting was not met;
- The 98% waiting time target for **non-urgent suspected cancers** was not met in March 2019 with 95.8% receiving treatment within 31 days;
- The **urgent suspected cancers** 95% waiting time target was not met in March but an improvement was seen from 80.7% in February to 84.2% in March;

### Key deliverable targets

| | | |
|---|---|---|
| 10 | 2 | 9 |

### All targets+

| | | |
|---|---|---|
| 63 | 17 | 78 |

+ Only those indicators for which it is possible to assign a red, amber or green rating are included here.

### All Wales rank*

Hywel Dda UHB ranked in the top 3 for 40.7% of indicators which is a 3.8% increase from the previous month's position.

1. 9 indicators
2. 15 indicators
3. 11 indicators
4. 16 indicators
5. 13 indicators
6. 11 indicators
7. 10 indicators
8. 1 indicators

- The 5% annual reduction target for **hospital initiated cancellations (HIC)** has not been met and the number of HICs increased from 129 in February to 158 in March;
- With only 2.5% at quarter 3 of **smokers attempting to quit via smoking cessation services**, the 5% cumulative target has not been met;
- In April, there were 18,199 patients with **delayed follow-up** across trauma & orthopaedics, ear nose & throat, urology, dermatology or ophthalmology outpatient appointments. The 12 month reduction target was not met.

## Potential challenges for the future

- **Mandatory Training** compliance has not met the 85% target but performance has improved considerably (by 11.4%) over the past 12 months (now 80.1% April 2019);
- **Non-medical appraisals** continue to be below the 85% target but compliance has improved by 15.1% in the last 12 months at April 2019.

There continues to be concerted efforts across the Health Board to make further improvements for both mandatory training and appraisal compliance over the coming few months. This is key to ensure staff are able to have their pay increment as per the Agenda for Change pay deal agreed in 2018/19.

## Performance management triggers

The Performance Team is working with the Programme Management Office to develop triggers to highlight indicators outside of expected ranges. This will involve the use of Statistical Process Control (SPC) charts.

## Improvements / additions / future developments

- The 2019/20 NHS Delivery Framework was published on 2nd May 2019. The stroke and delayed transfers of care indicators have been revised. Delayed transfer of care data is included and the revised stroke data will be included in the month 2 IPAR.
- In 2019/20, Public Health Wales are providing each Health Board with individual improvement targets for Health Care Acquired Infections. These will be made available to us in June and will be included in next month's IPAR;
- The Unscheduled Care report format has changed to make performance challenges easily identifiable by acute site. This format will be extended to the "What is being done?" section next month.

# Latest performance overview

## Key deliverable targets and workforce

| Staying Healthy | Safe | Dignified | Effective | Timely | | | Individual | Staff & Resources |
|---|---|---|---|---|---|---|---|---|
| % adult smokers make quit attempt | Clostridium difficile | Postponed admitted procedures | Mental health delayed transfer of care (DTOC) | Ambulance red calls | Urgent suspected cancer | Admission to stroke unit <4 hours[2] | Secondary mental health care and treatment plan | Finance |
| % smokers CO validated | E.coli bacteraemias | | NMH DTOC Carms Cered Pembs | Ambulance handover over 1 hour | Non urgent suspected cancer | Assessed by stroke consultant <24 hours[2] | | Sickness absence |
| | S.aureus bacteraemia | | | A&E 4 hour waiting times | Referral to treatment - % 26 weeks or less | Stroke patients: OT, PT & SALT[2] | | Performance appraisals (PADR) combined |
| | | | | A&E 12 hour waiting times | Referral to treatment - 36 weeks and over | Local primary mental health <28 days referral | | |
| | | | | Delayed follow-up appointments | Diagnostic waiting times | Local primary mental health <28 days assessment | | |

**KEY**

- Target delivered
- Within 5% of target
- Target not delivered

1. The latest smokers data was included in the month 12 final IPAR (publication May 2019)
2. New metrics for stroke will be published in the month 2 IPAR (publication date June 2019)

| Staying Healthy | Safe | Dignified | Effective | Timely | | Individual | Staff & Resources |
|---|---|---|---|---|---|---|---|
| | Klebsiella sp. & Pseudomonas aeruginosa | Hospital initiated cancellations | | Patients waiting > 14 weeks for therapies | Ambulance amber calls | | Mandatory training |
| | | Concerns and Complaints[3] | | Therapy waits:<br>- Speech & Language<br>- Audiology | | | |
| | | | | Therapy waits:<br>- Art Therapy<br>- Lymphoedema CMATS | | | |
| | | | | Therapy waits:<br>- Occ therapy<br>- Pulmonary rehab | | | |
| | | | | Therapy waits:<br>- Physiotherapy<br>- Podiatry<br>- Dietetics<br>- | | | |

3. Finalised concerns and complaints data for April 2019 will be included in the month 2 IPAR (publication June 2019)

# Integrated performance management dashboards

A set of four dashboards have been included in an attempt to contextualise the Directorates' overall performance:

- Unscheduled care;
- Scheduled care;
- Healthcare acquired infections;
- Oncology.

The dashboards include

1) Current performance for key metrics;

2) Latest sickness data;

3) Hywel Dda University Health Board (HDUHB) performance against All Wales.

Finances measures for March 2019 will be included in the final month 12 IPAR (publication May 2019);

In time, we aim to add a section to capture patient outcomes and experience.

# Unscheduled Care April 2019

**Lead Executive - Joe Teape**

**Responsible Officers - Sarah Perry, Hazel Davies, Brett Denning, Janice Cole Williams**

| Performance Metric | Latest Performance | Last available All Wales data Ranking (1st being the best and 7th being the worst) | | | |
|---|---|---|---|---|---|
| | | Hywel Dda | All Wales | Ranking | Time Period |
| Red Calls (estimate) | 67.9% | 62.9% | 71.2% | 6th out of 7 | Mar-19 |
| Ambulance handovers >1 hour | 417 | 407 | 2,544 | 3rd out of 6 | Mar-19 |
| A&E / MIU wait <4 hours | 81.1% | 81.7% | 78.7% | 3rd out of 6 | Mar-19 |
| A&E / MIU waits >12 hours | 959 | 948 | 4,472 | 5th out of 6 | Mar-19 |
| Direct to Stroke Unit <4 hours | NA | - | - | - | - |
| Stroke patients receiving required mins for OT, PT & | NA | - | - | - | - |
| Assessed by Stroke Consultant <24 hours | NA | - | - | - | - |
| Number of DTOC (in month) | 46 | 495 | 4,431 | 4th out of 8 | Feb-19 |

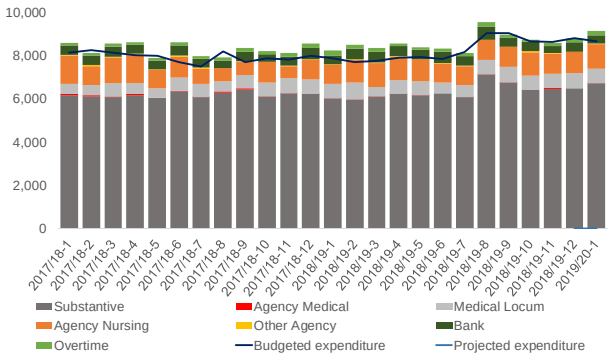
## Staffing

| Sickness (R12m end March 2019) | Proxy vacancies (budget vs actual wte) (Month 1) |
|---|---|
| 4.75% | 229.37 |

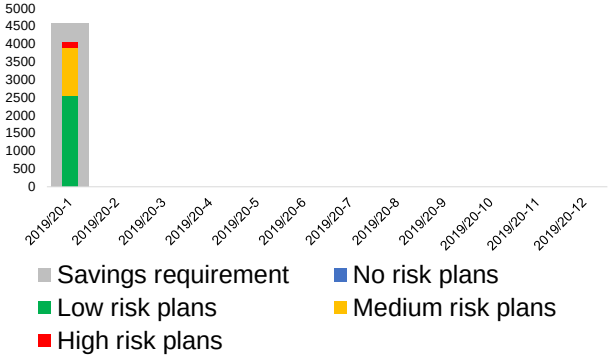
## Finance (Year to Date - Month 1) - excludes Pathology & Radiology

| In month RAG variance (Green favourable; Amber >0%; Red >3%) | | Variance against YTD ave (↑ deterioration; ↓improvement) | | | |
|---|---|---|---|---|---|
| | 4.76% | | - | In month variance (£'m) (adverse is positive) | 0.477 |
| | | | | Cumulative variance (£'m) | 0.477 |
| | | | | Projected variance (£'m) | 2.199 |

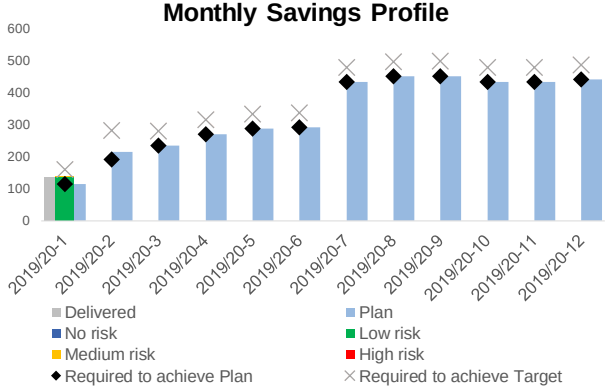
### Pay




### Total Savings Plan




### Monthly Savings Profile



# Scheduled Care April 2019

**Lead Executive - Joe Teape** | **Responsible Officers - Stephanie Hire**

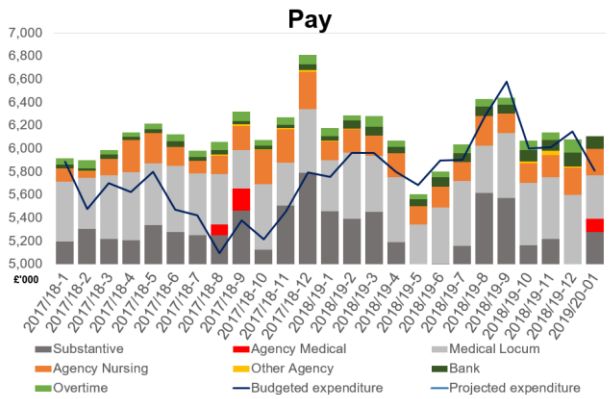
| Performance | | | | Last available All Wales data Ranking (1st being the best and 7th being the worst) | | | |
|---|---|---|---|---|---|---|---|
| | | | | Hywel Dda | All Wales | Ranking | Time Period |
| **Referral to Treat** | **Total open pathways** | **Breaches** | **%** | | | | |
| Waits >36 wks | 53,793 | 0 | 0.0% | 633 | 13,272 | 4th out of 7 | Feb-19 |
| Waits <26 Wks | 53,793 | 5,034 | 90.6% | 90.4% | 88.6% | 3rd out of 7 | Feb-19 |
| **Diagnostics Waits >8 weeks** | | 0 | | 1 | 3,458 | 1st out of 7 | Feb-19 |
| **Postponed Procedures** | | 50.0% | | - | - | - | - |
| **Delayed Follow Ups [all specialties]** | | 34,324 | | - | - | - | - |
| **Delayed Follow Ups [5 planned care specialties]** | | 16,629 | | 16,680 | 194,184 | 4th out of 7 | Dec-18 |
| **Outpatient DNA Rates (In Month)** | | 6.6% | | 7.0% | 6.2% | 5th out of 7 | Feb-19 |
| **Follow Up DNA Rates (In Month)** | | 7.6% | | 7.2% | 7.5% | 5th out of 7 | Feb-19 |

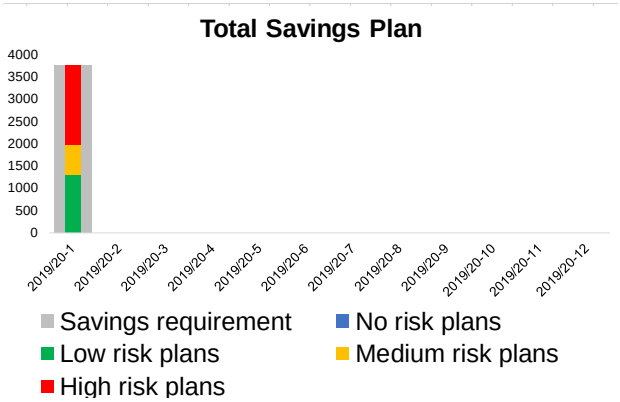
## Staffing

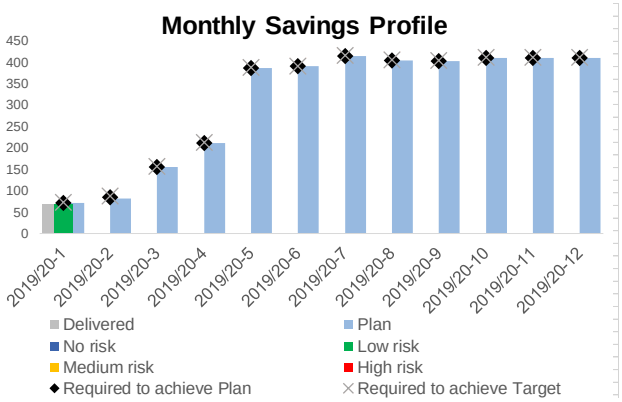
| Sickness (R12m end March 2019) | Proxy vacancies (budget vs actual wte) (Month 1) |
|---|---|
| 4.35% | 82.95 |

## Finance (Year to Date - Month 1)

| | | | | | |
|---|---|---|---|---|---|
| In month RAG variance (Green favourable; Amber >0%; Red >3%) | 0.60% | Variance against YTD ave (↑ deterioration; ↓improvement) | - | In month variance (£'m) (adverse is positive) | 0.036 |
| | | | | Cumulative variance (£'m) | 0.036 |
| | | | | Projected variance (£'m) | 0.732 |



# Oncology April 2019

**Lead Executive - Joe Teape**

**Responsible Officers - Keith Jones**

| Performance | | Last available All Wales data Ranking (1st being the best and 7th being the worst) | | | |
|---|---|---|---|---|---|
| | | Hywel Dda | All Wales | Ranking | Time Period |
| Urgent suspect cancer | 84.2% | 80.7% | 85.2% | 5th out of 6 | Feb-19 |
| Non urgent suspect cancer | 95.8% | 100.0% | 97.5% | 1st out of 6 | Feb-19 |

## Staffing

**Sickness (R12m end March 2019)**

2.66%

**Proxy vacancies (budget vs actual wte) (Month 1)**

-3.12

## Finance (Year to Date - Month 1)

In month RAG variance
(Green favourable; Amber >0%; Red >3%)

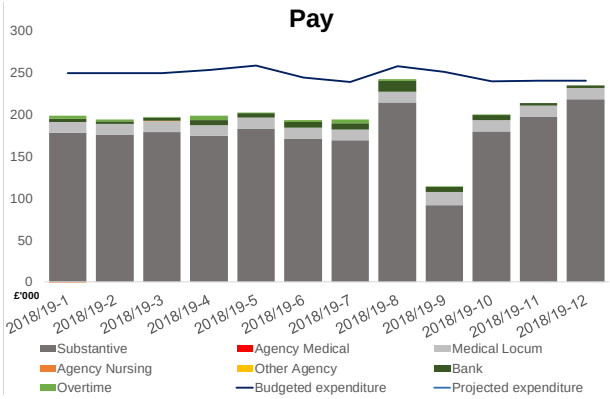
7.30%

Variance against YTD ave
(↑ deterioration; ↓improvement)

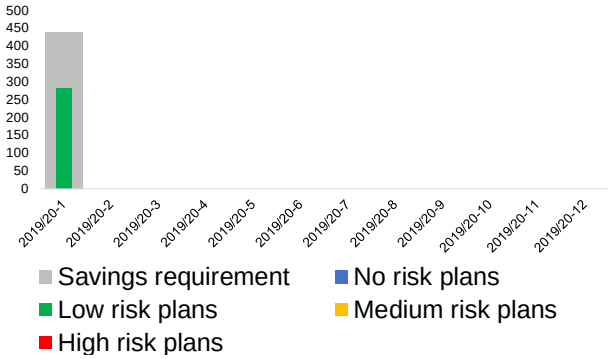
-

| | |
|---|---|
| In month variance (£'m) (adverse is positive) | 0.082 |
| Cumulative variance (£'m) | 0.082 |
| Projected variance (£'m) | 0.54 |

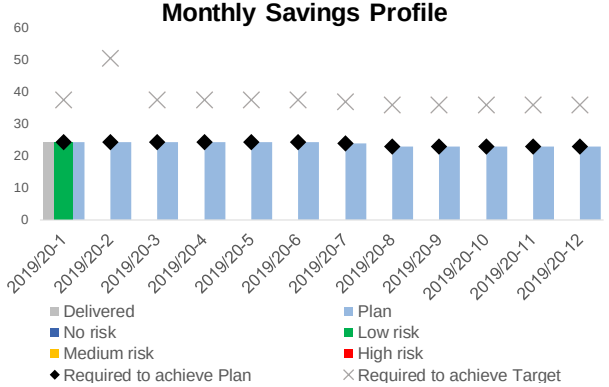
**Pay**




**Total Savings Plan**




**Monthly Savings Profile**



## Healthcare Acquired Infections April 2019

**Lead Executive - Mandy Rayani** **Responsible Officers - Sharon Daniel**

| Performance | | Last available All Wales data Ranking (1st being the best and 7th being the worst) | | | |
|---|---|---|---|---|---|
| | | Hywel Dda | All Wales | Ranking | Time Period |
| **C.difficile** <=26 per 100,000 population (cumulative) | **tbc in June '19** | 37.48 | 26.59 | 6th out of 6 | Apr 18 - Mar 19 |
| **S.aureus bacteraemias (MRSA and MSSA)** <=20 per 100,000 population (cumulative) | **tbc in June '19** | 34.09 | 29.47 | 4th out of 6 | Apr 18 - Mar 19 |
| **E.coli bacteraemias** <=67 cases per 100,000 population (cumulative) | **tbc in June '19** | 91.09 | 79.42 | 4th out of 6 | Apr 18 - Mar 19 |

## Safe Care

I am protected from harm and protect myself from known harm.

**Lead Executives**: Mandy Rayani and Joe Teape

**Exception reports:**

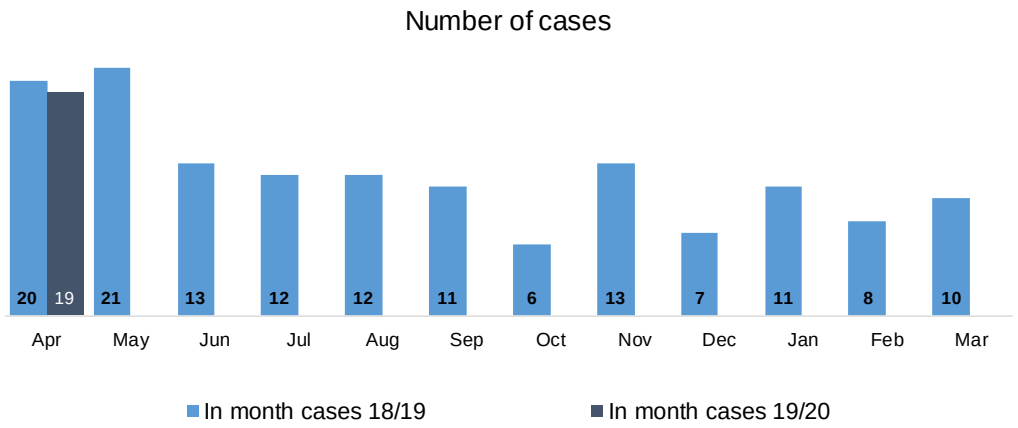
- Health care acquired infections - C.difficile
- Health care acquired infections - E.coli
- Health care acquired infections - S.aureus
- Health care acquired infections - Klebsiella sp. and Pseudomonas aeruginosa

## Safe Care – Healthcare Acquired Infections (HCAI) – cases per 100,000 population

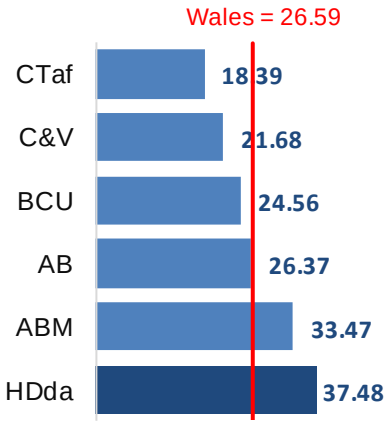
**Lead committee: QSEAC** | **Executive Lead: Mandy Rayani** | **Senior Responsible Officer: Sharon Daniel**

| **Metrics (targets):** | **Status as at April 2019** | **Performance the past 12 months** |
|---|---|---|
| • WG -Cumulative rate of C.difficile cases (<=25 cases per 100,000 population) | NA | NA |

### Latest data




### Benchmarking (Apr 2018 – Mar 2019)




### Where are we and are we on target?

Performance at the end of April 2019 shows the Health Board's in-month number of C. difficile Infections (CDI) is 19.

### Why has this occurred?

The table below shows the reasons for infection:

| | Healthcare Associated Infection | Community Associated Infection |
|---|---|---|
| HAI[1] | **April – 9**<br>• 6x Antibiotics for respiratory infections;<br>• 1x multiple antibiotics for cellulitis;<br>• 1x Relapse, end of life care, not treated not suitable for Faecal Microbiota Transplant (FMT);<br>• 1x Relapse, Liver failure. | **April – 1**<br>• 1x Antibiotics for cancer related systemic infection. |
| HCAI [2] | **April – 2**<br>• 1x Cardiac Surgery other HB;<br>• 1x Recent hospital discharge. | **April – 2**<br>• 1x Relapse in Care Home patient, potential for FMT to be discussed,<br>• 1x holidaymaker, previous gynaecology issues. |
| CAI [3] | **April – 0** | **April – 5**<br>• 1x Relapse, GP sample not currently suitable for FMT;<br>• 2x GP Samples;<br>• 1x Colitis patient;<br>• 1x Patient admitted with falls and diarrhoea. |

1. *Positive Stool Sample, patient admitted for more than 48 hours.*
2. *Healthcare Associated Infection - Positive Stool Sample, patient admitted within 48 hours of sample: Has been hospitalised in previous 30 days; received medical treatment in the last 30 days; lives in a nursing home or alternate care facility.*
3. *Community Associated Infection – Positive stool sample, patient admitted within 48 hours of sample who does not fulfil HCAI criteria*

## What are the challenges?

Detailed in the above tables, the challenges are;

- Of the 19 cases this month, 11 were from Pembrokeshire; 3 GP and 8 Hospital samples. Over the last three months, 5 wards have been identified in Withybush General Hospital (WGH) as having Periods Of Increased Incidence (PII); of these only 1 has been identified as having an episode of cross infection;
- Following discussions with Healthcare Associated Infection and Antimicrobial Resistance and Prescribing Programme (HARP) Team, they will review C.difficile carriers to look at the burden of infection in hospital and the community;
- Ward audits have identified issues with basic cleanliness, which have been addressed with Ward Management and Senior Nurses;
- Antibiotic audits are in progress using Start Smart Then Focus; from the first cases reviewed 20-25% of antibiotics were incorrectly prescribed.

## What is being done?

- WGH Action Plan is being worked through with support from the Hospital Triumvirate;
- Work is being done with HARP Team to look at the burden of hospital infection in WGH;
- Ultra Violet Decontamination of siderooms continues in Acute Clinical Decisions Unit (ACDU), WGH and is extended to isolation rooms. Daily disinfectant cleaning is being done in areas of concern;
- Education around antibiotic prescribing is being provided across the HB to support the launch of the new Antibiotic Guidelines on June 3rd 2019;
- The first patient has received a Faecal Microbiota Transplant - the procedure was successful and the patient will have further testing to assess if the transplant has worked.

## When can we expect improvement and by how much?

The WGH Action Plan is already having effect with increased scrutiny of antibiotics and cleanliness. Improvement expected over the next month but it will take until the end of Quarter 1 for actions to have effect.

## How does this impact on both patients and finances?

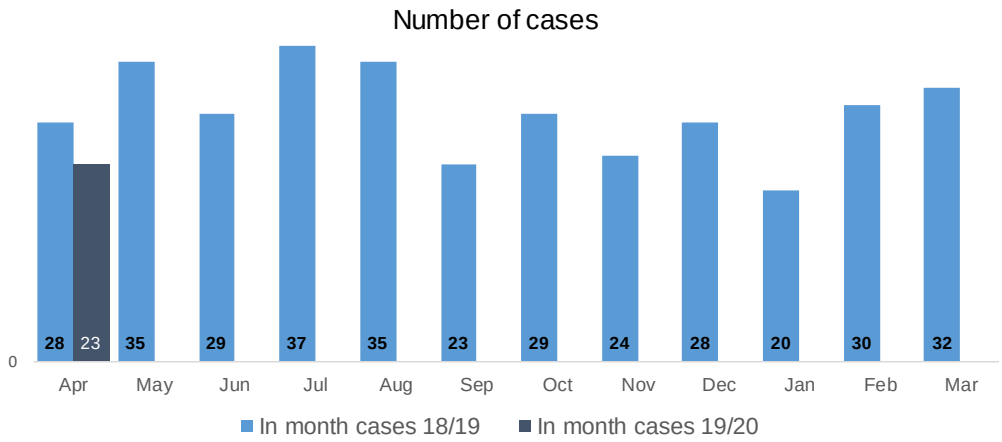
CDI has a detrimental impact on patients. The patient that received FMT has been positive 8 times in the last 18 months, leading to weight loss, restrictions in leaving the house and isolation from family and friends. FMT has an 85 – 90% success rate and this patient welcomed the opportunity to receive treatment.

## Safe Care – Healthcare Acquired Infections (HCAI) – cases per 100,000 population

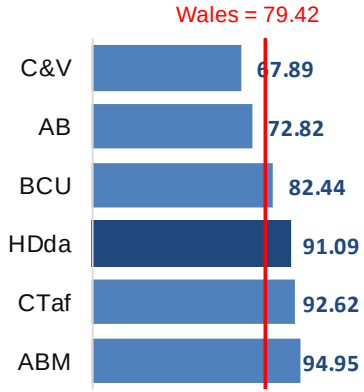
**Lead committee: QSEAC** | **Executive Lead: Mandy Rayani** | **Senior Responsible Officer: Sharon Daniel**

| **Metrics (targets):** | **Status as at April 2019** | **Performance the past 12 months** |
|---|---|---|
| • WG -Cumulative rate of E.coli cases (<=67 cases per 100,000 population) | NA | NA |

### Latest data




### Benchmarking (Apr 2017 – Mar 2019)




### Where are we and are we on target?

Performance at the end of April 2019 shows the Health Board's in month number of E. coli Blood Stream Infections (BSI) is 23.

### Why has this occurred?

The table below shows the reasons for infection:

| | Healthcare Associated Infection | Community Associated Infection |
|---|---|---|
| HAI[4] | **April - 3**<br>• 3x Catheter Associated Urinary Tract Infections (CAUTI). | **April - 1**<br>• 1x Biliary Sepsis; |
| HCAI[5] | **April - 2**<br>• 1x Urosepsis; recent discharge from hospital;<br>• 1x unknown source. | **April - 4**<br>• 4x CAUTI |
| CAI[6] | **April - 0** | **April - 13**<br>• 8x Urosepsis;<br>• 2x Biliary Sepsis;<br>• 1x Diabetic Foot Ulcer;<br>• 2x unknown source. |

*4. Hospital Acquired Infection - Positive Blood Culture, patient admitted for more than 48 hours*
*5. Healthcare Associated Infection -Positive Blood Culture, patient admitted within 48 hours of sample: has been hospitalised in previous 30 days; has received medical treatment in last 30 days; has a long term indwelling device; lives in a nursing home or alternate care facility.*
*6. Community Associated Infection - Positive Blood Culture, patient admitted within 48 hours of sample who does not fulfil HCAI Criteria*

### What are the challenges?

Detailed in the above tables, the challenging cases were:

- 7x cases related to Urinary Catheters; 3 of these were hospital acquired infections.

### What is being done?

As part of this years workplan we will focussing on Urinary catheter insertion and management, part of this work will relate to training on aseptic non-touch technique and use of catheter passports.

**When can we expect improvement and by how much?**
The HB continues to show improvement in this area, currently having 5 less cases than in April 2018. This improvement should continue throughout the year to achieve a 10% reduction on last year's case numbers.

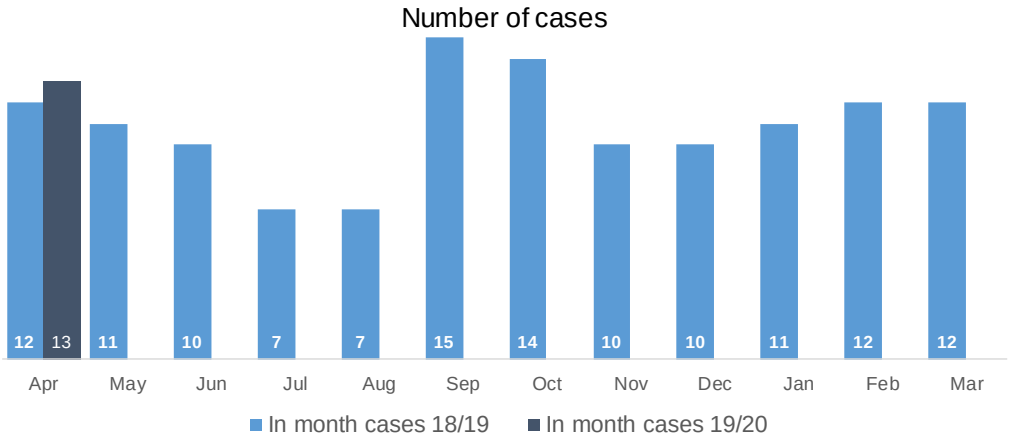
**How does this impact on both patients and finances?**
The work being done by the Community has had a dramatic effect on reducing the number of E.coli Blood Stream Infections by 22% in 2018/19. This equates to 101 people that did not require antibiotic treatment, which consequently reduces their risk of developing a *Clostridium difficile* Infection.

## Safe Care – Healthcare Acquired Infections (HCAI) – cases per 100,000 population

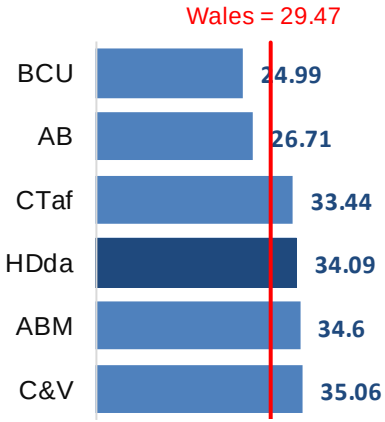
**Lead committee: QSEAC** | **Executive Lead: Mandy Rayani** | **Senior Responsible Officer: Sharon Daniel**

| **Metrics (targets):** | **Status as at April 2019** | **Performance the past 12 months** |
|---|---|---|
| • WG -Cumulative rate of S.aureaus cases (<=20 cases per 100,000 population) | NA | NA |

### Latest data




### Benchmarking (Apr 2017 – Mar 2019)




### Where are we and are we on target?

Performance at the end of April 2019 shows the Health Board's in month number of S. aureus BSI is 13; 12 of which were Meticillin Sensitive Staphylococcus aureus (MSSA) and 1 is a Meticillin Resistant Staphylococcus aureus (MRSA).

### Why has this occurred?

The table below shows the reasons for infection:

| | Healthcare Associated Infection | Community Associated Infection |
|---|---|---|
| HAI[4] | **April - 4**<br>• 1x Urinary related, patient with an urinary catheter and Cancer Prostate;<br>• 2x contaminant - follow up Special Care Baby Unit (SCBU) and A&E;<br>• 1x Device - peripheral vascular cannula (PVC). | **April - 0** |
| HCAI[5] | **April – 2**<br>• 1x systemic infection related to other HB;<br>• 1x osteomyelitis related to surgery in other HB. | **April – 3**<br>• 1x Infected skin tears from fall at home;<br>• 1x respiratory infection in patient receiving treatment for Cancer lung;<br>• 1x MRSA has regular carers. |
| CAI[6] | **April - 0** | **April – 4**<br>• 2x Respiratory infection; one related to flu<br>• 1x Urosepsis<br>• 1x Skin infection |

*4.Hospital Acquired Infection - Positive Blood Culture, patient admitted for more than 48 hours*
*5. Healthcare Associated Infection -Positive Blood Culture, patient admitted within 48 hours of sample: has been hospitalised in previous 30 days; has received medical treatment in last 30 days; has a long term indwelling device; lives in a nursing home or alternate care facility.*
*6. Community Associated Infection - Positive Blood Culture, patient admitted within 48 hours of sample who does not fulfil HCAI Criteria*

## What are the challenges?

Detailed in the above tables, the challenging cases were;

- Contaminated blood cultures; always a challenge and relate to poor practice; SCBU have already received training and follow up in A&E will happen shortly;
- Cannula related infection relates to a cannula, which was not managed appropriately, the area have developed an action plan and have received training.

## What is being done?

- Working with A&E and Admission Units is part of the Infection Prevention workplan for this year to provide support and education opportunities;
- Vascular Access Trolleys have been purchased across the Health Board to improve aseptic practise for taking blood cultures and inserting lines.

## When can we expect improvement and by how much?

The work being done around contaminants should show immediate improvement but this will not bring us in line with the challenging reduction targets. Improvement is expected by the end of Q2 so that the HB is achieving no more than 9 cases a month.

## How does this impact on both patients and finances?

A cannula infection results in patients receiving at minimum two-week course of intravenous antibiotics. This requires them to have an increased stay in hospital, a cannula inserted for a further 2 weeks and further investigations.

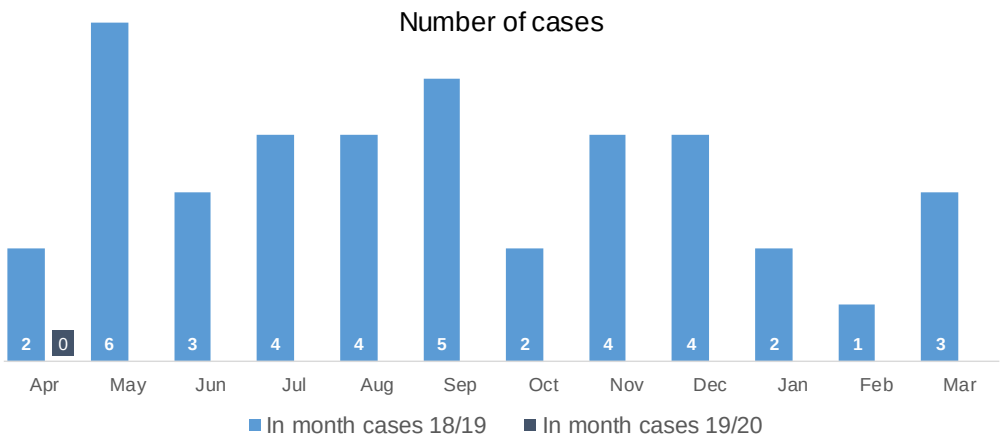
# Safe Care – Healthcare Acquired Infections (HCAI) – cases per 100,000 population

**Lead committee: QSEAC** | **Executive Lead: Mandy Rayani** | **Senior Responsible Officer: Sharon Daniel**

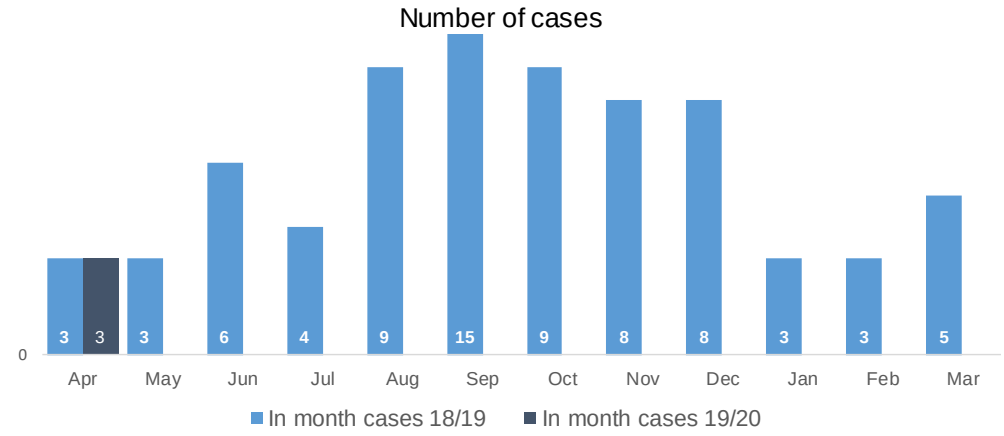
| **Metrics (targets):** | **Status as at April 2019** | **Performance the past 12 months** |
|---|---|---|
| • WG - Cumulative number of cases of Klebsiella sp. Bacteraemia (10% baseline reduction to 2018/19 – awaiting confirmation of target) | NA | NA |
| • WG - Cumulative number of cases of Pseudomonas aeruginosa bacteraemia (10% baseline reduction to 2018/19 – awaiting confirmation of target ) | | |

## Latest data

### Pseudomonas aeruginosa




### Klebsiella sp




## Where are we against target?

Klebsiella sp. and Pseudomonas aeruginosa have a reduction expectation of 10% in numbers of cases in 2019/20 compared to 2018/19. Klebsiella sp. have reported 3 cases this month - all are community cases. Pseudomonas aeruginosa have reported 0 cases this month.

## Why has this occurred?

One case is health care associated as they have had previous positive results and this is due to ongoing disease. Two other cases are community Infections.

## What are the challenges?

There is some difficulty in identifying a source of infection in all cases. We have minimal previous data to work from, so will be looking to identify themes for source of infection and areas where improvement work can be done over the coming year.

## What is being done?

Increased surveillance data is being collected and reviewed.

## When can we expect improvement and by how much?

To maintain this target, for the year ahead;

- Work with Critical Care in reduction of all Gram –ve Blood Stream Infections;
- Work with Community Teams aiming towards minimum standards in Leg Ulcer clinics;
- Review data at end of Q2 to identify themes and areas of improvement.

# Effective Care

I receive the right care & support as locally as possible and I contribute to making that care successful.

**Lead Executives**: Phil Kloer, Jill Paterson, Mandy Rayani, Karen Miles and Joe Teape.

**Exception reports:**

- Delayed Transfers of Care (DTOC) - Mental Health
- Delayed Transfers of Care (DTOC) - Non-Mental Health Carmarthenshire
- Delayed Transfers of Care (DTOC) - Non-Mental Health Ceredigion
- Delayed Transfers of Care (DTOC) - Non-Mental Health Pembrokeshire

# Effective Care – Delayed transfers of care (DTOC) – mental health

**Lead Committee: BPPAC** | **Executive Lead: Joe Teape** | **Senior Responsible Officer: Liz Carroll**

**Metrics (targets):**

- Number of Health Board DTOC in month (12 month reduction)

**Status as at Apr 2019**

**Performance the past 12 months**

Improving

## Latest data




All Wales benchmarking is currently not available.

## Where are we against target?

At the end of April 2019, the revised National target of a 12 month reduction was met, the number of in month patient delays decreased to 7 compared with 8 in March 2019.

## Why has this situation occurred?

The in month position has reduced and this is due to a reduction in the number of Older Adult Mental Health (OAMH) patients identified as DTOC remained the same at 2 with Adult DTOC having decreased from 6 to 5.

## What are the challenges?

- Availability of providers for those who require OAMH care;
- When providers are subject to escalating concerns this limits the availability of appropriate placements;
- Placement of choice by patient or family is not available;
- Difficulty of obtaining package, which is bespoke to particular patient requirements;
- There is a delay in accessing a specialist NHS provision in England – current timescale is unknown, however, an interim placement is being sought, assessment by interim provider took place on 8th May 2019;
- Lack of availability of domiciliary care to enable earlier discharge to less restrictive environments of care.

## What is being done?

- Regular monitoring of the DTOC position is key within services;
- Care co-ordinators focus on discharge planning as early on in the patient pathway as possible.

## When can we expect improvement and by how much?

Of the 7 individuals who are DTOC; 1 is currently on leave to the identified placement; 1 patient has been discharged. For another patient there had been a funding query with a Local Authority outside the Hywel Dda University Health Board footprint, which has now been resolved; 1 patient is awaiting specialist placement, an assessment by a provider is due to take place on the 10th May 2019. Another individual is awaiting specialist NHS provision and an interim alternative is being considered as it is difficult to determine the timescale of availability, so and the assessment by the provider took place on the 8th May 2019. For 1 other patient, the service is currently out to expressions of interest from potential providers and the service is still in the process of identifying suitable placements for another patient.

## How does this impact on both patients and finances?

Patients may end up having to stay in environments that are more restrictive than they require for longer periods. Step down and step up facilities allow individuals to live as independently as possible.

## Effective Care – Delayed transfers of care (DTOC) – non mental health – Carmarthenshire

**Lead Committee: BPPAC** | **Executive Lead: Joe Teape** | **Senior Responsible Officer: Rhian Dawson**

**Metrics (targets):**

- Number of Health Board DTOC in month (12 month reduction)

**HD Status as at Apr 2019:** ●

**HD Performance the past 12 months:** Improving

### Latest data

See the unscheduled care dashboard for the DTOC monthly trend chart.

All Wales benchmarking is currently not available.

### Where are we against target?

At the end of April 2019, the Health Board met the revised National target of showing a 12-month reduction. The number of in month patients for Carmarthenshire was 17, the same as in March 2019.

The breakdown was as follows:

- Reablement requests (3) – one with each Local Authority in the HB;
- Packages of Care (POC) (8) – The POC were long term complex high frequency and/or time critical packages although there were particular issues with domiciliary care capacity in certain remote/rural parts of the county. Several of these patients have been placed but a number remain due to difficulties in sourcing domiciliary care capacity in remote rural areas e.g. Talley, Gwynfe and Cilycwm;
- Continuing Health Care (CHC) processes (2) – one is awaiting a CHC POC, the other is going through the CHC process;
- Family dispute and Home of Choice (HOC) (2) - are consistent issues for delays recently and the team is reviewing this type of delay;
- Care Home Assessments (1) – where the care home manager still needs to assess and determine that they can meet the patient's needs. There is no agreed standard with our providers;
- Housing (1);

### Why has this situation occurred?

- There can be difficulties in commissioning domiciliary care in certain parts of the county that are very rural and remote. This has proven to be the case this month. The bridging service (funded from winter pressures money) concluded at the end of March which compounded the situation;
- Reablement provision has accounted for three patients stemming from insufficient response by each local authority;
- Home of choice. This is not necessarily linked to availability of residential and nursing care home placements, as there are a high level of vacancies across the County. It is more often the case that a patient and/or family are waiting for a specific care home which can cause significant delays if the home is a very good one and has a waiting list;
- Care Home assessments relates to the responsiveness of the Care Home Manager to assess the patient;

The above picture accords closely with the findings of the National Complex Discharge Review undertaken by the NHS Wales Delivery Unit (2018) that considered factors responsible for delays in hospital discharges**.**

### What are the challenges?

The challenge is to reduce not only the number of DTOCs, but to also reduce the associated number of days lost and improve other discharge rates for patients where the acute medical episode has ended. Across the HDUHB, the common challenges faced remain as previously reported in M9 IPAR (page 18).

### What is being done?

A variety of initiatives are undertaken continuously throughout the region with continuous joint working between the Health Board and local authority. Best practice is being shared by each county and practice modified to improve performance. Key initiative details are in M9 IPAR (page 18):

- Sharepoint (IT system) to support early identification;
- Sharepoint Length of Stay (LOS) reporting is being monitored on a weekly basis and is proving useful in improving performance;
- Discharge Liaison and access to social workers is proving beneficial in earlier identification of complex patients;
- The local authority is reviewing its domiciliary care model to make it more efficient and effective for the patients pathway and is seeking to increase domiciliary care capacity by targeting reductions in double handed care and calls requiring 26 calls or more per week (this will allow better recycling of finite capacity to meet demand both from hospital and the community) and whether its two week rule for recycling capacity could be re-considered for those individuals who are admitted from challenging parts of the county;
- Care in the community is co-ordinated to facilitate discharges and prevention of admissions through the Acute Response Team working in partnership with British Red Cross, Care and Repair and other Third Sector organisations to meet the needs of the patients and their carers;
- The Breaking the Cycle improvement plans will contribute to reducing LOS within community hospitals and reducing any delays in the system.

**When can we expect improvement and by how much?**

From April, the Service is aiming to improve performance going forward with more effective reablement interventions and other strategies to improve domiciliary care capacity as noted above e.g. reducing double handed care packages, reducing care packages with 26 calls or more per week, identifying alternatives to domiciliary care

**How does this impact on both patients and finances?**

The objective is to improve outcomes for patients and the performance of the health and social care organisations as previously reported in M9 IPAR (page 18).

# Effective Care – Delayed transfers of care (DTOC) – non mental health – Ceredigion

**Lead Committee: BPPAC** | **Executive Lead: Joe Teape** | **Senior Responsible Officer: Peter Skitt**

**Metrics (targets):**
- Number of Health Board DTOC in month (12 month reduction)

**HD Status as at Apr 2019**: ●

**HD Performance the past 12 months**: Improving

## Latest data
See the unscheduled care dashboard for the DTOC monthly trend chart. All Wales benchmarking figures are currently unavailable.

## Where are we against target?
At the end of April 2019, the Health Board met the revised National target of a 12-month reduction. The number of in month patients for Ceredigion was 9 compared to 8 in March 2019, an increase of 1.

Of these 9, the breakdown is as follows:
- 2 patients were waiting for the commencement of a new package of care;
- 2 patients require highly specialist Elderly Mentally Ill (EMI) Nursing placements which have proved difficult to source;
- 1 patient awaits assessment by specialist neurological rehabilitation centre;
- 2 patient discharges are delayed due to family dispute (1 where the relative has Power of Attorney for Health and Welfare);
- 2 patients were discharged very shortly after the census date to residential care homes.

## Why has this situation occurred?
The main reasons as noted above were:
- Availability of domiciliary care packages in remote areas remains a challenge;
- Availability of residential and nursing home placements, especially of Homes able to meet particularly complex needs, are also limited. This has recently been made more difficult by unrelated escalating concerns in four local Nursing Homes, which are now beginning to resolve.

The above picture accords closely with the findings of the National Complex Discharge Review.

## What are the challenges?
- Specialist placements for complex EMI and Neurological rehabilitation are difficult to source;
- Cross-border challenges in terms of communication with local teams and placement availability.

## What is being done?
A variety of initiatives are being undertaken continuously throughout the region. Best practice is being shared by each county and practice modified to improve performance. Key initiative details are in M9 IPAR (page 18):
- Sharepoint (IT system) to support early identification;
- The Breaking the Cycle improvement plans will contribute to reduce LOS within community hospitals and any delays in the system;
- Porth Gofal Multi agency triage is improving flow and informing priority areas;
- Third Sector Crisis Resolution Team (CRT) works closely with the Multi-Disciplined Team (MDT) to enable safe discharge;
- Community CRT provides in reach into the acute sites enabling timely discharge, this model of care is supported by access to interim beds in Nursing homes.

## When can we expect improvement and by how much?
In recognition of the additional pressures placed on the whole health and social care system during winter periods, the service aims to continually improve.

## How does this impact on both patients and finances?
Extended stays for patients not only potentially adversely affect their functional independence and well-being, but also create a need for surge beds, which has a financial impact.

# Effective Care – Delayed transfers of care (DTOC) – non mental health – Pembrokeshire

**Lead Committee: BPPAC** | **Executive Lead: Joe Teape** | **Senior Responsible Officer: Elaine Lorton**

**Metrics (targets):**

- Number of Health Board DTOC in month (12 month reduction)

**HD Status as at Apr 2019:** ●

**HD Performance the past 12 months:** Improving

## Latest data

See the unscheduled care dashboard for the DTOC monthly trend chart. All Wales benchmarking data is currently unavailable.

## Where are we against target?

At the end of April 2019, the Health Board met the revised National target of a 12-month reduction. The number of Pembrokeshire in month patient delays increased to 20 compared with 5 in March 2019.

In comparison to other months, the reasons for delay were more diverse. Of the 20, the breakdown is as follows:

- Awaiting completion of arrangements for Continuing Health Care (CHC) in the community,1 patient;
- Awaiting start of new home care package,7 patients
- Awaiting commencement of rehabilitation, 2 in patients;
- Selecting residential care placement of choice, 2 patients;
- Waiting for residential place in home of choice,1 patients;
- Other related reasons, completion of process, homeless, completion of Disabled Facilities Grant (DFG) adaptions, 7 patients.

55% of these patients were discharged in the days following census date.

## Why has this situation occurred?

The main reasons for the delays as noted above relate to:

- Availability of domiciliary care packages;
- Availability of residential placements;
- Challenging family and home situations and expectations.

The above picture accords closely with the findings of the National Complex Discharge Review.

## What are the challenges?

There remains an overall lack of domiciliary care in Pembrokeshire. This resulted in longer time spent in an acute and community hospital inpatient setting, which can lead to deconditioning and longer rehabilitation support, which is also constrained. Another independent care provider will cease to provide domiciliary care within Pembrokeshire from 30th June 2019.

## What is being done?

A variety of initiatives are being undertaken with the support of the Delivery Unit and learning from best practice 'Every Day Counts'. Ongoing actions are in place with Acute, Community and Local authority partners, as follows:

- The development of micro enterprises within Pembrokeshire to stimulate the provision of domiciliary care;
- Work fairs to encourage recruitment to independent care market and Local Authority provision of care;
- The Local Authority have developed an in house domiciliary care provision service – initially taking over the care delivery of clients who have been handed back from independent providers;
- Daily Joint Discharge Team (Mon – Fri) Community Pull reviews of all stranded patients with targeted discharge plans shared with wards on a daily basis. Family "Time to talk" meetings introduced to facilitate discharge planning;
- Use of Intermediate beds and Commissioning of step down beds to facilitate discharge and prevent long delays.

### Actions completed

- Discharge Liaison Nurses and Social Workers aligned to acute wards to support planning, board rounds and embed SAFER principles;
- Stranded patient ward rounds in acute with support of social services, voluntary sector and Community Long Term Condition team;
- Early supported discharge team providing care to minimise delays in discharge;
- Bridging care through Care at Home Team and Acute Response Team (ART).

### Actions in May

- Workshop held to support flow and discharge decision making – supported by the Service Improvement Team. Action Plan to be finalised by 15th May;
- Community Hospital weekly Stranded Patient Review meetings commencing May 14th. KPIs have been developed to monitor progress of the action, support from the Service Improvement team has been sought;

- Delivery Unit facilitated work to “Right-size community services” to determine capacity in community in support of flow and complex discharge – initial mapping work due June 2019;
- Intermediate Care, Rapid response and Frailty unit business case submitted to Transformation fund.

**When can we expect improvement and by how much?**
Ongoing improvement is expected and is measured, both in terms of the number of delayed patients, but also in terms of the number of stranded patients and reduced bed days.

**How does this impact on both patients and finances?**
Financial impact in Pembrokeshire relates to the costs of surge and emergency department pressures in Withybush Hospital and the unfunded cost of Community Care Beds.

# Dignified Care

I am treated with dignity and respect and treat others the same.

**Lead Executives**: Joe Teape and Mandy Rayani.

**Exception reports:**

 Postponed admitted procedures

 Hospital initiated cancellations (HIC)

# Dignified Care – Postponed Admitted Procedures

**Lead Committee: QSEAC** | **Executive Lead: Joe Teape** | **Senior Responsible Officer: Acute Site General Managers**

**Metrics (targets):**

- Postponed Admitted Procedures (12 month reduction target)
- Reduction in Hospital Initiated Cancellations (5% reduction to previous year).

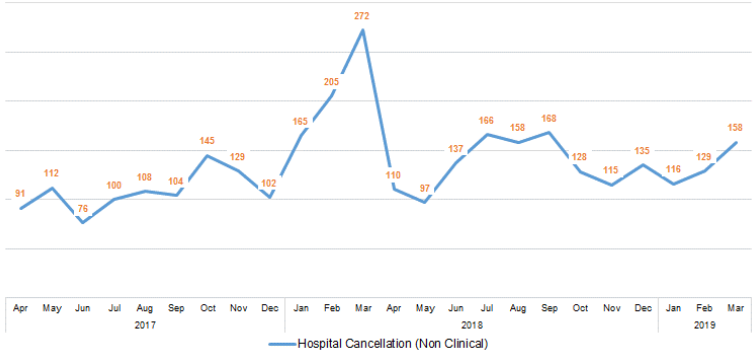
**Status as at Mar 19**

- ● Improving
- ● Not Available

**Performance the past 12 months**

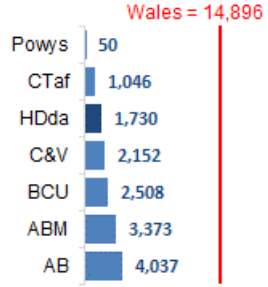
## Where are we and are we on target?

In March 2019, the number of Hospital Initiated Cancellations (HIC) was 158 which is 29 more than the reported 129 in the previous month. The majority of these cancellations (107) were at Withybush General Hospital (WGH).




In March 2019, following validation 16 patients fell within the government commitment. 8 patients were treated within the 14 day government target. In-month performance was 50%. 4 patients have since been treated, 2 have deferred treatment, 1 patient is awaiting a date and 1 patient no longer requires treatment and has subsequently been removed from the waiting list.

## Benchmarking data (February 2019)




The above benchmarking chart reflects the cumulative 12 month rolling number of procedures postponed either on the day of or the day before for specified non-clinical reasons. The target is to reduce by at least 5% (1,587 patients) on the previous financial year. The latest all Wales data ranks Hywel Dda third in this measure.

## Why has this occurred?

The most common reason for HICs is the lack of available capacity due to increased numbers of emergency admissions. Current performance reflects continuing unscheduled care pressures.

## What are the challenges?

- A combination of emergency demand pressures and the lack of available rebooking capacity can affect overall compliance with this measure;
- A significant deterioration in unscheduled care pressures at WGH due to a variety of factors including increased Length Of Stay (LOS), continuing challenges with consistency of middle grade medical cover for wards and an increase in the reported number of medically optimised patients awaiting discharge / transfer.

## What is being done?

- Service Delivery Managers (SDM), Service Managers (SM) and site Theatre leads are working daily with local Patient Flow teams to facilitate flow;
- Targeted unscheduled care improvement plans at WGH with a particular focus on improvements to acute (medical and surgical) assessment, enhanced frailty model designed to reduce avoidable emergency admissions and patient flow improvements;
- Actions to mitigate the risk of HICs are reflecting the broader unscheduled care improvement plans being progressed by each hospital site triumvirate team in partnership with supporting community teams. These actions will also be reflected in the associated winter plans for each location. The main themes reflect:
  - LOS reductions to mitigate the risk of medical patients being admitted to planned care beds;
  - Admission avoidance initiatives, planned reductions in the number of patients categorised as medically optimised for discharge and more targeted rehabilitation of patients. These initiatives are supported by broader improvement programmes including the Integrated Pathway for Older People (IPOP) and 'Breaking the Cycle'.

Successful delivery of these broader unscheduled care improvement plans will reduce the risk of HICs.

**When can we expect improvement and by how much?**
The unscheduled care improvement plan actions (as reflected in the unscheduled care exception report) are intended to deliver improvements in patient flow and discharge planning through 2019/20.

**How does this impact on both patients and finances?**
Reduced cancellations will significantly improve patient experience and the efficiency with which theatre and bed resources are utilised.

## Timely Care

I have timely access to the services based on clinical need and I am actively involved in decisions about my care.

**Lead Executives**: Joe Teape and Karen Miles.

**Exception reports:**

- Red calls
- Unscheduled care
- Delayed follow-ups
- Cancer - urgent
- Cancer – non-urgent
- Referral to treatment
- Diagnostics
- Occupational therapy
- Pulmonary rehabilitation
- Physiotherapy
- Podiatry
- Dietetics
- Amber calls

# Timely Care – Red calls

**Lead Committee: BPPAC** | **Executive Lead: Joe Teape** | **Senior Responsible Officer: Rob Jeffery (WAST)**

**Metrics (targets):**
- % of Red Calls responded to within 8 minutes (65%)

**Status as at Apr 2019**: ●

**Performance the past 12 months**: Declining

## Latest data

See the supporting unscheduled care performance charts.

## Where are we against target?

Provisional figures for April 2019:

| | Wales | Hywel Dda | Carms | Cere | Pembs |
|---|---|---|---|---|---|
| Red 8 min | 70.3% | 67.9% | 71.1% | 69.7% | 61.8% |
| Red 9 min | 76.1% | 72.2% | 71.9% | 78.8% | 69.7% |
| Red 10 min | 80.0% | 75.1% | 74.2% | 78.8% | 75.0% |
| Median red | 00:05:30 | 00:05:19 | | | |
| 95th percentile | 00:16:31 | 00:17:20 | | | |

Red call volume accounted for 6.6% of total call volume 237 incidents, of which 161 met the 8 minute target with 76 being outside.

Amber 1 median response time for Hywel Dda University Health Board (HDUHB) was 00:20:50, with all Wales 00:23:45 minutes. 95thpercentile 01:40:44 minutes with all Wales 02:08:29. Amber 1 call volume accounted for 48.2% 2,122 incidents

Amber 2 median response time for HBUHB was 00:37:49 with all Wales 00:43:34. 95th percentile 04:14:05, with all Wales 04:55:35. Amber 2 call volume accounted for 27.9% 894 incidents.

Total demand for April including Green and HCP calls accounted 3,940 responses.

## Why has this situation occurred?

Notification to handover across Wales saw an increase in lost hours. The recent upward trend in HDUHB has slightly reduced from the March figure of 919.98 hours lost, to 837 hours during this reporting period. This would equate to 72 double manned shifts being removed from the system. A further 46 hours were lost by HDUHB vehicles delayed outside Swansea Bay University Health Board (SBUHB) hospitals.

## What are the challenges?

- In addition to the 837 hours lost to handover delays, the continued upward trend for inter-hospital transfers continues and short term diverts continued;
- Of the 76 calls missed from 237 during April 2019, 57 were due to distance to travel or outside NDP (National Deployment Plan). 12 calls had no vehicle available at time of call due to demand. 1 due to delayed allocation, 3 due to slow mobilisation; 3 due to late booking on due to shift overrun from previous shift (11 hour break);
- 4 frequent callers accounted for 12 ambulance responses which committed 9.9 ambulance hours;
- Sickness decreased slightly to 6.99% (March 7.29%) which remains above the Welsh Ambulance Service Trust (WAST) target of 5.86%;
- Uniformed First Responders (UFR) and Community First Responders (CFR), although responding, did not contribute to Red performance;
- Conveyance rates across all localities remains above the 60% target at 68.3% (March 70.9%);
- Patients treated at scene was 10.6% (March 9.7%);
- The number of patients referred to other providers accounted for 10.8% (March 9.2%).

## What is being done?

- In depth analysis is being undertaken across a number of areas to support a more detailed performance plan;
- Additional resources are being targeted to uplift UHP (Unit Hour Production) across all localities and all shifts are being extended wherever possible with the agreement of staff;
- The Advanced Practitioner (AP) rotational Out Of Hours (OOH) model continues with APs now moving it to Clinical Contact Centre (CCC) to ensure a more focused deployment of resources;
- A further 3 trainee APs have been recruited and should be operational in early June 2019;

- A feasibility task and finish group has been formed to develop a standalone station in Milford Haven and has recommended that WAST should proceed with an implementation plan;
- Further funding has been secured from Welsh Government (WG) to recruit additional APs across WAST. The business case is currently with the Chief Ambulance Commissioner and it will be determined shortly where these will be allocated too.
- The allocation of NQPs (Newly Qulified Paramedics) will be agreed shortly, together with the Technician to Paramedic conversion students;

**When can we expect improvement and by how much?**

The performance gain from the reduction in cross HB activity is currently being reduced by the increase in both hospital delays and internal hospital diverts and transfers, together with deployment issues. However, the expectation is that 65% Red performance should be achieved as a minimum.

**How does this impact on both patients and finances?**

The maintenance of Red calls performance above the 65% performance, combined with continued improvement for both median and 95$^{th}$ percentile, will positively impact on patients although it is accepted that further work is required to maintain progress and will be undertaken as part of the demand and capacity review which will commence in 2019. WAST has secured agreement with the commissioner that a further demand and capacity review will be carried out and this is currently out to expression of interest.

# Timely Care – Unscheduled Care

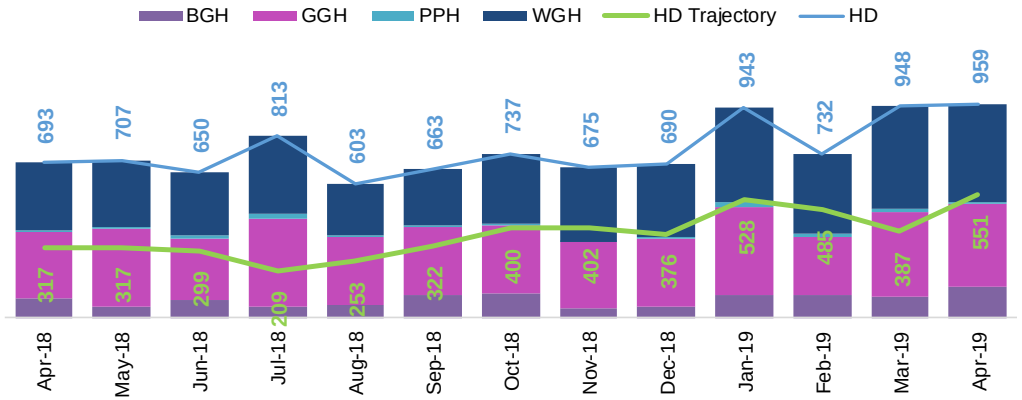
**Lead Committee: BPPAC** | **Executive Lead: Joe Teape** | **Senior Responsible Officer: Acute Site General Managers**

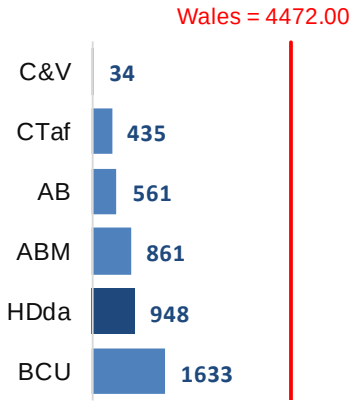
| **Metrics (targets):** | **Status as at Apr 2019** | **Performance the past 12 months** |
|---|---|---|
| • Number of ambulance handovers over one hour (0 target) | ● | Declining |
| • % of patients who spend less than 4 hours in A&E/MIU (95% target) | ● | Declining |
| • The number of patients who spend 12 hours or more in A&E/MIU (0 target) | ● | Declining |

## Latest data

See the unscheduled care charts and dashboard for a full set tables and charts.

### Patients spending >12 hours in A&E and MIU




### Where are we against target?

- The daily average ambulance arrivals in April 2019 have increased to 98.5 compared to 93.5 in April 2018;
- 85.9% of patients conveyed to the emergency care facilities by ambulance during April 2019 were handed over within 1 hour;
- There were 417 Ambulance handovers over 1 hour in April 2019, deterioration to the previous month and to April 2018 with performance of 202;
- April 2019 new A&E/MIU attendances compared to April 2018 have increased to 13,772; an increase of 6.8%; with Bronglais General Hospital (BGH) and Withybush General Hospital (WGH) having the largest increases, 7.1% and of 10.9% respectively;
- New Major attendances have increased from 4,526 in April 2018 to 5,044 in April 2019; an increase of 11.4%;
- 81.1% of patients spent less than 4 hours in all emergency care facilities from arrival until admission, transfer or discharge. This is an deterioration from 83.1% in April 2018;
- Conversion rates for new attendances to admitted patients has decreased from 17.7% in April 2018 to 17.2% April 2019, although the number of admitted patients increased from 2,283 to 2,371, 3.6%;
- The highest breach reason across all sites continues to be lack of medical beds. This has continued from 2018/19 into 2019/20;
- 959 patients spent 12 hours or more in an emergency care facility from arrival until admission, transfer or discharge. This is deterioration from 693 patients in April 2018;
- The average Length of Stay (LOS) for medical emergency inpatients has improved from 9.0 in April 2018 to 8.4 in April 2019. Both BGH and PPH have shown a decrease to LOS > 1.6 days whilst WGH has increased from 8.4 April 2018 to 11.7 April 2019.

**Why has this situation occurred?**

| BGH | GGH | PPH | WGH |
|---|---|---|---|
| • BGH experienced a 7.1% increase in front door demand;<br>• Unprecedented levels of A&E demand at BGH through the Easter Bank Holiday weekend impacted upon the site significantly – highest ever admissions with 72 across the weekend;<br>• BGH - Medically fit and medically optimised numbers have remained relatively stable but average LOS increased to 7.6 days (compared to 7.1 in March) and bed occupancy increased to 105% (compared to 101% in March). Primary reasons for this appear to be peaks of increased conversion rate of attendances to admission and acuity with some late flu incidence. | • New attendances at GGH in April 2019 have increased by 342, which is an increase of 8.9%;<br>• A&E Medical staffing in GGH continues to be a challenge particularly over night when Middle Grade cover cannot always be provided. This leads to increased waits for patients to be seen including Minors;<br>• A full time GGH A&E consultant was off sick long term during the month;<br>• GP Out of Hours (OOH) cover in Carmarthenshire has been an issue and at times the base closed overnight;<br>• A&E attendances in GGH are variable by day of week and not following any particular pattern, with high weekend attendances on the first weekend in GGH in April 2019;<br>• Although plans were in place for the Easter Bank Holiday weekend, the highest emergency admission day was Good Friday with 51 admissions exceeding the discharges by 25 by the end of Bank Holiday Monday. From Tuesday 23rd April, a control centre which included Community colleagues was set up to increase the discharge position due to the high number (59) of medically optimised patients with 29 of those ready to leave;<br>• Long length of stay in GGH continues to be an issue resulting in lack of capacity in A&E to see new and presenting patients;<br>• Continued work with Carmarthenshire Community and Local Authority colleagues is ongoing across all 3 counties. With the ceasing of winter monies the bridging service stopped at the end of March 2019 which did lead to delays in patients requiring re-ablement and packages of care being discharged during April 2019;<br>• Nursing deficits continue to be an issue with 70 WTE Registered Nurse vacancies within GGH. This is further pressurised, as Dewi ward was opened as a surge area, which was managing on 2-6 patients but when operational pressures increased this has been extended to 15 patients and continued at this level all month. | • PPH saw significant increases in demand in April via the Acute Medical Admissions Unit (AMAU) with an increase of 21% emergency admissions and 15% increase in ambulance arrivals compared to April 2018;<br>• PPH saw a 57% increase in Medically optimised patients during April to stand at 33 patients by the end of the month;<br>• Reduced GP OOH provision in PPH, with repeated base closures in month;<br>• The number of patients attending PPH MIU who cannot be treated by the Emergency Nurse Practitioner (ENP) has led to long waits to see the single handed GP. | • 4 hour performance in WGH was adversely affected by the GP (usually placed in A&E) being unavailable from the end of February and throughout March 2019. His phased return in mid April has supported an improvement in A&E clinician breaches. The return of the GP has enabled the A&E department doctors to focus on the Majors stream which will facilitate a more timely referral to specialty;<br>• LOS continues to be an issue in WGH resulting in lack of capacity in A&E to see new and presenting patients and a continued high number of 12 hour breaches;<br>• Middle Grade coverage continues to be challenging across Medicine and A&E in WGH as well as Juniors Doctors in Orthopaedics. |

**What are the challenges?**

| BGH | GGH | PPH | WGH |
|---|---|---|---|
| • BGH - The primary challenge continues to be nursing workforce – with now 57 WTE vacancies (5 newly qualified nurses joined since the last report);<br>• BGH - Cross border complex discharges continue to be a challenge with the need to develop a collaborative team approach which supports the principles of discharge to assess and trusted assessor;<br>• BGH - Variation in ambulance arrivals by day and peaks in evening activity (batching linked to GP surgery times) – all sites; particularly if there is a GP OOH deficit;<br>• BGH - Social work capacity continues to be an issue with often slow case allocation of social worker when complex patients reach a critical mass – this impacts significantly to lost bed days;<br>• BGH - Deficits in nursing and residential nursing home capacity in Ceredigion. This is impacted upon also by the difficulty we have in recruiting nurses to this rural location but is further challenged as two local facilities are embargoed currently. | • In GGH, increased A&E throughput, age, acuity and increased admission conversion rate has necessitated the use of unfunded surge bed capacity which puts additional pressure on the staff, the system as a whole and the financial position;<br>• Variation in ambulance arrivals by day and peaks in evening activity (batching linked to GP surgery times) – all sites; particularly if there is a GP OOH deficit;<br>• Continued therapy deficits at GGH with low levels of funded posts also vacancies leading to delays in treatment and assessment. Currently there are 5 WTE Occupational Therapy vacancies of which there are 2 locums in place;<br>• A number of overnight patients in A&E in GGH & WGH waiting for inpatient beds can at times exceed 20, which makes it extremely difficult for new patients to be assessed and treated. Also for nursing staff to provide the care needs of dependent medical patients;<br>• Top 6 breach reasons in GGH are bed medicine followed by A&E clinician (which has increased by 52), orthopaedic bed, surgical bed awaiting a urology bed has increased and is now in the top 6. | • Increases in AMAU demand in PPH ~~as~~ has provided additional challenges throughout the month. Up to 42% of patients attending PPH MIU have needs outside the scope of the nursing staff and have to be seen and treated by the single handed GP leading to considerable waits for these patients;<br>• The number of medically optimised patients across all sites have continued to increase with PPH now holding 30 to 35 significant waits for social work allocation, assessment and care provision, in the community resulting in a large number of lost bed days;<br>• Due to retirements, there is limited consultant cardiology cover in PPH. | • WGH have also seen a significant increase to 40-60 medically optimised being present per day. Capacity issues to accommodate patients with Long Term Care needs in the Community continues to be a challenge for WGH;<br>• Site pressures and continually high numbers of medically optimised patients have meant that WGH & GGH have been unable to consistently reduce surge following withdrawal of winter funded capacity initiatives at the end of March 2019. This impacts on safe delivery of care as well as financial plan delivery. |

**What is being done?**

- Continued twice weekly meetings to review stranded patients and all medically optimised patients in GGH with weekly meetings in PPH and BGH. A six-week implementation of three times weekly stranded patient reviews has commenced in WGH;
- GGH continue extended safety huddles in A&E so these are now done 5 times throughout the day and overnight and escalation on delays;
- Working with Carmarthenshire County and Local Authority to develop pathway improvement plans avoiding the acute hospital by the development of a crisis response team;
- Implementation of a multidisciplinary frailty clinic by end of April in GGH;
- In GGH, review of extended physiotherapy in A&E until 8.00pm. Findings to be presented to length of stay meeting with a view to further extension. Frailty support workers have been introduced into Clinical Decisions Unit (CDU) to prevent patients deconditioning and to increase mobility. This will be extended beyond winter pressures monies with use of vacant post to fund this for a further 6 months;
- GGH - Reviews documentation of Board Rounds in CDU incorporating safer principles then roll out to all wards in April/May 2019;
- "Manager of the day" in GGH & WGH in place which has increased to the wider management team, ensuring there is always a manager each day to support flow and escalation of delays;
- Focussed attention continues in order to embed the significant number of "partnership" agency nurses who are joining the rosters at BGH to mitigate the vacancy factor;
- BGH - Acute and community teams are working collaboratively to ensure a joined up USC plan across Ceredigion which drives efficiency and cost reduction;
- BGH - Establishment of a dedicated frailty team including the recently appointed Advanced Nurse Practitioner (ANP) with therapy support to be placed at the front door. This will help admission avoidance as well as better manage those frail elders who need a short acute admission and to ensure they leave hospital as quickly as possible; Therapist recruitment to take place in June 2019;
- BGH - Working with the mental health services team to establish a modern and innovative collaborative model of care for dementia sufferers at BGH;
- A large piece of work is continuing to understand the underlying reasons why the reduction in discharges has been seen over the past six months in WGH. WGH will then launch an improvement programme that will include a focus on A&E streaming, Ambulatory Care, Frailty Assessment Model, Assessment returning to the CDU & Surgical Assessment Unit, Hot Clinics and Inpatient flow management. A whole systems workshop is planned for May 9th 2019, to provide an overview of the programme and to engage with teams across Acute and Community. Changes will occur to the Ambulatory Care & Acute Clinical Decisions Unit (ACDU) model as of 15th May 2019;
- An Advanced Practitioner is now being rostered to cover the evening shift in WGH when the GP is not working;
- Ambulatory care review has been undertaken by the Delivery Unit which will support further development of ambulatory care services across the Health Board:
    - GGH has a specific action plan, all acute physicians are in post. Hot clinics are in place and will be expanded. Post Easter ambulatory care will be ring fenced and not used as a bedded area overnight. Weekly meetings are in place to progress the actions and development;
    - WGH has an action plan in place and Standard Operating Procedures (SOP) revisited. Patient scope reviewed and expanded. GP referrals to medicine to be taken by medical staff as of 15th May 2019. Streaming will commence to Ambulatory Care for all appropriate patients.
- System leaders across Carmarthenshire Health and Social Care services have developed a business case that will rapidly transform the intermediate care provision in the community. The new intermediate care service will offer intensive support to deliver care at home as an alternative to hospital admission. This service is due to start in the summer and will significantly reduce demand for hospital admissions;
- Within Llanelli, consultant geriatricians have been visiting a large care home to review patients in the care homes and provide a plan of care. Initial evaluations of this project have now taken place which shows a 50% reduction in admissions from the care home;
- Reviews undertaken of WGH A&E attenders aged over 75 who are 'frequent attenders' or attended WGH A&E after a fall. It has been

identified that a significant number of patients who present with a fall and are discharged from the Emergency Department, re-present on at least one further occasion. A falls bundle has been developed and will be piloted in Tenby MIU in June 2019 with appropriate patients being directed to a pilot falls clinic in Tenby, staffed by a geriatrician from WGH.

**When can we expect improvement and by how much?**

- The “partnership” arrangement with agencies at BGH will deliver a reduction in the cost of agency premium;
- BGH - Establishment of proper team working with these semi-permanent nurses who will join the ward teams will make the LOS and site efficiency improvements we need to deliver more achievable;
- GGH - Continued nurse recruitment is undergoing with 35 places offered for this September cohort and continued ongoing external recruitment;
- GGH maintains a continued focus on ambulance performance 4 and 12hr breaches at weekly operational group, which is underpinned by the length of stay meeting to deliver performance improvement;
- The unexpected recent increases in PPH AMAU demand seen in March and April make forecasting improved performance complex;
- WGH will be establishing 2 weekly review meetings with close monitoring against metrics from June 2019. The Service Improvement and Quality Improvement teams support this;
- Stranded patient reviews in WGH with increased focus are expected to see a reduction in patients with a length of stay over 7 days within 2 weeks.

**How does this impact on both patients and finances?**

- Improved recruitment across all sites will lead to improved team working and better focus, impacts positively on patient experience;
- It is very difficult for all sites to absorb large increases in demand without affecting finances and patient care;
- Improved patient flow has a positive impact on both patients and finances. Elimination of unnecessary stays in hospital reduces the risk of iatrogenic events such as falls or hospital acquired infections. It also saves money by reducing or eliminating the needs for surge capacity staffed by agency

# Timely Care – Delayed Follow Up Appointments

**Lead Committee: BPPAC** | **Executive Lead: Joe Teape** | **Senior Responsible Officer: Stephanie Hire/Keith Jones**

**Metrics (targets):**

- Delayed follow-up appointments booked and not booked – 5 planned care specialties (12 month reduction target)

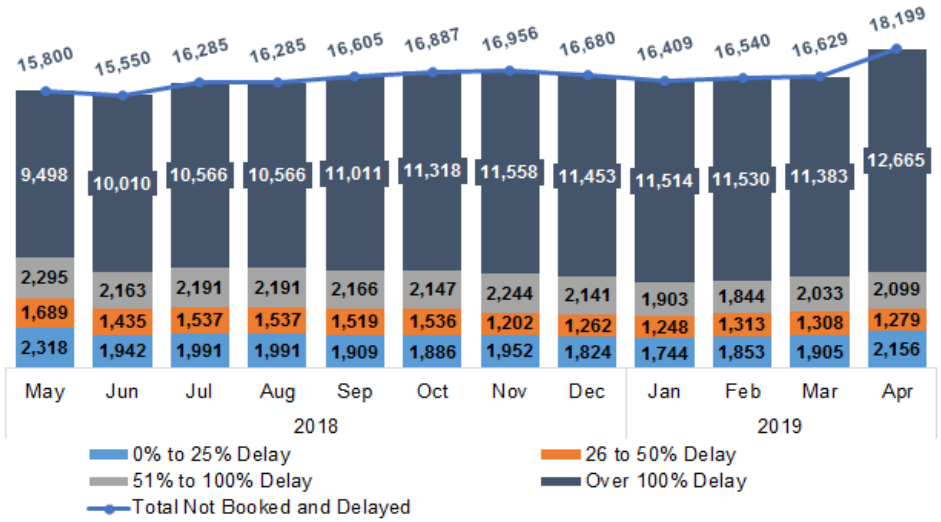
**Status as at Apr 2019**

**Performance the past 12 months**

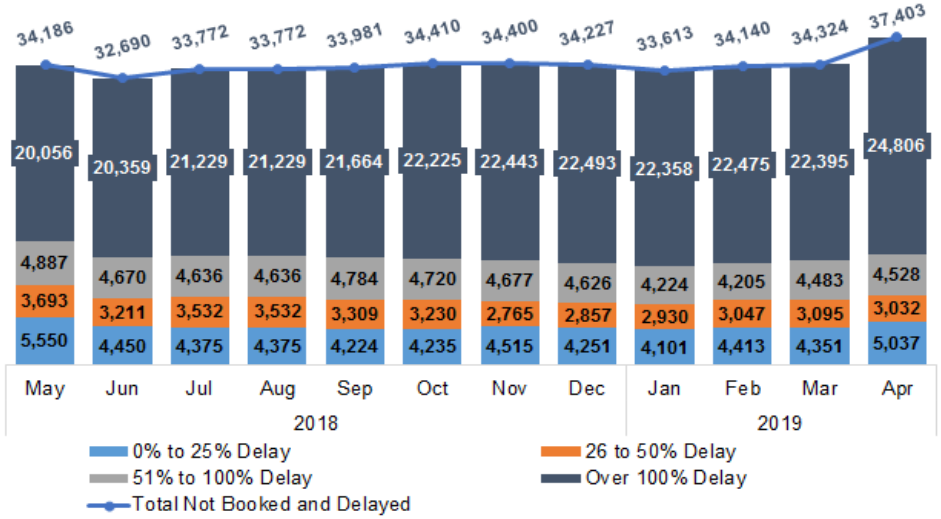
Declining

## Latest data

### 5 Planned Care Specialties




### All Specialties

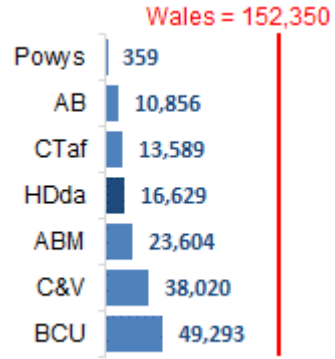



## Where are we and are we on target?

The total number of reported delayed follow-ups (booked/unbooked) in April 2019 was 37,403 which represents an increase of 3,079 patients compared with the previous month.

From April 2018 the 2018/19 Delivery Framework (page 26, measure 45) altered this metric to include the 5 Planned Care Programme (PCP) specialties only. These are Trauma and Orthopaedics, Ear, Nose and Throat, Urology, Dermatology and Ophthalmology. In April 2019, the total number of patients reported as waiting for a follow-up appointment past their target date in these specialties was 18,199 (an increase of 1,570 compared to the previous month).

## Benchmarking (March 2019)




The Health Board (HB) is not currently meeting its 12 month reduction target and ranks 4th in Wales for this measure when benchmarked using the 5 planned care specialties (January 2019 data).

## Why has this occurred?

These reported increases (for both metrics) represent the largest single reported monthly increase for over 12 months. As these increases vary significantly from the monthly trend noted during 2018/19, the data is being further interrogated to inform an assessment of the underlying reasons for the reported increases. Initial analysis indicates that the growth in the

volume of reported delayed follow ups relates primarily to the 0-25% and 100%+ delayed categories with 72% of this increase (2,205 of 3,079 patients) relating to patients with booked dates. This indicates the reported increases are a consequence of:

- The increased volume of new outpatient appointments delivered during quarters 3 & 4 2018/19 and the consequential volume of patients recommended for follow-up review (0-25% category);
- Reduced overall volumes of follow-up activity delivered in January & February 2019 (in favour of Stage 1 Referral to Treat (RTT) cohort patients) and a resultant temporary increase in patients with booked review dates receiving their appointments after the originally intended target dates (0-25% category);
- Reduced capacity within the Validation team and prioritisation of available validation resources for new patients at the expense of follow-ups (100% delayed category).

## What are the challenges?

It is recognised that the overall volume of reported delayed follow-up appointments is inflated by data accuracy challenges and the need to modernise clinical practice in the majority of specialties, to limit the volume of unnecessary clinic based reviews requested by (often) inexperienced clinical staff. The reported number of delayed follow-ups part reflects:

Access Policy variations – review of administrative policies has highlighted variations in practice relating to new and follow-up appointments such that follow-up patients are not routinely discharged if they do not respond to appointment invitations. This consequently inflates reported delayed follow-up numbers. Action is being taken to address this variation in accordance with the Access Policy.

Service / clinical transformation – it is acknowledged that historical clinical practice and supporting administrative systems promotes the planning of outpatient department (OPD) based follow-up reviews without full consideration of alternatives and/or the clinical necessity of planned reviews.

## What is being done?

The overall approach to reducing delayed follow-ups is reflected in three parallel work streams focussing on accurate pathway management, clinical transformation and the Planned Care Programme priority areas:

Pathway Management – targeted training and administrative / clinical validation activities to support improvement compliance with the Access Policy and a reduction in the volume of follow-up pathways which remain open unnecessarily.

Clinical Transformation – work being progressed across several specialties to review and update clinical guidance regarding follow-ups and the promotion of alternatives to traditional clinic based reviews including adoption of self-management programmes for some patient groups, expansion of 'See on Symptom' review protocols and expanded use of virtual clinics:

Planned Care Programme (PCP) Specialties

- ENT – continuing work within the specialty to identify alternatives to routine follow-up review and adoption of the clinical guidance developed by the ENT Planned Care Board;
- Orthopaedics – in accordance with national PCP guidance, the specialty commenced the introduction of Patient Reported Outcome Measures (PROMS) questionnaires in April 2019 as an alternative to routine clinic based follow up review of major joint replacement patients;
- Ophthalmology - the specialty is progressing implementation of the new Eye Care Measures and the roll out of community optometrist reviews of glaucoma patients. Commissioning tenders for optometrist practices to participate in this model are due to be launched by 31st May 2019;
- Urology – the specialty is currently developing proposals to introduce a self-care programme for prostate patients which is expected to significantly reduce the number of delayed Urology follow-ups.

In addition to these specialties, the Outpatient Turnaround process is continuing to focus on reducing delayed follow-ups across all specialties.

## When can we expect improvement and by how much?

It is notable that overall follow-up review activity levels increased in March and April 2019 (following the reductions noted in January & February 2019) which indicates that the reported increase in delayed follow-ups in April 2019 is likely to be temporary. It is expected that performance will improve in subsequent months as the temporary increased backlog of delayed follow-ups is reduced as a consequence of higher follow-up activity levels.

Welsh Government has proposed the following improvement targets for NHS Wales to be shadow reported during 2019/20 with formal reporting from April 2020:

- All Health Boards to have allocated a clinical review date to all patients on a follow-up waiting list from September 2019;
- All Health Boards to have allocated a clinical risk factor to patients on

the eye care measures from September 2019;
- All Health Boards to report accurately see on symptom patient pathways from September 2019;
- All Health Boards to reduce the overall size of the follow up waiting list by at least 15% by March 2020;
- Reduce the number of patients delayed by over 100% by at least 20% by March 2020

**How does this impact on both patients and finances?**
See the Month 9 IPAR (page 37) for details.

# Timely Care – Cancer

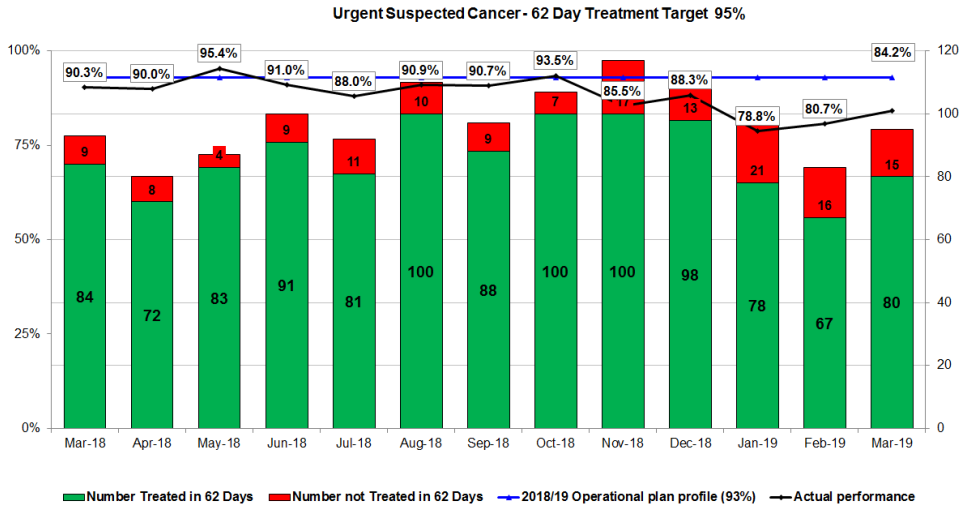
**Lead committee: BPPAC** | **Executive Lead: Joe Teape** | **Senior Responsible Officer: Keith Jones**

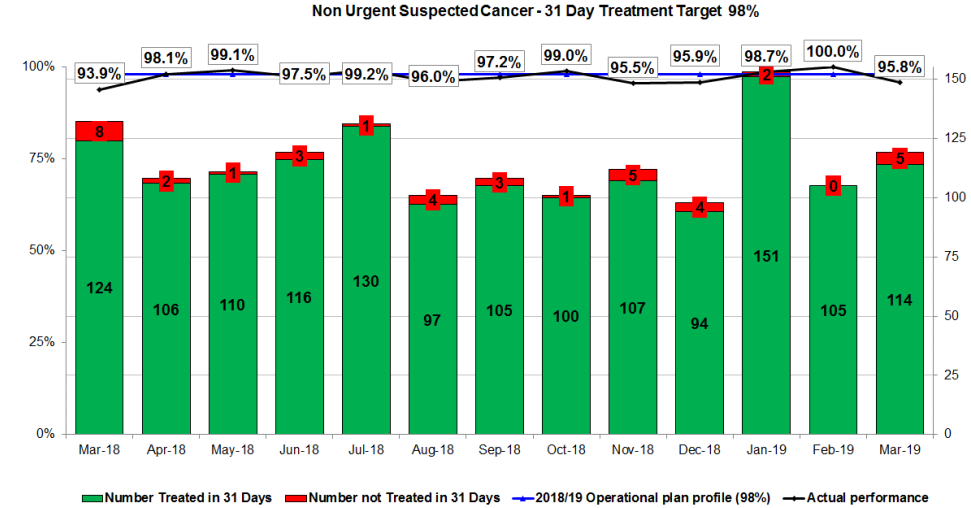
**Metrics (targets):**

- % of patients referred as urgent suspected cancer seen within 62 days – Target 95%
- % of patients referred as non-urgent suspected cancer seen within 31 days – Target 98%

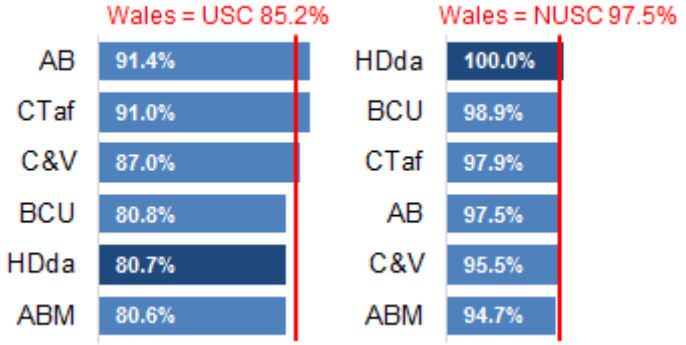
| Status as at Mar 19 | Performance the past 12 months |
|---|---|
| ● | Declining |
| ● | Declining |

## Latest data




## Benchmarking (February 2019)




The latest all Wales benchmarking data puts Hywel Dda ranked 1st in Wales for Non Urgent Suspected Cancer (NUSC) and 5th for Urgent Suspected Cancer (USC).

### Where are we and are we on target?

**USC** – confirmed March 2019 USC performance was 84.2% based on 15 breaches for the following reasons/areas:

- 8x tertiary surgery delays (3x Gynaecology, 1x Skin, 1 x UGI, 3x Urology);
- 1x tertiary oncology delay (1x LGI);
- 3x multi-factorial delays (including delays to tertiary surgery - 1x Gynaecology, 1x Skin, 1x Urology);
- 2x complex diagnostic pathways (1x Lung, 1x Haematology);
- 1x local diagnostic delay (1x Urology).

**NUSC** – confirmed March 2019 NUSC performance was 95.8% based on 5 breaches for the following reasons/areas:

- 3x Breast (1x tertiary surgery delay, 2x delay to local surgery);
- 2x Urology (2x delay local surgery).

**Why has this occurred?**

**USC** – whilst performance in March 2019 showed a further partial recovery following January & February 2019, further improvement in the month was compromised primarily due to a significant volume of tertiary service breaches with 8 tertiary surgery delays and 1 tertiary oncology delay (in addition to 3 further breaches where delays to tertiary surgery were one of several factors which led to treatment being delayed outside of the 62 day target).

Encouragingly, Dermatology pathway breaches reduced to 2 in the month which reflects further progress in addressing the backlog of outpatient assessments/treatment reported in previous months.

- Local diagnostic service pressures within Radiology & Pathology services, which led to delays in the investigation and reporting of results (5x related to the Urology pathway).

**NUSC** – performance was disappointing following 100% performance in February 2019. The deterioration in performance primarily reflected local delays in Breast surgery (due to consultant absence) and Urology (due to pressures on critical care capacity). 1 beach was due a delay in tertiary (Plastic) surgery for a breast pathway patient.

**What are the challenges?**

- **Tertiary centre capacity pressures** - continue to present a risk to the Health Board's performance across a number of USC and NUSC pathways. These pressures are similarly reflected in performance at Abertawe Bro Morgannwg University Health Board (ABMUHB), which continue to run significantly below the Welsh average. Lead in times to radiotherapy treatments regularly exceed 4 weeks for many patients and delays for Gynaecology surgery continue to feature as major breach reason. Concerns regarding Tertiary Centre capacity and associated delays continue to be escalated at operational and executive levels. The extent to which these tertiary capacity risks impact upon overall performance varies month to month depending on the volume of Hywel Dda patients requiring tertiary treatment and overall demand at ABMUHB;
- **Complex pathway delays** – the nature and complexity of tumours for some patients do not support rapid diagnosis and treatment as these patients are often subject to multiple investigations and Multi Discipline Team (MDT) reviews to determine the most appropriate clinical management plan;
- **Local service capacity pressures** – capacity pressures within Radiology & Pathology services continue to present a risk of delays in the investigation and reporting of results which ultimately impact upon delivery of any necessary treatments within the 62 day target.

**What is being done?**

The table below provides a current status assessment of the key risks:

| **Dermatology** | **Current Position:** |
|---|---|
| • Local diagnostic/treatment delays due to significant vacancy factor within service. | • Performance in March 2019 showed an improvement compared to previous months.<br>• 1 staff grade doctor has been appointed and locum consultant is due to commence early summer 2019 along with continued utilisation of an external provider to supplement local capacity.<br>• A joint planning workshop has been held with ABMUHB to consider further opportunities for regional solutions and a development/supervision programme for GPs with an interest in Dermatology;<br>• The Dermatology backlog has now reduced to 8 (with only 2 patients with confirmed cancer). |
| **Urology** | **Current Position:** |
| • Delays for tertiary surgery;<br>• Incidence of local diagnostic delays due to pressure on diagnostic service capacity. | • Pressures on the tertiary surgical and oncology service escalated with ABMUHB actively seeking additional capacity to reduce delays;<br>• Pressures impact upon waiting times for tertiary surgery and radiotherapy treatments;<br>• ABMUHB unable to confirm robust plans to mitigate these risks in the short term, although locum recruitment attempts are continuing;<br>• Locum solutions continue to be explored to support Radiology & Pathology capacity investigations and local pathology reporting. |
| **Gynaecology** | **Current Position:** |
| • Delays for surgical treatment at the tertiary centre in Swansea;<br>• Situation reflects capacity pressures within the ABMUHB Gynaecology consultant team and periodic bed capacity pressures at Morriston. | • This remains a risk to sustained performance improvement until Autumn 2019;<br>• ABMUHB have confirmed that a 4th Gynaecology Cancer Surgeon has been appointed but the successful candidate will not join the service until September 2019;<br>• No available interim capacity at alternative units in Wales. |

**When can we expect an improvement and by how much?**
Data for April 2019 indicates that USC performance will show a further recovery compared to March 2019 towards 88% with recovery above 90% expected by the end of Quarter 1 – this is subject to current review and validation.  NUSC performance is expected to be between 96-98%.

**How does this impact on both patients and finances?**
Evidence suggests early diagnosis and treatment of cancer can significantly influence longer term clinical outcomes for patients.  The impact of diagnostic and treatment pathways for individual patients will reflect a number of different factors including length of time between development of symptoms and initial presentation, the relative stage/progression of the tumour at the time of presentation, the nature of the tumour and treatment options available.

# Timely Care – Referral to Treatment (RTT)

**Lead Committee: BPPAC** | **Executive Lead: Joe Teape** | **Senior Responsible Officer: Keith Jones/Steph Hire**

| Metrics (targets): | Status as at Apr 2019 | Performance the past 12 months |
|---|---|---|
| • % patients waiting less than 26 weeks from referral to treatment (target = 95%) | 🟡 | Improving |
| • Number of patients waiting 36 weeks and over (target = 0) | 🔴 | Improving |

## Latest data
Please refer to the RTT charts.

## Where are we and are we on target?
- The number of 36 week+ breaches in April 2019 was 213. The percentage of patients waiting less than 26 weeks from Referral To Treatment (RTT) was 89.4% in April 2019 (49,120 patients);
- Both metrics are within the expected range for the end of April 2019 and show a minimal 'bounce back' compared with previous years. Achievement of zero breaches is expected by the end of Quarter 1.

## What are the challenges?
Breaches in April 2019 were primarily attributable to the impact of:
- Deferred consultant annual leave from February/March 2019;
- Continuing emergency pressures during/associated impact on cancelled operations during April 2019;
- Reduced Ophthalmology outsourcing throughput via BMI due to the Easter period and consultant sickness/absence;
- Overall impact of the Easter holiday period on activity levels in the month.

## What is being done?
Delivery plans are in place across all specialties with recovery to zero breaches targeted for the end of Quarter 1. Specialties currently identified with the highest delivery risks by end of Quarter 1 are:
- **Orthopaedics** - the impact of continued levels of cancelled orthopaedic operations (particularly at Withybush Hospital) is being profiled along with potential opportunities to re-provide this activity elsewhere within the Health Board to mitigate the impact on patients.
- **Cardiology** – opportunities currently being explored to mitigate the impact of reduced capacity due to consultant sickness, retirement (and return at reduced capacity) and an existing vacancy.

## When can we expect improvement and by how much?
Consolidation of waiting times improvements achieved during 2018/19 and sustained delivery of zero 36 week+ breaches from end quarter 1 onwards.

## How does this impact on both patients and finances?
Achievement of zero 36 week breaches represents a significant improvement in service quality and experience for our patients. Specialty teams continue to work on efficiency and productivity plans to address capacity pressures and improve sustainability in the shorter term whilst working on regional collaboration with regard to some specialties in the mid and long term. The Health Board is working closely with Abertawe Bro Morgannwg University Health Board and Welsh Government to address this.

# Timely Care – Physiotherapy - Therapy waits over 14 weeks

**Lead committee: BPPAC** | **Executive Lead: Joe Teape** | **Senior Responsible Officer: Helen Annandale**

**Metrics (targets):**

- Number of patients waiting 14 weeks plus for Physiotherapy (Target = 0)

**Status as at April 2019:** ●

**Performance the past 12 months:** Improving

## Latest data

The latest available data can be viewed within the therapies graphs.

## Where are we against target?

There were 29 breaches of the 14 week target in April 2019. In April 2018, 3 breaches were reported. The overall 12 month trend shows increasing numbers of patients on the waiting list. However, the numbers of breaches over the last 6 months have been relatively small.

## Why has this occurred?

Demand on the service has increased over the last 3 years as services have modernised to shift demand off Primary Care GP and Secondary Care Consultant specialties. Short-term funding in recent financial years has supported the service in absorbing some of the demand but there has still been a steady increase in the volume of patients on waiting lists. This has led to a position where there is a higher risk of breaches with small fluctuations in workforce.

### What are the challenges?

- Service capacity is challenged due to baseline staffing compounded by recruitment challenges and vacancies e.g. maternity leave and availability of newly qualified staffing. The latter is a national issue. There are currently 6.2 WTE staff on maternity in areas which impact 14 weeks targets;
- Increasing service demand including transforming services to focus on prevention e.g. increasing access with self-referral services, alternative services to Consultant assessment, pilot projects to support primary care Musculoskeletal Physiotherapy (MSK) caseloads;
- Clinical Musculoskeletal Assessment and Treatment Service (CMATS), new primary care first contact practitioner roles and the core MSK physiotherapy service are interlinked and capacity has been flexed between the services e.g. service cover for maternity leave. This decreases capacity within core MSK services, which compounds the capacity issue;
- Fixed term funding of new roles in primary care increases service reliance on agency backfill to maintain routine waiting times in core MSK services.

## What is being done?

Service redesign including:

- Skill mix review;
- Signposting/delegation to partners e.g. National Exercise Referral Scheme (NERS);
- Development of integrated community based education and rehab programs collaboratively delivered with local authority (NERS);
- Empowering self-management of chronic conditions;
- Recruitment and retention strategy to attract and support skilled practitioners to service;
- Appropriate utilisation of agency staffing via direct engagement;
- Continue performance management strategies e.g. patient management in line with national standards, electronic systems, and template based clinical diary systems;
- The service is working collaboratively with primary care to develop new roles in GP practices to allow early expert first point of contact support, improve quality, and reduce some of the demand into core MSK Physiotherapy/CMAT services;
- The service has submitted capacity demand reports to highlight workforce challenges.

## When can we expect improvement and by how much?

It is anticipated that the breach position will improve in May. This is dependent on the availability of agency workforce to back fill for service vacancies. There will be a continued risk of breaches over the next 3 months.

## How does this impact on both patients and finances?

Longer waiting times result in:

- Poorer patient experience;
- Poorer self-management of condition;
- Higher risk of developing chronic conditions;
- Increase referral behaviour e.g. utilisation of inappropriate imaging, repeat attendances to GPs, A&E or referral to secondary care;
- Increase in dependency can result in increased care package costs, loss of function and work;
- Utilisation of agency staffing does result in significant pressure on service budget and governance arrangements.

# Timely Care – Podiatry - Therapy waits over 14 weeks

**Lead Committee: BPPAC** | **Executive Lead: Joe Teape** | **Senior Responsible Officer: Alison Shakeshaft/ Mike Mulroy**

**Metrics (targets):**

- Number of patients waiting 14 weeks plus for Podiatry (Target = 0)

**Status as at Apr 2019**: ●

**Performance the past 12 months**: Improving

## Latest data

The latest available data can be viewed and interrogated within the therapies graphs.

## Where are we and are we on target?

There were 4 patients waiting over 14 weeks at the end of April 2019.

## Why has this occurred?

The Podiatry Service has consistently managed increased demand over recent years despite a limited growth in the service. Podiatry undertakes one of the highest patient direct contact treatments per year in therapies (60,000). Significant innovation and service improvement measures have been implemented to enable this. Demand consistently outstrips available capacity and short term funding has been relied upon to manage the waiting list position.

## What are the challenges?

Within Podiatry, there is a significant requirement for follow up appointments as part of patient management due to the range of conditions being referred e.g. Diabetic foot ulceration is likely to gradually deteriorate over the years as the underlying peripheral vascular disease worsens. Similarly, children with long-term chronic conditions will need ongoing care and re-provision of appliances as the patient develops. In addition, the service has evolved to manage musculoskeletal patients that previously may have gone to Orthopaedics or other Health Board services such as Accidents and Emergency; many of these patients are not simply a see and treat-discharge type. As a result, increasing numbers of referrals have an impact on follow up demand, which is consistently outstripping available capacity.

## What is being done?

Short-term referral to treatment (RTT) funding has been previously being utilised to increase new patient capacity. This will not deal with the impact on increased follow up requirements. Robust discharge processes are in place in addition to detailed eligibility criteria to be able to access the service. Some patient follow up capacity modelling has been undertaken and there are possible proposals to increase whole time equivalent staffing to permanently manage this problem.

Podiatry's Expert Patient Programme (EPP) programme commenced in August 2018 and is the latest innovation to try to streamline referrals and reduce waiting times.

## When can we expect an improvement and by how much?

Expert Patient Programme should help reduce patient numbers; however, a long term, sustainable approach is required and a sustainability plan for the service is being developed. Long-term sustainable improvement would need investment or further changes in eligibility criteria to limit patient access and the availability of certain products and treatments.

## How does this impact on both patients and finances?

A sustainable solution is required to address the demand and capacity gap across the service. Priority areas will be identified through the department's Integrated Medium Term Plan (IMTP). This in effect means ensuring that all possible efficiencies and new ways of working are undertaken to ensure value for money. If this is the case and without further investment, the result will be increased patient waiting times and possible increased morbidity and mortality rates. If no investment, possible then significant changes to eligibility criteria need to be adopted to ensure patients are seen in other sectors such as private practice. This could affect patient experience and could result in complaints from patients and other services that are having access restricted.

# Timely Care – Dietetics - Therapy waits over 14 weeks

**Lead Committee: BPPAC** | **Executive Lead: Joe Teape** | **Senior Responsible Officer: Zoe Paul-Gough/Karen Thomas**

| **Metrics (targets):** | **Status as at Apr 2019** | **Performance the past 12 months** |
|---|---|---|
| • Number of patients waiting 14 weeks plus for Dietetics (Target = 0) | ● | Improving |

## Latest data
The latest available data can be viewed within the therapies graphs.

## Where are we and are we on target?
There were 3 patients waiting over 14 weeks at the end of April 2019.

## Why has this occurred?
The breaches were in an area where we have a single handed practitioner, we unexpectedly had to cancel clinic when was off work unwell.

The service is struggling to meet the target when fully established, any gap in service due to leave / sickness results in loss of capacity. Additionally, the Service is expecting an increase in demand for this area (diabetes) due to evidence of diet / weight management in prevention / reversal.

## What are the challenges?
The service does not have the capacity to meet any growth in demand and any loss of routine clinic capacity due to leave, sickness or vacancy leads to increased pressure on waiting times.

## What is being done?
Maintaining the waiting times below 14 weeks will be dependent on the service being able to deliver additional sessions to address loss of core clinic capacity and to match any increase in demand. To sustain the waiting times across the service it will be necessary to sustain like for like agency cover until vacancies are filled and to have agreement that additional clinical sessions (i.e. over time) can be offered when demand is projected to out strip core clinic capacity recognising this will lead to budget pressures.

## When can we expect an improvement and by how much?
The aim continues to be to avoid breaches however, this is dependent on being able to consistently and responsively meet demand as indicated above.

## How does this impact on both patients and finances?
Delays in Dietetic access result in potential harm to patients and escalation of healthcare needs. There will be budget pressure if additional sessions/agency use is required to maintain core or deliver extra clinic activity.

# Timely Care – Occupational Therapy (OT) – Therapy waits over 14 weeks (excludes MHLD)

**Lead Committee: BPPAC** | **Executive Lead: Joe Teape** | **Senior Responsible Officer: Alison Shakeshaft/Claire Sims**

| Metrics (targets): | Status as at Apr 2019 | Performance the past 12 months |
|---|---|---|
| • Number of patients waiting 14 weeks plus for Occupational Therapy (Target = 0) | ● | Improving |

## Latest data
The latest available data can be viewed within the therapies graphs.

## Where are we against target?
There were 5 patients waiting over 14 weeks at the end of April 2019.

## Why has this situation occurred?
Additional capacity with short term funding for waiting times in 2018/19 has now ceased and the paediatric occupational therapy team have had insufficient capacity to sustain this improved position.

## What are the challenges?
- Sustaining the improvement in Paediatric Occupational Therapy without additional capacity is a challenge. This service has a small workforce (11.59wte) across 3 counties which is vulnerable to fluctuations in capacity (due to recruitment, planned and unplanned leave), as well as the nature of the caseload. The caseload is predominantly complex and progressive, often requiring long term service involvement;
- 2x new long term sickness episodes commenced in April 2019. This is in addition to 1x long term sickness which is ongoing & 1x vacancy in service;
- Service continues to undertake activity for social care and housing in Carmarthenshire within core capacity, pending agreement to reinstate ongoing funding;
- Service has open duty of care to additional children assessed and removed from waiting list during March 2019.

## What is being done?
- Monitoring of performance against target;
- Vacancy is being progressed through recruitment process;
- Vacancy funding being utilised for additional hours and bank band 4 hours;
- Long term sickness absences being managed in line with policy;
- Progressing agreement with Carmarthenshire Social Care & Housing to fund capacity (verbal agreement in place, finalising contract currently);
- Care Aims approach is being implemented in paediatric service, which will contribute to managing service demand in the longer term;
- Additional capacity to sustain waiting times position after April 2019 has been submitted to inform Annual Plan;
- Locum occupational therapist is being sought.

## When can we expect improvement and by how much?
If no further significant challenges in workforce capacity arise, paediatrics improvement will be seen by end of July as long term sickness and vacancies resolve. This will be sooner if we can attract a locum occupational therapist. Longer-term sustainability will be dependent on sign off of an agreement with Carmarthenshire County Council and subsequent recruitment and predicted impact of Care Aims approach and other strategies being realised.

## How does this impact on both patients and finances?
Children now have more timely access to Occupational Therapy to support them to overcome significant problems participating in everyday activities that are vital for their health, well-being, and development, this may include developing skills in self-care, having a bath, learning to feed, being able to play with their friends or engage in education. This improvement also impacts on the health and well-being of the child's family and carers, who may experience significant challenges physically and psychologically caring for the child. Earlier occupational therapy assessment and subsequent intervention/rehabilitation for children can resolve issues and improve lifelong outcomes, reducing need and costs of treatment, equipment, and long term care.

# Timely Care – Therapy waits - Pulmonary Rehabilitation

**Lead Committee: BPPAC** | **Executive Lead: Joe Teape** | **Senior Responsible Officer: Alison Shakeshaft/ Vicky Stevenson**

**Metrics (targets):**

- Number of patients waiting 14 weeks plus for Pulmonary Rehabilitation (Target = 0)

**Status as at Apr 2019**: ●

**Performance the past 12 months**: Improving

## Latest data

| Location | Under 14 Weeks | 14 to 35 Weeks | 36 to 52 Weeks | Over 52 Weeks | Total Waiting more than 14 weeks |
|---|---|---|---|---|---|
| Amman Valley | 8 | 2 | 0 | 0 | 2 |
| Glangwili | 16 | 7 | 16 | 5 | 28 |
| Prince Philip | 22 | 21 | 15 | 32 | 68 |
| North Ceredigion | 1 | 3 | 0 | 42 | 45 |
| South Ceredigion | 0 | 4 | 0 | 5 | 9 |
| Withybush | 39 | 10 | 3 | 1 | 14 |
| **Total** | **86** | **47** | **34** | **85** | **166** |

## Where are we against target?

At present, the waiting times are in excess of 52 weeks. The total number of patients waiting over 14 weeks has reduced from 183 at the end of March 2019 to 166 at the end of April 2019.

## Why has this occurred?

Extremely long waits have developed due to very limited staffing capacity for demand in this speciality and significant variation in service delivery across the Health Board localities.

## What are the challenges?

To date there has been no robust provision in Ceredigion. In Pembrokeshire, the location of programme delivery impacts on the individual's ability to access PR within a recommended timescale i.e. the programme rotates around the county. Carmarthenshire service is provided by single-handed practitioners within Physiotherapy and Occupational Therapy. Each county is experiencing significant numbers of patients admitted and re-admitted to all four hospitals with Chronic Obstructive Pulmonary Disease (COPD) and referred for PR as part of their management.

## What is being done?

The service has worked collaboratively with Primary Care to develop and pilot an innovative approach using a Hub and Spoke model and digital technology. Following the success of this, the service is working to roll this model of care out across the Health Board. A business case has been developed and recently approved to enable the delivery of sustainable PR services across the Health Board region in line with current demand

## When can we expect an improvement and by how much?

The service now has a clear plan of direction in terms of Health Board priorities. To date the service has prioritised delivery through the Hub and Spoke model pilots, alongside core delivery. A multi-disciplinary team business case Virtual Pulmonary Rehabilitation (VIPAR) supporting 2 Hub and 2 Spoke models which evidences prudency and efficiency has been agreed and planning is underway to deliver this model and recruit staff. A 1 Hub 2 Spoke model is planned for the next PR course to run in the summer and will address waits in Ceredigion. It is anticipated that the full service model will be implemented by end of Q2, with the backlog being cleared and a trajectory to zero 14 week breaches by September 2020.

## How does this impact on both patients and finances?

Pulmonary Rehabilitation is for people with Chronic Obstruction Pulmonary Disease. It is evidenced to:

- Reduce mortality;
- Support earlier discharge from Acute hospital care;
- Reduce unplanned readmissions;
- Increase positive health behaviours;
- Increase engagement with social and vocational activities

## Timely Care – Diagnostic wait 8 weeks and over

**Lead Committee: BPPAC** | **Executive Lead: Joe Teape** | **Senior Responsible Officer: Sarah Perry**

**Metrics (targets):**

- Diagnostic wait 8 weeks and over (Target = 0)

**Status as at Apr 2019**: ●

**Performance the past 12 months**: Improving

### Latest data

| Reported Diagnostic Tests | Total Waiting List | Waiting List > 8 Weeks |
|---|---|---|
| Cardiology | 2,255 | 4 |
| Diagnostic Endoscopy | 1,109 | 9 |
| Neurophysiology | 375 | 0 |
| Physiological Measurement | 18 | 0 |
| Radiology - Consultant referral | 3,350 | 26 |
| Radiology - GP referral | 2,467 | 17 |
| **Total** | 9,574 | 56 |

### Where are we and are we on target?

In April 2019, 4 Cardiology, 9 diagnostic and 43 radiology breaches were reported.

### Why has this occurred?

- **Cardiology –** 4 Contrast Echos not reported due to doctor unavailability;
- **Endoscopy -** 9 patients breached due to an increase in demand of unscheduled care referrals, bank holidays and lack of nursing staff to hold weekend additional lists;
- **Radiology** - failure of Bronglais General Hospital (BGH) MRI scanner leading to increased delays, work and staff was outsourced to Glangwili General Hospital (GGH) and the private sector but insufficient to meet demand within the month.

### What are the challenges?

- **Cardiology**
  - Reduced Prince Philip Hospital (PPH) Cardiologist availability due to long-term sickness, Retire & Return work-break and vacancy;
  - Reduced Cardio-Respiratory capacity due to long-term sickness at Withybush General Hospital (WGH) and BGH;
- **Endoscopy**
  - Long-term sickness, maternity leave and vacancies on all sites in nursing;
  - Lack of Endoscopist, relying on consultants to backfill sessions;
  - Band 8a vacancy;
  - Unfunded sessions in WGH and PPH;
- **Radiology**:
  - Shortages in consultant radiologists remain;
  - Single Cancer Pathway (SCP) will require a shift in waiting times with increasing pressures on the front end of the pathway. Without support for additional capacity via the Welsh Government SCP implementation fund, this may cause routine patients to be pushed further towards 8 week breaches due to additional pressure on reporting turnaround times;
  - Ongoing issues with aging equipment leads to unpredicted downtime especially for CT and MRI – BGH MRI scanner expected to be non-operational for a considerable time period;
  - Particular challenges in nuclear medicine with capacity for cardiology and cancer work competing.

### When can we expect improvement and by how much?

- **Cardiology**
  - Further work is being progressed to confirm a more detailed capacity / demand assessment for the cardiology diagnostic service to inform more sustainable solutions for the remainder of 2019/20;
  - A project group has been set up and the focus is on 'phase 2' Myrddin booking of all activity and referrals in cardiology diagnostics. This aligns to other Health Boards in Wales as Myrddin has been updated and improved, this has enabled the booking process to be undertaken. Project commenced January 2019 at PPH and is planned to commence in GGH from April 2019. Solus will still be progressed for the pacing module;
  - PPH Cardiologist long-term sickness phased return and Retire & Return work-break will end by the end of April 2019;

- Develop a plan by end of April 2019 to recruit to PPH Consultant Cardiology vacancy;
- Cardio-Respiratory long-term sickness will resolve early April 2019;
- Fortnightly performance monitoring of diagnostic RTT with Cardio-Respiratory Heads of Departments and General Manager/Service Delivery Manager for Cardiology continue;
- Newly appointed Service Delivery Manager for Cardiology and Service Support Manager for Cardiology RTT currently undergoing induction, familiarisation with role and handover.

- **Endoscopy**
  - Regular endoscopy scheduling meetings now in place, working closely with admissions staff and endoscopy lead for all sites;
  - Sickness reviews underway to address staffing issues;
  - Two additional nurse endoscopists now in post (one currently on maternity leave) Single Cancer Pathway bid to increase staffing levels to support six day working week;
  - Commencement of band 8a September 2019;
  - Currently working to establish funding for unfunded sessions.
- **Radiology**
  - Improvements to the patient management system due to be completed in May 2019 will allow for more detailed planning and coordination of services and bookings across the Health Board;
  - Recruitment of further consultants due in summer 2019 will assist with turnaround;
  - Work on pathways over the next financial year to reduce level of unnecessary imaging;
  - Workforce and 24 hour service review will potentially free up staffing for increasing capacity with extended days;
  - Recruitment of additional staff in nuclear medicine to increase capacity;
  - Interim arrangements for continued transfer of BGH MRI patient demand to GGH & private sector in advance of expected arrival of temporary mobile scanner in June 2019.

**How does this impact on both patients and finances?**

Early diagnosis can positively influence longer term clinical outcomes for the patients. The financial impact relates to the additional cost of any agency, locum, overtime, or bank working required to avoid breaches. Delays in diagnostic also contribute to delays in the outpatient Referral to Treatment (RTT) position. Whilst utilising capacity across the Health Board, patients are being asked to travel further from home.

## Timely Care – Amber calls

**Lead Committee: BPPAC** | **Executive Lead: Joe Teape** | **Senior Responsible Officer: Rob Jeffery (WAST)**

| **Metrics (targets):** | **Status as at Apr 2019** | **Performance the past 12 months** |
|---|---|---|
| • % of Amber Calls responded to within 20 minutes (Amber 1) and 30 minutes (Amber 2) | Not applicable | Not applicable |

### Latest data
See the supporting unscheduled care performance charts.

### Where are we against target?
*Amber calls are not officially reported*
Provisional April 2019 HDUHB Amber 1, 20 minutes closed at 48.2% of total call volume 2,122. Carmarthenshire 42.2 %, Pembrokeshire 54.9% and Ceredigion 52.9%. Amber 2, 30 minutes closed at 27.9% of call volume Amber median response reported in the Red calls report.

### Why has this situation occurred?
The requirement to retain ambulance resource at P1 & P2 (Priority 1&2) cover points across the three localities does have a marginal impact on the ability to respond to the Amber category of patients. It should be noted that calls could be upgraded to Red if the patient's condition deteriorates.

### What are the challenges?
- Handover delays in April accounted for 889 lost hours (March 919 lost hours) 77 double manned crews being removed from the Unit Hour Production (UHP);
- Increase in inter-hospital transfers;
- Slow development of additional pathways within Welsh Ambulance Service Trust (WAST) and HB area;
- Upskilling WAST staff over the next 3 years – challenges with portfolio submissions by registrants.

### What is being done?
- A further demand and capacity review is currently out to tender;
- National Amber Category Review, headed by Chief Ambulance Services Commissioner, issued November 2018; this will need discussion with HDUHB to respond to the report findings; The Review is currently being discussed at the next Emergency Ambulance Service Committee (EASC). The EASC implementation programme can be found at this link EASC Amber Review;
- Development and expansion of the AP rotational model to support Out of Hours (OOH) Service and provide capacity to target top 5 presenting conditions;
- Reinforce regular engagement and dialogue with HDUHB colleagues to ensure compliance against all Wales Handover Guidance and maximise the number of available resources;
- Advanced Practitioner (AP) rotational model with OOH, and Clinical Contact Centre (CCC);
- Implement audit report findings (Handover of Care at Emergency Departments); escalated to Chief Operational Officer (COO);
- Status Plan Management – the deployment of crews, reviewed regularly to ensure available crews are positioned most effectively;
- Fully embed Multi-Disciplinary Team (MDT) forum with each Health Board (HB) locality and key stakeholders to regularly review frequent service users (report will be refined);
- Identify the high volume activity nursing homes/residential homes across HDUHB and engage with them to reduce inappropriate calls;
- Increased number of Automated External Defibrillators in the community; 4 deployed during April 2019;
- Integrated seasonal plans, supported by Local Development Plan;

### When can we expect improvement and by how much?
Demand and capacity work ongoing to support realignment of rosters to ensure resources available at correct times to maximise performance.

### How does this impact on both patients and finances?
In line with the Transformation of Clinical Services (TCS) agenda, the implementation of alternative pathways combined with lower conveyance and further development of Advanced Practice will reduce the impact on Emergency Departments and reduce the cost base of hospital admissions.

## Staff and Resources

I can find information about how the NHS is open and transparent on its use of resources and I can make careful use of them.

**Lead Executives:** Lisa Gostling, Joe Teape, Karen Miles and Huw Thomas.

**Exception reports:**


Finance


Sickness Absence


Medical Appraisal/PADR


Mandatory Training

## Our Staff & Resources – Finance

**Executive Lead: Huw Thomas** | **Senior Responsible Officer: Rebecca Hayes**

| **Metrics :** | **Status as at April 2019** |
|---|---|
| • Expenditure does not exceed the aggregate of the funding allotted to it over a period of 3 financial years (as agreed by the Planned Care Board) | ● |
| • Stay Within Capital Resource Limit (cumulative year to date position) | ● |
| • Cash Expenditure is less than the Cash Limit | **NA** |
| • The Savings Plan is on target (cumulative year to date position) | ● |
| • Variable pay (Agency, Locum, Bank & Overtime) | ● |
| • Non NHS Invoices by Number are Paid within 30 Days (cumulative year to date position) | **NA** |

### Latest data

| Metric | Target | Apr-19 |
|---|---|---|
| Expenditure does not exceed the aggregate of the funding allotted to it over a period of 3 financial years (as agreed by the Planned Care Board) (cumulative year to date position) | <=0 | £2.917m Deficit |
| Stay Within Capital Resource Limit (cumulative year to date position) | <=0 | 0 |
| Cash Expenditure is less than the Cash Limit | Year end | Not Reported in Mth1 |
| The Savings Plan is on target (cumulative year to date position) | 100% | 100% |
| Variable pay (Agency, Locum, Bank & Overtime) | Achievement of 2018/19 variable pay savings plans | £4.878m |
| **Metric** | **Target** | **Apr-Jun 19** |
| Non NHS Invoices by Number are Paid within 30 Days (cumulative year to date position) | 95% | Not Reported in Mth1 |

### Where are we against target?

- It is a statutory duty to achieve financial breakeven. On 28th March 2019, the Health Board approved the 2019/20 draft interim financial plan which outlined a deficit plan of £29.8m; since submission to Welsh Government of this draft interim financial plan for 2019/20, Welsh Government have confirmed that the Health Board has a Control Total requirement of £25.0m deficit.
- The Health Board's financial position at the end of Month 1 represented a adverse variance against plan of £0.4m;
- £0.8m of Savings schemes were delivered in Month 1, which is 100% on target. However, the total required savings is £28.8m for the year which will mean that the target for future months will be greater. The current gap in identified assured savings schemes is £10.3m, against which there are identified pipeline opportunities of £8.3m. This represents a significant risk, despite the on-target position in Month 1;
- This deficit position will need to be recovered through a turnaround and recovery programme over the medium term.

### What are the challenges?

- The detailed narrative setting out the key changes in the month and the main drivers affecting this position is contained within a separate paper on the agenda of the April 2019 Business Planning & Performance Assurance Committee;
- The risk of delivering the forecast is rated 'High' given the balance remaining of pipeline and unidentified savings schemes and in recognition of the critical need for the delivery profile to accelerate significantly in order to achieve the full savings requirement.

### What is being done?

The actions being taken through increased control, use of slippage and reserves and the Turnaround process are detailed in the separate paper on the agenda.

| Performance Against Key Financial Targets Current Month (Statutory Financial Duties on Revenue & Capital) | | | | |
|---|---|---|---|---|
| | **Cumulative to Previous Month** | **Current Month** | **Cumulative to Current Month** | **Statutory Financial Duty** |
| **Revenue: Ytd Forecast/Outturn** | n/a | £2.217m deficit | £2.917m deficit<br>£25.000m deficit | Stay within Revenue Resource Limit |
| **Capital: Ytd Forecast/Outturn Current CRL** | n/a | £1.7m | £1.7m<br>£39.258m<br>£39.258m | Stay within Capital Resource Limit |
| **Performance Against Key Financial Targets Current Month (Other Financial Duties) Public Sector Payment Performance** | | | | |
| **Year to Date Forecast Year End** | n/a | This information is completed quarterly | >95% | Pay 95% of Non NHS Invoices within 30 days (basis of calculation changed in Nov 2015 to exclude Primary Care Contractor payments) |
| **Savings Requirement** | | | | |

| | **Cumulative to Previous Month** | **Current Month** | **Cumulative to Current Month** | **Savings Plans to achieve Statutory Duty** |
|---|---|---|---|---|
| **Ytd**<br><br>**Full Year Forecast/Outturn – Green and Amber schemes**<br><br>**Requirement** | n/a | £0.767m | £0.767m<br><br>£18.431m<br><br>£28.8m | These are gross savings as reported to Welsh Government, excluding the impact of cost pressures. |
| | | | | |
| **Closing Cash Balance** | | | Not reported in Mth1 | Cash management plans aim to deliver the 'best practice' period end balance 5% of the forecast monthly cash draw down from WG. |

# Our Staff & Resources – Sickness absence

**Lead Committee: QSEAC** **Executive Lead: Lisa Gostling** **Senior Responsible Officer: Steve Morgan**

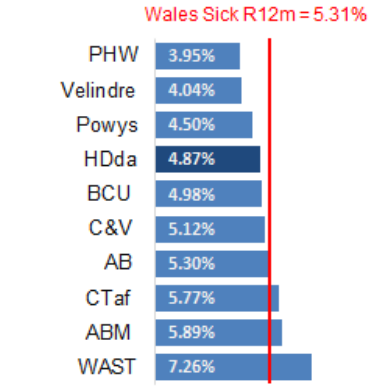
**Metrics (targets):** **Status as at Mar 19** **Performance the past 12 months**

- % of full time equivalent (FTE) days lost to sickness absence for rolling 12 months (Target = reduction) ● Improving

## Latest data

| Monthly Measures: Our Staff | Current | Historical Data | |
|---|---|---|---|
| % of full time equivalent (FTE) days lost to sickness absence for rolling 12 month period | Mar 19 | Feb 19 | Mar 18 |
| Health Board Total | 4.86 | 4.87 | 5.02 |
| Unscheduled Care | 4.75 | 4.80 | 4.90 |
| Planned Care | 4.35 | 4.37 | 4.95 |
| Women & Children | 4.53 | 4.44 | 5.25 |
| Oncology & Cancer Care | 2.66 | 2.50 | 4.15 |
| **Monthly Measures: Our Staff** | **Current** | **Historical Data** | |
| % of full time equivalent (FTE) days lost to sickness absence – in month | Mar 19 | Feb 19 | Mar 18 |
| Health Board Total | 4.99 | 5.17 | 5.05 |
| Unscheduled Care | 4.46 | 4.67 | 5.23 |
| Planned Care | 4.51 | 4.65 | 4.69 |
| Women & Children | 5.26 | 5.38 | 4.72 |
| Oncology & Cancer Care | 2.88 | 4.24 | 1.06 |

## Benchmarking (February 2019)




## Where are we against target?

The sickness information reported relates to the position as at 31/3/19.

The in month actual figure reported for March 2019 equates to 4.99% which is a decrease on the previous month (5.17%) and also represents a decrease against the corresponding rate in 2018 (5.05%). The rolling 12 month rate has improved slightly and is now 4.86% which is fractionally above the Welsh Government (WG) target and remains the lowest rate of the larger Health Boards (HB) in Wales. Hywel Dda has therefore reached the end of the financial year with the lowest absence rate in Wales (of the larger HB's).

## Why has this situation occurred?

The in-month position at 31st March 2019 is slightly above the WG target although below the Wales average. There is a new All Wales Attendance Policy with training being rolled out across the HB. This policy offers managers more discretion when escalating staff through the policy and emphasises a more compassionate approach to the management of attendance.

## What are the challenges?

The challenge is to achieve and sustain the WG target especially in light of the new policy which provides and encourages more management discretion.

## What is being done?

The HB is continuing to monitor and manage sickness closely throughout the organisation; sickness auditing is targeted to the wards and departments with the highest levels of absence and training is continuing. In addition, the performance assurance process is continuing to maintain a focus on sickness. Training in the new All Wales policy is ongoing.

## When can we expect improvement and by how much?

It is anticipated that the rolling 12 month rate will continue to decrease and has remained the lowest of the larger Health Boards in Wales for this financial year. The HB has ended the year with an improved absence rate in comparison to last year.

## How does this impact on both patients and finances?

Poor sickness impacts on quality of care for patients and also on variable pay costs.

## Our Staff & Resources – Medical Appraisal/Performance Appraisal and Development Review (PADR)

**Lead Committee: QSEAC** | **Executive Lead: Lisa Gostling** | **Senior Responsible Officer: Rob Blake**

**Metrics (targets):**

- % staff undertaking PADR: Medical and Non Medical (Target > 85%)

**Status as at Apr 19:** ●

**Performance the past 12 months:** Improving

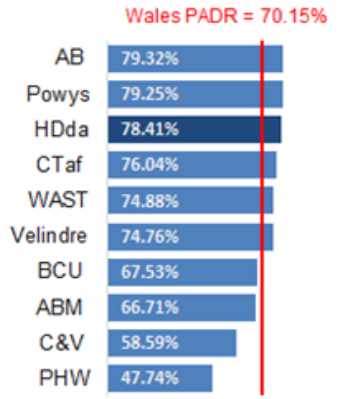
### Latest data

| Appraisal | Apr-19 | Mar-19 | 12m | Trend |
|---|---|---|---|---|
| Health Board Total (Combined) | **79** | **78** | **65** | ⇧ |
| Total Medical Appraisal | 96 | 95 | 96 | ⇧ |
| Total Non-medical appraisal | 77.05 | 76.04 | 61.98 | ⇧ |
| **Medical Appraisal** | | | | |
| Unscheduled Care | 95 | 92 | 94 | ⇧ |
| Planned Care | 95 | 96 | 98 | ⇩ |
| Women & Children | 94 | 94 | 95 | ⇔ |
| Mental Health & Learning Disabilities | 100 | 100 | 97 | ⇔ |
| **Non-Medical Appraisal** | | | | |
| Unscheduled Care | 76.50 | 74.50 | 54.95 | ⇧ |
| Planned Care | 78.23 | 72.75 | 58.93 | ⇧ |
| Women & Children | 74.10 | 73.95 | 75.00 | ⇧ |
| Mental Health & Learning Disabilities | 79.00 | 81.51 | 69.86 | ⇩ |
| Estates and Facilities | 86.93 | 86.78 | 69.55 | ⇧ |
| Carmarthenshire County | 76.90 | 82.02 | 68.53 | ⇩ |
| Ceredigion County | 67.06 | 68.64 | 64.29 | ⇩ |
| Pembrokeshire County | 84.12 | 83.03 | 70.37 | ⇧ |
| Director of Therapies & Health Science | 78.73 | 80.30 | 66.92 | ⇩ |
| Deputy CEO/DOE | 78.32 | 77.50 | 62.44 | ⇧ |
| Corporate Governance | 60.00 | 66.67 | 55.56 | ⇩ |
| Director of Finance | 75.00 | 76.40 | 41.46 | ⇩ |
| Director of PPIC | 95.63 | 87.34 | 55.77 | ⇧ |
| Director of Partnerships and Corporate | 80.85 | 80.00 | 42.00 | ⇧ |
| Medical Director | 69.88 | 70.24 | 80.25 | ⇩ |
| Director Nursing, Quality & Experience | 45.95 | 38.18 | 38.52 | ⇧ |
| Director of Public Health | 49.15 | 45.53 | 45.99 | ⇧ |
| Director of Workforce & OD | 91.91 | 93.82 | 84.47 | ⇩ |

### Where are we against target?

Hywel Dda UHB's PADR compliance rate rose by 1% for April but did not meet the required improvement target of 6% which would have achieved Welsh target of >85%. The organisation is still performing better than the NHS Wales average of 70.15% as of February 2019. There have been increases from March 2019 in 10 non–medical areas with compliance rates dropping in 8 from the previous month. There were significant increases in compliance rates in Planned Care, Director Nursing, Quality & Experience and Director of PPIC for the month. There are only three services in non-medical that achieved target of >85%. Medical Appraisal improved by 1% and remains well above target. PADR's are vital in performance management and a quality appraisal has to be completed for every member of the workforce on an annual basis, as a minimum requirement.

### Benchmarking (February 2019)




### Why has this situation occurred?

Overall PADR performance has improved by 13.7% over the last 12 months with the main reasons for this being the review of service/teams compliance rates within the performance monitoring process and the ongoing building of effective leaders that focus on the benefits of the PADR process. There remains ongoing focus through training and support mechanisms via the Workforce & OD teams, but improvement is still failing to meet required targets.

**What are the challenges?**

The quality of PADR's has been seriously questioned over the last month, with an audit highlighting the lack of SMART based objectives. Anecdotally a lot of leaders question the time taken in completing effective PADRs especially in large teams, but annual PADRs are a compulsory requirement of leadership.

**What is being done?**

The OD team have started to review current documenation to ensure the correct PADR is being completed for leaders and core team members. There has been a bespoke training session provided in April for managers requesting this learning. The team will review how they can faciliate extra sessions on peformance management and have collaberated with the ESR team to add an extra bespoke session for 19th June for 28 leaders that were identified through Global email.

**When can we expect improvement and by how much?**

Focus on PADR continues. The organisation has not met the required target of 85% for 2018/19. The W&OD team are currently reviewing various support mechanisms to try and build on the excellent improving position to help the organisation achieve the desired target and ensure that all PADR's undertaken are of the highest quality and align to a performance led culture.

# Our Staff & Resources – Mandatory Training

**Lead Committee: QSEAC** | **Executive Lead: Lisa Gostling** | **Senior Responsible Officer: Cheryl Raymond/Sian Hall**

**Metrics (targets):**

- % compliance for each completed Level 1 competency with Core Skills & Training (>85%)

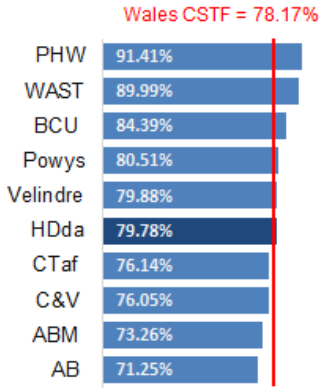
**Status as at Apr 2019:** ●

**Performance the past 12 months:** Improving

## Latest data

| Monthly Measures: Our Staff | Historical Data | | | |
|---|---|---|---|---|
| **Target >85%** | **Apr 19** | **Mar 19** | **Prior 12m %** | **Trend** |
| Core Skills Training Framework | 80.1 | 79.6 | 67.0 | ⇧ |
| Equality, Diversity & Human Rights | 80.9 | 80.5 | 67.3 | ⇧ |
| Fire Safety | 68.8 | 68.2 | 41.9 | ⇧ |
| Health, Safety and Welfare | 80.2 | 79.7 | 67.8 | ⇧ |
| Infection Prevention & Control - Level 1 | 81.6 | 81.7 | 77.7 | ⇩ |
| Information Governance | 79.1 | 79.1 | 65.5 | ⇔ |
| Moving and Handling - Level 1 | 79.2 | 78.6 | 71.5 | ⇧ |
| Resuscitation - Level 1 | 83.5 | 83.0 | 73.7 | ⇧ |
| Safeguarding Adults - Level 1 | 80.7 | 80.1 | 68.8 | ⇧ |
| Safeguarding Children - Level 2 | 78.3 | 77.4 | 60.6 | ⇧ |
| Violence & Aggression - Module A | 88.6 | 88.0 | 75.0 | ⇧ |

## Benchmarking (February 2019)




## Where are we and are we on target?

Hywel Dda is now at 80.1% which is less than 5% below target.

## Why has this situation occurred?

Access to the e-learning system continues to be challenging for some staff, particularly those who do not regularly use the ESR system.

## What are the challenges?

The system becomes inaccessible at a national level on occasions which is out of our control. This can affect the compliance levels.
Also lack of capacity to allow for dedicated ESR support and e-learning queries.

## What is being done?

We will continue to provide support by offering facilitated e-learning sessions when possible and we will ensure the message is reinforced at all other training opportunities. Monthly global emails focussing on one specific mandatory element each month has also commenced which will include support and guidance (e.g. training, guidance, telephone support, ESR support).

Although this plan focuses on one area per month, it should not be regarded as being the only mandatory training module that should be completed. All existing mechanisms to increase mandatory training compliance across the whole agenda must continue.

## When can we expect improvement and by how much?

All previous reports have shown month on month improvement so the extra focus on specific modules should take us to full compliance.

## How does this impact on both patients and finances?

Completion of mandatory training underpins all other staff development, ensuring the Health Board has a skilled and trained workforce, able to work safely.

## Additional Reports

Welsh Health Specialised Services Committee (WHSSC)
Management Group Meeting

# Welsh Health Specialised Services Committee (WHSSC) Management Group meeting

The information below is an update from 25 April 2019 Welsh Health Specialised Services Management Group meeting:

**Minutes of the Previous Meeting and Action Log**

The minutes of the meeting held on 28 March 2019 were approved subject to minor revisions.

Members noted the action log and received updates on:

- MG086 IVF: Royal Shrewsbury Hospital Referral to Treatment Time Escalation – Work was ongoing to confirm that waiting times had incorrectly included the 52 week planned wait, prior to counting recordable waiting time. An update would be brought to the September meeting following one quarter of 'clean' data;
- MG124 South Wales Blood and Marrow Transplant Programme: Review of Investment: Check information provided to patients under Duty of Candour – carried forward to May 2019.

**The Thomas Report: Access to Specialist Neuromuscular Care in Wales**

It reported that a complaint had been received by Public Health Wales in relation to dissatisfaction with progress in addressing recommendations identified in the Thomas Report and that a co-ordinated response might be required between WHSSC and health boards.

**Shrewsbury and Telford Hospital NHS Trust (SaTH): Special measures status**

It reported that concerns had been expressed regarding the renal service provided by Shrewsbury and Telford Hospital NHS Trust; it was understood that Shrewsbury and Telford Hospital NHS Trust would be writing to the Welsh Renal Clinical Network in this respect.

**Welsh Language Standards (WLS)**

Members discussed steps being taken to include contractual obligations on non-Welsh service providers to comply with the Welsh Language Standards, particularly in relation to interpreter and translation services for patients whilst receiving care. It was acknowledged that this could be a difficult issue to fully address within the spirit of the Standards but that Betsi Cadwaladr University Health Board (BCUHB) had received guidance that the Welsh Language Standards did not apply to English providers in any event and it was agreed that this would be raised with the Cross Border Network.

**Report from the Managing Director**

Members received the Managing Director's report, which included an update on the proposed Lynch Syndrome testing programme for all patients with colorectal cancer that would replace the existing service for high risk patients. It was noted that clarity on the pathway would be required.

**Project Update on the Development of an Aortic Stenosis Commissioning Strategy**

Members received a paper that provided an update on the development of a Commissioning Strategy for the treatment of Aortic Valve Stenosis, together with a presentation on the key points from the paper.

Members noted the progress in delivering the nine project products defined to achieve the objectives in the development of a Commissioning Strategy for the treatment of Aortic Valve Stenosis. The products that have been completed. Information from the findings of Products S1 and S2 will be taken forward for discussion in the workshop planned with the Clinical Working Group and that the completion dates for products S3 to S9 will require revision and completion of these are subject to achieving the agreed outputs from the workshop.

**Cystic Fibrosis: 2019-20 ICP**

Members received and noted a presentation on the current Cystic Fibrosis investment requirements, how these differed from those previously described by Cardiff and the Vale University Health Board and the proposed way forward.

**Congenital Heart Disease Services Peer Review**

Members received a paper that provided information regarding the forthcoming peer review of Congenital Heart Disease services. Members noted the information presented within the paper.

**Adult Thoracic Surgery Commissioning Plan**

Members received a paper that outlined the commissioning plan for thoracic surgery to support the implementation of the new single adult thoracic surgery centre at Morriston Hospital for the population of west Wales, South East Wales and south Powys.

Members supported the proposed commissioning plan for thoracic surgery to support the implementation of the new single adult thoracic surgery centre at Morriston Hospital for the population of West Wales, South East Wales and South Powys.

**Collective Commissioning of Specialised Paediatric Radiology Services**
Members received a paper that sought approval for the collective commissioning approach recommended by the Welsh Health Specialised Services Team for Specialised Paediatric Radiology Services.

Members supported the collective commissioning of Specialised Paediatric Radiology Services. The approach would involve Welsh Health Specialised Services Commission entering into a formal consultation on the service specification and then developing a commissioning plan outlining how on behalf of the seven Health Boards, Welsh Health Specialised Services Commission could plan, commission, procure, contract and fund the service. This will include the request for a detailed business plan from Cardiff and the Vale University Health Board.

**Advanced Therapeutic Medicinal Products (ATMPs): Horizon scanning**
Members received and noted a presentation on Advanced Therapeutic Medicinal Products and related horizon scanning, including indicative cost implications. The Welsh Health Specialised Services Commission Team had prepared the underlying information to support discussions with Welsh Government regarding overall affordability of Advanced Therapeutic Medicinal Products.

**2019-22 Integrated Commissioning Plan**
Members received and noted the Welsh Health Specialised Services Commission Integrated Commissioning Plan 2019-22 document and related annexes.

**WHSSC Policy Group: Update**
Members received a paper on the work of the Welsh Health Specialised Services Commission Policy Group and noted the information presented within the report.

**Integrated Performance Report**
Members received a report that provided a summary of the performance of services commissioned by Welsh Health Specialised Services Commission for February 2019 and noted the actions being undertaken to address areas of non-compliance.

**Finance Report 2018-19 Month 12**
Members received a report that set out the estimated financial position for WHSSC for the twelfth month of 2018-19. The Welsh Health Specialised Services Commission year-end position was a £2,589k underspend. The combined Welsh Health Specialised Services Commission and Emergency Ambulance Service Commission year-end position was a £3,192k underspend. Members noted the full year financial position.

## Supporting data

Supplementary dashboards have been developed for the areas listed below. Currently some users are unable to access the dashboards due to an IT issue so a selection of charts from each dashboard have been made available here as an interim solution.

Unscheduled care

Referral to treatment

Cancer

Diagnostics

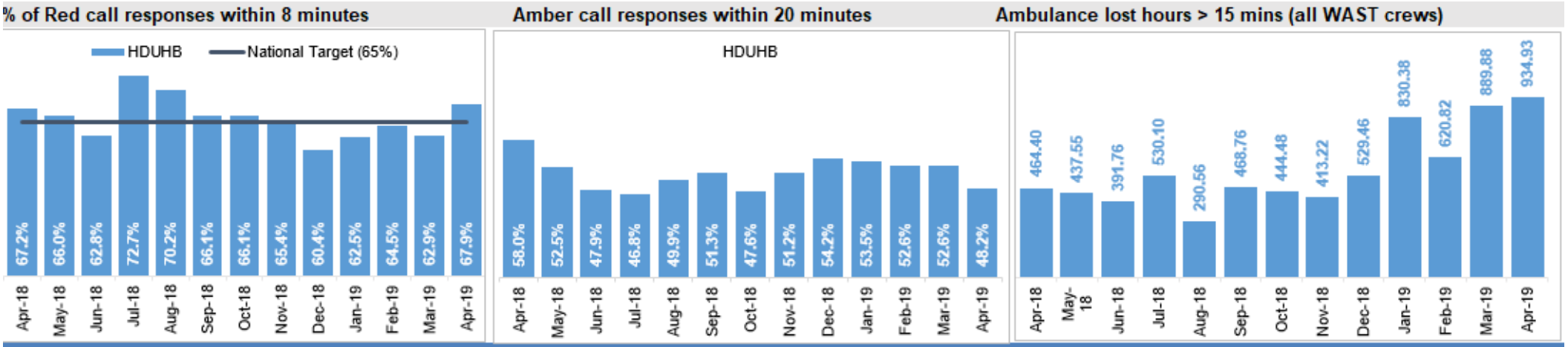
Therapies

Mental Health

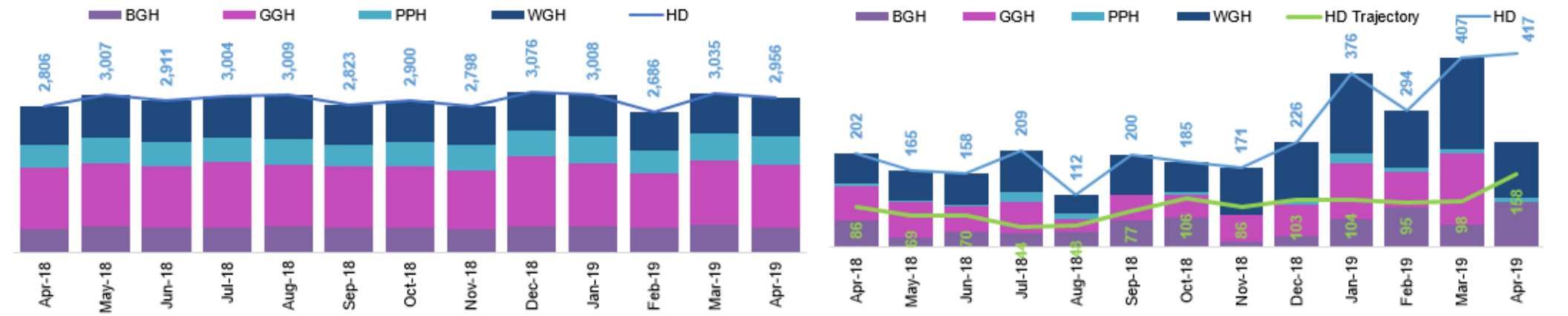
The dashboards can be accessed on the Hywel Dda University Health Board intranet site (NHS only) here.

## Unscheduled care

The charts below show the Health Board's position. Charts are also available by acute site in the unscheduled care dashboard.

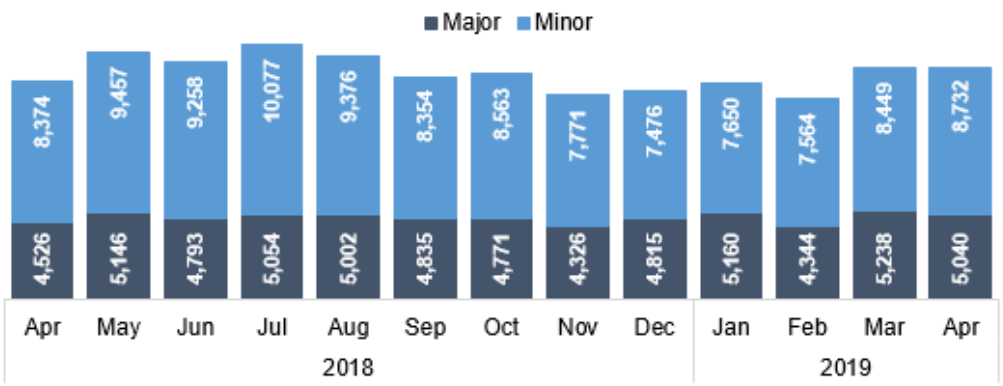



### Ambulance arrivals and handovers



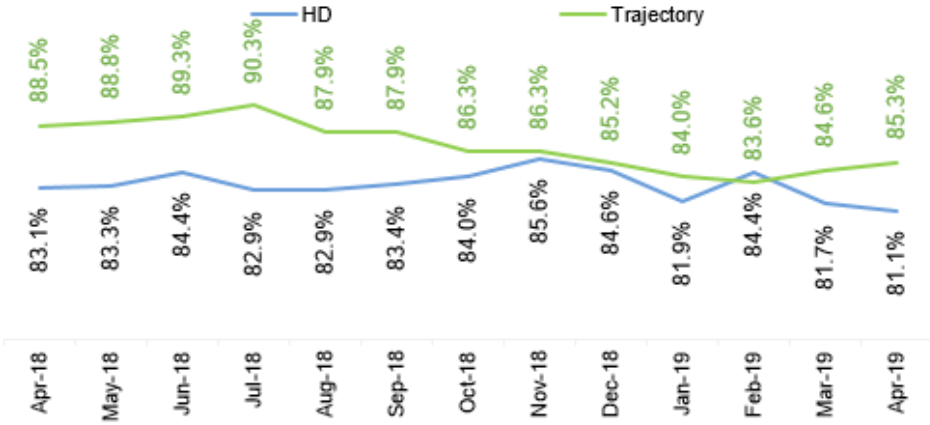
## Accident and emergency (A&E) and Minor injury unit (MIU) attendances

### A&E and MIU new attendances by type

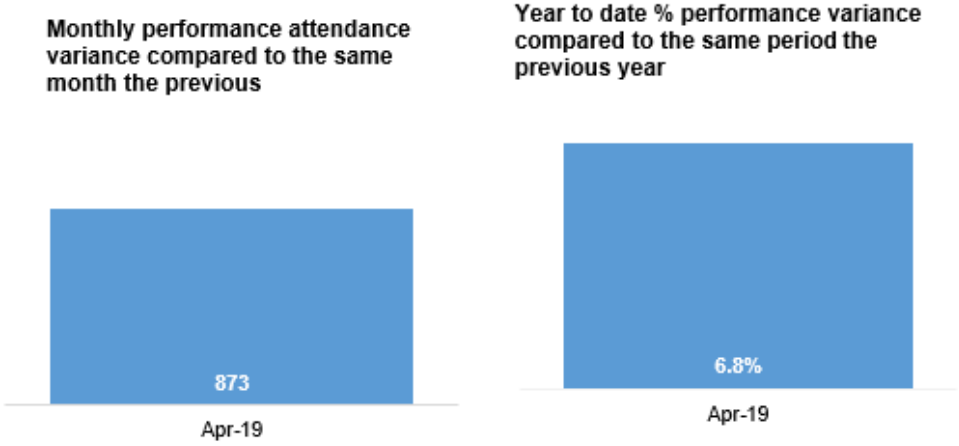



*Cardigan Hospital is not included for Apr-May 2017*

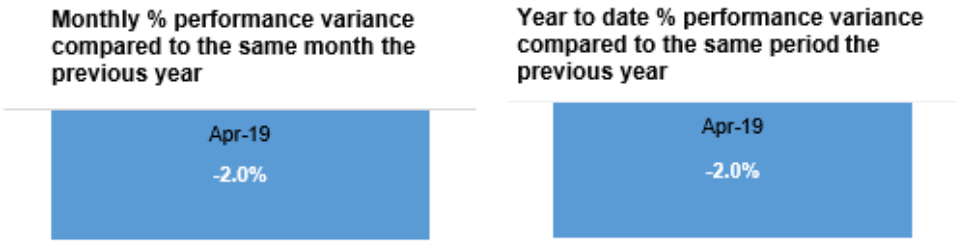
### % new patients spending < 4 hours in A&E and MIU



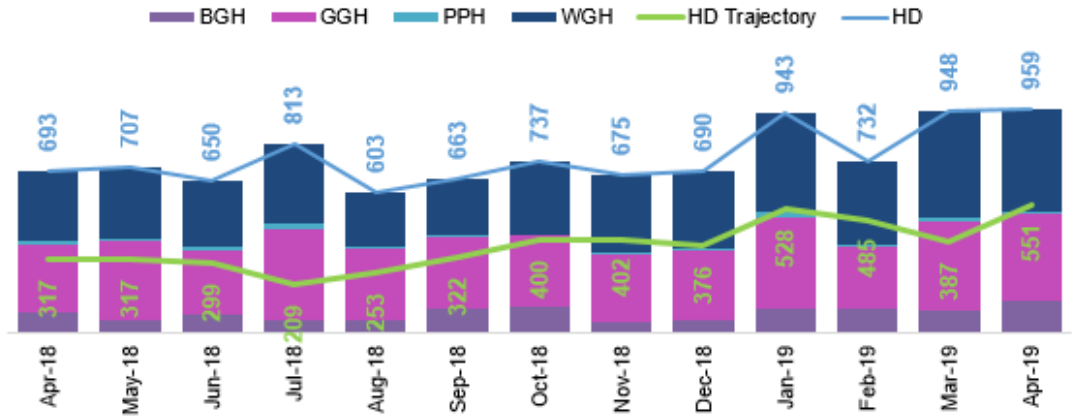

### A&E and MIU new attendance - 2 year comparison 19/20 to 18/19



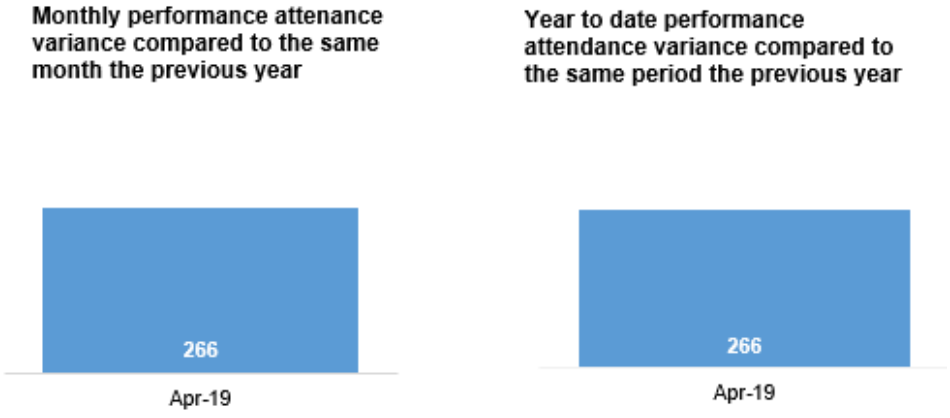

### % new patients spending < 4 hours in A&E/MIU - 2 year comparison 19/20 to 18/19



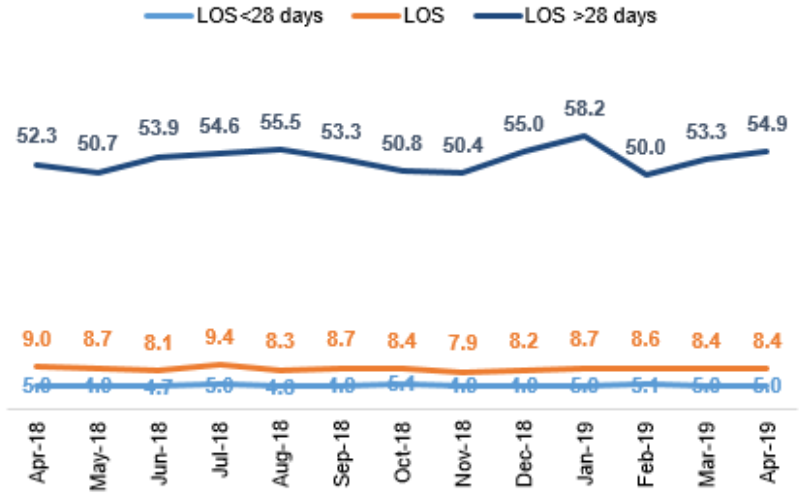
## Number of new patients spending > 12 hours in A&E and MIU by acute site




## New patients spending >12 hours in A&E/MIU - 2 year comparison 19/20 to 18/19

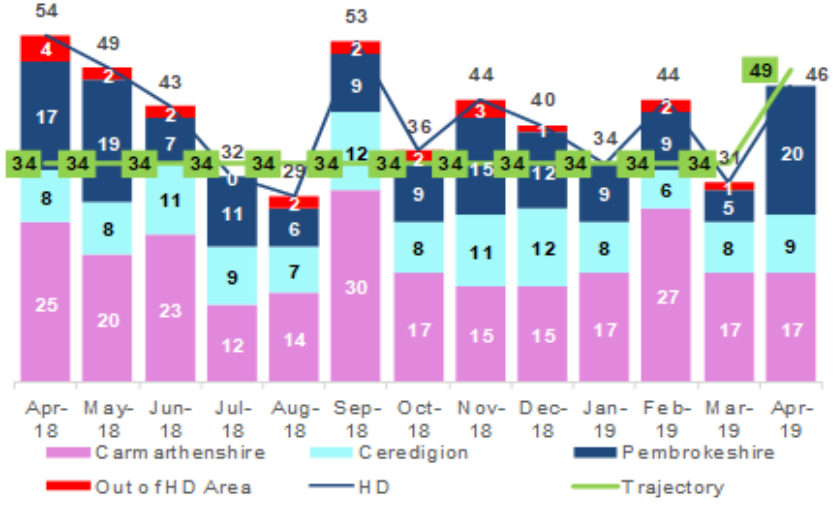



## Average length of stay (LOS) - medical emergency in patients including zero days



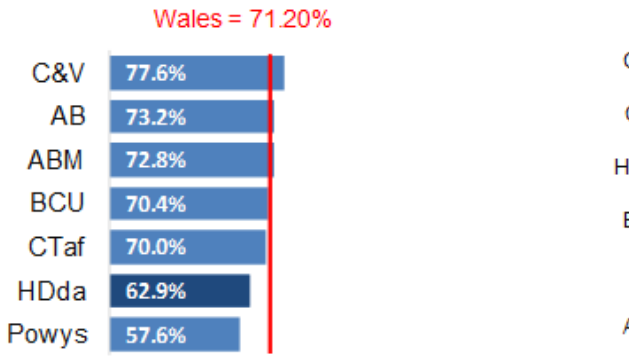

*Ceri ward is not included*

## Non mental health delayed transfer of care (DTOC) In month numbers



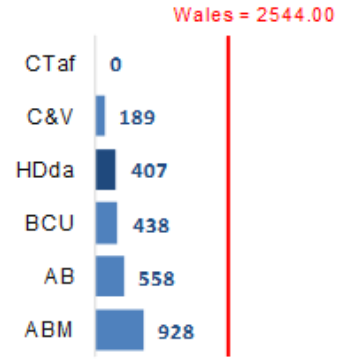
## Red calls

**% of Red call responses within 8 minutes (Mar-19)**




## Ambulance handovers

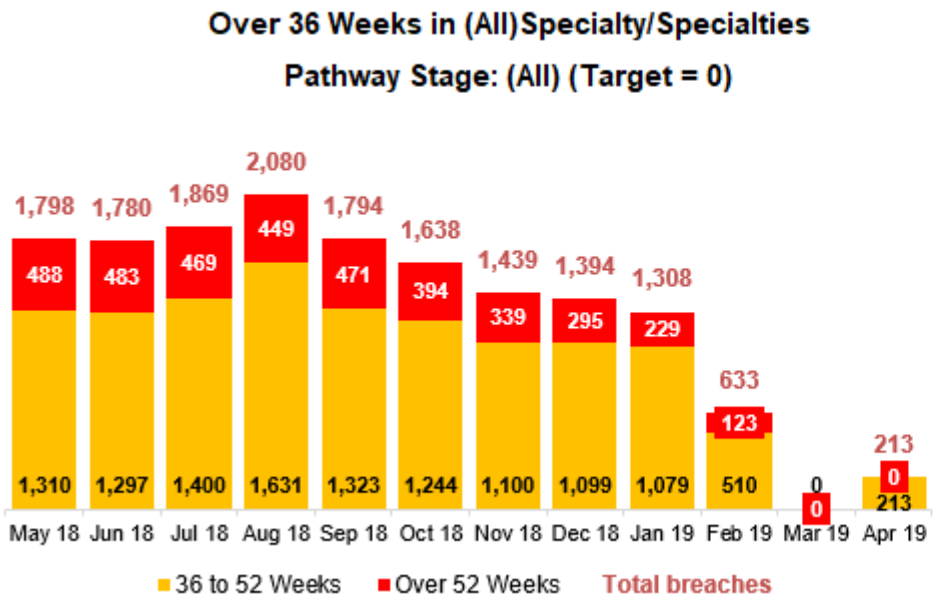
**Number of ambulance handovers waiting over 1 h by Health Board (Mar-19)**

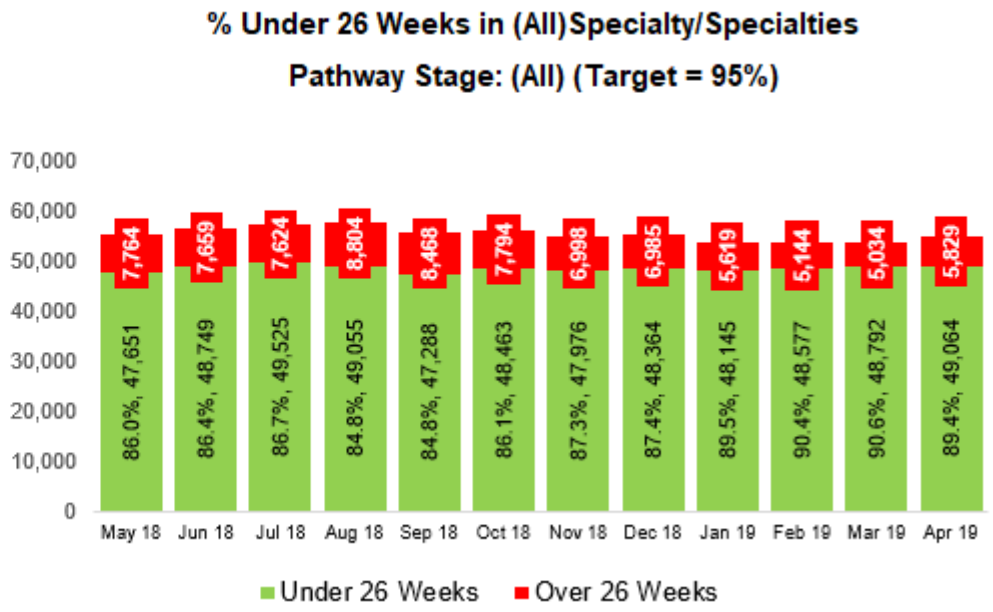


## Referral to treatment (RTT)

The charts below show the Health Board's position. In the RTT dashboard the 36 and 26 week charts below can be viewed by pathway stage and specialty.

**Graph Demonstrating: Specialty (All) & Pathway Stage - (All)**



**Longest Weeks Wait for Pathway Stage (All):**

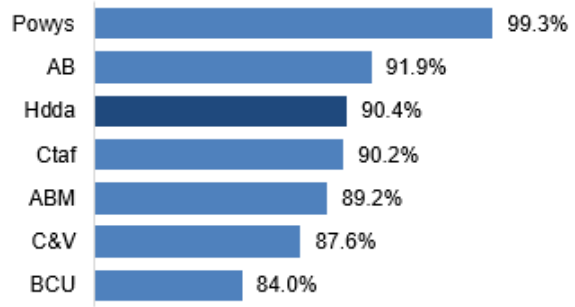
| Specialty | Longest Weeks Wait |
|---|---|
| Breast Surgery | 31 |
| Cardiology | 39 |
| Chemical Pathology | 24 |
| Clinical Haematology | 31 |
| Clinical Neuro-physiology | 20 |
| Colorectal Surgery | 40 |
| Dermatology | 39 |
| Diabetic Medicine | 34 |
| Endocrinology | 35 |
| ENT | 38 |
| Gastroenterology | 37 |
| General Medicine | 39 |
| General Surgery | 39 |
| Geriatric Medicine | 39 |
| Gynaecology | 39 |
| Nephrology | 30 |
| Neurology | 40 |
| Ophthalmology | 40 |
| Oral Surgery | 1 |
| Orthopaedics | 45 - 48 |
| Paediatrics | 34 |
| Pain | 39 |
| Rheumatology | 35 |
| Stroke Medicine | 30 |
| Thoracic/Respiratory | 35 |
| Unknown (998) | 9 |
| Urology | 40 |
| Vascular | 37 |
| **Grand Total** | 45 - 48 |

In the RTT dashboard the longest weeks wait chart above can also be viewed by pathway stage and month.

In the RTT dashboard the all Wales benchmarking charts below can also be viewed for previous months in the current financial year.

## % of Patients Referred for Treatment Within 26 Weeks (Target = 95%)

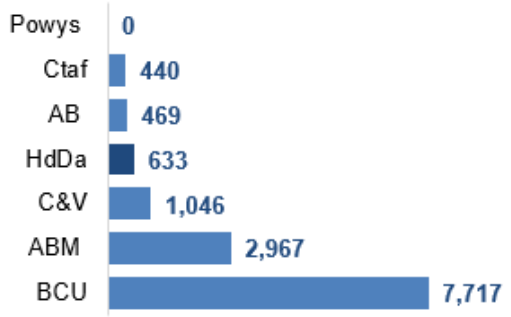
| | | | | | |
|---|---|---|---|---|---|
| May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 |
| Nov-18 | Dec-18 | Jan-19 | Feb-19 | | |

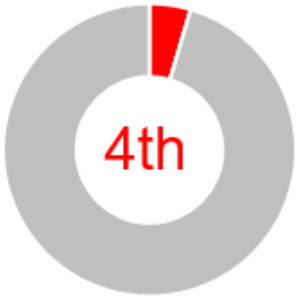




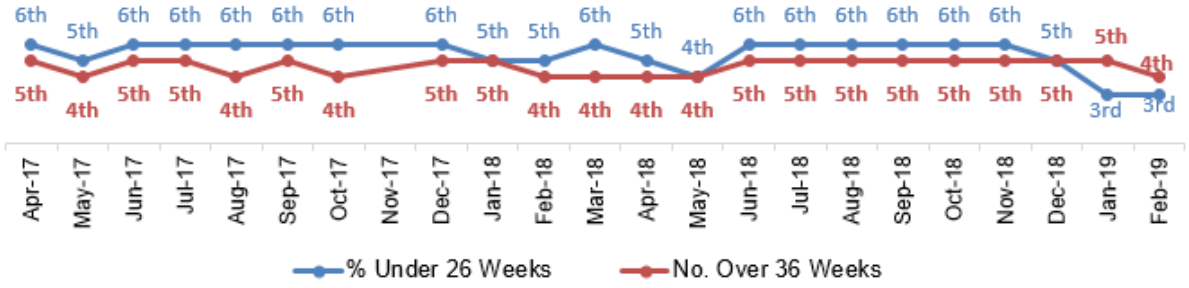
## Number of 36 Week Breaches (Target = 0)

| | | | | | |
|---|---|---|---|---|---|
| May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 |
| Nov-18 | Dec-18 | Jan-19 | Feb-19 | | |



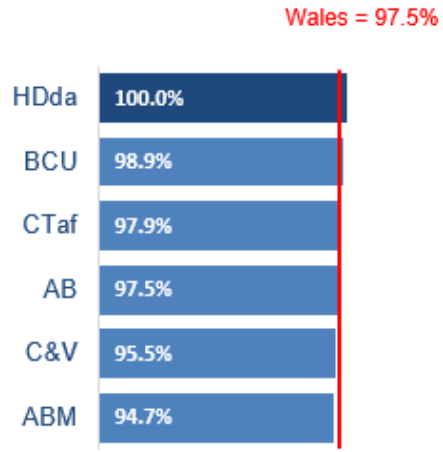

## All Wales Ranking (April to latest published data)



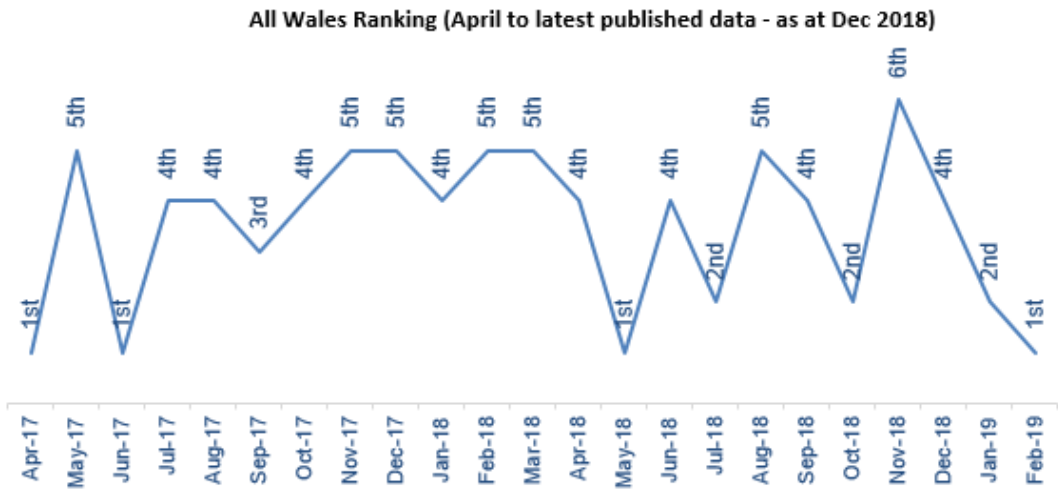
## Cancer

In the Cancer dashboard, the Health Board charts below can be also be displayed by Tumour site and month.

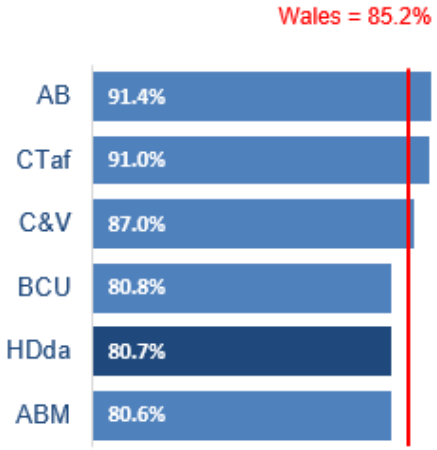
**Percentage of patients referred as non-urgent suspected cancer seen within 31 days – Target 98%**

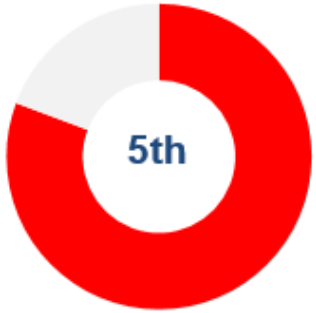


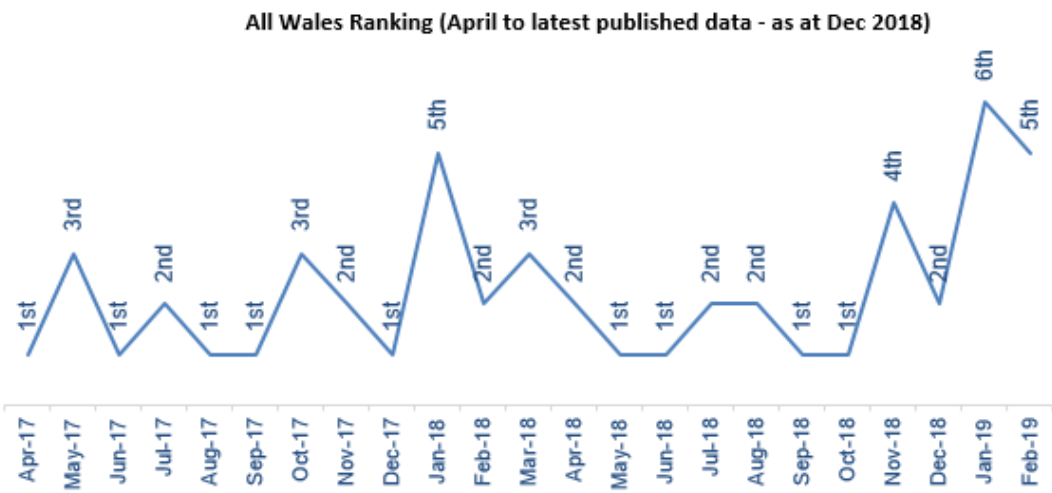





**Percentage of patients referred as urgent suspected cancer seen within 62 days – Target 95%**



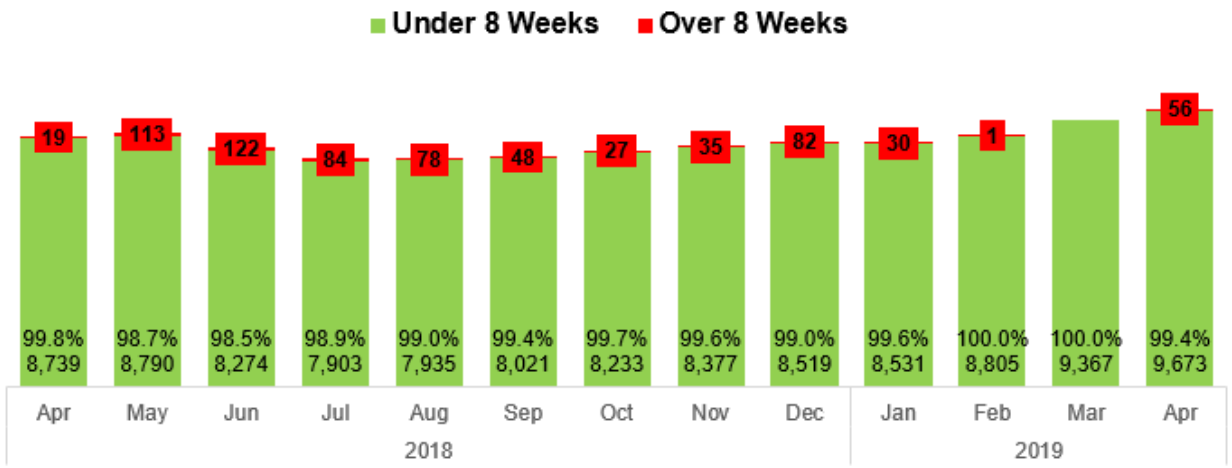



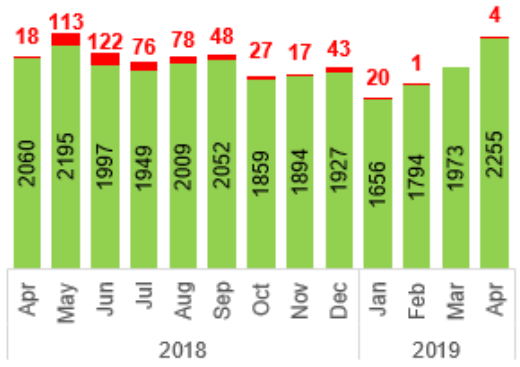
# Diagnostics

In the Diagnostics and Therapies dashboard the diagnostics metric can also be shown by acute hospital and service area.

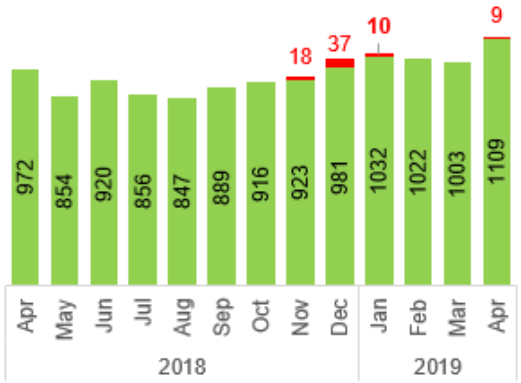
**Total number of patients waiting for all diagnostics (Target – 0)**



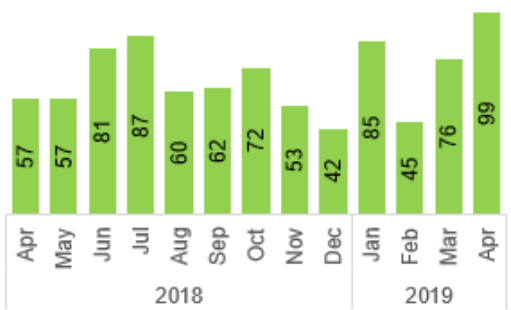
**Cardiology* (Target = 0)**



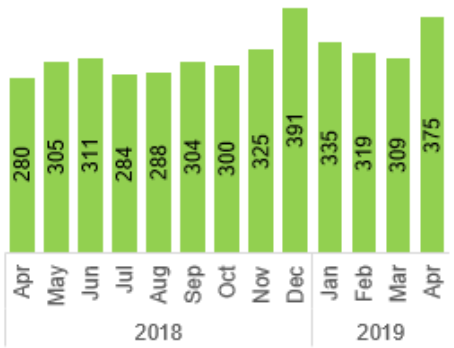

**Diagnostic Endoscopy (Target = 0)**




**Imaging (Target = 0)**

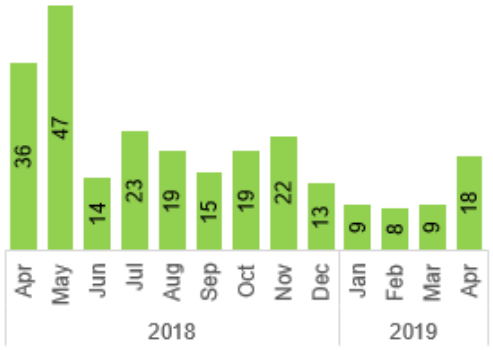



**Neurophysiology (Target = 0)**

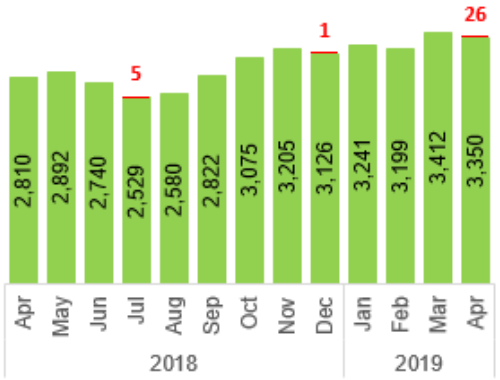



* See the 'Home' tab for information on definition change.

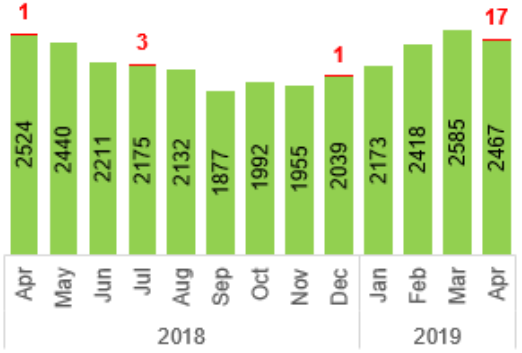
**Physiological Measurement (Target = 0)**



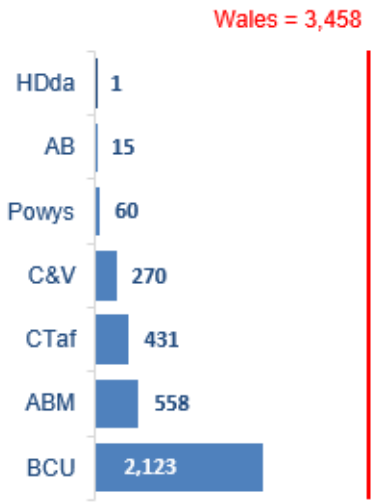

**Radiology - Consultant referral (Target = 0)**

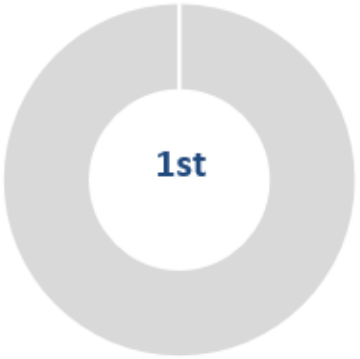


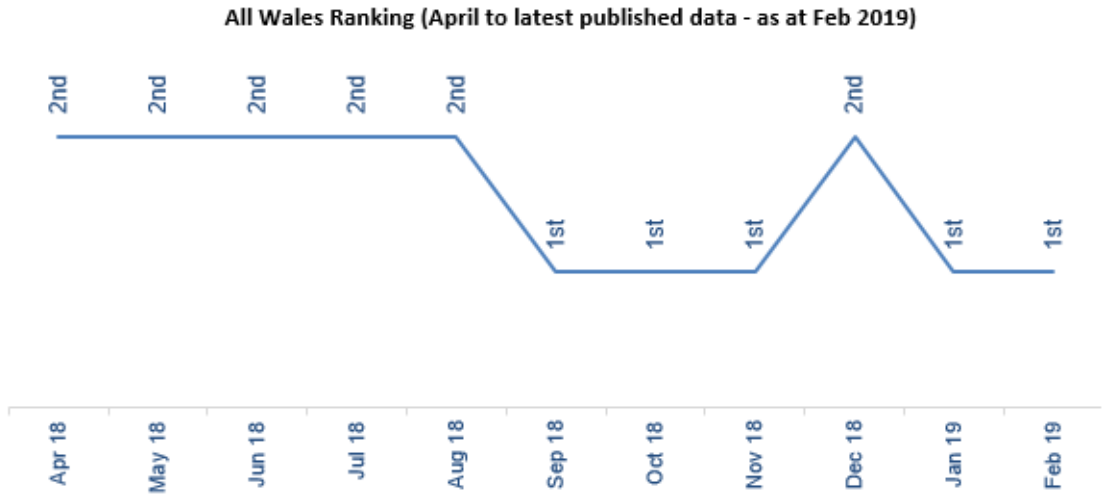

**Radiology - GP referral (Target = 0)**



**Number of patients waiting 8 weeks and over for a specified diagnostic (Target – 0)**



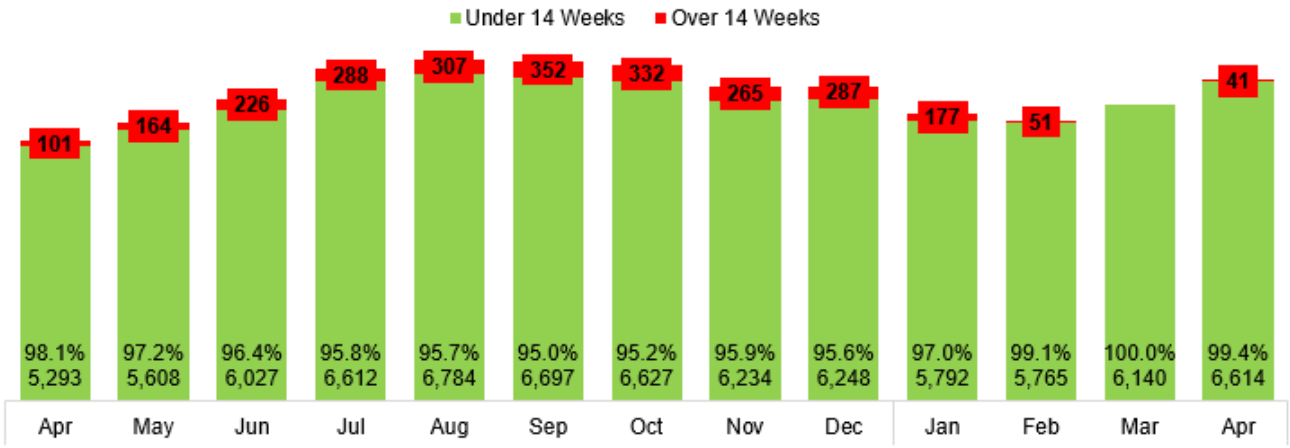



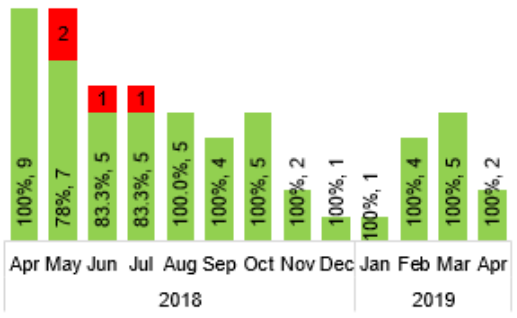
# Therapies

In the Diagnostics and Therapies dashboard the therapy waits metric can also be shown by acute hospital and service area.

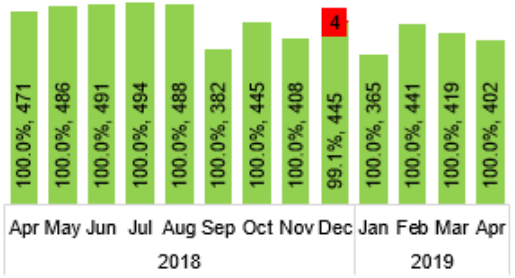
**Total number of patients waiting for all Therapies (Target - 0)**



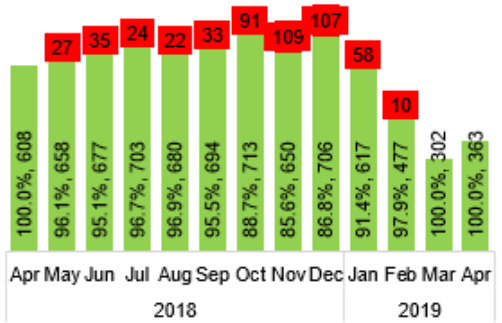
## Arts Therapies (Target = 0)



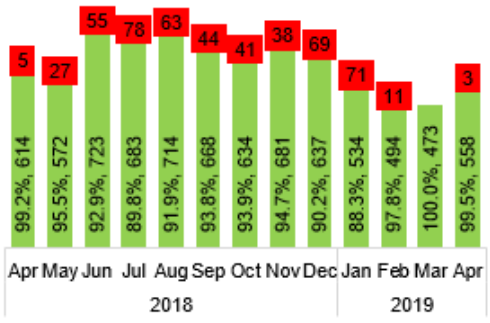

## Speech Language (Target = 0)



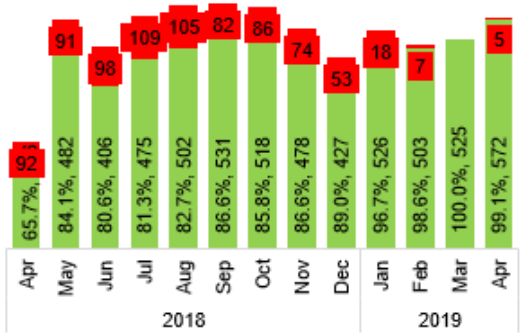

## Audiology (Adult hearing aids) (Target = 0)



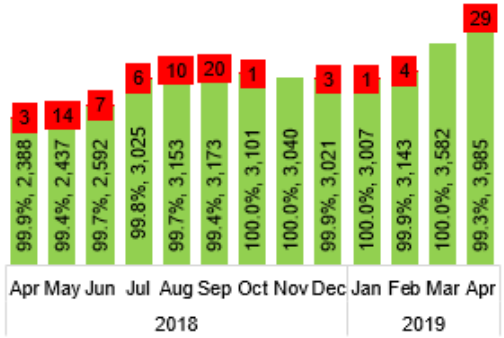

## Dietetics (Target = 0)



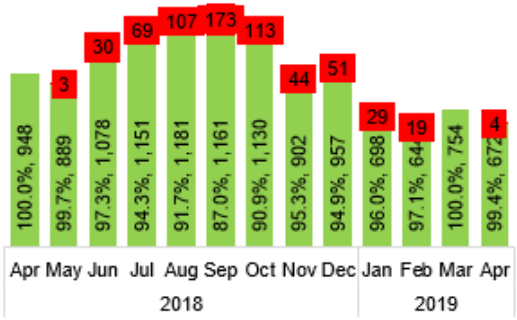

## Occupational Therapy (Target = 0)




## Physiotherapy (Target = 0)



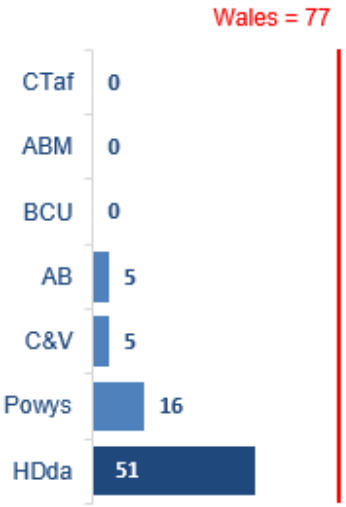

## Podiatry (Target = 0)

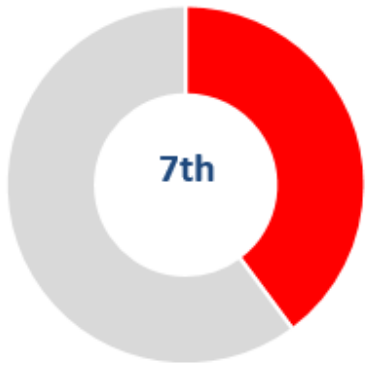


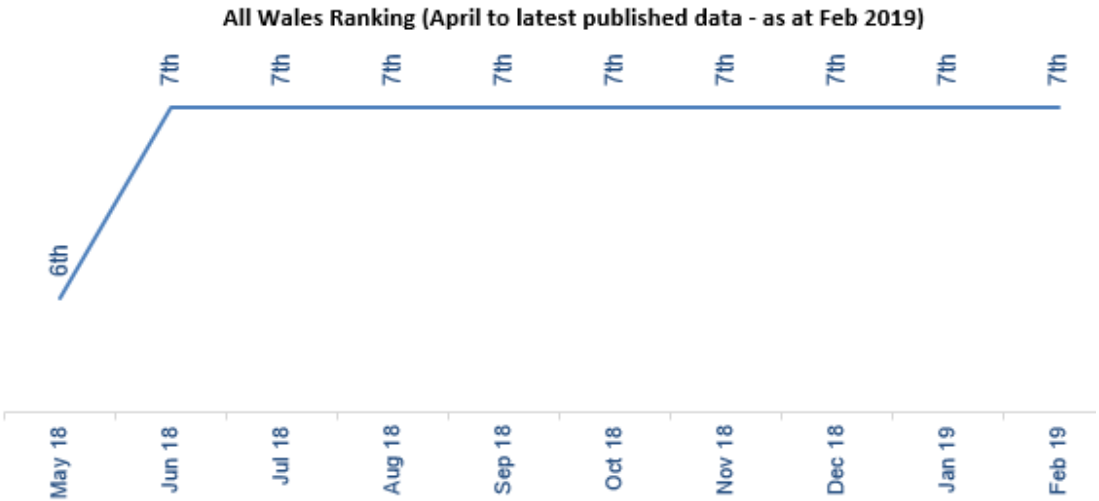
## Longest weeks wait for therapies –April 2019

| Specialty | Longest Weeks Wait |
|---|---|
| Arts Therapies | 7 |
| Audiology (Adult hearing aids) | 12 |
| Dietetics | 15 |
| Occupational Therapy | 15 |
| Physiotherapy | 19 |
| Podiatry | 14 |
| Speech Language | 13 |
| **Grand Total** | 19 |

## Number of patients waiting more than 14 weeks for specific therapy (Target – 0)

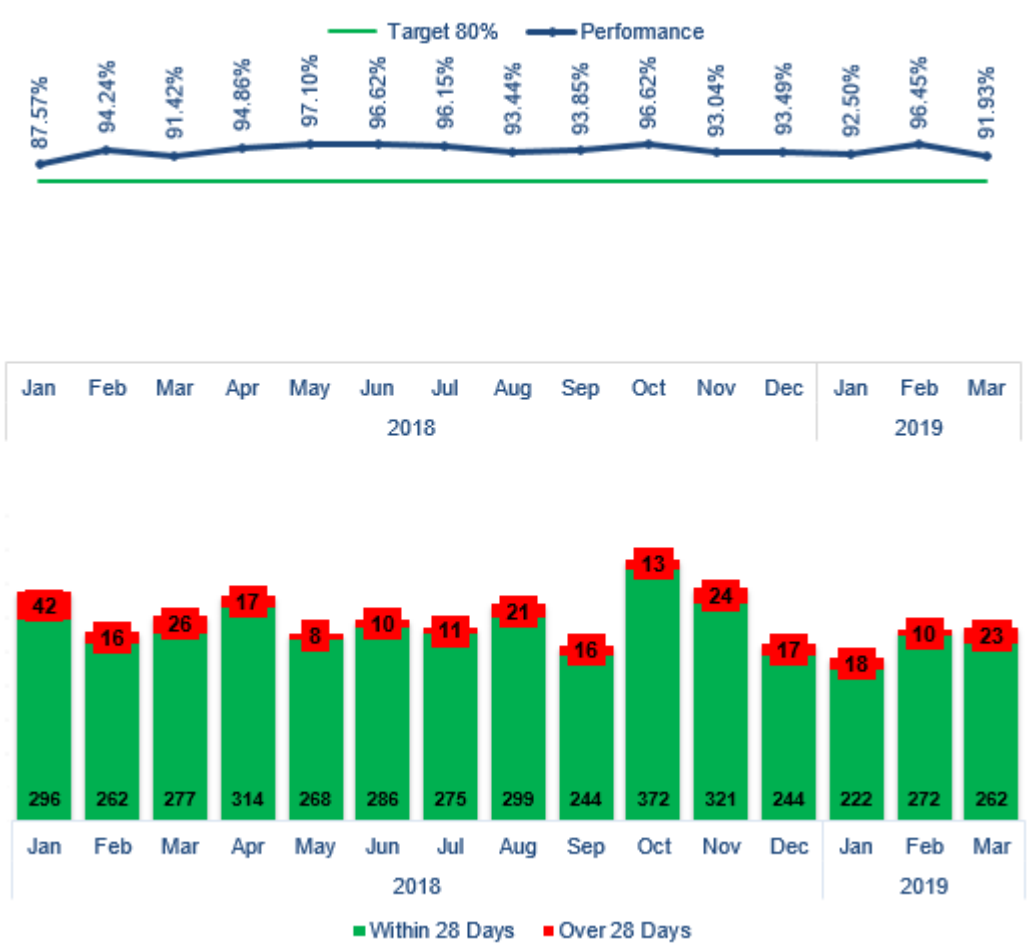


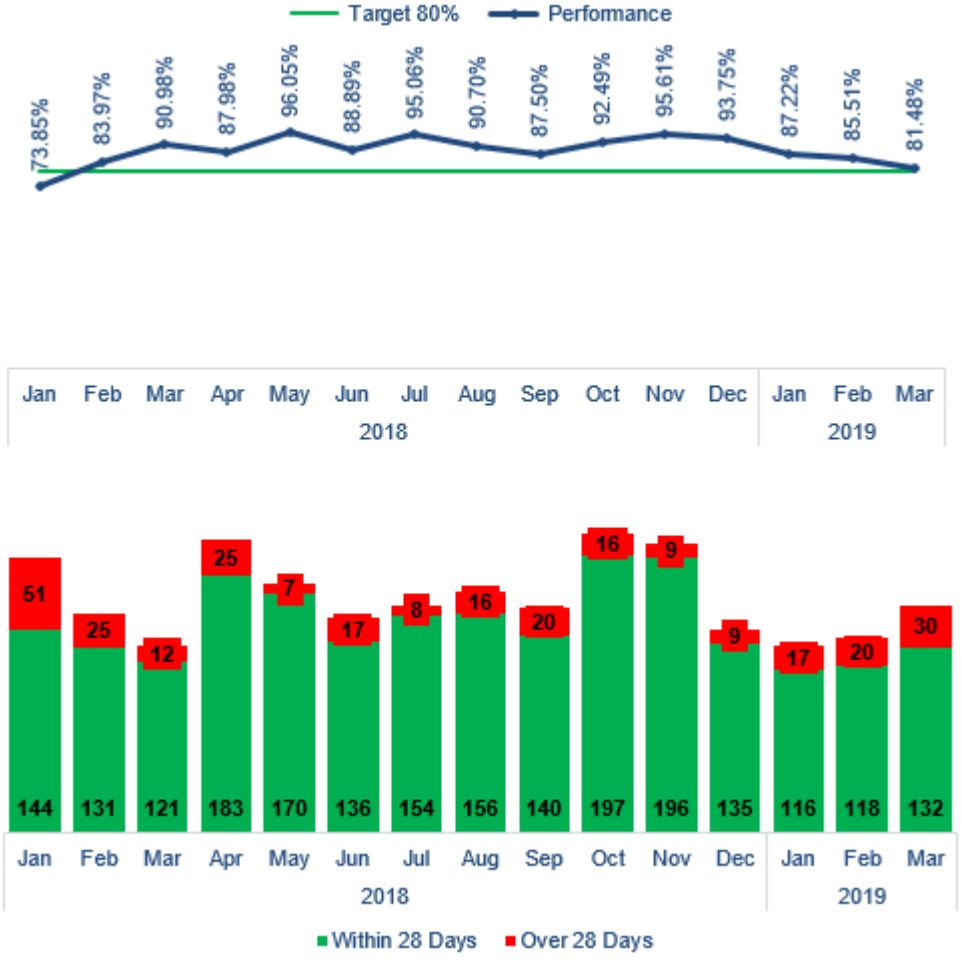



# Mental Health

## Part 1 (A) - assessed within 28 days of referral

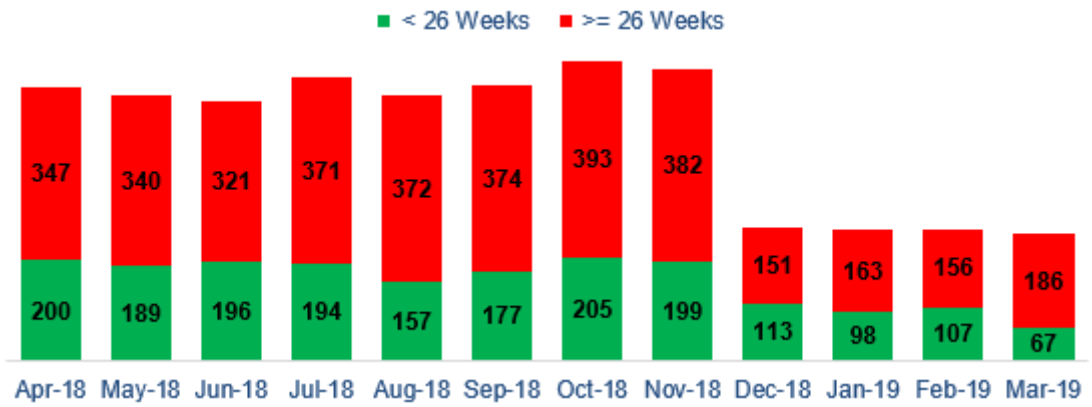



## Part 1 (B) - treated within 28 days of assessment

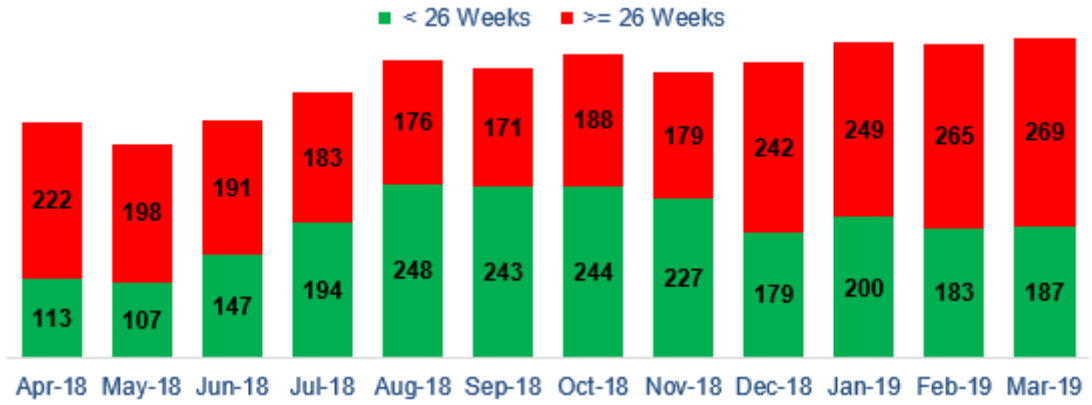


Neurodevelopmental waiting times for children and young people are included below:

**CAMHS ADHD**




**CAMHS ASD**



Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

**CYFARFOD BWRDD PRIFYSGOL IECHYD**
**UNIVERSITY HEALTH BOARD MEETING**

| | |
|---|---|
| **DYDDIAD Y CYFARFOD:**<br>**DATE OF MEETING:** | 30 May 2019 |
| **TEITL YR ADRODDIAD:**<br>**TITLE OF REPORT:** | Corporate Risk Register |
| **CYFARWYDDWR ARWEINIOL:**<br>**LEAD DIRECTOR:** | Steve Moore, Chief Executive |
| **SWYDDOG ADRODD:**<br>**REPORTING OFFICER:** | Joanne Wilson, Board Secretary<br>Charlotte Beare, Head of Risk and Assurance |

| **Pwrpas yr Adroddiad** (dewiswch fel yn addas)<br>**Purpose of the Report** (select as appropriate) |
|---|
| Er Sicrwydd/For Assurance |

**ADRODDIAD SCAA**
**SBAR REPORT**

## Sefyllfa / Situation

The Corporate Risk Register (CRR) and Board Assurance Framework (BAF) is presented to the Board to advise the Board of the principal risks of the University Health Board (UHB) and provide assurance that these risks are being assessed, reviewed and managed appropriately/effectively.

## Cefndir / Background

Risk management is a key component of the governance framework, and should underpin organisational strategy, decision-making and the allocation of resources, and as such the organisation is required to have effective risk management arrangements in place. The Board should receive sufficient and timely assurance information on the management of risk to enable them to exercise good oversight.

The Board agreed the approach, format and content of the CRR and BAF at its meeting on 27th September 2018, and that it should receive the CRR and the BAF twice a year, however moving forward both will be received twice a year. The in-depth scrutiny and monitoring of corporate risks was delegated to its Board Committees in order that they would provide assurance to the Board, through its Committee Update Report, on the management of its principal risks.

The CRR contains risks that have been identified by individual Executive Directors, and are:

- Associated with the delivery of the objectives set out in Annual Plan 2019/20; or
- Significant operational risks escalated by individual Directors and agreed by the Executive Team as they are of significant concern and need corporate oversight and management.

The BAF should set out strategic objectives, the risks in relation to each strategic objective, along with controls in place and assurance on their operation, and should support the Board in assessing progress against its strategic objectives and strategic risks to inform operational planning and delivery and shape future Board agendas. The attached BAF only includes the risks associated with the achievement of the UHB objectives as set out in the Annual Plan 2019/20 as the UHB refreshes its strategic objectives this year.

The Executive Team is responsible for reviewing and discussing the CRR at its monthly formal Executive Team, and agree the any new risks and the escalation/de-escalation of operational risks that are on directorate risk registers. It is the role of Executive Team to review controls and ensure appropriate action plans are in place, which might include the development of corporate risk management strategies to manage risk(s). Effective management of these risks enables the organisation to improve its chances of success and reduce the likelihood of failure.

## Asesiad / Assessment

There are 29 principal risks on the CRR/BAF at present which have been aligned to the UHB objectives listed below.

1. Deliver the Annual Plan 2019/20 by the end of March 2020
2. Deliver the agreed financial control total for 2019/20 by the end of March 2020
3. Achieve the agreed savings requirement for 2019/20 by the end of March 2020
4. Maintain performance and delivery of RTT by the end of March 2020
5. Deliver year 1 of the Health and Care Strategy by the end of March 2020
6. Deliver year 1 of Board approved strategies (Health and Well-Being, Continuous Engagement and Quality Improvement) by the end of March 2020
7. Development of the three year plan for 2020 – 2023 (IMTP)

Since the CRR was presented to the Board in January 2019, the corporate risks have been reviewed and discussed in detail at its Board Committees, and has been reported to the Board via the Committee Update Reports.

Attached to this report to provide the Board with assurance on the management of its principal and risks are:

Appendix 1 - CRR Summary
Appendix 2 - BAF Summary
Appendix 3 - Each risk detailing the strategic objective, controls, assurances, performance indicators and action plans to address any gaps in controls and assurances.

The following changes have taken place since the CRR was previously presented to the Board in January 2019. Whilst many of the scores remain unchanged, there is evidence that actions are being taken forward, although some dates in delivery have changed.

| | | |
|---|---|---|
| Total Number of Risks | 29 | |
| New risks | 4 | *See note 1* |
| Increase in risk score ↑ | 0 | |
| No change in risk score → | 23 | |
| Reduction in risk score ↓ | 3 | *See note 2* |
| De-escalated/Closed | 4 | *See note 3* |

***Note 1 – New Corporate Level Risks***
The Executive Team have approved the following 3 risks for adding/escalating to the CRR:

| Risk Ref | Risk Description | New Risk/ Escalated? | Date | Reason |
|---|---|---|---|---|
| 684 | Lack of agreed replacement programme for radiology equipment | Escalated from Unscheduled Care Directorate | 10/04/19 | This was escalated due to the wide scale disruption to all sites caused by breakdown of key imaging equipment which has a |

| | | | | |
|---|---|---|---|---|
| | | Risk Register | | significant impact on the UHB's ability to meet its RTT target and the impact to patients which can include delays in diagnosis and treatment. The Executive Team recently received a paper detailing the current state and patient facing impacts of the UHB's diagnostic imaging equipment which identified the immediate level of investment required to replace items of equipment considered to pose the greatest risk to clinical services and are also considered long overdue for replacement. |
| 718 | Health and Safety Capacity | New | 10/04/19 | High level gap analysis undertaken on current operational staffing levels identifies significant lack of capacity which means that key aspects of health and safety management are not being undertaken, such as audits, inspections and case reviews, timely learning and follow up after health and safety incidents. |
| 730 | Failure to realise all the efficiencies and opportunities for the Turnaround Programme in 2019/20 | New | 08/05/19 | This risk will replace the previous corporate risk (626) on delivery of the Turnaround Programme. This new risk reflects the risk to deliver the new savings target for delivery in 2019/20. |
| 735 | Ability to deliver the Financial Plan for 2019/20 | New | 22/05/19 | This risk will replaces the previous corporate risk (630) relating to the delivery of the Financial Plan 2018/19. This new risk reflects the risk to deliver the new financial plan in 2019/20. |

***Note 2 – Reduction in Risk Score***

| Risk Ref | Risk Description | Previous risk Score | Risk Score Jan-19 | Date | Reason |
|---|---|---|---|---|---|
| 117 | Delays in transfers to tertiary centres for urgent cardiac investigations, treatment and surgery | 4x5=20 | 2x5=10 | 21/03/19 | The risk has been reduced on account of recent success of the Regional 'Treat & Repat' arrangement. |
| 635 | No deal Brexit affecting continuity of | 3x4=12 | 3x3=9 | 19/03/19 | The risk has been reduced to reflect the work that on-going |

| | | | | | |
|---|---|---|---|---|---|
| | patient care | | | | to clearly identify the risks and impacts to the UHB in conjunction with Wales and UK Governments. |
| 648 | Ability to implement its Quality Improvement Strategic Framework within current financial and workforce resources | 4x3=12 | 2x4=8 | 21/03/19 | This risk has reduced as funding has been made available to fund the first collaborative cohort from June 2019. |

***Note 3 – De-escalated/Closed Risks***

The Executive Team has agreed the de-escalation of the removal of the following 3 risks from the CRR:

| Risk Ref | Risk Description | De-escalated /Closed? | Date | Reason |
|---|---|---|---|---|
| 43 | Ability to fully comply with the statutory Welsh Language Standards (WLS) by Mar19 | De-escalate risk from CRR to Directorate Risk Register (Partnerships & Corporate Services) | 08/05/19 | Funding has been agreed to implement the Welsh Language Standards and therefore this risk can be de-escalated and managed at Directorate level. |
| 626 | Failure to realise all the efficiencies and opportunities for the Turnaround Programme | Closed | 08/05/19 | The Executive Team agreed to close risk 626 following delivery of £30.7m savings by the agreed date of 31st March 2019. This was achieved through operational savings of £26.4m with the gap mitigated through a range of recovery savings actions to the value of £6m.<br>A new risk (above – risk 730) has been approved by Executive Team to reflect the UHB's new savings target for delivery in 2019/20. |
| 630 | Ability to deliver the Financial Plan for 2019/20 | Closed | 22/05/19 | This risk is no longer relevant as the 2018/19 financial year has ended. A new risk (above – Risk 735) has been approved in respect of the risk to deliver the financial plan for 2019/20. |
| 636 | Ability to deliver zero breaches for RTT with 36 weeks, diagnostic within 8 weeks and therapy services within 14 weeks | Closed | 08/05/19 | The UHB delivered against its objective to deliver 0 breaches for Referral to Treatment Time (RTT) within 36 weeks in 2018/19 therefore this risk did not materialise and is no longer relevant. |

| | | | | |
|---|---|---|---|---|
| | | | | The Planned Care Directorate are currently reviewing the risk associated with delivery of RTT in 2019/20', and dependent on the level and nature of the risk, the Executive Team may be asked to consider the new risk for inclusion on the CRR. |

**'Acceptance' of Risk**

At its Board meeting on 27th September 2019, the Board agreed its risk appetite and tolerance levels. These have been embedded within the risk management framework and those with responsibility for managing risk are aware of the agreed risk tolerance levels for risks within different impact domains. Risk tolerance provides guidance to risk owners within the organisation on the level of risk the Board will accept. If the risk is higher than the tolerance level, risk owners must take appropriate action to reduce the risk to within the 'acceptable' level', i.e. bring within risk tolerance levels set by the Board. Where it is not possible to reduce the level of risk to within risk tolerance, the Board must be asked whether it will 'accept' the risk.

It is the role of the Board and Committees, and performance management reviews, to challenge where current and target risk scores, set by those managing risks, do not meet the agreed tolerance levels. Where risk actions do not enable a risk to be reduced to the agreed tolerance level, a discussion needs to take place at the Board Committee aligned to the risk as to whether the target risk score is 'acceptable' based on the planned actions and resources available to manage the risk. It the Committee concludes that everything possible has been or is planning to be done (within available resources), then it should make recommendation to the Board to 'accept' that the risk will not be brought within its agreed tolerance level.

At the Business Planning and Performance Assurance Committee on 30th April 2019, the Committee discussed the risks aligned to the Committee, and considered in detail the risks where the target risk score was above the UHB agreed tolerance level. The Committee agreed to request that the Board 'accept' that that these risks will not be reduced to the UHB agreed tolerance level during the 2019/20 financial year unless there are significant changes in resources or circumstances. Risk owners will continue implement the planned actions to enable the risk to be reduced to the stated target risk score.

The Board is therefore asked to agree and 'accept' that the following risks can only be reduced to the stated target risk score and will remain above the UHB agreed tolerance level.

| Risk | Risk Title | Current Risk Score | Target Risk Score | Agreed Tolerance level (Impact Domain) | Discussion |
|---|---|---|---|---|---|
| 451 | Cyber Security Breach | 5x4=20 | 3x4=12 | 6 (Service/ Business Interruption/ Disruption) | The Committee agreed that cyber security was an inherent risk for all organisations and without infinite funds, it would be challenging to reduce the risk lower than 12. |
| 624 | Ability to maintain and address backlog maintenance and develop infrastructure to support long term strategic objectives | 4x4=16 | 4x4=16 | 6 (Business Objectives/ Projects) | The Committee agreed that given the significant challenge to address the backlog with limited capital resources, no further improvements are achievable and therefore the risk score will be |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | unable to be reduced further. |
| 629 | Ability to deliver against Annual Plan targets against rising demand in unscheduled care | 4x4=16 | 3x4=12 | 8 (Quality/ Complaints/ Audits) | Whilst improvement work continues, there is an unprecedented level of risk within unscheduled care given the complexity of the system, and the Committee accepted that a lower risk score is currently not attainable, due to multiple factors. |
| 632 | Ability to fully implement WG Eye Care Measures (ECM) | 4x4=16 | 2x4=8 | 6 (Safety - patients, Staff or Public) | Whilst the UHB has received some funding from the Welsh Government to implement Eye Care Measures, patients are still unable to access treatments in a timely manner, and therefore it would not be possible for the UHB to reduce the target likelihood and impact any lower than 2 x 4 = 8 at this point in time. |
| 295 | Inability to maintain routine & emergency services in the event of a severe pandemic influenza event | 3x4=12 | 3x3=9 | 6 (Service/ Business Interruption/ Disruption) | The Committee accepted that due to the focus on Brexit, the UHB is currently awaiting the publication of the Cabinet Office review therefore it will not be possible to reduce this risk further. |

## Argymhelliad / Recommendation

The Board is asked to

- Consider if they have sufficient assurance that principal risks are being assessed, managed and reviewed appropriately/effectively through the risk management arrangements in place, noting that these have been fully reviewed by its Board level Committees.
- Approve BPPAC's recommendation that the aforementioned risks will be unable to be reduced to within the UHB agreed tolerance level during the 2019/20 financial year, unless there are significant changes in resources or circumstances, and 'accept' that that the risks will not be reduced lower than the target risk score.

| **Amcanion: (rhaid cwblhau)**<br>**Objectives: (must be completed)** | |
|---|---|
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:<br>Datix Risk Register Reference and Score: | Not Applicable |
| Safon(au) Gofal ac Iechyd:<br>Health and Care Standard(s):<br>Hyperlink to NHS Wales Health & Care Standards | Governance, Leadership and Accountability |
| Amcanion Strategol y BIP:<br>UHB Strategic Objectives:<br>Hyperlink to HDdUHB Strategic Objectives | Not Applicable |

| | |
|---|---|
| Amcanion Llesiant BIP:<br>UHB Well-being Objectives:<br>Hyperlink to HDdUHB Well-being Statement | Not Applicable |

| **Gwybodaeth Ychwanegol:<br>Further Information:** | |
|---|---|
| Ar sail tystiolaeth:<br>Evidence Base: | |
| Rhestr Termau:<br>Glossary of Terms: | Current risk score – Existing level of risk taking into account controls in place.<br>Target risk score - The ultimate level of risk that is desired by the organisation when planned controls (or actions) have been implemented.<br>Risk appetite can be defined as '*the amount of risk that an organisation is willing to pursue or retain*' (ISO Guide 73, 2009).<br>ISO (2009) define risk tolerance as '*the organisation's readiness to bear a risk after risk treatment in order to achieve its objectives*', however it can be simpler to see it as a series of limits such as lines in the sand beyond which the organisation does not wish to proceed. |
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol:<br>Parties / Committees consulted prior to University Health Board: | Executive Team |

| **Effaith: (rhaid cwblhau)<br>Impact: (must be completed)** | |
|---|---|
| **Ariannol / Gwerth am Arian:<br>Financial / Service:** | No direct impacts |
| **Ansawdd / Gofal Claf:<br>Quality / Patient Care:** | No direct impacts |
| **Gweithlu:<br>Workforce:** | No direct impacts |
| **Risg:<br>Risk:** | Poor risk management systems will affect the UHB's ability to achieve its objectives, maintain safe and effective services, and compliance with legislation and regulations, as well as result poor regulatory feedback from auditors. |
| **Cyfreithiol:<br>Legal:** | No direct impacts |
| **Enw Da:<br>Reputational:** | No direct impacts |
| **Gyfrinachedd:<br>Privacy:** | No direct impacts |
| **Cydraddoldeb:<br>Equality:** | • Has EqIA screening been undertaken? No<br>• Has a full EqIA been undertaken? No |

| Risk Ref | Risk (for more detail see individual risk entries) | Included on BAF | Risk Owner | Domain | Tolerance Level | Previous Risk Score | Risk Score May-19 | Trend | Target Risk Score | Risk on page no... |
|---|---|---|---|---|---|---|---|---|---|---|
| 451 | Cyber Security Breach | 1 | Miles, Karen | Service/Business interruption/disruption | 6 | 5×4=20 | 5×4=20 | → | 4×3=12 | 19 |
| 730 | Failure to realise all the efficiencies and opportunities from the Turnaround Programme in 2019/20 | 3 | Carruthers, Andrew | Statutory duty/inspections | 8 | N/A | 4×5=20 | New risk | 2×4=8 | 22 |
| 627 | Ability to implement the UHB Digital Strategy within current resources to support the UHB's long term strategy | 5 | Miles, Karen | Business objectives/projects | 6 | 4×5=20 | 4×5=20 | → | 2×3=6 | 24 |
| 245 | Inadequate facilities to store patient records and investment in electronic solution for sustainable solution | 1 | Teape, Joe | Service/Business interruption/disruption | 6 | 5×4=20 | 5×4=20 | → | 1×4=4 | 27 |
| 624 | Ability to maintain and address backlog maintenance and develop infrastructure to support long term strategic objectives | 5 | Miles, Karen | Business objectives/projects | 6 | 4×4=16 | 4×4=16 | → | 4×4=16 | 30 |
| 628 | Fragility of therapy provision across acute and community services. | 1, 5 | Shakeshaft, Alison | Quality/Complaints/Audit | 8 | 4×4=16 | 4×4=16 | → | 3×4=12 | 33 |
| 629 | Ability to deliver against Annual Plan targets against rising demand in unscheduled care. | 1, 5 | Teape, Joe | Quality/Complaints/Audit | 8 | 4×4=16 | 4×4=16 | → | 3×4=12 | 36 |
| 735 | Ability to deliver the Financial Plan for 2019/20 | 2 | Thomas, Huw | Finance inc. claims | 6 | N/A | 4×4=16 | New risk | 2×4=8 | 40 |
| 625 | Ability to recruit, retain and engage clinical staff to meet rising demand and deliver the long term clinical services strategy | 1, 5 | Gostling, Lisa | Quality/Complaints/Audit | 8 | 4×4=16 | 4×4=16 | → | 2×4=8 | 42 |
| 632 | Ability to fully implement WG Eye Care Measures (ECM) | 1 | Teape, Joe | Safety - Patient, Staff or Public | 6 | 4×4=16 | 4×4=16 | → | 2×4=8 | 45 |
| 291 | Thrombectomy services being withdrawn by Cardiff and Vale Health Board | 1 | Teape, Joe | Quality/Complaints/Audit | 8 | 4×4=16 | 4×4=16 | → | 2×4=8 | 48 |
| 686 | Delivering the Transforming Mental Health Programme by 2023. | 1, 5 | Teape, Joe | Service/Business interruption/disruption | 6 | 4×4=16 | 4×4=16 | → | 2×4=8 | 50 |
| 684 | Lack of agreed replacement programme for radiology equipment across UHB | 1 | Teape, Joe | Service/Business interruption/disruption | 6 | N/A | 4×4=16 | New risk | 2×3=6 | 52 |
| 634 | Overnight theatre provision in Bronglais General Hospital | 1 | Teape, Joe | Safety - Patient, Staff or Public | 6 | 3×5=15 | 3×5=15 | → | 1×5=5 | 54 |
| 508 | Insufficient resources in fire safety management to undertake appropriate PPMs, risk assessments and audits | 1 | Teape, Joe | Safety - Patient, Staff or Public | 6 | 3×5=15 | 3×5=15 | → | 1×5=5 | 56 |
| 295 | Inability to maintain routine & emergency services in the event of a severe pandemic influenza event | 1 | Jervis, Ros | Service/Business interruption/disruption | 6 | 3×4=12 | 3×4=12 | → | 3×3=9 | 60 |
| 384 | Ability to fully comply with statutory and manufacturer guidelines for medical devices and equipment | 1 | Teape, Joe | Statutory duty/inspections | 8 | 3×4=12 | 3×4=12 | → | 3×3=9 | 62 |
| 44 | Ability to manage patients awaiting follow up appointments | 1 | Teape, Joe | Safety - Patient, Staff or Public | 6 | 3×4=12 | 3×4=12 | → | 2×4=8 | 65 |
| 631 | Failure to recognise increasing mortality rates | 1 | Kloer, Dr Philip | Safety - Patient, Staff or Public | 6 | 3×4=12 | 3×4=12 | → | 2×4=8 | 68 |
| 633 | Ability to meet the new waiting time target of 95% in the new Single Cancer Pathway by August 2019 | 1 | Teape, Joe | Quality/Complaints/Audit | 8 | 4×3=12 | 4×3=12 | → | 3×2=6 | 70 |
| 646 | Ability to achieve financial sustainability over medium term | 2, 3 | Thomas, Huw | Finance inc. claims | 6 | 3×4=12 | 3×4=12 | → | 2×3=6 | 72 |
| 647 | Failure to have robust systems in place to support the reporting requirements of the Nurse Staffing Levels (Wales) Act 2016 | 1 | Rayani, Mandy | Statutory duty/inspections | 8 | 3×4=12 | 3×4=12 | → | 2×3=6 | 75 |
| 129 | Ability to deliver a GP Out of Hours Service for Hywel Dda patients | 1 | Teape, Joe | Service/Business interruption/disruption | 6 | 4×3=12 | 4×3=12 | → | 2×3=6 | 77 |
| 652 | Security on acute hospital sites | 1 | Teape, Joe | Safety - Patient, Staff or Public | 6 | 3×4=12 | 3×4=12 | → | 1×4=4 | 80 |
| 117 | Delays in transfers to tertiary centres for urgent cardiac investigations, treatment and surgery | 1 | Teape, Joe | Safety - Patient, Staff or Public | 6 | 4×5=20 | 2×5=10 | ↓ | 2×5=10 | 82 |
| 635 | No deal Brexit affecting continuity of patient care | 1 | Jervis, Ros | Service/Business interruption/disruption | 6 | 3×4=12 | 3×3=9 | ↓ | 2×3=6 | 85 |
| 718 | Lack of Capacity within Health, Safety and Security Team | 1 | Teape, Joe | Statutory duty/inspections | 8 | N/A | 3×3=9 | New risk | 2×3=6 | 87 |

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|---|---|---|---|---|---|---|---|---|---|---|
| 650 | Quality and safety governance arrangements | 1, 6 | Rayani, Mandy | Quality/Complaints/Audit | 8 | 3×3=9 | 3×3=9 | → | 1×2=2 | 89 |
| 648 | Ability to implement its Quality Improvement Strategic Framework within current financial and workforce resources | 1, 6 | Rayani, Mandy | Business objectives/projects | 6 | 4×3=12 | 2×4=8 | ↓ | 2×2=4 | 91 |

| Risk Ref | Strategic Objectives | Risk Title (for more detail see individual risk entries) | Risk Owner | Controls | Domain | Current Risk Score (L x I) | Target Risk Score (L x I) | Performance Indicators | Assurance from What? (sources/providers of assurance) L1, L2 & L3 (see below key) | Latest paper | Assurance Sufficient? (Y/N) | Control RAG rating (see below key) | Risk on page no... |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 451 | 1 | Cyber Security Breach | Miles, Karen | * Controls have been identified as part of the national Cyber Security Task & Finish Group.<br>* Continued rollout of the patches supplied by third party companies, such as Microsoft, Citrix, etc.<br>* £1.4m national investment in national software to improve robustness of NWIS.<br>* Further Task and Finish Group established to review the future patching arrangements within NHS Wales - this will lead future work locally to implement recommendations.<br>* Capital funding has been made available by WG in 2018/19 to improve cyber security - this will be used to purchase required software/equipment for penetration testing. | Service/Business interruption/disruption | 5×4=20 | 4×3=12 | No of cyber incidents.<br><br>Current patching levels in UHB.<br><br>No of maintenance windows agreed with system owners.<br><br>Removal of legacy equipment. | * Department monitoring of KPIs (L1)<br>* IGSC monitoring of cyber security workplan addressing recent internal and external audits/assessments (L2)<br>* IGSC monitoring of National External Security Assessment (L2)<br>* Follow-up Information Backup, Disaster Recovery & Business Continuity and Data Quality: Update on Progress (L3)<br>* WAO IT risk assessment (part of Structured Assessment 2018 (report awaited) (L3)<br>* Internal Audit IM&T Security Policy & Procedures Follow-Up - Reasonable Assurance (L3) | External Security Assessment - IGSC - Jul 18 | N | | 19 |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 245 | 1 | Inadequate facilities to store patient records and investment in electronic solution for sustainable solution. | Teape, Joe | * Annual weeding and destruction programme agreed and facilitated accordingly across the Health Board up to 2018/19.<br>* Electronic clinic systems including: PACS (radiology), LIMS (Pathology), WAP e-referrals, CANIS (Cancer), Diabetes 3, Selma,<br>Myrddin & Secretarial systems/shared drives (Clinic Letters).<br>* Alteration to current racking and purchase of additional racking at GGH. Resourcing of additional racking for the offsite facility.<br>* Agreed and approved Health Records strategies, policies and procedures (approved Aug15).<br>* Electronic Records Project Group undertaking scoping work for Turnaround Project for long term solution (Sep18). | Service/Business interruption/disruption | 5×4=20 | 1×4=4 | Service KPIs in place. | * Weekly management audit to assess current capacity against demand (L1)<br>* Deputy Health Records Managers Meetings to review storage & weeding (L1)<br>* Health Records Audits (L1)<br>* Electronic Records Group (L2)<br>* Oversight by IGSC (L2)<br>* IA Records Management Report - Feb19 (Limited Assurance) (L3) | * Destruction of records report - Exec Team - Dec17.<br>* Records Management Brief report - Exec Team Nov 2018.<br>* Records Management Brief update report - Exec Team Dec 2018.<br>* Records Management Brief report - BPPAC April 2019. | N | | 27 |
| 624 | 1, 5 | Ability to maintain and address backlog maintenance and develop infrastructure to support long term strategic objectives. | Miles, Karen | * There is an annual programme of replacement in place for equipment, IT and Estates which follows a prioritisation process.<br>* The Business Planning & Performance Committee (BPPAC) and Capital Estates & IM&T Sub Committee (CEIM&T) (with IM membership and wide stakeholder engagement in prioritisation process), receive reports and recommendations on the prioritisation and allocation of available capital.<br>* When possible, aligning replacement equipment to large All Wales Capital schemes to minimise the impact on discretionary capital within the UHB.<br>* Completion of the medical devices inventory by the operational management team which helps in the prioritisation of available funds.<br>* Retention of a medical equipment capital contingency to manage urgent issues of repair or replacement.<br>*Review of regulatory reports which have a capital component ie. HIW, WAO, CHC.<br>* Investigating the potential for 'Charitable' funding rather than Discretionary Capital Programme as appropriate.<br>* Communication with Welsh Government via Planning Framework and IMTP (Infrastructure & Investment Enabling Plans) and regular dialogue through Capital Review meetings.<br>* Preparation of priority lists for equipment, Estates and IM&T in the event of notification of additional capital funds from Welsh Government i.e. in year slippage and to enable where possible, the preparation of forward plans. This is also addressed through the identification of high priority issues through the annual planning cycle. | Business objectives/projects | 4×4=16 | 4×4=16 | Performance against plan & budget. | * Reports of delivery against capital plan & budget (L1)<br>* Capital Audit Tracker in place to track implementation of audit recommendations (L1)<br>* Monitoring returns to WG include Capital Resource Limit (L1)<br>* Datix & risk reporting at an operational management level (L1)<br>* BPPAC & CEIM&T Sub-Committee reporting (supported by sub-groups) (L2)<br>* Bi-monthly Capital Review Meetings with WG to discuss/monitor Capital Programme (L2)<br>* NWSSP Capital & PFI Reports on capital audit (L3)<br>* WAO Structured Assessment 2017 (L3) | * DCP and Capital Governance Report - BPPAC Apr19 | N | | 30 |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 628 | 1, 5 | Fragility of therapy provision across acute and community services. | Shakeshaft, Alison | * Agency staff utilised where appropriate, funded from within core budget (2 vacancies fund 1 agency staff).<br>* Prioritisation of patients is undertaken through triage and risk assessment by therapy services.<br>* Introduction of the Malcomess Care Aims Framework for Paediatric Therapy Services.<br>* Local solutions include review of each vacant post to make them attractive, including skill mix review, early advertisements for new graduates.<br>* Priority areas agreed for development, plans being progressed to increase capacity in these areas during 19/20. | Quality/Complaints/Audit | 4×4=16 | 3×4=12 | Maintenance of 14 week waiting times for therapy services.<br><br>Clearance of backlog for pulmonary rehabilitation, with 100% achievement of 14 week maximum wait by Dec20.<br><br>Improved compliance with minimum standards for stroke therapy care by Q3 2020/21.<br><br>Improved staffing ratios for priority areas by Mar20 | * Management monitoring of breaches of 14 week waiting times (L1)<br>* Exceptions to achieving 14 week waiting times reported via IPAR to BPPAC (L2)<br>* Monitored nationally via SSNAP and monitored via Stroke Steering Group & RCP Annual Report with recommendations produced (L2)<br>* External Peer Reviews, Delivery Unit Reviews & national audits, eg Diabetes paediatric audit - action plans developed (L3) | | N | | 33 |
| 629 | 1, 5 | Ability to deliver against Annual Plan targets against rising demand in unscheduled care. | Teape, Joe | * Delivery plans in place supported by daily, weekly and monthly monitoring arrangements.<br>* Comprehensive daily management systems in place to manage unscheduled care risks on daily basis including multiple daily multi-site calls in times of escalation.<br>* Escalation plans for acute and community hospitals.<br>* Unscheduled Care Board includes system-wide representation (Local Authority, Out of Hours, 111).<br>* Annualised delivery plans aligned to Transforming Clinical Services.<br>* Annual winter plans developed to manage increased activity. | Quality/Complaints/Audit | 4×4=16 | 3×4=12 | Performance indicators for Tier 1 targets. | * Daily performance data overseen by service management (L1)<br>* Delivery Plans overseen by Unscheduled Care Board (L2)<br>* Executive Performance Reviews (L2)<br>* IPAR Performance Report to BPPAC & Board (L2)<br>* WAST IA Report Handover of Care (L3)<br>* 11 x Delivery Unit Reviews into Unscheduled Care (L3)<br>* Delivery Unit Report on Complex Discharge (L3) | IPAR Paper - Board 26/07/18.<br><br>A&E Waits & Evaluation of winter preparedness - QSEAC - Apr19 | N | | 36 |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 632 | 1, 4 | Ability to fully implement WG Eye Care Measures (ECM). | Teape, Joe | * Eye Care Action Plan in place.<br>* Ophthalmology RTT delivery plan in place.<br>* Identification of delivery opportunities to reduce costs of RTT delivery (identified in RTT paper to Board 26/07/18).<br>* Commissioning arrangements for outsourcing ophthalmology activity secured via an extension to 2017/18 contractual arrangements.<br>* Eye Care Collaborative Group established and meet quarterly to oversee performance against eye care standards.<br>* ECM Coordinators recruited.<br>* WG Monitoring information from W-PAS 18.1.standards is now functional and information is being submitted | Safety - Patient, Staff or Public | 4×4=16 | 2×4=8 | Reduction in number of follow-ups | * Monitoring arrangements by management (L1)<br>* Executive Performance Reviews (L2)<br>* IPAR Performance Report to BPPAC & Board (L2)<br>* Monthly oversight by WG (L3) | * IPAR Mth 11 - Board Mar19<br><br>* IPAR Mth 12 - BPPAC - Apr19<br><br>* EC Collaborative Group Meeting Feb19 | Y | | 45 |
| 686 | 1, 5 | Delivering the Transforming Mental Health Programme by 2023. | Teape, Joe | * Open commitment and mandate from the Board on the implementation of the TMH Programme. Board approved implementation plan (Jan18).<br>* Mental Health Implementation Group established to oversee delivery of the TMH Implementation Programme.<br>* Established work streams in place for Pathway and Access Design, Workforce and Cultural Change, Transport, and Estates and infrastructure, IT, Partnerships & Commissioning and Data & Evaluation. | Service/Business interruption/disruption | 4×4=16 | 2×4=8 | N/A | * Work streams report progress, key risks and issues to MHIG (L1)<br>* TMH Plan is monitored by TMH Implementation Group and Planning Sub-Committee, and to Board every 6 months (L2) | * TMH Progress Report - Board - Sep18&Nov18<br><br>* HOS reports - MHQSESC - Sep18<br><br>* MHLAC Update - Board - Jul18<br><br>* TMH update - Planning Subcommittee - Nov18 | Y | | 50 |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 625 | 1, 5 | Ability to recruit, retain and engage clinical staff to meet rising demand and deliver the long term clinical services strategy. | Gostling, Lisa | * Continuous national recruitment programmes are ongoing in addition to bespoke recruitment campaigns.<br>* Medical rotas sustained where possible by use of locum/agency staff through agreed frameworks such as Medacs when deemed essential.<br>* Service workforce plans in challenged areas developed to look ahead and control risk including nursing plans produced by Heads of Nursing and plans to recruit to core trainee numbers.<br>* Weekly workforce control panel under leadership of Director of Workforce & OD responsible for overseeing a series of workforce issues including vacancies.<br>* Revised authorisation process for high cost temporary staff.<br>* Bank & agency usage for all nursing areas authorisation process linked to nurse rosters<br>* Leadership development programmes in place across organisation.<br>* OD support & development in place | Quality/Complaints/Audit | 4×4=16 | 2×4=8 | Retention, recruitment, leavers data.<br><br>Workforce KPIs. | * WOD Sub Committee review of workforce information (L2)<br>* Review of workforce KPIs, recruitment/retention data and WOD workplan by WOD Sub-Committee (L2)<br>* Review of workforce tier 1 performance by BPPAC and Board (L2)<br>* Workforce Control Panel reviews series of workforce related issues eg corporate vacancies, bank & agency usage, secondments, etc (L2)<br>* IA Mandatory Training Compliance May-16 (Reasonable) (L3).<br>* IA Workforce Planning May-18 (Reasonable) (L3).<br>* WAO Temporary Staffing Jun-17 (L3). | *Paper for Mar19 Workforce & OD Sub Committee include updates relating to:<br>- Organisational Development<br>- Workforce Annual Plan<br>- HWCs & Audits<br>- Employee Relations Activity & trends<br>- Workforce Intelligence Report<br>- Absence Management<br>- Recruitment Update<br>- Risk Register<br>- Mandatory Training<br>- Medical Education<br>- Staff Experience<br>- Workforce Policies | Y | | 42 |
| 291 | 1 | Thrombectomy services being withdrawn by Cardiff and Vale Health Board. | Teape, Joe | * Re-commencement of thrombectomy services in Cardiff and Vale Health Board, dependent upon capacity<br>* WHSSC currently putting in place a service in North Bristol which is planned to be in place by May 2019 and will support the Cardiff and Vale service | Quality/Complaints/Audit | 4×4=16 | 2×4=8 | Datix incident reports. | * Daily/weekly/monthly/ monitoring arrangements by management (L1)<br>* Executive Performance Reviews (L2)<br>* IPAR Performance Report to BPPAC & Board (L2)<br>* Stroke Delivery Group review of patient cases (L2). | Thrombectomy Report - ET - Sep17. | N | | 48 |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 684 | 1 | Lack of agreed replacement programme for radiology equipment across UHB | Teape, Joe | * Service maintenance contracts in place and regularly reviewed to ensure value for money is maintained.<br>* The difficult to source spares can be obtained through bespoke manufacture but this invariably results in inherent delays in returning equipment to service.<br>* Regular quality assurance checks (eg daily checks).<br>* Use of other equipment/transfer of patients across UHB during times of breakdown.<br>* Ability to change working arrangements following breakdowns to minimise impact to patients.<br>* Site business continuity plans in place.<br>* Disaster recovery plan in place.<br>* CT Scanner including fluoroscopy room and WGH MRI included on all Wales Capital Programme (AWCP)(not yet agreed)and AWCP secured for replacing the BGH MRI.<br>* Replacement programme has been re-profiled by risk, usage and is influenced by service reports. | Service/Business interruption/disruption | 4×4=16 | 2×3=6 | Reduction of waiting times to under 6 weeks by Mar22.<br><br>Reduction in overtime costs to nil by Mar22. | * Monthly reports on equipment downtime and overtime costs (L1)<br>* IPAR report overseen by BPPAC and Board bi-monthly (L2)<br>* Internal Review of Radiology Service Report (Reasonable Rating (L3)<br>* External Review of Radiology - Jul18 (L3)<br>* WAO Review of Radiology - Apr17 (L3) | Radiology Equipment SBAR - Executive Team - Mar19 | N | | 52 |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 508 | 1 | Insufficient resources in fire safety management to undertake appropriate PPMs, risk assessments and audits. | Teape, Joe | * Fire Safety Policy approved Mar18 - implemented through fire training.<br>* Fire Management Structure in place (Head of Fire Safety plus 3.8wte fire advisors).<br>* 400+ valid fire risk assessments undertaken across UHB.<br>* Staff training programme in place with level 1 compliance at 67.41% and level 2 at 44.27% as at Jan19. Also the introduction of Managers training to ensure that managers are made fully aware of their responsibilities (These are being delivered throughout 2019). A further change is also being made to fire safety training where the merger of L1 and L2 training content will take place.<br>* Estate and statutory maintenance programme in place with focus on high risk in-patient facilities.<br>* 7 x local fire safety groups which report to the HB wide Fire Safety Group, which feeds into the Health and Safety & Emergency Planning Sub Committee (HSEPSC).<br>* Prioritised plan for fire safety investment in place which tackles highest risks coming out of the risk assessments as first calling. | Safety - Patient, Staff or Public | 3×5=15 | 1×5=5 | Improve mandatory fire safety training compliance for level 1 & 2 ideally above the 75% target by Nov19.<br><br>Increasing no of valid in date risk assessments to >95% by April 2019.<br><br>Reduce the no of unwanted fire signals (UwFS) to Fire Brigade by 40% by end of 2018 (from 119 UwFS for 2017 period).<br><br>Planned and Preventative Maintenance programme in place for high risk business critical areas with a target of >95% completion(defined by the operational maintenance policy). | * Review of compliance through fire safety groups (L2)<br>* Compliance reports regularly issued to HSEPSC (L2)<br>* Fire inspections by Fire Service (L3)<br>* NWSSP fire advisor inspections (L3)<br>* NWSSP IA Fire Precautions Follow Up May-18 - Reasonable Assurance (L3) | IA Fire Precautions Report - ARAC 19/06/18.<br><br>Quarterly reports to H&S EM SC. | Y | | 56 |
| 634 | 1 | Overnight theatre provision in Bronglais General Hospital | Teape, Joe | * Resident Operating Department Practitioners (OPD) Team<br>* 24/7 anaesthetic cover on site (obstetrician and consultant anaesthetist).<br>* All families are informed by the Maternity Service at Bronglais Hospital of the services available at the hospital and that they will be a Continual Risk Assessment throughout pregnancy for the suitability of the Mother to deliver at BGH. Maternity staff are trained to deal with emergencies, with protocols in place for transfer out to appropriate centre is issues are identified.<br>* Principle of removal of on-call compensatory rest approved by Executive Team. | Safety - Patient, Staff or Public | 3×5=15 | 1×5=5 | No of incidents reported where 30 minute response target is missed. | * Maternity Services governance systems review of incident reports (L1)<br>* Management audit of cases presented to QSEAC (L2)<br>* Discussions with WG Chief Nursing Officer & UHB Medical & Nursing Director (L3) | Executive Team - Jul18<br><br>Executive Team - Dec18 | N | | 54 |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 295 | 1 | Inability to maintain routine & emergency services in the event of a severe pandemic influenza event | Jervis, Ros | * Local Resilience Forum (LRF) multi-agency plans for managing pandemic influenza (updated in accordance with current data and approved by Strategic LRF 14/11/18).<br>* LRF Excess Deaths Plan (which supports the LRF multi-agency pandemic influenza management arrangements) developed as a recommendation from Exercise Cygnus. Plan was ratified by the LRF Strategic Group on 11/07/2018.<br>* Health Board Pandemic Influenza Response Framework and associated plans (currently outdated awaiting review).<br>* Quality assurance process via national & local exercise programmes.<br>* Access to national counter measures stockpile.<br>* Welsh Government Pandemic Influenza Guidance and National Pandemic Flu Service.<br>* Hywel Dda participation in Welsh Government Pandemic Influenza Group.<br>* Reinstated Hywel Dda Pandemic Influenza Group. | Service/Business interruption/disruption | 3×4=12 | 3×3=9 | | * Reports to Health & Safety and Emergency Planning Sub-Committee (L2)<br>* Emergency Planning Action Group (EPAG) Wales meetings re Pandemic Flu (L2)<br>* NHS Wales wide workshops (L3)<br>* LRF Cygnus Test of plans (L3)<br>* Reviewed LRF Pandemic Flu Plan (L3) | No recent reports. | | | 60 |
| 384 | 1 | Ability to fully comply with statutory and manufacturer guidelines for medical devices and equipment. | Teape, Joe | * Medical and Non-Medical Devices Control Group reviewing performance.<br>* HSE Action Plan is nearing completion.<br>* Management information including regular reports provided for scrutiny.<br>* Identification of devices and categorisation and inventory refresh complete and new database procured and commissioned.<br>* System review processes operating to ensure missed inspections are not allowed to go unchecked.<br>* 5 tier risk stratification system developed for Health Board device holding which facilitates high risk devices targeted for first attention.<br>* Increased capital allocation has been realised.<br>* Strategic replacement plan for the Health Board's medical device holding now in place and servicing capital decision making.<br>* Improved ultrasound governance in place.<br>* Training Needs Analysis has been undertaken in conjunction with L&D Team.<br>* Servicing and inspection capacity restored to 2015 levels in clinical engineering.<br>* Broader control over all aspects of all aspects of medical device management to include pathology, radiology and estates now in place. | Statutory duty/inspections | 3×4=12 | 3×3=9 | Maintain accuracy level at >95% items on Medical Devices inventory.<br><br>Performance data from Planned Preventative Maintenance set out in IPAR.<br><br>Performance data reported to control Medical Device Group.<br><br>Incident reports relating to medical devices. | * Internal Management Review 2018 (L1)<br>* Medical and Non-Medical Devices Control Group reviewing performance data (L2)<br>* Oversight of incidents by Health & Safety & Emergency Planning Sub-Committee (L2)<br>* PPM Performance reviewed by Medical Devices Assurance Group (which reports to Operational QSE Sub-Committee(L2)<br>* PPM Performance on medical devices reported in IPAR to BPPAC and Board (L2)<br>* HSE Improvement notices (L3) | * Update on Medical Devices Management - QSEAC - Aug18<br><br>* Medical Devices Assurance Group Update - Operational QSE Sub Committee- Nov18<br><br>*IPAR Month12 - BPPAC - Apr19 | N | | 62 |

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| 44 | 1 | Ability to manage patients awaiting follow up appointments | Teape, Joe | * The programme of work underway within the Health Board is focussing on a number of key stages, urology and cancer.<br>* Admin validation, cleaning up the waiting lists and removing obvious duplicate entries or patients that have been seen and the pathway not closed.<br>* Engaging Clinical Leads for each specialty in the prioritisation of their patients and the identification of those most at risk of harm.<br>* Specialty Service Delivery Manager (SDM) and clinical lead have identified patients on their follow up list who might be at risk.<br>* Lessons learned from SUI / adverse events / complaints relating to delayed care shared through Directorate QSE meetings. | Safety - Patient, Staff or Public | 3×4=12 | 2×4=8 | | * Watchtower meetings are held weekly to review all patient waits (L1)<br>* Ophthalmology ECM specifically report compliance with the follow up intervals (L1)<br>* Outpatients Turnaround Group reviewing levels of follow-up (L2)<br>* Planned Care Programme Board (WG) reviewing HB implementation of PCP (L3)<br>* Scrutiny of FUNB forms part of the Delivery Unit remit for scrutiny (L3) | * IPAR Report Month 9 - Board - Jan19<br><br>* IPAR Report Month 10 - BPPAC - Jan19<br><br>* Delayed Follow Up Improvement Plan 19/20 - BPPAC - Feb19 | Y | | 65 |
| 631 | 1 | HB wide risk: Failure to recognise increasing mortality rates. | Kloer, Dr Philip | * Stage 1 reviews are a standardised process across all sites in the Health Board<br>* Learning from mortality review learning shared at Whole Hospital audit Meetings.<br>* Stage 2 mortality reviews are in place on all sites however is being reviewed and standardised. | Safety - Patient, Staff or Public | 3×4=12 | 2×4=8 | No. of stage 1 mortality reviews undertaken in 28 days.<br><br>No. of stage 2 mortality reviews undertaken.<br><br>No of Datix incident reports. | * Mortality reviews (L1)<br>* IPAR reviewed by BPPAC/PMAF Reviews (L2)<br>* Each specialty to have established a quality and safety forum with mortality reviews as a standing agenda item (L2)<br>* Quality improvement meetings with WG (L3) | | N | | 68 |
| 633 | 1 | Ability to meet the new waiting time target of 95% in the new Single Cancer Pathway by August 2019 | Teape, Joe | * Working with all Wales Cancer Network to gain full understanding of implications of new pathway.<br>* Implementation Group established, reporting to Cancer Board with awareness / engagement sessions held on each hospital site.<br>* Shadow monitoring in place.<br>* Demand & Capacity planning in progress to assess anticipated impact on diagnostic services. | Quality/Complaints/Audit | 4×3=12 | 3×2=6 | Performance indicators for Tier 1 targets.<br><br>Shadow performance data. | * Daily/weekly/monthly/ monitoring arrangements by management (L1)<br>* Executive Performance Reviews (L2)<br>* IPAR Performance Report to BPPAC & Board (L2)<br>* Monthly oversight by WG (L3) | * IPAR Report Mth11- Board - Mar19<br><br>* Implementation of Single Cancer Pathway Report - BPPAC - Feb19 | Y | | 70 |

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| 647 | 1 | Failure to have robust systems in place to support the reporting requirements of the Nurse Staffing Levels (Wales) Act 2016 | Rayani, Mandy | * Temporary staffing arrangements in place.<br>* Risk based escalation arrangements and process in place in services.<br>* Emergency Pressure & Escalation Policy ((Approved Sept 2018).<br>* Nurse Staffing Levels (Wales) Act Steering Group.<br>* (Inconsistent) reporting arrangements in place. | Statutory duty/inspections | 3×4=12 | 2×3=6 | | * E-rostering system reviewed by Head of Nurses in Operation Teams (L1)<br>* Datix Reports reviewed by Corporate Nursing Team to identify reportable breaches (L1)<br>* Director of Nursing review of significant reported breaches (L2)<br>* Workforce & OD Sub-Committee review of workforce challenges (L2)<br>* Annual Report to Board (L2)<br>* WG Review HB Papers in 18/19 (L3)<br>* 3 yearly compliance report to Welsh Government (L2) | * Briefing on NSLA - QSEAC Aug18 and Feb19<br><br>* NSLA Update - Board May18, Jul18 and Nov18<br><br>* NSLA Annual Report - QSEAC Jun19 and Board May19 | N | | 75 |
| 129 | 1 | Ability to deliver a GP Out of Hours Service for Hywel Dda patients. | Teape, Joe | * GP's rotas are constantly reviewed and updated by the OOH staffing team with a view to improve resilience.<br>* 111 programme board with 111 now live across the HB area.<br>* The clinical advice hub as part of the '111' service is assisting with OOH demand<br>* Dedicated Advice GP rota in place at times of high demand (weekends).<br>* Health Professional feedback form in use between clinicians, service management and 111 leads.<br>* Patients directed to alternate OOH care where capacity allows. ED and MIU direction is made for most urgent cases<br>* GP Advisory Group established to improve communication/relationships with local GPs.<br>* WAST APP support in place and provides significant mitigation to risk when other staff unavailable.<br>* Health care support workers augmenting GP workloads by undertaking basic observations.<br>* Pharmacist deployed locally into GGH but working as extended arm of support hub. | Service/Business interruption/disruption | 4×3=12 | 2×3=6 | Performance against Wales Quality and Monitoring for Delivery of OOH standards.<br><br>Filled rotas. | * Daily sitreps/Weekend briefings for OOH (L1)<br>* Monitoring of performance against OOH standards (L1)<br>* Executive Performance Reviews (L2)<br>* BPPAC monitoring (last month) (L2)<br>* WAO Review of OOH in Wales (L3)<br>* WG Peer Review completed Sep-18 (L3) | Internal Review of 111 - BPPAC Jun-18. | N | | 77 |

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| 652 | 1 | Security on acute hospital sites | Teape, Joe | * Doors are in place.<br>* Porters locking each door in person at specific times.<br>* Staff wearing ID badges at all times across sites.<br>* Survey of access points on acute hospital sites identified gaps in access controls - Access controls in large number of areas. | Safety - Patient, Staff or Public | 3×4=12 | 1×4=4 | Reduction in no of incidents unauthorised access. | * Management investigation of unauthorised access and issues / H&S & Security Team identify trends across sites (L1)<br>* Site inspections by night staff (L1)<br>* Security compliance reports to H&S/ EM Planning Sub-Committee (L2)<br>* Security issues discussed at Site Staff Partnership forums (L2)<br>* Counter Terrorism Advisor Report on Security Controls in UHB (L3)<br>* IA Physical Security Follow up - May 2015 - Limited Rating (L3) | * Lockdown policy - H&S SC - Jan19<br><br>* Access Control, CCTV, Lockdown Report - H&S/EP SC - May18 | Y | | 80 |
| 117 | 1 | Delays in transfers to tertiary centres for urgent cardiac investigations, treatment and surgery | Teape, Joe | * Medical and nursing staff review patients daily and update the referral database as appropriate.<br>* Bi-monthly operational meeting with Abertawe Bro Morgannwg (ABMU) to improve flow.<br>* Daily telephone call Coronary Care Unit (CCU) to review all patients awaiting transfer with review of patients waiting for transfer to ABMU.<br>* Escalation process in place.<br>* All patients are risk scored by cardiac team in ABMU.<br>* Local evaluation of catheter laboratory project to identify more local solutions.<br>* Additional cardiac capacity for Winter 2018/19 providing 6 ring-fenced beds at PPH to enable timelier transfer to ABMU. ABMU have agreed to 2 transfers per day for HDUHB patients form 7/1/19 - this has achieved an average reduction from 10 to 3 days in the wait from 'referrals for angio' to ' angio undertaken'. | Safety - Patient, Staff or Public | 2×5=10 | 2×5=10 | Performance indicators for Tier 1 targets. | * Daily/weekly/monthly/ monitoring arrangements by management (L1)<br>* Audit of N-STEMI referral undertaken by Clinical Lead show average wait of 10.7 days (L1)<br>* Executive Performance Reviews (L2)<br>* IPAR Performance Report to BPPAC & Board (L2)<br>* Monthly oversight by WG (L3) | | N | | 82 |

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| 718 | 1 | Lack of capacity within Health, Safety and Security Team | Teape, Joe | * 1 x Head of H&S, 1 x H&S Manager and 1 x Security/Case Manager/Prevent Co-ordinator who currently take a reactive approach to health and safety issues, as opposed to a more beneficial proactive approach.<br>* Datix Risk module in place. The Health Board has invested in the Datix module which enables services to identify, assess and manage risks associated with health and safety.<br>* Standard operating procedures in laboratory, radiology, theatre environments which reflect some of the hazards/ risks (Policy approved, most departments have material safety data sheets but very few COSHH risk assessments, pathology have undertaken monitoring for Xylene and Formaldehyde)<br>* Incident/concerns investigations are undertaken however depth of investigations could be improved to ensure there is appropriate follow up, support for those affected and lessons are learnt across the organisation.<br>* H&S policies and procedures are in place and are published on staff intranet.<br>* Incident/concerns investigations are undertaken however depth of investigations could be improved to ensure there is appropriate follow up, support for those affected and lessons are learnt across the organisation.<br>* H&S policies and procedures are in place and are published on staff intranet. | Statutory duty/inspections | 3×3=9 | 2×3=6 | | * Incident and RIDDOR and progress against workplan reports to H&S/EP Sub-Committee (L2)<br>* Progress against workplan reports to H&S/EP Sub-Committee (L2)<br>* IA report on Health and Safety Sep16(Reasonable Rating) (L3) | SBAR Exec Team Oct-18 H&S/EP Sub-Committee | N | | 87 |
| 635 | 1 | No deal Brexit affecting continuity of patient care | Jervis, Ros | * Regular meetings with CEO, DPH & Head of Emergency Planning plus verbal updates/discussions and papers at Executive Team and Board.<br>* Brexit Steering Group has been established to manage the consequences of Brexit and its interface with partners.<br>* Wider governance infrastructure in place - of note the Dyfed Powys LRF Brexit Group and Welsh Government led groups.<br>* Risk assessments and business continuity plans feed into a dynamic risk summary document which continues to track on-going risks and controls assurance with business continuity.<br>* Scoping exercise undertaken within Workforce to identify EU nationals and resolve data gaps in ESR. Workforce Brexit Plan developed.<br>* Information flows are being co-ordinated to ensure that any discussions with respective Health Board services and national services and/or professional leads are captured within our planning.<br>* The Health Board is represented at the WG SRO's, Comms and Brexit Health & Social Care Civil Contingencies Group and also within the DP LRF Brexit Group.<br>* Staff Brexit Intranet page developed as single point of information plus a closed Facebook Group for EU staff.<br>* Exercise Brexit Challenge undertaken resulting in recommendations and an action plan that will be progressed via the Brexit Steering Group.<br>* Sitrep process in place at local, regional and national level for reporting and escalating impacts of consequences of Brexit.<br>* Systems in place to review and respond to new consequences of Brexit at local, regional and national level. | Service/Business interruption/disruption | 3×3=9 | 2×3=6 | To be identified when risk is fully understood. | * Response submitted on 19Nov18 to Andrew Goodall letter of 05 October stating approach to be taken by Health Boards confirming progress (L1)<br>* Response submitted to Wales Audit Office letter notifying of intention to undertake an initial baseline of arrangements by 30Nov19 (L1)<br>* Emergency Planning Team to review UHB no deal Brexit arrangements and associated BCPs (L1)<br>* Executive oversight of Brexit arrangements and BCPs (L2)<br>* Review of Exercise planned for Jan19 (L3)<br>* WAO Review of Brexit Preparedness (L3) | None to date. | | | 85 |

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| 650 | 1, 6 | Quality and safety governance arrangements | Rayani, Mandy | * Review of QSEAC Sub-Committee Structure undertaken.<br>* Nurse staffing levels reports.<br>* Quality metrics in place including Fundamentals of Care, Incident reporting, and concerns, etc.<br>* Quality & Safety Dashboard reviewed by QSEAC and assurance reports provided at each QSEAC. | Quality/Complaints/Audit | 3×3=9 | 1×2=2 | Incident reports<br><br>Q&S Dashboard | * Q&S metrics reported through IPAR to BPPAC (L2)<br>* Monthly meetings with WG Q&S Unit (L2)<br>* Q&S Dashboard and Sub-committee reports to QSEAC (QSEAC report to Board) (L2)<br>* HIW Reports indicate areas of improvement of Q&S (L3)<br>* WAO Structured Assessment 2018 - focus on Q&S governance (L3) | | N | | 89 |
| 648 | 1, 6 | Ability to implement its Quality Improvement Strategic Framework within current financial and workforce resources | Rayani, Mandy | * Small scale quality improvement activity taking place across the organisation.<br>* Quality Improvement Strategic Framework (QISF) & implementation plan developed.<br>* Launch of QISF in Mar19.<br>* Funding for first collaborative cohort has been agreed.<br>* Network of coaches identified from within and outside of organisation.<br>* Full support from 1000 Lives and the Director of Quality and Safety NHS Wales.<br>* Collaborative Steering Group established and meets monthly to monitor delivery of implementation plan. | Business objectives/projects | 2×4=8 | 2×2=4 | | * Collaborative Steering Group established to monitor delivery of QISF Implementation Plan (L2) | N/A | | | 91 |

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| 735 | 2 | Ability to deliver the Financial Plan for 2018/19. (under review) | Thomas, Huw | * Financial reports provided to directorates in a timely way, focused on trends; cost drivers; projected expenditure; risks and actions.<br>* Turnaround Director Holding to Account meetings.<br>* CEO Holding to Account meetings.<br>* Executive Performance meetings.<br>* Commissioning arrangements with key partners (Local Authorities; Care home sector; Other NHS providers; Primary Care; Third Sector).<br>* Process of reveiw of recovery plans process in place for Month 3 and approaching of system-wide issues. | Finance inc. claims | 4×4=16 | 2×4=8 | Identification and delivery of savings schemes.<br><br>Financial performance and projections reported on a monthly basis.<br><br>Breakeven recovery plans where deficits are projected.<br><br>Financial process assurances.<br><br>Internal Audit and Wales Audit Office reports. | * Finance dashboards (L1).<br>* Finance report to Finance Committee and Board (L2).<br>* CEO Holding to Account meetings (L1).<br>* Financial assurance report to Audit Committee (L2).<br>* Year-end reporting to Audit Committee (L3). | Month 1 Finance Report 2019/20 reports - Finance Committee - May 2019 | Y | | 40 |
| 646 | 2, 3 | Ability to achieve financial sustainability over medium term. | Thomas, Huw | * Understanding the underlying deficit. An initial assessment has been completed.<br>* Very high level base-case long term financial model.<br>* Assessing the full financial implications of Transforming Clinical Services. | Finance inc. claims | 3×4=12 | 2×3=6 | Operational agreement to underlying deficit assessment.<br><br>Plan in place to develop a long term financial plan.<br><br>High level financial assessment of TCS in place. | * Reporting to Finance Committee (L1). | N/A | N | | 72 |

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| 730 | 3 | Failure to realise all the efficiencies and opportunities from the Turnaround Programme in 2019/20 | Carruthers, Andrew | * Turnaround Programme Director in post.<br>* Fortnightly 'Holding to Account' (HTA) meetings including a monthly Chief Executive HTA session for the highest risk directorates.<br>* Each Directorate has signed up to a savings plan and recovery plan - costed and RAG rated.<br>* Identified Exec lead for red schemes and for key Turnaround Improvement Programmes.<br>* Specific aspect of Performance Review focus on finance and link to HTA session.<br>* Escalation process to HTA monthly meeting.<br>* Executive Team Turnaround Meetings. | Statutory duty/inspections | 4×5=20 | 2×4=8 | Performance against agreed savings plan<br><br>In-month financial monitoring | * Performance against plan monitored through HTA meeting with Services (L1)<br>* Executive Performance Reviews (L2)<br>* Finance Committee oversight of current performance (L2)<br>* Turnaround & Financial Report to Board & BPPAC (L2)<br>* WG scrutiny through Targeted Intervention (TI)(L3)<br>* WG scrutiny through Joint Executive Team (JET) (L3)<br>* WAO Structured Assessment 2018 (L3) | * Mth 12 Finance Report & Turnaround Report - Board Apr19<br><br>* Finance Report & Turnaround Report - Mar19 Finance Committee | Y | | 22 |
| 627 | 5 | Ability to implement the UHB Digital Strategy within current resources to support the UHB's long term strategy | Miles, Karen | * Board approved the 5 year Digital Strategy - Jan17.<br>* Board Approved the updated 2018 Digital Plan, and Operational Delivery Plan.<br>* Development of a Digital Futures Programme. | Business objectives/projects | 4×5=20 | 2×3=6 | | * Signed off project plans by the relevant committees (L1)<br>* Delivery of digital plans are overseen by Digital Steering Group (reports to Planning Sub Committee) (L2) | Digital strategy/plans included in annual plan document-action to Board. | Y | | 24 |

**Assurance Key:**

| 3 Lines of Defence (Assurance) | | |
|---|---|---|
| 1st Line | Business Management | Tends to be detailed assurance but lack independence |
| 2nd Line | Corporate Oversight | Less detailed but slightly more independent |
| 3rd Line | Independent Assurance | Often less detail but truly independent |

| Key - Assurance Required | |
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| | Detailed review of relevant information |
| | Medium level review |
| | Cursory or narrow scope of review |

*NB Assurance Map will tell you if you have sufficient sources of assurance not what those sources are telling you*

| Key - Control RAG rating | |
|---|---|
| **LOW** | Significant concerns over the adequacy/effectiveness of the controls in place in proportion to the risks |
| **MEDIUM** | Some areas of concern over the adequacy/effectiveness of the controls in place in proportion to the risks |
| **HIGH** | Controls in place assessed as adequate/effective and in proportion to the risk |
| **INSUFFICIENT** | Insufficient information at present to judge the adequacy/effectiveness of the controls |

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| **Strategic Objective:** | *1 -Deliver the Annual Plan 2019/20 by the end of March 2020* |

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| **Executive Director Owner:** | Miles, Karen | **Date of Review:** | 09/05/2019 |
| **Lead Committee:** | Business Planning and Performance Assurance Committee | **Date of Next Review:** | 09/06/2019 |

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| **Risk ID:** | **451** | **Principal Risk Description:** | There is a risk of the Health Board experiencing a cyber security breach. This is caused by a lack of defined patch management policy, lack of management on non-ICT managed equipment on network, end of life equipment no longer receiving security patching from the software vendor, lack of software tools to identify software vulnerabilities and staff awareness of cyber threats/entry points. This could lead to an impact/affect on a disruption in service to our users cause by the flooding of our networks of virus traffic, loss of access to data caused by virus activity and damage to server operating systems. |
| **Does this risk link to any Directorate (operational) risks?** | 451, 356 | | |

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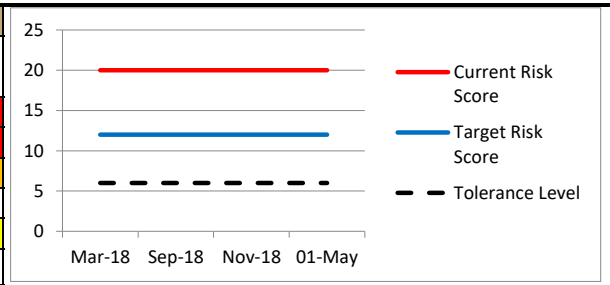
| **Risk Rating:(Likelihood x Impact)** | |
| **Domain:** | Service/Business interruption/disruption |
| **Inherent Risk Score (L x I):** | 5×4=20 |
| **Current Risk Score (L x I):** | 5×4=20 |
| **Target Risk Score (L x I):** | 4×3=12 |
| **Tolerable Risk:** | 6 |
| **Trend:** | ⟷ |




| **Rationale for CURRENT Risk Score:** |
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| There are daily threats to systems which are managed by NWIS and UHB. Current patching levels within the UHB of is 60% for Desktop / Laptops and 25% for the server infrastructure and there is lack of capacity to undertake this continuous work at the pace required. Severity score is 5 as a cyber attack has the potential to severely disrupt service provision across all sites for a significant amount of time. |

| **Rationale for TARGET Risk Score:** |
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| Increased patching levels will help to reduce to impact of disruption from a cyber threat. However this work is continuous and is dependent on obtaining the appropriate level of resources to undertake the patching anti-virus work at pace. A paper was prepared for the Formal Executive Team in Sep18 which identified the revenue resources required. The target risk score of 12 reflects the wider risk to other applications not Microsoft. |

| **Key CONTROLS Currently in Place:** (The existing controls and processes in place to manage the risk) | **Gaps in CONTROLS** | | | |
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| | **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working) | **How and when the Gap in control be addressed** Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
| Controls have been identified as part of the national Cyber Security Task & Finish Group.<br><br>Continued rollout of the patches supplied by third party companies, such as Microsoft, Citrix, etc.<br><br>£1.4m national investment in national software to improve robustness of NWIS.<br><br>Further Task and Finish Group established to review the future patching arrangements within NHS Wales - this will lead future work locally to implement recommendations.<br><br>Capital funding has been made available by WG in 2018/19 to improve cyber security - this will be used to purchase required software/equipment for penetration testing | Lack of comprehensive patching across all systems used in UHB.<br><br>Lack of staffing capacity to undertake continuous patching at pace.<br><br>Lack of dedicated maintenance windows for updating critical clinical systems. | Continue to focus on critical and security updates to clinical critical systems. | Solloway, Paul | Ongoing | These are implemented when received however this work does take time with current staffing resource level. |
| | | Review of cyber security measures underway following wannacry virus incident. | Solloway, Paul | Completed | Additional resources were received from Welsh Government to implement the necessary software to monitor cyber incidents. A further all Wales bid was submitted for 2 staff to undertake the remedial work. Presently awaiting formal funding letter for these posts. |
| | | Implement local UHB workplan developed in response to the National External Security Assessment. | Tracey, Anthony | Ongoing | Progress is reported to IGSC at every meeting. |

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| software/equipment for penetration testing. | | A paper has been prepared to request additional revenue resources from the Executive Team. | Tracey, Anthony | Completed | The Executive Team considered the paper and acknowledged that the steps outlined should be incorporated within Emergency Planning procedures as recommended. The Executive Team also requested that money saving opportunities elsewhere will need to be considered, and a risk assessment exploring all options needs to be undertaken and presented to the Board for considerations. The Executive Team acknowledge the importance of Cyber Security and requested a Dashboard on compliance to be developed. |
| | | Work with system owners to arrange suitable system down-time or disruption. | Solloway, Paul | Ongoing | Patching policies have been created however little progress has been made due to lack of resources. Service catalogue creation is progressing well and this will be amalgamated with Information Asset Owners group to agree down-time for the key local systems. However patching KPI's will not be met until sufficient technical resources are in place. |
| | | Purchase Vulnerability Scanning to adopt a proactive approach to identifying cyber threats. | Tracey, Anthony | Completed | The required software was purchased with year end capital released from Welsh Government. It has been implemented and is operational within the Health Board. |

| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls | Latest Papers (Committee & date) | Gaps in ASSURANCES | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Performance Indicators | Sources of ASSURANCE | Type of Assurance (1st, 2nd, 3rd) | Required Assurance / Current Level | | | Identified Gaps in Assurance: | How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps | By Who | By When | Progress |
| No of cyber incidents. | Department monitoring of KPIs | 1st | | | External Security Assessment - | Lack of committee oversight. | Update IGSC TORs to include responsibility to monitor cyber security. | Tracey, Anthony | Completed | Regular reports on progress on External assessment. |

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| Current patching levels in UHB.<br><br>No of maintenance windows agreed with system owners.<br><br>Removal of legacy equipment. | IGSC monitoring of cyber security workplan addressing recent internal and external audits/assessments | 2nd | | | IGSC - Jul 18 | | Internal Audit (IA) of GDPR (Dec 18) and cyber security (Sep 18). | Tracey, Anthony | Completed | The IA GDPR final report in Apr19 reported 'Substantial Assurance' whilst the Internal Audit deferred Cyber Security to the 2019/20 Internal Audit Plan. |
| | IGSC monitoring of National External Security Assessment | 2nd | | | | | | | | |
| | Follow-up Information Backup, Disaster Recovery & Business Continuity and Data Quality: Update on Progress | 3rd | | | | | | | | |
| | WAO IT risk assessment (part of Structured Assessment 2018 (report awaited) | 3rd | | | | | | | | |
| | Internal Audit IM&T Security Policy & Procedures Follow-Up - Reasonable Assurance | 3rd | | | | | | | | |

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| **Strategic Objective:** | 3 - Achieve the agreed savings requirement for 2019/20 by the end of March 2020 |

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| **Executive Director Owner:** | Carruthers, Andrew | **Date of Review:** | 08/05/2019 |
| **Lead Committee:** | Finance Committee | **Date of Next Review:** | 08/06/2019 |

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| **Risk ID:** | **730** | **Principal Risk Description:** | There is a risk of the UHB not delivering the planned recurrent savings of £24m by end of March 2020. This is caused by a failure to realise the opportunities identified in the Turnaround programme. This could lead to an impact/affect on a failure to meet its financial statutory duty to breakeven, attain an approvable IMTP, loss of stakeholder confidence in the organisation's ability to deliver its objectives and increased scrutiny by WG. |
| **Does this risk link to any Directorate (operational) risks?** | yes | | |

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| **Risk Rating:(Likelihood x Impact)** | ***No trend information available*** |
| **Domain:** | Statutory duty/inspections |
| **Inherent Risk Score (L x I):** | 5×5=25 |
| **Current Risk Score (L x I):** | 4×5=20 |
| **Target Risk Score (L x I):** | 2×4=8 |
| **Tolerable Risk:** | 8 |
| **Trend:** | *New risk* |

**Rationale for CURRENT Risk Score:**

At this point in time there is a possibility that the UHB will fail to deliver the full £24m savings in 2019/20. Currently as at the end of Mar19, the Health Board has identified £20.5m against that target for 2019/20.

**Rationale for TARGET Risk Score:**

As the Turnaround programme is an intervention aimed at supporting delivery of the overall financial plan, and as such has had the in year recovery actions required to achieve breakeven, the target score has been set to align with the risk to delivery of the overall financial plan.

| **Key CONTROLS Currently in Place:** (The existing controls and processes in place to manage the risk) | **Gaps in CONTROLS** | | | |
|---|---|---|---|---|
| | **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working) | **How and when the Gap in control be addressed** Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
| Turnaround Programme Director in post.<br><br>Fortnightly 'Holding to Account' (HTA) meetings including a monthly Chief Executive HTA session for the highest risk directorates.<br><br>Each Directorate has signed up to a savings plan and recovery plan - costed and RAG rated.<br><br>Identified Exec lead for red schemes and for key Turnaround Improvement Programmes.<br><br>Specific aspect of Performance Review focus on finance and link to HTA session.<br><br>Escalation process to HTA monthly meeting.<br><br>Executive Team Turnaround Meetings. | Lack of sufficient capacity to support and facilitate the delivery of Turnaround programme.<br><br>Ability to control operational priorities that adversely affect delivery of savings plans, eg, winter pressures, vacancy position.<br><br>Lack of clarity in organisation about true priorities specially achieving balance quality performance, TCS and finance delivery. | Increase capacity of programme management office (PMO) and service improvement capability to support delivery of Turnaround Programme. | Ryan-Davies, Libby | 30/06/2019 | Capacity to support the Turnaround programme activity has been agreed by the Board in Mar19 however the recruitment process will mean that the additional capacity will be unlikely to be in place before Jun19. |
| | | Work closely with the Director of Operations to ensure robust operational and contingency plans are in place that minimise additional cost, and align with turnaround savings actions. | Carruthers, Andrew | 31/03/2020 | Joint Chairs of Operational Effectiveness Group and Unscheduled Care Programme Board. |
| | | Chief Executive setting out the organisations goals for 2019/20 to Executive Team. | Moore, Steve | 31/05/2019 | Executive Team away day set up to clarify goals and the contribution each portfolio needs to make to them. |

| **ASSURANCE MAP** | **Control RAG** | **Latest Papers** | **Gaps in ASSURANCES** |
|---|---|---|---|

| Performance Indicators | Sources of ASSURANCE | Type of Assurance (1st, 2nd, 3rd) | Required Assurance / Current Level | Rating (what the assurance is telling you about your controls | (Committee & date) | Identified Gaps in Assurance: | How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps | By Who | By When | Progress |
|---|---|---|---|---|---|---|---|---|---|---|
| Performance against agreed savings plan<br><br>In-month financial monitoring | Performance against plan monitored through HTA meeting with Services | 1st | | | * Mth 12 Finance Report & Turnaround Report - Board Apr19<br><br>* Finance Report & Turnaround Report - Mar19 Finance Committee | None | | | | |
| | Executive Performance Reviews | 2nd | | | | | | | | |
| | Finance Committee oversight of current performance | 2nd | | | | | | | | |
| | Turnaround & Financial Report to Board & BPPAC | 2nd | | | | | | | | |
| | WG scrutiny through Targeted Intervention (TI) | 3rd | | | | | | | | |
| | WG scrutiny through Joint Executive Team (JET) | 3rd | | | | | | | | |
| | WAO Structured Assessment 2018 | 3rd | | | | | | | | |

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| **Strategic Objective:** | 5 - Deliver year 1 of the Health and Care Strategy by the end of March 2020 |

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| **Executive Director Owner:** | Miles, Karen | **Date of Review:** | 09/05/2018 |
| **Lead Committee:** | Business Planning and Performance Assurance Committee | **Date of Next Review:** | 09/06/2019 |

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| **Risk ID:** | **627** | **Principal Risk Description:** | There is a risk of the digital capability of the organisation not supporting the delivery of the outputs from the Transforming Clinical Services Programme (A Healthier Mid and West Wales: Health and Care Strategy). This is caused by a lack of resources to support the implementation of the UHB digital strategy. This could lead to an impact/affect on delays in implementing the Health Board's long term strategy and improvements to support the delivery of safe and effective patient care. |
| **Does this risk link to any Directorate (operational) risks?** | | | |

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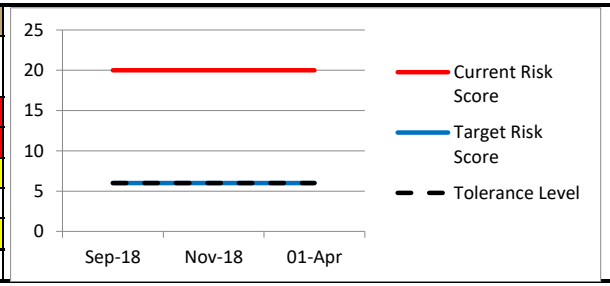
| **Risk Rating:(Likelihood x Impact)** | |
| **Domain:** | Business objectives/projects |
| **Inherent Risk Score (L x I):** | 4×5=20 |
| **Current Risk Score (L x I):** | 4×5=20 |
| **Target Risk Score (L x I):** | 2×3=6 |
| **Tolerable Risk:** | 6 |
| **Trend:** | ⟷ |




**Rationale for CURRENT Risk Score:**

The current Informatics Teams are not resourced to take forward the current strategic options. Around 95% of staff time is dedicated to "keeping the lights on" which comprises of ensuring that the infrastructure is robust and operational. The teams are not resourced to take forward any innovation or new builds at this time. Anything that is currently progressed, in terms of new builds is undertaken at the expense of guaranteeing robust ICT systems.

**Rationale for TARGET Risk Score:**

An assessment of the resources required has been supplied to the TCS programme. Further work is underway with the newly appointed management consultants, however the work to implement the recommendations is still not funded.

| **Key CONTROLS Currently in Place:** (The existing controls and processes in place to manage the risk) | **Gaps in CONTROLS** | | | |
|---|---|---|---|---|
| | **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working) | **How and when the Gap in control be addressed** Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
| Board approved the 5 year Digital Strategy - Jan17.<br><br>Board Approved the updated 2018 Digital Plan, and Operational Delivery Plan.<br><br>Development of a Digital Futures Programme. | Resourcing of digital strategy.<br><br>Resourcing of digital programme to deliver the Health and Care Strategy. | Where resources are required then Business Cases will be developed, in line with the digital plan. | Tracey, Anthony | ~~31/03/2018~~ 30/09/2019 | Progress is being monitored via the Planning Sub-Committee and the CE&IM&T Committee. Formal Business Case is in the process of being developed and will be finalised by Sep19. |
| | | A paper has been prepared to request additional revenue resources from the Executive Team. | Tracey, Anthony | 31/12/2019 | Progress is being monitored via the Planning Sub-Committee and the CE&IM&T Committee. The Planning Sub Committee has approved the establishment of a digital steering group to take forward the digital agenda. A number of sub-groups will also be established to ensure that a robust resource plan is identified, and to also improve the project management of large projects. |

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| | | Work with the 'A Healthier Mid and West Wales' Team to ensure that there is synergy and cross mapping of requirements. | Tracey, Anthony | Completed | An initial meeting has taken place between the Project Team and the ADI and CCIO, to ensure that the Digital Plan is linked to the strategy. Following the meeting a revised Digital Plan will be developed and presented as part of the updated enabling plans. |
| | | Develop a clear vision/scope for the digital workstream following the formal feedback from the consultation. | Tracey, Anthony | ~~31/03/2019~~ 31/05/2019 | An initial meeting has taken place between the newly appointed management consultants and the Director of Planning, Performance, Informatics and Commissioning along with the ADI to provide an update specification of the work required to enable digital transformation |

| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls | Latest Papers (Committee & date) | Gaps in ASSURANCES | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Performance Indicators | Sources of ASSURANCE | Type of Assurance (1st, 2nd, 3rd) | Required Assurance / Current Level | | | Identified Gaps in Assurance: | How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps | By Who | By When | Progress |
| | Signed off project plans by the relevant committees | 1st | | | Digital strategy/plans included in annual plan document- action to Board. | Lack of committee oversight | Information to be supplied to Planning Sub-Committee and CE&IM&T. | Tracey, Anthony | Completed | A newly established Digital Steering Group under the auspices of the Planning Sub Committee to ensure the appropriate governance is in place for the digital plan. |
| | Delivery of digital plans are overseen by Digital Steering Group (reports to Planning Sub Committee) | 2nd | | | | | | | | |

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| **Strategic Objective:** | *1 - Deliver the Annual Plan 2019/20 by the end of March 2020* |

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| **Executive Director Owner:** | Teape, Joe | **Date of Review:** | 02/05/2019 |
| **Lead Committee:** | Business Planning and Performance Assurance Committee | **Date of Next Review:** | 03/06/2019 |

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| **Risk ID:** | **245** | **Principal Risk Description:** | There is a risk of avoidable interruption to business continuity affecting all clinical teams. This is caused by poor and inadequate facilities within the Health Records Service with insufficient storage capacity for patient records and a lack of investment in electronic systems to deliver a sustainable model. This could lead to an impact/affect on patient record service with it unable to store records securely, potential loss, damage or inappropriate disclosure of patient records leading to breach of confidentiality, review and fine by the ICO, significant service disruption with several localities compromised, indirect adverse impact to patient safety arising from inappropriate clinical decisions, leading to poor patient care, complaints and litigation. |
| **Does this risk link to any Directorate (operational) risks?** | Yes | | |

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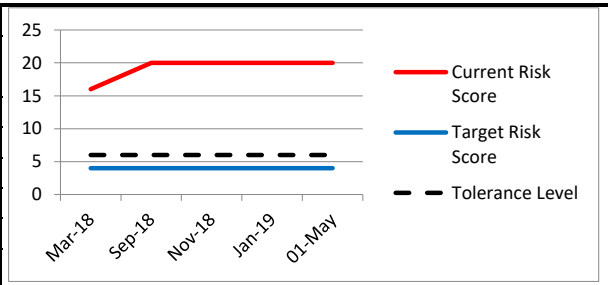
| **Risk Rating:(Likelihood x Impact)** | |
| **Domain:** | Service/Business interruption/disruption |
| **Inherent Risk Score (L x I):** | 5×4=20 |
| **Current Risk Score (L x I):** | 5×4=20 |
| **Target Risk Score (L x I):** | 1×4=4 |
| **Tolerable Risk:** | 6 |
| **Trend:** | ⟷ |




| **Rationale for CURRENT Risk Score:** |
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| Acute and mental health services are no longer able to transfer records for storage to the UHB's offsite facility. As a result of historical abuse and blood transfusion inquiries, further weeding and destruction programmes have been curtailed exacerbating the current situation. The relocation of deceased and non active records has also ceased from all main hospital localities. |

| **Rationale for TARGET Risk Score:** |
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| This risk needs significant resources and planning to identify, fund and implement a long term sustainable solution that will provide more effective patient care, more appropriate working conditions for staff and financial sustainability. Without this, the risk will not be reduced in the near or long term future. |

| **Key CONTROLS Currently in Place:** (The existing controls and processes in place to manage the risk) | **Gaps in CONTROLS** | | | |
|---|---|---|---|---|
| | **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working) | **How and when the Gap in control be addressed** Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
| Annual weeding and destruction programme agreed and facilitated accordingly across the Health Board up to 2018/19.<br><br>Electronic clinic systems including: PACS (radiology), LIMS (Pathology), WAP e-referrals, CANIS (Cancer), Diabetes 3, Selma, Myrddin & Secretarial systems/shared drives (Clinic Letters).<br><br>Alteration to current racking and purchase of additional racking at GGH. Resourcing of additional racking for the offsite facility.<br><br>Agreed and approved Health Records strategies, policies and procedures | Lack of sustainable long term solution for records management and storage.<br><br>Lack of capital funding to support sustainable solution (estimated to be in excess of £8m).<br><br>Lack of capacity within current storage facilities resulting in more records being stored on wards/service areas. | Implementation of the weeding and destruction plan 2017/2018. | Bennett, Mr Steven | Completed | The weeding plan for 2017/2018 was agreed and the plan was implemented in priority order. The plan has now been completed for all hospital localities removing and relocating all non-current records from 2015. The weeding programme for 2018/19 was unable to be undertaken due to the public inquiry into infected blood products during 1970s and 1980s. |

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| (approved Aug15).<br><br>Electronic Records Project Group undertaking scoping work for Turnaround Project for long term solution (Sep18). | Inability to store all records safely within current storage facility.<br><br>Difficulties in accessing records to comply with legal access timeframes and enable the UHB to deliver timely and clinical appropriate treatments, affecting RTT and unscheduled care targets. | Full implementation of Welsh Admin Portal (WAP) electronic referral system. | Tracey, Anthony | ~~31/12/2018~~ 31/10/2019 | The e-referral has now been fully implemented across 9 specialties within the health board. Testing has commenced in 4 other specialties and mapping has commenced in 4 specialties. Initial completion date of Mar19 will not be achieved due to staff resource initially allocated to the project being removed by NWIS. |
| | | Develop a business case for the implementation of a scanning solution to deal with long term issue. | Rees, Gareth | ~~31/03/2019~~ 30/09/2020 | The first meeting of the Health Records Project Group took place on the 23rd April 2019. Discussions confirmed there was a requirement for other key individuals to be added to the group membership and essentially there was a need for programme management support. The chair will shortly present a paper to the Executive Team identifying these requirements. The estimated delivery of a Business Case remain at approximately 18 months. |
| | | Re-establish Health Records Group. | Bennett, Mr Steven | Completed | First meeting of the Health Records Group took place on the 19th October 2018. |
| | | Development of an implementation plan to improve management of storage arrangements for current records by information asset owners across the UHB. | Bennett, Mr Steven | Completed | Implementation plan has been endorsed by the Executive Team in Dec18 however funding resources will need to be appropriately supported to deliver the outcomes. |

| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls) | Latest Papers (Committee & date) |
|---|---|---|---|---|---|
| **Performance Indicators** | **Sources of ASSURANCE** | **Type of Assurance (1st, 2nd, 3rd)** | **Required Assurance / Current Level** | | |
| Service KPIs in place. | Weekly management audit to assess current capacity against demand | 1st | | | * Destruction of records report - Exec Team - Dec17.<br>* Records Management Brief report - Exec Team Nov 2018 |
| | Deputy Health Records Managers Meetings to review storage & weeding | 1st | | | |
| | Health Records Audits | 1st | | | |

| Gaps in ASSURANCES | | | | |
|---|---|---|---|---|
| **Identified Gaps in Assurance:** | **How are the Gaps in ASSURANCE will be addressed<br>Further action necessary to address the gaps** | **By Who** | **By When** | **Progress** |
| Lack of recent independent review of Records Management. | Include on Internal Audit Plan. | Wilson, Joanne | Completed | Already included on IA Plan 2018/19 - planned for Q3. |
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|---|---|---|---|---|---|---|---|---|
| Electronic Records Group | 2nd | | | 2018.<br>* Records Management Brief update report - Exec Team Dec 2018.<br>* Records Management Brief report - BPPAC April | | | | |
| Oversight by IGSC | 2nd | | | | | | | |
| IA Records Management Report - Feb19 (Limited Assurance) | 3rd | | | | | | | |

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| **Strategic Objective:** | 1 - Deliver the Annual Plan 2019/20 by the end of March 2020<br>5 - Deliver year 1 of the Health and Care Strategy by the end of March 2020 |

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| **Executive Director Owner:** | Miles, Karen | **Date of Review:** | 03/05/2019 |
| **Lead Committee:** | Business Planning and Performance Assurance Committee | **Date of Next Review:** | 03/06/2019 |

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| **Risk ID:** | **624** | **Principal Risk Description:** | There is a risk of the UHB will not be able to maintain and address either the backlog maintenance or development of its estate, medical equipment and IM&T infrastructure, that it is safe and fit for purpose. This is caused by insufficient capital, both from the All Wales Capital Programme and Discretionary Capital allocation. This could lead to an impact/affect on delivery of strategic objectives, service improvement/development and delivery of day to day patient care. |
| **Does this risk link to any Directorate (operational) risks?** | Yes | | |

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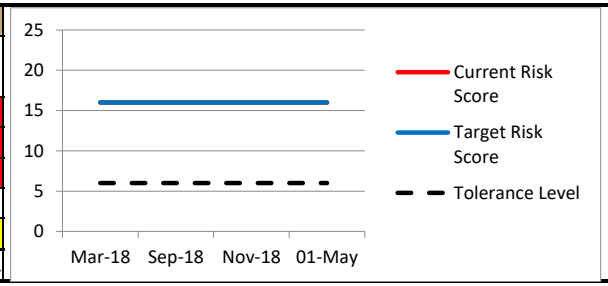
| **Risk Rating:(Likelihood x Impact)** | |
| **Domain:** | Business objectives/projects |
| **Inherent Risk Score (L x I):** | 5×4=20 |
| **Current Risk Score (L x I):** | 4×4=16 |
| **Target Risk Score (L x I):** | 4×4=16 |
| **Tolerable Risk:** | 6 |
| **Trend:** | ⟷ |




| **Rationale for CURRENT Risk Score:** |
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| Although there are a number of controls in place, the risk score cannot be reduced significantly within the current capital allocation. |

| **Rationale for TARGET Risk Score:** |
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| The target risk score of 16 reflects the actions and processes planned and controls in place to help mitigate the risk. |

| **Key CONTROLS Currently in Place:** (The existing controls and processes in place to manage the risk) | **Gaps in CONTROLS** | | | |
|---|---|---|---|---|
| | **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working) | **How and when the Gap in control be addressed** Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
| There is an annual programme of replacement in place for equipment, IT and Estates which follows a prioritisation process.<br><br>The Business Planning & Performance Committee (BPPAC) and Capital Estates & IM&T Sub Committee (CEIM&T) (with IM membership and wide stakeholder engagement in prioritisation process), receive reports and recommendations on the prioritisation and allocation of available capital.<br><br>When possible, aligning replacement equipment to large All Wales Capital schemes to minimise the impact on discretionary capital within | Capital funding is significantly short of the level required to deal with backlog maintenance programme for estates, IM&T & equipment.<br><br>An Estates Strategy aligned to the Board approved Health and Care Strategy. | Undertake backlog maintenance through the All Wales Capital programme for new equipment, IM&T and estates infrastructure. The Strategy is to apply discretionary capital in a prioritised way within the UHB however to take advantage of all Wales capital schemes where possible and any additional in-year (2019/20) capital allocations. | Miles, Karen | ~~31/03/2019~~ 31/03/2020 | At all Wales level, the development of the Specialist and Critical Care Centre at Aneurin Bevan University Health Board has affected the amount of available capital funding across Wales and therefore all Wales capital funding has been significantly constrained in 2018/19 and remains so for 2019/20 and will continue to impact into 2020/21. |

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| the UHB.<br><br>Completion of the medical devices inventory by the operational management team which helps in the prioritisation of available funds.<br><br>Retention of a medical equipment capital contingency to manage urgent issues of repair or replacement.<br><br>Review of regulatory reports which have a capital component ie. HIW, WAO, CHC.<br><br>Investigating the potential for 'Charitable' funding rather than Discretionary Capital Programme as appropriate.<br><br>Communication with Welsh Government via Planning Framework and IMTP (Infrastructure & Investment Enabling Plans) and regular dialogue through Capital Review meetings.<br><br>Preparation of priority lists for equipment, Estates and IM&T in the event of notification of additional capital funds from Welsh Government i.e. in year slippage and to enable where possible, the preparation of forward plans. This is also addressed through the identification of high | | Development of a medical devices inventory. | Rees, Gareth | Completed | A Medical Devices Coordinator is now in place and maintains the UHB medical devices inventory. The Inventory Report was submitted to the CEIM&T Sub Committee at its meeting Sep18 and formed part of the capital prioritisation process for DCP which was reported to BPPAC at its meeting in Oct18 and Feb19. This is now being utilised to inform the prioritisation of equipment process. |
| | | The annual planning cycle identifies key capital enabling plans and priorities. The 2019/20 planning cycle will also include the start of the development of an Estates Strategy in support of the clinical strategy which will establish the timing and scope of key estate developments which will help address backlog issues across the UHB. | Miles, Karen | 31/03/2020 | To be evidenced in work in support of implementation of 'A Healthier Mid & West Wales' and inclusion in the Infrastructure and Investment Enabling Plan to be produced as part of the 2019/20 Planning Cycle. |

| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls | Latest Papers (Committee & date) | Gaps in ASSURANCES | | | |
|---|---|---|---|---|---|---|---|---|---|
| Performance Indicators | Sources of ASSURANCE | Type of Assurance (1st, 2nd, 3rd) | Required Assurance / Current Level | | | Identified Gaps in Assurance: | How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps | By Who | By When | Progress |
| Performance against plan & budget. | Reports of delivery against capital plan & budget | 1st | | | * DCP and Capital Governance Report - BPPAC Apr19 | | | | | |
| | Capital Audit Tracker in place to track implementation of audit recommendations | 1st | | | | | | | | |
| | Monitoring returns to WG include Capital Resource Limit | 1st | | | | | | | | |
| | Datix & risk reporting at an operational management level | 1st | | | | | | | | |
| | BPPAC & CEIM&T Sub-Committee reporting (supported by sub-groups) | 2nd | | | | | | | | |

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| Bi-monthly Capital Review Meetings with WG to discuss/monitor Capital Programme | 2nd | | | | | | | | |
| NWSSP Capital & PFI Reports on capital audit | 3rd | | | | | | | | |
| WAO Structured Assessment 2017 | 3rd | | | | | | | | |

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| **Strategic Objective:** | 1 - Deliver the Annual Plan 2019/20 by the end of March 2020<br>5 - Deliver year 1 of the Health and Care Strategy by the end of March 2020 |

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| **Executive Director Owner:** | Shakeshaft, Alison | **Date of Review:** | 07/05/2019 |
| **Lead Committee:** | Quality, Safety and Experience Assurance Committee | **Date of Next Review:** | 07/06/2019 |

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| **Risk ID:** | **628** | **Principal Risk Description:** | There is a risk of patients in need of therapy services having poorer patient outcomes. This is caused by gaps in the therapy service provision across acute, community and primary settings from historical under-resourcing, exacerbated by vacancies and recruitment/retention issues due to national shortages. This could lead to an impact/affect on a detrimental impact on patient outcomes, longer recovery times, increased length of stay, a reduction in performance against 14 week waiting time and non-compliance with clinical guidance, with a potential adverse impact on patient safety/harm. |
| **Does this risk link to any Directorate (operational) risks?** | yes | | |

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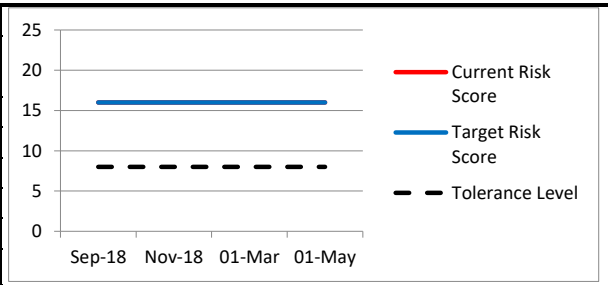
| **Risk Rating:(Likelihood x Impact)** | |
| **Domain:** | Quality/Complaints/Audit |
| **Inherent Risk Score (L x I):** | 5×4=20 |
| **Current Risk Score (L x I):** | 4×4=16 |
| **Target Risk Score (L x I):** | 3×4=12 |
| **Tolerable Risk:** | 8 |
| **Trend:** | ⟷ |




**Rationale for CURRENT Risk Score:**

There are significant gaps in the therapy service provision across acute, community and primary care settings from historical under-resourcing, exacerbated by vacancies and recruitment/retention issues due to national shortages. Across all therapy services, current demand does not align to current capacity and whilst this is being managed as far as possible by the controls in place, it is not sustainable and a long term solution needs to be developed and resourced.

**Rationale for TARGET Risk Score:**

The target risk score has been assessed as 12 as although priority areas have been agreed and progressed, the risk will not be completely addressed in the coming year. A sustainable therapy workforce solution aligned to the Health and Care Strategy has been agreed. The following 3 high impact/workforce priority areas have been identified within the Annual Plan for focus during 2019/20: older people (incorporating frailty, dementia and stroke); improving self-management (including pulmonary rehabilitation and diabetes); therapists as first point of contact in primary care (including musculoskeletal, older people and irritable bowel syndrome). An additional area requiring development is the Major Trauma Network and a sustainable solution is also required to maintain the 14 week waiting time target. These areas of development will require practical, prudent and incremental workforce solutions to improve patient care, outcomes and experience, and sustainable funding models will be required through whole-system review and shifting of resource from elsewhere in the health and care system.

| **Key CONTROLS Currently in Place:**<br>(The existing controls and processes in place to manage the risk) | **Gaps in CONTROLS**<br>**Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working) | **How and when the Gap in control be addressed**<br>Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
|---|---|---|---|---|---|
| Agency staff utilised where appropriate, funded from within core budget (2 vacancies fund 1 agency staff).<br><br>Prioritisation of patients is undertaken through triage and risk assessment by therapy services.<br><br>Introduction of the Malcomess Care Aims Framework for Paediatric Therapy Services.<br><br>Local solutions include review of each vacant post to make them attractive, including skill mix review, early advertisements for new | Inability to secure funding for all developments identified in 19/20 plan.<br><br>Shortage of qualified staff nationally limits applications to some posts. | Developing robust plans to evidence improved patient outcomes and experience through reprovision of resource from elsewhere in the health and care system aligned with strategic direction of the HB. This is a significant, long term piece of work, which will need to run alongside strategic development through the Health and Care Strategy. This will include skill mix review such as new HCSW and Advanced Practice roles | Shakeshaft, Alison | 31/03/2020 | Plans under development. Funding already secured for developments in pulmonary rehabilitation and dementia. |

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| attractive, including skill mix review, early advertisements for new graduates.<br><br>Priority areas agreed for development, plans being progressed to increase capacity in these areas during 19/20. | | Robust workforce planning to inform to inform HEIW in respect to future graduate numbers required by the UHB/Region, which are aligned to the Health and Care Strategy workforce plan. | Shakeshaft, Alison | 31/03/2024 | Long-term piece of work that needs to be informed by action above. |

| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls) | Latest Papers (Committee & date) | Gaps in ASSURANCES | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Performance Indicators | Sources of ASSURANCE | Type of Assurance (1st, 2nd, 3rd) | Required Assurance / Current Level | | | Identified Gaps in Assurance: | How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps | By Who | By When | Progress |
| Maintenance of 14 week waiting times for therapy services.<br><br>Clearance of backlog for pulmonary rehabilitation, with 100% achievement of 14 week maximum wait by Dec20.<br><br>Improved compliance with minimum standards for stroke therapy care by Q3 2020/21.<br><br>Improved staffing ratios for priority areas by Mar20 | Management monitoring of breaches of 14 week waiting times | 1st | | | | Reporting improved compliance with the Dementia Action Plan, including increased diagnostic rates. | | | | |
| | Exceptions to achieving 14 week waiting times reported via IPAR to BPPAC | 2nd | | | | | | | | |
| | Monitored nationally via SSNAP and monitored via Stroke Steering Group & RCP Annual Report with recommendations produced | 2nd | | | | | | | | |
| | External Peer Reviews, Delivery Unit Reviews & national audits, eg Diabetes paediatric audit - action plans developed | 3rd | | | | | | | | |

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| **Strategic Objective:** | 1 - Deliver the Annual Plan 2019/20 by the end of March 2020<br>5 - Deliver year 1 of the Health and Care Strategy by the end of March 2020 |

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| **Executive Director Owner:** | Teape, Joe | **Date of Review:** | 02/05/2019 |
| **Lead Committee:** | Business Planning and Performance Assurance Committee | **Date of Next Review:** | 02/06/2019 |

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| **Risk ID:** | **629** | **Principal Risk Description:** | There is a risk of the UHB not being able to deliver against annual plan targets to improve to health and well-being of citizens in Wales. This is caused by the inability to manage rising demand and acuity of patients within the unscheduled care pathway. This could lead to an impact/affect on delays in the treatment and care of patients, adverse publicity/reduction in stakeholder confidence and increased scrutiny/escalation from WG. |
| **Does this risk link to any Directorate (operational) risks?** | | | |

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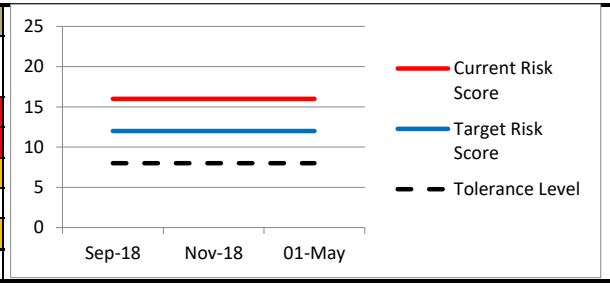
|---|---|
| **Risk Rating:(Likelihood x Impact)** | |
| **Domain:** | Quality/Complaints/Audit |
| **Inherent Risk Score (L x I):** | 5×5=25 |
| **Current Risk Score (L x I):** | 4×4=16 |
| **Target Risk Score (L x I):** | 3×4=12 |
| **Tolerable Risk:** | 8 |
| **Trend:** | ⟷ |




**Rationale for CURRENT Risk Score:**

Whilst current performance shows a improving trend since December 2017 across Unscheduled Care for 4 hour waits in A&E and ambulance delays, the number of 12 hour waits in A&E continues to increase. In addition, the recent Delivery Unit report on complex discharge advised that although the UHB is taking the right actions, they are not being consistently implemented across the system due to workforce and capacity pressures.

**Rationale for TARGET Risk Score:**

It is unlikely that the current workforce and service models will support the UHB to meet current standards and improve unscheduled care performance. The UHB's current financial position makes it unrealistic reduce the target risk score of 12 at this point in time.

| **Key CONTROLS Currently in Place:** (The existing controls and processes in place to manage the risk) | **Gaps in CONTROLS** | | | |
|---|---|---|---|---|
| | **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working) | **How and when the Gap in control be addressed** Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
| Delivery plans in place supported by daily, weekly and monthly monitoring arrangements.<br><br>Comprehensive daily management systems in place to manage unscheduled care risks on daily basis including multiple daily multi-site calls in times of escalation.<br><br>Escalation plans for acute and community hospitals.<br><br>Unscheduled Care Board includes system-wide representation (Local Authority, Out of Hours, 111).<br><br>Annualised delivery plans aligned to Transforming Clinical Services.<br><br>Annual winter plans developed to manage increased activity. | Workforce issues create an ongoing demand/capacity imbalance.<br><br>Inability to improve current unscheduled care system due to high reliance on temporary staff.<br><br>Inability to manage within current unscheduled care capacity continues to cause problems for elective programmes of work. | Redesign of services in unscheduled care through Transforming Clinical Services Programme. | Kloer, Dr Philip | 31/03/2028 | A Healthier Mid and West Wales: Health and Care Strategy was approved by the Board in Nov18. Since approval, significant work has been undertaken to plan for the delivery phase. |
| | | Development and delivery of community wide unscheduled care plans to reduce delays in acute hospitals of medically fit patients. | Bishop, Alison | ~~31/01/2019~~ 31/03/2021 | Work progressing and is on target. USC System plans have been developed on a county level, next steps are peer review and agreement of outcome measures. |
| | | Development and delivery of 7 cluster plans to support unscheduled care. | Paterson, Jill | ~~31/12/2018~~ 31/03/2021 | Cluster plans are in place however further work is required to ensure these align to the unscheduled care strategic objectives. These are now being considered for 2019/20 to ensure they are in place by Apr19. |

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| Development and delivery of Unscheduled Care Programme including frailty plan, older people plan, Red2Green, SAFER bundles, PJ paralysis, last 1000 days. | Bishop, Alison | ~~31/01/2019~~ 31/03/2021 | Work progressing and is on target. USC System plans have been developed on a county level, next steps are peer review and agreement of outcome measures. |
| Implementation of joint work plan with Welsh Ambulance Service NHS Trust. | Teape, Joe | Completed | Completed - Advanced paramedics were in post at end of Dec18. |
| Implementation of 111 project throughout Hywel Dda. | Teape, Joe | Completed | Completed - 111 was implemented in Ceredigion and Pembrokeshire on 31st October 2018. |
| Delivery of pilot Integrated Plan for Older People in Carmarthenshire and Pembrokeshire. | Dawson, Rhian | Completed | The pilot of IPOP has been undertaken in conjunction with WG and DSU colleagues. A series of meetings and actions have been undertaken and productivity and quality changes duly made. Each county has an integrated USC plan with actions across the complete pathway. These will be presented at the Apr19 USC Board (Mar19 meeting was cancelled) and will form the basis of the actions moving forward as part of operational effectiveness. |
| Develop winter plans for 2018/19. | Teape, Joe | Completed | Winter plans presented to HDUHB Exec team and Board in Nov19. Plan shared with 3 x LA for approval, regional partnership, and WAST. Evaluation of Winter Plan 18/19 will go to Board in May19. |
| Complete bids for transformational funding through Regional Partnership Board to support implementation of TCS over next 10 years. | Jennings, Sarah | Completed | Submission successful in securing £11.9m with further opportunity for £6.1m in coming months. This will be mapped across to the annual plan ambitions to establish the impact. Groups now working on implementing three approved programmes and extra evidence for further submission of four more programmes. |
| Implementation Plan to be developed and delivered by UHB following the review on 'Amber' ambulance 999 calls | Bishop, Alison | ~~31/03/2019~~ 31/03/2021 | The USC system plan will encompass any actions to be delivered in partnership with primary care and WAST colleagues. |

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| | | Implementation of integrated plans in each county. | Bishop, Alison | 31/03/2020 | Local progress on delivery of year 1 actions will be monitored as part of the operational effectiveness group, overseen by USC Board. Each county is presenting their plan to USC Board in Apr19. Responsibility for delivery of longer term actions (over 2-5 years) needs to be clarified (USC Board or transformation groups for hospital and community). |

| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls | Latest Papers (Committee & date) | Gaps in ASSURANCES | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Performance Indicators | Sources of ASSURANCE | Type of Assurance (1st, 2nd, 3rd) | Required Assurance / Current Level | | | Identified Gaps in Assurance: | How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps | By Who | By When | Progress |
| Performance indicators for Tier 1 targets. | Daily performance data overseen by service management | 1st | | | IPAR Paper - Board 26/07/18.<br><br>A&E Waits & Evaluation of winter preparedness - QSEAC - Apr19 | Unscheduled Care Board (UCB) does not report progress against delivery plans into HB Committee structure | Bi-annual reports to BPPAC on progress on delivery plans and outcomes (and to Board via update report) | Bishop, Alison | ~~31/03/2019~~ 31/05/2019 | Papers on the evaluation of winter and the associated quality and safety risks are going to Jun19 meeting. |
| | Delivery Plans overseen by Unscheduled Care Board | 2nd | | | | | | | | |
| | Executive Performance Reviews | 2nd | | | | | | | | |
| | IPAR Performance Report to BPPAC & Board | 2nd | | | | | | | | |
| | WAST IA Report Handover of Care | 3rd | | | | | | | | |
| | 11 x Delivery Unit Reviews into Unscheduled Care | 3rd | | | | | | | | |
| | Delivery Unit Report on Complex Discharge | 3rd | | | | | | | | |

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| **Strategic Objective:** | 2 - Deliver the financial control totoal for 2019/20 by the end of March 2020 |

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| **Executive Director Owner:** | Thomas, Huw | **Date of Review:** | 10/05/2019 |
| **Lead Committee:** | Finance Committee | **Date of Next Review:** | 10/06/2019 |

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| **Risk ID:** | **735** | **Principal Risk Description:** | There is a risk of the Health Board not achieving its agreed financial plan for the 2019/20 financial year. This is caused by :<br>1. The savings plans for the year not being delivered; or<br>2. Operational cost pressures arising from the requirement to meet performance targets of quality measures. This will lead to an impact/affect the Health Board's reputation with Welsh Government and other stakeholders. |
| **Does this risk link to any Directorate (operational) risks?** | | All directorates | |

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| **Risk Rating:(Likelihood x Impact)** | ***New Risk - no trend information*** |
| **Domain:** | Finance inc. claims |
| **Inherent Risk Score (L x I):** | 4×4=16 |
| **Current Risk Score (L x I):** | 4×4=16 |
| **Target Risk Score (L x I):** | 2×4=8 |
| **Tolerable Risk:** | 6 |
| **Trend:** | *New Risk* |

| **Rationale for CURRENT Risk Score:** |
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| The Health Board has not yet fully identified the savings requirement for the year in full. There are risks which are foreseeable through the operational unscheduled care pressures in particular, especially as we enter the latter part of the year; alongside other risks such as the closure of the Aseptic Unit and the management of commissioned solutions which could lead to reduced cost pressures. |

| **Rationale for TARGET Risk Score:** |
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| The Health Board needs to demonstrate that it is able to manage its financial position effectively, cognisant of the risks which are inherent in the delivery of safe and timely care. Given the challenge in delivering the financial position this year, it is unlikely that the Health Board will achieve a risk which is in line with the tolerable risk for the year. Consequently, the target risk score exceeds the tolerable risk at this point. This is not an acceptable position, and further work is ongoing to manage this risk. |

| **Key CONTROLS Currently in Place:** (The existing controls and processes in place to manage the risk) | **Gaps in CONTROLS** | | | |
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| | **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working) | **How and when the Gap in control be addressed** Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
| Financial reports provided to directorates in a timely way, focused on trends; cost drivers; projected expenditure; risks and actions.<br><br>Turnaround Director Holding to Account meetings.<br><br>CEO Holding to Account meetings.<br><br>Executive Performance meetings.<br><br>Commissioning arrangements with key partners (Local Authorities; Care home sector; Other NHS providers; Primary Care; Third Sector). | Finance support is not currently sufficient.<br><br>Responsiveness and accountabilities need to be reinforced.<br><br>Process to become embedded and refined.<br><br>Variable arrangements, to be harmonised to enable effective | Complete outstanding appointments to key finance roles through OCP to support in understanding and developing actions. | Thomas, Huw | 30/06/2019 | Assistant DoF and Senior Finance Business Partners appointed and in post. Finance Business Partners appointed, majority in post. Band 7 & 6 appointments made. Slotting of Band 5 completed, transitional arrangements in progress over Quarter 1. |
| | | Directorates to sign accountability statements in relation to Budget 2019/20. | Thomas, Huw | 31/05/2019 | Meetings embedded in monthly business processes. Queries being resolved and will be concluded by end of May 2019. |

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| Process of review of recovery plans process in place for Month 3 and approaching of system-wide issues. | commissioning. | Review of contracting arrangements. | Thomas, Huw | 30/06/2019 | Paper regarding proposed approach to healthcare contract management discussed at Finance Committee November 2018. Team being established as part of Finance OCP - Bands 8c, 8a, 7 and 6 now in post. Regular Papers providing updates on progress timetabled into Finance Committee Agendas. |

| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls | Latest Papers (Committee & date) | Gaps in ASSURANCES | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Performance Indicators | Sources of ASSURANCE | Type of Assurance (1st, 2nd, 3rd) | Required Assurance / Current Level | | | Identified Gaps in Assurance: | How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps | By Who | By When | Progress |
| Identification and delivery of savings schemes.<br><br>Financial performance and projections reported on a monthly basis.<br><br>Breakeven recovery plans where deficits are projected.<br><br>Financial process assurances.<br><br>Internal Audit and Wales Audit | Finance dashboards | 1st | | | Month 1 Finance Report 2019/20 reports - Finance Committee - May 2019 | | | | | |
| | Finance report to Finance Committee and Board | 2nd | | | | | | | | |
| | CEO Holding to Account meetings | 2nd | | | | | | | | |
| | Financial assurance report to Audit Committee | 2nd | | | | | | | | |
| | Year-end reporting to Audit Committee | 3rd | | | | | | | | |

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| **Strategic Objective:** | 1 - Deliver the Annual Plan 2019/20 by the end of March 2020<br>5 - Deliver year 1 of the Health and Care Strategy by the end of March 2020 |

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| **Executive Director Owner:** | Gostling, Lisa | **Date of Review:** | 03/05/2019 |
| **Lead Committee:** | Quality, Safety and Experience Assurance Committee | **Date of Next Review:** | 03/06/2019 |

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| **Risk ID:** | **625** | **Principal Risk Description:** | There is a risk of the UHB being unable to deliver against (a) some Tier 1 targets set by WG and (b) to fully realise the outputs of the Transforming Clinical Services Programme. This is caused by the UHB's ability to recruit, retain and engage clinical staff (allied health professionals, nursing and medical) to meet increasing demand. This will lead to an impact/affect on patients having delays in treatment and care, increased fragility of services, adverse publicity/reduction in stakeholder confidence, increased scrutiny/escalation by Welsh Government, closer scrutiny by regulators and a reduction in the allocation of future training posts by the Deanery. |
| **Does this risk link to any Directorate (operational) risks?** | Yes | | |

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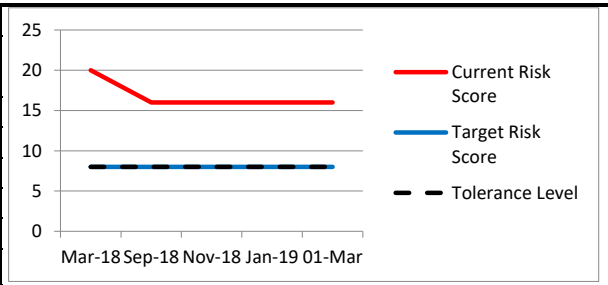
| **Risk Rating:(Likelihood x Impact)** | |
| **Domain:** | Quality/Complaints/Audit |
| **Inherent Risk Score (L x I):** | 5×4=20 |
| **Current Risk Score (L x I):** | 4×4=16 |
| **Target Risk Score (L x I):** | 2×4=8 |
| **Tolerable Risk:** | 8 |
| **Trend:** | ⟷ |




| **Rationale for CURRENT Risk Score:** |
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| The score was developed in reference to the guidance for WOD areas. The UHB's current reliance on locum and agency staff use remains higher than it would wish it to be. The fill rates for agency and locum staff however remain good. |

| **Rationale for TARGET Risk Score:** |
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| (1) Recognising the national shortages across a number of areas and our geographical area, it will take a number of years to know whether planned actions are successful in addressing the current recruitment issues. (2) There is renewed focus on retaining staff already employed by the UHB by reinforcing the values and behaviours framework and through targeted OD activities to reduce the need to recruit new staff. |

| **Key CONTROLS Currently in Place:**<br>(The existing controls and processes in place to manage the risk) | **Gaps in CONTROLS**<br>**Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working) | **How and when the Gap in control be addressed**<br>Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
|---|---|---|---|---|---|
| Continuous national recruitment programmes are ongoing in addition to bespoke recruitment campaigns.<br><br>Medical rotas sustained where possible by use of locum/agency staff through agreed frameworks such as Medacs when deemed essential.<br><br>Service workforce plans in challenged areas developed to look ahead and control risk including nursing plans produced by Heads of Nursing and plans to recruit to core trainee numbers.<br><br>Weekly workforce control panel under leadership of Director of Workforce & OD responsible for overseeing a series of workforce issues including vacancies.<br><br>Revised authorisation process for high cost temporary staff.<br><br>Bank & agency usage for all nursing areas authorisation process linked to nurse rosters | Lack of consistent focused development of leadership capability and talent amongst medical staff.<br><br>Reduced flexibility contributing to poor retention rates.<br><br>Lack of clear clinical service configuration to effectively plan future workforce. | Implement a Medical leadership forum for senior medical leaders. | Gostling, Lisa | Completed | First Medical leadership Forum held on 11.11.18 and dates and programme in place for Mar and Jul19. Further Forum planned for Nov19 which will complete the commitment of 3 days PA. |
| | | Develop and implement a leadership programme for aspiring medical leaders. | Gostling, Lisa | Completed | Cohort 1, including 20 Medical Leaders commenced on 11.1.19, programme completion by Dec19. Cohort 2 (another 20 combined leaders) commences in May19 with programme completion by Apr20. |
| | | Implement a System Level Leadership Improvement Programme aimed at triumvirate medical & nurse leaders; General Managers and Heads of Therapies/ologies. | Gostling, Lisa | Completed | Part 1 of programme for cohort 1 completed Nov18, Part 2 coaching and action learning underway and runs until Jul19. Recruitment is now complete for cohort 2 which commences in Jun19 and runs until Mar20. |

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| Leadership development programmes in place across organisation.<br><br>OD support & development in place | | Review UHB activities relating to Medical Workforce development as outlined in Together We Care and develop action plan for short (2019), medium (2022) and long term (2024) requirements. | Gostling, Lisa | 31/03/2024 | Gap analysis completed and action plan presented to Workforce & OD Sub Committee March 2019. Action plan to be implemented and progress monitored via Sub Committee |
| | | Reinforce UHB Values and Behaviours Framework through PADR process, using role models at all levels and within training programmes, e.g. Manager's Passport. | Gostling, Lisa | Completed | PADR compliance Feb19 is 77% and is currently above the NHS Wales average (68.7%). Values and behaviours are embedded into the PADR process, induction and management development programmes. Bespoke programmes also developed. |
| | | Development of action plan in response to NHS Staff Survey. | Gostling, Lisa | ~~31/03/2019~~ 28/06/2019 | Survey results received Q2 2018 and are currently being analysed from a range of lenses. Action plans will be developed at corporate, professional group and service level to address issues raised, and further improve on areas of good practice. |
| | | Develop and implement 'grow your own' schemes within different professional groups. | Gostling, Lisa | 30/12/2022 | Phase 1 in place. Ongoing programme of work. Additional pathway in development but dependent on changes in the way HE&IW commission pre-registration nurse training. Board Seminar Presentation Oct18. |
| | | Development of a robust workforce plan to deliver our defined Health and Care Strategy. | Gostling, Lisa | ~~31/03/2019~~ 31/03/2020 | Other than undertake baseline assessment of current workforce and skills, this action cannot be progressed until there is further clarity on the Health and Care Strategy. Therefore at this stage the revised date of completion is provisional and dependent on this further work being undertaken. |

| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls | Latest Papers (Committee & date) | Gaps in ASSURANCES | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Performance Indicators | Sources of ASSURANCE | Type of Assurance (1st, 2nd, 3rd) | Required Assurance / Current Level | | | Identified Gaps in Assurance: | How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps | By Who | By When | Progress |
| Retention, recruitment, leavers data. | WOD Sub Committee review of workforce information | 2nd | | | *Paper for Mar19 Workforce & | None identified | | | | |

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| Workforce KPIs. | Review of workforce KPIs, recruitment/retention data and WOD workplan by WOD Sub-Committee | 2nd | | | OD Sub Committee include updates relating to:<br>- Organisational Development<br>- Workforce Annual Plan<br>- HWCs & Audits<br>- Employee Relations Activity & trends<br>- Workforce Intelligence Report<br>- Absence Management<br>- Recruitment Update<br>- Risk Register<br>- Mandatory Training<br>- Medical Education<br>- Staff Experience<br>- Workforce | | | | | |
| | Review of workforce tier 1 performance by BPPAC and Board | 2nd | | | | | | | | |
| | Workforce Control Panel reviews series of workforce related issues eg corporate vacancies, bank & agency usage, secondments, etc | 2nd | | | | | | | | |
| | IA Mandatory Training Compliance May-16 (Reasonable) . | 3rd | | | | | | | | |
| | IA Workforce Planning May-18 (Reasonable) . | 3rd | | | | | | | | |
| | WAO Temporary Staffing Jun-17 . | 3rd | | | | | | | | |

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| **Strategic Objective:** | 1 - Deliver the Annual Plan 2019/20 by the end of March 2020 |

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| **Executive Director Owner:** | Teape, Joe | **Date of Review:** | 02/05/2019 |
| **Lead Committee:** | Business Planning and Performance Assurance Committee | **Date of Next Review:** | 02/06/2019 |

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| **Risk ID:** | **632** | **Principal Risk Description:** | There is a risk of the UHB not being able to fully comply the WG Eye Care Measures (ECMs). This is caused by a lack of identified funding and capacity to support progress with the ECM Plan. This could lead to an impact/affect on delivery of the Ophthalmology RTT delivery plan, lead to delays in the treatment and care of patients, adverse publicity/reduction in stakeholder confidence and increased scrutiny/escalation from WG. |
| **Does this risk link to any Directorate (operational) risks?** | | | |

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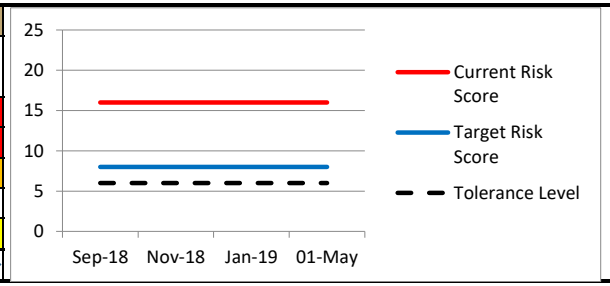
| **Risk Rating:(Likelihood x Impact)** | |
| **Domain:** | Safety - Patient, Staff or Public |
| **Inherent Risk Score (L x I):** | 5×4=20 |
| **Current Risk Score (L x I):** | 4×4=16 |
| **Target Risk Score (L x I):** | 2×4=8 |
| **Tolerable Risk:** | 6 |
| **Trend:** | ⟺ |




| **Rationale for CURRENT Risk Score:** |
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| The known number of current delays in ophthalmology follow-ups would indicate that the UHB would not currently meet the new ECM standards. |

| **Rationale for TARGET Risk Score:** |
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| The UHB aim to have a service where demand and capacity is aligned to meet the new ECM standards. |

| **Key CONTROLS Currently in Place:** (The existing controls and processes in place to manage the risk) | **Gaps in CONTROLS** | | | |
|---|---|---|---|---|
| | **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working) | **How and when the Gap in control be addressed** Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
| Eye Care Action Plan in place.<br><br>Ophthalmology RTT delivery plan in place.<br><br>Identification of delivery opportunities to reduce costs of RTT delivery (identified in RTT paper to Board 26/07/18).<br><br>Commissioning arrangements for outsourcing ophthalmology activity secured via an extension to 2017/18 contractual arrangements.<br><br>Eye Care Collaborative Group established and meet quarterly to oversee performance against eye care standards.<br><br>ECM Coordinators recruited.<br><br>WG Monitoring information from W-PAS 18.1.standards is now functional and information is being submitted | Lack of 3 year balanced plan for ophthalmology.<br><br>Lack of funding to utilise primary care to meet eye care standards.<br><br>Delay in go-live of IT systems to support shared care / remote delivery of evaluations away form Acute Sites.<br><br>Lack of investment / staffing funding to support required service developments across primary and secondary care. | Identify funding sources for ECM Coordinators and ophthalmology staff required to deliver Eye Care Plan. | Hire, Stephanie | Completed | RTT financial plan provides for partial progress with ECMs (recruitment of Ophthalmology co-ordinators) but not redirection of activity to Optometry service. |
| | | Development of a 3 year eye care plan. | Hire, Stephanie | ~~31/12/2018~~<br>28/02/2019<br>31/05/2019 | The service is undergoing a root and branch review to further develop workforce, financial, performance and quality models which are sustainable and fit for purpose. A workforce plan is being developed in discussion with both finance, planning, clinical and operational groups to include contribution to Mid Wales Plan. Two Locum Consultants have been recruited for Bronglais Hospital and are anticipated to commence by the end of Jul19 |

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| Identify funding sources to support primary care. | Hire, Stephanie | 31/05/2019 | Funding sources are under review to establish new processes with the optometric community. Welsh Government have provided project funding, however, there will be the requirement to identify sustainable funding to continue the use of this scheme beyond Mar20 |
| Development bid of £1.42million made to WG Planned Care Program to support infrastructure, staffing and IT deficits identified by the Eye Care Collaborative Group as key to the implementation of a sustainable model of care. | Hire, Stephanie | Completed | UHB received £196,117 in capital revenue to support infrastructure deficits. The service have completed the capital purchases and taken delivery of those items to support infrastructure deficits. |
| Ability to use W-PAS 18.1 to identify, monitor and report on outcomes against ECM. | Beynon, Gareth | Completed | Analysis of errors underway to isolate where data errors are occurring. Ongoing with NWIS. |
| Recruitment of ECM Coordinator | Wragg, Gordon | Completed | Successful candidate commenced in Nov18. |
| Installation of MediSIGHT software to allow for joint management of VR, Cataract, Medical Retinal and AMD patient pathways. | Tracey, Anthony | Completed | All work within the secondary care setting has been completed. Infrastructure has been built, tested and implemented, and MediSIGHT has been rolled out to the areas indicated. In terms of the community elements, VPN tokens have been allocated to the community areas identified, however a more sustainable solution for community optometrists is part of a wider work programme around the implementation of a Eye System for NHS Wales (the delivery date for this is yet to be determined). |

| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls | Latest Papers (Committee & date) | Gaps in ASSURANCES | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Performance Indicators | Sources of ASSURANCE | Type of Assurance (1st, 2nd, 3rd) | Required Assurance / Current Level | | | Identified Gaps in Assurance: | How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps | By Who | By When | Progress |
| Reduction in number of follow-ups | Monitoring arrangements by management | 1st | | | * IPAR Mth 11 - Board Mar19<br>* IPAR Mth 12 - BPPAC - Apr19<br>* EC | 3 year operational plan requires confirmation | Develop new IT reporting measures. | Hire, Stephanie | Completed | Completed - Welsh (PAS) Patient Administration System went live on 13/08/18. |
| | Executive Performance Reviews | 2nd | | | | | Identification of source of data errors. | Beynon, Gareth | Completed | Analysis of errors underway to isolate where data errors are occurring. Ongoing with NWIS. |

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| | IPAR Performance Report to BPPAC & Board | 2nd | | | Collaborative Group Meeting - Feb19 | | Root and branch review of operational, workforce and financial plans and sustainability models. | Buckingham, Carly | 31/05/2019 | Recent change in management structure has prompted a review of systems and plans to support the delivery of service. |
| | Monthly oversight by WG | 3rd | | | | | Review of management meetings and accountability structures within service. | Buckingham, Carly | 31/05/2019 | Recent change in management structure has prompted a review of systems and plans to support the delivery of service. |

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| **Strategic Objective:** | *1 -Deliver the Annual Plan 2019/20 by the end of March 2020* |

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| **Executive Director Owner:** | Teape, Joe | **Date of Review:** | 30/04/2019 |
| **Lead Committee:** | Business Planning and Performance Assurance Committee | **Date of Next Review:** | 15/05/2018 |

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|---|---|---|---|
| **Risk ID:** | **291** | **Principal Risk Description:** | There is a risk of patients having poorer outcomes and increased mortality due to the lack of access to mechanical clot retrieval services (thrombectomy). This is caused by thrombectomy services being withdrawn by Cardiff and Vale Health Board due to a lack of interventional neuroradiologists. This will lead to an impact/affect on increased mortality rates, increased dependency of patients and an inability to access a National Institute for Health and Care Excellence (NICE) approved intervention within 5 hours of onset of stroke symptoms. |
| **Does this risk link to any Directorate (operational) risks?** | | | |

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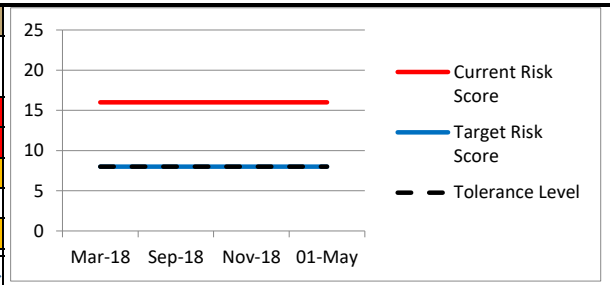
| **Risk Rating:(Likelihood x Impact)** | |
| **Domain:** | Quality/Complaints/Audit |
| **Inherent Risk Score (L x I):** | 4×4=16 |
| **Current Risk Score (L x I):** | 4×4=16 |
| **Target Risk Score (L x I):** | 2×4=8 |
| **Tolerable Risk:** | 8 |
| **Trend:** | ⟷ |




**Rationale for CURRENT Risk Score:**

The Cardiff and Vale service has been restarted, although access for patients of other Health Boards remains on an ad hoc basis, dependent upon capacity. WHSSC are working to bring online a new service in Bristol in support of the Cardiff and Vale service. This is planned to be made available in May 2019 but is pending confirmation from WHSSC.

Despite discussions with the Royal Stoke Hospital, North Bristol Hospital, the Walton Centre and QE Birmingham, Hywel Dda have been unable to make alternative arrangements for directly commissioned thrombectomy services for its patients.

Although a theoretical 10% of ischaemic strokes are suitable for mechanical clot retrieval, the numbers of suitable patients presenting within Hywel Dda are far less than this. It is suggested that around 30 patients per year would be suitable, but would require very rapid transport and diagnostics to be considered as realistic candidates for thrombectomy at either Cardiff or Bristol.

**Rationale for TARGET Risk Score:**

The uncertainty surrounding the changes proposed in the Transforming Clinical Services programme have a significant impact upon the development of acute and hyper acute services within the UHB. Thrombectomy services continue to be sought and escalated with English Neuroscience units until the Cardiff and Vale service is reinstated and the instigation of a WHSSC commissioned service with North Bristol NHS Trust.

**Key CONTROLS Currently in Place:**

(The existing controls and processes in place to manage the risk)

| **Gaps in CONTROLS** | | | | |
|---|---|---|---|---|
| **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working) | **How and when the Gap in control be addressed** Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |

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| Re-commencement of thrombectomy services in Cardiff and Vale Health Board, dependent upon capacity<br><br>WHSSC currently putting in place a service in North Bristol which is planned to be in place by May 2019 and will support the Cardiff and Vale service | Timely investigations that are required to support transfers for thrombectomy not supported 24/7 on all sites.<br><br>Work is ongoing to ensure that CT Angiography is available in all Hywel Dda units to provide the necessary diagnostic investigations prior to transfer to a specialist neuroscience centre. | Develop and review the Thrombectomy pathway, throughout the Health Board. | Mansfield, Simon | Completed | Review of thrombectomy pathway undertaken, no facility to procure ad hoc services from North Bristol or Stoke. National Stroke Implementation Group have worked with WHSSC to commission an all Wales Thrombectomy service with North Bristol NHS Trust for Welsh patients. |
| | | Development of pathway and protocols for the referral of stroke patients within each of the Hywel Dda Acute Hospitals to suitable neuroscience in England. | Mansfield, Simon | Completed | Briefing paper and protocols developed for the direct commissioning of ad hoc thrombectomy services from English Neuroscience units. |
| | | Negotiate short-term commissioning arrangements with neuroscience units. | Teape, Joe | Completed | Completed - however unable to secure new commissioning arrangements whilst WHSSC work to commission all Wales service |
| | | Work with WHSSC to ensure all Wales thrombectomy service is commissioned | Teape, Joe | ~~31/12/2018~~ 31/05/2019 | WHSCC are in the process of negotiating provision of all Wales service with North Bristol NHS Trust |

| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls | Latest Papers (Committee & date) | Gaps in ASSURANCES | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Performance Indicators | Sources of ASSURANCE | Type of Assurance (1st, 2nd, 3rd) | Required Assurance / Current Level | | | Identified Gaps in Assurance: | How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps | By Who | By When | Progress |
| Datix incident reports. | Daily/weekly/monthly/ monitoring arrangements by management | 1st | | | Thrombectomy Report - ET - Sep17. | | | | | |
| | Executive Performance Reviews | 2nd | | | | | | | | |
| | IPAR Performance Report to BPPAC & Board | 2nd | | | | | | | | |
| | Stroke Delivery Group review of patient cases . | 2nd | | | | | | | | |

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| **Strategic Objective:** | 1 - Deliver the Annual Plan 2019/20 by the end of March 2020<br>5 - Deliver year 1 of the Health and Care Strategy by the end of March 2020 |

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| **Executive Director Owner:** | Teape, Joe | **Date of Review:** | 07/05/2019 |
| **Lead Committee:** | Quality, Safety and Experience Assurance Committee | **Date of Next Review:** | 07/06/2019 |

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| **Risk ID:** | **686** | **Principal Risk Description:** | There is a risk of that the UHB will be unable to fully deliver Transforming Mental Health (TMH) Programme by 2023. This is caused by a number of key challenges, specifically the securing of £17m capital to implement TMH, potentially increased revenue costs from newer buildings, limited capital resources to fund implementation of both TMH and HCS, potential delays from co-production with service users, staff and key stakeholders, understanding of IT requirements, and adequate programme support. This could lead to an impact/affect on the UHB's ability to meet the rising demand on mental health services, meeting service users' expectations, recruitment and retention of professional staff, and result in adverse publicity/reduction in stakeholder confidence and increased scrutiny from regulators. |
| **Does this risk link to any Directorate (operational) risks?** | | | |

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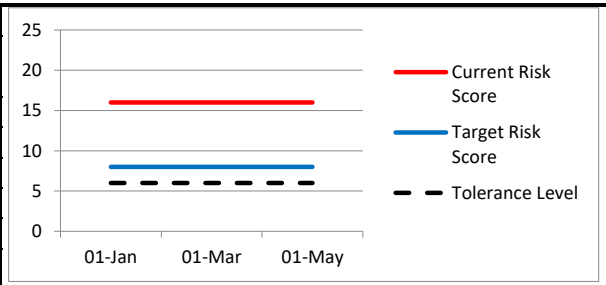
| **Risk Rating:(Likelihood x Impact)** | |
| **Domain:** | Service/Business interruption/disruption |
| **Inherent Risk Score (L x I):** | 5×4=20 |
| **Current Risk Score (L x I):** | 4×4=16 |
| **Target Risk Score (L x I):** | 2×4=8 |
| **Tolerable Risk:** | 6 |
| **Trend:** | ⟺ |




**Rationale for CURRENT Risk Score:**

Delivery of TMH is critical to the UHB's ability to manage the increasing demand on mental health services and improving recruitment and retention in key professional groups. Whilst there are work streams in place to identify keys risks and issues, the delivery of TMH is reliant on a significant amount of capital. Capital resources are limited and there is a risk that some elements of TMH may need to align with the UHB's Transforming Clinical Services programme which could result in a delay in the overall delivery of TMH. Capital is also dependent on the UHB demonstrating that it will be able to manage the increasing revenue costs associated with the increasing demand on services since the development of the TMH.

**Rationale for TARGET Risk Score:**

The Mental Health and Learning Disabilities Directorate has completed a consultation in respect of a revised service model which should reduce the reliance on our inpatient services. Delivery of the TMH programme within the timescales agreed by Board is dependent on securing the required capital and programme support therefore the target score reflects the uncertainty associated with both these requirements.

| **Key CONTROLS Currently in Place:** (The existing controls and processes in place to manage the risk) | **Gaps in CONTROLS** | | | |
|---|---|---|---|---|
| | **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working) | **How and when the Gap in control be addressed** Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
| Open commitment and mandate from the Board on the implementation of the TMH Programme. Board approved implementation plan (Jan18).<br><br>Mental Health Implementation Group established to oversee delivery of the TMH Implementation Programme.<br><br>Established work streams in place for Pathway and Access Design, Workforce and Cultural Change, Transport, and Estates and infrastructure, IT, Partnerships & Commissioning and Data & Evaluation. | Lack of dedicated Programme Director and adequate programme support.<br><br>Lack of agreed capital investment which is dependent on a balanced revenue position which will be able to address estates, IT and infrastructure requirements. | Establishment of additional workstreams for Partnerships and Commissioning, IT and Data Evaluation. | Jones, Richard | Completed | Additional work streams now in place. |
| | | Further development of the Communications and Engagement Plan to support delivery phase of TMH. | Jones, Richard | Completed | Progressing and will remain a working document throughout implementation. |
| | | Develop a programme business case to secure required capital allocation (currently estimated at £15m) to deliver TMH. | Jones, Richard | ~~30/04/2019~~ 30/06/2019 | Business case writers appointed. Business case in progress and expected to be finalised by end of Jun19. |

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| | Competing demand for capital with Transforming Clinical Services Programme. | Secure additional programme management support to the programme. | Jones, Richard | ~~31/01/2019~~ 30/04/2019 30/07/2019 | New programme resources have been allocated. Posts out to advert for new PMs and administration support. Further detail around clinical support and service user/carer input being finalised. |
| | | TMH programme fully aligned with TCS to ensure that risk of delays to TMH developments are minimised and opportunities for support are maximised. | Jones, Richard | Completed | TMH now formally sits and reports as one of three arms of the delivery of the new healthcare strategy. |

| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls) | Latest Papers (Committee & date) | Gaps in ASSURANCES | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Performance Indicators** | **Sources of ASSURANCE** | **Type of Assurance (1st, 2nd, 3rd)** | **Required Assurance / Current Level** | | | **Identified Gaps in Assurance:** | **How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps** | **By Who** | **By When** | **Progress** |
| N/A | Work streams report progress, key risks and issues to MHIG | 1st | | | * TMH Progress Report - Board - Sep18&Nov18<br>* HOS reports - MHQSESC - Sep18<br>* MHLAC Update - Board - Jul18<br>* TMH update - Planning Subcommittee - Nov18 | No gaps identified. | | | | |
| | TMH Plan is monitored by TMH Implementation Group and Planning Sub-Committee, and to Board every 6 months | 2nd | | | | | | | | |

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| **Strategic Objective:** | 1 - Deliver the Annual Plan 2019/20 by the end of March 2020 |

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| **Executive Director Owner:** | Teape, Joe | **Date of Review:** | 03/05/2019 |
| **Lead Committee:** | Quality, Safety and Experience Assurance Committee | **Date of Next Review:** | 03/06/2019 |

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| **Risk ID:** | **684** | **Principal Risk Description:** | There is a risk of radiology service provision from breakdown of key radiology imaging equipment (specifically MRI in WGH and BGH, fluoroscopy room in GGH, insufficient CT capacity UHB-wide and the general rooms in PPH) and generally a poor image quality offering to all patients. This is caused by equipment not being replaced in line with RCR (Royal College of Radiographers) and other guidelines. This could lead to an impact/affect on patient flows resulting from delays in diagnosis and treatments, delays in discharges, increased waiting times on cancer pathways and increased staffing costs to minimise the impact on patients when breakdowns occur. |
| **Does this risk link to any Directorate (operational) risks?** | 644 | | |

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|---|---|
| **Risk Rating:(Likelihood x Impact)** | ***No trend information available*** |
| **Domain:** | Service/Business interruption/disruption |
| **Inherent Risk Score (L x I):** | 5×4=20 |
| **Current Risk Score (L x I):** | 4×4=16 |
| **Target Risk Score (L x I):** | 2×3=6 |
| **Tolerable Risk:** | 6 |
| **Trend:** | *New risk* |

| **Rationale for CURRENT Risk Score:** |
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| The UHB's stock of imaging equipment routinely breaks down causing disruption to diagnostic imaging services across all sites which has a significant impact on the UHB's ability to meet its RTT target and impact to patients can include delays in diagnosis and treatment. Presently equipment downtime can be up to a week which can put significant pressures on all diagnostic services. |

| **Rationale for TARGET Risk Score:** |
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| With more modern equipment, breakdowns will be less likely and less significant in terms of downtime together with a reduced impact on the diagnostic services at the remaining hospital sites. Improved business continuity plans will also help reduce the impact of equipment breakdown across the UHB. |

| **Key CONTROLS Currently in Place:** (The existing controls and processes in place to manage the risk) | **Gaps in CONTROLS** | | | |
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| | **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working) | **How and when the Gap in control be addressed** Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
| Service maintenance contracts in place and regularly reviewed to ensure value for money is maintained.<br><br>The difficult to source spares can be obtained through bespoke manufacture but this invariably results in inherent delays in returning equipment to service.<br><br>Regular quality assurance checks (eg daily checks).<br><br>Use of other equipment/transfer of patients across UHB during times of breakdown.<br><br>Ability to change working arrangements following breakdowns to minimise impact to patients.<br><br>Site business continuity plans in place.<br><br>Disaster recovery plan in place. | Limitation of spare parts for some older equipment leading to extended outages.<br><br>Increased use of site contingency plans puts pressures on patient flows, discharges, diagnosis at other sites.<br><br>Lack of coordination between services and radiology department during service disruption. | Review and strengthen site business continuity plans with individual site leads to ensure robust response to breakdown. | Evans, Amanda | 30/06/2019 | RSM has met with planning colleagues in Feb19. Site leads in process of developing up-to-date and robust business continuity plans which will operationalise procedures following breakdowns. |
| | | Present report to executive team outlining the current situation and request support for more robust replacement programme. | Evans, Amanda | Completed | Paper presented to the Executive Team. Some further work required. |
| | | Work with planning colleagues about sourcing capital funding through DCP and AWCP. | Evans, Amanda | 30/06/2019 | Initial discussions have taken place at CEIMT Sub-Committee (Mar19). |

| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls | Latest Papers (Committee & date) | Gaps in ASSURANCES | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Performance Indicators | Sources of ASSURANCE | Type of Assurance (1st, 2nd, 3rd) | Required Assurance / Current Level | | | Identified Gaps in Assurance: | How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps | By Who | By When | Progress |
| Reduction of waiting times to under 6 weeks by Mar22.<br><br>Reduction in overtime costs to nil by Mar22. | Monthly reports on equipment downtime and overtime costs | 1st | | | Radiology Equipment SBAR - Executive Team - Mar19 | Lack of process of formal post breakdown review. | Formalise post breakdown review process to ensure lessons are learnt and improvements implemented following the most impactful breakdowns. | Evans, Amanda | 30/06/2019 | RSM has discussed with site leads and further work is underway. |
| | IPAR report overseen by BPPAC and Board bi-monthly | 2nd | | | | | | | | |
| | Internal Review of Radiology Service Report (Reasonable Rating | 3rd | | | | | | | | |
| | External Review of Radiology - Jul18 | 3rd | | | | | | | | |
| | WAO Review of Radiology - Apr17 | 3rd | | | | | | | | |

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| **Strategic Objective:** | 1 - Deliver the Annual Plan 2019/20 by the end of March 2020 |

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| **Executive Director Owner:** | Teape, Joe | **Date of Review:** | 08/05/2019 |
| **Lead Committee:** | Quality, Safety and Experience Assurance Committee | **Date of Next Review:** | 08/06/2019 |

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| **Risk ID:** | **634** | **Principal Risk Description:** | There is a risk of avoidable harm of maternity patients who require an emergency c-section (category 1) at Bronglais General Hospital (BGH) outside of normal working hours. This is caused by not being able to meet the required standard of 'call to knife' within 30 minutes as there is no overnight theatre provision located on site. This could lead to an impact/affect on complications for mother and baby resulting in long term, irreversible health effects. |
| **Does this risk link to any Directorate (operational) risks?** | | | |

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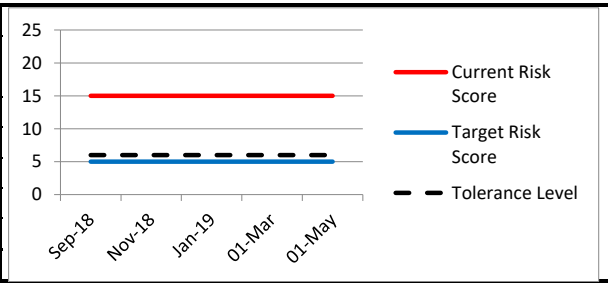
| **Risk Rating:(Likelihood x Impact)** | |
| **Domain:** | Safety - Patient, Staff or Public |
| **Inherent Risk Score (L x I):** | 3×5=15 |
| **Current Risk Score (L x I):** | 3×5=15 |
| **Target Risk Score (L x I):** | 1×5=5 |
| **Tolerable Risk:** | 6 |
| **Trend:** | ⟷ |




**Rationale for CURRENT Risk Score:**

There is currently a resident Operating Department Practitioner 24/7 at Bronglais Hospital along side a resident anaesthetic and obstetric team. The theatre scrub currently work on an on-call basis from home, which must be within 20 minutes travelling distance from the site. There is the potential for outside factors to impede timely arrival on site which are outside the control of the team which is reflected in the likelihood score of 3. While there have been no breaches of the 30 minute target it remains a potential risk which could have significant consequences. The Bronglais unit is classified as a low risk midwifery centre, with mothers assessed as being at high risk of complications during labour requiring medical intervention, being managed though the Maternity Unit in Carmarthen.

**Rationale for TARGET Risk Score:**

The UHB is aspiring to reduce this risk to the minimum by establishing a resident primary theatre team 24/7 in Bronglais Hospital to mitigate against the potential for outside factors to impact upon the delivery of care.

| **Key CONTROLS Currently in Place:** (The existing controls and processes in place to manage the risk) | **Gaps in CONTROLS** | | | |
|---|---|---|---|---|
| | **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working) | **How and when the Gap in control be addressed** Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
| Resident Operating Department Practitioners (OPD) Team<br><br>24/7 anaesthetic cover on site (obstetrician and consultant anaesthetist).<br><br>All families are informed by the Maternity Service at Bronglais Hospital of the services available at the hospital and that they will be a Continual | Not having 24/7 resident theatre team. | Establish funding for 24/7 resident theatre team. | Teape, Joe | Completed | Funding approved by Executive Team. Implementation Plan in place to be delivered by Apr19. |
| | | Advertise and appoint to expanded theatre Team following agreement on funding. | Hire, Stephanie | ~~31/03/2019~~ 30/06/2019 | Ongoing recruitment - Band 5 positions outstanding and are currently being advertised. |

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| Risk Assessment throughout pregnancy for the suitability of the Mother to deliver at BGH. Maternity staff are trained to deal with emergencies, with protocols in place for transfer out to appropriate centre is issues are identified.<br><br>Principle of removal of on-call compensatory rest approved by Executive Team. | | Agreement with theatre teams (employee relations) for removal of compensatory rest.<br><br>Formal 90 day OCP for Scrub and Band 3 circulatory staff to commence 16/01/19. | Barker, Karen | ~~30/11/2018~~ ~~30/04/2019~~ 14/06/2019 | OCP completed. Delayed start of implementation due to staffing concerns and numbers. Delayed start of implementation due to staffing concerns and numbers. Plan to commence ATOs (now fully recruited) on 24/7 roster and start either full 24/7 roster for Scrub from Mon 27 May - or hybrid of part night/part weekend (until full recruitment). Either will reduce ~~compensatory rest days for scrub~~ |
| | | E-roster build to support the new resident on call theatre team rota | Barker, Karen | ~~31/03/2019~~ ~~31/05/2019~~ 30/06/2019 | On progress for delivery by end of Jun19. |
| | | Develop a formal implementation plan for the new staffing arrangements. | Barker, Karen | ~~31/12/2018~~ ~~30/04/2019~~ 14/06/2019 | Delayed start of implementation due to staffing concerns and numbers. Plan to commence ATOs (now fully recruited) on 24/7 roster and start either full 24/7 roster for Scrub from Mon 27 May - or hybrid of part night/part weekend (until full recruitment) |

| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls) | Latest Papers (Committee & date) |
|---|---|---|---|---|---|
| **Performance Indicators** | **Sources of ASSURANCE** | **Type of Assurance (1st, 2nd, 3rd)** | **Required Assurance / Current Level** | | |
| No of incidents reported where 30 minute response target is missed. | Maternity Services governance systems review of incident reports | 1st | | | * Executive Team - Jul18<br><br>* Executive Team - Dec18 |
| | Management audit of cases presented to QSEAC | 2nd | | | |
| | Discussions with WG Chief Nursing Officer & UHB Medical & Nursing Director | 3rd | | | |

| Gaps in ASSURANCES | | | | |
|---|---|---|---|---|
| **Identified Gaps in Assurance:** | **How are the Gaps in ASSURANCE will be addressed<br>Further action necessary to address the gaps** | **By Who** | **By When** | **Progress** |
| None identified. | | | | |
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| **Strategic Objective:** | 1 - Deliver the Annual Plan 2019/20 by the end of March 2020 |

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| **Executive Director Owner:** | Teape, Joe | **Date of Review:** | 12/04/2019 |
| **Lead Committee:** | Business Planning and Performance Assurance Committee | **Date of Next Review:** | 12/05/2019 |

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| **Risk ID:** | **508** | **Principal Risk Description:** | There is a risk of harm to patients, staff and general public for failing to fully comply with the requirements of the Regulatory Reform (Fire Safety) Order 2005. This is caused by a lack of available resources in fire safety management to undertake appropriate planned preventative maintenance, risk assessments and audits. This could lead to an impact/affect on safety of patients, staff and general public, HSE investigations and enforcement, fines and/or custodial sentences, adverse publicity/reduction in stakeholder confidence. |
| **Does this risk link to any Directorate (operational) risks?** | | | |

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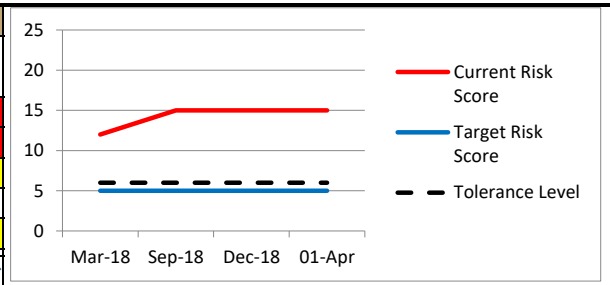
|---|---|
| **Risk Rating:(Likelihood x Impact)** | |
| **Domain:** | Safety - Patient, Staff or Public |
| **Inherent Risk Score (L x I):** | 4×5=20 |
| **Current Risk Score (L x I):** | 3×5=15 |
| **Target Risk Score (L x I):** | 1×5=5 |
| **Tolerable Risk:** | 6 |
| **Trend:** | ⟷ |




| **Rationale for CURRENT Risk Score:** |
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| Significant progress has been made since the NWSSP IA Fire Precautions Report in May 2017 to improve fire safety. Additional resources have been now been approved and posts commenced in Apr19. These posts will help to increase the pace of delivery of required improvements which will lead to an improvement in compliance and the level of fire safety in the UHB. |

| **Rationale for TARGET Risk Score:** |
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| The target score reflects the importance of fire safety and the UHB aims to have a robust system that is fit for purpose. |

| **Key CONTROLS Currently in Place:** (The existing controls and processes in place to manage the risk) | **Gaps in CONTROLS** | | | |
|---|---|---|---|---|
| | **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working) | **How and when the Gap in control be addressed** Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
| Fire Safety Policy approved Mar18 - implemented through fire training.<br><br>Fire Management Structure in place (Head of Fire Safety plus 3.8wte fire advisors).<br><br>400+ valid fire risk assessments undertaken across UHB.<br><br>Staff training programme in place with level 1 compliance at 67.41% and level 2 at 44.27% as at Jan19. Also the introduction of Managers training to ensure that managers are made fully aware of their responsibilities (These are being delivered throughout 2019). A further change is also being made to fire safety training where the merger of L1 and L2 training content will take place. | Shortfall in resources to have an effective fire safety management team which will resulting in slow progress of further improvements and inability to maintain current level of compliance.<br><br>62 fire risk assessments are currently out of date as at Apr19.<br><br>Ability to record accurate fire safety training attendance of staff within the HB and address current shortfall in | An SBAR is required to identify the issues surrounding the resource pressures faced by the Facilities Directorate regarding fire safety. This SBAR needs to set out clearly the expected number of resources for an organisation of such size and geography. | Teape, Joe | Completed | Additional resources have now been approved by executive team and can now be appointed to. Head of fire safety management has now been appointed. Fire Safety Advisor at Prince Philip Hospital now appointed with interviews for Fire Safety Advisor at Withybush scheduled for 04/03/19. |
| | | An SBAR on gaps in maintenance programme to be presented to the Executive Team. | Lewis, Mark | Completed | Paper submitted to Formal Executive Team in Oct18 and has been put forward for the IMTP 2019/20. |

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| Estate and statutory maintenance programme in place with focus on high risk in-patient facilities.<br><br>7 x local fire safety groups which report to the HB wide Fire Safety Group, which feeds into the Health and Safety & Emergency Planning Sub Committee (HSEPSC).<br><br>Prioritised plan for fire safety investment in place which tackles highest risks coming out of the risk assessments as first calling. | compliance<br><br>Lack of fire wardens to improve local fire safety awareness across UHB.<br><br>Lack of evidence of fire safety arrangements in leasehold properties used by the UHB staff.<br><br>Lower risk capital investment issues in respect of fire will remain for some time due to limited capital availability and the focus on high risk only.<br><br>Analysis of KPIs to fully ascertain PPM compliance. | Complete all outstanding high risk fire risk assessments (FRA) by April 2019 and complete all further medium and low risk fire risk assessments by August 2019. | Evans, Paul | ~~30/04/2019~~ 30/08/2019 | Significant progress has already been shown with a reduction of the out of date fire risk assessments from 110 in Feb19 to 62 by Apr19 representing a 44% decrease. Although there remain threats to achieving the targets set out in the revised time line agreed at the Feb19 HBW Fire Meeting, the current status is an improving situation. This takes into consideration the fire safety resource levels from Apr19 where the additional resources will be fully embedded. |
| | | The Fire Team and Workforce Team will undertake a joint review of the current systems used to record fire training to understand the underlying issues with accurate recording of training. | Evans, Paul | Completed | The workforce team and fire safety team have now undertaken a deep dive exercise to understand how fire training is being recorded in ESR. There has historically been discrepancies between the figures retained by the fire safety team and ESR. This has now been resolved. |
| | | Introduction of fire wardens (FSW) on every department/service across the UHB to increase fire safety awareness. | Evans, Paul | 30/11/2019 | A number of global emails requesting expressions of interest have been issued. As at Jan19 it is confirmed that circa 72 FSW's are in place across the HB in a variety of clinical and non-clinical departments and FSW's checks are being carried out. Despite this, further work still needs to be undertaken to understand the number of fire wardens required and focused effort to ensure appropriate coverage across UHB. |
| | | Obtain fire risk assessments for all leasehold properties utilised by UHB. | Evans, Paul | ~~31/03/2019~~ 31/05/2019 | Formal letter has been issued in Nov18 by the Fire Brigade on the UHB's behalf to request copies of fire risk assessments. |

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| Establish the risk to staff, patients and public in properties not owned by HB where a HB fire risk assessment has not been undertaken. | Evans, Paul | ~~31/12/2018~~ 30/04/19 | The fire safety team has now formally met with the fire brigade to discuss this issue and it has been agreed that the fire brigade will now provide the HB with a formal letter requesting information from property owners where the HB has been unable to obtain such detail. This letter will be issued by the fire safety team of the HB clearly stipulating a response time. If this action proves unsuccessful then the fire brigade may decide to put these properties onto their inspection programme. This action is being monitored by the Fire Safety Group - next meeting scheduled for Apr19. |
| Monitor the published KPI figures produced by the operational maintenance function in monthly performance meetings to assess ongoing achievements and report any discrepancies. | Evans, Paul | Completed | KPI figures for facilities information is regularly being monitored and presented at monthly performance meetings chaired by the Dir of Facilities at each of the acute sites. This information highlights any shortcomings in respect of achievement targets. Business critical and high risk PPM's remain the key focus of attention. |
| Improve mandatory fire safety training compliance to 75% by Nov19. | Evans, Paul | 30/11/2019 | Revised TNA for fire safety training to clarify training requirements for staff completed. Training awaiting uploading to the L&D staff intranet page. Fire Safety Advisors are now based on each acute hospital site who will deliver face to face training. Compliance figures reviewed bi-monthly with workforce and overseen by HS&EP Sub-committee. Directorate/Service training compliance is monitored at Executive Performance Reviews. |

**ASSURANCE MAP** | **Control RAG** | **Latest Papers** | **Gaps in ASSURANCES**

| Performance Indicators | Sources of ASSURANCE | Type of Assurance (1st, 2nd, 3rd) | Required Assurance / Current Level | Rating (what the assurance is telling you about your controls | (Committee & date) | Identified Gaps in Assurance: | How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps | By Who | By When | Progress |
|---|---|---|---|---|---|---|---|---|---|---|
| * Improve mandatory fire safety training compliance for level 1 & 2 ideally above the 75% target by Nov19.<br>* Increasing no of valid in date risk assessments to >95% by April 2019.<br>* Reduce the no of unwanted fire signals (UwFS) to Fire Brigade by 40% by end of 2018 (from 119 UwFS for 2017 period).<br>* Planned and Preventative Maintenance programme in place for high risk business critical areas with a target of >95% completion(defined by the operational maintenance | Review of compliance through fire safety groups | 2nd | | | IA Fire Precautions Report - ARAC 19/06/18.<br><br>Quarterly reports to H&S EM SC. | None identified. | | | | |
| | Compliance reports regularly issued to HSEPSC | 2nd | | | | | | | | |
| | Fire inspections by Fire Service | 3rd | | | | | | | | |
| | NWSSP fire advisor inspections | 3rd | | | | | | | | |
| | NWSSP IA Fire Precautions Follow Up May-18 - Reasonable Assurance | 3rd | | | | | | | | |

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| **Strategic Objective:** | 1 - Deliver the Annual Plan 2019/20 by the end of March 2020 |

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|---|---|---|---|
| **Executive Director Owner:** | Jervis, Ros | **Date of Review:** | 13/05/2019 |
| **Lead Committee:** | Business Planning and Performance Assurance Committee | **Date of Next Review:** | 13/07/2019 |

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|---|---|---|---|
| **Risk ID:** | **295** | **Principal Risk Description:** | There is a risk of the Health Board being unable to maintain routine & emergency service provision across the organisation in the event of a severe pandemic influenza event. This is caused by a novel influenza virus causing a pandemic as declared by the World Health Organisation (WHO) and the subsequent ability of the Health Board to respond to the scale and severity of the influenza outbreak. This could lead to an impact/affect on patients being able to access appropriate and timely treatment, the UHB being able to maintain safe and effective levels of staffing, financial loss, adverse publicity/reduction in stakeholder confidence, increased mortality and ill-health across our population. |
| **Does this risk link to any Directorate (operational) risks?** | | | |

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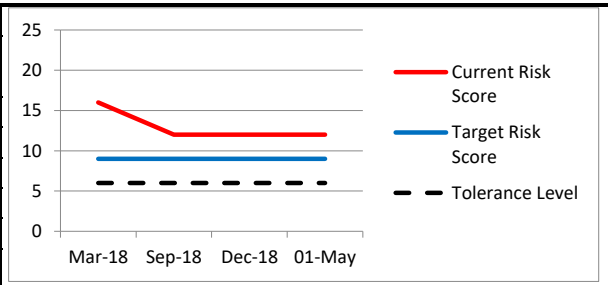
|---|---|
| **Risk Rating:(Likelihood x Impact)** | |
| **Domain:** | Service/Business interruption/disruption |
| **Inherent Risk Score (L x I):** | 4×4=16 |
| **Current Risk Score (L x I):** | 3×4=12 |
| **Target Risk Score (L x I):** | 3×3=9 |
| **Tolerable Risk:** | 6 |
| **Trend:** | ⟺ |




| **Rationale for CURRENT Risk Score:** |
|---|
| Pandemic Flu is the highest risk on the UK National Risk Register. Current likelihood scored at a 3 to reflect the risk of the Health Board being able to respond to the scale and severity of the pandemic - not the likelihood of the pandemic actually occurring. |

| **Rationale for TARGET Risk Score:** |
|---|
| Following outcome of Cabinet Office review and subsequent updating of Hywel Dda plans, in line with new and revised Welsh Government Guidance and planning assumptions, it is hoped to reduce either the likelihood and/or impact score. |

| **Key CONTROLS Currently in Place:** |
|---|
| (The existing controls and processes in place to manage the risk) |

| **Gaps in CONTROLS** | | | | |
|---|---|---|---|---|
| **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working) | **How and when the Gap in control be addressed** Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |

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| Local Resilience Forum (LRF) multi-agency plans for managing pandemic influenza (updated in accordance with current data and approved by Strategic LRF 14/11/18).<br><br>LRF Excess Deaths Plan (which supports the LRF multi-agency pandemic influenza management arrangements) developed as a recommendation from Exercise Cygnus. Plan was ratified by the LRF Strategic Group on 11/07/2018.<br><br>Health Board Pandemic Influenza Response Framework and associated plans (currently outdated awaiting review).<br><br>Quality assurance process via national & local exercise programmes.<br><br>Access to national counter measures stockpile.<br><br>Welsh Government Pandemic Influenza Guidance and National Pandemic Flu Service.<br><br>Hywel Dda participation in Welsh Government Pandemic Influenza Group. | Current Health Board pandemic framework will need to updated to incorporate new Cabinet Office review implications/recommendations however Pan Flu agenda and Cabinet Office review still delayed due to refocus of key staff to Brexit agenda at Cabinet Office and Welsh Governments levels. | Reinstate local Pan Flu Group to enact Cabinet Office Review implications (originally due Sept 2018) and develop ongoing work programme. | Hussell, Sam | ~~12/01/2018~~<br>31/03/2019<br>31/12/2019 | First meeting held on 09 Oct 2018. Workshop to be scheduled once Cabinet Office (CO) review is published (CO review currently delayed due to Brexit focus). |

| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls | Latest Papers (Committee & date) | Gaps in ASSURANCES | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Performance Indicators | Sources of ASSURANCE | Type of Assurance (1st, 2nd, 3rd) | Required Assurance / Current Level | | | Identified Gaps in Assurance: | How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps | By Who | By When | Progress |
| | Reports to Health & Safety and Emergency Planning Sub-Committee | 2nd | | | No recent reports. | | | | | |
| | Emergency Planning Action Group (EPAG) Wales meetings re Pandemic Flu | 2nd | | | | | | | | |
| | NHS Wales wide workshops | 3rd | | | | | | | | |
| | LRF Cygnus Test of plans | 3rd | | | | | | | | |
| | Reviewed LRF Pandemic Flu Plan | 3rd | | | | | | | | |

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| **Strategic Objective:** | *1 -Deliver the Annual Plan 2019/20 by the end of March 2020* |

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|---|---|---|---|
| **Executive Director Owner:** | Teape, Joe | **Date of Review:** | 01/05/2019 |
| **Lead Committee:** | Quality, Safety and Experience Assurance Committee | **Date of Next Review:** | 01/07/2019 |

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| **Risk ID:** | **384** | **Principal Risk Description:** | There is a risk of avoidable non-compliance with statutory and implied statutory standards where medical devices are concerned. This is caused by inadequate management of systems and the supporting governance in medical device management plus equipment not being maintained in accordance with manufacturers' instructions. This could lead to an impact/affect on overall treatment or suboptimal services with a potential impact of reputational harm and regulatory enforcement. |
| **Does this risk link to any Directorate (operational) risks?** | | | |

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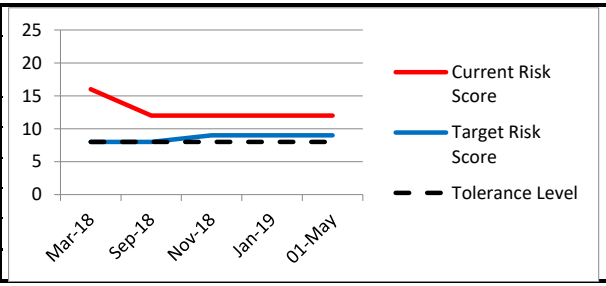
|---|---|
| **Risk Rating:(Likelihood x Impact)** | |
| **Domain:** | Statutory duty/inspections |
| **Inherent Risk Score (L x I):** | 4×4=16 |
| **Current Risk Score (L x I):** | 3×4=12 |
| **Target Risk Score (L x I):** | 3×3=9 |
| **Tolerable Risk:** | 8 |
| **Trend:** | ⟷ |




**Rationale for CURRENT Risk Score:**

The Medical Device Policy is approved however needs operationalising. There have been issues regarding medical devices governance resulting in clinical incidents. OCP (Organisational change Policy) to be concluded within Clinical Engineering in order to take remaining actions forward.

**Rationale for TARGET Risk Score:**

The UHB needs to safeguard staff and patients against medical devices issues and improve its systems and governance. Given the number devices within the UHB, there is a probability that an adverse event will happen from time to time however the planned actions and focus on high risk devices should mean that enforcing authorities will see the merits of the systems that have been developed to protect patients and staff safety.

| **Key CONTROLS Currently in Place:** (The existing controls and processes in place to manage the risk) | **Gaps in CONTROLS** | | | |
|---|---|---|---|---|
| | **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working) | **How and when the Gap in control be addressed** Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
| Medical and Non-Medical Devices Control Group reviewing performance.<br><br>HSE Action Plan is nearing completion.<br><br>Management information including regular reports provided for scrutiny.<br><br>Identification of devices and categorisation and inventory refresh complete and new database procured and commissioned.<br><br>System review processes operating to ensure missed inspections are not allowed to go unchecked.<br><br>5 tier risk stratification system developed for Health Board device holding which facilitates high risk devices targeted for first attention.<br><br>Increased capital allocation has been realised | Non-implementation of Medical Device Policy.<br><br>Lack of capital resources to address backlog of Equipment.<br><br>Medical Devices Safety Officer issue to be resolved.<br><br>Resolution to current alert system remains outstanding.<br><br>Community and managed practices devices remain elusive to achieving a complete inventory. However these items have been established as presenting low risk to those in | Implement Medical Devices Action Plan (inc development of inventory, categorisation of incidents) - delivery is monitored by Medical Devices Control Group. | Rees, Gareth | ~~30/04/2019~~ 07/01/2019 | Good progress can be evidenced with only two key actions remaining to be implemented by Jul19 - 1. Resolution to current alert system remains outstanding. 2. OCP to be concluded within Clinical Engineering in order to take remaining actions forward. |
| | | Operations Priorisation System and Programme in place which feeds into annual capital planning process. | Rees, Gareth | Completed | Completed. |
| | | Review Medical Devices Assurance Group which reports to Operational QSE Sub-Committee to improve reporting of assurance. | Rayani, Mandy | Completed | This has been resolved and the Medical Devices group now formally reports to Operational QSE Sub-Committee with escalation to QSEAC. |

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| Increased capital allocation has been realised.<br><br>Strategic replacement plan for the Health Board's medical device holding now in place and servicing capital decision making.<br><br>Improved ultrasound governance in place.<br><br>Training Needs Analysis has been undertaken in conjunction with L&D Team.<br><br>Servicing and inspection capacity restored to 2015 levels in clinical engineering.<br><br>Broader control over all aspects of all aspects of medical device management to include pathology, radiology and estates now in place. | presenting low risk to those in existence on the acute inventories.<br><br>Further work required on Ultrasound Governance training and competence user requirements.<br><br>Further work required on Pathology inventory. | Establish Information Governance requirements for medical devices. | Rees, Gareth | Completed | List of all equipment that holds PII or connects to the internet has now been forwarded to the IG team. |
| | | Agree current Medical Device alert system to be implemented. | Rayani, Mandy | ~~30/04/2019~~ 07/01/2019 | Resolution to current Medical Device alert system remains outstanding. Meeting has taken place with the Patient Safety team and agreement has been reached on opting for the ECRI system. Unable to secure £9K PA recurrent funding. Further discussion required on funding arrangements. |

| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls) | Latest Papers (Committee & date) | Gaps in ASSURANCES | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Performance Indicators** | **Sources of ASSURANCE** | **Type of Assurance (1st, 2nd, 3rd)** | **Required Assurance / Current Level** | | | **Identified Gaps in Assurance:** | **How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps** | **By Who** | **By When** | **Progress** |
| Maintain accuracy level at >95% items on Medical Devices inventory.<br><br>Performance data from Planned Preventative Maintenance set out in IPAR.<br><br>Performance data reported to control Medical Device Group.<br><br>Incident reports relating to medical devices. | Internal Management Review 2018 | 1st | | | * Update on Medical Devices Management - QSEAC - Aug18<br><br>* Medical Devices Assurance Group Update - Operational QSE Sub Committee- Nov18<br><br>*IPAR Month12 - BPPAC - Apr19 | Limited assurance has been secured via previous assurance committee. | Review Medical Devices Assurance Group which reports to Operational QSE Sub-Committee to improve reporting of assurance. | Rayani, Mandy | Completed | This has been resolved and the Medical Devices Group now formally reports to Operational QSE Sub-Committee with escalation to QSEAC. |
| | Medical and Non-Medical Devices Control Group reviewing performance data | 2nd | | | | | | | | |
| | Oversight of incidents by Health & Safety & Emergency Planning Sub-Committee | 2nd | | | | | | | | |
| | PPM Performance reviewed by Medical Devices Assurance Group (which reports to Operational QSE Sub-Committee | 2nd | | | | | | | | |
| | PPM Performance on medical devices reported in IPAR to BPPAC and Board | 2nd | | | | | | | | |
| | HSE Improvement notices | 3rd | | | | | | | | |

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| **Strategic Objective:** | 1 - Deliver the Annual Plan 2019/20 by the end of March 2020 |

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|---|---|---|---|
| **Executive Director Owner:** | Teape, Joe | **Date of Review:** | 20/03/2019 |
| **Lead Committee:** | Quality, Safety and Experience Assurance Committee | **Date of Next Review:** | 20/05/2019 |

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|---|---|---|---|
| **Risk ID:** | **44** | **Principal Risk Description:** | There is a risk of harm to patients on follow up waiting lists who have exceeded their follow up date. This is caused by the high number of patients on the follow up lists, the lack of capacity to review these patients in clinics, the lack of a sustainable plan to decrease the number of patients on follow up lists, the availability of clinical, OPD staffing and clinic space, the requirement to review clinical pathway management on W-PAS, and the necessity to rebalance patient pathways across primary and secondary care. This could lead to an impact/affect on the ability to meet follow up waiting times across all scheduled care specialties, poorer outcomes for patients, increased complaints, litigation and reputational harm. |
| **Does this risk link to any Directorate (operational) risks?** | 180 | | |

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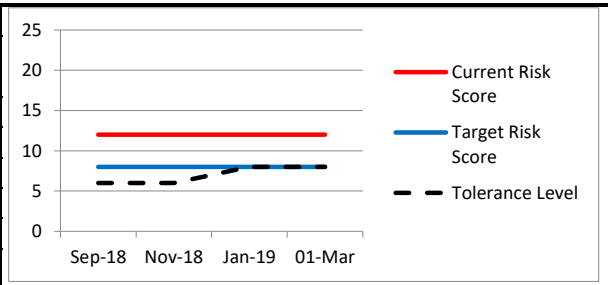
|---|---|
| **Risk Rating:(Likelihood x Impact)** | |
| **Domain:** | Safety - Patient, Staff or Public |
| **Inherent Risk Score (L x I):** | 4×4=16 |
| **Current Risk Score (L x I):** | 3×4=12 |
| **Target Risk Score (L x I):** | 2×4=8 |
| **Tolerable Risk:** | 6 |
| **Trend:** | ⟺ |




| **Rationale for CURRENT Risk Score:** |
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| It is acknowledged that too many patients experience lengthy delays in receiving their follow-up care and that significant improvement work is required to improve patient experience and reduce the potential for clinical harm to patients who experience delays. An improvement plan has been implemented under the Outpatient Improvement Group and Patient Pathway Management Group. The year-on-year growth in the number of patients experiencing a delay in follow-up review has been halted in 2018/19, with a reduction in the total number to patients awaiting a follow-up appointment beyond their target date has reduced by 800 between Nov18-Jan 19. |

| **Rationale for TARGET Risk Score:** |
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| The clinical risk for long-term condition patients remains high for all patients if they are not reviewed / seen in line with clinical follow-up intervals. |

| **Key CONTROLS Currently in Place:** (The existing controls and processes in place to manage the risk) | **Gaps in CONTROLS** | | | |
|---|---|---|---|---|
| | **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working) | **How and when the Gap in control be addressed** Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
| The programme of work underway within the Health Board is focussing on a number of key stages, urology and cancer.<br><br>Admin validation, cleaning up the waiting lists and removing obvious duplicate entries or patients that have been seen and the pathway not closed. | Variations in practice in application of access policy.<br><br>Duplicate patient pathways creating inaccurate waiting list. | Review of Myrddin to ensure that the system is able to identify sub-specialties and clinical conditions within the waiting list. | Hire, Stephanie | Completed | Subspecialty and clinical conditions set up in some specialties, work on-going. |
| | | Redesign of services through IMTP planning to reduce capacity gap | Hire, Stephanie | 31/03/2020 | Service transformation plans being prioritised via Planned Care IMTP. |

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| Engaging Clinical Leads for each specialty in the prioritisation of their patients and the identification of those most at risk of harm.<br><br>Specialty Service Delivery Manager (SDM) and clinical lead have identified patients on their follow up list who might be at risk.<br><br>Lessons learned from SUI / adverse events / complaints relating to delayed care shared through Directorate QSE meetings. | Workforce issues create an on-going demand/capacity imbalance.<br><br>High new/follow up ratio. | Efficiency & productivity work streams for all teams to reduce ratios to levels comparable to other Health Boards. | Hire, Stephanie | 31/03/2020 | Target performance set for all specialties and monitored through Transformation Workstream governance. A significant increase in the total number of patients delayed year to date has been avoided with an overall increase since Apr18 of 1.6%. The number of patients delayed in the 0%-25%, 26%-50% and 51%-100% delayed categories show an overall reduction year-to-date which indicates that improvement work to change follow-up practice in various specialties is having a positive effect. |
| | | Pathway management training to ensure that all staff groups are trained in the application of the RTT / Access Policy and WPAS usage. | Jones, Keith | 31/03/2020 | Project plan developed to role out the bespoke training has been developed for different staff groups. |
| | | Clinical Validation: Clinical time to be established in Job Planning to support protected validation time. | Hire, Stephanie | 31/03/2020 | Part of the Medical Job Planning exercise undertaken by Service Development Managers within Planned Care. |
| | | Clinical Outcomes: monitoring of outcome reporting against guidelines and recording of clinical condition to support pathway management. | Jones, Keith | 31/03/2020 | Work programme overseen by the Outpatient Improvement Group to support appropriate pathway management. |
| | | Development and implementation of Clinical Guidance for discharge. | Hire, Stephanie | 31/03/2020 | Pilot undertaken in Gynaecology to support detailed audit of follow-up practice in order to establish agreed practice for follow-up / discharge. Implementation under way in Respiratory and Paediatrics. |
| | | Development and implementation of Self-Management strategies as alternatives to traditional clinic based follow-up reviews. | Jones, Keith | 31/03/2020 | Longer term strategy of self management and digital transformation to develop alternative ways to follow up patients. Opportunities are begin assessed by the Outpatient Improvement Group for project planning. |
| | | Implementation of WG National Planned Care Programme (PCP). | Jones, Keith | 31/03/2020 | National project / guidance are being implemented under the PCP for ENT, Ophthalmology, Urology & Orthopaedics to support appropriate follow-up care. |

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| | | | | Development and agreement of a strategy and programme of work to reduce delays in follow-up care. | Hire, Stephanie | Completed | Presented to BPPAC in Feb19. |

| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls) | Latest Papers (Committee & date) | Gaps in ASSURANCES | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Performance Indicators | Sources of ASSURANCE | Type of Assurance (1st, 2nd, 3rd) | Required Assurance / Current Level | | | Identified Gaps in Assurance: | How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps | By Who | By When | Progress |
| | Watchtower meetings are held weekly to review all patient waits | 1st | | | * IPAR Report Month 9 - Board - Jan19<br><br>* IPAR Report Month 10 - BPPAC - Jan19<br><br>* Delayed Follow Up Improvement Plan 19/20 - BPPAC - Feb19 | None identified to date | | | | |
| | Ophthalmology ECM specifically report compliance with the follow up intervals | 1st | | | | | | | | |
| | Outpatients Turnaround Group reviewing levels of follow-up | 2nd | | | | | | | | |
| | Planned Care Programme Board (WG) reviewing HB implementation of PCP | 3rd | | | | | | | | |
| | Scrutiny of FUNB forms part of the Delivery Unit remit for scrutiny | 3rd | | | | | | | | |

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| **Strategic Objective:** | *1 -Deliver the Annual Plan 2019/20 by the end of March 2020* |

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|---|---|---|---|
| **Executive Director Owner:** | Kloer, Dr Philip | **Date of Review:** | 21/03/2019 |
| **Lead Committee:** | Quality, Safety and Experience Assurance Committee | **Date of Next Review:** | 21/05/2019 |

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| **Risk ID:** | **631** | **Principal Risk Description:** | There is a risk of the UHB failing to recognise increasing mortality rates. This is caused by a lack of consistent mortality review process across the UHB. This could lead to an impact/affect on missed opportunities to reduce avoidable deaths and improve clinical outcomes. |
| **Does this risk link to any Directorate (operational) risks?** | | | |

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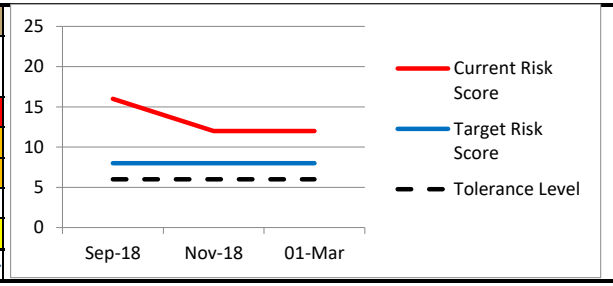
|---|---|
| **Risk Rating:(Likelihood x Impact)** | |
| **Domain:** | Safety - Patient, Staff or Public |
| **Inherent Risk Score (L x I):** | 4×4=16 |
| **Current Risk Score (L x I):** | 3×4=12 |
| **Target Risk Score (L x I):** | 2×4=8 |
| **Tolerable Risk:** | 6 |
| **Trend:** | ⟷ |




**Rationale for CURRENT Risk Score:**

Mortality review process is not sufficiently consistent across the UHB. A new process for stage 1 reviews has now been implemented across all acute sites. The Health board is now achieving 85% compliance to meet the 28 day target for mortality reviews. Learning from mortality reviews is not sufficiently embedded in the HB processes which risks learning from the reviews not being acted upon. The risk is maintained at 12 as the Stage 1 review process has been standardised across the Health Board, however more consistency is needed around developing themes and learning from reviews which will be taken forward by the newly established Mortality Review Group by end of Apr19

**Rationale for TARGET Risk Score:**

The newly established mortality review group will report to the Effective Clinical Practice Sub-Committee and is planning on agreeing a new standardised process for stage 2 process at its meeting in Apr19 for implementation in early Summer 2019.

| **Key CONTROLS Currently in Place:** (The existing controls and processes in place to manage the risk) | **Gaps in CONTROLS** | | | |
|---|---|---|---|---|
| | **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working) | **How and when the Gap in control be addressed** Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
| Stage 1 reviews are a standardised process across all sites in the Health Board | 28 day review target not consistently being met. | New review process put in place at PPH and GGH to mirror that already in BGH and WGH. | Davies, Mandy | Completed | Completed. |
| Learning from mortality review learning shared at Whole Hospital audit Meetings. | WHAMs not always well attended and themes too general to embed learning. | Each specialty to implement quality and safety meetings with mortality as a standing item. | Brown, Dr Ceri | ~~31/03/2019~~ 30/06/2019 | Discussions initiated with specialties. |
| Stage 2 mortality reviews are in place on all sites however is being reviewed and standardised. | Learning and key themes from stage 2 reviews need to be discussed by clinical teams. | Action plans to be developed by each clinical team that address areas identified in stage 2 reviews. | Brown, Dr Ceri | ~~31/03/2019~~ 30/06/2019 | Work to be commenced in 2019. |
| | Lack of trend analysis of mortality reviews. | Establish clear links with Datix system re stage 2 reviews to improve learning from mortalities and trends. | Davies, Mandy | Completed | Mortality Review Group has been established to drive the mortality review process. This group will identify improved processes to the stage 2 review including developing the links with Datix. |

| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls | Latest Papers (Committee & date) | Gaps in ASSURANCES | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Performance Indicators | Sources of ASSURANCE | Type of Assurance (1st, 2nd, 3rd) | Required Assurance / Current Level | | | Identified Gaps in Assurance: | How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps | By Who | By When | Progress |
| No. of stage 1 mortality reviews undertaken in 28 days.<br><br>No. of stage 2 mortality reviews undertaken.<br><br>No of Datix incident reports. | Mortality reviews | 1st | | | | Lack of formal process for addressing concerns from stage 2 reviews. | Standardised method of reporting of Stage 2 reviews to be agreed by the Mortality Review Group | Davies, Mandy | ~~31/01/2019~~ 30/06/2019 | The newly established Mortality Review Group will be looking to improve the process around Stage 2 reviews. |
| | IPAR reviewed by BPPAC/PMAF Reviews | 2nd | | | | | | | | |
| | Each specialty to have established a quality and safety forum with mortality reviews as a standing agenda item | 2nd | | | | | | | | |
| | Quality improvement meetings with WG | 3rd | | | | | | | | |

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| **Strategic Objective:** | 1 - Deliver the Annual Plan 2019/20 by the end of March 2020 |

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|---|---|---|---|
| **Executive Director Owner:** | Teape, Joe | **Date of Review:** | 15/04/2019 |
| **Lead Committee:** | Business Planning and Performance Assurance Committee | **Date of Next Review:** | 15/06/2019 |

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|---|---|---|---|
| **Risk ID:** | **633** | **Principal Risk Description:** | There is a risk of the UHB not being able to meet the anticipated waiting time target for the new Single Cancer Pathway by the confirmed shadow reporting implementation date of August 2019.(SCP Performance targets tbc). This is caused by the lack of capacity to meet expected increase in demand for diagnostics. This could lead to an impact/affect on meeting patient expectations in regard to timely access for appropriate treatment, adverse publicity/reduction in stakeholder confidence and increased scrutiny/escalation from WG. |
| **Does this risk link to any Directorate (operational) risks?** | | | |

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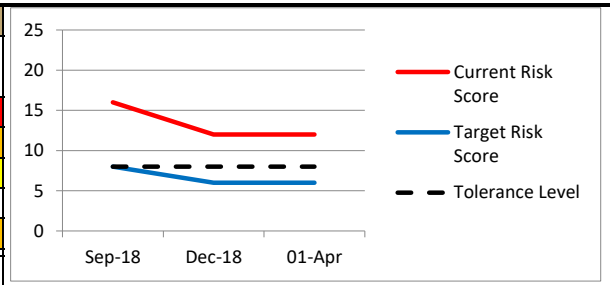
|---|---|
| **Risk Rating:(Likelihood x Impact)** | |
| **Domain:** | Quality/Complaints/Audit |
| **Inherent Risk Score (L x I):** | 4×4=16 |
| **Current Risk Score (L x I):** | 4×3=12 |
| **Target Risk Score (L x I):** | 3×2=6 |
| **Tolerable Risk:** | 8 |
| **Trend:** | ⟷ |




| **Rationale for CURRENT Risk Score:** |
|---|
| It is likely that public reporting of shadow reporting in respect of the new single cancer pathway will significantly reduce performance across Wales compared to current USC/NUSC pathways, as evidenced by current monitoring. The current impact is rated as a 3 due to the current absence of confirmed targets in respect of the SCP. |

| **Rationale for TARGET Risk Score:** |
|---|
| The aim is to treat patients within target waiting times (which are yet to be confirmed). |

| **Key CONTROLS Currently in Place:** (The existing controls and processes in place to manage the risk) | **Gaps in CONTROLS** | | | |
|---|---|---|---|---|
| | **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working) | **How and when the Gap in control be addressed** Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
| Working with all Wales Cancer Network to gain full understanding of implications of new pathway.<br><br>Implementation Group established, reporting to Cancer Board with awareness / engagement sessions held on each hospital site.<br><br>Shadow monitoring in place.<br><br>Demand & Capacity planning in progress to assess anticipated impact on diagnostic services. | Anticipated significant gaps within key diagnostic services to address required levels of activity to support SCP - unlikely to be addressed by August 2019<br><br>Full engagement for all supporting services.<br><br>Performance is lower than USC/NUSC published performance.<br><br>Key diagnostic information systems do not support effective demand / capacity planning.<br><br>Need for new, streamlined optimal clinical pathways to reduce diagnostic demand and expedite assessment | Demand & capacity assessment work continuing. Solutions will necessitate regional cooperation to address anticipated capacity gaps. | Perry, Sarah | 31/03/2020 | Currently managing SCP workload via pathway redesign. |
| | | Additional awareness / engagement sessions planned across HB. | Jones, Keith | Completed | Initial round of health board awareness sessions were held during September 2018, followed by a second round of awareness sessions, including attendance at MDT Site Specific Business meetings and hospital Grand Round sessions in early 2019 |
| | | See above re diagnostic services plus improved systems to support identification of 'date of suspicion'. | Jones, Keith | ~~31/03/2019~~ 31/08/2019 | HB performance compares well with other HBs however below current USC/NUSC performance level. Ongoing work in progress with OPD, Diagnostic & ED teams along with the informatics department to improve real time identification of date of suspicion |

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| | pathways. | Planned upgrade of Tracker 7 system via NWIS targeted for Summer 2019. | Jones, Keith | 31/08/2020 | The new Tracker 7 system was implemented within in the health board in Mar19. The service is currently looking at staffing levels to enable us to use the system fully. |
| | | Each MDT to review and adopt recommended optimal tumour site specific pathways | Jones, Keith | 31/08/2020 | Each MDT is currently assessing implications of published proposed pathways. A Macmillan Cancer Quality Improvement Manager has been appointed to work with the teams with regards to implementing the new pathways, starting with Lung and Urology pathways. |

| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls | Latest Papers (Committee & date) |
|---|---|---|---|---|---|
| **Performance Indicators** | **Sources of ASSURANCE** | **Type of Assurance (1st, 2nd, 3rd)** | **Required Assurance / Current Level** | | |
| Performance indicators for Tier 1 targets.<br><br>Shadow performance data. | Daily/weekly/monthly/ monitoring arrangements by management | 1st | | | * IPAR Report Mth11- Board - Mar19<br>* Implement-ation of Single Cancer Pathway Report - BPPAC - Feb19 |
| | Executive Performance Reviews | 2nd | | | |
| | IPAR Performance Report to BPPAC & Board | 2nd | | | |
| | Monthly oversight by WG | 3rd | | | |

| Gaps in ASSURANCES | | | | |
|---|---|---|---|---|
| **Identified Gaps in Assurance:** | **How are the Gaps in ASSURANCE will be addressed<br>Further action necessary to address the gaps** | **By Who** | **By When** | **Progress** |
| No gaps identified. | | | | |
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| **Strategic Objective:** | 2 - Deliver the agreed financial total for 2019/20 by the end of March 2020<br>3 - Achieve the agreed savings requirement for 2019/20 by the end of March 2020 |

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| **Executive Director Owner:** | Thomas, Huw | **Date of Review:** | 16/05/2019 |
| **Lead Committee:** | Finance Committee | **Date of Next Review:** | 16/06/2019 |

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| **Risk ID:** | **646** | **Principal Risk Description:** | There is a risk of the Health Board not achieving breakeven over the medium term. This is caused by the inability to either:<br>1. Develop a sufficiently robust financial plan which shows an achievable improvement trajectory, or<br>2. Manage the necessary changes in such a way that the financial gains are realised and an improvement trajectory is achieved. This will lead to an impact/affect on a detrimental impact on the Health Board's reputation with Welsh Government and other stakeholders. |
| **Does this risk link to any Directorate (operational) risks?** | | Corporate risk | |

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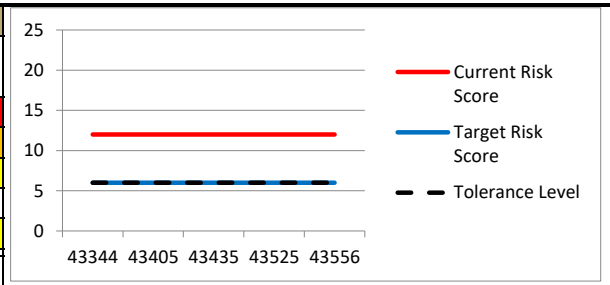
| **Risk Rating:(Likelihood x Impact)** | |
| **Domain:** | Finance inc. claims |
| **Inherent Risk Score (L x I):** | 4×4=16 |
| **Current Risk Score (L x I):** | 3×4=12 |
| **Target Risk Score (L x I):** | 2×3=6 |
| **Tolerable Risk:** | 6 |
| **Trend:** | ⟷ |




| **Rationale for CURRENT Risk Score:** |
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| The Health Board has not developed a full long term financial base-case model, which can then be used to assess the impact of TCS and other medium term changes. The Health Board's underlying deficit also requires further work to fully explore and understand the opportunities for improvement which can be realised over the medium term. |

| **Rationale for TARGET Risk Score:** |
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| Achieving financial balance on a three-year rolling basis is a statutory requirement for the Board, and a clear requirement from the Board and Welsh Government. |

| **Key CONTROLS Currently in Place:** (The existing controls and processes in place to manage the risk) | **Gaps in CONTROLS** | | | | |
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| | **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working) | **How and when the Gap in control be addressed** Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
| Understanding the underlying deficit. An initial assessment has been completed.<br><br>Very high level base-case long term financial model.<br><br>Assessing the full financial implications of Transforming Clinical Services. | Calculation has not been subject to operational scrutiny.<br><br>Assessment not subject to planning scrutiny.<br><br>High level assessment of resource requirements for social model for health. | Testing the underlying deficit assumptions with directorates. | Thomas, Huw | ~~30/11/2018~~ ~~31/05/2019~~ 31/12/2019 | Welsh Government and UHB commissioning external advisors to prepare report on deficit position. Specification being agreed. |
| | | Refining assessment in conjunction with W&OD and Planning. | Thomas, Huw | 30/11/2018 | Initial calculations regarding the effect of the zero based review allocation and early high level affordability for option B of the consultation has been shared via the TCS Design Team and with the Director of Finance. The Strategic Financial Planning Group (Strategy Finance Enabling Group) met on the 2nd May and agreed a series of actions to inform the work of the forthcoming meetings of the 3 Strategy Programme Delivery Groups and Integrated Enabling Group. |

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| | | | | | Developing a high level assessment of the resource requirements of "A Heathier Mid and West Wales" Strategy. Understanding full financial implications of TCS, including the Community/Social Care model. | Thomas, Huw | ~~31/03/2019~~ 31/03/2020 | Activity Based costing refined based on updated Activity and Capacity Assumptions and impact on the 2017/18 baseline financial data + Zero based Review funding (Completed)<br>Collated detail in draft Strategy to begin to build up a bottom up financial costing. Integrated Enabling Group working with Health and Care Strategy Programme Groups to both inform the groups regarding current detail and translate into financial and workforce end point model. |

| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls | Latest Papers (Committee & date) | Gaps in ASSURANCES | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Performance Indicators** | **Sources of ASSURANCE** | **Type of Assurance**<br>**(1st, 2nd, 3rd)** | **Required Assurance**<br>**Current Level** | | | **Identified Gaps in Assurance:** | **How are the Gaps in ASSURANCE will be addressed**<br>**Further action necessary to address the gaps** | **By Who** | **By When** | **Progress** |
| Operational agreement to underlying deficit assessment.<br><br>Plan in place to develop a long term financial plan.<br><br>High level financial assessment of TCS in place. | Reporting to Finance Committee . | 1st | | | N/A | Process to be put in place over May and June.<br><br>Approach to costing impact of TCS to be developed. | Communication with directorates and responses required in July. | Thomas, Huw | ~~31/10/2018~~ ~~31/07/2019~~ 31/12/2019 | Welsh Government and UHB commissioining external advisors to prepare report on deficit position. Specification being agreed. |
| | | | | | | | Now Strategy is agreed we are moving on to a bottom up assessment of the Financial Planning options and implications of "A Heathier Mid and West Wales".<br>TCS Finance Enabling "Plan for a Plan" - has been considered by the Strategic Financial Planning Group and Finance Committee. | Thomas, Huw | ~~31/03/2019~~ 31/03/2020 | Initiating the establishment of a multidisciplinary Integrated Enabling Group as agreed by the Board on 28/03/19 tied into the Strategy Governance to begin to flesh out service design options and trade-offs to inform and promote debate in co-design process.<br>Draft Financial Plan submitted to FDU; comments received. Response and actions to be completed before final submission by the end of Jan19.<br>Intensive work initiated for 2019-20 to support design process, inform 10 year finacial plan and feed into IMTP for 2020-2023. |

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| **Strategic Objective:** | 1 - Deliver the Annual Plan 2019/20 by the end of March 2020 |

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| **Executive Director Owner:** | Rayani, Mandy | **Date of Review:** | 02/05/2019 |
| **Lead Committee:** | Quality, Safety and Experience Assurance Committee | **Date of Next Review:** | 02/07/2019 |

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| **Risk ID:** | **647** | **Principal Risk Description:** | There is a risk of the Board not receiving accurate and timely information regarding variation from the planned staffing roster in line with requirements of S25B of the Nurse Staffing Levels (Wales) Act 2016 (NSLA). This is caused by not having sufficient capacity to (locally) develop robust arrangements and systems to support this requirement of the Act. This could lead to an impact/affect on the UHB being unable to report and review, in a timely manner, any variations in staffing levels, effectively workforce plan and review current staffing establishments, resulting in increased scrutiny from Welsh Government and reduced confidence from stakeholders. |
| **Does this risk link to any Directorate (operational) risks?** | | | |

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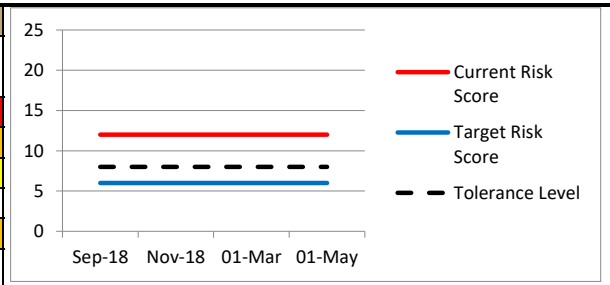
| **Risk Rating:(Likelihood x Impact)** | |
| **Domain:** | Statutory duty/inspections |
| **Inherent Risk Score (L x I):** | 4×4=16 |
| **Current Risk Score (L x I):** | 3×4=12 |
| **Target Risk Score (L x I):** | 2×3=6 |
| **Tolerable Risk:** | 8 |
| **Trend:** | ⟷ |




| **Rationale for CURRENT Risk Score:** |
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| The Board agreed NSLA Implementation plan is progressing with the first annual report being presented to QSEAC in Apr19 which demonstrates progress to date. A national approach to capturing variations from the planned staffing levels via the Health and Care Monitoring Software System (HCMS) is under development by NWIS and has been piloting in this Health Board. Both this system and an alternative (more labour intensive) data capture system was tested with Heads of Nursing in Apr19. The options for data capture were discussed with the Heads of Nursing with the agreement that the HCMS option was the preferred option. This system is currently being tested with a view to rolling this system to the wards in Jun19. An implementation plan has been agreed. |

| **Rationale for TARGET Risk Score:** |
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| The target risk score reflects that any system will rely on staff inputting timely and accurate information. |

| **Key CONTROLS Currently in Place:** (The existing controls and processes in place to manage the risk) | **Gaps in CONTROLS** | | | |
|---|---|---|---|---|
| | **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working) | **How and when the Gap in control be addressed** Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
| Temporary staffing arrangements in place.<br><br>Risk based escalation arrangements and process in place in services.<br><br>Emergency Pressure & Escalation Policy ((Approved Sept 2018).<br><br>Nurse Staffing Levels (Wales) Act Steering Group.<br><br>(Inconsistent) reporting arrangements in place. | Lack of a single, Health Board wide robust system to record variations from the planned roster as per requirements of S25B/C. | Phased implementation plan for the Nurse Staffing Levels (Wales) Act which includes the development of a single system of recording. | Rayani, Mandy | ~~31/03/2019~~ 30/06/2019 | Option appraisal undertaken The HCMS option was the preferred option. This system is currently being tested with a view to rolling this system to the wards in Jun19 for a period of testing. An implementation plan has been agreed. |
| | | Prepare a report for Formal Executive Team setting out resourcing requirements. | Rayani, Mandy | Completed | NWIS committed to developing all Wales system therefore no request for resources was submitted. |

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| Full implementation of the plan to fully comply with the Nurse Staffing Levels (Wales) Act which includes the development of a single system of recording. | Rayani, Mandy | 31/07/2019 | Implementation plan agreed at Board is progressing as planned. Updated position scheduled to be reported to QSEAC (which has been delegated responsibility for providing assurance to the Board) in Jul19. |
| Daily use of HCMS system to capture required data to be rolled out across HDUHB in Apr/May19 if enhancements are delivered by NWIS in line with current stated timetable: If NWIS fail to deliver, an alternative (interim) solution (selected by Heads of Nursing from two current options - one in use in one area of this HB and in one other HB in NHS Wales) will be implemented as an interim solution. | Rayani, Mandy | ~~31/05/2019~~ 30/09/2019 | Regular contact being maintained with NWIS to monitor progress with HCMS enhancement work: The system is currently being tested with a view to rolling it out to the wards in Jun19 for a period of testing. It anticipated that reliable data will be available from Sep19. |

| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls | Latest Papers (Committee & date) | Gaps in ASSURANCES | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Performance Indicators | Sources of ASSURANCE | Type of Assurance (1st, 2nd, 3rd) | Required Assurance / Current Level | | | Identified Gaps in Assurance: | How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps | By Who | By When | Progress |
| | E-rostering system reviewed by Head of Nurses in Operation Teams | 1st | | | * Briefing on NSLA - QSEAC Aug18 and Feb19<br><br>* NSLA Update - Board May18, Jul18 and Nov18<br><br>* NSLA Annual Report - QSEAC Jun19 and Board May19 | | | | | |
| | Datix Reports reviewed by Corporate Nursing Team to identify reportable breaches | 1st | | | | | | | | |
| | Director of Nursing review of significant reported breaches | 2nd | | | | | | | | |
| | Workforce & OD Sub-Committee review of workforce challenges | 2nd | | | | | | | | |
| | Annual Report to Board | 2nd | | | | | | | | |
| | WG Review HB Papers in 18/19 | 3rd | | | | | | | | |
| | 3 yearly compliance report to Welsh Government | 2nd | | | | | | | | |

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| **Strategic Objective:** | 1 - Deliver the Annual Plan 2019/20 by the end of March 2020 |

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| **Executive Director Owner:** | Teape, Joe | **Date of Review:** | 13/05/2019 |
| **Lead Committee:** | Quality, Safety and Experience Assurance Committee | **Date of Next Review:** | 12/07/2019 |

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| **Risk ID:** | **129** | **Principal Risk Description:** | There is a risk of disruption to business continuity of the Hywel Dda Out of Hours (OOH) Service. This is caused by a lack of available of labour supply as GPs near retirement age and pay rate differentials across Health Boards in Wales, implementation of the '111' service, workforce flexibility and other service change. This could lead to an impact/affect on further weakening of an already fragile service and a detrimental demand impact on patient experience and the unscheduled care pathway. |
| **Does this risk link to any Directorate (operational) risks?** | | | |

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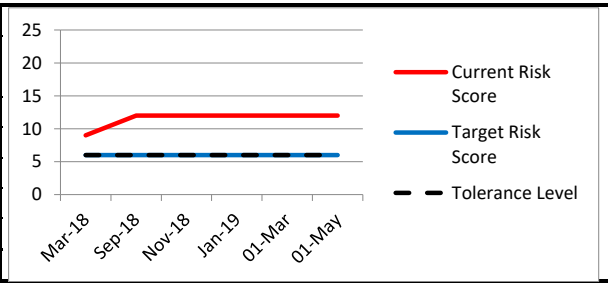
| **Risk Rating:(Likelihood x Impact)** | |
| **Domain:** | Service/Business interruption/disruption |
| **Inherent Risk Score (L x I):** | 5×3=15 |
| **Current Risk Score (L x I):** | 4×3=12 |
| **Target Risk Score (L x I):** | 2×3=6 |
| **Tolerable Risk:** | 6 |
| **Trend:** | ⟷ |




**Rationale for CURRENT Risk Score:**

Gaps in rota cover throughout the 3 counties continue with very limited additional work being undertaken by the sessional workforce.

Shift fill is improving over a weekday, with increasing numbers of GPs also available to support on most weekends. The exception to this continues to be Carmarthenshire (PPH) which is frequently adversely affected by rota gaps, although base closures have been noted in all areas in recent months

APP model is providing significant resilience (when available)

**Rationale for TARGET Risk Score:**

A long term viable plan is needed for OOH Services to reduce this risk and ensure the out of hours service provision is not interrupted.

**Key CONTROLS Currently in Place:**
(The existing controls and processes in place to manage the risk)

GP's rotas are constantly reviewed and updated by the OOH staffing team with a view to improve resilience.

111 programme board with 111 now live across the HB area.

The clinical advice hub as part of the '111' service is assisting with OOH demand

Dedicated Advice GP rota in place at times of high demand (weekends).

Health Professional feedback form in use between clinicians, service management and 111 leads.

Patients directed to alternate OOH care where capacity allows. ED and MIU direction is made for most urgent cases

**Gaps in CONTROLS**

| **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working) | **How and when the Gap in control be addressed** Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
|---|---|---|---|---|
| Workforce availability still fragile and results in frequent disruption. Need for formalised workforce plan required- support form OD to achieve this has been obtained | The service is actively looking to recruit Advanced Paramedic Practitioners to the service. | Rees, Gareth | Completed | Completed and in place. |
| | Develop long term service model for OOH. | Rees, Gareth | Completed | Completed - A long term model has been developed however this will need to align with the UHB Clinical Services Strategy going forward. |
| | Ensure Transforming Clinical Services Programme incorporates a long term, viable plan for OOH. | Rees, Gareth | 31/03/2020 | A short to medium term plan is under development for inclusion in the IMTP 2019/22 to manage the current gaps in rotas in the Out of Hours Service. |
| | Development of home working provision for GPs. | Rees, Gareth | Completed | Completed and evolving. |

GP Advisory Group established to improve communication/relationships with local GPs.

WAST APP support in place and provides significant mitigation to risk when other staff unavailable.

Health care support workers augmenting GP workloads by undertaking basic observations.

Pharmacist deployed locally into GGH but working as extended arm of support hub.

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|---|---|---|---|
| Recruitment programmes for increasing nurses and doctors into the services. | Rees, Gareth | Completed | APP posts with WAST commenced on 01.11.18 - 2 WTE APP deployed at peak demands to provide a degree of rota resilience. Additional APPs being deployed on an ad hoc basis. Rolling recruitment for salaried GP continues- high view count however no uptake - to be reviewed with recruitment.<br>5 new GPs have signed up for shifts in the Carms locality (Adhoc) in last 5 months. |
| Rollout of 111 to all 3 counties. | Rees, Gareth | Completed | Completed and in place from 31st October 2018. |
| Develop short to medium plan for out of hours service which builds resilience into service ahead of longer term action materialising. | Davies, Nick | ~~31/12/2018~~ 31/07/19 | Two meetings have been held with Asst Director Primary Care to scope the potential opportunities for 24 hour collaboration/ improved relationship with primary care teams. A concept paper will now be generated (first draft anticipated be end of July 19)- it is agreed that the existing service fragility and other changes to the service will need to improve significantly / be completed successfully before introduction of new ways of working. |
| OOH and MIU services in PPH to assess potential for closer working with a view to increasing rota resilience. | Davies, Nick | 28/06/2019 | Executive Team approval gained to further develop options. Initial scoping meeting held 17/4/19 with next meeting planned 20/6/19 to form task and finish. |

| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls | Latest Papers (Committee & date) | Gaps in ASSURANCES | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Performance Indicators | Sources of ASSURANCE | Type of Assurance (1st, 2nd, 3rd) | Required Assurance / Current Level | | | Identified Gaps in Assurance: | How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps | By Who | By When | Progress |
| Performance against Wales Quality and Monitoring for Delivery of OOH standards | Daily sitreps/Weekend briefings for OOH | 1st | | | Internal Review of 111 - BPPAC Jun-18. | None identified. | | | | |
| | Monitoring of performance against OOH standards | 1st | | | | | | | | |

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| standards.<br><br>Filled rotas. | Executive Performance Reviews | 2nd | | | | | | | | | |
| | BPPAC monitoring (last month) | 2nd | | | | | | | | | |
| | WAO Review of OOH in Wales | 3rd | | | | | | | | | |
| | WG Peer Review completed Sep-18 | 3rd | | | | | | | | | |

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| **Strategic Objective:** | *1 -Deliver the Annual Plan 2019/20 by the end of March 2020* |

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| **Executive Director Owner:** | Teape, Joe | **Date of Review:** | 07/05/2019 |
| **Lead Committee:** | Business Planning and Performance Assurance Committee | **Date of Next Review:** | 07/07/2019 |

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|---|---|---|---|
| **Risk ID:** | **652** | **Principal Risk Description:** | There is a risk of persons gaining unauthorised access to certain parts of the hospital sites. This is caused by the poor condition of certain external doors which compromises the security of the site and the ability to promptly lock down perimeter doors from a central point. This could lead to an impact/affect on the security of the site in terms of unauthorised access, increased risk to staff and patients from unauthorised persons and increased risk of thefts out of hours. |
| **Does this risk link to any Directorate (operational) risks?** | | | |

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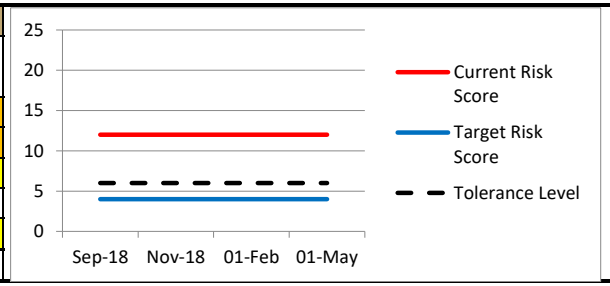
|---|---|
| **Risk Rating:(Likelihood x Impact)** | |
| **Domain:** | Safety - Patient, Staff or Public |
| **Inherent Risk Score (L x I):** | 3×4=12 |
| **Current Risk Score (L x I):** | 3×4=12 |
| **Target Risk Score (L x I):** | 1×4=4 |
| **Tolerable Risk:** | 6 |
| **Trend:** | ⟷ |




**Rationale for CURRENT Risk Score:**

In the event of an incident or an increase in threat level, the ability to restrict access to external doors will be important. This is currently only achievable by porters physically locking doors. Arrangements are in place to lock external exit doors to secure each hospital premises. However many of these exit doors are having to be manually locked and unlocked by porters physically securing them using a variety of keys. This task can take a considerable amount of time and will inevitably leave certain access points vulnerable if an emergency lock down is activated. In addition Porters are often otherwise engaged in patient transport/fire response and other duties when exterior doors require manually locking, effectively leaving them open when they should be secured. Barriers to full implementation of an effective lockdown capability remain as no identified security role has been identified on each site.

**Rationale for TARGET Risk Score:**

Planned actions will reduce risk of unauthorised access to certain parts of hospital sites however will investment to deliver the actions.

| **Key CONTROLS Currently in Place:** (The existing controls and processes in place to manage the risk) | **Gaps in CONTROLS** | | | |
|---|---|---|---|---|
| | **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working) | **How and when the Gap in control be addressed** Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
| Doors are in place.<br><br>Porters locking each door in person at specific times.<br><br>Staff wearing ID badges at all times across sites.<br><br>Survey of access points on acute hospital sites identified gaps in access controls - Access controls in large number of areas. | Lack of risk based approach to strengthening access controls to acute hospital sites.<br><br>Lack of robust process to instigate lockdown procedures on hospital sites. | Develop and implement a work programme to address gaps in access controls based on availability of capital funding. | Harrison, Tim | 30/09/2020 | Work plan developed and discretionary Capital bid submitted for approval to improve the capability of routinely locking up and, if required, locking down the Acute General Hospital Sites. The capital bid has been prioritised and is spread over 2 years. |
| | | Issuing swipe card controls across all hospital sites. | Elliott, Rob | ~~30/04/2019~~ 31/05/2019 | SBAR prepared for Operations Business meeting and H&S/EP SC with recommendations for improving current arrangements. |

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|---|---|---|---|---|
| | Development of systematic lockdown plans developed by site management - support by emergency planning & security teams. | Lloyd, Mr Philip | ~~31/03/2019~~ 30/06/2019 | Acute General Hospital Lockdown plans will be developed starting with WGH which is currently in draft. These Plans require site Management acceptance and allocation of appropriate personnel and infrastructure in order to implement an efficient and effective departmental or hospital wide lockdown. |
| | Testing lockdown plans. | Lloyd, Mr Philip | ~~30/06/2019~~ 30/06/2019 | As part of hospital lockdown plan development. |
| | Approval of Lockdown Policy at Health & Safety/Emergency Planning Sub-Committee. | Harrison, Tim | Completed | Lockdown policy approved at Jan19 meeting. |
| | Develop action plan in response to Counter Terrorism Security Advisor (CTSA) Report for review at H&S Sub-Committee. | Harrison, Tim | Completed | Annual Work Plan covers the external lockdown improvements (pending Capital Funding approval). |

| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls) | Latest Papers (Committee & date) |
|---|---|---|---|---|---|
| **Performance Indicators** | **Sources of ASSURANCE** | **Type of Assurance (1st, 2nd, 3rd)** | **Required Assurance / Current Level** | | |
| Reduction in no of incidents unauthorised access. | Management investigation of unauthorised access and issues / H&S & Security Team identify trends across sites | 1st | | | * Lockdown policy - H&S SC - Jan19<br><br>* Access Control, CCTV, Lockdown Report - H&S/EP SC - May18 |
| | Site inspections by night staff | 1st | | | |
| | Security compliance reports to H&S/ EM Planning Sub-Committee | 2nd | | | |
| | Security issues discussed at Site Staff Partnership forums | 2nd | | | |
| | Counter Terrorism Advisor Report on Security Controls in UHB | 3rd | | | |
| | IA Physical Security Follow up - May 2015 - Limited Rating | 3rd | | | |

| Gaps in ASSURANCES | | | | |
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| **Identified Gaps in Assurance:** | **How are the Gaps in ASSURANCE will be addressed<br>Further action necessary to address the gaps** | **By Who** | **By When** | **Progress** |
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| **Strategic Objective:** | 1 - Deliver the Annual Plan 2019/20 by the end of March 2020 |

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| **Executive Director Owner:** | Teape, Joe | **Date of Review:** | 21/03/2019 |
| **Lead Committee:** | Quality, Safety and Experience Assurance Committee | **Date of Next Review:** | 17/05/2019 |

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| **Risk ID:** | **117** | **Principal Risk Description:** | There is a risk of avoidable patient harm or death and serious deterioration in clinical condition, with patients having poorer outcomes. This is caused by the delay in transfers to tertiary centre for those requiring urgent cardiac investigations, treatment and surgery. This could lead to an impact/affect on delayed treatments leading to significant adverse outcomes for patients (the 72 hour timescales as per N-STEMI clinical guidance designed to provide urgent cardiac patients the best outcomes), prolonged hospital stays of up to 21 days, impaired patient flow into appropriate coronary pathway with beds in coronary care unit exceeding capacity and poorer outcomes for patients. |
| **Does this risk link to any Directorate (operational) risks?** | | | |

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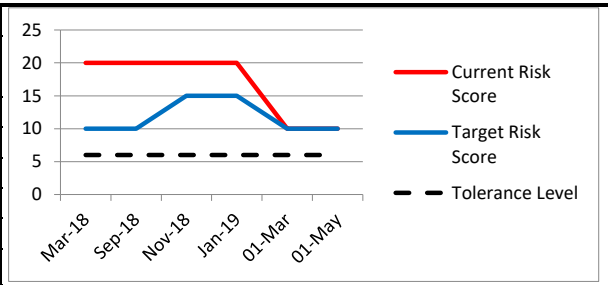
| **Risk Rating:(Likelihood x Impact)** | |
| **Domain:** | Safety - Patient, Staff or Public |
| **Inherent Risk Score (L x I):** | 5×5=25 |
| **Current Risk Score (L x I):** | 2×5=10 |
| **Target Risk Score (L x I):** | 2×5=10 |
| **Tolerable Risk:** | 6 |
| **Trend:** | |




**Rationale for CURRENT Risk Score:**

The UHB is still experiencing delays in transferring patients to tertiary service within the recommended 72 hours as per N-STEMI guidance. The absence of a cardiac CT service within Hywel Dda is constraint as this would reduce angiography demand. The current score is now reduced to 10 on account of recent success of the Regional 'Treat & Repat' arrangement.

**Rationale for TARGET Risk Score:**

The target of 15 is predicated on effective local and regional solutions coming forward, albeit these need to be developed. Once clarity on these is available, a review of the target can be undertaken. The target score is now reduced to 10 on account of recent success of the Regional 'Treat & Repat' arrangement.

| **Key CONTROLS Currently in Place:** (The existing controls and processes in place to manage the risk) | **Gaps in CONTROLS** | | | |
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| | **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working) | **How and when the Gap in control be addressed** Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
| Medical and nursing staff review patients daily and update the referral database as appropriate.<br><br>Bi-monthly operational meeting with Abertawe Bro Morgannwg (ABMU) to improve flow.<br><br>Daily telephone call Coronary Care Unit (CCU) to review all patients awaiting transfer with review of patients waiting for transfer to ABMU.<br><br>Escalation process in place.<br><br>All patients are risk scored by cardiac team in ABMU.<br><br>Local evaluation of catheter laboratory project to identify more local solutions.<br><br>Additional cardiac capacity for Winter 2018/19 providing 6 ring-fenced | Lack of Catheter Laboratory in Hywel Dda to reduce reliance on tertiary centre.<br><br>Lack of capacity in tertiary centre. | Review cardiology service to minimise transfer for some diagnostics (perfusion scanning, angio, cardiac CT). | Jenkins, Daniel | Completed | Myocardial Perfusion Scanning Service established in WGH. Cardiac CT provided at BGH. |
| | | Develop a business case to improve regional capacity. | Teape, Joe | Completed | Business case has been developed and submitted to Executive Team for consideration on 14th November 2018. Agreement with ABMUHB to hold a additional surgical list on Saturdays. |
| | | Develop a local solution for Winter 2018/19 | Teape, Joe | Completed | Additional cardiac capacity included in Winter Plan to provide 6 ring-fenced beds. Ring fenced beds in place Jan19 and as of 22/2/19 there are no patients waiting to go to ABMU. Further funding needs to be identified to continue arrangement to Apr19. |

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| beds at PPH to enable timelier transfer to ABMU. ABMU have agreed to 2 transfers per day for HDUHB patients form 7/1/19 - this has achieved an average reduction from 10 to 3 days in the wait from 'referrals for angio' to ' angio undertaken'. | | The Regional Working Group to identify regional solutions to improve patient outcomes. | Kloer, Dr Philip | Completed | Workshop took place on 22/02/19 and was chaired by Medical Directors from ABMU and HD UHBs. The work will be led by the regional cardiac group chaired by Dr Mark Ramsey. |
| | | Developing a proposal for a Catheter Laboratory for inclusion in Annual Plan for 2019/20. | Perry, Sarah | ~~31/01/2019~~ 30/06/2019 | Discussions have been undertaken with Planning Team. Draft paper sent to Director of Operations and further updates required and to review costs. Meeting with site GM's and finance Apr19. |
| | | Develop proposal for Executive strategic decision to establish a local Cardiac CT service in 2019/20. | Perry, Sarah | Completed | Draft paper submitted to Executive Team in Feb19. Sent back with comments for further work. Meeting with GMs and finance arranged for 11/04/19. |
| | | Develop long term regional plan. | Teape, Joe | 30/09/2019 | Regional network to be established to take this forward. |

| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls) | Latest Papers (Committee & date) |
|---|---|---|---|---|---|
| **Performance Indicators** | **Sources of ASSURANCE** | **Type of Assurance (1st, 2nd, 3rd)** | **Required Assurance / Current Level** | | |
| Performance indicators for Tier 1 targets. | Daily/weekly/monthly/ monitoring arrangements by management | 1st | | | |
| | Audit of N-STEMI referral undertaken by Clinical Lead show average wait of 10.7 days | 1st | | | |
| | Executive Performance Reviews | 2nd | | | |
| | IPAR Performance Report to BPPAC & Board | 2nd | | | |
| | Monthly oversight by WG | 3rd | | | |

| Gaps in ASSURANCES | | | | |
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| **Identified Gaps in Assurance:** | **How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps** | **By Who** | **By When** | **Progress** |
| Lack of oversight at the Board and Committees. | Review reporting arrangements of emergency and elective waits. | Teape, Joe | ~~10/01/2018~~ 30/04/19 | Discussions are underway with ABMuHB for information on cardiac patients (n-stemi pathway)to be provided to Hywel Dda for inclusion in the IPAR. This will include no of referrals, those seen within 72 hours, average and longest waiting times. |
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| **Strategic Objective:** | *1 -Deliver the Annual Plan 2019/20 by the end of March 2020* |

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| **Executive Director Owner:** | Jervis, Ros | **Date of Review:** | 13/05/2019 |
| **Lead Committee:** | Quality, Safety and Experience Assurance Committee | **Date of Next Review:** | 13/07/2019 |

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| **Risk ID:** | **635** | **Principal Risk Description:** | There is a risk of There is a risk of the consequences of a no-deal Brexit impacting on the business continuity of health care services. This is caused by a lack of clarity regarding UK position on Britain's exit from EU. This could lead to an impact/affect on the UHB being unable to continue to run services, patients being able to access appropriate and timely treatment, the UHB being able to maintain safe and effective levels of staffing, financial loss and adverse publicity/reduction in stakeholder confidence and increased mortality and ill-health across our population. |
| **Does this risk link to any Directorate (operational) risks?** | | | |

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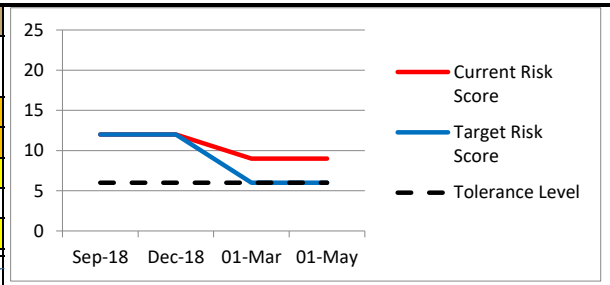
| **Risk Rating:(Likelihood x Impact)** | |
| **Domain:** | Service/Business interruption/disruption |
| **Inherent Risk Score (L x I):** | 3×4=12 |
| **Current Risk Score (L x I):** | 3×3=9 |
| **Target Risk Score (L x I):** | 2×3=6 |
| **Tolerable Risk:** | 6 |
| **Trend:** | |




| **Rationale for CURRENT Risk Score:** |
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| We have reduced the current risk score as this reflects the work that on-going to clearly identify the risks and impacts to the UHB in conjunction with Wales and UK Governments. Plans are now in place at local, regional and national levels supported through a robust governance infrastructure. |

| **Rationale for TARGET Risk Score:** |
|---|
| This will be affected by confirmation of Brexit outcome by UK Government. As planning/contingency work continues, it is hoped to reduce either the likelihood and/or impact score further. |

| **Key CONTROLS Currently in Place:** (The existing controls and processes in place to manage the risk) | **Gaps in CONTROLS** | | | |
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| | **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working) | **How and when the Gap in control be addressed** Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
| * Regular meetings with CEO, DPH & Head of Emergency Planning plus verbal updates/discussions and papers at Executive Team and Board.<br>* Brexit Steering Group has been established to manage the consequences of Brexit and its interface with partners.<br>* Wider governance infrastructure in place - of note the Dyfed Powys LRF Brexit Group and Welsh Government led groups.<br>* Risk assessments and business continuity plans feed into a dynamic risk summary document which continues to track on-going risks and controls assurance with business continuity.<br>* Scoping exercise undertaken within Workforce to identify EU nationals and resolve data gaps in ESR. Workforce Brexit Plan developed.<br>* Information flows are being co-ordinated to ensure that any discussions with respective Health Board services and national services and/or professional leads are captured within our planning.<br>* The Health Board is represented at the WG SRO's, Comms and Brexit Health & Social Care Civil Contingencies Group and also within the DP LRF Brexit Group.<br>* Staff Brexit Intranet page developed as single point of information plus a closed Facebook Group for EU staff. | Full understanding of potential impacts and implications for the UHB due to the unknown final outcome of Brexit. | Scoping Exercise and liaison with other HBs and WG. | Hussell, Sam | Completed | Completed. |
| | | Completion of suite of risk assessment and business continuity plans (BCPs) by service leads to mitigate highest risks. | Hussell, Sam | Completed | Completed. |
| | | Completion of workforce scoping exercise and resolution of ESR data gap. | Gostling, Lisa | ~~31/01/2019~~ 30/06/2019 | ESR Data Gap significantly reduced with on-going campaign to complete. |

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| * Exercise Brexit Challenge undertaken resulting in recommendations and an action plan that will be progressed via the Brexit Steering Group.<br>* Sitrep process in place at local, regional and national level for reporting and escalating impacts of consequences of Brexit.<br>* Systems in place to review and respond to new consequences of Brexit at local, regional and national level. | | NHS Wales exercise planned for Jan19 to rehearse Brexit no-deal contingencies. | Hussell, Sam | Completed | Completed. |

| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls) | Latest Papers (Committee & date) | Gaps in ASSURANCES | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Performance Indicators | Sources of ASSURANCE | Type of Assurance (1st, 2nd, 3rd) | Required Assurance / Current Level | | | Identified Gaps in Assurance: | How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps | By Who | By When | Progress |
| To be identified when risk is fully understood. | Response submitted on 19Nov18 to Andrew Goodall letter of 05 October stating approach to be taken by Health Boards confirming progress | 1st | | | None to date. | Further sources to be identified when risk is fully understood. | Respond to WG letter of 05/10/18 requesting further information on the approach taken by UHB and progress to date. | Hussell, Sam | Completed | Response sent by 19/11/18. |
| | Response submitted to Wales Audit Office letter notifying of intention to undertake an initial baseline of arrangements by 30Nov19 | 1st | | | | | Respond to WAO request for information to inform their baseline assessment of arrangements for Brexit. | Hussell, Sam | Completed | Response provided by 30/11/18. |
| | Emergency Planning Team to review UHB no deal Brexit arrangements and associated BCPs | 1st | | | | | | | | |
| | Executive oversight of Brexit arrangements and BCPs | 2nd | | | | | | | | |
| | Review of Exercise planned for Jan19 | 3rd | | | | | | | | |
| | WAO Review of Brexit Preparedness | 3rd | | | | | | | | |

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| **Strategic Objective:** | 1 - Deliver the Annual Plan 2019/20 by the end of March 2020 |

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| **Executive Director Owner:** | Teape, Joe | **Date of Review:** | 16/04/2019 |
| **Lead Committee:** | Business Planning and Performance Assurance Committee | **Date of Next Review:** | 16/06/2019 |

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| **Risk ID:** | **718** | **Principal Risk Description:** | There is a risk of the UHB will face enforcement action under the Health and Safety at Work Act 1974 and subordinate regulations. This is caused by a failure to comply with prevailing legislation by not undertaking proactive health and safety (H&S) management (such as audits, inspections and case reviews) due to a lack of capacity within the Health, Safety and Security Team. This could lead to an impact/affect on harm to patients, staff and the public, improvement notices, large fines and/or criminal prosecutions following HSE investigations, adverse publicity/reduction in stakeholder confidence. |
| **Does this risk link to any Directorate (operational) risks?** | | | |

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| **Risk Rating:(Likelihood x Impact)** | | ***No trend information available*** |
| **Domain:** | Statutory duty/inspections | |
| **Inherent Risk Score (L x I):** | 4×3=12 | |
| **Current Risk Score (L x I):** | 3×3=9 | |
| **Target Risk Score (L x I):** | 2×3=6 | |
| **Tolerable Risk:** | 8 | |
| **Trend:** | *New risk* | |

| **Rationale for CURRENT Risk Score:** |
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| The team have undertaken a high level gap analysis identifying gaps in the current staffing resource. When benchmarked against other health boards in Wales, it demonstrated that other H&S teams had over double the staffing resource and that they did not cover the counter terrorism remit that Hywel Dda's team does. The lack of capacity in the team means that key aspects of H&S management are not being undertaken, such as audits, inspections and case reviews, timely learning and follow up after incident investigations, promotion and implementation of H&S policies. |

| **Rationale for TARGET Risk Score:** |
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| H&S risks will inevitably exist within healthcare and therefore a reasonable level of risk rating has been considered as a score of 8. |

| **Key CONTROLS Currently in Place:** (The existing controls and processes in place to manage the risk) | **Gaps in CONTROLS** | | | |
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| | **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working) | **How and when the Gap in control be addressed** Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
| 1 x Head of H&S, 1 x H&S Manager and 1 x Security/Case Manager/Prevent Co-ordinator who currently take a reactive approach to health and safety issues, as opposed to a more beneficial proactive approach.<br><br>Datix Risk module in place. The Health Board has invested in the Datix module which enables services to identify, assess and manage risks associated with health and safety.<br><br>Standard operating procedures in laboratory, radiology, theatre environments which reflect some of the hazards/ risks (Policy approved, most departments have material safety data sheets but very few COSHH risk assessments, pathology have undertaken monitoring for Xylene and Formaldehyde)<br><br>Incident/concerns investigations are undertaken however depth of | Lack of staff capacity to undertake proactive H&S management.<br><br>Lack of UHB support for victims of assault and also lack of follow up with potential prosecutions. Lack of incident/concerns follow-up to identify and address lessons learnt<br><br>Due to lack of capacity, limited monitoring and assistance is currently being provided by the Health, Safety and Security team in relation to the 'H&S' risks identified on Datix, preventing the analysis and identification of trends/issues across | Look at existing resources across Estates and Facilities Directorate to address gap in control and take more proactive approach to health and safety (proactive reviewing of H&S risk assessments on Datix, provision of support for victims of assault, follow and learning lessons following incidents) | Elliott, Rob | Completed | Completed however no spare capacity identified with appropriate skill mix. A gap analysis has also been undertaken on the operational estates staff which identified 10.4wte shortfall for undertaking HTM compliance. |
| | | Request funding to recruit 3 additional posts to H&S structure. | Elliott, Rob | Completed | SBAR submitted to Executive Team in Oct18. The paper was accepted and concerns acknowledged with a commitment to fund when resources becomes available. Advised to mitigate risks as far as reasonably practicable and escalate those risks that cannot be managed. |

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| investigations could be improved to ensure there is appropriate follow up, support for those affected and lessons are learnt across the organisation.<br><br>H&S policies and procedures are in place and are published on staff intranet.<br><br>Incident/concerns investigations are undertaken however depth of investigations could be improved to ensure there is appropriate follow up, support for those affected and lessons are learnt across the organisation.<br><br>H&S policies and procedures are in place and are published on staff | the UHB and ability to take the appropriate organisational actions.<br><br>Limited environmental/personal exposure monitoring (COSHH).<br><br>Implementation of policies also needs strengthening across UHB. | Develop annual work plan aligned to prioritised goals agreed by Health and Safety and Emergency Planning Sub-committee (H&SEPSC). | Harrison, Tim | Completed | Completed |
| | | Improve COSHH compliance (as part of annual work plan). | Harrison, Tim | 31/03/2019 | COSHH Policy approved Training in spillage techniques and respiratory protection has been delivered to endoscopy staff in BGH. |
| | | CCTV Policy, Face-fit Procedure, Violent Patient Marker Procedure, Security Policy will be approved by Emergency Planning/Health and Safety Sub-Committee in line with the annual work plan schedule | Harrison, Tim | 31/03/2019 | COSHH Policy & Procedure, Violence & Aggression Policy, First Aid at Work Procedure, New & Expectant Mothers Procedure have been approved during 2018. |

| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls) | Latest Papers (Committee & date) | Gaps in ASSURANCES | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Performance Indicators | Sources of ASSURANCE | Type of Assurance (1st, 2nd, 3rd) | Required Assurance / Current Level | | | Identified Gaps in Assurance: | How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps | By Who | By When | Progress |
| | Incident and RIDDOR and progress against workplan reports to H&S/EP Sub-Committee | 2nd | | | SBAR Exec Team Oct-18 H&S/EP Sub-Committee | Lack of internal H&S audits and inspections | | | | |
| | Progress against workplan reports to H&S/EP Sub-Committee | 2nd | | | | | | | | |
| | IA report on Health and Safety Sep16 (Reasonable Rating) | 3rd | | | | | | | | |

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| **Strategic Objective:** | 1 - Deliver the Annual Plan 2019/20 by the end of March 2020<br>6 - Deliver year 1 of Board approved strategies (Health and Well-Being, Continuous Engagement and Quality Improvement) by the end of March 2020 |

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| **Executive Director Owner:** | Rayani, Mandy | **Date of Review:** | 07/05/2019 |
| **Lead Committee:** | Quality, Safety and Experience Assurance Committee | **Date of Next Review:** | 07/07/2019 |

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| **Risk ID:** | **650** | **Principal Risk Description:** | There is a risk of Board not receiving early intelligence and escalation of adverse/poor quality and safety (Q&S) standards within the organisation. This is caused by current Q&S arrangements not being fully embedded within operational and committee structures. This could lead to an impact/affect on the UHB's ability to respond quickly and appropriately to improve Q&S standards within organisation, adverse publicity/reduction in stakeholder confidence, and increased scrutiny/escalation from WG. |
| **Does this risk link to any Directorate (operational) risks?** | | | |

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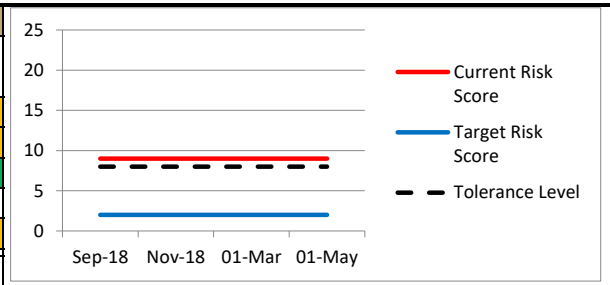
| **Risk Rating:(Likelihood x Impact)** | |
| **Domain:** | Quality/Complaints/Audit |
| **Inherent Risk Score (L x I):** | 4×3=12 |
| **Current Risk Score (L x I):** | 3×3=9 |
| **Target Risk Score (L x I):** | 1×2=2 |
| **Tolerable Risk:** | 8 |
| **Trend:** | ⟷ |




| **Rationale for CURRENT Risk Score:** |
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| Systems in place however not sufficiently mature or fully embedded within organisation to provide the level of assurance that Board requires that they are effective in reducing risks to clinical care and safety and issues are being escalated early and managed appropriately. |

| **Rationale for TARGET Risk Score:** |
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| Whilst the Sub-Committee within the QSEAC committee structure have been reviewed, further work to review the role, responsibly and reporting lines of the groups within QSEAC Committee structure needs to be undertaken. |

| **Key CONTROLS Currently in Place:**<br>(The existing controls and processes in place to manage the risk) | **Gaps in CONTROLS**<br>**Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working) | **How and when the Gap in control be addressed**<br>Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
|---|---|---|---|---|---|
| Review of QSEAC Sub-Committee Structure undertaken.<br><br>Nurse staffing levels reports.<br><br>Quality metrics in place including Fundamentals of Care, Incident reporting, and concerns, etc.<br><br>Quality & Safety Dashboard reviewed by QSEAC and assurance reports provided at each QSEAC. | Lack of confidence re early escalation of Q&S issues.<br><br>Lack of capacity to analyse/triangulate Q&S data effectively. | Review the QSE Groups under QSEAC committee structure. | Rayani, Mandy | Completed | Initial Review Completed. It is recognised that on-going evaluation of the local Quality Groups is required. This will be undertaken during Q1 of the new financial year with the support of the Director of Therapies and Health Sciences. |
| | | Development of a decision and action tracker across the QSEAC Sub-Committee Structure. | Gittins, Alison | Completed | Sub-Committee Decision Tracker in place and reported as a standing agenda item to QSEAC from 16 Oct 18. |
| | | Implementation of the QSEAC Development Plan. | Rayani, Mandy | ~~31/03/2019~~ 30/09/2019 | It was agreed at QSEAC that the actions currently being implemented would be reviewed in Sep19 to allow time for the improvements implemented to become embedded. |

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| Raising awareness of Quality across operational services through visibility of corporate nursing team at operational meetings and ensure this is incorporated within the Leadership Improvement Programme. | Passey, Sian | Completed | All Operational Governance Meetings are attended by a member of the ASI Team. A senior member of the ASI team attending the Managers Passport Plus training to deliver key training to all band 7+ leaders. There was a patient safety awareness day wc 11Mar19 |
| Develop skill set in the Assurance, Safety and Improvement (ASI) Team. | Passey, Sian | Completed | Training provided on Root Cause Analysis for team members by Welsh Risk Pool and Delivery Unit. |
| Scope future needs to develop analyst capabilities to produce intelligence from Q&S information. | Passey, Sian | ~~31/03/2019~~ 31/12/2019 | A draft JD has been developed and is being considered by the quality directorate. This will be considered further when the new Head of Quality & Safety commences in Apr19. |
| Implementation the Quality Improvement Strategic Framework. | Davies, Mandy | Completed | QISF was launched on 21Mar19. Delivery of QISF monitored by Collaborative Steering Group. |

| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls | Latest Papers (Committee & date) |
|---|---|---|---|---|---|
| **Performance Indicators** | **Sources of ASSURANCE** | **Type of Assurance (1st, 2nd, 3rd)** | **Required Assurance / Current Level** | | |
| Incident reports<br><br>Q&S Dashboard | Q&S metrics reported through IPAR to BPPAC | 2nd | | | |
| | Monthly meetings with WG Q&S Unit | 2nd | | | |
| | Q&S Dashboard and Sub-committee reports to QSEAC (QSEAC report to Board) | 2nd | | | |
| | HIW Reports indicate areas of improvement of Q&S | 3rd | | | |
| | WAO Structured Assessment 2018 - focus on Q&S governance | 3rd | | | |

| Gaps in ASSURANCES | | | | |
|---|---|---|---|---|
| **Identified Gaps in Assurance:** | **How are the Gaps in ASSURANCE will be addressed<br>Further action necessary to address the gaps** | **By Who** | **By When** | **Progress** |
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| **Strategic Objective:** | 1 - Deliver the Annual Plan 2019/20 by the end of March 2020<br>6 - Deliver year 1 of Board approved strategies (Health and Well-Being, Continuous Engagement and Quality Improvement) by the end of March 2020 |

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|---|---|---|---|
| **Executive Director Owner:** | Rayani, Mandy | **Date of Review:** | 21/03/2019 |
| **Lead Committee:** | Quality, Safety and Experience Assurance Committee | **Date of Next Review:** | 21/05/2019 |

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| **Risk ID:** | **648** | **Principal Risk Description:** | There is a risk of the UHB not delivering improved outcomes and overall experience of care for patients. This is caused by a lack of resources within the Quality Improvement Team to fully implement its Quality Improvement Strategic Framework (QISF). This could lead to an impact/affect on the UHB's ability to reduce major causes of harm, variation and waste, and deliver a value-based healthcare model to support its service transformation agenda. |
| **Does this risk link to any Directorate (operational) risks?** | | | |

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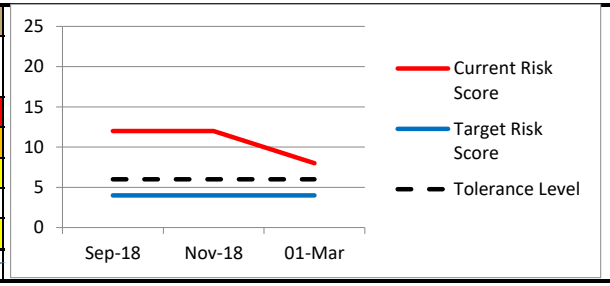
| **Risk Rating:(Likelihood x Impact)** | |
| **Domain:** | Business objectives/projects |
| **Inherent Risk Score (L x I):** | 4×4=16 |
| **Current Risk Score (L x I):** | 2×4=8 |
| **Target Risk Score (L x I):** | 2×2=4 |
| **Tolerable Risk:** | 6 |
| **Trend:** | |




| **Rationale for CURRENT Risk Score:** |
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| The risk score has been further reduced to 8 as funding has been made available to fund the first collaborative cohort from Jun19. The QISF was launched on 21Mar19. The framework and collaborative approach to be implemented with adequate resources from quality improvement expertise within the health board and engagement from operational teams and frontline staff to achieve measurable improvements. |

| **Rationale for TARGET Risk Score:** |
|---|
| Delivery of the QISF is dependent on having adequate resources in place to support its implementation. |

| **Key CONTROLS Currently in Place:**<br>(The existing controls and processes in place to manage the risk) |
|---|
| Small scale quality improvement activity taking place across the organisation.<br><br>Quality Improvement Strategic Framework (QISF) & implementation plan developed.<br><br>Launch of QISF in Mar19.<br><br>Funding for first collaborative cohort has been agreed.<br><br>Network of coaches identified from within and outside of organisation.<br><br>Full support from 1000 Lives and the Director of Quality and Safety NHS Wales. |

| **Gaps in CONTROLS** | | | | |
|---|---|---|---|---|
| **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working) | **How and when the Gap in control be addressed**<br>Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
| Human resources to deliver QISF.<br><br>Full engagement with the QISF from operational services.<br><br>No Associate Medical Director for Quality and Safety in place. | Identify funding to deliver QISF. | Rayani, Mandy | Completed | Completed. |
| | Establish steering group to drive the implementation of QISF and ensure implementation plan is delivered within agreed timescales. | Rayani, Mandy | Completed | QI steering group has been established and an inaugural meeting has been held. Self assessment of readiness being undertaken to inform launch and roll out. The Steering Group will monitor implementation of the collaborative programme |
| | Identification of quality leads for each site. | Rayani, Mandy | Completed | This still requires further discussion with the Director of Operations as part of the considerations regarding capacity building within Triumvirate teams. |

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|---|---|---|---|---|
| Collaborative Steering Group established and meets monthly to monitor delivery of implementation plan. | Identify human resources from the organisation to support the implementation of the QISF. | Rayani, Mandy | 30/06/2019 | The QISF was launched on 21Mar19. Coaches identified however project and administration support required to deliver programme. |
| | Implementation of QISF plan and the collaborative training programme. | Davies, Mandy | 31/03/2020 | Collaborative programme will start in Jun19. Delivery of QISF monitored by Collaborative Steering Group. |

| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls | Latest Papers (Committee & date) | Gaps in ASSURANCES | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Performance Indicators** | **Sources of ASSURANCE** | **Type of Assurance (1st, 2nd, 3rd)** | **Required Assurance / Current Level** | | | **Identified Gaps in Assurance:** | **How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps** | **By Who** | **By When** | **Progress** |
| | Collaborative Steering Group established to monitor delivery of QISF Implementation Plan | 2nd | | | N/A | Oversight of outcome delivery following implementation of QISF.<br><br>Need to establish process operational team prioritisation of Quality Goals and identification of Collaborative teams. | Reporting of achievement of project plan milestones to QISF Steering Group (when established). | Rayani, Mandy | Completed | The Steering Group been established to monitor implementation of the collaborative programme. |
| | | | | | | | Reporting of outcomes will be undertaken by QSEAC. | Rayani, Mandy | ~~31/12/2018~~ 31/12/19 | This will require further development during 2019/20. |
| | | | | | | | Collaborative Steering group to be established. | Rayani, Mandy | Completed | QI steering group has been established and an inaugural meeting has been held. Self assessment of readiness being undertaken to inform launch and roll out. The Steering Group will monitor implementation of the collaborative programme. |

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|---|---|
| **Enw'r Pwyllgor / Name of Committee** | Quality, Safety And Experience Assurance Committee Meeting |
| **Cadeirydd y Pwyllgor/ Chair of Committee:** | Professor John Gammon |
| **Cyfnod Adrodd/ Reporting Period:** | Meeting held on 4th April 2019 |

**Y Penderfyniadau a'r Materion a Ystyriodd y Pwyllgor / Key Decisions and Matters Considered by the Committee:**

- **Quality, Safety & Experience Assurance Committee Annual Report 2018/19** - the Committee received the QSEAC Annual Report, demonstrating the significant work undertaken by the Committee during 2018/19, focusing not only on the progress made but also highlighting where further work is required to meet the expectations of QSEAC. Following the suggestion of a number of minor amendments, Members approved the QSEAC Annual Report 2018/19 for submission to the Public Board meeting on 29th May 2019.

- **Final Draft Annual Quality Statement (AQS) Report** – the Committee received the final draft of the Annual Quality Statement (AQS) 2018/19. Members were advised that whilst the Readers Panel had provided positive feedback in regard to Primary and Community Care integration within the Health Board, a number of minor amendments have been proposed. The next stage would be the final design and Members agreed this would be approved by Chair's Action for onward submission to the 29th May 2019 Public Board meeting.

- **Outcome of QSEAC Self-Assessment of Effectiveness 2018/19** – the Committee received a verbal update on the outcome of the QSEAC self-assessment of effectiveness exercise 2018/19, with the full outcome report to be presented to the June 2019 QSEAC meeting. Initial feedback received has been positive, including considerable qualitative and quantitative data to review. Members believe that the Committee is maturing with robust discussions now taking place which are patient focused, and with a clear distinction between strategic and operational.

  **Operational Quality, Safety & Experience Sub Committee Exception Report and Annual Report 2018/19** – the Committee received the Operational Quality, Safety & Experience Sub-Committee (OQSESC) Exception Report and Annual Report 2018/19. Members expressed concern at the lack of meetings held by the Paediatric RRAILS Group, however for assurance were advised that following a meeting with the Clinical Lead and Chair of the Group, these would now be re-established. In addition, the scheduling of OQSESC and the Groups feeding into OQSESC will ensure a more timely feed to QSEAC going forward. Members commended the significant work undertaken in regard to medical devices which now provides assurance through the annual audits established. However, Members expressed concern regarding risk reporting to OQSESC and were advised that as operational risks are being discussed at the CEO Performance

Reviews meetings, it had been agreed to only receive risks by exception. In addition, a deep dive into 2 or 3 risks of particular concern would be undertaken during the year. In terms of the OQSESC Annual Report 2018/19, Members were advised that as the Sub-Committee is developing, more focused discussions are now taking place and Members views on the focus of discussions are requested following each meeting to improve the process going forward. The Committee endorsed the Operational Quality, Safety & Experience Sub-Committee Annual Report 2018/19.

**Medicines Management Sub Committee Exception Report and Annual Report 2018/19 and Workplan 2019/20** – the Committee received the Medicines Management Sub Committee Exception Report, Annual Report 2018/19 and workplan for 2019/20. Members were advised that the national group is currently reviewing the standards in relation to the storage of emergency drugs and an audit is being undertaken to establish the Health Board's position against the new standard with any concerns discussed at the Audit and Risk Assurance Committee (ARAC). Members were informed that the Medicines Management Annual Report 2018/19 is a reflection of the transition that has taken place during the previous 12 months from a Group to Sub-Committee, with a new approach adopted in terms of monitoring the risks assigned to the Sub-Committee which should provide for further assurance going forward. The Committee endorsed the Medicines Management Sub-Committee Annual Report 2018/19.

- **Mental Health & Learning Disabilities Quality, Safety & Experience Sub Committee Exception Report and Annual Report 2018/19** – the Committee received the Mental Health & Learning Disabilities Quality, Safety & Experience Sub Committee Exception Report and Annual Report 2018/19. Members recognised that the Sub-Committee had been a work in progress during the reporting period, with significant work undertaken by the Chair to ensure an appropriate focus for the meetings which now includes links to Healthcare Standards (HCS) and the monitoring of Healthcare Inspectorate Wales (HIW) reports. Members were advised that Care and Treatment Plans (CTP) are working well, however to ensure there is an equitable service for all service users, an audit for quality measure has been completed and currently being analysed. Members noted the **i**nequality of physiotherapy provision across the 3 counties however were assured that the Head of Therapies is working to improve service provision in this area. The Committee endorsed the Mental Health & Learning Disabilities Quality, Safety & Experience Sub-Committee Annual Report 2018/19.

- **Workforce & Organisational Development Sub Committee Exception Report and Annual Report 2018/19** – the Committee received the Workforce & Organisational Development Sub Committee Exception Report and Annual Report 2018/19. Members welcomed the approach of a deep dive into the risks assigned to the Sub-Committee which had been undertaken, providing assurance to QSEAC that risks are being monitored. The Chair commended the workforce team for their continued support to achieve 75% compliance for annual appraisal, with Hywel Dda above the NHS Wales average in all except one staff group. In terms of the Workforce & OD Annual Report, Members

noted that not all reporting groups had held regular meetings during 2018/19, however were assured that the Chairs of these groups had been reminded of the requirement and to provide update reports to subsequent Sub-Committee meetings. The Committee endorsed the Workforce & Organisational Development Sub-Committee Annual Report 2018/19.

- **Effective Clinical Practice Sub Committee Exception Report, Terms of Reference and Annual Report 2018/19** – the Committee received the Effective Clinical Practice Sub Committee Exception Report, Terms of Reference and Annual Report 2018/19. Members noted the newly established processes in place for the Sub-Committee and whilst acknowledging the number of areas that require addressing, were advised that it is too early in the process to provide this assurance. Members noted that the level of participation is lower than expected, regarding participation of national audits, and were advised that in order to increase focus on this, it had been agreed to establish a new reporting group. Whilst accepting a revised medical structure had taken place during the reporting period, Members expressed concern at the lack of progress of the Sub-Committee and directed that progress on delivering against the Sub-Committee's terms of reference would be expected at the next QSEAC meeting. The Committee approved the Effective Clinical Practice Sub-Committee Terms of Reference and endorsed the Annual Report 2018/19.

- **Strategic Safeguarding Sub Committee Exception Report, Annual Report 2018/19 and Workplan 2019/20** – the Committee received the Strategic Safeguarding Sub Committee Exception Report, Annual Report 2018/19 and Workplan and commended the Sub-Committee update report for the assurance it provided to QSEAC. Members noted that common themes regarding record keeping and sharing information are still occurring in investigations, however recognised these do not only relate to safeguarding and received assurance that the Sub-Committee has been in contact with operational teams across the Health Board to ensure that actions are being addressed. Members emphasised the need for partnership work in regard to the safeguarding of young carers, citing the significant growth in the number of children who have been identified as carers, and received assurance that Local Authority groups have raised awareness with GPs regarding referrals into their service. The Committee endorsed the Strategic Safeguarding Sub-Committee Annual Report 2018/19.

- **Improving Experience Sub Committee Annual Report 2018/19** – the Committee received the Improving Experience Sub Committee Annual Report 2018/19. Members noted the current direction and progress of the Sub-Committee and welcomed the implementation of the Patient Charter. The Committee endorsed the Improving Experience Sub-Committee Annual Report 2018/19.

- **Improving Experience – Development of a Patient Experience Charter** – the Committee received an update on the development of the revised Patient Experience Charter. Members were advised that based on discussions at the previous QSEAC meeting, a patient focused group workshop had taken place,

and that work continues with stakeholders including, the Community Health Council (CHC), to ensure this is a positive document.

- **Infection Prevention Sub-Committee Exception Report and Terms of Reference and Annual Report 2018/19** – the Committee received the Infection Prevention Sub Committee Exception Report, Terms of Reference and Annual Report 2018/19. Members were advised that given the background work that has been completed in regard to antibiotic use, the Health Board should be compliant before the new guidelines are initiated. Members were informed that where necessary, Heads of Nursing will reinforce and challenge staff to ensure that the 'Bare Below the Elbow' standard for hand hygiene is adhered to, however acknowledged the challenge to alter the culture with all staff groups within the Health Board. Members approved the Infection Prevention Sub-Committee Terms of Reference and endorsed the Annual Report 2018/19.

- **Corporate Risks Assigned to QSEAC** - the Committee received the Corporate Risk Report outlining the 14 corporate risks assigned to QSEAC from the Board. Members were informed that all risks are subject to the CEO's performance review and are challenged, where appropriate, to provide the necessary assurance to Board. Members noted the controls, amendments and plans in place, including the suggestions for future meetings.

- **Histopathology Staffing and Environment Issues – Update Report** - the Committee received an update on the inherent risks facing the Cellular Pathology (Histopathology) service. The CHC expressed concern from the public's perspective regarding the long term strategy to remove the Cellular Pathology services from Hywel Dda to be replaced by a regional service. However Members were advised that the intention will still be to provide a service within the Health Board which will link into the regional service at Morriston Hospital, which should provide a more sustainable service, with better expertise and quicker turnaround times in future. This should also have no impact on patients, given it is only the sample that will be moved to another location for testing rather than the patient. Whilst the Board have approved the long term plan as part of the 'A Regional Collaboration for Health' (ARCH) programme, the fragility of the current workforce is acknowledged, with Members receiving assurance that the Joint Regional Planning and Delivery Committee (JRPDC) has established a Task and Finish Group to work with the Health Board to develop opportunities for them.

- **NHS Wales Laundry Production Units** - the Committee received a report on the NHS Wales Laundry Production Units, given the concerns raised at the recent Board meeting on the potential quality and safety impacts due to the expected delivery timescale of any new arrangements in Wales. Members acknowledged the current challenges in becoming compliant with the new standards, however received assurance that to date no concerns have been raised. Members welcomed the positive engagement with staff to ensure they are updated on the progress of the Outline Business Case.

- **Nurse Staffing Levels (Wales) Act – Annual Report 2018/19** - the Committee received the Nurse Staffing Levels (Wales) Act – Annual Report 2018/19 and were advised of the requirement to update the Board twice a year on progress of implementation. Members noted the report highlights where the Health Board is not meeting the required standards, whilst acknowledging that robust standards are in place which is critical for QSEAC's assurance. In addition, the Health Board has adopted a risk based approach across the organisation, as well as working with District Nurses and the MH& LD Directorate, work has also taken place in the paediatric directorate regarding activity and staffing. QSEAC will receive an update report following the next round of staffing calculations. This exercise is completed every 6 months.

- **Quality and Safety Assurance Report** - the Committee received the Quality and Safety Assurance Report and advised that the information and data presented provides a high-level position against the organisation's assurance and improvement activities across the Health Board. Members welcomed the report noting that it provided greater assurance with regard to data, Statistical process control (SPC) charts and planned next steps. Given the noticeable increase in pressure damage indicators, Members queried whether this could be the result of good practice only being applied to individual locations rather than across the organisation. An assurance was received that the Quality Improvement (QI) team are sharing good practice in all areas, in addition to monthly pressure damage scrutiny meetings, where good practice has been extended to community services. Members welcomed the report which provided assurance to the Committee through the triangulation of data.

- **External Monitoring Activity Report** - the Committee received the findings within the Final External Monitoring Reports and were advised that following recent unannounced visits by Healthcare Inspectorate Wales (HIW), verbal feedback has been increasingly positive, particularly in regard to inspections undertaken in Bronglais General Hospital (BGH), Withybush General Hospital (WGH) and Glangwili General Hospital (GGH) where the sharing of good practice across these sites has been noted.

- **Management Response to the Delivery Unit Report Review of the Impact of Long Waits for Planned Care on Patients (November 2018)** - the Committee received the Management Response to the Delivery Unit (DU) Report: Review of the Impact of Long Waits for Planned Care on Patients (November 2018) and were advised that the report contains 10 recommendations for consideration by the Health Board. Members were informed that the review highlighted a significant gap from when a patient is referred for treatment, which could be due to a communication issue for this cohort of patients. Members acknowledged that whilst patient experience is important with any delay in treatments, the impact to family and carers should also not be underestimated. Members supported the proposed establishment of a Project Group and agreed that a further detailed report should be presented to QSEAC in August 2019, in addition to the report forward planned for October 2019.

- **Management of Follow-Up Outpatients (Including Current Assessment Of Clinical Risk / Harm)** - the Committee received a progress update in respect of the University Health Board's (UHB's) plans to reduce the volume of delayed follow-ups. Members noted that the report provides positive examples where numbers are being reduced within the Health Board, and that these will be monitored by both Business Planning, Performance Assurance Committee (BPPAC) and QSEAC during 2019/20. Whilst noting the recent validation to remove patients who had been on the follow up list for 3-5 years, Members suggested that a new approach could be adopted including multi-disciplinary teams to establish whether further follow ups are required and asking patients for their preference given the importance of listening to the patient voice. Members suggested that the next steps should be a review by OQSESC within the next 6 months, followed by an update to QSEAC.

- **South Wales Vascular Network Presentation** - the Committee received a presentation on the South Wales Vascular Network Presentation by the Vascular Surgery Clinical Network lead following the National Vascular Registry Report 2018. Members were advised that the service now has nine consultants, with the hub just short of the national average of 62% undertaking 10 operations per week. Members received an overview of the statistics for Carotids, Aortas and complex Abdominal Aortic Aneurysm (AAA) and noted that an aneurysm screening programme in place to address the medium to long term. Following recommendations from the National Vascular Registry Report 2018, the service is currently reviewing how to improve the supervision of a senior trainee undertaking amputations and improving procedures to ensure that amputations are recorded accurately on the register. Members welcomed the presentation which provided assurance for QSEAC on the service received by the patients of Hywel Dda.

- **Quality, Safety & Experience Assurance Committee Work Plan 2019/20** the QSEAC Work Plan 2019/20 was received for information.

**Materion y mae angen Ystyriaeth neu Gymeradwyaeth Lefel y Bwrdd are u cyfer /**
**Matters Requiring Board Level Consideration or Approval:**

- None

**Risgiau Allweddol a Materion Pryder /**
**Key Risks and Issues/ Matters of Concern:**

- **Operational Quality, Safety & Experience Sub Committee Exception Report and Annual Report 2018/19**
  - Concerns in regard to the lack of meetings held by the Paediatric RRAILS Group, however the Committee was assured that these would now be re-established.
  - Concerns regarding risk reporting to OQSESC, although the Committee was advised that as operational risks are being discussed at the CEO Performance Reviews meetings, it has been agreed to only receive risks by exception, and that going forward, a deep dive into 2 or 3 risks of particular concern would be undertaken during the year.

- **Effective Clinical Practice Sub Committee Exception Report, Terms of Reference and Annual Report 2018/19** - concerns at the lack of progress of the Sub-Committee with an update on the Sub-Committee's delivery against its terms of reference expected at the next QSEAC meeting.

**Busnes Cynlluniedig y Pwyllgor ar gyfer y Cyfnod Adrodd Nesaf / Planned Committee Business for the Next Reporting Period:**

**Adrodd yn y Dyfodol / Future Reporting:**

In addition to the items scheduled to be reviewed as part of the Committee's work programme, following up progress of the various actions identified above will be undertaken.

**Dyddiad y Cyfarfod Nesaf / Date of Next Meeting:**

4th June 2019

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

**CYFARFOD BWRDD PRIFYSGOL IECHYD**
**UNIVERSITY HEALTH BOARD MEETING**

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|---|---|
| **DYDDIAD Y CYFARFOD:**<br>**DATE OF MEETING:** | 30 May 2019 |
| **TEITL YR ADRODDIAD:**<br>**TITLE OF REPORT:** | Nurse Staffing Levels (Wales) Act – Annual Report 2018/19 |
| **CYFARWYDDWR ARWEINIOL:**<br>**LEAD DIRECTOR:** | Mandy Rayani, Director of Nursing, Quality and Patient Experience |
| **SWYDDOG ADRODD:**<br>**REPORTING OFFICER:** | Mandy Rayani, Director of Nursing, Quality and Patient Experience |

| **Pwrpas yr Adroddiad** (dewiswch fel yn addas)<br>**Purpose of the Report** (select as appropriate) |
|---|
| Er Sicrwydd/For Assurance |

**ADRODDIAD SCAA**
**SBAR REPORT**

## Sefyllfa / Situation

The Nurse Staffing Levels (Wales) Act (NSLWA) 2016 became law in March 2016 and has had a phased commencement. The final sections of the Act came 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, 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. This annual report represents the first of three annual reports which will, when aggregated in May 2021, form the basis of the statutory three year report to Welsh Government required by the NSLWA.

The Hywel Dda University Health Board Quality, Safety & Experience Assurance Committee (QSEAC) has reviewed and taken assurance from the attached annual report at its April 2019 meeting.

The Board is now asked to formally receive and note the information contained within the 2018/19 Nurse Staffing levels (Wales) Annual Report (Appendix 1) which has been produced using the prescribed NHS Wales reporting template.

## Cefndir / Background

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/ trust 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 2nd 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; and
- 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.

Below are links to the two main documents referred to within this report:
Welsh Government Nurse Staffing Levels (Wales) Act 2016 Statutory Guidance (2017):

https://gov.wales/docs/phhs/publications/171102nurse-staffingen.pdf

NHS Wales Operational Guidance (2018):

http://www.1000livesplus.wales.nhs.uk/sitesplus/documents/1011/Nurse%20Staffing%20Levels%20%28Wales%29%20Act%202016%20-%20Operational%20Guidance.pdf

## Asesiad / Assessment

**Requirements of Section 25A:** Section 25A sets out the HB's overarching responsibility to ensure they have robust workforce plans, recruitment strategies, structures and processes in place to make certain that there are appropriate nurse staffing levels across their organisations. This duty came into effect in April 2017.

The process to systematically review the nurse staffing levels to be able to demonstrate the above statutory requirement explicitly for ALL clinical nursing teams has begun this year with the plan being to undertake a review of the (circa) 300 departments/services/teams where Section 25A applies by the time that the first report to Welsh Government (under the requirements of Section 25E of the Act) is prepared in April 2021

**Requirement of Section 25B:** For the period 2018-19, 34 medical and surgical wards have been considered and, of these, Section 28B (paragraph 28) applied to 31 of these wards. The nurse staffing levels calculation has been undertaken using the triangulated methodology and in additional to the bi-annual calculations undertaken in Spring (March 2018) and Autumn

(October 2018), 14 wards have been reviewed outside of the bi-annual calculation. The Spring 2018 calculation cycle identified that it would require an uplift of 19 Whole Time Equivalent (WTE) to the required establishments of the 32 wards to enable the Senior Sister/Charge Nurse to be 'fully supernumerary'. After consideration, it was agreed that there would need to be a phased implementation as the recruitment situation made it unlikely that the HB would be in a position to recruit to these posts in the immediate future; given the nurse recruitment challenges both locally and across the UK (see pages 5-7 of the Annual Report). Informing patients: The statutory guidance states that "LHBs and Trusts must make arrangements to inform patients of the nurse staffing level" (paragraph 20). To this end, the HB is currently complying with the requirements of the act by:

- Displaying the nurse staffing level calculated for each adult acute medical and surgical ward at the entrance of the Section 25B wards (in accordance with paragraph 22); and
- Provided each of the wards with a patient leaflet (English and Welsh versions) with 'frequently asked questions' (FAQ) on the nurse staffing level which have been developed as part of the operational guidance work (paragraph 23 & 25). The FAQ leaflet is being reviewed as part of the all Wales review of the Operational Guidance currently taking place.

**Section 25E (2a):** The process for maintaining the nurse staffing levels is set out on pages 9-10 of the Annual Report.

Board members are asked to note the risk that has been included on the HB's risk register around the requirement 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 employed staff but temporary workers can be engaged if required" (paragraph 13). A written control document is currently going through the All Wales Nurse Staffing programme governance system which will result in the publication of an All Wales view on what steps would comprise 'all reasonable steps' in Spring 2019. Once issued, this list will be incorporated immediately into the HB's own Operating Framework for the Act, which is contained with Policy 409 (Nurse Staffing Levels and Escalation Plan: Adult Acute Services Policy. Until this time, this risk is included on the HB's risk register.

**The process for monitoring the nurse staffing levels** is set out on page 10-14 of the Annual Report.

Board members are asked to note that under section 25E of the Act, health boards/trusts are required to report "the extent to which nurse staffing levels have been maintained". However, there is no one system within the HB that can provide us with the data required to show compliance with the above. The Annual Report includes examples of some proxy measures that can be used to demonstrate compliance however there is further work to do before we will have robust data.

Board members are asked to note that the NSLWA statutory guidance also requires that ''LHB's 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" (paragraph 15). It must be acknowledged that although there are systems in place within the nursing structures on each of the acute sites to review and record those occasions when the number of nurses deployed varies from the planned roster, there is no single consistently used system to record this information. There is work both locally and nationally to develop systems which would enable the capture of this information on one system, however, the Board is asked to note that until that time, a single source of the information to enable an assessment of the actual number of times there is variation from the planned roster is not available across the HB. This is a recognised risk for the HB and has been included on the HB's risk register (number 647) and is

being monitored via the Nurse Staffing Levels Implementation Group and on behalf of the Board though updates provided to QSEAC.

**Impact on care:** The impact on care is included on page 15-17 of the Annual Report. Board members are asked to note that there are 16 incidents (up to 22nd March 2019) relating to those indicators that require formal reporting under the requirements of the Act. Of the 16 incidents, the investigator concluded that not maintaining the nurse staffing levels did not contribute to the incident occurring in 13 of the incidents, the remaining three are currently being reviewed.

**Actions taken if Nurse Staffing Level is not maintained:** Pages 17-22 of the Annual Report includes narrative both at strategic and operational level on the actions have been taken when the nurse staffing level is not maintained. These include:

- Recruitment initiatives;
- 'Made In Hywel Dda' programme;
- Operational examples from each of the acute sites

**Next Steps:** Implementation of the All Wales Nurse Staffing (Levels) Act Wales is being progressed at pace in line with the implementation plan outlined at Board in July 2018 and the subsequent update to Board in November 2018.

The level of detailed work required to implement the requirements of the Act cannot be underestimated. Likewise, the dynamic nature of the calculations for each and every area where nurses deliver care needs to be acknowledged as the calculations will not remain static and will continue to be informed through service change and reconfiguration as well as the development of other professional roles within the multi-disciplinary team.

**Argymhelliad / Recommendation**

The Board is asked to note:

- The content of the attached Annual Report;
- That the implementation plan will continue to remain a live document subject to continuous review and iteration. Prioritisation and phasing within the implementation plan will, by necessity, be continually monitored by the Director of Nursing, Quality and Patient Experience;
- That, as the committee to which Board has delegated responsibility for monitoring compliance with the NSLWA, QSEAC will continue to receive regular updates on the risks which have been identified within the annual report and any impact on care as a result of not maintaining the nurse staffing levels.

| **Amcanion: (rhaid cwblhau)<br>Objectives: (must be completed)** | |
|---|---|
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:<br>Datix Risk Register Reference and Score: | Corporate risk register 647 Score 12<br>2. Safe Care<br>4.1 Dignified Care<br>7. Staff and Resources<br>Choose an item. |

| | |
|---|---|
| Safon(au) Gofal ac Iechyd:<br>Health and Care Standard(s):<br>Hyperlink to NHS Wales Health & Care Standards | All Health & Care Standards Apply |
| Amcanion Strategol y BIP:<br>UHB Strategic Objectives:<br>Hyperlink to HDdUHB Strategic Objectives | 4. Improve the productivity and quality of our services using the principles of prudent health care and the opportunities to innovate and work with partners. |
| Amcanion Llesiant BIP:<br>UHB Well-being Objectives:<br>Hyperlink to HDdUHB Well-being Statement | Improve efficiency and quality of services through collaboration with people, communities and partners |

| **Gwybodaeth Ychwanegol:<br>Further Information:** | |
|---|---|
| Ar sail tystiolaeth:<br>Evidence Base: | The evidence underpinning the effectiveness of the maintenance of nurse staffing levels in ensuring the delivery of safe care has been articulated through the working papers of the All Wales Nurse Staffing Group over the past two years. |
| Rhestr Termau:<br>Glossary of Terms: | Contained with the body of the report. |
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol:<br>Parties / Committees consulted prior to University Health Board: | Nurse Staffing Levels (Wales) Act Implementation Group<br>Executive Team |

| **Effaith: (rhaid cwblhau)<br>Impact: (must be completed)** | |
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| **Ariannol / Gwerth am Arian:<br>Financial / Service:** | The financial impact of this paper is significant and is outlined in detail within the paper. |
| **Ansawdd / Gofal Claf:<br>Quality / Patient Care:** | The intention underpinning the Act is to ensure safe, effective and quality patient care. One of the key requirements of the Act is to monitor the impact of nurse staffing levels on care quality; therefore, this metric will be carefully monitored as part of the work to implement the Act. |
| **Gweithlu:<br>Workforce:** | This paper relates to the additional permanent staffing required within the Health Board's workforce in order to implement Section 25B and C of the Act. It is anticipated the Act will have a positive impact on the sense of well-being of the workforce. The nursing workforce in acute adult ward areas will require an uplift of permanent nursing staff (Registered Nurses and Health Care Support Workers) as a result of the implementation of the Act. The Health Care Support Worker recruitment will require a targeted approach however is likely to be achievable in |

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| | the short term. The additional registered nurses required will further compound the vacancy issues the Health Board is currently experiencing and interim solutions to consider alternative ways of working (e.g. development of interim Band 4 posts within the team skill mix) may be required. |
| **Risg:**<br>**Risk:** | Risk of non-compliance with the Nurse Staffing Levels (Wales) Act 2016 if the work streams do not achieve the planned outcomes. |
| **Cyfreithiol:**<br>**Legal:** | Risk of non-compliance with the Nurse Staffing Levels (Wales) Act 2016 if the work streams do not achieve the planned outcomes. |
| **Enw Da:**<br>**Reputational:** | The reputation of the nursing services of the Health Board is enhanced through the level of engagement and contribution that staff of the Board are currently making to the All Wales work streams. This would be countered by the negative reputational risk if the Health Board were perceived to be not acting in the spirit of the Act. |
| **Gyfrinachedd:**<br>**Privacy:** | Currently no impact in relation to privacy identifiable within this work |
| **Cydraddoldeb:**<br>**Equality:** | No negative EqIA impacts identified. |

| Nurse Staffing Levels (Wales) Act 2016 - Health Board/NHS Trust Reporting template | |
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| **Health Board** | Hywel Dda University Health Board (HDUHB) |
| **Reporting period** | 1st April 2018- 31st March 2019 |
| **Requirements of Section 25A** | Section 25A sets out the HB's overarching responsibility to ensure they have robust workforce plans, recruitment strategies, structures and processes in place to make certain that there are appropriate nurse staffing levels across their organisations. This duty came into effect in April 2017.<br><br>The process to systematically review the nurse staffing levels to be able to demonstrate the above statutory requirement explicitly for ALL clinical nursing teams began in 2018/19 with the plan being to undertake a review of the (circa) 300 departments/services/teams where Section 25A applies by the time that the first report to Welsh Government (under the requirements of Section 25E of the Act) is submitted in May 2021.<br><br>To achieve this systematic review of the 25A areas, the Heads of Nursing for each service will be required to utilise the triangulated approach described in Section 25C of the Act and apply it to the review of the calculated nurse staffing level for their service. During the review they will therefore be asked to show how they have utilised the three distinct sources of information that Section 25C refers to i.e. :<br>• Patient acuity/workload data (where it exists for that speciality);<br>• Quality indicators data around any nurse sensitive quality indicators deemed appropriate for the clinical area under review ; and<br>• Professional judgement (as it applies within that particular clinical setting).<br><br>There are a number of national work streams set up as part of the NHS Wales Nurse Staffing Programme to support the work to enable the Nurse Staffing Level (Wales) Act (NSLWA) to be extended to other clinical areas over time (i.e. paediatrics, mental health, district nursing, health visiting and care homes). A number of these national work streams have developed interim nurse staffing principles which have/are due to be issued by the Chief Nursing Officer (CNO) and the health boards' compliance against them is/will be monitored. The current position within the HDUHB in relation to these work streams is as follows**:**<br><br>**District Nursing**<br>Interim Nursing Staffing Levels Principles were issued by the Chief Nursing Officer (CNO) in 2017 and the |

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| | HDUHB has submitted three sets of data at six monthly intervals to the CNO Office in response to the WG monitoring requirement. These returns have shown some small improvements in compliance over the eighteen month period covered by the three reports submitted to date e.g. a small increase in the number of hours of administrative support available to the teams and an increase in the number of DN teams which meet the principles relating to clinical leadership.<br><br>In addition to monitoring of compliance against the principles themselves, a robust review of the staffing levels within every DN team across HDUHB (24 in total) has been undertaken during 2018/19. This process has reflected the triangulated methodology explained above and has also taken account of the Interim DN nurse staffing principles. This review process will be concluded in May 2019 when the financial implications of any changes to staffing levels which the review has shown may be required will have been calculated and will be presented to the 'designated person' (Director of Nursing, Quality and Patient Experience (DNQPE) ) for consideration. Once this piece of work is concluded, there will remain work to be undertaken to review the nursing staffing levels of the (several) other nursing teams which form part of the overall community nursing services. Account will have to be taken of the strategic direction of services within the HDUHB when the totality of the required community/district nursing service nurse staffing levels across HDUHB are finally proposed to the DNQPE during 2019/20<br><br>**Mental Health:**<br>The All Wales Nurse Staffing Programme - Mental Health Acuity Group is currently developing (draft) nurse staffing level principles to apply to inpatient mental health wards (8 in HDUHB). There is strong HDUHB representation on this group and also on the All Wales Nurse Staffing group which will need to approve and recommend any principles to the CNO before they are finalised.<br><br>A workforce and financial 'impact assessment' to enable an understanding of the implications of approving the draft principles is in the process of being prepared by all health boards across Wales and both the principles and the collated impact assessment will be considered by the All Wales Nurse Staffing Group prior to them being recommended for approval to the CNO. These next steps will take place during the first two quarters of 2019/20. Aware of the progress being made at an All Wales level in respect of this work stream, and also because of a professional recognition within this HB that the adult/older adult ward nurse staffing levels required review, a series of meetings have been held with senior representatives from the Mental Health Teams over Quarters 3 and 4 of 2018/19 in order to review and re-calculate the nurse |

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| | staffing levels for the eight adult inpatient mental health wards. The draft nurse staffing principles for mental health as well as the triangulated methodology described above has again been utilised within these discussion. This review is concluded and the proposed nurse staffing levels have been agreed with the 'designate person'. The agreed staffing levels are currently undergoing financial assessment. It is recognised that the Transforming Mental Health services strategy will need to be taken full account of when considering the next steps impact of the revised proposed staffing levels is available.<br><br>**Paediatrics:**<br>The All Wales Nurse Staffing group - Paediatric Acuity work stream is also in the process of developing (draft) nurse staffing level principles for inpatient paediatric wards. Again, there is strong HDUHB representation on this group which, additionally, is chaired by a senior officer of this HB. As with the mental health nurse staffing principles, an impact assessment to which each HB in Wales has contributed has been collated and this, together with the draft principles themselves, are being finalised and will be submitted by the All Wales Nurse Staffing group to the CNO early in 2018/19.<br><br>Within this Health Board, work to formally review and recalculate the nurse staffing levels for the paediatric in-patient wards using the triangulated methodology and taking account of the draft principles has commenced in March 2019 and it is anticipated this will be finalised during Quarter 2 of 2019/20.<br><br>**Health Visiting.**<br>The All Wales Health Visiting work stream is currently developing draft nurse staffing level principles for the Health Visiting teams and there are HB representatives on the all Wales group taking this forward. An impact assessment against the draft principles has been and submitted to the All Wales group.<br><br>**Community Hospitals inpatient wards.**<br>In addition to their work in relation to the DN team staffing levels, the Heads of Nursing for Community nursing services across Carmarthenshire, Ceredigion and Pembrokeshire are currently undertaking a review of the nurse staffing levels for the inpatient wards in the community hospitals, using the triangulated methodology set out in Section 25C of the Act. These wards are utilising the Welsh Levels of Care patient acuity tool (this is the evidence-based patient acuity/dependency tool that the adult medical/surgical in-patient wards are using) to contribute the<br>Patient acuity/workload data element into this review process. This work should be finalised during Quarter |

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| | 2 of 2019/20<br><br>**Scheduled Care Directorate**<br>Initial planning meetings have taken place during Quarter 4 2018/19 with representatives from the Scheduled Care Directorate. It has been agreed that the nurse staffing levels for the significant number of clinical areas covered by this service (including endoscopy, critical care, out patients departments, theatres and day surgical units) will be reviewed, recalculated and presented to DNQPE for consideration, during the second half of 2019/20. |
| **Financial Year 2018/2019** | |
| **Date annual report on the Nurse Staffing level submitted to Board** | May 2019 |
| **Number of adult medical inpatient wards where section 25B applies** | For the period 2018-19, 21 medical wards have been considered and of these, Section 28B (paragraph 28) applied to 19 wards.<br><br>Of the remaining 2 wards:<br><br>• One ward was initially included under Section 25B but a change in function of the ward has meant that the ward no longer meets the definition of an adult acute medical ward; and<br>• One ward did not meet the definition of an adult acute medical ward throughout the reporting period.<br><br>A list of the wards is included in Appendix 1. |
| **Number of adult surgical inpatient wards where section 25B applies** | For the period 2018-19, 13 surgical wards have been considered and of these, Section 28B (paragraph 29) applied to 12 wards (one of the wards is a combined medical and surgical ward but has been included in this section for reporting purposes).<br><br>• The remaining one ward was initially included under Section 25B but a change in function during the reporting period has meant that the ward no longer meets the definition of an “adult acute surgical inpatient ward”.<br><br>A list of the wards is included in Appendix 1. |

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| **Number of occasions where Nurse Staffing Level recalculated in addition to the bi annual calculation** | In additional to the bi-annual calculations undertaken in Spring (March 2018) and Autumn (October 2018) 14 wards have been reviewed outside of the bi-annual calculation. The recalculations were triggered by one of the following triggers:<br>• The ward being identified as a ward requiring an 'early review' following one of the biannual calculation cycles;<br>• A change in function for the ward;<br>• Plans for reconfiguration of services; or<br>• A recalculation was deemed necessary because of the professional judgement of the Head of Nursing, in conjunction with the 'Designated Person |
| **The process and methodology used to inform the triangulated process** | A series of meetings have been arranged as part of each calculation cycle and the triangulated methodology, set out in the Statutory Guidance, has been the basis of the discussions around the nurse staffing levels for each ward, between the 'Designated Person' (the Director of Nursing, Quality & Patient Experience I i.e. DNQPE), the Heads of Nursing, Nurse Staffing Programme Lead, and these discussions have been underpinned by a review of three distinct sources of data i.e.<br><br>• Patient acuity data;<br>• Quality indicator data (relating to pressure damage, falls, medication administration errors and complaints); and<br>• Professional judgement data.<br><br>In addition, the Heads of Nursing had discussions with the relevant Senior Nurse Managers and Senior Sisters/Charge Nurses in preparation for the discussions with the Director of Nursing, Quality & Patient Experience and were invited to attend these meetings where appropriate.<br><br>The detailed discussions have been captured for each ward area using a template which was included in the Operational Guidance, circulated via a Welsh Health Circular in March 2018 (Welsh Health Circular number 013-18).<br><br>The template has been used to ensure consistency in the information being captured and has enabled additional action points/data for each ward to be complied which have been followed up prior to the final nurse staffing level being confirmed by the designated person. The template used to document the detailed discussions have been reviewed and amended over the reporting period to reflect the learning from each of |

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| | the calculation cycles.<br><br>The sources of the data that would be reviewed as part of the triangulated methodology have been reviewed and the mechanisms by which this information is shared with the Heads of Nursing have also been confirmed to ensure that the Heads of Nursing receive accurate and timely information to help inform their decisions around the nurse staffing levels for each ward.<br><br>The quality of the data being collected has also being reviewed over the reporting period to ensure that the data is accurate and complete. Examples include reviewing the data currently available in relation to recent past use of additional Health Care Support Workers (HCSW) to provide 'enhanced patient support' in line with current HB policy; and Welsh levels of Care workshops to ensure consistent understanding of the levels of acuity as part of the biannual acuity audits.<br><br>The nurse staffing levels for each of the wards where Section 25B applies have received "an uplift of 26.9%" applied in accordance with paragraph 39 of the Statutory Guidance.<br><br>The publication of the Nurse Staffing Levels (Wales) Act 2016 statutory guidance set out a clear expectation that ward sisters/charge nurses will be supernumerary to the planned roster. Prior to the commencement of the nurse staffing levels work, the nurse staffing establishments for the Section 25B wards had included within them the capacity for the Senior Sister/Charge Nurse to be supernumerary for two day per week. Although it needs to be noted that due to the recruitment challenges, the Senior Sister/Charge Nurse was not always able to be supernumerary for these two days and often had to step in to provide direct patient care as part of the rostered workforce.<br><br>The Spring 2018 calculation cycle identified that it would require an uplift of 19 WTE to the required establishments of the 32 wards to enable the Senior Sister/Charge Nurse to be 'fully supernumerary'. After consideration, it was agreed that there would need to be a phased implementation as the recruitment situation made it unlikely that we would be able to recruit to these posts in the immediate future; given the nurse recruitment challenges both locally and across the UK. In May 2018, the Board agreed that for 2018-19 there would be 'formal protection' of the two days a week of supernumerary time for each Senior Sister/Charge Nurse (using contract agency staff if required). In readiness for the Band 7 post holders to be fully supernumerary during 2019/20, the Band 7 job description has been reviewed to ensure that it reflect |

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| | the attributes required from the Senior Sister/Charge Nurse being supernumerary and supervisory.<br><br>The Board also agreed that the clinical leadership on each ward would be strengthened by having two Band 6 Sister/Charge Nurse posts as a norm for all wards with 18 beds or more: This has equated to an additional 13 WTE Band 6 Sister posts being created across the acute wards of the Health Board. In preparation for the appointment of the additional Band 6 posts, the Band 6 job description has been reviewed, approved by the Senior Nursing & Midwifery team (SNMT) and job matched through the Agenda for Change Panel. Monies for the additional band 6 posts was added to the establishments for the identified wards in October 2018 and the Heads of Nursing are finalising recruitment into these posts at the time of writing this report.<br><br>During the reporting period, monies has also been allocated to 10 wards across the HB to uplift the Band 2 Health Care Support Worker establishments and, in some cases, Band 3 Frailty Support Worker and Rehabilitation Support Worker posts which have been created or increased in number in order to provide focussed care aimed at better meeting the specific care needs of particularly vulnerable patient groups.<br><br>The 10 wards were identified as priority areas by the Heads of Nursing. The total number of additional band 2 posts created within the establishments of these 10 wards during 2018/19 were 40.28 WTE; whilst the number of Band 3 posts created were 9 WTE.<br><br>In preparation for the Band 3 appointments, the job description for the Frailty Support worker as well as the Rehabilitation Support Worker have been reviewed and standardised for use across the health board; and the training programme which all post holders in these roles are required to undertake have been revised and brought fully in line with the HCSW Career Framework requirements.<br><br>As noted above, the Board agreed a phased implementation to the uplifts required as part of the calculation of the Nurse Staffing Levels both from a financial and recruitment perspective and this approach is a risk to the Board until full implementation is achieved. This risk is included on the HB's risk register and will be monitored on behalf of the Board, through QSEAC.<br><br>In May 2018, it was anticipated that full implementation of the financial uplifts would be achieved by 2020-21, and this remains the target date with full financial uplift to be achieved early in 2020/21 financial year. |

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<tr><td></td><td></td></tr>
<tr><td>Informing patients</td><td>The statutory guidance states that “LHBs and Trusts must make arrangements to inform patients of the nurse staffing level” (paragraph 20). To this end, the HB is currently complying with the requirements of the act by<ul><li>Displaying the nurse staffing level calculated for each adult acute medical and surgical ward at the entrance of the Section 25B wards (in accordance with paragraph 22); and</li><li>Provided each of the wards with a patient leaflet (English and Welsh versions) with ‘frequently asked questions’ (FAQ) on the nurse staffing level which have been developed as part of the operational guidance work (paragraph 23 & 25). The FAQ leaflet is being reviewed as part of the all Wales review of the Operational Guidance currently taking place.</li></ul>The Statutory guidance also states that “the LHB’s (or Trust’s) public board papers should include the nurse staffing level of each individual adult acute medical and surgical ward annually” (paragraph 21). Since July 2016 the Board received a number of papers setting out the progress with the planning for the Act and since April 2018, the Board (or a delegated committee of the board) has received regular updates on progress with the implementation of the Nurse Staffing levels (Wales) Act:<table><tr><td>April 2018</td><td>A detailed briefing on the outcome of the extensive review undertaken by the Director of Nursing during the Board seminar</td></tr><tr><td>May 2018</td><td>Paper submitted to Board outlining the outcome of the extensive nurse staffing level reviews, which have been led by the Director of Nursing, Quality and Patient Experience in collaboration with the Heads of Nursing, Senior Nurses and a senior member of the finance team, and the three main options for consideration</td></tr><tr><td>July 2018</td><td>Update provided to Workforce and OD sub-committee to discuss the implications of the Act for Workforce and OD.</td></tr><tr><td>July 2018</td><td>Paper received by Board providing a update on progress against the detailed Implementation Plan (Appendix 1) as well as the outcome of the Autumn 2018 (6 monthly) calculation cycle will inform the planning for the 2019/20 IMTP planning cycle and the next stage of the implementation plan to meet the Nurse Staffing Levels (Wales) Act 2016 requirements.</td></tr><tr><td>August 2018</td><td>Paper submitted to QSEAC noting the progress against the statutory guidance and further actions as set out in the detailed Implementation Plan (</td></tr><tr><td>September</td><td>Update provided to the Workforce Control Panel</td></tr></table></td></tr>
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<tr><td>2018</td><td></td></tr>
<tr><td>November 2018</td><td>Paper submitted to Board noting the outcome of the Autumn nurse staffing levels calculation cycle an progress with the implementation plan</td></tr>
<tr><td>February 2019</td><td>The Quality, Safety and Experience Assurance Committee received an update of the calculation of the nurse staffing level for each ward where section 25B applies</td></tr>
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<br>The HDUHB Nurse Staffing Levels (Wales) Act Implementation Group oversees the work required to fully meet the HB's statutory obligations around the Act and this group reports to the Nursing Workforce Management Group and the Workforce and OD sub-committee.<br><br>The Director of Nursing, Quality and Patient Experience has also committed dedicated resources to this work stream and 2018/19 saw the appointment of the Nurse Staffing Programme Lead, who supported by the Senior Nurse - Staffing and Practice Development, oversees the Nurse Staffing Levels (Wales) Act implementation Plan. Both the Nurse Staffing Programme Lead, and the Senior Nurse - Staffing and Practice Development contribute both locally within the HB but also to the national work around the Act, through their contribution to each of the work streams and supporting key All Wales work, for example, leading the development and subsequent reviewing of the operational handbook published to support the implementation of the Act in practice; key drivers in having a 'Once for Wales' position on what would constitute "all reasonable steps" and when it would be deemed necessary to recalculate the nurse staffing levels; active members of the All Wales Health & Care Monitoring System Group which oversee the enhancements required to the electronic system used across Wales to capture the acuity data.</td></tr>
<tr><td colspan="2">Section 25E (2a) Extent Nurse Staffing Levels Maintained</td></tr>
<tr><td>Process for maintaining the nurse staffing level</td><td>A number of HB policies have been/are being reviewed as part of the NSLWA implementation preparedness work, to ensure they are fully aligned and compliant with the Act. These include:<br>• Procedure for Flexible Deployment of Staff;<br>• Enhanced Patient Support Policy;<br>• Rostering Policy; and<br>• Nurse Staffing Levels and Escalation Plan: Adult Acute Services Policy.<br><br>Significant work has been undertaken to review and update Nurse Staffing Levels and Escalation Plan: Adult Acute Services Policy as this document is seen as the primary policy which will meet the requirements within</td></tr>
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| | the statutory guidance for the Health Board to have an operating framework in place to support the implementation of the Act. The policy includes sections which cover:<br><br>• The systems and processes in place in relation to maintaining the nurse staffing level; and<br>• 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.<br><br>It must be acknowledged that there are already well embedded processes within the nursing structures on each of the acute sites for reviewing staffing levels operationally on a daily basis and making decisions about the movement of staff via the bed/staffing meetings.<br><br>The statutory guidance states that LHBs and Trusts are required 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 employed staff but temporary workers can be engaged if required*" (paragraph 13*).* The Statutory Guidance provides guidance on what the statement 'all reasonable steps' might be considered to include and it lists some examples of steps that can be taken at national, strategic and operational levels.<br><br>A written control document is currently going through the All Wales Nurse Staffing programme governance system which will result in the publication of an All Wales view on what steps would comprise 'all reasonable steps' in the Spring 2019. Once issued, this list will be incorporated immediately into the HB's own Operating Framework for the Act, which is contained with Policy 409 (Nurse Staffing Levels and Escalation Plan: Adult Acute Services Policy. Until this time, this risk is included on the HB's risk register and will be monitored on behalf of the Board through QSEAC. |
| **Process for monitoring the nurse staffing level** | Under section 25E of the Act, health boards/trusts are required to report "*the extent to which nurse staffing levels have been maintained*".<br><br>Currently there is no single system in place across each acute hospital site that can provide us with the data required to report on the above and this remains one of the significant risks relating to the HDUHB's implementation of the requirements of the Act. As an interim position whilst these enhancements are made by NWIS, a proxy measure of compliance with this requirement has been utilised until a proper option appraisal can be conducted with Heads of Nursing and a single consistent system for capturing this data can be |

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| | implemented across all sites, as a priority action, during the first weeks of 2019/20.<br><br>The proxy measure used to give the Board an indication of the 'extent to which the nurse staffing level has been maintained' during 2018/19 is the '*care hours per patient day' (CHPPD).* This measure is used in Australia, New Zealand, the USA and more recently in England.as a measure of workforce deployment at ward, service or (when aggregated) organizational level. The potential of using this measure for meeting this requirement of the Act is being actively explored within this HB, as well at an All Wales level at this time.<br>It produces a single comparable figure that represents both the staffing levels provided and also the patient requirements,. This measure if used consistently would enable wards (even if they have different bed numbers) within a hospital, and wards in the same specialty, to benchmark against each other. It offers the ability to differentiate registered nurses from healthcare support workers for reporting purposes, to ensure skill-mix is well-described and the nurse-to-patient ratio taken account of in staff deployment, along with an aggregated overall score. Although there are limitations to using the CHPPD, it provides a reliable and consistent information collection point and a common basis for productive comparisons to measure, review and reduce variation at ward level within organizations and within similar specialties. The CHPPD is calculated by taking the total number of hours worked by the Registered Nurse or Health Care Support Worker or both and divide this figure by the total number of patients at an agreed point in time during that 24 hour period. In Tables 1 and 2 below are examples of data that has been captured for a single month (January 2019) within the wards of HDUHB and show how it is possible to utilize it to meet the reporting requirement of the Act. The data presented here is shown as an example of what might be feasible to make available on an ongoing basis in the future. In addition to meeting the statutory reporting requirements, such reports would assist with operational decision making and performance monitoring once the phased implementation of the nurse staffing levels uplifts have been fully implemented.<br><br>Further development and refinement of the systems for capturing, presenting and monitoring this information will be prioritized during first quarter of 2019/20.<br><br>Table 1 Actual care hours provided as a percentage of care hours planned within planned roster for the Health Board |

| Table 1: Actual care hours provided as a percentage of the care hours planned for within the planned roster: January 2019 data – Health Board | | |
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| | **Percentage actual v planned care hours: Registered Nurse** | **Percentage actual v planned care hours: RN & HCSW combined** |
| Health Board (based on 30 wards) | 91% | 94% |

Table 2 Actual care hours provided as a percentage of care hours planned within planned roster v planned hours for each acute site.

| Table 2: Actual care hours provided as a percentage of the care hours planned for within the planned roster: January 2019 data - by Acute site | | |
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| | **Percentage actual v planned care hours: Registered Nurse** | **Percentage actual v planned care hours: RN & HCSW combined** |
| BGH ( based on 5 wards) | 90% | 92% |
| GGH | 94% | 93% |
| PPH | 91% | 100% |
| WGH | 91% | 94% |

*(NB In interpreting the above data, it must be noted that further work is still required to ensure that full account is taken of the impact of any 'surge' beds being opened. Also, please note that due to the previously agreed phased implementation of the nurse staffing level uplift which was agreed at Board in May 2018, the planned care hours would not be expected to be fully met until the full nurse staffing level uplifts have been implemented since wards roster to these increased levels only following a risk assessment of the ward acuity and dependency: This is likely to account for much of the variation between the actual CHPPD and the planned CHPPD seen in the tables above)*

There is still further work required on the above proxy measures but has been included in this report to demonstrate that there is a level of compliance with the reporting requirements of the Act, albeit this will evolve and further develop in the coming year.

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| | The NSLWA statutory guidance also requires that ‘*’LHB’s 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*” (paragraph 15).<br><br>It must be acknowledge that although there are systems in place within the nursing structures on each of the acute sites to review and record those occasions when the number of nurses deployed varies from the planned roster, there is no single consistently used system to record this information.<br><br>In the August 2018 update to the QSEAC, the committee were advised that, consistent with other Health Boards, the Health Board did not have a single system for capturing this information. Work is taking place at an All Wales level to seek the resources to enable enhancements to be made to the national Health and Care Monitoring System which would enable daily capture of such information about compliance/variation from the planned roster. The resource for this system enhancement work has been allocated within NWIS and the enhancement work is due to complete shortly, with testing to take place during March 2019 and release of the enhancements to the NHS in Wales at the end March 2019. The implementation plan to ensure that these enhancements are being fully utilised; reports generated and scrutinised; thus allowing the requirements of the Act to be fully complied with, will take place across the Section 25B wards during Quarter 1 and 2 2019/20, with the plan that the first accurate report to be recorded in respect of this requirement of the statutory guidance will be produced for Quarter 3 2019/20.<br><br>Until that time, a single source of the information to enable an assessment of the actual number of times there is variation from the planned roster is not available across the HB instead a narrative description of level of compliance would be provided in response to the reporting requirement for this part of the reporting period of the Act (i.e. April 2018- March 2021) based on the information captured via the systems being used by the nursing structures in the acute sites. This is a recognised risk for the HB and has been included on the HB’s risk register (number 647) and is being monitored via the Nurse Staffing Levels Implementation Group and on behalf of the Board though updates provided to the QSEAC. |
| **Section 25E (2b) Impact on care of not maintaining Nurse Staffing Levels** | |
| **Impact of Care overview:**<br>Since April 2018 a series of questions have been added to the DATIX incident reporting system to ascertain whether not maintaining the nurse staffing levels have contributed to any incidents of harm. The questions are now asked for all incidents where the patient was | |

under the supervision of a registered nurse at the time of the incident; and incidents that occur in ALL clinical areas of the Health Board.

**Overall Health Board position for the reporting period.**
Across the whole Health Board, there have been 7213 closed incidents reported between 1st April 2018-31st March 2019 where the patient was receiving care provided under the supervision of a registered nurse during the period of the incident.

Of these the nurse staffing levels was maintained i.e. the number of staff on duty was per the planned roster in 5309 of the incidents, there were 430 incidents were the nurse staffing levels were not maintained as per the planned roster and 1474 incidents where this question wasn't answered.

Of the 430 were the nurse staffing levels were not maintained, the top five incidents reported were patient accidents/falls (105); pressure ulcers (97); service disruptions (60); behaviour (45) and behaviour (violence and aggressions)(40). These five incident types accounted for 81% of the incidents reported.

Of the 430 incidents were the nurse staffing levels were not maintained, there were 108 incidents where the investigator concluded that not maintaining the nurse staffing levels contributed to the incident.

- Of the 108, 85 incidents resulted in level 1 harm (no harm), 18 resulted in level 2 harm (minimal harm) and 5 resulted in level 3 harm (short term harm requiring further treatment).

Of these 108 incidents, the top five incidents reported were patient accidents/falls (41); service disruptions (25); Exposure to environmental hazards (11); pressure ulcers (9) and behaviour (8).

**Section 25B wards**
The above data is provided to enable contextualisation of the data relating specifically to the 30 plus wards that have fallen under the requirements of Section 25B of the NSLWA during 2018/19. In these wards, there were 2267 closed incidents reported for where the patient was receiving care provided under the supervision of a registered nurse during the period of the incident.

Of these the nurse staffing levels was maintained i.e. the number of staff on duty was per the planned roster in 1783 of the incidents, there were 111 incidents were the nurse staffing levels were not maintained and 373 incidents where the question wasn't answered.

Of the 111 incidents were the nurse staffing levels were not maintain, there were 43 incidents where the investigator concluded that not maintaining the nurse staffing levels contributed to the incident. Of the 43 incidents, 32 resulted in level 1 harm (no harm), 9 resulted in

level 2 harm (minimal harm) and 2 resulted in level 3 harm (short term harm requiring further treatment).

There are 16 incidents relating to those indicators that require formal reporting under the requirements of the Act and these are set out in the below table. Please note that although the complaints about nursing care resulting in patient harm is included in the below table, there is not a requirement to report against this indicator for this reporting period as further work was required to define the indicator to ensure consistency in interpretation across Wales. This work has now been concluded and HBs are expected to report on this indicator from the beginning of the 2019-20 reporting period.

| **Patients harmed with reference to quality indicators and complaints (closed incidents)** | **Total Number of closed)serious incidents/complaints during the reporting period 2017/18** | **Total number of closed**serious incidents/complaints during the reporting period 2018/19) (Data available through DATIX system as at the 1st May 2019)** | **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). | 23 hospital acquired | 8 hospital acquired | ↓ (subject to change as not all incidents in the reporting period have been investigated and closed) | 0 |
| • Falls resulting in serious harm or death (i.e. level 4 and 5 incidents). | 17 | 8 | ↓ (subject to change as not all incidents in the reporting period have been investigated and closed) | 0 |
| • Medication error never events | 0 | 0 | ↔ (subject to change as not all incidents in the reporting period have been | 0 |

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| | | | investigated and closed) | |
| • Complaints about nursing care resulting in patient harm | n/a for 2018-19 reporting period | n/a for 2018-19 reporting period | n/a for 2018-19 reporting period | n/a for 2018-19 reporting period |

*NB The total number of closed incidents will include ALL incidents that occurred during the 2017/2018 reporting period as ALL incidents have been closed

**NB The total number of closed incidents will NOT include all incidents that occurred during the 2018/19 reporting period due to the timing of when this report is required to be drafted - the annual incidence data is therefore not entirely comparable between the two years of 2017/18 and 2018/19.

| **Section 25E (2c) Actions taken if Nurse Staffing Level is not maintained** | |
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| **Actions taken** | ***Strategic Steps***<br><br>A significant element of the strategic action taken has been aimed at finding innovative ways of recruiting both Registered Nurses and Health Care Support Workers into the HB within an increasingly challenging workforce situation. Through collaborative efforts led by the Workforce and Organisational Development team and supported by both corporate and operational nursing teams, initiatives have included:<br><br>• Advertising through social media (geographically targeted nationally and internationally) and through London Transport.<br>• Targeted recruitment events.<br>• Active presence on Facebook (Swyddi Hywel Dda Jobs) and Twitter @HywelDdaJobs.<br>• LinkedIn is also used as a promotional platform<br>• Headhunting methodology used with success<br>• Development of targeted recruitment literature and videos<br><br>Outcomes from these initiatives have included:<br>• Targeted recruitment campaigns have led to approximately 10 RN direct expressions each month to the Health Board.<br>• 'Time to hire' performance has significantly improved (reduced) and now achieves the national target |

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| | of 71 day thus reducing length of time posts remain vacanctRecruitment of experienced RNs from Australia, London, Birmingham, Cambridge, Scotland and Cardiff<br>• Recruitment of over 100 student nurses – not only from within Wales but also from across England.<br><br>The Health Board recognises that recruitment initiatives alone will not solve the challenges of recruiting Registered Nurses into our rural localities in the longer term and has developed an ambitious, long term programme which aims to target sections of the local workforce for whom an ambition to become a registered nurse might have previously been an impossible dream. The 'Made In Hywel Dda' programme aims to employ young people who live locally but have limited qualifications on leaving school. The aim of the programme is to provide them with the knowledge, skills and experience - and, importantly, the support - necessary to progress from a Level 2 apprenticeship to a Registered Nurse. By working with HE and IW, Further and Higher Education providers and operational teams, the programme enables participants to:<br>• Commence as two year Level 2 Apprenticeship (paid at an apprentice rate) during which time the candidates will undertake four rotational placements working with multi-disciplinary teams as an Apprentice Health Care Assistant.<br>• This is followed by a Level 3 apprenticeship which will enable them to work as a Clinical Health Care Assistant (in a range of possible clinical settings);<br>• The candidates then commence a Level 4 Certificate in Health Care and on successful completion of this Certificate together with application to Swansea University they will commence a<br>• Four year Part-time Pre-registration Nursing Programme.<br><br>It is planned that the first cohort of 40 students will commence in September 2019.<br><br>***Acute site-specific operational actions taken***<br>The nature of the geography served by HDUHB means that there are unique workforce challenges within each of our acute sites and thus the actions required to maintain the nurse staffing levels will require bespoke responses depending on the site in question.<br><br>***Bronglais General Hospital (BGH):***<br>In 2018/19, it became clear that maintaining the nurse staffing level within Bronglais General Hospital in the longer term would require a local, bespoke solution and this has led to nurse recruitment and retention strategy being developed for this hospital. This strategy includes: |

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| | • Working with Nursing Workforce team to review potential for staffing level<br>• Improving roster management and planning on all wards<br>• Senior Nursing Leadership weekly reviews of roster planning and rule compliance<br>• Promoting exit interviews (as traditionally low take up of these)<br>• Commencing nursing leadership development forum with Head of Nursing and Senior Nurse Manager with support of Senior Organisational Development Facilitator<br>• Performance and Development Review timetable for 2019 put in place by Senior Nurse Managers<br>• Weekly hospital wide planning meetings led by Senior Nurse Manager for site to engage staff in improvement opportunities<br>• Flexible ward moves supported by Head of Nursing<br>• Rotational opportunities between acute and community settings being explored with community Head of Nursing<br>• Development of local leadership development programme/action learning sets for Band 6 and Band 7 staff<br>• Consideration of professional educational opportunities that can be offered and included in recruitment advertisements<br>• Partnership Arrangement with Swansea and Aberystwyth University to seek to establish pre-registration nurse education programme in Aberystwyth with a project group established joint chaired jointly by leads from Swansea and Aberystwyth University<br>o Training environments and mentors established<br>o Library resources on Bronglais General Hospital site being reviewed with potential for positive collaboration and working<br>• Bespoke and focused recruitment campaigns for BGH acute services<br>• Testing of collaborative recruitment campaign with BCU and Powys<br>• Establishing a partnership arrangement with high volume on-contract agency providers to create:<br>o consistent ward teams on all acute wards and department<br>o create a workforce that can support:<br>▪ mentorship for pre-registration students<br>▪ preceptorship HCSW in training<br>▪ Induction of new recruits. |

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| | ▪ eliminates the use of off contract agency<br><br>• Deliver mentorship training to substantive staff and to agency staff (through honorary contract arrangement)<br>• Reviewing current establishments and skill mix and maximise opportunities to adjust through the development of assistant practitioner posts within the confines of the Nurse Staffing Act.<br>• Exploring and developing rotational and developmental posts with community services<br>• Providing regular and consistent skills to care training at BGH to maintain the HCSW workforce.<br>• Take full advantage of 'cadet' schemes to grow and capture the HCSW workforce potential.<br><br>Whilst the 'whole hospital' nature of the challenge in Bronglais General Hospital has required a global strategy, on other sites some of the most challenging situations to maintain the staffing levels have been more localised and have been overcome through some creative vision and leadership which has maintained the patient at the centre of the solutions implemented :<br><br>***Glangwili General Hospital (GGH):***<br>In April 2018, the Glangwili General Hospital clinical leadership team took over responsibility for the management of the surgical wards. The first review of the nurse staffing level for these wards, using the triangulated methodology required under the Nurse Staffing Levels (Wales) Act had been undertaken and a particular concern about the nurse staffing levels within one of the trauma wards was highlighted. Through careful examination of the existing staff in post, the high level of vacancies and the recent staff attrition rates, the risk to patient safety and staff wellbeing was felt to be unmanageable within current control measures.<br><br>Following a number of consultation exercises with the executive team, staff side representatives, the community health council and our staff it was decided that an urgent, temporary change to the configuration of the trauma care provision was required to be able to continue to provide sensitive care. It was agreed therefore to consolidate the two trauma ward teams into a single trauma ward provision which would then enable the one team to provide the appropriate and skilled workforce required for this patient group. Through a triangulated review of the acuity data relating to patients cared for on both original wards, together with the quality indicators for each ward and the professional judgement of the nursing teams, a revised staffing level calculation was reached for the newly merged ward and also for the remaining |

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| | surgical wards which were impacted on through this change.<br><br>This temporary ward merger and consolidation of appropriately trained staff into a single team took place on the 3rd May 2018 in order to ensure that an appropriate staffing level could be maintained in the short to medium term, although it was always recognised that this could only be an interim solution. The action taken however has resulted in a reduction in reported pressure damage, reduction in falls and improvement (reduction) in the number of medication errors.<br><br>Building on this position, Stage 2 of the surgical ward reconfiguration is currently underway and is seeking to identify an agreed permanent solution to the provision of both trauma and surgical inpatient care within Glangwili General Hospital. At every stage of this process the review and recalculation of the nurse staffing level using the triangulated methodology has been at the heart of the discussions held.<br><br>***Withybush General Hospital (WGH)***<br>By the end of 2017/2018 recruitment to WGH had become particularly challenging with very high agency usage and reducing poor skill mix in some acute wards. This situation was beginning to cause concern about the potential for a risk to patient care and staff wellbeing. Due to these challenges, actions were taken to review and remodel the current inpatient acute bed base within the surgical wards i.e. Wards 1, 3, and 4. This was achieved, in part, by supporting the development of a home support team which aims to enable suitable patients to be discharged at an earlier point than would normally occur from these wards. This re-focus enabled a reduction of four inpatient beds, reducing the registered nurse requirement to enable a nurse staffing level to be achieved which was in line with the Nurse Staffing Levels (Wales) Act. This remodelling was undertaken following a very detailed review of the patients cared for across all these wards and resulted in a recognition that a large part of one of the wards could appropriately be re-designated as a ward for patients who were 'medically optimised' . This 'cohorting' of patients with similar care needs led to a re-designation of the ward (in as much as the ward no longer falls under the requirements of Sections 25B/C of the Nurse Staffing levels (Wales) Act ; and an appropriate change to the Registered Nurse: Health Care Support Worker staffing ratio which then enabled the staffing levels to be maintained both in this area and also the other wards where registered nurses were subsequently redeployed into.<br><br>***Prince Phillip Hospital (PPH):***<br>In January 2019, an acute coronary syndrome (ACS) 'bay' was (temporarily) created and opened on ward |

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| | 4, PPH. The aim of this 'bay' was to enable coordinated care to be provided to patients with cardiac conditions from across the HB (predominantly Withybush General Hospital): the aim was to reduce waiting times to a maximum wait of 72 hours for an angiogram for patients with NSTEMIs, (as recommended by NICE) with the effect that this reduces the risk of arrhythmias and other physiological issues arising due to prompt percutaneous intervention. As a result of this temporary change in service model, patient outcomes have been improved as patients have received their diagnosis and treatment in a more timely manner by improving patient flow across Hywel Dda. This short stay ACS bay promotes our HB values, ensuring that the patient is at the heart of everything we do. It has shown that, working together as a team (both as a wider health board and also across health board boundaries with ABMUHB colleagues at Morriston Hospital), we can ensure that our patient's receive the appropriate care, in a timely and efficient manner in the right setting and the feedback has been that this has helped to helped to reduce anxiety and stress for patient's and family.<br><br>The success of this 'bay' , developed and implemented very quickly in response to winter pressures, has been achieved through agile management and maintenance of the required nurse staffing level through the use of a day by day risk assessment – and operational expertise in then obtaining the required staff to meet the staffing level requirements.<br><br>Whilst this initiative has achieved excellent patient outcomes, the lack of patient acuity data to draw on to inform the triangulated approach to the calculation of the nurse staffing level prior to the establishment of the 'bay', and the subsequent challenge there has been operationally on a day by day basis to ensure that the required staffing level has been met – has helped to demonstrate the value of the nurse staffing level calculation process that has become embedded across HDUHB during 2018/19.<br><br>This example has shown how embedding the triangulated methodology of calculating the nurse staffing levels as a routine part of early service planning processes, has the potential to enable operational management of such initiatives to be much smoother in the future, ensuring that nurse staffing levels can be effectively calculated using all available information, prior to the establishment of a new facility/ service model. |
| **Next Steps** | Implementation of the All Wales Nurse Staffing (Levels) Act Wales is being progressed at pace in line with the implementation plan outlined at Board in July 2018 and the subsequent update to Board in November 2018. |

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| | The level of detailed work required to implement the requirements of the Act cannot be underestimated. Likewise the dynamic nature of the calculations for each and every area where nurses deliver care needs to be acknowledged as the calculations will not remain static and will continue to be informed through service change and reconfiguration as well as the development of other professional roles within the multi-disciplinary team.<br><br>The implementation plan will continue to remain a live document subject to continuous review and iteration. Prioritisation and phasing within the implementation plan will by necessity therefore be continually monitored by the Director of Nursing, Quality and Patient Experience.<br><br>Throughout 2019/20, QSEAC (which has been formally delegated the responsibility to monitor the implementation of the Act by the Board ) will receive regular updates on the progress being made to reduce the risks identified within this report; and on any impact on care as a result of not maintaining the nurse staffing levels. |

Appendix 1

| Section 25B ward: position as at March 2019 | | Excluded: position as at March 2019 |
|---|---|---|
| **Medical:** | | **Medical:** |
| | PPH Ward 1 | |
| BGH Meurig | PPH ward 3 | |
| BGH Ystwyth | PPH Ward 4 | GGH Ceri (Rehabilitation/Reablement Unit) (previously known as Dewi). |
| BGH Dyfi (previously CMU/iorwerth) | PPH Ward 5 | |
| BGH Y Banwy | PPH Ward 9 | |
| GGH Cadog | WGH Ward 10 | PPH Mynydd Mawr Rehabilitation Unit |
| GGH Gwenllian | WGH Ward 11 | |
| GGH Padarn | WGH Ward 12 | |
| GGH Steffan | WGH Ward 7 | |
| GGH Towy | WGH Ward 8/CCU | |
| **Surgical:** | | **Surgical:** |
| BGH Ceredig | PPH Ward 6 | WGH Ward 4 |
| BGH Rhiannon | PPH Ward 7 (combined medical and surgical ward) | |
| GGH Cleddau | | |
| GGH Derwen | WGH Ward 1 | |
| GGH Merlin | WGH Ward 3 | |
| GGH Preseli | | |
| GGH Picton | | |
| GGH Teifi | | |

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

**CYFARFOD BWRDD PRIFYSGOL IECHYD**
**UNIVERSITY HEALTH BOARD MEETING**

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|---|---|
| **DYDDIAD Y CYFARFOD:**<br>**DATE OF MEETING:** | 30 May 2019 |
| **TEITL YR ADRODDIAD:**<br>**TITLE OF REPORT:** | Evaluation of Unscheduled Care Performance through Winter 2018/19 |
| **CYFARWYDDWR ARWEINIOL:**<br>**LEAD DIRECTOR:** | Joe Teape, Director of Operations |
| **SWYDDOG ADRODD:**<br>**REPORTING OFFICER:** | Alison Bishop, Service Delivery Manager, Unscheduled Care |

| **Pwrpas yr Adroddiad** (dewiswch fel yn addas)<br>**Purpose of the Report** (select as appropriate) |
|---|
| Ar Gyfer Trafodaeth/For Discussion |

**ADRODDIAD SCAA**
**SBAR REPORT**

## Sefyllfa / Situation

This paper provides an evaluation of the planning arrangements for winter 2018/19 and the benefits received by Hywel Dda University Health Board (HDdUHB) patients accessing unscheduled and scheduled care pathways during the period of greatest pressure on the local care system.

This evaluation is based on a rapid review of the winter period and will inform winter plans being developed for 2019/20 to ensure lessons are learned as the UHB plans for the forthcoming seasonal period of highest demand.

## Cefndir / Background

2018/19 Winter Planning Process

The UHB commenced its preparations for winter 2018/19 in June 2018, ahead of Welsh Government (WG) issuing winter planning directions to the service. The first Winter Resilience Summit meeting between Welsh Government and the UHB was held on 15th August 2018, with a subsequent event held on 8th October 2018 and a further meeting later in November 2018.

Integrated Winter Assurance Toolkit

The process for 2018/19 differed to that of previous years as the UHB was not be required to submit its winter plan to Welsh Government or publish it online. Instead, the UHB was required to complete and submit an integrated winter resilience assurance toolkit, which focused on the following 5 priority areas:

- Optimising clinical and organisational engagement and partnerships to deliver timely and high quality access to services.
- Explicit focus on better management of demand in the community.
- Enhanced operational grip and clinically focused hospital management to mitigate peaks in pressure and manage risks effectively.
- Focus on significant opportunities to enable people to return home (or as close to home as possible) when ready from a hospital bed.
- Wherever possible, people should be supported to return from acute hospital sites to their home for assessment (implementing a discharge to assess model).

Representatives from each part of the local health and care system and local authorities and Welsh Ambulance Services NHS Trust (WAST) partners took part in a locally run workshop to enable co production and participative completion of the return. The toolkit was submitted to Welsh Government on 31st October 2018.

Winter Resilience Plan

In the spirit of continuous improvement, the Director of Operations adopted a more evolved approach to winter preparedness and planning. The general approach to effective safe navigation through the winter was predicated on two central tenets, namely reducing avoidable demand coupled with effective management of remaining demand. The plan was built around these two tenets and delivery of the actions was centered on better collaboration with primary care teams, local authority and WAST partners together with the private sector (care homes, residential beds, transport providers, etc). It could be said that the 2019/20 plan was co designed in the true spirit of agency collaboration with the three co-terminus local authorities and WAST all being stakeholders to the plan. For the first time since the UHB's creation the winter plan displayed the logos of the five partner organisations on its facing page.

The focus during the first few months of planning was centred on closing a calculated gap of 150 beds with either additional beds or measures in substitution of.

The final plan was focused on 5 key areas, with actions from across the wider unscheduled care system:

1. Reducing demand
2. Managing demand
3. Reducing length of stay
4. Improving patient experience
5. Enhancing operational grip

Targeted Financial Support from Welsh Government

The UHB's initial allocation confirmed in November amounted to £1.941 million, which formed part of a broader NHS Wales allocation of £20 million and was determined based on a direct needs formula applied by Welsh Government. Of the £20 million, a sum amounting to £4 million was top sliced from the allocation and directed to nationally agreed priorities promoted by the National Programme for Unscheduled Care following engagement with local leads. These initiatives included a pilot of 'Emergency Department Enhancement and Assisted Discharge Support' commissioned from British Red Cross, a pilot of 'Hospital to Home' support commissioned from 'Care and Repair' and a trial of pharmacists working as part of multi-disciplinary teams in emergency departments. The UHB's benefit from these initiatives was valued at £356,740.50, however there were also further gains arising from a number of schemes funded from the £4m allocation in relation to broader Welsh Ambulance Services initiatives, including additional control centre resources and additional falls response vehicles.

By 6th February 2019, further sums had been allocated to the UHB, after discussions at winter summit meetings with Welsh Government highlighted targeted schemes that the organisation wished to progress but were unable to because of the need to remain within allocations. These included a broad range of schemes such as community capacity in various forms, additional therapies and pharmacy capacity, 111/Out of Hours (OOH) support, community equipment and extended British Red Cross support; all aimed at supporting both admission avoidance and more effective discharge processes. The additional £347,662 brought the UHB's total winter support package to £2,645,402.50.

## Asesiad / Assessment

### 1. / 2. Reducing / Managing Demand

Ambulance Arrivals
The number of ambulance arrivals across all four acute hospital sites was 4% lower in 2018 compared to the same period in 2017. All sites saw a reduction in ambulance numbers with Glangwili and Withybush Hospitals seeing the largest reduction of 6% and 5% respectively.

A&E New Attenders
In contrast to the ambulance arrivals, the UHB saw an increase of 2% or 1568 new attendees across the four sites during the winter period 2018. However this was not evenly distributed across the hospitals as shown;

- Bronglais hospital 7% / 988 increase
- Glangwili hospital 4% / 861 increase
- Prince Philip hospital showed no increase in numbers
- Withybush hospital 2% / 317 decrease

**Performance**
Ambulance Handovers
The number of patients held in an ambulance outside A&E departments for more than 1 hour increased from 1467 to 1656, a 13% increase. However all sites except for Withybush saw a reduction in ambulance handover delays;

- Bronglais hospital 4% / 11 patient reduction
- Glangwili hospital 27% / 197 patient reduction
- Prince Philip hospital 54% / 64 patient reduction
- Withybush hospital 144% / 461 patient increase

Ambulance Lost Hours
Similarly the number of ambulance lost hours outside A&E departments increased from 3,168 to 3,740, an 18% increase. Again the performance varied across the acute sites;

- Bronglais hospital 2% / 15 hours' reduction
- Glangwili hospital 16% / 230 hours' reduction
- Prince Philip hospital 53% / 149 hours' reduction
- Withybush hospital 126% / 936 hours' increase

A&E Performance
Whilst the 4-hour performance held compared to last year (83.53% in 2018/19 and 83.59% for the previous winter) the number of patients waiting more than 12 hours in A&E significantly deteriorated this year increasing from 3849 to 4739, and uplift of 23%;

- Bronglais hospital 2% / 11 12-hour breach reduction
- Glangwili hospital 10% / 180 12-hour breach increase
- Prince Philip hospital 36% / 38 12-hour breach reduction
- Withybush hospital 51% / 759 12-hour breach increase

Emergency Admissions
Overall the number of emergency admissions in the UHB remained the same as the previous year however there were 2 notable exceptions;

- Bronglais hospital had an increase in admissions of 10% / 255 patients
- Withybush hospital had a reduction in admissions of 7% / 284 patients, however this is reflective of the number of patients concluding their episode of care in the A&E department which would not be recorded as an admission.

If a proxy of those aged over 75 is used as a measure of acuity then the number of admissions to the UHB was 6,515 against 6,900 the previous winter, a reduction of 6% / 158 admissions. The largest reductions were seen at Glangwili hospital with a reduction of 5% and Withybush hospital with a reduction of 8%. This is indicative of the All Wales position which reports fewer 85-year olds admitted to all hospitals than the last two winters.

**Escalation levels**
Escalation levels at 'red' have been for shorter periods throughout 2018/19 compared to 2017/18.

**Tertiary pathways**
As part of additional monies provided by WG, a new 6 bedded cardiac facility at Prince Philip Hospital was developed and has been successful in reducing Acute Coronary Syndrome waits for Morriston Hospital for patients from Withybush and Bronglais Hospitals. Between 7th January 2019 and 14th March 2019 (10 weeks), 82 patients were referred via this service. In addition, 23 low risk patients had their diagnostic cardiac procedures in Prince Philip Hospital, which avoided the need for onward referral to Morriston. There have been extremely positive results:

- A reduction in the average wait between referral to angiography from 10 days to 4 days;
- Increased throughput of activity through the Morriston catheter laboratory with less reliance on ad-hoc hot lists;
- Equitable waits for patients;
- Significant reduction in the backlog compared to winter 2017;

**GP OOH Services**
Winter 2018/9 continued to be challenging in terms of workforce shortfalls – especially during January to March 2019. Traditionally, reductions in locum GP availability are anticipated in quarter 4 of the financial year, and are related to personal tax and pension contribution thresholds. However, this year has seen a more significant reduction in cover, sometimes to unprecedented levels. Utilisation of telephone based advice GPs has been one successful area of mitigation which has helped to address the worst of staffing shortages. The second resource which has helped with resilience and often minimised absolute risks to business continuity is the deployment of Advance Paramedic Practitioners (APP) via WAST. Although the UHB has funded both of these models, the OOH service was able to secure additional winter monies investment to fund increased resources. This has provided additional capacity in terms of telephone advice over peak demand periods in winter, and additional APPs were secured, when possible, over and above the substantive model.

This was the first winter working within the remit of the 111 service UHB-wide and so absolute comparisons with previous years cannot be made. Overall demands on OOH services on the whole appear to remain stable, with requirements to conduct face to face assessments reducing as expected following the increase in GP advice consultations. There was one weekend which saw an increase of nearly 40% over expected demand; however, the pressures were simultaneously mirrored across the wider unscheduled care system throughout Wales.

**Increased Capacity**
Following on from last year and the positive impact that was evidenced, additional capacity was put in place at the acute sites over the extended 21-day holiday period; and was then extended until the end of March 2019 once additional monies were received and wherever possible.

Initiatives included:

- Additional medical cover at weekends focused on discharge

- Additional A&E nursing staff (Band 5 & Band 2); Ambicare and Pitstop Health Care Support Worker (HCSW) support
- Additional consultants; weekend additional medical consultants in cardiology and respiratory, bank holiday shop floor cover for A&E
- Extended Minor Injuries Unit (MIU) opening hours until 02:00 hours
- Additional pharmacy resource at weekends
- Additional therapy support; Additional Physiotherapy x 2 and Occupational Therapy x 2 support for weekday and weekends
- Additional phlebotomy resource at weekends
- Additional radiography resource at weekends
- Additional discharge vehicle

At Withybush hospital 14 additional beds were funded at Ward 4, this allowed for the cohorting of medically optimised (General Medicine) patients to improve patient flow.

Additional surge beds on all four acute sites were funded and opened when demand highest dictated. Community services commissioned and spot purchased additional beds in Ceredigion, and community nursing supported discharge to assess placements.

In Pembrokeshire, additional Community Care Beds (CCB) were commissioned in care homes to relieve pressures at the hospital. This allowed exit blocks to be temporarily avoided. The intention was to commission an additional 4 beds per week to complement the existing commissioned beds. However, with increased and sustained demand for emergency admission, and no increase in capacity for packages of care and re-ablement in community, the numbers of beds averaged 10 per week, peaking at 16 beds at the end of March 2019.

All three counties received additional monies to allow the purchase of community equipment to facilitate discharge home from hospital.

**New Initiatives**

In both Carmarthenshire and Pembrokeshire a new bridging service was introduced, this was an ‘on demand’ service to facilitate timely discharge from hospital and maintain people in the community for as long as possible. This was a ‘proof of concept’ proposal that aimed to reduce delays in discharge from hospital related to the inability of the independent care sector providers to increase their domiciliary care workforce capacity rapidly enough to meet increased demand experienced in hospitals during winter months. The service supported the person’s transition home from hospital and worked with the individual to establish their personal outcomes and how these will be met.

A Community Care Home pilot project was established through the additional winter monies which enabled a Consultant Acute Geriatrician to deliver services to a large care home in Llanelli with over 100 residents. This project provided three consultant sessions per week to undertake a targeted Comprehensive Geriatric Assessment for the most frail residents. The aim of the project was to reduce pressure on primary care, implement advanced care planning and improve the quality of end of life care with the ultimate aim of reducing hospital attendance and admission. Early indications of the outcomes measures have suggested a 50% reduction in hospital attendance and admissions compared to the same period last year.

In collaboration with WAST the UHB funded two advanced paramedic practitioners (APP) on rotational scheme working collaboratively with WAST and OOH services. Following release of additional winter monies from WG this was increased to a total of nine. The first cohort of APPs was introduced in November 2018 and the second cohort implemented in January 2019.

In supporting the GP OOH service during the 5 months to the end of March, APPs attended a total of 355 / 21% home visits, had 645 / 2.6% contacts and treated 265 patients / 3.6% in treatment centres, alongside this APPs attended 785 WAST incidents, an average of 11 patients per day. Of these 67% were discharged at scene and the remaining 33% were conveyed to hospital.

Welsh Government also commissioned a number of pilot projects across Wales;

- British Red Cross pilot to provide pastoral support and a resettlement service to A&E patients at Glangwili & Withybush Hospitals. The initial pilot has since been extended until September 2019 in recognition of the success of the pilot schemes. Both Glangwili and Withybush hospitals have seen large numbers of patients supported whilst in the A&E departments, and both sites had over 50 patients supported on their discharge home with none of those patients being readmitted to the hospital within 30 days.
- In collaboration with WAST and St John's Ambulance a falls response service was provided in Llanelli, this was aimed at non-injury fallers who would require assistance following the fall and intended to avoid an attendance at hospital. The service saw a total of 195 individuals; 138 of these calls were made as a 999 call, and only 52 individuals were conveyed to A&E, a non-conveyance rate of 74%. Following the success of this pilot a full evaluation is being undertaken and talks are underway with the Fire & Rescue Service to assess whether this can be rolled out on a more sustainable basis.

## 3. Reducing Length of Stay

The average length of stay (LoS) of medical admissions increased only slightly across the UHB, from 7.2 to 7.9 days, an increase of 0.7 day, however the number of patients with a LoS >28 days rose significantly from 9,579 patients in 2017/18 to 11,499 this year, an increase of 20% or 1,920 patients.

Again the trend was not consistent across all four acute sites;

- Bronglais Hospital saw an increase in LoS in December 2018 compared to the same period last year this then reduced over the remainder of the winter period, giving an overall increase of 0.3 days.
- Glangwili Hospital saw a LoS which was lower for the second half of the winter, December 2018 to March 2019.
- Price Philip Hospital saw an increase in LoS for the second half of the winter.
- Withybush Hospital saw an increased LoS throughout the winter period, with the LoS increasing from 7.6 days in 2017/18 to 10.2 in 2018/19, an increase of 2.5 days.

In terms of patients with a LoS > 28 days;

- Bronglais hospital showed reduced numbers for the first 2 months of the winter period; however the numbers increased from December onwards, with an overall increase of 12%
- Glangwili hospital had increased numbers throughout the winter, with an overall increase of 12%
- Prince Philip Hospital had the largest increase of the 4 acute sites at 30%
- Withybush Hospital also had an increase in numbers of 24%

It is worth noting that the domiciliary care market also remains extremely fragile across the UHB area and this has compromised efficient discharge from hospital and impacted on length of stay and medically fit numbers.

## 4. Improving the Patient Experience

### Quality Issues

Impact on Elective Work

The UHB cancelled significantly less elective activity this winter enabling the Referral to Treatment (RTT) position of zero 36-week waits by 31st March 2019 to be achieved. As an example there were no operations cancelled at Prince Philip Hospital due to bed availability during the winter period 2018/19. During winter 2017/18 the elective orthopaedic ward had to be used as a medical ward for 3 weeks in January 2018.

Setting of care

A&E departments were regularly full overnight at Glangwili and Withybush Hospitals, an increasing number of medical patients are completing their episode of care in the A&E department due to a shortfall in inpatient capacity. As such, patients were cared for in less than ideal settings. At Prince Philip Hospital there were instances where patients were bedded overnight in the Minor Injuries Unit.

Falls

The number of inpatient falls across the four acute sites has slightly reduced this year, down from 1,290 to 1,278, a reduction of 12; Bronglais, Glangwili and Prince Philip Hospitals all reducing their falls between 20 and 30%.

Pressure damage

The number of hospital acquired pressure ulcers decreased over this winter by 28 cases to 138, compared to the previous winter, a reduction of 17%. Pressure damage continues to be seen as a priority area for improvement.

Complaints

The number of all complaints received in the UHB increased over the winter this year, from 308 complaints to 373, an uplift of 65 or 21%.

All complaints received into the A&E Department also rose by 7 or 7%, however this relates to all complaints received. If complaints were isolated to escalation, access and patient experience the number would show a reduction of 5 / 11% this winter, from 47 to 42.

## 5. Enhancing Operational Grip

In order to prevent staffing challenges post-Christmas; clinical staff were asked not to book leave in the run up to the extended holiday period and into the first week in January 2019.

Two sites, Glangwili and Withybush hospitals, ran ‘perfect week’ initiatives prior to Christmas. This proved successful in reducing medically fit for discharge numbers for the period the work was undertaken and involved cancelling meetings during the first 3 weeks of January 2019.

The Director of Operations assumed the Executive on call role for the post New Year 10-day period, supplemented by an additional tier of on-call operational management through January into March 2019. In addition, ‘ward buddy’ systems were in place on some sites which involved senior managers pairing up with wards to provide additional support.

## CONCLUSIONS

A general synopsis of winter 2018/19 could be set out as follows:

- Ambulance arrivals were down, however A&E demand increased on previous years.
- Escalation levels were lower than expected and periods of high escalation were reduced.
- Delays in cardiac transfers to ABMUHB decreased.
- Medically fit patients were significantly higher, and options to address these numbers outside of hospital – through assessment beds, packages of care etc. were not adequate.
- Performance significantly deteriorated and manifested acutely in 12-hour waits and ambulance delays.
- A number of patients were unavoidably bedded in inappropriate areas for longer than ideal periods – A&E, treatment rooms, MIU etc.
- Out of Hours was less fragile than it was the same time in 2017/18 as a result of the advice resources in place and the additional support from APPs to cover rota gaps.
- Planning started earlier and lessons learnt previously enabled the plan to be more concise and effective.
- Additional winter monies were received earlier than in previous years and early agreement by the Executive Team for targeted initiatives allowed resources to be in place prior to the Christmas period.
- Withybush Hospital was and continues to be the site with the highest risk. Community interventions put in place mitigated what could have been a much worsened position.

The approach and processes developed in our planning process without a doubt facilitated the UHB navigating safe passage through the winter 2018/19. The headlines being:

- Creating a reliable bed model upon which to plan
- Abridging the plan to the most essential components only (plan on a page)
- Planning on the basis of what resources are known as well as what might be to take good advantage from opportunity monies
- Adopting pragmatic approaches to addressing bed gaps
- Early confirmation of support funding which in turn facilitates for early bookings of agency/ locum staff and care home beds securing best value services
- Institution of regular but short review and cost monitoring sessions

**NEXT STEPS**

A number of the initiatives progressed during winter 2018 have been individually evaluated. Each of these evaluations will inform both the winter planning cycle for 2019 as well as being reviewed by the Health Board's unscheduled care programme. Any successful schemes will be progressed for ongoing funding and where appropriate signposted into the strategy development process. Alongside this a more formal evaluation of winter is being undertaken by Welsh Government and a workshop has been arranged in June 2019 to evaluate initiatives and develop priorities for next winter. The Board can be assured the Health Board will continue to actively engage in national work to ensure that best practice is embedded across Hywel Dda.

**Argymhelliad / Recommendation**

The Board is asked to receive this report and discuss any issues arising from its content.

| **Amcanion: (rhaid cwblhau)**<br>**Objectives: (must be completed)** | |
|---|---|
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:<br>Datix Risk Register Reference and | Corporate Risk 629 – Unscheduled Care |

| | |
|---|---|
| Score: | |
| Safon(au) Gofal ac Iechyd:<br>Health and Care Standard(s):<br>Hyperlink to NHS Wales Health & Care Standards | 2. Safe Care<br>2.1 Managing Risk and Promoting Health and Safety<br>5. Timely Care |
| Amcanion Strategol y BIP:<br>UHB Strategic Objectives:<br>Hyperlink to HDdUHB Strategic Objectives | 4. Improve the productivity and quality of our services using the principles of prudent health care and the opportunities to innovate and work with partners. |
| Amcanion Llesiant BIP:<br>UHB Well-being Objectives:<br>Hyperlink to HDdUHB Well-being Statement | Improve Population Health through prevention and early intervention<br>Improve efficiency and quality of services through collaboration with people, communities and partners |

| **Gwybodaeth Ychwanegol:<br>Further Information:** | |
|---|---|
| Ar sail tystiolaeth:<br>Evidence Base: | Contained within the report |
| Rhestr Termau:<br>Glossary of Terms: | Contained within the report |
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol:<br>Parties / Committees consulted prior to University Health Board: | Executive Team<br>Public Board<br>Unscheduled Care Board |

| **Effaith: (rhaid cwblhau)<br>Impact: (must be completed)** | |
|---|---|
| **Ariannol / Gwerth am Arian:<br>Financial / Service:** | Financial impacts and considerations are inherent in the report. |
| **Ansawdd / Gofal Claf:<br>Quality / Patient Care:** | Robust winter plans ensure patient care continues to be provided throughout the winter period. |
| **Gweithlu:<br>Workforce:** | Use of agency resources to mitigate internal human resource capacity limitations details are contained within the winter plans |
| **Risg:<br>Risk:** | The winter period presents heightened risk to the UHB with increased demand across the unscheduled care system.<br><br>The risk issues associated with the unscheduled care system and across winter are recorded on existing risk registers. |
| **Cyfreithiol:<br>Legal:** | Not applicable |
| **Enw Da:<br>Reputational:** | There could be significant reputational risks for the HB and partners in the event of major incident. |

| | |
|---|---|
| **Gyfrinachedd:**<br>**Privacy:** | Not applicable |
| **Cydraddoldeb:**<br>**Equality:** | Bespoke winter plans are in place for the three counties which reflect the needs of the population within each of these counties. |

**CYFARFOD BWRDD PRIFYSGOL IECHYD**
**UNIVERSITY HEALTH BOARD MEETING**

| | |
|---|---|
| **DYDDIAD Y CYFARFOD:**<br>**DATE OF MEETING:** | 30 May 2019 |
| **TEITL YR ADRODDIAD:**<br>**TITLE OF REPORT:** | Health & Care Standards Fundamentals of Care 2018 Annual Report |
| **CYFARWYDDWR ARWEINIOL:**<br>**LEAD DIRECTOR:** | Mandy Rayani, Director of Nursing, Quality and Patient Experience |
| **SWYDDOG ADRODD:**<br>**REPORTING OFFICER:** | Sharon Daniel, Assistant Director of Nursing |

| **Pwrpas yr Adroddiad** (dewiswch fel yn addas)<br>**Purpose of the Report** (select as appropriate) |
|---|
| Er Sicrwydd/For Assurance |

**ADRODDIAD SCAA**
**SBAR REPORT**

## Sefyllfa / Situation

The 2018 Health & Care Standards Fundamental of Care annual audit was undertaken in 137 areas across Hywel Dda University Health Board (HDdUHB) between 1st October and 30th November 2018. The 2018 report is being presented to inform the Board of results of the whole audit exercise and to highlight the audit findings in relation to key areas of practice. The report provides an overview of the UHB findings, makes comparisons to the results from the previous five audits and highlights where compliance has increased or decreased. The narrative also highlights the areas of good practice identified and the areas requiring improvement.

It is acknowledged that, although the decreases in score are marginal in some cases, the UHB cannot be complacent and needs to ensure that any deterioration, no matter how small, is reviewed and actions taken where required. Each service/directorate is reviewing their specific findings to highlight the areas of good practice identified and the areas requiring improvement. Each service/directorate is developing their action plans and will monitor these actions plans to improve outcomes. Each service/directorate is responsible for providing assurance to their respective Quality, Safety & Experience sub-committees by providing updates as part of their Quality and Safety presentations.

The Board is asked to note the Health & Care Standards Fundamentals of Care audit findings for 2018 which are presented in this report.

Unless indicated otherwise, the compliance levels are given as percentages, rounded up to the nearest one percent.

## Cefndir / Background

Since 2009, the NHS in Wales has undertaken a national audit of care and service delivery. The standards set in the 'Fundamentals of Care: guidance for health and social care staff' (2003) were the basis for the 2009-2014 audits. However, since 2015, the annual audit has been undertaken using the standards set in the Health and Care Standards (2015) document. The Health and Care Standards are the core standards for the NHS in Wales and brings together and updates the expectations previously set out in "*Doing Well Doing Better Standards for Health Services in Wales",* and the *"Fundamentals of Care"* Standards 2003.

The Health and Care Standards provide the framework for how services are organised, managed and delivered on a day-to-day basis. They establish a basis for improving the quality and safety of healthcare services by providing a framework which can be used in identifying strengths and highlighting areas for quality improvement.

Between 2009 and 2014 the Chief Nursing Officer (CNO) for Wales mandated that the three elements of the audit should be undertaken in all applicable clinical areas, and all Health Boards were expected to submit a report of the findings to the CNO office. In 2015, the CNO mandated that each Health Board would undertake the patient survey element to gather patients' views on their experience of receiving care and this element would be the only element reported to Welsh Government. Since 2016 the CNO has not mandated that any element of the audit needed to be undertaken; however, the Senior Nursing and Midwifery Team within HDdUHB made the decision that all applicable clinical areas would continue to undertake all three elements of the audit.

## Asesiad / Assessment

### The 2018 Report

There were three elements to the audit:

- Patient survey – the feedback from over 1548 patients are included in the UHB report.
- Staff survey – 1011 staff completed the staff survey.
- Operational questions – 701 patients' records including 457 medication charts, 209 food charts, 221 daily fluid charts and 132 weekly fluid charts were reviewed as part of the audit.

The summary findings include:
**Feedback from patients, families and carers** which shows that for the vast majority of the time we do get their care right, although there are times when we don't. When patients were asked to rate their overall satisfaction with the care provided to them and their families, using a 1-10 rating score, with 1 being very bad and 10 being excellent, they gave the organisation a satisfaction rating of **9.3 out of 10 (93%)** ensuring that Hywel Dda University Health Board achieved a RAG rating of **green** for this question in accordance with the All Wales Fundamentals of Care audit criteria for a fifth consecutive year.

| **Overall satisfaction with overall experience/whole HB, using a 1-10 rating score (with 1 being very bad and 10 being excellent), Breakdown per year.** | | | |
|---|---|---|---|
| Year | Score | RAG rating | |
| 2013 | 9.1 out of 10 (91%) | **Green** | |
| 2014 | 9.3 out of 10 (93%) | **Green** | ↑ |
| 2015 | 9.2 out of 10 (92%) | **Green** | ↓ |
| 2016 | 9.3 out of 10 (93%) | **Green** | ↑ |
| 2017 | 9.4 out of 10 (94%) | **Green** | ↑ |
| 2018 | 9.3 out of 10 (93%) | **Green** | ↓ |

In addition to the patient satisfaction question, patients were asked 25 core questions. 22 of the 25 questions showed compliance scores of above 90%, however 13 have seen a decrease in the percentage compliance when compared to last year's data (between 1-2%). Three aspects of care scored between 85-90%:

- Only 84% of the patients who responded stated that they were able to speak Welsh to staff if they needed to (↓2% on last year's position) and this question has changed from a green RAG rating last year to an amber RAG rating this year.
- Only 84% of the patients who responded felt they were able to get enough rest and sleep (↓3% on last year's position). Rest & Sleep has always been one of the lowest scoring aspects of care from a patient's perspective.

- 88% of the patients who responded felt they were given help and advice on how to prevent damage to their skin (↓2% on last year's position).

The overall patient experience scores for the previous five audit cycles and the 2018 findings are presented in table 8. In addition to the core questions there are specialty specific patient questions and these are included in the relevant service/directorate reports.

| **Table 8: overall results/core questions/HB** | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Summary/Indicator** | **2013** | **2014** | **2015** | **2016** | **2017** | **2018** | |
| **First and Lasting Impressions** | | | | | | | |
| Patients felt that they were treated with dignity and respect | 98% | 99% | 98% | 99% | 99% | 98% | ↓ |
| Patients felt they were given enough privacy | 99% | 99% | 98% | 97% | 99% | 97% | ↓ |
| Patients felt that people were polite to them | | | | 98% | 99.5% | 99% | ↓ |
| Patients felt that if they asked for assistance they got it when they needed it | 95% | 96% | 97% | 96% | 98% | 97% | ↓ |
| Patients felt they received help quickly and discreetly to use the toilet | 95% | 97% | 97% | 96% | 95% | 96% | ↑ |
| Patients felt they were kept informed regarding delays | | 93% | 92% | 90% | 91% | 92% | ↑ |
| Patients felt that they were able to speak Welsh to staff if they needed to | | | | | 86% | 84% | ↓ |
| **Receiving care in a safe, supportive, healing environment** | | | | | | | |
| Patients felt safe | 99% | 99% | 98% | 98% | 99% | 99% | ↔ |
| Patients felt they were made to feel comfortable | 96% | 98% | 97% | 98% | 99% | 98% | ↓ |
| Patients felt they were kept, as far as possible, free from pain | 96% | 97% | 96% | 96% | 98% | 96% | ↓ |
| Patients felt they were provided with water and drinks | 96% | 97% | 97% | 98% | 98% | 97% | ↓ |
| Patients felt that the clinical area was kept clean and tidy | 98% | 99% | 99% | 99% | 99% | 99% | ↔ |
| Patients felt they were provided with nutritious snacks | 93% | 93% | 95% | 93% | 93% | 95% | ↑ |
| Patients felt that staff were kind and helpful | | | | 99% | 99% | 99% | ↔ |
| Patients felt they were given help with feeding if needed it | 96% | 98% | 97% | 96% | 94% | 93% | ↓ |
| Patients felt they were able to get enough rest and sleep | 84% | 88% | 85% | 83% | 87% | 84% | ↓ |
| Patients felt that they had their hygiene needs met | 98% | 99% | 98% | 98% | 98% | 98% | ↔ |
| Patients felt they were given help with their mouth care | 91% | 97% | 95% | 94% | 88% | 93% | ↑ |
| Patients felt that were given help and advice on how to prevent damage to your skin | | | | 97% | 90% | 88% | ↓ |
| **Understanding and Involvement in Care** | | | | | | | |
| Patient felt that they were given full information about their care | 95% | 96% | 95% | 95% | 97% | 97% | ↔ |
| Patients felt that things were explained to them in a way that they could understand | | | | | 93% | 96% | ↑ |

| Summary/Indicator | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | |
|---|---|---|---|---|---|---|---|
| Patients felt that they understood what was happening in their care | | | | | 97% | 96% | ↓ |
| Patients felt that they were given help to be as independent as possible | 98% | 98% | 98% | 97% | 97% | 97% | ↔ |
| Patients felt that they were listened to | | | | 96% | 97% | 97% | ↔ |
| Patients felt that they were involved as much as you wanted to be in decisions about their care | | | | | 96% | 95% | ↓ |
| Patients felt that they were involved as much as they wanted to be in decisions about their discharge | | | | 90% | 90% | 91% | ↑ |

**Operational:** The 2018 national audit results demonstrate that:

- Of the 22 standards included in the audit, the HB achieved 85% or above in 19 of the standards with the remaining three achieving amber RAG ratings (scores between 50-85%).
- Where previous data is available, the 2018 show an increase in compliance for eight standards, a decrease in compliance for nine standards with five showing an unchanged position.
- Standard 3.1 has seen a significant decrease when compared to last year's position (↓9%).
- Standard 2.8 has seen a significant increase compared to the 2017 position (↑10%). This standard only has specialty specific questions.
- A general theme across all the standards related to care planning and this is an area that is highlighted in a number of the action plans developed by the services.

| Table 10: Operational questions: Overall Standard Summary | | 2013 RAG % | 2014 RAG % | 2015 RAG % | 2016 RAG % | 2017 RAG % | 2018 RAG% | |
|---|---|---|---|---|---|---|---|---|
| Staying Healthy | | | | | | | | |
| 1.1 | Health Promotion, Protection and Improvement | n/a | n/a | 100% | 79% | 78% | 77% | ↓ |
| Safe Care | | | | | | | | |
| 2.1 | Managing Risk and Promoting Health and Safety | 94% | 91% | 92% | 92% | 95% | 94% | ↓ |
| 2.2 | Preventing Pressure and Tissue Damage | 93% | 88% | 88% | 93% | 93% | 92% | ↓ |
| 2.3 | Falls Prevention | 96% | 85% | 86% | 90% | 89% | 88% | ↓ |
| 2.4 | Infection Prevention and Control (IPC) and Decontamination | 89% | 99% | 96% | 97% | 99% | 98% | ↓ |
| 2.5 | Nutrition and Hydration | 93% | 91% | 92% | 93% | 94% | 94% | ↔ |
| 2.6 | Medicines Management | 88% | 91% | 92% | 98% | 96% | 95% | ↓ |
| 2.7 | Safeguarding Children and Safeguarding Adults at Risk | 96% | 98% | 97% | 96% | 93% | 98% | ↑ |
| 2.8 | Blood Management | n/a | n/a | 100% | 80% | 73% | 83% | ↑ |
| 2.9 | Medical Devices, Equipment and Diagnostic Systems | 92% | 90% | 90% | 96% | 96% | 95% | ↓ |
| Effective Care | | | | | | | | |
| 3.1 | Safe and Clinically Effective Care | n/a | n/a | n/a | 82% | 90% | 81% | ↓ |
| 3.2 | Communicating Effectively | 84% | 86% | 86% | 88% | 86% | 88% | ↑ |
| 3.3 | Quality Improvement, Research and Innovation | n/a | n/a | n/a | 94% | 85% | 89% | ↑ |
| 3.4 | Information Governance and Communications Technology | n/a | n/a | n/a | n/a | 100% | 100% | ↔ |
| 3.5 | Record Keeping | 94% | 86% | 89% | 90% | 90% | 89% | ↓ |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Dignified Care | | | | | | | | |
| 4.1 | Dignified Care | 80% | 84% | 86% | 86% | 84% | 87% | ↑ |
| 4.2 | Patient Information | 80% | 87% | 87% | 91% | 89% | 90% | ↑ |
| Timely Care | | | | | | | | |
| 5.1 | Timely Access | n/a | n/a | n/a | n/a | 100% | 100% | ↔ |
| Individual Care | | | | | | | | |
| 6.1 | Planning Care to Promote Independence | 86% | 87% | 87% | 87% | 88% | 88% | ↔ |
| 6.2 | Peoples Rights | n/a | 81% | 93% | 92% | 85% | 93% | ↑ |
| 6.3 | Listening and Learning from Feedback | 91% | 96% | 96% | 98% | 96% | 97% | ↑ |
| Staff and Resources | | | | | | | | |
| 7.1 | Workforce | 78% | 76% | 88% | 86% | 90% | 90% | ↔ |

**Staff Survey**: When asked to rate their overall satisfaction with the care provided to patients and relatives, staff gave the organisation a satisfaction rating of **8.1 out of 10** (**81%)** which, in accordance with the All Wales Fundamentals of Care Steering Group compliance matrix, is an **amber** RAG rating. This has seen an increase of 1% on last year's position.

When asked to rate their overall satisfaction with the organisation, staff gave the organisation a satisfaction rating of **7.3 out of 10** (73%), which, in accordance with the All Wales Fundamentals of Care Steering Group compliance matrix, is an amber RAG rating (this is an increase of 1% on last year's position).

Staff were also asked to respond 'always', 'usually', 'sometimes', 'never' to a further 16 questions and the results show that there has been a decrease in the percentage compliance for 14 of these questions, whilst the remaining two questions are unchanged from last year. Five of the 16 questions show a green RAG rating (one more than last year) and the remaining 11 questions show an amber RAG rating. The table below shows the overall compliance percentage per question.

**Table 42: Whole HB/Staff Survey**

| Description/Indicator | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | |
|---|---|---|---|---|---|---|---|
| Make sure you are able to access up to date information in order to be able to do your job. | **87%** | **90%** | **90%** | **92%** | **90%** | **92%** | ↑ |
| Ensure that as an employee you are treated with dignity and respect. | **66%** | **75%** | **82%** | **85%** | **83%** | **85%** | ↑ |
| Make you feel safe at work. | **77%** | **82%** | **83%** | **88%** | **85%** | **87%** | ↑ |
| Make you feel you have a positive contribution to patient care. | **75%** | **81%** | **83%** | **88%** | **85%** | **88%** | ↑ |
| Provide you with sufficient equipment to do your job. | **80%** | **82%** | **81%** | **82%** | **80%** | **79%** | ↓ |
| Provide you with opportunities to enhance your skills and professional development. | **55%** | **59%** | **66%** | **74%** | **73%** | **76%** | ↑ |
| Provide you with feedback on the outcomes of any incidents/accidents that you report or that are reported within your clinical area? | **51%** | **57%** | **61%** | **68%** | **68%** | **70%** | ↑ |
| Provide you with opportunity to identify and learn from good practice to bring about improvements in care. | **65%** | **70%** | **71%** | **81%** | **80%** | **81%** | ↑ |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Provide opportunities for you to raise any concerns that you have. | 68% | 73% | 77% | 82% | 80% | 81% | ↑ |
| Provide you with the opportunity to establish a work life balance. | 61% | 67% | 69% | 75% | 71% | 74% | ↑ |
| Make you feel a valued member of the organisation and have a sense of belonging. | 54% | 62% | 64% | 72% | 71% | 73% | ↑ |
| Make you feel proud to be a nurse / allied health professional. | 56% | 65% | 69% | 75% | 75% | 76% | ↑ |
| Put local citizens at the heart of everything we do'. | | 61% | 66% | 79% | 73% | 77% | ↑ |
| Ensure that you have the knowledge and skills to deliver a consistent standard in the fundamental aspects of compassionate care. | 76% | 82% | 86% | 90% | 86% | 90% | ↑ |
| Work together to be the best that we can be. | | | | 79% | 76% | 80% | ↑ |
| Strive to deliver and develop excellent services. | | | | 84% | 82% | 84% | ↑ |

Each service/directorate will use their specific findings to highlight the areas of good practice identified and the areas requiring improvement and develop and monitor their action plans to improve outcomes. Each service/directorate is responsible for providing assurance to their respective Quality, Safety & Experience sub-committees by providing updates as part of their Quality and Safety presentations.

## Argymhelliad / Recommendation

The Board is asked to accept the Health & Care Standards/Fundamentals of Care 2018 audit findings which are presented in this report as an assurance that the care delivered within the UHB continues to achieve a high level of satisfaction amongst patients, whilst also identifying areas of improvement.

| **Amcanion: (rhaid cwblhau)**<br>**Objectives: (must be completed)** | |
|---|---|
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:<br>Datix Risk Register Reference and Score: | Not applicable |
| Safon(au) Gofal ac Iechyd:<br>Health and Care Standard(s):<br>Hyperlink to NHS Wales Health & Care Standards | All Health & Care Standards Apply |
| Amcanion Strategol y BIP:<br>UHB Strategic Objectives:<br>Hyperlink to HDdUHB Strategic Objectives | All Strategic Objectives are applicable |

| | |
|---|---|
| Amcanion Llesiant BIP:<br>UHB Well-being Objectives:<br>Hyperlink to HDdUHB Well-being Statement | Improve Population Health through prevention and early intervention<br>Support people to live active, happy and healthy lives<br>Improve efficiency and quality of services through collaboration with people, communities and partners<br>Develop a sustainable skilled workforce |

| **Gwybodaeth Ychwanegol:<br>Further Information:** | |
|---|---|
| Ar sail tystiolaeth:<br>Evidence Base: | The themes within the Fundamentals of Care Audit are derived from multiple research studies (as well as narrative reports) which inform the aspects of care that patients identify to be of importance to meeting their core care needs. |
| Rhestr Termau:<br>Glossary of Terms: | Contained within the body of the report. |
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol:<br>Parties / Committees consulted prior to University Health Board: | The report was discussed by the Senior Nursing and Midwifery Team (SNMT) at their April 2019 meeting. |

| **Effaith: (rhaid cwblhau)<br>Impact: (must be completed)** | |
|---|---|
| **Ariannol / Gwerth am Arian:<br>Financial / Service:** | It is recognised that good quality care will cost less than poor quality care, although showing this in cash releasing terms is known to be very difficult. However, this report recognises that standards of care can still be improved in key areas. If areas of local improvement work are supported and prioritised, there remains potential to both improve the care experience and also deliver greater efficiencies. |
| **Ansawdd / Gofal Claf:<br>Quality / Patient Care:** | The report provides an assurance that the care delivered within the University Health Board continues to achieve a high level of satisfaction amongst patients, whilst also identifying areas of improvement work.<br>The audit enables **patients/**carers:<br>• To share their views and experiences on what we do well and where we need to improve, which will be used to help improve services that we provide,<br>• To have a voice in the quality of care they receive and it ensures an openness and transparency with the quality standards.<br>It empowers **staff:**<br>• To make a difference and ensures ownership of their practice.<br>• To have a voice in the care that they provide and ensures the focus is on essential elements of care and caring.<br>• To identify areas of good practice and issues for concern.<br>• To develop action plans which enable them to monitor change |

| | |
|---|---|
| **Gweithlu:**<br>**Workforce:** | Attention is drawn to the staff survey section of the report, which aims to ascertain staff views about the organisation in relation to key aims and not on any one standard. Many of the findings of this survey reflect those of the NHS Staff Survey (2018) and previous Fundamentals of Care annual audit reports and there needs to be further investigation into all of the domains explored within the audit to ensure that our staff are at the forefront of what we do. |
| **Risg:**<br>**Risk:** | The report provides a measure of the standard of fundamental care identified in the Health & Care Standards delivered to UHB patients and thus offers an assessment of the risk (or otherwise) posed by the care delivered to our hospital in-patient population<br><br>Areas for improvement have been identified and will be included as part of the service specific reports and action plans currently being written. |
| **Cyfreithiol:**<br>**Legal:** | Not applicable |
| **Enw Da:**<br>**Reputational:** | Not applicable |
| **Gyfrinachedd:**<br>**Privacy:** | No patient identifiable information has been included in the report. |
| **Cydraddoldeb:**<br>**Equality:** | The Health & Care Standards Fundamentals of Care Audit 2018 report assesses the care standards delivered to all patients in our care. No significant inequality issues were identified through the audit although work to improve aspects of care for all patients is reflected in the action plan developed in response to the audit and which forms part of the report. |

## Health & Care Standards

# Fundamentals of Care

# Annual Audit Report

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

I have nothing but admiration and thanks to all the staff for their hard work and diligence in caring for me.

The staff are efficient and sympathetic and a 100% professional.

I have been treated with great care and consideration by everyone.

Questions have been answered as fully as possible and at all times there has been such a show of genuine concern and care

Staff brilliant, helpful, kind and caring.

Wonderful care, dedicated staff, nice, friendly atmosphere. Treated with dignity and respect +

At such a stressful and emotional time, it is so reassuring that all the staff are so compassionate and considerate.

**2018**


# Index

## 1. Executive Summary

Providing high quality care is the highest priority for the Health Board and this report helps us to understand what we have done well and where we need to do better in the year to come.

This is Hywel Dda University Health Board's tenth Health & Care Standards/Fundamentals of Care report and sets out the results from the 2018 Health & Care Standards annual audit, which focuses on the quality, the safety and experience of the services we provide to our population. By engaging with our patients/carers/service users and staff we can give assurance of where we are providing excellent standards of care, and the areas that we need to do better in.

**Patient Experience:** I would like to thank all the patients, families and carers who took part in the patient survey. Feedback confirms the high standards of care provided across the Health Board with an overall patient satisfaction rating of 9.3 out of 10 (93%). There are three aspects of care that will require some focused work over the next 12 months. These are:

- Rest & sleep;
- Help and advice on how to prevent damage to their skin; and
- Patients being able to speak Welsh to staff if they need to.

**Operational Questions:** Of the 22 standards included in the audit, the HB achieved 85% or above (green RAG rating) for 19 of the standards with the remaining three achieving amber RAG rating. Standard 3.1 (safe and clinically effective care) has seen a significant decrease when compared to last year's position and requires focused work over the next 12 months.

**Staff Survey:** I would like to thank all the staff who took part in the staff survey. The themes that our staff identified are very similar to previous years and there is still work for us to do to ensure that we continue to put staff at the forefront of what we do.

**Mandy Rayani**
**Director of Nursing, Quality & Patient Experience,**
**Hywel Dda University Health Board.**

## 2. Situation

The 2018 Health & Care Standards Fundamentals of Care annual audit was undertaken in 138 clinical wards/units/services across Hywel Dda University Health Board (HDUHB) between 1st October and 30th November 2018. The areas that took part were:

**Table 1: breakdown of areas from Acute Services who participated in the annual audit**

| | Bronglais General Hospital | Glangwili General Hospital | Prince Philip Hospital | Withybush General Hospital | Total |
|---|---|---|---|---|---|
| **General medical wards.** | 3 | 6 | 6 | 4 | **19** |
| **General surgical wards.** | 2 | 5 | 2 | 3 | **12** |
| **Critical Care** | 1 | 1 | 1 | 1 | **4** |
| **Cardiac Care** | 1 | 1 | 1 | 1 | **4** |
| **Outpatients Departments** | 2 | 1 | 2 | 3 | **8** |
| **Endoscopy Units.** | 1 | 1 | 1 | 1 | **4** |
| **Day Surgery Units** | 1 | 2 | 1 | 1 | **5** |
| **Medical Day Units** | 1 | 1 | 1 | 1 | **4** |
| **Theatres** | 1 | 1 | 1 | 1 | **4** |
| **Pre-Assessment Units** | 1 | 1 | 1 | 1 | **4** |
| **Rheumatology** | - | - | 1 | - | **1** |
| **Intravitreal Injection service (Amman Valley Hospital)** | - | 1 | - | - | **1** |
| **Accident & Emergency/Clinical Decision units/Acute Medical Admissions Unit/Minor Injuries Unit** | 1 | 2 | 2 | 2 | **7** |
| **Total** | **15** | **23** | **20** | **19** | **77** |

**Table 2: breakdown of areas from Women and Children Services who participated in the annual audit**

| | Bronglais General Hospital | Glangwili General Hospital | Prince Philip Hospital | Withybush General Hospital | Total |
|---|---|---|---|---|---|
| **In patient ward** | - | 1 | - | - | **1** |
| **Maternity.** | 1 | 1 | - | 1 | **3** |
| **Neonatal Care.** | - | 1 | - | - | **1** |
| **Paediatrics.** | 1 | 3 | - | 1 | **5** |
| **Total** | **2** | **6** | **-** | **2** | **10** |

Table 3: breakdown of areas from Mental Health & Learning Disabilities Services who participated in the annual audit

| | Ceredigion | Carms | | Pembs | Hafan Derwen site | Total |
|---|---|---|---|---|---|---|
| | | Glangwili | Prince Philip | | | |
| **Mental Health – inpatient** | 1 | 1 | 2 | 2 | 2 | **8** |
| **Learning Disabilities** | - | - | - | - | 2 | **2** |
| **Total** | **1** | **1** | **2** | **2** | **3** | **10** |

**Table 4: breakdown of areas from Community Services who participated in the annual audit**

| | Ceredigion | Carmarthenshire | Pembrokeshire | Total |
|---|---|---|---|---|
| **Adult inpatient areas** | 1 | 2 | 2 | **5** |
| **Palliative Care Unit** | - | 1 | - | **1** |
| **Day Units** | - | - | 1 | **1** |
| **Outpatient departments** | 2 | - | - | **2** |
| **Minor Injuries Units** | 1 | 1 | 1 | **3** |

| | | | | |
|---|---|---|---|---|
| **District Nursing Teams** | 8 | 8 | 7 | **23** |
| **Total** | **12** | **12** | **11** | **35** |

| **Table 5: breakdown of areas from Health Visiting who participated in the annual audit** | | | | |
|---|---|---|---|---|
| | **Ceredigion** | **Carmarthenshire** | **Pembrokeshire** | **Total** |
| **Generic teams** | 1 | 2 | 2 | **5** |
| **Flying Start** | - | 1 | - | **1** |
| **Total** | **1** | **3** | **2** | **6** |

The HB findings from the 2018 Annual Health and Care Standards operational audits, patient survey and staff survey are presented in this report which makes some comparisons to the results from the previous audits and will highlight where compliance has increased or decreased. Although the decreases in score are marginal in some cases, we cannot be complacent and we need to ensure that any deterioration, no matter how small, needs to be reviewed and actions taken where required.

Each service/directorate will use their specific findings to highlight the areas of good practice identified and the areas requiring improvement and develop and monitor their action plans to improve outcomes. Each service/directorate is responsible for providing assurance to their respective Quality, Safety, Experience and Assurance sub-committees by providing updates as part of their Quality and Safety presentations.

The audit results are local measurement to inform quality improvement and to share and celebrate good practice and the results should not be used to compare services/directorates within the HB. It must be recognised that there are limitations in making summative comparisons as the number of areas undertaking the audit has increased year on year and also some areas undertook the audit for the first time in 2018.

Unless indicated otherwise, the compliance levels are given as percentages, rounded up to the nearest one percent.

## 3. Background

The NHS in Wales has undertaken a national audit of care and service delivery since 2009 and the audit has included three elements:

- Patient Experience Survey – where we asked patients about their experiences of care.
- Operational – This included a retrospective examination of patient records to measure compliance against the standards and triangulation of information and observation of clinical practice.
- Staff Survey –where we asked staff about their experience of working within the organisation.

The standards set in the 'Fundamentals of Care: guidance for health and social care staff' (2003) were the basis for the 2009-2014 audits. However, since 2015, the annual audit has been undertaken using the standards set in the **Health and Care Standards (2015)** document. The Health and Care Standards are the core standards for the NHS in Wales and brings together and updates the expectations previously set out in "*Doing Well Doing Better Standards for Health Services in Wales",* and the *"Fundamentals of Care"* Standards (2003). The Health and Care Standards provide the framework for how services are organised, managed and delivered on a day-to-day basis. They establish a basis for improving the quality and safety of healthcare services by providing a framework which can be used in identifying strengths and highlighting areas for quality improvement.


It is recognised that the audit:

*Enables patients/carers to:*

- Share their views and experiences on what we do well and where we need to improve, which will be used to help improve the services we provide.
- Have a voice in the quality of the care they receive.

*Empowers staff to:*

- Make a difference and ensure ownership of their practice.
- Have a voice in the care that they provide and ensure the focus is on essential elements of care and caring.
- Identify areas of good practice and highlight issues for concern.
- Develop action plans to monitor change.

*Enables organisations to:*

- Have a mechanism to monitor/measure the quality of nursing care.
- Develop organisational policies and procedures.
- Identify key themes for improvement.
- Adopt a culture of openness and transparency with the quality standards.

The audit is no longer mandated by the CNO; however HBs/Trust continue to undertake the audit to complete the audit as it provides a mechanism to monitor/measure the quality of nursing care provided within our organisations, whilst giving patients and staff an opportunity to share their views and experience.

## 4. Assessment

**4.1 Learning from the 2017 audit -**The All Wales Health & Care Standards Monitoring Network Group continues to oversee and coordinate the programme of work required for each annual audit cycle. As in previous years, following the conclusion of the 2017 audit, the operational, patient survey and staff survey questions were reviewed to ensure they remain fit for purpose and reflect current practice. Minimal changes were made to the 2018 audit tools.

**4.2 Undertaking the Fundamentals of Care Audit 2018 –** As in previous years, the time scale for staff to complete this year's audit was 1st October - 30th November 2018. The senior nursing and midwifery team agreed that, as in previous years, all three elements of the audit (user experience, staff survey and operational audits) would be undertaken in all the relevant clinical wards/services/units within the HB. This is in line with most other HBs/Trusts across Wales who are undertaking at least one or more elements of the audit.

**4.2.1 Patient Survey:** For the 2018 patient survey, it was agreed that the sample size would be 15 patients on the ward/department/case load on a given day. It was agreed that teams could chose any day between the 1st October and the 31st October 2018. Patients from 130 wards/units/services participated in the audit (theatres were excluded from this element of the audit and four wards/units/services did not complete this element of the audit).

**4.2.2 Staff Survey:** The survey was available as an online survey or staff could complete a paper version if they wished. The online version of the survey was available from the 1st November to the 4th December 2018. As in previous years, the primary focus of the staff survey was nursing staff but any member of the multidisciplinary team could complete the survey if they wished.

**4.2.3 Operational:** 137 clinical wards/units/services participated in the audit.

**4.2.4 Compliance Matrix –** the agreed compliance matrix for all elements of the audit is set out in diagram 1.

| Diagram 1: Compliance Matrix |
|---|
| >85% |
| 50%-85% |
| <50% |

**4.3 Triangulation of data –**The results from the Health and Care Standards Audit is only one method by which we monitor the quality delivered and therefore only part of the wider picture. The results need to be triangulated with other user experience, performance and outcome measures to help the organisation understand if it is doing the right things well and providing care which is dignified, safe and effective to meet the needs of individuals.

**4.4 Health & Care Standards Fundamentals of Care Results:** The results from the Health & Care/Fundamentals of Care Audit can be found in the following pages and incorporates the results from the following service areas:

- Medical wards.
- Surgical wards.
- Theatres.
- Outpatients Departments.
- Endoscopy Units.
- Day Surgery Units.
- Unscheduled Care.
- Mental Health.

- Maternity.
- Neonatal Care.
- Paediatrics.
- Learning Disabilities.
- District Nursing Teams.

8 new areas undertook the audit for the first time: 6 health visiting teams, the rheumatology unit in Prince Philip Hospital and the IVT service in Amman Valley Hospital.

As stated previously, there were three elements to the audit:

- **Patient experience** – 1548 patients/carers completed the patient survey across the HB (a decrease of 124 patients when compared to the number of patients who took part in the 2017 survey).
- **Our staff** – 1011 staff completed the staff survey (the same number of staff as last year).
- **Operational questions** – 701 patients' records including 457 medication charts, 209 food charts, 221 daily fluid charts and 132 weekly fluid charts were reviewed as part of the audit.

### 4.4.1 Source of the data

- **Individual question compliance** – the source of the data in this report is taken from the Health & Care Monitoring System.

**4.5 Patient Experience: Overall Patient Satisfaction**: 1548 patients/families/carers participated in the general patient survey and when asked to rate their satisfaction with their overall experience, using a 1-10 rating score, with 1 being very bad and 10 being excellent, patients gave us a rating of **9.3 out of 10 (93%)** ensuring that Hywel Dda University Health Board achieved a RAG rating of green, in accordance with the All Wales Fundamentals of Care audit criteria, for a six consecutive year. The table below gives a breakdown per year:

**Table 6: Overall satisfaction with Overall experience, using a 1-10 rating score (with 1 being very bad and 10 being excellent), Breakdown per year.**

| Year | Number of patients | Score | RAG rating | |
|---|---|---|---|---|
| 2013 | 642 | 9.1 out of 10 (91%) | Green | |
| 2014 | 1018 | 9.3 out of 10 (93%) | Green | ↑ |
| 2015 | 1256 | 9.2 out of 10 (92%) | Green | ↓ |
| 2016 | 1637 | 9.3 out of 10 (93%) | Green | ↑ |
| 2017 | 1672 | 9.4 out of 10 (94%) | Green | ↑ |
| 2018 | 1534 | 9.3 out of 10 (93%) | Green | ↓ |

Table 7 shows the breakdown per score and shows that 62% of the patients who responded gave the HB a 10 out of 10 rating (99 patients less than last year). However, 35 patients gave the HB a rating of 5 out of 10 or below (an increase of 12 patients).

**Table 7: Overall satisfaction with Overall experience, using a 1-10 rating score (with 1 being very bad and 10 being excellent), Breakdown per score.**

| | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | |
|---|---|---|---|---|---|---|---|
|  10 out of 10 | 58.4% n=377 | 64.7% n=659 | 59.73% n=742 | 62.18% n=1018 | 63.04% n=1054 | 62.17% n=955 | ↓ |

# Health & Care Standards

| | | | | | | | |
|---|---|---|---|---|---|---|---|
|  9 out of 10 | 20.6% n=133 | 18.7% n=190 | 19.77% n=246 | 18.45% n=302 | 19.92% n=333 | 18.95% n=291 | ↓ |
|  8 out of 10 | 13.8% n=89 | 9.2% n=94 | 12.94% n=161 | 12.95% n=212 | 11% n=184 | 11.52% n=177 | ↑ |
|  7 out of 10 | 5.6% n=36 | 3.9% n=40 | 3.46% n=43 | 3.30% n=54 | 2.87% n=48 | 3.06% n=47 | ↑ |
|  6 out of 10 | 0.6% n=4 | 1.7% n=18 | 1.77% n=22 | 1.28% n=21 | 1.14% n=19 | 1.89% n=29 | ↑ |
|  5 out of 10 | 0.8% n=5 | 0.9% n=10 | 1.45% n=18 | 1.16% n=19 | 0.90% n=15 | 1.50% n=23 | ↑ |
|  4 out of 10 | 0.2% n=1 | 0.4% n=4 | 0.16% n=2 | 0.12% n=2 | 0.06% n=1 | 0.20% n=3 | ↑ |
|  3 out of 10 | 0% | 0.1% n=1 | 0.08% n=1 | 0.37% n=6 | 0.12% n=2 | 0.26% n=4 | ↑ |
|  2 out of 10 | 0% | 0% n=0 | 0% n=0 | 0.12% n=2 | 0.06% n=1 | 0.13% n=2 | ↑ |
|  1 out of 10 | 0.2% n=1 | 0.1% n=1 | 0.56% n=7 | 0.06% n=1 | 0.18% n=3 | 0.20% n=3 | ↑ |
|  0 out of 10 | 0% | 0.1% n=1 | 0.08% n=1 | 0% n=0 | 0.06% n=1 | 0% | ↓ |

*12 patients chose not to respond to this question.
** 2 patients gave a score of greater than 10 out of 10.

In addition to the patient satisfaction question, patients were asked 25 core questions. The data shows that we achieved a green RAG rating for 23 of the 25 of the core questions (85% or above). Where there is comparable data, six questions have seen an increase in percentage compliance compared to last year, fourteen have seen a decrease in percentage compliance and seven remain unchanged on last year's position.

22 of the 25 questions showed compliance scores of above 90%, however 13 have seen a decrease in the percentage compliance when compared to last year's data (between 1-2%).

Three aspects of care scored between 85-90%.

- Only 84% of the patients who responded stated that they were able to speak Welsh to staff if they needed to (↓2% on last year's position) and this question has changed from a green RAG rating last year to an amber RAG rating this year.
- Only 84% of the patients who responded felt they were able to get enough rest and sleep (↓3% on last year's position). Rest & Sleep has always been one of the lowest scoring aspects of care from a patient's perspective.

- 88% of the patients who responded felt they were given help and advice on how to prevent damage to their skin (↓2% on last year's position).

The overall patient experience scores for the previous five audit cycles and the 2018 findings are presented in table 8. In addition to the core questions there are specialty specific patient questions and these are included in the relevant service/directorate reports.

| **Table 8: overall results/core questions/HB** | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Summary/Indicator** | **2013** | **2014** | **2015** | **2016** | **2017** | **2018** | |
| **First and Lasting Impressions** | | | | | | | |
| Patients felt that they were treated with dignity and respect | 98% | 99% | 98% | 99% | 99% | 98% | ↓ |
| Patients felt they were given enough privacy | 99% | 99% | 98% | 97% | 99% | 97% | ↓ |
| Patients felt that people were polite to them | | | | 98% | 99.5% | 99% | ↓ |
| Patients felt that if they asked for assistance they got it when they needed it | 95% | 96% | 97% | 96% | 98% | 97% | ↓ |
| Patients felt they received help quickly and discreetly to use the toilet | 95% | 97% | 97% | 96% | 95% | 96% | ↑ |
| Patients felt they were kept informed regarding delays | | 93% | 92% | 90% | 91% | 92% | ↑ |
| Patients felt that they were able to speak Welsh to staff if they needed to | | | | | 86% | 84% | ↓ |
| **Receiving care in a safe, supportive, healing environment** | | | | | | | |
| Patients felt safe | 99% | 99% | 98% | 98% | 99% | 99% | ↔ |
| Patients felt they were made to feel comfortable | 96% | 98% | 97% | 98% | 99% | 98% | ↓ |
| Patients felt they were kept, as far as possible, free from pain | 96% | 97% | 96% | 96% | 98% | 96% | ↓ |
| Patients felt they were provided with water and drinks | 96% | 97% | 97% | 98% | 98% | 97% | ↓ |
| Patients felt that the clinical area was kept clean and tidy | 98% | 99% | 99% | 99% | 99% | 99% | ↔ |
| Patients felt they were provided with nutritious snacks | 93% | 93% | 95% | 93% | 93% | 95% | ↑ |
| Patients felt that staff were kind and helpful | | | | 99% | 99% | 99% | ↔ |
| Patients felt they were given help with feeding if needed it | 96% | 98% | 97% | 96% | 94% | 93% | ↓ |
| Patients felt they were able to get enough rest and sleep | 84% | 88% | 85% | 83% | 87% | 84% | ↓ |
| Patients felt that they had their hygiene needs met | 98% | 99% | 98% | 98% | 98% | 98% | ↔ |
| Patients felt they were given help with their mouth care | 91% | 97% | 95% | 94% | 88% | 93% | ↑ |
| Patients felt that were given help and advice on how to prevent damage to your skin | | | | 97% | 90% | 88% | ↓ |
| **Understanding and Involvement in Care** | | | | | | | |
| Patient felt that they were given full information about their care | 95% | 96% | 95% | 95% | 97% | 97% | ↔ |
| Patients felt that things were explained to them in a way that they could understand | | | | | 93% | 96% | ↑ |

| Summary/Indicator | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | |
|---|---|---|---|---|---|---|---|
| Patients felt that they understood what was happening in their care | | | | | 97% | 96% | ↓ |
| Patients felt that they were given help to be as independent as possible | 98% | 98% | 98% | 97% | 97% | 97% | ↔ |
| Patients felt that they were listened to | | | | 96% | 97% | 97% | ↔ |
| Patients felt that they were involved as much as you wanted to be in decisions about their care | | | | | 96% | 95% | ↓ |
| Patients felt that they were involved as much as they wanted to be in decisions about their discharge | | | | 90% | 90% | 91% | ↑ |

**Who completed the survey:** Teams were advised to randomly select the patients who were given the questionnaire as it is important that patients who are frail and vulnerable and who might not be able to complete the questionnaire independently are not excluded from having the opportunity to provide feedback about their care. 74% of the questionnaires were completed by the patient (↑2% on last year), 15% were completed by family/carer/friend on behalf of the patient (↓1% on last year) and 11% were completed by health care professional on the patient's behalf (↓1% on last year).

The data shows that the majority of patients who completed the survey were independent enough to complete the questionnaire on their own; however, 26.5% (n=402) of the patients who were included in the survey required the support of someone else to complete the survey (↓1.5% on last year). Where the questionnaires were completed by family/carer/friend or healthcare professional, the individual completing the questionnaire was asked to document the reason why so that we could better understand the reasons why the patients needed support to complete the survey. Where the family or healthcare professional had responded to this question, the main reasons the patients required support were, in order of frequency:

- Ability to write - the majority of the patients who required support in this year's audit (n=50) noted that they were either unable to write or had lost the ability to write because of an illness or had lost the dexterity to hold a pen. This was nine more patients than last year.
- Clinical Condition – 45 patients required support to complete the questionnaire because of their clinical condition as they were too unwell to complete it themselves (↑13 patients on last year).
- Vision– 42 patients required support as they were unable to complete the questionnaire because they could not see to read it either because of a visual impairment or because they had left their glasses at home. This was nine less than last year.
- Cognitive impairment – the number of patients who required support due to cognitive impairment e.g. dementia, memory loss remains low (N=19) considering that a growing number of patients admitted to hospital have a cognitive impairment.
- Ability to read - A small number of patients (n=12) required support as they were unable to read the questions or the print was too small for them to read (number unchanged from last year).

The 2017 data showed that vision was the most frequent reason followed by ability to write and clinical condition.

63% of the patients (n=945) who complete the survey were aged 60 year and above (↓2% on last year). The table below gives a breakdown of the number of patients who completed the patient survey per age group:

**Table 9: Breakdown per age group.**

| | 0-18 | 18-29 | 30-39 | 40-49 | 50-59 | 60-69 | 70-79 | 80 Plus |
|---|---|---|---|---|---|---|---|---|
| **Number of patients** | 34 | 120 | 145 | 97 | 158 | 222 | 379 | 352 |
| **Percentage per age group** | 2% | 8% | 9% | 6% | 10% | 14% | 24% | 23% |

*41 patients chose not to answer this question.

**What does the Fundamentals of Care Patient Experience Survey tell us?**

**First & Lasting Impressions:** The survey shows that most of the time we do provide a positive patient experience and a good standard of care, however, there are occasions when this isn't always the case and we need to ensure that all staff maintain the HB's organisational values of treating people with dignity and respect**.**

*I have nothing but praise for all staff that have been involved with me today. Everyone has been kind, polite, patient and helpful.*

*I'd like to thank everybody who has treated me and I am very grateful to the kindness I have received. I have been treated with great care and consideration by everyone.*

*Some nursing staff need to look at their attitude towards patients. The team on my ward was 95% excellent - let down by a few.*

*In the first few weeks I found one or two of the nurses dismissive of my fears and feelings, to the point of being rude to me when I was particularly upset. This has now improved and I find most of the staff helpful and friendly.*

A number of patients commented on the staffing levels on the wards/departments and the impact that this has on their care. A number of patients made reference to "*more staff needed*"- both nursing and other disciplines.

**Receiving care in a safe, supportive, healing environment:** the survey shows that patients feel that, most of the time, they receive care in a safe, supportive, healing environment but we don't get it right for everyone.

*Could not be happier and more grateful for the care and dedication by the staff. In such a stressful and emotional time it is so reassuring that all the staff are so compassionate and considerate to making you aware of everything and don't hesitate to reassure you of what is going on and answer any and all questions.*

*Despite the stress and concern this has been a very positive journey. All staff have been most helpful. Questions have been answered fully as possible and at all times there has been such a show of genuine concern and care (for all of us involved).*

*Staff should not "forget that every patient is different and needs to be listened to, even if it seems a nuisance".*

A small number of patients made reference to Transforming Clinical Services and the changes to the function of the sites and number included comments such as "*make sure the hospital is kept open".*

A small number of patients commented on the car parking facilities and commented that care parking continues to be a problem across all four of our acute hospital sites. Patients noted that *"parking was very difficult"* on one site, whilst on another site *"car parking is dreadful"* and the *"biggest problem at the hospital is parking. My wife on average had to drive around for 1/2 hour each day before she could find a space"* and one patient concluded that "*the parking facilities needs improving".*

**Understanding and Involvement in Care:** The survey shows that the majority of patients understand and are involved in their care but there are examples when we could do better,

*I've been able to ask questions without feeling daft and have felt listened to.*

*I am very pleased with the advice and support i have received during and after my pregnancy.*

*I had concerns about various aspects of my husband's care which were not listened to.*

**4.6 Other mechanisms by which we have feedback on the care that patients' receive:**

- **Big Thank You initiative:**
- **Friends and Family Test (FFT):** The Friend and Family Test is an opportunity for people to provide feedback on their experience of services, it involves asking a standard question after patients have received care and treatment: "How likely are you to recommend our service to friends and family if they need similar care or treatment"? This service has been available for all A&E and Minor Injury Units since February 2017 and there are plans to roll this out to other services.
- **Care Opinion:** Care Opinion is a non-profit feedback platform for health and social care services for people to share their experiences of health and care in ways which are safe, simple, and lead to learning and change. Whilst Hywel Dda University Health Board does not currently promote the Care Opinion portal or subscribe to paid for services from Care Opinion, we do monitor any feedback "stories" that have been made about the Health Board.
- **On line Survey feedback:** the survey is available via the intranet site and provides another mechanism for the patient to provide us feedback.
- **Service Specific Patient Surveys:** Patient surveys are undertaken regularly within specific service areas, more recently surveys have been undertaken in the area of critical care, rheumatology, endoscopy and outpatients. This supports the ongoing communication methods such as patient comments book and feedback boxes that are in place.
- **Unannounced Health Inspectorate Wales (HIW) inspections:** HIW regulate and inspect NHS services and independent healthcare providers in Wales against a range of standards, policies, guidance and regulations. During the inspections, the inspection team ask people about their experience of care and check that the right systems and processes are in place.

**4.7 Operational Findings –** Table 10 provides the overall total percentage compliance for the operational questions, per standard for each ward/department included. A comparison between the audit results for the previous audit cycles has been provided to show where improvements have been noted. There are limitations to making comparisons and it is important to note:

- The sample size for 2018 is greater than for the previous audit with new areas undertaking the audit for the first time this year.
- Each standard includes additional specialty specific questions and for some standards, only specialty specific questions were asked and the report highlights where this applies.

It must also be noted that although there are 22 standards in the Health & Care Standards (2015) document, there were no operational questions included for two of the standards (Standard 3.4 Information Governance and Communications Technology and Standard 5.1: Timely Access) prior to the 2017 audit. For the 2017 and 2018 audits the two standards only have specialty specific questions.

The results show:

- That of the 22 standards included in the audit, the HB achieved 85% or above in 19 of the standards with the remaining three achieving amber RAG ratings (scores between 50-85%).
- Where previous data is available, the 2018 show an increase in compliance for eight standards, a decrease in compliance for nine standards with five showing an unchanged position.
- Standard 3.1 has seen a significant decrease when compared to last year's position (↓9%).
- Standard 2.8 has seen a significant increase compared to the 2017 position (↑10%). This standard only has specialty specific questions.

| **Table 10: Operational questions: Overall Standard Summary** | | **2013 RAG %** | **2014 RAG %** | **2015 RAG %** | **2016 RAG %** | **2017 RAG %** | **2018 RAG%** | |
|---|---|---|---|---|---|---|---|---|
| Staying Healthy | | | | | | | | |
| 1.1 | Health Promotion, Protection and Improvement | n/a | n/a | 100% | 79% | 78% | 77% | ↓ |
| Safe Care | | | | | | | | |
| 2.1 | Managing Risk and Promoting Health and Safety | 94% | 91% | 92% | 92% | 95% | 94% | ↓ |
| 2.2 | Preventing Pressure and Tissue Damage | 93% | 88% | 88% | 93% | 93% | 92% | ↓ |
| 2.3 | Falls Prevention | 96% | 85% | 86% | 90% | 89% | 88% | ↓ |
| 2.4 | Infection Prevention and Control (IPC) and Decontamination | 89% | 99% | 96% | 97% | 99% | 98% | ↓ |
| 2.5 | Nutrition and Hydration | 93% | 91% | 92% | 93% | 94% | 94% | ↔ |
| 2.6 | Medicines Management | 88% | 91% | 92% | 98% | 96% | 95% | ↓ |
| 2.7 | Safeguarding Children and Safeguarding Adults at Risk | 96% | 98% | 97% | 96% | 93% | 98% | ↑ |
| 2.8 | Blood Management | n/a | n/a | 100% | 80% | 73% | 83% | ↑ |
| 2.9 | Medical Devices, Equipment and Diagnostic Systems | 92% | 90% | 90% | 96% | 96% | 95% | ↓ |
| Effective Care | | | | | | | | |
| 3.1 | Safe and Clinically Effective Care | n/a | n/a | n/a | 82% | 90% | 81% | ↓ |
| 3.2 | Communicating Effectively | 84% | 86% | 86% | 88% | 86% | 88% | ↑ |
| 3.3 | Quality Improvement, Research and Innovation | n/a | n/a | n/a | 94% | 85% | 89% | ↑ |

# Health & Care Standards

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 3.4 | Information Governance and Communications Technology | n/a | n/a | n/a | n/a | 100% | 100% | ↔ |
| 3.5 | Record Keeping | 94% | 86% | 89% | 90% | 90% | 89% | ↓ |
| Dignified Care | | | | | | | | |
| 4.1 | Dignified Care | 80% | 84% | 86% | 86% | 84% | 87% | ↑ |
| 4.2 | Patient Information | 80% | 87% | 87% | 91% | 89% | 90% | ↑ |
| Timely Care | | | | | | | | |
| 5.1 | Timely Access | n/a | n/a | n/a | n/a | 100% | 100% | ↔ |
| Individual Care | | | | | | | | |
| 6.1 | Planning Care to Promote Independence | 86% | 87% | 87% | 87% | 88% | 88% | ↔ |
| 6.2 | Peoples Rights | n/a | 81% | 93% | 92% | 85% | 93% | ↑ |
| 6.3 | Listening and Learning from Feedback | 91% | 96% | 96% | 98% | 96% | 97% | ↑ |
| Staff and Resources | | | | | | | | |
| 7.1 | Workforce | 78% | 76% | 88% | 86% | 90% | 90% | ↔ |

**Standard 1.1 Health Promotion, Protection and Improvement:**

People are empowered and supported to take responsibility for their own health and wellbeing and carers of individuals who are unable to manage their own health and wellbeing are supported. Health services work in partnership with others to protect and improve the health and wellbeing of people and reduce health inequalities.

*NMC (2015): Prioritise People: Standard 3.1: Pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages.*

**Operational Audit Narrative:** Of the 15 questions included for this standard, eight achieved a score of 85% or above. Four questions have seen an increase in percentage compliance compared to last year, seven have seen a decrease in percentage compliance and four remain unchanged on last year's position.

There are seven areas that have an amber RAG rating and these are around assessment and care planning and these need further improvement work over the next 12 months.

There are eight new questions included for this standard which are health visiting specific. Seven achieved a score of 85% or above whist the remaining question has a red RAG rating and required immediate action.

**Table 11: Whole HB/Standard 1.1 Health Promotion, Protection and Improvement**

| | | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | |
|---|---|---|---|---|---|---|---|---|
| Maternity only | Is all staff aware of Baby Friendly initiatives? | n/a | n/a | 100% | 100% | 100% | 100% | ↔ |
| All excluding neonates, theatres, District Nursing | For this episode of care, is there evidence that the patient's smoking habits been assessed? | n/a | n/a | n/a | 78% | 81% | 76% | ↓ |
| All excluding neonates, theatres, District Nursing | For this episode of care, where the patient is identified as a smoker and wishes to stop smoking, is there evidence that they have been provided with information in relation to smoking cessation? | n/a | n/a | n/a | 66% | 69% | 65% | ↓ |
| All excluding neonates, theatres, District Nursing | For this episode of care, is there evidence that the patient's weight has been measured? | n/a | n/a | n/a | 88% | 91% | 90% | ↓ |
| All excluding neonates, theatres, District Nursing | For this episode of care is there documented evidence that where the patients weight is unhealthy that they have been provided with information in relation to a healthy diet? | n/a | n/a | n/a | 84% | 83% | 74% | ↓ |
| All excluding neonates, theatres, District Nursing | For this episode of care has the patient's alcohol intake been assessed? | n/a | n/a | n/a | 75% | 76% | 72% | ↓ |
| All excluding neonates, | Where the patient has an identified problem with their alcohol intake, is there an up to date | n/a | n/a | n/a | 76% | 62% | 59% | ↓ |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| theatres, District Nursing | plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale? | | | | | | | |
| All excluding neonates, theatres, District Nursing | For this episode of care has the patient's illicit substance use been assessed? | **n/a** | **n/a** | **n/a** | **70%** | **57%** | **64%** | ↑ |
| All excluding neonates, theatres, District Nursing | Where the patient has an identified problem with illicit substance use, is there an up to date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale? | **n/a** | **n/a** | **n/a** | **63%** | **68%** | **58%** | ↓ |
| District Nursing | Is the community nursing service able to demonstrate that systems and processes are in place for patients and their carers to access appropriate health improvement opportunities within the community? | **n/a** | **n/a** | **n/a** | **100%** | **92%** | **100%** | ↑ |
| District nursing | Is the community nursing service able to demonstrate that systems and processes are in place to achieve individual service user outcomes? | **n/a** | **n/a** | **n/a** | **100%** | **96%** | **100%** | ↑ |
| Minor Injuries Units only | Are health promotion resources available to patients whilst waiting for assessment or treatment | **n/a** | **n/a** | **n/a** | **n/a** | **100%** | **100%** | ↔ |
| Minor Injuries Units only | Are patient information leaflets regarding treatment and management o the injury given to patients on discharge | **n/a** | **n/a** | **n/a** | **n/a** | **40%** | **95%** | ↑ |
| Paeds only | Are health promotion boards displayed within the clinical areas, to inform and empower CYP and their parent/carer to take responsibility for their health & well being? | **n/a** | **n/a** | **n/a** | **n/a** | **100%** | **100%** | ↔ |
| Paeds only | Are staff able to signpost CYP and their parent/carer to services for information, advice and support? | **n/a** | **n/a** | **n/a** | **n/a** | **100%** | **100%** | ↔ |
| Health Visiting | Is there written evidence that the infant's feeding was discussed? | **n/a** | **n/a** | **n/a** | **n/a** | **n/a** | **97%** | New |
| Health Visiting | Is there written evidence that the infant feeding checklist was commenced? | **n/a** | **n/a** | **n/a** | **n/a** | **n/a** | **93%** | New |
| Health Visiting | Is there written evidence that the feeding data was recorded? | **n/a** | **n/a** | **n/a** | **n/a** | **n/a** | **100%** | New |
| Health Visiting | Is there evidence that the 10 steps approach to nutrition and infant feeding was discussed? | **n/a** | **n/a** | **n/a** | **n/a** | **n/a** | **27%** | New |
| Health Visiting | Is there written evidence that the blood spot screening results have been discussed? | **n/a** | **n/a** | **n/a** | **n/a** | **n/a** | **97%** | New |
| Health Visiting | Is there written evidence that Neonatal hearing screening results have been discussed? | **n/a** | **n/a** | **n/a** | **n/a** | **n/a** | **90%** | New |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Health Visiting | Is there evidence that the appropriate proformas used for assessment have been undertaken? (e.g. SOGS/developmental proformas) | **n/a** | **n/a** | **n/a** | **n/a** | **n/a** | **90.00%** | New |
| Health Visiting | Is there evidence that immunisations have been discussed? | **n/a** | **n/a** | **n/a** | **n/a** | **n/a** | **97%** | New |

**Standard 2.1 Managing Risk and Promoting Health and Safety**

People's health, safety and welfare are actively promoted and protected. Risks are identified, monitored and where possible, reduced or prevented.

*NMC (2015: Preserve Safety: Standard 19.1: Take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place.*

*NMC (2015): Preserve Safety: Standard 19.4: Take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public).*

**Operational Audit Narrative:** All 15 questions include for this standard, achieved a compliance score of 85% or above. Eight questions achieved a compliance score of 100%. Two questions have seen an increase in percentage compliance compared to last year, four have seen a decrease in percentage compliance and nine remain unchanged on last year's position.

There were two new questions for this standard which are health visiting specific. Both achieved a compliance score of 85% or above.

**Table 12: Whole UHB/Standard 2.1 Managing Risk and Promoting Health and Safety**

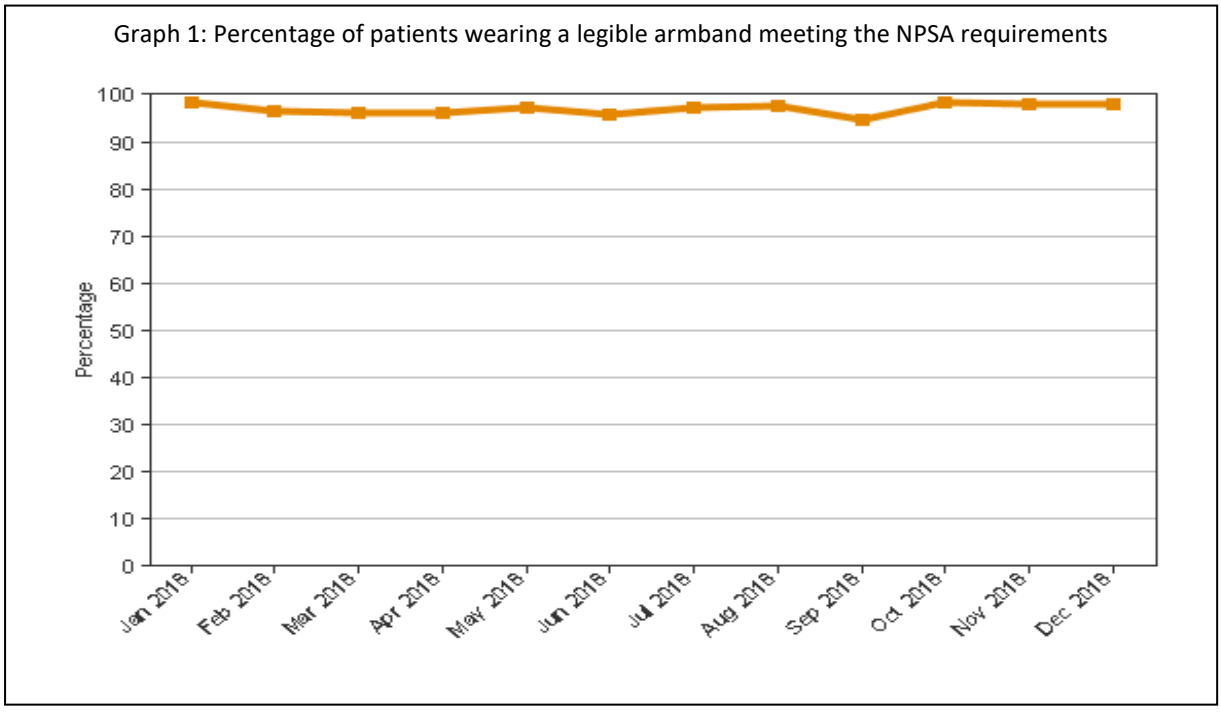
| | | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | |
|---|---|---|---|---|---|---|---|---|
| ALL except OPD | Do all patients wear an identification band which states their first and last name, date of birth and NHS number? | 94% | 96% | 97% | 95% | 99% | 97% | ↓ |
| ALL | Is the patient's identity checked visually and verbally prior to undertaking a procedure? | n/a | 98% | 99% | 99% | 99% | 99% | ↔ |
| ALL except Neonates, OPD, Theatres | For this episode of care, is there documented evidence that the patient has an up to date manual handling risk assessment? | 94% | 91% | 93% | 91% | 92% | 92% | ↔ |
| ALL Except Neonates, OPD, Theatres | For this episode of care, where the patient has an identified manual handling risk, is there evidence that there is an up to date plan of care which is being implemented and evaluated and has been reviewed within the agreed timescale? | 84% | 81% | 82% | 87% | 89% | 87% | ↓ |
| ALL except Neonates, OPD | If a patient has been assessed as requiring bed rails, is there an up to date risk assessment in place? | 87% | 87% | 91% | 85% | 96% | 87% | ↓ |
| ALL | Within the clinical area, are all fire restraint doors free from obstruction or closed if not automatic self closing? | 97% | 91% | 92% | 92% | 91% | 91% | ↔ |
| Paeds only | Is the Child/Young Person in an age appropriate bed with cot sides/bed rails in situ? | n/a | 100% | 100% | 100% | 100% | 100% | ↔ |
| Maternity only | Do women have access to general information about the birth centre/midwife led unit/obstetric unit prior to admission or on | n/a | 100% | 100% | 100% | 100% | 93% | ↓ |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | arrival? | | | | | | | |
| Maternity only | Is there evidence that women are receiving the Bump, Baby and beyond Book or how to access it online? | n/a | 93% | 100% | 100% | 80% | 100% | ↑ |
| Maternity Only | Are the security doors and cameras operating effectively? | n/a | 100% | 100% | 100% | 100% | 100% | ↔ |
| Maternity Only | Are entrances to the Birth Centre/Midwife Led Unit/Obstetric Unit visible both day and night? | n/a | 100% | 100% | 100% | 100% | 100% | ↔ |
| Endoscopy & theatres only | Is there evidence of the team brief and de brief being undertaken? | n/a | n/a | 75% | 100% | 100% | 100% | ↔ |
| Endoscopy & theatres only | Is there evidence that the department is compliant with the WHO checklist? | n/a | n/a | 100% | 100% | 100% | 100% | ↔ |
| Minor Injuries Units only | Are bed/trolley rails used on patients requiring a trolley for completion of a procedure? | n/a | n/a | n/a | n/a | 87% | 100% | ↑ |
| Minor Injuries Units only | Are wheelchairs available to all patients who are unable to weight bear due to nature of minor injury? | n/a | n/a | n/a | n/a | 100% | 100% | ↔ |
| Health Visiting | Is there written evidence that sudden Infant Death was discussed? | n/a | n/a | n/a | n/a | n/a | 97% | New |
| Health Visiting | Is there evidence that the home environmental risk assessment has been completed? | n/a | n/a | n/a | n/a | n/a | 93% | New |

**Examples of Good Practice:**

Teams monitor the percentage of patients wearing a legible armband meeting the NPSA requirements on a monthly basis. The below graph demonstrates the percentage compliance for between January 2018-December 2018.

Graph 1: Percentage of patients wearing a legible armband meeting the NPSA requirements

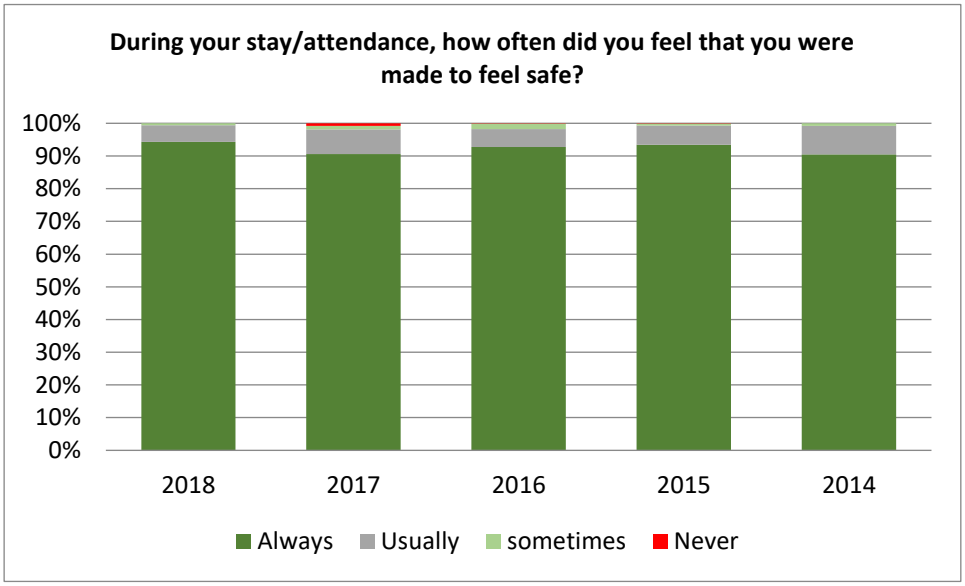


Patient safety incidents are reported where any unintended or unexpected incident occurs, which may have or did lead to harm for one or more patients receiving NHS care.

All community staff have undertaken sepsis awareness training and have been equipped with the necessary equipment to assess for sepsis.

**Patient perspective**: The vast majority of patients *felt that they were made to feel safe with* 99% of the patients responding positively to this question (unchanged from last year).

Graph 2: During your Stay/attendance, how often did you feel that you were made to feel safe?




*They have made us both feel so safe*

*I have felt safe and secure in their care.*

*Some patients can be loud and move furniture around.*

## Standard 2.2 Preventing Pressure and Tissue Damage

People are helped to look after their skin and every effort is made to prevent people from developing pressure and tissue damage.

*NMC (2015): Prioritise People: Standard 1.2: Make sure you deliver the fundamentals of care effectively*

*NMC (2015): Prioritise People: Standard 1.4: Make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay.*

**Operational Audit Narrative:** Three of the four questions include for this standard, achieved a compliance score of 85% or above. One question has seen an increase in percentage compliance compared to last year whilst the remaining three have seen a decrease in percentage compliance.

One specialty specific question has an amber RAG rating and has seen a decrease in percentage compliance and needs further improvement work over the next 12 months.

**Table 13: Whole UHB/ Standard 2.2 Preventing Pressure and Tissue Damage**

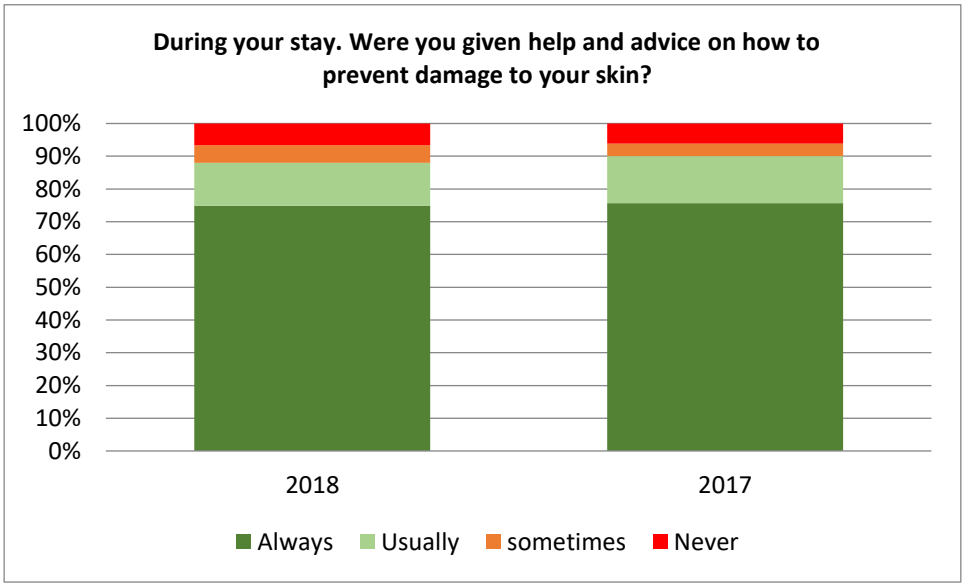
| | | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | |
|---|---|---|---|---|---|---|---|---|
| ALL except neonates | For this episode of care, is there documented evidence that the patient's skin condition has been assessed and discussed with the patient or advocate? | 96% | 90% | 86% | 92% | 94% | 93% | ↓ |
| ALL except neonates | For this episode of care, where the patient has been identified as requiring assistance with looking after their skin, is there evidence that there is an up to date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale? | 86% | 86% | 87% | 94% | 92% | 90% | ↓ |
| Neonates | For this episode of care, is there documented evidence that the baby's skin integrity has been assessed? | n/a | 80% | 100% | 80% | 60% | 100% | ↑ |
| Neonates | For this episode of care, where the baby has been identified as requiring assistance with looking after their skin integrity, i.e. nappy rash, extravasation injury, stoma care is there evidence that there is an up to date plan of care, which is being implemented and evaluated and has been reviewed within the last 24 hours? | n/a | 100% | 50% | 80% | 100% | 80% | ↓ |

**Examples of Good Practice:**

- **Pressure Damage Improvement Group:** a multidisciplinary group has been set up to over see the improvement work needed and ensure a whole system approach to support reducing the incidents of pressure damage both hospital and community acquired.
- Our community teams are achieving a 60% healing rate within 12 weeks for patients with venous leg ulcers

**Patient Perspective**: 88% of the patients who responded felt that were given help and advice on how to prevent damage to your skin (↓2% on last year's position).

Graph 3: During your Stay/attendance, were you given help and advice on how to prevent damage to your skin?




*Advice sheets on every bedside*

## Standard 2.3 Falls Prevention

People are assessed for risks of falling and every effort is made to prevent falls and reduce avoidable harm and disability.

*NMC (2015): Preserve Safety: Standard 19.1: Take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place.*

**Operational Audit Narrative:** Two of the four questions include for this standard achieved a compliance score of 85% or above. Three questions have seen a decrease in percentage compliance whilst the remaining question has remained unchanged on last year's position.

Two questions have an amber RAG rating and are related to care planning following assessment and needs further improvement work over the next 12 months.

**Table 14: Whole UHB/ Standard 2.3 Falls Prevention**

| | | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | |
|---|---|---|---|---|---|---|---|---|
| ALL except neonates & OPD | For this episode of care, is there documented evidence the patient's mobility has been assessed and discussed with the patient or advocate? | 96% | 95% | 94% | 95% | 94% | 94% | ↔ |
| | For this episode of care, where the patient has been identified as requiring support and/or assistance with mobility, is there evidence that there is an up to date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale? | 84% | 77% | 82% | 88% | 85% | 83% | ↓ |
| ALL except maternity neonates, paediatrics, OPD, theatres | For this episode of care, is there documented evidence the patient's risk of falls has been assessed and discussed? | 86% | 87% | 88% | 90% | 92% | 91% | ↓ |
| | For this episode of care, where the patient has been identified as being at risk of falls, is there evidence that there is an up to date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale? | 71% | 80% | 79% | 84% | 82% | 80% | ↓ |

**Examples of Good Practice:**

- The quality improvement teams are working with wards and service areas and a number of improvement projects have commenced, for example, introducing falls improvement boards, introducing bay watching at night etc.

## Standard 2.4 Infection Prevention and Control (IPC) and Decontamination

Effective infection prevention and control needs to be everybody's business and must be part of everyday healthcare practice and based on the best available evidence so that people are protected from preventable healthcare associated infections.

*NMC (2015): Preserve Safety: Standard 19.3: Keep to and promote recommended practice in relation to controlling and preventing infection.*

**Operational Audit Narrative:** All nine questions include for this standard achieved a compliance score of 85% or above. Seven questions achieved a compliance score of 100%. Two questions have seen a decrease in percentage compliance whilst seven remain unchanged on last year's position.

It should be noted that the Infection Control questions included in the audit are process measures and focus on the environment.

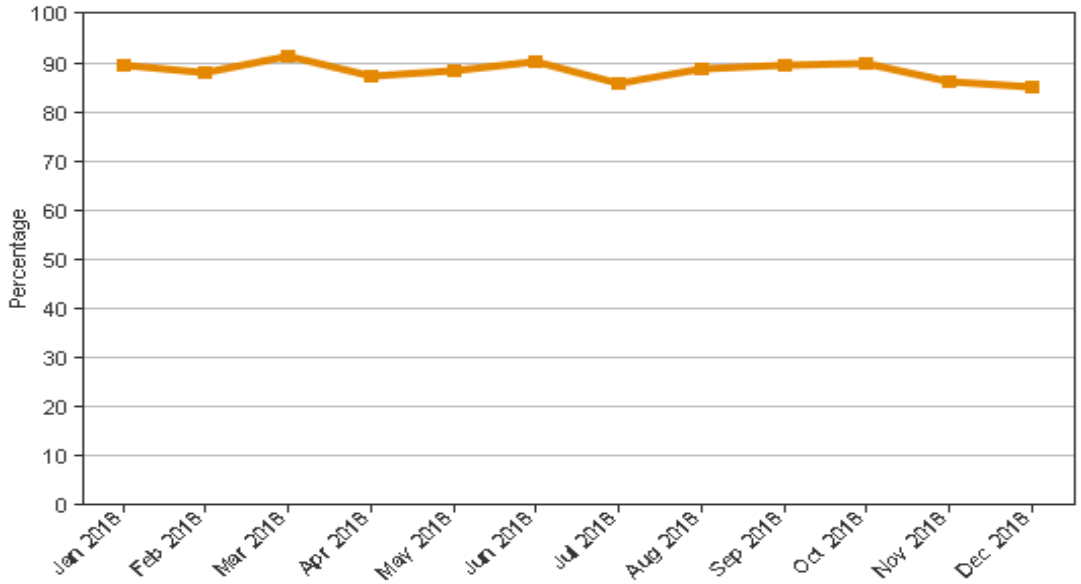
There are two new questions for this standard which are health visiting specific. One achieved a compliance score of 100% whilst the other achieved an amber RAG rating which will require improvement work over the next 12 months.

Table 15: Whole UHB/Standard 2.4 Infection Prevention and Control (IPC) and Decontamination

| | | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | |
|---|---|---|---|---|---|---|---|---|
| ALL | Are staff able to give examples of the correct procedure for infection control? | 100% | 100% | 98% | 99% | 100% | 100% | ↔ |
| ALL except maternity, paeds, LD, OPD, | Are staff able to give examples of the correct procedure for isolating patients? | n/a | 100% | 100% | 99% | 100% | 99% | ↓ |
| ALL Except maternity, neonates, OPD, | Are all patients given the opportunity to wash or cleanse their hands with hand wipes prior to eating food? | 100% | 97% | 92% | 93% | 98% | 95% | ↓ |
| Maternity & paeds | Are baby baths cleaned after each use and stored dry? | n/a | 100% | 100% | 100% | 100% | 100% | ↔ |
| Neonates | Can staff demonstrate the safe and hygienic handling and storage of breast milk? | n/a | n/a | 100% | 93% | 100% | 100% | ↔ |
| Neonates | Is there evidence that equipment that is 'not in use' is stored according to infection control policy and there is documented evidence to show that it has been cleaned? | n/a | n/a | 100% | 100% | 100% | 100% | ↔ |
| Paeds only | Is hand gel available within the clinical area? | n/a | n/a | n/a | n/a | 100% | 100% | ↔ |
| Paeds only | Is PPI equipment (gloves, aprons, masks etc) available within the clinical area? | n/a | n/a | n/a | n/a | 100% | 100% | ↔ |
| Paeds only | Has a monthly WHO hand washing audit for the unit been undertaken? | n/a | n/a | n/a | n/a | 100% | 100% | ↔ |
| Health Visiting | Are staff compliant with infection prevention control mandatory training? | n/a | n/a | n/a | n/a | n/a | 78% | New |
| Health Visiting | Are staff compliant with immunisation training? | n/a | n/a | n/a | n/a | n/a | 100% | New |

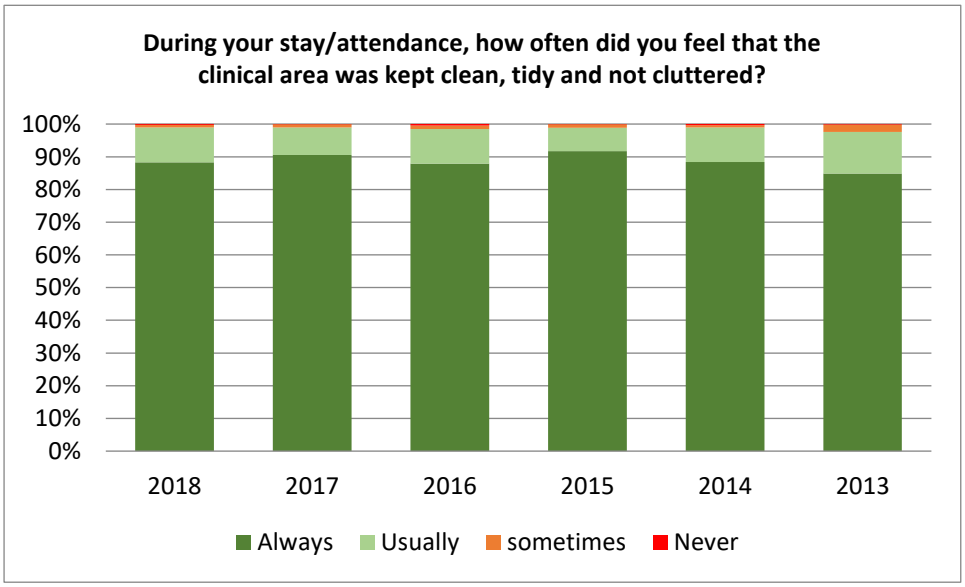
In addition to the annual audit on infection control, teams undertake monthly audits on hand hygiene compliance. The graph below shows the compliance for the past 12 months. The audit process is currently being reviewed.

Graph 4: Percentage compliance with Hand Hygiene (WHO 5 moments)




**Patient Perspective:** The vast majority of the patients were satisfied that the clinical area was always/usually *kept clean, tidy and clutter free* with 99% of the patients responding positively to this question (unchanged from the previous four years).

Graph 5: During your Stay/attendance, how often did you feel that the clinical area was kept clean, tidy and not cluttered?




*Spotless*

*Domestic staff work hard*

*Ward always clean and tidy*

*The ward was scrupulously clean as was the toilet*

*Immaculate ward.*

*There was ample seating and the area was clean and warm*

*Lockers and bedside cabinets perhaps could be improved as they are not large or designed well enough to keep the bedside clean and tidy.*

*Perhaps repair the toilets when not working more quickly. The handle fell off one and another was often blocked*

*Blood on floor and sofa*

*Lack of space*

*I feel like bathrooms need cleaning more often through the day but in order for this to be done it would require more staff as the current staff work extremely hard everyday*

*I was put in a 4 bed room which had a patient with MRSA. I though MRSA should be isolated. Not bring people into a room with it. Very upsetting on top of everything else.*

## Standard 2.5 Nutrition and Hydration

People are supported to meet their nutritional and hydration needs, to maximise recovery from illness or injury.

*NMC (2015): Prioritise Safety: Standard 1.2: Make sure you deliver the fundamentals of care effectively.*

*NMC (2015): Prioritise Safety: Standard 1.3: Make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay.*

**Operational Audit Narrative:** 13 of the 18 questions include for this standard, achieved a compliance score of 85% or above. Eight questions achieved a compliance score of 100%. Seven questions have seen an increase in percentage compliance compared to last year, two have seen a decrease in percentage compliance and eight remain unchanged on last year's position.

There are five questions that have an amber RAG rating.

- Two of the questions relate to the standards for hydration set out in the All Wales Catering and Nutrition Standards for Food and Fluid Provision for Hospital Inpatients and the expectation that water jugs should be changed 3 times a day and there should be a minimum of 7 beverage rounds a day.
- One of the question which has an amber RAG rating relates to the All Wales Catering and Nutrition Standards for Food and Fluid Provision for Hospital Inpatients standard where by HBs should be able to demonstrate that there were systems in place to identify which Registered Nurse has professional accountability for ensuring patients receive appropriate food and assistance to eat where required
- The remaining two specialty specific questions, both of which had a red RAG rating in 2017, have changed to an amber RAG rating, however, there is still work to do to ensure full compliance with these two aspects of care.

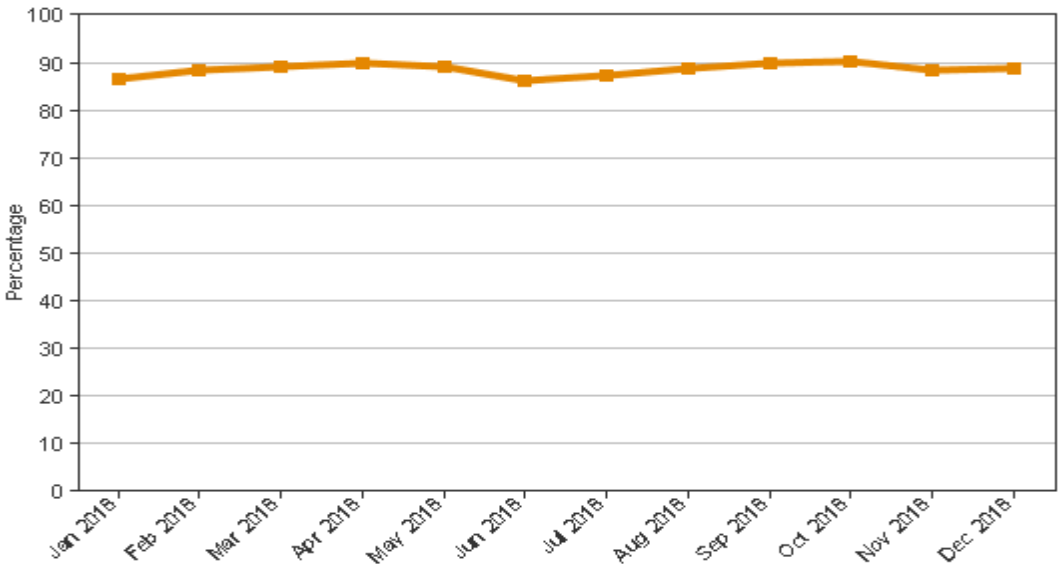
**Table 16: Whole UHB/ Standard 2.5 Nutrition and Hydration**

| | | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | |
|---|---|---|---|---|---|---|---|---|
| ALL except Maternity, neonates, LD, theatres | Prior to eating, are patients that require help, assisted into a suitable position? | 100% | 98% | 100% | 100% | 100% | 100% | ↔ |
| ALL except Maternity, neonates, LD, theatres | Prior to meal service, are bed tables and communal areas cleared and tidied prior to eating? | 100% | 97% | 99% | 99% | 98% | 100% | ↑ |
| ALL except Maternity, neonates, LD, theatres | Are patients meals placed within easy reach? | 100% | 99% | 100% | 99% | 100% | 100% | ↔ |
| Inpatient, paeds, MH & LD only | Is there evidence that the systems in place to enable staff to identify patients with special eating and drinking requirements are being implemented and their effectiveness | 100% | 98% | 97% | 99% | 97% | 99% | ↑ |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | evaluated? | | | | | | | |
| Inpatient, maternity MH, Day Units only | Are water jugs changed 3 times daily? | 55% | 75% | 74% | 77% | 83% | 78% | ↓ |
| ALL except neonates, MH, OPD, endoscopy, theatres | Are drinking water jugs and glasses within the patient's reach? | n/a | 96% | 100% | 100% | 100% | 100% | ↔ |
| Inpatient, ED, Maternity, MH & LD only | During a 24 hour period, are a minimum of 7 beverage rounds are carried out within your clinical area? | 75% | 56% | 61% | 60% | 76% | 80% | ↑ |
| Inpatient, ED, paeds, MH & LD only | Does a Registered Nurse co-ordinate every meal time? | 88% | 80% | 72% | 80% | 77% | 75% | ↓ |
| Inpatient, ED, MH & LD only | Is there evidence that all members of the nursing team are engaged in the mealtime service? | 98% | 93% | 98% | 97% | 95% | 95% | ↔ |
| ALL except neonates, OPD, theatres | Is a range of snacks available for patients who have missed a meal or who are hungry between meals? | 100% | 100% | 99% | 97% | 99% | 99% | ↔ |
| Inpatient, ED, paeds, MH & LD, endoscopy only | Is there a system in place to allow family/friends to assist with meal times? | 95% | 99% | 98% | 96% | 97% | 99% | ↑ |
| Maternity | Have all women had their Body Mass Index recorded at booking? | n/a | 100% | 100% | 100% | 100% | 100% | ↔ |
| Neonates | Is there evidence in the nursing documentation that the babies nutritional needs have been assessed within 24 hours of their admission? | n/a | n/a | 100% | 100% | 100% | 100% | ↔ |
| Neonates | Is there a system in place to allow parents to feed their babies at feeding times? | n/a | n/a | 100% | 100% | 100% | 100% | ↔ |
| Theatres only | IS there documented evidence of IV fluid administration as prescribed for the surgical procedure? | n/a | n/a | n/a | n/a | 93% | 96% | ↑ |
| | Do patients have access to healthy snacks or drinks? | n/a | n/a | n/a | n/a | 0% | 50% | ↑ |
| Minor Injuries Units only | Is there access to hot meals for patients that are waiting for inter hospital transport or referral to other specialty? | n/a | n/a | n/a | n/a | 25% | 66.67% | ↑ |

In addition to the annual audit, the "percentage of nutrition score completed and appropriate action taken within 24 hours of admission", is monitored on a monthly basis. Of the 8638 patients reviewed between 1st January 2018 and 31st December 2018, 89% of patients had a nutritional assessment within 24 hours of admission (unchanged from the same period in 2017). Graph 6 provides the compliance with this indicator per month.

Graph 6: Percentage of Nutrition Score Completed and Appropriate Action Taken within 24 hours of admission.

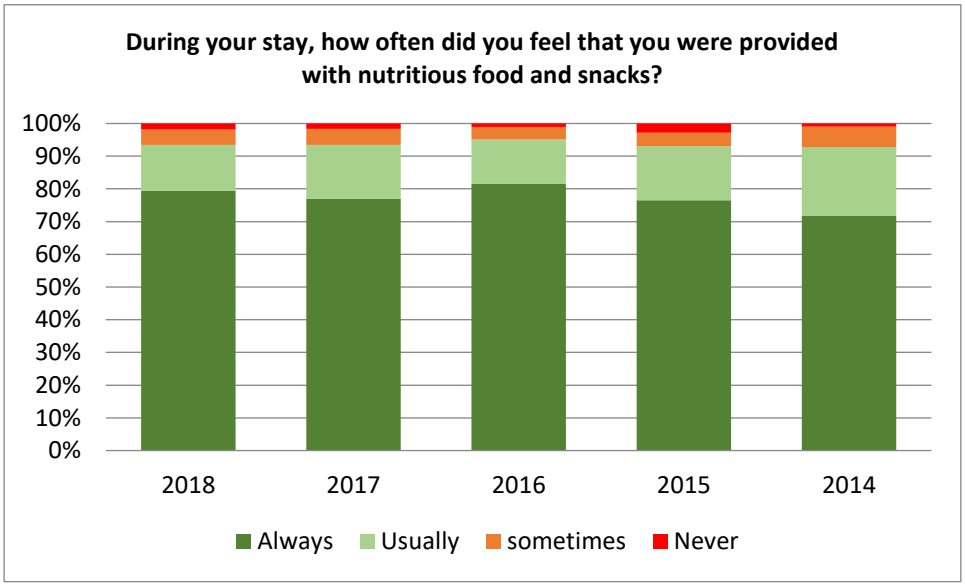



**Patient Perspective:** The All Wales Nutrition & Catering Standards for Food and Fluid for Hospital inpatients state that patients must be supported in meeting their nutritional needs and the vast majority of our patients felt that we met their needs with 93% of the patients stating that they felt that they were always/usually *given help with feeding and drinking if they needed help* (↓1% on last year's position). Since the 2014 audit, this question has seen a year on year decrease in the percentage score from 98% in 2014 to the current 93%.

Graph 7: Patient responses to: During your stay, how often did you feel that you were given help with feeding and drinking if you needed this?

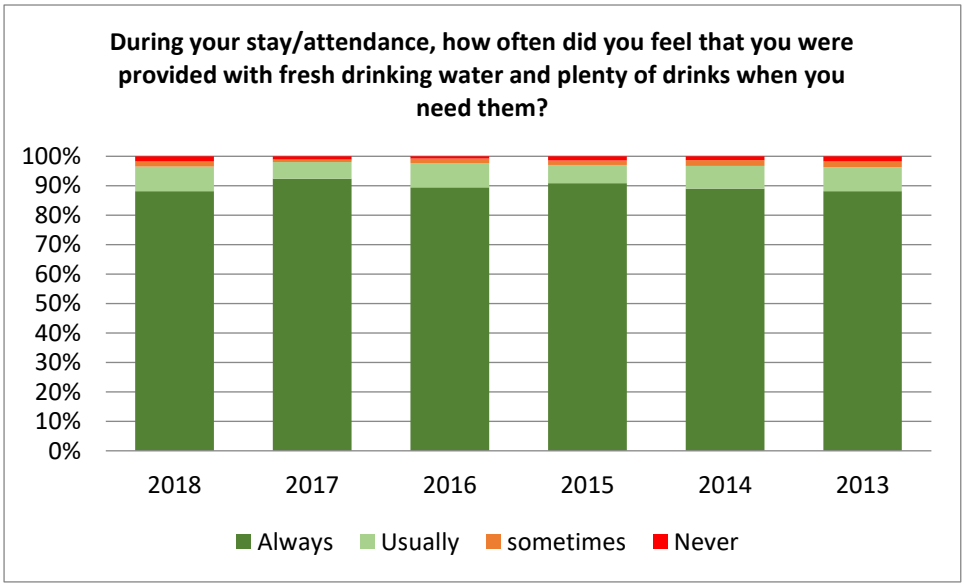
***Patient Perspective:*** *95% of the patients felt that they always/usually were provided with nutritious food and snacks (↑2% from last year).*

Graph 8: Patient responses to: During your stay, how often did you feel that you were provided with nutritious food and snacks?




**Patient Perspective**: 97% of the patients felt that they were always/usually *provided with fresh drinking water and plenty of drinks when they needed them* (↓1% from last year's position).

Graph 9: Patient responses to: During your stay/attendance, how often did you feel that you were provided with fresh drinking water and plenty of drinks when you need them?




*Thank you kitchen staff*

*I like the meals*

*The food is good.*

*I am able to continue assisting my parent with eating at mealtimes; I thought this might not be allowed because of the protected mealtimes. It has been important to me to be able to participate in my parents care in this way and thank the staff for being so forward thinking.*

*They help those who cannot feed themselves and they are always encouraging people to eat.*

*Vending machine for drinks and snacks.*

*Portions were to big for me.*

*Nice food cold sometimes though.*

*Smaller amounts at meal times*

*Need to have a brighter colour plastic beakers as patients can see them more.*

*Need ice machine.*

*Would like to have information leaflets from the hospital on snacks available as I am diabetic. The food is not suitable for diabetics, meals are a major issue on a daily basis, and the food is too high in fat, sugar and carbs. Would like to have salads with more flavour such as onion slices or peppers.*

## Standard 2.6 Medicines Management

People receive medication for the correct reason, the right medication at the right dose and at the right time.

*NMC (2015): Preserve Safety: Standard 18.1: Prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs.*

*NMC (2015): Preserve Safety: Standard 18.2: keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs.*

*NMC (2015): Preserve Safety: Standard 18.3: make sure that the care or treatment you advise on, prescribe, supply, dispense or administer for each person is compatible with any other care or treatment they are receiving, including (where possible) over-the-counter medicines.*

*NMC (2015): Preserve Safety: Standard 18.4: Take all steps to keep medicines stored securely.*

**Operational Audit Narrative:** Six of the nine questions include for this standard, achieved a compliance score of 85% or above. Two questions achieved a compliance score of 100%. Three questions have seen an increase in percentage compliance compared to last year, five have seen a decrease in percentage compliance and one remains unchanged on last year's position.

One specialty specific question, which achieved a red RAG rating in 2017, has changed to an amber RAG rating in 2018 but there is still work to do to ensure full compliance.

Three questions have an amber RAG rating. These areas of improvement include the percentage of medication charts completed with the patients' demographics and allergies which has seen a decrease when compared to the 2017 position (↓6%). The remaining two questions are speciality specific questions.

The number of medication errors reported across the Health Board has remained consistent.
The Medicines Event Review Group (MERG):

- Identifies trends and 'hot spots' from reports of incidents and near misses for proactive targeted work;
- Identifies any medicines that are more frequently associate with errors to focus actions to reduce risks; and
- Shares learning across directorates, sites and sectors.

There was one new question for this standard which is health visiting specific. The question achieved an amber RAG rating and will require some focused improvement work over the next 12 months.

**Table 17: Whole UHB/ Standard 2.6 Medicines Management**

| | | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | |
|---|---|---|---|---|---|---|---|---|
| ALL except OPD | Are all medication charts completed with the following information: patient demographics and allergies and it is clear whether there is more than one medication chart? | 66% | 62% | 67% | 88% | 90% | 84% | ↓ |

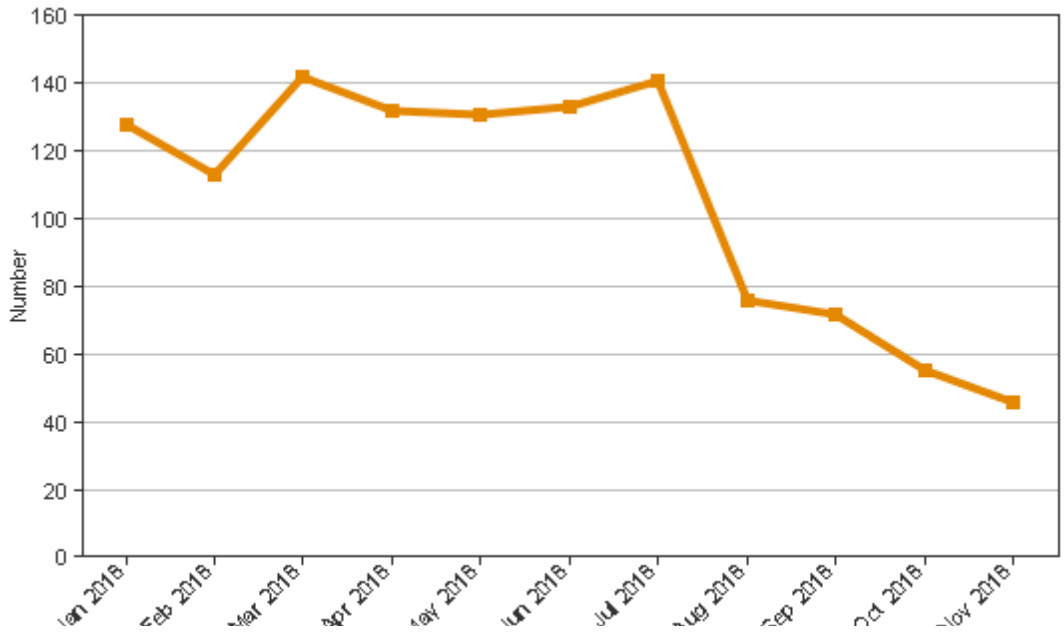
| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| ALL | Is the patient's identity checked visually and verbally prior to giving medication? | n/a | 96% | 99% | 99% | 98% | 97% | ↓ |
| ALL | Are all drug cupboards/trolleys locked and secure as per local policy? | 95% | 96% | 99% | 96% | 96% | 99% | ↑ |
| All except neonates & OPD | Has the nurse witnessed the patient taking the medication given to them? | n/a | 97% | 97% | 100% | 100% | 95% | ↓ |
| All except neonates & OPD | Is there evidence that medication is taken in a timely manner and is not left on lockers/around patient beds? | n/a | 98% | 96% | 100% | 100% | 99% | ↓ |
| Neonates & Paeds | Are all medications checked by two qualified nurses? | n/a | 100% | 100% | 100% | 100% | 100% | ↔ |
| District Nursing | Is the community nursing service able to demonstrate clearly defined processes including policies and procedures for obtaining and storing medication and for medicines management? | n/a | n/a | n/a | 100% | 92% | 100% | ↑ |
| Paeds only | Are staff compliant with the medication omissions form as per medication management policy? | n/a | n/a | n/a | n/a | 93% | 78% | ↓ |
| Paeds only | Has a medication safety audit been conducted and action plan feedback? | n/a | n/a | n/a | n/a | 40% | 80% | ↑ |
| Health Visiting | Is there documented evidence of discussion about vitamins? | n/a | n/a | n/a | n/a | n/a | 82% | New |

In addition to the annual audit, monthly audits are undertaken around medication safety and checking of controlled drugs.

Medication safety audits are undertaken in 61 inpatient areas, including paediatrics and mental health. The national audit tool for this audit is currently being reviewed.

Controlled drugs are expected to be checked on a daily basis but it was identified that this was not always the case. The Senior Nursing and Midwifery team discussed and agreed that an indicator would be added to the Health & Care Monitoring System so that the daily checking could be monitored. A safety cross was also developed to support teams in practice. Graph 11 shows the number of days when controlled drugs were not being checked as per policy and this has seen a significant decrease from when we first started to monitor this indicator although there is still work to do. Where teams are not able to check the controlled drugs daily, this is usually because of operational issues.

Graph 11: If the ward / unit uses controlled drugs- the number of days CDs not checked as per Guidelines




**Patient perspective** – although there was not a specific patient experience question on medication, patients did make reference to medication in their responses. One patient noted that the biggest problem had been "*not receiving their medication on time, the effect of this caused severe pain for me for most of the day, resulting in me not being able to function properly*".

## Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk

Health services promote and protect the welfare and safety of children and adults who become vulnerable or at risk at any time.

*NMC (2015): Preserve Safety: Standard 17.1: Take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse*

*NMC (2015): Preserve Safety: Standard 17.2: Share information if you believe someone may be at risk of harm, in line with the laws relating to the disclosure of information.*

*NMC (2015): Preserve Safety: Standard 17.3: Have knowledge of and keep to the relevant laws and policies about protecting and caring for vulnerable people.*

**Operational Audit Narrative:** Six of the seven questions include for this standard, achieved a compliance score of 85% or above. Four questions achieved a compliance score of 100%. Five questions have seen an increase in percentage compliance compared to last year whilst the remaining two are unchanged on last year's position.

There is one specialty specific question which has an amber RAG rating. This specialty specific question achieved a red RAG rating in 2017 and has changed to an amber RAG rating in 2018 but there is still work to do to ensure full compliance.

There are two new questions for this standard which are health visiting specific. Both achieved compliance scores of 85% or above.

**Table18: Whole UHB/ Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk**

| | | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | |
|---|---|---|---|---|---|---|---|---|
| ALL | Can staff demonstrate they know the procedure if a safeguarding concern is identified? | 95% | 98% | 98% | 96% | 97% | 99% | ↑ |
| Maternity only | Are babies securely and appropriately labelled? | n/a | 100% | 97% | 93% | 100% | 100% | ↔ |
| Maternity only | Are all staff aware of what to do in the event of a baby abduction? | n/a | 100% | 67% | 100% | 67% | 100% | ↑ |
| Neonates only | Within the clinical area, babies are safe and secure while on the unit and parents are informed of security arrangements on admission? | n/a | 80% | 100% | 100% | 60% | 100% | ↑ |
| Paeds only | Are all staff within the unit complaint with safeguarding training for children | n/a | n/a | n/a | n/a | 60% | 100% | ↑ |
| Paeds only | Are all staff within the unit compliant with POVA training for adults | n/a | n/a | n/a | n/a | 20% | 80% | ↑ |
| Paeds only | Can staff demonstrate they know the safeguarding lead nurse for their area and | n/a | n/a | n/a | n/a | 96% | 96% | ↔ |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | how to contact them | | | | | | | |
| Health Visiting | Is there written evidence that the routine enquiry questions have been asked? | **n/a** | **n/a** | **n/a** | **n/a** | **n/a** | **93%** | New |
| Health visiting | Is there written evidence that the safeguarding supervision has been documented in the family card, where applicable? | **n/a** | **n/a** | **n/a** | **n/a** | **n/a** | **100%** | New |

## Standard 2.8 Blood Management

People have timely access to a safe and sufficient supply of blood, blood products and blood components when needed.

*NMC (2015): Prioritise People: Standard 1.4: Make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*

**Operational Audit Narrative:** The three questions are specialty specific questions – one for our neonatal unit and one for the paediatric areas.

One of the questions include for this standard, achieved a compliance score of 85% or above. The other two questions, have an amber RAG rating.

**Table 19: Neonates/ Standard 2.8 Blood Management**

| | | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | |
|---|---|---|---|---|---|---|---|---|
| Neonates only | All staff involved in direct nursing care should have been trained in Blood Transfusion Administration | n/a | n/a | 100% | 80% | 0% | 82% | ↑ |
| Paeds only | Can staff demonstrate they know the safe administration of blood, blood products and blood components | n/a | n/a | n/a | n/a | 88% | 92% | ↑ |
| Paeds only | How many staff are compliant with training on administration of blood, blood products and blood components? | n/a | n/a | n/a | n/a | n/a | 71% | New |

## Standard 2.9 Medical devices, Equipment and Diagnostic Systems

Health services ensure the safe and effective procurement, use and disposal of medical equipment, devices and diagnostic systems.

**Operational Audit Narrative:** All three questions include for this standard, achieved a compliance score of 85% or above. One question has seen an increase in percentage compliance compared to last year whilst the remaining two have seen a decrease in percentage compliance.

There is one new question for this standard which is health visiting specific. The question achieved 100% compliance.

**Table 20: Whole UHB/ Standard 2.9 Medical devices, Equipment and Diagnostic Systems**

| | | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | |
|---|---|---|---|---|---|---|---|---|
| ALL except neonates | Are any Manual Handling aids and slings regularly checked for wear and tear? | 100% | 99% | 98% | 99% | 100% | 96% | ↓ |
| Neonates only | Are any Developmental Care aids regularly checked for wear and tear? | n/a | n/a | 100% | 60% | 80% | 100% | ↑ |
| ALL | Is all equipment used up to date with maintenance and calibration? | 98% | 97% | 96% | 96% | 95% | 93% | ↓ |
| Health visiting | Is there evidence that staff have access to relevant equipment to fulfil their role e.g. Scales, Paper tape measure, height measure etc? | n/a | n/a | n/a | n/a | n/a | 100% | New |

**Standard 3.1 Safe and Clinically Effective Care**

Care, treatment and decision making should reflect best practice based on evidence to ensure that people receive the right care and support to meet their individual needs.

*NMC (2015): Practise effectively: Standard 6.1: Make sure that any information or advice given is evidence-based, including information relating to using any healthcare products or services.*

*NMC (2015): Practise effectively: Standard 6.1: Maintain the knowledge and skills you need for safe and effective practice.*

**Operational Audit Narrative:** This standard has seen a decrease in overall compliance when compared to the 2017 position, from 90% in 2017 to 79% this year.

One of the six questions include for this standard, achieved a compliance score of 85% or above. One question has seen an increase in percentage compliance compared to last year whilst the remaining five have seen a decrease in percentage compliance.

There is one question with a red RAG rating. This question achieved an amber RAG rating in 2017 but has seen a significant decrease in 2018 and required urgent action (↓80%). Further work is required to ensure that teams who completed this question understand the context of the question and whether this is reflective of what happens in practice. The results for this standard will be discussed with the Mental Capacity Team to ensure that where it has been identified that the patient lacks capacity to make decisions, there is evidence that best interest decisions have been documented and that the patient, their families and an advocate has been involved..

There are four questions which have an amber RAG rating. One of the questions had a red RAG rating in 2017 but has seen an improvement in compliance. Two of the questions had a green RAG rating in 2017 but have seen a decrease in percentage compliance which has seen the RAG rating change to amber.

Significant work is required to ensure full compliance with this standard.

There are eight new questions included for this standard which are health visiting specific. Five achieved a compliance score of 85% or above. The remaining three achieved an amber RAG rating and require improvement work over the next 12 months.

**Table 21: Whole HB/Standard 3.1 Safe and Clinically Effective Care**

| | | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | |
|---|---|---|---|---|---|---|---|---|
| Inpatient areas, emergency departments mental health and learning disabilities | For this episode of care, where there is doubt about the patients' capacity to make decisions, is there documented evidence that an assessment of capacity has been undertaken? | n/a | n/a | n/a | 85% | 96% | 81% | ↓ |
| | Where it has been identified that the patient lacks capacity to make decisions, is there evidence that best interest decisions have been documented and that the patient, their | n/a | n/a | n/a | n/a | 80% | 0% | ↓ |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | families and an advocate has been involved? | | | | | | | |
| Inpatient areas, emergency departments mental health and learning disabilities | Where it has been identified that the patient lacks capacity, is there evidence that there is an up to date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale? | n/a | n/a | n/a | 77% | 83% | 75% | ↓ |
| Inpatient areas, emergency departments mental health and learning disabilities | For this episode of care, is there documented evidence that where a patients liberty has been restricted, that a Deprivation of Liberty Safeguard application has been made? | n/a | n/a | n/a | 84% | 97% | 85% | ↓ |
| Inpatient areas, emergency departments mental health and learning disabilities | Where it has been identified that the patients liberty is being restricted/deprived, is there evidence of an up to date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale? | n/a | n/a | n/a | 84% | 91% | 79% | ↓ |
| Paeds only | Are staff able to demonstrate they are aware of the Paediatric Best Practice guidelines and how to access this document? | n/a | n/a | n/a | n/a | 40% | 81% | ↑ |
| Health visiting | Is there evidence that Child & Family records are written in SOAP? | n/a | n/a | n/a | n/a | n/a | 100% | New |
| Health visiting | Is there evidence that the FRAIT assessment has been undertaken at all core contacts, and inward transfers? | n/a | n/a | n/a | n/a | n/a | 70% | New |
| Health visiting | Subjective – is there evidence of clients statements e.g. says, reports, states, etc? | n/a | n/a | n/a | n/a | n/a | 100% | New |
| Health visiting | Objective – is there evidence of the child's appearance and home conditions related to the Framework for Assessment? | n/a | n/a | n/a | n/a | n/a | 93% | New |
| Health visiting | Assessment – is there evidence that relevant assessment has been completed? | n/a | n/a | n/a | n/a | n/a | 100% | New |
| Health visiting | Analysis –is there evidence of analysis based on subjective and objective data? | n/a | n/a | n/a | n/a | n/a | 58% | New |
| Health visiting | Advice – is there evidence of advice given? | n/a | n/a | n/a | n/a | n/a | 87% | New |
| Health visiting | Plan – is there evidence that the plan reflects the identified needs? SMART] | n/a | n/a | n/a | n/a | n/a | 77% | New |

**Standard 3.2 Communicating Effectively**

In communicating with people health services proactively meet individual language and communication needs.

*NMC (2015): Practise effectively: Standard 7.1: Use terms that people in your care, colleagues and the public can understand.*

*NMC (2015): Practise effectively: Standard 7.2: Take reasonable steps to meet people's language and communication needs, providing, wherever possible, assistance to those who need help to communicate their own or other people's needs.*

*NMC (2015): Practise effectively: Standard 7.3: Use a range of verbal and non-verbal communication methods, and consider cultural sensitivities, to better understand and respond to people's personal and health needs.*

*NMC (2015): Practise effectively: Standard 7.4: Check people's understanding from time to time to keep misunderstanding or mistakes to a minimum.*

**Operational Audit Narrative:** Four of the eight questions include for this standard, achieved a compliance score of 85% or above. Five questions have seen an increase in percentage compliance compared to last year; two questions have seen a decrease in percentage compliance whilst one remains unchanged when compared to last year's position.

There are four questions which have an amber RAG rating (two of which are specialty specific). One specialty specific question achieved a red RAG rating in 2017 but has seen this change to an amber RAG rating in 2018 although there is still work to do to ensure full compliance.

There are three new questions included for this standard which are health visiting specific. Two achieved a compliance score of 100%. The remaining question achieved an amber RAG rating.

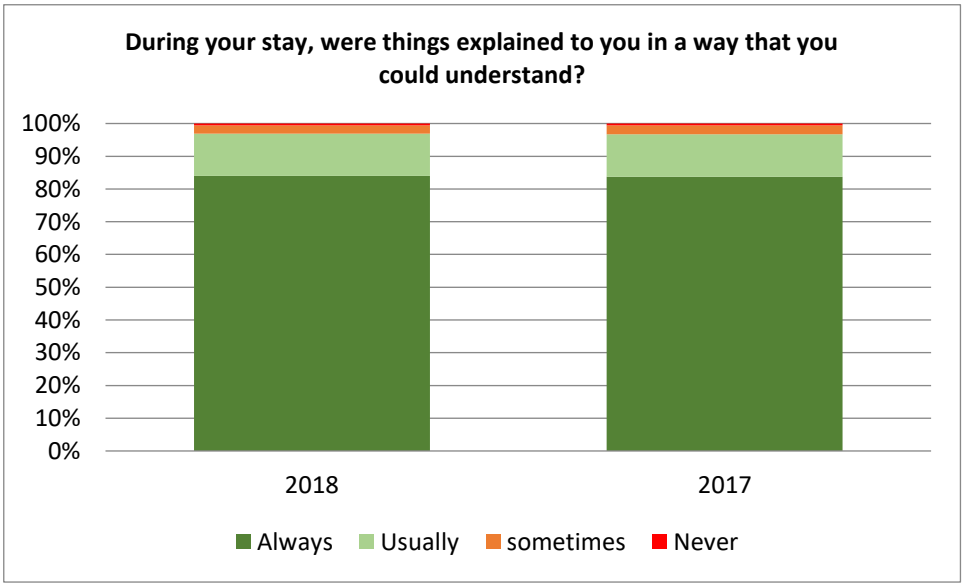
**Table 22: Whole HB/Standard 3.2 Communicating Effectively**

| | | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | |
|---|---|---|---|---|---|---|---|---|
| ALL except OPD | For this episode of care, is there documented evidence that the patient's ability to achieve effective communication has been assessed and discussed with the patient or advocate? | 92% | 94% | 93% | 95% | 94% | 94% | ↔ |
| ALL except OPD | For this episode of care, where the patient requires assistance to achieve effective communication, is there evidence that there is an up to date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale? | 66% | 84% | 84% | 84% | 83% | 81% | ↓ |
| ALL except | Is a nurse present to support the patient during formal senior contact between | 91% | 97% | 98% | 97% | 95% | 98% | ↑ |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| theatres | healthcare professional's doctors/consultants/GPs and patients? | | | | | | | |
| ALL except neonates, day units, theatres | For this episode of care, is there documented evidence that an assessment of the carer's needs has been considered? | 70% | 65% | 66% | 74% | 73% | 72% | ↓ |
| Neonates | For this episode of care, is there documented evidence that the parent's ability to achieve effective communication has been assessed? | n/a | n/a | 80% | 100% | 60% | 100% | ↑ |
| Neonates | For this episode of care, is there documented evidence that an assessment of the parent's needs i.e. emotional, social, financial and psychological have been considered? | n/a | n/a | 60% | 0% | 80% | 100% | ↑ |
| Minor Injuries unit | Do patients whose first language is not English have access to translation services? | n/a | n/a | n/a | n/a | n/a | 100% | New |
| Minor Injuries Unit only | Do deaf patients have access to working hearing loop equipment? | n/a | n/a | n/a | n/a | 67% | 75% | ↑ |
| Minor Injuries Unit only | Is there pathways to fast track patients with dementia/Alzheimer's/learning difficulties? | n/a | n/a | n/a | n/a | 33% | 50% | ↑ |
| Health visiting | Is there evidence that appropriate methods of communication were used? (Verbal and non verbal)? | n/a | n/a | n/a | n/a | n/a | 100% | New |
| Health visiting | Is there evidence that staff support ethnic minority families in communication? | n/a | n/a | n/a | n/a | n/a | 100% | New |
| Health visiting | Is there evidence that staff support Welsh speaking families in the Welsh language? | n/a | n/a | n/a | n/a | n/a | 80% | New |

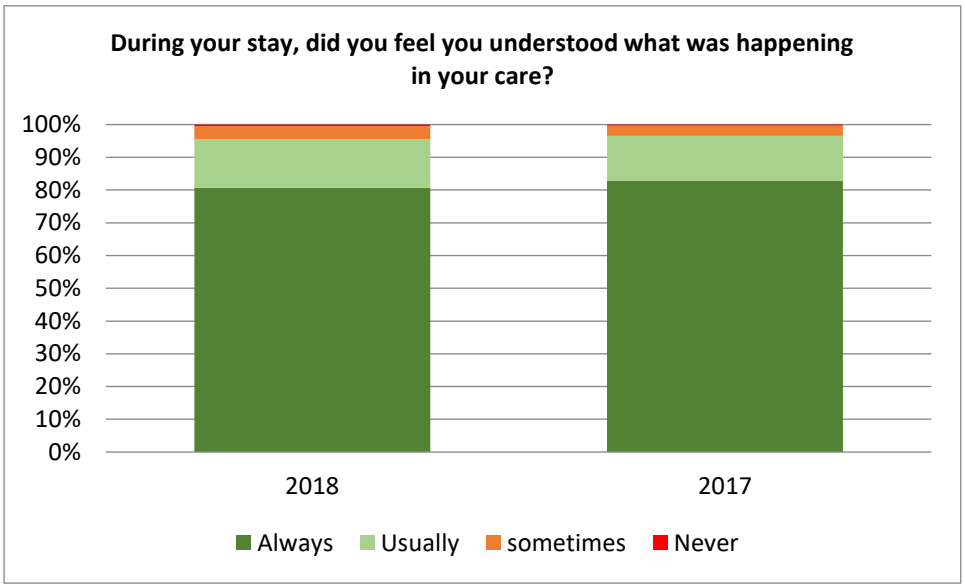
**Patient perspective:** 96% of the patients felt that *things had been explained to them in a way that they could understand* (↑3% on last year).

Graph 12: During your Stay/attendance, were things explained to you in a way that you could understand?



96% of the patients *felt that they had understood what was happening in their care* (↓1% on last year).

Graph 13: During your Stay/attendance, id you feel you understood what was happening in your care?




*The tests were thoroughly explained to me.*

*They explained every step and procedure with us in detail.*

*Everything was explained clearly and any concerns/questions answered.*

*Went the extra mile to ensure I understood what was happening to me.*

*I was treated by the staff with respect and, given choices and informed throughout the whole process what was happening to me.*

*I don`t feel like things have been explained to me properly and that I am repeating myself over and over like my notes and history haven't been read and just been put in more pain being poked and prodded.*

*Lack of communication from the doctors.*

**Standard 3.3 Quality Improvement, Research and Innovation**

Services engage in activities to continuously improve by developing and implementing innovative ways of delivering care. This includes supporting research and ensuring that it enhances the efficiency and effectiveness of services.

*NMC (2015); Practise Effectively: Standard 6.1 make sure that any information or advice given is evidence-based, including information relating to using any healthcare products or services.*

*NMC (2015); Practise Effectively: Standard 10.6: collect, treat and store all data and research findings appropriately.*

*NMC (2015): Promote Professionalism and Trust: Standard 25.1: identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first.*

**Operational Audit Narrative:** All four questions included for this standard are specialty specific questions. Three of the four questions achieved a compliance score of 85% or above. Three questions have seen an increase in percentage compliance compared to last year, whilst the remaining one question remains unchanged on the 2017 position.

There is one question, for our district nursing teams, with an amber RAG rating and required improvement work over the next 12 months.

There are two new questions for this standard which are health visiting specific. Both achieved a compliance score of 85% or above.

**Table 23: Whole HB/Standard 3.2 Communicating Effectively**

| | | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | |
|---|---|---|---|---|---|---|---|---|
| District Nursing | Is the community nursing service able to demonstrate compliance with systems/ procedures/ policies in place to respond to service user and carer feedback? | n/a | n/a | 92% | 85% | 76% | 78% | ↑ |
| District Nursing | Is the community nursing service able to demonstrate a process to evidence achievement of outcomes which will include patient reported outcomes, a regular process to audit care plans and discharge records. | n/a | n/a | 92% | 100% | 88% | 100% | ↑ |
| District Nursing | Is the community nursing service able to demonstrate engagement with the Health Boards Quality Improvement strategy, | n/a | n/a | 92% | 96% | 88% | 87% | ↓ |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | using initiatives and projects to effect real, significant and sustainable change? | | | | | | | |
| **Paeds only** | Are staff supported and engaged in regular audits? | **n/a** | **n/a** | **n/a** | **n/a** | **92%** | **100%** | ↑ |
| **Health visiting** | Is there evidence that staff have knowledge of national and local initiatives? | **n/a** | **n/a** | **n/a** | **n/a** | **n/a** | **100%** | New |
| **Health visiting** | Is there evidence that staff have knowledge of quality assurance? | **n/a** | **n/a** | **n/a** | **n/a** | **n/a** | **93%** | New |

**Standard 3.4 Information Governance and Communication Technology**

Health services ensure all information is accurate, valid, reliable, timely, relevant, comprehensible and complete in delivering, managing, planning and monitoring high quality, safe services.

Health services have systems in place, including information and communications technology, to ensure the effective collection, sharing and reporting of high quality data and information within a sound information governance framework.

*NMC (2015); Prioritise People: Standard 5.2 make sure that people are informed about how and why information is used and shared by those who will be providing care.*

*NMC (2015); Prioritise People: Standard 5.4 share necessary information with other healthcare professionals and agencies only when the interests of patient safety and public protection override the need for confidentiality.*

*NMC (2015); Prioritise People: Standard 5.5 share with people, their families and their carers, as far as the law allows, the information they want or need to know about their health, care and ongoing treatment sensitively and in a way they can understand.*

**Operational Audit Narrative:** The three questions included for this standard are specialty specific questions. All achieved 100% compliance in the 2018 audit and remain unchanged from the 2017 position.

**Table 24: Whole HB/Standard 3.2 Communicating Effectively**

| | | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | |
|---|---|---|---|---|---|---|---|---|
| Paeds only | Can staff demonstrate they know how to ensure that confidential patient information is stored safely and securely? | n/a | n/a | n/a | n/a | 100% | 100% | ↔ |
| Paeds only | Can staff demonstrate they know how to report an incident, accident or near miss via the DATIX reporting system and where applicable conduct an investigation? | n/a | n/a | n/a | n/a | 100% | 100% | ↔ |
| Paeds only | How many staff are complaint with information governance? | n/a | n/a | n/a | n/a | n/a | 100% | New |

**Standard 3.5 Record Keeping**

Good record keeping is essential to ensure that people receive effective and safe care. Health services must ensure that all records are maintained in accordance with legislation and clinical standards guidance.

*NMC (2015 NMC (2015): Practise effectively: Standard 10.1: complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event.*

*NMC (2015): Practise effectively: Standard 10.2: identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need.*

*NMC (2015): Practise effectively: Standard 10.3: complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements.*

*NMC (2015): Practise effectively: Standard 10.4: attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation.*

*NMC (2015): Practise effectively: Standard 10.5: take all steps to make sure that all records are kept securely.*

**Operational Audit Narrative:** 11 of the 15 questions included for this standard achieved a compliance score of 85% or above. Four questions have seen an increase in percentage compliance compared to last year; eight of the questions have seen a decrease in percentage compliance, whilst three questions remain unchanged on the 2017 position.

There are four questions with an amber RAG rating. One specialty specific question, which had a red RAG rating in 2017, has seen a significant increase in 2018 and is now an amber RAG rating, but still requires work to ensure full compliance. The other three questions have seen a decrease in percentage compliance when compared to 2017.

There are two new questions included for this standard which are health visiting specific. One achieved 100% compliance whilst the other achieved an amber RAG rating.

**Table 25 Whole HB/ Standard 3.5 Record Keeping**

| | | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | |
|---|---|---|---|---|---|---|---|---|
| ALL | For this episode of care, are the patient's demographic details clearly recorded (and where required, has a photograph) on all the patient's documentation? | 99% | 97% | 99% | 98% | 98% | 97% | ↓ |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| ALL except Neonates, OPD, Theatres | For this episode of care, is there documented evidence that each plan of care has been assessed and discussed with the patient or advocate? | 81% | 82% | 87% | 90% | 88% | 90% | ↑ |
| ALL except theatres | For this episode of care, are the contact details of the first point of contact recorded in the patient's documentation? | 96% | 94% | 96% | 95% | 96% | 97% | ↑ |
| ALL | Is the patient's preferred language clearly indicated in the nursing documents? | n/a | 84% | 89% | 92% | 88% | 86% | ↓ |
| ALL except neonates | Does the patient's documentation capture their preferred name and/or title? | 93% | 82% | 88% | 93% | 86% | 87% | ↑ |
| Inpatients, ED, paeds, LD, endoscopy, only | For this episode of care, where the patient has an identified swallowing problem, is there evidence that there is an up to date plan of care which is being implemented and evaluated and has been reviewed within the agreed timescale? | 87% | 89% | 89% | 87% | 89% | 84% | ↓ |
| Inpatients, neonates, MH, LD, OPD only | For patients who require a food chart, is there evidence that they are being kept up to date. | 94% | 93% | 97% | 89% | 98% | 91% | ↓ |
| Inpatients, MH, LD, OPD only | For patients who require a food chart, is it signed by a registered nurse for each 24 hour period? | n/a | 77% | 85% | 78% | 83% | 75% | ↓ |
| ALL except OPD, theatres | For patients who require a fluid chart, is there evidence that they are kept up to date and evaluated? | 84% | 90% | 88% | 86% | 92% | 89% | ↓ |
| ALL except neonates, OPD, Theatres | For patients who require a weekly fluid chart, is signed by a registered nurse for each 24 hour period? | n/a | 70% | 69% | 72% | 72% | 61% | ↓ |
| Maternity | Is there a clear plan of care following all episodes of care throughout the pregnancy and postnatal period? | n/a | 100% | 97% | 93% | 100% | 87% | ↓ |
| Neonates | Have the baby's dependency needs been individually assessed within the last 24 hours? | n/a | 100% | 100% | 100% | 100% | 100% | ↔ |
| Neonates | Have the babies' Dependency needs been staffed according to their levels of care? | n/a | 100% | 100% | 100% | 100% | 100% | ↔ |
| OPD, Medical Day Units & Radiology only | Is the documented evidence that, where indicated, the presence of a chaperone has been considered? | n/a | n/a | n/a | n/a | 28% | 67% | ↑ |
| Paeds only | Does the nursing documentation show that the following information has | n/a | n/a | n/a | n/a | 96% | 96% | ↔ |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | been completed, name of CYP, DOB, CRN/ NHS number and that each entry includes the date & time of entry, and the name, signature, designation of person making entry in records? | | | | | | | |
| Health visiting | Is there evidence that Child & Family records are written in SOAP? | **n/a** | **n/a** | **n/a** | **n/a** | **n/a** | **100%** | New |
| Health visiting | Is there evidence that the FRAIT assessment has been undertaken at all core contacts, and inward transfers? | **n/a** | **n/a** | **n/a** | **n/a** | **n/a** | **67%** | New |

Examples of good practice:

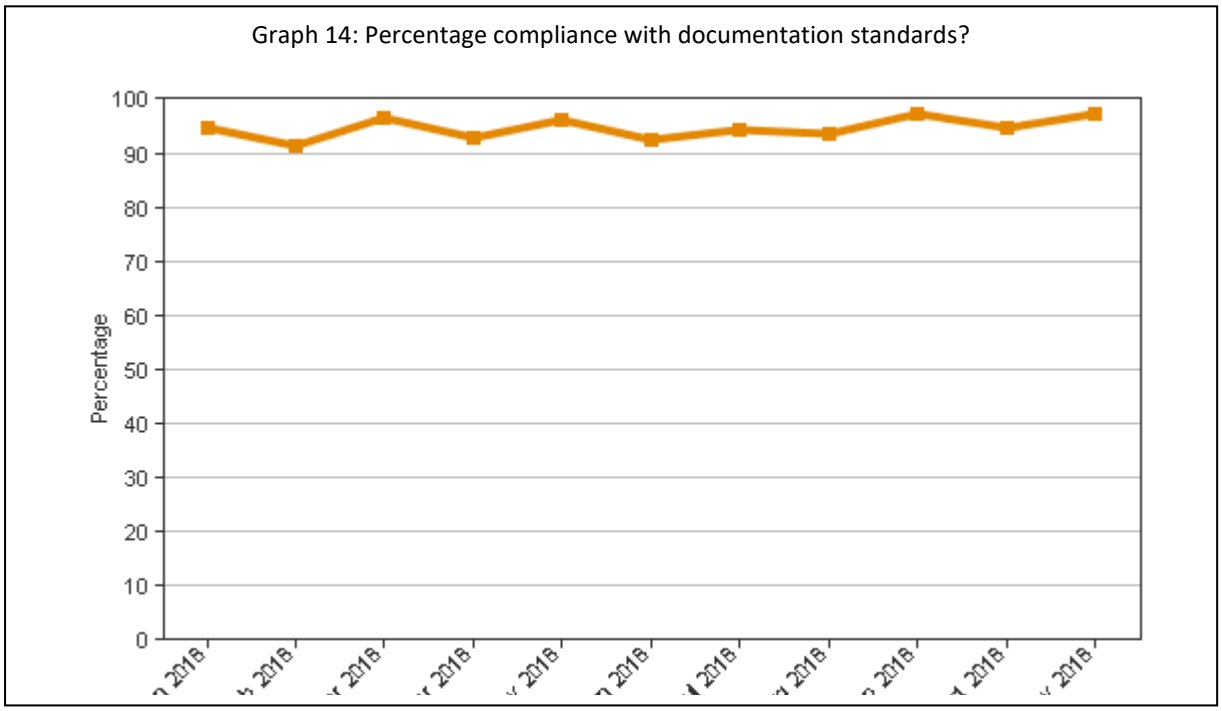
**Digitisation of Nursing Documentation**: HB representatives are working on this national project which, aims to transform the documentation nurses are required to complete every day. It is standardising forms across NHS Wales and making them digital. The documents will use the same standardised nursing language to reduce duplication, and give back time to nurses to care for patients. The first documents to be standardised and digitised will included:

- Unified admission assessment;
- Falls Risk Assessment;
- Skin Pressure Damage Risk Assessment;
- Continence Assessment;
- Nutrition Risk Assessment; and
- Manual handling Assessment.

A number of clinical areas undertake bi-monthly record keeping audits around documentation standards, completion and policies and processes. The graphs below show the HB's compliance with these audits over the last 12 months.

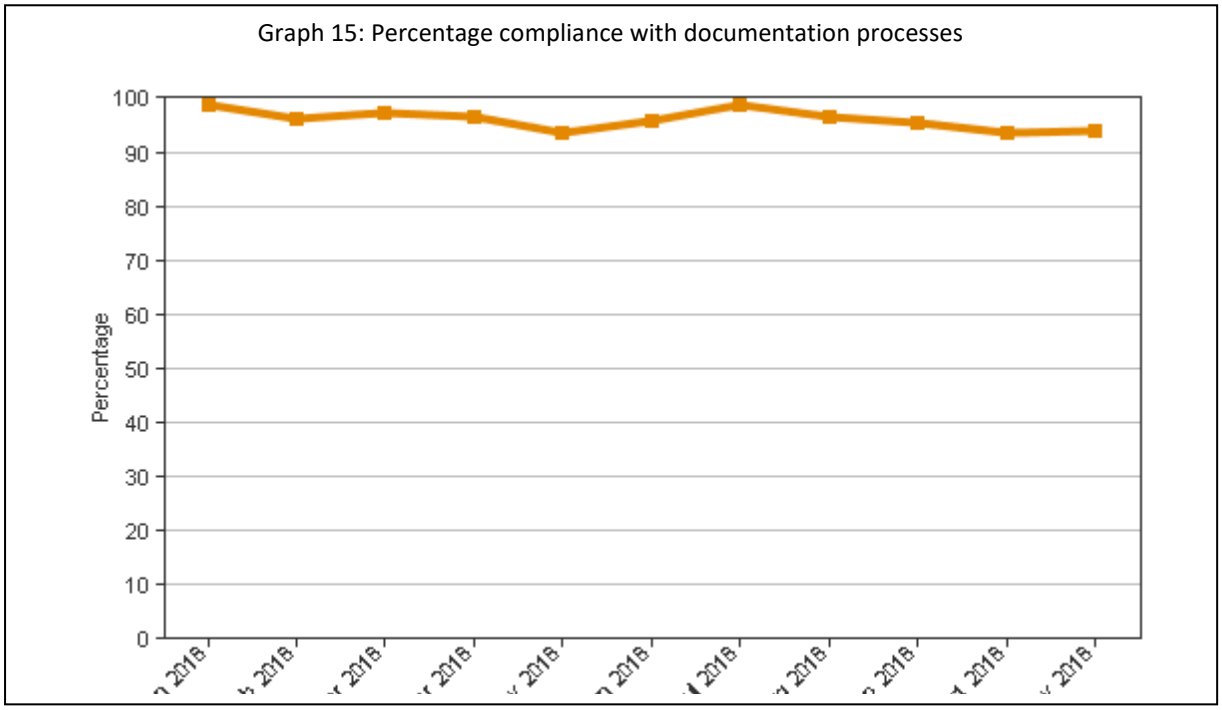
Graph 14 shows the compliance with documentation standards over the last 12 months.

Graph 14: Percentage compliance with documentation standards?



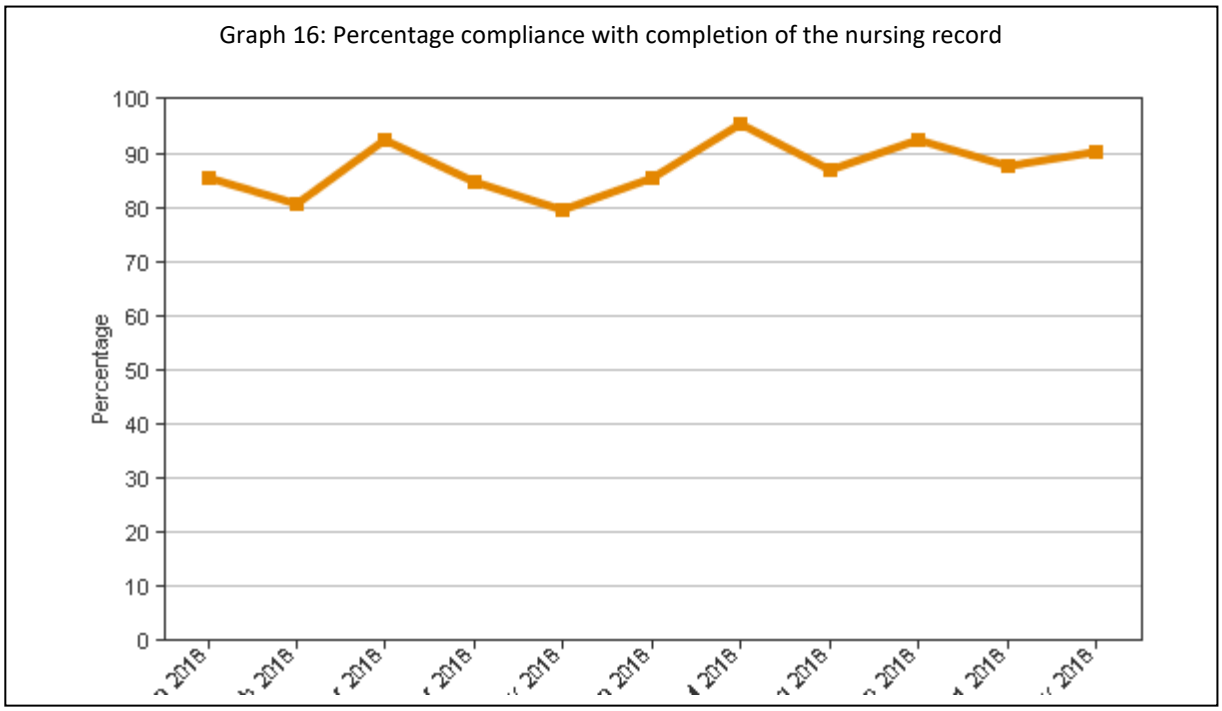
The audit on documentation processes is to review staff's awareness with the management of the patient record

Graph 15: Percentage compliance with documentation processes




The completion of the nursing record audit reviews the content of the record and whether the relevant sections are completed in full.

Graph 16: Percentage compliance with completion of the nursing record

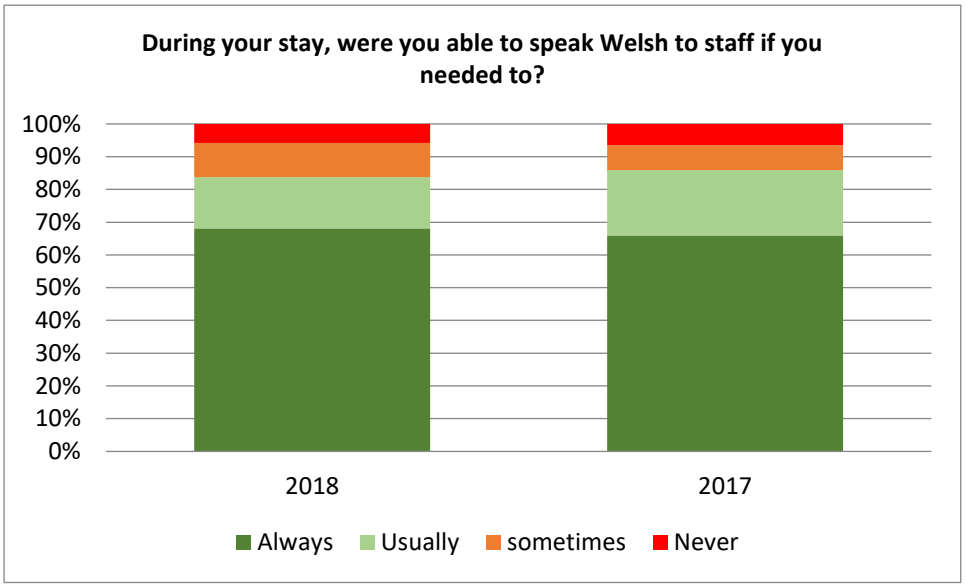



**Patient perspective:**

84% of the patients felt *that they were able to speak Welsh to staff if they needed to* (↓2% on last year's position). This was one of the lowest scoring aspects of care for a patient's perspective for this year's

audit. 45 patients said that they were never able to speak Welsh to staff if they needed to with a further 78 saying that this was only sometimes the case.

Graph 17: During your Stay/attendance, were you able to speak Welsh to staff if you needed to?




*I speak Welsh and was glad the member of staff looking after me could too*

*Several staff members were fluent Welsh speakers*

*I found that not everyone was a welsh speaker*

*Signage not always in Welsh*

**Standard 4.1 Dignified Care**

People must receive full information about their care which is accessible, understandable and in a language and manner sensitive to their needs to enable and support them to make an informed decision about their care as an equal partner.

*We must "treat people as individuals and uphold their dignity".*

*NMC (2015): Prioritise People: Standard 1.1: Treat people with kindness, respect and compassion.*

*NMC (2015): Prioritise People: Standard 1.2: Make sure we deliver the fundamentals of care effectively.*

*NMC (2015): Prioritise People: Standard 1.3: Avoid making assumptions and recognise diversity and individual choice.*

*NMC (2015): Prioritise People: Standard 1.4: Make sure that any treatment, assistance or care for which we are responsible is delivered without undue delay.*

**Operational Audit Narrative:** 23 of the 38 questions included for this standard achieved a compliance score of 85% or above (green RAG rating). 13 questions achieved an amber RAG rating and one question achieved a red RAG rating. 21 questions have seen an increase in percentage compliance compared to last year; nine of the questions have seen a decrease in percentage compliance, whilst seven questions remain unchanged on the 2017 position. One question was not applicable for 2018.

Improvement has been seen in the assessment of most aspects of care although there is still work to do in relation to care planning. An updated, streamlined adult inpatient assessment document was being introduced at the time of the audit which may have contributed to the increase in percentage compliance around assessment.

There are two new questions for this standard which are health visiting specific. One achieved a compliance score of 85% or above and the other achieved an amber RAG rating.

**Table 27 Whole HB/ Standard 4.1 Dignified Care**

| | | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | |
|---|---|---|---|---|---|---|---|---|
| ALL | If a patient's language of need is Welsh, do staff know how to access a Welsh speaking member of staff? | 93% | 100% | 96% | 99% | 100% | 99% | ↓ |
| Paeds only | If a patient's language is not English, do staff know how to access an interpreter? | n/a | n/a | n/a | n/a | 100% | 100% | ↔ |
| ALL | For this episode of care, is there documented evidence that the patient's cultural needs have been assessed and discussed with the patient or advocate? | 63% | 65% | 69% | 78% | 73% | 75% | ↑ |
| ALL | For this episode of care, is there documented evidence that the patient's spiritual needs has been assessed and discussed with the patient or advocate? | 66% | 71% | 73% | 80% | 70% | 73% | ↑ |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| ALL except from theatres | Is there a facility for patients to talk in private to staff (e.g. a quiet room or office)? | 93% | 94% | 93% | 94% | 98% | 97% | ↓ |
| ALL except maternity, neonates. OPD, theatres | Is there a quiet room for patients to spend time with their visitors away from their bedside? | 70% | 80% | 77% | 78% | 78% | 91% | ↑ |
| Maternity & Neonates only | Are there facilities to preserve a mother's dignity if she wishes to express or feed at the cotside i.e. patient screens? | n/a | 100% | 100% | 100% | 100% | 100% | ↔ |
| Inpatients, paeds, MH, Endoscopy, Day units | Within the clinical area, are all the bays single sex bays? | 82% | 76% | 81% | 75% | 70% | 74% | ↑ |
| Inpatients, paeds, LD, OPD, Endoscopy, Day units | Do all patients have access to single sex toilet and washing facilities? | 77% | 74% | 70% | 71% | 72% | 72% | ↔ |
| All except maternity & neonates | Is there a facility to preserve patient's dignity by communicating to others that care is in progress? | 97% | 98% | 97% | 95% | 96% | 96% | ↔ |
| Minor Injuries Units only | Within the clinical area are there facilities to meet hygiene needs, which are suitable for all patients including those that are disabled? | n/a | n/a | n/a | n/a | 67% | 87% | ↑ |
| ALL except neonates & theatres | Within the clinical area, are washing and bathing facilities suitable for all Patients? | n/a | 90% | 89% | 90% | 84% | 85% | ↑ |
| ALL except neonates & theatres | Within the clinical area, are toilet facilities suitable for all service users? | n/a | 89% | 90% | 86% | 84% | 89% | ↑ |
| Inpatients, paeds, MH & LD | Does the clinical area allow patients to bring in personal items to assist with patient orientation/familiarity? | 100% | 100% | 100% | 100% | 100% | 100% | ↔ |
| Inpatients, paeds neonates MH, LD only | For this episode of care, is there documented evidence that the patient's normal sleep pattern and needs have been assessed and discussed with the patient or advocate? | 74% | 82% | 82% | 90% | 85% | 89% | ↑ |
| Inpatients, paeds, MH, LD only | For this episode of care, where the patient has an identified sleep issue or sleep has been recorded as poor/disrupted is there evidence that there is an up to date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale? | 47% | 78% | 74% | 60% | 66% | 59% | ↓ |
| Neonates only | Does the clinical area allow for a | n/a | 100% | 100% | 100% | 100% | 0% | ↓ |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | period of 'quiet time' during the day to ensure that babies have a period of rest/sleep period? | | | | | | | |
| Neonates only | Does the clinical area allow for the noise levels to be controlled at the cot-side especially during periods of rest and sleep? | n/a | 100% | 100% | 100% | 100% | 100% | ↔ |
| Neonates only | Does the clinical area allow for the lighting particularly during periods of rest and sleep to be individually controlled at the cotside? | n/a | 100% | 100% | 100% | 100% | 100% | ↔ |
| Inpatients, ED, neonates, paeds, MH, LD only | Are lights in sleeping areas, other than the over the bed night lights, switched off or dimmed at night? | n/a | 100% | 100% | 100% | 97% | 100% | ↑ |
| ALL except OPD | For this episode of care, is there documented evidence that the patient's pain has been discussed and assessed using an appropriate pain assessment tool? | 86% | 90% | 95% | 91% | 85% | 93% | ↑ |
| All except OPD | For this episode of care, where the patient has an identified problem with pain is there evidence that there is an up to date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale? | 85% | 83% | 88% | 83% | 85% | 79% | ↓ |
| Neonates only | For this episode of care, is their documented evidence that the baby's comfort has been discussed and assessed using a developmental care tool? | n/a | 80% | 80% | 100% | 60% | 80% | ↑ |
| Neonates only | For this episode of care, where the baby has been an identified problem with comfort is their evidence that there is an up to date plan of care, which is being implemented and evaluated and has been reviewed within the last 24 hrs? | n/a | 40% | 100% | 80% | 60% | n/a | |
| ALL except ED, neonates, OPD, theatres | For this episode of care, is there documented evidence that the patient's concerns/anxieties or fears has been assessed and discussed with the patient or advocate? | 85% | 84% | 89% | 90% | 83% | 92% | ↑ |
| ALL except ED, neonates, OPD, theatres | For this episode of care, where the patient has expressed concerns, anxieties or fears, is there evidence that there is an up to date plan of care, which is being implemented and evaluated and has been | 72% | 82% | 90% | 76% | 71% | 80% | ↑ |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | reviewed within the agreed timescale? | | | | | | | |
| ALL except OPD, endoscopy, theatres | For this episode of care, is there documented evidence that the patient's hygiene needs have been assessed and discussed with the patient or advocate? | 90% | 92% | 94% | 94% | 94% | 96% | ↑ |
| ALL except OPD, endoscopy, theatres | For this episode of care, where the patient's hygiene needs have been identified is there evidence that there is an up to date plan of care which is being implemented and evaluated and has been reviewed within the agreed timescale? | 87% | 80% | 92% | 90% | 83% | 85% | ↑ |
| District Nursing | Is there evidence that patient's self care ability to meet their own hygiene needs have been met | n/a | n/a | n/a | 92% | 85% | 92% | ↑ |
| Inpatients, paeds, MH, LD, day units only | Are patients given the opportunity to go to the toilet before eating? | 100% | 98% | 99% | 99% | 100% | 97% | ↓ |
| Inpatients paeds, MH, LD only | For this episode of care, is there documented evidence that the patient's foot and nail condition has been assessed, and discussed with the patient or advocate? | 48% | 73% | 74% | 82% | 73% | 84% | ↑ |
| Inpatients paeds, MH, LD only | For this episode of care, where the patient has an identified risk or requires assistance with foot or nail care, is there evidence that there is an up to date plan of care which is being implemented and evaluated and has been reviewed within the agreed timescale? | 37% | 61% | 68% | 73% | 70% | 74% | ↑ |
| ALL except maternity, OPD, day units | For this episode of care, is there documented evidence that the patient has been assessed using an evidence based oral health tool with respect to their oral health needs? | 37% | 65% | 78% | 76% | 80% | 88% | ↑ |
| ALL except maternity, OPD, day units | For this episode of care, where the patient has an identified risk or requires assistance with oral health, is there evidence that there is an up to date plan of care which is being implemented and evaluated and has been reviewed within the agreed timescale? | 59% | 67% | 84% | 83% | 83% | 80% | ↓ |
| ALL except neonates | For this episode of care, is there documented evidence that the patient's toilet needs/continence has been assessed and discussed with the patient or advocate? | 84% | 83% | 78% | 92% | 92% | 89% | ↓ |

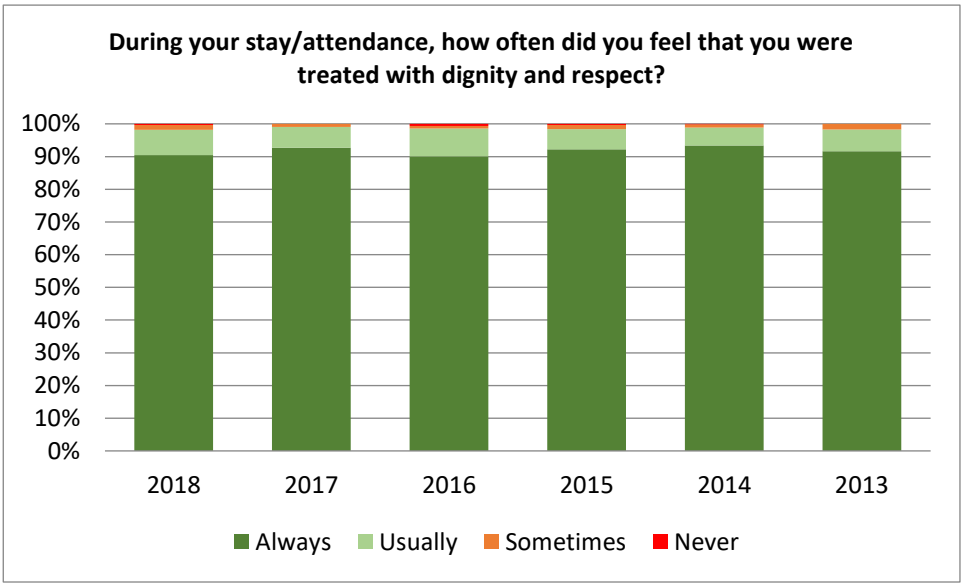
| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| ALL except neonates | For this episode of care, where the patient has been identified as requiring assistance with their toilet/continence needs, is there evidence that an appropriate assessment has taken place with an up to date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale? | **82%** | **73%** | **84%** | **85%** | **84%** | **83%** | ↓ |
| Inpatient areas, Emergency Departments | Can staff demonstrate they know the procedure for organ donation? | **n/a** | **n/a** | **n/a** | **70%** | **75%** | **85%** | ↑ |
| Inpatient areas, Emergency Departments | Can staff demonstrate they know the procedure for tissue donation? | **n/a** | **n/a** | **n/a** | **61%** | **68%** | **78%** | ↑ |
| Health visiting | Is there written evidence that Health Visitor Observations and Assessment of the Infant (HOAI) was commenced effectively? | **n/a** | **n/a** | **n/a** | **n/a** | **n/a** | **97%** | New |
| Health visiting | Is there written evidence that Family Resilience Assessment Instrument Tool has been completed at 1-6 weeks? | **n/a** | **n/a** | **n/a** | **n/a** | **n/a** | **67%** | New |

**Examples of Good Practice:**

- We have rolled out centralised prescribing of continence appliances in order to improve patient care and efficiencies. This service has been rolled out across all areas. It provides centralised prescribing by specialised nursing staff. This has improved patient experiences by reducing travel and time for our patients that need these products, it is been positively received and has proved efficient and cost effective service.
- Oral health & hygiene: our inpatient areas monitor compliance on a monthly basis and the data shows that of the 6,339 patient records audited 1st January -31st December 2018, 93% had a mouth care risk assessment within 24 hours of admission and of those patients identified as requiring a care plan, 89% had a care plan in place.
- A new in-patient assessment document was introduced in October 2018, with the aim of improving patient assessment and sign posting to care plans.
- New district nursing assessment documents were also introduced in August 2018 with the aim of standardising the documents being used across our community teams and ensuring consistency in the assessment process for this group of patients.

***Patient Perspective:*** *98% of our patients stated that they were always/usually treated with dignity and respect (↓1% from last year's position).*

Graph 18: Patient responses to: During your stay/attendance, how often did you feel that you were treated with dignity and respect?




*I have always been treated with dignity and care and compassion.*

*I find the staff very friendly and treated me with respect and dignit.*

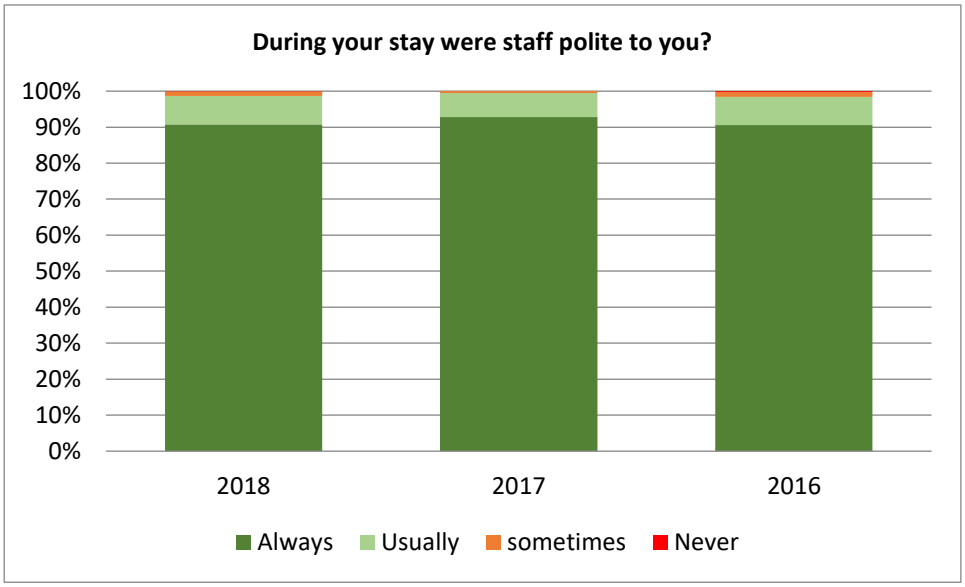
*All staff are very respectful and my relative has been treated with the utmost respect and dignity.*

*Staff all treated me very well with compassion and dignity. They were all very patient and professional.*

*Occasionally when this was not the case.*

*99% of our patients states that they felt that people were polite to them (↓0.5% on last year).*

Graph 19: During your Stay/attendance, were staff polite to you?



*All the nurses polite and friendly and always explained everything they were doing and going to do.*

*All staff polite, helpful and supportive.*

*All staff were very professional and polite.*

*Professional, courteous, polite, fantastic!!*

*I had contact with very helpful, considerate, polite and went the extra mile to ensure I understood what was happening to me.*

*99% of our patients stated that staff were kind and helpful (unchanged from last year's position.*

Graph 20: During your Stay/attendance, were staff kind and helpful?


*Everybody has been polite, kind and helpful.*

*All staff helpful, informative and polite.*

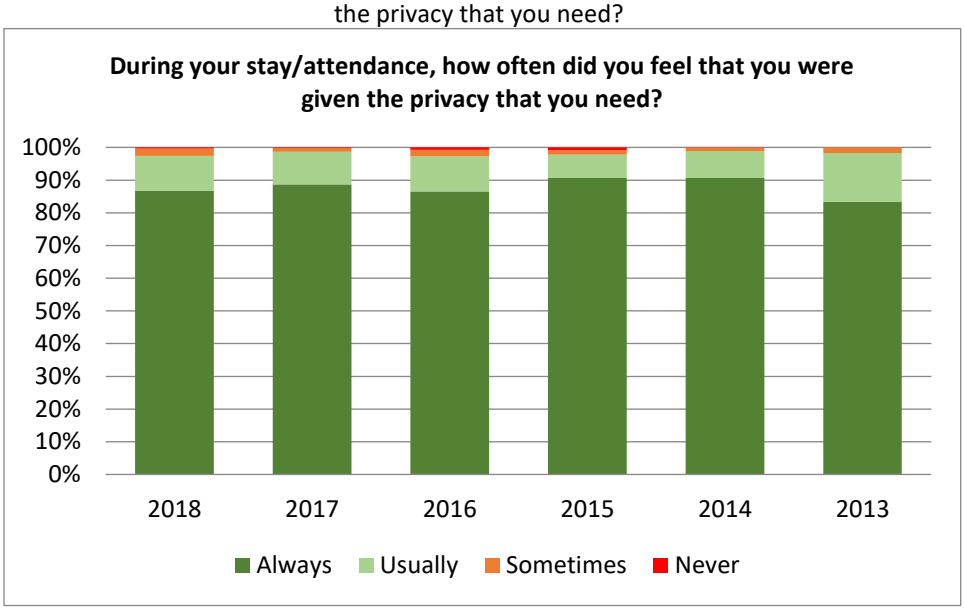
*Very caring, understanding, polite and helpful.*

*Lovely staff. Very helpful and friendly.*

*Something to change would be: For the night staff to be kind.*

*97% of our patients also states that they felt that they were always/usually given the privacy that they needed (↓2% on last year's position).*

Graph 21: Patient responses to: During your stay/attendance, how often did you feel that you were given the privacy that you need?




*Experience on this ward extremely good.*

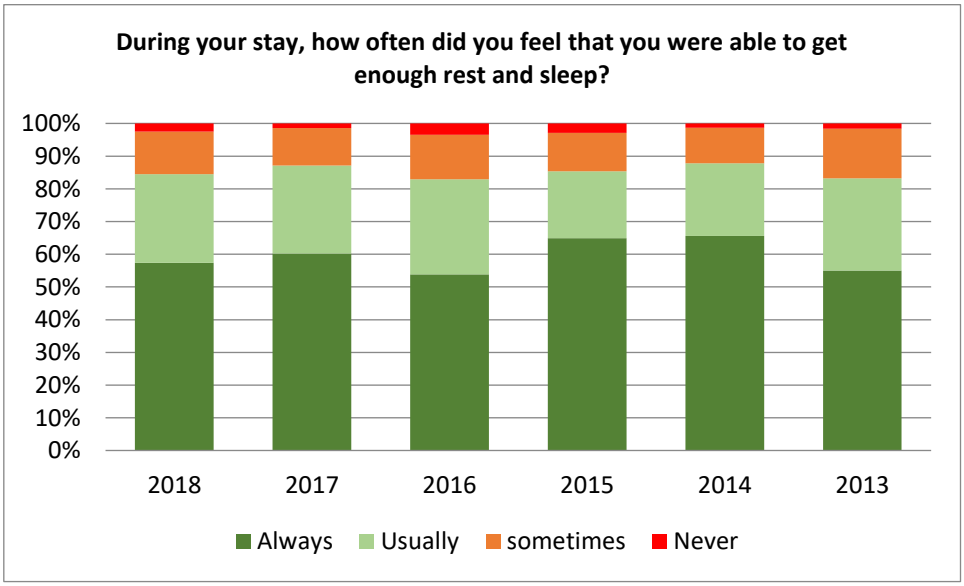
*Some wards less favourable regarding dignity respect and privacy.*

*The ward can be noisy and other patients come into my room.*

*Lack of privacy is hard but necessary at times.*

**Patient Perspective:** 84% of the patients stated they always/usually *felt able to get enough rest and sleep* (↓3% on last year's position).

Graph 22: Patient responses to: During your stay, how often did you feel that you were able to get enough rest and sleep?



*The level of noise at night by some of the night staff is ridiculous.*

*Night staff could be quieter.*

*Mattress intermittently noisy, keeping me awake at night, mattress occasionally bumpy depending on how I lie.*

*Some patients shouting in the night.*

*I have found night time difficult due to the inability to sleep and consequently finding the time long and discomforting at times.*

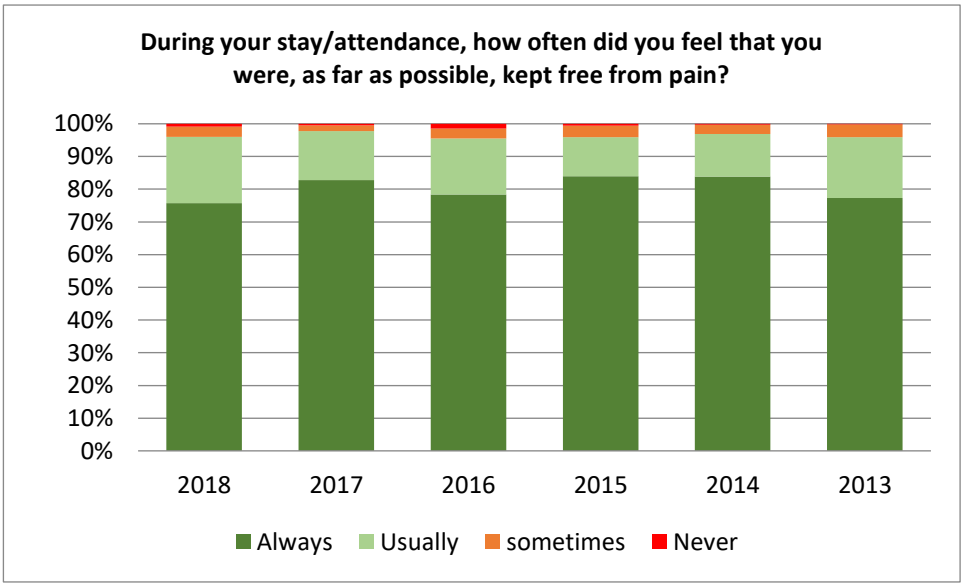
*Noisy at night, bells , bells, bells, patients confused shouting.*

*Bins noisy.*

*Some nights there was too much going on on the ward to sleep well.*

**Patient Perspective:** the majority of our patients *felt that they were, as far as possible, always/usually kept free from pain* with 96% of the patients responding positively to this question (↓2%).

Graph 23: Patient responses to: During your stay/attendance, how often did you feel that you were, as far as possible, kept free from pain?




*Procedure was made as painless as possible with plenty of support given.*

*I came into hospital in a great deal of pain and within a short space of time a doctor had spoken to me and endeavoured to treat my terrible back and leg pain, which became a lot easier.*

*My grandmother is in a wheelchair in pain.*

*It took 5 hours for pain relief.*

*Most of the nurses are exceptional care givers and have gone above and beyond to ensure my comfort. However a couple of night nurses can be slow if giving out medication sometimes meaning I don't receive pain relief until 11pm or midnight.*

***Patient Perspective:*** *The vast majority of our patients felt that they were always/usually made to feel comfortable with 98% of the patients responding positively to this question (↓1% on last year).*

Graph 24: Patient responses to: During your stay, how often did you feel that you were made to feel comfortable?


*Nurses here have worked excellently and have made me feel comfortable during my stay.*

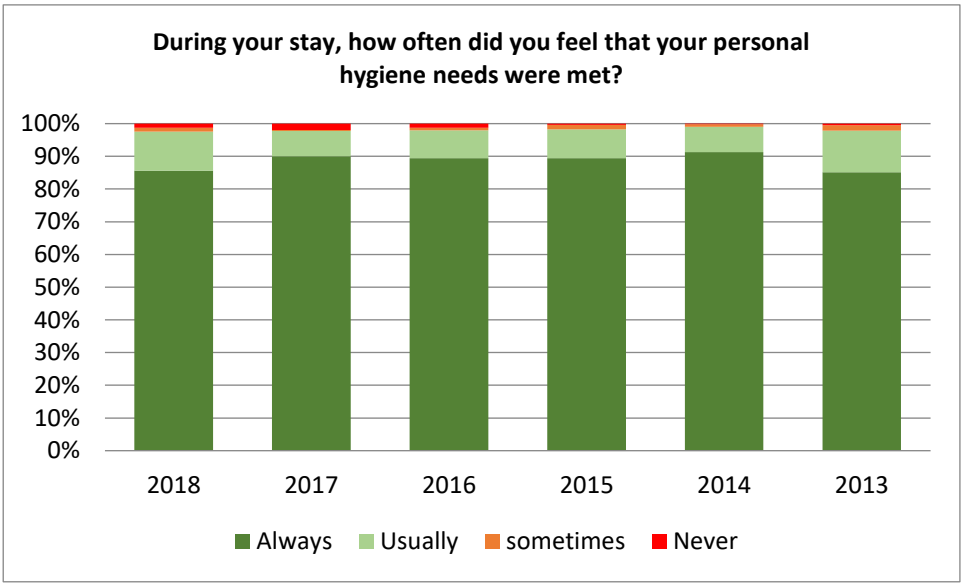
*Was made to feel welcome and made comfortable, the nursing staff are great, nothing too much trouble.*

*During our time at the hospital we feel as if all nursing staff went above and beyond in making our son and us feel comfortable.*

*Not always comfortable due to lines & interventions.*

***Personal Hygiene: Patient Perspective:*** *98% of the patients felt that their personal hygiene needs were always/usually met (unchanged from last year).*

Graph 25: Patient responses to: During your stay, how often did you feel that your personal hygiene needs were met?

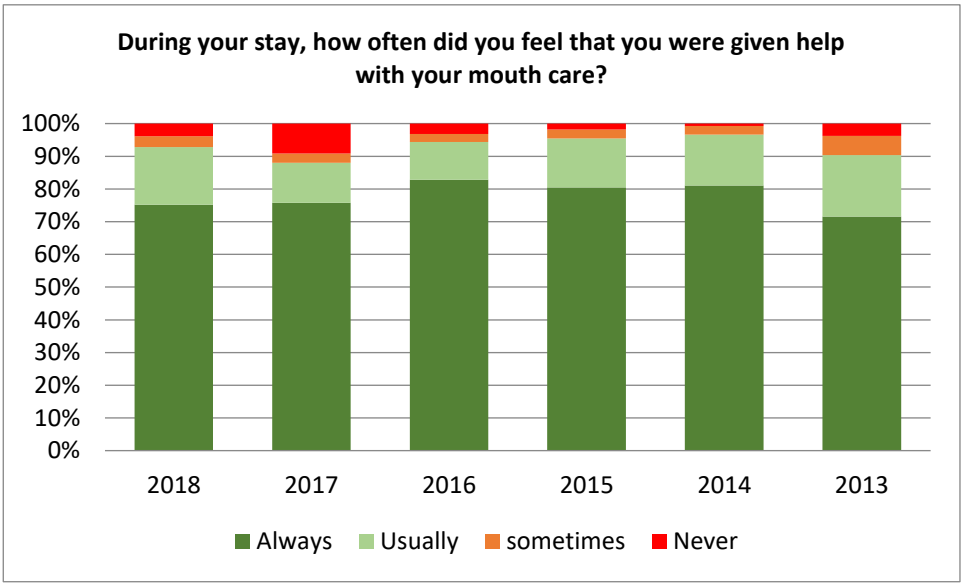



*He came in with no toiletries; these were immediately provided by the ward which enabled him to maintain his hygiene needs.*

*Washing facilities could be improved. Very small sinks etc to attend to personal hygiene.*

***Oral Health & Hygiene: Patient Perspective:*** *93% of the patients responded positively when asked if they were given help with their oral hygiene (↑7% on last year).*

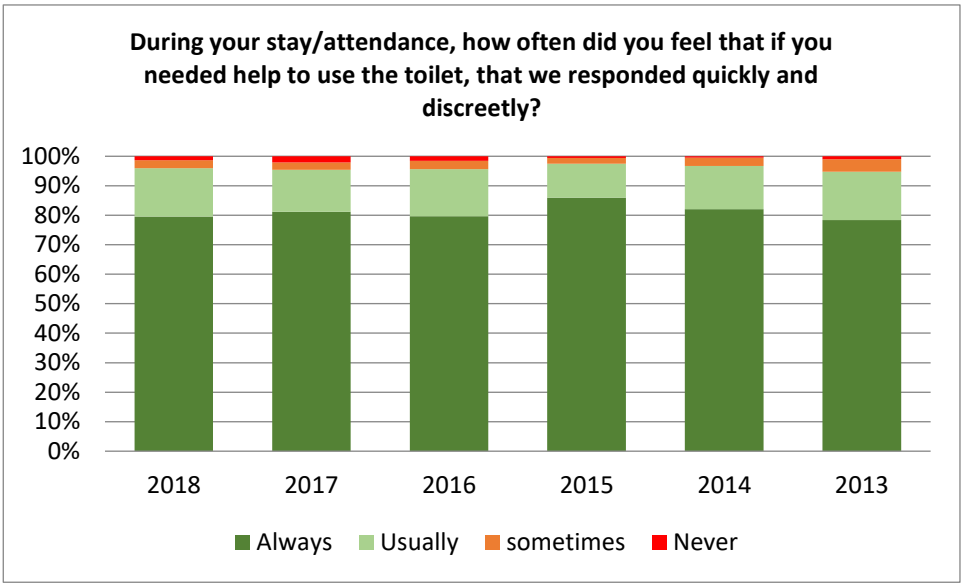
Graph 26: Patient responses to: During your stay, how often did you feel that you were given help with your mouth care?




*My Father has a dental hygiene book that is individualised to his needs and preferences which will go with him when he is well enough for discharge to a nursing home.*

***Continence: Patient Perspective:*** *96% of the patients felt that we always/usually responded quickly and discreetly if they needed help to use the toilet (↑1% on last year).*

Graph 27: Patient responses to: During your stay/attendance, how often did you feel that if you needed help to use the toilet that we responded quickly and discreetly?




*Sometimes the nurses were busy but they came to me as soon as they could.*

*Commodes are too small compared to normal toilets.*

*Bathroom toilet arrangements not adequate.*

*Day staff always did but not always the night staff.*

*Sometimes they were very busy.*

*More staff needed to help the nurses on buzzer duties.*

*The time it takes for bedpan to get to you, I know staff are busy but it seems to take a long time.*

*It would be good not to have to wait so long for help to toilet.*

**Standard 4.2 Patient Information**

People must receive full information about their care which is accessible, understandable and in a language and manner sensitive to their needs to enable and support them to make an informed decision about their care as an equal partner.

*NMC (2015): Prioritise People: Standard 5: Respect people's right to privacy and confidentiality.*

*NMC (2015): Practise Effectively: Standard 7.2: take reasonable steps to meet people's language and communication needs, providing, wherever possible, assistance to those who need help to communicate their own or other people's needs.*

*NMC (2015): Practise Effectively: Standard 7.3: Use a range of verbal and non-verbal communication methods, and consider cultural sensitivities, to better understand and respond to people's personal and health needs.*

**Operational Audit Narrative:** Seven of the nine questions included for this standard achieved a compliance score of 85% or above. Six of the questions achieved 100% compliance. One question has seen an increase in percentage compliance compared to last year; two of the questions have seen a decrease in percentage compliance, whilst four questions remain unchanged on the 2017 position. Two of the questions for this standard are new for 2018.

There is one new question for this standard which is health visiting specific.

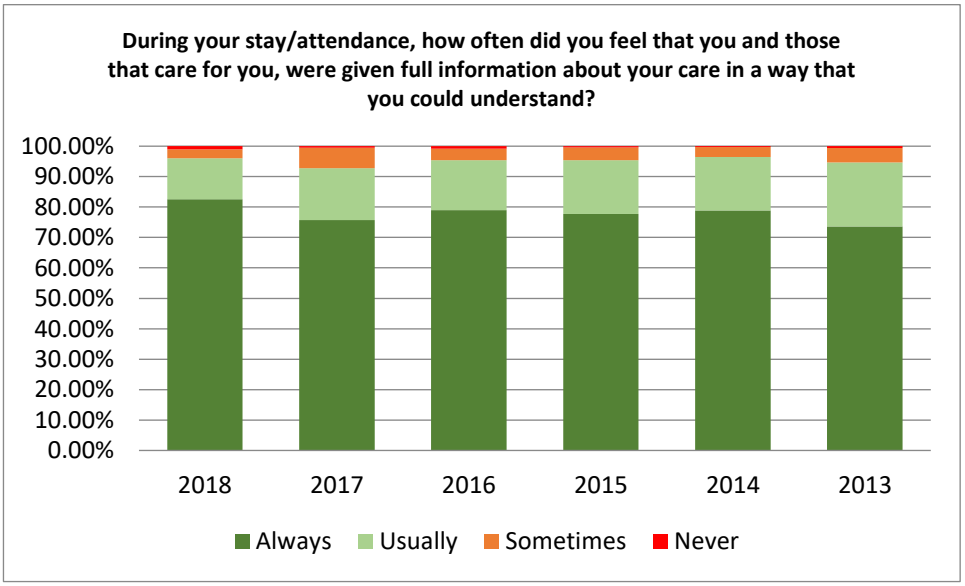
**Table 28 Whole HB/ Standard 4.2 Patient Information**

| | | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | |
|---|---|---|---|---|---|---|---|---|
| ALL | Is there evidence to demonstrate that patient identifiable information is treated in a confidential and secure manner? | 95% | 99% | 97% | 99% | 99% | 98% | ↓ |
| ALL except neonates, theatres | For this episode of care, is there written evidence in the patient's clinical notes that the patient's consent to the sharing of information with others has been obtained? | 66% | 74% | 74% | 81% | 76% | 79% | ↑ |
| Neonates only | Does your unit inform parents that information regarding their baby may be shared with other professionals to ensure appropriate care? | n/a | n/a | 0% | 100% | 100% | 100% | ↔ |
| Maternity & neonates only | Is there evidence of information available for women and their families on infant feeding? | n/a | 100% | 100% | 100% | 100% | 100% | ↔ |
| Neonates only | Does the clinical area offer translation services and/or professional interpreters to parents? | n/a | n/a | 100% | 100% | 100% | 100% | ↔ |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Neonates only | Does the clinical area have written information available in a language and format appropriate to their local community? | n/a | n/a | 100% | 100% | 100% | 0% | ↓ |
| Neonates only | In the clinical area, is there information available regarding unit facilities, local amenities, parking, visiting, local support groups and arrangements for going home? | n/a | n/a | 100% | 100% | 100% | 100% | ↔ |
| Neonates only | Are Parents provided with information on how to access further information including useful websites i.e. BLISS, local neonatal services and the Wales Neonatal Network | n/a | n/a | n/a | n/a | n/a | 100% | New |
| Paeds only | Is the CYP/parent/carer aware of the named nurse who is responsible for the patient during their stay | n/a | n/a | n/a | n/a | n/a | 100% | New |
| Health visiting | Is there evidence that the records are kept securely | n/a | n/a | n/a | n/a | n/a | 96% | New |

**Patient Perspective:** The vast majority of patients are satisfied with the information they were given about their care with 97% of the patients responding positively when asked "how often did you feel that you were given full information about your care" (unchanged from last year).

Graph 28: Patient responses to: During your stay/attendance, how often did you feel that you and those that care for you, were given full information about your care in a way that you could understand?




*I have been given very informative booklets in the Ward Round meeting about Dementia, I have learnt more about Dementia since my mother was admitted than I knew in the two years prior.*

*Clear information of care.*

*Information freely given until understood.*

*Staff always made sure that we had information needed and went over and above the call of duty.*

*Conflicting information.*

*Better across hospital board information sharing.*

*Information on what's going on more often & more in depth.*

*Lack of info for relatives.*

*Print too small and faint large print correspondence and good quality large print information leaflets needed.*

*Sometimes the waiting times between things happening are lengthy and a little more information on progress would be nice.*

## Standard 5.1 Timely Access

All aspects of care are provided in a timely way ensuring that people are treated and cared for in the right way, at the right time, in the right place and with the right staff.

*NMC (2015): Preserve Safety: Standard 13.2: Make a timely and appropriate referral to another practitioner when it is in the best interests of the individual needing any action, care or treatment*.

**Operational Audit Narrative:** The question included for this standard is a specialty specific question for the paediatric areas. The question achieved 100% compliance.

There is one new question for this standard which is health visiting specific. The question achieved 100% compliance.

**Table 29 Whole HB/ Standard 5.1 Timely Access**

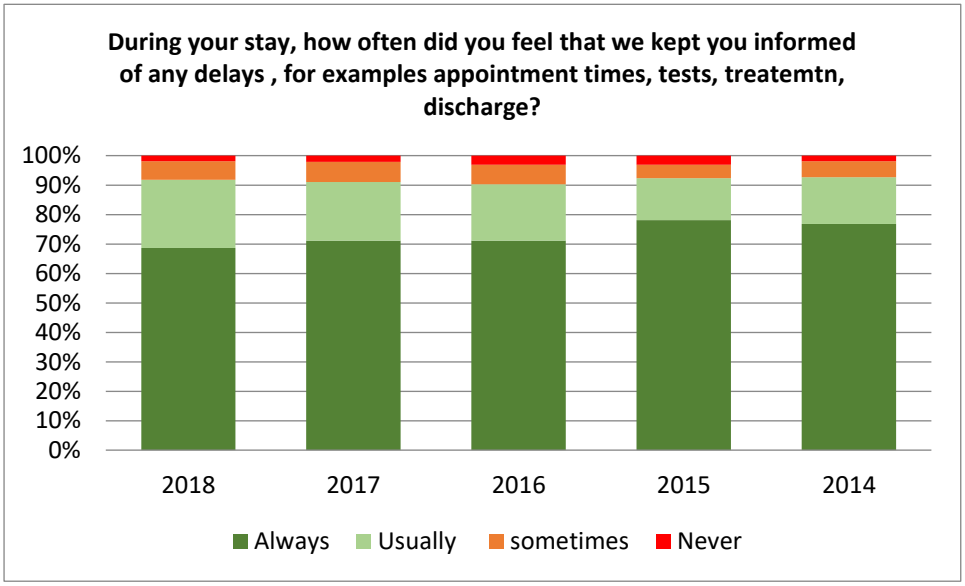
| | | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | |
|---|---|---|---|---|---|---|---|---|
| Paeds only | Is there evidence that the CYP has been correctly triaged on admission? | n/a | n/a | n/a | n/a | 100% | 100% | ↔ |
| Health visiting | Is there written evidence that the Primary Birth Visit was completed within 10-14 days? | n/a | n/a | n/a | n/a | n/a | 100% | New |

**Examples of Good Practice:**

- We have implemented the "Red to Green" initiative and tool across the Health Board. This tool is being used to help reduce length of stay.
- #EndPJparalysis day has also been implemented and this has shown an increase in patients outside of their bed environment, supporting increased independence of our patients.

**Patient Perspective:** 92% of the patients felt that they were always/usually *kept informed of any delays, for example appointment times, tests, treatment, discharge* (↑1% on last year).

Graph 29: Patient responses to: During your stay, how often did you feel that we kept you informed of any delays , for examples appointment times, tests, treatment, discharge?



*No delays*

*Tests were carried out immediately*

*all the blood tests have been acted on*

*Staff have always accommodated our requests for early appointments*

*Tests and investigatory works were carried out despite it being the early hours of the morning*

*Doctors communication very poor*

*be more honest with dates of future appointments / surgery*

*Occasional delays in passing information to concerned others*

*long delays and several complaints before getting and appointment*

*waited for scan for long time*

*Sometimes the waiting times between things happening are lengthy and a little more information on progress would be nice.*

**Standard 6.1 Planning Care to Promote Independence**

Care provision must respect people's choices in how they care for themselves as maintaining independence improves quality of life and maximises physical and emotional well being.

*NMC (2015): Prioritise People: Standard 1.2: Make sure you deliver the fundamentals of care effectively.*

*NMC (2015): Prioritise People: Standard 1.4: Make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay.*

*NMC (2015): Prioritise People: Standard 4.3: Keep to all relevant laws about mental capacity that apply in the country in which you are practising, and make sure that the rights and best interests of those who lack capacity are still at the centre of the decision-making process.*

**Operational Audit Narrative:** 15 of the 23 questions included for this standard achieved a compliance score of 85% or above. Six questions have seen an increase in percentage compliance compared to last year; ten of the questions have seen a decrease in percentage compliance, whilst six questions remain unchanged on the 2017 position. One is a new question which is specialty specific.

Two questions which achieved an amber RAG rating for 2017 are now showing a red RAG rating (both neonates' specific questions) and will require urgent action.

**Table 30/Whole HB / Standard 6.1 Planning Care to Promote Independence**

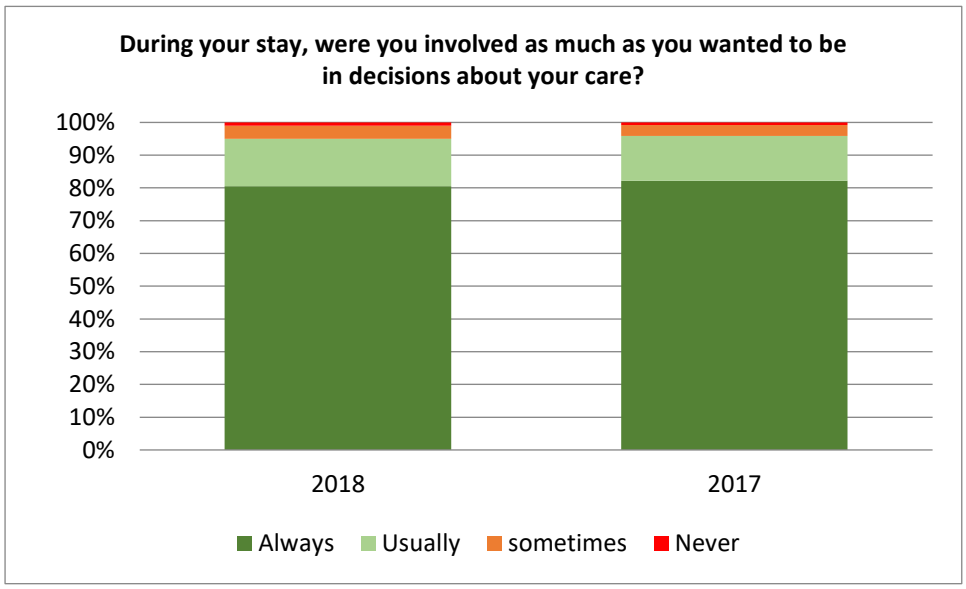
| | | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | |
|---|---|---|---|---|---|---|---|---|
| Inpatients, paeds, MH, Endoscopy, theatre, day units only | For patients with no known diagnosis of dementia, delirium or other cognitive impairment at admission, there is documented evidence that within 72 hours of admission, the following screening question has been asked, Have you/has the patient been more forgetful in the past 12 months to the extent that it has significantly affected your/their daily life? | 62% | 72% | 77% | 67% | 69% | 80% | ↑ |
| ED | For this episode of care, is there documented evidence that the patient's cognition has been assessed? | | | | | | 60% | New |
| Inpatients, ED, MH, day units only | For this episode of care, where the patient has an identified care need in respect of cognitive impairment, is there evidence that there is an up to date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale? | 59% | 64% | 76% | 63% | 72% | 73% | ↑ |
| Inpatients, ED, paeds, MH, Endoscopy, | For patients with no formal diagnosed learning disabilities, is there documented evidence that | n/a | n/a | n/a | n/a | 90% | 76% | ↓ |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| theatre, day units only | the patient has been assessed for a formal diagnosed learning disability? | | | | | | | |
| Inpatients, ED, paeds, MH, Endoscopy, theatre, day units only | For this episode of care, where the patient has been identified as having a formal diagnosed learning disability, is there evidence that there is an up to date learning disability passport? | n/a | n/a | n/a | n/a | 94% | 78% | ↓ |
| Inpatients, ED, paeds, MH, Endoscopy, theatre, day units only | For this episode of care, where the patient has been identified as having a formal diagnosed learning disability, is there evidence that the learning disabilities care bundle is being implemented and evaluated? | n/a | n/a | n/a | n/a | 100% | 79% | ↓ |
| ALL except neonates, OPD | For this episode care, is there documented evidence that the patient's level of independence has been assessed and discussed with the patient or advocate? | 94% | 93% | 91% | 96% | 97% | 93% | ↓ |
| ALL except neonates, OPD | For this episode of care, where the patient has been identified as requiring support and/or assistance to maximise independence, is there evidence that there is an up to date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale? | 89% | 86% | 90% | 90% | 86% | 88% | ↑ |
| ALL except OPD, Theatres | Where appropriate, do all patients have written evidence of a discharge assessment and plan? | 82% | 90% | 90% | 86% | 87% | 89% | ↑ |
| ALL except OPD, Theatres | Where appropriate, is there written evidence that the patient's family/carer has been involved in discharge planning? | 84% | 88% | 86% | 87% | 89% | 88% | ↓ |
| ALL except maternity, neonates, OPD, Theatres | Does the clinical area have access to mirrors for patients to use? | 94% | 93% | 94% | 94% | 95% | 94% | ↓ |
| Inpatients, ED, paeds, MH, LD only | Does the clinical area have supplies of toiletries for patients who have been admitted without them? | 94% | 98% | 97% | 100% | 99% | 97% | ↓ |
| MH & LD only | For this episode of care, where the patient has been assessed under the Mental Health Measure to be a relevant patient, has a Care Treatment Plan been completed? | n/a | 100% | 100% | 100% | 100% | 100% | ↔ |
| MH & LD only | For this episode of care is there an individual Positive Behaviour Plan | n/a | 100% | 76% | 91% | 100% | 90% | ↓ |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | in place prescribing individual restrictive practices that can be used to support the patient if need be. | | | | | | | |
| neonates only | For this episode of care, is there documented evidence that the mother is shown parent craft skills prior to going home? | n/a | 100% | 60% | 100% | 100% | 100% | ↔ |
| Neonates only | Does the clinical area allow for parents to room in with their baby prior to going home? | n/a | 100% | 100% | 100% | 100% | 100% | ↔ |
| Neonates only | Where appropriate, do all babies have written evidence of a discharge plan from the point of admission and are continually reviewed, involving both parents and a multidisciplinary team? | n/a | 100% | 80% | 100% | 100% | 100% | ↔ |
| Neonates only | For this episode of care, is there documented evidence that the mother is shown how to make feeds and sterilise bottles and teats prior to going home? | n/a | 100% | 0% | 100% | 60% | 0% | ↓ |
| Neonates only | Does the clinical area have access to appropriate baby clothes for babies who have been admitted without them? | n/a | n/a | 100% | 100% | 100% | 100% | ↔ |
| Neonates only | Does the clinical area have supplies of nappies and baby toiletries for babies who have been admitted? | n/a | n/a | 100% | 100% | 100% | 100% | ↔ |
| Neonates only | For this episode of care, is there documented evidence that the baby has an up to date Developmental Care assessment? | n/a | 60% | 80% | 80% | 80% | 0% | ↓ |
| Paeds only | For this episode of care, is there written evidence in the CYP's clinical notes that the CYP/parent/carer as been given an e-discharge letter and the discharge arrangements explained? | n/a | n/a | n/a | n/a | 75% | 96% | ↑ |
| Paeds only | For this episode of care, where required is there written evidence that the CYP developmental needs have been assessed/discussed with the CYP or advocate? | n/a | n/a | n/a | n/a | 96% | 100% | ↑ |

**Patient Perspective:** 95% of the patients responded positively when as about whether they *were involved as much as they wanted to be in decisions about their care* (↓1% from last year).

Graph 30: Patient responses to: During your stay, were you involved as much as you wanted to be in decisions about your care?



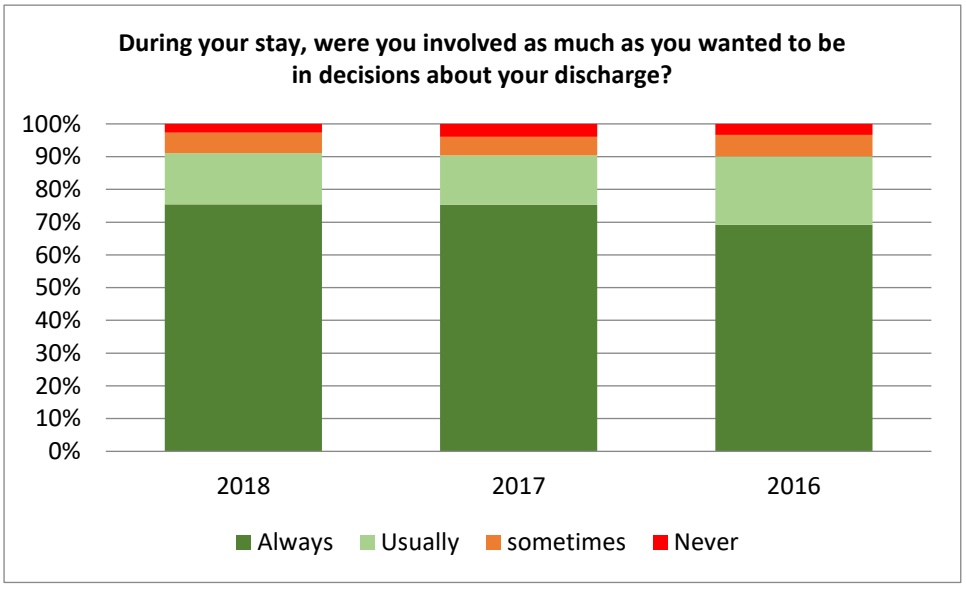

*Family also involved*

*The medication practice and the assumption that once you have got the hospital identity band on you have lost any intelligence you ever had and cannot possibly make any decisions for yourself with medication*

*I find a difference in the bank nurses who do not know the patient and their capabilities.*

***Patient Perspective:*** *91% of the patients responded positively when as about whether they were involved as much as they wanted to be in decisions about your discharge (↑1% from last year).*

Graph 31: Patient responses to: During your stay, were you involved as much as you wanted to be in decisions about your discharge?

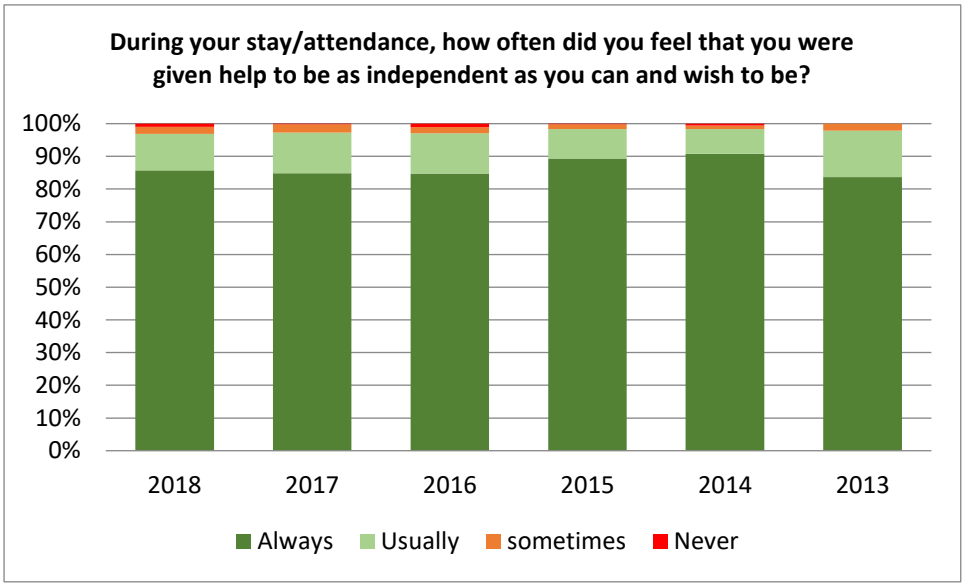



*My daughter supports me in understanding and making decisions.*

*Would have liked more involvement.*

***Patient Perspective:*** *97% of the patients felt they were given help to be as independent as possible (unchanged from last year).*

Graph 32: Patient responses to: During your stay, how often did you feel that you were given help to be as independent as you can and wish to be?




*Lack of independence is difficult.*

*Not as independent as I wanted.*

Patient Perspective: 97% of the patients felt that when they asked for assistance, they got it when they needed it (↓1% from last year).

Graph 33: Patient responses to: During your stay, if you asked for assistance did you get it when you needed it?

**Standard 6.2 Peoples Rights**

Health services embed equality and human rights across the functions and delivery of health services in line with statutory requirement recognising the diversity of the population and rights of individuals under equality, diversity and human rights legislation.

*NMC (2015): Prioritise People: Standard 1.5: Respect and uphold people's human rights.*

**Operational Audit Narrative:** Four of the five questions included for this standard achieved a compliance score of 85% or above. Three questions have seen an increase in percentage compliance compared to last year, whilst the remaining two questions remain unchanged on the 2017 position.

There is one new question for this standard which is health visiting specific. The question achieved an amber RAG rating.

**Table 31 /Whole HB / Standard 6.2 Peoples Rights**

| | | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | |
|---|---|---|---|---|---|---|---|---|
| Inpatients and paeds only | Does the clinical area allow CYP/family/carers to bring in personal items to assist with CYP's orientation/familiarity/anxiety? | n/a | 100% | 100% | 100% | 100% | 100% | ↔ |
| Maternity & neonates only | For this episode of care, is there documented evidence that mothers who require breastfeeding support and/or assistance has been assessed and discussed? | n/a | 89% | 89% | 90% | 70% | 95% | ↑ |
| Maternity & neonates only | For this episode of care, where the mother has been identified as requiring support and/or assistance to establish breastfeeding on the unit, prior to going home, is there evidence that there is an up to date plan of care, which is being implemented and evaluated and has been reviewed within the last 24 hours? | n/a | 100% | 90% | 100% | 64% | 80% | ↑ |
| Paeds only | Are there age appropriate playrooms, toys, books and activities for children/young people? | n/a | 67% | 100% | 80% | 100% | 100% | ↔ |
| Paeds only | For this episode of care, is there documented evidence that the CYP and their parents/carers have been involved in the decision making process regarding the CYP care? | n/a | n/a | n/a | n/a | 84% | 92% | ↑ |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Health visiting | Is there evidence that staff are aware of the rights of the clients? | **n/a** | **n/a** | **n/a** | **n/a** | **n/a** | **84%** | New |

**Standard 6.3 Listening and Learning from Feedback**

People, who receive care, and their families, must be empowered to describe their experiences to those who provided their care so there is a clear understanding of what is working well and what is not, and they must receive an open and honest response.

Health services should be shaped by and meet the needs of the people served and demonstrate that they act on and learn from feedback.

*NMC (2015): Standard 2: We must listen to people and respond to their preferences and concerns.*

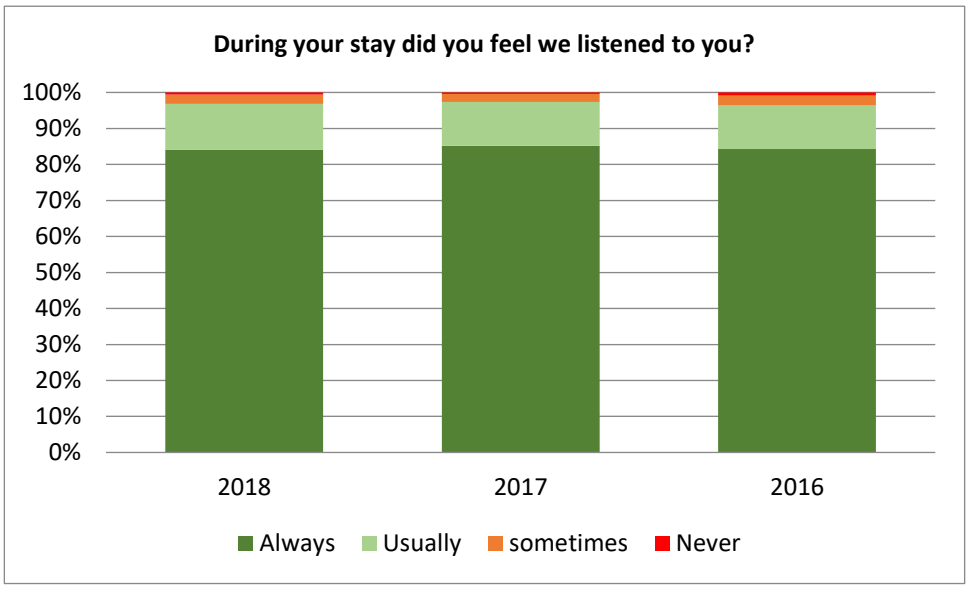
**Operational Audit Narrative:** All four questions included for this standard achieved a compliance score of 85% or above. One questions have seen an increase in percentage compliance compared to last year, whilst the other three question remain unchanged on the 2017 position.

**Table 32/Whole HB / Standard 6.3 Listening and Learning from Feedback**

| | | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | |
|---|---|---|---|---|---|---|---|---|
| ALL except theatres | In the clinical area, is there accessible information regarding how patients/relatives/advocates can raise a formal or informal concern? | 91% | 96% | 97% | 98% | 95% | 96% | ↑ |
| Neonates only | Does the clinical area allow parents to regularly feedback their experience of the service? | n/a | n/a | 100% | 100% | 100% | 100% | ↔ |
| Neonates only | Does the clinical area allow parents to be involved in the planning and development of service improvements? | n/a | n/a | 0% | 100% | 100% | 100% | ↔ |
| Minor Injuries Units only | Do the patients have access to patient satisfaction questionnaires and/or written or verbal feedback mechanisms | n/a | n/a | n/a | n/a | 100% | 100% | ↔ |
| Paeds Only | Is feedback sought from CYP and their parents/carer relating to their experience | n/a | n/a | n/a | n/a | n/a | 100% | New |
| Paeds only | Can staff demonstrate they know what action to take if a CYP, their parent/carer or member of the public raises a concern about the care/treatment that they have received? | n/a | n/a | n/a | n/a | n/a | 100% | New |

**Patient Perspective:** 97% of the patients felt they were listened to (unchanged from last year).

Graph 34: Patient responses to: During your stay, did you feel we listened to you**?**




*I've been able to ask questions without feeling daft and have felt listened to.*

*I felt well cared for and listened*

*Listened to my questions and answered them fully.*

*Nurses always, not so much by the doctors*

*Need to provide a regular refresher course for all general nurses so that those who are set in their ways and those that have much to learn can benefit from the example of the staff nurses who do not forget that every patient is different and needs to be listened to, even if it seems a nuisance.*

*I had concerns about various aspects of his care which were not listened to.*

**Standard 7.1 Workforce**

Health services should ensure there are enough staff with the right knowledge and skills available at the right time to meet need.

*NMC (2015): Practice Effectively: Standard 6.2: maintain the knowledge and skills you need for safe and effective practice.*

*NMC (2015): Practice Effectively: Standard 8: Work cooperatively.*

*NMC (2015): Practice Effectively: Standard 9: Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues.*

*NMC (2015): Promote professionalism and Trust: Standard 20.1: uphold the reputation of your profession at all times.*

**Operational Audit Narrative:** Both questions for this standard achieved a compliance score of 85% or above. One has seen an increase in compliance whilst the other has seen a decrease in compliance.

**Table 37: Whole HB/Standard 7.1 Workforce**

| | Question | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | |
|---|---|---|---|---|---|---|---|---|
| ALL | All clinical staff wear identification badges | 73% | 65% | 84% | 81% | 87% | 85% | ↓ |
| ALL | All clinical staff comply with All Wales Dress Code | 84% | 87% | 94% | 90% | 94% | 95% | ↑ |

**Examples of Good Practice:**

- **Board to Floor walk arounds**: Walk arounds are undertaken by an Executive team member and Independent Member, supported by the Assurance. Safety and Improvement Team and are a useful tool to connect senior leaders with staff working on the front line; both as a way to educate senior leaders about patient safety issues and to signal to front line workers the senior leaders commitment to creating a culture of safety. Key areas of good practice identified include professionalism and openness of staff; staff development; positive patient safety culture and evidence of health board values . Areas requiring improvement included environmental issues; out of date information on notice boards; staffing challenges and lack of IT hardware.

**Staff Survey Findings:** The annual HCS/FoC audit includes a survey aimed at ascertaining staff's views about the organisation in relation to key aims. The survey has been undertaken annually since 2013.

A total of 1011 staff completed the staff survey. Although the main focus of the staff survey was to ascertain the views of nursing staff, there was opportunity for other staff groups to participate. The table 38 demonstrates the breakdown of staff that completed the survey by staff group.

**Table 38: Breakdown of staff per staff group**

| Staff group | Total Number | Percentage |
|---|---|---|
| **Nurse** | 518 | 51% |
| **District Nurse** | 49 | 5% |
| **Doctor** | 9 | 1% |

| | | |
|---|---|---|
| **Administrative Assistant** | 13 | 1% |
| **Midwife** | 18 | 2% |
| **Health Care Support Worker** | 301 | 30% |
| **Health Visitors** | 3 | 0.2% |
| **Allied Health Professional** | 11 | 1% |
| **Operating Department Practitioner** | 8 | 0.8% |
| **Other (please specify)** | 84 | 8% |
| Total | 1011 | |

**Results per question** Staff are asked to response always, usually, sometimes, never to 16 questions and asked to rate two questions on a scale of 0-10.

**Staff Satisfaction -** staff were asked to rate their overall satisfaction with the care that they provide to patients and their families and their overall satisfaction with the organisation, using a scale of 1-10, with 1 being very bad and 10 being excellent.

When asked to rate their overall satisfaction with the care provided to patients and relatives, staff gave the organisation a satisfaction rating of 8.1 out of 10 (81%) which, in accordance with the All Wales FoC Steering Group compliance matrix, is an amber RAG rating. This has seen a increase of 1% on last year's position.

**Table 39: Compliance Score when staff were asked to rate their overall satisfaction with the care that you provide to your patients and their families**

| | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | |
|---|---|---|---|---|---|---|---|
| **Overall satisfaction with the care that you provide to your patients and their families.** | **76%** | **84%** | **73%** | **81%** | **80%** | **81%** | **↑1%** |

*As a team on the ward we all work together to provide the best care we can. Families are include in all discussions with patients and sisters are always available to talk to patients and families.*

*I love my job and the chance that I have been given, but I am so eager to give more and take on more responsibilities but the option to isn't there.*

*Sometimes pressures are too high..... This often makes nurses feel that they are unable to give their patients the care that they need or deserve and in the most appropriate area.*

*Due to the nature and business of the ward and also the staffing levels at time, I feel we do not have enough time to spend with patients or their families.*

*Patients and families often make comments such as 'we know you're doing your best but...' 'we know you have not got enough staff but....'*

When asked to rate their overall satisfaction with the organisation, staff gave the organisation a satisfaction rating of **7.3** out of 10 (**73%),** which, in accordance with the All Wales FoC Steering Group compliance matrix, is an **amber** RAG rating (this is increase of 1% on last year's position).

**Table 40: Compliance Score when staff were asked to rate their overall satisfaction with the organisation**

| | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | |
|---|---|---|---|---|---|---|---|
| **Overall satisfaction with the organisation** | | **67%** | **73%** | **73%** | **72%** | **73%** | **↑1%** |

*This is a rural Health Board which faces problems as a whole. Things could be better but things could be much worse.*

*As on overall organisation, in my opinion, and from feedback from other patients, the response is positive. Patients are happy with the care they receive.*

*I have found Hywel Dda to be progressive and determined to improve care standards with learning and development opportunities available for staff. There are staff vacancies, however this is nationwide.*

*Staffing is often an issue which makes it very difficult and stressful.*

*My dissatisfaction stems from various areas... IT and the computer systems in place. Trying to get things repaired or replaced is difficult.*

*There is still a significant blame culture and minimal positive feedback or support to teams.*

**Staff Survey Questions:** staff were asked to respond always, usually, sometimes, never to further 16 questions and the results show that there has been a decrease in the percentage compliance for 14 of these questions, whilst the remaining two questions are unchanged from last year. Five of the 16 questions show a green RAG rating (one more than last year) and the remaining 11 questions show an amber RAG rating.

Areas requiring improvement include:

- ensuring that there is further investigation and improvement work to all of the domains explored within the audit to ensure that we continue to put staff at the forefront of what we do. We need to show staff that we responded to the issues identified in the survey as this helps address the perception that 'nothing is done' with the survey results, which can lower future response rates. The relevant results will also be discussed with the organisational values team
- All the staff survey results will be reviewed by the service leads for each ward/department/team and where specific issues or concerns have been raised then these will be address through the local action plans.

Table 42 demonstrates the overall compliance percentage per question.

**Table 42: Whole HB/Staff Survey**

| Description/Indicator | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | |
|---|---|---|---|---|---|---|---|
| Make sure you are able to access up to date information in order to be able to do your job. | 87% | 90% | 90% | 92% | 90% | 92% | ↑ |
| Ensure that as an employee you are treated with dignity and respect. | 66% | 75% | 82% | 85% | 83% | 85% | ↑ |
| Make you feel safe at work. | 77% | 82% | 83% | 88% | 85% | 87% | ↑ |
| Make you feel you have a positive contribution to patient care. | 75% | 81% | 83% | 88% | 85% | 88% | ↑ |

| Table 42: Whole HB/Staff Survey | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Description/Indicator** | **2013** | **2014** | **2015** | **2016** | **2017** | **2018** | |
| Provide you with sufficient equipment to do your job. | **80%** | **82%** | **81%** | **82%** | **80%** | **79%** | ↓ |
| Provide you with opportunities to enhance your skills and professional development. | **55%** | **59%** | **66%** | **74%** | **73%** | **76%** | ↑ |
| Provide you with feedback on the outcomes of any incidents/accidents that you report or that are reported within your clinical area? | **51%** | **57%** | **61%** | **68%** | **68%** | **70%** | ↑ |
| Provide you with opportunity to identify and learn from good practice to bring about improvements in care. | **65%** | **70%** | **71%** | **81%** | **80%** | **81%** | ↑ |
| Provide opportunities for you to raise any concerns that you have. | **68%** | **73%** | **77%** | **82%** | **80%** | **81%** | ↑ |
| Provide you with the opportunity to establish a work life balance. | **61%** | **67%** | **69%** | **75%** | **71%** | **74%** | ↑ |
| Make you feel a valued member of the organisation and have a sense of belonging. | **54%** | **62%** | **64%** | **72%** | **71%** | **73%** | ↑ |
| Make you feel proud to be a nurse / allied health professional. | **56%** | **65%** | **69%** | **75%** | **75%** | **76%** | ↑ |
| Put local citizens at the heart of everything we do'. | | **61%** | **66%** | **79%** | **73%** | **77%** | ↑ |
| Ensure that you have the knowledge and skills to deliver a consistent standard in the fundamental aspects of compassionate care. | **76%** | **82%** | **86%** | **90%** | **86%** | **90%** | ↑ |
| Work together to be the best that we can be. | | | | **79%** | **76%** | **80%** | ↑ |
| Strive to deliver and develop excellent services. | | | | **84%** | **82%** | **84%** | ↑ |

**Feedback from our staff:**

This section will make reference to the relevant questions from the NHS Wales (2018) Staff Survey results. It is noted that the NHS Staff Survey (2018) was open to all staff groups where as the primary focus of the HCSFOC survey is nursing staff, therefore there are limitations in being able to compare the data from the two surveys.

| Description/Indicator | **2013** | **2014** | **2015** | **2016** | **2017** | 2018 | |
|---|---|---|---|---|---|---|---|
| Make sure you are able to access up to date information in order to be able to do your job. | **87%** | **90%** | **90%** | **92%** | **90%** | **92%** | ↑ |

Access to the intranet and the lack of user friendly systems were common themes of the comments made by staff. Staff noted that "*policies are all available on the intranet, however the intranet page is not that user friendly and policies/information can be hard to find*"; and "*accessing a computer is not always easy nor is having the time because of ward demands*".

62% of the staff who responded to the NHS Staff Survey (2018) said that the organisation provides them with enough information to enable them to do my job well whilst 46% of the staff said that the organisation provides them with information at the right time.

| Description/Indicator | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | |
|---|---|---|---|---|---|---|---|
| Ensure that as an employee you are treated with dignity and respect. | 66% | 75% | 82% | 85% | 83% | 85% | ↑ |

Whilst some staff felt that they are treated with dignity and respect particularly by other team members others noted that *"I feel there is sometimes a lack of respect amongst colleagues" and* "I *do not feel respected by the board".* A HCSW noted that *"I sometimes feel we are undervalued by senior management*". One member of staff noted that "*I feel that constant pressures on staff may be contributing to others not being respectful in their approach*".

83% of the staff who responded to the NHS Staff Survey (2018) said that the people they work with treat them with respect. However, 19% of staff who responded to said that they had experienced harassment, bullying or abuse at work from their manager/team leader or other colleagues – up from 15% in 2016.

| Description/Indicator | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | |
|---|---|---|---|---|---|---|---|
| Make you feel safe at work. | 77% | 82% | 83% | 88% | 85% | 87% | ↑ |

Staff noted that the main reasons why they did not feel safe at work was around staffing. Other reasons included concerns about security and caring for patients who are aggressive and/or confused. One member of staff noting that a "*culture of blame, short staffing levels; worry about accountability and ability to maintain patient safety*" were the reason why they didn't not feel safe.

32% of the staff who responded to the NHS Staff Survey (2018) said that there were enough staff at this organisation for them to do their job properly.

| Description/Indicator | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | |
|---|---|---|---|---|---|---|---|
| Make you feel you have a positive contribution to patient care. | 75% | 81% | 83% | 88% | 85% | 88% | ↑ |

Although some felt "*we always aim to do our best*" others felt that *"my opinion isn't always valued when contributing to patient care*"; and that sometimes "*we do not provide the high standards of holistic care ... because of staffing issues, increased activity*" and "mo*st of the time there is so much paper work to do and so much pressure I feel guilty for spending time with patients.*"

88% of the staff who responded to the NHS Staff Survey said that they felt that their role made a difference to patients / service users.

| Description/Indicator | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | |
|---|---|---|---|---|---|---|---|
| Provide you with sufficient equipment to do your job. | 80% | 82% | 81% | 82% | 80% | 79% | ↓ |

Staff gave examples of the equipment that they don't have or needs replacing. One member of staff noted that "*cut backs to ordering and stock means that we often run out of things"* whilst another said that they *"regularly have a shortage of equipment that compromises patient care".*

48% of the staff who responded to the NHS Staff Survey (2018) said that they had adequate supplies, materials and equipment to do their job, down from 56% in 2016.

| Description/Indicator | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | |
|---|---|---|---|---|---|---|---|
| Provide you with opportunities to enhance your skills and professional development. | 55% | 59% | 66% | 74% | 73% | 76% | ↑ |

Staff noted that they are provided opportunities to enhance their skills; however, staffing levels often prohibited staff from being able to attend training opportunities. Some staff noted that the "*opportunities for HCSW to progress are very limited and it is a shame, as some members of staff have the abilities to make a large contribution*".

60% of the staff who responded to the NHS Staff Survey (2018) said that they were supported to keep up to date with developments in their field; and 62% said tat they were encouraged to develop their own expertise but only 49% said that thy were able to access the right learning and development materials when they need to.

| Description/Indicator | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | |
|---|---|---|---|---|---|---|---|
| Provide you with feedback on the outcomes of any incidents/accidents that you report or that are reported within your clinical area? | 51% | 57% | 61% | 68% | 68% | 70% | ↑ |

Although some staff noted that they get feedback on incidents that they report, others noted that this was not always the case and a number noted that "*negative feedback is always received not so much of the positive*".

| Description/Indicator | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | |
|---|---|---|---|---|---|---|---|
| Provide you with opportunity to identify and learn from good practice to bring about improvements in care. | 65% | 70% | 71% | 81% | 80% | 81% | ↑ |

Staff noted that *"often we are fire fighting and there is insufficient protected time to reflect and identify good practice"* and "*things are spoken about to improve things but not always followed through".* Another member of staff noted that "*good practice very rarely gets highlighted".*

61% of the staff who responded to the NHS Staff Survey (2018) said that team members take time out to reflect and learn and 57% of the staff said that they were involved in discussions / decisions on change introduced in their work / department / team. 75% of the staff said that they were able to make improvements in their area of work.

| • *Description/Indicator* | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | |
|---|---|---|---|---|---|---|---|
| Provide opportunities for you to raise any concerns that you have. | 68% | 73% | 77% | 82% | 80% | 81% | ↑ |

Although some staff felt that they "*always feel ready to raise concerns*" others felt "*afraid to voice concerns*" and even staff who felt able to raise concerns "*don't feel these are taken on board*".

| Description/Indicator | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | |
|---|---|---|---|---|---|---|---|
| Provide you with the opportunity to establish a work life balance. | 61% | 67% | 69% | 75% | 71% | 74% | ↑ |

Although some staff noted that they had opportunity to establish a work life balance, others noted that "*work loads are increasing and making it more difficult to have a work life balance"* with concerns about off duty a recurring theme of the comments e.g. split days off, working a mixture of days and nights in the same week, working most weekends, off duty issued at short notice. Some noted that the reassurance that *"long days are here to stay staff positivity has greatly improved, giving a much better work life balance".*

77% of the staff who responded to the NHS Staff Survey said that they could approach their line manager to talk openly about flexible working. 72% of the staff said that their line manager took a positive interest in their health and wellbeing. However, only 45% said that the organisation was committed to helping staff balance their work and home life.

| Description/Indicator | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | |
|---|---|---|---|---|---|---|---|
| Make you feel a valued member of the organisation and have a sense of belonging. | 54% | 62% | 64% | 72% | 71% | 73% | ↑ |

Although some noted that they felt "*a valued member of the team*" this was "*more to do with the team members than with the organisation".* One noted that team members were "a*lways appreciative and respectful to me and vice versa.*" But others felt that despite trying to "*" give the best possible care; I am sometimes made to feel it isn't good enough*" and "*we are just a number".*

73% of staff who responded to the NHS Staff Survey (2018) said that they were proud to tell people they work for this organisation, higher than in 2016 (65%).

| Description/Indicator | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | |
|---|---|---|---|---|---|---|---|
| Make you feel proud to be a nurse / allied health professional. | 56% | 65% | 69% | 75% | 75% | 76% | ↑ |

Although a number of staff commented that they were proud to be a nurse, many felt that this wasn't because of anything that the organisation had done. One noted that "*I am very proud of being a nurse and am grateful that I can practice but it is not through anything the organisation has influenced*" whilst others noted that "*when I started I was proud to be a nurse but as the years have gone by with the demand of the job and poor staffing levels the 'proudness' has gone*" and "*I feel very disillusioned with nursing*".

| Description/Indicator | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | |
|---|---|---|---|---|---|---|---|
| Ensure that you have the knowledge and skills to deliver a consistent standard in the fundamental aspects of compassionate care. | 76% | 82% | 86% | 90% | 86% | 90% | ↑ |

Availability of certain training was seen as the main reason why staff were unable to access the training required to ensure that they have the knowledge and skills to deliver compassionate care.

67% of the staff who responded to the NHS Staff Survey (2018) said that their training, learning and development had helped them to do their job better.

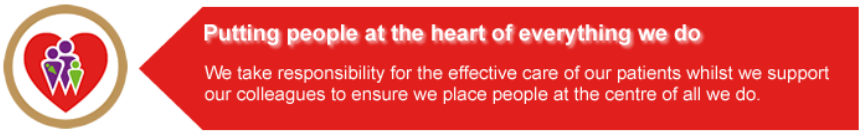
***Organisational Values:*** *"The leaders of any NHS organisation have a duty to set the appropriate tone and promote the right culture, and ensure that individual members of staff can fulfil their responsibility to deliver high quality and safe services" (Health & Care Standards 2015).*

The HB launched the Hywel Dda organisational values in July 2016 and there are three questions in the staff survey which link to our organisational values statements which are:

- Putting people at the heart of everything we do;
- Working together to be the best we can be; and
- Striving to deliver and develop excellent services.

It is recognised that the primary focus of the staff survey is nurses but the results do provide valuable information to the organisation on staff's opinions on the organisational values to date.

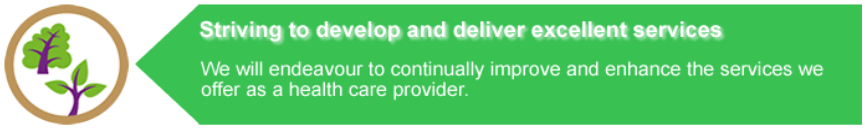
**77% of the staff felt that we always/usually** *put local citizens at the heart of everything we do* **(↑4% on last year's position).** 72% of staff who responded to the NHS Staff Survey (2018) said that the care of patients/service users is their organisation's top priority, compared to 75% in 2016.




| Description/Indicator | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | |
|---|---|---|---|---|---|---|---|
| Put local citizens at the heart of everything we do'. | | 61% | 66% | 79% | 73% | 77% | ↑ |

The comments provide examples when staff feel this is not the case including services being moved away from their locality and the impact on patients around having to travel to access some services. A number of comments made reference to the outcomes of the 'Transforming Clinical Services' consultation into the future of NHS health and care services in Hywel Dda.

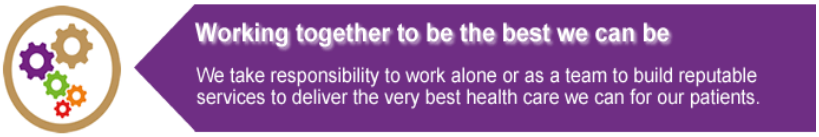
84% of the staff feel that we always/usually ***strive to deliver and develop excellent services*** **(**↑2% on last year's position). 71% of the staff who responded to the NHS Staff Survey (2018) said that if a friend or relative needed treatment, they would be happy with the standard of care provided by the organisation, compared to 67% in 2016.




| Description/Indicator | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | |
|---|---|---|---|---|---|---|---|
| Strive to deliver and develop excellent services. | | | | 84% | 82% | 84% | ↑ |

The comments show that staff don't always feel that this is possible in the current climate of staffing deficits, stretched services and low morale.

80% of the staff feel that we ***work together to be the best that we can be*** **(**↑4% on last year's position). 78% of the staff who responded to the NHS Staff Survey (2018) said that team members work well with people in other teams.




| Description/Indicator | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | |
|---|---|---|---|---|---|---|---|
| Work together to be the best that we can be. | | | | **79%** | **76%** | **80%** | ↑ |

Staff gave examples of when teams "*don't work together*" including teams within the hospitals, the hospital and community teams and occasions when "*the health board works independently of the staff on the ground".*

**Learning from the 2018 audit:** the service specific results of this audit will be review within the operational teams' current governance structures and included in each of the services report to ensure that any areas of good practice and areas for improvement are identified and shared. Local action plans will be developed by individual wards/departments/services and will form part of the wider service action plans and these will be monitored by the operational governance forums.

**Looking Forward to 2019:** As part of the review of the 2018 audit and the preparation for the 2019 audit, the audit questions will be reviewed by the national group and feedback from our teams will help to inform the amendments required.

**Conclusion:**

**Patient Experience:** We know that patients are generally satisfied with their overall experience and gave us a rating of 9.3 out of 10 (93%). The majority of the feedback/comment from our patients about our staff is very positive and it is evident that we provide a good standard of care that includes treating people with dignity and respect. However, there are times when we don't get it right and we need to learn from these situations.

There are three aspects of care from a patient's perspective that will require some focused work over the next 12 months. These are:

- Rest & sleep;
- Help and advice on how to prevent damage to their skin; and
- Patients being able to speak Welsh to staff if they need to.

**Operational Questions:** Of the 22 standards included in the audit, the HB achieved 85% or above (green RAG rating) for 19 of the standards with the remaining three achieving amber RAG rating. Where previous data is available, the 2018 results show an increase in compliance for eight standards, a decrease in compliance for nine standards with five showing an unchanged position. Although the decreases in scores are only 1-2% in some cases, we cannot be complacent and we need to ensure that any deterioration, no matter how small, needs to be reviewed and actions taken where required.

Standard 3.1 has seen a significant decrease when compared to last year's position (9%) and required focused work over the next 12 months.

**Staff Survey:** the two questions relating to staff satisfaction have seen an increase in compliance scores this year.

Of the 16 additional questions, there has been an increase in percentage compliance for 15 of the questions, whilst the remaining question has seen a decrease in compliance. Five of the 16 questions show a green RAG rating (one more than last year) and the remaining 11 questions show an amber RAG rating. The themes of the comments are very similar to previous years and there is still further investigation and improvement work required to ensure that we continue to put staff at the forefront of what we do.

**Recommendation:** The board are asked to accept the Health & Care Standards/Fundamentals of Care (2018) audit findings which are presented in this report as an assurance that the care delivered within the

UHB continues to achieve a high level of satisfaction amongst patients, whilst also identifying areas of improvement.

**References**


1. **All Wales Health & Care Monitoring Network Group (2016):** Resources **http://howis.wales.nhs.uk/sites3/page.cfm?orgid=910&pid=69605**

2. **Nursing & Midwifery Council (2015)** Code: professional standards of practice and behaviour for nurses and midwives.

3. **Welsh Assembly Government (WAG) (2003)** Fundamentals of Care. Guidance for Health and Social Care Staff. Improving the quality of fundamental aspects of health and social care for adults

4. **Welsh Government** (2015) Health & Care Standards

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

**CYFARFOD BWRDD PRIFYSGOL IECHYD**
**UNIVERSITY HEALTH BOARD MEETING**

| | |
|---|---|
| **DYDDIAD Y CYFARFOD:**<br>**DATE OF MEETING:** | 30 May 2019 |
| **TEITL YR ADRODDIAD:**<br>**TITLE OF REPORT:** | Committee Update Reports |
| **CYFARWYDDWR ARWEINIOL:**<br>**LEAD DIRECTOR:** | Joanne Wilson, Board Secretary |
| **SWYDDOG ADRODD:**<br>**REPORTING OFFICER:** | Clare Moorcroft, Committee Services Officer |

| **Pwrpas yr Adroddiad** (dewiswch fel yn addas)<br>**Purpose of the Report** (select as appropriate) |
|---|
| Er Sicrwydd/For Assurance |

**ADRODDIAD SCAA**
**SBAR REPORT**

## Sefyllfa / Situation

The purpose of this report is to provide the Board with a level of assurance in respect of recent Board level Committee meetings that have been held since the previous Board report and are not reported separately on the Board agenda, as follows:

- Charitable Funds Committee (CFC) held on 14th March 2019;
- Mental Health Legislation Assurance Committee (MHLAC) held on 21st March 2019.

Additionally, in respect of the In-Committee Board meetings held on 28th March and 11th April 2019.

This report also provides an update to the Board in respect of recent Advisory Group meetings held including the following:

- Partnership Forum held on 1st April 2019;
- Stakeholder Reference Group held on 2nd April 2019;
- Healthcare Professionals Forum held on 9th April 2019.

## Cefndir / Background

The Hywel Dda University Health Board (UHB) Standing Orders, approved in line with Welsh Government guidance, require that a number of Board Committees are established.

In line with this guidance, the following Committees have been established:

- Audit & Risk Assurance Committee
- Charitable Funds Committee
- Quality, Safety and Experience Assurance Committee
- Mental Health Legislation Assurance Committee
- Remuneration and Terms of Service Committee

The Board has established the following additional Committees:

- Business Planning & Performance Assurance Committee
- Primary Care Applications Committee
- University Partnership Board
- Health Strategy Committee

Attached to this report are individual summaries of the key decisions and matters considered by each of the Committees held since the previous Board report, where these are not separately reported to the Board.

Approved minutes from each of the Committees meetings are available on the UHB's website via the link below:

http://www.wales.nhs.uk/sitesplus/862/page/72048

The UHB has approved Standing Orders, in line with Welsh Government guidance, in relation to the establishment of Advisory Groups. In line with this guidance, the following Advisory Groups have been established:

- Stakeholder Reference Group
- Partnership Forum
- Healthcare Professionals Forum

## Asesiad / Assessment

**Matters Requiring Board Level Consideration or Approval:**

The Charitable Funds Committee requested that the following items be raised at Board level:

- Charitable Funds Committee's Terms of Reference for ratification, for the Board's separate consideration as part of agenda item 3.7.1 (Revised Standing Orders, Standing Financial Instructions and Committee Terms of Reference)

There were no matters raised by the Mental Health Legislation Assurance Committee which require Board level consideration or approval.

There were no matters raised by the In-Committee Board which require Board level consideration or approval.

The Stakeholder Reference Group requested that the following items be raised at Board level:

- Issues relating to young carers;
- The Education Programme for Patients programme.

There were no matters raised by the Partnership Forum or Healthcare Professionals Forum which require Board level consideration or approval.

**Key Risks and Issues/Matters of Concern:**

There were no key risks and issues or matters of concern raised by the Charitable Funds Committee or Mental Health Legislation Assurance Committee.

There were no key risks and issues or matters of concern raised by the In-Committee Board.

The Healthcare Professionals Forum raised the following key risks and issues/matters of concern:

- Concern that a Task and Finish Group, set up to look at Children's Services (particularly the Withybush Hospital site), consisted mainly of clinical leads in Paediatrics, OOH and A&E. The role of pharmacy and the pharmacy model with children's services was noted as an important consideration for input to this Group.
- The Forum highlighted, that in any service redesign going forward, all professional groups need to be involved. The importance of focusing on whole system service design and service planning in terms of all professional groups (and all partners and third sector, where required) is emphasised.
- The move to generic chronic condition nurses from, provision available in some counties, of Heart Failure Nurse. Whereas equitable services across the 3 counties was welcomed, the value of 'specific specialism' should not be underestimated in favour of the efficiencies that can be offered by Chronic Condition Nurses trained to deal with a number of conditions.
- Bronglais Hospital's role in the Trauma network – concerns raised should Bronglais Hospital be designated a Local Emergency Hospital only. Consideration needed of Bronglais being recognised as having a different type of role in the Trauma network from other hospitals due to the particular characteristics of this hospital.

There were no key risks and issues or matters of concern raised by the Partnership Forum or Stakeholder Reference Group.

**Argymhelliad / Recommendation**

The Board is asked to:

- Endorse the updates, recognising any matters requiring Board level consideration or approval and the key risks and issues/matters of concern identified, in respect of work undertaken on behalf of the Board at recent Committee meetings;
- Receive the update report in respect of the In-Committee Board meeting;
- Receive the update reports in respect of recent Advisory Group meetings.

| **Amcanion: (rhaid cwblhau)**<br>**Objectives: (must be completed)** | |
|---|---|
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:<br>Datix Risk Register Reference and Score: | Not Applicable |
| Safon(au) Gofal ac Iechyd:<br>Health and Care Standard(s):<br>Hyperlink to NHS Wales Health & Care Standards | Governance, Leadership and Accountability |
| Amcanion Strategol y BIP:<br>UHB Strategic Objectives:<br>Hyperlink to HDdUHB Strategic Objectives | Not Applicable |

| | |
|---|---|
| Amcanion Llesiant BIP:<br>UHB Well-being Objectives:<br>Hyperlink to HDdUHB Well-being Statement | Improve efficiency and quality of services through collaboration with people, communities and partners |

| **Gwybodaeth Ychwanegol:<br>Further Information:** | |
|---|---|
| Ar sail tystiolaeth:<br>Evidence Base: | Standing Orders<br>External Governance Review |
| Rhestr Termau:<br>Glossary of Terms: | Included within the body of the report |
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol:<br>Parties / Committees consulted prior to University Health Board: | Committee and Advisory Group Chairs |

| **Effaith: (rhaid cwblhau)<br>Impact: (must be completed)** | |
|---|---|
| **Ariannol / Gwerth am Arian:<br>Financial / Service:** | Explicit within the individual Update Reports where appropriate. |
| **Ansawdd / Gofal Claf:<br>Quality / Patient Care:** | Explicit within the individual Update Reports where appropriate. |
| **Gweithlu:<br>Workforce:** | Not Applicable |
| **Risg:<br>Risk:** | Not Applicable |
| **Cyfreithiol:<br>Legal:** | The Board has approved Standing Orders in relation to the establishment of Board level Committees. In line with its model Standing Orders, the Health Board has established Board level Committees, the activities of which require reporting to the Board.<br>In line with its model Standing Orders, the Health Board has established a Stakeholder Reference Group, a Healthcare Professionals Forum and a Partnership Forum, the activities of which require reporting to the Board. |
| **Enw Da:<br>Reputational:** | Not Applicable |
| **Gyfrinachedd:<br>Privacy:** | Not Applicable |
| **Cydraddoldeb:<br>Equality:** | Not Applicable |

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| **Enw'r Pwyllgor / Name of Committee** | Charitable Funds Committee |
| **Cadeirydd y Pwyllgor/ Chair of Committee:** | Simon Hancock, Independent Member |
| **Cyfnod Adrodd/ Reporting Period:** | Meeting held on 14th March 2019 |

**Y Penderfyniadau a'r Materion a Ystyriodd y Pwyllgor / Key Decisions and Matters Considered by the Committee:**

- **Review of Charitable Funds Committee Terms of Reference** – A brief discussion was held on the Committee's Terms of Reference and its membership. The Community Health Council's (CHC) attendance at Committee meetings was discussed and it was noted that the CFC is unable to resource attendance at each Committee and Sub-Committee. Ms Sarah Jennings noted that the Committee retains the option of extending the membership at any time. The Committee agreed that an amendment be made to the Terms of Reference in respect of any decisions taken outside of Committee meetings to be as an exception rather than the norm. The Committee approved the Charitable Funds Committee's Terms of Reference for onward ratification by the Board.

- **Outcome of the Self-Assessment of Effectiveness Questionnaire** – The Committee discussed the results of the completed questionnaires received. The main areas that were noted from the questionnaires were:
  - Clinical representation in charitable funds expenditure decision making as an area for future development.
  - Encouraging additional charitable expenditure for next year.
  - Ongoing development of Board members on the role of the corporate trustee and ensuring that charitable funds forms part of the induction process for new members.

- **Chair's Actions & Decisions taken outside of CFC meetings** – There were no actions or decisions taken outside of Charitable Funds Committee meetings.

- **Charitable Funds Committee Draft Annual Report 2018-19** – The Charitable Funds Committee Draft Annual Report for 2018/19 was presented outlining how the Committee has complied with its key responsibilities throughout the year. The report also identified key areas of work undertaken by the Committee to provide assurance that the Committee's terms of reference have been adequately discharged. The report confirmed that the Committee has operated in line with its Terms of Reference in respect of all aspects of the Committee and the Sub-Committee. This includes membership, meetings held, how we report to Board, what has been escalated, what our principal duties are and also the financial controls and that we have worked within our agreed spending objectives and charitable expenditure. It also gave assurance that we have managed risks, investments and reserves. It was agreed that a paragraph be added to the report noting that the Committee is working towards increasing expenditure levels. The draft report was endorsed by the Committee with final amendments to be approved via Chair's Actions following the meeting.

- **Charitable Funds Operations Sub-Committee Update Report** – Members received an update on the work of the Charitable Funds Operations Sub-Committee for the period 21st December 2018 to 14th March 2019. Members were updated on charitable items approved for purchase, items rejected and items pending decision as well as those approved by Chair's Actions. One application for setting up a new charitable fund was approved; a Health Board Wide Colorectal Fund. A brief update was provided on the purchase of mobile electronic devices to support patient centred care and service improvement across the UHB. It was noted that assurance had now been provided on wi-fi access across all of the community sides outside of the main acute wards. Members asked that the report's author was reminded of the importance that no orders were placed without the agreed pre-conditions having been met and assurance provided to the Committee. Future visits for members to see charitable funded items in situ during site visits across the Health Board was discussed and recommended as a future area for planning

- **Charitable Funds Committee Risk Register** – A brief update was provided on a risk identified and originally reported to the Committee in December 2018. The risk is of a decrease in charitable giving to Hywel Dda Health Charities due to a potential lack of trust by members of the public. The Committee reviewed and scrutinised the new risk that has been identified to seek assurance that all relevant controls and mitigating actions are in place. The Committee discussed the implementation of the planned action plan within the stated timescales to reduce the risk further and/or mitigate the impact of the risk.

- **Charitable Funds Committee Internal Audit Report 2018-19** – it was noted that an audit was undertaken of the systems around charitable funds. The main objective of the audit is that Health Board property and potential Health Board property is identified and properly safeguarded, recorded and accounted for and is being used, invested and expended in accordance with the requirement of the donor. Substantial assurance rating had been awarded for the year.

- **Charitable Funds Operations Sub-Committee Annual Report 2018-19** – The Sub-Committee's Annual Report was presented to members, to provide assurance in respect of the work it has undertaken and decisions taken on behalf of the main committee in 2018/19. The report outlined the main achievements which have contributed to furthering the governance of charitable funds across the University Health Board. The Committee noted the content of the report.

- **Integrated Hywel Dda Health Charities Performance Report –** An update report was provided on the charity's financial performance and position as of 31st January 2019. The report also provided an update on the progress made on the Hywel Dda Health Charities work plan. A decrease of 8.8% in charitable donations compared to the same time last year was highlighted in the port however it was noted that this can be attributed to the one appeal fund which is nearing its fundraising target. Legacy donations for the same period have significantly increased.

- **Presentation of Annual Plan for 2019/20** – The Hywel Dda Health Charities Team provided a presentation on the key areas of work for the charity during 2019-20. An overview of the 4 key work areas to be prioritised during 2019/20 was provided and

endorsed by the Committee:

1. Further increase the charity's income levels
2. Increase our charitable expenditure
3. Build and maintain strong and effective relationships with our stakeholders
4. Increase awareness of the charity and its impact

- **Expenditure & Commitments Requiring Approval** – A paper was provided on the charity's estimated expenditure and financial commitments requiring approval for the 2019/20 financial year, to include charity governance and support costs and service agreements. The Committee approved the annual governance and support charge of £305,160 for 2019/20 as well as support costs of Tŷ Bryngwyn of £52,848 for 2019/20.

- **Charitable Funds Committee Work Programme 2019/20** – The Committee was advised of recent changes that had been made to the work programme which was noted by members.

- **Hydrotherapy Pool Development Update –** Following a verbal update at the last meeting in respect of the Health Board's position on the Delta Lakes Development, the UHB have received assurance that the leisure element of the facility was progressing as planned. The finance and fundraising team will therefore resume discussions with the American Legacy Endowment Fund to submit a follow-up proposal on the Hydrotherapy Pool development. The external Llanelli Hydrotherapy Pool charity holds c. £300,000 available for the development and the trustees have indicated that they now wish to wind down as a charity and donate the money to the Health Board to support the development.

**Materion y mae angen Ystyriaeth neu Gymeradwyaeth Lefel y Bwrdd ar eu cyfer /Matters Requiring Board Level Consideration or Approval:**

- The Committee approved the Charitable Funds Committee's Terms of Reference for onward ratification by the Board on 30th May 2019

**Risgiau Allweddol a Materion Pryder /**
**Key Risks and Issues/ Matters of Concern:**

- No risks or issues/matters of concern identified to escalate to the Board.

**Busnes Cynlluniedig y Pwyllgor ar gyfer y Cyfnod Adrodd Nesaf /**
**Planned Committee Business for the Next Reporting Period:**

**Adrodd yn y Dyfodol / Future Reporting:**

In addition to the items scheduled to be reviewed as part of the Committee's work programme, following up progress of the various actions identified at the previous Committee meeting will be undertaken.

**Dyddiad y Cyfarfod Nesaf / Date of Next Meeting:**

19th September 2019

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| **Enw'r Pwyllgor / Name of Committee** | Mental Health Legislation Assurance Committee (MHLAC) |
| **Cadeirydd y Pwyllgor/ Chair of Committee:** | Mr Paul Newman, Interim Vice-Chair |
| **Cyfnod Adrodd/ Reporting Period:** | QTR 3 (1 October – 31 December 18)<br>Meeting date: 21st March 2019 |

**Y Penderfyniadau a'r Materion a Ystyriodd y Pwyllgor / Key Decisions and Matters Considered by the Committee:**

This report summarises the work of the Mental Health Legislation Assurance Committee at its meeting held on the 21st March 2019, with the following highlighted:

- **MHLAC Effectiveness Review 2018-19 Results** – It was noted that there has been an improvement in the timeliness of papers being sent in advance of meetings and that the views of both constituencies, in attendance members and Independent Members are broadly aligned.

- **MH&LD Performance Paper Q3** – the report was presented to the Committee. The new performance dashboard now sits alongside the performance paper so that members are provided with comparison data to make the information provided within the report more meaningful. The Chair suggested that further discussions need to be held to ascertain what information the Committee is provided with to be assured about performance.

- **MH Scrutiny Group Update** – A multidisciplinary Section 136 group has been set up under the Crisis Care Concordat to potentially look at outcomes of Section 136 as a whole to understand frequent attendees, referrals to Community Mental Health Teams and whether individuals are known to primary care. This group will report quarterly to scrutiny group.

  The Committee was informed that a formal evaluation of the Mental Health Triage service will commence, with support from Swansea University, from the end of April 2019.

  The scrutiny group may need to consider developing an annual work plan to coordinate the different work streams and reporting elements of the group going forward.

- **Locked Door Policy** – This has been approved by the MH&LD Written Control Documentation Group and is now out for global consultation, a final version of the policy will be presented at the June 2019 meeting.

- **Annual work plan** – This was circulated to members for comment.

- **Recent HIW Visit** – Cwm Seren Ward has recently had its third HIW unannounced visit within three years, the directorate are awaiting a draft report and action plan. No immediate actions were identified and positive feedback was provided during the visit.

**Materion y mae angen Ystyriaeth neu Gymeradwyaeth Lefel y Bwrdd are u cyfer / Matters Requiring Board Level Consideration or Approval:**

None

**Risgiau Allweddol a Materion Pryder / Key Risks and Issues/ Matters of Concern:**

None

**Busnes Cynlluniedig y Pwyllgor ar gyfer y Cyfnod Adrodd Nesaf / Planned Committee Business for the Next Reporting Period:**

**Adrodd yn y Dyfodol / Future Reporting:**

- Angie Darlington to present a Service User Story from the Recovery Wall section of the West Wales Action for Mental Health website.
- Head of Adult MH Services to determine how best to feedback results of the Datix exercise on the availability of Section 12 Doctors to the Committee.
- Head of Adult MH Services agreed to bring a paper on the Bespoke Repatriation Unit to the June 2019 meeting.
- Angie Darlington and Joe Teape to meet to discuss service user representation on the MH&LD Quality, Safety and Experience Sub-Committee.
- Paul Newman and Joe Teape to discuss which external reports are presented to each Committee/Sub-Committee.
- Paul Newman and Joe Teape to discuss the direction of the Scrutiny Group and direction from the Mental Health Legislation Assurance Committee and to feedback at the next meeting.

**Dyddiad y Cyfarfod Nesaf / Date of Next Meeting:**

24th June 2019

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| **Enw'r Pwyllgor / Name of Committee** | In-Committee Board |
| **Cadeirydd y Pwyllgor/ Chair of Committee:** | Mrs Judith Hardisty |
| **Cyfnod Adrodd/ Reporting Period:** | Meetings held on 28th March and 11th April 2019 |

**Y Penderfyniadau a'r Materion a Ystyriodd y Pwyllgor / Key Decisions and Matters Considered by the Committee:**

Meeting held on 28th March 2019:

- **Brexit – Local Contingency Planning** – an update regarding progress on Brexit planning was presented.
- **Suspensions Report** – the In-Committee Board received the suspensions report.
- **In-Committee Audit & Risk Assurance Committee (ARAC)** – the In-Committee Board received an update report from ARAC.
- **In-Committee Quality, Safety & Experience Assurance Committee (QSEAC)** – the In-Committee Board received an update report from QSEAC.
- **Remuneration & Terms of Service Committee (RTSC)** – the In-Committee Board received an update report from RTSC.
- **Annual Plan 2019/20** – an update on informal Welsh Government feedback was presented.

Meeting held on 11th April 2019:

- **Annual Plan 2019/20** – the In-Committee Board received an update on the Annual Plan and discussed the letter from Welsh Government, setting out the UHB's control total for delivery in 2019-20.
- **Orthodontics** – a verbal update on discussions at Public Board on 28th March 2019 was provided.

**Materion y mae angen Ystyriaeth neu Gymeradwyaeth Lefel y Bwrdd are u cyfer / Matters Requiring Board Level Consideration or Approval:**

None.

**Risgiau Allweddol a Materion Pryder / Key Risks and Issues/ Matters of Concern:**

None.

**Busnes Cynlluniedig y Pwyllgor ar gyfer y Cyfnod Adrodd Nesaf / Planned Committee Business for the Next Reporting Period:**

**Adrodd yn y Dyfodol / Future Reporting:**

To be confirmed.

**Dyddiad y Cyfarfod Nesaf / Date of Next Meeting:**

30th May 2019.

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| **Enw'r Pwyllgor / Name of Committee** | Partnership Forum |
| **Cadeirydd y Pwyllgor/ Chair of Committee:** | Joint Chairs - Lisa Gostling & Ann Taylor Griffiths |
| **Cyfnod Adrodd/ Reporting Period:** | Meeting held on 1st April 2019 |

**Y Penderfyniadau a'r Materion a Ystyriodd y Pwyllgor / Key Decisions and Matters Considered by the Committee:**

Transforming Clinical Services/Health & Care Strategy

Lisa Davies provided an update relating to Transforming Clinical Services (TCS). Members were informed that since Board approval of the Health & Care Strategy in November 2018, significant work has been undertaken to plan for the delivery phase. This has included: scoping a portfolio of programmes and enablers; giving consideration to the necessary governance structure in the context of ongoing work to strengthen regional governance and developing a 'check and challenge' process to underpin the portfolio.

Role and Intentions regarding the Health Board's Counter Fraud Policy

Ben Rees explained that the prime focus of counter fraud work involved the raising of awareness of NHS fraud in order to embed a counter fraud culture within the Health Board. He emphasised the importance of proactive prevention and the deterrence of fraud attempts through risk management principles and the provision of assurance to the Health Board in relation to counter fraud matters.

Mr Rees made reference to the key principles and stated that a significant element of training has been provided by the team to raise awareness and ensure staff know that fraudulent and corrupt activity will not be tolerated. It was explained that it was cheaper to prevent crime and this was a more effective strategy going forward.

Car Park Management Update

Gareth Skye, Transport and Sustainable Travel Manager, provided a further update on the proposed car parking proposals and sought approval of various charging and appeals procedures.

Business Planning and Performance Assurance Committee

Karen Miles provided an update on the Business Planning and Performance Assurance Committee (BPPAC).

Members were informed that Month 11 had been particularly challenging in terms of unscheduled care and it was also reported that four other specialties, Dermatology, Neurology, Ophthalmology and Orthopaedics were also of concern. Mrs Miles reported that the Health Board was working closely with other providers to ensure the target for patients waiting over 36 weeks is achieved and funding of £11.6m had been provided from Welsh Government (WG) to help the Health Board meet this target.

Finance/Turnaround Update

Huw Thomas provided an update with regard to the Health Board's financial position. Mr Thomas reported that performance in Month 11 represented an adverse variance against plan of £0.1m (year to date). An Interim Annual Plan had been was agreed on 29 March 2018 which included a deficit of £62.5m. It was also reported that the Health Board received additional funding of £27m in relation to Zero based review giving a forecast deficit of £35.5m. This required the achievement of £26.7m of savings schemes to be delivered in year, which needed to be re-current in order to sustain an improvement in the underlying financial position. Mr Thomas stated that the end of year projection would not exceed £45.5m position and that the Health Board would deliver against its promise to WG.

Nurse Staffing Levels (Wales) Act 2016

Mandy Rayani provided an update in relation to progress concerning the Nurse Staffing Levels Act.

Pay Award

Steve Morgan updated members in relation to the closure of Band 1 roles and also in terms of the progress made at national level regarding pay progression.

Managing Attendance at Work

Steve Morgan explained some of the expectations regarding the new Managing Attendance at Work Policy. Mr Morgan explained the status of the enhancement to sick pay and the link to lower sickness rates. In addition Mr Morgan encouraged Managers to ensure appropriate release of Trade Union officials in order to assist and participate in the joint training which was also a requirement of the new pay deal.

No Deal Brexit Preparations

Will Oliver provided a brief update in terms of Brexit. He informed members that there is a Brexit Steering Group which meets every two weeks which Sam Hussell and Ros Jervis lead on. Staff can keep up to date with developments via the dedicated Brexit web pages, which are updated regularly: https://bit.ly/2Si2VUw.

There were key workstreams to identify EU workers on ESR and how to help staff apply for settled status. It was noted that staff had until 2021 to apply. Members were encouraged to ensure their staff had their nationalities recorded on ESR.

Staff Restaurant Single Tier Prices

Tim Baines provided an update on the staff restaurant single tier price structure. Mr Baines explained that food costs have increased by 3.3% in the last 12 months which equated to 3p in the £. It was recommended that staff dining room prices are increased by the RPI – 3.3% from 1st April 2019.

Withybush General Hospital Crèche Childcare Services

Tim Baines provided an update on Withybush General Hospital (WGH) childcare services. Mr Baines explained that WGH was the only crèche that was in house and there had been no price increase since 2014. Mr Baines also reported that the facility is heavily subsidised.

It was recommended that the crèche charges are increased to £4.50 per hour for all ages with effect from 1st May 2019 and a formal arrangement of a 20 minute window for late pick up and drop off without charge to fully support our staff. Members approved the increase in WGH crèche childcare charges.

Employment Policy Update

Kim Warlow presented the following policies which were approved by members:

- Overtime Policy
- Personal Relationships at Work Policy
- Allegations against employees of HDd University Health Board of Harm/Abuse involving children or adults (Professional Abuse Policy)

Staff Benefits Update

Kim Warlow provided an update on Staff Benefits.

Locality Partnership Forums

Feedback was received from the Local Partnership Forums for information.

Any other Business

Following the retirement of Wendy Evans, members were informed that Adam Morgan had been elected as Union Vice Chair.

| **Materion y mae angen Ystyriaeth neu Gymeradwyaeth Lefel y Bwrdd are u cyfer / Matters Requiring Board Level Consideration or Approval:** |
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| There were no matters requiring Board level consideration or approval. |
| **Risgiau Allweddol a Materion Pryder / Key Risks and Issues/ Matters of Concern:** |
| None. |
| **Busnes Cynlluniedig y Pwyllgor ar gyfer y Cyfnod Adrodd Nesaf / Planned Committee Business for the Next Reporting Period:** |
| **Adrodd yn y Dyfodol / Future Reporting:** |
| Update on the regular agenda items included above. |
| **Dyddiad y Cyfarfod Nesaf / Date of Next Meeting:** |
| 10th June 2019. |

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| **Enw'r Pwyllgor / Name of Committee** | Stakeholder Reference Group |
| **Cadeirydd y Pwyllgor/ Chair of Committee:** | Hilary Jones |
| **Cyfnod Adrodd/ Reporting Period:** | Meeting held on 2nd April 2019 |

**Y Penderfyniadau a'r Materion a Ystyriodd y Pwyllgor / Key Decisions and Matters Considered by the Committee:**

**Young Carers Services**

Representatives from the West Wales Care Partnership Regional Young Carers Group provided a presentation highlighting their work with young carers across the region.

SRG members were surprised by the numbers of young people providing care. Concerns raised were:

- Safety of a younger carer (4-7 years) cooking and using electrical equipment at home
- Child protection issues
- Caring for family members with substance misuse issues
- Young carers not known to services, including those being home schooled
- Should we be "employing" young people to care?
- Is a child allowed to say they do not want to care?
- Young carers need to be identified early to get the support they require
- Potential difficulties with education, such as homework, and being able to go to university or college

The SRG stated that work undertaken with young carers within the 3 Counties is exceptional. SRG would like to raise to the Board's attention for information purposes the following :

- Services are delivered differently in each county. There needs to be continuity throughout the Hywel Dda area
- There needs to be a team around the family to provide holistic approach and seamless services
- More younger children are being identified as carers
- Lower the age limit to 4 years old. This will enable younger children to access services
- Raising awareness of young carers to professionals
- Services do not have a single referral from GP practices although practices receive awareness training
- District nurses, health visitors and midwifes must be seeing the young carers at home; why are they not referring?
- More work could be done with housing officers

**Education Programme for Patients (EPP Cymru)**

A presentation was provided informing of the range of self management health and wellbeing courses and workshops available to people with chronic conditions in West Wales. All courses are free and provide opportunity to learn new coping skills which can help to improve the quality of daily life. The courses vary from 45 minutes long to

2½ hours for six weeks.

The Education Programme for Patients programme is delivered by 3 team members who are supported by 14 volunteer tutors and 17 staff from various disciplines within the UHB.

SRG members were informed the courses are cost effective, saving £452 per patient each year, reducing the need to access A&E services, hospital admittance, medical costs and supporting patients' participation in their care.

The Education Programme for Patients delivers 11 courses. Only one course, Healthy Footsteps for podiatry services, is part of a patient pathway. The programme assists with routine and none urgent referrals, resulting in reduced waiting times for podiatry appointments.

SRG members were surprised that such a small team delivers an excellent service on limited resources and would like to advise the Board of the following:

- The programmes need to become an integral part of all care pathways
- The courses should be part of social prescribing

**Engagement Update**

The SRG were advised that throughout March 2019 residents within Cross Hands, Penygroes, Amman Valley, Cardigan and Aberaeron were provided with an opportunity to find out about how plans are progressing for future service provision at:

- Cross Hands Health and Wellbeing Centre
- Amman Valley Hospital
- Cardigan Integrated Care Centre
- Aberaeron Integrated Care Centre

This was an opportunity for residents to have their say in shaping future services within their area.

**Transformation Bid**

SRG members were provided with an update on the outcomes of the Transformation Fund application. SRG were informed Welsh Government had approved £12 million out of the original bid of £18 million to support delivery of 3 programmes. For the remaining £6 million, plans are currently being reworked and will be resubmitted to Welsh Government.

The SRG, whilst fully support this initiative, raised the following concerns:

- challenging to implement
- needs excellent project management skills to deliver the programmes
- needs robust monitoring tools for evaluation
- needs sensible investment
- it will only work if partners work together
- services need to be delivered closer to home

**Regional Engagement**

The SRG were provided with a brief update on the Regional Engagement Workshop

held on 6th March 2019 which was facilitated by the Consultation Institute. The workshop brought together public and third sector partners to look at a regional engagement infrastructure including developing an integrated digital platform to support collaborative engagement activity. The digital platform would house databases, analytical tools and engagement tools. Work is ongoing and all partners are committed to delivering this project and leading the way nationally.

**A Healthier Mid and West Wales – Communication**

SRG members were notified that in the coming weeks the UHB will be launching various formats of the document "A Healthier Mid and West Wales". Alternative formats will include:

- Summary document
- Easy Read
- Youth Friendly
- Animation (with BSL translation)
- Audio

**Re- election of Vice Chair SRG**

SRG members were notified that Claire George, Pembrokeshire Town and Community Council representative, has resigned as Vice Chair. Election of new Vice Chair to take place at the next SRG meeting.

**Materion y mae angen Ystyriaeth neu Gymeradwyaeth Lefel y Bwrdd are u cyfer / Matters Requiring Board Level Consideration or Approval:**

- Issues relating to young carers;
- The Education Programme for Patients programme

**Risgiau Allweddol a Materion Pryder / Key Risks and Issues/ Matters of Concern:**

None

**Busnes Cynlluniedig y Pwyllgor ar gyfer y Cyfnod Adrodd Nesaf / Planned Committee Business for the Next Reporting Period:**

**Adrodd yn y Dyfodol / Future Reporting:**

- Transformation Fund
- Patient Experience
- Patient Charter
- Election of Vice Chair

**Dyddiad y Cyfarfod Nesaf / Date of Next Meeting:**

17th July 2019

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| **Enw'r Pwyllgor / Name of Committee** | Health Care Professionals Forum |
| **Cadeirydd y Pwyllgor/ Chair of Committee:** | Dr Kerry Donovan |
| **Cyfnod Adrodd/ Reporting Period:** | 29th March - 30th April 2019<br>Meeting held on 9th April 2019 |

**Y Penderfyniadau a'r Materion a Ystyriodd y Pwyllgor / Key Decisions and Matters Considered by the Committee:**

The Forum held a meeting on 9th April 2019 and discussed two presentations:

a) Fragile Services, Sustainability and Priorities
b) Risk Registers

The following is a summary of the Forum's discussion relating to both of the above.

Specialist services which the Health Board were most concerned about in terms of fragility, were highlighted to the Forum. The Forum was reassured that work is being undertaken to reduce the levels of risk associated with these services. The Forum acknowledged that, for certain of these services, work will be undertaken imminently due to immediate risks and pressures. For others, the work will be undertaken over the next year in terms of sustainability. The fragile specialist services discussed included:

Children's Services – The Forum noted that a Task and Finish group has been set up to look at Children's Services across the Health Board, particularly provision on the Withybush site, where there are issues around Paediatric cover and staffing at night. Whilst the Forum was reassured that this complex piece of work included clinical leaders from Anaesthetics, Paediatrics, A&E and Out of Hours (OOH) services, it highlighted that in any service redesign going forward all professional groups need to be involved as professional groups already have specific models e.g. pharmacy with Attention Deficit Hyperactivity Disorder (ADHD). The Forum noted that engagement and consultation events will be held with the public.

Adult Mental Health – The Forum acknowledged the pressures that were unsustainable and that medical rotas precipitated the need for service change and that this would be a priority for action over the coming year. Medical members queried the impact of resultant pressures on bed occupancy as a result of the transformation. The Forum accepted the explanation that the number of beds will not be reducing but that beds will be used for different functions according to the nature of need.

Heart Disease – The Forum noted the challenges of the length of wait for services. The Forum was pleased to hear that the new triage and treat service offered to Non-ST-Elevation Myocardial Infarction (NSTEMI) patients has reduced the length of hospital stay, prior to transfer to Morriston, and that a business case is being developed to expand certain procedures. Medical members of the Forum informed that a new Consultant Cardiologist had been appointed to Bronglais Hospital and that Computed Tomography (CT) Angio and Pacing services were being developed on the site. The positive outcomes of dedicated Heart Failure Nurses in some parts of the Health Board were stated. The value of specific specialism was discussed in line with the argument

in favour of Chronic Conditions Nurses trained to deal with a number of conditions and the efficiencies of this. The Forum also emphasised the need to consider whole system design in redesign of services and the role of other professions such as pharmacy and Occupational Therapy.

Stroke – The Forum noted the evidence linking better stroke outcomes with designated Hyper Acute Stroke Units (HASU) and that work is being undertaken to take this forward. Challenges with our current structure of services associated with the design of an HASU (including the right rehabilitation therapy model and 24hr access to a stroke physician) were appreciated. The Forum noted sensitivities with this and agreed to invite leaders of this work to a forthcoming Forum meeting.

Trauma – The Forum acknowledged the evidence of better health care outcomes with a dedicated Major Trauma Centre supported by Trauma Units in other Health Boards as part of a clinical network . The Forum acknowledged the reasons why Cardiff had been agreed as the site for South and West Wales. The Forum was reassured that a business case is being put together for a 24 hour Emergency Medical Retrieval Service to cover Mid Wales and Pembrokeshire. The Forum noted that Glangwili is being explored to host the new trauma unit (until the new hospital is built) however voiced some concern that Bronglais may become a Local Emergency Hospital and suggested consideration of a different model which acknowledged characteristics of this particular site in the network. The Forum agreed that further discussion would be welcomed and agreed to invite key people involved in planning to a future Forum meeting.

Dermatology – The Forum was informed that this was a high risk area and that there had been struggles around Consultant recruitment. The Forum appreciated that Hywel Dda UHB and Abertawe Bro Morgannwg University Health Board (ABMUHB) have been working closely to address some of the challenges faced and GPs with a specialist interest in Dermatology have been identified to support the service.

Ophthalmology – The Forum noted the struggles surrounding recruitment of medical staff, in addition to long waiting lists and suggested that dedicated eye theatre time would assist with some of this (staffing dependent). The Forum noted that joint Health Board posts were also being explored.

Neurology – Given the historic gaps in provision, the Forum was pleased to hear that this service is being developed as part of the A Regional Collaboration for Health (ARCH) project and a community focused model is being presented.

Histopathology – The Forum noted that due to ongoing issues with the recruitment of medical staff in this area, a hub and spoke model is being developed. Equal access to laboratory reporting and Multi-Disciplinary Team (MDT) representation was identified as a requirement in the long term model.

Out of Hours (OOH) – The Forum acknowledged the challenges and ongoing issues in this area, across the Health Board, which attracts regular media attention.

**Materion y mae angen Ystyriaeth neu Gymeradwyaeth Lefel y Bwrdd are u cyfer / Matters Requiring Board Level Consideration or Approval:**

None

**Risgiau Allweddol a Materion Pryder /**
**Key Risks and Issues/ Matters of Concern:**

- Concern that a Task and Finish group, set up to look at Children's Services (particularly the Withybush site), consisted mainly of clinical leads in paediatrics, OOH and A&E. The role of pharmacy and the pharmacy model with children's services was noted as an important consideration for input to this group.

- The Forum highlighted, that in any service redesign going forward, all professional groups need to be involved. The importance of focussing on whole system service design and service planning in terms of all professional groups (and all partners and third sector, where required) is emphasised.

- The move to generic chronic condition nurses from, provision available in some counties, of Heart Failure Nurse. Whereas equitable services across the 3 counties was welcomed, the value of 'specific specialism' should not be underestimated in favour of the efficiencies that can be offered by Chronic Conditions Nurses trained to deal with a number of conditions.

- Bronglais Hospital's role in the Trauma network – concerns raised should Bronglais Hospital be designated a Local Emergency Hospital only. Consideration needed of Bronglais being recognised as having a different type of role in the Trauma network from other hospitals due to the particular characteristics of this hospital.

**Busnes Cynlluniedig y Pwyllgor ar gyfer y Cyfnod Adrodd Nesaf /**
**Planned Committee Business for the Next Reporting Period:**

**Adrodd yn y Dyfodol / Future Reporting:**

- Trauma Network: update on planning
- Stroke Services

**Dyddiad y Cyfarfod Nesaf / Date of Next Meeting:**

12th June 2019.

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

**CYFARFOD BWRDD PRIFYSGOL IECHYD**
**UNIVERSITY HEALTH BOARD MEETING**

| | |
|---|---|
| **DYDDIAD Y CYFARFOD:**<br>**DATE OF MEETING:** | 30 May 2019 |
| **TEITL YR ADRODDIAD:**<br>**TITLE OF REPORT:** | Hywel Dda University Health Board (HDdUHB) Joint Committees and Collaboratives Update Report |
| **CYFARWYDDWR ARWEINIOL:**<br>**LEAD DIRECTOR:** | Steve Moore, Chief Executive |
| **SWYDDOG ADRODD:**<br>**REPORTING OFFICER:** | Rosie Frewin, Partnership Governance Officer |

| **Pwrpas yr Adroddiad** (dewiswch fel yn addas)<br>**Purpose of the Report** (select as appropriate) |
|---|
| Er Gwybodaeth/For Information |

**ADRODDIAD SCAA**
**SBAR REPORT**

## Sefyllfa / Situation

The purpose of this report is to provide an update to the Board in respect of recent Joint Committee and Collaborative meetings to include the following:

- Welsh Health Specialised Services Committee (WHSSC)
- Emergency Ambulance Services Committee (EASC)
- NHS Wales Shared Services Partnership (NWSSP) Committee
- NHS Wales Collaborative Leadership Forum (CLF)
- Joint Regional Planning & Delivery Committee (JRPDC)

## Cefndir / Background

The Hywel Dda University Health Board (HDdUHB) has approved Standing Orders in line with Welsh Government guidance, in relation to the establishment of the Welsh Health Specialised Services Committee (WHSSC), Emergency Ambulance Services Committee (EASC) and NHS Wales Shared Services Partnership (NWSSP) Committee. In line with its Standing Orders, these have been established as Joint Committees of HDdUHB, the activities of which require reporting to the Board.

The confirmed and unconfirmed minutes, agendas and additional reports from WHSSC, EASC and NWSSP Committee meetings are available from each Committee's websites via the following links:
Welsh Health Specialised Services Committee Website
Emergency Ambulance Services Committee Website
NHS Wales Shared Services Partnership Website

The Mid Wales Healthcare Collaborative was established in March 2015 following a study of healthcare in Mid Wales commissioned by Welsh Government and undertaken by the Welsh Institute for Health and Social Care (WIHSC) (*ref: Mid Wales Healthcare Study, Report for Welsh Government, WIHSC – University of South Wales, September 2014*). In March 2018, the Mid Wales Healthcare Collaborative transitioned to the Mid Wales Joint Committee for Health and Social Care whose role will have a strengthened approach to planning and delivery

of health and care services across Mid Wales and will support organisations in embedding collaborative working within their planning and implementation arrangements.

The NHS Wales Collaborative Leadership Forum was constituted in December 2016. As the responsible governance group for the NHS Wales Health Collaborative it has been established to agree areas of service delivery where cross-boundary planning and joint solutions are likely to generate system improvement. The forum also considers the best way to take forward any work directly commissioned by Welsh Government from Health Boards and Trusts as a collective; and provides a vehicle for oversight and assurance back to Welsh Government as required. Assurance is given to individual Boards by providing full scrutiny of proposals.

The Joint Regional Planning & Delivery Committee (JRPDC) has been established as a Joint Committee of Swansea Bay (formally Abertawe Bro Morgannwg) and Hywel Dda University Health Boards and constituted from 24th May 2017. It provides joint leadership for the regional planning, commissioning and delivery of services for Swansea Bay and Hywel Dda University Health Boards.

## Asesiad / Assessment

The following Joint Committee minutes are attached for the Board's consideration:

**Welsh Health Specialised Services Committee (WHSSC)**

- Summary of key matters considered by WHSSC and any related decisions made at its meeting held on 26th March 2019

**Emergency Ambulance Services Committee (EASC)** –

- Confirmed minutes of the meeting held on 13th November 2018
- Summary of key matters considered by EASC and any related decisions made at its meeting held on 5th February 2019

**NHS Wales Shared Services Partnership (NWSSP) Committee**

- Confirmed minutes of the meeting held on 14th March 2019.

**NHS Wales Collaborative Leadership Forum (CLF)** –

- Confirmed minutes of the meeting held on 6th December 2018

**Joint Regional Planning and Delivery Committee (JRPDC)**

- Update Report following the meeting held 10th April 2019

**Mid Wales Joint Committee for Health and Social Care (MWJC)** – No meeting has taken place within this period.

## Argymhelliad / Recommendation

The Board is asked to receive for information the minutes and updates in respect of recent WHSSC, EASC, NWSSP, CLF and JRPDC meetings.

| **Amcanion: (rhaid cwblhau)<br>Objectives: (must be completed)** | |
|---|---|
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:<br>Datix Risk Register Reference and Score: | Not Applicable |
| Safon(au) Gofal ac Iechyd:<br>Health and Care Standard(s):<br>Hyperlink to NHS Wales Health & Care Standards | Governance, Leadership and Accountability |
| Amcanion Strategol y BIP:<br>UHB Strategic Objectives:<br>Hyperlink to HDdUHB Strategic Objectives | Not Applicable |
| Amcanion Llesiant BIP:<br>UHB Well-being Objectives:<br>Hyperlink to HDdUHB Well-being Statement | Not Applicable |

| **Gwybodaeth Ychwanegol:<br>Further Information:** | |
|---|---|
| Ar sail tystiolaeth:<br>Evidence Base: | Link to WHSSC Website<br>Link to EASC Website<br>Link to NWSSP Website<br>Link to MWJC Website |
| Rhestr Termau:<br>Glossary of Terms: | Included within the body of the report |
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol:<br>Parties / Committees consulted prior to University Health Board: | Welsh Health Specialised Services Committee<br>Emergency Ambulance Services Committee<br>NHS Wales Shared Services Partnership Committee<br>NHS Wales Collaborative Leadership Forum<br>Mid Wales Joint Committee for Health and Social Care Joint Regional Planning and Delivery Committee |

| **Effaith: (rhaid cwblhau)<br>Impact: (must be completed)** | |
|---|---|
| **Ariannol / Gwerth am Arian:<br>Financial / Service:** | Explicit within the individual Joint Committee and Collaborative reports where appropriate. |
| **Ansawdd / Gofal Claf:<br>Quality / Patient Care:** | Not Applicable |
| **Gweithlu:<br>Workforce:** | Not Applicable |

| | |
|---|---|
| **Risg:**<br>**Risk:** | The Board has approved Standing Orders in relation to the establishment of WHSSC, EASC and NWSSP Joint Committees, and Terms of Reference for the CLF, MWJC and JRPDC. |
| **Cyfreithiol:**<br>**Legal:** | In line with its Standing Orders, the Health Board has established WHSSC, EASC and NWSSP Joint Committees, the activities of which require reporting to the Board. |
| **Enw Da:**<br>**Reputational:** | Not Applicable |
| **Gyfrinachedd:**<br>**Privacy:** | Not Applicable |
| **Cydraddoldeb:**<br>**Equality:** | Not Applicable |

**WELSH HEALTH SPECIALISED SERVICES COMMITTEE**
**JOINT COMMITTEE MEETING – MARCH 2019**

The Welsh Health Specialised Services Committee held its latest public meeting on 26 March 2019. This briefing sets out the key areas of discussion 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:

http://www.whssc.wales.nhs.uk/2018-19-whssc-joint-committee

## Action log & matters arising

Members noted the action log.

## Chair's Report

The Joint Committee received a written report that covered:

- The appointment of Paul Griffiths and Ian Phillips as Independent Members of the Joint Committee, succeeding Chris Turner and Lyn Meadows;
- The appointment of Dr Kieron Donovan as Interim Chairman of the Welsh Renal Clinical Network, succeeding Prof John Williams;
- The appointment of Dilys Jouvenat and Trish Buchan as Independent Members of the Quality & Patient Safety Committee; and
- The Chair's action taken on 31st January to approve the Integrated Commissioning Plan document for submission to Welsh Government.

The Chair thanked Prof John Williams for the tremendous work that he has done with the Renal Network since its formation.

## Managing Director's Report

The Joint Committee noted the content of the Managing Director's report and in particular updates on the status of development of the Cystic Fibrosis service at CVUHB and the new Gender pathway.

**Rehabilitation – Monitoring Arrangements for Driving Change**
The Joint Committee received a paper that provided an update on how the implementation of monitoring arrangements is driving change in Specialised Rehabilitation services.

Members supported the continued monitoring arrangements within Specialised Rehabilitation services and increased investigation where required.

**Integrated Commissioning Plan 2019-22: work plan**
The Joint Committee received a paper that presented the WHSSC Integrated Commissioning Plan 2019-22 and outlined the schedule for presenting the funded schemes within it for release of funding.

Members were informed of:

- The WHSSC Integrated Commissioning Plan (ICP) 2019-22 and appendices that have been submitted to Welsh Government; and
- The schedule for presenting the schemes included for funding within the ICP to Management Group for funding release.

**Mechanical Thrombectomy – update**
The Joint Committee received a paper setting out the progress made for formally commissioning Mechanical Thrombectomy from April 2019.

Members noted the progress made for formally commissioning Mechanical Thrombectomy from April 2019.

**Other reports**
The Joint Committee received the Integrated Performance Report and the Financial Performance Report. The Joint Committee also noted the update reports from the following joint sub committees and advisory groups:

- Management Group (Briefings);
- Quality & Patient Safety Committee;
- All Wales (WHSSC) Individual Patient Funding Request Panel;
- Welsh Renal Clinical Network; and
- NHS Wales gender Identity partnership Group.

GIG CYMRU NHS WALES

Pwyllgor Gwasanaethau Ambiwlans Brys
Emergency Ambulance Services Committee

# EMERGENCY AMBULANCE SERVICES JOINT COMMITTEE MEETING

## 'CONFIRMED' MINUTES OF THE MEETING HELD ON 13 NOVEMBER 2018 AT THE EASC OFFICES, HEOL BILLINGSLEY, NANTGARW

**PRESENT**

**Members**

| | |
|---|---|
| Chris Turner | Independent Chair |
| Allison Williams (Vice Chair) | Chief Executive, Cwm Taf UHB |
| Stephen Harrhy | Chief Ambulance Services Commissioner |
| Judith Paget | Chief Executive, Aneurin Bevan UHB |
| Gary Doherty | Chief Executive, Betsi Cadwaladr UHB |
| Tracy Myhill | Chief Executive, Abertawe Bro Morgannwg UHB |
| Carol Shillabeer | Chief Executive, Powys Teaching LHB |

**In Attendance:**

| | |
|---|---|
| Jason Killens | Chief Executive, Welsh Ambulance Services NHS Trust |
| Sharon Hopkins | Deputy Chief Executive Cardiff and Vale UHB |
| Karen Miles | Director of Planning and Performance, Hywel Dda UHB |
| Julian Baker | Director, National Collaborative Commissioning Unit |
| Shane Mills | National Collaborative Commissioning Unit |
| Ross Whitehead | Assistant Chief Ambulance Services Commissioner |
| Ami Jones | Intensivist, Emergency Medical Retrieval and Transfer Service (EMRTS) |
| Matthew Edwards | EMRTS |
| Gwenan Roberts | Interim Board Secretary, Host Body |

| Part 1. PRELIMINARY MATTERS | | ACTION |
|---|---|---|
| EASC 18/96 | **WELCOME AND INTRODUCTIONS**<br><br>Chris Turner welcomed Members to the meeting of the Emergency Ambulance Services Committee and those present introduced themselves. | |

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| EASC 18/97 | **APOLOGIES FOR ABSENCE**<br><br>Apologies for absence were received from Len Richards, Robert Williams, Steve Moore and Tracey Cooper. | |
| EASC 18/98 | **DECLARATIONS OF INTERESTS**<br><br>There were no additional interests to those already declared. | |
| EASC 18/99 | **MINUTES OF THE MEETING HELD ON 13 NOVEMBER 2018**<br><br>The minutes were confirmed as an accurate record of the meeting held on 13 November 2018. | |
| EASC18/100 | **ACTION LOG**<br><br>Members **received** the action log and **NOTED** that progress with some of the related matters.<br><br>**EASC 18/58:** Allison Williams explained that the Chief Executives would discuss their nomination for the Vice Chair position at their next meeting and provide as soon as possible to the Chair.<br><br>**EASC 18/79:** It was **agreed** that any further comments on the Amber Review would be received by the Chief Ambulance Services Commissioner by 20 November 2018.<br><br>Members **noted** that Stuart Davies would discuss the financial consequences with the Directors of Finance regarding the strategic commissioning intentions **(Added to the Action Log)**.<br><br>The Committee **RESOLVED** to:<br>• **NOTE** the action log. | Allison Williams<br><br>All<br><br>Stuart Davies |
| EASC18/101 | **MATTERS ARISING**<br><br>There were no additional matters arising that had not been contained within the Action Log. | |
| EASC18/102 | **CHAIR'S REPORT**<br><br>Members warmly welcomed the Chair to his first meeting of the Committee. | |

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| EASC18/103 | **CHIEF AMBULANCE SERVICES COMMISSIONER'S REPORT**<br><br>Stephen Harrhy presented a verbal report on one key area of concern which was the continued poor attendance at the EASC Sub groups – this would need to be addressed otherwise the EASC would increasingly need to deal with more operational rather than strategic matters. A review of the sub groups had been planned for the new year and the options would need to be discussed including potentially consolidating activities.<br><br>Members **RESOLVED** to:<br>• **NOTE** the update and ensure appropriate representation at sub group meetings. | All |
| EASC18/104 | **PROVIDER ISSUES BY EXCEPTION**<br><br>Jason Killens raised issues around activity. Members **NOTED** that:<br>• Red activity had increased by 12% from last year although the performance had reduced<br>• Amber activity had increased by 5.9% and in the last 4 weeks there had been a steep increase in activity<br>• Less conveyance to A&E<br>Jason Killens agreed to provide the data collected to Stephen Harrhy.<br><br>Discussion took place on the use of community paramedics and the need to include this initiative in the IMTP; discussion had taken place in the Planning, Delivery and Evaluation Group to debate on the models across Wales. The difference between the community paramedic and the advanced paramedic was also discussed. It was **NOTED** that further work was progressing with a chief pharmacist and the development of patient group directions (PGDs). Members suggested that this could be a discussion paper in a development session in the future although it was recognised that this was an urgent matter.<br><br>Members **RESOLVED** to **NOTE** the update. | Jason Killens |
| EASC18/105 | **AMBULANCE QUALITY INDICATORS (AQIs)**<br><br>Ross Whitehead, Deputy Ambulance Services | |

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| | Commissioner presented the quarterly AQI report.<br><br>Members **NOTED**:<br>• A major difference to the AQIs presented included that information was available by health board area<br>• The user friendly approach (part of Stats Wales) which would allow for trend information<br>• Analysis would show how variation was being dealt with by different areas<br>• The CASC met with the executive team from WAST on a monthly basis to challenge the variation and progress with changes planned<br>• A different approach in line with the work of the Amber review including patients not conveyed and this as work in progress.<br>Members agreed that having additional information and using the learning from the Amber Review was helpful. It was **NOTED** that the Integrated performance report would also support the work.<br><br>Members **RESOLVED** to **NOTE** the last latest version of the ambulance quality indicators. | |
| EASC18/106 | **PUBLICATION OF THE AMBER REVIEW AND DELIVERY OF THE RECOMMENDATIONS**<br><br>The report was presented by Stephen Harrhy and a full discussion was held by Members on the AMBER Review and it was **NOTED** that a lively debate had been held in the Senedd with interest from the press. The Members were asked to **RATIFY** the Chair's Action to publish the Review in line with the agreed expectations.<br><br>The following issues were discussed and **NOTED**:<br>• An action plan would be developed<br>• The team would meet with the Stroke Association as part of the engagement with patient groups and develop an appropriate model of care<br>• Programme of engagement would be developed to co-create and fully describe the model<br>• How winter funding would be prioritised<br>• Ongoing discussions with the Welsh Ambulance Services NHS Trust (WAST)<br>• Work continued to capture the detail by health board site in terms of lost hours<br>• that clarity would be provided on reasonable expectations for patients | |

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| | • lifting cushions (aids) were being provided to ambulance crews and care homes to safely lift patients following falls<br>• the ongoing pilot involving having mental health nurses in the 999 control room<br>• demand and capacity plans were being developed with the WAST<br>• the Cabinet Secretary was keen to start and action the recommendations at pace.<br><br>Stephen Harrhy explained that further detail was available to support the recommendations which would be shared; key matters would need to be linked back to the Integrated Medium Term Plans to inform the process. Members felt that the data was helpful particularly by site and the team would be meeting with health boards to discuss ways to progress areas of work.<br>This would include handover delays and the work to develop and implement the winter plan. Members discussed the importance of the link to the IMTP and to reflect in the commissioning intentions. Members felt that the opportunities presented by the data within the report would allow for more bespoke work with health boards in the future.<br><br>In view of the number of recommendations Members felt it would be helpful to highlight a small number of key areas to deliver ensuring a whole systems approach and also to track progress.<br><br>Stephen Harrhy explained that a tailored report would be provided for all health boards which would be of interest to Board Committees dealing with performance matters as the information would provide locality based information.<br><br>The Team were thanked for their work to date to deliver the report.<br><br>Members **RESOLVED** to:<br><br>• **NOTE** the ongoing actions related to the Amber Review<br>• **RATIFY** Chair's action to publish the Amber Review report. | Ross Whitehead/ Shane Mills<br><br>Stephen Harrhy |
| EASC18/107 | **EMERGENCY MEDICAL RETRIEVAL AND TRANSFER SERVICE (EMRTS) SERVICE** | |

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| | **EXPANSION REVIEW**<br><br>Stephen Harrhy presented the EMRTS service expansion review report and Members were requested to discuss and **ENDORSE** the preferred option.<br>The Service Expansion Review had been prepared following discussions at recent committee meetings, recommendations made in the Welsh Government (WG) Gateway Review (May 2017) and in response to correspondence from the Chief Executive, NHS Wales (dated 14 June 2018).<br><br>The service had worked with the EMRTS Delivery Assurance Group (DAG) to explore the options and opportunities to extend the service and to prepare a business case for consideration by EASC to provide advice to the Cabinet Secretary. Members **NOTED** as a key partner, there has been engagement with the Wales Air Ambulance Charity throughout this work.<br><br>The Chair welcomed Ami Jones & Matt Edwards to give a short presentation on the propose service expansion for EMRTS. Members **NOTED** the overview of the services provided and the aims for the current service. The rationale for expansion was discussed including the unmet need and highlighted areas where a difference could be made for patients.<br><br>Members **NOTED** the ongoing work with Swansea University in terms of quality measures, population health and undertaking complex analysis for survival rates. Questions raised included the pattern change for maternity, neonatal and children's services and the potential impact. The potential of phasing was discussed and learning lessons at each phase of development.<br><br>Members felt that the presentation had been helpful to clarify some key operational and medical issues. Members felt it was important to move forward in partnership with the Air Ambulance Charity and need to provide the strategic context, mindful of the desire to increase the service across Wales. The aspects of retrieval were key although the actual process would need to be clarified.<br><br>Following discussion Members felt that expansion should also include work on major trauma and its impact. A detailed business case would be required to | Ami Jones / Matthew Edwards |

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|---|---|---|
| | ensure all options were fully considered to move ahead. The options for funding were considered and further discussion would need to take place with the Welsh Government officials.<br><br>Members discussed the option of the phased approach to the full option of services 24 hours a day over a timescale of the next few years and should align to the three year plan. Members felt in principle that it was important to address the unmet need identified. Other options included having a hybrid approach with other ways of working to provide high quality services for patients across Wales including advanced paramedic practitioners.<br><br>Members **RESOLVED** to<br>• **NOTE** the work to date and requested further information to ensure a strategic approach. | |
| EASC18/108 | **FORWARD PLAN OF BUSINESS**<br><br>Members **received** the forward plan of business. | *ALL* |
| EASC18/109 | **RECEIVE AND ENDORSE THE CHAIRS UPDATES FROM THE ESTABLISHED EASC SUB GROUPS**<br><br>Members **RECEIVED** and **ENDORSED** the following updates:<br>• Emergency Medical Retrieval and Transport Service Delivery Assurance Group (EMRTS DAG) Chair's Summary 18 June 2018<br>• Emergency Medical Retrieval and Transport Service Delivery Assurance Group (EMRTS DAG) Action Notes 18 June 2018<br>• Non-Emergency Patient Transport Services (NEPTS) Commissioning and Delivery Assurance Group (CDAG) Action Notes 25 June 2018<br>• NEPTS CDAG Action notes 23 July 2018<br>• NEPTS Chair's Summary 23 April 2018<br>• Joint Management Assurance Group (JMAG) Action Notes 24 April 2018<br>• JMAG Action Notes 21 Sept 2018<br>• Quality & Delivery Framework: Planning, Development & Evaluation Group (PDEG) Action Notes 26 June 2018 EASC 17 Oct 2018<br>• PDEG Chair's Summary 29 Aug 2018<br><br>Members **NOTED** that good representation was taking place at the NEPTS DAG but Members were struggling | All |

| | | |
|---|---|---|
| | to give feedback into organisations. | |
| **ANY OTHER BUSINESS** | | |
| EASC18/110 | **EASC INTEGRATED MEDIUM TERM PLAN (IMTP)**<br><br>Julian Baker outlined the requirements of the planning framework and sign off by the end of January.<br><br>A letter had been sent to the Directors of Planning and shared with the Welsh Ambulance Services NHS Trust (WAST) and finance colleagues and shared the process regarding commissioning.<br><br>Members **AGREED** that when finalised the Chair would sign the IMTP for submission and this action would be ratified at the meeting on 5 February.<br><br>Members **RESOLVED** to:<br>• **NOTE** the timescale for the EASC IMTP. | Chris Turner |
| **DATE AND TIME OF NEXT MEETING** | | |
| EASC18/111 | A meeting of the Joint Committee would be held at 13:30hrs, on Tuesday 5 February 2018 at the Bowel Screening Wales, Training Room 1, Unit 6, Greenmeadow, Llantrisant, CF72 8XT. | Committee Secretary |

Signed .....
**Christopher Turner (Chair)**

Date .....

| | |
|---|---|
| **Reporting Committee** | **Emergency Ambulance Services Committee** |
| **Chaired by** | Chris Turner |
| **Lead Executive Directors** | Health Board / Trust Chief Executives |
| **Author and contact details.** | Gwenan.roberts@wales.nhs.uk |
| **Date of last meeting** | 5 February 2019 |

**Summary of key matters including achievements and progress considered by the Committee and any related decisions made.**

An electronic link to the papers considered by the EAS Joint Committee is provided via the following link: EASC Joint Committee meeting agenda and papers 5 Feb 2019

**CHAIRS REPORT**

Members **NOTED** that the Chair had met with the Director General of the NHS and with the all Wales Chairs of health boards and NHS Trusts.

**CHIEF AMBULANCE SERVICES COMMISSIONERS REPORT**

Stephen Harrhy presented an update on the following areas:

- Mental Health staff and the Clinical Desk - Discussions would take place with the Chief Constable of South Wales Police regarding the effectiveness of the clinical desk and how the initiative would work with other emergency services.
- Attendance at Audit Committee – internal audit report on Non Emergency Patient Transport Services (NEPTS)
- Update on emergency medical retrieval and transport services (EMRTS) – the phasing of the ongoing work was discussed and a briefing report would be developed for the Minister (as requested)
- Cross Border and Regional Activity (WAO Report) - as part of IMTP developments, quarter 3/4 (2018/19) this would be discussed further with Powys Health Board.

**PROVIDER ISSUES**

Jason Killens, CEO of the Welsh Ambulance Services NHS Trust gave an overview of the emerging lessons from the winter plan. Members **NOTED**:

- RED performance was better than last year
- Adverse weather plans worked well – minimal impact
- Good operational performance
- Reduction in handover losses
- Over 20 advanced paramedic practitioners recruited
- Winter schemes were still being implemented with staff for the clinical desk and advanced paramedic practitioners becoming available and having an impact.

**AMBULANCE QUALITY INDICATORS**

Members **NOTED** the most recently published Ambulance Quality Indicators and received an update on progress with related work to improve and strengthen their presentation and usefulness to Health Boards and Members of the public.

Members **NOTED** plans to hold workshops to help develop a comprehensive integrated performance report from the perspective of the health boards with sufficient detail to be useful and also to describe how the WAST service fits into the unscheduled care system. Members **AGREED** to nominate staff to attend in order that all health boards were well represented.

The key performance information when compared with the previous year showed:

- 999 calls reduced
- Conveyances to hospital reduced
- Lost hours reduced

However, the information was not available on a board by board basis and more granularity would be required to develop a comprehensive report for each health board.

**ROLE FUNCTION AND MEMBERSHIP OF SUB GROUPS**

The Chief Ambulance Services Commissioner provided an oral update in relation to the role, function and membership of the sub groups of the Committee.

Members were aware of the difficulties for some the sub groups to maintain consistent membership and representation and it was suggested that the sub groups could be streamlined into two groups.

It was suggested that the following sub groups could combine as an overall management group:

- The Quality & Delivery Framework: Planning, Development & Evaluation Group (PDEG) and
- The Joint Management Assurance Group (JMAG)

The aim would be to progress the work of the Committee and provide the necessary governance arrangements as to where decisions could be made. Combining the two groups would help health board staff to attend and to represent their organisations more consistently.

An update would be received at the meeting in May 2019.

**EASC INTEGRATED MEDIUM TERM PLAN (IMTP)**

The Committee received the Integrated Medium Term Plan for EASC and the report was presented by Stephen Harrhy.

Members **RESOLVED** to:

- **ENDORSE** the EASC element of the IMTP as presented and the Chair's action taken.
- **NOTE** and support the WAST IMTP as received by the Welsh Ambulance Services NHS Trust Board on 29 January 2019 was consistent with the commissioning intentions of the EASC.

**AMBER REVIEW IMPLEMENTATION PROGRAMME**
Members **NOTED** that work was underway and a small task and finish group had been set up to ensure momentum and pace. Each recommendation had been identified alongside the assurance mechanism and the Committee would provide oversight for the whole programme.

**EASC GOVERNANCE UPDATE**
Members **NOTED** that Welsh Government officials were working with the Board Secretaries to develop model Standing Orders, this would include for EASC and would be presented to the Committee in due course. Members **AGREED** to provide a nominated deputy for each health board; were aware that the deputies would have delegated voting rights and that all decisions would be subject to a 2/3 majority of voting EASC members present.

Members **received** and **APPROVED** the Risk Register

**RECEIVE AND ENDORSE THE CHAIRS UPDATES FROM THE ESTABLISHED EASC SUB GROUPS**

Members **RECEIVED** and **ENDORSED** the following updates:

- Emergency Medical Retrieval and Transport Service Delivery Assurance Group (EMRTS DAG) 10 Dec 2018
- Quality & Delivery Framework: Planning, Development & Evaluation Group (PDEG) – Chairs summary 15 Jan 2019.

| **Key risks and issues / matters of concern and any mitigating actions** |
|---|
| • The Committee **NOTED** matters considered within the Risk Register. |
| **Matters requiring Board level consideration and / or approval** |
| • |
| **Forward Work Programme** |
| Considered and agreed by the Committee. |

| | | | | |
|---|---|---|---|---|
| Committee minutes submitted | Yes | √ | No | |
| **Date of next meeting** | **26 March 2019** | | | |

# MINUTES OF THE SHARED SERVICES PARTNERSHIP COMMITTEE (SSPC) PART A

## THURSDAY 14TH MARCH 2019

## 10:00 – 13:00

## NWSSP HQ, BOARDROOM

**Present:**

| Attendance | Designation | Health Board / Trust |
|---|---|---|
| Margaret Foster (MF) | Chair | NWSSP |
| Neil Frow (NF) | Managing Director | NWSSP |
| Huw Thomas (HT) | Director of Finance | HddaUHB |
| Bob Chadwick (BC) | Director of Finance | Cardiff & Vale UHB |
| Andy Butler (AB) | Director of Finance & Corporate Services | NWSSP |
| Phil Bushby (PB) | Director of People & OD | PHW |
| Eifion Williams (EW) | Director of Finance | PTHB |
| Geraint Evans (GE) | Director of Workforce & OD | ABUHB |
| Gareth Hardacre (GH) | Director of Workforce & OD | NWSSP |
| Chris Turley (CT) | Interim Director of Finance | WAST |
| Steve Elliott (SE) | Deputy Director of Finance | Welsh Government |
| Stephen Harrhy (SHa) | Chief Ambulance Service Commissioner / CTUHB Director | CTUHB |
| Steve Ham (SH) | Chief Executive | Velindre |
| **Other Attendees** | | |
| Martyn Pennell (MP) | Head of Finance | HEIW |
| Denise Roberts (DR) | Financial Accountant (VC) | BCUHB |
| Martin Riley (MR) | Head of Finance (item 4.1 only) | NWSSP |
| Mark Harris (MH) | Legal & Risk Services (item 4.1 only) | NWSSP |
| Peter Stephenson (PS) | Head of Finance & Business Improvement | NWSSP |

| **1. PRELIMINARY MATTERS** | | |
|---|---|---|
| **WELCOME AND INTRODUCTIONS** | | |
| **No.** | **Minute** | **Action** |
| **1.1** | The Chair welcomed everyone to the March 2019 Shared Services Partnership Committee (SSPC) meeting. | |
| **APOLOGIES FOR ABSENCE** | | |

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| **1.2** | Apologies of absence were **received** from the following:<br>Hazel Robinson – ABMU<br>Steve Ham – Velindre University NHS Trust (present for item 1.4 only)<br>Sue Hill – BCU<br>Danielle Neale – HEIW<br>Joanna Davies – Cwm Taf | |
| **DECLARATIONS OF INTEREST** | | |
| **1.3** | There were no additional declarations of interest to those already declared. | |
| **LAUNDRY UPDATE – NEIL FROW** | | |

1.4 – NF presented the paper on the Laundry Project.

The November SSPC meeting had endorsed the OBC, which included a reduction of operational laundry sites to three, with further work needed on management arrangements. These were discussed at a workshop held on 30 January, and the output from the workshop was included with the papers for members to discuss. NF outlined three options for the hosting arrangements as follows:

- **Model A** – Single provider for governance and management;
- **Model B** – Central governance and Health Board delivery; and
- **Model C** – Health Board hosted providers.

The attendees at the workshop voted for Model A, but did not determine who was to provide the service (i.e. NWSSP or a Health Board). NF stated that the Committee needed to endorse the overarching delivery model and then decide who was best placed to provide the service. He confirmed that following the last Committee meeting the OBC had been submitted to Welsh Government, but they confirmed that they would not consider the case further until SSPC confirm the management arrangements and therefore it is important that this is resolved as soon as possible.

MF therefore asked whether there were any objections to Model A – DR confirmed on behalf of BCU having discussed it with the CEO that they were not in agreement with the sole provider model, and that they intended to submit their own proposal separately to Welsh Government. All other attendees were supportive of Model A.

In terms of the provider, GE suggested that Health Boards should be asked whether they want to provide the service. HT stated that it should not be assumed that Shared Services would run the laundry without further discussion. MF stated that effectively running a beauty parade for the laundry between Shared Services and a HB(s) contradicts the reasons for establishing a Shared Service. EW stated that if there was a beauty parade of potential candidates for this service, who would make the decision as no one would be independent.

EW stated that there was merit in the laundry service being reviewed, previously investment for laundry services was not a priority, capital investment in this area was very poor, and it should be considered as an all-Wales provision, to ensure that the service is fit for purpose. EW stated that we have a Shared Service Organisation that has proper governance arrangements, with all organisations represented at Committee, and he saw no reason why NWSSP should not be the provider for the service.

BC stated that the business case provides for a £2.1m annual saving, and that the Committee should therefore focus on realising these savings as soon as practically possible. BC stated that NWSSP should be supported in taking forward the management of the service, as it is not a core service for Health Boards.

SHa stated that CT have a laundry service currently, but are not interested in providing services to the rest of Wales. He is supportive of NWSSP providing the service so long as there are appropriate procedures in place to hold it to account.

PB stated that PHW are not a user of the Service, but support it being provided by NWSSP as this is a non-core service that would seem very appropriate for NWSSP to deliver. SH agreed that it would be odd for NWSSP not to deliver this service.

SE stated that from the Welsh Government perspective, they considered that the provision of laundry services was an operational matter for NHS Wales to decide. The SSPC have the authority to make the decision and the expectation would be that NWSSP would be the default provider for a non-core service such as laundry. If however, Welsh Government were needed to make the decision they would, but they would prefer this to be resolved within the SSPC.

EW re-iterated that there are significant potential savings across NHS Wales from this initiative. Any Health Board providing this service to NHS Wales would not be able to be truly independent, in the way that NWSSP can be. EW suggested that the Committee is creating a problem when it should be taking the obvious solution. SH stated that this is why we set up Shared Service (i.e. to operate non-core services on behalf of NHS Wales in a cost-effective way) and it works on behalf of all NHS organisations, so they should be embracing it. MF added that the service would be run the same as other NWSSP services (i.e. on a cost basis with any savings channelled back to NHS organisations).

It was suggested that clarification was needed on whether BCU would want to run a single service for Wales. DR stated that this is not the case but that they are not supporting a single management arrangement either. DR again stated that Welsh Government were apparently happy to receive an OBC from them in respect of laundry services.

GE stated that ABUHB agree to a single provider, but would still wish to ask health boards if they would want to provide the service. GE stated that ABUHB would like to be asked and there is a possibility that they would like to provide this service. NF asked if anyone else in Committee wanted to run the laundry service and if not was there any support for ABUHB to deliver the service. Members confirmed that there was no support for this proposal.

It was highlighted that ABMU were not present at today's meeting but from the workshop it is suggested that they are in support of the single provider.

MF stated that it was disappointing that there was some disagreement in the Committee on the way forward. The Committee are in a difficult position; the decision on laundry services has been delayed too long already and there is a need to move things on. PS reminded the Committee that the recent directive from Welsh Government on the constitution of the Committee allowed for a 2/3 majority in terms of voting on decisions.

MF asked for endorsement of the single provider option. With the exception of BCU, all members endorsed this proposal.

MF then asked for approval of the decision for NWSSP to provide this service. Although not subject to a formal vote, it was clear that there was in excess of a 2/3 majority to support this proposal.

MF confirmed that if individual organisations do not want to go with the decision, they would have to raise this formally. NF will write to all NHS Wales organisations to inform them of the outcome of the meeting.

**The Committee (by a majority):**

1. **Endorsed the single provider model; and**
2. **Approved NWSSP to provide the service.**

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| **UNCONFIRMED MINUTES OF THE MEETING HELD ON 17th JANUARY 2019** | | |
| **1.5** | The unconfirmed minutes of the meeting held on 17th January 2019 were agreed as a true and accurate record of the meeting. | |
| **ACTION LOG** | | |
| **1.6** | Members **NOTED** the updates provided and **ENDORSED** the Action Log.<br><br>All actions were either complete or were on the agenda. | |

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| **MATTERS ARISING** | | |
| **1.7** | No further matters were raised. | |
| **2. SERVICE REVIEW** | | |
| **Deep Dive** | | |
| **2.1** | **Employment Services**<br><br>This item will be carried forward to the next meeting. | |
| **3. CHAIR AND MANAGING DIRECTOR'S REPORT** | | |
| **3.1** | **Chairman's Report**<br><br>MF attended the Health Board and Trust Chairs meeting and spoke to them about the GP Indemnity Project.<br><br>Anne-Louise Ferguson, Director, Legal & Risk Services, received the MBE from Prince Charles last month.<br><br>The Committee **RESOLVED** to:<br><br>**NOTE** the update | |
| **3.2** | **Managing Director's Report**<br><br>NF presented his report.<br><br>AB, GH and NF visited Shared Business Services (SBS) last week, who provide a smaller range of Shared Services to a significant number of NHS bodies in England. SBS is a joint venture with the department of Health in England and an outsourced provider. Following the meeting the expectation would be to have a number of follow up meetings across Employment Services and Procurement to share knowledge, experience and ideas. Robert Prince, from the Royal Free Hospital is visiting NWSSP shortly to share ideas, as he is involved in a Shared Service for NHS organisations in London.<br><br>Prices for the new NHAIS system have been received and are more expensive than anticipated. The Northern Ireland Team are visiting next week to progress this matter. Delays with the decommissioning programme in England are reducing the pressure for an urgent resolution, but this remains a red risk on the NWSSP Corporate Risk Register.<br><br>The TRAMs project continues to make progress and further updates would be provided through to the Committee and the National Executive Board.<br><br>SHa gave thanks to the support of staff from NWSSP for the assistance they have provided to Cwm Taf with the Bridgend transfer.<br><br>The Committee **RESOLVED** to:<br><br>**NOTE** the update | |
| 4**. ITEMS FOR APPROVAL/ENDORSEMENT** | | |
| **4.1** | **GP Indemnity Protocol**<br><br>Martin Riley and Mark Harris introduced this item.<br><br>MR provided some background to the proposal.<br><br>There had been an announcement in England of a state-backed GP Indemnity Scheme, so it was requested by Welsh Government that | |

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| | NWSSP consider a similar scheme for Wales. NWSSP has now been confirmed as the provider of the Scheme in Wales.<br><br>There has been extensive stakeholder communication on the scheme, and particularly with GPC Wales, who are supportive. The protocol that requires approval by the SSPC, was endorsed by the WRP Committee at its meeting on the 13.03.2019.<br><br>Initially, the scheme will only cover future liabilities (i.e. those liabilities arising from incidents occurring after 1 April 2019). It is estimated that the scheme is likely to attract approximately 100 claims annually. There are currently approximately 350 live claims against GPs, and these will continue to be handled by Defence Organisations for the time being. There is a possibility that these might transfer to WRP in future.<br><br>The scheme is optional to GPs, but they are either in it or they are not. It will only cover clinical negligence, but it is expected that most GPs will join, and the benefits of doing so are set out in the paper. The Welsh Government has approved the budget for 2019/20 and it is likely that the constitution of the WRP Committee will have to change.<br><br>MH explained that there are three broad elements of the scheme:<br><br>1. First Contact<br>2. WRP Decision to Accept (or not)<br>3. Reimbursement.<br><br>There was discussion on whether the introduction of the scheme would lead to a reduction in the GMS contracts. SE stated that this was subject to current negotiation.<br><br>The Committee **RESOLVED** to:<br><br>**APPROVE** the Protocol. | |
| **4.2** | **Updated Scheme of Delegation**<br><br>PS introduced the paper. The Committee approved a number of changes to the Scheme of Delegation at its January meeting but two further changes are required to give greater flexibility to the Managing Director and Director of Finance & Corporate Services in signing off internal invoices.<br><br>The Committee **RESOLVED** to:<br><br>**APPROVE** the update | |
| **5. PROJECT UPDATES** | | |
| **5.1** | **PMO Highlight Report**<br><br>AB introduced the PMO Highlight Report.<br><br>There are 20 projects in progress, with four being closed in January.<br><br>There is a new member of staff that has joined the team on an 18-month secondment to specifically cover two projects for the Ystadau Cymru Wales and Welsh Government.<br><br>The majority of the projects are showing as green and on target, however, there are currently five that are highlighted as being at risk including two that remain red, which are relatively small projects, and which have previously been discussed. | |

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| | GE stated that the way the report is presented is very helpful.<br>The Committee **RESOLVED** to:<br>**NOTE** the update | |
| **6. GOVERNANCE, PERFORMANCE AND ASSURANC** | | |
| | **Finance Report**<br>AB introduced the Finance report. He emphasised that NWSSP was on track to exceed its financial targets. He also emphasised that the Risk Pool risk sharing agreement would not be invoked this year<br>It was noted that the majority of KPIs were green, with a few ambers and a red, regarding recruitment. It was noted that work was on going to address this.<br>AB highlighted that an additional capital allocation of £600k had recently been received.<br>The Committee **RESOLVED** to:<br>**NOTE** the update. | |
| **6.1** | **Workforce Report**<br>GH introduced the Workforce report to the Committee.<br>KPIS – GH reported that resource has been strengthened in an attempt to improve the time to hire data.<br>Sickness rates are higher compared to last year, which is consistent with the current picture across NHS Wales. Stress and anxiety is the most common cause of sickness absence.<br>Medical Examiner – The project is progressing with recruitment of a Programme Manager underway. The original deadline for implementation of the 1st April has been extended. There is still a lot to do, but the situation should be easier in Wales than in England where there is a need to engage with Local Authorities.<br>The Committee **RESOLVED** to:<br>**NOTE** the update | |
| **6.2** | **Corporate Risk Register**<br>PS introduced the report regarding the Corporate Risk Register.<br>There are currently two red risks, both of which have already been covered on the agenda:<br>• The demise of the Exeter Software System<br>• Threat of a No Deal Brexit.<br>One new risk has been added to the register, that being the risk relating to the capacity within the Workforce Team.<br>PB enquired as there appears to be a high number of risks for a small organisation. PS stated that while the number was on the high side, five risks are for monitoring only and the 13 for action are subject to constant review.<br>The Committee **RESOLVED** to:<br>**NOTE** the update | |

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| **6.3** | **Audit Committee Highlight Report**<br>PS presented the Audit Committee Highlight Report, covering the meeting held on 22 January.<br>Six internal reports were submitted, all of which provided reasonable assurance. No audit recommendations were outstanding for implementation.<br>The WAO presented their position statement and audit arrangements for 2019 and advised that their report would be available in June or July.<br>Updates were also provided on Counter Fraud and Declarations of Interest.<br>The Committee **RESOLVED** to:<br>**NOTE** the update | |
| **6.4** | **2019/20 Forward Plan**<br>PS presented the forward plan for the SSPC meetings for 2019/20.<br>The earlier submission dates for the IMTP may require a review of Committee dates to allow this to be effectively reviewed and approved.<br>SHa stated that the business case for IP5 and the laundry review should be added to the plan.<br>The Committee **RESOLVED** to:<br>**NOTE** the update | PS |
| **7. ANY OTHER BUSINESS** | | |
| **7.2** | **Date of next meeting**<br>**23rd May 2019** | |

# NHS Wales Collaborative Leadership Forum

## *Approved Minutes of Meeting held on 6 December 2018*

| **Author:** Mark Dickinson | **Version:** 1 (Approved) |
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| **Members present** | Ann Lloyd (Chair), Chair, Aneurin Bevan UHB (AL)<br>Maria Battle, Chair, Cardiff & Vale UHB (MB)<br>Andrew Davies, Chair, Abertawe Bro Morgannwg UHB (AD)<br>Steve Ham, Chief Executive, Velindre NSH Trust (SH)<br>Vivienne Harpwood, Chair, Powys tHB (VH)<br>Glyn Jones, Director of Finance and Procurement, Aneurin Bevan UHB (for Judith Paget) (GJ)<br>Marcus Longley, Chair, Cwm Taf UHB (ML)<br>Pushpinder Mangat, HEIW (for Alex Howells) (PM)<br>Steve Moore, Chief Executive, Hywel Dda UHB (SM)<br>Carol Shillabeer, Chief Executive, Powys tHB (CS)<br>Allison Williams, Chief Executive, Cwm Taf UHB (AW)<br>Tracey Cooper, Chief Executive, Public Health Wales<br>Gary Doherty, Chief Executive, Betsi Cadwaladr UHB<br>Mark Polin, Chair, Betsi Cadwaladr UHB<br>Len Richards, Chief Executive, Cardiff & Vale UHB |
| **In attendance** | Mark Dickinson, NHS Wales Health Collaborative (MD)<br>Rosemary Fletcher, Director, NHS Wales Health Collaborative (RF)<br>Sian Lewis, Managing Director, WHSSC (SL) |
| **Apologies** | Alex Howells, Chief Executive, Health Education & Improvement Wales<br>Chris Jones, Chair, Health Education and Improvement Wales |

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| | Donna Mead, Chair, Velindre NHS Trust<br>Tracy Myhill, Chief Executive, Abertawe Bro Morgannwg UHB<br>Judith Paget, Chief Executive, Aneurin Bevan UHB<br>Bernadine Rees, Chair, Hywel Dda UHB<br>Jan Williams, Chair, Public Health Wales |

| **Welcome and introduction** | **Action** |
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| AL welcomed colleagues to the meeting and noted apologies for absence. | |

| **Minutes of previous meeting** | **Action** |
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| The minutes of the meeting held on 6 September 2018 were **approved** as a correct record. The minutes will be forwarded to board secretaries for noting at health board and trust board meetings. | **MD** |

| **Action log and matters arising** | **Action** |
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| The action log was reviewed. It was noted that three actions (LF/A/054, 086 and 092) had been completed and one action (LF/A/020) was dependent on more information about the future of the NHS Wales executive function.<br><br>Action LF/A/093, relating to flexibility of budgets within the Collaborative, was discussed. RF reported that she had discussed with Andrew Goodall who had been supportive of such flexibility, but that written confirmation was awaited. It was **agreed** that AL would write to Andrew Goodall to confirm the position of the Collaborative Leadership Forum and to request that work required from the Collaborative by WG is appropriately commissioned.<br><br>In relation to matters arising, the following points were noted:<br>• A closure report on the establishment of the Imaging Academy will be taken to the Collaborative Executive Group<br>• The bid to the Industrial Strategy Challenge Fund for digital pathology had been unsuccessful, although the concept is still live and useful feedback had been received. The team are investigating alternative funding sources<br>• Members shared views on the most recent Health and Social Care Leadership Event and it was agreed that it had still been too NHS focused for local government colleagues. It was noted that more could be done to support WG in the design and planning for these | **AL** |

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| events. It was **agreed** that CS would offer support during her forthcoming 1:1 with Andrew Goodall and that AL would do the same in writing on behalf of the group | **CS**<br><br>**AL** |
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| **Major trauma network** | **Action** |
| RF talked the group through the main report and supporting documents. Ongoing work with WHSSC, and particularly the agreement of commissioning arrangements by Joint Committee, was noted. RF reported that the recent meeting with CHCs had been positive, with a rich discussion with chief officers. It was noted that the formal position of CHCs remains that they neither agree or otherwise to the plans for the development of the network. The unsatisfactory nature of this position had been picked up in discussion with WG colleagues. Engagement with CHCs continues at both network and health board levels. It was **agreed** that the Collaborative should adopt a proactive approach to its relationship with CHCs, meeting regularly, rather than only meeting in relation to specific developments.<br><br>Some specific changes to the map of services in the documentation were proposed and **agreed**.<br><br>RF reported that the main limiting factor for the programme was now the availability of central resources. Action in relation to pressing WG for a decision on programme funding was discussed, but subsequently news was received, prior to the end of the meeting, that the Cabinet Secretary had confirmed the funding requested. This was welcomed by the group.<br><br>It was noted that recommendations for trauma unit designation had been agreed through the WHSSC Joint Committee. It was **agreed** that, as this was consistent with the South Wales Programme and in Hywel Dda with the new strategic plan, designation decisions should be reported to January meetings of health boards, rather than being taken to boards for approval. The same report would be provided to CHCs.<br><br>The 'lessons learned' report was considered. This had been produced following a multi agency workshop and amended following prior consideration by the Collaborative Executive Group, to better distinguish the views of particular parties from accepted conclusions. The new version was **agreed** | **RF**<br><br>**RF**<br><br>**CEs**<br><br>**RF** |

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| and will be sent out to participants, including CHCs.<br><br>Two significant recommendations from the report were highlighted:<br>• In future, there is a need to be explicit at an early stage when a decision is based on clinical evidence which elements of the service change can be shaped through engagement and consultation<br>• There is a need for national guidance on collaborative working on cross boundary consultations<br>The latter point was discussed and it was agreed that an ambitious redesign of consultation requirements and processes was required. It was **agreed** that this point would again be stressed to WG, in the context of the extant Green Paper. | **RF** |
| | |
| **LINC** | **Action** |
| RF presented the executive summary of the LINC outline Business Case (OBC). The full OBC will be formally considered by the boards of health boards and trusts in January. The OBC is also being considered by NIMB at its December meeting. It was noted that progress with LINC was reviewed by the Collaborative Executive Group on a monthly basis with Judith Bates, Programme Director.<br><br>It was noted that, subject to board approval, it is hoped to begin procurement in March. TC highlighted that Public Health Wales contributions need to be included appropriately, which was **agreed.**<br><br>The need for preparatory discussions with board members was **agreed**.<br><br>The role of NIMB in NHS Wales decision making was discussed. It was noted that NIMB may be making decisions that should be on the agenda for chief executives.<br><br>It was agreed that a bespoke paper, to accompany the OBC should be developed and taken to each board in January, providing board specific information on the current situation with regard to LIMS and next steps with both LIMS and LINC. It was agreed that the Collaborative will provide a standard core paper for local adaptation.<br><br>It was also **agreed** to take the OBC to WIGB, in relation to information governance and for intellectual property opportunities to be considered. | **RF**<br><br>**All**<br><br>**RF / All**<br><br>**RF** |

| Delivery plans and implementation groups | Action |
|---|---|
| RF introduced the paper, which included a recent response to WG on the future of delivery plans and implementation groups. It was noted that there was considerable uncertainty about the situation post 2019/20. This has the potential to create instability with, for example, staff on fixed term contracts obtaining other posts. The Collaborative currently has many staff, including very senior staff, in fixed term posts or seconded in. It was noted that significant progress can only be made in addressing these issues once there is greater clarity over the proposals for an NHS Wales national executive function. Work by WG on a national clinical plan was also noted as being relevant.<br><br>It was **agreed** that AL will write to Andrew Goodall on behalf of the group to raise the current risks and to request early clarification of plans. | **AL** |

| Collaborative update | Action |
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| RF introduced the Collaborative Update Report and covered the following specific items:<br><br>*Mental Health Network*<br>Progress with the establishment of the network was noted. The post of National Director for Mental Health is currently being banded.<br><br>*Case for Cancer/Single Cancer Pathway*<br>TC updated the group on the development and submission of the 'case for cancer' to WG and on progress with the single cancer pathway. Funding announcements by WG were noted, including £1m for endoscopy and £3m for the SCP, but it was noted that there is not yet full clarity over how these will be directed/used.<br><br>*Endoscopy*<br>The forthcoming national workshop was noted.<br><br>*Women's Health Implementation Group*<br>The establishment of this group and associated work programme was noted. The Collaborative is currently recruiting a programme manager.<br><br>*Collaborative Work Plan – Quarter 2 Report*<br>Progress was noted. | |

| Other Business | Action |
|---|---|
| Members of the group raised the following additional items of business:<br><br>*Health Impact Assessment on Brexit*<br>TC reported that this has been produced by Public Health Wales. It was **agreed** that a confidential draft will be shared with the group. | **TC** |
| *Prevention and early intervention*<br>TC reported that Public Health Wales had produced and submitted to WG in April a 'high level think piece' on prevention and early intervention. This identified a quantum of investment in the order of £20m. Public Health Wales has now been asked by CMO for further advice to inform decision making. TC intended to pull together a group to work on the development of shared priorities as a matter of urgency and it was **agreed** that this will include representatives of chairs and chief executives. The need for this to integrate with IMTPs was noted. Other specific offers of support were provided by group members. | **TC** |
| *Thoracic Surgery*<br>LR raised this issue and referred to dynamics in the Cardiff and Vale board relating to the need to support the major trauma centre. Practical progress in the development of firm plans for how the new service will work is needed and LR will be following up with TM. | **LR** |
| | |
| **Date of next meeting** | |
| It was noted that the next meeting will be held at 10am on 7 March 2019 at the NHS Wales Health Collaborative, River House, Cardiff. | |

**JOINT REGIONAL PLANNING AND DELIVERY COMMITTEE UPDATE**

## 1. INTRODUCTION

The purpose of this report is to provide the Hywel Dda University Health Board with an update on work within the Joint Regional Planning and Delivery Committee (JRPDC) and discussion at the last meeting of that group on 10th April 2019.

## 2. BACKGROUND

The Joint Regional Planning & Delivery Committee (JRPDC) has a key role in driving forward, at pace, a range of projects that have been identified by both Hywel Dda University Health Board (HDdUHB) and Swansea Bay University Health Board (SBUHB) as priorities for joint working on a regional basis; to deliver Ministerial objectives, especially those relating to the NHS Outcomes Framework, as well as alignment to the more strategic 'A Regional Collaboration for Health' (ARCH) Programme Board and that of the Service Transformation Programme.

This paper is an update of the meeting held on 10th April 2019.

Key points to note in this report are:

- The submission of the Pathology Strategic Outline Case (SOC) to Welsh Government;
- The outputs of the Endoscopy workshop held in March 2019;
- The regional Workforce Update; and
- The work being undertaken to develop a Regional Clinical Services Plan.

## 3. ASSESSMENT

### 3.1 Pathology Update

A verbal update was received by the Committee on the submission of the Pathology SOC approved by both Boards, and including Public Health Wales at our public board meetings in March 2019.

The Pathology SOC was submitted to Welsh Government on 29th March and is currently subject to Welsh Government scrutiny. Advance discussions took place with Welsh Government and Pathology Network colleagues in completion of the SOC which it is hoped will be reflected in a positive response to the submission.

Four options have been submitted with a preferred option and indicative timelines to 2020; an interim solution will need to be found to sustain services until such time as the preferred option is in place. The costs associated with four options range from

minimum option at £50m; Intermediate option (preferred) at £77m and maximum option at £93m.

The development is dependent upon road access at Morriston Hospital, and as such, Mr Andrew Davies, Chair of SBUHB, has written to Welsh Government Ministers in recent months regarding the importance of road access to the Morriston Health Campus, and to regional plans.

**3.2 Orthopaedics Update**

The Committee received an update on the modelling work undertaken between the University Health Boards (UHBs) in respect of elective orthopaedic backlog and sustainability for 2019/20.

The paper set out that both UHBs have plans in place to deliver a broadly sustainable orthopaedic position in 2019/20. However this was considered differently in each Health Board given the relative projected delivery points for March 2019.

The projected March 2019 positions were presented for the over 36 week volumes in each UHB. The draft positions were that HDdUHB would achieve its planned zero 36 week position and that SBUHB would have 921 (maximum) patients waiting over 36 weeks which was ahead of its modelled position of 1,048.

Both UHBs are having ongoing discussions with Welsh Government in respect of their Annual Plans for 2019/20 to agree the final delivery plans.

The JRPDC was asked to note the extant modelled demand and capacity position for the region, and the draft March 2019 waiting times position.

It was agreed at the JRPDC meeting that the challenge for SBUHB to reach zero wait would be taken forward as part of Integrated Medium Term Plan (IMTP) planning.

**3.3 Proposal to sustain on a permanent basis the pilot treat and repatriate service for Acute Coronary Syndrome (ACS) transfers**

A report providing an analysis of evaluation data of the Treat and Repatriate service for Acute Coronary Syndrome (ACS) was received. This service has operated as a pilot during 2018/19 and the report outlined the support required to continue on a permanent basis.

Significant progress has been made between January and March 2019, with a total of 82 patients referred via this pilot service and the results have been extremely positive. Success has been such that there is an impetus to continue the service post March 2019, continuing beds in Hywel Dda and ‘Hot Lists’ in Swansea Bay.

These improvements were recognised by the Health Minister in the meeting in March 2019.

Next steps were to develop a costed plan detailing benefits to bring back to the June JRPDC.

**3.4 Endoscopy Update**

A paper was received on the first regional endoscopy workshop held in March 2019. The paper outlined the key work priorities to develop a regional work-programme, and, aligning work which was also underway to prepare a draft scoping document to support the capital and estate redesign of endoscopy services in Prince Phillip Hospital and how this would support planned care services on a regional footprint.

The outputs of the workshop included some key areas for consideration as part of the work programme, as follows:

- To scope demand and capacity models across the region
- To explore and scope skill development and support
- To scope service models at a local and regional level
- To review 'physical' facilities opportunities
- To explore digital opportunities
- To explore rota changes

The agreed next steps were to further develop a proposed work programme to include an agreement on timelines, roles and responsibilities and outputs and this would be presented to the next meeting of the JRPDC in June 2019 following a further workshop in May 2019.

**3.5 DERMATOLOGY UPDATE**

A verbal update on the first regional dermatology meeting was provided.

At the meeting it was discussed that both UHBs experienced great difficulty in recruiting dermatologists, despite a locum being recruited in HDdUHB starting in June and 0.6wte locum starting in SBUHB, this is not permanent or sufficient for the need.

It has been identified that there is a requirement at present to in-source and map capacity and demand regionally and it is hoped that by Quarter 2 of 2019/20 there would be a better picture of what could be provided.

In the medium term the aim is for a development programme for nurses and GPs with Special Interest (GPwSIs). The longer term vision will need to be articulated in 3-5 year strategic plan.

The committee noted the update and it was agreed that a formal update paper would be prepared for the JRPDC in June 2019.

### 3.6 REGIONAL WORKFORCE UPDATE

The paper updated the Committee on the current priorities within the ARCH Workforce Skills and Education (WSE) Programme and highlighted the workforce challenges identified within the regional Pathology Project.

The ARCH WSE Programme, under the executive leadership of Directors for Workforce and Organisational Development (OD) in both UHBs have agreed three areas for focus as follows:

1. An Apprenticeship Career Framework
2. Schools Experience Programme (16-18yrs)
3. Workplace Well-being

Work is on-going to fully scope the projects. The WSE Board will be reinstated in Quarter 1 2019/20, to provide steer and oversight to the projects, and will provide robust reporting through the ARCH Delivery Leadership Group and Programme Board, as per the ARCH governance structure.

A number of issues were reported for the attention of the committee, which include:

1. Consultant level recruitment and retention issues;
2. Workload pressures result in technical staff not being able to focus on their own and others training and development and increased work required to meet ISO 15189 standards e.g. audit etc.;
3. Limited time to be able to focus on new technology e.g. digital;
4. Reliance on small teams often means that over skilled staff are undertaking tasks which could be performed by lower skilled staff.

The Committee noted the priorities and challenges presented and requested that a full update by the Directors of Workforce and OD be received in June 2019.

### 3.7 Developing a Regional Clinical Services Plan (RCSP) for South West Wales

The two UHBs have been developing their Clinical Services Plans, both of which have been approved by their Boards in recent months, and there would a jointly agreed Regional Planning and Delivery section in each of the organisations' Annual Plans, with the key actions and deliverables for 2019/20 also being outlined in both UHBs' Annual Plans

There are a large number of service plans at both a strategic and operational level across both UHBs, however, they have not yet been pulled together into a single regional clinical services plan.

The ARCH Service Transformation Project Initiation Document (PID) provides a strong foundation for development, and could be updated as the basis for a regional clinical services plan to reflect:

- Progress on ARCH
- JRPDC plans
- UHB Clinical Services Plans
- UHB Annual Plans

A regional workshop was held in April 2019 sponsored by the Executive Directors of Planning from both UHBs and the ARCH Programme Management Office, to review both Clinical Services Plans, as well as the NHS Scotland work on a regional clinical services plan for the North of Scotland, as the basis for developing a Regional Clinical Services Plan.

JRPDC members agreed a draft composite regional clinical services plan would be presented to the JRPDC in June 2019.

## 4. RECOMMENDATION

Members are asked to note the update on the JRPDC.

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

**CYFARFOD BWRDD PRIFYSGOL IECHYD**
**UNIVERSITY HEALTH BOARD MEETING**

| | |
|---|---|
| **DYDDIAD Y CYFARFOD:**<br>**DATE OF MEETING:** | 30 May 2019 |
| **TEITL YR ADRODDIAD:**<br>**TITLE OF REPORT:** | Statutory Partnerships Update |
| **CYFARWYDDWR ARWEINIOL:**<br>**LEAD DIRECTOR:** | Sarah Jennings, Director of Partnerships and Corporate Services |
| **SWYDDOG ADRODD:**<br>**REPORTING OFFICER:** | Anna Bird, Head of Strategic Partnerships, Diversity and Inclusion<br>Martyn Palfreman, Head of Regional Collaboration |

| **Pwrpas yr Adroddiad** (dewiswch fel yn addas)<br>**Purpose of the Report** (select as appropriate) |
|---|
| Er Gwybodaeth/For Information |

**ADRODDIAD SCAA**
**SBAR REPORT**

## Sefyllfa / Situation

Hywel Dda University Health Board (HDdUHB) is a statutory member of Public Services Boards (PSBs) in Carmarthenshire, Ceredigion and Pembrokeshire and the West Wales Regional Partnership Board.

The purpose of this report is to provide an update to the Board in respect of the recent work of the three Public Services Boards and Regional Partnership Board.

## Cefndir / Background

PSBs were established under the Well-being of Future Generations (Wales) Act 2015 (the Act) and their purpose is to improve the economic, social, environmental and cultural well-being in its area by strengthening joint working across all public services in Wales.

The effective working of Public Services Boards is subject to overview and scrutiny by the Well-being of Future Generations Commissioner, Wales Audit Office as well as designated local authority overview and scrutiny committees.

Regional Partnership Boards, based on LHB footprints, became a legislative requirement under Part 9 of the Social Services and Wellbeing (Wales) Act 2014 (SSWBWA). Their core remit is to promote and drive the transformation and integration of health and social care within their areas.

## Asesiad / Assessment

**Carmarthenshire Public Services Board (PSB)**
The PSB has not met since the last Board meeting but a link to the Carmarthenshire PSB website is provided below where copies of previous agenda and meeting papers are available to review. The next meeting is scheduled to take place on 20th May 2019 and a verbal update can be provided to Board.
http://www.thecarmarthenshirewewant.wales/meetings/

**Ceredigion Public Services Board (PSB)**
Ceredigion PSB last met on 8th April 2019 at Ceredigion County Council offices in Aberaeron. In addition to updates from the project groups, members were shown an early version of a video presentation of the Ceredigion PSB Annual Report. The PSB is working, in conjunction with students from University of Wales Trinity St David to develop the Annual Report in a video format in order to take a more innovative approach to make the annual update more accessible to the wider population. As well as the main video the intention is that this can be split into "bite size" podcasts for use by the PSB and partners.

The PSB received three formal presentations during the meeting:

- Welsh Government Energy Service; and there was subsequent discussion regarding the Heat Exchange Network opportunities and work which is currently ongoing with the UHB.
- Ceredigion County Council officers shared the work which is ongoing to refresh the Ceredigion Local Development Plan (LDP) and the plans for stakeholder events and discussions. Following the meeting, the UHB has refreshed the stakeholder list to ensure that a wider group of key Executives and officers within the UHB are included in future invitations to participate in stakeholder discussions. It was noted that Ceredigion County Council intend to undertake a health impact assessment on the draft LDP later in the spring.
- Ceredigion County Council officers shared the work which they are undertaking on Signs of Safety and the close working with children's services, in particular, health visiting and Flying Start, as well as our contribution to Integrated Family Support Services, was acknowledged.

A link to the agenda and papers of Ceredigion PSB is provided below:
https://www.ceredigion.gov.uk/your-council/partnerships/ceredigion-public-services-board/public-services-board-meetings/

**Pembrokeshire Public Services Board (PSB)**
The PSB met on 30th April 2019 at the offices of Pembrokeshire Local Action Network for Enterprise and Development (PLANED) in Narberth. Two presentations were made on the day:

- Chris Harrison and Sue Leonard jointly delivered a presentation on behalf of Pembrokeshire Preventions Programme Board (which is part of the Regional Partnership Board governance structure). They summarised some of the work which has been ongoing via Pembrokeshire Intermediate Voluntary Organisations Team (PIVOT) to reduce hospital admissions, and also talked about the Caring Communities Innovation Grant which is administered by Pembrokeshire Association of Voluntary Services (PAVS) and has seen the development of over 40 new initiatives/projects in the county and significant additional matched funding from the investment that community projects receive (which is up to £5k). The work undertaken by the community in Newport to initiate a Well-being Survey was also showcased, and highlighted how community action can drive forward local resilience and well-being. This work has resulted in the development of a local community "handbook" giving a flavour of what's happening in the area and how to get involved.
- The UHB officers gave a presentation on A Healthier Mid & West Wales and the work that the County Director has been leading on the integrated community network discussions. There was positive support for our Strategy and the Dyfed Powys Police representative noted that Withybush is one of the top centres of demand for calls in the Haverfordwest area and would welcome further discussions regarding potential changes to service locations, as this may impact on the need to review their operational bases.

In addition to the presentations the project group leads provided updates. This included a verbal update on the work that Natural Resources Wales are leading and it was noted that the Climate Change Risk Assessment report has identified 6 communities at risk of climate change; this information has been shared with the Local Resilience Forum and will inform further work.

The Department for Work and Pensions representative updated on the recruitment and employment workstream and it was pleasing to see that the UHB's work in relation to work experience opportunities and working with job centres was highlighted.

A link to the agenda and papers of Pembrokeshire PSB is provided below:
https://www.pembrokeshire.gov.uk/public-services-board/psb-agendas-and-minutes

**Collaborative working between PSBs**
A small regional grant has been made available to the PSBs across Carmarthenshire, Ceredigion and Pembrokeshire and a bid for the development of a digital information sharing platform has been developed for which each PSB has confirmed support. This would enable the sharing of high level data to better inform future planning and assessments of local wellbeing. There are clear links between this work and various proposals within the regional Transformation Bid *A Healthier West Wales*, namely (1) implementation of an Involvement Summary Record (ISR) to enable sharing of client information across public agencies (part of programme 2 – *sharing data for a person-centred approach*) and (2) development of a digital engagement tool to facilitate virtual conversations with different communities (part of programme 5a – *continuous citizen engagement).* If these bids are successful, opportunities for a single system performing all functions or, as a minimum, full interoperability between separate systems, will be actively explored.

**Regional Partnership Board update**
The next meeting of the RPB will take place on 16th May 2019 and a verbal update on proceedings and outcomes will be provided to the Board when presenting this item.

To meet requirements of revised regulations relating to Part 9 of the SSWBWA, membership of the RPB will be expanded to include senior representation from Education and Housing, the latter from both local authorities and a registered social landlord operating in the area. This will be invaluable in supporting the engagement of these key services in the health, care and wellbeing agenda. Appointments are being progressed currently.

Over recent months a primary focus for the RPB and wider West Wales Care Partnership (WWCP) has been preparing for delivery of those programmes within the Transformation Bid *A Healthier West Wales* and drafting resubmissions for those programmes included in the original bid but not yet approved by the national panel. Delivery of approved programmes will provide genuinely once in a generation opportunities to transform our combined care and support offer to our population and radically improve outcomes for individuals and communities. The establishment of proactive, technology-enabled care (programme 1), further integration of localities and establishment of crisis response services that deflect people from core services in primary and acute care to support within communities (programme 2) and further expansion of community assets (programme 3) will be key drivers for this transformation and align closely with the priorities set out in the UHB's health and care strategy *A Healthier Mid & West Wales*. Preparatory discussions in relation to each programme involving representatives from health, social care, wider local government and the third sector and are focusing on how the £12m awarded so far can be optimised to deliver the desired change across all parts of the footprint.

Resubmitted bids for the remaining programmes will be considered by the national panel on 7th May 2019 and an update on the current position will be provided when presenting this item. Programmes that have been resubmitted as follows:

- Programme 2 – data sharing for a person-centred approach (£0.91m)
- Programme 4 – Proactive, supported self-management (£0.85m)
- Programme 5a – Continuous citizen engagement (£0.78m)
- Programme 8 – Building the infrastructure to deliver differently (£2.1m)

In addition, a further £1.5m has been requested to supplement the £3.2m already awarded for programme 3 (fast-tracked, consistent integration). This would enable the crisis response service outlined above to be rolled out across all localities in the region. Programme 5b (development of a behaviour change framework and testing it through a programme focused on First 1000 days and ACEs) is being revised with the aim of resubmitting it later this month.If allocated, the additional funding will enable the Partnership to capitalise on the benefits identified within approved programmes.

Effective delivery of *A Healthier West Wales* and the wider objectives of the RPB will be supported by strengthened governance structures which were considered by this Board at its meeting on 28th March 2019. An Integrated Executive Group comprising the UHB's Deputy Chief Executive, Medical Director, Director of Primary Care, Community and Long-Term Care and Director of Partnerships and Corporate Services, alongside the three Directors of Social Services and a Chief Officer from the third sector is in now in place. The Regional Leadership Group comprising the UHB Chair and Chief Executive, local authority Chief Executives and Lead Cabinet Members, will be established in the coming months. Together with robust, integrated programme governance overseeing delivery of the range of programmes across *A Healthier West Wales* and *A Healthier Mid & West Wales* these improvements will ensure clear strategic direction and timely delivery of our shared priorities.

A link to the WWCP website is provided below:
https://www.wwcp.org.uk/

**Joint working between PSBs and the RPB**
A number of meetings have taken place over recent months to strengthen PSB and RPB links at a local level, seek synergy between population well-being actions and care and support actions which are being led via the RPB and agree opportunities to align work streams and reduce duplication; for example in relation to green health and social prescribing, which provides a potential model for delivering shared objectives through a collaborative approach. This work is being taken forward through monthly meetings between PSB Lead Officers, the Head of Regional Collaboration (WWCP) and Head of Strategic Partnerships, Diversity and Inclusion. It has the potential to address within West Wales a number of challenges identified at a recent national event for PSBs and RPBs convened by Welsh Government and looking at opportunities for closer joint working, namely:

- The respective roles and responsibilities of PSBs and RPBs are not always clearly understood – a fact sheet was shared to summarise the two pieces of legislation.
- PSBs have a responsibility for population well-being at a local authority area level; RPBs have a responsibility to drive forward the integration of health and social services across a regional footprint.
- It is intended that PSBs and RPBs will complement each other rather than work in isolation, building on common areas of interest e.g. prevention and early intervention, involvement and co-production.
- PSBs have a key role working across local public services but also need to determine

how best to combine their efforts and work differently. Welsh Government will support PSBs who wish to work more closely together and it was indicated that there may be funding available to support this.

Carmarthenshire PSB will be hosting a regional meeting of PSBs which is scheduled to take place on 7th June 2019. This builds on an inaugural regional event which took place in June 2018, and members of the West Wales RPB together with Powys PSB and Powys RPB have also been invited to attend, reflecting the wider regional working arrangements in mid-Wales. This offers an important opportunity to progress discussions about local arrangements for joint working between PSBs as well as between PSBs and RPBs.

**Argymhelliad / Recommendation**

This report is for information and the Board is asked to:

- Note the progress updates for each PSB and the RPB, and the key areas of discussion highlighted in the report.
- Note the links to the PSB and RPB websites where the agenda, papers and minutes of recent meetings can be accessed.

| **Amcanion: (rhaid cwblhau)**<br>**Objectives: (must be completed)** | |
|---|---|
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:<br>Datix Risk Register Reference and Score: | Not applicable |
| Safon(au) Gofal ac Iechyd:<br>Health and Care Standard(s):<br>Hyperlink to NHS Wales Health & Care Standards | Governance, Leadership and Accountability |
| Amcanion Strategol y BIP:<br>UHB Strategic Objectives:<br>Hyperlink to HDdUHB Strategic Objectives | 4. Improve the productivity and quality of our services using the principles of prudent health care and the opportunities to innovate and work with partners. |
| Amcanion Llesiant BIP:<br>UHB Well-being Objectives:<br>Hyperlink to HDdUHB Well-being Statement | Improve efficiency and quality of services through collaboration with people, communities and partners |

| **Gwybodaeth Ychwanegol:**<br>**Further Information:** | |
|---|---|
| Ar sail tystiolaeth:<br>Evidence Base: | Well-being of Future Generations (Wales) Act 2015<br>Social Services and Well-being (Wales) Act 2014 |
| Rhestr Termau:<br>Glossary of Terms: | Contained within the body of the report. |
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: | Not applicable |

| | |
|---|---|
| Parties / Committees consulted prior to University Health Board: | |

| **Effaith: (rhaid cwblhau)<br>Impact: (must be completed)** | |
|---|---|
| **Ariannol / Gwerth am Arian:<br>Financial / Service:** | HDdUHB staff time to support progression of PSB project and delivery group meetings being established to drive forward implementation of the Well-being Plans.<br>The Regional Partnership Board is working collaboratively to deliver "A Healthier West Wales: Transformation proposal by the West Wales Regional Partnership Board". The proposal totalling £18.2m was submitted in November 2018 and Welsh Government has already approved £12m of the proposal, and work is on-going to re-submit some elements of the bid. |
| **Ansawdd / Gofal Claf:<br>Quality / Patient Care:** | Improving the well-being of the population is at the forefront of the two key pieces of legislation that provide a focus for PSBs and RPBs. "A Healthier West Wales: Transformation proposal by the West Wales Regional Partnership Board" embraces a "through-age" model which will support people in Starting and Developing Well; Living and Working Well; and Growing Older Well. |
| **Gweithlu:<br>Workforce:** | Implementing the five ways of working required under the Well-being of Future Generations (Wales) Act 2015 should lead to increased collaboration and integration between services, professionals and communities. "A Healthier West Wales: Transformation proposal by the West Wales Regional Partnership Board" includes a key programme of work focused on "an asset-based workforce". |
| **Risg:<br>Risk:** | Whilst each PSB Well-being Plan is different, there are consistent themes of activity. There is a risk that whilst addressing local need, there may be some inconsistency in approach between counties for our wider population. We have a duty as PSB members to encourage consistency of approach where appropriate in order to minimise inequity. Resourcing the project and delivery groups of PSBs could be considered an "add on" responsibility by staff and the synergy with achieving HDdUHB's goals need to be understood. |
| **Cyfreithiol:<br>Legal:** | It is a statutory duty for each PSB to produce a Well-being Plan and Area Plan and for the UHB as named statutory partners to work with the PSBs and RPB to support the development and delivery of the actions within the Plan. |
| **Enw Da:<br>Reputational:** | There is a statutory requirement for HDdUHB to contribute to the work of the PSBs and RPB. There is a statutory duty for the UHB to work in partnership with its three partner local authorities to transform health and social care delivery. The RPB Governance arrangements for an essential framework to support |

| | |
|---|---|
| | operational action. |
| **Gyfrinachedd:**<br>**Privacy:** | Not applicable |
| **Cydraddoldeb:**<br>**Equality:** | The focus of equality runs throughout the work of the PSBs aligned to the Well-being goal: A More Equal Wales. This is an update paper therefore no EqIA screening has been undertaken. |

# HYWEL DDA UNIVERSITY HEALTH BOARD – WORK PLAN MARCH 2019 – MARCH 2020

The Board meets in public bi-monthly. The following table sets out the Board's business for 2019/20, including standing agenda items (denoted by *); items denoted by ** are those that are reported to the Board as and when required.

| AGENDA ITEM/ ISSUE | LEAD | OFFICER | 28 Mar 2019 | 29 May 2019 | 30 May 2019 | 25 Jul 2019 | 26 Sep 2019 | 28 Nov 2019 | 30 Jan 2020 | 26 Mar 2020 |
|---|---|---|---|---|---|---|---|---|---|---|
| **GOVERNANCE** | | | | | | | | | | |
| Public Forum Questions* | **Chair** | **JW** | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Patient/Staff Story * | **MR** | **LO'C** | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Apologies* | **Chair** | **CM** | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Declaration of Interests* | **Chair** | **All** | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Minutes from previous meeting* | **Chair** | **CM** | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Matters Arising & Table of Actions* | **Chair** | **CM** | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Report of the Chair*<br>• Chair's Action | **Chair** | **JW** | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Report of the Chief Executive*<br>• Register of Sealings<br>• Consultations Update<br>• Brexit<br>• Apprenticeship Update<br>• Annual Report from Healthcare Inspectorate Wales (HIW) 2017/18<br>• Thoracic Surgery<br>• Major Trauma<br>• Health & Care Strategy | **SM** | **SMJ** | ✓<br>✓<br>✓<br>✓<br>✓ | | ✓<br>✓<br>✓<br>✓<br>✓<br>✓<br>✓ | ✓<br>✓ | ✓ | ✓ | ✓ | ✓ |
| Committee Annual Reports<br>• Audit & Risk Assurance Committee<br>• Business Planning & Performance Assurance | **Chairs** | **Lead Execs JW** | | ✓ | | ✓<br>MHLAC | | | | |

| AGENDA ITEM/ ISSUE | LEAD | OFFICER | 28 Mar 2019 | 29 May 2019 | 30 May 2019 | 25 Jul 2019 | 26 Sep 2019 | 28 Nov 2019 | 30 Jan 2020 | 26 Mar 2020 |
|---|---|---|---|---|---|---|---|---|---|---|
| Committee<br>• Charitable Funds Committee<br>• Finance Committee<br>• Mental Health Legislation Assurance Committee<br>• Primary Care Applications Committee<br>• Quality, Safety & Experience Assurance Committee<br>• University Partnership Board | | | | | | | | | | |
| Governance, Leadership & Accountability Standard | **SM** | **JW** | | ✓ | | | | | | |
| Annual Governance Statement | **SM** | **JW** | | ✓ | | | | | | |
| Accountability Report | **SM** | **JW** | | ✓ | | | | | | |
| Final Accounts for 2018/19 | **HT** | **HT** | | ✓ | | | | | | |
| Letter of Representation | **HT** | **HT** | | ✓ | | | | | | |
| Wales Audit Office ISA 260 | **WAO** | **HT** | | ✓ | | | | | | |
| Approval of Charitable Funds Annual Report & Accounts | **SJ** | **NLI** | | ✓ | | | | | | |
| HDdUHB Annual Quality Statement | **MR** | **SM** | | ✓ | | | | | | |
| HDdUHB Annual Report 2018/19 | **Chair** | **SJ** | | | | ✓ | | | | |
| HDdUHB Annual General Meeting | **Chair** | **JW** | | | | ✓ | | | | |
| CHC Annual Report | **CHC** | | | | | | ✓ | | | |
| Organ Donation Annual Report | **JT** | | | | | | | ✓ | | |
| WAO Annual Audit Report | **WAO** | **JW** | | | | | | | ✓ | |
| WAO Structured Assessment | **WAO** | **JW** | | | | | | | ✓ | |

| AGENDA ITEM/ ISSUE | LEAD | OFFICER | 28 Mar 2019 | 29 May 2019 | 30 May 2019 | 25 Jul 2019 | 26 Sep 2019 | 28 Nov 2019 | 30 Jan 2020 | 26 Mar 2020 |
|---|---|---|---|---|---|---|---|---|---|---|
| Standing Orders/Standing Financial Instructions | **SM** | **JW** | ✓ | | ✓ | ✓ | ✓ | | | |
| Committee Terms of Reference | **SM** | **JW** | ✓<br>ARAC<br>BPPAC<br>QSEAC<br>SRG | | ✓<br>CFC<br>Fin C<br>PCAC<br>HPF | ✓<br>UPB<br>MHLAC<br>RTSC | ✓<br>PF | | | |
| **STRATEGIC ISSUES/FOR DECISION** | | | | | | | | | | |
| Ceredigion Community Equipment Services: Section 33 Agreement | **SJ** | **SMJ** | | | ✓ | | | | | |
| Carmarthenshire Section 33 Agreement | **SJ** | **SMJ** | | | | ✓ | | | | |
| Annual & Financial Plan 2019/20 | **KM** | | ✓ | | | | | | | ✓ |
| Transforming Clinical Services/ Future Health & Care Strategy: A Healthier Mid and West Wales | **PK/RJ** | **PK/RJ** | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Strengthening Regional Partnership Board Governance | **SJ** | | ✓ | | | | | | | |
| Pathology Strategic Outline Case | **KM** | | ✓ | | | | | | | |
| Implementing the Welsh Language Standards | **SJ** | | ✓ | | | | | | | |
| Thoracic Surgery Consultation | **SM** | | | | ✓ | | | | | |
| Pooled Budgets/Funding Arrangements | **JP/SJ** | | | | ✓ | | | | | |
| Major Trauma | **SM/KM** | | | | ✓ | | | | | |
| Retention and Attraction Strategy | **LG** | | | | | ✓ | | | | |
| Sexual Assault Referral Centre (SARC) | **SM** | | | | | ✓ | | | | |
| Performance Management Assurance Framework | **KM** | | | | | ✓ | | | | |
| Strategic Equality Plan Annual Report 2018/19 | **SJ** | **JH** | | | | ✓ | | | | |

| AGENDA ITEM/ ISSUE | LEAD | OFFICER | 28 Mar 2019 | 29 May 2019 | 30 May 2019 | 25 Jul 2019 | 26 Sep 2019 | 28 Nov 2019 | 30 Jan 2020 | 26 Mar 2020 |
|---|---|---|---|---|---|---|---|---|---|---|
| Winter Planning 2019/20 | **JT** | | | | | ✓ | ✓ | ✓ | | |
| Bronglais CDU | **JT** | | | | | ✓ | | | | |
| OOH/MIU PPH | **JT** | | | | | ✓ | | | | |
| HDdUHB Major Incident Plan | **RJ** | **SH** | | | | | ✓ | | | |
| HDdUHB Seasonal Influenza Plan 2019/20 | **RJ** | | | | | | ✓ | | | |
| Well-being Objectives Annual Report 2018/19 | **SJ** | **AB** | | | | | | ✓ | | |
| **QUALITY, SAFETY & PERFORMANCE** | | | | | | | | | | |
| Focus on Hospital & Community Services* | **JT** | **County Director** | ✓ Cere | | ✓ Carms | ✓ Pembs | ✓ Cere | ✓ Carms | ✓ Pembs | ✓ Cere |
| Integrated Performance Assurance Report (to include)*<br>• Performance<br>• Finance<br>• Workforce & OD (including AAC)<br>• Concerns<br>• Six Monthly Individual Patient Funding Request (IPFR) Data<br>• CHC Quarterly Performance | **SM** | **KM** | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Board Assurance Framework | **SM** | **JW** | | | ✓ | | | | ✓ | |
| Corporate Risk Register | **SM** | **JW** | | | ✓ | | | | ✓ | |
| Finance and Turnaround Update | **HT/AC** | | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Dental Plan Progress Update | **JP** | | ✓ | | | ✓ | | | | |
| Update on Nurse Staffing Levels (Wales) Act | **MR** | | | | ✓ | | | ✓ | | |
| Winter Planning 2018/19 – Evaluation | **JT** | | | | ✓ | | | | | |
| Health & Care Standards Fundamentals of Care Audit 2018 | **MR** | **CH** | | | ✓ | | | | | |

| AGENDA ITEM/ ISSUE | LEAD | OFFICER | 28 Mar 2019 | 29 May 2019 | 30 May 2019 | 25 Jul 2019 | 26 Sep 2019 | 28 Nov 2019 | 30 Jan 2020 | 26 Mar 2020 |
|---|---|---|---|---|---|---|---|---|---|---|
| Paediatric Care Task & Finish Group – Progress Update | **JT** | | | | | ✓ | | | | |
| Learning Disability Services | **JT** | | | | | ✓ | | | | |
| Maternity Services | **JT** | | | | | ✓ | | | | |
| Staff Survey | **LG** | | | | | ✓ | | | | |
| Bi-Annual Improving Experience Report | **MR** | **LO'C** | | | | ✓ | | | ✓ | |
| Medical Revalidation and Appraisal Annual Report 2018/19 | **PK** | **HW** | | | | ✓ | | | | |
| HDdUHB Primary Care Annual Report 2018/19 | **JP** | **EL** | | | | ✓ | | | | |
| Quality Improvement Framework | **MR** | | | | | ✓ | | | | |
| HDdUHB Director of Public Health Annual Report | **RJ** | | | | | | ✓ | | | |
| Mid Year Review of Annual Plan | **KM** | **PW** | | | | | ✓ | | | |
| International Health Governance Framework | **RJ** | **RF** | | | | | | ✓ | | |
| Ombudsman Reports** | **MR** | **LO'C** | | | | | | | | |
| **COMMITTEE UPDATE REPORTS** | | | | | | | | | | |
| HDdUHB Board Level Committees Update Report (to include)*<br>• Audit & Risk Assurance Committee<br>• Business, Planning & Performance Assurance Committee<br>• Charitable Funds Committee<br>• Finance Committee<br>• Mental Health Legislation Assurance Committee<br>• Primary Care Applications Committee | **Chairs** | **JW** | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |

| AGENDA ITEM/ ISSUE | LEAD | OFFICER | 28 Mar 2019 | 29 May 2019 | 30 May 2019 | 25 Jul 2019 | 26 Sep 2019 | 28 Nov 2019 | 30 Jan 2020 | 26 Mar 2020 |
|---|---|---|---|---|---|---|---|---|---|---|
| • Quality, Safety & Experience Assurance Committee<br>• University Partnership Board | | | | | | | | | | |
| In-Committee Board Update Report | **Chair** | **JW** | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| HDdUHB Advisory Groups Update Reports (to include)*<br>• Stakeholder Reference Group<br>• Healthcare Professionals Forum<br>• Local Partnership Forum<br>  ○ New Ways of Working | **Chairs** | **JW** | ✓ | | ✓ | ✓<br>✓ | ✓ | ✓ | ✓ | ✓ |
| HDdUHB Joint Committees & Collaboratives Update Report (to include)*<br>• EASC<br>• NWSSP<br>• WHSSC<br>• JRPDC<br>• MWJC<br>• Collaborative Leadership Forum | **Chairs** | **RF** | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Update Report from Public Services Boards | **SJ** | **AB** | ✓ | | | | | | | |
| Statutory Partnerships Update (incl Public Services Boards) | **SJ** | **AB** | | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| **FOR INFORMATION** | | | | | | | | | | |
| Board Annual Workplan | **JW** | **CM** | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Head of Internal Audit Opinion | **JW** | | | ✓ | | | | | | |
| Ombudsman Annual Letter ** | **MR** | **LO'C** | | | | | | | | |

**Initials**

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|---|---|---|
| **AB – Anna Bird** | **JH – Jackie Hooper** | **NLl – Nicola Llewellyn** |
| **AC – Andrew Carruthers** | **JP – Jill Paterson** | **PS – Peter Skitt** |
| **AG – Alison Gittins** | **JPJ – Jenny Pugh-Jones** | **PW – Paul Williams** |
| **AS – Alison Shakeshaft** | **JT – Joe Teape** | **RE – Rob Elliott** |
| **CH – Chris Hayes** | **JW – Joanne Wilson** | **RF – Rosie Frewin** |
| **CHC – Community Health Council** | **KJ – Keith Jones** | **RJ – Ros Jervis** |
| **CM – Clare Moorcroft** | **KM – Karen Miles** | **SH – Sam Hussell** |
| **ED's – Executive Directors** | **LC – Liz Carroll** | **SJ – Sarah Jennings** |
| **EL – Elaine Lorton** | **LO'C – Louise O'Connor** | **SM – Steve Moore** |
| **GM – Gareth Morgan** | **LG – Lisa Gostling** | **SMJ – Sian-Marie James** |
| **HT – Huw Thomas** | **LRD – Libby Ryan-Davies** | **SP – Sian Passey** |
| **HW – Helen Williams** | **MR – Mandy Rayani** | **WAO – Wales Audit Office** |
| **PK – Philip Kloer** | | |